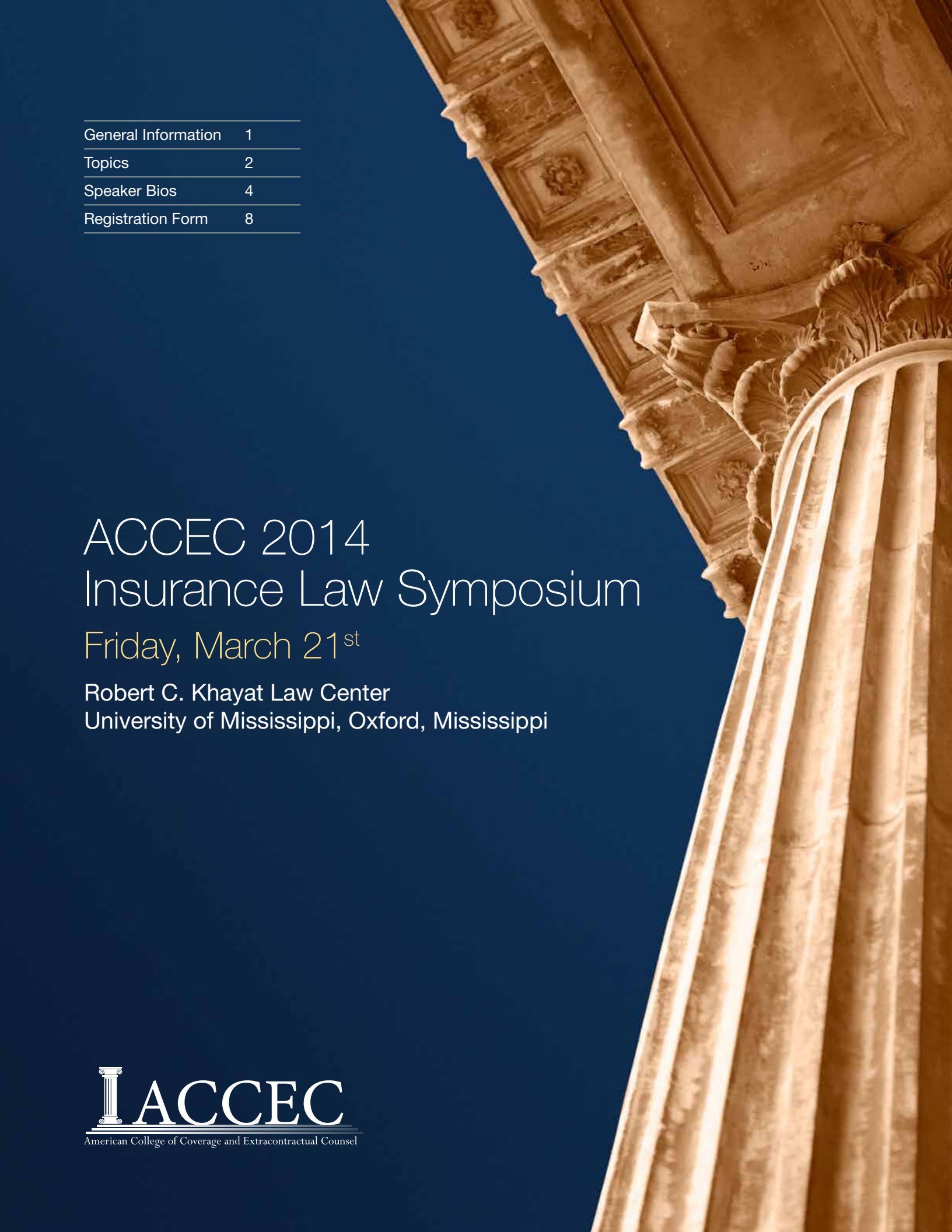

ACCEC 2014 Insurance Law Symposium

Friday, March 21st

Robert C. Khayat Law Center
University of Mississippi, Oxford, Mississippi

ACCEC
American College of Coverage and Extracontractual Counsel

General Information

American College of Coverage and Extracontractual Counsel (ACCEC)

ACCEC brings together pre-eminent lawyers representing the interests of both insurers and policyholders to improve the quality of the practice of insurance law and to increase civility and professionalism in our field. Our mission includes educating all sectors involved in insurance disputes—including judiciary, legal, and insurance professionals and businesses—on critical topics such as best practices in policy formation and claims handling, developing trends in insurance law, and bad faith.

Symposium Location

The ACCEC Law Symposium will be held at the Robert C. Khayat Law Center on the campus of the University of Mississippi.

Date

Friday, March 21st

Schedule

Registration will open at 8:00 am. The symposium will begin at 8:30 am and will end at 5:00 pm.

Continuing Legal Education (CLE)

The States of Tennessee and Mississippi have awarded 6.3 CLEs for the Symposium.

Accommodations

A block of rooms for has been reserved for the weekend at The Inn at Ole Miss. Anyone needing accommodations should call the hotel at 888-486-7666.

Registration

The cost for registration is $100, which covers a luncheon and presentation handouts. Checks should be made out to ACCEC.

Registration Deadline

The registration deadline is Friday, March 14. Space is limited and available on a first-come, first-served basis.

Questions

Contact ACCEC's Meetings Department at (240) 404-6502.

Topics

A Principled Approach To Coverage: The Scope and Future Of The American Law Institute's Principles of Liability Insurance Project

Presenters: Lori Masters and Mike Aylward

The American Law Institute's (ALI's) 2010 Principles of the Law of Liability Insurance sets forth what the ALI believes the law should be. In May 2013, the ALI tentatively approved the first sections, including contract interpretation, misrepresentation, and the duty to defend. Additional duty to defend principles, bad faith, allocation, and other issues will be addressed in the future. Hear what the ALI has done and what the future holds, and find out the likely impact of these principles.

Experts in Insurance Coverage and Bad Faith Litigation: How to Choose, Use, and Lose

Presenters: Tom Segalla, L.D. Simmons, Ned Currie, and Hon. Michael P. Mills, United States District Court Judge for the Northern District of Mississippi

The panel will discuss the application of expert witnesses to insurance issues and coverage and bad faith litigation, including: general law on the admissibility and scope of expert testimony in insurance coverage and bad faith litigation.

Choosing the expert.

- When to use an expert
  - » The appropriate role of the expert
- How to choose an expert—what are the considerations and qualifications necessary for the case?
- Using the expert
  - » Qualifying the expert for admissibility of opinions
  - » What makes a credible and persuasive expert witness in insurance litigation?
- Losing the expert
  - » At all stages: retention, deposition, pretrial, voir dire and trial
  - » Challenging the expert: application of Daubert standards to insurance expert testimony
- A demonstration on expert testimony in a bad faith case: mock direct and cross examination of an insurance bad faith expert presided over by Hon. Mike Mills, United States District Judge, Northern District of Mississippi

Update on Mississippi Insurance Litigation

Presenters: Farish Percy, Professor of Law, University of Mississippi School of Law, Richard T. "Flip" Phillips, and Myles Parker

Professor Farish Percy and attorneys Richard T. Phillips and Myles A. Parker will present on issues arising in insurance coverage disputes in Mississippi and elsewhere. Professor Percy will be reviewing and breaking down some of the more recent cases impacting the insurance practitioner. Mr. Phillips and Mr. Parker will then follow up on this update with strategic and technical observations involved in extracontractual litigation, including venue and forum selection, the scope of extracontractual damages, and the first-to-file doctrine. All are issues that insurance coverage attorneys routinely face when handling complex matters, and all often have critical implications on the final resolution of disputed claims.

Topics *continued*

Defective Construction Claims: Where Breach of Warranty and Covered Occurrences Merge or Divide

Presenters: Jill Berkeley, Stacy Broman, and Bruce Celebrezze

Insurance can play a crucial role in repairing and remediating defective construction. Unfortunately, all too often, owners, general contractors, and subcontractors treat insurance as an afterthought. This session will explore some recent developments in Mississippi relating to insurance coverage issues and, more generally, will explore the line between uninsured warranty work and covered insurance claims.

Waiving Goodbye to the Attorney-Client Privilege in Insurance Litigation: Express, Implied, and Subject Matter Waivers

Presenters: John Jones and Jean Lawler

This session will involve a discussion of the scope of the implied waiver of the attorney-client privilege when an "advice of counsel" defense is raised in bad faith claims alleging extracontractual and punitive damages. As a general rule, raising "advice of counsel" works a waiver of the privilege, and the plaintiff is entitled to review the complete, unexpurgated file of the defense counsel whose advice led to the challenged claim decision. To meet the defense, the plaintiff is generally required to show that the legal advice was not "objectively reasonable" in fact or law. Issues to be discussed include:

1. The extent of the agency relationship between defense counsel and the insurer for purposes of tort liability.
2. Whether "advice of counsel" can be raised in defense of the underlying claim of "bad faith." That is, is the claim decision supported by legitimate or arguable reason in fact or law, or is it limited to "willfulness" issues related to the level of intent that must be shown to send punitive damages issues to jury?
3. Whether "advice of counsel" is an affirmative defense. Which party bears the burden of proof on the issue?
4. Whether claims of partial waiver of the privilege can succeed. If so, under what parameters?
5. How "advice of counsel" defense can be effectively met through the plaintiff's proof at trial.
6. Other circumstances in which advice of in-house legal counsel involved in claim decision can be protected from/disclosed in discovery.

The Government and Plaintiffs Come Knocking: Do You Know Where Your D&O Coverage Is?

Presenters: Wayne Taylor and Caroline Spangenberg

When governmental investigations and the shareholder class actions and derivative suits start to pile on, insurance might not be one of the first things on your mind. It should be. This panel will deal with important issues that can ensure—or interfere with—insurance coverage for civil and criminal liability issues facing corporate officers and directors, including notice under claims made policies, selection of counsel, coverage for external and internal investigations, the ramifications of discovery admissions or criminal pleas, and exhaustion traps.

Speaker Bios

Michael Aylward is a partner in the Boston office of Morrison Mahoney, LLP, where he chairs the firm's complex insurance claims practice. For the past three decades, he has represented insurers and reinsurers in disputes throughout the United States involving diverse sources of liability ranging from asbestos to Y2k. He has written widely on insurance and bad faith issues and is a frequent speaker at insurance claims conferences.
In addition to his work with ACCEC, he currently chairs the DRI Law Institute and is a past member of the DRI board of directors and past chair of its Insurance Law Committee. He has also held similar leadership positions with the Association of Defense Trial Attorneys, the Federation of Defense and Corporate Counsel, the International Association of Defense Counsel, and the Massachusetts Reinsurance Bar Association.

Jill B. Berkeley chairs Neal Gerber & Eisenberg's Insurance Policyholder Practice Group. In 2012, *Chambers USA* reported that clients describe her as a "a breath of fresh air in litigation." Ms. Berkeley represents policyholders and claimants in insurance coverage disputes involving toxic torts and hazardous wastes, environmental pollution, construction, product liability, intellectual property, first-party property, business interruption, and excess liability matters.

Stacy Broman focuses her practice on complex commercial litigation defending insurers in insurance coverage and bad faith litigation, and she represents professionals in professional liability litigation.
For her work on behalf of the insurance industry, she was named by *Best Lawyers*® as Minneapolis Insurance Lawyer of the Year for 2013. She is listed in *The Best Service Professionals in the United States* (under Lawyers: Insurance) and in *The Best Lawyers in America*®. Additionally, she was selected as a 2014 Top-Rated Lawyer in Insurance Law by *American Lawyer* and *Corporate Counsel* magazines and *Martindale – Hubbell* and has been included in the *Minnesota Super Lawyers* list each year from 2005 through 2013. In 2013, Ms. Broman was elected to the American College of Coverage and Extracontractual Counsel.

Bruce D. Celebrezze is chair of the Insurance Division of the international law firm Sedgwick LLP and is a member of the firm's Executive Committee. Mr.Celebrezze represents a wide variety of international, national, and regional primary and excess insurers and reinsurers, with an emphasis on litigating coverage issues arising out of complex third-party casualty and first-party property disputes as well as life, health, and disability claims. In addition, Mr. Celebrezze is a frequent lecturer and is widely published as a legal expert in the field. He is recognized by the top legal directories as a leader in insurance, including being ranked in *Chambers USA* (2010–2012), where he is noted for his "dedication" and "practical and common-sense approach." In 2012, commentators in *Chambers USA* described him as being "incredibly smart, down to earth and one of the most hard-working people I have ever seen."

Edward "Ned" Currie is a founding member of Currie Johnson Griffin & Myers P.A. Ned focuses his practice on the gamut of insurance defense matters and represents insurers in litigating insurance coverage and bad faith issues. With thirty seven years in the courtroom, Ned has tried over one hundred seventy five cases to verdict. He is a former adjunct professor of law at the Mississippi College School of Law, former president of the Mississippi Defense Lawyers Association and former president of the Mississippi Chapter of the Federal Bar Association. He presently serves on the Mississippi Supreme Court Advisory Committee for the Rules of Civil Procedure. Ned was selected as 2012 Lawyer of the Year for Insurance Law in Mississippi by Best Lawyers and as a 2013 and 2014 Top Rated Lawyer for in Insurance Law by *American Lawyer* and *Corporate Counsel Magazine* and Martindale Hubbell. He is listed in Top 100 Lawyers for 2013 and was named by International Global Law Experts as 2013 Product Liability Lawyer of the Year in Mississippi. Ned also is listed in Top 10 Leaders in Law for 2013 by the *Mississippi Business Journal.*

Speaker Bios *continued*

John Griffin Jones is senior partner at the Jackson, Mississippi, law firm of Jones, Funderburg, Sessums, Peterson & Lee, PLLC. A native of Jackson and a product of the Jackson public schools, he attended Millsaps College and the University of Mississippi ("Ole Miss"), double majoring in English and History. He returned to Ole Miss for graduate school but switched over to the Ole Miss law school, receiving his J.D. in 1985. Mr. Griffin served a clerkship from 1985 to 1986 with United States District Judge Tom S. Lee, Southern District of Mississippi, before starting in private practice in Jackson, where he has remained. He has published articles and papers on both non-legal and legal issues, including more than 50 papers in his fields of concentration: workers' compensation; insurance litigation of all types, including bad faith tort actions arising in the first-person-contract and compensation settings; contract law; employment law; and a broad personal injury practice.

Dan D. Kohane, a senior member of the New York law firm of Hurwitz & Fine, P.C., is a nationally recognized insurance coverage counselor who serves as an expert witness and conducts extensive training, consultation, and in-house seminars on this highly specialized practice. Mr. Kohane is known in the industry for his comprehensive newsletter, *Coverage Pointers*, a biweekly publication summarizing important insurance coverage decisions. An accomplished trial lawyer and litigator, Mr. Kohane also has considerable experience mediating complex casualty and insurance coverage disputes. He teaches insurance law as an adjunct professor at the University at Buffalo Law School and heads his firm's Insurance Coverage Practice Group.

Jean M. Lawler is a Senior Partner of Murchison & Cumming, LLP, resident in the firm's Los Angeles office. She served as Managing Partner of the firm from 2008 through 2013, is Co-Chair of the firm's International Law practice group and founded the firm's Insurance Law practice group more than 25 years ago. Her practice includes representing insurers in complex insurance and bad faith litigation, at trial and on appeal; providing insurers with coverage, underwriting and risk management advice; and defending professionals (including agents, brokers and other non-medical professionals) in professional liability litigation. Ms. Lawler is a Regent of the American College of Coverage & Extra-Contractual Counsel and is a Past-President of the Federation of Defense & Corporate Counsel. She is rated AV Preeminent by Martindale, has served as an expert witness in matters involving insurance law and is a frequent speaker and author on a variety of legal issues.

Lorelie S. Masters is a partner in Jenner & Block's Insurance Litigation and Counseling Practice Group and has more than 30 years of experience representing policyholders in insurance coverage counseling and litigation. She is co-author of two treatises on insurance coverage issues: 1) *Insurance Coverage Litigation*, published in its second edition in January 2000 and updated yearly, and 2) *Liability Insurance in International Arbitration*, published in its second edition in early 2011.

Honorable Michael P. Mills is a United States District Court Chief Judge for the Northern District of Mississippi. He was a representative in the Mississippi House of Representatives from 1984 to 1995 and served as a justice of the Mississippi Supreme Court from 1995 to 2001. On September 4, 2001, Mr. Mills was nominated by President George W. Bush to a seat on the United States District Court for the Northern District of Mississippi that had been vacated by Neal B. Biggers. Mr. Mills was confirmed by the United States Senate on October 11, 2001, and received his commission on October 16, 2001. He became chief judge in 2007, and he continues to serve in this capacity to the present.

Speaker Bios *continued*

Myles A. Parker is recognized by various organizations as one of the top litigators in the country. His career spans more than 23 years, and his practice primarily concentrates on representing domestic and international insurance and reinsurance clients in the major loss context. This involves working with diverse professionals around the world from different cultural and educational backgrounds in various jurisdictional settings. His approach to losses like this is to keep the clients fully informed and to be forward-thinking in terms of moving the matter toward ultimate resolution—whether it be in litigation, alternative dispute resolution, or some less formal forum. He has applied this skill set and experience in effectively serving as lead counsel in complex coverage matters exceeding $1 billion in claimed value.

Farish Percy joined the Ole Miss Law Faculty in 2001, after practicing with the Tollison Law Firm, P.A. in Oxford, Mississippi, for eight years. While engaged in private practice, Professor Percy specialized in tort litigation, commercial litigation, and appellate practice. She tried numerous civil cases in state and federal courts in Mississippi and briefed and argued several appellate cases before the United States Court of Appeals for the Fifth Circuit and the Mississippi Supreme Court. Prior to practicing in Oxford, Professor Percy practiced with Latham & Watkins in Washington D.C, where she concentrated in corporate tax. Immediately after graduating from law school, Professor Percy clerked for Judge E. Grady Jolly of the United States Circuit Court of Appeals for the Fifth Circuit. While at the University of Virginia School of Law, Professor Percy was a member of the Articles Review Board for the *Virginia Law Review*. She was also made a member of the Order of the Coif.

Richard T. (Flip) Phillips is a founding partner of the law firm Smith, Phillips, Mitchell, Scott & Nowak, LLP. He is a 1972 graduate of the University of Mississippi School of Law where he served as a member of the *Mississippi Law Journal* and president of the Law School Student Body. From 1973, when he argued the seminal *Rampy* and *McMinn/Crestman* uninsured motorist cases before the Mississippi Supreme Court, to the nationally-watched post-Katrina *Corban v. USAA*, which defined Mississippi anti-concurrent causation law in 2009, Flip has been a pioneer in the development of Mississippi insurance law. His jury verdicts have been recognized in the WALL STREET JOURNAL and the NATIONAL LAW JOURNAL "Top Verdicts in America." From 1994 through 2004, Flip represented policyholders nationwide in "vanishing premium" and life insurance deceptive sales practices cases, serving as lead counsel, co-lead counsel and a member of the Plaintiffs Steering Committees in nationwide class actions and Multi-District Litigation from coast to coast. He is a former President of the William C. Keady American Inns of Court. Flip is the author of numerous law journal articles, one book, MISSISSIPPI AUTOMOBILE INSURANCE, First Ed. (1987), and chapters in two multi-volume MATTHEW-BENDER national treatises.

Thomas Segalla is a nationally recognized authority on bad faith, reinsurance, and insurance; an ARIAS board-certified arbitrator and mediator; and a founding partner of the firm. He has been retained as counsel and as a consultant by numerous major insurance carriers and policyholders in more than 35 jurisdictions nationally and internationally, and he has served as an expert witness in more than 100 bad faith, coverage, and extracontractual cases across the country. His active practice focuses on the defense and insurance coverage aspects of matters involving bad faith; construction site personal injury accidents [Labor Law §§ 200, 240(1) and 241(6)]; toxic tort and environmental issues; and extracontractual, product liability, professional liability, and railroad litigation. Mr. Segalla also has experience representing and advising life science, pharmaceutical, and medical device industry clients.

Speaker Bios *continued*

L.D. Simmons is a co-chair of McGuireWoods insurance recovery practice and has 20 years of experience representing clients in state and federal courts in high-exposure insurance disputes. Clients frequently call on him to handle matters pending in jurisdictions where juries are hostile to corporate defendants. He has represented clients in cases in Alabama, California, Mississippi, Florida, Delaware, Pennsylvania, Tennessee, Washington, Georgia, North Carolina, Kentucky, New Mexico, New York, New Jersey, South Carolina, West Virginia, Texas, and Virginia.

Caroline Spangenberg, a Partner at Kilpatrick Townsend, has thirty years of experience representing policyholders in insurance coverage matters and related indemnity disputes. She has helped her clients recover hundreds of millions of dollars in insurance proceeds through negotiation, mediation and other forms of ADR, arbitration (including international arbitrations) and litigation throughout the United States and overseas. Ms. Spangenberg was recognized byThe Best Lawyers in America® for Insurance Law in 2014 and the six years immediately preceding. In 2004, 2011, 2012 and 2013, she was recognized as a Georgia “Super Lawyer” in Insurance Coverage by SuperLawyers magazine.

Registration Form

Registration Information

Full Name

First Name on Badge/Nickname

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☐ I require special accommodations to participate. *Please attach a description of your needs.*

☐ *Vegetarian* ☐ *Kosher* ☐ *Other*_____

Registration Fee

$100

Registration Deadline

March 14, 2014

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American College of Coverage and Extracontractual Counsel
9707 Key West Avenue, Suite 100
Rockville, MD 20850

Phone: (240) 404-6502 • Fax: (301) 990-9771

Questions, email Linda Bernetich at lbernetich@mgmtsol.com

Cancellation Policy

If a cancellation is received by March 7, a refund of 75% of the registration fee will be issued. There are no refunds for cancellations received after that date.

A "Principled" Approach to Coverage?
The American Law Institute and Its "Principles of the Law of Liability Insurance"

By
Michael F. Aylward and Lorelie S. Masters[1]

I. INTRODUCTION

As much as any area of U.S. law, insurance law varies widely from jurisdiction to jurisdiction. In an effort to homogenize these areas of difference and put forward a set of best practices to follow, the venerable American Law Institute ("ALI") is midway through the creation of the *Principles of Liability Insurance*. Although this *Principles* project has been in the works for nearly four years and addresses issues of profound importance to the insurance industry, policyholders, and insurance practitioners regarding the interpretation and scope of liability insurance, many insurance claims professionals, risk managers, policyholders, and outside counsel know little of it.

The idea for this project appears to have begun with a suggestion by Professor Kenneth Abraham, an active and influential member of ALI's Board. The ALI Council approved the proposal for the *Principles* project in May 2010. Professors Thomas Baker of the University of Pennsylvania Law School and Kyle Logue of the University of Michigan Law School were appointed as the Reporters, and a team of 36 lawyers chosen from the judiciary, academia, industry (on both the insurer and policyholder sides), and active law-firm practitioners were invited to serve as the *Principles* project's Advisors. The group of Advisors is fixed. As with other ALI *Restatement* and *Principles* projects, the effort also includes a large "Members Consultative Group" that also has offered comments and advice as the project has progressed.

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[1] Michael F. Aylward is a senior partner at Morrison Mahoney in Boston, Massachusetts. He is a former member of the Board of the Defense Research Institute and presently chairs its Law Institute and is an active member of the FDCC and IADC. He advises insurance companies and represents them in disputes with policyholders.

Lorelie S. Masters is a partner at Perkins Coie LLP in Washington, DC, and an Advisor to the ALI's *Principles of the Law of Liability Insurance* project. She advises policyholders and represents them in litigation and arbitrations over coverage. Ms. Masters speaks and writes extensively on topics related to her practice and is co-author of two widely recognized legal treatises: *Insurance Coverage Litigation*, updated annually, and *Liability Insurance in International Arbitrations: The Bermuda Form*. Ms. Masters served as the policyholder Co-Chair of the American Bar Association's Insurance Coverage Litigation Committee from 2000-2003 and as an editor of the group's award-winning journal.

Both have written extensively on insurance coverage issues and have served as arbitrators and expert witnesses.

The views expressed in this article are the authors' own and should not be attributed to their clients, the ALI, or others.

Any member of the ALI can participate in the Members Consultative Group ("MCG"). The Advisors and Members Consultative Group include representatives of insurers and policyholders.

The ALI creates its *Restatement* and *Principles* projects through a dialectic, involving input from Advisors and Members Consultative Group members and discussions in the ALI Council and yearly meetings of the ALI general membership, a process that takes place over (often many) years. The objective is to produce a product of broad usefulness and applicability that reflects a consensus from constituencies representing different perspectives on the subject matter in question.

Unlike the more familiar ALI *Restatements*, which seek to summarize principles of the law where there is a general consensus, a *Principles* project seeks to declare what the ALI, through its deliberative process, thinks the law *ought* to be. As one of the Reporters has said, a *Principles* project seeks to set forth "best practices."

In 2005, the ALI published a Handbook setting out four types of projects: Restatements, Legislative Recommendations, Principles, and Studies. It discussed *Restatements* and *Principles* as follows:

> Restatements were "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. Then there was the Principles category. This had not previously been used in ALI terminology, and had clearly been created in connection with the Corporate Governance project and its ramifications. Principles, the Handbook announced, "may be addressed to courts, legislatures, or governmental agencies. They assume the stance of expressing the law as it should be, which may or may not reflect the law as it is."

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 http://www.ali.org/doc/stylemanual.pdf).

The Reporters for the *Principles* project observed in the Memorandum introducing Tentative Draft No. 1 that:

> Although this is a Principles project rather than a Restatement, we support many existing rules. We have attempted to provide clear articulations of and to set forth the primary justifications for those rules. In a few Sections, our statement of a rule is a bit more direct than that of the courts in at least some jurisdictions, but in each of those instances we believe that the rule we propose describes what courts actually do in a substantial number of jurisdictions. In a number of instances, however, we propose adjustments to existing

> rules that we believe are superior. That, of course, is the point of a Principles project.

Principles of the Law of Liability Insurance, Tentative Draft No. 1 (Apr. 9, 2013) (hereafter "*Principles*"; available for purchase at www.ali.org/publication), at xv.

At the ALI's May 2013 meeting, some members raised the issue of whether the *Law of Liability Insurance* project should be transformed into a *Restatement*. As the original proposal to create this project evidently generated much discussion about whether the project should result in *Principles* or a *Restatement*, many knowledgeable about the project believe that this issue has been resolved, however, and is unlikely to be revisited.

In general, the approach of the Reporters has been to state existing state law with an eye towards principles that encourage economic efficiency and fairness to both insurers and policyholders and serve the interests of the public, including individual consumers and small businesses. Discussions at the Advisors' and Members' meetings, ALI Council, and ALI general membership meetings have focused in part on the effect that these rules will have on ordinary consumers. The Reporters have also stated that a key objective is trying to reduce the amount of litigation between policyholders and insurers.

As this is not a *Restatement*, the Reporters for the *Principles* project have taken care to distinguish between what they view as "mandatory rules" that must be applied regardless of what an insurance contract says, and "default rules" that apply unless an insurance policy provides otherwise. In particular, as discussed below, the sections of the project produced thus far develop a concept that "default rules" may be waived by so-called "large commercial policyholders." Certain sections include a "bright line" definition of "large commercial policyholders," using as a general criterion businesses with assets exceeding $10 million in accordance with definitions employed by the SEC. This definition generated extensive discussion with many questioning the use in coverage disputes of this $10 million threshold and, assuming the use of such a criterion, the appropriate way to define it. Comments also questioned the assumption that the use of an insurance broker provides protection for policyholders, even commercial policyholders with at least $10 million in assets, given that liability insurance even for very large companies is sold on standardized policy forms, or using key terms that are standardized and that, for the most part, are not subject to revision or negotiation.

With regard to the concept of "mandatory rules," the Reporters' Memorandum states:

> One important, cross-cutting innovation in Chapters 1 [on interpretative rules and waiver and estoppel] and 2 [on the duty to defend and pay defense costs] is to specify when a rule is a mandatory rule (meaning that the rule cannot be changed by contract) and when a rule is a default rule (meaning that the rule applies only if the liability insurance policy does not specify a different rule). A substantial number of the rules stated in Tentative Draft No. 1 are default rules for large commercial liability insurance policies. Most of those rules are mandatory for other liability insurance policies, however. In many cases, this

> innovation provides greater protection to consumers and small commercial policyholders than the prevailing common law of liability insurance, which generally grants insurers broad latitude in the drafting of insurance policies.

Id. at xvii.

Like *Restatements*, the drafts of this *Principles* project include statements of "black-letter" rules followed by Comments, examples, and Reporters' Notes.

II. THE SCOPE OF THE *PRINCIPLES* PROJECT

The *Principles of the Law of Liability Insurance* will ultimately 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. Still to come are Chapters Three and Four. 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.

Chapter One was presented as a "discussion draft" at ALI's May 2012 Annual Meeting. Following further drafts and input from the Advisors and the Members Consultative Group, Chapter One and part of Chapter Two, presented as "Tentative Draft No. 1," were approved at ALI's Annual Meeting in May 2013. The ALI approved Sections 1 through 15 of Tentative Draft No. 1, which included Interpretation (Ch. 1, Topic 1); Waiver and Estoppel (Ch. 1, Topic 2); and Misrepresentation (Ch. 1, Topic 3 and subsequently voted to approve Sections 16-23.

On September 3, 2013, the Reporters issued Council Draft No. 4 which contains new Sections 24-34 addressing the obligation of insurers to make reasonable settlement decisions (and the consequences of failing to do so) and whether insurers have a right to recoup defense cost or settlement payments. These materials will be reviewed and voted on by the Council at its meeting in Washington, D.C. in May 2014. The Reporters state in the prologue to Council Draft No. 4 that "even more so than Chapter 1, Chapter 2 attempts to clarify and unify existing liability insurance law. Almost without exception, Chapter 2 states rules that already apply in many jurisdictions."

III. OUTLINE

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).

§ 1: Definitions

The following definitions are key to the *Principles* project and are quoted below for context. Subsection 2 defines "commercial policyholder" as a "policyholder with a commercial liability insurance policy." *Principles*, § 1(2). Subsection (4) defines a "large commercial policyholder" as:

> A commercial policyholder that, at the time the policy is issued, has assets equal to the threshold set forth in § 12(g)(1)(A) of the Securities Exchange Act of 1934 as amended, unless the Commissioner of Insurance or equivalent official shall establish a different threshold for policies issued within the jurisdiction of the official. If this section of the Securities Exchange Act is repealed or superseded, the threshold shall be equal to the threshold immediately preceding the repeal or supersession, adjusted over time for inflation.

Id., § 1(4). To be clear, Section 1 also defines a "small commercial policyholder" in Subsection (10) stating that such a policyholder "is a commercial policyholder that does not satisfy the definition of a large commercial policyholder set forth in § 1(4)." *Id.*, § 1(10).

Subsection (6) defines a "mandatory rule" as:

> A rule of contract law or insurance law that cannot be changed by agreement of the parties. Unless otherwise indicated, the principles stated in this project are to be mandatory rules.

Id., § 1(6). That definition is followed in Subsection (7) by the definition of "non-mandatory rule" which states:

> A "non-mandatory rule," otherwise known as a default rule, is a rule of contract law or insurance law that can be changed by agreement of the parties.

Id., § 1(7). Given the distinction drawn between "mandatory" and "non-mandatory" rules, those definitions are potentially very important.

Finally, Section 1 defines "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.

Id., § 1(11). Comment e. to Section 1 states with regard to this definition:

> 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.

Id., § 1, Comment e. This Comment gives the term wide applicability. The objective was to give the term a meaning drawn from real-life experience about how standardized terms are used in a wide variety of liability insurance policies.

Potential Points of Controversy

1. The effort to distinguish between large and small commercial policyholders generated significant discussion at the Advisors meetings and at meetings of the ALI Council and the Membership (and presumably also at meetings of the Members Consultative Group). Many participants expressed the need to protect consumers, including small (or smaller) businesses, that, the Comments say, "are not likely to be substantially more sophisticated, or to have any greater ability to bargain over terms, than the average homeowner or auto owner." *Id.*, § 1, Comment b. By contrast, that same Comment also says that:

> By the same token, the large commercial policyholders that have enough resources to hire expert legal counsel should be permitted of contracting around certain policy terms that consumer policyholders and small-business policyholders cannot.

While the Comments to this Section generally accepted the notion that policyholders with sufficient power should be able to negotiate specific policy terms, many participants in the process questioned how many businesses actually have such power or use it. The Reporters took those Comments from the May 2013 Annual Meeting under consideration.

2. Many participants in the *Principles* project expressed the view that the changes sought, both in this regard and others, could increase, rather than reduce, litigation over insurance disputes. In part, these concerns focused on the incentives that parties to insurance coverage litigation, whether policyholders or insurance companies, may have to challenge existing law in a particular jurisdiction to the extent it may not conform with the guidelines set forth in this *Principles* project. There was marked concern over the potential for this to be the case with regard to the "bright-line rule" defining a "large commercial policyholder."

Topic 1 – Interpretation (Sections 2-4)

As the Reporters stated at the outset, these three Sections attempt to chart "a middle course between a formal, strict approach to interpretation and a highly contextual approach."

§ 2: Insurance Policy Interpretation

For the most part, this Section sets forth accepted interpretive principles (*e.g.*, insurance policies shall be interpreted in the same manner as other contracts).

Potential Points of Controversy

1. Section 2 states that insurance policy interpretation is a "question of law." Accordingly, the Reporters' Notes suggest that coverage should generally be determined by judges, not juries. This approach seems to ignore or avoid conflicting rules in many states with respect to when policyholders or insurers can claim a trial by jury, as well as the broader problem that many insurance coverage controversies arise out of the application of policy terms to facts rather than merely interpreting them in the abstract.

2. Administrative approval of a policy form should not be a factor in assessing its meaning or potential ambiguity. Section 2 is unclear whether the same is true when a particular policy provision is actually written or mandated by state insurance regulators. The rule in most states also is that *contra proferentem* does not apply in circumstances where the drafting of the wording in question is not standard form but was, instead, jointly negotiated, or out of the insurer's control. *See, e.g.*, *Commerce Ins. Co. v. Ultimate Livery Serv., Inc.*, 452 Mass. 639 (2008); *Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1103 (N.J. 1994); *Terra Indus. v. Com. Ins. Co. of Am.*, 981 F. Supp. 581, 590 (N.D. Iowa 1997) ("rules of statutory interpretation, rather than the *contra proferentem* rule, ought to apply when the terms of an insurance contract are dictated by statute, because, in such circumstances, the real question is or ought to be the intent of the legislature, not the intent of the parties to a contract in which neither has any real say as to the terms of the agreement").

3. The Comments identify the following objectives for interpreting insurance policies:

- Effecting the dominant protective purpose of insurance
- Facilitating the resolution of coverage disputes
- Determining the meaning of policy terms in a manner consistent with what a reasonable policyholder would expect
- Encouraging the accurate marketing of insurance policies
- Providing clear guidance concerning the meaning of policy terms, and
- Promoting the financial responsibility of insured parties for the benefit of injured third parties.

Id., § 1, Comment b. In earlier drafts of this Section, these objectives were included in the black-letter, rather than in the Reporters' Notes. At ALI's May 2013 meeting, concern was expressed that these objectives had been moved and, given their current location in the Reporters' Notes, rather than in the black-letter, would receive little focus.

Policyholder representatives and those concerned about individual consumers, in particular, expressed concern about the movement of these objectives into the Reporters' Notes. The "drafting history" of the objectives was raised by these members. The first draft of this Chapter did not refer to objectives. Later, the first draft of these objectives contained no reference to "effecting the dominant protective purpose of insurance." That reference was added as a result of comments by Advisors, Members of ALI's Council, and at the 2012 Annual Meeting; after revised drafts were reviewed, that objective was moved from sixth place on this list to first in the black-letter, given concerns expressed about the need to stress this as an objective when considering liability insurance policy interpretation. Thereafter, the objectives were moved to the Reporters' Notes, with the "the dominant purpose of insurance" and other objectives listed in a series, not (as they had been when in the black-letter) in separate bullets. It is not clear whether these objectives will remain in the Reporters' Notes or whether they will be moved back into the black-letter.

§ 3: The Presumption in Favor of the Plain Meaning of Standard-Form Insurance Policy Terms

Section 3 states that insurance terms are to be interpreted in accordance with their "plain meaning" and presumes that a reasonable policyholder would share that plain meaning unless the other side presents "highly persuasive evidence demonstrating that a reasonable person in this policyholder's position would give the term a different meaning under the circumstances." This principle – that, at the outset, a court should interpret an insurance policy according to its plain meaning – is recognized in most jurisdictions. *See, e.g.*, discussion of plain meaning rule in various treatises: Barry R. Ostrager & Thomas N. Newman, *Handbook of Insurance Coverage Disputes*, § 1.01 (15th ed.); Jeffrey W. Stempel, *Law of Insurance Coverage Disputes*, § 4.04 (2d ed.); *accord* Lorelie S. Masters & Jordan S. Stanzler, *et al.*, *Insurance Coverage Litigation* § 2.03 (2000 & Supp. 2014).

Section 3 would allow consideration of extrinsic evidence to find ambiguity with respect to terms that are clear on their face. Comment a. argues that "extrinsic evidence is admissible to show the meaning of a policy term that is unambiguous on its face, but the language of the term must be susceptible to the alternative interpretation and that evidence must be sufficiently persuasive to the court to overcome the presumption in favor of the plain meaning of the term." *Principles*, § 2, Comment a.

This proposal is in conflict with Mississippi law. As the Mississippi Supreme Court declared in *Cherry v. Anthony Gibbs, Sage*, 501 So. 2d 416, 419 (Miss. 1987), the construction of an insurance contract is limited to the written terms of the policy. Extrinsic evidence is not permitted to interpret policy meaning unless the language is ambiguous and cannot be understood from a reading of the policy as a whole.

§ 4: Ambiguous Terms

Section 4 states that a term will be deemed ambiguous if it has "at least two objectively reasonable interpretations that could be applied to a given set of circumstances." It also states, "[A] term that has a plain meaning [. . .] can be applied to one claim may not have a plain meaning in relation to another claim."

Potential Points of Controversy

1. Ambiguity will be measured by a mixed objective-subjective standard, and not, as some courts have held, purely in accordance with the policyholder's subjective beliefs or understanding.[2]

2. An insurance policy that is unambiguous when applied to one set of circumstances may have separate meanings and thus be found to be ambiguous when applied to another.

3. A finding of ambiguity will result in a declaration of coverage only if a judge is otherwise unable to divine the meaning of the policy.

4. These rules apply without regard to the size or sophistication of a policyholder.

Discussion of law relevant to the four points of controversy follows.

a. How Contra Proferentem Is Applied

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. *E.g.*, *Vargas v. Ins. Co. of N. Am.*, 651 F.2d 838, 840 (2d Cir. 1981) (applying New York law). 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, the *Principles*, as adopted by the ALI, do not adopt the standard "tie breaker" rule followed in many jurisdictions but instead declare 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." *Principles*, § 2, Comment j.

Under Mississippi law, a clear and unambiguous policy term will be enforced as written. *Delta Pride Catfish, Inc. v. Home Ins. Co.,* 697 So .2d 400 (Miss. 1997). The mere fact that parties disagree about the meaning of a provision of a contract does not make it ambiguous. *Burton v. Choctaw County,* 730 So. 2d 1, 6 (Miss. 1997); and *Farmland Mut. Ins. Co. v. Mitchell Scruggs*, 886 So. 2d 714 (Miss. 2004).

b. Application of Contra Proferentem to "Sophisticated Insureds"

Comment k. disapproves of the rule adopted in some jurisdictions eliminating *contra proferentem* in cases involving "sophisticated insureds." The Reporters observe that, "[b]ecause

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[2] *See, e.g.*, *City of Johnstown v. Bankers Std. Ins. Co.*, 877 F.2d 1146 (2d Cir. 1989) (applying New York law).

contra proferentem is a doctrine of last resort . . . the doctrine should be applied irrespective of the sophistication of the parties." *Principles*, § 2, Comment k. In addition, an objective of the project is to promote uniformity of rules of interpretation (and, as stated above, to eliminate unnecessary coverage litigation). A rule that distinguishes between or among policyholders on the basis of alleged "sophistication" could promote litigation, and, as the Reporters have noted, create two sets of rules (and, this, again, can create more fodder for coverage litigation), comments on the drafts of this Section have noted, as recognized in the discussion of the definition of "large commercial policyholders," that even large businesses often do not have the market power to change standard-form provisions. A question also arises about the wisdom or utility of seeking to establish such a distinction regarding "sophistication" given that standardization of insurance policy terms allows for the mass marketing of insurance.[3]

In *Enniss Family Realty I, LLC v. Schneider National Carriers, Inc.*, a non-insurance case, a federal court held that "'[e]mployment of the canons of construction is discretionary' and there is no indication that [the parties to the contract at issue] were of 'unequal bargaining power.'" No. 3:11cv-739-ks-MTP, 2013 WL 2468864 (S.D. Miss. June 7, 2013) (quoting *Refalt v. Refalt*, 94 So. 3d 1222, 1225 (Miss. Ct. App. 2011)). The district court noted in a footnote as follows: "Numerous authorities have refused to construe ambiguities against the drafting party where both contracting parties were commercially sophisticated and their agreement was the result of arms'-length negotiations. *See, e.g., Beanstalk Group, Inc. v. AM Gen. Corp.*, 283 F.3d 856, 858-59 (7th Cir. 2002); *Eagle Leasing Corp. v. Hartford Fire Ins. Co.*, 540 F.2d 1257, 1261 (5th Cir. 1976); *W. Sling & Cable Co. v. Hamilton*, 545 So. 2d 29, 31-32 (Ala. 1989)."

Discussions among Advisors and others deliberating about this Section have focused on the following points:

- A uniform rule applicable to all policyholders would promote certainty and administrability.

- Ordinary consumers often do not have the resources to contest denials of coverage. Given the importance of insurance to the economy, its ability to help foster innovation, and its sale on a mass basis, it is advisable to ensure, to the extent possible, a common understanding of how insurance should apply.

- Many states use "file and use" procedures for new policy forms or provisions; hence, insurance departments in many states exercise no advisory true function until (if at all) complaint is made. Insurance companies, therefore, may have disproportionate power, particularly with regard to individual consumers.

- Insurance brokers or intermediaries often perform little advisory or protective function for policyholders, particularly small businesses or individual policyholders.

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[3] For a comprehensive discussion of the advantages and disadvantages of standardization of policy terms, see Richard Keeton, *Basic Text on Insurance Law* 69 (1971).

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. What is likely to prove controversial in both Sections is the idea that an insurer can "waive into coverage."

At common law, an insurer could not "waive into coverage" absent evidence of an express or implied intent to do so. At most, some states had ruled that a policyholder could forfeit the right to insist on certain conditions to coverage. However, an insurer's claim handling could not manufacture coverage for losses that were not otherwise intended to be covered. As one court explained, "While an insured may be estopped by its conduct or its knowledge from insisting upon a forfeiture of a policy, the coverage, or restrictions on coverage, cannot be extended by the doctrine of waiver or estoppel." *Liberty Ins. Underwriters v. Westport Ins. Corp*, No. 04-LV-01856-WYD-BNB, 2006 WL 2130728 (D. Colo. July 28, 2006); *see also Hartford Live Stock, Inc. v. Phillips*, 372 P.2d 740, 742 (Colo. 1962).

Some states have adopted a limited form of common-law waiver where the insurer has reserved rights or denied coverage on certain stated bases but failed to assert others that were equally apparent at the time. *See Home Indem. Co. v. Reed Equip. Co.*, 381 So. 2d 45, 50 (Ala. 1980); *Flat Iron Paving Co. v. Great SW Fire Ins. Co.*, 812 P.2d 668 (Colo. Ct. App. 1990); *Prescott's Altama Datsun, Inc. v. Monarch Ins. Co.*, 319 S.E.2d 445, 446 (Ga. 1984); *Steptore v. Masco Constr. Co.*, 643 So. 2d 1213 (La. 1994). *But see Richards Mfg. Co. v. Great Am. Ins. Co.*, 773 S.W.2d 916, 919 (Tenn. Ct. App. 1988); *Merrimack Mut. Fire Ins. Co. v. Nonaka*, 606 N.E.2d 904 (Mass. 1993) (insurer's defense of case for several months did not give rise to finding of waiver or estoppel without proof of actual prejudice to insured).

Likewise, courts generally have ruled that estoppel does not allow a finding of coverage that did not otherwise apply. *See Matia v. Carpet Transp., Inc.*, 888 F.2d 118, 120 (11th Cir. 1989) (applying Georgia law); *Doe v. Allstate Ins. Co.*, 653 So. 2d 371 (Fla. 1995); *Bourne v. Seal*, 203 N.E.2d 12 (Ill. 1964); *Redeemer Covenant Church of Brooklyn Park v. Church Mut. Ins. Co.*, 567 N.W.2d 71, 76 (Minn. Ct. App. 1997) (insurer's two-year delay in responding did not estop it from raising policy exclusions). *But see Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388 (Ariz. 1984). In jurisdictions such as New York, courts have ruled that insurers may be estopped to raise conditions or exclusions that defeat coverage but cannot be estopped to raise issues with respect to the insuring agreement and the original intended scope of coverage. *See, e.g.*, *Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 969 N.Y.S.2d 808 (N.Y. 2013).

The black-letter of Section 5 states the general principle that waiver must be intentional, but also makes clear that conduct may constitute an intentional waiver either because of express knowledge or because inconsistency with the insurer's position can reasonably be interpreted as a waiver:

> (1) A party to an insurance policy waives a right under the policy if that party, with actual or constructive knowledge of the facts giving rise to that right, expressly relinquishes the right, or

> engages in conduct that would reasonably be regarded by the counter party as an intentional relinquishment of that right, and the waiver is communicated to the counter party.
>
> (2) Except as otherwise provided by these Principles or other applicable law, statements or other actions of an insurer made or taken after receiving notice of a claim do not waive the insurer's right to deny coverage for the claim.

Principles, § 5(1), (2). Subsection (2) also states that, except as provided in the *Principles* or applicable law, post-claim conduct will "not waive an insurer's right to deny coverage." *Id.*, § 5(2).

The Comments state the reasons for these provisions:

> Enforcing express waiver of contract terms serves a similar function to that of enforcing contracts generally, by enabling parties to make legally binding commitments that others can trust will be honored. Enforcing some waivers also protects the reliance interests of non-waiving parties. Such reliance interests can and sometimes are also protected by the doctrine of estoppel.

Id., Comment a. The Comments also discuss the "knowledge requirement":

> This rule has the effect of imposing on the waiving party, which in most insurance cases is the insurer, the risk associated with not having perfect knowledge of rights or obligations under the contract – an allocation of risk that is especially appropriate where the waiving party is the insurer that supplied the insurance policy term creating the right being waived.

Id., Comment e. The Comments discuss the right to retract as follows:

> Effective retraction requires communication of the retraction, the presence of sufficient time or other conditions necessary for the other party to satisfy the original contractual requirement, and the absence of detrimental reliance on the waiver by the other party. If there has been such detrimental reliance, the waiver cannot be retracted; and the waiver would also satisfy the requirements of estoppel.

Id., Comment f.

The Comments discuss several reasons why waiver should not be limited to "relatively minor or nontechnical terms." *Id.*, Comment g. On the point of waiver expanding coverage, the Comments argue that this assumption overstates what happens in practice and may create an adverse incentive for insurance policy drafters:

> *h. Waiver can expand coverage.* It is sometimes said that waiver cannot expand coverage. However, if the elements of waiver are satisfied and the waiver results in a claim being covered under circumstances in which, absent the waiver, there would not have been coverage, then waiver obviously does expand coverage. For example, if the president of an insurer writes a letter to the policyholder expressly waiving a limiting term in an insurance policy, then coverage under that policy has unambiguously been expanded beyond the coverage that existed immediately before the waiver. In each of the Illustrations above, the result of the waiver is that the insured has coverage that it would not have had absent the waiver. In some cases, statements that waiver cannot expand coverage may be attempting to distinguish between (minor, technical) "conditions," which may be waived, and (important, nontechnical) "coverage provisions," which may not be waived. That distinction is exceedingly difficult to draw in practice, and provides an unfortunate incentive for redrafting of insurance policies so that "conditions" are drafted so as to be framed as "coverage provisions."

Id., Comment h. (illustrations omitted). The Comments make clear that the non-waiving party has the burden of proof. *Id.*, Comment i.

Estoppel requires detrimental reliance, consistent with black-letter law. *Id.*, § 6. As Comment a. states, a party seeking estoppel must prove its reasonable reliance to its detriment on the other party's promise.

> Estoppel is a general contract-law doctrine that permits the enforcement of terms different from those in the original contract, without requiring all of the elements of a new contract, for example, new consideration. Estoppel requires some action or representation on the part of the promisor and reasonable and detrimental reliance on the part of the promisee. The core function of estoppel is to protect the parties' reliance interests. Thus, while waiver requires only proof of an express or implied waiver by a party of a right contained in the policy, estoppel requires the counter party to also prove his or her reasonable and detrimental reliance on the first party's promise or representation.

Id., § 6, Comment a. The *Principles* expressly provide that post-loss statements or conduct can form the basis of an estoppel, rejecting a position taken in some jurisdictions. *Id.*, Comment f. Again, the party seeking to enforce this extra-contractual promise bears the burden of proof. *Id.*, Comment g.

Although Mississippi follows the general rule that estoppel cannot create coverage for claims that are otherwise excluded, an exception exists in cases involving the duty to defend. *Twin City Fire Ins. Co. v. City of Madison*, No. 01-60378 (5th Cir. Oct. 28, 2002) (applying

Mississippi law) (analyzing cases). Upon withdrawal from the defense of an action, for example, an insurer may be estopped from denying liability under a policy, if its conduct results in prejudice to the insured. *Southern Farm Bureau Cas. Ins. Co. v. Logan*, 119 So. 2d 268, 272 (Miss. 1960).

In *Hartford Accident & Indemnity Co. v. Lockard*, 124 So. 2d 849 (Miss. 1960), the Mississippi Supreme Court distinguished between waiver based on an agent's knowledge and waiver based on the insurer's handling of the duty to defend. For waiver based on an agent's alleged knowledge that the insured used his truck with a trailer, the insurer was not estopped to deny coverage and did not "waive" the clear exclusion of the trailer in the policy. *Id.* at 852-55. However, for waiver under the very same policy based on different alleged conduct – refusal to defend – a different analysis applies. Despite the express policy exclusion, the insurer may become liable if the insured was "misled to his hurt or prejudice" by the conduct or representations of the insurer on which he relied. *Id.* at 856.

A federal district court ruled in *Liberty Mutual Insurance Co. v. Tedford*, 658 F. Supp. 2d 786, 797 (N.D. Miss. 2009) that coverage might be created by estoppel where the insurer had failed to notify the policyholder of its right to independent counsel pursuant to the court's ruling in *Moeller*.

While an insurer may waive the right to insist upon compliance with conditions to coverage, substantive limitations may not be waived by implication from an insurer's conduct or inaction. *Yazoo County, Miss. v. Int'l Surplus Lines Ins. Co.*, 616 F. Supp. 153, 156 (S.D. Miss. 1985).

Potential Points of Controversy

1. The *Principles'* standard for waiver arguably recasts the well-known and accepted "voluntary relinquishment of a known right" standard. Instead, waiver must be "intentional" or must consist of conduct that reasonably could be interpreted as a waiver. Section 5(1). Arguably, though the actual or constructive knowledge standard in Section 5(1) meets the typical standard.

2. Section 5(2) expressly states that post-claim conduct cannot constitute a waiver.

3. The Comment that says that waiver can expand coverage has generated significant commentary by insurer representatives. This Comment (cmt. H to § 5) maintains that the common statement in some courts that "waiver cannot expand coverage" is wrong in practice. The comment states clearly that the non-waiving party bears the burden of proof.

