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Reconsidering the Fraud Exception to the Parol Evidence Rule and Its Impact on Insurance: *Riverisland Cold Storage, Inc. v. Fresno-Madera Production Credit,* 55 Cal.4th 1169 (Cal.)

by John K. DiMugno

John K. DiMugno is a member of the California bar. He is an advisor and expert witness on a wide variety of insurance coverage and bad faith issues for both policyholders and insurance companies. His experience encompasses every type of insurance—personal lines, commercial lines, commercial general liability, D&O, umbrella excess liability, health and disability, and property insurance. He is a frequent speaker on insurance law topics and a former member of the adjunct faculty at the University of California at Berkeley, Boalt Hall School of Law, where he taught insurance law. He is the Editor–in–Chief of *Insurance Litigation Reporter, California Tort Reporter,* and *California Insurance Law & Regulation Reporter*, the author of numerous articles, and a co-author of several books, including "California Insurance Law Handbook," "California Insurance Laws Annotated," and "CAT Claims: Insurance Coverage for Natural and Man-Made Disasters." He is an elected member of the American Law Institute's Consulting Group on "Principles of Liability Insurance."

Insurance law is a specialized application of general contract law. Judicial decisions that do not involve insurance can have significant implications for contract disputes between insurers and insureds.

The California Supreme Court's decision in *Riverisland Cold Storage, Inc. v. Fresno-Madera Production Credit,* 55 Cal.4th 1169, 151 Cal.Rptr.3d 93, 291 P.3d 316 (2013), involved a dispute between delinquent mortgagor-borrowers and their lender. It will affect coverage disputes in which insureds allege that the insurer or its agent misrepresented policy terms.

Until *Riverisland,* the California Supreme Court's broad interpretation of the parol evidence rule in *Bank of America National Trust & Savings Ass'n v. Pendergrass,* 4 Cal.2d 258, 48 P.2d 659 (1935) (*Pendergrass)*, made proof of promissory fraud difficult in California. In *Riverisland,* the supreme court ended *Pendergrass's* 78-year reign and restored the full force of the fraud exception to the parol evidence rule. As a result, insurers and other defendants in fraud and misrepresentation cases are less likely to obtain summary judgment on the ground that the parol evidence rule bars extrinsic evidence of promises "directly at variance with the promise of the writing."[1] During *Riverisland*'s short reign, insureds already have invoked the decision to defeat parol evidence rule defenses to promissory fraud claims.[2]

The *Riverisland* Case

The *Riverisland* case involves the type of dispute that has become all too common during of the economic crisis of past few years. Plaintiffs fell behind on their loan payments to defendant Fresno-Madera Production Credit Association ("Credit Association") in 2006. On March 26, 2007, plaintiffs entered into a written loan modification agreement with the Credit Association in which plaintiffs confirmed delinquent payments totaling $776,380. The agreement provided that the Credit Association would take no enforcement action for approximately *three months*, until July 1, 2007, if plaintiffs made the required payments. Plaintiffs also signed a security agreement pledging *eight parcels* as additional collateral, and initialed each page of the agreement bearing the legal descriptions of the parcels.

Despite the terms of the written loan modification, plaintiffs made no payments after signing it. The Credit Association recorded a notice of default on

1. *Eastwood Insurance Services, Inc. v. Titan Auto Insurance of New Mexico,* 469 Fed.Appx. 596, 2012 WL 619531 (9th Cir. [Cal.] Feb. 27, 2012), *quoting Bank of America National Trust & Savings Ass'n v. Pendergrass,* 4 Cal.2d 258, 48 P.2d 659 (1935). *Accord, Diamond Insurance Co. v. Marin County Bikes,* 2012 WL 6680259 (N.D.Cal., Dec. 21, 2012) (dismissing fraud claim because alleged oral misrepresentations about insurance coverage contradicted terms of policy).
2. *Negrete v. Allianz Life Insurance Co. v. North America,* __ F.Supp.2d __, 2013 WL 753475 (C.D. Cal., Feb. 27, 2013)

March 21, 2008, nearly nine months after it was authorized to do so under the loan modification agreement. At that point, plaintiffs paid off the loan in full and the Credit Association dismissed its foreclosure proceedings.

Plaintiffs then sued the Credit Association. They sought damages for fraud and negligent misrepresentation, rescission, and reformation of the loan modification agreement. They alleged that two weeks before signing the March 7, 2007 loan modification agreement, they met with the Credit Association's vice president, who told them the Credit Association would extend the loan for *two years* in exchange for collateral consisting of *two ranches,* not the eight parcels they eventually pledged in the modification and security agreements. They further alleged that in reliance on the vice president's oral representations, they did not read the agreement, but simply signed it at the locations tabbed for signature. Thus, they claim they thought they were signing an agreement for a two-year forbearance, not the three-month forbearance promise in the written agreement, in exchange for two parcels of land, not the eight parcels in the written agreement.

The Credit Association moved for summary judgment on the ground that the parol evidence rule barred evidence of any representations contradicting the terms of the written loan modification agreement. In opposition, plaintiffs argued that the vice president's misrepresentations were admissible under the fraud exception to the parol evidence rule. Relying on *Pendergrass, supra,* the trial court granted summary judgment, ruling that the fraud exception does not allow parol evidence of promises at odds with the terms of the written agreement.

The Court of Appeal reversed, and the California Supreme Court granted review to decide the scope of the fraud exception to the parol evidence rule in California.

The Parol Evidence Rule and *Pendergrass*

In contract disputes, including insurance contract disputes, the parol evidence rule bars a litigant from introducing extrinsic evidence that contradicts the terms of an integrated written agreement.[3] Although the parol evidence results in the exclusion of evidence, it is not a rule of evidence, but a substantive rule that establishes the enforceable terms of a contract. Courts often describe the purpose of the rule as ensuring that the parties' final understanding, deliberately expressed in writing, is not subject to change.[4]

The parol evidence rule is subject to an exception allowing parol evidence to establish fraud[5] or to dispute the validity of a written agreement.[6] Despite this statutory language, the *Pendergrass* court imposed limitations on the fraud exception that made introduction of prior or contemporaneous statements at odds with the language of a written contract difficult in California. *Pendergrass* was factually similar to *Riverisland.* After borrowers fell behind on their payments, they and the bank agreed on a new promissory note, which was secured by additional collateral and payable on demand. When the bank seized the encumbered property and sued to enforce the note, the borrowers claimed the bank had assured them it would give them time to raise and harvest their crop and that it would accept the proceeds of the sale of the crop as payment. The borrowers alleged that the bank had no intention of performing these promises, but made them for the fraudulent purpose of obtaining the new note and additional collateral.

The supreme court in *Pendergrass* ruled that the bank's promises not to require payment until the borrowers sold their crop was inadmissible under the parol evidence rule. In finding the fraud exception inapplicable, the court formulated a very narrow understanding of the fraud exception:

> Our conception of the rule which permits parol evidence of fraud to establish the invalidity of the instrument is that it must tend to establish some independent fact or representation, some fraud in the

3. Code of Civil Procedure § 1856 and Civil Code § 1625.
4. *See, e.g.*, *Casa Herrera, Inc. v. Beydoun*, 32 Cal.4th 336, 345, 9 Cal.Rptr.3d 97, 83 P.3d 497 (2004).
5. Code of Civil Procedure § 1856 subdivision (g) provides: "This section does not exclude other evidence ... to establish ... fraud."
6. Code of Civil Procedure § 1856, subdivision (f) provides: "Where the validity of the agreement is the fact in dispute, this section does not exclude evidence relevant to that issue."

