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CONTENTS

FEATURE ARTICLE

A Professional Responsibility Perspective on Independent Counsel in Insurance 5
by Douglas R. Richmond

CASES

Additional Insureds

10 Ellicott Square Court Corp. v. Mountain Valley Indemnity Co. (2d Cir.) **20**
Under New York Law, where a contractor's blanket additional insured endorsement required that the underlying prime contract be "executed" prior to the loss, the owner was not covered where the prime contract was unsigned when the loss occurred

Automobile Insurance

Federal Ins. Co. v. Executive Coach Luxury Travel, Inc. (Ohio) **23**
Driver employed by a travel service that had entered into a contract with a university baseball team was "hired" by the baseball team and therefore "an insured" under the omnibus definition in the university's auto policy

Bad Faith

Dunn v. American Family Ins. Co. (Colo.App.) **25**
Property insurer's duty of good faith does not obligate insurer to monitor work of independent contractor recommended by insurer but duty does require insurer to communicate promptly and adequately with insured and contractor

Bad Faith/Duty to Settle

Howard v. American National Fire Insurance Company (Cal.App.) **27**
Where multiple liability insurers cover claim, duty to settle may arise even if settlement demand exceeds any single insurer's policy limit

Contractual Liability Exclusion/Estoppel

Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London (Tex.) **29**
Texas Supreme Court rules that CGL policy's contractual liability exclusion precludes a duty to indemnify an insured general contractor's liability for damage to neighboring property, where the only basis for the insured's liability is a contractual promise to be responsible for such damage

Directors & Officers Insurance

Wintermute v. The Kansas Bankers Surety Co. (8th Cir.) **34**
Personal profit and dishonesty exclusions in D & O policy require proof beyond the allegations in the complaint

WEST®

(Continued on Inside Page)

Excess Insurance

Trinity Homes LLC v. Ohio Casualty Ins. Co. (7th Cir.) **36**
Policyholder's settlement with primary insurers for less than policy limits triggers excess insurance coverage

Liability Insurance

Lexicon, Inc. v. Ace American Ins. Co. (8th Cir.) **38**
Destruction of insured's product was not "occurrence"

Rucker v. Columbia Natl. Ins. Co. (Ga. App.) **39**
Negligent hiring not an "occurrence" in Georgia

Liability Insurance/Choice of Law

National Union Fire Insurance Co. v. Standard Fusee Corp. (Ind.) **40**
Applies law of single state, Maryland, to dispute over coverage for environmental damage in California and Indiana

Liability Insurance/Property Damage

Advanced Network, Inc. v. Peerless Ins. Co. (Cal.App.) **41**
Theft of cash from credit union's cash machine is not "loss of use" within meaning of servicing company's liability policy's "property damage" definition

Life Insurance

Protective Life Insurance Co. v. Hansen (7th Cir.) **43**
Seventh Circuit Refuses to reform life insurance policy's beneficiary designation

Property Insurance/ "Collapse"

Council Tower Association v. Axis Specialty Insurance Co. (8th Cir.) **44**
Falling of decorative brick from one-third of structure's wall was not covered "collapse"

Public Adjusters

Kortum v. Sink (Fla.App.) **45**
Law banning public adjusters from initiating contact with insured for at least 48 hours declared unconstitutional

Litigation Developments

Lloyd's Syndicate Named as Defendant in United States Suit against BP and Others **46**

By: Joseph G. Grasso and Charles Platto

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Editor-in-Chief: John K. DiMugno, Esq.
Editorial Board Director and Senior Contributing Editor: William T. Barker
Senior Contributing Editor: Stephen S. Ashley
Contributing Editors: Robert D. Phillips Jr., Michael Sean Quinn, John Torigian, Dennis J. Wall

Editorial Offices: Litigation Research Group, 3450 Palmer Dr., Cameron Park, CA 95682
Telephone: (530) 344-0239 Facsimile: (530) 344-0189 E-Mail dimugno@pacbell.net

Editorial Board

Pamella A. Hopper
Nickens Keeton Lawless Farrell Flack,
327 Congress Avenue, Suite 490
Austin, TX 78701
512.472.3067
512.472.3068 (Fax)
phopper@nickenskeeton.com

Peter J. Laufenberg
Wendel Rosen Black & Dean, L.L.P.
1111 Broadway, 24th Floor
Oakland, CA
(P) 510-834-6600
(F) 510-588-4974

Linda Oliver
Reed Smith LLP
1999 Harrison St., Suite 2400
Oakland, CA 94612
(P) 510–466-6729
(F) 510–273–8832
loliver@reedsmith.com

Vincent E. Morgan
Pillsbury Winthrop LLP
909 Fannin, Suite 2200
Houston, Tx 77010
(P) 713-425-7325
vmorgan@pillsburywinthrop.com

Steven Plitt
Kunz Plitt Hyland Demlong & Kleifield
3838 North Central Avenue, 15th Floor
Phoenix, AR 85012
(P) 602-331-4600
(F) 602-331-8600
sp@kunzlegal.com

Robert D. Phillips Jr.
Reed Smith LLP
Two Embarcadero Center, Suite 2000
San Francisco, CA 94111
(P) 415-659-5965
rphillips@reedsmith.com

Charles Platto
Law Offices of Charles Platto
1020 Park Ave., Suite 6B
New York, New York 10028
212-423-0579
cplatto@plattolaw.com

Michael Sean Quinn
Quinn Hayes & Quinn
5511 Parkcrest Dr., #107
Austin, TX 78731
(P) 512-542-9243
mquinn@@qhq-law.com

Douglas R. Richmond
Aon Risk Services
200 East Randolph, 12th Floor
Chicago, IL 60601
(P) 312-381-4000

Matthew J. Sekits
Bullivant Houser Bailey PC
1601 Fifth Ave., Suite 2300
Seattle, WA 98101
206-521-6452
matthew.sekits@bullivant.com

Dan Syhre
Betts, Patterson & Mines, P.S.
1 Convention Place, Suite 1400
701 Pike Street
Seattle, WA 98101
(P) 206–292–9988

John S. Torigian
Krell & Torigian
1600 Smith Street
Suite 3885
Houston, TX 77002
(P) 713–951–7603
jtorigian@msn.com

Christopher L. Troy
The Chartwell Law Offices, LLP
Valley Forge Corporate Center
970 Rittenhouse Road, Suite 300
Eagleville, PA 194203
(P) 610-666-7700

Jason Vacha
Reed McClure, Attorneys at Law
601 Union Street, Suite 1500
Seattle, WA 98101-1363
(206) 292-4900 main office line
(206) 386-7017 direct dial
jvacha@rmlaw.com

Dennis J. Wall
Dennis J. Wall & Associates
3452 Lake Lynda Drive, Suite 170
Orlando, FL 32817–1472
(P) 407–381–5887
(F) 407–381–8199
djw@denniswall.com

Janice Wang
Gordon & Polscer
1000 Second Avenue
Seattle, WA 98104
(P) 206–223–4226
(F) 206–223–5459
jwang@gordon-polscer.com

A Professional Responsibility Perspective on Independent Counsel in Insurance

Douglas R. Richmond

Doug Richmond is Senior Vice President in the Global Professions Practice of Aon Risk Services in Chicago. Before joining Aon, he was a partner with Armstrong Teasdale LLP in Kansas City, Missouri (1989-2004). He is a co-author of a leading insurance law treatise, *Understanding Insurance Law* (4th ed. 2007), and the lead author of a new legal ethics book published by the American Bar Association entitled, *Professional Responsibility in Litigation.* Opinions expressed here are the author's alone.

1. Introduction

In most cases, a liability insurer that is called upon to defend its insured in litigation does so through a lawyer or law firm with whom or which it has an ongoing business relationship. If the insurer loses the right to control the defense because of an irreconcilable conflict of interest, however, the insured is entitled to a defense by "independent counsel" at the insurer's expense. This is because the conflict does not erase the insurer's duty to defend the insured; rather, the insurer must cure the conflict to honor its duty.[1] The insurer does this by ceding control of the defense to independent counsel. In most jurisdictions, the insured is entitled to select independent counsel.[2] Other jurisdictions permit the insurer to appoint independent counsel for the insured.[3] In any event, the lawyer selected as independent counsel makes all tactical decisions concerning the insured's defense, shares an attorney-client relationship solely with the insured, and is loyal only to the insured; the insurer pays the lawyer's fees. Lawyers who are engaged as independent counsel are sometimes described as "*Cumis* counsel" in recognition of the seminal California case on the subject, *San Diego Navy Federal Credit Union v. Cumis Insurance Society, Inc.*[4]

Lawyers serving as independent counsel clearly must conform their behavior to rules of professional conduct. Most ethics rules apply to lawyers filling independent counsel roles just as they do in other engagements. Several rules and the conduct they regulate, however, are of special significance in the independent counsel context.

2. Professional Responsibilities of Independent Counsel

Lawyers' professional responsibilities are best evaluated under or measured against the American Bar Association's Model Rules of Professional Conduct, although other principles also influence

1. W. Cas. & Sur. Co. v. Herman, 405 F.2d 121, 124 (8th Cir. 1968); All-Star Ins. Corp. v. Steel Bar, Inc., 324 F. Supp. 160, 165 (N.D. Ind. 1971); Roussos v. Allstate Ins. Co., 655 A.2d 40, 43 (Md. Ct. Spec. App. 1995); Satterwhite v. Stolz, 442 P.2d 810, 814 (N.M. Ct. App. 1968).

2. *See, e.g.,* Liberty Mut. Ins. Co. v. Tedford, 658 F. Supp. 2d 786, 794 (N.D. Miss. 2009) (interpreting Mississippi law); Union Ins. Co. v. Knife Co., 902 F. Supp. 877, 880-82 (W.D. Ark. 1995) (predicting Arkansas law); Cunniff v. Westfield, Inc., 829 F. Supp. 55, 57 (E.D.N.Y. 1993) (applying New York law); Great Divide Ins. Co. v. Carpenter *ex rel.* Reed, 79 P.3d 599, 604 (Alaska 2003); Joseph v. Markovitz, 551 P.2d 571, 576-77 (Ariz. Ct. App. 1976); Compulink Mgmt. Ctr., Inc. v. St. Paul Fire & Marine Ins. Co., 87 Cal. Rptr. 3d 72, 75 (Cal. Ct. App. 2008); Am. Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc., 843 N.E.2d 492, 498 (Ill. App. Ct. 2006); Smith v. Reliance Ins. Co. of Ill., 807 So. 2d 1010, 1022 (La. Ct. App. 2002); Belanger v. Gabriel Chems., Inc., 787 So. 2d 559, 565 (La. Ct. App. 2001); Moeller v. Am. Guar. & Liab. Ins. Co., 707 So. 2d 1062, 1070 (Miss. 1996).

3. *See, e.g.,* Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., 433 F.3d 365, 371-74 (4th Cir. 2005) (interpreting South Carolina law); H.K. Sys., Inc. v. Admiral Ins. Co., No. 03 C 0795, 2005 WL 1563340, at *16 (E.D. Wis. June 27, 2005) (predicting Wisconsin law); Travelers Indem. Co. v. Royal Oak Enters., Inc., 344 F. Supp. 2d 1358, 1374-76 (M.D. Fla. 2004) (predicting Florida law); United States v. Daniels, 163 F. Supp. 2d 1288, 1290 (D. Kan. 2001) (interpreting Kansas law); Cent. Mich. Bd. of Trustees v. Employers Reins. Corp., 117 F. Supp. 2d 627, 633-37 (E.D. Mich. 2000) (interpreting Michigan law); Cardin v. Pac. Employers Ins. Co., 745 F. Supp. 330, 335-37 (D. Md. 1990) (discussing Maryland law); Fed. Ins. Co. v. X-Rite, Inc., 748 F. Supp. 1223, 1228-30 (W.D. Mich. 1990); Finley v. Home Ins. Co., 975 P.2d 1145, 1154 (Haw. 1998).

4. 208 Cal. Rptr. 494 (Cal. Ct. App. 1984), *superseded by statute as stated in* Dynamic Concepts, Inc. v. Truck Ins. Exch., 71 Cal. Rptr. 2d 882, 883 n.1 (Cal. Ct. App. 1998).

lawyers' professional obligations.

a. Lawyers' Duty of Competence

Competence is a basic requirement of all lawyers. Model Rule 1.1 provides: "A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation."[5] Competence is commonly the product of experience. As a general rule, however, a lawyer need not be experienced in a type of matter in order to competently handle a case.[6] A lawyer may achieve competence through reasonable preparation.[7] There is a first time for everything, after all, and it is ethically proper for a lawyer to accept an unfamiliar matter and thereafter achieve related competence.[8] Were the rule otherwise, a lawyer could never acquire the initial skills necessary to practice. Certainly, lawyers who are concerned about their ability to handle a particular matter may cure their perceived inadequacies by associating with a lawyer of established competence in the field.[9]

What is generally acceptable in terms of achieving or establishing competence from an ethics perspective, however, is not necessarily the correct focus insofar as independent counsel is concerned. An insurer has the right to insist that lawyers selected as independent counsel by an insured be competent to handle the matter at the time of appointment.[10] Although insurers may permit independent counsel to achieve competence in the course of matters through study or preparation, and may do so to accommodate their insureds, such indulgence is not required. It is therefore possible for a lawyer selected as independent counsel by an insured to be competent or capable of competence in professional responsibility terms, yet be unqualified to fill the role of independent counsel as a matter of insurance law. Courts, policyholders, and lawyers must be able to separate these concepts.

b. Independent Counsel's Duties Concerning Settlement

Almost all civil litigation settles short of trial. In a case in which the insurer has accepted coverage, the right to settle belongs to the insurer as a matter of contract. Things are less clear in any case in which the insured is being defended by independent counsel.[11] Related case law is sparse and split. Some courts hold that when an insurer defends under a reservation of rights, the decision to settle rests with the insured.[12] Other courts hold that an insurer's loss of the right to control the defense does not divest it of the right to control settlement.[13] Courts in this second category reason that because the right to defend and the right to settle are separate, the loss of the former does not affect or impair the latter.[14] From a professional responsibility perspective, of course, Model Rule 1.2(a) compels a lawyer to "abide by a client's decision whether to settle a matter."[15] A lawyer cannot usurp a client's right to control settlement even if the lawyer believes that the client's position is unreasonable.[16]

5. MODEL RULES OF PROF'L CONDUCT R. 1.1 (2009).

6. *Id.* cmt. 2.

7. *Id.* cmt. 3.

8. This does not mean that a client should have to bear the full expense of a lawyer's education in unfamiliar matters. *See, e.g., In re* Fordham, 668 N.E.2d 816, 822-24 (Mass. 1996) (finding inexperienced lawyer's fee excessive even though he worked all of the hours billed and won the case); Robert L. Wheeler, Inc. v. Scott, 777 P.2d 394, 396 (Okla. 1989) (stating that if a lawyer takes a case "in an area in which he or she is totally unfamiliar or inexperienced, the client should not have to pay for every minute of the lawyer's preparation"); *In re* Estate of Larson, 694 P.2d 1051, 1059 (Wash. 1985) (observing that "clients should not be expected to pay for the education of a lawyer when he spends excessive amounts of time on tasks which, with reasonable experience, become matters of routine").

9. MODEL RULES OF PROF'L CONDUCT R. 1.1 cmt. 2 (2009).

10. CHI of Alaska v. Employers Reins. Corp., 844 P.2d 1113, 1121 (Alaska 1993); Center Found. v. Chicago Ins. Co., 278 Cal. Rptr. 13, 21 (Cal. Ct. App. 1991).

11. *See* James M. Fischer, *The Professional Obligations of* Cumis *Counsel Retained for the Policyholder But Not Subject to Insurer Control,* 43 TORT TRIAL & INS. PRAC. L.J. 173, 194-97 (2008) (discussing settlement-related complications in cases involving independent counsel).

12. *See, e.g.,* Carrier Express, Inc. v. Home Indem. Co., 860 F. Supp. 1465, 1483 (N.D. Ala. 1994) (quoting L & S Roofing Supply Co. v. St. Paul Fire & Marine Ins. Co., 521 So. 2d 1298, 1303 (Ala. 1987)); Tank v. State Farm Fire & Cas. Co., 715 P.2d 1133, 1138 (Wash. 1986).

13. *See, e.g.,* W. Polymer Tech., Inc. v. Reliance Ins. Co., 38 Cal. Rptr. 2d 78, 81-85 (Cal. Ct. App. 1995); Orion Ins. Co. v. Gen. Elec. Co., 493 N.Y.S.2d 397, 401-03 (N.Y. Sup. Ct. 1985), *aff'd sub nom.* United States Aviation Underwriters v. Gen. Elec. Co., 509 N.Y.S.2d 778 (N.Y. App. Div. 1986).

14. *Orion Ins. Co.,* 493 N.Y.S.2d at 402-03.

15. MODEL RULES OF PROF'L CONDUCT R. 1.2(a) (2009).

In the independent counsel context, the insured is the defense lawyer's sole client.[17] The lawyer serving as independent counsel must honor the insured's decision concerning settlement and must ensure that the policyholder is fully informed about the advantages and disadvantages of any proposed settlement.[18] Absent a prior agreement or understanding with the insured, the lawyer must communicate all settlement offers to the insured.[19] Perhaps less obviously, the lawyer should also communicate all settlement offers to the insurer. In any jurisdiction in which the insurer retains the right to control settlement notwithstanding its loss of defense control, the insured's duty to cooperate likely requires that the insurer receive timely notice of all settlement opportunities. It is therefore reasonable to assume that the lawyer's duty of competence requires her to convey all settlement offers to the insurer, lest she risk defeating any prospect of coverage for her client by creating a breach of the duty to cooperate. Even if the insurer's right to control settlement is unclear or non-existent, it is still prudent for independent counsel to convey all settlement offers to the insurer because the insurer may be willing to fund a settlement despite its coverage defenses. Furthermore, the failure to convey settlement offers to the insurer might be construed by a court (and certainly argued by the insurer) as evidence of the insured's belief or understanding that no coverage existed for the underlying claim or occurrence.

c. Reasonable Fees for Independent Counsel

A principal concern for insurers required to provide independent counsel of an insured's choosing is the cost of those legal services. This is a recurring source of controversy, as lawyers who are selected by insureds often charge much higher hourly rates than those an insurer pays to its panel counsel. Even when independent counsel control the defense, however, an insurer is only bound to pay reasonable defense costs.[20] The clear challenge for all concerned is defining "reasonable" in this context.

i. Reasonableness Under Rules of Professional Conduct

Model Rule 1.5(a) provides that "[a] lawyer shall not make an agreement for, charge, or collect an unreasonable fee or an unreasonable amount for expenses."[21] The rule applies regardless of who pays the lawyer's fees. Model Rule 1.5(a) lists eight factors to consider when weighing the reasonableness of a lawyer's fee:

> (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
>
> (2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
>
> (3) the fee customarily charged in the locality for similar legal services;
>
> (4) the amount involved and the results obtained;
>
> (5) the time limitations imposed by the client or by the circumstances;
>
> (6) the nature and length of the professional relationship with the client;
>
> (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and

16. *In re* Indeglia, 765 A.2d 444, 447 (R.I. 2001).

17. Lifestar Response of Ala., Inc. v. Admiral Ins. Co., 17 So. 3d 200, 217 (Ala. 2009).

18. Fischer, *supra* note 11, at 195.

19. MODEL RULES OF PROF'L CONDUCT R. 1.4(a)(1) & cmt. 2 (2009).

20. Chicago Title Ins. Co. v. FDIC, 172 F.3d 601, 605 (8th Cir. 1999); Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 93 (D.R.I. 2002); MetLife Capital Corp. v. Water Quality Ins. Synd., 100 F. Supp. 2d 90, 96 (D.P.R. 2000); CHI of Alaska, Inc. v. Employers Reins. Corp., 844 P.2d1113, 1121 (Alaska 1993); IMC Global v. Cont'l Ins. Co., 883 N.E.2d 68, 80 (Ill. App. Ct. 2007); Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490-91 (Okla. Ct. App. 1996).