4. The *Principles* provide that, in contrast to waiver, estoppel can arise from post-loss conduct. Again the party seeking estoppel bears the burden.

Topic 3 – Misrepresentation (Sections 7-11)

§ 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. It provides that an insurer may rescind an insurance policy if, after "returning all premiums paid by the policyholder," the following conditions are satisfied:

(a) The misrepresentation was intentional or reckless.

(b) The insurer reasonably relied on the misrepresentation, as set forth in Section 9.

(c) The misrepresentation was material as defined in Section 10.

Id., § 7(2)(a)-(c). The *Principles* specify that these conditions are non-mandatory for large commercial policyholders. *Id.*, § 7(5). The insurer has the burden of proof under commonly accepted state standards for fraudulent misrepresentation. *Id.*, § 7(4).

Rescission is appropriate only where material facts are misrepresented intentionally or recklessly. Rescission is not allowed under the *Principles* in cases of so-called "innocent misrepresentation." *Id.*, § 7(3). Additionally, the insurer must have relied to its detriment on the misrepresentation. *Id.*, § 7(b). Finally, the misrepresented facts must be "material." *Id.*, § 7(2)(c).

The standards set forth for this defense seeks to "encourage contracting parties to provide accurate information during the contracting process to protect those who are misled to their detriment, and to penalize those who mislead." *Id*., Comment a. The Comments state the basic principle that the "efficient functioning of insurance markets requires that applications be accurate," allowing insurers to price policies accurately. *Id.*, Comment a. These rules also apply to renewal, also as the same objectives apply in the renewal process. *Id.*, Comment i.

Under Mississippi law, an insurance "company has the right to rely on the information supplied in the application in determining whether or not to accept the risk . . . ." *Mattox v. Western Fidelity Ins. Co.*, 694 F. Supp. 210, 216 (N.D. Miss. 1988) (citation omitted). An insurer may rescind a contract for insurance, treating it void *ab initio*, where the application for insurance contains misstatements of material fact. *Nationwide Mut. Fire Ins. Co. v. Dungan*, 634 F. Supp. 674, 681 (S.D. Miss. 1986) (*citing*, *inter alia*, *Colonial Life & Acc. Ins. Co. v. Cook*, 374 So. 2d 1288, 1292 (Miss. 1979)). *See also Wilson v. State Farm Fire & Cas. Co.*, 761 So. 2d 913, 921 (Miss. Ct. App. 2000) ("In Mississippi, a material misrepresentation in an application for an insurance policy allows the insurer to void or rescind the policy.").

Potential Points of Controversy

1. Section 7 rejects any distinction between warranties and policy representations generally. As discussed in Comment g., some states continue to apply warranties to marine

insurance policies and beyond and may void coverage without regard to issues such as materiality or intent. Section 7 would appear to leave the doctrine intact as far as marine policies go. Comment g. states that, "when policyholders are relatively unsophisticated (as in the case of consumer policyholders), and when marine risks are not involved, the strict application of warranty provisions is unduly harsh and unfair to insureds, as the law has increasingly recognized."

2. Return of premiums, although not stated as a "condition," is a prerequisite to rescission under Section 7. Many misrepresentation cases proceed even when premiums have not been refunded.

3. In what the Comments call an "innovation" (*Id.*, Comment b.), Section 7 would also preclude insurers from rescinding policies based upon an insured's concealment of material facts. Comment c. says this encourages insurers to pursue "best practices" in information gathering. *Id.*, Comment c. Comment h. argues that concealment is difficult for insurers to prove and presents practical problems, as policyholders may not always know what it is that insurers need to know. The Reporters argue that, if subjects are important to insurers, insurers should include them in their policy application forms or discussions and should not expect applicants to volunteer this information. Comment b. argues that concealment is "inefficient":

> The strict-liability version of the misrepresentation defense is also inefficient, insofar as it results in a misallocation of risk. Policyholders purchase liability insurance in significant part because of the efficiency gains from shifting the financial risks of their negligent conduct to insurers. Therefore, this Section articulates a rule that exempts innocent misrepresentations from the most draconian remedies available under the misrepresentation defense. Specifically, this Section limits the remedies of claim-denial and policy-rescission to misrepresentations that are either intentional or reckless, where the efficiency and fairness arguments for those remedies are strongest.

Id., Comment b.

3. More troubling to insurers is Section 7's proposal that an insurer must establish a misrepresentation by the same standard of evidence applicable to claims of fraudulent misrepresentation under applicable state tort law. *Id.*, § 7(4).

§ 8: Intentional and Reckless Misrepresentation by Policyholder

A misrepresentation is intentional or reckless if it was known to be false at the time that it was made or if the applicant was "willfully indifferent" to its truth or falsity. Comment b. explains the objectives behind this Section:

> The misrepresentation defense articulated in § 7 is more protective of policyholders in cases involving intentional or reckless misrepresentation than is the common law of fraudulent

> misrepresentation. Traditional misrepresentation doctrine does not require a showing of reliance in fraud cases. The rationale for that rule seems to be that the protection afforded by the reliance requirement is unnecessary when the misrepresenting party has committed fraud. That rule, however, can result in harsh outcomes in the insurance context. Consider, for example, a situation in which a policyholder has answered a question falsely, either knowing it is false or with indifference as to its truth or falsity, and the question turns out to be trivial – that is, the question provides information that does not lead to reasonable detrimental reliance on the part of the insurer. The insurer should not then, after a loss has occurred and a claim has been filed by the insured, be allowed to deny coverage for the claim and to retroactively rescind the policy.
>
> * * *
>
> The benefit of this rule is that it creates incentives for policyholders to refrain from making intentional misrepresentations without creating an incentive for insurers to ask trivial questions.

Id., § 8, Comment b. This Comment reflects discussion by Advisors, members of the Members Consultative Group, Council, and ALI membership.

§ 9: Requirement of Reasonable Detrimental Reliance

An insurer will be deemed to have been prejudiced by a misrepresentation if it would not have issued the policy, or would have issued the policy with substantially different terms, had it known the truth. The Comments to this Section of the *Principles* states that the standard articulated, like existing doctrine, includes both subjective and objective elements:

> Misrepresentation doctrine includes both subjective and objective aspects. The reliance element primarily addresses the subjective aspect: the impact of the misrepresentation on the particular insurer. This element requires an insurer to demonstrate that the misrepresentation caused it significant harm. If the insurer would have issued the policy on substantially the same terms even if it had received the correct information, then the insurer did not rely to its detriment on the misrepresentation. Thus, a misrepresentation by an insured will not render a policy voidable when the insurer has actual knowledge of the true facts or of the falsity of the insured's representation. While the materiality requirement focuses on what a reasonable insurer in this insurer's position would have done absent the misrepresentation in question, the reliance requirement focuses on what the particular insurer

> seeking to invoke the misrepresentation doctrine would have done absent the misrepresentation.

Id., § 9, Comment a. The "substantiality aspect of the reliance requirement" is intended to discourage rescissions for trivial reasons. *Id.*, Comment b.

The *Principles* do not support the "contribute to the loss" or "cause relation approach" which limits an insurer's ability to assert a misrepresentation defense to situations in which the policyholder's misrepresentation actually "materialized in ('contributed to') to the loss that occurred." *Id.*, Comment c. The *Principles* reject this approach for three reasons:

> First, the contribute-to-the-loss rule does not address the primary concern addressed by the doctrine of misrepresentation: the problem of relatively high-risk policyholders intentionally and dishonestly understanding their risks in order to get coverage at a price that is subsidized by honest members of the same risk pool. Such adverse selection is unfair and inefficient (as discussed in Comment *a* of § 7) and should be discouraged even if the policyholder's misrepresentation did not give rise to the loss under the policy . . . . Second, the contribute-to-the-loss rule can be unreasonably difficult for an insurer to satisfy, because of the absence of proof of the precise connection between the misrepresentation in question and the cause of the loss for which a claim is being filed . . . . Finally, the arbitrary outcomes that the contribute-to-the-loss approach is intended to avoid are better addressed by limiting the insurer's misrepresentation defense to situations in which the policyholder acted intentionally or recklessly, as stated in §7(2)(a). If, however, a jurisdiction were to reject the innocent insured exception to the rescission remedy (see §§ 7(2)(a) and 11), the contribute-to-the-loss or casual-relation requirement might be appropriate.

Id., Comment c.

Potential Point of Controversy

1. The rejection of the "contribute-to-the-loss" approach may be controversial.

§ 10: 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. Some states include this as a specific statutory requirement. *E.g.*, New York Ins. Law § 3105.

The insurer must present clear and convincing evidence that:

(1) misrepresentations were made by the applicant, and

(2) those misrepresentations were material to the risk that was undertaken by the insurer when it issued the policy.

See Golden Rule Ins. Co. v. Hopkins, 788 F. Supp. 295, 299 (S.D. 1991). However, where there is proof that a material misstatement of fact is contained within the application, "there is no requirement that the insurance company prove intent to misrepresent material facts on the part of the insured." *Id. See also State Life Insurance Co. v. O'Brien*, 921 F. Supp. 420, 424 (S.D. Miss. 1995) ("Although fraudulent misrepresentations certainly give the insurer the right to rescind a policy, that right exists where even an innocent misrepresentation was given to the insurer, the truth of which would have materially affected the risk or caused the insurer to not issue the policy."). According to the court in *Dukes v. South Carolina Insurance Co.*::

> It is the universal rule that any contract induced by misrepresentation or concealment of material facts may be avoided by the party injuriously affected thereby. If the applicant for insurance undertakes to make a positive statement of fact, if it be material to the risk, such fact must be true. It is not sufficient that he believes it true, but it must be so in fact, or the policy will be avoided. Provided, always, that the misstatement be about a material matter.

590 F. Supp. 1166, 1168 (S.D. Miss. 1984) (quoting *Fidelity Mut. Life Ins. Co. v. Miazza*, 46 So. 817, 819 (Miss. 1908)).

Mississippi law clearly holds that an insurance policy can be voided due to material misrepresentation in the application, the issue in any given case is whether there is a material misrepresentation. "To establish that, as a matter of law, a material misrepresentation has been made in an insurance application, (1) it must contain answers that are false, incomplete, or misleading, *and* (2) the false, incomplete, or misleading answers must be material to the risk insured against or contemplated by the policy." *Carroll v. Metro. Ins. & Ann. Co.*, 166 F.3d 802, 805 (5th Cir. 1999) (applying Miss. law) (emphasis in original). A misrepresentation is material if it affects "(1) the acceptance of the risk or (2) the hazard assumed by the company." *O'Brien*, 921 F. Supp. at 424. Materiality does not appear to be strictly limited to an insurer's decision whether or not to issue the policy at all. According to the United States Court of Appeals for the Fifth Circuit in *Carroll,* "a fact is material if it might have led a prudent insurer to decline the risk, accept the risk only for an increased premium, or otherwise refuse to issue the exact policy requested by the applicant." 166 F.3d at 805. Additionally, proof "that the insured would have been eligible for another type of insurance" had representations in the application been truthful is irrelevant. *See Wesley v. United Nat'l Life Ins. Co.*, 919 F. Supp. 234, 234 (S.D. Miss. 1995).

According to the Mississippi Supreme Court in *Sanford v. Federated Guaranty Insurance Co.*, "[t]he materiality of a representation is determined by the probable and reasonable effect which truthful answers would have had on the insurer." 522 So. 2d 214, 217 (Miss. 1988) (citing Appleman, *Insurance Law and Practice* § 7294). However, federal cases applying Mississippi law arguably have applied a slightly different test for materiality. The test applied in *Sanford* focuses on the particular insurer at issue; however, federal courts focus on the "prudent" insurer. *See, e.g., Wesley*, 919 F. Supp. 232 (S.D. Miss. 1995). In *Wesley*, the court stated that "[a] misstatement is material if knowledge of the true facts would have influenced *a prudent insurer* in determining whether to accept the risk." *Id.* at 234 (citing 45 C.J.S. § 595(3), pp. 406-07)

(emphasis added). *See also Carroll*, 166 F.3d at 805 (same). While the language employed by the federal courts differs from that used in *Sanford*, the distinction may result in little practical difference. While *Sanford* seems to focus on the individual insurer at issue, rather than a "prudent" insurer, the inquiry addresses the "reasonable" effect on the individual insurer. The use of the term "reasonable" arguably makes the *Sanford* test an objective one, like that used by the federal courts; at a minimum, it is a mixed subjective-objective test.

Regardless of the language of the test employed, materiality is ordinarily a question of fact for a jury to decide. *See Sanford*, 522 So. 2d at 217. However, the Mississippi Supreme Court has "declined to hold that in all cases the question of materiality of the misrepresentations should be submitted to the jury." *Id.* (internal quotations omitted).

The insurer bears the burden of proof on the issues of misrepresentation and its materiality under Mississippi law. *See, e.g., Reserve Life Ins. Co. v. McGee*, 444 So. 2d 803 (Miss. 1983); *Reserve Life Ins. Co. v. Brunson*, 172 So. 2d 571 (Miss. 1965). Proof of both must be established by clear and convincing evidence. *See, e.g., Mass. Mut. Life Ins. Co. v. Nicholson*, 775 F. Supp. 954, 959 (N.D. Miss. 1991); *Chapman v. Safeco Ins. Co. of Am.*, 722 F. Supp. 285, 288 (N.D. Miss. 1989).

With regard to proof, the court in *Sanford* found that "[t]he primary evidence as to materiality is in [the insurer's] underwriting rules." 522 So. 2d at 217. Proof of materiality exists where the insurer has "clearly defined guidelines" showing that it would not have issued an insurance policy had the applicant's representations been truthful. *See, e.g.*, *Dukes*, 590 F. Supp. at 1167, 1169 (insurer's guidelines clearly showed that it did not issue policies for tractors over twelve years old). Where an insurer's underwriting guidelines were less than clear and the insurance company's witnesses testified that "they would have denied coverage if they had known about [the true facts]," the issue of materiality was for the jury to decide. *Sanford*, 522 So. 2d at 217. In *Sanford*, the underwriting rules said that no policies would be issued to "youths" who had more than one traffic ticket within the last year. The applicant was twenty years old. While the insurance company witnesses testified that they would have considered the applicant a "youth," the term was not defined in the underwriting guidelines.

At least one federal court applying Mississippi law, however, ignored the *Sanford* rule requiring consideration of underwriting guidelines as "primary evidence as to materiality." In *Pendersen v. Chrysler Life Insurance Co.*, 677 F. Supp. 472, 475 (N.D. Miss. 1988), the court entered summary judgment for the insurer where the policyholder failed to contest the evidence submitted by the manager of the insurer's claims department. The claims manager's affidavit stated that the insurance company typically relied on the health representations of the applicant and that the company would not have issued the policy if the applicant had been truthful about his health. Although the insurer in *Pendersen* presented no separate, corroborating evidence of underwriting guidelines, as many Mississippi courts require, the court found that the insurer had met its burden of proof given that the applicant failed to refute the claim manager's affidavit.

An insurer may waive its right to rescind a policy under Mississippi law where the insurer:

(1) has the right to rescind,

(2) is aware of its right to rescind, and

(3) expresses "its intention to waive its right to rescind, or undertake[s] such clear and unequivocal conduct as would warrant an inference that the right is waived."

Hopkins, 788 F. Supp. at 303-04. Also, "[e]ven if a misrepresentation exists . . . an insurance company cannot rely on it to rescind the policy if facts were known that would cause a prudent insurer to start an inquiry, which, if carried out with reasonable thoroughness, would reveal the truth." *Carroll*, 166 F.3d at 806 (internal quotations omitted).

Mississippi courts also may find that an insurer is bound by the acts of an insurance agent. the Mississippi Supreme Court has held that an insurer is bound by the knowledge acquired by its agent when the agent prepares the application, and by mistake or omission, fails to correctly record the answers provided by the applicant. *See Jefferson Life & Cas. Co. v. Johnson*, 120 So. 2d 160, 162 (Miss. 1960). *See also Nicholson*, 775 F. Supp. at 961 (holding that the right to rescind an insurance contract is removed where the insurance agent "takes charge of the preparation of the application and records the information inaccurately") (internal quotations omitted). Moreover, the fact that the insured signs the agent's incorrect application "is of no avail to the [insurance] company . . . because the signing of the completed application by the insured does not undo the fact that the insured has communicated the information to the agent." *Mattox*, 694 F. Supp. at 215. In such cases, the insurance company is bound by the acts of its agent: "Absent some proof of collusion between the applicant and the agent . . . the information relayed to the agent is imputed to the company and the company cannot then rescind the policy because it was not told what its agent was told." *Id.* (citing *S. United Life Ins. Co. v. Caves*, 481 So. 2d 764, 767 (Miss. 1985)).

§ 11: Remedy for Misrepresentations That Are Neither Reckless Nor Intentional

Where an applicant has made a misrepresentation that is material but that is neither reckless nor intentional, Section 11 provides unusual curative remedies. This provision resulted in objections across a wide spectrum (insurance representatives, policyholder representatives, academics, judges).

1. If the insurer would have issued the same policy but at a higher premium, the insurer must pay the claim that has been tendered to it but may collect from the policyholder or deduct it from the claim payment the additional premium that would have been charged. *Id.,* § 11(i). It is believed that this new provision is contrary to the law in some states. It also leads to problematic fact issues and could increase, rather than decrease, both litigation and uniformity of rules and their application.

2. If the insurer would not have issued the policy for any premium, the insurer must pay the claim at issue but may collect "a reasonable additional premium for the increased risk." Comment d. states:

> As with every element of the misrepresentation defense, the insurer bears the burden of proof with respect to the elements of § 11 as

> well. Thus the insurer must prove either that the policy would not have been issued had it been aware of the true facts or that the policy would have carried a higher premium. In the latter case, the insurer has the burden of proving the amount of the additional premium the insurer would have charged if it had issued a policy with the knowledge of the correct facts. Evidence that would be especially important to the resolution of this issue would include examples of policies that were issued for the asserted premium under circumstances closely similar to those of the policyholder at the time of the application or renewal.

Id., Comment d. As stated above, this innovation could prove problematic.

3. Having paid the loss, the insurer may cancel the policy prospectively within a reasonable time after discovering the misrepresentation. Comment d. specifies that the insurer bears the burden of proof on these issues. *Id*.

Potential Points of Controversy

Law on Deductions to Payments to Third Party. This Section has sparked considerable controversy. Some have pointed out that it is illegal in many states for an insurer to diminish a payment to a third party based on disputed amounts owed by the policyholder, as would be the case here.

Calculation of Premium. In addition, how is it that an insurer can calculate a new premium where it is conceded that the insurer would never have issued the policy at any premium had it been aware of certain misrepresented facts? Conversely, what protection does a policyholder have against a punitive increase in premium that an insurer necessarily arbitrarily sets given the impossibility of calculating a proper premium for the now-known set of risks.

B. Chapter Two: Management of Potentially Insured Liability Claims (Sections 12-23)

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.

Topic 1 – Defense

§ 12: Scope of the Right to Defend

Section 12 states that, 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. *Principles*, § 12, Comment b.

While an insurer's right to defend is deemed "unlimited" in so-called "full coverage" cases, Comment c. 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. *Id.*, Comment a. Whether such circumstances curtail or preclude the insurer from exercising its right to defend is discussed in Section 18.

Comment d. notes that Section 12 is the default rule and that insurers may set forth separate rules governing the scope of their duty to defend in their insurance contracts for large commercial policyholders. *Id.*, Comment d.

§ 13: Confidentiality

Section 13 provides that information communicated by a policyholder to its insurer does not waive the confidentiality of such communications. *Id.*, § 13(1). It further provides in Subsection (2) that a liability insurer does not have the right to compel the insured to produce information that "could be used to advantage the insurer at the expense of the insured." While this Section is entitled "Confidentiality," by its terms, it applies to "information protected by attorney-client privileged, work-product immunity, or other confidentiality protections." It, thus, raises issues under the "common-interest doctrine" and the "tripartite relationship" among a policyholder, its appointed insurance defense counsel, and its insurer. The Comments state that the "non-waiver rule stated in this Section applies whenever the insured provides information to the liability insurer, including but not limited to the provision of information pursuant to the right to defend, the duty to defend, the right to associate, and the duty to cooperate."[4]

As discussed below, courts have refused to find an expectation of confidentiality by a policyholder in situations in which the insurer has not accepted or has outright rejected the policyholder's defense. *E.g.*, *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 623 A.2d 1118 (Del. Super. Ct. 1992). Evidently recognizing such case law, Comment b. states that the scope of this confidentiality and non-waiver should extend to non-defending insurers on the grounds that they may later be called upon to pay indemnity or to take up the defense after the defending insurer ends its obligation. The Comment further notes that, under "the rule stated in § 76 of the Restatement (Third) of the Law Governing Lawyers," disclosure to non-defending insurers "could also come within the scope of the common interest rule so long as the non-defending insurer is represented by counsel in the matter." *Principles*, § 13, Comment b.

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.

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[4] Sections 12-25 deal with the duty to defend and other topics relating to an insurer's defense obligation. Section 26 deals with an insurer's right to associate in the policyholder's defense, and Sections 33-34 deal with the insured's duty to cooperate.

A handful of states have taken a broad view of the "common interest" between an insurer and its policyholder and have compelled disclosure, even when the parties are in litigation with each other. *See Waste Mgt. v. Int'l Surplus Lines*, 144 Ill. 2d 178, 190-95 (1991) (insurer entitled to privileged materials because cooperation clause obligated insured to produce privileged materials, "joint client" doctrine applies, and insurers are "joint clients," and insured put privileged materials "in issue" in bringing declaratory relief action), and *Vicor Corp. v. Vigilant Ins. Co.*, 674 F.3d 1, 16-19 (1st Cir. 2012) (holding that, under Massachusetts law, even if insurers are defending under a reservation of rights or otherwise disputing their coverage obligations, the common interest doctrine requires that they be given access to privileged defense-related materials).

Most jurisdictions, however, do not follow this rule; many have expressly rejected the *Waste Management* rule or reasoning. In California, for instance, the Court of Appeal expressly rejected the *Waste Management* approach, ruling in *Rockwell Int'l Corp. v. Superior Court*, 26 Cal. App. 4th 1255, 1260-69 & n.3 (1994), that non-defending insurers were not entitled to the insured's privileged information regarding defense of underlying claims. *See also Metropolitan Life Ins. Co. v. Aetna Cas. & Sur. Co.*, 249 Conn. 36, 52-62 (1999) (insured did not put attorney-client communications at issue merely by suing to recover monies and "common interest doctrine" and cooperation clause did not entitle insurer to access); and *State v. Hydrite Chem. Co*., 582 N.W.2d 423, 70-77 (Wis. Ct. App. 1998) (insurers could not rely upon the cooperation clause or the "at issue" or "common interest" doctrines to compel their insured to disclose privileged communications with its defense counsel).

Potential Points of Controversy

Confidentiality, Common-Interest Doctrine, and "In-Issue Documents." The effort to address confidentiality and the applicability of the common-interest doctrine with regard to so-called in-issue documents may do little to quell disputes over insurer requests for production of such documents in cases where the insurer has yet to accept the policyholder's defense without reservation. It is hoped that the rules proposed in Section 13 could have a significant salutary effect on this issue, which has bedeviled insurers and policyholders – and courts – for years. While insurers assert that they need this information to reserve cases properly and prepare for settlement, policyholders worry about the waiver of privilege if privileged materials were shared with parties with whom they did not share a complete "common interest." A waiver could allow claimants against the policyholder to obtain privileged documents – a situation that could help the claimants prove liability against the policyholder which benefits neither the policyholder nor the insurer.

Use of Confidential Materials to Disadvantage Policyholder. The position stated in one of the Comments to this Section could continue to lead to disputes over whether the information sought (*e.g.*, privileged communications generated by the policyholder's counsel in the underlying matter) might "disadvantage" the policyholder. *Id.*, § 13, Comment c. The Comment refers to "a defense lawyer," presumably one hired by the insurer to defend the insured in the underlying claim. *Id.* It does not address the relatively common situation in which the insurer has not appointed defense counsel and the policyholder is "going it alone."

Given the complexities that often arise, the position stated in this Section may not reduce either disputes or litigation. In situations in which the claim or mass tort (meaning a series of claims) against the policyholder have not concluded, a policyholder faces a substantial risk under applicable state law that provision of privileged information to an insurer that has not accepted its obligations in full will be found to work a waiver of privilege. Policyholders have faced situations in which third-party claimants (and sometimes others) have sought production of privileged information submitted to an insurance company which has not accepted its defense obligations in full. A finding that the policyholder has, by submitting privileged information to an insurer that has not accepted its obligations in full, may result in a subject-matter waiver of privilege over all privileged communications relating to the underlying claim and, thus, use of such privileged materials against the policyholder in the claim against it. The provisions on confidentiality in this Section may give policyholders little comfort that their interests are protected adequately in such situations.

§ 14 Vicarious Liability

Section 14 provides 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.

Comment a. discusses the common law applicable to vicarious liability in tort, recognizing the distinction drawn between employees and independent contractors, and the factors considered in defining a principal's right to control his or her agent. Comment b. then discusses the "[j]ustification for rejecting the independent contractor/employee distinction." It rejects the distinction as consistent with the aim of reducing "considerable" litigation, and as being difficult to apply. Instead, like several other Sections of these *Principles*, Section 14 advocates a more pragmatic, market-based approach because doing so will give liability insurers an "incentive" to monitor the actions of defense counsel and because insurers are "in the best position to shift or spread losses if they do occur."

Potential Points of Controversy

Propriety of *Principles*' Market-Based Approach. Is this market-based approach appropriate? Comment b. notes that insurers can impose indemnity agreements on defense counsel or require them to maintain malpractice coverage.

In fact, however, numerous courts have refused to allow insurers to sue defense counsel for malpractice on the grounds that the insurer is not a "client." *Atlanta Int'l Ins. Co. v. Bell*, 475 N.W.2d 294, 297 (Mich. 1991) (declaring that "the relationship between the insurer and the retained defense counsel [is] less than a client-attorney relationship"); *Continental Cas. v. Pullman, Comley*, 929 F.2d 103, 108 (2d Cir. 1991) ("[i]t is clear beyond cavil that in the insurance context the attorney owes his allegiance, not to the insurance company that retained him but to the insured defendant"); *Pine Island Farmers Coop. v. Erstad & Riemer, P.A.*, 649 N.W.2d 444 (Minn. 2002); *Point Pleasant Canoe Rental v. Tinicum Township*, 110 F.R.D. 166, 170 (E.D. Pa. 1986) ("[w]hen a liability insurer retains a lawyer to defend an insured, the insured is considered the lawyer's client"); *In re Petition of Youngblood*, 895 S.W.2d 322, 328 (Tenn. 1995) (counsel's sole client is insured). *But see Great Am. Excess & Surplus Ins. Co. v.*

Quintairos, Prieto, Wood & Boyer, 100 So. 3d 420 (Miss. 2012) (allowing excess insurer to pursue equitable subrogation claim against the law firm that the primary insurer had hired to defend a nursing home suit).

Divergence from Rule That Defense Counsel Are Independent Contractors. This proposal diverges from the majority rule that defense counsel are independent contractors for whom an insurer is responsible only if it specifically was aware of or directed defense counsel's misconduct. *See State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 637 (Tex. 1998); *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 788 N.E.2d 522 (Mass. 2003). *But see Smoot v. State Farm Mut. Ins. Co.*, 299 F.2d 525, 530 (5th Cir. 1962) (allowing suit under Georgia law).

§ 15: Conditions Under Which the Insurer Must Defend

Section 15 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." *Principles*, § 15(1). 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.

Id., Comment c. Another Comment 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.

Id., Comment a.

Section 15 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." *Id.*, § 15(2)(b).

Briefly stated, Section 15 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. *Id.*, § 15(1).

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." *Id.*, § 15, Comment c. Except with regard to the two situations identified in Section 15(3), this rule works in one direction only: facts or circumstances not alleged in the complaint or comparable discount may not be used to justify a refund or failure to defend." *Id.*, Comment c.

3. Questions regarding the following coverage questions "are determined based on all of the facts and circumstances reasonably available to the insurer at the time the determination is made": (a) whether the claimant is an entity "insured" under the policy, and (b) whether the events "required for the claim to trigger the policy" in question took place during the policy period. *Id.*, § 15(3). Extrinsic facts on these two issues may be used to justify a refusal to defend.

This Section appears to reflect a compromise between those states that take a strict four-corners approach and the growing number that permit consideration of extrinsic facts to supplement (but not refute) the pleaded facts.

Section 15 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 21 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.

Mississippi courts have ruled that "true facts" may create coverage once they become known to the insurer even if they are not pleaded in the underlying complaint. *E.g.*, *Nationwide Mut. Ins. Co. v. Lake Caroline, Inc.*, 515 F.3d 414, 418 (5th Cir. 2008) (applying Miss. Law); *Acceptance Ins. Co. v. Powe Timber Co.*, 403 F. Supp. 2d 552, 558 (S.D. Miss. 2005). However, an insured cannot manufacture a duty to defend merely by denying the allegations in the complaint. *American States Ins. Co. v. Natchez Steam Laundry,* 131 F.3d 551, 553 (5th Cir. 1998) (applying Mississippi law).

Potential Point of Controversy

Objective of Reducing Litigation. Given that most states have adopted a broad standard governing duty to defend, the approach suggested here may be contrary to the objective of reducing litigation, at least in the short run, if parties seek to revise a jurisdiction's rule.

§ 16: Duty to Defend: Basic Obligations

Section 16 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. The declaration that, if an insurer has a duty to defend any part of a case, it must defend the entire case is consistent with the rule followed in nearly every jurisdiction. *See, e.g.*, *First Newton Nat'l Bank v. Gen. Cas. Co. of Wis.*, 426 N.W.2d 618 (Iowa 1988); *Gibson v. Farm Family Mut. Ins. Co.*, 673 A.2d 1350 (Me. 1996).

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 18. It further states that, unless the policy provides otherwise, the costs of defense are assumed to exist independent of policy limits.

Potential Point of Controversy

Staff Counsel and State Rules Regarding "Unauthorized Practice of Law." The staff counsel issue can raise thorny issues. With the notable exceptions of Arkansas, Kentucky, and North Carolina, most jurisdictions have ruled that insurers do not engage in the unauthorized practice of law by using staff counsel to defend insureds. *See, e.g.*, *Gafcon, Inc. v. Ponsor & Assocs.*, 98 Cal. App. 4th 1388, 1406 (2002); *Bowers v. State Farm Mut. Auto. Ins. Agency*, 932 N.E.2d 607 (Ill. Ct. App. 2010); *Am. Home Assur. Co. v. Unauthorized Practice of Law Committee*, 261 S.W.3d 24 (Tex. 2008).

While Section 16 states the majority view, it does not take into account the vagaries of state rules and regulations governing the unauthorized practice of law. Comment f. recognizes these distinctions. However, it is cryptic, merely noting that, while insurers have the contractual right to use staff counsel, the issue is "appropriately committed to the insurance market and, if necessary, regulatory authorities." *Principles*, § 16, Comment f.

§ 17: Reserving the Right to Contest Coverage

Section 17 deals with insurer reservations of rights. It 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. *Id.*, § 17(1). 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. *Id.*, § 17(2).

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. *Id.*, § 17(4).

Potential Points of Controversy

While most of Section 17 is unremarkable, two provisions may spark controversy.

Rejection of Minority Rule Giving Policyholder Right to Reject Defense. Comment e. states that the *Principles* "reject the minority rule that gives insureds the option to reject the defense" under an insurance policy that does not "explicitly grant the insured this option."

Massachusetts and a few other states follow the minority rule that a policyholder is entitled to demand independent counsel in any case where an insurer reserves rights, no matter what the issue involved or whether it will create a conflict of interest with respect to the conduct of the insured's defense. Comment e. rejects this "reject the defense" approach and observes that "managing conflicts of interest does not require the insurer to relinquish the right to defend in every case in which the insurer reserves the right to contest coverage." *Id.*, § 17, Comment e.

Opportunity for Policyholder to Consult on Coverage With Appointed Defense Counsel. Subsection 2 requires that the policyholder be given the opportunity to consult with defense counsel concerning the significance of an insurer's reservation of rights.

More controversial is the suggestion in Subsection (2) that, except in the case of large commercial policyholders, an insurer must 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." *Id.*, § 17(2)(b). This proposal raises a number of issues.

First, it assumes or imposes an obligation on defense counsel a level of knowledge and sophistication concerning insurance law that counsel may not have. In many cases, defense counsel will not have a copy of the subject policy. While in simpler cases such as those involving premises liability or auto claims, an understanding of basic coverage terms (e.g., the "expected or intended" exclusion) may be assumed, this is hardly the case with more complex insurance coverage disputes.

Second, requiring defense counsel to explain to an insured whether the insurer's reservation of rights is of such a nature that the insured could hire someone else might potentially give rise to a conflict of interest for less scrupulous counsel.

Third, defense counsel may well face malpractice claims from disgruntled policyholders at the conclusion of a case for their alleged failure to ensure that the policyholder gave "informed consent" with respect to the insurer's coverage position.

Comment f. explains that lawyers retained by insurance companies should at least have a general understanding of the forms of insurance pursuant to which companies pay their fees and assumes that "such lawyers are better prepared to read and interpret a liability insurance policy and a reservation of rights letter than an ordinary consumer or small business insured." While this is likely true, it is not necessarily true that skilled defense counsel necessarily understand or are familiar with more complex insurance coverage issues as would a lawyer specializing in insurance matters.

The Comment appears to give an escape valve to defense counsel, stating that, "[g]enerally, such conversations will include assistance in identifying such a specialist." Comment f. indicates, however, that defense counsel may perform their obligations in this regard by communicating general knowledge to the insured and by helping the policyholder "understand the impact of the reservation of rights on the defense and to make a reasonably informed judgment about whether to consult an insurance-coverage specialist at the insured's own expense." *Id.* The Comment suggests that such conversations have always taken place on an informal basis and that the new proposal merely recognizes this "practical reality." This proposal also may do nothing to reduce litigation.

§ 18: The Obligation to Provide an Independent Defense

Where an insurer has a duty to defend under Section 18(1) 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 California "*Cumis*" approach. 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.

Subsection (2) states that the fact that a claim seeks damages in excess of policy limits does not, by itself, entitle the policyholder to independent counsel.

Mississippi law provides that, where a conflict of interest exists, an insurer is required to pay for independent defense counsel of the insured's choosing. *Moeller v. Am. Guar. & Lia. Ins. Co.,* 707 So. 2d 1062 (Miss. 1996). In *Moeller*, the Mississippi Supreme Court declared that, "when defending under a reservation of rights . . . a special obligation is placed upon the insurance carrier . . . not only must the insured be given the opportunity to select his own counsel to defend the claim, the carrier must also pay the legal fees reasonably incurred in the defense." *Id.* at 1069.

Potential Point of Controversy

Independent Counsel When Punitive Damages Sought Against Policyholder. 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. *Id.*, § 18, Comment c.

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.

§ 19: The Conduct of an Independent Defense

If independent counsel is justified pursuant to Section 18, the policyholder may select defense counsel and the insurer "does not have a right to defend the claim." *Id.*, § 19(1)-(2). The insurer must pay reasonable fees in a timely manner. *Id.*, § 19(3). However, it appears that the insurer will have a right to associate in the defense at its own expense. *Id.*, § 19(4). Moreover, under such circumstances, the insurer will not be deemed vicariously liable for any misconduct on the part of independent counsel, and the policyholder's provision of confidential information to the insurer does not waive confidentiality. *Id.*, § 19(6).

Comment b. states that, where fees are in dispute, the insurer must nonetheless pay the entire amount demanded subject to its right to bring an action against defense counsel to recoup the allegedly excessive amount. *Id.*, Comment b. Comment d. makes clear that an insurer has no exposure to vicarious liability for independent counsel as this does not qualify as the duty to defend under § 14. *Id.*, Comment d. Comment e. states that information shared should remain confidential. *Id.*, Comment e.

Potential Points of Controversy

Policyholder's Choice of Counsel. The *Principles* take the position that the insurer must assent to the policyholder's choice of counsel. Comment a. makes clear that the insured has the unilateral right to hire independent counsel and need not obtain its insurer's consent to the selection of counsel. Where, in fact, the policyholder makes an unwise choice in selecting proposed independent counsel, the insurer is free to object and explain the reasons why other counsel should be selected or can object to the reasonableness of any fees presented. Additionally, Comment a. states that the insurer can demand, as a condition of paying fees, that counsel maintain professional liability insurance that is adequate to protect the insured (and the insurer) from the financial consequences of incompetence. *Id.*, Comment a.

Reasonableness of Fees. Panel counsel fees do not determine the "reasonableness" of independent counsel's fees. Comment b. states that the determination of what is a "reasonable" fee is a factual question. *Id.*, Comment b. The rates that insurers pay to panel counsel are declared to be a relevant fact but not dispositive as panel counsel are assumed to work for reduced rates in return for a steady supply of work from the insurer. The Comment states that "a

lawyer providing an independent defense should not be required to accept the rates paid to the insurer's regular defense lawyers, unless the lawyer so regularly accepts other business at those rates that they represent the reasonable value of his or her services." *Id.*, Comment b. On the other hand, if the regular rate charged by defense counsel is excessive as it relates to the particular matter, the insurer is entitled not to pay the full amount and the policyholder has the option of making up the difference.

This proposal reflects the view of recent Massachusetts case law but contradicts statutory authority in Alaska and California, for example. *Compare N. Sec. Ins. Co. v. R.H. Realty Trust*, 941 N.E.2d 688 (Mass. App. Ct. 2011) (insurer could not force independent counsel to accept rate of $150 an hour merely because that is what it typically paid to panel counsel); *with* California Ins. Code § 2860(c) ("insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended").

***Principles*' Requirement That Insurer Pay Entire Bill.** This position may not reduce disputes over independent counsel fees. Existing law requires insurers to pay at least the amount of a fee that they deem reasonable subject to future disposition of the disputed component of defense bills. This proposal goes much further, however, requiring insurers to pay the entire bill in the first instance. Comment b. suggests that the insurer may require defense counsel to post a bond or some type of security for the disputed amount.

Notably, any subsequent litigation is declared to be solely between the insurer and independent counsel and will not involve the policyholder. This may prove problematic in states that have rejected the "dual client" rule and that have already limited the ability of insurers to sue defense counsel for malpractice. *Id.*, Comment b.

§ 20: Terminating the Duty to Defend a Claim

An insurer's obligation to defend will end only following an explicit waiver by the policyholder of its right to the defense or final adjudication of the claim or as the result of a partial adjudication that eliminates the original basis for coverage or a settlement or partial settlement that eliminates those claimed bases. Comment a. states that this is a "mandatory rule for duty to defend policies." *Id.*, § 20, Comment a. 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. *Id.*, Comment d. Further, if so stated in the policy, exhaustion of the applicable policy limit will eliminate any continuing duty to defend. *See id.*, Comment e.

Potential Point of Controversy

Effect of Partial Settlement on Duty to Defend. Does a partial settlement end the duty to defend? Comment f. states that an insurer may terminate its defense obligation by entering into a partial settlement that resolves the claims or allegations that give rise to the duty to defend. Only a few states have expressly so found, to date. *See, e.g.*, *Meadowbrook v. Tower Ins. Co.*, 559 N.W.2d 411 (Minn. 1997).

As with other Sections, Section 20 attempts to reach a middle ground that harmonizes a strict interpretation of an insurer's rights with the practical impact of such actions on the policyholder. Thus, in this case, Section 20 states that an insurer may enter into such a partial settlement only with the consent of the policyholder after the insured is informed of all the consequences of such an agreement.

The Reporters state, "Otherwise, insurers would have an incentive to avoid their obligation to defend the whole claim by settling the covered portions of the claim in a manner that would disadvantage the insured." *Id.*, Comment f. In practice, few insurers will seek to terminate their defense duties in this manner without first consulting with, and obtaining, their insured's consent. In the experience of insurer counsel, insurers are loath to effect partial settlements that leave their policyholders exposed to other claims and that help to bankroll a plaintiff's future litigation costs. Additionally, such settlements can create an ethical quandary for defense counsel if the insured client instructs him or her not to go forward with the settlement.

§ 21: Consequences of Ordinary Breach of the Duty to Defend

Where a dispute exists, the insurer must at least pay the amount of fees that it deems reasonable. If an insurer wrongly fails to defend a claim, it loses not only the right to control the defense or settlement of the claim but also the right to contest coverage for its claimed indemnity duties. In the event of breach, damages that the policyholder may recover include not only the amount of any settlement entered into in the underlying action or the reasonable portion of a settlement entered into by or on behalf of the insured after breach, but also the reasonable defense costs incurred by or on behalf of the insured. Subsection (2) provides that the insurer has the burden of proof that any amount of settlement or defense costs was unreasonable if it chooses to contest such claims. Subsection (3) provides that the policyholder may assign to the claimant or to an insurer that takes over the defense all or part of any cause of action for the breach of any duty to defend.

The Fifth Circuit has ruled that, if a primary insurer breaches its duty to defend, it will be liable for all damages that are causally related to the breach. The insurer is not, however, unconditionally obligated to pay for any subsequent settlement, especially where the sums were paid by an excess insurer to protect its own interests. *Liberty Mut. Fire Ins. Co. v. Canal Ins. Co.,* 177 F.3d 326 (5th Cir. 1999) (applying Mississippi law).

Potential Points of Controversy

Application of Estoppel if Insurer Breaches Duty to Defend. Most controversial in this Section is the statement that an insurer is estopped to contest indemnity if it breaches the duty to defend. While a growing number of states have adopted this principle, it remains a minority viewpoint. *Compare Missionaries of Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 230 A.2d 21, 24 (Conn. 1967); *Farmers Mut. Ins. Co. v. Staples*, 90 P.3d 381 (Mont. 2004) ("Where an insurer refuses to defend a claim and does so unjustifiably, that insurer becomes liable for defense costs and judgments."); *with Sentinel v. First Hawaii Ins. Co.*, 875 P.2d 894 (Haw. 1994) (an insurer that wrongfully refuses to defend its insured may not dispute the reasonableness of a subsequent settlement of the underlying claim but may still question whether coverage is

otherwise owed*)*; *Timberline Equip. Co. v. St. Paul Fire & Marine Ins. Co.*, 576 P.2d 1244 (Or. 1978) (an insurer is not estopped from disputing the extent of its claimed indemnity obligation by having previously refused to provide a defense to the claim), and *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 943 (Tex. 1988) (while the insurer cannot dispute the factual basis for liability, its breach of the defense obligation does not estop it from showing that no basis for indemnity exists). The New York Court of Appeals, after a rehearing *en banc*, recently reversed a decision following the minority rule, agreeing with the insurer that the initial decision estopping the insurer was inconsistent with earlier precedent. *K2 Inv. Group v. Am. Guar. & Liab. Ins. Co.*, 21 N.Y.3d 384, 391, *vacated*, __ N.E.3d __, 2014 WL 590662 (N.Y. Feb. 18, 2014) (relying on *Servidone Constr. Co. v. Sec. Ins. Co. of Hartford*, 64 N.Y.2d 419, 424-25 (1985)).

Most states addressing the issue have found that an insurer's failure to defend has serious consequences for its ability to avoid a claimed indemnity obligation but have stopped short of imposing this automatic indemnity penalty. Under this rule, an insurer that fails to defend forfeits the right to challenge the determination of its policyholder's liability and, absent evidence of fraud or collusion, the reasonableness of any applying ensuing settlement. *See Esicorp, Inc. v. Liberty Mut. Ins. Co.*, 193 F.3d 966 (8th Cir. 1999) (applying Missouri law). *See also Red Giant Oil Co. v. Lawlor*, 528 N.W.2d 524 (Iowa 1995) (insurer that wrongfully refuses to defend a suit has the burden of showing that any settlement that its policyholder subsequently enters into is collusive or unreasonable).

Massachusetts has adopted an intermediate approach, declaring that, where an insurer wrongly fails to defend, it must thereafter face a reversed burden of proof such that there is a presumption of coverage that it must overcome. *Polaroid Corp. v. Travelers Indem. Co.*, 610 N.E.2d 912, 919-23 (Mass. 1993) (refusing to adopt a rule that insurer is automatically liable for amount of settlement if it wrongly fails to defend; policyholder must show that failure by insurer to defend caused it to settle the case on terms to which it would not otherwise have agreed).

Finally, several states have imposed this estoppel penalty but only if an insurer that refused to defend also failed to seek a declaratory judgment to determine its coverage obligations. *See Northbrook Prop. & Cas. Co. v. U.S. Fidelity & Guar. Co.*, 501 N.E.2d 817 (Ill. Ct. App. 1986); *Liberty Mut. Ins. Co. v. Metzler*, 586 N.E.2d 897 (Ind. Ct. App. 1992).

Against the background of this case law, Comment c. declares automatic estoppel to be the "better rule" as it "properly aligns the defense incentives of the insurer and the policyholder in situations in which the insurer's potential coverage defenses otherwise would reduce the incentive to defend the claim." *Id.*, Comment a. This position in part may reflect input that focused on the need to protect consumers.

§ 22: 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 21 and the policyholder may select another insurer 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.

Potential Points of Controversy

Limitation of Illinois' Targeted Tenders. This Section appears to limit targeted tenders as allowed under Illinois law. Although Section 22 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 22 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.

Section 22 again illustrates an approach that insurers may feel prefers practicality over literal application of policy provisions. It may well be more practical to have a single insurer handle a policyholder's defense but insurers will dispute whether that should compromise the rights of other insurers to associate in or control that defense.

To date, only one state has adopted the approach proposed by Section 22. In *Pennsylvania General Insurance Co. v. Park-Ohio Industries, Inc.*, the Ohio Supreme Court ruled that, in "long-tail" cases involving multiple insurance policies and insurers, only the insurer selected by the insured defends the insured and participates in the underlying tort claim litigation. 930 N.E.2d 800, 805-08 (Ohio 2010). As a result, the court held that, while other insurers must contribute to the policyholder's costs of defense, they do not necessarily have equal rights in determining issues of litigation strategy and settlement. *Id.*

Allocation Rules Same for Indemnity and Defense. The *Principles*' position on allocating defense costs follows rules applied to indemnity. Comment e. states that defense costs should be allocated on the same basis as indemnity. It does not discuss whether that means that policyholders must contribute to defense costs in states that have adopted "time on the risk" or another non- "all sums" approach to allocation issues.

Rejection of Use of Other Insurance Clauses to Avoid Defense. The *Principles* reject use of "other insurance" clauses to avoid defense obligations. Comment a. makes clear that insurers may not rely upon so-called "excess" or "escape" other insurance clauses to avoid their defense duties. *Id.*, § 22, Comment a.

§ 23: Exceptions to Joint Obligation When Multiple Insurers Have a Duty To Defend

In contrast to the general rule set forth in Section 22, Section 23 provides that parties may enter into separate agreements for allocating insurers' defense obligations in cases where insurance policies insure the same or overlapping periods so long as the policies "coherently and

consistently allocate the defense duties of the insurers." *Id.*, § 23, Comment a. Current general liability policies do not contain such provisions, but the Comments note that markets may react to the current legal controversies with respect to allocation and priorities of coverage by inserting contractual provisions setting clearer rules.

Topic 2 – Reimbursement

§ 24: Reimbursement for the Cost of Defense

Section 24 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. *Id.*, § 24, Comment a. 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." *Id.* 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. The Comment 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.

Id. Comment c. acknowledges that barring a right to reimbursement may discourage insurers from voluntarily undertaking the defense of claims that are probably not covered. *Id.*, § 24, Comment c. 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. *Id.*

If an insurance policy sets forth such a right, the insurer may seek reimbursement only under the following conditions:

(i) the insurer has reserved its right to seek reimbursement in accordance with Section 17 of the *Principles*;

(ii) the underlying claim has been resolved; and

(iii) a determination of no coverage has been made.

Id., § 24(2). Where a right to reimbursement exists, however, the insured "must make reasonable offers to facilitate the allocation of defense costs between uncovered and covered claims." *Id.*, Comment d. states, "What constitutes reasonable efforts to facilitate allocation is a question for

the fact-finder." *Id.*, § 24, Comment d. Creating a fact-based allocation regime arguably does not support a stated goal of the *Principles* of reducing litigation. However, it is a reasonable conclusion under general liability policies, which traditionally have provided a broad duty to defend, that a determination of reasonableness must be left to the finder of fact. The Comment also says, "Because the insurer and the insured have a conflict of interest regarding that allocation, the insurer may not unilaterally instruct the defense lawyer to collect the confidential information of the insured that is needed to assist in the allocation." *See id.*; *see also* § 13(2) (entitled "Confidentiality"). If the policyholder does not do so, the insurer has the burden of establishing those costs that are not subject to reimbursement. *Id.*, § 24(3). The Comment also points to the role the default rule plays in insurance regulation:

> This Section follows the recent trend, on the grounds that a no reimbursement default rule furthers the objectives of the rules governing the duty to defend. In addition, a no default reimbursement rule better informs insurance regulators of the coverage that the insurer intends to provide under the policy form, facilitating informed administrative review of insurers' intent to seek reimbursement, and, once the form permitting reimbursement is approved, better informs insurance purchasers of the more limited defense coverage provided by the policy."

Id., § 24, Comment d. The Comment then cites this Section as "an example of an information-forcing rule that facilitates informed decisions by insurance regulators and purchasers." *Id.*

As yet, the Mississippi Supreme Court has not weighed in on this issue. However, in *Liberty Mutual Insurance Co. v. Tedford*, 658 F. Supp. 2d 786, 800 (N.D. Miss. 2009), the U.S. District Court noted that "[t]here is no explicit Mississippi statute or case law advocating or prohibiting reimbursement to an insurer of expenses and costs expended in defense of an action which is later determined not to be covered by the insurance contract." Without holding that Mississippi recognizes or should recognize a right of reimbursement, the court ruled that, under the facts of this case, namely Liberty Mutual's duty to defend the underlying complaint, even jurisdictions that authorize a right of reimbursement would not find reimbursement proper here. Accordingly, the court ruled that there could be no claim for reimbursement unless the policy specifically provides for such. *See Certain Underwriters at Lloyds, London v. Magnolia Mgmt. Corp.*, No. 3:04CV504TSL-JCS, 2009 WL 1873026, at *1-2 (S.D. Miss. June 26, 2009).

Potential Points of Controversy

Contractual Approach Versus Equitable Approach. As noted in Comment a., the issue of whether general liability insurers have a right to reimbursement has been hotly contested throughout the United States. Comment a. cites a "recent trend" in case law rejecting such reimbursement. It distinguishes between a "contractual approach," relying on policy language and the role insurance regulators can play; and an "equitable approach," redressing what insurers see as unfairness in the traditional approach. *Id.*, § 24, Comment a. This issue will continue to be hotly contested before the courts and may be addressed by insurance regulators.

Unjust Enrichment Issues. Insurers will argue that Section 24's approach to the issue conflicts with the ALI's own discussion of unjust enrichment in the *Restatement (Third) of Restitution*. *See Principles*, § 24, Comment b. Insurers have argued for an equitable right to reimbursement on the ground that the insured would otherwise be unjustly enriched by receiving a defense for claims that the policy ultimately does not cover. Policyholders, of course, argue that the duty to defend (and the right to retain defense costs paid before a determination of no coverage) is one of the key rights the policyholder purchases when it buys liability insurance. Indeed, a policyholder may never have to pay a settlement or judgment, but yet be faced with significant defense costs; regardless, defense costs can be significantly greater than indemnity costs. Case law generally has upheld the principle that the duty to defend is broader than the duty to indemnify, for example. Comment b. strives to reconcile any perceived inconsistency between the *Restatement* and these *Principles*:

> As long as an insurer's decision not to defend is made in good faith, there is no risk of the "enhanced" or "extracontractual" liability upon which the reimbursement in Comment c to § 35 of the Restatement [of Restitution and Unjust Enrichment] is based. Moreover, an insurer that chooses to defend under a reservation of rights receives substantial benefits from exercising that choice, such as maintaining control over the cost, quality, and direction of the defense, obtaining access to privileged defense-related materials, avoiding the potential loss of coverage defenses if it is found to have breached the duty to defend, and participating in settlement discussions. All of these benefit the insurer in the event that the claim is later determined to be within the scope of coverage. Thus, the provision of the defense does not unjustly enrich the insured.