> procurement of the instrument or some breach of confidence concerning its use, *and not a promise directly at variance with the promise of the writing.* We find apt language in *Towner v. Lucas' Exr.* [(1857)] 54 Va. (13 Gratt.) 705, 716, in which to express our conviction: "It is reasoning in a circle, to argue that fraud is made out, when it is shown by oral testimony that the obligee contemporaneously with the execution of a bond, promised not to enforce it. Such a principle would nullify the rule: for conceding that such an agreement is proved, or any other contradicting the written instrument, the party seeking to enforce the written agreement according to its terms, would always be guilty of fraud. The true question is, Was there any such agreement? And this can only be established by legitimate testimony. For reasons founded in wisdom and to prevent frauds and perjuries, the rule of the common law excludes such oral testimony of the alleged agreement; and as it cannot be proved by legal evidence, the agreement itself in legal contemplation, cannot be regarded as existing in fact."[7]

In other words, parol evidence may be introduced under the fraud exception only to prove fraud in the execution of a contract—essentially that the proponents of extrinsic evidence believed they were signing a different agreement than they signed. Examples of "fraud in the execution" include a party's substitution of a new document of the same kind as the one previously read and agreed to by the other party but containing materially different terms. The fraud exception does not permit proof of promissory fraud—that the promisor made a promise without the intention of performing in order to induce plaintiff to enter into a contract—based on a prior or contemporaneous oral agreement that contradicts the terms of a written agreement.[8] The trial court in *Riverisland* relied on the literal language of *Pendergrass* to exclude evidence of the bank vice president's oral promises.

In the nearly 80 years that *Pendergrass* remained the law of California,[9] courts endeavored to create "detours" around the decision based on "elusive" distinctions. The most well developed "detour" was the distinction between false *promises* at variance with the terms of a contract and misrepresentations of *fact* about the contents of the document, with the former being inadmissible and the later being admissible.[10] Some courts have put a temporal gloss on the "misrepresentation of fact" exception to *Pendergrass,* holding that the exception applies only to "misrepresentations of fact over the content of an agreement *at the time of signing*."[11] In *Riverisland,* the court of appeal relied on the distinction between "false promises" statements and "misrepresentations of fact" in reversing the trial but expanded the distinction's temporal reach by holding that the "misrepresentation of fact" exception to the parol

7. *Pendergrass, supra,* 4 Cal.2d at pp. 263-264, 48 P.2d 659 (Emphasis added).

8. During the *Pendergrass* reign, California courts were in the minority in allowing the introduction of parol evidence only when the alleged fraud does not vary the terms of an integrated writing. Nationally, the majority of courts follow the Restatement (Second) of Contracts § 214 or the Restatement (First) of Contracts § 238 (1932), and allow parol evidence of contradictory prior representations to establish fraud. *See, e.g., Touche Ross, Ltd. v. Filipek*, 7 Haw. App. 473, 778 P.2d 721, 728 (1989) ("The majority rule admits the parol or extrinsic evidence even though it conflicts with the terms of the integrated written instrument."); *Pinnacle Peak Developers v. TRW Investment Corp.*, 129 Ariz. 385, 631 P.2d 540 (Ariz. App. 1980) (collecting cases); *Howell v. Oregonian Publishing Co.*, 85 Ore. App. 84, 735 P.2d 659 (1987). However, the California court were not alone in excluding parol evidence of promissory fraud. *Regus v. Gladstone Holmes, Inc.*, 207 Cal.App.2d 872, 25 Cal. Rptr. 25 (1962); *Greenwald v. Food Fair Stores Corp.*, 100 So.2d 200 (Fla., 1958); *Simmons v. Wooten*, 241 Ga. 518, 246 S.E.2d 639 (1978); *Jack Richards Aircraft Sales, Inc. v. Vaughn*, 203 Kan. 967, 457 P.2d 691 (1969); *Lougbery v. Central Trust Co.*, 258 Mass. 172, 154 N.E. 583 (1927); *Dahmes v. Industrial Credit Co.*, 261 Minn. 26, 110 N.W.2d 484 (1961); *Hoff v. Peninsula Drainage Dist. #2*, 172 Or. 630, 143 P.2d 471 (1943); *Kilgore v. Hix*, 205 Tenn. 564, 327 S.W.2d 474 (1959); and *Beers v. Atlas Assur, Co.*, 215 Wis. 165, 253 N.W. 584 (1934).

9. As recently as 2004, the California Supreme Court reaffirmed *Pendergrass* in *Casa Herrera, Inc. v. Beydoun*, 32 Cal.4th 336 (2004), stating that "the parol evidence rule, as a practical matter, provides 'absolute protection from liability' for prior or contemporaneous *statements* at variance with the terms of a written integrated agreement." (*Id.* at 347, fn. omitted, emphasis added.)

10. *Continental Airlines, Inc. v. McDonnell Douglas Corp.* (1989) 216 Cal.App.3d 375

11. *Pacific State Bank v. Greene*, 110 Cal.App.4th 375, 392, 394, 396 (2003) (emphasis added).

evidence rule encompasses any "false *statement* about the terms contained in the contract" made "after the written contract was prepared."[12]

The problem with the distinction between false promises and misrepresentation of fact was that it often produced unpredictable and divergent results when applied to apparently indistinguishable facts. What one court found to be an inadmissible "promise," another court found to be an admissible "misrepresentation of fact." For example, *Bank of America v. Lamb Finance Co.*, 179 Cal.App.2d 498 (1960) (inadmissible false promise); *West v. Henderson*, 227 Cal.App.3d 1578 (1991) (inadmissible false promise); *Pacific State Bank v. Greene* (2003) 110 Cal.App.4th 375 (2003) (admissible misrepresentation of fact); and the court of appeal in *Riverisland* (admissible misrepresentation of fact) reached different results on substantively similar facts. In another case, *Continental Airlines, Inc. v. McDonnell Douglas Corp.*, 216 Cal.App.3d 388, 264 Cal.Rptr. 779 (1989), the court of appeal examined similar statements in pre-contract sales brochures and found that certain statements qualified as admissible misrepresentation while others were inadmissible false promises. After examining *Continental,* the supreme court in *Riverisland* pronounced the distinction "elusive" at best.

Pendergrass Revisited and Overruled

To borrow a phrase from former California Supreme Court Justice Stanley Mosk, plaintiffs in *Riverisland* came to the court asking for a loaf of bread and the court gave them the entire bakery.[13] Rather than attempt to sort out and clarify the "tenuous"[14] distinctions employed to avoid the harsh results under *Pendergrass*, the court unanimously overruled *Pendergrass* "and its progeny."[15] Justice Corrigan's opinion thoroughly repudiates *Pendergrass,* stating that the decision was "bad policy,"[16] "inconsistent with the governing statute,"[17] "poorly reasoned,"[18] an "aberration" that "led to instability in the law,"[19] "out of step with established California law,"[20] divergent "from the path followed by the Restatements, the majority of other states, and most commentators,"[21] the cause of "vagaries of its interpretation in the Courts of Appeal,"[22] and was a decision with "diminished"[23] weight because it "departed from an established general rule without discussing the contrary authority."[24]

Her opinion relied heavily on Professor Justin Sweet's oft-cited article criticizing the *Pendergrass* rule, *Promissory Fraud and the Parol Evidence Rule*, 49 Cal. L.Rev. 877 (1961). The overriding concern expressed by the court and Professor Sweet was that the *Pendergrass* rule, "while intended to prevent fraud, . . . may actually provide a shield for fraudulent conduct."[25] As Professor Sweet observed, "[p]romises made without the intention on the part of the promisor that they will be performed are unfortunately a facile and effective means of deception."[26] Accordingly, the court concluded that excluding parol evidence to prove promissory fraud can "undermine[] the essential validity of the parties agreement" because "[w]hen fraud is proven, it cannot be maintained that the parties freely entered into an agreement reflecting a meeting of the minds."[27]

The court went on to note a number of other reasons raised in Professor Sweet's article for