21. MODEL RULES OF PROF'L CONDUCT 1.5(a) (2009).

(8) whether the fee is fixed or contingent.[22]

No single factor controls the reasonableness of a lawyer's fee.[23] Not all factors are relevant in all cases.[24] The weight to be assigned to any given factor depends on the facts of the particular case.[25] Moreover, the Rule 1.5(a) factors are not exclusive.[26] Courts may consider other factors in appropriate cases. Indeed, there is at least some authority for the proposition that a court may determine a lawyer's fee to be unreasonable without considering any of the Rule 1.5(a) factors.[27] It should therefore come as no surprise that there is generally no precise measure of reasonableness.[28] Regardless, the burden of establishing the reasonableness of a fee rests with the lawyer.[29]

Most liability insurers employ outside counsel guidelines to which their panel counsel are required to adhere. These guidelines typically address defense counsel's billing practices, and may provide, for example, that the insurer will not pay for intra-office conferences, will not pay for legal research in excess of a specified number of hours absent prior approval, will not pay for local travel time, will not pay for clerical tasks, or limit the number of lawyers for which the insurer will pay to appear at depositions and hearings. Whatever the scope or merits of such guidelines, an insurer's preemptive refusal to pay for activities does not alone render legal fees charged for those activities unreasonable. Independent counsel may perform activities contrary to insurers' billing guidelines if they believe them necessary and an insurer may decline to pay for those activities or pay under protest, thus framing a dispute for resolution by a court or other neutral third-party, but the mere fact that an insurer does not want to pay for independent counsel's activities does not alone determine the reasonableness of the associated fees.

ii. Evaluating Reasonableness: Fee Comparisons

A key factor when evaluating the reasonableness of legal fees is "the fee customarily charged in the locality for similar legal services."[30] As frequent and sophisticated purchasers of legal services that tend to supply their panel counsel with respectable volumes of business, insurance companies generally negotiate hourly rates well below what those law firms typically charge their other commercial clients. Thus, an insurer usually considers the fee customarily charged in the locality for similar services to be the discounted hourly rates to which its panel counsel have agreed. After all, that is the hourly rate the insurer would pay to defend the insured but for the conflict of interest requiring independent counsel.

Proposed independent counsel frequently consider insurers' discounted hourly rates to be unacceptable. While insurers may negotiate material discounts with their panel counsel, lawyers proposed as independent counsel are generally not receiving sufficient work from the insurer to justify a substantial rate reduction. They may have full workloads at their regular rates and thus feel no need to accept a new engagement on less favorable terms. From their standpoint, the fee customarily charged in the locality for similar services is either the hourly rate they normally charge commercial clients to defend similar cases, or the hourly rate charged by lawyers at their level at peer law firms for similar representations. One way or another, it is certainly not an "insurance defense" rate.

The fact that an insurer's panel counsel are

22. *Id.*

23. Rodriguez v. Ancona, 868 A.2d 807, 814 (Conn. App. Ct. 2005); Heng v. Rotech Med. Corp., 720 N.W.2d 54, 65 (N.D. 2006).

24. Twp. of W. Orange v. 769 Assocs., LLC, 969 A.2d 1080, 1088 (N.J. 2009).

25. McCabe v. Arcidy, 635 A.2d 446, 452 (N.H. 1993); *In re* Malone, 886 A.2d 181, 185 (N.J. Super. Ct. App. Div. 2005).

26. Nunn Law Office v. Rosenthal, 905 N.E.2d 513, 520 (Ind. Ct. App. 2009); Diamond Point Plaza Ltd. P'ship v. Wells Fargo Bank, N.A., 929 A.2d 932, 955 (Md. 2007); *Twp. of W. Orange,* 969 A.2d at 1088.

27. *See, e.g.,* Disciplinary Counsel v. Smigelski, 4 A.3d 336, 342-43 (Conn. App. Ct. 2010). *But see* Palmer v. Bill Gallagher Enters., L.L.C., 240 P.3d 592, 600 (Kan. Ct. App. 2010) (stating that courts must consider the Rule 1.5(a) factors).

28. Of course, fees charged for work not actually performed are necessarily unreasonable. *In re* Disciplinary Action Against Wolff, 788 N.W.2d 594, 596 (N.D. 2010); Flowers v. Bd. of Prof'l Responsibility, 314 S.W.3d 882, 899 (Tenn. 2010).

29. Kovitz Shifrin Nesbit, P.C. v. Rossiello, 911 N.E.2d 1180, 1187 (Ill. App. Ct. 2009); Gold, Weems, Buser, Sues & Rundell v. Granger, 947 So. 2d 835, 842 (La. Ct. App. 2006); *In re* Dawson, 8 P.3d 856, 860 (N.M. 2000); Bass v. Rose, 609 S.E.2d 848, 853 (W. Va. 2004).

30. MODEL RULES OF PROF'L CONDUCT R. 1.5(a)(3) (2009).

compensated at a lower rate does not compel the conclusion that higher rates proposed by independent counsel are unreasonable.[31] Even so, the few courts that have considered the issue have been sympathetic to insurers' arguments that the reasonableness of legal fees charged or proposed by independent counsel is appropriately measured by comparing independent counsel's fees to the fees the insurers would otherwise pay panel counsel.[32] That is the statutory approach employed in Alaska and California.[33]

Decisions tying independent counsel's fees to insurers' panel counsel rates rarely reveal courts' reasoning. In an effort to lend reason to the panel counsel equivalency approach, some accomplished and knowledgeable lawyers representing insurers have attempted to invoke the contract law doctrines of impracticability and substitute performance. These doctrines derive from section 270 of the Restatement (Second) of Contracts, which provides:

> Where only part of an obligor's performance is impracticable, his duty to render the remaining part is unaffected if
>
> (a) it is still practicable for him to render performance that is substantial, taking account of any reasonable substitute performance that he is under a duty to render; or
>
> (b) the obligee, within a reasonable time, agrees to render any remaining performance in full and to allow the obligor to retain any performance that has already been rendered.[34]

Advocates of what we will call the substitute performance approach reason that a conflict of interest entitling an insured to independent counsel of its choosing renders an insurer's ability to perform its duty to defend as intended under its policy impracticable. But because the conflict does not excuse the insurer's duty to defend, the doctrine of substitute performance should be understood to effectuate the terms of the contract, i.e., the insurance policy, without conferring an advantage on either party. "Substitute performance" should therefore be a minimal variation from the performance originally contemplated. This approach is said to track courts' general recognition that a party injured by a contract breach should receive the benefit of its bargain but never a windfall.

Continuing, substitute performance advocates theorize that courts that allow an insured to select defense counsel and control the defense because of a conflict of interest rendering the insurer's duty to defend impractical are supplying a substitute for the carrier's performance so as to preserve the carrier's remaining contractual obligations. As a substitute for the carrier's duty to defend, it follows that the alternative performance must conform to the original. The insured's defense should not be funded at a level substantially lower than the defense the carrier otherwise would have provided so that the insured receives the benefit of its bargain, but nor should the insured's defense costs substantially exceed those which the carrier would have paid were it in control lest the insured be unjustly enriched. Therefore, the carrier cannot be obligated to pay independent counsel hourly rates greater than those it would pay panel counsel.

The substitute performance approach supposedly reflects desirable public policy because it does not discriminate among insureds by providing one insured with a better contract than it bargained for solely because of a fortuitous conflict of interest. When reasonable defense costs are viewed from an insurer's perspective, every insured receives an equal defense. There is no reason to allow an insured in a conflict-ridden case to consume more of an insurer's resources than an insured who is sued in a case that is conflict-free. In contrast, evaluating reasonableness from an insured's perspective would be disadvantageous because it would produce inconsistent and chaotic results. Carriers' defense obligations would

31. Mobil Oil Corp. v. Md. Cas. Co., 681 N.E.2d 552, 563 (Ill. App. Ct. 1997).

32. *See, e.g.,* Lone Star Indus., Inc. v. Liberty Mut. Ins. Co., C.A. No. 89C-SE-187-1-CV, 1990 WL 127826, at *2 & n.3 (Del. Super. Ct. Aug. 28, 1990) (requiring independent counsel chosen by insured to accept insurer's hourly rate caps); Aquino v. State Farm Ins. Cos., 793 A.2d 824, 832 (N.J. Super. Ct. App. Div. 2002) (noting that independent counsel might be required to accept less than his standard hourly rate given discounted rates normally paid by insurers).

33. ALASKA STAT. § 21.89.100(d) (2007); CAL. CIV. CODE § 2860(c) (2009).

34. RESTATEMENT (SECOND) OF CONTRACTS § 270 (1981).

be subject to individual policyholders' potentially unreasonable preferences. Allowing insureds to determine the cost of independent counsel would last be poor public policy because it would prevent insurers from forecasting defense costs and impair their ability to set premiums for all insureds.

Unfortunately for insurers, while the substitute performance approach is superficially appealing, it quickly unravels when closely scrutinized.[35] The impracticability doctrine, which expands the contract law doctrine of impossibility of performance, is limited to extreme situations; inconvenience and unexpected difficulty do not equate to impracticability.[36] For that matter, the fact that a contractual obligation "'may be carried into effect, although not in the manner contemplated by the obligor at the time the contract was entered into,'" generally defeats a party's claim of impracticability.[37] A conflict of interest does not eliminate an insurer's duty to defend, of course, but simply modifies the manner in which the insurer fulfills its duty.[38] At most, a conflict of interest requiring independent counsel inconveniences an insurer and complicates its duty to defend. In other words, it is incorrect to describe an insurer that must defend a case with independent counsel rather than panel counsel as a victim of impracticability.

It is of no moment that the central issue here is substitute performance and the associated cost in terms of the legal fees to be paid to independent counsel, because that focus does not alter the analysis. As a general rule, increased expense in performance does not rise to the level of impracticability.[39] Although it is true that some courts hold that "excessive and unreasonable expense" may amount to impracticability,[40] that rare doctrinal exception does not aid insurers. Insurers have no obligation to pay excessive or unreasonable fees to independent counsel under any circumstances,[41] and Model Rule 1.5(a) and state analogs prevent independent counsel from charging unreasonable fees. There certainly is no support for the proposition that the original contract price (if a liability insurance policy can even be said to fix one for defense counsel) sets a ceiling above which performance costs cannot be allocated to the promisor. Indeed, settled case law is exactly to the contrary.[42]

Second, for the doctrine of impracticability to operate, the non-occurrence of the event—here a conflict of interest requiring independent counsel—must have been a basic assumption on which the parties' contract—in this instance an insurance policy—was made.[43] Furthermore, the assumption must have been made by both parties; impracticability cannot be based on one party's private assumptions.[44] This second element further involves a judgment as to which party assumed the risk of the event's occurrence.[45] The party assuming the risk cannot invoke impracticability as a basis for relief. In

35. In some states, impracticability is a Uniform Commercial Code-based defense. *See, e.g.,* Specialty Beverages, L.L.C. v. Pabst Brewing Co., 537 F.3d 1165, 1176 (10th Cir. 2008) (discussing Oklahoma law). The UCC plainly does not apply to, or in any way govern or influence, the enforcement or interpretation of insurance policies.

36. Island Dev. Corp. v. Dist. of Columbia, 933 A.2d 340, 350 (D.C. 2007) (quoting Bergman v. Parker, 216 A.2d 581, 583 (D.C. 1966)); State v. Chacon, 198 P.3d 749, 752 (Idaho Ct. App. 2008); Record v. Kempe, 928 A.2d 1199, 1206 (Vt. 2007).

37. Associated Acquisitions, L.L.C. v. Carbone Props. of Audubon, L.L.C., 962 So. 2d 1102, 1107 (La. Ct. App. 2007) (quoting Dallas Cooperage & Woodware Co. v. Creston Hoop Co., 109 So. 844 (La. 1926)).

38. *See* IMC Global v. Cont'l Ins. Co., 883 N.E.2d 68, 80 (Ill. App. Ct. 2007) (explaining that where there is a conflict of interest, an insurer fulfills its duty to defend by reimbursing the insured for the cost of independent counsel).

39. E. ALLAN FARNSWORTH, CONTRACTS § 9.6, at 646 (3d ed. 1999); *see, e.g.,* Carabetta Enters., Inc. v. United States, 482 F.3d 1360, 1366 (Fed. Cir. 2007) (finding that increased cost of performance did not make government agency's performance impracticable); E. Capitol View Cmty. Dev. Corp. v. Robinson, 941 A.2d 1041 (D.C. 2008) (noting the rule).

40. Habitat Trust for Wildlife, Inc. v. City of Rancho Cucamonga, 96 Cal. Rptr. 3d 813, 843 (Cal. Ct. App. 2009).

41. Chicago Title Ins. Co. v. FDIC, 172 F.3d 601, 605 (8th Cir. 1999); Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 93 (D.R.I. 2002); MetLife Capital Corp. v. Water Quality Ins. Synd., 100 F. Supp. 2d 90, 96 (D.P.R. 2000); CHI of Alaska, Inc. v. Employers Reins. Corp., 844 P.2d 1113, 1121 (Alaska 1993); IMC Global v. Cont'l Ins. Co., 883 N.E.2d 68, 80 (Ill. App. Ct. 2007); Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490-91 (Okla. Ct. App. 1996).

42. *See, e.g.,* Transatlantic Fin. Corp. v. United States, 363 F.2d 312, 315 (D.C. Cir. 1966) (rejecting original contract price as a ceiling by requiring shipper to bear cost of substitute performance that exceeded contract price of $305,842.92 by $43,972.00).

43. FARNSWORTH, *supra* note 39, § 9.6, at 643.

44. *Id.* § 9.6, at 647.

45. *Id.*

making this judgment, a court may examine context to determine where the risk should lie.[46]

The insured entitled to independent counsel probably thought nothing of a conflict of interest either when procuring its policy or any other time before the conflict surfaced. Even when a conflict arises an insured may not recognize it, hence the rule in some jurisdictions that an insurer must inform an insured of a conflict of interest entitling the insured to independent counsel.[47] The insurer, on the other hand, surely did know that a conflict of interest entitling the insured to independent counsel was possible when it sold the policy to the insured. Such conflicts are old-hat for insurers. As a matter of fact, the insurance industry is so aware of conflicts that it has sought to mitigate independent counsel costs by creating selection of counsel clauses and endorsements. For example, such an endorsement might provide:

> "In the event the insured is entitled by law to select independent counsel to defend a suit at our expense, the attorney fees and all other litigation expenses we must pay to that counsel are limited to the rates we actually pay to counsel we retain in the ordinary course of business in the defense of similar claims or suits in the community where the claim or suit arose or is being defended."[48]

Similarly, a so-called *Cumis* endorsement might state:

> In the event the insured is entitled by law to select independent counsel to defend the insured at the insurer's expense, the attorney fees and all other litigation expenses the insurer must pay to that counsel are limited to the rates the insurer actually pays to counsel the insurer retains in the ordinary course of business in the defense of similar claims or suits in the jurisdiction where the claim arose or is being defended. Additionally, the insurer may exercise the right to require that such counsel have certain minimum qualifications with respect to their competency including experience in defending claims or suits similar to the one pending against the insured and to require such counsel to have errors and omissions insurance coverage. As respects any such counsel, the insured agrees that counsel will timely respond to the insurer's requests for information regarding the claim or suit.[49]

The fact that an insurer has not included such a clause in its policy does not mean that it never considered the possibility of independent counsel or associated costs, but only that it decided to forgo the clause and surrender the certainty that it might provide.

As for allocating the risk of excessive independent counsel costs between the insured and insurer, it is reasonable to assign that risk to the insurer as policy drafter. Even if employing unduly costly independent counsel were deemed to be an abnormal risk, it would still be fair to assign the risk to the insurer as the party that contractually reserved to itself the duty to defend. Furthermore, and although it is often an unappealing option, an insurer can avoid excessive independent counsel costs by not reserving its rights or by withdrawing a reservation of rights already issued, thereby eliminating any conflict of interest creating a right to independent counsel and retaining or regaining control of the defense.[50] Although an insured exposed to a conflict might also be required to accept the insurer's choice of independent counsel, and that might be a fair allocation of risk in many cases, it is not so obviously desirable as to outweigh the allocation of risk to the insurer. To

46. BRIAN A. BLUM, CONTRACTS: EXAMPLES AND EXPLANATIONS 461 (3d ed. 2004).

47. *See, e.g.,* Christian Builders, Inc. v. Cincinnati Ins. Co., 501 F. Supp. 2d 1224, 1237-38 (D. Minn. 2007) (applying Minnesota law and referring to insurers' duty of good faith); Lloyd's Inst. of London Underwriting v. Fulton, 2 P.3d 1199, 1204 (Alaska 2000) (quoting a treatise); Roussos v. Allstate Ins. Co., 655 A.2d 40, 43 (Md. Ct. Spec. App. 1995) (basing this requirement on the duty to defend); Elacqua v. Physicians' Reciprocal Insurers, 800 N.Y.S.2d 469, 473 (N.Y. App. Div. 2005) (imposing this requirement as an aspect of the insurer's duty to defend).

48. JACO Envtl., Inc. v. Am. Int'l Specialty Lines Ins. Co., No. 2:09-cv-0145 JLR, 2009 WL 1591340, at *7 (W.D. Wash. May 19, 2009) (quoting selection of counsel endorsement).

49. William J. Carter et al., *Insurance Companies' Exposure Resulting From Appointment of Independent Counsel,* July 2010, http://www.carrmaloney.com/news/newsletters/07_10.html (last visited Jan. 15, 2011) (internal quotation marks omitted).

conclude on this point, the risk the insurer is supposedly being forced to bear is questionable. Even where the insured selects independent counsel, the insurer is still required only to pay reasonable defense costs.[51] This requirement protects insurers against exorbitant legal fees.[52]

Some courts analyzing alleged impracticability speak not of the parties' assumptions, but rather of foreseeability; that is, to excuse performance, the contingency at issue must have been unforeseeable.[53] If that is the standard, then the substitute performance approach is lost at the outset, because conflicts of interest entitling insureds to independent counsel are foreseeable to insurers. For example, insurers are regularly required to defend mixed actions, cases where the insured's conduct was arguably intentional as opposed to negligent, and cases involving multiple insureds, all of which are regular sources of conflicts.

Third, policyholders will rightly challenge as overreaching the argument that requiring an insurer to pay independent counsel more than it pays panel counsel gives the insured more than it bargained for, grants the insured a windfall, or unjustly enriches the insured. To repeat, the fact that independent counsel charge more than panel counsel does not alone make their fees unreasonable.[54] As a rule, the insured bargained for a defense—it did not bargain for a defense at a particular price. An insured does not receive a windfall by selecting independent counsel, nor is it unjustly enriched. An insured is always entitled to a defense by competent and loyal counsel, and allowing the insured to select independent counsel simply protects this right where it otherwise might be jeopardized. As for fees paid to independent counsel above those that the insurer would pay panel counsel, those payments do not go to the insured and therefore cannot grant it a windfall or unjustly enrich it.

Finally, it is hard to understand how insurance industry chaos will result absent judicial mandates that independent counsel's fees never exceed those paid to insurers' panel counsel. Insureds' right to independent counsel at insurers' expense has been recognized for more than half a century,[55] yet the predicted chaos either has not materialized or has been suppressed. Although it is true that both policyholders and insurers benefit from reasonable and predictable defense costs, insurers can achieve this certainty by including selection of counsel clauses in their policies. Furthermore, in all other areas of the law, judging the reasonableness of lawyers' fees routinely requires case-specific inquiry. Courts weighing the reasonableness of lawyers' fees in civil rights litigation, bankruptcy cases, matters involving contracts with fee-shifting provisions, and lawyer disciplinary cases, for example, have easily and responsibly applied the Model Rule 1.5(a) factors to reach reasonable resolutions. Insurance cases are no different. Indeed, and analogously, courts apply the Model Rule 1.5(a) elements and similar factors to measure the reasonableness of fees in cases in which an insurer has breached its duty to defend and must reimburse the insured for its attorneys' fees,[56] and where an insured is entitled to recover its reasonable attorney's fees as an element of bad faith damages.[57]

50. *See* Carucci v. Argonaut Ins. Co., No. 06-CV-862A, 2009 WL 2600907, at *5 (W.D.N.Y. Aug. 24, 2009) (noting that withdrawal of reservation of rights eliminated need for independent counsel); Bartolotta v. Gibney, 731 N.W.2d 385, 2007 WL 754999, at *7 (Wis. Ct. App. Mar. 14, 2007) (finding that insurer's withdrawal of coverage defense eliminated conflict of interest, thus allowing law firm hired by insurer to also represent the insured).