Postponement of Reimbursement. Comment e. states, "Postponing the reimbursement until after the duty to defend has terminated reduces the possibility that disputes over the amount of reimbursement will interfere in the defense of the claim or lead to impermissible disclosure of confidential information of the insured." *Id.*, § 24, Comment c. This Comment could encourage a delay in acceptance of defense in disputed cases.

§ 25: 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.

This Section defines a "defense costs indemnification policy" as a "liability insurance policy in which the insurer agrees to pay the costs of defense of a covered claim and does not undertake the duty to defend." *Id.*, § 25(1). Subsection (2) recognizes an exception for policies issued to large commercial policyholders. It provides that, unless a policy issued to a large commercial policyholder provides to the contrary, "when a defense cost indemnification policy obligates an insurer to pay the costs of defense on an ongoing basis," the scope of the insurer's obligation is determined in accordance with Sections 15, 20, 22, and 23 of the *Principles*. It

further provides that an insurer must follow the procedure set forth in Section 17 of the *Principles* in order to preserve its right to contest coverage. *Id.*, § 25(2)(b). To preserve a right to reimbursement, the insurer must follow the principles set forth in Section 24. *Id.*, § 25(2)(c). A breach of this obligation causes the insurer to lose its right to "associate in the defense of the claim under Section 26, the right to exercise any control in the settlement of the claim, and the right to contest coverage for the claim." *Id.*, § 25(2)(d). Subsection (3) provides that, when a defense cost indemnification policy does not require the insurer to pay defense on an ongoing basis, the insurer's "obligation to pay defense costs is determined on the basis of all of the facts and circumstances, unless otherwise provided in the policy." *Id.*, § 25(3).

Comment a. defines the scope of an insurer's defense obligation under such a policy when the insurer has agreed to pay defense costs on an ongoing basis. Comment a. notes that courts to have considered this subject "treat defense costs indemnification policies the same as duty to defend policies" when they agree to pay defense costs on an ongoing basis: "By contracting to pay defense costs on an ongoing basis, an insurer promises to provide the policyholder access to a timely, insurer-funded defense." Therefore, the rules that apply to the duty to defend apply to this obligation also. *Id.*, § 25, Comment a.

Comment a. further notes that these rules are default rules for policies issued to large commercial policyholders, given that such policyholders often buy policies that provide for retrospective reimbursement of defense costs. For that reason, such policies are not subject to the rules that govern the duty to defend. *Id.* The Reporters' Note specifically states that "[t]his section does not adopt a default rule as to whether an insurer's duty to pay defense costs is on an ongoing basis," *Id.*, § 25, Reporters' Note a.

Potential Point of Controversy

Application of Duty to Defend Rules to Indemnification Policies. Insurers may dispute whether defense cost indemnification policies that agree to advance defense costs should be subject to the same rules as policies including a contractual duty to defend. However, Section 25 appears to have struck a reasonable balance between the parties' contractual obligations under such policies and the ability of large commercial policyholders and their insurers to contract on another basis.

§ 26: 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 26 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." *Id.*, § 26(1)(b).

Potential Points of Controversy

Insurer Input in Defense. While Section 26 seems to reflect the prevailing view and practice in cases of this sort, it is unclear how parties will address the extent to which insurers who associate in the defense can have meaningful input based on their "level of engagement."

Policyholder Confidentiality. An insurer's right to associate in the defense of a claim against the policyholder does not effect a waiver of "any confidentiality rights of the insured with respect to parties other than the insurer." *Id.*, § 26(2); *see also id.*, § 26(1)(a). In considering the provisions protecting a policyholder's "confidential information," it is important to keep the definition of "confidentiality" from Section 13 of the *Principles* in mind. That Section states that the provision of information "protected by attorney-client privilege, work-product immunity, or other confidentiality protections" does not effect a waiver of the policyholder's rights to assert confidentiality of that information with respect to parties other than the insurer. *Id.*, § 13(1). Section 13 also explicitly provides, as do provisions in Section 26, that an insurer does not have a right to receive any confidential information if it could be "used to advantage the insurer at the expense of the insured." *Id.*, § 13(2); *see also* § 26(1)(a), and 26(2).

As noted with regard to Section 13 of the *Principles*, the provisions relating to an insurer's right to confidential information and asserted protection against waiver of such rights may do little to reduce the number of disputes over whether an insurer, particularly one that has either denied coverage or reserved its right to coverage, is entitled to production or review of a policyholder's confidential information (defined here to include privileged information). These provisions may represent relatively little danger in a context in which an insurer at least is paying for the policyholder's defense, even under a reservation of rights. It is possible in that situation for a court to find some "common interest" between the policyholder and its liability insurer, although the applicable state law will define whether provision of such information to an insurer that has reserved its rights provides a sufficient "common interest" to protect the information from disclosure to third parties. A waiver of the insured's privileges with regard to documents created in the underlying litigation does not benefit either the policyholder or the insurer if provision of such information is found to constitute a waiver of privilege, allowing a claimant or other third party access to such information. Policyholders worry that waiver of privilege will allow claimants access to privileged information that then can be used to support the claimant's arguments for liability in the underlying action.

Topic 2 – Settlement

§ 27: The Liability Insurer's Duty to Make Reasonable Settlement Decisions

Section 27 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. *Id.*, § 27(1). 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." *Id.*, § 27(2).

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." *Id.*, § 27(3). The duty also includes the "duty to contribute its policy limits . . . if that settlement exceeds those policy limits." *Id.*, § 27(4).

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.

Id., § 27, Comment a.

Comment b. refers to this principle as a "long-standing rule of insurance law." *Id.* 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 27(2) of the black-letter. *Id.*, Comment b. The reasonableness standard is "flexible," permitting the finder of fact "to take into account the whole range of reasonable settlement values." *Id.*, Comment d. This range includes consideration of whether an insurer made reasonable offers and counteroffers. *Id.*, Comment e.

The Comments specifically distinguish 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.

Id., Comment f. 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. *Id.* This rule applies to both duty to defend and defense costs indemnification policies. *Id.*

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." *Id.*, Comment g. 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." *Id.* 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." *Id.* 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 . . . ." *Id.*

Section 27 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." *Id.* 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." *Id.* Section 27 specifically includes both the amount of the potential judgment and the costs of defending a claim in its definition of "reasonable settlement decision." *Id.*, § 27(2).

Comment h. notes inconsistency in the case law about whether defense costs should be considered in the definition of a reasonable settlement decision. *Id.*, Comment h. This Section includes defense costs in that definition because "defense costs are an important component of the costs of" a policyholder's liability and, among other things, excluding defense costs increases "the insured's exposure to excess judgments." *Id.*

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. *Id.*, Comment m. 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. See Section 28 on subrogation. *Id.*, Comment n. 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. *Id.*, Comment o. 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). *See also* Lorelie S. Masters,

et al., *Insurance Coverage Litigation* §8.02-8.05 (2000 & Supp. 2014). This Section "follows the majority rule."

The Mississippi Supreme Court declared in *Hartford Accident Indemnity Co. v. Foster,* 528 So. 2d 255, 265 (Miss. 1988), that, "[w]hen a suit covered by a liability insurance policy is for a sum in excess of the policy limits and an offer of settlement is made within the policy limits, the insurer has a fiduciary duty to look after the insured's interest at least to the same extent as its own, and also to make a knowledgeable, honest and intelligent evaluation of the claim commensurate with its ability to do so." The court ruled that Home's failure to settle within limits when the offer was made, combined with its failure to inform its insured of the offer, automatically increased the insurers' limits to the full amount of the excess judgment.

Potential Points of Controversy

Standard Applicable to Duty to Settle. "Duty to settle" case law differs from state to state with respect to whether insurers are strictly liable for excess judgments where they have foregone an opportunity to settle within limits and as to whether the insurer's conduct should be measured based on an objective ("any reasonable insurer") or subjective standard. Section 27 seems to take an intermediate approach, avoiding strict liability but also focusing the specific circumstances of each case, taking into account the perspective of the insurer and the insured at the time the decision is made.

Duty to Make Settlement Offer Versus Duty to Respond. Section 27 does not take a position on whether insurers have an affirmative duty to make offers of settlement or must merely respond to demands. Comment e. merely states that, in deciding whether an insurer has breached its duty, "the trier of fact may also take into account whether the insurer declined to make reasonable settlement offers or counter-offers." *Id.*, Comment e. Comment f. also observes that an insurer's failure to make a reasonable 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 from an excess judgment." *Id.*, Comment f.

Including Defense Costs in "Reasonable Settlement Decision." The inclusion of defense costs in the definition of "reasonable settlement decision" may prove controversial. Comment k. refers to the "duty to contribute" as a default rule for large commercial policyholders. *Id.*, Comment k.; *see also* § 27(3) and (4). Comment k. rejects the argument that requiring a duty to contribute may lead to settlement payments for non-meritorious claims "that pose a small risk of very large damages." *Id.* The Reporters reason that, "[w]hether this argument is correct or not, liability insurance law should not interfere with experimentation in the large commercial liability insurance market that could have a beneficial effect on the deterrence and other objectives of the underlying liability regime." *Id.*

§ 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. *See Certain Underwriters at Lloyd's London v. General Acc. Ins.*, 909 F.2d 228, 232 (7th Cir. 1990)

(applying Illinois law); *Twin City Fire Ins. Co. v. Superior Cour*t, 792 P.2d 758 (Ariz. 1990); and *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.,* 628 N.E.2d 14 (Mass. 1994).

§ 29: Damages for Breach of the Duty to Make Reasonable Settlement Decisions

Section 29 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." *Id.*, § 29(3). If there is an excess judgment, this liability encompasses possible liability for emotional distress. *Id.*, Comment b. This rule applies only if there is an excess judgment. *Id.*

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." *Id.*, § 29, Comment d. 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." *Id.* 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." *Id.*, Comment d.

Potential Points of Controversy

Adoption of Majority Rule. The Section's adoption of the majority rule with regard to judgment-proof insureds may prove controversial.

Effect of Failure to Achieve "Reasonable Settlement." 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. *Id.*, Reporters' Note e. In those cases, courts in some of the states that do not allow for coverage of punitive damages,[5] 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, the *Principles* have come out in favor of "a strong public policy in favor of encouraging reasonable settlement decisions by liability insurers." *Id.*, Comment e. Including punitive damages as an element of damages for breach of this duty to make reasonable settlement decisions compensates insureds

[5] For a chart of the law in the various states on this issue, see *Insurance Coverage Litigation*, ch. 8.

for "the full harm caused by an insurer's unreasonable decision" and, thus, "is integral to the regulatory function of the duty." *Id.*

This aspect of the *Principles* appears to be consistent with *Andrew Jackson Life Ins. Co. v. Williams,* 566 So. 2d 1172, 1186, n. 13 (Miss. 1990), in which the Mississippi Supreme Court ruled that insurers that are not liable for punitive damages may nonetheless be liable for consequential or extra-contractual damages such as attorney's fees, court costs, and other economic losses when their decision to deny had no reasonably arguable basis. *See also S.W. Miss. Regional Med. Center v. Lawrence,* 684 So. 2d 1257, 1267 (Miss. 1996) (reversing award of punitive damages against insurer but affirming award of consequential damages, including emotional distress damages as a result of the insurer's denial). While acknowledging a certain tension between the principle of barring the availability of liability insurance for punitive awards, the court concluded that that concern was outweighed by the strong public policy in favor of encouraging reasonable settlement decisions by liability insurers.

§ 30: Assignment of a Claim for Breach of the Duty to Settle

Just as Section 28 acknowledges the right of equitable subrogation by excess insurers in cases where a primary insurer fails to make a reasonable settlement decision, Section 30 provides that the insurer may assign to a tort claimant all or part of any cause of action for a breach of this duty. This Section follows the majority rule, which is "upheld in virtually every state."[6] *Id.*, § 30, Comment a. The Comments identify the following two rationales supporting such an arrangement: (i) assignment "maximizes the value to the insured of its claims against the insurer"; and (ii) it "enhances the deterrence provided by the" duty to make reasonable settlement discussions. *Id.*, Comment b.

Potential Point of Controversy

Assignments. In many cases, an insurer's refusal to accept or fund a settlement follows a separate settlement that the insured enters into over the insurer's objections, accepting a consent judgment and assigning its coverage rights to the tort claimant. Comment a. to Section 30 seems to imply that such assignments may not occur without a trial and require that there has been an excess judgment in the trial of the underlying claim. The language is far from clear, however.

§ 31: 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 sums 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. *E.g.*, *Mowry v. Badger State Cas. Ins. Co.*, 385 N.W.2d 171 (Wis.

[6] The Reporters identify Tennessee as "the only state" not to allow such an assignment. *Id.*, § 30, Reporters' Note a.

1986) (cited in Reporters' Note a.). The majority of jurisdictions, however, hold that a good-faith denial of the duty to defend does not insulate the insurer for liability for an excess judgment. *E.g.*, *Johansen v. Calif. State Auto. Assn' Inter-Ins. Bureau*, 15 Cal. 3d, 9, 19, 538 P.2 744, 123 Cal. Rptr. 288 (1975); see discussion in Kenneth S. Abraham, *Insurance Law and Regulation: Cases and Materials*, 666 (5th ed. 2010); 1 Jeffrey W. Stempel, *Stempel on Insurance Contracts* § 9.05[C] (1999 & Supp. 2013).

Section 31 precludes such claims. It states that, unless specifically provided for in the policy or the insured has otherwise agreed, an insurer "may not settle a claim and thereafter demand reimbursement of the settlement and not from the insured on the grounds that the claim was not covered." *Id.*, § 31(2). A large commercial policyholder can agree to a contrary rule. *Id.*, § 31(3). However, absent such a provision in a large commercial policy, when the insurer has reserved its rights, 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.

Id., § 31(3)(a)-(d).

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. *Id.*, § 31, Comment a.

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*.

Potential Point of Controversy

Allocation to Insurer for Reasonable But Mistaken Belief About Coverage. This rule, which allocates the insurer a portion of the risk associated with reasonable but mistaken beliefs by the insurer about coverage, is intended to discourage insurers from delaying settlement negotiations while defenses to coverage are being resolved. The rule set forth in Section 31 states the majority rule. However, some jurisdictions follow the rule permitting an insurer to further discount the value of a proposed settlement by the likelihood that coverage will be found not to apply. This distinction could lead to controversy in those states that follow the minority rule.

The rule set forth in this Section states a default rule, not a mandatory rule; thus, an insurance policy provision "explicitly stating that the insurer does not have the right to seek reimbursement from the insured of the cost of settlement in a case in which it has reserved its rights." Choosing as a default rule the rule of no reimbursement is, according to the Comments, "fair and efficient in the vast majority of settings" because "doing so minimizes the transaction costs incurred by those who wish to contract around the rule and minimizes the unfairness and inefficiency to those parties who are not able to contract around the rule." *Id.*, § 31, Comment b. Comments also describe concerns about adopting a pro-reimbursement rule as follows:

> Insurers with potential coverage defenses will have a tendency to settle more cases than otherwise and to work less hard to keep the amount of the settlements low. Thus, a pro-reimbursement rule creates a moral hazard on the part of insurers. From the insured's perspective, a relevant question would be which prospect is more worrisome: the increased risk of uncovered trial judgments (resulting from a no-reimbursement rule) or the increased risk of uncovered settlements (resulting from a pro-reimbursement rule). This is an empirical question that has no easy answer.

Id. Ultimately, the Reporters take support for the rule stated in Section 31 from the fact that such provisions generally are not included in insurance policies; this absence "can be taken as evidence that the fairest and most efficient default rule is one of no reimbursement." *Id.* The parties to insurance contract, of course, can contract around this issue.

§ 32: 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 32, 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." *Id.*, § 32(1). 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." *Id.*, § 32(2).

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. *Id.*, § 32(2)(a)-(c). This is the default rule. As stated in Subsection (3), large commercial policyholders can contract to the contrary. *Id.*, § 32(3).

Potential Point of Controversy

Interpleader as "Safe Harbor"? The Comments refer to the interpleader option set forth in Subsection (2) as a "safe harbor." This safe harbor may prove controversial. *Id.*, § 32, Comment b. The Comments also note that, although the procedure outlined should, with most "rational claimants," end the litigation. However, when faced with an insured with substantial assets, a claimant may decide "to reject the court-ordered settlement allocation and pursue the case to trial."[7]

Topic 3 – Cooperation

§ 33: The Insured's Duty to Cooperate

Section 33 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.

Id., § 33(i)-(3). 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. *Id.*, § 33, Comment a. 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. *Id.*, Comment b. 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 in Sections 17 and 20 of the *Principles* for reserving rights and pursuing a declaratory judgment action in such situations. *Id.*, Comment c. Similarly, Comment d. states that the duty to cooperate does not obligate the insured to comply with unreasonable requests.

§ 34: Consequences of the Breach of the Duty to Cooperate

Section 34 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. *Id.*, § 34(1). 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." *Id.*, § 34(2).

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[7] The Reporters' Note cites Professor Keeton in support of the interpleader approach. See Reporters' Note b (citing Robert Keeton & Alan Widiss, *Insurance Law* § 7.4(d) n.1 (1988)).

The rule set forth in Section 34 is the default rule, and the introductory clause to the Section states that a large commercial policyholder can contract around this rule. *Id.*, § 34(2).

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." *Id.*, Comment a. 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." *Id.*, Comment b. 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. *Id.* 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." *Id.* 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." *Id.*, Comment e. 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." *Id.* 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." *Id.*

It is important to note that this is a mandatory rule for insurance policies sold to policyholders other than large commercial policyholders. Under this Section's substantial prejudice rule, "insurance policy terms that treat the duty to cooperate as a strict condition precedent are ignored." *Id.*, Comment f. However, for large commercial policies, the "substantial prejudice requirement is merely a default rule." *Id.*, Comment g.

Potential Points of Controversy

"Substantial Likelihood" Test. Insurers likely will resist Section 34, given its use of the "substantial likelihood test," and the difficulty of predicting how a case might have come out but for the insured's collusive conduct or failure to cooperate.

Substantial Prejudice Test. The use of the substantial prejudice rule may be controversial with insurers, particularly coupled with statements in the Comments that say that policy provisions establishing a duty to cooperate as a strict condition precedent "are ignored." However, this result is consistent with one of the objectives of the *Principles* project, which is to provide protection for ordinary consumers. It is with regard to ordinary consumers and businesses that do not have the market power to negotiate the terms of standard-form policies that the rule stated in this Section is a mandatory one. Large commercial policyholders, as stated in Comment g., can contract around this principle.

IV. THE FUTURE OF THE *PRINCIPLES* PROJECT

What is the long-term significance of the *Principles* project? Insurance law is, of course, notoriously a matter of state law and thus subject to different legal standards and principles that resist codification or national standards. Insofar as states already have clear precedent on these issues, the *Principles* may have little effect in persuading judges to take a contrary view. However, these *Principles* may certainly guide the development of the law in jurisdictions where courts have yet to rule on many of these matters.

Indeed, the Reporters suggest in their opening Memorandum to Tentative Draft No. 1 that they hope that the *Principles* may help shape the future course of insurance law in a number of different ways:

> The first and most obvious way is as guides to the rules adopted and applied by the courts in insurance coverage litigation. But it is also possible that the principles might guide Insurance Commissioners' review of policy provisions submitted for their approval; that insurance companies might provide in an insurance policy that should be interpreted in accord with these principles; or even that a legislature might adopt all or part of the principles as governing certain insurance policies issued in a state. Our object, however, is simply to develop the principles and to leave it to these other institutions to decide how they might best be employed.

Id., at xvii.

As stated at the outset, the Advisors group is established. However, any member of ALI may join the Members Consultative Group. Both Advisors and Members are consulted about drafts and all revisions of the draft *Principles*. The ALI's Council and full membership later weigh in as well and thus also affect the direction of the project. If you are a member of ALI, you may join the Members Consultative Group. See the ALI website (www.ali.org) or contact the ALI. If you are not a member of the ALI, you can apply to join. Again, see the website or contact an ALI member who can sponsor you (a list of members is on the ALI website). Dues are $250/year, and the ALI has many other interesting projects in which you can get involved. With regard to this project, if you are not an ALI member or do not wish to join the Members Consultative Group, you can ask an Advisor or participant in the Members Consultative Group to submit your comments.

Bad Faith: The Admissibility of Expert Testimony and the Challenges That Follow

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BAD FAITH: THE ADMISSIBILITY OF EXPERT TESTIMONY AND THE CHALLENGES THAT FOLLOW

A. *Introduction*

The issues involved in most bad-faith cases tend to be fairly complex. This is not completely surprising in a circumstance where there must be a strong disagreement between the two sides as to some insurance issue before there will be any action. Apart from potential concerns that a jury may weigh expert opinions too heavily, there is little denying that expert testimony may serve the cause of both sides to a bad-faith action.

Professor Samuel Gross from the University of Michigan outlined the 'essential paradox' of expert testimony by noting that: "We call expert witnesses to testify about matters that are beyond the ordinary understanding of lay people (that is both the major practical justification and a formal legal requirement for expert testimony), and then we ask lay judges and jurors to judge their testimony."[1]

Accordingly, while courts hold that expert testimony in a bad-faith case is not a necessity,[2] it is widely held that expert testimony on pertinent issues and insurer practices is admissible in the general discretion of the trial court when offered by an appropriately qualified expert.[3]

B. *The Issue*

The admissibility of expert witness testimony and the documentary evidence upon which such testimony is based are currently subject to a myriad of challenges in all types of litigation, both at the state and federal levels. A clear understanding of the application of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[4] *General Electric v. Joiner*,[5] and *Kumho Tire Co. v. Carmichael*,[6] is critically important to defense practitioners and their ability to exclude expert evidence offered by the plaintiff/policyholder/insured. The wrangling about whether *Daubert* standards apply only to scientific evidence or whether the *Daubert* gatekeeping function applies equally to nonscientific evidence has been laid to rest. Consequently, as noted below, those practicing in the insurance-related defense and coverage arenas must be prepared to challenge a plaintiff's proof in bad faith, claims handling, and policy interpretation cases. Similarly, counsel must be prepared to challenge the documentary evidence upon which any expert opinion is based that is offered by plaintiff's counsel to justify plaintiff's interpretation of the policy. Of course, counsel for the insurance company should be aware that the insurer/defense expert's testimony undoubtedly will undergo similar challenge.

A proactive approach that challenges expert testimony within the nonscientific, insurance-related fields must begin with an understanding of

Daubert, Joiner, and *Kumho*. However, if the applicable state jurisdiction does not follow *Daubert* and its progeny, the practitioner should consider the test articulated in *Frye v. United States*,[7] or perhaps a combination of the two. Though it is beyond the scope of this article, the practitioner should also consider whether the expert is qualified in its field of expertise. This article will next consider a historical analysis of these cases together with their applicable tests. Defense counsel will be urged to consider several projects covering application of these tests to expert evidence within the context of the traditional insurance case.

C. *The Standard*

Any analysis of the standard that courts will apply to "junk science" and "junk expert testimony" must begin with *Daubert, Joiner* and *Kumho* since difficult questions clearly remain regarding how these opinions apply outside scientific disciplines. Junk science has been defined as "jargon-filled, serious-sounding deception."[8]

1. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*[9]

In *Daubert*, the parents of children suffering birth defects allegedly caused by the drug Bendictin instituted an action against the manufacturer of that drug. Bendictin was an anti-nausea drug used by mothers during pregnancy. Procedurally, the defendant moved for summary judgment on the issue of causation contending there was no link between the use of Bendictin and the alleged birth defects. To support its motion, defendant offered the affidavit of a scientific expert. Plaintiff countered this proof with affidavits from eight expert witnesses who argued that there was a causal link. The district court granted the defendant's motion and plaintiffs appealed to the Ninth Circuit Court of Appeals. Affirming the lower court's holding, the Ninth Circuit cited *Frye v. United States*,[10] noting that scientific testimony would only be admitted if it were "generally accepted in the relevant scientific community."[11] Plaintiff petitioned the United States Supreme Court contending that since *Frye*, the United States Congress had enacted the Federal Rules of Evidence (specifically Rules 104(a) and (b) and Rule 702), which arguably liberalized evidentiary standards. These rules provide as follows:

> **Federal Rule of Evidence 104(a):**
> Preliminary questions concerning the qualifications of a person to be a witness . . . or the admissibility of evidence shall be determined by the Court.
>
> **Federal Rule of Evidence 104(b):**
> When the relevancy of evidence depends on the fulfillment of a condition of fact, the Court shall admit it upon, or subject to, the introduction of evidence sufficient to support a finding of the fulfillment of the condition.

Federal Rule of Evidence 702:
If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise.

Recognizing that the Federal Rules of Evidence were intended to be more liberal than the historical *Frye* test, the Supreme Court noted that the *Frye* Court's "rigid general acceptance requirement would be at odds with the liberal thrust of the Federal Rules."[12] With that said, the Court defined the trial court's "gatekeeping" function and its obligation to exclude evidence based only on "subjective belief or unsupported speculation."[13] The Court also enumerated several factors for the trial court to consider when analyzing the reliability of evidence:

1) Can the theory or technique be tested or has it been tested?
2) Has the theory or technique been subject to peer review and publication?
3) Is there a known or potential rate of error?
4) Do standards and controls exist and are they maintained?
5) Has the theory been generally accepted?[14]

The Court emphasized, however, that these factors are "general observations" that should not be considered a definitive test.[15] The Court also cautioned that it had only addressed scientific expert evidence; it was not addressing technical or other specialized knowledge. Legal analysts immediately questioned whether the *Daubert* "gatekeeping" function extended to other types of expert testimony.

In his dissenting opinion, Justice Rehnquist initiated this same concern: "[D]oes all of the dicta apply to an expert seeking to testify on the basis of 'technical or other specialized knowledge' the other types of expert knowledge to which Rule 702 applies, or are the 'general observations' limited only to scientific knowledge?"[16] Other commentators speculated as well.[17] Further, there developed a significant split among the various lower courts about how *Daubert* would be interpreted and whether it would apply to nonscientific evidence.[18]

It should be noted that the Supreme Court remanded *Daubert* to the Ninth Circuit Court of Appeals. On remand, the Ninth Circuit found that the evidence was inadmissible. In addition to the *Daubert* factors, it noted that expert testimony is presumptively unreliable if the research was conducted in anticipation of, rather than independent of, the litigation.[19]

2. *General Electric v. Joiner*[20]

The *Daubert* Court also left unresolved the issue of what standard should be applied by an appellate court when reviewing a trial court ruling on the admissibility of evidence. In *Joiner*, the Supreme Court addressed this issue and resolved the conflict among the various districts that had developed after *Daubert*.[21]

The *Joiner* dispute involved a plaintiff's claim that his cancer was caused by exposure to PCB and chemical fumes. The district court had ruled that a causal link did not exist between the exposure and the cancer. On appeal, the Eleventh Circuit reversed the district court's ruling, applying a de novo standard of review. The United States Supreme Court rejected this standard, however, ruling that the decision of the district court should not be revised unless that court abused its discretion.[22] Of significance, the Court reaffirmed the *Daubert* standard but without the clarification that had been anticipated:

> [N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence, which is connected to existing data, only on the *ipse dixit* of the expert. A Court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.[23]

Subsequent to *Daubert* and *Joiner*, confusion still existed among the federal district and state courts regarding which standard to apply.[24] Further, the Court did not answer the question posed by Chief Justice Rehnquist in *Daubert*: Did the Court's ruling apply to nonscientific and other technical evidence? As a result, after *Daubert* and *Joiner*, courts in the various circuits answered this question differently. For example, the Second, Ninth, and Tenth Circuits held that *Daubert* was limited to scientific testimony and not applicable to experience-based testimony.[25] In contrast, the Fifth, Sixth, Seventh, and Eighth Circuits authorized the use of *Daubert* factors to analyze admissibility of expert evidence, both scientific and nonscientific in nature.[26]

3. *Kumho Tire Co. v. Carmichael*[27]

Recognizing the foregoing conflict, the Supreme Court in *Kumho* confronted the issue directly, analyzing whether the "gatekeeping" function of the district court applied to scientific, nonscientific and other technical evidence. The *Kumho* plaintiffs had been injured as the result of a tire blowout on a minivan. They sued the tire manufacturer, claiming that either a design or manufacturing defect caused the blowout. In support of their theory, plaintiffs offered the testimony of a tire expert. On motion of the defendant, the trial court excluded the tire expert's testimony utilizing *Daubert* factors (general acceptance, rate error, peer review and publication). The Eleventh Circuit reversed, holding that *Daubert* was limited to scientific evidence and did not apply to the tire expert's testimony since that testimony was skill- or experience-based.[28] The United States Supreme Court reversed the Eleventh Circuit, noting that the language of

Rule 702 makes no distinction between "scientific" knowledge and "technical" or "other specialized" knowledge. Further, the high Court determined that the evidentiary rationale underlying the basic *Daubert* "gatekeeping" function was not limited to "scientific" knowledge:

> [W]e conclude that the trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable. That is to say, a trial court should consider the specific factors identified in *Daubert* where they are reasonable measures of the reliability of expert testimony."[29]

Citing *Joiner*, the Supreme Court further noted that the appellate courts must apply an abuse of discretion standard when reviewing a trial court decision to admit or exclude expert testimony.[30] The Court then applied the abuse of discretion standard to the relevant facts, concluding that the testimony of plaintiffs' tire expert was properly excluded by the trial court under that standard.

Several recent cases have considered the application of *Daubert* standards post-*Kumho*. The case of *Jaurequi v. Carter Manufacturing Co.*,[31] involved the testimony of a mechanical engineer and human factors expert regarding safety barriers and improper safety warnings. The court there noted that when applying the *Daubert* standard to all types of expert testimony, the trial court is left with "great flexibility in adapting its analysis to fit the facts of each case." Further, the trial court did not abuse its discretion when excluding evidence that was nothing more than "unabashed speculation."[32]

The United States Supreme Court later refused to grant the plaintiff's petition for *certiorari* in *Moore v. Ashland Chemical, Inc.*[33] This case involved a doctor's causation testimony based on clinical assessment and diagnosis of the plaintiff's illness following exposure to chemical toxins. Relying on *Daubert* and Federal Rule of Evidence 702, the district court excluded the testimony. The Fifth Circuit reversed, however, noting that *Daubert* factors do not apply to clinical medicine which is not hard science. An en banc court subsequently abandoned the panel determination, holding that no such distinction exists and that Rule 702 and *Daubert* apply to both scientific and nonscientific expert testimony.

The court in *Johnson v. District of Columbia*[34] refined the issue further. That case involved scalding injuries to an infant child amid allegations that a water heater malfunction caused the injuries. Pursuant to the defendant's motion *in limine*, the trial court excluded the testimony of plaintiff's plumbing expert on grounds that he was only experienced in the installation of water heaters, did not have any experience in the design or control function, and was unfamiliar with commercial heaters. The court of appeals determined that as long as the trial judge has the facts necessary to assess the expert's qualifications, the judge can

admit or exclude expert testimony without a hearing, based on those facts contained in the record or the attorney's offer of proof.[35]

4. *Frye v. United States*[36]

Under *Frye*, the sole determinant of the reliability and admissibility of an expert's testimony is whether the expert's testimony is based on scientific principles or procedures, or whether the principles or procedures have sufficiently gained "general acceptance" in the specific field to which the principles or procedures relate. Decided over seventy-five years ago, the attorneys representing Frye attempted to admit expert testimony on the reliability of a systolic blood pressure test to disprove that Frye committed a murder. The federal court excluded the offer of proof because the test had not "gained general acceptance in the particular field to which it belongs;" therefore, it was inadmissible because it was "experimental" as opposed to "demonstrable."[37] The *Frye* standard is often considered less flexible than the *Daubert* standard. Under *Frye*, the party offering the scientific evidence must conclusively show general acceptance. If the proof is accepted only by a minority of scientists in the applicable/relevant field, such expert proof would be excluded. Under *Daubert*, however, proof that is accepted by a minority of scientists would provide only a basis to impeach the expert witness.[38]

5. *Mississippi Adopts Daubert Rule*

In *Mississippi Transp. Com'n v. McLemore,* 863 So.2d 31, 39 (Miss. 2003), the Mississippi Supreme Court adopted the *Daubert* standard, stating:

> Considering this Court's recent May 29, 2003, adoption of revised Rule 702 with the additional language found in the federal rule, this Court today adopts the federal standards and applies our amended Rule 702 for assessing the reliability and admissibility of expert testimony. This standard recognizes the distinction between lay and expert witnesses. Like the Federal Rules, our rules grant wide latitude for experts to give opinions even when the opinions are not based on the expert's firsthand knowledge or observations. With a focus on relevance and reliability, this approach is superior to the "general acceptance" test in *Frye,* because the *Frye* test can result in the exclusion of relevant evidence or the admission of unreliable evidence.
>
> The gatekeeping function of the trial court is consistent with the underlying goals of relevancy and reliability in the Rules. *Daubert* ensures that the relevancy requirements of the rules are properly considered in an admissibility decision. Rule 702 gives the judge "discretionary authority, reviewable for abuse, to determine reliability in light of the particular facts and circumstances of the particular case." *Kumho Tire,* 526 U.S. at 158, 119 S.Ct. 1167.

D. *Application to Insurance Issues*

There is considerable authority holding that expert testimony is generally not required to establish bad faith or other improper handling of claims.[39] In some instances, courts have held that the admission of expert testimony was prejudicial,[40] although the admission of expert testimony on the point has been deemed nonprejudicial in other cases.[41]

1. *General Principles*

There is little doubt that the insurance industry held serious interest in *Daubert* and its progeny because inconsistencies that developed after *Daubert* could have adversely affected the standards by which claims professionals, underwriters, and the insurance industry as a whole would be judged. For example, concerns of the American Insurance Association and the National Association of Independent Insurers were expressed in their amici curiae briefs,[42] where they encouraged the Court to extend *Daubert* standards to "applied science," including insurance issues within the context of Y2K litigation.[43] The ultimate concern was whether the testimony of an insurance expert, which is based on general personal experience, skill, and knowledge, would withstand application of the relevant standards.

Under existing standards, it must be determined initially whether the testimony offered assists the trier of fact in understanding the issues at hand and leaves undisturbed the province of the jury. The case of *Buckner v. Sam's Club, Inc*.[44] confirms this analysis when discussing the testimony of a safety management expert.[45] Within the insurance context, the court of appeals in New York has traditionally held that "the opinions of experts, which intrude on the province of the jury to draw inferences and conclusions are both unnecessary and improper."[46]

The court in *Kulak v. Nationwide Mutual Insurance Co*.[47] similarly excluded expert testimony when deciding whether an insurer acted in bad faith in allegedly failing to settle:

> While it might be suggested that an experienced trial attorney . . . who has had frequent occasion to observe the results of juries' deliberations in personal injury actions might be expected reliably to predict the outcome in a particular case, we know of no empirical support for such a conclusion. Moreover, any such result would be based on exposure rather than expertise; and would treat of subject matter calling for no special scientific or professional education, training or skill.[48]

After recognizing the underlying need for special qualifications *and* testimony, the court further noted: "[a]ny experience advantage enjoyed by such witnesses would not establish the inability or incompetence of jurors, on the basis of their day-to-day experience and observation, to comprehend the issues, to

evaluate the evidence, and finally to estimate the likely outcome of a specific action."[49] Citing Federal Rule of Evidence 702, the one dissenting judge in *Kulak* endorsed an approach that takes a more realistic view of the need for expert testimony in today's complex society. He also identified areas where expert testimony is necessary in a bad faith case.[50]

With this overview, the practitioner should next assess how the *Daubert* standards become operative. What is certain is that each situation must be assessed on a case-by-case basis because not all *Daubert* factors will apply to all experts and, in fact, none will apply in some cases. As one commentator has observed:

> [T]he *Daubert* factors may or may not apply in each case. Rather than employ a mechanistic application of specific factors, courts should focus on *Daubert's* goal, which is to make certain that the expert, whether basing testimony on professional studies or personal experiences, employs the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.[51]

As noted in *Tyus v. Urban Search Management*,[52] "the measure of intellectual rigor will vary by the field of expertise, and the way of demonstrating expertise may vary."[53] However, the court in *Tyus* also concluded that: "In all cases . . . the district court must ensure that it is dealing with an expert, not just a *hired gun*."[54]

While there is limited case law to govern whether a particular "insurance expert" meets the applicable *Daubert* tests, there are several recent cases within the coverage context that provide some guidance. In each case under scrutiny, the practitioner should determine whether the expert's opinion is based on mere speculation or whether the expert used the "types of information, analyses, and methods relied on by experts in his field." Also, "the information that he gathers and the methodology he uses must reasonably support his conclusions."[55]

2. *Between Daubert and Kumho*

When applying the foregoing principles, several cases that postdate *Daubert* but predate *Kumho* should be considered. These address whether the *Daubert* standards are applicable to expert testimony concerning-claims handling procedures. In *Reedy v. White Consolidated Industries, Inc.*,[56] the insured alleged, among other things, that his employer acted in bad faith in refusing to pay workers' compensation benefits. The plaintiff had designated two individuals or experts to testify on claims-handling procedures, and the defendant moved to strike the testimony of these witnesses. In denying the defendant's motion, the court made several statements that will assist the practitioner in determining when the testimony of "insurance experts" should be allowed:

1) An individual can qualify as an expert where that individual possesses significant knowledge gained from practical experience, even though academic qualifications in the particular field of expertise may be lacking.
2) The central issue is whether the expert's testimony will assist the trier of fact; merely telling the jury what result to reach is not helpful.
3) Competency goes to weight, not admissibility.
4) Expert testimony must be reliable and relevant under *Daubert*.
5) The witness should have specialized knowledge about relevant activities in the case with which most jurors are not familiar.

The court held that the "claims adjusting procedure is . . . something about which the average juror is unlikely to have sufficient knowledge or experience to form an opinion without expert guidance, thus expert testimony would not be superfluous."[57] In reaching its decision to permit expert testimony about whether the defendant's claims procedure was usual and appropriate, the court reviewed the expert's practical experience with claims adjustment and the types of claims processed. However, while the testimony of the two experts was admissible, the defendant was still "entitled to pursue further challenges to these expert's skill or knowledge in order to attack the weight to be accorded their expert testimony."[58]

In *United States Fidelity & Guaranty Co. v. Sulco, Inc.*,[59] the court likewise considered the proffered expert testimony of a claims processing manager and, without discussing the *Daubert* factors, allowed it as sufficient. Again, in *Kraeger v. Nationwide Mutual Insurance Co.*,[60] the court considered the testimony of the insured's bad faith expert and denied the insurer's motion *in limine*. In doing so, the court made certain observations that are helpful in assessing the parameters of a bad faith expert's testimony:

1) Testimony about how insurance claims are managed and evaluated and the statutory or regulatory standards to which insurance companies must adhere could be helpful to the jury in evaluating whether the claim was handled in bad faith.
2) The expert witness cannot provide legal conclusions that the insurer violated a particular statute or that the insurer acted in bad faith.
3) The expert witness can testify that, based upon expertise and experience, the insurer had no reasonable basis for its actions.

In reaching its conclusion, the court specifically determined that the *Daubert* factors did not apply to this type of testimony.

There are many post-*Kumho* nonscientific cases that likewise provide some guidance to those practitioners who litigate insurance issues. For example, in the antitrust case of *City of Tuscaloosa v. Harcros Chemicals, Inc.*,[61] the Eleventh Circuit considered the nonscientific testimony of a certified public accountant and the testimony of a statistician and held: "[w]e conclude that the

district court abused its discretion in excluding Garner's [CPA] testimony . . . . We further conclude that the district court's interpretations of *Daubert* and of Rules 104 and 702 . . . were erroneous as a matter of law."[62] With respect to the statistician's testimony, the court excluded portions of his testimony only because such testimony was outside his competence and the methodology was flawed.[63]

3. *Case Law Supporting Exclusion of Expert Testimony*

Attempts to exclude expert testimony have been successful in the following cases:

- *Hutton v. American General Life & Acc. Ins. Co.*[64] The Mississippi Court of Appeals upheld a trial court's order to exclude plaintiff's insurance expert opinion that the insurer acted in bad faith. The plaintiff alleged she was the rightful beneficiary of her alleged common law husband's life insurance policy. The plaintiff brought suit against the defendant insurance company, alleging they denied her the life insurance benefits in bad faith. The plaintiff designated an expert witness, but the trial judge struck him as the proffered testimony was that the defendant had acted in bad faith. The judge later granted summary judgment in favor of the defendant. The plaintiff appealed, arguing that summary judgment was improper and that her expert should not have been stricken.

  The Mississippi Court of Appeals upheld summary judgment, finding no evidence from which a reasonable jury could have found that a life insurance contract existed between the plaintiff and the defendant. Because summary judgment was proper, the question of whether the expert was improperly stricken was now moot.

- *Marmillion v. American Intern. Ins. Co.*[65] The Southern District of Mississippi court held that a coverage expert's opinion that the policy in question was improperly cancelled was an impermissible legal conclusion.

  The plaintiff purchased multiple insurance policies with defendant insurer. The plaintiff did not stay up-to-date with her payments, as she changed addresses and did not receive bills and other correspondence from the defendant. Ultimately defendant cancelled the policies. The plaintiff's property was later damaged during Hurricane Katrina, prompting her to file a claim with the defendant. The defendant denied that there was a valid insurance policy on the property when it was damaged. The plaintiff brought suit alleging the defendant denied her claims in bad faith. Plaintiff's carrier, Willis, was also a party to the lawsuit. Willis designated an insurance expert, Wayne Davidson. Davidson's proffered testimony included his opinion that the plaintiff's policy was improperly cancelled because the defendant "didn't have any contractual right to issue a cancellation notice."[66] The defendant filed a Motion to Exclude the expert,

arguing that this was an impermissible legal conclusion. The Court granted the Motion, agreeing that the testimony amounted to "a legal conclusion that is not helpful to the Court."

• A Pennsylvania federal court recently precluded testimony of a proposed bad faith expert. In *Schifino v. GEICO General Ins. Co. et al.*,[67] the district court for the Western District of Pennsylvania precluded a plaintiff from offering expert testimony supporting an insurer's alleged bad faith. The court reasoned that expert testimony addressing the reasonableness of an insurer to deny a claim was unnecessary as a matter of evidence, and interfered with the fact finding role of the jury.

In *Schifino*, an insured filed suit against various insurers, including GEICO, seeking underinsured motorist benefits (UIM) following a motor vehicle accident. The insured alleged that GEICO violated the Pennsylvania bad faith statute, 42 Pa.C.S. § 8371, when it failed to pay the insured the UIM limits. Under Pennsylvania law, a plaintiff must prove that an insurer did not have a reasonable basis for denying benefits under the policy. Stuart Setcavage was offered to testify on behalf of the plaintiff that GEICO failed to comply with insurance statutes and regulations, and improperly handled the insured's claim.

The district court held that Setcavage's testimony was unnecessary and unhelpful to the jury as a matter of evidence, agreeing with GEICO that it should be excluded. The court opined that it was within then jury's province to determine the reasonableness of GEICO's claims handling.

• *Hyde Athletic Industries, Inc. v. Continental Casualty Co.*[68] The court in this case excluded the plaintiff's expert testimony when determining whether the environmental containment was "sudden or accidental" or whether it occurred over a long period of time. The exclusion of the evidence initially was based on inconsistencies between the expert's deposition testimony and the affidavits submitted on the summary judgment motion. In addition, the court noted that it was "concerned that Robertson's opinion would be inadmissible at trial under Federal Rule of Evidence 702 because it may not meet the standards outlined in *Daubert* "[69]

• *Brown v. Auto-Owners Insurance Co.*[70] This case involved expert testimony by a civil engineer regarding the structural damage to a warehouse, which was alleged to be speculative. In rejecting the expert testimony proffered by the insured/policyholder, the court noted that "the expert's testimony must be grounded in the methods and procedures of science and not subjective belief or unsupported speculation."[71] Because the testimony was based on nothing more than the witness's subjective belief and personal observations regarding the cause of the damages,

rather than mathematical calculation or scientific methodology, it was excluded.

• *Talmage v. Harris*[72] Plaintiff, a former client, filed a legal malpractice suit against his former attorney in connection with his handling of the client's suit against his fire insurer. Plaintiff retained an expert witness on liability. The expert was an attorney, with over 20 years of experience performing defense work for insurance companies. The expert's work as an insurance defense attorney included adjusting claims. He never represented a claimant who was pursuing a claim against an insurer for fire loss and making a claim under the insurance policy. The expert had never defended an insurance company against a claim by its own insured for coverage arising out of a fire loss.

The court explained the Seventh Circuit's test for evaluating the admissibility of expert testimony under F.R.E. 702 and *Daubert*:

> First, the court must decide "whether the expert's testimony pertains to scientific knowledge" and "must rule out subjective belief or unsupported speculation."[73] Second, the court needs to determine "whether the evidence or testimony assists the trier of fact in understanding the evidence or in determining a fact in issue."[74] Regarding this second inquiry, "[a]n expert's opinion is helpful only to the extent the expert draws on some special skill, knowledge, or experience to formulate that opinion; the opinion must be an *expert* opinion (that is, an opinion informed by the witness' expertise) rather than simply an opinion broached by a purported expert."[75] "Because an expert's qualifications bear upon whether he can offer special knowledge to the jury, the *Daubert* framework permits-indeed, encourages-a district judge to consider the qualifications of a witness."[76]

The court held that the expert was qualified to offer an opinion regarding the reasonableness of the insurer's handling of the plaintiff's claim. The expert was a lawyer with substantial experience in insurance law. The court noted that although he did not specialize in fire loss claims, the expert had special knowledge of the insurance claims adjustment process in general as a result of his 20 years' experience as a lawyer defending insurance companies against claims by policy holders. The court concluded by stating that it was satisfied that the expert had "enough experience with insurance claims and knowledge of the law of bad faith in Wisconsin to make his opinion regarding the viability of plaintiff's bad faith claim admissible under *Daubert*."[77]

- *Jordan v. Allstate Insurance Company*[78] In this 2007 California Court of Appeals case, the court held that expert testimony on statutory violation was admissible. Over Allstate's objection, the trial court considered the declaration of an expert on insurance industry claims settlement practice.[79] In his declaration, the expert expressed the opinion that various actions undertaken by Allstate violated certain provisions of the Unfair Insurance Practices Act (Ins.Code, § 790.03, subdivision (h)).[80] Allstate objected to the trial court's consideration of the expert's declaration on the ground that section 790.03, subdivision (h) cannot provide the basis for a bad faith action.[81] Allstate did not counter the expert's declaration, but objected on the ground that it was inadmissible for the reason stated above.[82] The court overruled that objection.

  The court held that the plaintiff was not seeking to recover on a claim based on a violation of section 790.03, subdivision (h). Rather, her claim was based on a claim of common law bad faith arising from Allstate's breach of the implied covenant of good faith and fair dealing which she is entitled to pursue.[83] Plaintiff's reliance upon the expert's declaration was for the purpose of providing *evidence* supporting her contention that Allstate had breached the implied covenant by its actions. This is a *proper* use of evidence of an insurer's violations of the statute and the corresponding regulations.[84] (See *Rattan v. United Services Automobile Assn*. 84 Cal.App.4th 715, 724, 101 Cal.Rptr.2d 6, 4th Dist. 2000).

4. *Case Law Supporting Admission of Expert Testimony*

In the following cases the courts have allowed the admission of expert testimony:

- *Jones v. Reynolds*.[85] In this case, the plaintiffs had a home insurance policy with the defendant insurer. Plaintiffs' home burned, and they sought coverage under the policy. Defendant's investigated the fire, and determined that the home may have burned due to arson. Defendant began investigating the plaintiffs' by seeking their cell phone records and requiring them to submit to an examination. Before the conclusion of the investigation, plaintiffs' filed a bad faith claim against the defendant.

  The plaintiffs' proffered the expert testimony of Donald Dinsmore. Dinsmore had twenty-six years of experience as a claims adjuster. The defendant argued that Dinsmore should be excluded because his opinions were impermissible legal conclusions. The court found Dinsmore to be qualified to give his expert opinion, and rather than excluding him, the court delineated the scope of his expert testimony.[86]

In sum, this case is substantially similar to *Rosamond* in that the court found the expert was qualified, and specifically categorized the proffered testimony into what was and was not acceptable. He was precluded from embracing ultimate questions of fact, nor could he make legal conclusions. Dinsmore could opine as to industry standards and explain the adjusters' conduct, but could not draw conclusions from them.

• *Michigan Millers Mutual Insurance Co. v. Benfield*.[87] In this case, the testimony of the insurer's fire and origin expert was excluded because it was not sufficiently reliable for admission under *Daubert*. Specifically, the court rejected the opinion evidence because it was not supported by reliable procedure and scientific methodology.

• *Douglas v. State Farm Lloyds*.[88] Though the issue here did not arise in the *Daubert* context, its determination affects the use of experts in insurance cases. In this "failure to investigate and settle" case, the court noted that "an insurer's reliance upon an expert report, standing alone, will not necessarily shield the carrier if there is evidence that the report was not objectively prepared or the insurer's reliance on the report was unreasonable."[89]

• *Aetna Casualty & Surety Co. v. Dow Chemical Co*.[90] This environmental case involved a claim by an insurance carrier that it was prejudiced because the insured's report regarding the removal of underground storage tanks did not contain information as to when releases or contamination occurred. The court noted that because the insurer did not utilize an expert on hydrogeology to establish the nature and timing of the discharge, the insurer's claim for prejudice was in doubt.

• *Watts v. Organogenesis, Inc*.[91] In a case involving the construction and interpretation of the phrase, "underlying medical condition," within a medical insurance contract, the insured's doctor had testified that dysreflexia was an underlying medical condition. Accepting the insured's expert testimony, the court noted: "If the phrase is a term of art, then a medical expert's unrebutted designation of the dysreflexia as such is sufficient as the last word on this issue. If it is not, then use of the phrase in the plan document is ambiguous, and therefore should be construed in accordance with the singular/plural rule . . . ."[92]

• *California Shoppers, Inc. v. Royal Globe Ins. Co*.[93] California Shoppers and four of its shareholders brought an action against its insurance carrier, Royal Globe to recover damages allegedly resulting from the breaches of two duties arising under the policy. One such breach was the refusal to indemnify the insured for a judgment awarded against it in a third-party action (the *Uneedus* action) brought by a competitor. The other was the failure to defend the *Uneedus* action. The main action also

> included a count for willful breach of the implied covenant of good faith and fair dealing allegedly occurring in connection with the failure to defend, as well as a count for fraud allegedly occurring at the time the insurance was purchased. The appellate court held that the lawyer who represented the policyholders against the shareholders did *not* qualify as a bad faith expert. The court reasoned that he could not testify as an expert because he had never been employed by an insurance company, or even retained as counsel by an insurance company.[94]

By virtue of the determination in *Kumho*, the rules espoused by these cases also apply to nonscientific evidence. Within the insurance context, these include bad faith, policy interpretations and claims-handling cases.