12. *Riverisland Cold Storage, Inc. v. Fresno-Madera Production Credit,* 119 Cal.Rptr.3d 380, 391 (5th Dist. 2011).
13. *Moradi-Shalal v. Fireman's Fund Insurance Cos.,* 46 Cal.3d 287, 314, 758 P.2d 58, 250 Cal.Rptr. 116 (1988), J. Mosk, dissenting ("The insurance industry asked for a loaf of bread. The majority, with remarkable magnanimity, give it the whole bakery.")
14. 55 Cal.4th at 1177.
15. 55 Cal.4th at 1182.
16. 55 Cal.4th at 1179.
17. 55 Cal.4th at 1179.
18. 55 Cal.4th at 1180.
19. 55 Cal.4th at 1182.
20. 55 Cal.4th at 1181.
21. 55 Cal.4th at 1179.
22. 55 Cal.4th at 1180.
23. 55 Cal.4th at 1180.
24. 55 Cal.4th at 1172.
25. 55 Cal.4th at 1172.

abandoning *Pendergrass,* including:

- The decisions leading up to the *Pendergrass* decision did not support making the fraud exception to the parol evidence rule inapplicable to promissory fraud cases. (*Promissory Fraud* at pp. 881-83, citing decisions such as *Lompoc Valley Bank v. Stephenson*, 156 Cal. 350 (1909); *Harrison v. McCormick*, 89 Cal. 327 (1891); and *Consolidated Lumber Co. Frew*, 32 Cal. App. 118 (1916). Indeed, in an earlier decision, *Langley v. Rodriguez*, 122 Cal. 580 (1898), the California Supreme Court had specifically recognized "a promise made without any intention of performing it" as a type of "actual fraud" that would be admissible despite the contrary terms of a subsequent written contract. (*Promissory Fraud, supra*, 49 Calif. L. Rev. at p. 882, citing *Langley, supra*, 122 Cal. at p. 581-82.)

- The *Pendergrass* approach found no support in the language of Civil Code §§ 1572 and 1710, which both define fraud to include a "promise made without any intention to perform it." (*Promissory Fraud*, 49 Calif. L. Rev. at p. 880.)

- The authorities upon which the *Pendergrass* court relied did not support its holding. The primary case it cited, *Towner v. Lucas' Ex'r*, 54 Va. (13 Gratt.) 705 (1857), a Virginia case, did not involve promissory fraud, and the passage from Wigmore upon which this Court relied, and which cited the Virginia case, likewise was not cited "to support his view that only evidence of actual fraud is exempted from the parol evidence rule." (*Promissory Fraud, supra*, 49 Calif. L. Rev. at p. 884, citing 9 Wigmore Evidence § 2439 (3d. Ed. 1940).)

- The Courts of Appeal have had substantial difficulty applying the *Pendergrass* holding, leading to instability and unpredictability in the law. (*Promissory Fraud, supra*, 49 Calif. L. Rev. at pp. 885-87.)

Proof of Promissory Fraud after *Riverisland*

The California Supreme Court's decision in *Riverisland,* by allowing plaintiffs to prove a false promise was made, removes a significant hurdle to recovery for promissory fraud and undoubtedly will allow plaintiffs to more easily defeat defendants' motions for summary judgment. But other obstacles remain. As the supreme court observed, recovery for promissory fraud requires more than "proof of an unkept promise or mere failure of performance."[28] Plaintiffs must still satisfy the heightened pleading standard for fraud actions, which requires that each element of a fraud claim be alleged with particularity, including the intent element. Furthermore, the party alleging fraud may have credibility problems when faced with their signature on an unambiguous written document. The standard jury instructions advise jurors to consider the following questions: "Did the witness have any reason to say something that was not true?" "Does the witness have a personal stake in how this case is decided?"[29] Plaintiffs will have to convince the trier of fact that statements made in preliminary

26. 49 Cal. L.Rev. at 896, quoted in supreme court's *Riverisland* opinion at 55 Cal.4th at 1177. *See, also, Howell v. Oregonian Publishing Co.*, 85 Or.App. 84, 735 P.2d 659, 661 (1987) ("Oral promises made without the promisor's intention that they will be performed could be an effective means of deception if evidence of those fraudulent promises were never admissible merely because they were at variance with a subsequent written agreement."); 6 Corbin on Contracts,§ 25.20[A], p. 280 ("The best reason for allowing fraud and similar undermining factors to be proven extrinsically is the obvious one: if there was fraud, or a mistake or some form of illegality, it is unlikely that it was bargained over or will be recited in the document. To bar extrinsic evidence would be to make the parol evidence rule a shield to protect misconduct or mistake.").

27. 55 Cal.4th at 1182. *See also Dellcar & Co. v. Hicks* (N.D. Ill. 1988) 685 F. Supp. 679, 681 ("Both parties make reference to the fraud 'exception' to the parol evidence rule. As should be plain, this is a *non sequitur*. A showing that one was fraudulently induced into executing a contract assumes no valid contract exists, whereas application of the rule requires the existence of a valid contract.").

28. 55 Cal.4th at 1183.

29. California Civil Jury Instructions § 107.

negotiations are indeed misrepresentations.

Plaintiffs also still must prove the justifiable reliance element of fraud or misrepresentation claims, and defendants will invoke plaintiffs' admission that they did not read the policy as a defense. In *Rosenthal v. Great Western Fin. Securities Corp.*, 14 Cal.4th 394, 419, 58 Cal.Rptr.2d 875, 926 P.2d 1061 (1996), the supreme court ruled that a plaintiff's failure to read the contract at issue precluded a claim for fraud in the *execution* of the contract, reasoning that "[o]ne party's misrepresentations as to the nature or character of the writing do not negate the other party's apparent manifestation of assent, if the second party had "'reasonable opportunity to know of the character or essential terms of the proposed contract.'" In *Riverisland,* however, the court was careful to limit *Rosenthal* to fraud in the execution claims and refused to "explore the degree to which failure to read the contract affects the viability of a claim of fraud in the inducement."[30]

In the insurance context, a line of California cases has held that an insured who fails to read her policy cannot establish the justifiable reliance element of a cause of action for fraud or negligent misrepresentation based on her insurer's false representations regarding coverage where the policy excludes coverage in plain, clear, and conspicuous language.[31] Courts in other jurisdictions have reached similar results.[32] However, other cases have distinguished rulings such as *Spray, Gould* and *Hadland* on the ground that, when there is no dispute regarding the policy terms or their meaning, but instead the dispute concerns an agent actively misleading an applicant/insured as to the effect of the policy terms, then the insured's failure to read the policy does not defeat justifiable reliance.[33]

In another context, the supreme court ruled that, "a presumption, or at least an inference, of reliance arises wherever there is a showing that a misrepresentation was material."[34] And, in *Engalla v. Permanente Medical Group, Inc.*, 15 Cal.4th 951, 64 Cal.Rptr.2d 843, 938 P.2d 903 (1997), the supreme court held that the arbitration provision in a health care service plan was unenforceable due to the plan's misrepresentation of the nature of the arbitration procedure. In so ruling, the court observed that in fraud in the inducement cases:

> A misrepresentation is judged to be "material" if "a reasonable man would attach importance to its existence or nonexistence in determining his choice of action in the transaction in question" [citations omitted], and as such materiality is generally a question of fact unless the "fact misrepresented is so obviously unimportant that the jury could not reasonably find that a reasonable man would have been influenced by it." (Rest.2d Torts, §

30. 55 Cal.4th at 1183.