51. Chicago Title Ins. Co. v. FDIC, 172 F.3d 601, 605 (8th Cir. 1999); Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 93 (D.R.I. 2002); MetLife Capital Corp. v. Water Quality Ins. Synd., 100 F. Supp. 2d 90, 96 (D.P.R. 2000); CHI of Alaska, Inc. v. Employers Reins. Corp., 844 P.2d 1113, 1121 (Alaska 1993); IMC Global v. Cont'l Ins. Co., 883 N.E.2d 68, 80 (Ill. App. Ct. 2007); Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490-91 (Okla. Ct. App. 1996).

52. *MetLife Capital Corp.,* 100 F. Supp. 2d at 96.

53. Specialty Beverages, L.L.C. v. Pabst Brewing Co., 537 F.3d 1165, 1176 (10th Cir. 2008); Transatlantic Fin. Corp. v. United States, 363 F.2d 312, 315 (D.C. Cir. 1966).

54. Mobil Oil Corp. v. Md. Cas. Co., 681 N.E.2d 552, 563 (Ill. App. Ct. 1997).

55. *See, e.g.,* Prashker v. United States Guar. Co., 136 N.E.2d 871, 876 (N.Y. 1956) (offering independent counsel paid for by insurer as solution to expected conflicts of interest).

56. *See, e.g.,* Oscar W. Larson Co. v. United Capitol Ins. Co., 845 F. Supp. 458, 462 (W.D. Mich. 1993); Cont'l Corp. v. Aetna Cas. & Sur. Co., Civ. Action No. 85-C-1165, 1987 U.S. Dist. LEXIS 16133, at **18-19 (E.D. Wis. Oct. 30, 1987) (citing Standard Theatres, Inc. v. Dep't of Transp., 349 N.W.2d 661 (Wis. 1984)).

57. *See, e.g.,* Geraci v. Byrne, 934 So. 2d 263, 268 (La. Ct. App. 2006).

iii. Analysis

Insurers are bound only to pay reasonable fees for independent counsel.[58] In most cases, the insurer and independent counsel selected by the insured will be able to negotiate a reasonable fee agreement. But what of the case in which the insurer and the lawyers offered as independent counsel are unable to agree on compensation? In such cases, the lawyers selected as independent counsel may undertake the insured's defense subject to an agreement with the insurer to later arbitrate or mediate the reasonableness of their fees, probably with the insurer advancing some amount for fees until the controversy can be resolved. Regardless, the reasonableness of the lawyers' fees should be determined principally by the factors specified in Model Rule 1.5(a). Which factors apply, and the weights to be assigned them, will depend on the case.

In examining the Model Rule 1.5(a) factors, several require elaboration, starting with the first one, i.e., "the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly."[59] In short, not all cases are alike. The "novelty and difficulty" of a matter may be either factual or legal.[60]

This leads smoothly into the next important factor, which is "the fee customarily charged in the locality for similar legal services."[61] The "locality" is the geographic area from which it would be reasonable to obtain counsel, and it is not necessarily limited to a particular city, judicial district, or even a state.[62] The baseline should be the rate the insurer would pay one of its panel firms that it regularly uses in the jurisdiction to defend a similar case. That rate may vary by the nature of the litigation, since insurers often distinguish between the capabilities or expertise of the firms they include on their panels, but it still should be the insurer's customary rate that principally governs because that is the rate the insurer would pay one of its panel firms were it allowed to appoint counsel. Despite the conflict of interest, the case remains an insurance defense representation when pricing similar legal services. The obvious opposing argument that a court should focus on the substantive nature of the litigation when evaluating the cost of legal services rather than the nature of the entity bearing the cost is unpersuasive, because liability insurers defend cases involving most every substantive area of the law. In any event, when evaluating the reasonableness of independent counsel's fees, the fact that the lawyer picked as independent counsel normally charges more for her services is immaterial,[63] as is the fact that the insured agreed to pay independent counsel's higher rate.[64]

On the other side of the coin, independent counsel who believe themselves due an hourly rate higher than that which the insurer normally pays should be prepared to establish why that is so according to the Model Rule 1.5(a) factors. The best argument for independent counsel is that unlike the insurer's panel counsel, they neither maintain nor desire a continuing relationship with the insurer that would justify a substantial downward departure from their standard rates.[65] In fact, they might understandably argue, it is precisely that professional separation that qualifies them to serve as independent counsel.

58. Chicago Title Ins. Co. v. FDIC, 172 F.3d 601, 605 (8th Cir. 1999); Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 93 (D.R.I. 2002); MetLife Capital Corp. v. Water Quality Ins. Synd., 100 F. Supp. 2d 90, 96 (D.P.R. 2000); CHI of Alaska, Inc. v. Employers Reins. Corp., 844 P.2d 1113, 1121 (Alaska 1993); IMC Global v. Cont'l Ins. Co., 883 N.E.2d 68, 80 (Ill. App. Ct. 2007); Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490-91 (Okla. Ct. App. 1996).

59. MODEL RULES OF PROF'L CONDUCT R. 1.5(a)(1) (2009).

60. West v. Club at Spanish Peaks, L.L.C., 186 P.3d 1228, 1248 (Mont. 2008).

61. MODEL RULES OF PROF'L CONDUCT R. 1.5(a)(3) (2009).

62. Lettunich v. Lettunich, 185 P.3d 258, 262-63 (Idaho 2008).

63. *See* Stokes v. Norwich Taxi, LLC, 958 A.2d 1195, 1214 (Conn. 2008) (discussing use of local market rates generally).

64. *In re* Malone, 886 A.2d 181, 185 (N.J. Super. Ct. App. Div. 2005) (stating that a claimant seeking attorney's fees from government agency was not entitled to be reimbursed for her lawyer's high hourly rate "merely because she signed a retainer agreement to that effect"; the lawyer's rate was determined by applying Rule 1.5(a) factors).

65. *See* MODEL RULES OF PROF'L CONDUCT R. 1.5(a)(6) (2009) (listing as a factor "the nature and length of the professional relationship with the client"); *see, e.g.,* Oscar W. Larson Co. v. United Capitol Ins. Co., 845 F. Supp. 458, 462 (W.D. Mich. 1993) (comparing insurance defense rates with higher hourly rates "for legal services provided to a corporate client on a temporary or ad hoc basis" and awarding rates higher than those the insurer normally would have paid to defense counsel).

d. Lawyers' Duty of Confidentiality

Among the most important duties that lawyers owe clients is the duty to maintain the confidentiality of client information. The duty to maintain client confidences is an agency law principle. The duty is further found in ethics rules. Model Rule 1.6(a) states that a lawyer "shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is authorized to carry out the representation or the disclosure is permitted by [Model Rule 1.6(b)]."[66]

Lawyers' duty of confidentiality is very broad. It attaches to initial consultations even if no attorney-client relationship results, and continues after a representation concludes.[67] The duty exists regardless of a request to that effect by the client.[68] Moreover, under Model Rule 1.6(a), a lawyer's duty of confidentiality attaches "not merely to matters communicated in confidence by the client, but also to all information relating to the representation, whatever its source."[69] Lawyers may breach their duty of confidentiality under Rule 1.6(a) by revealing information available from sources other than their clients, including public information.[70]

Lawyers serving as independent counsel must guard the insured's confidentiality at all times, but they must be especially careful not to reveal information that the insurer might use to defeat coverage. To the extent that client information relates not to coverage but to other aspects of the claim or suit being defended, litigation strategy or tactics, procedural issues, the status of the litigation against the insured, or things of that nature, however, independent counsel cannot generally invoke their duty of confidentiality to resist requests for information from the insurer. Because the communication of such information advances the insured's interests by perpetuating the insurer's defense of the suit, its disclosure should be treated as impliedly authorized to carry out the representation.[71] Moreover, there should be no doubt that the insured's contractual duty to cooperate with the insurer imposed by the cooperation clause in its policy constitutes implied authorization to disclose this sort of information in order for independent counsel to carry out the representation.[72] The fact that the insurer is defending under a reservation of rights does not excuse the insured's duty to cooperate.[73]

Insureds may share confidential information with defense counsel that they do not want revealed even though it is unrelated to coverage for fear that it will harm their reputations or impair important relationships. The same information may cause the insurer to settle the case despite its coverage defenses because of the effect on the value of the case if revealed, and the cooperation clause in the insured' policy arguably requires the insured to share the information with the insurer. For example, the insured may disclose that she was under the influence of alcohol or drugs at the time of an accident. Such information, while unquestionably detrimental to the insured, is immensely important to the insurer because it is inflammatory and is likely to ratchet up the insured's compensatory damage exposure.[74] The question for independent counsel in such a situation is whether they may share the insured's confidences

66. MODEL RULES OF PROF'L CONDUCT R. 1.6(a) (2009).

67. Dunlap v. People, 173 P.3d 1054, 1070 (Colo. 2007); Elkind v. Bennett, 958 So. 2d 1088, 1090-91 (Fla. Dist. Ct. App. 2007); Cont'l Resources, Inc. v. Schmalenberger, 656 N.W.2d 730, 735 (N.D. 2003).

68. Hurley v. Hurley, 923 A.2d 908, 911 (Me. 2007).

69. State *ex rel.* Okla. Bar Ass'n v. McGee, 48 P.3d 787, 791 (Okla. 2002); *see also* State v. Meeks, 666 N.W.2d 859, 868 (Wis. 2003) (expressing the same principle).

70. *See, e.g., In re* Anonymous, 654 N.E.2d 1128, 1129-30 (Ind. 1995) (holding that lawyer violated Rule 1.6(a) by revealing information "readily available from public sources"); Iowa Sup. Ct. Attorney Disciplinary Bd. v. Marzen, 779 N.W.2d 757, 766 (Iowa 2010) (holding that "confidentiality is breached when an attorney discloses information learned through the attorney-client relationship even if that information is otherwise publicly available"); *In re* Bryan, 61 P.3d 641, 657 (Kan. 2003) (recognizing "the survival of the ethical duty of confidentiality in instances where the information was available through other sources"); Lawyer Disciplinary Bd. v. McGraw, 461 S.E.2d 850, 861-62 (W. Va. 1995) ("The ethical duty of confidentiality is not nullified by the fact that the information is part of a public record or by the fact that someone else is privy to it.").

71. ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 01-421, at 8 (2001).

72. *See* MODEL RULES OF PROFESSIONAL CONDUCT R. 1.6(a) (2009) (referring to implied authorization).

73. Mid-Continent Cas. Co. v. Am. Pride Bldg. Co., 601 F.3d 1143, 1149 (11th Cir. 2010) (applying Florida law); *see, e.g.,* Zurich Am. Ins. Co. v. Frankel Enters., Inc., 509 F. Supp. 2d 1303, 1311 (S.D. Fla. 2007) (finding that insured breached duty to cooperate in case being defended under a reservation of rights).

with the insurer.

If the confidential information is the kind that the insured might be required to disclose to the insurer pursuant to the duty to cooperate, the lawyer must explain to the insured the duty to cooperate and the potential effect of her failure to cooperate.[75] Having informed the insured about the consequences of secrecy, the lawyer may ask for permission to share the information with the insurer. If the insured consents, the lawyer may divulge the insured's confidences to the insurer. If the insured does not consent, however, the lawyer must maintain the insured's confidentiality; the lawyer cannot share the information with the insurer. Even if the lawyer might otherwise be impliedly authorized to share the information with the insurer, the insured's instruction to maintain confidentiality trumps the lawyer's implied authority.

Although this dilemma may pose a conflict of interest for defense lawyers functioning in the traditional tripartite relationship in which both the insured and the insurer are clients, there is no conflict in the independent counsel context because here the lawyer has only one client—the insured. A more subtle problem is whether independent counsel who are competent to do so should explain the duty to cooperate to the insured in light of the general admonition that independent counsel must have no role in coverage issues or questions.[76] Be that as it may, the lawyer's ethical duties to "reasonably consult with the client about the means by which the client's objectives are to be accomplished,"[77] and to explain the matter "to the extent reasonably necessary to permit the client to make informed decisions regarding the representation,"[78] both require the sort of consultation outlined above. At the very least, independent counsel must alert the insured to the issue and refer the insured to separate coverage counsel for advice.

If independent counsel do advise the insured concerning the duty to cooperate, the insurer has no obligation to compensate them for time spent preparing or providing that advice because it is outside the scope of their engagement. From a practical standpoint, independent counsel should not charge the insurer for such time lest the related entries in their invoices alert the insurer to a possible coverage defense.

e. Ensuring Independence

Conflicts of interest are a professional responsibility concern in many representations—sometimes including those in which a lawyer has a single client. Model Rule 1.8(f) addresses the situation where a third-party pays a lawyer's fees for representing a client, which is, of course, the independent counsel situation:

> A lawyer shall not accept compensation for representing a client from one other than the client, unless:
>
> (1) the client gives informed consent;
>
> (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
>
> (3) information relating to representation of a client is protected as required by Rule 1.6.[79]

Model Rule 1.8(f) clarifies the essential principle that where a third-party pays for a client's legal services, a lawyer's duties still run to the client. It is augmented by Model Rule 5.4(c), which provides that a lawyer "shall not permit a person who recommends, employs or pays the lawyer to render legal services for

74. Facts of this sort may additionally support a punitive damage award. The insurability of punitive damages varies widely by jurisdiction and further depends on the language of the subject insurance policy.

75. This position assumes that the lawyers serving as independent counsel are competent to advise the insured concerning the duty to cooperate and consider rendering such advice to be within the scope of their representation. It may be sufficient for independent counsel to flag the issue for the insured and refer the insured to separate insurance coverage counsel.

76. *See* 1 ALAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 4:22, at 4-189 to -190 (5th ed. 2007) (stating that lawyers serving as independent counsel should not be asked to comment on coverage issues and commenting that because of their role there is no reason for them to even have a copy of the insurance policy at issue).

77. MODEL RULES OF PROF'L CONDUCT R. 1.4(a)(2) (2009).

78. *Id.* R. 1.4(b).

79. *Id.* R 1.8(f).

another to direct or regulate the lawyer's professional judgment in rendering such services."[80]

To serve as independent counsel, a lawyer must obtain the insured's informed consent to the representation.[81] "Informed consent" denotes the client's agreement "to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the materials risks and reasonably available alternatives" thereto.[82] In light of the parties' certain awareness of the conflict of interest necessitating independent counsel, and especially where the insured selects independent counsel, a lawyer selected to fill that role might logically believe that the client understands the nature of the representation. Indeed, such a belief would be entirely reasonable. Regardless, a lawyer is wise to obtain the client's informed consent in all cases.[83] Although a lawyer need not inform a client of facts about which it already knows, a lawyer who does not inform a client assumes the risk that the client is not as knowledgeable as believed and that any consent will prove to be invalid.[84] It is certainly necessary for a lawyer intending to serve as independent counsel to obtain informed consent in a jurisdiction in which the insurer controls the appointment process, inasmuch as the lawyer in such a case may be perceived as more inclined to favor the insurer's interests.[85]

To obtain informed consent, a lawyer selected as independent counsel must reveal any financial incentives—such as an attorney-client relationship with the insurer in other cases—that might cause the insured to reasonably question the lawyer's independence.[86] The lawyer need not phrase these disclosures in such a way that they are likely to discourage the insured from engaging the lawyer, but the lawyer must make them in such a fashion that the insured can make an informed decision concerning the representation.

Again, insurers often require defense counsel to adhere to outside counsel guidelines mandating the form and timing of case reports, consultation with claims professionals before incurring extraordinary expenses, and the like. While independent counsel can generally be required to follow such guidelines, they cannot obey them if doing so will interfere with their professional judgment.[87] Fortunately, outside counsel guidelines seldom interfere with defense lawyers' judgment. As a general rule, outside counsel guidelines simply steer defense lawyers' communication and planning. The requirement that independent counsel communicate their professional judgments to the insurer, or do so at particular times, is neither interference with the lawyers' judgment, nor direction or regulation thereof.

Commentators discussing lawyers' objections to outside counsel guidelines that interfere with their professional judgment in cases in which the insurer controls the defense suggest that lawyers have two options short of refusing to comply with the guidelines or withdrawing from the insured's representation. First, lawyers may ask the insurer to amend the guidelines or modify their application so that they do not interfere with the lawyers' professional judgment. Most insurers' outside counsel guidelines anticipate and allow such requests.[88] Second, they may seek the insured's informed consent to adherence to the offending guidelines.[89] Returning now to independent counsel, there is nothing wrong with a lawyer who wants to maintain a good relationship with the insurer seeking exceptions to guidelines that interfere with her professional judgment or with her professional relationship with the insured. It would be odd if the insurer did not agree to the lawyer's requested exceptions, since it is essentially powerless to refuse under the circumstances, and adhering to an unreasonable position will potentially expose it to breach of contract and bad faith claims by the insured. As for seeking the insured's informed consent to their adherence to unreasonable guidelines, it is difficult to

80. *Id.* R. 5.4(c).
81. *Id.* R. 1.8(f)(1).
82. *Id.* R. 1.0(e).
83. Fischer, *supra* note 11, at 178.
84. MODEL RULES OF PROF'L CONDUCT R. 1.0 cmt. 6 (2009).
85. Fischer, *supra* note 11, at 179.
86. *Id.* at 180.
87. MODEL RULES OF PROF'L CONDUCT R. 1.8(f)(2) & 5.4(c) (2009).
88. Ian A. Stewart & Gregory K. Lee, *Considerations Presented by Litigation Management Guidelines,* FOR THE DEF., June 2009, at 70, 70.
89. *Id.*

imagine that competent independent counsel would ever seek such consent, and it is equally hard to understand why the insured would ever knowingly consent to the impairment of its representation when it has no obligation to do so.

Although under Model Rule 5.4(c) a lawyer serving as independent counsel cannot permit the insurer "to direct or regulate the lawyer's professional judgment" in defending the insured,[90] that does not mean that independent counsel are divorced from all obligations to the insurer. Despite the insurer's loss of defense control, the insured is generally obligated to cooperate with the insurer in its defense.[91] An insurer's reservation of rights does not eliminate the insured's duty to cooperate because a defense under reservation is not a breach of contract that would excuse the insured's performance. A reservation of rights cannot even be described as an anticipatory breach of the insurance contract because an insurer's correct denial of coverage is no breach at all. Those essential principles remain true where a conflict of interest necessitates the appointment of independent counsel.[92] The insured remains obligated to cooperate in its defense in all respects except that in this context, the duty to cooperate cannot require the insured to share with the insurer information that the insurer could use to defeat coverage.[93] Independent counsel, as the insured's agents, must carry out the insured's duty to cooperate to the extent they are called upon to do so.