As the various district and state courts begin applying the *Kumho* analysis of *Daubert* to nonscientific evidence, inconsistencies between rigid application of the standards and a flexible approach should dissolve. For example, in *Moore v. Ashland Chemical, Inc.*,[95] the Fifth Circuit sitting en banc likely applied *Daubert* too rigidly when it held that the district court had discretion to exclude the causation testimony of the plaintiff's clinical physician because there existed an "analytical gap between the causation opinion and the scientific knowledge and data that were cited in support."[96] "Courts that have applied *Daubert* broadly have demonstrated that, as a general framework, *Daubert* plays an important role in requiring experts to do more than 'come to court with their credentials and a subjective opinion.'"[97] Since inconsistency is still a possibility, it is absolutely necessary that the practitioner grasp the standards applied in both state and federal courts within the applicable jurisdictions. An example of such analysis is included below. It considers the status of New York law subsequent to *Daubert, Joiner*, and *Kumho*. Such an analysis should be undertaken within the practitioner's relevant jurisdiction.

5. *Daubert Standard Codified*

The Florida legislature recently codified the *Daubert* standard in the state's evidence code. On June 4, 2013, Florida signed into law a bill amending Florida's evidence code that replaced the *Frye* standard with the *Daubert* standard. [98] Under Florida's new standard, as with Federal Rule of Evidence 702, if scientific, technical, or other specialized knowledge will assist the trier of fact, a witness qualified as an expert by knowledge, skill, experience, training, or education may provide opinion testimony if: (1)the testimony is based upon sufficient facts or data; (2) the testimony is the product of reliable principles and methods; and (3) the witness has applied the principles and methods reliably to the facts of the case. [99] The Florida statute also specifies that facts or data that are otherwise inadmissible may not be disclosed to the jury unless the court determines that their probative value substantially outweighs their prejudicial effect.[100]

E. *Mississippi Approach*

1. *Mississippi and Daubert*

Mississippi recently ruled on the scope of an insurance expert's testimony referencing the Daubert test. The Mississippi court held that expert testimony is limited to industry standards and whether the insurer conformed to those standards. [101] In *Rosamond v. Great American Ins. Co.*, the plaintiff alleged bad faith on the part of the defendant insurer, who denied the plaintiff coverage based on a finding that his injury was caused by a pre-existing condition. The defendant filed a Motion for Summary Judgment. The plaintiff responded to the Motion and included an affidavit from the plaintiff's insurance expert.[102] The defendant moved to strike the affidavit, challenging the relevance and reliability of the proffered expert's opinions under Rule 702 and the standards in *Daubert* and *Kumho Tires*.[103]

The court did not strike the affidavit in its entirety, but delineated certain permissible and impermissible subjects. (1) As an insurance expert with thirty years of experience, the expert was allowed to testify regarding relevant industry standards for the adjustment of claims, and whether the defendant conformed to those standards. (2) He was prohibited from expressing opinions as to whether the defendant acted in "good faith" or "bad faith," as this was a "patent legal conclusion."[104] (3) He had no medical training, so he could not offer opinions as to medical conditions, treatment, or causation. (4) He could not offer an opinion regarding the usual and customary meaning of the term "pre-existing condition" because the policy clearly defined this, and his opinion would not have been useful to the jury. (5) He was prohibited from offering opinions as to legal duties owed to the insured; this was for the court to determine. (6) He was also precluded from testifying that the claim was covered under the policy, or that the defendant "improperly denied benefits," as these determinations were for the jury. (7) He was also prohibited from suggesting that the policy in question was controlled by the Mississippi Worker's Compensation Act, as this was not a worker's compensation policy. (8) Finally, the court struck certain opinions that had no factual basis and were thus immaterial.

The court held that "[the expert] is not precluded from testifying as to the applicable standard of conduct and explaining the conduct of the persons involved in the adjustment of plaintiffs' claim, but he is not permitted to draw conclusions from those standards and explanations of conduct, as this is a determination for the jury."[105]

In Mississippi, insurers have a duty to "perform a prompt and adequate investigation and make a reasonable, good faith decision based on that investigation," or else they may be liable for denying a claim in bad faith.[106] To recover against an insurer who acted in bad faith, the plaintiff bears the burden of proving that the insurer denied the claim 1) without an arguable or legitimate

basis to do so, and 2) with "malice or gross negligence in disregard to the insured's rights."[107]

Where specialized knowledge may assist the jury, a witness qualified in such knowledge may testify where 1) the testimony is based on sufficient facts or data, 2) the testimony is the product of reliable methods, and 3) the expert has applied the methods or principles reliably to the facts of the case.[108] The trial court acts as a gatekeeper, and must make preliminary determinations as to whether the expert is qualified to give his proffered testimony, and whether the testimony is both relevant and reliable. [109]

2. *Unqualified Expert Testimony*

In *Trapani v. Treutel*[110] the Mississippi Court of Appeals recently excluded a coverage expert's opinion because the expert was not qualified to opine regarding casualty underwriting. The plaintiff, a restaurant owner, asked the defendant insurer to increase her windstorm policy limits. Plaintiff's property was damaged during Hurricane Katrina, prompting her to file an insurance claim. The plaintiff learned that the policy limits had not been increased, and she brought a bad faith suit against defendant. The defendant counters that plaintiff never asked for the increase.

At trial, the judge struck plaintiff's insurance expert, who had only one year of experience as a "casualty underwriter," and was to testify regarding the defendant underwriter's lack of diligence. The trial judge found the proffered expert's experience too limited to qualify as an expert on this issue. Without this evidence, the judge granted a directed verdict for the defendant, and the plaintiff appealed. The appellate court, finding no abuse of discretion, affirmed the decision. The court also stated that this was merely a negligence case against an insurance salesman, and thus did not require expert testimony on underwriting.

In *Brown v. Empire Fire and Marine Ins. Co., Inc.*[111] defendant argued that the plaintiff's expert testimony from the same expert proffered in *Trepani*, was unqualified similar to the *Trapani* case. In *Brown*, The plaintiff acquired a health insurance policy with the defendant insurer. The defendant investigated plaintiff's claims and determined he had misrepresented his medical history in his application for the policy. Defendant denied claims and rescinded the policy, and the plaintiff filed suit alleging the defendant had acted in bad faith. The plaintiff proffered expert testimony from the same insurance expert used in *Trepani*. The expert was to testify regarding the defendants' underwriting practices.[112] The defendant moved to strike the expert's testimony on the basis that he had no experience in underwriting during his 44-year career, and therefore he could not offer expert testimony regarding underwriting practices. The plaintiff countered that while the expert had no experience as an underwriter, he *was* an expert regarding "guidelines and procedures used by [sic] underwriting and issuing policies and what the standards are."[113] The PACER docket shows the case was

dismissed before the court could rule on this motion to strike. However, it should be noted that this case is substantially similar to the *Trapani* case; the defendant in that case made precisely the same argument in her motion to strike the same expert in the *Trapani* case.

3. *Unambiguous Policy Language*

The Mississippi federal district courts have held that unambiguous policy language precludes the relevance of a coverage expert's testimony.

In *WMS Industries, Inc. v. Federal Ins. Co.*,[114] the plaintiff's property was damaged during Hurricane Katrina. The plaintiff filed suit against the defendant insurer, alleging they denied coverage under the policy in bad faith. The plaintiff claimed to have suffered business income losses as a result.

The plaintiff designated insurance coverage experts. The experts proffered testimony included opinions as to the meaning of terms within the policy, the coverage available under the policy, and the "subjective intent of the parties."[115] The defendant moved to strike the testimony, arguing that (1) the interpretation of contracts is a question of law for the court,[116] and (2) the plain meaning of Federal Rule 702 is that expert witnesses may not testify about legal issues.[117] The defendant went on to argue that the contract's language was clear and unambiguous, and therefore the experts' opinions would be impermissible legal opinions at trial. The plaintiff responded that the experts' testimony should be admitted because (1) the Fifth Circuit prefers the admittance of evidence having some potential for assisting the trier of fact, (2) that ruling on the motion is premature without first ruling on defendant's Motion to Summary Judgment, and (3) that the witness' opinions were reliable.[118] The judge ruled that because the court had not yet determined whether the policy contract was unambiguous, the motions would be denied as premature.[119]

The defendant later argued that one of the experts should be excluded because (1) his opinions only related to the interpretation of the insurance policy, (2) his opinions would not assist the jury because they are "perfectly comprehensible to individuals without expertise in insurance adjusting," and (3) he does not purport to rely on any discernible methodology.[120] The judge granted the motion to exclude this expert, as "the policy is clear and unambiguous, [thus] coverage opinion testimony will not be admitted."[121]

In *GuideOne Mut. Ins. Co. v. Rock,*[122] a coverage expert's opinion on contractual duties was excluded because the policy contract was unambiguous. The plaintiff insurer brought this action to seek declaratory judgment against its insured. The plaintiff denied the insureds coverage under the homeowner's insurance after a home and two vehicles were destroyed by fire. The plaintiffs alleged that they rescinded the policy because the insureds made material misrepresentations and breached their post-loss duties. The plaintiff sought to

exclude the insureds' coverage expert. The expert was to testify as to whether the plaintiffs lacked a legitimate basis for denial. As the court dismissed the bad faith claim, The expert would only be allowed to testify regarding the contractual relationship. His opinion as to whether the claims were covered under the policy would not be helpful to the jury because the court determined the contract was unambiguous. However, since the expert was a certified fraud and financial examiner, he was allowed to testify as to the plaintiff's forensic accounting analysis.

4. *Impermissible Legal Conclusions*

The Mississippi federal courts have also held that a coverage expert's testimony will be stricken as impermissible when the expert makes a conclusion of law, rather than an opinion on the matter.

In *Young v. State Farm Mut. Auto. Ins. Co.*,[123] the plaintiff alleged that the defendant insurer denied coverage in bad faith. The plaintiff's adult daughter was injured when an uninsured motorist struck her as she was crossing the street. The defendant determined that she was not covered under plaintiff's insurance policy because she was not a member of his household. The defendant moved to strike the testimony of the plaintiff's insurance expert. The expert stated that "in his opinion, [the daughter] was covered under the policy, and the defendants had no arguable basis to deny coverage." The court struck this testimony, holding that this was an impermissible conclusion of law and therefore violated Federal Rule 704. [124]

Old Line Life Ins. Co. v. Brooks[125] held that a coverage expert was also excluded due to impermissible legal conclusions. In *Brooks*, Rufus Brooks had a life insurance policy with the plaintiff insurer. The policy named his two sons and one daughter as the beneficiaries. Rufus died at the hands of his sons, and thus his daughter, Amanda Brooks, argued that she was the only beneficiary legally entitled to the life insurance proceeds. The plaintiff insurer filed this interpleader action as a result of the dispute. Plaintiff hired an insurance expert to opine as to what percent Brooks was entitled to take. Defendant moved to strike this testimony, because it embraced an ultimate issue to be reached by the jury. The court granted the defendant's motion to strike the expert's testimony; his opinions as to the testator's subjective intent, and what percentages the beneficiaries were allowed to take, constituted impermissible legal conclusions from the evidence presented.

In *Tab Industries, Inc. v. Nationwide Mut. Ins. Co.*,[126] the plaintiff's property was damaged during Hurricane Katrina. The plaintiff filed a claim with the defendant insurer, who subsequently denied the claim. The plaintiff filed suit against the defendant, alleging they denied the claim in bad faith.

The defendant moved to exclude two of the plaintiff's expert witnesses. one of whom was a former judge, who offered opinions that the policy contract was ambiguous. One expert, the same one in *Trepani*, was to testify regarding claims practices. The court excluded the witnesses, holding that "the interpretation of policy provisions and the manner in which the claim was handled is not appropriate."[127] The court held that the testimony constituted impermissible legal conclusions that invaded the province of the court. As questions of fact and law, these conclusions were reserved for the court and jury.

5. *"Moral Risk" Opinions*

Certain coverage expert opinions categorized as "moral risk," i.e. risks that the insured will intentionally destroy property, are admissible. In *Russ v. Safeco Ins. Co. of America*,[128] the plaintiff had an insurance policy on his property with the defendant insurer. The plaintiff suffered a fire loss, and the insurer refused to cover the damage. Defendant suspected that the fire was purposefully caused by plaintiff, and plaintiff would not cooperate with insurer's investigation. Plaintiff filed suit, alleging breach of contract and bad faith. The court granted summary judgment on the bad faith claim. The court discussed the defendant's coverage witness in relation to the breach of contract claim.

The insurer's coverage expert had more than 40 years of experience in the insurance industry, having taught insurance for a university, and serving as President of an insurance consulting firm. The court struck most of his testimony as it interpreted "straight-forward" policy decisions, and contained legal conclusions that the defendant made a "good faith attempt" to investigate the plaintiff. His opinions regarding the plaintiff's subjective intent were also legal conclusions. The only proffered testimony the court did not strike was regarding "moral risk," or the risk that the insured will intentionally destroy property. The expert was allowed to discuss the threat of "moral risk" when the policy is exorbitant in relation to the worth of the insured property.

F. *Conclusion*

"Junk science" and the "junk expert" must be challenged early in the litigation process to thwart frivolous and speculative litigation and to preclude testimony of expert witnesses bearing specious credentials. The plaintiffs' bar should be tested and required to provide the defense with evidence concerning the qualifications, reliability and relevance of expert opinions well in advance of trial. Such an approach certainly will control the litigation and settlement costs and is critical to a proactive approach that challenges the "hired gun."

[1] Samuel R. Gross, *Expert Evidence*, 1991 Wis.L.Rev. 1113, 1182.

[2] *Douglas v. U.S. Fidelity & Guaranty Co.*, 81 N.H. 371, 127 A. 708 (1924).

[3] See, for example, *American Cas. Co. of Reading, Pa. v. Howard*, 187 F.2d 322 (4th Cir. 1951) (opinions as to advisability of going to trial rather than accepting compromise); *Kabatoff v. Safeco Ins. Co. of America*, 627 F.2d 207 (9th Cir. 1980); *Hanson By and Through Hanson v. Prudential Ins. Co. of America*, 783 F.2d 762 (9th Cir. 1985); *Worden v. Tri-State Ins. Co.*, 347 F.2d 336 (10th Cir. 1965); *Clark v. Interstate Nat. Corp.*, 486 F.Supp. 145 (E.D. Pa.), *aff'd*, 636 F.2d 1207 (3d Cir. 1980); *Rawlings v. Apodaca*, 151 Ariz. 149, 726 P.2d 565 (1986); *Neal v. Farmers Ins. Exchange*, 21 Cal.3d 910, 582 P.2d 980, 21 Cal. Rptr. 389 (1978); *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 261 Kan. 806, 934 P.2d 65 (1997).

[4] 509 U.S. 579 (1993).

[5] 522 U.S. 136 (1997).

[6] 526 U.S. 137 (1999).

[7] 293 F. 1013 (D.C. Cir. 1923).

[8] *PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM* (Basic Books 1991); *see also* Erica Beecher-Monas, *Blinded by Science: How Judges Avoid the Science in Scientific Evidence*, 71 TEMP. L. REV. 55 (1998). For an excellent discussion of the *Daubert* progeny *see* Neil E. Mathews & Leondra M. Hanson, *Daubert After Kumho Tire; How the Gatekeeper Evaluates the "Non-Scientific Expert,"* DRI Business Litigation Seminar 131 (1999); Scott R. Jennette, *Attacking the Plaintiff's Hazardous Substance Expert in the Post-Kumho Era*, 41 FOR THE DEFENSE 33 (May 1999); Jonathan M. Hoffman & Bert Black, *Old Tires and New Limbs: The Effect of* Kumho Tire *on Expert Testimony*, 27 PROD. SAFETY & LIAB. REP. (BNA) 354 (Apr. 2, 1999).

[9] 509 U.S. 579 (1993).

[10] 293 F. 1013 (D.C. Cir. 1923).

[11] *Daubert*, 509 U.S. at 588.

[12] *Id.* at 588.

[13] *Id.* at 590.

[14] *Id.* at 593-94.

[15] *Id.* at 592.

[16] *Id.* at 600.

[17] *See generally* Bert Black et al., *The Law of Expert Testimony—A Post-Daubert Analysis*, *in* Bert Black & Patrick W. Lee, Expert Evidence: A PRACTITIONER'S GUIDE TO LAW, SCIENCE AND THE FJC MANUAL 9, 47 (West 1997).

[18] *See* discussion in section B.1.b., *infra*.

[19] *Daubert v. Merrell Dow Pharm., Inc.*, 43 F.3d 1311 (9th Cir. 1995).

[20] 522 U.S. 136 (1997).

[21] For a discussion of which circuits applied the abuse of discretion standard of review or the de novo standard, *see United States v. Jones*, 107 F.3d 1147 (6th Cir.), *cert. denied*, 521 U.S.1127 (1997).

[22] *GE v. Joiner*, 522 U.S. 136, at 137 (1997).

[23] *Joiner, 522 U.S.* at 146.

[24] For a discussion of the standard adopted by the various states, *see* Mathews & Hanson, *supra* note 8, at 150.

[25] *See Iacobelli Const. v. County of Monroe*, 32 F.3d 19 (2d Cir. 1994); *Tamarin v. Adam Caterers, Inc.*, 13 F.3d 51 (2d Cir. 1993). The First, Fourth and Eleventh Circuits allowed district judges to review nonscientific expert evidence, but held that they could not utilize the *Daubert* factors. *See Bogosian v. Mercedes-Benz of N. Am., Inc.*, 104 F.3d 472 (1st Cir. 1997); *Michigan Millers Mut. Ins. Co. v. Benfield*, 140 F.3d 915 (11th Cir. 1998).

[26] *See Watkins v. Telsmith, Inc.*, 121 F.3d 984 (5th Cir. 1997); *Deimer v. Cincinnati Sub-Zero Prod.*, 58 F.3d 341 (7th Cir. 1995); *Cummins v. Lyle Indus.*, 93 F.3d 362 (7th Cir. 1996); *Peitzmeier v. Hennessy Indus.*, 97 F.3d 293 (8th Cir. 1996), *cert. denied,* 520 U.S. 1196 (1997). For a discussion of the conflict among the circuits, *see* Hoffman & Black, *supra* note 8, at 356-59.

[27] 526 U.S. 137 (1999).

[28] *Carmichael v. Samyang Tires, Inc.*, 923 F. Supp. 1514, 1521-22 (S.D. Ala. 1996), *rev'd.*, 131 F.3d 1433 (11th Cir. 1997).

[29] *Kumho*, 526 U.S. at 152.

[30] *Id.*

[31] 173 F.3d 1076 (8th Cir. 1999).

[32] *Jaurequi,* 173 F.2d at 1084; *see also Peitzmeier v. Hennessy Indus., Inc.*, 97 F.3d 293 (8th Cir. 1996), *cert. denied*, 520 U.S. 1196 (1997).

[33] 151 F.3d 269 (5th Cir. 1998), *cert. denied,* 526 U.S. 1064 (1999).

[34] 728 A.2d 70 (D.C. 1999).

[35] *Id.* at 75.

[36] 293 F. 1013 (D.C. Cir. 1923).

[37] *Id.* at 1014.

[38] *See Castrichini v. Rivera,* 175 Misc.2d 530, 669 N.Y.S.2d 140 (Sup. Ct., Monroe Co. 1997).

[39] *Thompson v. State Farm Fire and Cas. Co.*, 34 F.3d 932 (10th Cir. 1994); *State v. Merchants Ins. Co. of New Hampshire*, 109 A.D.2d 935, 486 N.Y.S.2d 412 (3d Dept. 1985); *Groce v. Fidelity General Ins. Co.*, 252 Or. 296, 448 P.2d 554 (1968); *Weiss v. United Fire and Cas. Co.*, 197 Wis. 2d 365, 541 N.W.2d 753 (1995).

[40] *Thompson v. State Farm Fire and Cas. Co.*, 34 F.3d 932 (10th Cir. 1994).

[41] In *Groce v. Fidelity General Ins. Co.*, 252 Or. 296, 448 P.2d 554 (1968), the court held that the fact that jury did not necessarily need expert testimony as to whether insurer acted in bad faith in failing to settle claim did not render his testimony inadmissible.

[42] *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

[43] For a recent discussion of the applicability of the *Daubert* standards to the insurance industry, see Walter J. Andrews, *Insurance 'Experts' and the Daubert Doctrine After Kumho Tire*, presented at the Defense Research Institute, Insurance Coverage and Practice Seminar, December 9-10, 1999.

[44] 75 F.3d 290, 293 (7th Cir. 1996).

[45] *See also United States v. Hall*, 165 F.3d 1095 (7th Cir. 1999).

[46] *Kulak v. Nationwide Mut. Ins. Co.*, 40 N.Y.2d 140, 351 N.E.2d 735, 386 N.Y.S.2d 87 (1976) (citations omitted).

[47] *Id.*

[48] *Id*. at 148.
[49] *Id*.
[50] *Id*. at 151.
[51] Patricia A. Krebs & Bryan J. De Tray, *Kumho Tire Co. v. Carmichael: A Flexible Approach to Analyzing Expert Testimony Under Daubert*, 34 TORT & INS. L.J. 989, 1003-04 (1999) (citation omitted).
[52] 102 F.3d 256 (7th Cir. 1996).
[53] *Id*. at 263.
[54] *Id*. (emphasis added).
[55] *Tassin v. Sears, Roebuck & Co*., 946 F. Supp. 1241, 1248 (M.D. La. 1996). For a discussion of the admissibility of computer models on environmental cases, *see* Allen Kezsbom & Alan V. Goldman, *The Boundaries of Groundwater Modeling Under the Law: Standards for Excluding Speculative Expert Testimony*, 27 TORT & INS. L.J. 109 (1991).
[56] 890 F. Supp. 1417 (N.D. Iowa 1995).
[57] *Id*. at 1447.
[58] *Id*. at 1448.
[59] 171 F.R.D. 305 (D. Kan. 1997).
[60] No. 95-7550, 1997 WL109582 (E.D. Pa. Mar. 7, 1997).
[61] 158 F.3d 548 (11th Cir. 1998).
[62] *Id*. at 563.
[63] *Id*.
[64] 909 So.2d 87 (Miss. App. 2005).
[65] No. 1:07CV1132-LG-RHW, 2008 WL 4514375 (S.D. Miss., Oct. 1, 2008).
[66] Def.'s Mot. To Exclude, ECF No. 117.
[67] 2013 U.S. Dist. LEXIS 76532 (W.D. Pa. May 31, 2013).
[68] 969 F. Supp. 289 (E.D. Pa. 1997).
[69] *Id*. at 299 n.7.
[70] 121 F.3d 697 (4th Cir. 1997).
[71] *Id*. at 697.
[72] 354 F.Supp.2d 860 (W.D. Wis. 2005).
[73] *Porter v. Whitehall Lab*., 9 F.3d 607, 614 (7th Cir.1993).
[74] *Ancho v. Pentek*, 157 F.3d 512, 515 (7th Cir. 1998).
[75] *Id*. at 518 (quoting *United States v. Benson*, 941 F.2d 598, 604 (7th Cir.1991)).
[76] *United States v. Vitek Supply Corp*., 144 F.3d 476, 486 (7th Cir.1998).
[77] *Talmage v. Harris*, 354 F.Supp.2d 860, 866 (W.D. Wis. 2005).
[78] 56 Cal.Rptr.3d 312 (Cal.App.2d Dist. 2007).
[79] *Id*.
[80] *Id*.
[81] *Moradi-Shalal v. Fireman's Fund Ins. Companies*, 46 Cal.3d 287, 304-305, 758 P.2d 58, 250 Cal.Rptr. 116 (1988).
[82] *Jordan v. Allstate*, 56 Cal.Rptr.3d 312 (Cal. App. 2nd Dist. 2007).
[83] See *Moradi-Shalal v. Fireman's Fund Ins. Companies*, *supra*, 46 Cal.3d at pp. 304-305, 758 P.2d 58, 250 Cal.Rptr. 116 (1988).
[84] *See, Rattan v. United Services Automobile Assn*., 84 Cal.App.4th 715, 724, 101 Cal.Rptr.2d 6 (4th Dist. 2000).
[85] No. 2:06cv57, 2008 WL 2095679, at * 11 -12 (N.D. Miss. May 16, 2008).
[86] (1) Dinsmore could not testify that the insureds were "unsophisticated;" (2) there was no need for him to instruct the jury on applicable law; (3) Dinsmore was not to testify regarding whether or not the Defendants adhered to the National Association of Insurance Commissioners' model code; (4) he could testify as to the policy limits, but not to what is "valued policy law;" (5) Dinsmore could not testify as to whether the insurers "fulfilled all policy conditions; (6) he could testify as to industry standards and explain the adjusters' conduct, but was not permitted to draw conclusions about this conduct; (7) Dinsmore could testify as to the recognized procedure for handling questions of coverage; (8) he could not opine whether the insurer refused to pay in a reasonable manner, as it embraced the ultimate fact; (9) Dinsmore could not address claims

outside the Plaintiffs' cause of action; and (10) he could not opine as to whether the insurers breached the duty of good faith.

[87] 140 F.3d 915 (11th Cir. 1998).
[88] 37 F. Supp. 2d 532 (S.D. Tex. 1999).
[89] *Id*. at 541.
[90] 10 F. Supp. 2d 800 (E.D. Mich. 1998).
[91] 30 F. Supp. 2d 101 (D. Mass. 1998).
[92] *Id*. at 110.
[93] 175 Cal. App. 3d 1, 221 Cal. Rptr. 171 (4th Dist. 1985).
[94] *Id*.
[95] 151 F.3d 269 (5th Cir. 1998), *cert*. *denied*, 526 U.S. 1064 (1999).
[96] *Id*. at 279 (citing *Joiner)*. *See* Krebs & De Tray, *supra* note 51, at 1007 and the dissenting opinion in *Moore*, 151 F.3d at 284, which calls for a grant of wide latitude to the district court when exercising its gatekeeping function.
[97] Krebs & De Tray, *supra* note 51, at 1007 (citing *Tassin v*. *Sears Roebuck,* 946 F. Supp. at 1248).
[98] *See* Brianne Bharkhda, *Florida Adopts Daubert Standard for Exert Testimony,* Inside Medical Devices (June 17th, 2013), *available at* http://www.insidemedicaldevices.com/2013/06/17/florida-adopts-daubert-standard-for-expert-testimony/.
[99] Fla. Evid. Code § 90.702.
[100] Bharkhda *supra* note 69.
[101] *Rosamond v*. *Great American Ins*. *Co*., No. 3:10CV263TSL–MTP, 2011 WL 4433582 (S.D. Miss. Aug. 4, 2011).
[102] [102] The Plaintiff also filed an affidavit from a physician expert. The Defendant moved to strike this affidavit on the grounds that the opinions in it were not contained in the physician's office notes, thus the Plaintiff should have filed a signed written report of this testimony pursuant to Local Rule 26(a)(2)(D). The Court held that the Local Rule recognized an exception to "treating physicians" such as this expert, so no report was necessary. Rosamond v. Great American Ins. Co., No. 3:10CV263TSL–MTP, 2011 WL 4433582, at *2 (S.D. Miss. Aug. 4, 2011).
[103] Fed. R. Evid. 702; *Daubert*, 509 U.S. 579 (1993); *Kumho Tire Co*., 526 U.S. 137 (1999).

[104] *See Young v*. *State Farm Mut*. *Auto*. *Ins*. *Co*., 1999 WL 33537177, at *2 (N.D. Miss. 1999) (Holding that an expert may not render conclusions of law).
[105] *Rosamond,* 2011 WL 4433582, at *5.
[106] *Liberty Mut*. *Ins*. *Co*. *v*. *McKneely*, 862 So.2d 530, 535 (Miss.2003).
[107] *Broussard v*. *State Farm Fire and Cas*. *Co*., 523 F.3d 618 (5th Cir. 2008).
[108] Miss. R. Evid. 702.
[109] *Daubert v*. *Merrell Dow Pharmaceuticals, Inc*., 509 U.S. 579 (1993); *Kumho Tire Co*. *v*. *Carmichael*, 526 U.S. 137 (1999).
[110] 87 So.3d 1096 (Miss. App. 2012).
[111] No. 3:07cv644 DPJ–JCS, 2009 WL 2242437 (S.D. Miss. Jul. 24, 2009).
[112] Def.'s Mot. To Exclude, ECF No. 88.
[113] Plf.'s Mot. In Opp., ECF No. 93.
[114] No. 1:06CV977–LG–JMR, 2008 WL 5622538 (S.D. Miss. April 16, 2008).
[115] Def.'s Mot. To Exclude, ECF Nos. 123-125
[116] *Id*. (citing Leonard v. Nationwide Mut. Ins. Co., 499 F.3d 419, 428-429 (5th Cir. 2007) ("The interpretation of an insurance policy, like any contract, is a legal question …").
[117] *Id*. (citing Fed. R. Evid. 702) ("If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence of to determine a fact in issue) (emphasis added).
[118] Plf.'s Resp. to Def.'s Mot. To Exclude, ECF Nos. 202-205
[119] *WMS Industries, Inc*. *v*. *Federal Ins*. *Co*., No. 1:06CV977–LG–JMR, 2008 WL 5622538 (S.D. Miss. April 16, 2008).

[120] Def.'s Mot. To Exclude, ECF No. 189.

[121] Hr'g, Mar. 5, 2009.

[122] No. 1:06-CV-218-SA-JAD, 2009 WL 2252206 (N.D. Miss. July, 28 2009).

[123] No. 2:97–CV–24–B–B, 1999 WL 33537177 (N.D. Miss. Feb. 16, 1999).

[124] *Young v. State Farm Mut. Auto. Ins. Co.*, No. 2:97–CV–24–B–B, 1999 WL 33537177 (N.D. Miss. Feb. 16, 1999) (citing Fed. R. Evid. 704; United States v. $9,041,598.68, 163 F.3d 238, 254 (5th Cir.1998)).

[125] No. 3:05-cv-722 DPJ-JCS, 2007 WL 892448 (S.D. Miss. Mar. 21, 2007).

[126] No. 1:08CV453–LTS–RHW, 2009 WL 1938983 (S.D. Miss. July 6, 2009).

[127] *Tab Industries, Inc. v. Nationwide Mut. Ins. Co.*, No. 1:08CV453–LTS–RHW, 2009 WL 1938983, at *4 (S.D. Miss. 2009).

[128] No. 2:11cv195–KS–MTP, 2013 WL 1310501 (S.D. Miss. Mar. 26, 2013).

THE SCOPE AND SIGNIFICANCE OF EXTRA-CONTRACTUAL DAMAGES IN MISSISSIPPI INSURANCE LITIGATION TODAY

by

Richard T. (Flip) Phillips

The topic of my talk today is the obligation of good faith and fair dealing that accompanies every contract of insurance, and the damages recoverable by policyholders in Mississippi and throughout the United States for breach of that obligation. This is a topic of increasing importance to insurance policyholders in today's world, where virtually every practice by an insurance company, or any national or global business, is standardized, computerized, and institutionalized. I want to address both the theory of the law in this area, and the practical application of the law on behalf of policyholders today.

There are three key points I wish to make that are important to attorneys who represent policyholders in Mississippi and throughout the nation:

1. Extra-contractual liability for breach of an insurance company's obligation of good faith and fair dealing is **not limited** to liability for " 'Bad Faith' failure to pay claims without arguable reason."
2. Extra-contractual damages in the insurance context in Mississippi, as in the majority of states, include extra-contractual *compensatory* as well as punitive damages, and
3. In Mississippi, as in the majority of states, extra-contractual compensatory damages, including attorneys' fees, are included in the actual damages to be

multiplied for purposes of applying the "constitutional ratio" test to determine the reasonableness of the amount of punitive damages.

These points are of importance to the real world, *practical* enforcement and protection of the contractual rights of insurance policyholders today.

INTRODUCTION
Insurance in the 21st Century

The insurance industry has undergone massive changes in practices over the past twenty-five years as the world burst from an Industrial Age into a new, global, digitally-driven Information Age. The industry is not alone in this regard. Banking, finance, manufacturing, communications, distribution, retail, medical, legal – every aspect of life, both personal and professional, of every member of society – has been impacted by tectonic changes in how business is conducted as the world enters the 21st Century. The very nature of the actuarial foundation of insurance, however, places the insurance industry at the forefront in opportunities for improvements in competitiveness, efficiency and profitability made available by these changes.[1]

Whether in sales practices, claims adjusting practices, policy provision interpretation, actuarial calculations, or the computation and payment of policy benefits, any action that impacts

[1]For a discussion of the impact of epochal changes in technology on civil litigation in general, *see* "The THIRD AGE, Civil Litigation at the Dawn of the 21st Century, Oct. 28, 2000, Keynote Address, by the author of this paper, to the 9th Annual Consumer Litigation Rights Conference in Denver, Colorado, available at http://www.smithphillips.com/publications.php.

an individual policyholder by *$ X* today, impacts the insurance company by *$ X* thousands (or hundreds of thousands) through systemic or institutional application. Enforcing the rights of a policyholder through the legal system in this environment has become an increasingly challenging and expensive task.

The old "Bad Faith" litigation for "tortious refusal to pay a claim without an arguable reason" which (particularly in California, Florida, and a few other states) occupied the attention of lawyers, judges, and legal scholars during the final decades of the 20th Century, is becoming a "relic" in today's world. Pushed by the competitive forces of consolidation and globalization of the industry and the quest for increasing efficiency and profitability, insurance companies and their officers are driven, in every aspect of the business, to "push the envelope" or, with increasing frequency in the post-*State Farm v. Campbell* legal system, **cross the line** of good faith and fair dealing.

It is in this environment that I want to discuss: (a) the **scope** of extra-contractual damages in insurance litigation, and (b) the **significance** of extra-contractual damages in insurance litigation today. In Mississippi – as in the majority of states throughout the nation – the scope of extra-contractual damages in insurance litigation is broader than frequently recognized. It includes extra-contractual compensatory, as well as punitive damages. The **significance** of extra-contractual compensatory damages, particularly in the post-*State Farm v. Campbell* and *Philip Morris v. Williams* legal system, is much **greater** than commonly recognized.

EXTRA-CONTRACTUAL DAMAGES
Mississippi in the Mainstream

Mississippi is frequently viewed as an "outlier" in many areas of civil law. Whether "ahead of the times" or "behind the times," the Mississippi legal system has often occupied positions considered "out of step" with current law in other states with regard to significant issues, both substantive and procedural.[2] With regard to the theory and scope of extra-contractual damages in insurance litigation, however, Mississippi is, and has always been, **squarely in the mainstream**. In almost four decades of well-articulated and recently *unanimous* opinions, the Mississippi Supreme Court has put Mississippi squarely in the center of the **majority** of states throughout the United States with regard to both (1) the *extent* of the obligation of good faith and fair dealing by insurance companies, and (2) the compensatory, as well as punitive, damages recoverable for breach of that obligation.[3]

The law in Mississippi as to extra-contractual damages is built on solid legal ground. The seminal Mississippi " 'bad faith' failure to pay a claim without an arguable reason" case, the *Veal*

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[2]In 1910, for instance, as early 20th Century tort law developed, Mississippi was the **first state** (by 21 years) to adopt the doctrine of **comparative negligence**. Act of April 16, 1910, ch. 135, 1910 MISS. LAWS 125 (codified as amended at MISS. CODE ANN. § 11-7-15 (Rev. 2004). The next state to do so was Wisconsin in 1931, followed by Alabama in 1955. *See* Victor E. Schwartz, Comparative Negligence § 1.04 (b) (4th ed. 2002); Dan B. Dobbs, Paul T. Hayden and Ellen M. Bublick, The Law of Torts § 220 (2d ed.). A century later, on the other hand, in 2014, Mississippi remains the **last state** with no state court procedure **for class actions**, a factor that puts state courts in Mississippi at a disadvantage in addressing institutional or systemic wrongful actions. *See* Linda S. Mullenix, *Should Mississippi Adopt A Class-Action Rule? Balancing the Equities: Ten Considerations That Mississippi Rulemakers Ought to Take into Account in Evaluating Whether to Adopt A State Class-Action Rule*, 24 Miss. C.L. Rev. 217 (2005).

[3]It is for this reason, that an examination of Mississippi law on the subject *today* is beneficial not only to Mississippi attorneys, but to attorneys representing policyholders, and the courts hearing their cases, throughout the United States.

case, was decided in 1977. *Standard Life Ins. Co. of Indiana v. Veal*, 354 So. 2d 239 (Miss. 1977). The *Veal* case expressly rested on the premise that an intentional wrong, or *actions that rise to the level of an independent tort*, gives rise to extra-contractual or punitive damages. ["We are of the opinion that the refusal to pay the legitimate claim in this cases was an intentional wrong and constituted an independent tort, as contemplated in *Progressive Casualty Insurance Company v. Keys*."] *Id.* at 248, citing *Progressive Casualty Insurance Company v. Keys*, 317 So.2d 396 (Miss. 1975).

In reaching its decision in *Veal*, the Mississippi Supreme Court reviewed the history of punitive and extra-contractual damages in Mississippi, noting that "[p]unitive damages may be recovered for a willful and intentional wrong, or for such gross negligence and reckless negligence as is equivalent to such a wrong." *Seals v. St. Regis Paper Co.*, 236 So.2d 388 (Miss. 1970); Such damages serve as "an example so that others may be deterred from the commission of similar offenses thereby in theory protecting the public." *Snowden v. Osborne*, 269 So.2d 858 (Miss. 1972); For such damages to lie "there must enter into the injury some element of aggression or some coloring of insult, malice or gross negligence, evincing ruthless disregard for the rights of others." *Fowler Butane Gas Co. v. Varner*, 244 Miss. 130, 150-51, 141 So.2d 226, 233 (1962); And that punitive damages are recoverable for breach of contract in Mississippi where "such breach is attended by intentional wrong, insult, abuse or such gross negligence as to consist of an independent tort." *Standard Life Ins. Co. of Indiana v. Veal*, 354 So.2d 239, (Miss. 1977), citing *Progressive Casualty Insurance Company v. Keys*, 317 So.2d 396, 398 (Miss. 1975).

On this solid foundation, there arose over the next three decades a body of substantive law in Mississippi regarding the duty of good faith and fair dealing implicit in contracts of insurance – and the extra-contractual liability of insurance companies for violation of that duty. *See, e.g., Andrew Jackson Life Ins. Co. v. Williams*, 566 So.2d 1172, 1186 (Miss. 1990); *Lewis v. Equity Nat'l Life Ins. Co.* 637 So. 2d 183, 185 (Miss 1994); *Stewart v. Gulf Guaranty Life Ins. Co.*, 846 So. 2d 192, 201 (Miss. 2003); *United American Insurance Company v. Merrill,* 978 So.2d 613, 630 (Miss. 2007), *cert denied*, 128 S.Ct. 1257, 170 L.Ed.2d 68, 76 USLW 3324, 76 USLW 3433, 76 USLW 3339 (Feb. 19, 2008).

In Mississippi, as in a majority of states throughout the nation, extra-contractual liability for breach of an insurance company's obligation of good faith and fair dealing is not limited to "'Bad Faith' failure to pay claims without arguable reason." The implied covenant of good faith and fair dealing exists with regard to every policy of insurance. Liability may exist for violation of that covenant whenever the breach reaches the level of an independent tort.

Extra-contractual damages in the insurance context in Mississippi, as in the majority of states, include extra-contractual *compensatory* as well as punitive damages. Where an insurance company's wrongdoing is accompanied by conduct that rises to the level of an intentional tort, damages for emotional distress, mental anguish and costs, including attorneys' fees, are recoverable.

> Applying the familiar tort law principle that one is liable for the fall measure of the reasonably foreseeable consequences of her actions, it is entirely foreseeable by an insurer that the failure to pay a valid claim through the negligence of its employees should cause some adverse result to the one entitled to payment. Some anxiety and emotional distress would ordinarily follow, especially in the area of life insurance where the loss of a loved one is exacerbated by the attendant financial effects of that loss. Additional inconvenience and expense, attorneys fees and the like should be expected in an effort to have the oversight corrected. It is no more than just that the injured party be compensated for these injuries.

United American Insurance Company v. Merrill, 978 So.2d 613, 630 (Miss. 2007).

As the law regarding the obligation of good faith and fair dealing and extra-contractual damages has developed throughout the United States, Mississippi has remained in the mainstream, also, with regard to "third party" Bad Faith actions, as opposed to "first party" actions for breach of obligation of good faith and fair dealing.

Ten (10) of the 50 states have Third Party, as well as First Party, actions for "Bad Faith" refusal to pay without an arguable reason.[4] Twelve (12) States have either no, or limited, actions for breach of the obligation of good faith and fair dealing. Mississippi is squarely in the middle of the growing majority, Twenty-Eight (28) States whose laws provide for First Party actions only. *See*, Appendix A: "50 STATE ANALYSIS, 'Bad Faith Law' (Obligation of Good Faith and Fair Dealing)", March 2014, page 1.

As illustrated by page 2 of Appendix A, Mississippi is in the solid majority of Thirty Eight (38) states whose laws provide insurance policyholders the protection afforded by First Party extra-contractual liability in insurance. Appendix A: "50 STATE ANALYSIS, (Protected Policyholder Status)," March 2014, page 2.

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[4]Much of the "Bad Faith" litigation, as it is commonly thought of throughout the country, revolves around these Third Party states, particularly California and Florida.

The Scope of Extra-Contractual Liability

The scope of Extra Contractual Liability ["ECL"] for breach of the obligation of good faith and fair dealing in Mississippi, as elsewhere, is much broader than simple "failure to pay a claim without an arguable reason." The obligation of good faith and fair dealing in a contract of insurance relates to all dealings by the insurer with the insured regarding the policy. An insurance company's obligation of good faith and fair dealing to its insured is much broader than implied by the often mis-applied, short-hand term "Bad Faith."[5]

A few examples of actual Mississippi cases illustrate the extensive breadth and increasing importance of ECL for protection of insurance policyholders in situations other than simple "bad faith refusal to pay with out an arguable reason." All materials referenced here are available as a matter of public record.

1. Institutional and systemic claims practices

A classic example of institutional and systemic actions in the modern era of claims handling that give rise to liability for breach of the obligation of good faith and fair dealing is

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[5] *See,* "The Law of Insurance Claim Practices - Beyond Bad Faith," 47 TORT TRIAL & INSURANCE PRACTICE LAW JOURNAL 693, (publication of the American Bar Association, Tort Trial & Insurance Practice Section) Winter 2012, by Professor Jay Feinman of the Rutgers School of Law, Camden, New Jersey. A basic premise of Professor Feinman's article, which reexamines the law of first-party claims practices generally, is that **"bad faith" is an ill-advised term** for the area. For an even more recent, "philosophical" examination of the "obligation resting on the nature and contemporary importance of insurance," *see*, Kenneth S. Abraham, LIABILITY FOR BAD FAITH AND THE PRINCIPLE WITHOUT A NAME (YET), 19 Conn. Ins. L.J. 1 (2012). "Insurers owe, or ought to owe those with whom they deal," writes Professor Abraham, "a higher obligation of fair dealing than ordinary private enterprises typically owe those with whom they deal," *Id*. 11. Over the past two decades of evolution of "bad faith law" there has arisen, says Abraham, an "as yet unnamed principle" relating to institutional or systemic conduct by insurance companies. "The character of the principle I discern in insurance law is one of obligation resting on the nature and contemporary importance of insurance. . . . ." *Id*. 8-9.

Kuykendoll v. Progressive Gulf Insurance Co., et al., Cause Number CV2000-60(P2), Circuit Court of the Second Judicial District of Panola County, Mississippi.[6] The *Kuykendoll* case addressed systemic "claim withdrawals" procured in the company's Southeast Region, including Mississippi, via allegedly intimidatory tactics, employing standardized forms prepared at the home office for each state. Even in the absence of a claim "denial," actions by the insurance company and its employees that violate the obligation of good faith and fair dealing may give rise to extra-contractual and punitive damages.[7]

2. Post-Catastrophe modification of claims practices (The Post-Katrina "Wind-Water Protocol")

Post-catastrophe scenarios with increasing frequency give rise to situations where extra-contractual damages afford the only practical means of redress for a policyholder who is one of thousands impacted by the catastrophe. *See, for example*, *Guice v. State Farm*, Civil Action No. 1:06cv1 LTS-RHW, United States District Court, Southern District of Mississippi, **Doc. 195**, Second Amended Complaint, ¶¶ 54-59; 64-70, available at **2007 WL 607472**; *also*, **Doc. 386**, Plaintiff's Response to State Farm Defendants' Motion for Protective Order, available at **2007 WL 1623838**. [Post-catastrophe reinterpretation of anti-concurrent causation clause].

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[6]*Kuykendoll v. Progressive* was one of two (2) cases in Panola County, Mississippi, arising from identical "claims withdrawal" practices, allegedly systemic in the southeast region and motivated by an institutional "Gainsharing" program for compensation of employees including adjusters. The other case was *Davis v. Progressive Gulf Insurance Company, et al.*, Cause Number CV2001-92(P1), Circuit Court of the First Judicial District of Panola County, Mississippi.

[7]Details of facts in the case, and the legal basis for liability, can be found in the publically-available June 1, 2004 Memorandum in Opposition to Motion for Partial Summary Judgment in the *Kuykendoll* case. [Copies available]

3. Actuarial Illustration and Sales Practices

Breach of the obligation of good faith and fair dealing was at issue, also, in the intentional illustration of interest-sensitive "vanishing premium" life insurance based on dividends which were actuarially unsustainable at current earnings for purpose of illustrating earlier "vanish dates" for competitive sales purposes. *See*, *Phillips v. New England Mutual Life Ins. Co.*, 36 F. Supp.2d 345, 347 (S.D. Miss. 1998). [Sales illustrations based on inflated dividend assumptions and actuarial computations manipulated to portray more favorable 'vanish date'. Causes of action stated under Mississippi law for fraudulent misrepresentation, fraudulent concealment and fraudulent inducement.] *Also, Myers v. Guardian Life Insurance Co.*, 5 F. Supp.2d 423 (N.D. Miss. 1998); *Hignite v. American General Life & Accident Ins. Co.*, 142 F. Supp.2d 785. 789-90 (N.D. Miss., 2001); *and Haggan, et al v. Jackson National Life Ins. Co, et al*, Cause No. 96-0295, Circuit Court of Copiah County, Mississippi. [Jury verdict on behalf of policyholders for actual and punitive damages for life insurance deceptive sales practices]

4. Unilateral reduction of Policy benefits to "on-claim" Cancer Victims:

Perhaps the best example of the critical role of extra-contractual compensatory and punitive damages (and the interplay between the two) is found in the recent Life Investors supplemental cancer policy litigation. *See*, *Wright, et al v. Life Investors Insurance Company of America*, No. 2:08cv003-WAP-SAA, **Doc. 202**, Plaintiffs' Memorandum in Opposition to Life Investors Insurance Company of America's Motion for Partial Summary Judgment, pp.6-16, United States District Court, Northern District of Mississippi, **2010 WL 3252605**; also available on PACER. [Nationwide unilateral modification of benefits payable to "on claim" cancer victims

based on prior, express calculation by insurance company of potential aggregate post-*State Farm v. Campbell* punitive damage liability, including costs of defending policyholder cases; computation of potential net savings; and intentional implementation of new policy interpretation and method of calculating benefits under cancer policies.]

Publically-available materials from each of the above cases illustrate the breadth and scope of both compensatory, extra-contractual and punitive damages for the protection and enforcement of policyholders rights in Mississippi, as in a majority of states throughout the nation.

Significance of Extra-Contractual Compensatory Damages in Insurance Litigation Today (The *State Farm/Campbell* Punitive Damage Ratio)

Attorneys fees and costs of prosecuting the case for tortious breach of the obligation of good faith and fair dealing are not punitive damages in Mississippi. They are part of the *compensatory* damages to be multiplied in the *State Farm/Campbell* "ratio" analysis. The fees and costs of enforcing the contract are recoverable as compensatory damages in Mississippi for tortious breach of the obligation of good faith and fair dealing implicit in every contract of insurance. *Universal Life Ins. Co. v. Veasley,* 610 So. 2d 290, 295 (Miss. 1992); *United American Insurance Company v. Merrill*, 978 So.2d 613, 630 (Miss. 2007).[8]

The recovery of punitive damages is governed in Mississippi by statute. MISS. CODE § 11-1-65. The Mississippi punitive damage statute was enacted in 1993. The statute limits the

[8]Such damages, frequently referred to as "*Veasley* damages" in Mississippi, are commonly known in other states by the names of their cases to similar effect.

amount of punitive damages recoverable in certain situations. [§ 11-1-65(3)]. It also specifies the elements the fact finder shall consider in determining the amount of punitive damages. [Section 11-1-65(1)(e)]. Attorneys' fees and costs of litigation are not factors to be included by the fact finder in the determining the amount of punitive damages to be awarded. They are a part of the actual, compensatory damages to be multiplied by the Court in applying the single-digit "ratio" test pursuant to *State Farm v. Campbell*.

Mississippi is again in the majority. It is one of twenty-seven (27) states in which such extra-contractual damages are compensatory. In only nine (9) states – including Utah – are such damages a part of the *punitive* damages. In fourteen (14) states the issue appears undecided, but the trend is clearly toward the majority/Mississippi view. *See*, Appendix B, "50 STATE ANALYSIS, Attorneys' Fees as Compensatory (For Punitive Damage Multiplier)" [including citations].

In Mississippi, as in other states where attorneys' fees and litigation costs are part of the compensatory damages, a policyholder's attorneys' fees and costs are to be included in his actual damages for purposes of the applying the *State Farm v. Campbell* constitutional, single-digit "ratio" test. *Blount v. Stroud*, 915 N.E.2d 925, 943 (Ill.App.Ct. 2009), *cert. denied*, 131 S.Ct. 503 (2010) [noting that the majority of the courts across the country that have considered this issue have agreed that attorney fees should be taken into account as part of the compensatory damages factor in the "ratio" analysis.] *See, also, Willow Inn, Inc. v. Public Service Mut. Ins. Co.*, 399 F.3d 224 (3rd Cir. 2005).

The inclusion of policyholders' attorneys' fees and litigation expenses as part of the compensatory damages for purposes of application of the *Campbe*ll punitive damage "multiplier" ratio enables individual policyholders, as a practical matter, to combat improper institutional practices. It helps "narrow the gap" between the amount the two parties have at issue in the dispute. It helps eliminate abusive practices which exploit that disparity on both an individual and mass basis. In cases of (sometimes calculated) tortious breach of an insurer's obligation of good faith and fair dealing, it helps prevent insurance companies from using their superior economic power, in a post-*State Farm*/*Campbell* legal system, to profit via systemic or institutional wrongful practices.[9]

CONCLUSION

Extra contractual liability for breach of the obligation of good faith and fair dealing plays an increasingly important role in protecting the ability of policyholders to enforce their contracts of insurance. It is hoped that the above paper may shed some light on the scope and proper application of extra-contractual liability in Mississippi and throughout the United States today.

[9]*See*, e.g., *Wright, et al v. Life Investors Insurance Company of America*, No. 2:08cv003-WAP-SAA, Doc. 202, 2010 WL 3252605.