31. *Spray, Gould & Bowers v. Associated Internat. Ins. Co.,* 71 Cal.App.4th 1260, 1272, 84 Cal.Rptr.2d 552 (1999); *Hadland v. NN Investors Life Ins. Co.*, 24 Cal.App.4th 1578, 1584–1587, 30 Cal.Rptr.2d 88, 91–94 (4th Dist.1994); *Hackethal v. National Casualty Co.*, 189 Cal.App.3d 1102, 1111, 234 Cal.Rptr. 853, 857 (2d Dist.1987); *Taff v. Atlas Assur. Co.*, 58 Cal.App.2d 696, 137 P.2d 483 (2d Dist.1943). *See, also*, *Aetna Casualty & Surety Co. v. Richmond*, 76 Cal.App.3d 645, 652, 143 Cal.Rptr. 75, 79 (2d Dist.1977) ("[i]t is a general rule that the receipt of [the] policy binds the insured, as well as the insurer, and the insured cannot thereafter complain that he or she did not read it or know its terms. It is [the] duty of the insured to read the policy"); *Malcom v. Farmers New World Life Ins. Co.*, 4 Cal.App.4th 296, 304 n. 6, 5 Cal.Rptr.2d 584, 588 n. 6 (4th Dist.1992) ("'A reasonable person will read the coverage provisions of an insurance policy to ascertain the scope of what is covered.' ... Generally the insured is 'bound by clear and conspicuous provisions' in the policy even if evidence suggests that the insured did not read or understand them."). *But see Clement v. Smith*, 16 Cal.App.4th 39, 44–45, 19 Cal.Rptr.2d 676, 678–679 (4th Dist.1993) (an insurance agent may be liable for negligent misrepresentations regarding the extent to which an insured is covered, when the insured's reliance on the information was reasonable and the insured would have purchased additional insurance had he known the coverage was not adequate. "Absent some notice or warning, an insured should be able to rely on an agent's representations of coverage without independently verifying the accuracy of those representations by examining the relevant policy provisions.").

32. *Southern Healthcare Services, Inc. v. Lloyd's of London,* __ So.3d __, 2013 WL 628661 (Miss., Feb. 21, 2013) (insured could not recover based on their insurer's agent's failure to disclose their liability policy's $250,000 self-insured retention where they did not read the policy).

33. *Paper Savers, Inc. v. Nacsa,* 51 Cal.App.4th 1090, 1102, 59 Cal.Rptr.2d 547 (1996); *Broberg v. Guardian Life Ins. Co. of Am.,* 171 Cal.App.4th 912, 923, 90 Cal.Rptr.3d 225 (2009); *Dias v. Nationwide Life Insurance Company,* 700 F.Supp.2d 1204 (E.D. Cal. 2010).

34. *In re Tobacco II Cases*, 46 Cal. 4th 298, 326 (2009).

> 538, com. e, p. 82.) *Thus, the Engallas need only make a showing that the misrepresentations were material, and that therefore a reasonable trier of fact could infer reliance from such misrepresentations, in order to survive this summary-judgment-like proceeding, absent evidence conclusively rebutting reliance.*[35]

In *Engalla,* the health plan was purchased by the plaintiff's employer, and the employer's representative read the arbitration provision before purchasing the health plan. There therefore was no need to address whether an insured's failure to read the policy precludes a court from inferring reliance from the materiality of the misrepresentation. The supreme court could have clarified the broader applicability of the *Engalla* reliance analysis in *Riverisland,* but chose not to do so. Consequently, the full impact of the *Riverisland* decision on insurance disputes remains unsettled.

35. 15 Cal.4th 976-977.

In Re: Deepwater Horizon Insurance Litigation – Fifth Circuit Reverses in Favor of BP's Additional Insured Claim

By Charles Platto*, Joseph G. Grasso**, and Michael Menapace***

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During the very same week in which the trial of the multibillion dollar claims by the U.S. Government and private parties against BP and the other parties involved with the Deepwater Horizon drilling rig was just getting under way in Federal Court in New Orleans, the Fifth Circuit Court of Appeals was putting the finishing touches on its decision in the declaratory judgment case brought by Transocean's primary and excess insurers against BP, involving BP's claim for coverage as an additional insured under Transocean's policies. In a decision issued on Friday, March 1, 2013, the Fifth Circuit unanimously reversed the decision of the E.D.La., which had previously granted judgment in the insurers' favor denying coverage to BP. In a major victory for BP, the Fifth Circuit ruled that BP was entitled to coverage as an additional insured under the Transocean policies. *In Re: Deepwater Horizon, Ranger Ins., Ltd., Transocean Offshore Deepwater Drilling., Inc., et al. and Certain Underwriters at Lloyd's London, v. BP P.L.C. et al.*, No. 12-30230, 2013 WL 776354.

We have been following and reporting on this case since its inception. (Insurance Litigation Reporter, Vol. 32, No. 9, Vol. 32, No. 14, Vol 33, No. 1, Vol 33, No. 20). As previously reported, Transocean maintained primary and excess liability coverage in the amount of $750 million covering the period during which the explosion of the Deepwater Horizon drilling rig took place. Transocean was a contractor to BP, and BP and its affiliated entities were named as additional insureds under the policies. The dispute with the insurers arose because under the Drilling Contract between BP and Transocean, Transocean was only obligated to indemnify BP and to name BP as an additional insured for surface pollution, and the major pollution claims resulted from subsurface pollution resulting from the well blowout. However, there was a question as to whether the insurance policies were similarly limited.

In its decision issued on November 15, 2011, the District Court, applying Texas Law, held that the additional insured coverage was only as broad as the indemnity requirements in the underlying contract and, therefore, denied coverage to BP and issued judgment on the pleadings in favor of the insurers. 2011 WL 5547259 at 75.

The Fifth Circuit ruled to the contrary:

"Applying Texas law, especially as clarified since the district court's decision, we find that the umbrella insurance policy [and the primary insurance policy as well]—not the indemnity provisions of Transocean's and BP's contract—controls the extent to which BP is covered for its operations under the Drilling Contract. Because we find the policy imposes no relevant limitations upon the extent to which BP is covered, we REVERSE the judgment of the district court and

REMAND the case for entry of an appropriate judgment in accordance with this opinion." __ F.3d __, 2013 WL 776354, at *1.

The Fifth Circuit reached this conclusion for the following reasons.

Initially, the Court of Appeals noted that the $50 million primary policy issued by Ranger Insurance Ltd., and the $700 million excess policies had materially identical provisions, so it treated all insurers as one for purposes of its decision. *Id.* The Drilling Contract between Transocean and BP required that Transocean maintain insurance covering its operations, and that BP be named as an additional insured under Transocean's policies. *Id.* at *2. The parties agreed that the Drilling Contract was an "insured contract" under the policies. The issue in contention was the scope of BP's insurance coverage. *Id.* at *2.

Under Article 24 of the Drilling Contract, Transocean was responsible for, and indemnified BP with respect to, pollution or contamination originating on or above the surface of the water, whereas BP was responsible for, and indemnified Transocean with respect to, pollution or contamination not assumed by Transocean, i.e. originating from sub surface conditions (such as the well blow out). *Id.* at *2. The District Court had found that the Drilling Contract only required Transocean to carry insurance and name BP as an additional insured for above surface pollution, and that the policies that were obtained by Transocean only provided coverage to the extent of Transocean's contractual liabilities. The Court of Appeals disagreed.

The Court of Appeals conducted a de novo review of the District Court's decision granting judgment on the pleadings to the insurers and of the contract and the policies. *Id.* at *3 It applied standard principles under Texas law, holding that if there are ambiguities in or more than one reasonable interpretation of a policy, coverage will be interpreted in favor of the insured. *Id. at *3*. As applied to this case, the Court was guided by the following principle:

"Under Texas law, to discern whether a commercial umbrella insurance policy [or the primary policy], that was purchased to secure the insured's indemnity obligation in a service contract with a third party also provides direct liability coverage for the third party, we look to the terms of the umbrella policy itself, instead of looking to the indemnity agreement in the underlying contract. We apply this analysis so long as the indemnity agreement and the insurance coverage provision are separate and independent." *Id.* at *4 (internal citations omitted).