For these reasons, an insurer can reasonably insist that independent counsel fully inform it of factual and legal developments related to the defense, consult with it on defense strategy and tactics,[94] and consult with it before incurring major expenses in the course of the defense.[95] So long as the consultations do not reveal confidential information held by the insured that might be used to defeat coverage, allowing the insurer to consult on the defense cannot harm the insured. If the insurer's suggestions or advice are not advantageous, the insured and independent counsel are free to ignore them. Having lost the right to control the defense, the insurer cannot demand that the insured or independent counsel heed its advice or suggestions.[96] As for consultation on major expenses, an insurer has no obligation to pay for services or items that "are overpriced or inappropriate," and, no matter how well-intentioned independent counsel may be, they are not the sole arbiter of the reasonableness of all defense expenditures.[97] In addition, advance notice of substantial expenses may cause an insurer to explore settlement on a cost of defense basis, or withdraw its reservation of rights in order to regain control of the defense, both of which benefit the insured. To be sure, both the insurer and independent counsel must act reasonably when debating the value or worth of defense expenditures. The insurer cannot risk unreasonableness because crossing that line will expose it to bad faith liability. On the other hand, independent counsel cannot pass along unreasonable expenses as a matter of professional responsibility.[98]

f. Lawyers' Duty of Honesty

Independent counsel representations are characterized by a conflict of interest between the insured and the insurer. It is therefore common for the insured and independent counsel to view the insurer as an adversary, or at least as a party to be kept at arm's length, rather than as an ally. If that perspective is prudent, it is also important that independent

90. MODEL RULES OF PROF'L CONDUCT R. 5.4(c) (2009).

91. See *supra* note 73 and the accompanying text.

92. Fischer, *supra* note 11, at 185-86.

93. *But see* Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co., 579 N.E.2d 322, 327-31 (Ill. 1991) (expressing the minority view that cooperation clause in insurance policy overrides the insured's attorney-client privilege and work product immunity, thus allowing insurer access to defense counsel's files for use in subsequent declaratory judgment action).

94. William T. Barker, *Insurer Control of Defense: Reservations of Rights and Right to Independent Counsel,* 71 DEF. COUNS. J. 16, 25 (2004); *cf. In re* Rules of Prof'l Conduct & Insurer Imposed Billing Rules & Procedures, 2 P.3d 806, 814 (Mont. 2000) (requiring consultation where insured is sole client of defense lawyer hired by insurer).

95. 1 WINDT, *supra* note 76, § 4:22, at 4-190.

96. *See* Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 90 (D.R.I. 2002) (explaining that "the litigation cannot be controlled by the insurer"); Jacob v. W. Bend Mut. Ins. Co., 553 N.W.2d 800, 805 (Wis. Ct. App. 1996) (explaining that unless the insurer is willing to withdraw its reservation of rights and accept coverage, it has no authority to intervene in or interfere with independent counsel's defense of the insured).

97. Barker, *supra* note 94, at 26.

98. MODEL RULE OF PROF'L CONDUCT R. 1.5(a) (2009).

counsel not carry it to extremes. In short, lawyers serving as independent counsel may not lie to insurers. They cannot knowingly mislead insurers. There may be times that independent counsel's duties to an insured require them to withhold information from an insurer because it is confidential or might be used by the insurer to defeat coverage, or decline to answer an insurer's questions for the same reasons, but they cannot lie or deliberately misrepresent matters. If pressed for answers or information by insurers in situations where they cannot reasonably comply, independent counsel must hold the line at refusal or silence. Beyond the insured's duty to cooperate, which does not accommodate dishonesty by the insured or its agents, rules of professional conduct prohibit even well-intentioned independent counsel from lying to insurers. This is clear first from Model Rule 4.1(a), which states that in representing a client, "a lawyer shall not knowingly . . . make a false statement of material fact or law to a third person."[99]

Although Rule 4.1(a) clearly refers to false statements by a lawyer, it is a bit broader than it initially appears. More particularly, a lawyer may violate Rule 4.1(a) by knowingly affirming or ratifying another person's false statement,[100] or by failing to correct it.[101] As for the audience, the reference to "a third person" in Rule 4.1(a) establishes the rule's relation to lawyers' communications with non-clients.[102] The term "knowingly" denotes "actual knowledge";[103] it does not describe "evil intent or bad purpose."[104] Lawyers' knowledge may be inferred from the circumstances.[105] Rule 4.1(a) applies only to statements of fact or law; statements of opinion will not violate the rule.[106] Innocent misstatements do not implicate Rule 4.1(a),[107] although statements made with reckless disregard for the truth may.[108] A statement of fact or law is "material" if it is essential or significant, or if it "could have influenced the hearer."[109] Courts evaluate materiality on a case-by-case basis. The rule does not include a causation or reliance element; thus, a lawyer violates Rule 4.1(a) simply by making a prohibited statement.

Lawyers' duty of honesty may also be enforced under Model Rule 8.4(c), which prohibits "conduct involving dishonesty, fraud, deceit or misrepresentation."[110] Indeed, Rule 8.4(c) is the rule most commonly invoked by courts to discipline lawyers for dishonesty in any form. The standard by which a lawyer's alleged dishonesty is to be judged varies by jurisdiction. Many courts hold that a lawyer's false statement must be knowingly made to violate Rule 8.4(c).[111] This is clearly the most advantageous standard from a lawyer's perspective. Other jurisdictions are less forgiving and hold that lawyers may violate Rule 8.4(c) through statements made with reckless disregard for their truth or falsity,[112] or, similarly, through grossly negligent misstatements.[113]

Model Rule 8.4(c) does not require a statement for a violation; deceit and dishonesty can be based on lawyers' alleged concealment or omission of facts or information.[114] As with Model Rule 4.1(a), lawyers violate Rule 8.4(c) even if their dishonesty misleads no one or causes no harm.[115] Unlike Model Rule 4.1,

99. MODEL RULES OF PROF'L CONDUCT R. 4.1 (2009).

100. *See, e.g., In re* Winkler, 834 N.E.2d 85, 89 (Ind. 2005).

101. *See, e.g., In re* PRB Docket No. 2007-046, 989 A.2d 523, 526 (Vt. 2009).

102. State *ex rel.* Okla. Bar Ass'n v. Bolusky, 23 P.3d 268, 275 (Okla. 2001).

103. MODEL RULES OF PROF'L CONDUCT R. 1.0(f) (2009).

104. *In re* Edison, 724 N.W.2d 579, 584 (N.D. 2006).

105. *In re* Disciplinary Action Against Johnson, 743 N.W.2d 117, 123 (N.D. 2007); MODEL RULES OF PROF'L CONDUCT R. 1.0(f) (2009).

106. Office of Disciplinary Counsel v. Wrona, 908 A.2d 1281, 1289 (Pa. 2006).

107. *See, e.g.,* People v. Chambers, 154 P.3d 419, 425-26 (Colo. 2006) (finding no Rule 4.1 violation for apparently innocent misstatement of number of claims or suits).

108. *See In re* Wagner, 744 N.E.2d 418, 421 (Ind. 2001); Office of Disciplinary Counsel v. Price, 732 A.2d 599, 606 (Pa. 1999).

109. *In re* Fisher, 202 P.3d 1186, 1202 (Colo. 2009).

110. MODEL RULES OF PROF'L CONDUCT R. 8.4(c) (2009).

111. *See, e.g.,* Fla. Bar v. Mogil, 763 So. 2d 303, 309-11 (Fla. 2000); *In re* Firstenberger, 878 N.E.2d 912, 913-14 (Mass. 2007); *In re* Conduct of Skagen, 149 P.3d 1171, 1184 (Or. 2006) (discussing the analogous Oregon rule).

112. *In re* Ukwu, 926 A.2d 1106, 1113-14 (D.C. 2007); Iowa Sup. Ct. Attorney Discipline Bd. v. Gottschalk, 729 N.W.2d 812, 818 (Iowa 2007); Office of Disciplinary Counsel v. Surrick, 749 A.2d 441, 445 (Pa. 2000).

113. Walker v. Sup. Ct. Comm. on Prof'l Conduct, 246 S.W.3d 418, 424 (Ark. 2007).

114. Attorney Grievance Comm'n of Md. v. Floyd, 929 A.2d 61, 70 (Md. 2007); *In re* Disciplinary Proceedings Against Knickmeier, 683 N.W.2d 445, 464 (Wis. 2004).

115. Ansell v. Statewide Grievance Comm., 865 A.2d 1215, 1223 (Conn. App. Ct. 2005).

Model Rule 8.4(c) has no materiality requirement, although courts occasionally graft one on.[116] Even in jurisdictions where courts have not injected materiality into the analysis, however, they tend to interpret Rule 8.4(c) sensibly, thus excusing lawyers' trivial deceptions and misrepresentations.

116. *See, e.g., In re* Conduct of Skagen, 149 P.3d 1171, 1184 (Or. 2006) (involving Oregon equivalent to Rule 8.4(c) and imposing a materiality requirement).

Conclusion

Independent counsel are now an entrenched feature on the insurance litigation landscape. Like all lawyers, those who are selected as independent counsel must conform their conduct to the rules of professional conduct in the jurisdictions in which they practice. Some of those rules, however, take on special meaning or find particular application in the independent counsel context. Lawyers who serve as independent counsel must appreciate and understand their professional responsibilities in order to fully serve their clients and protect themselves.

Additional Insureds

Under New York Law, Where a Contractor's Blanket Additional Insured Endorsement Required that the Underlying Prime Contract Be "Executed" Prior to the Loss, the Owner Was Not Covered Where the Prime Contract Was Unsigned When the Loss Occurred

Certification to New York Court of Appeals Regarding Estoppel Based on Certificate of Insurance

10 Ellicott Square Court Corp. v. Mountain Valley Indemnity Co., No. 10-0799-CV, 2010 WL 5295420 (2d Cir. [N.Y.] Dec. 23, 2010)

[Editor's Note: On January 31, 2011, after this issue of *Insurance Litigation Reporter* was ready for press, the Second Circuit amended its December 23, 2010 opinion. The amended opinion is reported at 2011 WL 285140 (2d Cir. Jan. 31, 2011). The court's amended opinion adds a new footnote number 1 which states that, although the parties have settled, "the other parts of this decision stand," including certification of a question to the New York Court of Appeals.]

Case at Glance

Under New York Law, where a contractor's blanket additional insured endorsement required that the underlying prime contract be "executed" prior to the loss, the owner was not covered where the prime contract was unsigned at the time a worksite accident occurred.

Certification to the New York Court of Appeals: whether a certificate of insurance, issued by the insurer's agent, estops the insurer from denying the existence of insurance for a party claiming to be an additional insured.

Under New York Law, where an excess liability policy defines an insured as any person with whom the named insured has "agreed in writing prior to any loss … to provide insurance such as is afforded by this policy," a project owner is an insured even if it would not be under the primary policy's additional insured endorsement.

Summary of Decision

The named insured is a general contractor on a building demolition project in Buffalo, New York. As required by the prime contract, the insured obtained both a primary commercial general liability (CGL) and umbrella insurance policy from Mountain Valley Indemnity Company. The primary policy named the building owner and project's construction manager (CM) as additional insureds. The additional insured endorsement extended coverage "but only with respect to liability arising out of [the contractor's] operations," and only when "the written contract or agreement [between the contractor and the owner] ha[d] been *executed* … prior to the 'bodily injury." (Italics added.)

Mountain Valley, through its agent, issued a certificate of insurance (COI) evidencing the policies and the status of the owner and CM as additional insureds. The COI provided, all in capital letters, that "This certificate is issued as a matter of information only and confers no rights upon the certificate holder," and further cautioned that the certificate "does not constitute a contract between the issuing insurer … and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon."

The day after it received the COI, the insured began the demolition work. Before the prime contract had been signed by either party, and while demolition work was still ongoing, an employee of the contractor was injured when the building's roof collapsed. The injured employee sued the owner and CM, who requested a defense from Mountain Valley. The insurer, however, took the position that the owner and CM were not additional insureds because the prime contract was not "executed" prior to the date of the accident, as the construction contract had neither been signed by both parties nor fully performed.

After settling the underlying personal injury action, the plaintiffs owner and CM brought this action against Mountain Valley in federal district court in New York for breach of contract and declaratory judgment. They asserted that, even though the prime contract had not been signed prior to the date of the accident, the contract had been "executed" for purposes of the policy because of the parties' partial performance and because the parties to the contract

understood its signing to be ministerial. Plaintiffs further argued that, even if the prime contract had not been executed, the COI bound Mountain Valley to provide coverage because the COI, issued by Mountain Valley's authorized representative, represented that such coverage was in place. Last, plaintiffs argued that they had coverage under the umbrella policy, even if they did not have coverage under the primary policy. The district court granted plaintiffs' motion for summary judgment, and Mountain Valley appealed.

The United States Court of Appeals for the Second Circuit reversed, ruling first that the prime contract, having not been signed by either party nor fully performed, was not "executed" within the meaning of the additional insured endorsement. *Black's Law Dictionary* defines "executed" as: "1. (Of a document) that has been signed. 2. That has been done, given, or performed <executed consideration>." *Black's Law Dictionary* 650 (9th ed. 2009). While the New York Court of Appeals has not addressed the issue, the appellate courts uniformly agree with the dictionary definition and require that an "executed" contract be one that is either signed or fully performed. For example, in *Burlington Ins. Co. v. Utica First Ins. Co*., 71 A.D.3d 712, 896 N.Y.S.2d 433 (2010), the subcontractor, as required by the subcontract, obtained liability insurance which listed the CM as an additional insured. The policy's additional insured endorsement provided as a condition to coverage that the subcontract was "executed prior to the 'bodily injury' [or] 'personal injury'." Before either the subcontractor or CM had signed the subcontract, and before work at the site was completed, a man was injured at the construction site. The injured man sued the CM, who sought coverage from the defendant insurance company. The defendant denied coverage on the ground that the CM was not an additional insured because the subcontract was not signed at the time of the accident, and so was not "executed" within the meaning of the endorsement. Although the CM argued that the subcontract had been executed by virtue of the parties' partial performance, the appellate division agreed with the insurer, stating that "the defendant demonstrated that the contract was not 'executed' at the time of the alleged accident … since it was both unsigned and had not been fully performed at that time." In light of the *Burlington* decision, the *Ellicott* court readily concluded that "New York law unambiguously requires either the signing of a contract or its full performance for it to be 'executed' within the meaning of an insurance policy requiring such prior execution," and the district court erred in concluding otherwise.

Turning next to plaintiffs' estoppel argument, the circuit court found a split among the appellate courts as to whether a COI issued by an insurer's agent estops the insurer from denying coverage. Some appellate courts hold that a COI is merely evidence of a contract of insurance but is not, in itself, a contract of insurance. Other appellate division departments have held that a certificate, issued by the insurer's agent acting within the scope of his authority, estops an insurer from denying coverage where the party seeking coverage reasonably relied on the COI by, for example, beginning construction work; see *Niagara Mohawk Power Corp. v. Skibeck Pipeline Co*., 270 A.D.2d 867, 868-69, 705 N.Y.S.2d 459, 460-61 (2000). In response to this uncertainty, the *Ellicott* court certified the following question to the New York Court of Appeals:

> In a case brought against an insurer in which a plaintiff seeks a declaration that it is covered under an insurance policy issued by that insurer, does a certificate of insurance issued by an agent of the insurer that states that the policy is in force but also bears language that the certificate is not evidence of coverage, is for informational purposes only, or other similar disclaimers, estop the insurer from denying coverage under the policy?

Umbrella Policy Coverage

Last, the court addressed Mountain Valley's assertion that the plaintiffs' noncoverage under the primary policy (assuming the high court finds the prime contract was not executed) meant that there was also no coverage under the umbrella policy. The insurer cited in support § 3(d) of the umbrella policy, which provided: "Each person or organization who is an 'insured' in the 'underlying insurance' is an 'insured' under this insurance subject to all the limitations of such 'underlying insurance' other than the limits of the underlying insurer's liability."

The court ruled that plaintiffs had coverage under

an alternative provision, § 3(c), which provides: "Any person or organization with whom or with which you have agreed in writing prior to any loss … to provide insurance such as is afforded by this policy is an insured …" The court interpreted §§ 3(c) and (d) as providing alternative grounds for qualification as an additional insured. Under § 3(c), plaintiffs are insureds under the umbrella policy if the prime contract is in writing. The prime contract, although unsigned at the time of the accident, may be enforceable "provided there is objective evidence establishing that the parties intended to be bound," quoting *Flores v. Lower East Side Service Center, Inc.*, 4 N.Y.3d 363, 369, 795 N.Y.S.2d 491, 828 N.E.2d 593, 597(2005). Here, it is undisputed that the owner and contractor intended to be bound by the prime contract, regardless of whether it was signed.

Comment

The *Ellicott* court held that, under New York law, an additional insured endorsement that requires as a condition for coverage that the underlying contract be "executed" prior to the loss, must have been either signed by both parties or fully performed. Recently interpreting similar language, the Texas Supreme Court came to the opposite conclusion. In *Mid-Continent Casualty Co. v. Global Enercom Management, Inc.*, 323 S.W.3d 151 (Tex. 2010), the court ruled that an accident that occurs after performance begins under an "insured contract" is covered, even though the party seeking coverage did not sign the contract until after the accident, and the policy's definition of an insured contract required that liability occur "subsequent to the execution" of the contract; a contract need not be signed to be "executed" under Texas law.

It appears that the additional insured endorsement is a modified version of the Insurance Services Office, Inc. (ISO) "blanket" endorsement used by contractors. The primary policy was effective from March 15, 2003 to March 15, 2004. The ISO CG 20 33 07 04, titled "Additional Insured — Owners, Lessees or Contractors — Automatic Status When Required in Construction Agreement with You," does *not* require that the underlying construction contract "have been executed … prior to the 'bodily injury,'" as was the case in *Ellicott*. Instead, the ISO endorsement requires only that loss have occurred "in the performance of your ongoing operations for the additional insured" and then adds that "this endorsement ends when your operations for that additional insured are completed."

Assuming the ISO language providing that "this endorsement ends when your operations for that additional insured are completed" was part of the additional insured endorsement used by the parties in *Ellicott*, this language would eliminate "full performance" as a means by which the prime contract could be "executed." After all, once the construction work were fully performed, the contractor's "operations" would be "completed" and endorsement would no longer be in effect. Thus, with regard to a blanket additional insured endorsement, signatures by both parties would be the only way the underlying contract could be "executed."

The *Ellicott* court, although refusing to rule on the estoppel effect of a certificate of insurance, cogently outlined the arguments on both sides of the issue. In the court's words:

> There is reason to conclude that the primary insured—here, Ellicott Maintenance—should bear the burden of ensuring that all the conditions of providing "additional insured" status to those with whom it contracts to provide that status have been met. At oral argument, counsel for both sides acknowledged that it is not customary for an insurer or for the insurer's agent to see the contract ostensibly requiring a contractor to procure insurance; rather, a certificate of insurance naming the additional insured is issued as a matter of course upon the request of the primary insured. Nor is there evidence in the record of which we are aware that the plaintiffs ever saw the policy issued to Ellicott Maintenance, or that a party in the plaintiffs' position would typically see such a policy. The additional insureds did not have a relationship with the insurer that would have given them the right to obtain or question the accuracy of a certificate of insurance. It is, after all, the primary insured which has explicitly agreed to the execution of the underlying contract as a condition of coverage for additional insureds, which has the ability to seek to obtain that execution prior to the

beginning of work pursuant to the contract, and which is otherwise best positioned to assure compliance with the conditions of its insurance.

On the other hand, there is a reasonable argument to be made that, disclaimers notwithstanding, an insurer has an obligation not to issue false or potentially misleading certificates of insurance—or to permit an agent to issue them—if it or the agent is aware the parties may rely upon the certificate despite disclaimers to the contrary. … Moreover, insurers typically have greater control over the terms of insurance contracts and certificates of insurance than their insureds, along with greater knowledge of the applicable law; estoppel therefore may be appropriate for much the same reason that ambiguities in insurance contracts are construed against insurers.