50 STATE ANALYSIS

"BAD FAITH" LAW

(Obligation of Good Faith and Fair Dealing)

March 2014

First Party and <u>Third Party</u> "Bad Faith" Claims (10 States)	**First Party Actions Only (28 States)**	**Limited or NO Actions (12 States)**
1. Alabama	1. Alaska	1. Georgia
2. **California**	2. Arizona	2. Illinois
3. **Florida**	3. Arkansas	3. Kansas
4. Iowa	4. Colorado	4. Maine
5. Kentucky	5. Connecticut	5. Maryland
6. Louisiana	6. Delaware	6. Missouri
7. Michigan	7. Hawaii	7. New York
8. Montana	8. Illinois	8. Oregon
9. Washington	9. Idaho	9. Pennsylvania
10. West Virginia	10. Indiana	10. Tennessee
	11. Massachusetts	11. Utah
	12. Minnesota	12. Virginia
	13. **Mississippi**	
	14. Nebraska	
	15. Nevada	
	16. New Jersey	
	17. New Mexico	
	18. North Carolina	
	19. North Dakota	
	20. Ohio	
	21. Oklahoma	
	22. Rhode Island	
	23. South Carolina	
	24. South Dakota	
	25. Texas	
	26. Vermont	
	27. Wisconsin	
	28. Wyoming	

APPENDIX A

50 STATE ANALYSIS

PROTECTED POLICYHOLDER STATUS

(FIRST PARTY Extra-Contractual Damages)

March 2014

POLICYHOLDER Actions Available (38 States)

1. Alabama
2. Alaska
3. Arizona
4. Arkansas
5. California
6. Colorado
7. Connecticut
8. Delaware
9. Florida
10. Hawaii
11. Illinois
12. Idaho
13. Indiana
14. Iowa
15. Kentucky
16. Louisiana
17. Massachusetts
18. Michigan
19. Minnesota
20. **Mississippi**
21. Montana
22. Nebraska
23. Nevada
24. New Jersey
25. New Mexico
26. North Carolina
27. North Dakota
28. Ohio
29. Oklahoma
30. Rhode Island
31. South Carolina
32. South Dakota
33. Texas
34. Vermont
35. Washington
36. West Virginia
37. Wisconsin
38. Wyoming

Limited or NO Actions (12 States)

1. Georgia
2. Illinois
3. Kansas
4. Maine
5. Maryland
6. Missouri
7. New York
8. Oregon
9. Pennsylvania
10. Tennessee
11. Utah
12. Virginia

APPENDIX A

50 STATE LAW ANALYSIS

ATTORNEYS' FEES AS COMPENSATORY
(For Punitive Damages Multiplier)
March 2014

Compensatory: (27 States)	**Punitive: (9 States)**	**Undecided: (14 States)**
1. Arizona	1. Alabama	1. Alaska
2. Florida	2. California	2. Arkansas
3. Georgia	3. Colorado	3. Connecticut
4. Idaho	4. Delaware	4. Hawaii
5. Illinois	5. Kentucky	5. Indiana
6. Iowa	6. New York	6. Louisiana
7. Kansas	7. Tennessee	7. Maine
8. Massachusetts	8. Texas	8. North Carolina
9. Maryland	9. **Utah**	9. North Dakota
10. Michigan		10. New Hampshire
11. Minnesota		11. Rhode Island
12. Missouri		12. South Carolina
13. **Mississippi**		13. South Dakota
14. Montana		14. Virginia
15. Nebraska		
16. New Jersey		
17. New Mexico		
18. Nevada		
19. Ohio		
20. Oklahoma		
21. Oregon		
22. Pennsylvania		
23. Vermont		
24. Washington		
25. Wisconsin		
26. West Virginia		
27. Wyoming		

APPENDIX B
REFERENCES ATTACHED

50 STATE LAW ANALYSIS

ATTORNEYS' FEES AS COMPENSATORY
(For Punitive Damages Multiplier)

COMPENSATORY

STATE		LEGAL AUTHORITY
AZ	Compensatory	A.R.S. § 12-341.01; Schwartz v. Farmers Ins. Co. of Ariz., 800 P.2d 20, 23 (Ariz.Ct.App.1990) ("attorney's fees are compensable damages in the bad faith claim")
FL	Compensatory	Fla. Stat. § 624.155. See Progressive Express Ins. Co. v. Scoma, 975 So.2d 461, 465 (Fla. 2d DCA 2007); Talat Enters., Inc. v. Aetna Cas. & Sur. Co., 217 F.3d 1318, 1319 (11th Cir. 2000); McLeod v. Continental Ins. Co., 591 So. 2d 621, 623 (Fla. 1992)
GA	Compensatory	Action Marine, Inc. v. Cont'l Carbon, Inc., 481 F.3d 1302, 1321 (11th Cir. 2007) ("In Georgia, awards of attorney fees in tort cases involving bad faith are compensatory in nature."); O.C.G.A. § 13-6-11 (2006 Supp.) City of Warner Robins v. Holt, 220 Ga.App. 794, 470 S.E.2d 238, 240 (1996)(purpose of award of attorney fees and litigation expenses is to compensate injured party, in order that such parties are not further injured by the cost as result of seeking legal redress); Ross v. Hagler, 209 Ga.App. 201, 433 S.E.2d 124, 127 (1993)(award of attorney fees under 13-6-11 not punitive in nature).
ID	Compensatory	I.C. § 41-1839; Halliday v. Farmers Ins. Exchange, 404 P.2d 634 (Idaho 1965) ("Not being a penalty, such attorney fee is an additional sum rendered as compensation")
IL	Compensatory	Blount v. Stroud, 915 N.E.2d 925 (Ill.App.Ct. 2009), *cert den'd* by United States Supreme Court 131 S.Ct. 503 (2010); Lawlor v. North American Corp. of Illinois, 949 N.E.2d 155, 176 (Ill. App. 2011); aff'd in part; rev'd in part on other issues, 983 N.E. 2d 414 (Ill. 2012); 215 ILCS 5/155 (1992)

IA	Unsure	Deters v. USF Ins. Co., 797 N.W.2d 621 (Iowa Ct. App. 2011); Smutz v. Central Iowa Mut. Ins. Ass'n, 742 N.W.2d 605 (Iowa App. 2007)
KS	Compensatory	K.S.A. 40-256; Wolf v. Mutual Ben. Health and Acc. Ass'n, 366 P.2d 219 (Kan. 1961) ("*compensatory and not penal*")
MA	Compensatory	G.L. c. 176D, § 3(9) (f); G.L. c. 93A, § 9(3) and (4) (reasonable attorneys' fees and costs); Hopkins v. Liberty Mut. Ins. Co., 750 N.E.2d 943 (Mass. 2001); Siegel v. Berkshire Life Ins. Co., 873 N.E.2d 1202 (Mass.App.Ct. 2007) (evidence supported award of fees as damages); Hanover Ins. Co. v. Golden, 436 Mass. 584, 766 N.E.2d 838 (Mass. 2002) (bad faith showing not required for fee award against insurer); Fascione v. CNA Ins. Companies, 435 Mass. 88, 754 N.E.2d 662 (Mass. 2001) ("compensated for their litigation expenses")
MD	Compensatory	Poku v. F.D.I.C., CIV.A. RDB-08-1198, 2011 WL 1599269 (D. Md. Apr. 27, 2011); Hoffman v. Stamper, 385 Md. 1, 48-49, 867 A.2d 276, 304-305 (Md.2005) (citing Golt v. Phillips, 308 Md. 1, 12, 517 A.2d 328, 333 (1986); Md.Code Ann., Com. Law § 13-408; Kilsheimer v. Dewberry & Davis, 665 A.2d 723 (Md.App. 1995)
MI	Compensatory	Murphy v. Cincinnati Ins. Co., 576 F Supp 542 (E.D. Mich. 1983)
MN	Compensatory	Morrison v. Swenson, 142 N.W.2d 640 (MINN 1966) (fees are recovered as compensation for loss caused by the insurers' breach)
MO	Compensatory	Mo.Rev.Stat. s 375.420; Columbia Union Nat. Bank v. Hartford Acc. and Indem. Co., 669 F.2d 1210 (8th Cir. 1982)
MS	Compensatory	Universal Life Ins. Co. v. Veasley, 610 So.2d 290, 636 (Miss. 1992); United American Insurance Company v. Merrill, 978 So.2d 613 (Miss. 2007); *cert denied*, United States Supreme Court, 128 S.Ct. 1257, 170 L.Ed.2d 68, 76 USLW 3324, 76 USLW 3433, 76 USLW 3339,(U.S. Miss. Feb. 19, 2008)

MT	Compensatory	Mountain West Farm Bureau Mut. Ins. Co. v. Brewer, 69 P.3d 652 (MT 2003); Goodover v. Lindey's Inc., 843 P.2d 765, 774 (Mont. 1992); Riordan v. State Farm Mut. Auto. Ins. Co., 2008 WL 2512023 (D.Mont. June 20, 2008).
NE	Compensatory	Neb.Rev.Stat. § 44-359; Guenther v. Time Ins., Company, 2008 WL 731593 (D.Neb. Mar. 17, 2008)
NJ	Likely Compensatory	Taddei v. State Farm Indem. Co., 401 N.J.Super. 449, 951 A.2d 1041 (N.J.Super.A.D. 2008) (measure of damages for breach of duty of good faith and fair dealing is "any foreseeable consequential damages," including attorneys' fees); *but see* Baker v. National State Bank, 801 A.2d 1158 (N.J. Super. 2002) (applying only to certain actions with fee awards by statute)
NM	Compensatory	State ex rel. New Mexico State Hwy. & Transp. Dep't. v. Baca, 120 N.M. 1, 5, 896 P.2d 1148, 1152 (1995)
NV	Compensatory	In re USA Commercial Mortg. Co., 802 F.Supp. 2d 1147 (D. Nev. 2011); N.R.S. 686A.310 (awarding "any damages sustained by the insured as a result of the commission of any act set forth"); Union Pacific R. Co. v. Zurich American Ins. Co., 2010 WL 4983466, *1 (D.Nev. Nov 30, 2010) (attorneys' fees may be used to establish jurisdictional amount for diversity jurisdiction); NRS 18.010 allows attorney fee recovery where prevailing party has not been awarded more than $20,000.
OH	Compensatory	Furr v. State Farm Mut. Auto. Ins. Co., 128 Ohio App.3d 607, 716 N.E.2d 250, 265 (Ohio Ct.App.1998); Estate of Millhon v. UNUM Life Ins. Co. of America, 2009 WL 2431252 (S.D.Ohio Aug. 5, 2009) ("Compensatory damages arising from a bad-faith insurance claim may include attorney's fees.")

OK	Likely Compensatory	36 Okl.St.Ann. § 3629; Christian v. American Home Assur. Co., 577 P.2d 899 (Okl. 1977) ("[W]here a litigant has acted in bad faith, wantonly or for an oppressive reason, the trial court, in exercise of its equitable power, may award attorney fees."); Badillo v. Mid Century Ins. Co., 121 P.3d 1080 (Okla. 2005); Barnes v. Okla. Farm Bureau Mut. Ins. Co., 11 P.3d 162, 180 (Okla. 2000); *Hebble v. Shell W. E & P, Inc*., 238 P.3d 939 (OK CIV APP 2010)
OR	Compensatory	O.R.S. § 742.061; Hardware Mut. Cas. Co. v. Farmers Ins. Exchange, 256 Or. 599, 474 P.2d 316 (Or. 1970) ("The statute is compensatory, not penal.")
PA	Compensatory	Willow Inn, Inc. v. Public Service Mut. Ins. Co., 399 F.3d 224 (3rd Cir. 2005); Jurinko v. Medical Protective Co., 305 Fed.Appx. 13 (3rd Cir. 2008)
VT	Compensatory	Burlington Drug Co., Inc. v. Royal Globe Ins. Co., 616 F.Supp. 481, 483 (D.C.Vt. 1985); Monahan v. GMAC Mortg. Corp., 893 A.2d 298, 323-24 (Vt. 2005)
WA	Compensatory	Clausen v. Icicle Seafoods, Inc., 174 Wash.2d 70, 272 P.3d 827, 836 (2012); Olympic Steamship Co., Inc. v. Centennial Ins. Co., 811 P.2d 673 (1991) ; fees also available under Washington Consumer Protection Act
WI	Compensatory	Roehl Transport, Inc. v. Liberty Mut. Ins. Co., 784 N.W.2d 542 (Wis. 2010); Stewart v. Farmers Ins. Group, 2009 WI App 130, ¶ 14, 321 Wis.2d 391, 773 N.W.2d 513 ("[A]s damages resulting from the tort of bad faith, attorney fees do not remain attorney fees, but instead are transformed into damages.")
WV	Compensatory	Quicken Loans, Inc. v. Brown, 737 S.E.2d 640, 666 (W.Va. 2012); Jordan v. National Grange Mut. Ins. Co., 183 W. Va. 9, 393 S.E.2d 647 (W. Va. 1990) (attorneys' fees awarded for bad faith as element of compensatory damages)

WY	Compensatory	W.S.1977 § 26-15-124; State Farm Mut. Auto. Ins. Co. v. Shrader, 882 P.2d 813 (Wyo. 1994) (“recovery of attorney's fees and interest as a form of compensatory damages”); Smith v. Equitable Life Assur. Soc., 614 F.2d 720 (10th Cir. 1980) (“Statutory provisions allowing recovery of expenses incurred in pursuing a just and reasonable claim are not penal, but remedial or compensatory, in that actual loss is at issue, traceable directly to the insurer's improper conduct. Thus, statutes awarding attorney's fees to successful insurance claimants are properly considered compensatory, not penal . . . .”).

50 STATE LAW ANALYSIS
ATTORNEYS' FEES NOT COMPENSATORY
(For Punitive Damages Multiplier)

PUNITIVE

STATE		LEGAL AUTHORITY
AL	Punitive / Attorneys' Fees Generally Not Recoverable	Jackson v. National Sec. Fire and Cas. Co., Inc., 962 So.2d 855 (Ala.Civ.App. 2006); Clark v. Exchange Ins. Assn., 161 So.2d 817 (Ala.1964) (strict American Rule)
CA	Punitive	Amerigraphics, Inc. v. Mercury Cas. Co., 107 Cal.Rptr.3d 307 (Cal. App. 2010); Bardis v. Oates, 14 Cal. Rptr.3d 89 (Cal. App. 2004); *but see* Brandt v. Superior Court, 693 P2d 796 (Cal. 1985).
CO	Punitive / Attorneys' Fees Not Generally Recoverable	Bernhard v. Farmers Ins. Exchange, 915 P.2d 1285 (Colo. 1996). May be able to get fees under Colo. Rev. Stat. Ann. § 13-17-101 (2008) (allowing attorneys' fees to address the problem of excessive litigation)
DE	Punitive	E. I. Du Pont De Nemours and Co. v. Admiral Ins. Co., 1994 WL 465547 (Del.Super. Aug. 03, 1994) (not compensatory)
KY	Punitive	Aetna Casualty & Surety Co. v. Commonwealth, 179 S.W.3d 830, 842 (Ky.2005) (strict American Rule); Blue Cross and Blue Shield of Kentucky, Inc. v. Whitaker, 687 S.W.2d 557 (Ky.App. 1985)
NY	Punitive / Fees Generally Not Recoverable	White v. Blue Cross & Blue Shield, 549 NYS2d 598 (1989) (recoverable only with punitive damages). New York has the unusual rule that bad faith damages must have been "within the contemplation of the parties at the time of the execution of this insurance contract." Harriman v. Norfolk & Dedham Mut. Fire Ins. Co., 172 A.D.2d 585 (N.Y.A.D. 1991)

TN	Likely Punitive	T. C. A. § 56-7-105 ("refusal to pay the loss was not in good faith, and that the failure to pay inflicted additional expense, loss, or injury including attorney fees"); St. Paul Fire & Marine Ins. Co. v. Kilpatrick, 129 Tenn. 55, 164 S.W. 1186 (1913) (holding statute to be penal, with numerous future citing cases referring to attorneys' fee award as "penalty"); but see Williamson v. Aetna Life Ins. Co., 481 F.3d 369 (6th Cir. 2007) (amount considered in determining jurisdictional amount for diversity jurisdiction).
TX	Not Compensatory	In re Nalle Plastics Family Ltd. Partnership, 406 S.W.3d 168 (Tex. 2013); Tex. Civ. Prac. & Rem. Code Ann. § 38.001(8) (Vernon 1986); Grapevine Excavation, Inc. v. Maryland Lloyds, 35 S.W.3d 1 (Tex. 2000); Standard Fire Insurance Co. vs. Stephenson, 963 S.W.2d 81, 90-91 (Tex. App.--Beaumont 1997); Nationwide Mutual Insurance Co. vs. Holmes, 842 S.W.2d 335 (Tex. App.--San Antonio 1992); Colonial County Mutual Insurance Co. vs. Valdez, 30 S.W.2d 514 (Tex. App.--Corpus Christi 2000); *but see* TXJUR DAMAGES § 400.
UT	Punitive	Campbell v. State Farm Mut. Auto. Ins. Co., 98 P.3d 409 (Utah 2004) (holding attorney fees were not used in calculating punitive damages ratio)

50 STATE LAW ANALYSIS
ATTORNEYS' FEES AS COMPENSATORY
(For Punitive Damages Multiplier)

UNDECIDED

STATE		LEGAL AUTHORITY
AK	Unsure / Fee Schedule in Statute Based on Compensatory Award / Unique English Rule Statute	Civil Rule 82(a) directs that attorney's fees be awarded to the prevailing party and sets out a statutory fee schedule. Hillman v. Nationwide Mut. Fire Ins. Co., 855 P.2d 1321 (Alaska 1993) (attorneys' fees awarded to prevailing party even where no "compensatory and punitive damages (were awarded) against the insurance company on their claim of bad faith"). In Tobeluk v. Lind, 589 P.2d 873, 876 (Alaska 1979), the court commented that it "intend[s] fee awards [under Rule 82] to be compensatory rather than punitive." However, in Williams v. Eckert, 643 P.2d 991, 997 (Alaska 1982), the court permitted a Rule 82 award in an admiralty case because the purpose of Rule 82 was "remedial." At the same time, the court has emphasized that Rule 82 was not intended to penalize a losing party for litigating a good faith claim. Gilbert v. State, 526 P.2d 1131, 1136 (Alaska 1974); Malvo v. J.C. Penney Co., 512 P.2d 575, 588 (Alaska 1973).
AR	Unsure	A.C.A. § 23-79-208 (taxed as "costs," "for the prosecution and collection of the loss")
CT	Unsure. Attorney fees are separate from punitive damages under CUTPA	Odell v. Wallingford Mun. Fed. Credit Union, CV 106012228S, 2013 WL 4734783 (Conn. Super. Ct. Aug. 8, 2013); ACMAT Corp. v. Greater New York Mutual Ins. Co., 282 Conn. 576, 582-83, 923 A.2d 697 (2007); Lincoln General Ins. Co. v. Rodriguez , 2010 WL 5064463 (Conn.Super. Nov. 17, 2010) (attorneys' fees may be awarded if prevailing party can prove bad faith); Hartford Hosp. Medical Plan v. State Farm Mut. Auto. Ins. Co., 2010 WL 2365657 (Conn.Super. May 5, 2010)

HI	Unsure / Reasonable Fee Awarded by Statute When Insurer Ordered to Pay Under Policy	HRS § 431:10-242 (attorneys' fees automatically awarded when insurer is ordered to pay under policy); Liberty Mut. Ins. Co. v. Sentinel Ins. Co., Ltd., 205 P.3d 594 (Hawaii App. 2009); Commerce & Industry Ins. Co. v. Bank of Hawaii, 832 P.2d 733 (Haw. 1992)
IN	Compensatory in some situations.	Indiana Patient's Comp. Fund v. Brown, 949 N.E.2d 822, 824 (Ind. 2011). Ind.Code § 34-52-1-1; Sanyo Laser Products, Inc. v. Royal Ins. Co. of America, 2003 WL 23101793 (S.D.Ind. Nov. 7, 2003); Weidman v. Erie Ins. Group, 745 N.E.2d 292 (Ind.App. 2001)
LA	Unsure / Statute Allows for Attorney Fee Awards	La. R.S. 22:1892; Second Highway Baptist Church v. State Farm Ins. Co., 2009 WL 5245735 (E.D.La. Feb. 18, 2009)
ME	Unsure	24-A M.R.S.A. § 2436-A; Saucier v. Allstate Ins. Co., 742 A.2d 482 (Me. 1999) (awarding fees based on counsel's submission of work performed, but stating that statute's purpose is remedial)
NC	Unsure	N.C. Gen.Stat. § 75-16.1 ("taxed as a part of the court costs"); Country Club of Johnston County, Inc. v. United States Fidelity, 563 S.E.2d 269 (N.C.App. 2002); N.C.G.S.A. § 6-21.1 (said attorney's fee to be taxed as a part of the court costs in cases where damages are $10,000 or less)
ND	Unlikely Compensatory	State Bank & Trust of Kenmare v. Brekke, 1999 ND 212, 602 N.W.2d 681, 685; Nord v. Herman, 1998 ND 91, 577 N.W.2d 782. Hoge v. Burleigh County Water Management Dist., 311 N.W.2d 23, 31 (N.D. 1981).
NH	Unsure	N.H. Rev. Stat. § 417:20 (cost of suit, including reasonable attorneys' fees); Drop Anchor Realty Trust v. Hartford Fire Ins. Co., 496 A.2d 339 (N.H. 1985); Johnson v. Phoenix Mut. Fire Ins. Co., 445 A.2d 1097 (N.H. 1982).
RI	Unsure / Attorney Fee Award Allowed by Statute	R.I.Gen. Laws § 9-1-33; Mello v. DaLomba 798 A.2d 405 (R.I. 2002)
SC	Unsure / Likely Not Compensatory	S.C. Code Ann. § 38-59-40 (West 2002) ("The amount of reasonable attorneys' fees must be determined by the trial judge and the amount added to the judgment.")

SD	Unsure / Awarded as Costs by Statute	SDCL 58-12-3; SDCL 58-33-46.1
VA	Unsure	Va. Code Ann. § 38.2-209 (statutory award of attorneys' fees in bad faith cases)

Recent Mississippi Insurance Cases

E. Farish Percy[1]

In recent years, the Mississippi Supreme Court and Court of Appeals have decided several insurance cases involving numerous and interesting issues. I have summarized some of these recent cases below and hope to discuss most of them during the ACCEC CLE Seminar.

Table of Contents

[1] E. Farish Percy is an Associate Professor at the University of Mississippi School of Law and regularly teaches Insurance Law.

I. Property Insurance

A. First-Party Coverage

Hoover v. United Servs. Auto. Ass'n, 125 So. 3d 636 (Miss. 2013). Homeowners who suffered property damage to their home caused by Hurricane Katrina filed a claim with USAA for more than $240,000 in costs to repair their home, an additional $80,000 to repair the roof, and more than $1,300 for additional living expenses (ALE) pursuant to their "all-risk" or "open-peril" policy. USAA determined that the majority of the loss was caused by excluded storm surge and that the roof did not need to be replaced. Accordingly, USAA paid the insureds almost $57,000. The insureds sued USAA for breach of contract, bad faith and punitive damages. The trial court granted USAA a directed verdict on the insureds' claim for emotional distress, determined that the evidence indicated that storm surge caused the damage to the lower part of the house, and let the jury decide whether the roof needed to be replaced and whether the insureds were entitled to coverage for ALE. The jury returned a verdict in favor of the insureds for $81,342.97 – the amount claimed by the insureds for the cost to replace the roof and ALE. The trial court denied the insureds' claim for punitive damages. The insureds appealed and USAA cross-appealed.

The Supreme Court found that the trial court erred in granting USAA a directed verdict on the insureds' claim for unpaid dwelling losses to the lower part of their home because it found that the trial court incorrectly placed the burden of proving that the losses were caused by something other than storm surge upon the insureds. In its order, the trial court determined that USAA introduced evidence indicating that the damage to the lower part of the home was caused by storm surge, and that "the plaintiff should have had to put on something to show it was other than surge." The Court found that the trial court improperly placed the burden upon the insureds to prove that the loss was caused by something other than storm surge. The Court noted that prior case law, including *Corban v. USAA*, 20 So. 3d 601 (Miss. 2009), clearly places the burden of proving that the loss was caused by an excluded peril such as storm surge, upon an insurer when the policy is an "all-risk" policy. Thus, the Court reversed the trial court's grant of directed verdict with respect to the insureds' claim for additional dwelling loss.

The Court held that the trial court did not err in granting a directed verdict on the insureds' claims for bad faith and punitive damages, finding that the insureds failed to prove that USAA lacked an arguable basis for the denial of the claim. The Court held that USAA reasonably relied upon the reports of its adjusters and its investigating engineering firm regarding the cause of damage.

The Court then turned to USAA's cross-appeal and found that the trial court did not err in admitting the insureds' expert's testimony regarding the damage to the roof and the cost to repair the roof. Although the expert had not inspected the roof when he wrote his report, he had inspected the roof by the time he testified at trial and he stated that his inspection confirmed his report. He testified that his report was based upon his extensive experience studying and actually testing wind-loading on structures. The Court found that the trial court did not abuse its discretion under M.R.E. 702 in admitting the plaintiffs' expert's testimony regarding the cause of loss nor in admitting the expert's testimony regarding the cost to repair the roof. The expert testified that he was an engineering professor and often taught construction-cost estimation and

further testified that his calculation was based upon the cost per square foot to replace the roof. The Court held that the expert used an acceptable method of calculating the cost to repair the roof.

Justices Dickinson and Coleman dissented, each arguing that the trial court did not improperly shift the burden to the insureds to prove that their loss was not caused by storm surge. They argued that once USAA introduced evidence that the loss was caused by storm surge, the insureds were required to introduce some evidence sufficient to create a jury question on the issue.

Holding: The trial court erred in directing a verdict on the insureds' claim for additional dwelling losses to the lower part of their home because it improperly shifted the burden of proof to the insureds to prove that their loss was caused by something other than excluded storm surge.

Coastal Hardware & Rental Co. v. Certain Underwriters at Lloyd's, London, 120 So. 3d 1017 (Miss. Ct. App. 2013). Coastal Hardware operated a hardware store in Kiln, Mississippi. For July 2004 – July 2005, Coastal had obtained a "named-risk" or "named-peril" policy through Lloyd's that did not name flood, earthquake or wind as covered perils. In July 2005, Coastal worked with its agent, Dan MacManus of Statewide Insurance, to renew its policy. The Underwriters quoted an "all-risk" policy that excluded flood, earthquake and mold. Wind was not listed as an excluded peril. When deductibles were addressed, however, the quote indicated that wind was "excluded" or that a deductible for wind was "not required." McManus called the Underwriters' American agent and asked whether wind was to be covered under the all-risk policy. The agent did not directly answer the question and simply directed MacManus to read the quote himself. Coastal accepted the Underwriters' quote and paid a premium. Underwriters agreed to bind coverage as of July 23, 2005, and issued a two-page binder on July 29, 2005. The binder indicated that it was for an "all perils" policy, and listed "mold" as the only exclusion. The binder stated:

> READ THIS CONFIRMATION CAREFULLY AND COMPARE IT WITH ANY QUOTE AND SUBMISSION DOCUMENTS AND REVIEW THE POLICY FORMS FOR THE ACTUAL COVERAGE PROVIDED.
> ***
> THIS INSURANCE BINDER WILL BE TERMINATED AND SUPERSEDED UPON DELIVERY OF THE FORMAL POLICY(IES) ISSUED TO REPLACE IT.

The binder also included information about the deductibles, and in the blank space after "Wind," the binder indicated "excluded."

The Underwriters emailed a copy of the final insurance policy which contained a wind exclusion to its American agent on August 24, 2005. The agent testified that he printed the policy and mailed it to Statewide, the insured's agent. A Statewide agent testified that Statewide never received a copy of the policy and did not deliver the policy to the insured. Hurricane Katrina destroyed the Kiln post office and Statewide's office on August 29. 2005; the mailed policy was never recovered. The hurricane also destroyed the insured's hardware store, forcing it to operate

out of a smaller location for several weeks. Coastal contacted the Underwriters' American agent to make a claim and was informed that the policy did not cover wind damage. Coastal sued the Underwriters for breach of contract for failing to pay the damages caused by wind and for extra-contractual damages in the form of lost income based upon the Underwriters' alleged bad faith. The trial court granted Coastal partial summary judgment, finding that the binder controlled and did provide coverage for wind damage. The case went to trial on the amount of Coastal's contractual damages and on the merits of its extra-contractual claims. Coastal's claim for extra-contractual damages in the form of lost net profits was separate and distinct from its contractual claim for business-interruption loss. The trial court excluded the plaintiff's accounting expert's testimony concerning lost profit because the expert failed to clearly distinguish between business-interruption loss and extra-contractual damages for lost future profits and because the expert's disclosure addressed lost market share and lost gross sales rather than lost net profits. The trial court directed a verdict in favor of the Underwriters on Coastal's tort claim for bad faith because the only extra-contractual damages alleged to have been caused by the Underwriters' bad faith were lost net profits for which the plaintiff had no evidence given that the expert's testimony was excluded. The jury awarded $1.17 million in contractual damages and found in favor of the Underwriters on Coastal's claim for punitive damages. The trial court denied Coastal's post-trial Rule 59(e) motion to amend the judgment so as to include attorney's fees and prejudgment interest. Both sides appealed.

The Court of Appeals affirmed the trial court's grant of partial summary judgment to Coastal on the issue of coverage. The Court held that the binder rather than the final insurance policy controlled because the final insurance policy was never delivered. The Court concluded that if the binder were interpreted so as to include all of the final policy provisions, the binder "would be rendered completely nugatory by the unilateral act of [the Underwriters]." The Court further held that insurance binders must be construed by looking at the circumstances of their formation and by examining the binder language. The Court held that the circumstances did not support the Underwriters' argument that the binder excluded wind coverage because the new policy was intended to be an "all-risk" policy rather than a "named peril" or "specified peril" policy and because the Underwriters' American agent was specifically asked whether wind was covered and responded that the binder language controlled. The Court further held that the binder language was ambiguous because it indicated that it was an "all-risk" policy that only excluded mold and that the quote only excluded flood and earthquake (in which case wind would be covered). The binder also indicated "excluded" in the space provided for the wind deductible. The Court held that the rules of construction applicable to insurance policies also applied to binders and that, accordingly, any ambiguity must be construed against the drafter. Thus, the Court held that the trial court did not err in granting summary judgment to Coastal on the issue of coverage based upon the ambiguity in the binder.

The Court of Appeals determined that the trial court did not abuse its discretion in excluding Coastal's expert accountant's testimony. The Court held that the trial court appropriately found that the testimony was inadmissible pursuant to M.R.E. 702 because it would not assist the jury because the expert was unable to distinguish between contractual business-interruption loss and extra-contractual damages for lost future profit and could not adequately explain how he arrived at a net-loss figure rather than a gross-loss figure. The Court further held that the trial court appropriately excluded the evidence based upon its determination

that the plaintiff's expert disclosure did not comply with M.R.C.P. 26(b)(4)(A)(i) because it did not disclose the substance of every fact and opinion to be offered by the expert in a meaningful way because the report referred to lost gross profit and lost market share rather than lost net profit.

The Court of Appeals held that the trial court did not err in denying Coastal's post-trial motion for attorney's fees given that the jury did not award punitive damages and given that there was no other authority authorizing attorney's fees. The Court acknowledged that, pursuant to *Universal Life Insurance Company v. Veasley*, 610 So. 2d 290 (Miss. 1992), attorney's fees may be awarded as extra-contractual damages when the insurer has no arguable reason upon which to deny coverage, but found that a claim for such attorney's fees must be asserted at trial and awarded by the jury as part of the plaintiff's extra-contractual damages rather than awarded by the trial judge as a collateral matter pursuant to a post-trial motion.

Finally, the Court held that the trial court did not err in refusing prejudgment interest because the amount owed was not liquidated when the claim was made and the refusal to pay was not frivolous given the ambiguity in the binder. Specifically, the Court found that the insurer did not act frivolously or in bad faith in denying coverage because the ambiguity created a legitimate reason for the Underwriters to dispute coverage.

Holding: Binders do not necessarily incorporate all terms of the final insurance policy and instead must be construed in light of the circumstances surrounding the formation of the binder and the language of the binder. Ambiguities in insurance binders are construed against the drafter. In insurance coverage cases, extra-contractual damages for attorney's fees cannot be awarded collaterally pursuant to a post-trial Rule 59(e) motion unless punitive damages are awarded. Although attorney's fees may be recovered as part of an insured's extra-contractual claim for damages, such claims for damages must be presented at trial as part of the plaintiff's claim for extra-contractual damages rather than in a post-trial motion.

B. THIRD-PARTY COVERAGE/MEANING OF "ACCIDENT" AND CRIMINAL ACTS EXCLUSION

* ***Lambert v. Safeco Ins.***, 87 So. 3d 1123 (Miss. Ct. App. 2012). Brian and his father, Michael Kees, attended a pool party at the home of Al Ellis. At some point, Michael exited the house and hurried to his car with Brian. Ellis, believing that Michael had stolen money from his house, retrieved his pistol and followed them out to the driveway. Ellis shot at Michael's vehicle in an alleged attempt to disable it. Ellis claims he did not know Brian was in the car and that he was not trying to shoot anybody. One of the bullets ricocheted off the driveway and hit Brian. Brian died as a result of the gunshot wound and his mother brought a wrongful death claim against Ellis. Ellis pled guilty to manslaughter by culpable negligence. Safeco filed a motion to intervene in the wrongful death case and sought a declaratory judgment that it did not have to provide liability coverage to Ellis pursuant to the homeowner's insurance policy it had issued him. The circuit court found in favor of the plaintiff and awarded $75,000. The circuit court, however, found that Ellis was not entitled to liability coverage under his homeowner's policy issued by Safeco because the policy excluded liability coverage for "bodily injury or property damage … arising out of any illegal act committed by or at the direction of any insured." The Court of Appeals affirmed the circuit court, finding that coverage was excluded under the illegal

acts exclusion. The Court further held that because Ellis intended to discharge his gun, his actions were not an "accident" or an "occurrence" as required by the policy.

Holding: Insured who shot a gun at a car and killed a passenger was not entitled to liability coverage because coverage was excluded by the illegal acts exclusion. In addition, the insurer owed no coverage because there was no "accident" or "occurrence," given that the insured intended to discharge his gun, even though the insured may not have intended to shoot or injure the passenger.

II. Liability Insurance

A. COVERAGE – MEANING OF "ACCIDENT"

W.R. Berkley Corp. v. Rea's Country Lane Constr., 2013 WL 3884909 (Miss. Ct. App. Jul. 30, 2013). Contractor sued its commercial general liability (CGL) insurer for breach of contract and bad faith. The chancellor found that the insurer breached its duty to defend because the complaint at issue against the insured contractor included a claim for "property damage" caused by an "occurrence." The plaintiff in the underlying lawsuit sued the contractor for negligence and breach of contract, and sought money damages as well as court-ordered remediation of her property. The plaintiff alleged that the insured contractor failed to dig three dirt pits on her property in the manner required by the governing contractual specifications. The court entered judgment against the insurer for $193,684.95. The insurer appealed after its motion for j.n.o.v. was denied.

The Court of Appeals found that the complaint against the insured contractor did include claims for "property damage" given that the plaintiff alleged that her property had been physically injured by "pits being dug, topsoil being stripped, and mounds of waste being dumped." The Court then turned to the issue of whether the alleged "property damage" was caused by an "occurrence" and noted that the policy defined an "occurrence" as an "accident." The Court found that the alleged property damage was not caused by an accident because the conduct alleged by the plaintiff – digging pits, stripping topsoil, and depositing waste – was intentional rather than accidental. The Court held that the plaintiff failed to allege any inadvertent act or accident that caused her "property damage." Finally, the Court held that the plaintiff's claim against the insured contractor was excluded by two of the business-risk exclusions in the policy. Exclusion j(5) excludes property damage to "[t]hat particular part of real property on which [the insured's] or any contractors or subcontractors working directly or indirectly on [insured's] behalf are performing operations, if the 'property damage' arises out of those operations[.]" Exclusion j(6) excludes property damage to "[t]hat particular part of [the plaintiff's] property that must be restored, repaired, or replaced because 'your work' "—i.e., "[w]ork or operations performed ... on [the insured's] behalf"—"was incorrectly performed on it." Given that the plaintiff only alleged property damage to her property where the insured defendant was working, the business-risk exclusions were applicable.

Holding: CGL insurer did not breach the insurance contract or its duty to defend its insured because the claims against the insured in the underlying lawsuit were not within coverage. Liability for "property damage" is only covered if the damage was caused by an "occurrence,"

which is defined as an "accident." To be covered, the "property damage" must have been caused by inadvertent or accidental acts – not intentional acts.

B. "ADDITIONAL INSURED" COVERAGE FOR GENERAL CONTRACTOR

Noble v. Wellington Assocs., Inc., 2013 WL 6067991 (Miss. Ct. App. Nov. 19, 2013). Contractor hired subcontractor to perform dirt work. The subcontract required the subcontractor to obtain an additional-insured endorsement to its commercial general liability (CGL) policy and to name the general contractor as an additional insured under the policy. After the contractor built a house on the site and sold it to the homebuyers, the homebuyers sued the general contractor for damages arising from defects in the house allegedly caused by foundation problems related to faulty dirt work. The general contractor sued the subcontractor's liability insurer for coverage and breach of the duty to defend. The circuit court granted summary judgment to the insurer, finding that the policy limited coverage to liability caused by the "[subcontractor's] ongoing operations performed for [the additional named-insured]." The policy further excluded coverage for (i) property damage that occurred after all work on the project by or on behalf of the additional insured, the general contractor, had been completed; and (ii) property damage that occurred after the work performed by the subcontractor had been put to its intended use.

The Court held that "in order for 'ongoing operations' to have any meaning, it cannot encompass liability arising after the subcontractor's work was completed." The Court held that the endorsement clearly limited coverage to the subcontractor's active work. The Court also rejected the general contractor's argument that coverage was established by waiver and estoppel (arguing that the insurer should be estopped from taking a certain position based upon the insurer's actions in a previous lawsuit). The Court did so based upon precedent holding that waiver and estoppel cannot operate so as to bring a loss within coverage if such loss is expressly excluded. In rejecting the general contractor's estoppel claim, the Court also noted that the general contractor had no contract with the agent and failed to allege that the agent made promises regarding coverage that were not fulfilled.

Holding: The CGL insurer was entitled to summary judgment on the general contractor's claim for coverage and breach of the duty to defend. The general contractor was named as an additional insured under the subcontractor's CGL but the policy clearly limited liability coverage to the subcontractor's ongoing operations.

C. DUTY TO DEFEND

S. Healthcare Servs., Inc. v. Lloyd's of London, 110 So. 3d 735 (Miss. 2013). Various related nursing home entities purchased liability insurance coverage from Lloyd's of London with the assistance of an agent at Fox-Everett, Inc. During the relevant policy period, five tort lawsuits were filed against the insured nursing homes. The insurer's third-party administrator, Caronia Corporation, sent reservation of rights letters to the insureds, indicating that certain issues would be defended under a reservation of rights and that "the first $250,000 of indemnity and/or claims related expenses will be paid directly by [the insured]." The insureds claimed to be shocked by the $250,000 deductible per claim. Two of the insured nursing homes paid the defense costs until early 2005, when they filed for bankruptcy. In March 2005, Caronia and

Lloyd's instructed defense counsel to continue defending, indicating that they would pay the defense costs. By March 2006, however, the outstanding defense costs had not been paid and the attorneys withdrew from the case.

In August 2006, the insured nursing homes and the named insured managing company sued Lloyd's, Caronia, and Fox-Everett. The insureds claimed that: (i) Lloyd's breached the insurance contract by failing to provide coverage and defense costs; (ii) Lloyd's and Caronia made fraudulent misrepresentations and breached their duty of good faith and fair dealing by telling the insureds that the insureds must pay the $250,000 deductible per claim before they were entitled to coverage; and (iii) that Fox-Everett breached its fiduciary duties and acted with gross negligence in failing to inform the insureds of the $250,000 deductible per claim. Lloyd's counterclaimed seeking a declaratory judgment that the insureds were required to pay the deductible.

The defense attorneys were rehired sometime between December 2006 and August 2007 and were paid by Lloyd's to defend the underlying nursing home litigation. All five cases were eventually settled. After the settlement, Lloyd's moved for summary judgment on the claims against it and Caronia and also on its counterclaim against the insureds. The trial court granted the motion and ordered the insureds to pay Lloyd's $701,153.54 for the cost of defense and settlement within the $250,000 per claim deductible. Although the claims against Fox-Everett were still pending, the trial court certified its orders as final orders pursuant to Rule 54(b). The insureds appealed and the Court of Appeals dismissed the appeal after finding that the trial court inappropriately certified the order as a final order because the claims on appeal were intertwined with the claims against Fox-Everett which were still pending in the trial court. Judge Griffis, joined by Judges Barnes, Roberts and Maxwell, dissented, arguing that certification was proper and further arguing that the summary judgment was improperly granted because there was sufficient evidence to support the plaintiffs' claims given that the liability policy did not clearly condition the insurer's duty to defend upon the insureds' payment of defense costs of up to $250,000 in each case. Judge Griffis argued:

> Under the policy, the Appellees had the right to reimbursement of the deductible, but they had absolutely no contractual right to demand payment of the deductible before the insured [*sic*] had a duty to defend. If the Appellees had no right to condition the duty to defend on the prior payment of the deductible, the Appellees were in breach of the insurance contract the moment the "Acknowledgment of Claim Reservation Rights" letters were mailed.

S. Healthcare Servs., Inc. v. Lloyd's of London, 20 So. 3d 84, 98-99 (Miss. Ct. App. 2009).

On remand, the insureds filed a motion to reconsider the summary judgment, which was ruled upon by a newly assigned judge after the original judge died. The newly assigned judge vacated the summary judgments, ordered the parties to proceed with discovery and set the case for trial. After some confusion, the judge reinstated the summary judgments in favor of Caronia and Lloyd's. After the insureds settled with Fox-Everett, the trial court entered a final order from which the insureds appealed.

The liability policy at issue provided:

I. INSURING AGREEMENT

We will pay those sums that you are legally required to pay others as damages resulting from a medical incident arising out of professional services provided by any Insured. ***

In addition to our Limit of Insurance we will also pay defense costs. We have the right and duty to defend and appoint an attorney to defend any suit against an Insured for a covered claim….

Our duty to defend any suit ends, and we may withdraw from the defense, after the applicable Limit of Insurance has been exhausted by settlements, judgments, awards and interest ….

The Declarations page indicated that the deductible was $250,000 per claim, "Defense Costs included." The policy further provided:

DEDUCTIBLE

A. The First Named Insured shall be responsible for the deductible amount shown in the Declarations, WHICH DEDUCTIBLE AMOUNT SHALL BE IN ADDITION TO AND SHALL NOT ERODE THE APPLICABLE LIMITS OF INSURANCE SHOWN IN THE DECLARATIONS. Expenses we incur in the investigating and defending claims and suits are included in the deductible. ***

***

C. We may pay all or part of the deductible to settle a claim or suit. The First Named Insured agrees to repay us promptly after we notify the First Named Insured of the settlement.

The policy also included the following provision:

APPLICATION OF ENDORSEMENT
***

C. The terms of insurance, including those with respect to:
1. Our right and duty to defend the Insured against any "suits" seeking those damages; and
2. Your duties in the event of an "occurrence", "claim", "suit" or "medical incident" apply irrespective of the deductible amount.

> D. We may pay any part or all of the deductible amount to effect settlement of any claim or "suit" and, upon notification of the action taken, you shall promptly reimburse us for such part of the deductible amount as has been paid by us.

The policy also contains an endorsement entitled "Supplementary Payments and Defense Costs Within the Limits of Liability," which included the following language:

> Subject to the Deductible Liability Insurance Endorsement, it is agreed that we will pay the following Supplementary Payments and Defense Costs, which will be included within, not in addition to and will erode the Limits of Liability of the policy.
> …
>
> E. all defense costs….

The Court found that the policy was unambiguous and that the insureds had a duty to read the policy and therefore could not argue they were unaware of the $250,000/claim deductible. The Court held that the policy clearly required the insured to pay the first $250,000 in legal fees and payments as they were incurred. Although, the Court held that the insurer's duty to defend arose when it received notice of the underlying claims, the Court held that the insurer satisfied the duty by selecting counsel to defend the underlying suits.

Holding: The liability insurer did not breach its duty to defend by refusing to pay attorney's fees incurred in the defense because the policy included a $250,000/claim deductible that was applicable to defense costs.

D. EXCESS INSURER'S EQUITABLE SUBROGATION AND LEGAL MALPRACTICE CLAIMS AGAINST DEFENSE COUNSEL RETAINED BY PRIMARY INSURER

Great Am. E & S Ins. Co. v. Quintairos, Prieto, Wood & Boyer, P.A., 100 So. 3d 420 (Miss. 2012). Numerous tort claims were filed against an insured nursing home. The nursing home's primary liability insurer retained a law firm to assume the defense of the tort cases. Defense counsel informed the insured nursing home's excess insurer that settlement would not likely exhaust the insurer's primary coverage of $1 million. After defense counsel in the nursing home litigation was unable to designate a physician expert witness long after the expert designation deadline had passed, defense counsel then provided the excess insurer an "updated lawsuit evaluation" indicating that the settlement value had increased to a maximum of $3 to $4 million, thereby potentially triggering the excess coverage. After learning of the increased settlement value and that defense counsel had no licensed Mississippi attorneys who could try the case, the excess insurer retained its own counsel. The primary insurer tendered policy limits and the excess insurer negotiated a settlement agreement with the plaintiffs in the nursing home litigation that exceeded the limits of the nursing home's primary liability insurance policy by an undisclosed amount. The excess insurer sued the law firm for negligent misrepresentation, legal malpractice, negligence, and equitable subrogation. The law firm moved to dismiss for failure to state a claim, arguing that the excess insurer could not assert a malpractice claim against the law

firm in the absence of a contract between the law firm and the excess insurer. The trial court agreed and granted the motion.

The Court of Appeals reversed, finding that the excess insurer had stated a claim for negligent misrepresentation, legal malpractice, negligence, and equitable subrogation. Most notably, the Court of Appeals held that the excess insurer had stated a claim for legal malpractice against the law firm because the excess insurer had pleaded sufficient facts from which an attorney-client relationship could be inferred. In so finding, the Court focused upon the status updates sent by the law firm to the excess insurer regarding the expected settlement value of the case and held that such communications could be viewed as privileged attorney-client communications. The Court of Appeals also held that the excess insurer stated a claim for equitable subrogation because the excess insurer may step into the shoes of its insured and recover from the law firm for malpractice. The Court of Appeals reasoned that failing to recognize an equitable subrogation claim would only benefit the negligent law firm, given that the insured had no incentive to sue for malpractice.

The Supreme Court affirmed the Court of Appeals' holding that the excess insurer had an equitable subrogation claim against the law firm for legal malpractice. The Supreme Court, however, reversed the Court of Appeals' holding that the excess insurer could sue the law firm directly for legal malpractice. The Supreme Court held that defense counsel's provision of settlement evaluations and status reports to the excess insurer was insufficient to create an attorney-client relationship. Finally, the Court held that the excess insurer could not sue defense counsel for negligent misrepresentation because the estimated settlement valuations were opinions rather than statements of fact.

Justice Randolph partially dissented, joined by Justices Kitchens and Pierce, arguing that Mississippi law provides that any foreseeable plaintiff may sue a professional for negligent misrepresentation. Justice Randolph further argued that the negligent misrepresentation claim should not be dismissed for failure to state a claim because defense counsel's settlement valuations may have been misrepresentations of fact.

Justice Chandler partially dissented, arguing that the excess insurer should not be permitted to pursue an equitable subrogation claim against the primary insurer's defense counsel because of the potential harm to the attorney-client relationship between the primary insurer and its retained defense counsel.

Holding: Defense counsel hired by primary insurer did not create attorney-client relationship with excess insurer by providing status updates and settlement valuations. Absent an attorney-client relationship, an excess insurer cannot bring direct legal malpractice claims against defense counsel hired by the primary insurer. Excess insurer may bring an equitable subrogation claim against defense counsel.

III. Automobile Insurance

A. LIABILITY INSURANCE

1. *Primary Liability Insurer's Claim for Contribution from Excess Insurer Based Upon Settlement of Claims Against Insured*

Indem. Ins. Co. of N. Am. v. Guidant Mut. Ins. Co., 99 So. 3d 142 (Miss. 2012). James Hingle, a Marshall County volunteer firefighter, was driving his personal vehicle on his way to the scene of a fire when his vehicle collided with the vehicle in which the Andersons were riding. The Andersons sued Hingle, Marshall County and the volunteer fire department. Hingle had two insurance policies with Guidant, an automobile policy that provided liability limits of $250,000 per person and $500,000 per accident, and an umbrella policy containing a $1,000,000 limit. Marshall County had a business automobile liability insurance policy with INA with applicable coverage containing a $300,000 limit. INA filed a declaratory judgment action against Guidant seeking the court to declare that Guidant was the primary insurer for all defendants and therefore had a duty to defend all defendants. In the underlying tort case, INA defended the volunteer fire department and Marshall County and Guidant defended Hingle. Guidant negotiated a $750,000 settlement with the Andersons and allocated $300,000 of the payment to Hingle's personal policy and $450,000 of the payment to Hingle's umbrella policy. INA refused Guidant's request for contribution, asserting that INA would not consider contribution until Guidant reimbursed INA for its defense costs. Guidant then filed a motion for summary judgment on its contribution claim. In response, INA argued that Guidant was not entitled to contribution because it was a voluntary payor. The trial court made various rulings on both summary judgment motions in the declaratory judgment action, some of which were appealed by Guidant, and some of which were cross-appealed by INA.

On appeal, the Supreme Court found that Hingle's personal policy with Guidant was required to pay first, that Marshall County's policy with INA was required to pay second, while Hingle's umbrella policy with Guidant was truly excess, and was required to pay only after exhaustion of the other policy limits. The Court further held that Guidant could proceed with its claim for contribution against INA if Guidant could prove that "it was legally liable to settle, and that the amount it paid the [Andersons] was reasonable." *Guidant Mut. Ins. Co. v. Indem. Ins. Co. of N. Am.*, 13 So. 3d 1270 (Miss. 2009) (*Guidant I*). Finally, the Court held that INA was entitled to reimbursement of the reasonable and necessary expenses it incurred in defending Marshall County and the volunteer fire department.

On remand, INA filed a motion for summary judgment for $55,846 in defense costs and pre-judgment interest. Guidant filed a motion for summary judgment for contribution from INA for its policy limit of $300,000. The trial court granted summary judgment, and awarded $300,000 to Guidant in contribution and $55,846 to INA for defense costs plus post-judgment interest. The trial court denied INA's request for pre-judgment interest. On appeal, INA argued that the trial court erred in granting Guidant contribution because Guidant was not "legally liable to settle" the Andersons' claims and further argued that the trial court erred in refusing INA pre-judgment interest on its defense costs.

The Supreme Court held that Guidant was entitled to summary judgment on its claim for contribution because the court held that an insurer has a fiduciary duty to settle claims within policy limits on "objectively reasonable terms." The Court also noted that law and public policy generally favor the settlement of disputes. Thus, the Court concluded that the "legally liable to settle" language it used in *Guidant I* meant a "legal *duty* to settle, or at least a legal duty to consider the insured's best interest and to make an honest evaluation of a settlement offer within the policy limits." The Court then determined that the settlement offer of $750,000 was a settlement offer within limits because the limits of all three policies totaled $1.8 million. The Court referred to the "duty to defend" language in both of the Guidant policies and concluded that the Guidant policies put Guidant in control of defense and settlement and that Guidant's settlement of the claims for $750,000 was reasonable in light of the evidence indicating the severity of the Andersons' injuries and the extent of their damages (permanent blindness, medical expenses approaching $200,000, and lost wages calculated at $100,000). The Court found that Guidant was only entitled to $250,000 in contribution because Hingle's personal automobile liability policy provided $500,000 of coverage per accident, which coverage had to be totally exhausted before INA's obligation to contribute was triggered.

Finally, the Supreme Court held that the trial court did not abuse its discretion in denying INA pre-judgment interest pursuant to M.C.A. § 75-17-7 on INA's claim for reimbursement of defense costs because INA's claim for defense costs was not liquidated when INA filed its declaratory judgment action. In addition, the Court observed that INA had not argued, and the trial court had not found, bad faith on the part of Guidant.