Applying this analysis, the Court of Appeals looked first to the policy language, and applied Texas law as set forth in *Evanston Ins. Co. v. ATOFINA Petrochems, Inc.*, 256 S.W.3d 660 (Tex. 2008) and *Aubris Resources LP v. St. Paul Fire & Marine Ins. Co.*, 566 F. 3d 483 (5th Cir. 2009), which the District Court had distinguished, and *Pasadena Refining System, Inc. v. MCraven*, Nos. 14-10-00837-CV, 14-10-00860-CV, 2012 WL 1693697 (Tex. App. May 15, 2012), which came down after the District Court's opinion, in concluding that even if the indemnity obligations of Transocean were limited under the Drilling Contract, only the policy itself may establish limits upon the extent to which an additional insured is covered. *Id.* at *6. The Court found that, as in *ATOFINA*, *Aubris* and *Pasadena Refining*, the fact that the policy referred to the underlying contract in the definition of additional insured was not sufficient, without more, to impose any limitations of liability in the underlying contract, on the policy obligations. *Id.* at *7. The Court of Appeals concluded that "there is no relevant limitation to BP's coverage under the policy as an additional insured, that is so long as the insurance provision and the indemnities clauses in the Drilling Contract are separate and independent." *Id.* (internal citations omitted). The Court of Appeals then went on to hold that it is "unmistakable" that the provision in the Drilling Contract extending direct insured status to BP was separate and independent from BP's agreement to forego contractual indemnity in various circumstances. *Id*. at *8 (internal citations omitted).

The Court of Appeals' final conclusion was as follows:

> Because we find that the umbrella policies [and the underlying policy] between the Insurers and Transocean do not impose any relevant limitation upon the extent to which BP is an additional insured, and because the additional insured provision in the Drilling Contract is separate from and additional to the indemnity provisions therein, we find BP is entitled to coverage under each of Transocean's policies as an additional insured

as a matter of law. *Id.* at *9.

Thus, the bottom line is quite simple. Even if the obligations of an additional insured are limited in an underlying contract, if the insurance policy is broader than those obligations, unless the policy provides specific limitations on coverage to the additional insured—by specific reference to the limitations in the underlying contract, or otherwise, at least under Texas law, the policy will provide the full extent of coverage to the additional insured.

This case represents an important development in additional insureds law, and carriers will undoubtedly in the future more carefully tailor their policies to limit coverage to additional insureds if there are limits in the underlying contracts. The decision also represents a major win for BP, to the tune of $750 million. (Of course, compared to the billions BP has already spent as a result of the Gulf Oil spill, and the billions at issue in the current trial, $750 million may not seem like so much, but as they say, every little bit helps.)

Agents & Brokers

Failure to Read Insurance Policy Is Not a Complete Bar to Malpractice Suit Against Broker

Failure to Read Might Constitute Contributory Negligence

O&G Industries, Inc. v. Aon Risk Services Northeast, Inc., — F.Supp.2d —, 2013 WL 424774 (D. Conn. Jan. 29, 2013)

Case at a Glance

Under Connecticut law, the insured's agreement to read the insurance policy and notify the broker of any inadequacies with the procurement will not bar a claim for malpractice against the insurance broker when the insured failed to notify the broker of the inadequate coverage that had actually been purchased. At best, the conduct of the insured, in violating its agreement to read the policy and notify the broker of any problems would give rise to a possible defense of contributory negligence but would not be a complete bar to the suit.

Summary of Decision

Plaintiffs O&G Industries, Inc. and Kleen Energy Systems entered into an "Engineering, Procurement and Construction Agreement" ("EPC Agreement") in connection with a construction project. The EPC Agreement required O&G to provide insurance to protect O&G from claims arising out of O&G's operations. The EPC Agreement also required O&G to maintain CGL insurance on an occurrence basis with defense expenses paid in addition to policy limits. To fulfill these obligations, O&G entered into a Service Agreement with Aon Risk Services to procure insurance for the project. A Contractor Controlled Insurance Program (CCIP) was utilized which included general liability coverage. The Service Agreement entered into between O&G and Aon required O&G to review all insurance policies procured by Aon to insure that they were accurate as to the insurance coverage terms, requirements and policy limits. O&G was also required to notify Aon of any errors or desired changes in the policies.

A large explosion occurred at the project site. As a result of the explosion there were various deaths, injuries and losses. At the time of the explosion, it was learned that the CCIP procured by Aon should have included defense costs outside of limits. O&G alleged that it had requested that Aon provide the coverages outlined in the EPC Agreement and that Aon was aware or should have been aware that the EPC Agreement required umbrella/excess liability coverage that included defense costs. Aon raised as a defense to the claim that the CCIP participants failed to review the policies procured by Aon to make sure they fit within their insurance needs and that the participants failed to alert Aon to any problem with the excess coverage. Aon argued that O&G's failure to alert Aon to any problem with the excess coverage was the proximate and superseding cause of O&G's injuries. However, the court rejected this argument.

In rejecting Aon's claim, the court noted that Aon was relying upon an interpretation of New York law which was not binding upon the Connecticut court. Moreover, recent New York case law stated that, when a plaintiff requested specific coverage and upon receipt of the policy did not read it and lodged no complaint, "the failure to read the policy, at most, may give rise to a defense of comparative negligence but should not bar, altogether, an action against a broker." Citing *American Building Supply Corp. v. Petrocelli Group, Inc.*, 19 N.Y.3d 730, 736-37, 955 N.Y.S.2d 854, 979 N.E.2d 1181 (2012). The fact that Aon procured CCIP coverage in which the excess policies did not require payment of defense costs established the duty and causation. Under Connecticut law, the test of proximate cause was whether the defendant's conduct was a substantial factor in bringing about the plaintiffs' injuries. The court found, therefore, that any argument that the CCIP participants failed to meet their own obligation to review the policies to insure that they met their needs did not obviate Aon's role in causing the injury. At most, the obligation to review the policy would support a possible defense of contributory negligence but would not be a bar to the claim. // Plitt

Automobile Insurance/ Allocation

Policy Covering Employer's Vicarious Liability for Employee's Negligent Driving Is Excess of Policies Covering Employee Directly

Statutory Scheme Governing Priority of Allocation of Auto Insurance Coverage Does Not Apply

GuideOne Mutual Insurance Company v. Utica National Insurance Co., __ Cal.App.4th __, __ Cal.Rptr.3d __, 2013 WL 765651 (4th Dist., Feb. 28, 2013)

Case at a Glance

In a dispute over allocation of automobile liability coverage for an accident, all policies covering the negligent driver, primary and excess, must be exhausted before an umbrella policy insuring only the negligent driver's employer's vicarious liability must make a contribution.

Summary of Decision

GuideOne involved the $4.5 million settlement of a lawsuit for personal injury resulting from a serious auto accident caused by an individual driving his own car for business purposes. The suit named both the driver and the employer, and alleged that the employer was vicariously liable for the driver's negligence. Five liability policies contributed to the settlement: (1) the driver's $100,000 personal auto liability policy with State Farm; (2) a primary policy which Guideone Mutual Insurance Company (GuideOne) issued to the driver's employer and which covered the driver while acting within the course and scope of employment; (3) an umbrella policy that Guideone issued to the driver's employer and which provided the same coverage as the underlying primary policy; (4) a primary policy that Utica National Insurance Company (Utica) issued to the driver's employer and which covered only the employer for vicarious liability; and (5) an umbrella policy issued by Utica to the employer which, like the underlying primary policy, covered only the employer's vicarious liability.