For further discussion of an insured's right to rely upon a certificate of insurance, see Bruner & O'Connor on Construction Law § 11:172 (Westlaw database BOCL). See also 43 Am. Jur. 2d, *Insurance* § 189, stating unequivocally that "[a] certificate of insurance is only evidence of insurance coverage …." (Footnote omitted.) A far more in-depth analysis of such certificates is provided in Donald S. Malecki, Pete Ligeros & Jack P. Gibson, *The Additional Insured Book*, ch. 20 (International Risk Management Institute, Inc. 5th ed. 2004). // Schneier

Automobile Insurance

Driver Employed by a Travel Service That Had Entered into a Contract with a University Baseball Team Was "Hired" by the Baseball Team and Therefore "An Insured" under the Omnibus Definition in the University's Auto Policy

Ohio Supreme Court Broadly Construes Definition of Insured

Federal Ins. Co. v. Executive Coach Luxury Travel, Inc., __ N.E.2d __, 2010 WL 5392904 (Ohio Dec. 28, 2010)

Case at a Glance

Following a tragic auto accident involving a commercial bus contracted to transport a University baseball team, a dispute arose as to whether the driver of the bus qualified as "an insured" under the University's commercial auto policy. The policy language defined "an insured" in relevant part as "anyone else while using with your permission a covered 'auto' you own, hire or borrow." The trial court and the Court of Appeals both ruled that the driver did not qualify as "an insured" under this definition because the University did not have sufficient control or authority over the bus and the driver. The Ohio Supreme Court reversed, however, ruling that the bus driver qualified as "anyone while using with your permission a covered 'auto' you … hire." The Court ruled that the test used by the lower courts focusing on control and authority was not the appropriate test here, but that the facts would result in the same conclusion if the test were adopted.

Summary of Decision

In March of 2007, the Bluffton University baseball team contracted with Executive Coach Luxury Travel, Inc. ("Executive") to transport players and coaches to Sarasota, Florida where they were to play multiple games. Jerome Niemeyer, a driver for Executive, mistook an exit ramp for another lane on the highway causing a collision that killed Niemeyer, his wife and

five Bluffton players. Others were injured in the collision.

Bluffton had a commercial automobile policy with Hartford Fire Ins. Co., a commercial umbrella policy with American Alternative Ins. Corp, and an excess follow-form policy with Federal Ins. Co. The Federal policy had a clause stating that its coverage was subject to the terms, conditions, agreements, exclusions and definitions of its "controlling underlying insurance," which was the American policy. The American policy was also subject to underlying insurance, which was the Hartford policy. The court was asked to resolve whether Niemeyer was an "insured" under the language and meaning of Bluffton's Hartford policy.

The Hartford policy defined "an insured" as "anyone else while using with your permission a covered 'auto' you own, hire or borrow."

Injured passengers and estates of the deceased argued that Niemeyer was an "insured" because he drove a bus that Bluffton hired and with Bluffton's permission. Federal Insurance Company and American both argued that Bluffton did not "hire" the bus because Bluffton did not exert control over and possess the bus. They argue, instead, that Bluffton contracted for transportation and assented to Executive's authority over its own bus and drivers. (Apparently there was no dispute that the bus was otherwise a "covered auto" as that is not discussed in the majority opinion).

In a consolidated declaratory judgment action, the trial court ruled that Bluffton had neither hired the bus nor permitted Niemeyer to drive the bus and concluded that Bluffton did not have control or authority over the bus and the driver. On appeal, the court of appeals affirmed. The case was then taken to the Supreme Court of Ohio.

The court held that Bluffton hired the bus from Executive and granted permission to Niemeyer to drive the bus. Therefore, the court held the plain language of the policy covered Niemeyer at the time of loss. The court also dismissed an argument that the insurers never intended to insure someone like Niemeyer who was an unforeseen third party. The court found this argument disingenuous based on the breath of the clause at issue.

The insurers argued the word "hire" should be determined in terms of control and possession, citing e.g. *United States Fid. Guar. Co. v. Heritage Mut. Ins. Co.,* 230 F.3d 331, 333 (7the Cir. 2000) and *Toops v. Gulf Coast Marine Inc.,* 72 F.3d 483, 487-88 (5th Cir. 1996). The Court was not persuaded that such cases (concerning the hauling of construction equipment and materials) should be the law of Ohio, and held that even under the five part test the cases advocated Bluffton hired the bus.

The court noted specifically that Bluffton's coach had requested a bus from Executive with certain size and leisure requirements (a DVD player), and that Executive had sought and obtained express permission to have Niemeyer drive the bus, and that the coach had had prior experience with Niemeyer. The coach testified in deposition that he had authority to have Niemeyer stop driving if he was driving recklessly and he could also request a stop at anytime for breaks and meals. The coach also stopped the bus and fixed a DVD player when it was not working properly. The court ruled that these facts collectively established the requisite level of control and possession to meet the post posited by the insurers, even though the court did not adopt the test.

The court distinguished *Combs v. Black,* 2006 WL 1351510, an unreported Ohio decision, wherein the policy at issue contained an exception to the "insured" clause not present here. The exception excluded agents and employees of the owner from the definition of "an insured." The court ruled such an exception would bar coverage here, but it was not present in the Hartford policy.

The court therefore ruled that the lower courts erred when they determined that Niemeyer was not "an insured."

In the dissent, Judge Lundberg Stratton agreed with the trial court that Bluffton had contracted with Executive for services and did not own, hire or borrow a vehicle at the time of the accident. The dissent noted specifically that the majority's ruling could result in coverage under a similar provision for a lawyer who hails a taxi that causes an accident or a bridde and groom who get into a limousine after a wedding ceremony.

Comment

This decision construes the policy definition of "an insured" quite broadly, and the dissent's concerns about the potential application of such a definition are valid. The tragic nature of the fact pattern may have

been a factor here, but even so, this case stands as yet another reason an insurer is well advised to specifically tailor its policy language whenever possible. // Vacha

Bad Faith

Property Insurer's Duty of Good Faith Does Not Obligate Insurer to Monitor Work of Independent Contractor Recommended by Insurer But Duty Does Require Insurer to Communicate Promptly and Adequately with Insured and Contractor

Case of First Impression under Colorado Law

Dunn v. American Family Insurance Company, __ P.3d __, 2010 WL 4791948 (Colo.App., Nov. 24, 2010)

Case at a Glance

In a bad faith suit in which the plaintiff insureds acknowledge that they received all financial benefits due under the policy for flood damage and mold remediation, plaintiffs are entitled to damages resulting from the insurer's failure to communicate promptly and adequately with plaintiffs and the contractor regarding whether certain repairs were covered under the policy. In order to recover, plaintiffs must prove that the contractor acted reasonably in refusing to proceed without the insurer's confirmation of coverage, that the insurer's refusal to confirm coverage was unreasonable, that the insurer knew or recklessly disregarded the unreasonableness of its refusal, and that any resulting delay caused plaintiffs' emotional distress and health problems. However, the insurer's duty of good faith and fair dealing does not obligate the insurer to monitor the contractor, who was hired by the insureds on the insurer's recommendation. Nor does the insurer have a duty to warn the insureds to anticipate further damage to their home as a result of the flooding.

Summary of Decision

Plaintiffs' home sustained damage when a sewer and water backup caused sewage to seep into and flood their basement. They submitted a claim to their homeowners insurer. The insurer provided plaintiffs with contact information for a company, Insurance Contractors and Associates (ICA), which plaintiffs hired to remediate the flooding. ICA was unsuccessful, however, and sewage and water remained standing in plaintiffs' basement and, in particular, around their HVAC system. In the course of the remediation attempt, black mold was detected on the furnace wall. Plaintiffs, who were suffering from respiratory and other health problems, vacated their home on the following day. The house remained vacant throughout that winter and, because the furnace was not functioning, water froze in the pipes, which had to be replaced. Plaintiffs eventually hired three additional contractors to complete the remediation work. Ultimately, because mold had spread throughout the home, plaintiffs replaced its entire contents, including clothing, furniture, carpeting, and tile flooring. Plaintiffs' insurer acknowledged coverage for the cost of these items, paying plaintiffs approximately $340,000 in insurance benefits.

In the instant lawsuit, plaintiffs did not contend that their insurer failed to pay benefits owed under its policy. Instead, they sought extra-contractual damages, arguing that the insurer breached its duty of good faith (1) by failing to screen ICA for expertise and liability insurance coverage before recommending it to plaintiffs, and to observe, coordinate, and monitor the remediation it performed; (2) by failing to advise plaintiffs about dangers associated with their initial loss, specifically, the potential for mold contamination, and the need to protect their home against freezing conditions; and (3) by failing to communicate with plaintiffs and the contractors they hired regarding policy claims and coverage. They asserted that the insurer's breach caused them "extreme mental anguish and emotional distress," derived from the loss of their personal property, loss of occupancy of their home, and illness associated with mold contamination.

The trial court granted summary judgment for the insurer on the ground that the insurer's conduct did not breach the duty of good faith. The court reasoned that an insurer's duty of good faith and fair dealing

does not encompass conduct unrelated to the adjustment and payment of claims.

The Colorado Court of Appeals reversed. Addressing a question of first impression under Colorado law, the court probed the outer limits of the duty of good faith and fair dealing, beginning with a discussion of what the duty does not obligate insurers to do. The court agreed with the trial court that the duty does not include supervision of independent contractors recommended by the insurer to perform repairs on a policyholder's property, unless the insurer agrees to assume that duty. "To hold otherwise," the court explained, "would effectively render an insurer the liability carrier for any independent contractor performing work for its insured."

The court also refused to impose on the insurer a good faith duty to ensure that the home was adequately heated. Doing so, the court pointed out, would transfer to the insurer obligations that the policy expressly imposes on the policyholder. Specifically, the policy provided that, in the event of a loss, plaintiffs were required to make reasonable and necessary repairs to the property and protect it from further damage. It also explicitly set forth that defendant would not cover damages resulting from the freezing of plumbing or heating systems while the property was vacant unless plaintiffs had taken precautions either to maintain heat in the building or to shut off the water supply and drain the system and appliances. Here, the insurer had paid for damage resulting from the frozen pipes, even though it was not obligated to do so, and the court categorically rejected plaintiffs' request for additional damages in tort. For similar reasons, the court rejected plaintiffs' contention that the duty of good faith obligated the insurer to warn plaintiffs that flooding could cause further damage to their home, including mold contamination, which, in turn, could cause adverse health consequences.

Turning to what the duty of good faith obligated the insurer to do, the court pointed to Colorado Supreme Court's observation in *Ballow v. PHICO Ins. Co.,* 875 P.2d 1354, 1363 (Colo.1993), that an insurer's good faith duty is "broad and wide-ranging . . . , extending to everything pertaining' to the provision of insurance services to the public." Thus, an insurer's conduct in investigating and handling a claim may give rise to bad faith liability even if the insurer honors the express terms of the insurance contract. In the context of this case, the court of appeal reasoned that the duty of good faith obligated the insurer to communicate promptly and adequately with "anyone it was reasonably aware had or legitimately needed information pertaining to the handling of plaintiffs' claim," including the contractors hired to work on plaintiffs' home.

Accordingly, the court concluded that the insurer's alleged failure to respond adequately to the contractor's inquiry about whether certain repairs were covered gave rise to triable issues of fact regarding whether the insurer acted in bad faith, regardless of whether the repairs inquired about were actually covered. On remand, plaintiffs will be required to prove that the contractor acted reasonably in refusing to proceed without insurer's confirmation or authorization, that the insurer's refusal to affirm or deny that certain remediation was covered under plaintiffs' policy was unreasonable, that defendant was aware of or recklessly disregarded the unreasonableness of its refusal, and that plaintiffs suffered damages as a result.

Comment

Can an insurer's failure to communicate effectively give rise to liability even where the policy does not provide coverage? The court's opinion suggests the answer is "yes," at least where the manner in which the insurer handles the insured's claim results in additional injury to the insured. The court cited as authority for its decision the Arizona Supreme Court's decision in *Rawlings v. Apodaca*, 151 Ariz. 149, 726 P.2d 565 (1986), where the Arizona high court allowed a suit for bad faith in the absence of coverage because the insurer exploited its relationship with the insured to make the insured worse off than if the insured had no coverage at all. In *Rawlings*, the insurer had interfered with the insured's right to seek from another source the type of *benefits* that would have been available under the policy but for a policy exclusion or limits on coverage. The insureds suspected that their neighbors were responsible for a fire that resulted in extensive damage to their dairy farm. They informed the investigator hired by the insurer of their suspicions and of the existence of substantial uninsured losses. The insureds asked whether they should hire their

own investigator and were told not to do so because they would receive a copy of the insurer's report. Although the insurer paid the insured's their $10,000 policy limits, both the insurer and the investigator refused the insured's repeated requests for the report. The insurer's reluctance was understandable because the report revealed that the insured's neighbors were liable for the fire and that the insurer had issued a $100,000 liability policy to the neighbors. The insureds sued their insurer for the tort of insurance bad faith, alleging that the insurer's refusal to provide the report impeded their action against their neighbors. A jury returned a verdict of $10,000 in compensatory damages and $50,000 in punitive damages. The Arizona Supreme Court affirmed the finding of liability and remanded the punitive damages award for reconsideration under a clarified legal standard. The insurer's liability was based on its unreasonable conduct impeding its insureds from obtaining compensation for their fire loss. // DiMugno

Bad Faith/Duty to Settle

Where Multiple Liability Insurers Cover Claim, Duty to Settle May Arise Even If Settlement Demand Exceeds Single Insurer's Policy Limit

Genuine Dispute Regarding Coverage Does Not Excuse Failure to Settle

Howard v. American National Fire Insurance Company, 187 Cal.App.4th 498, 115 Cal.Rptr.3d 42 (1st Dist. 2010)

Case at a Glance

Where multiple liability insurers cover a claim, a duty to settle may exist even if a claimant's settlement demand exceeds one insurer's policy limit.

A liability insurer may not rely upon a genuine dispute regarding coverage to refuse a reasonable settlement.

Summary of Decision

Plaintiffs were two brothers who brought an action alleging that they were repeatedly molested by a priest during much of their childhood. The suit alleged that the Bishop who headed the diocese that employed the priest acted negligently in retaining the priest. The Bishop was covered by various comprehensive liability insurance (CGL) policies and tendered the defense of the suit to the insurers. Two insurers undertook the defense under a reservation of rights. Defendant—a third insurer—refused to participate in providing a defense, taking the position that its policy provided no coverage because the acts of molestation occurred after its policy period ended. Defendant also refused to attend mediation or make any settlement offers when plaintiffs made demands of approximately $5 million. When plaintiffs dropped their demand to $3,7 million, defendant attended a mediation but offered only a minimal amount in settlement.

Trial proceeded against the Bishop, and a jury found him liable and awarded $6.35 million in compensatory damages and $24 million in punitive damages. The trial court reduced the compensatory award to $5.25 million to reflect the jury's finding that the Bishop was 80 percent at fault for plaintiffs' injuries. The trial court also found the punitive award excessive and reduced it to $6 million. Both parties appealed.

The Bishop had difficulty obtaining collateral for an appeal bond. He paid $1 million toward satisfaction of the punitive award and entered into settlement negotiations with plaintiffs and the insurers in an attempt to protect the assets of the diocese. The parties reached a settlement agreement under which the two insurers that had contributed to the defense paid their remaining policy limits (a combined total of $3.3 million), and the Bishop contributed an additional $3.4 million. The Bishop agreed to pursue an action against his insurers and to pay plaintiffs the proceeds from that litigation.

Plaintiffs and the Bishop then filed a bad faith action against the insurers. Plaintiffs and the two insurers that had contributed to the defense reached a partial settlement under which the parties agreed to submit the insurance policy benefit claims to a private judge, and each of the insurers would pay $75,000 for non-contractual (bad faith) claims at the conclusion of the trial. The two insurers also assigned to plaintiffs their contribution rights against defendant for defense costs. The two insurers later reached a comprehensive settlement with plaintiffs that includ-

ed a release of policy claims. The insurers paid $1.25 million, which included the $150,000 for bad faith claims.

Plaintiffs claim against defendant proceeded to trial before a private judge, who found that molestation had occurred during defendant's policy period. The judge further found that defendant had acted in bad faith by refusing to defend the underlying action, refusing to make a reasonable settlement offer, and refusing to indemnify for the judgment against the Bishop. The judge ordered defendant to pay plaintiffs (a) its $500,000 policy limit; (b) approximately $75,000 in defense costs as assignee of the insurers who defended the underlying suit; (c) $1.5 million in bad faith damages to reimburse the Bishop for his settlement payment to plaintiffs; (d) approximately $200,000 to reimburse the Bishop for out-of-pocket, post-judgment attorney fees; and (e) approximately $660,000 in attorney fees incurred to compel payment of benefits under the insurance policy. Defendant appealed.

The California Court of Appeal, First District, affirmed the judge's decision. Initially, the court determined that the evidence supported the judge's finding that molestation occurred during defendant's policy period. Defendant relied upon one plaintiff's deposition testimony regarding his first memory of abuse, but the court examined other evidence and upheld the judge's finding. The court rejected defendant's attempt to bar evidence that was not introduced in the underlying trial, since the issue of liability in that proceeding did not require a determination of when the incidents occurred for purposes of insurance coverage.

Defendant argued that if coverage existed under its policy, its liability should be reduced to reflect the partial satisfaction of the judgment by the other insurers. The court concluded, however, that the insurers' settlement payments included interest as well as principal in satisfaction of the judgment, leaving more than defendant's $500,000 policy limit unsatisfied.

Defendant argued that it was not subject to liability for defense costs based on its failure to defend because the Bishop received a full defense from his other insurers. The court rejected this argument, noting that the Bishop was exposed to personal liability and forced to retain counsel at his own expense following the judgment. The court further noted that the judge's award for bad faith was based on breaches of multiple duties to defend, settle and indemnify.

The court then approved the judge's finding that defendant had breached its duty to make a reasonable effort to settle the underlying suit. Defendant argued that it had no duty to settle because plaintiffs' demands exceeded its policy limit. The court rejected this argument, ruling that a duty to settle arises in a case involving multiple insurers if the combined limits of all applicable policies exceed a settlement demand. Otherwise, the court reasoned, multiple insurers could all act in bad faith and thereby immunize themselves from bad faith liability. The court concluded that plaintiffs had made a reasonable demand for $3.7 million, and that the insurers' failure to settle the case was likely to lead to an excess judgment.

Defendant argued that it could not be held liable for bad faith because its refusal to defend, settle or indemnify was premised upon a genuine dispute regarding coverage. The court disagreed, drawing a distinction between first-party and third-party insurance and ruling that, in the third-party context, an insurer may not rely upon a genuine dispute regarding coverage to refuse a reasonable settlement. The court further found that plaintiff's deposition testimony did not provide a reasonable basis for defendant's assertion that no molestation occurred during its policy period. // Bushnell

Contractual Liability Exclusion/ Estoppel

Texas Supreme Court Rules that CGL Policy's Contractual Liability Exclusion Precludes a Duty to Indemnify an Insured General Contractor's Liability for Damage to Neighboring Property, Where the Only Basis for the Insured's Liability Is a Contractual Promise to Be Responsible for Such Damage

Excess Insurer Not Estopped from Contesting Coverage

Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London, __ S.W.3d __, 2010 WL 5133658 (Tex. Dec. 17, 2010)

Case at a Glance

A CGL policy's contractual liability exclusion precludes a duty to indemnify an insured contractor against liability for damage to neighboring property, where the only basis for the insured's liability is a contractual promise to the owner to be responsible for damage to adjacent properties; the exclusion is not limited to an insured's liability under a hold harmless or indemnity agreement.

An excess insurer's invocation of its policy's cooperation clause, to force its insured to move for summary judgment on potentially covered claims, did not estop the insurer from contesting its duty to indemnify on the ground that the contract liability exclusion applied to the only remaining basis for the insured's liability.

Summary of Decision

The insured (Gilbert) was the general contractor on a project to build a light rail system for the Dallas Area Rapid Transit Authority (DART). The prime contract contained a "Protection of Existing Site Conditions" provision under which Gilbert agreed to protect from damage properties and improvements adjacent to the work site, even if they were owned by someone other than DART. If Gilbert failed to keep this agreement and failed to pay for repairs, then DART could handle the problem and charge Gilbert for doing so.