Holding: The primary insurer in control of defense and settlement has a legal duty to consider the insured's best interest and make an honest evaluation of a settlement offer within the total policy limits of all available primary and excess coverage. If the primary insurer negotiates and pays a reasonable settlement within the total policy limits, the primary insurer may seek contribution from the excess insurer for amounts paid over and above the primary insurance limit of liability. Absent bad faith, pre-judgment interest should not be awarded if the amount due the claimant is not liquidated at the time the claim is filed.

2. *Named-Driver Exclusion*

Lyons v. Direct Gen. Ins., 2014 WL 561984 (Miss. Feb. 13, 2014). A passenger who was injured in a vehicle being driven by the owner's son sued the driver and obtained a judgment for $72,500. The passenger then filed a declaratory judgment action against the vehicle owner's liability insurer, seeking the court to declare that the judgment against the driver, who was the insured owner's son, was covered by the insured's policy. The plaintiff argued that the named-driver exclusion void and unenforceable in light of Mississippi's mandatory automobile liability insurance statutes. The trial court granted summary judgment to the insurer. The Court of Appeals reversed and the Mississippi Supreme Court affirmed the reversal, finding that the policy provision purporting to exclude coverage for certain drivers failed to comply with the statutory mandate requiring liability insurance up to the statutory minimum.

Holding: "Named-driver" exclusions contained in automobile liability insurance policies are unenforceable up to the statutorily required minimum amount of liability coverage. "[E]very

vehicle operated within this State must have the statutorily required minimum-coverage requirements."

B. UNINSURED MOTORIST COVERAGE

1. *Knowing and Intelligent Waiver of UM Coverage*

Honeycutt v. Coleman, 120 So. 3d 358 (Miss. 2013). A minor passenger was injured when the vehicle in which he was riding turned left at a flashing yellow light and collided with a vehicle being driven by a state trooper in the course of his employment. The minor's parents brought claims on his behalf against the state trooper and two automobile insurers that had provided UM coverage to the minor's parents. The trial court granted summary judgment to the trooper, finding him immune pursuant to the MTCA, to one insurer finding that it had canceled the policy prior to the accident in question based upon nonpayment of premiums, and to the other insurer, American Premier, based upon the insurer's argument that it owed no uninsured motorist coverage because UM coverage had been waived by the minor's father. The minor argued below that the waiver of UM coverage was unenforceable because the insurance agent had not explained UM coverage to his parents. The trial court found that the insurer had no duty to explain UM coverage to the insured. The Court of Appeals affirmed, finding that the contents of insurance policies are imputed to insureds who sign them.

The Supreme Court reversed, holding that: (i) any waiver of UM coverage must be made knowingly and intelligently and in writing; (ii) insurers bear the burden of proving a knowing and intelligent waiver by the insured; (iii) such burden may be met by establishing that the insurer provided an explanation of UM coverage appropriate to the client; (iv) a written waiver signed by the client is relevant but not dispositive as to the issue of whether there was a knowing and intelligent waiver; (v) the client may rebut proof offered by the insurer; and (vi) whether there was a knowing and intelligent waiver is a question of fact for the jury. The Court held that summary judgment was inappropriate because there was a genuine issue of material fact regarding whether the waiver was knowing and intelligent. Although the insureds signed and dated the waiver, they both testified that they did not read the full provision and did not understand the importance of UM coverage. They also testified that the agent did not explain it. The Court noted that the waiver itself did not explain the costs and benefits of UM coverage or the consequences of rejecting such coverage.

Holding: Automobile insurer bears the burden of proving that the insured made a knowing and intelligent waiver of UM coverage. Insurers have a duty to explain the costs and benefits of UM coverage. The fact that the insured signed a written waiver is not dispositive of the issue.

2. *Attorney's Fees Award*

Fulton v. Miss. Farm Bureau Cas. Ins. Co., 105 So. 3d 284 (Miss. 2012). After being struck by a vehicle driven by an uninsured intoxicated driver who lost control of a car at a racetrack, the insured submitted a claim for coverage to his automobile insurance company pursuant to his uninsured motorist coverage. In response to the insurer's failure to pay, the insured sued the insurer, asserting a contractual right to coverage, grossly negligent delay in investigation and payment, and bad faith. The insured sought economic damages caused by the

negligent delay in processing, including attorney's fees. After the lawsuit was filed, the insurer paid the insured about half of the coverage amount.

The jury returned a verdict for the insured and awarded him the remainder of available coverage and $10,000 in extracontractual damages. The jury did not find that the insurer acted in bad faith and awarded no punitive damages claims. The plaintiff filed a post-trial motion for attorney's fees, which motion the trial court treated as a M.R.C.P. 59(e) motion to alter or amend the judgment. The trial court denied the motion after finding that none of the requirements for a Rule 59(e) motion were met.

The Court of Appeals reversed, finding that attorney's fee awards in cases of this nature are damages to be awarded by the court as a collateral matter rather than damages to be determined by the jury as part of the plaintiff's actual extracontractual damages. Thus, the Court of Appeals held that the trial court erred in treating the attorney's fee motion as a Rule 59(e) motion.

The Supreme Court reversed and reinstated the trial court's order denying the motion for attorney's fees. Noting that attorney's fees in the case were not authorized by contract or statute and noting that the jury did not award punitive damages, the Court found that the insured's claim for attorney's fees was not judgment-derivative and that therefore the motion for fees fell within the scope of Rule 59(e) governing motions to alter or amend the judgment.

The Supreme Court held that prevailing parties, such as the insured, are not automatically entitled to attorney's fees. The Court held that extracontractual damages awarded in a case such as this include reasonably foreseeable costs and expenses, including attorney's fees. The insured did not argue that the award of extracontractual damages was insufficient on appeal. The Supreme Court concluded that allowing an award of attorney's fees in addition to the extracontractual damages awarded by the jury would amount to a double recovery. The Court further held that absent an award for punitive damages in this case, there was no independent ground for post-judgment attorney's fees. Finally, the Court held that *Universal Life Ins. Co. v. Veasley*, 610 So. 2d 290 (Miss. 1992) did not create a right to post-judgment attorney's fees in cases where extracontractual damages are awarded because the award of extracontractual damages may include reasonably foreseeable attorney's fees.

Holding: The insured's recovery of extracontractual damages in an insurance coverage case did not give rise to a right to post-judgment attorney's fees.

IV. Workers' Compensation Coverage

Liberty Mut. Ins. Co. v. Shoemake, 111 So. 3d 1207 (Miss. 2013). Workers' compensation carrier brought reimbursement action against employee who had recovered settlement proceeds for his injuries. Shoemake, a Mississippi employee acting with the scope of his employment by a Mississippi employer, was injured when his truck collided with a train in Alabama. Shoemake received more than $132,000 in workers' compensation benefits. He sued the train owner and engineer in Alabama and recovered $315,000 in settlement proceeds. He then reimbursed the workers' compensation carrier the amount to which it was entitled pursuant

to Alabama law. Pursuant to Alabama law, the carrier was not entitled to full subrogation because the common fund doctrine applied and required the carrier to contribute to the attorneys' fees incurred in recovering from the tortfeasors. The workers' compensation carrier sued Shoemake in Mississippi, arguing that it was entitled to full subrogation and reimbursement pursuant to M.C.A. § 71-3-71. The trial court granted Shoemake's motion for summary judgment and denied the insurer's motion, finding that Alabama law controlled and further finding that, pursuant to Alabama law, the insurer's claim for subrogation and/or reimbursement was subject to the common fund doctrine, thereby making the insurer responsible for a portion of the attorney's fees incurred in recovering the settlement proceeds in Shoemake's personal injury action. The trial court further found that the insurer had waived its subrogation claim because it did not intervene in Shoemake's personal injury claim in Alabama.

The Court of Appeals reversed, finding that "choice-of-law" questions are to be resolved by applying the seven factor test in the Restatement (Second) of Conflict of Laws (1971). The Court held that Shoemake's residency in Mississippi and employment by a Mississippi corporation are facts weighing in favor of applying Mississippi law. In addition, the Court noted that application of Alabama law would not protect the parties' "justified expectations." The Court then held that the insurer was not required to intervene in Shoemake's personal injury lawsuit in order to preserve its statutory right to subrogation.

The Supreme Court reversed, finding that M.C.A. § 71-3-71 requires a workers' compensation carrier to intervene or join in the employee's third-party tort case to preserve its claim for statutory subrogation or reimbursement. M.C.A. § 71-3-71 provides in pertinent part:

> The acceptance of compensation benefits from or the making of a claim for compensation against an employer ... shall not affect the right of the employee or his dependents to sue any other party at law for such injury or death, but the employer or his insurer shall be entitled to reasonable notice and opportunity to join in any such action or may intervene therein. If such employer or insurer join in such action, they shall be entitled to repayment of the amount paid by them as compensation and medical expenses from the net proceeds of such action (after deducting the reasonable costs of collection) as hereinafter provided.

The Court noted that an employer and employee could enter into a contractual subrogation agreement that joinder or intervention is not necessary. The Court further held that the Mississippi circuit court lacked jurisdiction because the workers' compensation statutory scheme clearly contemplated that only one lawsuit be brought (assuming notice to the employer). The Court acknowledged that if a plaintiff employee files the underlying tort action in another state, such as Alabama, the court might well apply the law of that state and further acknowledged that the law of that state might not preserve the full claim for subrogation because, for instance, the common fund doctrine might apply. Nevertheless, the Court held that the carrier's only opportunity to argue that Mississippi law controls is in the underlying tort lawsuit after the carrier has intervened.

Holding: M.C.A. § 71-3-71 requires the employer or the workers' compensation carrier, upon proper notice, to intervene in the employee's tort case against the third-party in order to preserve a claim for statutory subrogation.

V. Agent's Actual or Apparent Authority

Strait v. McPhail, 2013 WL 5976619 (Miss. Ct. App. Nov. 12, 2013). Insured's caretakers sued insurer and Jackie McPhail, the insurer's former agent, alleging that the plaintiffs were entitled to the proceeds of a cancer policy because the insured had instructed McPhail to change the beneficiary of the policy from his estate to the plaintiffs. The policy provided for repayment of medical expenses incurred for the treatment of cancer and indicated that all amounts owed at the death of the insured would be paid to the insured's estate. The policy itself did not require the proceeds to be paid to a beneficiary. The policy's claim form, however, did allow for an assignment of benefits to third-parties.

McPhail had served as the insured's agent for several years and was an authorized agent for the insurer when the policy at issue was sold. Although McPhail was no longer authorized to sell policies for the insurer at the time the insured sought to change the beneficiary, McPhail testified that she retained the ability to service the pre-existing policy. After the insured asked McPhail to help him fill out the claim form so as to change the beneficiary, McPhail instructed him not to use the "assignment of benefits" provision on the claim form unless he wanted to assign benefits to the hospital, which he did not. McPhail apparently thought any assignment of benefits would be to the hospital. McPhail later had the insured sign a change-of-beneficiary form which was witnessed by a doctor and nurse at the hospital. The form did not include the name of the caretakers as the new beneficiaries at the time it was signed by the insured. When the doctor suggested to McPhail that the form was not valid because it did not contain the names of the "new" beneficiaries when executed by the insured, McPhail left two phone messages with the insurer. The insurer did not return the calls. The trial court granted summary judgment to the defendants, finding that the issue regarding the appropriate beneficiary had already been litigated and resolved in the insured's estate proceedings.

The Court of Appeals reversed. First, the Court held that res judicata and collateral estoppel were inapplicable because there was no identity of parties. The Court emphasized the insured's caretakers were not parties to the estate proceedings and had not previously litigated their claims. The Court further held that the caretakers were not in privity with the estate because their interests were in conflict with the interests of the estate.

The Court then held that summary judgment was not warranted because there were genuine issues of material fact regarding whether the insurer was negligent in training McPhail how to change the beneficiary of the policy at issue and in failing to return McPhail's calls regarding changing the beneficiary. The Court also held that there was a genuine issue of material fact regarding whether McPhail was an actual or apparent agent of the insurer given that: (i) McPhail had previously acted as an agent for the insurer; (ii) McPhail testified that she retained the ability to "service" policies sold while she acting as an agent for the insurer, and (iii) the plaintiffs were unaware that the insurer had revoked McPhail's authority to act as an agent. Thus, the Court determined that there were genuine issues of material fact regarding whether the

insurer could be held vicariously liable for McPhail's activities in servicing the policy. The Court rejected the insurer's argument that the plaintiffs' claims must fail because they were not parties to the insurance contract. The Court held that the plaintiffs were intended third-party beneficiaries of the policy.

Holding: Summary judgment was not proper where there were genuine issues of material fact regarding whether McPhail was acting as an actual or apparent agent for the insurer when she attempted to change the beneficiaries of the insured's health policy and whether the insurer was directly liable for negligently training McPhail.

ACCEC 2014
INSURANCE LAW SYMPOSIUM
Robert C. Khayat Law Center
University of Mississippi, Oxford, MS
Friday March 21, 2014

DEFECTIVE CONSTRUCTION CLAIMS:

BREACH OF WARRANTY OR COVERED OCCURRENCE?

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Defective Construction Claims:
Breach of Warranty or Covered Occurrence?

I. INTRODUCTION.

Insurance coverage for construction defect claims was once a relatively steady and predictable area of the law. However, several recent judicial decisions have adopted a more expansive view of coverage for such claims. Often claims that are better suited as warranty claims are being presented as insurance claims resulting in litigation to determine whether coverage exists.

The case of *Am. Fam. Mut. Ins. Co. v. Am. Girl, Inc.*[1] presents an example of how courts have struggled with distinguishing breach of warranty issues from potentially covered claims for property damage. In *American Girl*, the Renschler Company agreed to construct a new warehouse to store American Girl dolls. Shortly after construction, the building sank nearly two feet, the roof buckled, and the sides of the building cracked. The entire structure was a loss and had to be demolished. American Girl sued Renschler who then tendered the suit to its insurer. American Family denied coverage as the claims in the suit were for breach of contract and breach of warranty. If this matter was filed in Pennsylvania, the insurer would almost assuredly prevail on a motion to dismiss. If this matter was filed in Alabama, there would only be coverage for the faulty workmanship that caused damage to personal property or the property of others. And finally, as this matter was filed in Wisconsin, American Family was found to have a duty to defend and indemnify all claims, regardless of whether they were pled as breach of contract or breach of warranty claims.

This paper will briefly discuss the evolution of the commercial general liability coverage and will then discuss cases with similar fact patterns that were analyzed very differently by the

[1] 673 N.W.2d 65 (Wis. 2004).

courts. Finally, this paper will examine the coverage issues from the insurers' perspective and analyze why certain arguments are falling out of favor in certain jurisdictions.

II. CGL POLICY HISTORY AND COMMONLY USED CLAUSES AT ISSUE IN CONSTRUCTION DEFECT CLAIMS.

A. Brief History Of The Evolution Of The CGL Language.

The coverage grant of a CGL policy typically insures "property damage" caused by an "occurrence" as long as the property damage happened during the policy period. The policy then narrows the coverage grant by listing various exclusions.

The 1973 standard form contained two exclusions that were relevant to construction defect claims. The exclusions stated:

> This insurance does not apply to:
>
> (n) property damage to the named insured's products arising out of such products or any part of such products.
>
> (o) property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof; or out of materials, parts or equipment furnished in connection therewith. [2]

These were the first "business risk" exclusions to appear in a standard CGL form.

The Broad Form Property Damage Endorsement began as an endorsement to the 1973 policy. In 1976, insureds had the option of purchasing this endorsement for an increased premium. This was significant because it deleted exclusion (o) above and replaced it with three more specific exclusions.[3] The exclusions provided that insurance did not apply:

> (p) To that particular part of any property . . .

[2] Clifford J. Shapiro, *Point/Counterpoint: Inadvertent Construction Defects Are an "Occurrence" Under CGL Policies*, Constr. Law. Spring 2002 at 14.

[3] *Id*.

(i) upon which operations are being performed by or on behalf of the named insured at the time of the property damage arising out of such operations; or

(ii) out of which any property damage arises; or,

(iii) the restoration, repair or replacement of which has been made or is necessary by reason of faulty workmanship thereon by or on behalf of the insured.[4]

The 1986 version of the CGL policy attempted to clarify aspects of the policy that had been the subject of much litigation.[5] Exclusion (l) in the 1986 form states that insurance does not apply to: "'Property Damage' to 'your work' arising out of it or any part of it and included in the 'Products-Completed Operations Hazard.' This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor."[6] The 1986 form also attempted to clarify the previous exclusion:

2. This insurance does not apply to:

* * *

j. "Property Damage" to:

* * *

(5) That particular part of a real property on which your or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or

---

[4] *Id*.

[5] *See Baugh Constr. Co. v. Mission Ins. Co*., 836 F.2d 1164, 1172 (9th Cir. 1988) (holding that the faulty workmanship exclusion applied and barred coverage, but only for damage that was caused to "that particular part" of the property that contains defective work that must be repaired or replaced; *but see Transcontinental Ins. Co v. Ice Sys. of Am*., 847 F. Supp. 947 (M.D. Fla. 1994) (holding that no coverage existed because damage for which coverage was sought fell within "that particular part" of the property that had to be restored due to faulty workmanship).

[6] Insurance Services Office, 1986 CGL Form.

(6) That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.[7]

* * *

Paragraph (6) of this exclusion does not apply to "property damage" included in the "products-completed operations hazard."

Exclusion (j) remains unchanged in the most recent iteration of the standard CGL form.

B. Commonly Used Clauses In Construction Defect Cases Today.

Many construction defect disputes first center around the question of whether the property damage was caused by an "occurrence." An "occurrence" is defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."[8] While "occurrence" is defined, the term "accident" is not. The term "accident" plays a key role in determining whether courts are willing to consider construction defects as an occurrence as will be discussed in later sections of this paper.

Once the threshold question of whether there has been an occurrence is answered, the exclusions to coverage can be analyzed. Relevant exclusions are listed below:

2. This insurance does not apply to:

* * *

j. "Property Damage" to:

* * *

(5) That particular part of a real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or

[7] *Id*.

[8] *Id*.

(6) That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.[9]

* * *

Paragraph (6) of this exclusion does not apply to "property damage" included in the "products-completed operations hazard."

k. Damage to Your Product

"Property damage" to "your product" arising out of it or any part of it.

l. Damage to Your Work

"Property damage" to "your work" arising out of it or any part of it and included in the "products-completed operations hazard."

This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.[10]

The policy defines "Products-completed operations hazard" as:

a. Includes all "bodily injury" and "property damage" occurring away from premises you own or rent and arising out of "your product" of "your work" except:

(1) Products that are still in your physical possession; or

(2) Work that has not yet been completed or abandoned. However, "your work" will be deemed completed at the earliest of the following times:

(a) When all of the work called for in your contract has been completed.

(b) When all of the work to be done at the job site has been completed if your contract calls for work at more than one job site.

(c) When that part of the work was done at a job site has been put to its intended use by any person or organization other

[9] Insurance Services Office, 2000 CGL Form

[10] *Id*.

than another contractor or subcontractor working on the same project.

Work that may need service, maintenance, correction, repair or replacement, but which is otherwise complete, will be treated as completed.

b. Does not include "bodily injury" or "property damage" arising out of:

(1) The transportation of property, unless the injury or damage arises out of a condition in or on a vehicle not owned or operated by you, and that condition was created by the "loading or unloading" of that vehicle by any insured;

(2) The existence of tools, uninstalled equipment or abandoned or unused materials; or;

(3) Products or operations for which the classification, listed in the Declarations or in a policy schedule, states that products-completed operations are subject to the General Aggregate Limit.[11]

C. *Weedo v. Stone-E-Brick* -- The Trendsetter.

Weedo v. Stone-E-Brick[12] is widely recognized as the first major case to analyze insurance coverage for construction defects. *Weedo* has been cited over 1,000 times and continues to be cited in many cases today.

Pennsylvania National Mutual Insurance Company ("Pennsylvania National") issued CGL coverage to Stone-E-Brick.[13] Calvin and Janice Weedo contracted with Stone-E-Brick during the policy period to provide concrete flooring on a veranda and stucco to the exterior of the home. After the job was completed, the Weedos discovered cracks in the stucco and other signs of faulty workmanship. The Weedos were forced to remove the stucco and replace it with proper material. The Weedos then filed suit against Stone-E-Brick and alleged that faulty

[11] *Id*.

[12] 405 A.2d 788 (N.J. 1979)

[13] *Id*. at 789.

workmanship caused the Weedos to expense time and money remedying the defective work. Stone-E-Brick tendered the suit to Pennsylvania National, who denied coverage.

The court found that there was no coverage under the policy and noted that "the risk intended to be insured is the possibility that the goods, products or work of the insured, once relinquished or completed, will cause bodily injury or damage to property other than to the product or completed work itself."[14] The court went on to articulate the boundaries of the coverage and the business risk exclusions:

> An illustration of this fundamental point may serve to mark the boundaries between "business risks" and occurrences giving rise to insurable liability. When a craftsman applies stucco to an exterior wall of a home in a faulty manner and discoloration, peeling and chipping result, the poorly-performed work will perforce have to be replaced or repaired by the tradesmen or by a surety. On the other hand, should the stucco peel and fall from the wall, and thereby cause injury to the homeowner or his neighbor standing below or to a passing automobile, an occurrence of harm arises which is the proper subject of risk-sharing as provided by the type of policy before us in this case. The happenstance and extent of the latter liability is entirely unpredictable[.] [T]he neighbor could suffer a scratched arm or a fatal blow to the skull from the peeling stonework. Whether the liability of the businessman is predicated upon warranty theory or, preferably and more accurately, upon tort concepts, injury to persons and damage to other property constitute the risks intended to be covered under the CGL.[15]

Weedo clearly illustrates that the court contemplated the entire policy and determined that the type of damages in the Complaint were foreseeable "business risks" and not a product of happenstance. The court determined that the purpose of insurance is not to warrant a contractor's workmanship.

III. A FORK IN THE ROAD -- OCCURRENCE OR WARRANTY?

The trend in the current construction defect cases is one of unpredictability. No matter how similar the cases are to *Weedo*, or no matter how many similarities any two cases may share,

[14] *Id*. at 791.

[15] *Id*. at 791-92.

the outcome regarding coverage can no longer be predicted with absolute certainty. The two cases discussed below demonstrate how the courts might reach conflicting results on similar facts. While the cases share a similar set of facts, the ultimate resolutions vary.

A. *Kvaerner Metals Div. of Kvaerner U.S. v. Commercial Union Ins. Co.*

In *Kvaerner Metals Div. of Kvaerner U.S. v. Commercial Union Ins. Co.*[16] the Pennsylvania Supreme Court analyzed a CGL policy as it applied to construction defects at a coke oven battery. Bethlehem Steel had contracted with Kvaerner for the construction of the coke oven battery.[17] Kvaerner agreed to build the battery according to specifications, warranted the materials, equipment, and work would be free from defect, and agreed to repair any defective work. Bethlehem alleged that Kvaerner breached this agreement by constructing a battery that did not meet the applicable industry standards. Bethlehem presented Kvaerner with a non-performance list that included numerous problems with the battery, including cracked paver bricks, water penetration, distorted oven walls, and displaced centerlines of the battery's ovens that caused multiple door jams. The list included sixteen different defects in the battery.[18]

After being served with Bethlehem's complaint, Kvaerner tendered the suit to its insurer, National Union. National Union had insured Kvaerner under two CGL policies with different policy periods.[19] National Union subsequently notified Kvaerner of its decision to disclaim coverage, because the allegations did not fall within the coverage grant. Kvaerner filed a declaratory judgment action, and both parties filed motions for summary judgment.

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[16] 908 A.2d 888 (Pa. 2006)

[17] *Id*. at 891.

[18] *Id*.

[19] *Id*. at 892.

Kvaerner argued that damage to the battery was caused by an occurrence because it was an unintended and unexpected event. Kvaerner argued "longitudinal movement of the roof" resulted from the bricks in the battery's roof being "grouted" too early.[20] Kvaerner argued that it did not expect or intend the early grouting and argued the rain caused the movement. Kvaerner suggested the damage was caused by an "accident."[21] Kvaerner also argued that because the policies contained "Completed Operations Coverage" he was entitled to coverage because the damages to the battery occurred after the battery was completed and was the result of the subcontractor's decision to permit Kvaerner to grout the bricks on the battery's roof earlier than scheduled.

The court focused on the word "accident" included in the "occurrence" definition.[22] The court examined whether the damage that was the impetus of the suit was caused by an accident, so as to constitute an occurrence.[23] The court looked to the dictionary definition of the term "accident" and noted the ordinary definition is "unexpected." The court noted this definition implied a degree of fortuity that is not present in a claim for faulty workmanship.[24] The court held that National Union had no duty to defend or indemnify stating:

> We hold that the definition of "accident" required to establish an "occurrence" under the policies cannot be satisfied by claims based upon faulty workmanship. Such claims simply do not present the degree of fortuity contemplated by the ordinary definition of "accident" or its common judicial construction in this context. To hold otherwise would be to convert a policy for insurance into a

[20] *Id*. at 892-93.

[21] *Id*. at 893.

[22] *Id*. at 897.

[23] *Id*.

[24] *Id*.

> performance bond. We are unwilling to do so, especially since such protections are already readily available for the protection of contractors.[25]

This holding has been cited in many construction defect cases in Pennsylvania. In *Millers Capital Ins. Co. v. Gambone Bros. Dev. Co., Inc.*,[26] the underlying complaints alleged that "Gambone and/or its subcontractors built homes with defective stucco exteriors, windows, and other artificial seals intended to protect the home interiors from the elements."[27] Gambone argued that the claims were more than claims for faulty workmanship and argued for coverage for the ancillary claims relating to accidental damage caused by resulting water leaks to non-defective work inside the home interiors. The Pennsylvania Superior Court disagreed. The court applied *Kvaerner* and held that "natural and foreseeable acts, such as rainfall, which tend to exacerbate the damage, effect, or consequences caused by faulty workmanship also cannot be considered sufficiently fortuitous to constitute an 'occurrence' or 'accident' for the purposes of an occurrence-based CGL policy."[28]

B. *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*

While *Kvaerner* and *Gambone* both seem to follow *Weedo's* reasoning and logic, *Lamar Homes* is representative of cases adopting a more expansive view of coverage for construction defects. In *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*,[29] Vincent and Janice DiMare purchased a new home from Lamar Homes and several years later discovered problems they

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[25] *Id.* at 899.

[26] 941 A.2d 706, 712 (Pa. Super. Ct. 2008).

[27] *Id.* at 713.

[28] *Id.*

[29] 242 S.W.3d 1 (Tex. 2007).

attributed to a defective foundation.[30] They sued Lamar and Lamar's subcontractor. Lamar tendered the suit to its insurer Mid-Continent Casualty Company. Mid-Continent refused to defend or indemnify Lamar. Lamar then commenced a declaratory action and the parties filed cross-motions for summary judgment. The Fifth Circuit noted disagreement exists among Texas courts regarding the application of CGL policies to construction defect matters. The Fifth Circuit certified the following three questions to the Texas Supreme Court:[31]

> 1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?
>
> 2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?
>
> 3. If the answers to certified questions 1 and 2 are answered in the affirmative, does Article 21.55 of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend?[32]

Mid-Continent argued that the policy does not cover defective construction that injures only the general contractor's work. Mid-Continent reasoned that the purpose of a CGL policy is to protect the insured from tort liability, not claims of defective performance under a contract.[33] Mid-Continent argued that even though the claim was for negligence, in actuality it is a contract claim because the economic-loss rule dictates that all damages arising from faulty workmanship constitute economic damages for breach of contract. Mid-Continent further argued that faulty work cannot be an occurrence because it was not accidental. Finally, Mid-Continent argued that

[30] *Id*. at 5.

[31] *Id*.

[32] *Id*. at 4.

[33] *Id*. at 7.

extending CGL coverage for these claims would transform a CGL policy into a performance bond.[34]

After analyzing the dictionary definition of "accident" and Fifth Circuit precedent, the court reasoned that "a deliberate act, performed negligently, is an accident if the effect is not the intended or expected result; that is, the result would have been different had the deliberate act been performed correctly."[35] The court answered the first two certified questions in the affirmative holding:

> The proper inquiry is whether an "occurrence" has caused "property damage," not whether the ultimate remedy for that claim lies in contract or in tort. An "occurrence" depends on the fortuitous nature of the event, that is, whether the damage was expected or intended from the standpoint of the insured. "Property damage" consists of physical injury to tangible property and includes the loss of use of tangible property. Thus, we agree with the Fifth Circuit that "claims for damage caused by an insured's defective performance or faulty workmanship" may constitute an "occurrence" when "property damage" results from the "unexpected, unforeseen or undersigned happening or consequence" of the insured's negligent behavior.[36]

In *Century Surety Co. v. Hardscape Construction Specialties, Inc.*, the Fifth Circuit applied *Lamar Homes* to a construction defect claim involving the construction of two pools, a bath house and pool equipment building, sidewalks, fences, a playground, and landscaping.[37] After construction was complete, the property owners sued Hardscape and various subcontractors alleging that faulty design and construction caused physical and aesthetic damage

[34] In response to this argument the court stated, "Any similarities between CGL insurance and a performance bond under these circumstances are irrelevant, however. The CGL policy covers what it covers. No rule of construction operates to eliminate coverage simply because similar protection may be available through another insurance product. Moreover, the protection afforded by a performance bond is, in fact, different from that provided by the CGL insurance policy here."

[35] *Lamar Homes*, 242 S.W.3d at 8.

[36] *Id.* at 16.

[37] 578 F.3d 262, 264 (5th Cir. 2009).

to the pool and surroundings.[38] Applying *Lamar Homes*, the Fifth Circuit held that the allegations amounted to an "occurrence" because "[n]o one alleges that [the contractors] intended or expected its work or its subcontractors' work to damage [the property]."[39]

IV. RECENT TRENDS IN CASE LAW.

Recent trends in case law reinforce the unpredictable nature of this area of law. Some states that were once "pro-insurer" have found coverage in various construction defect settings.

A. Pennsylvania.

The complaint in *Indalex, Inc. v. Nat'l Union Fire Ins. Co.*[40] addressed Indalex's allegedly defective windows and doors. The underlying plaintiff alleged that Indalex's windows and doors were defectively designed resulting in water leakage that caused physical damage, including mold and cracked walls.[41] The insurer, National Union Fire Insurance Company, argued that it was not required to provide coverage because there was no occurrence triggering coverage as required by Pennsylvania law. The Pennsylvania Superior Court analyzed Pennsylvania precedent which had held that various construction defects were not occurrences.[42] But the *Indalex* court distinguished each case it analyzed.

The court held that *Kvaerner* was limited to situations "where the underlying claims were for breach of contract and breach of warranty, and the only damages were to the insured's work

[38] *Id*. at 265.

[39] *Id*. at 266.

[40] 2013 WL 6237312.

[41] *Id*. at *1.

[42] *Id*. at *4-5 (discussing *Kvaerner*, 908 A.2d at 899, *Millers Capital Ins. Co. v. Gambone Bros. Dev. Co. Inc.*, 941 A.2d 706 (Pa. Super. 2007) and *Erie Ins. Exch. v. Abbott Furnace Co.*, 972 A.2d 1232 (Pa. Super. 2009)) .

product."[43] Additionally, the court noted one key distinction from *Kvaerner*—Indalex's policy at issue contained a subjective definition of occurrence. The definition stated, "[a]s respects Bodily Injury or Property Damage, an accident, including continuous or repeated exposure to conditions, which results in Bodily Injury or Property damage neither *expected nor intended from the standpoint of the Insured*."[44] In distinguishing *Gambone*, the court held that "the court in *Gambone* framed the issue as faulty workmanship in the application of stucco and other items [and] [h]ere there are issues framed in terms of a bad product, which can be construed as an 'active malfunction,' and not merely bad workmanship."[45] The court distinguished *Abbott*[46] by noting that while *Abbott* involved a negligence pleading, the "gist of the action doctrine" meant it was essentially a breach of contract matter.[47] Ultimately the court held that "because [the complaint] set forth tort claims based on damages to persons or property, other than the insured's product, we cannot conclude that the claims are outside the scope of coverage."

B. North Dakota.

A similar change in course occurred in North Dakota when the North Dakota Supreme Court decided *K & L Homes, Inc. v. Am. Fam. Mut. Ins. Co.* in 2013.[48] In 2006, the North Dakota Supreme Court decided *ACUITY v. Burd & Smith Constr.*[49] The contractors, Burd & Smith, contracted to replace a roof on an apartment building and allegedly failed to take precautions to protect the building during a rainstorm. Burd & Smith were sued by the owner of

[43] *Indalex, Inc.*, 2013 WL 6237312 at *6 (quotation omitted).

[44] *Id.* (emphasis added).

[45] *Id.*

[46] 972 A.2d 1232 (Pa. Super. 2009).

[47] *Id.*

[48] 829 N.W.2d 724 (N.D. 2013).

[49] 721 N.W.2d 33 (N.D. 2006).

the apartment building and sought coverage from their insurer.[50] The issue for the supreme court was whether the contractor's CGL policy covered the damage to the building. The supreme court held that "property damage caused by faulty workmanship is a covered occurrence to the extent the faulty workmanship causes bodily injury or property damage to property other than the insured's work product."[51]

Seven years later, the North Dakota Supreme Court decided *K & L Homes*. K & L constructed a single-family house and used a subcontractor to complete the footings and foundation.[52] The homeowners claimed that improper footings and improperly compacted soil caused shifting and cracking. The homeowners brought an action for breach of warranty and breach of contract against K & L. The homeowners were awarded a judgment for $253,629.25. American Family provided K & L a defense under a reservation of rights in the underlying action but denied coverage for damages after the adverse judgment.

In analyzing the coverage dispute, the *K & L Homes* court stated that *Burd & Smith* "incorrectly decided the question of whether faulty workmanship may constitute an 'occurrence' by drawing a distinction between faulty workmanship that damages the insured's work or product and faulty workmanship that damages a third party's work or property."[53] The court conducted a historical analysis of CGL coverage and cited fourteen state court decisions in which the courts have held that faulty workmanship can be considered an "occurrence." The court reasoned that "[t]here is nothing in the definition of 'occurrence' that supports that faulty workmanship that damages the property of a third party is a covered 'occurrence,' but faulty

[50] *Id*. at 35.

[51] *Id*. at 39.

[52] *K & L Homes* at 727.

[53] *Id*. at 735.

workmanship that damages the work or property of the insured contractor is not an 'occurrence.'"[54] The North Dakota Supreme Court concluded that "faulty workmanship may constitute an 'occurrence' if the faulty work was 'unexpected' and not intended by the insured, and the property damages was not anticipated or intentional, so that neither the cause nor the harm was anticipated, intended, or expected."[55]

The second issue the *K & L* court decided was whether the faulty workmanship resulted in "property damage" as defined in the policy. The court noted that the coverage grant for "property damage" is limited by the exclusion for damages to "your work."[56] The court further noted that this exclusion would eliminate coverage in this instance but for the subcontractor exception to the exclusion. The court held that "when a general contractor becomes liable for damage to the general contractor's own work arising out of a subcontractor's work—the subcontractor exception preserves coverage that the 'your work' exclusion would otherwise negate." [57]

C. Georgia.

The Supreme Court of Georgia also expanded the meaning of "occurrence" in *Taylor Morrison Servs., Inc. v. HDI-Gerling Am. Ins. Co.* Taylor Morrison, a homebuilder, was sued by a prospective class of more than 400 homeowners.[58] The homeowners alleged that the concrete foundations of their homes were improperly constructed resulting in water intrusion, floor

[54] *Id.* at 736.

[55] *Id.*

[56] *Id.* at 737.

[57] *Id.* (citation and quotation omitted).

[58] 746 S.E.2d 587 (Ga. 2013).

cracks, driveway cracks and warped and buckled flooring.[59] HDI-Gerling at first agreed to defend Taylor Morrison subject to a reservation of rights and in 2009 filed a declaratory action. The Northern District of Georgia awarded summary judgment to the insurer finding that the claims asserted against HDI-Gerling did not amount to an occurrence. Taylor Morrison appealed and the Eleventh Circuit certified the following questions to the Georgia Supreme Court:[60]

> 1. Whether, for an "occurrence" to exist under a standard CGL policy, Georgia law requires there to be damage to "other property," that is, property other than the insured's completed work itself.
>
> 2. If the answer to Question One (1) is in the negative, whether, for an "occurrence" to exist under a standard CGL policy, Georgia law requires that the claims being defended not be for breach of contract, fraud, or breach of warranty form the failure to disclose material information.[61]

After analyzing Georgia precedent, the court held that an "occurrence" does not require damage to the property or work of someone other than the insured, and answered the first certified question in the negative.[62] The court reasoned that the usual and common usage of "accident" conveys information about the nature or extent to which a happening was intended or expected. "Standing alone, the word is not used usually and commonly to convey information about the nature or extent of injuries worked by such a happening, much less the identity of the person whose interests are injured."[63]

In answering the second certified question, the court noted that claims for fraud in Georgia require intent. The court noted that the intent element makes fraud claims inconsistent with the common understanding of an "accident' and would likely not be considered an

[59] *Id*. at 589.

[60] *Id*.

[61] *Id*. at 588.

[62] *Id*. at 591.

[63] *Id*.

occurrence.[64] Therefore, the court answered the second question in the affirmative with respect to fraud. But the court viewed claims for breach of warranty differently. The court noted that while breach of warranties could be intentional, in many cases they are not intentional. "In many cases, faulty workmanship may cause a product or other work to amount to a breach of a warranty for the product or work. And we already have held that faulty workmanship can constitute an 'occurrence.'"[65]

The court went on to reason that a breach of warranty may not always result in coverage because the standard CGL policy only insures against the liability to pay damages due to bodily injury or property damage. And when faulty workmanship is the occurrence, the property damage must be sustained to non-defective property or work. "As such, for an 'occurrence' to exist for purposes of a standard CGL policy, it is not always necessary that the claim be for something other than breach of warranty, and as to breach of warranty, we answer the second question in the negative."[66]

D. Colorado.

The 2012 decision in *Colorado Pool Sys. v. Scottsdale Ins. Co.* involved an interesting battle between the judicial and legislative branches of government.[67] The issue was whether a builder is covered under a CGL policy for damages arising from the builder's faulty workmanship. Colorado Pool agreed to build a swimming pool for a community center.

[64] *Id.* at 595.

[65] *Id.*

[66] *Id.*

[67] No. 10CA2638, 2012 WL 5265981 (Colo. App. Nov. 21, 2012) *cert. granted* , No. 12SC1000, 2013 WL 4714283 (Colo. Sept. 3, 2013).

Colorado Pool hired a subcontractor to construct the pool's concrete shell.[68] Once the shell was poured, an inspector noticed some rebar that was too close to the surface. After remedial measures were rejected, the community center demanded that the pool be demolished and replaced. Colorado Pool notified Scottsdale, its CGL insurer, of its intent to demolish the pool and sought preapproval from Scottsdale. After approval was given, Colorado Pool began to reconstruct the pool. Six weeks later Scottsdale denied coverage.[69]

Colorado Pool then sued Scottsdale for beach of the duty to defend and alleged bad faith. Scottsdale argued that faulty workmanship is not an "occurrence." The court analyzed a recent Colorado statute, the Builders Insurance Act, which was enacted to address claims for faulty workmanship. The legislature declared that previous Colorado precedent "does not properly consider a construction professional's reasonable expectation that an insurer would defend the construction professional against an action or notice of claim."[70] The Builders Insurance Act states:

> (3) In interpreting a liability insurance policy issued to a construction professional, a court shall presume that the work of a construction professional that results in property damage, including damage to the work itself or other work, is an accident unless the property damage intended and expected by the insured. Nothing in this subsection (3):
>
> (a) Requires coverage for damage to an insured's own work unless otherwise provided in the insurance policy; or
>
> (b) Creates insurance coverage that is not included in the insurance policy.[71]

[68] *Id*. at *1.

[69] *Id*.

[70] Colo. Rev. Stat. § 13-20-808(1)(b)(III).

[71] Colo. Rev. Stat. § 13-20-808(3)(a)-(b).

The court analyzed the legislative intent and concluded that the statute was written to apply retroactively. However, the court also noted that applying the statute retroactively "would retroactively alter the reasonableness of Scottsdale's actions in refusing to defend and indemnify Colorado Pool. That sort of change is unconstitutional."[72]

The court ultimately held that the policy does not cover damage incurred in demolishing and replacing the pool itself. "This damage resulted solely from [Colorado Pool's] obligation—necessarily expected—to replace defective work product."[73] Additionally, the court held that the "rip and tear damage to non-defective third-party work" is covered.[74] However, the Colorado Supreme Court will have the final say on the issues presented in *Colorado Pool* including whether the Builders Insurance Act can constitutionally apply retroactively and whether faulty workmanship is an "occurrence."

E. Alabama.

While Alabama has not changed course in its analysis of construction defects, the Supreme Court of Alabama recently reiterated its stance that faulty workmanship is not an occurrence. In *Owners Ins. v. Jim Carr Homebuilder*, the homeowners contracted with Jim Carr Homebuilder for the design and construction of a house.[75] Within one year, the homeowners noticed several problems related to water leaking through the roof, walls and floors. After notifying Jim Carr Homebuilder, some problems were remedied but the homeowners were not satisfied and sued alleging breach of contract, fraud, negligence and wantonness.[76] Jim Carr

[72] *Colorado Pool*, 2012 WL 5265981 at *5.

[73] *Id*. at *7.

[74] *Id*.

[75] 1120764, 2013 WL 5298575 (Ala. Sept. 20, 2013).

[76] *Id*. at * 1.

Homebuilder's carrier, Owners Insurance Company, instituted a declaratory action. The homeowners were awarded $600,000 at the final arbitration.

Owners Insurance Company argued that the property damage upon which the arbitration award was based was not the result of an "occurrence." The court noted that previous Alabama cases had held that whether poor workmanship constitutes an occurrence depends "on the nature of the damage caused by the faulty workmanship."[77] The homeowners and Jim Carr Homebuilders relied on Alabama Supreme Court case *Town & Country Prop., LLC v. Amerisure Ins. Co.*[78] *Town & Country* held that "faulty workmanship may lead to an occurrence if it subjects personal property or other parts of the structure to 'continuous or repeated exposure' to some other 'general harmful condition.[79]'" They argued that *Town & Country* supported their claim that there was an occurrence because faulty workmanship related to the roof, windows, and doors, led to the damage in other parts of the home.[80] The court was not convinced and noted the context in which the *Town & Country* statement was made. The court noted,

> That discussion makes it clear that faulty workmanship performed as part of a construction or repair project may lead to an occurrence if that faulty workmanship subjects personal property or other parts of the structure *outside the scope of that construction or repair project* to "continuous or repeated exposure" to some other "general harmful condition" and if, as result of that exposure, that personal property or other *unrelated* parts of the structure are damaged.[81]

[77] *Id*. at *3 (quotation omitted).

[78] 111 So.3d 699, 706 (Ala. 2011).

[79] *Id*.

[80] *Jim Carr Homebuilder*, 2013 WL 5298575 at *5.

[81] *Id*.

The court reasoned that Jim Carr Homebuilder had contracted to build a house and any damage that resulted from poor workmanship was damage to Jim Carr Homebuilder's own product.[82]

F. Ohio.

In *Westfield Ins. Co. v. Custom Agri Sys., Inc.*, the Ohio Supreme Court relied on the lack of fortuity present in faulty workmanship in holding that the defective construction was not an occurrence.[83] In *Custom Agri*, Younglove Construction contracted with PSD Development for the construction of a feed-manufacturing plant. PSD alleged it incurred damages as a result of defects in a steel grain bin. The bin was constructed by Custom Agri Systems as a subcontractor. When PSD withheld payment, Younglove sued PSD. Custom Agri filed third-party complaints against its subcontractors and notified its insurer, Westfield Insurance Company. Westfield intervened in order to pursue a judgment declaring that it had no duty to defend or indemnify Custom Agri.[84]

Custom Agri was being sued under a defective construction theory. Westfield argued that the claims against Custom Agri did not seek compensation for "property damage" caused by an "occurrence" and therefore the claims were not covered.[85] The United States District Court for the Northern District of Ohio granted Westfield summary judgment. Custom appealed, and Westfield moved to certify the following questions to the Ohio Supreme Court:

> (1) Are claims of defective construction/workmanship brought by a property owner claims for "property damage" caused by and "occurrence" under a commercial general liability policy?

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[82] *Id.* at *6.

[83] 979 N.E.2d 269 (Ohio 2012).

[84] *Id.* at 270.

[85] *Id.*

(2) If such claims are considered "property damage" caused by an "occurrence," does the contractual liability exclusion in the commercial general liability policy preclude coverage for claims for defective construction/workmanship?[86]

The Ohio Supreme Court held that claims for faulty workmanship "are not fortuitous in the context of a CGL policy like the one here."[87] The court held, "[i]n keeping with the spirit of fortuity that is fundamental to insurance coverage, we hold that the CGL policy does not provide coverage to Custom for its alleged defective construction of and workmanship on the steel grain bin."[88] The court supported its position further by citing a similar holding in Arkansas.[89]

G. Connecticut.

Whether damage to a project, which was caused by faulty workmanship, may constitute "property damage" resulting from an "occurrence" was an issue of first impression for the Supreme Court of Connecticut in *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*[90] Capstone was the general contractor for a large construction project for the University of Connecticut. After the project was completed, the University discovered that there were elevated levels of carbon monoxide in parts of the finished structure. During the investigation, the University also discovered other defects and deficiencies attributable to the Capstone's work.[91] Capstone then sought a defense from American Motorists. American Motorists concluded that the University's

[86] *Id.*

[87] *Id.* at 274.

[88] *Id.*

[89] *See Essex Ins. Co. v. Holder*, 261 S.W.3d 456, 459 ("Defective workmanship standing alone—resulting in damages only to the work product itself—is not an occurrence under a CGL policy.").

[90] 67 A.3d 961 (Conn. 2013).

[91] *Id.* at 971.

claims were not covered because the defects arose out of Capstone's own work.[92] After the University and Capstone settled, Capstone sued American Motorists in Alabama for breach of contract and bad faith. The district court then certified this question to the Connecticut Supreme Court:

> 1. Whether damage to a project contracted to be built, which was caused by defective construction or faulty workmanship associated with the construction project, may constitute "property damage" resulting from an "occurrence," triggering coverage under a commercial general liability insurance policy.[93]

American Motorists argued that defective construction lacks the element of fortuity required in order for there to be an "accident." The court disagreed and reasoned, "because negligent work is unintentional from the point of view of the insured, we find that it may constitute the basis for an 'accident' or 'occurrence' under the plain terms of the commercial general liability policy."[94]

The court then analyzed the 'property damage' dividing the property damage into four categories: (1) damage to non-defective property stemming from defective construction; (2) carbon monoxide; (3) defective work, standing alone and (4) repairs to damaged work.[95] For the first category the court held, "[t]o the extent that the plaintiffs' claims are based on physical injury to or loss of use of [non-defective] property, we hold that they are within the insuring agreement's coverage."[96] The court followed New Hampshire's reasoning regarding the escape of carbon monoxide and held that the escape of the gas alone does not qualify as property

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[92] *Id*.

[93] *Id*. at 969-70.

[94] *Id*. at 975.

[95] *Id*. at 978.

[96] *Id*. at 979.

damage.[97] The court followed Florida's reasoning and held that "faulty workmanship or defective work that has damaged otherwise [non-defective] completed project has caused 'physical injury to tangible property' within the plain meaning of the definition of the policy."[98] As such, "[i]f there is no damage beyond the faulty workmanship or defective work, then there may be no resulting 'property damage.'"[99] Finally, the court found coverage for claims for property damage caused by defective work, "but not claims for repair of the defective work itself."[100]

H. South Carolina.

South Carolina adopted a different approach when trying to define an "occurrence." Instead of trying to define it, or adopting a dictionary definition, the South Carolina Supreme Court decided the term is ambiguous and must be construed in favor of the insured.[101] In *Crossmann Communities of N.C., Inc. v. Harleysville*, Crossmann constructed multiple condominium projects. Shortly after the projects were complete, the homeowners discovered construction defects which caused the condominiums to decay and deteriorate.[102] Crossmann settled with the homeowners and then sought coverage from Harleysville. After Harleysville denied coverage, Crossmann instituted a declaratory action. The trial court held the progressive

[97] *Id*.

[98] *Id*. at 981 (quotation omitted).

[99] *Id*.

[100] *Id*. at 982.

[101] *Crossmann Communities of North Carolina, Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d589 (S.C. 2011).

[102] *Id*. at 591-92.

damage, "that resulted from, and was in addition to, the subcontractors' negligent work itself" was caused by an occurrence.[103] The court held:

> [N]egligent or defective construction resulting in damage to otherwise non-defective components may constitute "property damage," but the defective construction would not. We find the expanded definition of "occurrence" is ambiguous and must be construed in favor of the insured, and the facts of the instant case trigger the insuring language of Harleysville's policies."[104]

I. Virginia.

In *Stanley Martin v. Ohio Cas. Grp.*, [105] the Fourth Circuit, applying Virginia law, recognized a distinction between damage to defective property and damage to non-defective caused by the defective property. Stanley Martin, a residential builder, was the general contractor for the construction of duplex townhomes that experienced mold growth in a development in Maryland. Shoffner, the subcontractor, warranted to Stanley Martin that the trusses Shoffner provided were free of mold. The mold problem was traced to defective trusses and led to litigation and substantial remediation expenses. After the litigation, Stanley Martin sued its insurer, Ohio Casualty Company seeking a declaratory judgment that Ohio Casualty breached its duty to indemnify Stanley Martin.[106]

The Fourth Circuit was tasked with analyzing whether the spread of mold from the defective trusses to non-defective surrounding components constituted "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."[107] The

[103] *Id*. at 592.

[104] *Id*. at 594.

[105] 313 F. App'x. 609 (4th Cir. 2009).

[106] *Id*. at 610.

[107] *Id*. at 612.

Fourth Circuit cited, and followed, *French v. Assurance Co. of Am.*[108] In *French*, the general contractor hired a subcontractor to apply synthetic stucco to the exterior of a residential home. This synthetic stucco allowed moisture intrusion causing moisture and water damages to the home's structure and walls.[109] The *French* court held that "by itself, the subcontractor's defective work did not constitute an accident or occurrence under the policy because an insured's obligation to repair the defective work is not unexpected or unforeseen under the terms of the general contract.[110] The *French* court further held that damage to surrounding non-defective components did constitute an accident and occurrence.[111] Applying *French*, the Fourth Circuit held "Stanley Martin's obligation to repair or replace the defective trusses was not unexpected or unforeseen under the terms of its building contract and does not trigger a duty to indemnify."[112] However, in keeping with *French*, the court further held "any mold damage that spread beyond the defective trusses and the gypsum fire walls to non-defective components of the townhouses was an unintended accident, or an occurrence that triggered coverage under the Ohio Casualty policy."[113]

V. AN INSURER'S PERSPECTIVE ON INCONSISTENCY IN THE CASE LAW.

As illustrated in the cases cited, courts can reach seemingly inconsistent decisions regarding whether claims for construction defects can constitute an "occurrence." The inconsistent decisions seem to center on the definition and application of the term "occurrence."

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[108] 448 F.3d 693 (4th Cir. 2006).

[109] *Id.* at 703.

[110] *Id.*

[111] *Id.* at 704-05.

[112] *Stanley Martin Cos.*, 313 F.App'x at 614.

[113] *Id.*

While Pennsylvania holds that construction defects are not fortuitous enough to be considered an accident and thus not an occurrence, Texas adopts the opposite view. The recent trend in expanding coverage for construction defect cases is troublesome for insurers. A few reasons are outlined below.