California Insurance Code § 11580.9(d) provides that "where two or more policies affording valid and collectible liability insurance apply to the same motor vehicle or vehicles in an occurrence out of which a liability loss shall arise, it shall be conclusively presumed that the insurance afforded by that policy in which the motor vehicle is described or rated as an owned automobile shall be primary *and the insurance afforded by any other policy or policies shall be excess*. (Emphasis added.). Pursuant to § 11580.9(d), the negligent driver's $100,000 personal auto liability policy paid first. GuideOne and Utica disagreed on how the remaining liability should be allocated between them. Based on § 11580.9d), GuideOne argued that all four commercial auto policies must be treated as excess policies and pay out on the same basis. The trial court, however, held that both primary level policies had to be exhausted before reaching either umbrella policy. The trial court then found that the "other insurance clauses" in both the subsidiary and the employer's policies balanced such that the excess policies would be required to pro rate. Under this formula, Utica had underpaid by $600,000, and the trial court entered summary judgment in that amount.

The California Court of Appeal, Fourth District, reversed, rejecting both the trial court's and GuideOne's approach to allocation. The court instead adopted Utica's argument that both of the GuideOne policies were primary to both of the policies Utica issued to the employer. Central to the court's decision was the fact that Utica's policies covered only the vicarious liability claims against the employer, while GuideOne's claims covered both the vicarious liability claims against the employer and the negligence claims against the driver. The court relied heavily on *United States Fire Ins. Co. v. National Union Fire Ins.* Co., 107 Cal. App. 3d 456, 165 Cal.Rptr. 726 (1980), which held that where an employer's nonowned aircraft coverage was expressly limited to vicarious liability of the named insured, such coverage "is secondary to any coverage" held by the pilot individually. // Bushnell

Bad Faith/Discovery

Washington Supreme Court Restricts Attorney-Client Privilege in First-Party Insurance Bad Faith Litigation

Court Creates Rebuttable Presumption of No Privilege

Cedell v. Farmers Ins. Co. of Washington, 295 P. 3d 239 (Wash. 2013)

Case at a Glance

An insured brought a claim against its homeowners' insurer alleging bad faith failure to provide coverage following a fire. During the course of litigation the insured moved to compel production of documents and responses to interrogatories; in response, the insurer moved for a protective order, asserting attorney-client privilege to certain requested communications. The Supreme Court of Washington held that when an attorney performs "quasi-fiduciary" tasks on behalf of an insurer, attorney-client privilege may be waived.

Summary of Decision

In November of 2006, a fire destroyed the home of the insured/plaintiff, Bruce Cedell. Following the fire, the fire department concluded that the fire was "likely" accidental and consistent with a candle being the cause.

In January of 2007, a Farmers adjuster estimated that Farmers' exposure would be about $70,000 for the house and $35,000 for its contents. Six months later, an attorney who had been hired by Farmers to make the coverage decision sent Cedell a letter stating the origin of the fire was unknown and that coverage might be denied based on a delay in reporting and inconsistent statements regarding the facts of the loss. The letter also extended a one-time offer of settlement of $30,000, good for 10 days. Cedell tried unsuccessfully to contact Farmers about the offer during the 10 days, but no one from Farmers returned his call. In November, Cedell brought suit against Farmers alleging bad faith in handling his claim.

During the course of discovery, in response to a request for Farmers' claim file, Farmers produced the file in heavily-redacted form, asserting that the redacted information was not relevant and/or was privileged; Farmers also claimed attorney-client privilege with respect to several interrogatories. Cedell filed a motion to compel, contending that the claim of privilege and work product in bad faith litigation is severely limited and does not apply to an insurer's benefit in bad faith actions. The trial court held that because of the fiduciary duty owed by the insurer to its insured the insured was entitled to the entire claim file without exceptions for the attorney-client privilege. The Court of Appeals reversed holding that "a factual showing of bad faith" was insufficient to trigger an in camera review of the claims file and the apparent use of the attorney to further bad faith conduct did not pierce the attorney-client privilege. The Washington Supreme Court held that in first party insurance claims where an insured is claiming bad faith in the handling and processing of claims there is a presumption against the assertion of attorney-client privilege. However, the insurer may assert an attorney-client privilege upon a showing in camera that the attorney was providing counsel to the insurer regarding its own exposure and not simply evaluating or processing the claim. Upon such a showing, the insured may be entitled to pierce the attorney-client privilege if the civil fraud exception is asserted.

In reaching this holding, the Supreme Court recognized that in the case of first party bad faith litigation, an insured is typically permitted unfettered access to the relevant claim file to prove its case. However, the insured's need to access the claims file may be in tension with the insurer's right to assert the attorney-client privilege. To balance these competing needs, the court must start with the presumption that there is no attorney-client privilege. The insurer may overcome the presumption of discoverability of attorney-client communications in a first-party bad faith claim by showing that its attorney was *not* engaged in the quasi-fiduciary tasks of investigating and evaluating or processing the claim, but was instead providing the insurer with counsel as to its own potential liability. Upon a successful showing, the insurance company is entitled to an *in camera* review

of the claims file, and to the redaction of communications from counsel that reflect the mental impressions of the attorney to the insurance company, unless those mental impressions are directly at issue in its quasi-fiduciary responsibilities to its insured. At this point, the burden shifts back to the insured to assert an exception in order to pierce the attorney client privilege.

If the insured is able to show that a reasonable person would believe that an act of bad faith occurred, *i.e.*, an act tantamount to civil fraud, the trial court will perform an *in camera* review of the claimed privileged materials. If the documents show foundation to permit a claim of bad faith to proceed, the attorney-client privilege shall be deemed to be waived.

The *Cedell* court held that it appeared the attorney retained by Farmers did more than simply advise the company on coverage issues. Instead, the attorney assisted in claim investigation, negotiated the claim, failed to return calls to the insured, and drafted the "one-time" settlement offer letter. These activities were more in line with what an insurer owes as quasi-fiduciary duties to an insured, and in those functions, are discoverable materials. The Court remanded the case to the trial court to conduct an in camera review of the file with its holding as guidance as to what material, if any, was subject to attorney-client privilege. // Troy

Duty to Defend/ Conflict of Interest

Florida Appellate Court Requires Insurer to Pay for Separate Independent Counsel for Additional Insured and Named Insured Where Complaint Alleged Both Were Directly Liable for Plaintiff's Injuries

Case of First Impression under Florida Law

University of Miami v. Great American Assurance Company, __ So.3d __, 2013 WL 616156 (Fla.App., Feb. 20, 2013)

Case at a Glance

Conflicting legal defenses to a personal injury action asserted by co-insured defendants, a swim camp on a university campus and the university, required the swim camp's insurer, which also insured the university as an additional insured, to appoint separate independent counsel to represent the university and the swim camp. Appointment of separate independent defense counsel was necessary because: (1) the underlying complaint alleged each insured was independently negligent, and (2) each insured defended by alleging that the other was at fault. Consequently, the defense counsel appointed by the insurer to defend them both faced a "legal dilemma"—he could not advance the interests on one insured without harming the interests of the other.

Summary of Decision

MagiCamp ran a summer swim camp at the University of Miami. Great American Insurance Company covered MagiCamp as the named insured and the University as an additional insured under a commercial general liability policy.

A four-year-old child suffered extensive injuries while participating in the swim camp. His parents sued both MagiCamp and the University. Their complaint alleged that each defendant was directly and actively negligent in failing to supervise the pool.

Great American retained a single law firm to

represent both MagiCamp and the University. The law firm filed an answer with affirmative defenses on behalf of MagiCamp. The answer alleged that the University caused the child's injuries, sought an apportionment of damages based on the percentage of fault attributable to each defendant, and claimed that MagiCamp was entitled to indemnification and contribution from the University.