Heavy rains fell during construction. A neighboring owner (RTR) claimed flood damage to its building caused by runoff from the work site. RTR sued DART and Gilbert in tort, and for breach of contract as a third-party beneficiary to the "Protection of Existing Site Conditions" provision. The trial court granted the defendants' motions for summary judgment based on the defense of governmental immunity, which resulted in dismissal of DART and of the tort claims against Gilbert. This left Gilbert as the sole defendant, with breach of contract as the sole claim.

Gilbert's excess liability carrier (Underwriters), whose policy was identical in relevant respects to the primary policy, refused to provide a defense. Underwriters sent a series of reservation of rights letters to Gilbert. However, after summary judgment was granted on the tort theories of liability, and Gilbert was the only remaining defendant with respect to a breach of contract claim, Underwriters sent another reservation of rights letter. This time, Underwriters stated that breach of contract claims were not covered based on the policy's contractual liability exclusion. That exclusion eliminates coverage for property damage "for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement." Gilbert then settled with RTR for nearly $6.2 million, and Underwriters formally denied coverage.

Gilbert sued Underwriters for breach of contract and also asserted that Underwriters had waived its right to deny coverage, or was estopped from exercising it. The key to the waiver and estoppel theories was that Underwriters had provided Gilbert a defense without a proper reservation of rights under the contractual liability exclusion. Both sides moved for summary judgment. The trial court granted Gilbert's motion as to coverage and Underwriters' motion as to Gilbert's statutory, waiver and estoppel claims. After both sides appealed, the court of appeals reversed as to coverage, finding that the contractual liability exclusion precluded coverage, but otherwise affirmed the trial court.

Texas Supreme Court's Opinion

Before the Texas Supreme Court, Gilbert argued

that (1) the contractual liability exclusion did not apply because its liability arose out of its own breach and not some liability it had assumed, (2) in any case, there was an exception to the exclusion which would resurrect coverage, since Gilbert would have been liable to RTR on covered grounds anyway, and (3) Underwriters had waived or was estopped from asserting any no-coverage defense. Affirming the court of appeals, the supreme court rejected each of these contentions. Central to its positions is its analysis of the meaning of the word "assume," and its cognates, first in the language of the policy and then in the context of waiver and estoppel.

Contractual Liability Exclusion

The contractual liability exclusion, found in Insurance Services Office, Inc. (ISO) standard form CGL policies, provides that the insurance does not apply to

> "Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the *assumption of liability* in a contract or agreement. This exclusion does not apply to liability for damages:
>
> (1) Assumed in a contract or agreement that is an "insured contract;" or
>
> 2) That the insured would have in the absence of the contract or agreement. (Emphasis added.)

The policy defined an "insured contract" as "[t]hat part of any other contract or agreement pertaining to your business *under which you assume the tort liability of another* to pay damages because of 'bodily injury' or 'property damage' to a third person or organization, if the contract or agreement is made prior to the 'bodily injury' or 'property damage.' Tort liability means a liability that would be imposed by law in the absence of any contract or agreement." In response to Gilbert's arguments, Underwriters countered that, in this duty to indemnify case, the contractual liability exclusion applied because, once the tort claims were dismissed, Gilbert's sole liability was for breach of contract—specifically, the provision making it responsible for damage to neighboring property damage.

The court explained briefly that, "[c]onsidered as a whole, the contractual liability exclusion and its two exceptions provide that the policy does not apply to bodily injury or property damage for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement, except for enumerated, specific types of contracts called 'insured contracts' and except for instances in which the insured would have liability apart from the contract." It acknowledged that most states and scholars view the exclusion's term "assumption of liability" the same way Gilbert does—as a contract in which the insured assumed the liability *of another*, as in the case of a hold harmless or indemnity agreement.

The court was not swayed, finding this majority interpretation to be at odds with the plain meaning of the policy. The exclusion applies when the insured is obligated to pay damages "by reason of the assumption of liability in a contract or agreement." These terms are not further defined, but dictionaries define "assume" to mean "undertake" and "liability" to mean "the quality or state of being legally obligated or accountable." Independent of the prime contract, Gilbert owed RTR the duty to conduct its operations with ordinary care so as not to damage RTR's property and, absent immunity, Gilbert may have been liable to RTR for breaching its duty. In the prime contract, however, Gilbert undertook a legal obligation to protect properties adjacent to the work site, and to repair or pay for damage to any such property "resulting from a failure to comply with the requirements of this contract *or failure to exercise reasonable care* in performing the work." (Emphasis added.) The court reasoned:

> The latter obligation—to exercise reasonable care in performing its work—mirrors Gilbert's duty to RTR under general law principles. The obligation to repair or pay for damage to RTR's property "resulting from a failure to comply with the requirements of this contract" extends beyond Gilbert's obligations under general law and incorporates contractual standards to which Gilbert obligated itself. The trial court granted summary judgment on all RTR's theories of liability other than breach of contract, so

> Gilbert's only potential liability remaining in the lawsuit was liability in excess of what it had under general law principles. Thus RTR's breach of contract claim was founded on an obligation or liability contractually assumed by Gilbert within the meaning of the policy exclusion.

Considering the exclusion and its exceptions as a whole further militated against Gilbert's interpretation that the exclusion applies only to the assumption of a third party's liability, the court added. The contract defines an "insured contract" as seven specific types of contracts. The seventh item addresses assumption of another's tort liability: "That part of any other contract or agreement pertaining to your business under which you assume the tort liability *of another* to pay damages because of 'bodily injury' or 'property damage' *to a third person* or organization …" "The fact that the definition explicitly references assumption of the tort liability of another demonstrates that the parties are capable of using such narrow, specific language when that is their intent," the court remarked. In sum, the court stated, "[w]e hold that it means what it says: it excludes claims when the insured assumes liability for damages in a contract or agreement, except when the contract is an insured contract or when the insured would be liable absent the contract or agreement."

The court disagreed with Gilbert's argument that its interpretation of the exclusion "effectively eviscerates" *Lamar Homes, Inc. v. Mid-Continent Casualty Co*., 242 S.W.3d 1 (Tex. 2007), where the court held that CGL insurance may cover a contract claim, so long as the complaint alleged property damage caused by an "occurrence." Gilbert asserted that if the contractual liability exclusion could exclude breach of contract claims, then the decision in *Lamar Homes* would have been unnecessary.

The court stated that it found no conflict between its decision in this case and in *Lamar Homes*. *Lamar Homes* considered whether property damage to a house that resulted from construction defects could constitute an "occurrence" as defined by the CGL policy; that decision did not address the contractual liability exclusion. In addition, *Lamar Homes* addressed the duty to defend, while this case involves a duty to indemnify. A duty to defend is evaluated broadly under the eight-corners rule, while a duty to indemnify is evaluated under the actual facts. Here, the facts are that Gilbert settled RTR's breach of contract claim after the trial court granted judgment in Gilbert's favor on all theories of liability besides the contractual one.

Gilbert argued in the alternative that the second exception to the exclusion—that "[t]his exclusion does not apply to liability for damages: … That the insured would have in the absence of the contract or agreement"—brought RTR's claim back into coverage. Gilbert reasoned that in the absence of its contract with DART, Gilbert would have been liable to RTR in tort because without the contract Gilbert would not have enjoyed governmental immunity.

The court rejected the insured's argument. A claim based on a contract that provides indemnification from liability does not accrue until the indemnitee's liability becomes fixed and certain. The duty to indemnify is based on the actual facts proven and adjudicated liability, and the only liability theory remaining when Gilbert settled with RTR was the breach of contract claim. "As modified by the second exception, the exclusion precludes the insurer's liability for indemnity if the insured is obligated to pay only because of its contractually assumed liability. If the insured's liability is because of an otherwise covered basis in addition to its contractually-assumed liability, the second exception brings the claim back into coverage."

Estoppel

Gilbert argued that even if it is substantively wrong about the policy, Underwriters is estopped from denying coverage, since it took control of the defense of Gilbert and prejudiced its insured. The prejudice, it alleged, arose in several ways. First, Underwriters did not specifically reserve its rights in a timely manner as to the contractual liability exclusion; it however urged a motion for summary judgment based upon governmental immunity, but after that motion was won, it denied its insured's claim based upon precisely that exclusion. Second, Underwriters controlled its insured's defense since it announced that it intended to become more active in the case and independently evaluated the governmental immunity issues. Indeed, defense counsel testified that he was pressured by Underwriters to move for summary judgment on the basis of

governmental immunity and went forward because he believed that if he did not, Underwriters would invoke the lack-of-cooperation-clause and deny coverage. Finally, Underwriters also controlled the defense but did not believe the case should be mediated until after summary judgment was heard and dealt with. (Of course, the value of the case from the point of view of the insurer's exposure depended substantially upon what happened to the governmental immunity motion for summary judgment.)

The court stated that it need not address whether Underwriters assumed control of Gilbert's defense, because "we conclude that even if Gilbert was deprived of the opportunity to make an informed decision as it claims, it was not prejudiced by the deprivation because in the final analysis, Gilbert did not have coverage for the contract claim regardless of whether it asserted the immunity defense as Underwriters directed it to do." Furthermore, Gilbert had pleaded governmental immunity long before Underwriters got involved. Hence, the insured "independently raised this issue without any prompting from underwriters."

Gilbert argued that Underwriters prejudiced Gilbert in accordance with the conceptualization articulated in *Employer's Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973). The court rejected this comparison. First, in *Tilley* the insurer had a duty to defend and abused it. Second, in *Tilley* the defense lawyer for the insured was also coverage counsel for the insurer. Third, there was evidence that Gilbert did not itself need to move for summary judgment on the basis of governmental immunity, since the court would have probably issued it anyway. Nothing like this was true in *Tilley*. Fourth, there was coercion involved in *Tilley*, but there was nothing of the sort shown here. Fifth, in this case, unlike *Tilley*, the insurer consistently acted within its contractual rights. The court summed up:

> Gilbert does not explain how it was prejudiced by being unable to make an informed decision about whether to assert immunity when the ultimate risk to Gilbert under either choice—whether asserting immunity or refusing to assert immunity—was the same. While Gilbert claims that if it did not assert immunity Underwriters would have denied coverage for lack of cooperation, there is no evidence that Gilbert would have had coverage for the claims even if it had refused to assert the immunity defense. … Thus, Underwriters did not have coverage for RTR's claims regardless of whether Gilbert would have breached the policy's cooperation clause if it had refused to assert immunity, a question on which we express no opinion.

Comment

The *Gilbert* decision was originally decided in June 2010 and summarized in the July 1, 2010 issue of *Insurance Litigation Reporter*; see *Gilbert Texas Construction, L.P. v. Underwriters at Lloyd's London*, No. 08-0246, 2010 WL 2219645 (Tex. June 4, 2010), 32 ILR 327 (2010). However, that opinion was withdrawn and this substituted with this December 17, 2010 opinion, and this CLR summary replaces the one in the September 2010 issue.

As the *Gilbert* court acknowledged, its view of the contractual liability exclusion is not in accord with the majority of jurisdictions and opinions of scholars. The clear majority rule is that the exclusion's reference to the insured's "assumption of liability" in a contract or agreement, means the assumption of *another's* liability; i.e., a hold harmless or indemnity agreement. One of those cases following the majority rule is *Federated Mutual Ins. Co. v. Grapevine Excavation, Inc*., 197 F.3d 720, 726 (5th Cir. 1999), in which the court, applying Texas law, stated: "This exclusion operates to deny coverage when the insured assumes responsibility for the conduct of a third party. As GEI is not being sued as the contractual indemnitor of a third party's conduct, but rather for its own conduct, the exclusion is inapplicable." (Footnote omitted.) That language is no longer a correct statement of Texas law after *Gilbert*; however, the *Grapevine* court then added that, even if the exclusion was found generally applicable, it would not defeat coverage because the insured had also been negligent; hence, its liability was not solely contractual (as was Gilbert's).

The following cases adopt the majority rule: *Ferrell v. W. Bend Mutual Ins. Co*., 393 F.3d 786, 795 (8th Cir. 2005) (citing *American Girl, infra*, and stating that the contractual liability exclusion would apply only if the insureds had entered into an

agreement with the plaintiffs to assume liability for the plaintiffs' damages); *Olympic, Inc. v. Providence Wash. Ins. Co. of Alas.*, 648 P.2d 1008, 1011 (Alaska 1982) (citing an earlier version of the exclusion but also stating that the exclusion's application to "liability assumed by the insured under any contract" only "refers to liability incurred when one promises to indemnify or hold harmless another, and does not refer to the liability that results from breach of contract."); *Day v. Toman*, 266 F.3d 831, 836 (8th Cir. 2001) (Nebraska law); *Fisher v. American Family Mutual Ins. Co.*, 1998 ND 109, 579 N.W.2d 599, 603-04 (1998) (citing a treatise for the proposition that in liability policies, "an 'assumed' liability is generally understood and interpreted by the courts to mean the liability of another which one 'assumes' in the sense that one agrees to indemnify or hold the other person harmless therefor."); *ACUITY v. Bird & Smith Construction, Inc.*, 2006 ND 187, 721 N.W.2d 33, 40 (2006), (reaffirming *Fisher*); *Gibbs M. Smith, Inc. v. U.S. Fidelity & Guaranty Co.*, 949 P.2d 337, 341 (Utah 1997) (where insured publisher lost author's photographic transparencies, the court held that the contract exclusion clause did not apply to the insured's breach of its own contract with author to take good care of transparencies, stating: "Courts have over and over again interpreted the phrase 'liability assumed by the insured under any contract' to apply only to indemnification and hold-harmless agreements, whereby the insured agrees to 'assume' the tort liability of another."); and *American Family Mutual Ins. Co. v. American Girl, Inc.*, 2004 WI 2, 268 Wis.2d 16, 673 N.W.2d 65, 70 (2004) (stating that the exclusion "does not exclude coverage for all breach of contract liability. Rather, it excludes coverage for liability that arises because the insured has contractually assumed the liability of another, as in an indemnification or hold harmless agreement.")

As support for its reasoning, the *Gilbert* court cited *Silk v. Flat Top Construction, Inc.*, 192 W.Va. 522, 453 S.E.2d 356 (1994). In that case, the homeowners acted as their own general contractor on a custom home construction contract. They separately hired a consultant to supervise the construction and the trade contractors. The owners sued the consultant for breach of the supervision contract, who sought coverage from its liability insurer. The court upheld a summary judgment holding that the insurer had no duty to defend. The court's analysis is very cursory, consisting entirely of the following:

> In the underlying claim, the plaintiffs seek damages for breach of contract. The policy does not extend coverage for breach of contract. It states, in part, that "[t]his insurance does not apply to: … 'Bodily injury' or 'property damage' for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement."

Id., 192 W.Va. at 525, 453 S.E.2d at 359. In light of the near unanimity of the majority opinion, the *Silk* decision provides scant support for the ruling in *Gilbert*.

Treatises are in accord that the contractual liability exclusion applies to damages the insured paid pursuant to an indemnity or hold harmless agreement. See *Bruner and O'Connor on Construction Law* § 11:109 (Westlaw database BOCL), in which this explanation is provided:

> While technically not accurate, for ease of description we will refer to the coverage reinstated by the exceptions to the contractual liability as "contractual liability." A fairly common scenario in which contractual liability coverage is a benefit is where a subcontractor has agreed to indemnify a general contractor for claims asserted against the general contractor alleging property damage. Where the subcontractor commits some act of negligence which results in damage to property, and the general contractor is also found to be negligent, perhaps in some supervisory capacity, the coverage afforded to the subcontractor under the contractual liability provision can be significant. In this situation, the subcontractor may not have coverage for the general contractor's and owner's nonindemnity claims in light of certain business risk exclusions. The general contractor's indemnity claim, however, might be covered, thus affording the subcontractor, in most jurisdictions, a complete defense for the claims asserted against it. (Footnote omitted.)

Other treatises are in accord; see 21 Eric Mills Holmes, *Holmes' Appleman on Insurance* § 132.3, 36-40 (2d ed. 1996) (the contractual liability exclusion refers to the assumption of another's liability as in an indemnity agreement); 2 Rowland H. Long, *The Law of Liability Insurance* § 10.05[2], 10-61 (1st ed. 2006) ("Although it could be argued that one assumes liability (i.e., a duty of performance, the breach of which will give rise to liability) whenever one enters into a binding contract, in the CGL policy and other liability policies an 'assumed' liability is generally understood and interpreted by the courts to mean the liability of another which one 'assumes' in the sense that one agrees to indemnify or hold the other person harmless therefor."); Marc M. Schneier, *Construction Accident Law: A Comprehensive Guide to Legal Liability and Insurance Claims* 527-31 (ABA 1999); and 1 Scott C. Turner, *Insurance Coverage of Construction Disputes*, ch. 10 at 10-2 (Thomson Reuters/West 2010) (Westlaw database ICCDS) (the exclusion's reference to "assumption of liability is under an indemnity, or hold harmless, provision." (Footnote omitted.)). // Schneier

Directors & Officers Insurance

Personal Profit and Dishonesty Exclusions in D & O Policy Require Proof Beyond the Allegations in the Complaint

Court Analyses the Proof Necessary to Establish Personal Profit Exclusion and Dishonesty Exclusion

Wintermute v. The Kansas Bankers Surety Co., __ F.3d __, 2011 WL 31531 (8th Cir. Jan. 6, 2011)

Case at a Glance

The Eighth Circuit reverses grant of summary judgment in favor of the insurer where the trial court relied upon only the allegations of the indictment against the insured director to conclude the personal profit exclusion and the dishonesty exclusion applied. The case was remanded for a determination of whether the insured in fact received a personal gain to which she was not entitled and whether the insured was actually involved in any dishonest acts.

Summary of Decision

Susan Wintermute, a director of Sinclair National Bank (SNB), was indicted on criminal charges for filing false statements in connection with her purchase of the bank. In addition, she was indicted for various bank fraud charges related to loans SNB later purchased from two companies in which Wintermute held financial interests. Wintermute was ultimately convicted of two counts of the criminal indictment related to the false filings and acquitted of four counts related to fraudulent banking activities engaged in after the bank was purchased and while Wintermute was acting as a director.

Prior to the convictions, Wintermute tendered her defense against and indemnity for the criminal charges to SNB's D&O liability insurer, The Kansas Bankers Surety Co. (KBS). The insuring grant in the KBS policy provided coverage for a "Loss" that an insured Director is "legally obligated to pay by reason of any Wrongful Act solely in [the] capacities of Director." The term "Loss" meant "any amount which the Directors . . . are legally obligated to pay . . . for a claim . . . for Wrongful Acts and shall include but not be limited to damages, judgments . . . and defense of legal claims."

The policy also contained two relevant exclusions. One exclusion barred coverage for claims based upon a Director's "gaining in fact any personal profit." The other exclusion barred coverage for claims "brought about or contributed to by the dishonesty of the Directors." The dishonesty exclusion further provided that it did not apply to any Director "who was not involved in the dishonest acts." Citing these provisions in the policy, KBS denied coverage for Wintermute.

Wintermute sued KBS in the U.S. District Court for the Western District of Missouri. The trial court, applying Arkansas law, ruled on summary judgment that KBS owed no coverage under the insuring grant. The court reasoned that a criminal indictment, absent a count for restitution, was not a claim for money or something owed and, therefore, was not a claim for Loss. In addition, the personal profit exclusion and the dishonesty exclusion defeated coverage as a

matter of law based upon the allegations in the indictment.

Wintermute appealed and the U.S. Court of Appeals for the Eighth Circuit reversed. The court first analyzed the coverage afforded by the insuring grant. The court examined the difference between a claim for Loss—e.g., money damages—and a claim for a wrongful act, noting that the policy provided for only the latter. That is, the counts of the criminal indictment against Wintermute were claims for wrongful acts and, therefore, there was coverage under the insuring grant, even though Wintermute did not owe restitution.

Turning to the exclusions, the Eighth Circuit concluded the trial court had improperly considered only the allegations in the indictment rather than requiring some proof that the exclusions applied. More specifically, there were fact issues concerning whether Wintermute actually received personal profit and whether Wintermute was actually involved in the alleged dishonest acts.