A. Breach Of Contract Claims.

While many construction defect claims are pled as negligence, the crux of many of these disputes is actually a breach of contract action or breach of warranty claim. In the example in the Introduction, American Girl did not get the benefit of their bargain with the builder. While they contracted for a warehouse to store their inventory of American Girl dolls, the defective construction denied them this benefit. Therefore, this defective construction risk should not be borne by the insurer, but instead by the original party that breached the construction contract, the builder. "A CGL policy is not intended to insure business risks, i.e. risks that are the normal, frequent, or predicable consequences of doing business, and which business management can and should control and manage."[114] There is nothing fortuitous or unexpected of a contractor breaching its warranty to its customer. Yet, in Wisconsin, courts hold that warranty breaches are unexpected.

B. The Policy Should Be Read In Its Entirety.

By reading the policy as a whole, and not taking portions of the policy out of context, courts should be able to apply the policies to construction defect claims in a more consistent manner. "A commercial general liability insurance policy is generally designed to provide coverage for tort liability for physical damages to others and not for contractual liability of the insured for economic loss because the product or work is not that for which the damaged person

[114] *Westfield Ins. Co. v. Custom Agri Sys.*, 979 N.E.2d 269, 272 (Ohio 2012).

bargained."[115] Furthermore, a CGL policy is not intended to apply to every scenario where damage has occurred.

> The qualifying phrase, "to which this insurance applies," underscores the basic notion that the premium paid by the insured does not buy coverage for all property damage but only for that type of damage provided for in the policy. The limitations on coverage are set forth in the exclusion clauses of the policy, whose function it is to restrict and shape the coverage otherwise afforded.[116]

C. Performance Bonds.

Finally, CGL policies are not performance bonds. A performance bond guarantees the satisfactory completion of a project. A performance bond protects the owner against possible losses in case the contractor fails to perform or fails to deliver the project as it was contracted for. Many court decisions appear to come close to converting CGL coverage into performance bonds. The purpose of the policy is to provide coverage for property damage that results from an occurrence—not to guarantee performance.

VI. CONCLUSION.

The application of commercial general liability policies to construction defect claims has been applied inconsistently across various jurisdictions. The expansion of terms like "occurrence" and "accident" has transformed what often should be simple warranty and breach of contract claims between a contractor and customer into insurance claims. While some jurisdictions remain true to the policy language and intent, the trend in expanding CGL coverage may make it difficult for insurers to accurately predict whether a court will find the claim to be a simple warranty claim or a claim for property damage resulting from an occurrence.

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[115] 9A Couch on Ins. § 129:1.

[116] *Weedo*, 405 A.2d at 790.

Insurance Issues – Policyholder and Insurer Perspectives in Mississippi and Elsewhere

Myles A. Parker[1]
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I. Venue/Forum Considerations – Are you going to arbitrate or litigate?

Disputes often arise between insurers and insureds regarding whether the parties are bound to arbitrate their coverage disputes pursuant to an arbitration provision in the applicable policy. Insurers often desire arbitration, while insureds often want to litigate. If the insured refuses to submit to arbitration, the insurer will either file a declaratory judgment action against the insured seeking to compel arbitration, or move to compel arbitration in a coverage suit filed by the insured. As discussed below, enforcement of an arbitration provision in an insurance policy will most likely be governed by the Federal Arbitration Act. The nature of the dispute will determine which of the three chapters of the Federal Arbitration Act applies. The bases for compelling arbitration pursuant to these chapters, as well as the federal court's jurisdiction to do so, are discussed in this article.

A. Disputes between Domestic Insurers and Insureds

Where the insurer and insured are domestic entities, and where no foreign property is involved, it is likely that the arbitrability of a dispute will be governed by Chapter 1 of the Federal Arbitration Act, which is codified at 9 U.S.C. § 1, *et seq.* Despite the existence of other chapters, Chapter 1 of the Federal Arbitration Act is commonly referred to in case law as the "FAA" or the "Act" and is most frequently cited as the basis for compelling arbitration in federal and state courts. The Mississippi Supreme Court has noted that "[t]he Arbitration Act [Chapter 1], resting on Congress's authority under the Commerce Clause, creates a body of federal

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substantive law that is applicable in both state and federal courts." *IP Timberlands Operating Co. v. Denmiss Corp.*, 726 So. 2d 96, 107 (Miss. 1998).

1. Enforcement of an Arbitration Agreement under Chapter 1

9 U.S.C. § 2 ("Validity, irrevocability, and enforcement of agreements to arbitrate") provides the following:

> A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

Pursuant to § 2, the Mississippi Supreme Court has stated that "[t]he Federal Arbitration Act provides a two-pronged inquiry for determining the validity of a motion to compel arbitration." *Cleveland v. Mann*, 942 So. 2d 108, 112 (Miss. 2006). "The first prong requires a threshold finding that the agreement to be arbitrated has a nexus to interstate commerce, followed by a finding that the terms of the arbitration agreement require the parties to arbitrate the kind of dispute involved in the litigation." *Id.*

a. Sufficient Nexus with Interstate Commerce

"While for the FAA [Chapter 1] to apply there must be some involvement with commerce, it need not be substantial in each particular transaction." *Caplin Enter., Inc. v. Arrington*, Nos. 2011-CA-01332-COA, 2011-CA-01932-COA, 2013 WL 1878879, at *3 (Miss. Ct. App. May 7, 2013). The United States Supreme Court has interpreted the phrase "involving commerce" within § 2 as the "functional equivalent" of "affecting commerce." *Citizens Bank v. Alafabco, Inc.,* 539 U.S. 52, 56 (2003) (citing *Allied–Bruce Terminix Cos. v. Dobson,* 513 U.S. 265, 273–74 (1995)). "The Supreme Court has recognized that Congress, in enacting the Federal

Arbitration Act, meant to exercise the full extent of its powers under the commerce clause of the Constitution to ensure that the FAA applies to any arbitration contract involving interstate commerce." *Joiner v. Performance Ins. Servs., Inc.*, 2:10CV235KS-MTP, 2010 WL 5209391, at *3 (S.D. Miss. Dec. 16, 2010) (citing *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 277 (1995)); *see also Cleveland v. Mann*, 942 So. 2d 108, 113 n.2 (Miss. 2006) (noting same).

Courts have found again and again that insurance policies affect interstate commerce and are therefore governed by the FAA. *See Miller v. Nat'l Fid. Life Ins. Co.*, 588 F.2d 185, 187 (5th Cir. 1979) ("It is undisputed that the insurance policy involves interstate commerce."); *Joiner*, 2:10CV235KS-MTP, 2010 WL 5209391, at *3 ("The transaction in this case constituted a transaction concerning insurance solicited in Mississippi and underwritten in Indiana and elsewhere imbuing it with the necessary interstate character."); *see also Gulf Ins. Co. v. Neel-Schaffer, Inc.*, 904 So. 2d 1036, 1045 (Miss. 2004) (holding that FAA controlled enforcement of arbitration agreement in insurance policy and that state law did not reverse-pre-empt the FAA pursuant to the McCarran-Ferguson Act).[2]

b. Arbitrability of the Dispute between the Insurer and Insured

After it is determined that interstate commerce is affected, it should next be determined whether the arbitration agreement in the applicable policy requires arbitration of the coverage dispute in question. 9 U.S.C. § 2 above states that arbitration agreements "shall be valid,

[2] As discussed above, courts have interpreted the phrase "involving commerce" broadly and have found insurance policies to affect interstate commerce. However, even if interstate commerce is found not to be affected, the Mississippi Supreme Court has held that Mississippi courts should still follow case law interpreting the FAA. In *Slater-Moore v. Goeldner*, 113 So. 3d 521, 523-26 (Miss. 2013), an attorney-fee dispute, the court found that the FAA did not apply because the contracts did not affect interstate commerce. *Id.* The Mississippi Supreme Court stated that it "will follow the caselaw [sic] interpreting the Federal Arbitration Act to determine whether a contract that does not involve interstate commerce may be enforced." *Id.* at 526; *see also Univ. Nursing Assocs., PLLC v. Phillips*, 842 So. 2d 1270, 1276 n.6 (Miss. 2003) (in a dispute involving an employment contract, the Court stated that "[e]ven though the Federal Arbitration Act may not apply to this case (because interstate commerce is not involved), we will follow the case law which interprets the Act because the case law is based on sound principles which are easily transferable to non-interstate commerce litigation.").

irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2. The Mississippi Supreme Court has cited the United States Supreme Court and stated that "[t]he Act establishes a federal policy favoring arbitration, requiring that we rigorously enforce agreements to arbitrate." *E. Ford, Inc. v. Taylor*, 826 So. 2d 709, 713-14 (Miss. 2002) (internal citations omitted) (quoting *Shearson/Am. Exp., Inc. v. McMahon,* 482 U.S. 220, 226 (1987)). The Mississippi Supreme Court has further stated that "[q]uestions of arbitrability must be addressed with a healthy regard for the federal policy favoring arbitration. The Arbitration Act establishes that, as a matter of federal law, any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration, whether the problem at hand is the construction of the contract language itself or an allegation of waiver, delay, or a like defense to arbitrability." *E. Ford, Inc.*, 826 So. 2d at 713-14 (internal citations omitted) (quoting *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.,* 460 U.S. 1, 24-25 (1983)).

The Mississippi Supreme Court has stated that state-law principles that govern the formation of contracts should be applied to determine whether legal constraints exist which would preclude arbitration. *E. Ford, Inc.*, 826 So. 2d at 713-14. Therefore, the scope of the arbitration clause, as well as legal constraints external to the agreement will be considered by the court. *See Cleveland v. Mann*, 942 So. 2d 108, 112-13 (Miss. 2006) ("The second prong addresses whether legal constraints external to the agreement, such as fraud, duress, or unconscionability, foreclose arbitration of the claims.").

2. Federal Jurisdiction

Another consideration that often arises in the context of an insurer seeking to compel arbitration pursuant to an arbitration clause in a policy is whether a federal court has jurisdiction

over the matter in the absence of diversity. The insurer may want to file a declaratory judgment action in federal court or remove a coverage suit filed against it by the insured in state court. Despite the fact that the Chapter 1 applies to a matter, an independent basis for subject matter jurisdiction must exist in order for a federal court to have jurisdiction over the dispute.

9 U.S.C. § 4 provides the following:

> A party aggrieved by the alleged failure, neglect, or refusal of another to arbitrate under a written agreement for arbitration may petition any United States district court which, save for such agreement, ***would have jurisdiction under Title 28*** ["Judiciary and Judicial Procedure"], in a civil action or in admiralty of the subject matter of a suit arising out of the controversy between the parties, for an order directing that such arbitration proceed in the manner provided for in such agreement. . . .

(emphasis added). The United States Supreme Court has stated that "[a]s for jurisdiction over controversies touching arbitration, the Act [Chapter 1] does nothing, being 'something of an anomaly in the field of federal-court jurisdiction' in bestowing no federal jurisdiction but rather requiring an independent jurisdictional basis." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 581-82 (2008) (citing *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.,* 460 U.S. 1, 25 n. 32 (1983)); *see also Smith v. Rush Retail Ctrs., Inc.*, 360 F.3d 504, 505 (5th Cir. 2004) ("In short, for a federal court to enter an order to compel arbitration under § 4, there must be diversity of citizenship or some other independent basis for federal jurisdiction before the order can issue.") (internal citations omitted)); *Bank One, N.A. v. Shumake*, 281 F.3d 507, 513 (5th Cir. 2002) (noting that "the FAA does not provide an independent ground of federal jurisdiction. To sue in federal court to enforce an arbitration claim, a petitioner must demonstrate the existence of federal subject matter jurisdiction on the *underlying* contract claim. As a result, suits to compel

arbitration may only be brought in federal court if diversity of citizenship or a federal question exists.").[3]

B. Disputes where Foreign Parties are Involved

The parties to an insurance policy often include foreign insureds or insurers. The United States has ratified and codified two Conventions that allow courts in one country to enforce arbitral awards rendered in other signatory countries, the "New York Convention" (Chapter 2 of the Federal Arbitration Act) and the "Panama Convention" (Chapter 3 of the Federal Arbitration Act). "The purpose of the New York Convention, and similarly the Panama Convention, is to encourage the recognition and enforcement of commercial arbitration agreements in international contracts and to unify the standards by which agreements to arbitrate are observed and arbitral awards are enforced in the signatory countries." *Int'l Ins. Co. v. Caja Nacional De Ahorro y Seguro*, 293 F.3d 392, 399 (7th Cir. 2002) (internal citations omitted).

1. The New York Convention

The Convention on the Recognition and Enforcement of Foreign Arbitral Awards or "New York Convention" is codified in Chapter 2 of the Federal Arbitration Act, 9 U.S.C. § 201, *et seq*. At present, there are 149 Contracting States to the New York Convention, including the United States. *See* UNCITRAL, Convention on the Recognition and Enforcement of Foreign Arbitral Awards (New York, 1958), http://www.uncitral.org/uncitral/en/uncitral_texts/arbitration/NYConvention_status.html (last visited Mar. 6, 2014).

[3] It should be noted that even if subject matter jurisdiction does exist, a party seeking to compel arbitration pursuant to Chapter 1 should read its provisions carefully since all of its intricacies are not discussed herein. Notably, among other things, 9 U.S.C. § 4 provides that "[t]he hearing and proceedings, under such agreement, shall be within the district in which the petition for an order directing such arbitration is filed."

a. Enforcement of an Arbitration Agreement under the New York Convention

Courts have held that "[i]f the arbitration clause falls under the Convention Act [New York Convention], the district court is required to order the arbitration." *Northrop Grumman Ship Sys., Inc. v. Ministry of Def. of Republic of Venezuela*, 1:02CV785WJG-JMR, 2010 WL 5058645, at *3 (S.D. Miss. Dec. 4, 2010). In doing so, the courts have cited 9 U.S.C. § 202 ("Agreement or award falling under the Convention"), which provides the following:

> An arbitration agreement or arbitral award arising out of a legal relationship, whether contractual or not, which is considered as commercial, including a transaction, contract, or agreement described in section 2 of this title, falls under the Convention. An agreement or award arising out of such a relationship which is entirely between citizens of the United States shall be deemed not to fall under the Convention unless that relationship involves property located abroad, envisages performance or enforcement abroad, or has some other reasonable relation with one or more foreign states. For the purpose of this section a corporation is a citizen of the United States if it is incorporated or has its principal place of business in the United States.

The Fifth Circuit has noted that "[i]n determining whether the Convention requires compelling arbitration in a given case, courts conduct only a very limited inquiry." *Freudensprung v. Offshore Technical Servs., Inc.*, 379 F.3d 327, 339 (5th Cir. 2004). "[A] court should compel arbitration if (1) there is a written agreement to arbitrate the matter;[4] (2) the agreement provides for arbitration in a Convention signatory nation; (3) the agreement arises out of a commercial legal relationship; and (4) a party to the agreement is not an American citizen." *Id.* (internal citations omitted). The Fifth Circuit has found that the fourth factor is met even in the absence of a foreign party, if "there is a reasonable connection between the parties' commercial relationship and a foreign state that is independent of the arbitral clause itself." *Id.* at 341. If these factors are met, then the arbitration agreement is deemed to "fall under the Convention."

[4] "The Convention provides that the phrase 'agreement in writing' shall include an arbitral clause in a contract or an arbitration agreement, signed by the parties or contained in an exchange of letters or telegrams." *Sphere Drake Ins. PLC v. Marine Towing, Inc.*, 16 F.3d 666, 669 (5th Cir. 1994).

"Once these requirements are met, the Convention requires the district court to order arbitration, unless it finds that the said agreement is null and void, inoperative or incapable of being performed." *Id.* (internal citations omitted).

Courts must also determine whether the claims at issue are within the scope of the arbitration clause. *See Mosaic Underwriting Serv., Inc. v. MONCLA Marine Operations, LLC*, 926 F. Supp. 2d 865, 869 (E.D. La. 2013) ("Having found that the arbitration agreement 'falls under' the Convention, the Court must now determine whether [the insured]'s claims are within the scope of the arbitration clause."). It should be noted that courts have specifically found arbitration clauses in insurance policies to "fall under" the Convention. *See id.*[5]

b. Federal Jurisdiction

Unlike Chapter 1, the New York Convention specifically provides that district courts have original jurisdiction over arbitration agreements that "fall under" the Convention. Therefore, an insurer may file a declaratory judgment action in federal court and seek to compel arbitration so long as the insurance policy is deemed to "fall under" the Convention. Specifically, 9 U.S.C. § 203 ("Jurisdiction; amount in controversy") provides the following:

> An action or proceeding falling under the Convention shall be deemed to arise under the laws and treaties of the United States. The district courts of the United

[5] In *Mosaic Underwriting Serv., Inc. v. MONCLA Marine Operations, LLC*, 926 F. Supp. 2d 865, 869 (E.D. La. 2013), the district court found the following:

> There is no serious dispute that the four elements required for an agreement to "fall under" the Convention are met in this case. First, both the Hull and Primary P & I policies are in writing and contain an agreement to arbitrate "any dispute arising under or in connection with this insurance." Second, the agreement provides for arbitration in London, England, which is a Convention signatory nation. Third, the agreement arises out of a commercial relationship, because contracts of marine insurance have been held to constitute a "commercial relationship" within the context of an arbitration dispute. Finally, the fourth element is met because the record establishes that none of the third-party defendants are United States citizens. Osprey is domiciled in London, England, and both the Hull Underwriters and Primary P & I Underwriters are also domiciled for business purposes in London, England.

(internal citations omitted).

> States (including the courts enumerated in section 460 of title 28) shall have original jurisdiction over such an action or proceeding, regardless of the amount in controversy.

Pursuant to § 203, the Fifth Circuit has noted that "[t]he FAA grants the United States district courts original federal question jurisdiction over arbitral awards and agreements to arbitrate that fall within the Convention." *Sunkyong Eng'g & Const. Co., LTD. v. Born, Inc.*, No. 97-207931, 149 F.3d 1174, at *5 (5th Cir. June 16, 1998); *see also Chew v. KPMG, LLP*, CIV A 304CV748BN, 2005 WL 5353281, at *3 (S.D. Miss. Jan. 6, 2005) (noting that "§ 203 grants federal courts jurisdiction over cases involving arbitration agreements which fall under the Convention").

An insurer's ability to remove a coverage action to federal court, where the applicable policy contains an arbitration clause, is governed by 9 U.S.C. § 205 ("Removal of cases from State courts"), which provides the following:

> Where the subject matter of an action or proceeding pending in a State court relates to an arbitration agreement or award falling under the Convention, the defendant or the defendants may, at any time before the trial thereof, remove such action or proceeding to the district court of the United States for the district and division embracing the place where the action or proceeding is pending. The procedure for removal of causes otherwise provided by law shall apply, except that the ground for removal provided in this section need not appear on the face of the complaint but may be shown in the petition for removal. For the purposes of Chapter 1 of this title any action or proceeding removed under this section shall be deemed to have been brought in the district court to which it is removed.

The District Court for the Southern District of Mississippi has instructed that "§ 205 allows for removal of a state court case to federal court when the claims in the state court proceeding 'relate to' an arbitration agreement 'falling under the Convention.'" *Chew*, CIV A 304CV748BN, 2005 WL 5353281, at *3. Accordingly, if it is determined that the arbitration agreement "falls under the Convention" as discussed above, then removal is proper so long as the subject claims "relate to" an arbitration agreement.

In *Beiser v. Weyler*, 284 F.3d 665, 669 (5th Cir. 2002), the Fifth Circuit held that "whenever an arbitration agreement falling under the Convention could *conceivably* affect the outcome of the plaintiff's case, the agreement 'relates to' the plaintiff's suit." The court went on to state that "[t]hus, the district court will have jurisdiction under § 205 over just about any suit in which a defendant contends that an arbitration clause falling under the Convention provides a defense. As long as the defendant's assertion is not completely absurd or impossible, it is at least conceivable that the arbitration clause will impact the disposition of the case. That is all that is required to meet the low bar of 'relates to.'" *Id.*; *see also Chew*, CIV A 304CV748BN, 2005 WL 5353281, at *5 (finding that "under the *Beiser* court's broad interpretation of the phrase 'relates to' in the § 205 context, the claims asserted in this suit certainly relate to the subject arbitration agreement" and that removal was proper).[6]

2. The Panama Convention

The Inter-American Convention on International Commercial Arbitration or "Panama Convention" is codified in Chapter 3 of the Federal Arbitration Act, 9 U.S.C. § 301, *et seq*. At present, there are 19 signatories to the Panama Convention, all of which are Latin American countries with the exception of the United States. *See* Organization of American States, The Panama Convention, http://www.sice.oas.org/dispute/comarb/iacac/iacac2e.asp (last visited March 6, 2014).

Notably, 9 U.S.C. § 302 ("Incorporation by reference") provides the following:

> Sections 202 ["Agreement or award falling under the Convention"], 203 ["Jurisdiction; amount in controversy"], 204 ["Venue"], 205 ["Removal of cases from State courts"], and 207 ["Award of arbitrators; confirmation; jurisdiction;

[6] Notably, the Fifth Circuit has affirmed that "section 205 does not vest exclusive jurisdiction over Convention cases in the federal courts." *McDermott Int'l, Inc. v. Lloyds Underwriters of London*, 944 F.2d 1199, 1208 n.12 (5th Cir. 1991) (noting that "the language and history of the Convention Act indicate nothing other than Congress' intent to grant federal courts concurrent jurisdiction over Convention cases and defendants a right to remove state-filed Convention cases to federal court.").

> proceeding"] of this title shall apply to this chapter as if specifically set forth herein, except that for the purposes of this chapter "the Convention" shall mean the Inter-American Convention.

Pursuant to § 302, the same analyses discussed above under the New York Convention will apply to agreements falling under the Panama Convention and some courts have even found discussion of the Panama Convention unnecessary. *See TermoRio S.A. E.S.P. v. Electranta S.P.*, 487 F.3d 928, 933 (D.C. Cir. 2007) (noting that "codification of the Panama Convention incorporates by reference the relevant provisions of the New York Convention (*see* 9 U.S.C. § 302), making discussion of the Panama Convention unnecessary."); *Int'l Ins. Co. v. Caja Nacional De Ahorro y Seguro*, 293 F.3d 392, 396 (7th Cir. 2002) (holding that "the Panama Convention provides us with independent federal question jurisdiction" after noting that 9 U.S.C. § 203 is incorporated by reference into the Panama Convention by 9 U.S.C. § 302); *Corporacion Mexicana de Mantenimiento Integral, S. de R.L. de C.V. v. Pemex-Exploracion y Produccion*, No. Civ. 206 (AKH), 2013 WL 4517225, at *10 (S.D.N.Y. Aug. 27, 2013) (noting that "[t]he Panama Convention and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the 'New York Convention') are largely similar, and so precedents under one are generally applicable to the other."); *Freaner v. Valle*, No. 11CV1819JLS(MDD), 2013 WL 4763418, at *5 (S.D. Cal. Aug. 22, 2013) (noting that "[t]he two Conventions share many of the same features and characteristics and Congress has even indicated that the two Conventions are intended to achieve the same results.") (internal citations omitted).

To the extent it is necessary to determine whether the New York Convention or Panama Convention applies, courts look to 9 U.S.C. § 305 of the Panama Convention ("Relationship between the Inter-American Convention and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards of June 10, 1958"), which provides the following:

> When the requirements for application of both the Inter-American Convention and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards of June 10, 1958, are met, determination as to which Convention applies shall, unless otherwise expressly agreed, be made as follows:
>
> > **(1)** If a majority of the parties to the arbitration agreement are citizens of a State or States that have ratified or acceded to the Inter-American Convention and are member States of the Organization of American States, the Inter-American Convention shall apply.
> >
> > **(2)** In all other cases the Convention on the Recognition and Enforcement of Foreign Arbitral Awards of June 10, 1958, shall apply.

In sum, "[i]n cases where countries have signed both the New York Convention and the Panama Convention, the Panama Convention will apply if 'a majority of the parties to the arbitration agreement are citizens of a State or States that have ratified or acceded to the Inter–American [or Panama] Convention and are member States of the Organization of American States.'" *Caja Nacional De Ahorro y Seguro*, 293 F.3d at 396 n.9 (citing 9 U.S.C. § 305(1)) ("Since all of the parties to this arbitration are signatories to the Panama Convention, our jurisdiction is under that Convention."); *see also Freaner*, 11CV1819JLS(MDD), 2013 WL 4763418, at *6 (noting same and finding that the arbitration agreement at issue "falls under the Panama Convention").

II. Effect of Policy Wording on Forum Selection

In the event of a coverage dispute, insurers and insureds often turn to the courts for resolution (particularly in the absence of an arbitration clause). It is not uncommon for an insurer to file a declaratory judgment action against the insured in one court followed soon after by the insured filing a coverage action in another court against the insurer. The question of who has the right to pick the forum for resolution of the coverage dispute may arise. This determination may be affected by the language of the relevant policy.

Policies often contain service-of-suit clauses like the following:

> It is agreed that in the event of the failure of Underwriters hereon to pay any amount claimed to be due hereunder, Underwriters hereon, at the request of the Assured, will submit to the jurisdiction of any court of competent jurisdiction within the United States and will comply with all requirements necessary to give such court jurisdiction and all matters arising hereunder shall be determined in accordance with the law and practice of such court.

Insureds will often point to service of suit clauses like this one to support the argument that they have the exclusive right to choose the court in which to litigate the coverage dispute. Although courts have held that clauses such as these do prevent insurers from removing a suit filed by an insured in state court, courts have also held that such clauses do not prevent an insurer from bringing suit in a court of its choosing.

In *City of Rose City v. Nutmeg Ins. Co.,* 931 F.2d 13, 15-16 (5th Cir. 1991), the Fifth Circuit held that a service of suit clause almost identical to the one above gave the insured the right to choose the forum in which to try its claims against the insurer and prohibited the insurer from removing an insured's state court action to federal court. *See also Southland Oil Co. v. Miss. Ins. Guar. Ass'n*, 182 F. App'x 358, 361-62 (5th Cir. 2006) (holding that service of suit clause gives the policyholder the right to select the forum, thus foreclosing the insurers' right to remove the action to federal court).

Despite its holding in *Nutmeg*, the Fifth Circuit held in *International Insurance Co. v. McDermott Inc.*, 956 F.2d 93, 96 (5th Cir. 1992) that "the Service of Suit clause does not give the insured the right to prevent the insurer from bringing an action of its own, in a forum of the insurer's choosing, against the insured." The court noted that "the Service of Suit clause itself speaks only to actions brought by the insured. Thus, when the action is first instituted by the insurer, the Service of Suit clause simply has no application." *Id.* at 95-96. In doing so, the court refused to dismiss the insurer's declaratory judgment suit despite the existence of a later-filed state court action by the insured. *Id.* The court noted the following:

> The Court realizes that construing the Service of Suit clause to allow the insured to choose which forum will hear *its* action and to allow the insurer to choose which forum will hear *its* action may in some cases lead to an unfortunate race to the courthouse. On the other hand, the far-reaching construction of the Service of Suit clause advocated by [the insured] leads to untenable results. If [the insured's] position were to prevail, then the insured could effectively block an otherwise valid federal action simply by a later filing in state court. Indeed, under [the insured's] absolute reading of the clause, [the insured] might not even be required to respond to a declaratory judgment or other action filed against it by the insurer. [The insured] could simply choose another forum, file suit, and have the insurer's action stayed or dismissed. [The insured] would thus make the Service of Suit clause a convenient mechanism by which the insured could deprive the insurer of its right to seek a declaratory judgment or other redress from the courts. The Service of Suit clause certainly was not so intended.

Id.; *see also Northfield Ins. Co. v. Odom Indus. Inc.*, 119 F. Supp. 2d 631, 634-35 (S.D. Miss. 2000) (citing *McDermott* in support of conclusion that Service of Suit Clause did not prevent insurer from filing first).

Courts outside of Mississippi have interpreted service of suit clauses in a similar manner. *See PBM Nutritionals, LLC v. Dornoch Ltd.,* 667 F. Supp. 2d 621, 627 (E.D. Va. 2009) (finding that service of suit clause unambiguously gave insurer right to bring action); *Westchester Surplus Lines Ins. Co. v. Pass Condo. Ass'n, Inc.,* No. 09-0175-WS-B, 2009 WL 1904309, at *2-3 (S.D. Ala. July 1, 2009) (citing court's holding in *McDermott* that Service of Suit Clause does not give insured right to block action by insurer and noting that "[a] host of federal and state courts have embraced *McDermott's* reasoning and result in similar circumstances"); *Ace Capital v. Varadam Found.*, 392 F. Supp. 2d 671, 675 (D. Del. 2005) (citing *McDermott* and stating that "[n]othing in the Service of Suit clause prevents an insurer from bringing an action of its own against the insured. If the insurer does so, the Service of Suit provision does not prescribe the forum for the action"); *Chubb Custom Ins. Co. of Am.* v. *Prudential Ins. Co. of Am.*, 948 A.2d 1285, 1292 (N.J. 2008) ("We read the service of suit clause as it has been read by nearly every court that has considered it-as a consent to jurisdiction by the insurer and a prohibition against an insurer

interfering with a forum initially chosen by the insured. The clause is no more expansive than that. It does not inhibit the insurer from filing first. Nor does it allow the insured to trump a first-filed action by the insurer. Fears about inappropriate forum choices by the insurer are unfounded."). Accordingly, while a service of suit clause similar to the one above may prevent an insurer from removing an action filed by an insured in state court, it should not prevent an insurer from seeking a declaration regarding coverage.

It should be noted that a court's interpretation will depend on the specific language of the service of suit clause at issue. Some insurance policies contain service of suit clauses like the following:

> It is agreed that in the event of the failure of the Insurers hereon to pay any amount claimed to be due, the Insurers, at the request of the Insured will submit to the jurisdiction of any court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute waiver of 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 seek a transfer of a case in the United States.

This service of suit clause clearly states that the clause should not be interpreted to constitute waiver of the insurers' right to commence an action OR remove or transfer an action. This language was likely included in order to address the issues faced by the Fifth Circuit in *Nutmeg* and *McDermott*. Accordingly, if the service of suit clause at issue includes this additional language, then a court could find that removal of a suit filed by an insured in state court is not prohibited.

III. First to File – Does it Matter?

After a coverage dispute arises, insurers are often faced with the decision of whether to file a declaratory judgment action requesting a court to determine coverage. An insurer may desire to file suit in order to end a coverage dispute with an insured, negate a bad faith argument,

or gain access to a particular forum based on perceived advantages. Sometimes, the insurer and insured will each file suit in separate forums and the question arises of which suit should go forward. The following discusses which suit will take priority.

A. Federal Court vs. Federal Court

The "first-to-file" rule, which has been adopted by the Fifth Circuit and federal courts in Mississippi, "is a discretionary doctrine which provides that when related cases are pending before two federal courts, the court in which the case was last filed may refuse to hear it if the issues raised by the cases substantially overlap." *Street v. Smith*, 456 F. Supp. 2d 761, 767-69 (S.D. Miss. 2006) (citing *Cadle Co. v. Whataburger of Alice, Inc.,* 174 F.3d 599, 603 (5th Cir.1999)). "The concern manifestly is to avoid the waste of duplication, to avoid rulings which may trench upon the authority of sister courts, and to avoid piecemeal resolution of issues that call for a uniform result." *Achari v. Signal Int'l, LLC*, 1:13CV222-LG-JMR, 2013 WL 5705660, at *3 (S.D. Miss. Oct. 18, 2013) (citing *W. Gulf Mar. Ass'n v. ILA Deep Sea Local 24,* 751 F.2d 721, 728–29 (5th Cir. 1985)). "The Court's inquiry is focused on whether the cases 'substantially overlap,' but where the overlap is less than complete, the judgment is made case by case, based on such factors as the extent of overlap, the likelihood of conflict, the comparative advantage and the interest of each forum in resolving the dispute." *Achari*, 1:13CV222-LG-JMR, 2013 WL 5705660, at *3 (internal citations omitted) (citing *Save Power Ltd. v. Syntek Fin. Corp.,* 121 F.3d 947, 950 (5th Cir.1997)); *see Fat Possum Records, Ltd. v. Capricorn Records, Inc.*, 909 F. Supp. 442, 445-46 (N.D. Miss. 1995) (finding substantial overlap after finding that the suits involved identical parties and subject matter and that "[b]oth actions seek to determine the status of the contractual relationship between the parties.").

"[O]nce the second-filed court finds that the issues in the two suits might substantially overlap, the proper course of action is for the court to transfer the case to the first-filed court to determine which case should, in the interests of sound judicial administration and judicial economy, proceed." *Street*, 456 F. Supp. 2d at 768 (internal citations omitted) (citing *Cadle*, 174 F.3d at 606). "The rule permits transfer between divisions in the same federal district as well as districts organized under different federal circuits." *White v. Peco Foods, Inc.*, 546 F. Supp. 2d 339, 341-42 (S.D. Miss. 2008). "A party can only avoid application of the first-to-file rule by demonstrating the presence of 'compelling circumstances' that caution against the transfer." *Id.* at 342; *see Fat Possum Records, Ltd.*, 909 F. Supp. At 447 (rejecting argument that party's financial condition was a sufficiently compelling reason to disregard the first to file rule where party argued that litigating outside of its locality would be financially burdensome); *Jesco Const. of Del., Inc. v. Clark*, 1:10CV453-HSO-JMR, 2011 WL 2460872, at *4 (S.D. Miss. June 17, 2011) (rejecting argument that anticipatory nature of first-filed suit and location of witnesses and evidence was a compelling circumstance). Accordingly, where the insurer and insured have both filed suit in federal court, or where one party has filed suit in federal court and has also removed a separate state court action to federal court, the court in which suit was first filed should prevail if substantial overlap is found and in the absence of compelling circumstances.

B. Federal Court vs. State Court

Often times, an insurer will file a declaratory judgment action in federal court and an insured will file a separate action in state court. "[B]oth Mississippi and Fifth Circuit case law plainly hold that the first-to-file rule is not applicable when one suit is pending in state court and the other is pending in federal court." *Channel Control Merchants, LLC v. Davis*, 2:11CV21KS-

MTP, 2011 WL 1356937, at *5 (S.D. Miss. Apr. 11, 2011).[7] Regardless of which suit was filed first, the insured will likely seek to dismiss the federal suit pursuant to the Declaratory Judgment Act and the United States Supreme Court's decision in *Brillhart.*

The Declaratory Judgment Act states that "[i]n a case of actual controversy within its jurisdiction, . . . any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration" 28 U.S.C. § 2201(a) ("Creation of remedy"). "Unlike other cases, over which the district courts have a 'virtually unflagging obligation' to exercise their jurisdiction notwithstanding that there is a pending state court action involving the very same issues, the Declaratory Judgment Act has been understood to confer on federal courts unique and substantial discretion in deciding whether to declare the rights of litigants." *Canopius Ins. Inc. v. Arbor Experts, LLC*, 3:13CV225TSL-JMR, 2013 WL 3367096 (S.D. Miss. July 5, 2013) (internal citations omitted) (citing *Wilton v. Seven Falls Co.,* 515 U.S. 277, 286 (1995)). In *Brillhart v. Excess Insurance Company of America,* 316 U.S. 491, 495, 62 S.Ct. 1173, 1175-76 (1942), the United States Supreme Court recognized district courts' discretion to dismiss a declaratory judgment action when a parallel suit not governed by federal law and presenting the same issues is pending in state court, holding that it would be "uneconomical as well as vexatious for a federal court to proceed in a declaratory judgment suit where another suit is pending in a state court presenting the same issues . . . between the same parties." The Court in *Brillhart* instructed that district court should determine "whether the questions in controversy between the parties to the federal suit . . . can better be settled in the proceeding pending in the state court." *Id.* at 1176.

[7] *See Am. Bankers Life Assurance Co. v. Overton,* 128 F. App'x. 399, 403 (5th Cir. 2005) (holding that the "first-to-file" rule applies only when two similar actions are pending in two federal courts); *Crawford v. Morris Transp., Inc.,* 990 So.2d 162, 169 (Miss. 2008) ("As a general rule, the principle of priority jurisdiction does not apply where like suits are pending in both state and federal courts.").

The Fifth Circuit has instructed that this decision involves the following three questions: "(1) is it justiciable; (2) does the court have the authority to grant such relief; and (3) should it exercise its discretion to decide the action based on the factors stated in *St. Paul Insurance Co. v. Trejo,* 39 F.3d 585 (5th Cir.1994)." *AXA Re Prop. & Cas. Ins. Co. v. Day,* 162 F. App'x 316, 319 (5th Cir. 2006). With regard to the first factor, "the question is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." *Id.* at 913 (internal citations omitted).

With regard to the second factor, the Fifth Circuit has held that district courts do not have authority to consider the merits of a declaratory judgment action when "***1) a declaratory defendant has previously filed a cause of action in state court against the declaratory plaintiff;*** 2) the state case involves the same issues as those involved in the federal case; and 3) the district court is prohibited from enjoining the state proceedings under the Anti–Injunction Act."[8] *Travelers Ins. Co. v. La. Farm Bureau Fed'n, Inc.,* 996 F.2d 774, 776 (5th Cir. 1993) (emphasis added).

The third factor, whether a district court should exercise its discretion, is based on the *Trejo* factors, which are stated as follows:

> 1) whether there is a pending state action in which all of the matters in controversy may be fully litigated, 2) whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant, 3) whether the plaintiff engaged in forum shopping in bringing the suit, 4) whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist, 5) whether the federal court is a convenient forum for the parties and witnesses, ... 6) whether retaining the lawsuit in federal court would serve the purposes of judicial economy ... and [7)] whether the federal court is being called on to construe a

[8] The Anti-Injunction Act, 28 U.S.C. § 2283, states that "[a] court of the United States may not grant an injunction to stay proceedings in a State court except as expressly authorized by Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments."

> state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

St. Paul Insurance Co. v. Trejo, 39 F.3d 585, 590-91 (5th Cir.1994).

Pursuant to the above, it seems likely that an insurer's federal declaratory judgment action would be dismissed in favor of a first-filed state court action because the district court would find that it does not have authority to consider the merits of the declaratory judgment action. However, if the insurer files the declaratory judgment action first, then the outcome will depend on the court's application of the *Trejo* factors. If the court refuses to dismiss the declaratory judgment action pursuant to the *Trejo* factors, then it is possible that both suits could go forward.

C. State Court vs. State Court

Mississippi state courts have adopted a similar first-to-file rule where suits are pending in separate Mississippi courts. In *Issaquena Warren Counties Land Co., LLC v. Warren County*, 996 So. 2d 747, 750 (Miss. 2008), the Mississippi Supreme Court stated the following:

> The priority-of-jurisdiction rule stands for the premise that if the first court in which the action is filed has proper subject matter jurisdiction, that court should retain jurisdiction over the whole controversy. To this end, this Court has stated, the 'first to file' or 'race to the courthouse' rule is well-established in Mississippi case law: where two suits between the same parties over the same controversy are brought in courts of concurrent jurisdiction, the court which first acquires jurisdiction retains jurisdiction over the whole controversy to the exclusion or abatement of the second suit. For the purpose of determining which court first had proper jurisdiction, this Court looks to the date the initial pleading is filed, provided process issues in due course.

(internal citations omitted).

However, it should be noted that Mississippi's "priority-of-jurisdiction rule" does not apply where a first-filed action is pending in a state outside of Mississippi. Instead, the decision of whether to dismiss or stay a suit in favor of a first-filed suit pending in another state is entirely

within the trial court's discretion. In *Brown v. Brown*, 493 So. 2d 961, 963 (Miss. 1986), the Mississippi Supreme Court held that the Mississippi trial court acted within its discretion in staying Mississippi divorce proceedings pending the outcome of California divorce proceedings. However, in doing so, the Mississippi Supreme Court noted the following:

> That there is another action regarding the same subject matter pending in the courts of a sister state poses no jurisdictional obstacle to a court of this state of otherwise competent jurisdiction hearing and adjudging the matter in controversy. The question is not whether the Chancery Court has jurisdiction of this matter but how it should exercise such jurisdiction as it has.
>
> Whether under these facts Mississippi should defer to California is a matter committed to the sound discretion of the Chancery Court, informed by the presence or absence of exigent circumstances, the legitimate needs and conveniences of the parties, and considerations of interstate comity and the need to avoid unseemly forum shopping.

Id. (internal citations omitted); *see also Sauvage v. Meadowcrest Living Ctr., LLC*, 28 So.3d 589, 594 n. 3 (Miss. 2010) (holding that wrongful-death suit filed in Mississippi was subject to dismissal during the pendency of a suit for the same wrongful death in a sister state, but noting that "[t]his decision does not erode the general rule that a previously-filed action in a sister state is no bar to an action in Mississippi."); Restatement (2nd) of Conflict of Laws § 86 ("Pendency of Foreign Action") ("A state may entertain an action even though an action on the same claim is pending in another state."). Accordingly, unless one of the state courts dismisses or stays its action in favor of the other, a race to judgment will likely occur.

IV. Conclusion[9]

The issues addressed herein are intended to give the practitioner some tactical and procedural issues to consider at the outset of an insurance coverage dispute. Whether the matter will be litigated in the court system or arbitrated before a panel of appointed arbitrators is of

[9] We would like to extend special thanks to Maggie Nasif, an associate in Carroll Warren & Parker PLLC's Jackson office, who provided valuable assistance in the development of this article.

extreme importance. Many manuscript policies – particularly those underwritten outside of the United States – provide for arbitration of all disputes related to the policy. Often the arbitration seat is in New York or London, which will impact the approach taken in the arbitration. Such clauses are clearly enforceable, and can provide an independent basis for federal court jurisdiction to enforce the agreement in the event one party resists arbitration.

Additionally, if there is no arbitration agreement, the service of suit clause can impact where coverage dispute litigation will be conducted. Understanding the specific wording of the clause and the applicable case law is essential in positioning the dispute in the most appropriate forum available. A proactive approach in understanding these issues and initiating first-filed litigation when disputes arise will go a long way in achieving a satisfactory outcome.

The Government and Plaintiffs Come Knocking: Do You Know Where Your D&O Coverage Is?

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I. Notice Under Claims Made Policies

The primary purpose of a Directors and Officers (D&O) insurance policy is to protect individual directors, officers, and certain other individuals for claims arising out of "wrongful acts." D&O insurance polices typically are written on a "claims-made and reported" basis. This means that the claim both must be made and reported as soon as practicable and usually within the policy period (*i.e.*, one year), or within the extended reporting period. An extended reporting provision in a D&O liability policy permits an insured to make and report a claim after the policy expires. Depending on the extended reporting provision and the particular state's requirements, an insured may report a claim within thirty (30), sixty (60), or ninety (90) days after the expiration of the policy. For D&O policies, notice of a claim within the policy period (or extended reporting provision) is required to trigger the policy. Most jurisdictions will uphold an insurer's denial of coverage based on late notice without showing of prejudice by the insurer.

Because an insured is obligated to report a "claim," it is important to understand exactly how the term "claim" is defined in a D&O policy. Generally, D&O policies define claim as any civil, criminal or administrative proceeding seeking damages, or written demand for damages against an insured. Some D&O policies require only notice of a lawsuit be provided to the insurer, while others require that all written demands for money, arbitration demands, informal investigations, formal investigations, or subpoenas by a regulatory body be reported.

Most D&O policies contain a provision commonly referred to as a "notice of circumstances" provision, which permits an insured to provide notice of potential claims. A "notice of circumstances" provision allows the insured to invoke the insurance coverage under the current policy for matters that are reasonably expected to give rise to a claim, even if that claim may not develop into an actual claim until months later. Notice of circumstances given during the policy period can protect an insured from a future claim that might be excluded under a subsequent policy. Generally, notice of circumstances under D&O policies is considered optional. However, a court may hold that the policy language requires the insured to give notice whenever it learns of alleged wrongful acts committed by its directors or officers or under any circumstances that could reasonably give rise to a claim in the future where the insured later might seek coverage.

An insured should provide specific information related to the potential claimant and claim in order to ensure that it has properly submitted notice under a "notice of circumstances" provision. Compare the following two examples of notice submitted by ABC Corporation under a "notice of circumstances" provision:

NOTICE #1: ABC Corporation fired John Doe and anticipates a claim.

NOTICE #2: John Doe was fired from ABC Corporation on January 10, 2014 after he assaulted another employee in the office. John Doe reported ABC Corporation for OSHA violations in December 2013, and ABC Corporation is concerned that John Doe will attempt to characterize his termination as a retaliation for the OSHA report.

What key information is present in Notice #2 and not in Notice #1?

(1) A specific allegation of a wrongful act is anticipated
(2) Grounds for anticipating a claim
(3) The details of a potential claim (date, location, persons)

Relevant Cases:

Minnesota Lawyers Mutual Insurance Company v. Baylor & Jackson*, *PLLC, 531 Fed. Appx. 312 (4th Cir. 2013) (applying Maryland law)

The United States Court of Appeals for the Fourth Circuit held that an insured's three-year delay in providing notice of circumstances of a potential claim resulted in actual prejudice to the insurer sufficient to disclaim coverage. The court found that the insured possessed adequate notice of the possibility of a legal malpractice claim at the time of the trial court's judgment, and should have notified its insurer of this circumstance at that time instead of waiting until the appellate court affirmed the trial court's judgment three years later. The Fourth Circuit found that the insurer showed actual prejudice because, by the time it received notice after the appellate court had affirmed the trial court's judgment, it could not fulfill its

contractual duties, had "few options" to remedy the insured's wrongdoing, and the harm done by the delay was "irreversible."

Florida Department of Financial Services v. National Union Fire Insurance Company, No. 4:11cv242/RS-WCS, 2012 U.S. Dist. LEXIS 29944 (N.D. Fla. Mar. 7, 2012)

The United States District Court for the Northern District of Florida held that an insured's letter stating that it was aware of a claimant that intended to assert claims against the insured's former directors, officers and shareholders for "wrongful acts including, but not limited to breach of duty, neglect, error, mistaken statement, misleading statement, omission or other wrongful acts . . . resulting in injury in excess of $5 million" satisfied the policy's notice requirement. The notice of circumstances provision in the claims made and reported directors and officers liability policy required that the notice include a description of the "full particulars" of potential claims. The insurer contended that the letter was "boilerplate," and therefore, did not identify the required "full particulars" of the prospective claim. The court dismissed the insurer's view as too narrow, and stated that, "by its very nature, a notice of circumstances will be less specific than an actual claim." *Id.* at *11.

Rupracht v. Certain Underwriters at Lloyd's of London, No. 3:11-cv-000654-LRH-VPC, 2012 U.S. Dist. LEXIS 137098 (D. Nev. Sept. 25, 2012)

The United States District Court for the District of Nevada, applying California law, held that there was no coverage for a suit filed against the insured six months before the directors and officers policy's inception. In April 2007, a claimant and her husband invested in a life insurance policy on the recommendation of their financial advisor who worked at the insured brokerage firm. The financial advisor mismanaged the investment, and the claimant filed suit against the insured brokerage firm and the financial advisors, alleging breach of contract, breach of fiduciary duty, deceptive trade practices, negligence and negligent supervision, accounting malpractice, fraud, and negligent misrepresentation. The parties settled the suit for $100,000.00 plus an assignment of the insured brokerage firm's rights under its directors and officers liability policy to the claimant. The directors and officers policy was a claims-made policy for the period of September 1, 2007 to September 1, 2008, which provided coverage only for a "claim first made during the policy period." The court held that the April

2007 lawsuit constituted a claim under the policy, but because the claim was made several months before the inception of the policy, the April 2007 lawsuit was not covered by the directors and officer policy.

National Union Fire Insurance Company v. Willis, 296 F.3d 336 (5th Cir. 2002) (applying Texas law)

A lawsuit was filed against a corporation and an officer in 1998. The initial complaint asserted claims against the officer for fraud, fraud in the inducement, statutory fraud in a stock transaction, tortious interference with a contract, and conspiracy. The plaintiffs filed their fourth amended petition in March 2000, adding a claim for negligent misrepresentation against the officer and the corporation. The first time the officer notified the insurance company of the lawsuit was by letter in 2000. The insurance company denied coverage because the claims were not timely reported. The district court found in favor of the insurance company. The Fifth Circuit found that, in order to invoke coverage under a "claims-made" policy, such as the D&O insurance policy at issue, a claim must be made against the insured during the coverage period of the policy and the insured must notify the insurer of the claim during the same period. Under a plain reading of the insurance policy, the directors, officers, and corporate liability insurance policy defined "claim" as a civil proceeding which was commenced by service of a complaint or similar pleading. The court found that, under that definition, the initial complaint brought against the officer commenced the civil proceeding as a whole, and that nothing in the record supported the officer's contention that the negligent misrepresentation claim gave rise to a new theory of recovery that was a separate claim under the 2000 policy. Therefore, the court held that the officer was required to notify the insurance company during the 1998 policy period.

Resolution Trust Corporation v. Ayo, 31 F.3d 285 (5th Cir. 1994) (applying Louisiana law)

The United States Court of Appeals for the Fifth Circuit granted summary judgment in favor of the insurer, holding that the general information provided by the insured, including regulatory reports, management reports prepared by an independent auditing agency, audited financial statements, financial reports, and copies of complaints and other documents, did not constitute adequate notice under the claims-made D&O policy. The insured had contended that the documentation provided was

evidence of improper lending practices and financial difficulties that could result in a potential future claim. The policy's notice provision required the insured to provide written notice, within the policy period, of "acts, errors, or omissions which may subsequently give rise to a claim" against a director or officer for a specified "wrongful act." The court found that an insured could not presume that the insurer will draw subjective inferences from general information provided to it. Rather, an insured must provide objective information about specific wrongful acts to satisfy the notice provision.

II. Selection of Counsel

Most public corporation D&O policies do not require the insurer to defend the insured in connection with potentially covered litigation. As a result, it is the duty of the insured to retain competent counsel to defend the litigation. Most policies, however, require that an insured obtain an insurer's consent before appointing its preferred defense counsel. Nevertheless, D&O policies typically provide that an insurer's approval of an insured's choice of counsel cannot be "unreasonably withheld." Some D&O policies require the insured to select counsel from a "panel counsel" list provided by the insurer when the insured is involved in certain types of litigation, particularly complex litigation such as securities claims.

Corporations either select their normal corporate firm or a top-of-the-market law firm with outstanding credentials that charge top-dollar fees. A corporation, however, should select defense counsel with an eye toward obtaining an effective yet cost-efficient defense. In other words, a corporation should select its defense counsel based on value, which will allow the corporation enough leeway to defend and resolve the litigation within policy limits. To do so, a corporation should consult with its D&O insurers who have experience in D&O litigation and can offer significant insight as to the best counsel for a particular case.

Although most public D&O policies do not impose a duty to defend on an insurer, an insurer is obligated to reimburse the insured for those defense costs. Under most D&O policies, an insurer is required only to reimburse reasonable defense costs arising out of covered claims. Thus, an insured and its chosen counsel must ensure that defense expenses remain "reasonable and necessary." Every expense incurred in defense of the litigation typically reduces the available coverage limit.

III. Coverage for External and Internal Investigations

Today, corporations are allocating significant resources to conducting internal investigations and responding to external investigations. The subject of internal and external investigations can include the corporation and/or individual directors, officers, or employees. These investigations can impact future D&O litigation against the corporation's directors and officers. Consequently, many corporations submit the costs of those investigations to their insurers for coverage under their D&O insurance policies.

Whether these investigation costs are covered under a D&O policy depends upon the specific policy language, as well as the type of investigation. Corporations may conduct their own independent internal investigation of potential wrongdoing. These internal investigations often are triggered by shareholder complaints, whistleblowers, and outside auditors. External investigations are either formal or informal investigations conducted by governmental organizations (*e.g.*, U.S. Securities and Exchange Commission, U.S. Department of Justice), legislative investigative committees, federal and state law enforcement entities, or industry self-regulatory organizations. External investigations typically occur before a regulator initiates a formal proceeding against a corporation.