On the same day that MagiCamp filed its answer and affirmative defenses, the University demanded, by way of letter, that Great American pay for independent counsel selected by the University to handle the University's defense. The letter asserted that a conflict of interest existed between MagiCamp and the University that precluded Great American from satisfying its duty to defend by hiring one attorney to defend them both. In outlining the conflict, the letter explained that the University intended to blame MagiCamp for the accident in the same way that MagiCamp accused it of blame. Great American denied the request, and the University retained separate counsel at its own expense.

After the underlying case settled, the University sued Great American for declaratory relief and breach of contract seeking to recover defense costs, including the cost of hiring independent counsel. Great American took the position that because MagiCamp was contractually bound to indemnify and hold harmless the University for any liability arising out of the use of its facilities by MagiCamp, there could be no conflict of interest in its single representation by counsel. The trial court agreed, and granted Great American's motion for final summary judgment.

In reversing, the Florida Court of Appeal, Third District, held that the conflicting defenses gave rise to a conflict of interest requiring separate counsel even though the conflict did not affect coverage and the University might ultimately be able to shift liability back to MagiCamp through their contractual hold harmless clause. The court determined that "in this factual scenario" in which the insured defendants' legal positions were "inherently adverse" the single law firm hired by the insurer to defend both defendants was caught in a "legal dilemma" and could not satisfy Great American's defense obligation. The court pointed out that "Great American's counsel *would have had to* argue conflicting legal positions, that each of its clients was not at fault, and the other was, even to the extent of claiming indemnification and contribution for the other's fault." (Emphasis added). The court further noted that "[i]n doing so, legal counsel *would have had* to necessarily imply blame to one co-defendant to the detriment of the other." (Emphasis added).

A single dissenting justice characterized the conflict as nothing more than a "paper conflict" arising from generic claims for contribution and indemnity. He noted that neither defendant was required to prove the other's liability in the underlying litigation. That burden rested solely with the plaintiff. The dissent also differed with the majority on the more fundamental question of whether a liability insurer should not be forced to relinquish its contractual right to control its insureds' defense "merely because there exists the potential for insurer-selected counsel to become impermissibly conflicted in its representation." Forcing insurers to pay for separate counsel in such circumstances, the dissent observed, "opens a new frontier in insurance litigation of benefit only to the legal profession." He opined that the rules of professional conduct and the threat of a malpractice suit provide the insured sufficient protection.

Comment

The *University of Miami* decision is significant if only because it offers a rare example of a court addressing whether a conflict of interest between co-insured defendants, rather than between the insured and the insurer, gives rise to a conflict of interest requiring the insurer to pay for independent counsel. The importance of the court's decision depends on whether other courts extend its reasoning to create a right to independent counsel anytime co-insured defendants are alleged to be directly liable for the same injury. Insurers will point to language in the opinion limiting the court's analysis to cases in which an attorney *could not* defend one insured without harming the other. Policyholders, on the other hand, will focus on the court's refusal to consider MagiCamp's contractual obligation to indemnify the University in analyzing the conflict. Manufacturers and suppliers as well as contractors and subcontractors commonly have such provisions in their contracts and they frequently find themselves co-defendants in cases. // DiMugno

Liability Insurance/ Advertising Injury

False Advertising Suit Alleged No Advertising Injury

Complaint Must Involve Misuse of— Not Just Mention—a Purloined Slogan

Basic Research LLC v. Admiral Ins. Co., __ P.3d __, 2013 WL 563359 (Utah Feb. 8, 2013)

Case at a Glance

In a unanimous decision, the Utah Supreme Court has held the mere mention of another's slogan in an advertisement, without more, fails to trigger "advertising injury" coverage. Rather, coverage is only implicated when the plaintiff seeks damages for the *appropriation* of its slogan.

Summary of Decision

According to Basic Research LLC's advertisements, purchasers of its Akävar weight-loss product could "Eat All [They] Want And Still Lose Weight," a claim that "We Couldn't Say . . . In Print If It Wasn't True." According to several class action suits, however, the purchasers couldn't, yet Basic Research did. As a result, the claimants sued for false advertising.

Basic Research sought coverage for the false advertising suits under the advertising injury clause of its Admiral CGL policy, reasoning that it did not actually own the quoted slogans and therefore it had been sued over "the use of another's advertising idea in [its] 'advertisement.'" The trial court found no duty to defend, and the Supreme Court affirmed.

On appeal, as below, the parties urged distinctly different standards of causation for determining the duty to defend. Basic Research argued the underlying actions literally "arose out of" the use of another's advertising ideas, since someone else (Western Holdings) owned the slogans that were alleged to be false. Admiral, in contrast, contended its coverage was only triggered by an alleged *misappropriation* of an advertising idea, not merely by the sale of a product using an unauthorized slogan.

The Utah Supreme Court sided with Admiral. At bottom, Basic Research had essentially proposed a "but for" standard of causation, whereas Admiral urged a "resulting from" (or proximate cause) test. Although the advertising ideas may have been lifted from another person, the court noted, the underlying claims were based on the *falsity* of the representations, not their ownership or origin. Because the claims would have been equally meritorious whether Basic Research owned the slogans or not, the claims did not arise out of the *use* of another's slogans, but because the slogans were allegedly *false*. That Western Holdings never objected to the slogans' use only buttressed the court's conclusion. And in any event, even if the claims alleged an "advertising injury," they would have fallen within the exclusion for the failure of the insured's product to conform to an advertisement.

Comment

The *Basic Research* decision is unusual in at least of couple of respects. First, in rejecting a literal application of the policy language in favor of one based on the reasonable intent of the contract, the Utah court displayed a much more nuanced and sophisticated approach than many courts in similar situations. As the court recognized, even if the underlying suits literally "arose out of" the use of another's advertising slogans, the plaintiffs were only concerned about the truth, not the provenance, of the slogans. Because the policy focused on the *unauthorized use*—not the truth—of another's advertising ideas, the claims fell outside contractually-intended scope of coverage.

Second, the *Basic Research* court defied the conventional wisdom that courts decide cases on the narrowest possible ground. Because the underlying suits plainly fell within the "failure-to-conform" exclusion, it would have been far simpler to decide the case based on the exclusion and skip the controversial discussion of the causal link envisioned by the coverage grant. The court should be commended for addressing the tougher issue and, in so doing, actually providing guidance to the litigants and counsel for future disputes. // Barnes

Liability Insurance/Allocation

Policyholder Bound by Position on Timing of Environmental Contamination before Massachusetts Supreme Judicial Court Adopted "Pro Rata" Method of Allocating Coverage among Multiple Triggered Policies

Own Property Exclusion Applies to Air Pollution on Insured's Property

Boston Gas Company v. Century Indemnity Co., __ F.3d __, 2013 WL 203578 (1st Cir. Jan. 18, 2013)

Case at a Glance

A policyholder was judicially estopped from changing its factual position, taken when it believed that Massachusetts law imposed joint and several liability on each liability policy triggered by continuous and progressive injury or damage up to policy limits, that property damage occurred continuously over a 121-year period. The intervening decision of the Supreme Judicial Court of Massachusetts to adopt a pro rata or time on the risk method of allocation did not justify allowing the policyholder to change its position to assert that all the damage occurred during the 18 years that the defendant insurer was on the risk.

Summary of Decision

For more than 100 years, from the early part of the 19th Century until 1930, the insured, Boston Gas Company, produced gas fuel at several manufactured gas plants in Massachusetts. Faced with liability for the cost of cleaning up environmental contamination at two of the plants (Plant 1 and Plant 2), Boston Gas sought coverage from one of its liability insurers, Century Indemnity Company, which insured both Plant 1 and Plant 2 from 1951-1969. Century contested coverage on a variety of grounds, including the amount of damage that could be allocated to its policy periods and the applicability of a policy exclusion for damage to the insured's "own property."

Coverage litigation ensued in federal district court, and separate trials were held to determine coverage at each plant. When each trial started, Massachusetts law on the allocation of coverage among multiple triggered policies was unsettled.