The appellate court noted that the personal profit exclusion applied only where a director "gain[ed] in fact" any personal profit. And there was a conflict of authority over whether exclusion provisions using the term "in fact" require the court to look beyond the face of the complaint. The court cited *Brown & LaCounte, L.L.P. v. Westport Ins. Corp.*, 307 F.3d 660, 663 (7th Cir. 2002), as an example. There, the Seventh Circuit concluded that a personal profit exclusion applied to a whole class of claims, at least where the underlying complaint unequivocally and directly alleges personal gain by the insured. Otherwise, if an insurer had to await the outcome of the underlying litigation to determine whether the director "in fact" gained a personal profit, the insurer would always have to defend the director, eviscerating the exclusion.

Acknowledging *Brown*, the Eighth Circuit elected instead to follow the opposing line of cases, including *PMI Mortg. Ins. Co. v. Am. Int'l Specialty Lines Ins. Co.*, 2006 WL 825266, at *7 (N.D.Cal. Mar. 29, 2006) (unpublished). Those cases interpret the term "in fact" in the exclusion to require at least some evidence that the insured actually reaped an illegal profit or gain. Allegations of personal gain in the complaint alone are insufficient to trigger the exclusion. As for whether such a ruling would impose a final adjudication requirement on a policy that contains none, the Eighth Circuit noted that the "in fact" language is generally read more broadly that a "final adjudication" clause and can be satisfied by a final decision on the merits in either the underlying case or a separate coverage case, or by an admission by the insured. Moreover, as a factual matter, the allegations in the particular indictment at issue did not unequivocally assert that Wintermute illegally gained personal profit. Thus, the trial court erred in granting summary judgment based on the personal profit exclusion by relying solely on the allegations in the indictment.

Like the personal profit exclusion, the Eighth Circuit applied similar reasoning in interpreting the dishonesty exclusion. The last sentence of the dishonesty exclusion says that it is inapplicable to a director not involved in the dishonest acts. That sentence, according to the court, served the same purpose as the "in fact" language in the personal profit exclusion. Namely, it makes the exclusion inapplicable if the specific director was not actually involved in the dishonest acts. Thus, it was not enough that the indictment charged Wintermute with committing fraud. Rather, material fact disputes existed concerning whether Wintermute "was involved in the dishonest acts" alleged, particularly in light of her acquittal on those counts for which Wintermute was an insured.

The court reversed and remanded the case for a determination of whether Wintermute in fact received a personal gain to which she was not entitled and whether Wintermute was involved in any dishonest acts. In so doing, the appellate court noted that, although Wintermute was acquitted on the counts related to her activities as an insured, this did not mean the exclusions applied. A criminal conviction requires proof beyond a reasonable doubt on each of the elements of the underlying offense. According to the court, this is a separate issue from whether, for the purposes of the duty to defend, the insurer can establish that the personal profit or dishonesty exclusions apply. // Sekits

Excess Insurance

Policyholder's Settlement with Primary Insurers for Less Than Policy Limits Triggers Excess Insurance Coverage

Seventh Circuit Addresses Question of First Impression under Indiana Law

Trinity Homes LLC v. Ohio Casualty Insurance Co., __ F.3d __, 2010 WL 5174967 (7th Cir. [Ind.] Dec. 22, 2010)

Case at a Glance

Under Indiana law, a commercial general liability (CGL) insurance policy issued to general contractor engaged in new home construction covers construction defects resulting from faulty subcontractor work. Damage to homes resulting from faulty subcontractor work is "property damage" caused by an "occurrence" within the meaning of the general contractor's policies, absent evidence that the subcontractor's work was intentionally faulty.

Under Indiana law, a policyholder's acceptance of seventy-five percent of its primary CGL policy limits to settle a coverage dispute exhausts the policyholder's primary coverage and triggers coverage under the policyholder's excess umbrella policy for the amount of liability in excess of the full primary CGL limits, absent unambiguous language in the excess umbrella policy requiring payment of primary policy limits.

Summary of Decision

The insured was in the business of new home construction throughout Indiana. Rather than build the homes itself, the insured used subcontractors to take care of the actual home construction. Due to faulty work by the insured's subcontractors, a number of the homes were plagued with structural problems. These defects allowed water to enter the homes, which in turn resulted in physical damage to the residences and health problems for the occupants. Beginning in 2002, the homeowners sued the insured in Indiana state court for the costs associated with remedying the subcontractors' deficient work. In all, the insured faced thirteen lawsuits, including multiple class actions.

The insured sought coverage under the its primary liability policies and an excess umbrella policy for liability incurred in the homeowners lawsuits. All of the primary insurers contested coverage on the ground that damage to the homes arising from faulty subcontractor work was not "property damage" caused by an "occurrence" within the meaning of their policies' coverage provisions. However, all but one of the primary insurers settled for at least seventy-five percent of the relevant policy limit, and each settlement agreement provided that the insured would be responsible for the remainder of the limit, functionally exhausting the CGL policy.

Following the settlement, coverage litigation proceeded against a single primary and the excess umbrella insurer. The district court granted summary judgment for both insurers, holding that the primary policy's did not cover damage to the homes, and that the insured's acceptance of less than full policy limits from the settling primary insurers precluded coverage under the excess umbrella policy. In reversing, the Seventh Circuit ruled that the district court misstated Indiana law as recently announced by the Indiana Supreme Court in *Sheehan Constr. Co. v. Cont'l Cas. Co.,* 935 N.E.2d 160 (Ind.2010), with respect to coverage under the primary policy and as predicted by the Seventh Circuit with respect to coverage under the excess policy.

CGL Coverage

In granting summary judgment for the primary insurer, the district court had relied on the Indiana Court of Appeals' decision in *Sheehan Constr. Co. v. Cont'l Cas. Co.,* 908 N.E.2d 305 (Ind.Ct.App.2009), which drew a distinction between two types of damage caused by a subcontractor's work: damage to property distinct from the home, which would typically be covered by a standard CGL policy, and damage to the home's structure itself, which would not be covered. The district court further relied Indiana appellate law holding that faulty construction does not constitute an "accident" and thus is an "occurrence" within the policy's coverage provision. However, after the district court ruled, the Indiana Supreme Court reversed and vacated the court of

appeals' decisions in the *Sheehan* case, and authoritatively ruled that a standard CGL policy does cover damage to a home's structure resulting from shoddy subcontractor work unless the subcontractor work was intentionally faulty. The Seventh Circuit reversed the summary judgment in favor of the primary insurer on the authority of the Indiana Supreme Court's *Sheehan* decision.

Excess Umbrella Coverage

Without definitive guidance from the Indiana Supreme Court, or any lower Indiana court, the circuit court attempted to predict Indiana law on the effect of an insured's acceptance of less than full policy limits from a primary insurer on an excess insurer's duty to provide coverage. The excess policy obligated the insurer to pay either covered damages excluded or not covered by "underlying insurance," or damages the insured is legally obligated to pay "in excess of underlying insurance" if those damages are covered by both the primary and the excess policy. The Indiana Supreme Court's decision in *Sheehan* had established the primary insurers' obligation to cover the homeowners' damages, so the issue here was whether the underlying primary insurers' payout of less than their full policy limits to settle a coverage dispute with the insured could trigger coverage under the excess policy. The excess policy defined "underlying insurance" as "the policies of the insurance listed in the Schedule of Underlying Policies and the insurance available to the insured under all other insurance policies applicable to the 'occurrence.'" The excess policy also included a "Limits of Insurance" clause, which provided:

> a. If the limits of "underlying insurance" have been reduced by payment of claims, this policy will continue in force as excess of the reduced "underlying insurance"; or
>
> b. If the limits of "underlying insurance" have been exhausted by payment of claims, this policy will continue in force as "underlying insurance."

Reading the limits of insurance provision together with the grant of coverage, the district court interpreted the policy to provide coverage only when underlying limits are exhausted via actual payment by the underlying insurer. Under the district court's analysis, an insured cannot "exhaust" underlying insurance by paying the difference between what the insurer is willing to pay and the policy limits.

The Seventh Circuit rejected the district court's conclusion that the excess policy unambiguously required exhaustion of the CGL limit by insurer payout alone. The policy required only that underlying coverage be unavailable. Nowhere did the policy clearly state how the underlying insurance must be exhausted or rendered unavailable. Accordingly, the court determined that the policy was ambiguous and susceptible to the meaning put forth by the insured—that primary CGL coverage can be exhausted when an insured and a CGL insurer enter into a settlement agreement where the primary insurer will pay a large percentage of the total limit and the insured takes responsibility for the remainder. Applying the contra insurer rule, the court resolved the ambiguity in favor of coverage.

The circuit court noted that its resolution of the ambiguity in the excess policy reinforced Indiana public policy favoring out-of-court settlements. A contrary holding, the court pointed out, would force an insured to litigate each and every one of its primary CGL policy claims before seeking recourse from an excess insurer. Moreover, nothing in its decision would alter the excess insurer's underwriting considerations. The court was careful to point out that the insured was not asking the excess insurer to drop down and pay the remainder of the CGL limits after its settlement with the CGL insurers.

Comment

The *Trinity Home* case underscores the importance of policy language. The court was able to point to examples of excess policies that unambiguously require payout by the underlying insurer before excess coverage is triggered. *See, e.g., Comerica Inc. v. Zurich Am. Ins. Co.,* 498 F.Supp.2d 1019, 1022 (E.D.Mich.2007) (policy required payment by the "applicable insurers" before coverage was triggered); *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London,* 161 Cal.App.4th 184, 73 Cal.Rptr.3d 770, 778 (2008) (CGL policy exhausted 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"). The court observed that the excess insurer in this case "could have used similarly clear language in its policy, but it did not, and it must now bear the burden of its ambiguity." // DiMugno

Liability Insurance

Destruction of Insured's Product Was Not "Occurrence"

Arkansas Law Limits Coverage to Consequential Damage

Lexicon, Inc. v. Ace American Ins. Co., 627 F.3d 1087 (8th Cir. [Ark.] 2010)

Case at a Glance

The Eighth Circuit Court of Appeals, applying Arkansas law, has held that the sudden and accidental destruction of an insured's product was not a covered "occurrence," even if caused by a subcontractor's negligence. Collateral damage caused by that event, however, was covered.

Summary of Decision

The *Lexicon* case arose from the collapse of a silo in the West Indies, after a company called Nu-Iron had moved its production facilities to Trinidad from Louisiana. Lexicon was responsible for relocating Nu-Iron's iron plant, which included the fabrication and construction—entirely subcontracted to Damus—of six new storage silos. Due to a faulty weld by Damus, one of the silos collapsed, resulting in destruction of the silo, its stored contents, and nearby equipment. Ace and National Union denied coverage, resulting in Lexicon's suit. The trial court found there was no coverage for any of the loss, but the Eighth Circuit reversed in part.

The basis of the trial court's ruling was *Essex Ins. Co. v. Holder*, 261 S.W.3d 456 (Ark. 2008) and related precedent, which held that damage to the insured's own product was not an "accident." The trial court read too much into *Holder*, however, which expressly limited its holding to faulty workmanship to the insured's own product. Although the destruction of the silo was indeed a noncovered event under *Holder*, the product stored in the silo and the adjacent equipment were not Lexicon's product and thus the damage to them was covered. That conclusion was consistent, in the court's view, with the exclusion for damage to "your work," which excluded damage to the named insured's work but not to collateral damage. Accordingly, the insurers were obligated to cover the underlying loss except for the cost of rebuilding the silo.

Comment

The *Lexicon* ruling simply seems incorrect. Although *Holder* did hold that faulty workmanship per se is not an "accident," that ruling involved garden variety shoddy work—the home the insured built was simply not very well made. In *Lexicon*, by contrast, the silo was not just an inferior silo: rather, it collapsed suddenly and dramatically, resulting in its complete destruction and collateral damage to its contents and adjacent equipment. Although the faulty construction of the silo was not an "occurrence," its collapse certainly was.

Moreover, the court's superficial treatment of the "your work" exclusion is highly questionable. As the court noted, the exclusion for damage to "your work" expressly does not apply where "the work out of which the damage arises was performed . . . by a subcontractor." In the *Lexicon* case, the entire silo was fabricated and erected by Damus, a subcontractor. Whether the damage is considered to have "arisen" from the faulty weld or the entire silo, the work was all performed by Damus. The court properly focused on the exception, but drew precisely the wrong conclusion from it. // Barnes

Negligent Hiring Not an "Occurrence" in Georgia

Insured's Failure to Conduct Background Check Was Volitional

Rucker v. Columbia Natl. Ins. Co., __ S.E.2d __, 2010 WL 4869787 (Ga. App. 2010)

Case at a Glance

The Georgia Court of Appeals has held that a violent assault by the insured's agent was not an "occurrence" because the insured was sued for a deliberate act—not performing a background check on the employee. Absent an "occurrence," the exclusion for "expected or intended" injuries was immaterial.

Summary of Decision

In 2006, Anthony and Rhonda Rucker purchased a home appliance service contract from American Home Shield (AHS). When they needed a repair, AHS sent Jeffery Taylor, a technician with Pro Tech Appliance Service, to investigate. Taylor, in turn, sent a trainee named Leon Phillips to the Rucker home. Unbeknownst to any of them, Phillips was extremely violent and had a long history of criminal activity. After entering the Rucker home, Phillips assaulted and murdered Rhonda Rucker and assaulted and kidnapped her son. Anthony Rucker and his son's guardian subsequently sued Phillips, Taylor and AHS, the latter two of whom tendered their defense to Columbia National under Taylor's general liability policy. When the insurer sought declaratory relief, the trial court found the suit alleged no "occurrence" and the Court of Appeals affirmed.

Turning first to Taylor, the appellate court agreed that he had not been sued over an "accident," which under Georgia law means an event that occurs without foresight, expectation or design. As he conceded in his deposition, Taylor conducted background investigations on new permanent employees but not on trainees, because he did not want to make the investment until the trainees showed some promise. Because Taylor had followed a conscious practice in foregoing a background check on Phillips, his deliberate conduct was not "accidental."

As for AHS, the Ruckers focused on its contractual commitment to monitor and the screen the service technicians sent to its customers' homes. The Ruckers' complaint did not allege that AHS's failure to do so was "accidental," and an insured's breach of a contractual obligation is no "accident" under Georgia law.

Comment

It seems that the Georgia court blew this one. Although it is certainly true that the failure to conduct a background check on Phillips was no "accident," Phillips's murder-and-kidnapping spree was surely unexpected from the perspective of Taylor and AHS. The court's error was in confusing the "occurrence" (the Ruckers' injuries) with the legal theories employed to hold Taylor and AHS responsible for it (negligent hiring/supervision). The failure to screen Phillips was no "accident," but it was not a "bodily injury," either. The Ruckers did not sue over the poor screening of Phillips, but because he committed assault, kidnapping and murder. Those *injuries* certainly were not inflicted by Taylor or AHS with "foresight, expectation or design." Likewise, dismissing AHS's liability as nothing more than a "breach of contract" seems particularly callous in view of the underlying tragedy.

Although courts have reasonably come to different conclusions in addressing coverage for intentional acts by an insured's agents or employees, the *Rucker* court did not contribute to that debate but seems to have simply misunderstood the question. // Barnes

Liability Insurance/ Choice of Law

Indiana Supreme Court Applies Law of Single State, Maryland, to Dispute over Coverage for Environmental Damage in California and Indiana

Under Uniform-Contract-Interpretation Approach Single State's Law Applied to Entire Contract

National Union Fire Insurance Co. v. Standard Fusee Corp., __ N.E.2d __, 2010 WL 5392678 (Ind. Dec. 29, 2010)

Case at a Glance

Under Indiana law, the choice of law governing suits against liability insurers arising from disputes over environmental claims in two different states, California and Indiana, was Maryland, the state with which the facts of the case were in most intimate contact. The insured's headquarters was in Maryland when it took out the liability policies, suggesting that it was the principal location of the insured risk. The insured's communication with its brokers originated from its Maryland headquarters, and its insurance procurement, review process, and decision making all occurred in Maryland, where the policies were retained and the premiums were paid. Although the location where the insurance funds would be put to use was Indiana, that site was not exclusive as funds would also be used in California, and the overall number and quality of contacts favored Maryland over Indiana as the state in most intimate contact.

Summary of Decision

Standard Fusee Corporation (SFC), a manufacturer of signal flares, was incorporated in Delaware and headquartered in Maryland. In 1988 it began leasing facilities in Indiana and California. SFC also operated facilities in other states. SFC purchased comprehensive general liability (CGL) insurance policies from various insurers through two brokers, one located in Maryland and one in Massachusetts. The policies did not specify the law of the state that would govern their interpretation. In 2002 SFC learned that perchlorate, a chemical used in the production of flares, had been discovered in groundwater samples at and around its California facility. More than 250 lawsuits were filed against SFC in California thereafter, but they were dismissed when it was determined that SFC had never discharged perchlorate there. SFC was not subject to remediation orders with respect to its California facility. In 2004 SFC voluntarily tested its Indiana facility. The test suggested potential perchlorate contamination. SFC was granted inclusion in the Indiana Department of Environmental Management's Voluntary Remediation Program the following year.

SEC unsuccessfully requested defense and indemnification from its insurers with respect to the proceedings in California and Indiana. In 2005 SFC filed an action in an Indiana court seeking a declaratory judgment that the insurers were required to defend and indemnify SFC under the liability policies against environmental liabilities arising in Indiana and California and seeking damages for the insurers' failure to defend and indemnify. SFC sought partial summary judgment that Indiana law governed the interpretation of the policies and that the insurers had a duty to defend. The trial court granted partial summary judgment on these grounds. The insurers sought, and were granted, an interlocutory appeal of the trial court's order.

An Indiana court of appeals reversed the trial court's determination that Indiana law governed the entire dispute. Instead, the court of appeals adopted a "site-specific" approach to choice of law, whereby Indiana law governed the interpretation of the policies with respect to the Indiana site and California law with respect to the California site.

The Indiana Supreme Court reversed the trial court and remanded the case for application of Maryland law to the entire dispute. The court observed that *W.H. Barber Co. v. Hughes,* 223 Ind. 570, 63 N.E.2d 417 (Ind. 1945) provided the following choice-of-law rule in Indiana contracts cases: "The court will consider all acts of the parties touching the transaction in relation to the several states involved and will apply as the law governing the transaction the law of that state with which the facts are in *most intimate contact.*" The general development of Indiana's choice-of-law rules since *W.H. Barber* led the court to conclude that a uniform-contract-interpretation approach was more consistent with Indiana

jurisprudence, as it applied a single state's law to the entire contract. Indiana followed a choice-of-law rule in contracts cases that contemplated contacts in multiple states but applied only the law of the state with the most intimate contacts.

This "most intimate contact" rule was consistent with the approach taken by the *Restatement (Second) of Conflict of Laws* (1971. The *Restatement* approach looked for the state with the "most significant relationship to the transaction and the parties" and, in determining that relationship, considered certain contacts: (1) the place of contracting; (2) the place of negotiation of the contract; (3) the place of performance; (4) the location of the subject matter of the contract; and (5) the domicile, residence, nationality, place of incorporation and place of business of the parties.

Applying the intimate contact rule and *Restatement* approach in SFC's case, the Indiana high court concluded that Maryland was the state with the most intimate contacts. SFC's headquarters was in Maryland, suggesting that it was the principal location of the insured risk. The fifth *Restatement* factor favored Maryland, as it was home to SFC's headquarters when SFC took out the policies. All of SFC's written and verbal communication with the brokers originated from its Maryland headquarters. SFC's insurance procurement, review process, and decision making all occurred in Maryland. The policies were retained in and the premiums were paid from Maryland. Although there was no conclusive evidence of where the contract was formed or the exact location of negotiation, the facts tended to favor Maryland.