Another type of investigation is a shareholder derivative demand investigation. Generally, a shareholder derivative demand is a demand made by a corporate shareholder to the corporation's board of directors to bring a lawsuit to enforce a right or seek a recovery that belongs to the corporation, but which the corporation has not brought on its own behalf. In the context of D&O coverage, a shareholder derivative demand calls on the board of directors to authorize and pursue a lawsuit on behalf of the corporation against individual directors or officers for alleged wrongdoing. In response to a shareholder derivative demand, the board of directors will appoint a "special litigation committee" comprised of independent directors to conduct a shareholder derivative demand investigation. The purpose of the shareholder derivative demand investigation is to conduct an independent investigation into the relevant facts and law regarding the alleged violations in order to determine whether the corporation should pursue the claims made by the shareholder or reject the shareholder's demand. Some D&O policies expressly include coverage for a corporation's investigation costs in response to a shareholder derivative demand.

In addition to the type of investigation, the existence of coverage under a D&O liability policy for investigation costs will depend upon specific policy provisions and factors such as: (1) whether an insured is the subject of the investigation, (2) whether the investigation is a "claim" against an insured for a wrongful act, and (3) whether investigation costs are covered as defense costs.

Most D&O policies provide coverage for claims against insureds only for wrongful acts. Generally, a claim is defined to include a written demand for money and a civil proceeding. Internal and external investigations typically are not included within the definition of a "claim" because they do not focus on a specific individual insured for an alleged wrongdoing. Costs associated with such investigations usually are considered to be pre-claim inquiry costs that are not covered under a D&O policy absent a specific coverage provision.

Formal investigations by governmental or enforcement entities that target an individual insured as the subject of the investigation may be covered under a D&O policy. Often times, these formal investigations are initiated by an individual director or officer's receipt of a subpoena. Subpoenas, however, will be viewed on a spectrum. On one end are subpoenas issued to informational witnesses. On the other end are subpoenas to clear investigation targets that are precursors to indictments and/or prosecutions. Generally, a subpoena that merely seeks to obtain documents and information from the director or officer should not constitute a claim against an insured for a wrongful act. Such a subpoena does not identify a specific target of an investigation, identify a specific alleged wrongful act, or make a demand for relief. A D&O policy does not provide coverage for directors or officers that are merely identified as relevant witnesses, but against whom no claim of alleged wrongdoing has been made. Therefore, the costs incurred by a corporation in responding to an informational subpoena issued to a director or officer in connection with an external investigation may not be covered under a D&O policy.

Similarly, an internal investigation conducted by a corporation to confirm or dispel allegations against a director or officer of wrongdoing is not a cost incurred as a result of a claim against an insured. Such costs are more akin to business expenses rather than expenses associated with the cost incurred to defend against allegations of wrongdoing.

Relevant Cases:

Employers Fire Insurance Company. v. Promedica Health System, 524 Fed. Appx. 241 (6th Cir. 2013) (applying Ohio law)

The Federal Trade Commission ("FTC") issued subpoenas and civil investigatory demands in connection with the insured's proposed acquisition. The FTC later filed complaints to stop the acquisition. The D&O policy defined a claim to include "a written demand for monetary, non-monetary or injunctive relief . . . against an Insured for a Wrongful Act." The United States Court of Appeals for the Sixth Circuit held that the subpoenas and civil investigative demands were not demands for relief because they sought information related to the FTC's investigation, not a remedy provided by a court. Moreover, the subpoenas did not redress any alleged wrong; they simply enabled the FTC to further investigate whether an antitrust violation may occur.

MBIA Inc. v. Federal Insurance Company, 652 F.3d 152 (2d Cir. 2011) (applying New York law)

The United States Court of Appeals for the Second Circuit rejected an insurers' view that subpoenas issued by the New York Attorney General were a mere discovery device not sufficient to trigger coverage under the D&O policies. The New York Attorney General's investigation of MBIA was part of a larger investigation by other state and federal regulators into MBIA's accounting practices. In connection with its investigation, the New York Attorney General issued a subpoena to MBIA regarding MBIA's alleged accounting misstatements. The subpoena did not identify specific transactions, but compelled MBIA to produce all documents regarding transactions involving "non-traditional products." The court agreed with the district court's finding that a business person "would view a subpoena as a 'formal or informal investigative order' based on the common understanding of these words." *Id.* at 159 (internal citation omitted).

Diamond Glass Companies, Inc. v. Twin City Fire Insurance Company, No. 06-CV-13105, 2008 U.S. Dist. LEXIS 86752 (S.D.N.Y. Aug. 18, 2008)

Diamond learned of a government investigation into its business practices when a federal grand jury sitting in the United States District Court for the Middle District of Pennsylvania issued a subpoena to Diamond's

records custodian, commanding Diamond to produce documents to and appear and testify before the grand jury. Approximately twenty Diamond employees were later interviewed by federal investigators or testified before the grand jury. Diamond also was served with a search warrant allowing FBI agents to conduct a search of its headquarters and to seize various business records and electronic data storage devices. Diamond notified its D&O insurer of the federal grand jury investigation and sought expenses incurred in responding to the federal grand jury investigation. The insurer treated the matter as notice of a potential claim and disclaimed coverage on the basis that an actual claim had not yet been made against Diamond. Diamond filed suit, seeking a declaration that it was entitled to insurance coverage for expenses incurred in connection with the ongoing federal grand jury investigation.

The United States District Court for the Southern District of New York stated that "it is clear that investigative subpoenas and search warrants are not demands for non-monetary relief . . . D&O liability insurance policies are intended to protect insureds from potential liability based on allegations of wrongdoing or other breaches of duty; they are not a means of holding insureds harmless from costs with any participation in the legal system." *Id.* at *3, *5. The ***Diamond Glass*** court specifically disagreed with another case, ***Minuteman International v. Great American Insurance Co.***, No. 03 Civ. 6067, 2004 U.S. Dist. LEXIS 4660, (N.D. Ill. March 22, 2004), finding that demands to produce documents were demands for non-monetary relief, and other cases that have found that subpoenas in connection with a government investigation are more likely to constitute claims.

IV. The Ramifications of Discovery Admissions or Criminal Pleas

Most D&O policies contain exclusions precluding coverage for certain types of conduct by the directors and officers. These conduct exclusions generally include: (a) intentionally dishonest acts or omissions, (b) fraudulent acts or omissions, (c) criminal acts or omissions, (d) willful violations of any statute, rule or law; and (e) illegal profits or remuneration to which the insured was not legally entitled. In the past, any finding of fact of intentional wrongdoing or illegal profit could trigger these conduct exclusions. More recently, D&O policies typically require a prior "adjudication" (final and non-appealable) that the precluded conduct has occurred in order to trigger the applicable exclusion.

Recently, questions have been raised regarding the implications of the Securities and Exchange Commission's ("SEC") new admissions of wrongdoing requirements on D&O insurance coverage. In 2013, the SEC implemented its new policy requiring defendants seeking to settle civil enforcement actions to provide admissions of wrongdoing. This new policy amends the long-standing practice of not requiring admissions of wrongdoing unless there was an underlying criminal conviction and allowing defendants to resolve actions with a "no admit, no deny" settlement.

The SEC policy has raised the issue of whether admissions in an SEC enforcement action are sufficient to trigger the conduct exclusions contained in D&O policies. In two recent settlements of SEC enforcement actions, corporate defendants attempted to avoid this coverage issue by structuring the settlement in a way to alleviate the impact of the admissions. For example, in the JP Morgan "London Whale" settlement, which settled several SEC enforcement actions for $900 million, JP Morgan admitted wrongdoing, but did not make any admissions on behalf of any particular individual and refrained from mentioning any intent. Similarly, billionaire Philip Falcone and his hedge fund, Harbinger Capital Partners, settled two SEC enforcement actions for $18 million and agreed to extensive admissions of wrongdoing. The settlement agreement, however, states that Falcone and Harbinger are not prohibited from taking contrary legal or factual positions in litigation or other proceedings that do not involve the SEC. In doing so, Falcone and Harbinger have attempted to preserve their right to argue that, although they made certain admissions in the SEC enforcement action, those admissions do not affect their right to deny allegations in subsequent litigation arising out of the same conduct.

V. Exhaustion Language

Exhaustion is typically an issue where the exposure to corporate directors and officers is particularly large and corporations obtain coverage under several separate D&O policies from various insurers. These policies typically include a primary policy and one or more excess policies. The excess policies are intended to provide coverage only after the available underlying coverage has been exhausted. A significant issue is whether an excess insurer's obligations may be triggered if the primary or lower excess insurer has paid less than the full amount of its coverage limits. Several

courts have held that an excess D&O insurer is not obligated to pay until each underlying insurer makes actual payment of its coverage limits.

Relevant Cases:

Mehdi Ali v. Federal Insurance Company, 719 F.3d 83 (2d Cir. 2013) (applying New York law)

The United States Court of Appeals for the Second Circuit recently held that several excess directors and officers insurance policies were not triggered unless and until each underlying carrier had paid its full coverage limits. In ***Ali***, the former directors and officers of a corporation were insured by a $50 million tower of insurance coverage consisting of a primary D&O policy and eight excess policies. The insurers of four of the excess policies, including the excess policy attaching directly above the primary policy, were insolvent and unable to pay losses. The directors and officers argued that the excess policies of the solvent excess insurers were triggered once the directors and officers had incurred losses exceeding the amount of insurance underlying each excess policy of the remaining solvent excess insurers, even though the insolvent insurers were unable to pay losses. The Second Circuit held that, in each excess policy, coverage is not triggered until the underlying insurance coverage is exhausted "solely as a result of payment of losses thereunder." The Second Circuit reasoned that coverage under the excess policies was not triggered merely by the aggregation of the directors and officers losses; rather, the losses actually had to have been paid by the underlying insurers.

Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 161 Cal. App. 4th 184 (Cal. App. 4th Dist. 2008)

The California Court of Appeals affirmed the dismissal of an insured's declaratory judgment action against its excess D&O insurer because the primary insurer did not pay the full amount of its coverage limit under the primary policy. In ***Qualcomm***, the excess insurer refused to pay under an excess D&O insurance policy after the insured settled a coverage dispute with its primary insurer for an amount less than the primary insurer's coverage limit and released its primary insurer. The excess policy contained an exhaustion clause providing that the excess insurer "shall be liable only after the insurers under each of the Underlying Policies have paid or have

been held liable to pay the full amount of the Underlying Limit of Liability." *Id.* at 189.

VI. Conclusion

The issues that typically arise when a potential D&O liability claim is made underscore the importance of policy language. As a practical matter, it is important to review the policy's notice requirements, including notice of circumstances provision, and definitions and conditions. D&O policies may require notice during the policy period, even if an insured does not have much knowledge. If a claim (or circumstances of a potential claim) has arisen, and should have been reported, but was not, there may not be coverage under a D&O policy. When a claim is made, the obligations to appoint counsel and make defense decisions belong to an insured because most standard D&O policies do not impose a duty to defend on an insurer. Even absent a duty to defend, the insurer is nevertheless entitled to participate in the defense and settlement of a claim covered by the D&O policy and is required to reimburse an insured for reasonable defense costs. Costs for internal and external investigations, however, may not be covered under a D&O policy, even if the findings of an investigation lead to an actual claim against directors and officers. Another recurring D&O insurance coverage issue is the question of an excess D&O insurer's obligations when the underlying insurers have paid less than their full coverage limits as a result of a compromise between the underlying insurers and the policyholder.

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WAIVING GOOD-BYE TO THE ATTORNEY-CLIENT PRIVILEGE IN INSURANCE LITIGATION: EXPRESS, IMPLIED AND SUBJECT MATTER WAIVERS

THE ADVICE OF COUNSEL DEFENSE AND WAIVER OF THE ATTORNEY-CLIENT PRIVILEGE IN COVERAGE AND BAD FAITH CASES

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The attorney-client privilege has been described as the "oldest rule of privilege known to the common law." *Upjohn Co. v. United States*, 449 U.S. 383, (1981), quoting Wigmore, Evidence §2290 (McNaughton Rev. 4th ed. 1961)

In insurance coverage or bad faith litigation, the attorney client privilege protects from disclosure in discovery the communications between coverage/insurer counsel and the insurer client. That privilege and the protections it provides are waived, however, where the "advice of counsel" defense is asserted by an insurer as a defense to liability in bad faith litigation where the decision it made was wrong.

> "The defense of advice of counsel is offered to show the insurer had 'proper cause' for its actions even if the advice it received is ultimately unsound or erroneous." *State Farm Mut. Auto Ins. Co. v. Sup. Ct. (Johnson Kinsey, Inc.)* 228 CA 3d 721, 725-726 (1991)

As set forth in The Rutter Group *California Practice Guide for Insurance Litigation,* sections 12:1248 – 12:1253:

> "The elements of this defense appear similar to those required for the "advice of counsel" defense in malicious prosecution cases:
>
> - It acted in *good faith reliance* upon advice of counsel and in what it believed was a manner necessary to protect its interests;
> - The insurer was *not so knowledgeable* as to the *legal standard* involved that it knew the advice of counsel was erroneous;
> - It made *full disclosure of all relevant facts* to counsel (or counsel acted on the basis of facts determined by his or her own investigation on behalf of insurer);
> - Finally, it was willing to reconsider, and act accordingly, when it determined that the lawyer's advice was incorrect."

The interaction of assertion of the defense with the attorney-client privilege is succinctly summarized in *The Tripartite Relationship: Guidebook for Defense Lawyers*, prepared by the Federation of Defense & Corporate Counsel (2011), at page 20:

> "The opinions of coverage counsel are generally privileged and confidential and therefore not subject to discovery in coverage litigation. This also tends to be true in subsequent bad faith litigation. Although there are exceptions, generally speaking, coverage opinions cannot be discovered in connection with any subsequent bad faith case unless the carrier chooses to rely upon the "advice of counsel" defense. The carrier can defend the bad faith case without relying upon the advice of counsel defense, simply by stating the reasons why it felt that there

> was no coverage. If, however, the advice of counsel defense is asserted, then the coverage counsel's file is opened up and any potentially unfavorable information becomes discoverable. *See Connecticut Indem. Co. v. Markman*, 1993 U.S. Dist. LEXIS 15202 (E.D. Pa. 1993); *Stonewall Surplus Lines Ins. Co. v. Industrial Indem.*, 1992 U.S. Dist. LEXIS 21914 (N.D. Cal. 1992); *Palmer v. Farmers Ins. Exchange*, 861 P.2d 895 (Mont. 1993). fn. 1 It has been suggested that the privilege can be impliedly waived when an insurance company asserts, in bad faith litigation, that its behavior was based on an understanding of the applicable law, after it had sought and received legal advice. *See State Farm Mut. Auto. Ins. Co. v. Lee*, 13 P.3d 1169 (Ariz. 2000)."

Communications between defense counsel in the underlying action and his or her clients (which may or may not be both the insured and insurer) will generally not be protected from disclosure by the privilege, assuming that it is the insured client who is now suing the insurer for bad faith. In particular, in states that recognize the tripartite relationship, such as California, the "client" includes both insured that is being defended and the insurer under whose policy the defense is being provided. The privilege will belong to both clients but the insured will be able to waive the privilege such that it will not be able to be asserted by the insurer to protect against disclosures of communications related to the handling of the defense of the underlying action.

> "It should also be remembered that in cases involving allegations of bad faith failure to settle, any privilege applicable to the defense of the underlying case is the insured's to waive and thus the entire file of the carrier-retained defense counsel can be exposed to discovery. So, too, may be independent evaluations from other counsel obtained by the insurer as an aid to evaluating the case. *See*

Birth Center v. The St. Paul Companies, 727 A.2d 1144 (Pa. Super. 1999)." *The Tripartite Relationship: Guidebook For Defense Lawyers*, *supra* at page 22.

Generally the "advice" at issue for purposes of the "advice of counsel" defense will be coverage advice, although it can include advice as to a number of issues involving claims handling, such as whether or not to assume the defense of an insured, appointment or not of independent counsel, reasonableness or not of attorney fees/costs for which reimbursement is sought by the insured, settlement demands/offers and policy limits demands.

If the defense is asserted and privilege consequently waived, all pertinent communications between the attorney and client, verbal and written, that would otherwise have been protected from disclosure, are generally subject to disclosure in discovery. *Transamerica Title Ins. Co. v. Superior Court (Bank of the West)* 188 CA3d 1047, 1053 (1987); *California Evidence Code* section 912(a). However, "An insurer does not waive the attorney-client privilege when it is not defending itself on the basis of the advice received." *Transamerica, supra* at 1053. It also does not waive the privilege by simply disclosing that a communication between client and attorney had occurred. *Mitchell v. Sup. Ct. (Shell Oil)* 37 C3d 591, 602 (1984); *So. Cal. Gas Co. v. Public Util. Commission* 50 C3d 31, 42 (1990).

Simply stated, there is no waiver where the advice is not asserted as a defense in the case, i.e. the insurer is not defending itself on the basis of the advice it received, but rather on the correctness of the action it took, even if the action was the same as the advice provided.

> "Aetna claims it acted as it did not because it was advised to do so, but because the advice was, in its view, correct; and it is prepared to defend itself on the basis of that asserted correctness, rather than the mere fact of the advice. Such a

defense does not waive the attorney-client privilege." *Aetna Cas. & Sur. Co. v. Sup. Ct. (Pietrzak)* 153 CA3d 467, 475 (1984).

Assuming that the advice is asserted as a defense in the case, what should one expect? Once the privilege is waived, the counsel's entire legal file is subject to production as is the complete claim file (rather than just the non-privileged portions of the claim file). Counsel's legal bills for services rendered may be subject to production. Verbal communications between the counsel and client are subject to exploration in deposition.

However, waiver of the attorney-client privilege, does not waive the attorney work product privilege, that privilege belonging to the attorney, not the client, and providing absolute protection for an attorney's "impressions, conclusions, opinions or legal research" and not being limited to documents prepared in anticipation of litigation, providing protection for opinions and conclusions of attorneys hired to provide legal counsel to a client. See The Rutter Group *California Practice Guide for Insurance Litigation,* section12:1268; *Aetna, supra* at 478-479.

Assertion of the defense of "advice of counsel" is not necessary to support the reasonableness of the coverage or claims handling decision at issue in a bad faith claim.

Why is it then that an insurer would want to waive its attorney-client privilege, opening up to scrutiny its lawyer's legal file and the other communications between it and its lawyer? Quite simply, to protect itself from punitive damages and, in certain jurisdictions, extra-contractual bad faith damages where its decision was in fact incorrect and there is a large damage exposure. See for example, *Melorich Builders, Inc. v. Sup. Ct. (Serabia)* 160 CA3d 931(1984), *Fox v. Aced* 49 C2d 281, 284-385 (1957).

"An insurer may offer proof that it acted in good faith reliance on advice of competent counsel for several purposes in bad faith litigation:

- To negate allegations that it acted in "bad faith" toward its insured;
- To negate that it had the requisite scienter or other state of mind required for any alternative tort claim based on its handling of the case (fraud, intentional infliction of emotional distress, etc.); and
- To negate claims that it acted with the requisite "oppression, fraud or malice" for an award of punitive damages.

The Rutter Group *California Practice Guide for Insurance Litigation,* sections 12:1248-12:1253.

LESSONS:

The "advice of counsel" defense is rarely used in this author's experience, precisely because waiver of the attorney-client privilege will result, and with it the natural consequence of exponentially expanding the scope of discovery and perhaps in the process creating issues that did not previously exist and/or need not exist.

Counsel for insurers need to think long and hard about whether or not to claim the advice of counsel defense and, if any doubt that it is needed to be waived, should err on the side of caution and not claim it until or unless it becomes obvious that it needs to be asserted. Depending on your jurisdiction, you may not need to assert the defense at the outset of the case (in California, you do not need to specially plead the defense. Rather, it is considered to be in issue under a general denial of the complaint *because it negates an essential element* of the

plaintiff's claim (i.e. that the insurer acted "unreasonably" and "without proper cause"). *State Farm, supra* at 725-726.

Plaintiff lawyers will usually ask the question at some point early in the litigation as to whether or not the defense is going to be asserted, because it will obviously change the scope of discovery, to which an answer will need to be provided. But the insurer generally does not have to waive its right to assert the defense at any given time, short of the practicality of how evidence is being produced and testimony being given and timing issues as to discovery and motion deadlines.

For the insurer, the best course of action is to defend on the merits of the coverage decision or claims activity, not to defend on the "my lawyer told me to do this so I did it" basis, unless it is a high exposure, bad case where it is clear that the legal advice was erroneous. If the advice was correct, or believed to be correct, insurers should not lightly claim the defense and waive the privilege.

In conclusion, there is always a risk associated with waiving the "oldest rule of privilege known to the common law". The attorney-client privilege is a right, a gift if you will, and is one that should be carefully tended to and not inadvertently or lightly given away.

WAIVING GOOD-BYE TO THE ATTORNEY-CLIENT PRIVILEGE IN INSURANCE LITIGATION: EXPRESS, IMPLIED AND SUBJECT MATTER WAIVERS

THE MISSISSIPPI VERSION: USE OF THE "ADVICE OF COUNSEL" DEFENSE IN BAD FAITH LITIGATION

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The dilemmas: under what circumstances can an insurer avoid "bad faith" claims and punitive damages by relying on "advice of counsel" as an affirmative defense? Does the defense go to the independent tort of bad faith or only to issue of punitive damages? If raised, what are the costs? Does asserting "advice of counsel" constitute a complete waiver of the attorney-client privilege, or is there any residual privilege left that may be asserted by an insurer attempting to avoid the more damning communications with counsel? And after all, isn't the insurer's attorney an "agent" for whose acts or omissions the insurer is liable under traditional theories of vicarious liability? What is the extent to which insurer's counsel in bad faith litigation throws previous counsel "under the bus" by placing in dispute the "objective reasonableness" of the advice allegedly relied upon to deny/delay payment of a legitimate claim? Under present Mississippi law, what are we, in the end, asking the jury to determine? And since the lawyer-witness rule works both ways, and defending allegations of bad faith "delay" in paying the claim almost always involves

allegations that the insured's lawyer could have done something to force the issue earlier, what is gained by making the case about lawyer conduct? Does a strategy that makes opposing counsel a witness advocating for the opposition, as opposed to simply occupying space at counsel table, actually help your case?

As usual in serious litigation over common-law principles with a lot of money at stake, there are no settled answers. Perhaps no civil litigation is as fact-driven, more dependent upon the eye of the beholder, than claims for bad faith denial/delay of insurance claims in which extra-contractual and punitive damages may lie for claims decisions by insurers that are unsupported by legitimate or arguable reason in fact or law. Indeed, while the test for establishing the tort of bad faith generally requires proof by plaintiff that the insurer lacked a "legitimate and arguable reason" for refusing to pay a claim or otherwise perform its contractual obligations, "seventy-nine [79] other opinions [construing Mississippi law] have likewise recognized that that [*sic]* there are exceptional circumstances where punitive damages may be recovered from insurers even in cases where the insurer has an arguable reason for denying a claim." Jackson, J., *Mississippi Insurance Law and Practice,* §13:9, 2010 Thompson Reuters/West, 6/2010. Perhaps expectedly, Mississippi's bad faith jurisprudence is no model of consistency; indeed, it is often difficult to identify coherent legal principles that run through the cases and provide sound and reliable guidance for practitioners attempting to prove or disprove essential elements of claims and defenses. More on this will follow during the presentation of this paper, but for present purposes we need to cover the waterfront in a general sense to understand the scope of the "advice of counsel" defense as it has been applied since Mississippi appellate courts first recognized it in the earliest iterations of the bad faith tort.

The Fundamental Concept

The framework for establishing bad faith and entitlement to punitive damages is fairly well established, with important exceptions. To prevail, the insured must prove: (1) liability on the underlying contract or entitlement as a third-party beneficiary to contractual benefits; (2) that *at the time of the claim decision* the insurer had no legitimate or arguable reason to deny or delay payment; and (3) that the insurer's actions in breaching the contract "result[ed] from an intentional wrong, insult, or abuse as well as from such gross negligence as constitutes an independent tort." *See generally Caldwell v. Alfa Ins. Co.,* 686 So.2d 1092, 1095 (Miss. 1996); Jackson, §13:2 (collecting cases); *but see State Farm Mut. Auto. Ins. Co. v. Grimes,* 722 So.2d 637 (Miss. 1998). Although a strong case can be made that *Grimes* and its progeny did away with the requirement that insured establish not only absence of an arguable reason but what has been called "bad-faith *plus,"* or that the breach was attended by intent or some species of quasi-intent usually subsumed by reference to "gross negligence in reckless disregard for the rights of the insured," most of the more recent cases have incorporated this element in the proof requirements. Most important – because it is usually forgotten or ignored in the recent cases – under Mississippi law there has always been recovery for compensatory or consequential damages allowed in breach-of-contract actions, *without* a showing of heightened misconduct, gross negligence or the old "bad-faith *plus.*" *See Universal Life Ins. Co. v. Veasley,* 610 So.2d 290 (Miss. 1992). Yet compensatory damages, including damages for mental distress, out-of-pocket loss and attorney fees, are still referred to a recovery of "extra-contractual damages" to which an insured is entitled upon a showing that the claim was denied without legitimate or arguable reason. It is chiefly a semantic distinction, but it has huge consequences.

The important question when considering the "advice of counsel" defense is whether it goes to defeat the legitimate/arguable reason element (similar to simple negligence, clerical error, and the like), or only goes to "bad-faith *plus*." The cases provide ample support for either argument.

In *Travelers Indemnity Co. v. Wetherbee,* 368 So.2d 829 (Miss. 1979), the insurer in a fire-loss case breached a policy provision requiring payment within 60 days of receipt of proof of loss, and followed that breach by withholding partial payment of undisputed contents loss in an effort to force the insured to accept a low offer of the needed repairs to the dwelling. In every context in which the bad faith tort has been recognized and justified by any Mississippi appellate court, the use of the superior bargaining position of the insurer – after all, who holds the money? – has condemned efforts to withhold policy benefits for which no defense exists in an effort to bargain the insured down on disputed benefits. The courts seem willing to make the leap to intent, willfulness, and employ all euphemisms for bad faith-plus where such proof can be implied from the facts. *Weatherbee* was just the first articulation of the theory. *See also Southern Farm Bureau Ins. Co. v. Holland,* 469 So.2d 55 (Miss. 1984) (allowed bad faith remedy against carriers in workers' compensation context based upon allegation of intentional abuse of relative bargaining positions of carriers and injured employees). In *Weatherbee,* the insurer raised, albeit indirectly, the advice of its counsel to attempt to resolve all claims for a global release rather than paying piecemeal the undisputed contents coverage. The court, citing Mississippi law on the severability or "divisibility" of policy coverages, as well as the insurer's breach of the 60-day payment deadline in the policy provisions, upheld a $50,000.00 punitive damages verdict. Based upon the seminal bad faith case under Mississippi law, *Standard Life Ins. Co. of Indiana v. Veal,* 354 So.2d 239 (Miss. 1977), the court reasoned that the insurer's

attempt to utilize the insured's desperate financial condition arising from the failure to pay benefits admittedly owing could not be adequately addressed by limiting the insured's recovery by traditional contract-law principles, and that punitive damages exposure for such post-loss misconduct, sufficient to constitute an intentional tort, was proper. The fact that withholding the contents coverage came in the midst of litigation and obviously had the support of the insurer's lawyer was not credited as a defense on any issue.

The first articulation of the defense appeared in *Henderson v. U.S.F.&G. Co.,* 695 F.2d 109 (5th Cir. 1983) (applying Mississippi law), as follows: "We agree that good faith reliance upon advice of counsel may prevent imposition of punitive damages. *Fox v. Aced.* 49 Cal.2d 381, 317 P.2d 608 (1957); 22 AmJur.2d, Damages §253 (1965)." Based upon such venerable authority, the "advice of counsel" defense was born; however, as in the early cases from the Mississippi Supreme Court, it wasn't fleshed out or followed for many years. In *Henderson* the Fifth Circuit affirmed a punitive damages verdict for plaintiff based upon the jury's finding, helped along by the trial judge (Judge Harold W. Cox, whose comments at trial were a focus of the appeal), that the insurer hid a $50,000 auto liability policy from its insured on the mistaken grounds that the policy had been cancelled. Oddly, while noting that the insurer failed to reveal the existence of the policy in response to interrogatories in the underlying litigation against the insured, the Fifth Circuit concluded that, by failing to call its defense counsel in that litigation to support the "advice of counsel" defense, the defense was effectively waived by the insurer. Thus, the "lying exception" to the "legitimate and arguable" element of the bad faith tort applied, and "rendered ineffectual any other defenses it had to the punitive damages award." 695 F.2d at 113.

Employers Mut. Cas. Co. v. Tompkins, 490 So.2d 897 (Miss. 1986), is the true origin of the defense from the Mississippi Supreme Court. After the adjuster denied a claim for "stacked" UM benefits in reliance upon a policy exclusion that had been voided by the Supreme Court in 1973, and the insurer rested upon that position from September 1981 through February 1982 before they received a "legal opinion of an experienced insurance attorney" supporting the insurer's position, the court refused to reverse a $400,000 punitive damages award on grounds that the insurer's denial was later supported by their counsel. The insurer's argument on appeal centered on defending its counsel's argument, based upon intervening authority, that the exclusion, which had been kept in the policy despite the 1973 case voiding it as against public policy, could be read to apply to excess UM coverage beyond the per-vehicle minimums. The court didn't buy it, holding: "[W]e are of the opinion that local counsel's advice was *not altogether reasonable* because it relied upon *Talbot's* [the 1973 case] broad terms while overlooking the great probability the insured would read the exclusion as written oblivious to any legal implications imposed upon it by *Talbot."* 490 So.2d at 905 (emphasis added). While the burden placed upon counsel's advice was heavy – it is difficult to blame counsel for not anticipating correctly the probable reading of exclusions by insureds – *Tompkins* is nonetheless the progenitor of the "objective reasonableness" requirement in the context of the "advice of counsel" defense to bad faith.

In *Szumigala v. Nationwide Mut. Ins. Co.,* 853 F.2d 274 (5th Cir. 1988) (applying Mississippi law), the Fifth Circuit again rejected an "advice of counsel" defense, reasoning at length: "[I]t is simply not enough for the carrier to say it relied on advice of counsel, however unfounded, and then expect that valid claims for coverage can be denied with impunity pursuant to such advice. The advice of counsel is but one factor to be considered in deciding whether the

carrier's reason for denying a claim was arguably reasonable. We believe that where, though verbal sleight of hand, the advising attorney concocts an imagined loophole in the policy whose plain language extends coverage, such advice is heeded at the carrier's risk." *Id.* at 282. Similarly, where the insurer proffers the advice of its counsel as "justification for denying a claim … which was clearly within the statute … cannot be a valid excuse." *Murphree v. Federal Ins. Co.,* 707 So.2d 523, 530 (Miss. 1997). Both *Szumigala* and *Murphree* held that the "advice of counsel" defense was not a complete defense; rather it was merely a factor in the jury's consideration of the ultimate issue of whether the denial was "arguably reasonable." Much confusion persists.

THE KEY: TIMING OF THE ADVICE OF COUNSEL

It is critical to understanding the scope of the defense, and indeed most issues relating to the commission of the "bad faith" tort, to narrow the focus of the "arguable reason" inquiry to the time the decision to deny/delay were made. "In determining whether State Farm had an arguable basis for denying the claim in the present case, the Court should consider the facts that were available to State Farm at the time the claim was denied." *Grimes,* 722 So.2d at 641. "We therefore hold that under Mississippi law, the trial court should determine whether there is a jury question regarding arguable basis solely with respect to the reasons State Farm gave the Sobleys for denying the claim." *Sobley v. Southern Natural Gas Co.,* 210 F.3d 561 (5th Cir. 2000); *rev'd on other grounds,* 302 F.3d 325 (5th Cir. 2002) (applying Mississippi law); *see also United American Ins. Co. v. Merrill,* 978 So.2d613 (Miss. 2007); *cert. den'd,* 552 U.S. 1185 (2008) (life insurer limited to medical records it gathered and considered at time claim decision to deny was made, calling it "evidentiary rule.").

In truth, most of the cases rejecting the "advice of counsel" defense utilize some form of this quasi-causation ground. All of the cases discussed above rejected its application for this reason, among others. Conversely, an insurer that delays payment of a claim awaiting advice from its counsel on its coverage obligations, which was timely requested, and promptly pays the claim upon receiving the advice of its counsel to do so, does not commit bad faith by reason of the delay alone. *Cossitt v. Federated Guar. Mut. Ins. Co.,* 541 So.2d 436, 443 (Miss. 1989). And before an insurer can be held liable in bad faith for failing to anticipate that it will have coverage responsibilities, the insured must at least demand the coverage. *Moeller v. American Guar. and Liability Ins. Co.,* 707 So.2d 1062 (Miss. 1996).

But in the usual case where the insurer, acting through its adjusters and other agents, make the decision to deny or delay payment of a valid claim, and only later request a coverage opinion for support, or is supported by its defense counsel in litigation arising from the denial, "advice of counsel" is not a defense to allegations of bad faith. Such advice usually has nothing to do with the claims decision at issue. Even where the insurer's counsel has equal access to information that creates a duty to pay the claim, withholding payment on grounds that the insurer was acting in reliance on its attorney's failure to act is not "advice of counsel." *Amfed Co., LLC v. Jordan,* 34 So.3d 1177 (Miss. App. 2009). In a bad faith case arising in the workers' compensation context, the carrier raised advice of counsel as its chief defense to its failure to pay an award for an extended period. In rejecting the defense, the court held: "Here, there was no evidence that Amfed's delay was based upon Bolen's advice. Instead, Amfed abdicated its investigation to Bolen and relied on him solely to perform the administrative functions of verifying that a lump sum order existed and requesting a calculation of benefits. Amfed's own written policy stated that 'file abandonment to defense counsel is unacceptable.'" *Id.* at 1185.

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"OBJECTIVE REASONABLENESS" STANDARD

As shown, the origin for this standard in addressing "advice of counsel" defenses is the court's relatively unexamined statement in *Tompkins,* 490 So.2d at 905, finding "local counsel's advice not *altogether reasonable* ..." based upon a number of factors. From there the cases simply assume that the insurer must show that the proffered advice of counsel was "reasonable," or "objectively reasonable." An interesting morphing of the standard is in the court's reversal of a bench-trial punitive damages award arising in the workers' compensation context. *Liberty Mut. Ins. Co. v. McKneely,* 862 So.2d 530 (Miss. 2003). Liberty Mutual's attorney recommended termination of medical treatment based upon his review and interpretation of the treating physician's medical records. Since the carrier could show the requisite causal connection between the attorney's advice and the claim decision, the court credited it. "As the attorney's advice was apparently almost entirely based on Dr. Weatherly's letter as outlined above, the analysis is similar to the analysis above [citing *Murphree* and *Henderson].* We find that Liberty Mutual was entitled to rely on the attorney's *reasonable interpretation* of Dr. Weatherly's statement that McKneely's fibromyalgia was not related to his workplace injury." *Id.* at 536. The court did not, however, discuss how a lawyer's interpretation of disputed medical

opinion evidence constitutes competent and "reasonable" advice of counsel, but there you have it.

Again, the secret to the defense is timing. For the defense to have legs, there must be proof that the insurer timely requested it – that is, before the challenged claim decision was made – and that the attorney's advice was "reasonable" under the facts. From the perspective of those of us who regularly litigate bad faith cases in Mississippi, *McKneely* opened the floodgates for the "advice of counsel" defense, especially in cases arising in the compensation context.

THE DOWN SIDE: THE DEFENSE WAIVES THE PRIVILEGE

Since the advent of the defense, all courts and most counsel have assumed that raising it works a complete waiver of the privilege, and plaintiff is thus entitled to the entire file of the insurer's counsel. While I have not seen any court take any position other than this, we have seen insurer counsel in recent cases take the position that the waiver is partial and works only a waiver as to the advice leading to the claim decision. There is no authority for this position, but we can hardly blame counsel for attempting to come up with a legal basis for withholding the usual letters and communications on matters such as, to quote counsel in one of our cases, "We lost the case as I predicted. However, we made it clear to all our employees that filing a claim will not be treated as a matter of right, and that to beat the company out of benefits they will have to go all the way." Hence, the fight over limiting the scope of the waiver.

As usual, there is not much direct authority on the proposition, which seems self-evident. No party can use the privilege as both shield and sword.

In *Jackson Clinic for Women, P.A. v. Henley,* 965 So.2d 643, 648 (Miss. 2007), the Supreme Court held:

> Moore's voluntary use of advice and communication from her former attorney as a basis to avoid the Defendant's statute of limitations defense waived the attorney-client privilege so as to allow the Defendants to conduct discovery regarding the former attorney's file and advice. This Court held that it did, and reversed and remanded the case to the trial court, stating: When Moore used confidential communications with her attorney to toll the statute of limitations, she used the attorney-client privilege as a sword; fairness requires that she not be allowed to hide behind the shield of that attorney-client privilege…

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In *Baptist Health v. BancorpSouth Ins. Services, Inc.,* 270 F.R.D. 268 (N.D. Miss. 2010), the court held: "The great weight of authority holds that the attorney-client privilege is waived when a litigant 'places information protected by it in issue through some affirmative act for his own benefit, and to allow the privilege to protect against disclosure of such information would be manifestly unfair to the opposing party." *Id. at 270* (quoting *Conkling v. Turner,* 883 F.2d 431, 444 (5th Cir. 1989).

In every seminar paper I have ever read in which the "advice of counsel" defense is discussed, the presumption is made that the waiver is complete and cannot be limited by the party asserting it. We have never seen a Mississippi court hold otherwise. But the authority under Mississippi law is quoted above and, to my knowledge, has not been applied in the context of bad faith litigation. However, the reasoning seems unassailable: no party can use the attorney-client privilege as a "sword" as opposed to a "shield." Where, as in this context, the attorney's advice is interposed as an affirmative defense, there is no basis for claiming a partial or limited waiver.

LESSONS:

Be careful what you ask for. In the vast majority of instances in which "advice of counsel" has been raised as an affirmative defense, it has failed, usually on causal-connection grounds. Unless there can be a direct cause-and-effect relationship can be established leading to the challenged claim decision, it doesn't work. In its most frequently encountered context – the carrier in a bad faith action arising out of denial/delay of workers' compensation benefits alleges that the withholding of benefits was based upon the advice of its counsel in the underlying compensation litigation – we have never seen it work as a complete defense outside of the very limited circumstance in *McKneely*. Even then, as the earlier cases reasoned, the defense is merely one of the factors going to the overall reasonableness of the insurer's actions, not a complete bar or defense in and of itself. Using the test of "objective reasonableness" as the standard by which the defense is tested, the plaintiff is put to the task of calling a lawyer with experience in the field on insurance at issue to challenge the proffered advice. The result is that bad faith litigation becomes a battle between lawyers with differing interpretations and prejudices, and a judge to decide whether to allow "expert" testimony on the applicable law to

create an issue of fact for a jury. It is an unwieldy and extremely problematical proof problem, for which no answers have been offered in the cases to date. From the perspective of the plaintiff in bad faith litigation, I can say that I've never seen the defense raised and litigated to conclusion where the potential benefit from raising the defense was not outweighed by other information – admissions and, worse, direct expressions of intent – that can be gleaned from unfettered access to the defense lawyer's file. Nonetheless, what should be a very limited defense applicable only to direct advice to take a position on payment of a claim, or not, based upon considered advice from competent and experienced counsel acting within the scope of his legal expertise, has become the primary defense in Mississippi bad faith litigation in 2014.

WAIVING GOOD-BYE TO THE ATTORNEY-CLIENT PRIVILEGE IN INSURANCE LITIGATION: EXPRESS, IMPLIED AND SUBJECT MATTER WAIVERS

THE MISSISSIPPI VERSION: USE OF THE "ADVICE OF COUNSEL" DEFENSE IN BAD FAITH LITIGATION

John Griffin Jones, Esquire
Jackson, Mississippi

The dilemmas: under what circumstances can an insurer avoid "bad faith" claims and punitive damages by relying on "advice of counsel" as an affirmative defense? Does the defense go to the independent tort of bad faith or only to issue of punitive damages? If raised, what are the costs? Does asserting "advice of counsel" constitute a complete waiver of the attorney-client privilege, or is there any residual privilege left that may be asserted by an insurer attempting to avoid the more damning communications with counsel? And after all, isn't the insurer's attorney an "agent" for whose acts or omissions the insurer is liable under traditional theories of vicarious liability? What is the extent to which insurer's counsel in bad faith litigation throws previous counsel "under the bus" by placing in dispute the "objective reasonableness" of the advice allegedly relied upon to deny/delay payment of a legitimate claim? Under present Mississippi law, what are we, in the end, asking the jury to determine? And since the lawyer-witness rule works both ways, and defending allegations of bad faith "delay" in paying the claim almost always involves

allegations that the insured's lawyer could have done something to force the issue earlier, what is gained by making the case about lawyer conduct? Does a strategy that makes opposing counsel a witness advocating for the opposition, as opposed to simply occupying space at counsel table, actually help your case?

As usual in serious litigation over common-law principles with a lot of money at stake, there are no settled answers. Perhaps no civil litigation is as fact-driven, more dependent upon the eye of the beholder, than claims for bad faith denial/delay of insurance claims in which extra-contractual and punitive damages may lie for claims decisions by insurers that are unsupported by legitimate or arguable reason in fact or law. Indeed, while the test for establishing the tort of bad faith generally requires proof by plaintiff that the insurer lacked a "legitimate and arguable reason" for refusing to pay a claim or otherwise perform its contractual obligations, "seventy-nine [79] other opinions [construing Mississippi law] have likewise recognized that that [*sic]* there are exceptional circumstances where punitive damages may be recovered from insurers even in cases where the insurer has an arguable reason for denying a claim." Jackson, J., *Mississippi Insurance Law and Practice,* §13:9, 2010 Thompson Reuters/West, 6/2010. Perhaps expectedly, Mississippi's bad faith jurisprudence is no model of consistency; indeed, it is often difficult to identify coherent legal principles that run through the cases and provide sound and reliable guidance for practitioners attempting to prove or disprove essential elements of claims and defenses. More on this will follow during the presentation of this paper, but for present purposes we need to cover the waterfront in a general sense to understand the scope of the "advice of counsel" defense as it has been applied since Mississippi appellate courts first recognized it in the earliest iterations of the bad faith tort.

The Fundamental Concept

The framework for establishing bad faith and entitlement to punitive damages is fairly well established, with important exceptions. To prevail, the insured must prove: (1) liability on the underlying contract or entitlement as a third-party beneficiary to contractual benefits; (2) that *at the time of the claim decision* the insurer had no legitimate or arguable reason to deny or delay payment; and (3) that the insurer's actions in breaching the contract "result[ed] from an intentional wrong, insult, or abuse as well as from such gross negligence as constitutes an independent tort." *See generally Caldwell v. Alfa Ins. Co.,* 686 So.2d 1092, 1095 (Miss. 1996); Jackson, §13:2 (collecting cases); *but see State Farm Mut. Auto. Ins. Co. v. Grimes,* 722 So.2d 637 (Miss. 1998). Although a strong case can be made that *Grimes* and its progeny did away with the requirement that insured establish not only absence of an arguable reason but what has been called "bad-faith *plus,"* or that the breach was attended by intent or some species of quasi-intent usually subsumed by reference to "gross negligence in reckless disregard for the rights of the insured," most of the more recent cases have incorporated this element in the proof requirements. Most important – because it is usually forgotten or ignored in the recent cases – under Mississippi law there has always been recovery for compensatory or consequential damages allowed in breach-of-contract actions, *without* a showing of heightened misconduct, gross negligence or the old "bad-faith *plus.*" *See Universal Life Ins. Co. v. Veasley,* 610 So.2d 290 (Miss. 1992). Yet compensatory damages, including damages for mental distress, out-of-pocket loss and attorney fees, are still referred to a recovery of "extra-contractual damages" to which an insured is entitled upon a showing that the claim was denied without legitimate or arguable reason. It is chiefly a semantic distinction, but it has huge consequences.

The important question when considering the "advice of counsel" defense is whether it goes to defeat the legitimate/arguable reason element (similar to simple negligence, clerical error, and the like), or only goes to "bad-faith *plus*." The cases provide ample support for either argument.

In *Travelers Indemnity Co. v. Wetherbee,* 368 So.2d 829 (Miss. 1979), the insurer in a fire-loss case breached a policy provision requiring payment within 60 days of receipt of proof of loss, and followed that breach by withholding partial payment of undisputed contents loss in an effort to force the insured to accept a low offer of the needed repairs to the dwelling. In every context in which the bad faith tort has been recognized and justified by any Mississippi appellate court, the use of the superior bargaining position of the insurer – after all, who holds the money? – has condemned efforts to withhold policy benefits for which no defense exists in an effort to bargain the insured down on disputed benefits. The courts seem willing to make the leap to intent, willfulness, and employ all euphemisms for bad faith-plus where such proof can be implied from the facts. *Weatherbee* was just the first articulation of the theory. *See also Southern Farm Bureau Ins. Co. v. Holland,* 469 So.2d 55 (Miss. 1984) (allowed bad faith remedy against carriers in workers' compensation context based upon allegation of intentional abuse of relative bargaining positions of carriers and injured employees). In *Weatherbee,* the insurer raised, albeit indirectly, the advice of its counsel to attempt to resolve all claims for a global release rather than paying piecemeal the undisputed contents coverage. The court, citing Mississippi law on the severability or "divisibility" of policy coverages, as well as the insurer's breach of the 60-day payment deadline in the policy provisions, upheld a $50,000.00 punitive damages verdict. Based upon the seminal bad faith case under Mississippi law, *Standard Life Ins. Co. of Indiana v. Veal,* 354 So.2d 239 (Miss. 1977), the court reasoned that the insurer's

attempt to utilize the insured's desperate financial condition arising from the failure to pay benefits admittedly owing could not be adequately addressed by limiting the insured's recovery by traditional contract-law principles, and that punitive damages exposure for such post-loss misconduct, sufficient to constitute an intentional tort, was proper. The fact that withholding the contents coverage came in the midst of litigation and obviously had the support of the insurer's lawyer was not credited as a defense on any issue.

The first articulation of the defense appeared in *Henderson v. U.S.F.&G. Co.,* 695 F.2d 109 (5th Cir. 1983) (applying Mississippi law), as follows: "We agree that good faith reliance upon advice of counsel may prevent imposition of punitive damages. *Fox v. Aced.* 49 Cal.2d 381, 317 P.2d 608 (1957); 22 AmJur.2d, Damages §253 (1965)." Based upon such venerable authority, the "advice of counsel" defense was born; however, as in the early cases from the Mississippi Supreme Court, it wasn't fleshed out or followed for many years. In *Henderson* the Fifth Circuit affirmed a punitive damages verdict for plaintiff based upon the jury's finding, helped along by the trial judge (Judge Harold W. Cox, whose comments at trial were a focus of the appeal), that the insurer hid a $50,000 auto liability policy from its insured on the mistaken grounds that the policy had been cancelled. Oddly, while noting that the insurer failed to reveal the existence of the policy in response to interrogatories in the underlying litigation against the insured, the Fifth Circuit concluded that, by failing to call its defense counsel in that litigation to support the "advice of counsel" defense, the defense was effectively waived by the insurer. Thus, the "lying exception" to the "legitimate and arguable" element of the bad faith tort applied, and "rendered ineffectual any other defenses it had to the punitive damages award." 695 F.2d at 113.

Employers Mut. Cas. Co. v. Tompkins, 490 So.2d 897 (Miss. 1986), is the true origin of the defense from the Mississippi Supreme Court. After the adjuster denied a claim for "stacked" UM benefits in reliance upon a policy exclusion that had been voided by the Supreme Court in 1973, and the insurer rested upon that position from September 1981 through February 1982 before they received a "legal opinion of an experienced insurance attorney" supporting the insurer's position, the court refused to reverse a $400,000 punitive damages award on grounds that the insurer's denial was later supported by their counsel. The insurer's argument on appeal centered on defending its counsel's argument, based upon intervening authority, that the exclusion, which had been kept in the policy despite the 1973 case voiding it as against public policy, could be read to apply to excess UM coverage beyond the per-vehicle minimums. The court didn't buy it, holding: "[W]e are of the opinion that local counsel's advice was *not altogether reasonable* because it relied upon *Talbot's* [the 1973 case] broad terms while overlooking the great probability the insured would read the exclusion as written oblivious to any legal implications imposed upon it by *Talbot."* 490 So.2d at 905 (emphasis added). While the burden placed upon counsel's advice was heavy – it is difficult to blame counsel for not anticipating correctly the probable reading of exclusions by insureds – *Tompkins* is nonetheless the progenitor of the "objective reasonableness" requirement in the context of the "advice of counsel" defense to bad faith.

In *Szumigala v. Nationwide Mut. Ins. Co.,* 853 F.2d 274 (5th Cir. 1988) (applying Mississippi law), the Fifth Circuit again rejected an "advice of counsel" defense, reasoning at length: "[I]t is simply not enough for the carrier to say it relied on advice of counsel, however unfounded, and then expect that valid claims for coverage can be denied with impunity pursuant to such advice. The advice of counsel is but one factor to be considered in deciding whether the

carrier's reason for denying a claim was arguably reasonable. We believe that where, though verbal sleight of hand, the advising attorney concocts an imagined loophole in the policy whose plain language extends coverage, such advice is heeded at the carrier's risk." *Id.* at 282. Similarly, where the insurer proffers the advice of its counsel as "justification for denying a claim … which was clearly within the statute … cannot be a valid excuse." *Murphree v. Federal Ins. Co.,* 707 So.2d 523, 530 (Miss. 1997). Both *Szumigala* and *Murphree* held that the "advice of counsel" defense was not a complete defense; rather it was merely a factor in the jury's consideration of the ultimate issue of whether the denial was "arguably reasonable." Much confusion persists.

THE KEY: TIMING OF THE ADVICE OF COUNSEL

It is critical to understanding the scope of the defense, and indeed most issues relating to the commission of the "bad faith" tort, to narrow the focus of the "arguable reason" inquiry to the time the decision to deny/delay were made. "In determining whether State Farm had an arguable basis for denying the claim in the present case, the Court should consider the facts that were available to State Farm at the time the claim was denied." *Grimes,* 722 So.2d at 641. "We therefore hold that under Mississippi law, the trial court should determine whether there is a jury question regarding arguable basis solely with respect to the reasons State Farm gave the Sobleys for denying the claim." *Sobley v. Southern Natural Gas Co.,* 210 F.3d 561 (5th Cir. 2000); *rev'd on other grounds,* 302 F.3d 325 (5th Cir. 2002) (applying Mississippi law); *see also United American Ins. Co. v. Merrill,* 978 So.2d613 (Miss. 2007); *cert. den'd,* 552 U.S. 1185 (2008) (life insurer limited to medical records it gathered and considered at time claim decision to deny was made, calling it "evidentiary rule.").

In truth, most of the cases rejecting the "advice of counsel" defense utilize some form of this quasi-causation ground. All of the cases discussed above rejected its application for this reason, among others. Conversely, an insurer that delays payment of a claim awaiting advice from its counsel on its coverage obligations, which was timely requested, and promptly pays the claim upon receiving the advice of its counsel to do so, does not commit bad faith by reason of the delay alone. *Cossitt v. Federated Guar. Mut. Ins. Co.,* 541 So.2d 436, 443 (Miss. 1989). And before an insurer can be held liable in bad faith for failing to anticipate that it will have coverage responsibilities, the insured must at least demand the coverage. *Moeller v. American Guar. and Liability Ins. Co.,* 707 So.2d 1062 (Miss. 1996).

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