Lastly, the supreme court considered the place of performance of the contract, or "the location where the insurance funds will be put to use." The trial court held that Indiana is the place of performance because it was the location of the "single clean-up site where the funds would be used." However, SFC explicitly stated in oral argument before the supreme court that a large amount of its claim arose from SFC successfully defending itself in California, and, after it remediated the site in Indiana, the dollars it received would be put toward the expenses it incurred in California. Thus, the place of performance was not exclusively Indiana. Although none of the factors were determinative, "the overall number and quality of contacts" favored Maryland over Indiana as the state in most intimate contact, and the supreme court held that the substantive law of Maryland applied to the entire dispute. // Holt

Liability Insurance/ Property Damage

Theft of Cash from Credit Union's Cash Machine Is Not "Loss of Use" within Meaning of Servicing Company's Liability Policy's "Property Damage" Definition

Credit Union's Lawsuit against Servicing Company Sought Replacement Value of Misappropriated Cash, Not Rental Value of Temporarily Unusable Property

Advanced Network, Inc. v. Peerless Insurance Co., ___ Cal.App.4th ___, ___ Cal.Rptr.3d ___ , 2010 WL 5030082 (4th Dist., Dec. 10, 2010)

Case at a Glance

The theft of cash in a credit union's cash machine does not result in a "loss of use" of the cash within the meaning of the machine servicing company's liability policy, which defined covered property damage to include the "loss of use of tangible property that is not physically injured." Thus, the insurer had no duty to defend the credit union's claims for conversion against the servicing company.

Summary of Decision

The term "property damage" is defined by most CGL policies to include the "loss of use of tangible property that is not physically injured." The *Advanced Network* case examined the difference between loss of property and loss of *use* of property, and concluded that liability insurance coverage for loss of use applies only to claims seeking compensation for the rental value of temporarily lost property.

Advanced Network, Inc. (ANI) contracted with Mission Federal Credit Union (Mission) to service cash distribution machines in Mission's stores. In October 2004, it was discovered that an ANI employee

had stolen approximately $2 million in cash from Mission's machines, which he concealed by filing false records. Mission made a demand against its fidelity bond holder, Cumis Insurance Company (Cumis), which reimbursed the entire amount, less Mission's deductible. Thereafter, Cumis filed suit against ANI in federal court for equitable subrogation, negligence, breach of contract and respondeat superior.

The issue in the present litigation was whether ANI's commercial general liability insurer, Peerless Insurance Company (Peerless), had a duty to defend and indemnify ANI against liability to Cumis. The CGL policy issued by Peerless defined "property damage" as (1) "Physical injury to tangible property, including all resulting loss of use of that property," and (2) "Loss of use of tangible property that is not physically injured." Peerless denied coverage, taking the position that money is not considered "tangible property" and the theft of money is not a covered occurrence because it is not an "accident."

Following Peerless's rejection of coverage, ANI settled with Cumis for $1,000,000. ANI then sued Peerless for breach of contract and breach of the duty of good faith and fair dealing. Both parties brought summary judgment motions. The trial court denied Peerless' motion, explaining that cash is tangible property, and there was an "occurrence" because from the standpoint of ANI, its employee's theft of cash was unforeseen and unintended. The court also found that while there was no known injury or damage to the stolen cash, there was potential coverage under the "property damage" provision of the CGL policy because Mission Federal "did sustain a 'loss of use' of the bills." The matter proceeded to trial, where ANI prevailed. The trial court awarded ANI $750,000 on the breach of contract claim—the amount of the settlement less the $250,000 contributed by ANI's crime insurer. A jury awarded $2 million in punitive damages and $17,709.19 in attorneys fees ANI incurred in defending the Cumis action. The trial court awarded ANI an additional $170,675 in so-called "*Brandt* fees." Peerless appealed.

The California Court of Appeal, Fourth District, reversed the judgment for ANI and ordered that on remand judgment be entered for Peerless. The court based its ruling on the reasoning of *Collin v. American Empire, Ins. Co,* 21 Cal.App.4th 787, 818, 26 Cal.Rptr.2d 391 (1994) (*Collin*). In *Collin,* the court of appeal held that conversion of furniture was not covered as "loss of use" property damage. The court explained that "loss of use" of property is different from "loss" of the property." "Loss of use" occurs only when the deprivation of property is "temporary," and the claimant seeks compensation for the rental value of the property during the period when she is deprived of its use. In contrast, the conversion of property is the taking or complete deprivation of property, and the claimant seeks compensation for the value of the property itself.

Here, the Fourth District held that the lawsuit brought by Cumis against ANI did not seek recovery for the loss of use of the funds because the cash ANI's employee took was permanently lost and the recovery sought was the replacement value of cash. Because neither the underlying action nor any extrinsic facts showed any claim being made for loss of use, there was no coverage under Peerless' policy and it owed neither a defense nor indemnity to ANI on the action.

ANI also argued that even if the underlying action did not claim "loss of use" under the policy, Peerless was equitably estopped from denying coverage because it did not mention the loss of use prong of the property damage definition in its denial of coverage letter. The court disagreed, holding that Peerless provided ANI sufficient notice by raising the "loss of use" defense in its summary adjudication motion, its joint trial readiness report, and its petition for a writ of mandate challenging the trial court's ruling on loss of use. // DiMugno

Life Insurance

Seventh Circuit Refuses to Reform Life Insurance Policy's Beneficiary Designation

Wisconsin Law Applied

Protective Life Insurance Co. v. Hansen, __ F.3d __, 2011 WL 148812 (7th Cir. [Wis.], January 19, 2011)

Case at a Glance

The Seventh Circuit refused to reform a life insurance policy purchased by a business as "key man" coverage to make the insured's girlfriend the beneficiary. The person in charge of winding up the business, after the insured was found to have misappropriated funds, submitted a form attempting to change the ownership of the policy from the business to the insured, and the insured then submitted a change of beneficiary form naming his girlfriend as the new beneficiary instead of the business. The life insurance company declined to make the requested ownership and beneficiary changes because the change of ownership form was signed by only one person on behalf of the business. The business was incorrectly named in the policy as a corporation rather than a limited liability company, and the insurer required two signatures on behalf of a corporation. The Seventh Circuit found that it could not make assumptions as to what the life insurer would have done if the forms were correctly submitted, and it also found that the equities did not lie in the girlfriend's favor, because the policy was purchased for the company's benefit, not hers.

Summary of Decision

Richard McDonald was the founding member of B&K LLC, a limited liability company that developed, built, owned and operated a gas station and convenience store. He was the manager and day-to-day operator of the station. B&K purchased "key man" life insurance with a death benefit of $1,000,000 on McDonald's life, and assigned its interest in the proceeds as security for various loans.

In 2007, members of the LLC suspected that McDonald was mismanaging the operation, and found that he had appropriated almost $50,000 in funds from the company. B&K removed McDonald as the manager and hired Michael Culligan to wind up the company and liquidate its assets, including the life insurance policy issued by Protective. At the time of the liquidation, the policy was paid through March 1, 2008. Because the cash surrender value was very low, B&K decided to dispose of the policy by letting it lapse. Without informing the members of B&K, Culligan signed and submitted a change of ownership form to Protective in January 2008 asking it to transfer ownership of the policy from B&K to McDonald. McDonald then signed and submitted a change of beneficiary form to change the beneficiary from B&K to his girlfriend, defendant Megan Hansen. He then committed suicide.

Protective allows an LLC to submit an ownership transfer form with only one officer's signature, but a corporation must include at least two corporate officer signatures. The owner named on the policy was incorrectly recorded as "B&K Inc." rather than B&K LLC. When Protective received the ownership transfer form signed only by Culligan, it returned it to him and told him that he would need to obtain the signature of another corporate officer, because according to its records, B&K was a corporation. Culligan did not resubmit the form, so Protective never changed the owner of the policy. Only the owner of a policy can change the beneficiary.

B&K went into receivership, and the liquidation of its assets did not generate enough to pay its secured debt. All members of the LLC had to make cash contributions to pay off the debt, but McDonald refused, forcing other members to cover his share.

Protective filed an action in interpleader after McDonald's death naming Hansen and B&K as defendants. Hansen and B&K filed cross motions for summary judgment, each claiming to be the beneficiary. Hansen contended that she was the beneficiary because (1) B&K and Protective made a mutual mistake when they named "B&K Inc." the owner of the policy, and the policy should be reformed to make the "B&K LLC" the owner; (2) the court should then find that Culligan transferred ownership from B&K to McDonald, because an LLC may transfer ownership with only one signature; and

(3), Hansen would then be the beneficiary because McDonald, as the owner, had the authority to name Hansen as the beneficiary.

The Seventh Circuit rejected Hansen's arguments and found that B&K remained the owner and was entitled to the death benefit. The court did agree that reforming the policy to read "B&K LLC" was proper. However, the court also found that it had no way to know what Protective would have done if B&K had been correctly listed as an LLC, and that transfer of the ownership was not a simple ministerial task. A Protective vice president did testify that if B&K had been listed as an LLC, then Culligan's signature alone would have satisfied its requirements. However, she never testified that Protective would have actually transferred ownership. The court refused to assume what Protective would have done if B&K had been named as an LLC because it found that it had to focus not on what should have happened, but on what actually did happen. Protective rejected the transfer of ownership form, and the court refused to unwind what actually happened.

Hansen also argued that the court should find that McDonald was the owner of the policy because B&K and McDonald formed a binding contract to transfer ownership which Hansen can enforce as an intended third-party beneficiary. The court rejected that argument, finding that the change of ownership form was a contract between B&K and Protective, not McDonald, because he had no control over the form. In addition, there was no evidence that Hansen was the intended third-party beneficiary. Even if the change of ownership form was a contract between B&K and McDonald, it did not mention Hansen.

The court also noted that even if Hansen had satisfied all elements of reformation, it would be improper because the equities did not lie in her favor. B&K purchased the policy to finance its business, and paid all of the premiums. McDonald was a dishonest employee who misappropriated funds. He attempted to transfer ownership of the policy so he could make Hansen the beneficiary before he killed himself. B&K's creditors remained largely unpaid, but Hansen sought a windfall from the policy which was purchased to protect the creditors, not her. She had no connection with B&K's business at all. // Oliver

Property Insurance/"Collapse"

Falling of Decorative Brick from One-third of Structure's Wall Was Not Covered "Collapse"

Building Was Not Reduced to Flattened Form or Rubble

Council Tower Association v. Axis Specialty Insurance Co., __ F.3d __, 2011 WL 31519 (8th Cir. [Mo.] Jan. 6, 2011)

Case at a Glance

Under Missouri law the falling into the street of 7 out of 26 stories of a building's decorative brick veneer was not a "collapse" of all or part of the building covered by insurance. Although the Missouri Supreme Court had not ruled on the issue, Missouri appellate courts have consistently interpreted "collapse" to mean a falling or reduction to a flattened form or rubble. Further, under the broader definition of "collapse" used in other jurisdictions, courts have refused to find a covered "collapse" when there is no substantial impairment of the structural integrity of a building or part of a building. The falling of part of the decorative veneer did not impair the structural integrity of the entire part.

Summary of Decision

Plaintiff Council Tower Association owned a 26-story building covered with decorative brick veneer. The building, located in St. Louis, Missouri, was insured by Axis Specialty Insurance Co., a Connecticut insurer. During the policy coverage period every brick of the veneer below the 8th floor on one wall fell to the ground along with several of the supporting steel shelf angles. Plaintiff filed a timely claim under the policy for reimbursement of its loss. The policy excluded losses for collapse, except under an additional coverage provision that covered damaged caused by collapse of an insured building or any part of the building the collapse was caused by hidden decay. Collapse did not include settling, cracking, shrinkage, bulging or expansion.

After an investigation by Jim Vavak, an independent insurance adjuster in Missouri, Axis denied the claim on the ground that the loss was caused by inadequate design or construction and was therefore excluded. When an expert reported that a loss of lateral stability had caused the bricks to "collapse somewhat vertically" Council Tower commenced a lawsuit against Axis and Vavak in a federal district court in Missouri for breach of contract and vexatious refusal to pay its claim. Plaintiff argued that the wall failure was a collapse of a part of the building caused by decay. Axis countered that the failure was not a covered collapse under Missouri law. The district court granted Axis summary judgment and dismissed all claims.

The Eighth Circuit affirmed the district court's conclusion that the falling of less than one-third of the decorative brick veneer was not a collapse of a part of the building within the meaning of the policy's additional coverage for collapse. The Eight Circuit noted that the Missouri Supreme Court had not addressed the issue, and although only that court's decisions were controlling in a diversity case, the federal court could not disregard decisions of the Missouri Court of Appeals unless it was convinced by other persuasive data that the state high court would decide otherwise. The Eighth Circuit observed that Missouri appellate courts had consistently followed the line of authority interpreting "collapse" to mean a falling or reduction to a flattened form or rubble. (*Williams v. State Farm Fire & Cas. Co.,* 514 S.W.2d 856,8 59 (Mo.App.1974), quoting *Eaglestein,* 377 S.W.2d at 545; *accord Heintz v. U.S.Fid. & Guar. Co.,* 730 S.W.2d 268, 269 (Mo.App.1987.)

Even under the broader definition of "collapse" used in other jurisdictions; the district court concluded that there would be no collapse in plaintiff's case, and the Eighth Circuit agreed. Under that broader definition, rubble on the ground is not necessary for a collapse, and courts focus on whether there was a substantial impairment of the structural integrity of a building or part of a building. Applying this test, the district court concluded that the falling of 7 out of 26 stories of decorative veneer did not impair the structural integrity of the entire part. Therefore, even if the Missouri Supreme Court were to adopt the broader definition, there would be no collapse, the district court determined. The Eighth Circuit agreed.

The Eighth Circuit also upheld the district court's dismissal of claims against Vavak, agreeing that the adjuster's preliminary opinion played no role in Axis' denial of coverage, and that plaintiff failed to show lack of justification for any of the statements in Vavak's report, because his job was to investigate and report to Axis on the cause of loss. // Holt

Public Adjusters

Law Banning Public Adjusters from Initiating Contact with Insured for at Least 48 Hours Declared Unconstitutional

Absolute Ban Violated Adjuster's Free Speech Rights

Kortum v. Sink, __ So.3d __, 2010 WL 5381934 (Fla.App., 1st Dist. Dec. 29, 2010)

Case at a Glance

A statute banning all solicitation of an insured by a public adjuster within 48 hours of the occurrence of a covered event violated free speech requirements of the Florida constitution, and a determination upholding the ban was reversed. The statutory ban was unambiguous, and a state regulatory agency's interpretation that the statute constitutionally regulated only the time, place, and manner of commercial solicitation was therefore rejected. The agency failed to demonstrate the 48 hour ban was justified by the possibility that some public adjuster may unduly pressure traumatized victims or otherwise engage in unethical or unprofessional behavior.

Summary of Decision

Frederick Kortum, a public adjuster in Florida, filed a complaint for declaratory and injunctive relief against the Florida Department of Financial Services alleging that § 626.854(6), Florida Statutes (2008) violated his constitutional rights to free speech, equal protection of the laws, and to be rewarded for his industry. The Department regulated public adjusters.

Section 626.845(6) read: "A public adjuster may not directly or indirectly through any other person or entity *initiate contact or* engage in face to- face or telephonic solicitation or enter into a contract with any insured or claimant under an insurance policy until at least *48* hours after the occurrence of an event that may be the subject of a claim under the insurance policy unless contact is initiated by the insured or claimant." (Emphasis added.)

At trial, Kortum introduced testimony that the first 48 hours after a claim inducing event are critical because an uninformed policyholder can make decisions that would substantially diminish recovery under the insurance policy by failing to preserve evidence, by failing to find damaged property, and by overspending on mitigation or restoration efforts. The Department's expert witness disagreed. Further, the Department asserted that § 626.854(6) did not prohibit a public adjuster from contacting a potential claimant through email or in writing. Both Kortum and his expert witness contended that the statute prohibited contact or communication of any kind with claimants during the 48-hour period.

The trial court determined that the statute was ambiguous and that the agency's interpretation should therefore be upheld unless that construction was clearly unauthorized or erroneous. The court found that the statute regulated conduct and only narrowly affected speech by prohibiting face-to-face solicitations and telephonic solicitations. The trial court further found that a legitimate governmental purpose existed to provide a citizen who has been traumatized by a casualty loss with some "breathing room before making weighty decisions." To accomplish such purpose, the trial court found that § 626.854(6) was narrowly drawn and did not prohibit anything other than face-to-face solicitation and telephonic solicitations. The court concluded that the primary purpose of the statute was to control conduct, but recognized that the statute did affect the public adjuster's ability to speak.

A Florida appellate court reversed and remanded, rejecting the Department's contention that the statute was ambiguous and that, as a result, the Department's interpretation that the statute constitutionally regulated only the time, place, and manner of commercial solicitation should be accepted. The court held that the statute unambiguously banned all solicitation for 48 hours, and that this restriction violated free speech requirements of Article I, § 4 of the Florida constitution. The court concluded that the Department had not demonstrated that prohibiting property owners from receiving any information from public adjusters for a period of 48 hours was justified by the possibility that some public adjuster may unduly pressure traumatized victims or otherwise engage in unethical or unprofessional behavior. Nor had the Department demonstrated that the other provisions of section 626.854 nd the Rules of Professional Conduct and Ethics governing the Florida Association of Public Insurance Adjusters were insufficient to regulate unduly coercive or misleading solicitation by public adjusters. // Holt

Litigation Developments

Lloyd's Syndicate Named as Defendant in U.S. Suit Against BP and Others

By: Joseph G. Grasso* and Charles Platto**

We have endeavored to provide periodic updates with regard to disputes involving insurance coverage of BP and others for the Deepwater Horizon Gulf oil spill. In June, we reported that TransOcean's insurer's had sued BP challenging BP's additional insured claims. *Insurance Litigation Reporter,* Vol. 32, No. 9 (June 18, 2010). In August, we reported that BP counterclaimed along with AIG in a subrogation claim because AIG had paid out on a BP claim. *Insurance Litigation Reporter*, Vol. 32, No. 14 (August 30, 2010).

Now, we have an additional development with regard to BP's coverage. On December 15, 2010, the United States Government brought a major claim against BP and a number of other parties involved in the operation of the mobile offshore drilling rig Deepwater Horizon, as well as a syndicate at Lloyd's of London which had provided a Certificate of Financial Responsibility (COFR) for the Deepwater Horizon under the Oil Pollution Act of 1990 (OPA). *U.S. v. BP Exploration & Production Inc. et al* (E.D. La. 10-cv-04536). In the suit, the Government seeks various damages in connection with the blowout and subsequent oil spill in April 2010. The action seeks penalties and damages from the operating defendants (all those with the exception of the Lloyd's syndicate) under the Clean Water Act (CWA) and a declaration

that the defendants are liable for damages under OPA. The damages include damage to natural resources, clean up expenses, wreck removal expenses and other costs.

The sole claim against the Lloyd's syndicate is in its capacity as a COFR guarantor under OPA, and the complaint notes that suit may be brought directly against the insurer in its capacity as a guarantor (damages payable by the Lloyd's syndicate would be limited to "the amount of its COFR guarantee").

We will continue to monitor this proceeding as well as.

* Mr. Grasso is the current Co-Chair of the Insurance Practice Group of Wiggin and Dana LLP and Chair of the Committee on marine insurance and General Average of the U.S. Maritime Law Association. He is counsel to the American Institute of Marine Underwriters and wrote the Institute's amicus brief to the United States Supreme Court in the Exxon Valdez case. Mr. Platto and Mr. Grasso have been appointed as co- editors of the Additional Insured Handbook, to be published by the American Bar Association in 2011.

** Mr. Platto is Adjunct Professor of Insurance Law and Litigation at Fordham Law School, a Vice Chair of the ABA Insurance Coverage Litigation Committee and a Member of the Editorial Board of the Insurance Litigation Reporter. He was formerly Chair of the Insurance Practice Group at Wiggin and Dana LLP, and previously a partner at Cahill Gordon & Reindel, and is now an independent arbitrator and mediator in domestic and international commercial and insurance matters.

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