"All Sums" v. "Pro Rata" Allocation. Boston Gas advocated adoption of the "all sum" or "joint-and-several liability" approach to allocation. Under the all sums approach, each triggered policy is liable for "all sums" the insured is legally obligated to pay up to policy limits, regardless of whether most of continuous damage occurred outside the insurer's policy period. The insured need only establish that some damage occurred during Century's policy period in order to trigger coverage. The insured can then impose "joint-and-several" liability on that insurer for damage that occurs during other policy periods. Under the all sums approach, Boston Gas would have an incentive to spread the continuous damage over as long a period as possible in order to trigger as many policies as possible.

Century urged adoption of the "pro rata" approach to allocation. The pro rata method attempts to enforce the policy requirement that injury or damage occur during the policy period by matching as closely as possible harm or damage with the policy in which it occurs. Consequently, a single continuous loss must be prorated across all policy periods. The policyholder is allowed to recover from each insurer only the portion of the loss that occurs during that insurer's policy period. Under the pro rata approach, Boston Gas would have an incentive to concentrate all damage during Century's 18 years of coverage.

Based on a then existing intermediate Massachusetts appellate court decision, the trial court applied the all sums allocation approach and Boston Gas developed and presented evidence in a manner designed to maximize coverage under that approach in both trials. A jury awarded Boston Gas $6.1 million in the Plant 1 trial. In the Plant 2 trial, the jury was asked to determine Boston Gas's *total* cleanup costs, but not the percentage of those costs that were attributable to the 18 years when the Century policies were in effect. The jury determined the amount Boston gas was legally obligated to pay for investigation and remediation of contamination at Plant 2 was $1.7 million. Century appealed the judgment in the Plant 1 trial, and the trial court deferred ruling on post-trial motions in the Plant 2

trial pending resolution of that appeal.

Certification of Allocation Question to the Supreme Judicial Court of Massachusetts. Unwilling to rely on the opinion of a single intermediate appellate court decision, the First Circuit certified the allocation question to the Supreme Judicial Court of Massachusetts (SJC) in the Plant 1 appeal. The SJC rejected an "all sums" approach in favor of pro rata allocation. *See Boston Gas Co. v. Century Indem. Co.,* 454 Mass. 337, 910 N.E.2d 290, 312 (2009). The court held that the preferred method for allocating damages on a pro rata basis is a "fact-based" determination of the losses occurring during each policy period, but in the event that the evidence does not permit such an allocation, losses should be allocated based on the insurer's "time on the risk." *Id.* at 316. Under the time-on-the-risk method, "each triggered policy bears a share of the total damages [up to its policy limit] proportionate to the number of years it was on the risk [the numerator], relative to the total number of years of triggered coverage [the denominator]." *Id.* at 313 (quoting 23 E.M. Holmes, *Appleman on Insurance* § 145.4[A][2][b], at 24 (2d ed.2003)). "Given the factual complexities of cases of this sort," the SJC explained, "we defer to trial judges in the first instance to determine whether losses can be allocated based on the amount of property damage that in fact occurred during each policy period, or must instead be allocated on the basis of each insurer's time on the risk." *Id.* at 316.

The Litigation Proceeds. Upon receiving the guidance from the SJC, the First Circuit remanded the Plant 1 case to district court. Boston Gas and Century settled their coverage dispute with respect to Plant 1, but the litigation proceeded with respect to Plant 2. In the wake of the SJC ruling, Century successfully moved for entry of judgment in its favor on the issue of allocation. The trial judge ruled that Boston Gas was bound, under the doctrine of judicial estoppel, by its representations at trial that property damage had occurred continuously from the beginning of plant operations until the date of remediation. Accordingly, the court allocated less than 15 percent of the damages to Century pursuant to the "time on the risk" formula adopted by the SJC.

The First Circuit's Opinion. The First Circuit reviewed the district court's allocation ruling for an abuse of discretion and affirmed. The circuit court agreed that the trial evidence itself did not permit an accurate fact-based allocation, that resort to the time-on-the risk formula was appropriate, and that Boston Gas was judicially estopped from contesting coverage. The court found sufficient evidence of both conditions to imposition of judicial estoppel: (1) the estopping position and the estopped position [were] directly inconsistent, and (2) Boston Gas succeeded in persuading a court to accept its prior position. The fact that Boston Gas was not playing "fast and loose" with the court, and was merely responding to a change in the law, did not change the court's analysis. The court acknowledged that judicial estoppel is an equitable doctrine, and that a change in the law may justify a change in a party's *legal* position. Boston Gas, however, had changed its *factual* position about when damage occurred—a position it took deliberately, not as the result of inadvertence or mistake.

The Own Property Exclusion. The First Circuit also upheld the jury's finding that the policy's exclusion of coverage for damage to the insured's own property applied to the cost of cleaning up air pollution at the site. Boston Gas argued that the air was owned by the Commonwealth of Massachusetts and therefore the owned property exclusion did not apply. The court, however, found that question of ownership of the air was not dispositive as to whether the exclusion applied. Instead, the court held that the correct test is whether the environmental hazard posed "a significant risk to the public or to private third parties' *use and enjoyment*" of public or third-party property, which turns on whether "the evidence indubitably established a significant risk of migration." (Emphasis added). The evidence showed that the risk of inhaling contaminated air was limited to Boston Gas's own employees working in a confined space, and not to the public at large. Accordingly, the court found no risk of harm to the public's or a third-party's use and enjoyment of the air. // DiMugno

Liability Insurance/ Assignments

Insurer Had No Duty to Defend Successor Owner Absent Signed Consent by Insurer

Even if Policy Applied, It Did Not Cover Investigatory Actions by EPA

Water Applications and Systems Corp. v. Bituminous Casualty Corp., __ N.E.2d __, 2013 WL 593748 (Ill. App., 1st Dist. Feb. 15, 2013)

Case at a Glance

The purchaser of the assets of a company identified by the Environmental Protection Agency as a potentially responsible party for environmental cleanup expenses was not entitled to a defense or indemnity from the predecessor company's liability insurer where the insurer had not consented to assignment of interest under the policy. Under applicable Maryland law, the policy's anti-assignment provision, which required signed consent by the insurer for assignment, was valid and enforceable. Even assuming the policy applied, however, coverage of a regulatory action by the EPA was not provided.

Summary of Decision

Plaintiff WASCO purchased the assets of PORI International in 1997. PORI's predecessors had liability insurance policies issued by defendant Bituminous Casualty Corp. The purchase agreement between plaintiff and PORI provided that the agreement was to be governed by California law, and stated PORI's desire to sell and assign to plaintiff all of PORI's assets and certain of its liabilities on the terms set forth in the agreement. The section of the agreement concerning insurance purported to disclose all insurance policies on an "occurrence" basis with respect to which PORI was the owner, insured or beneficiary. That section did not list or refer to the defendant's policies. The policies contained an anti-assignment clause that provided assignment of interest under the policy was not binding on the insurer unless "its consent is endorsed hereon."

In 2007, the Environmental Protection Agency (EPA) sent a notice of potential liability to PORI's successor, identifying it as a potentially responsible party (PRP) to an environmental cleanup action in a Maryland site under the federal Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA). The successor forwarded a copy of the PRP to plaintiff, which entered into negotiations with the EPA. Plaintiff then forwarded the letter to the defendant, requesting that the insurer provide a defense to the EPA's impending action under the provisions of its policies. Defendant declined because plaintiff was not a named insured on the policies, and defendant was unable to verify that plaintiff properly assumed the policies. Plaintiff then successfully defended the EPA action and incurred $28,186 in legal fees. Defendant declined to reimburse plaintiff for the fees.

Plaintiff sued defendant in an Illinois trial court for breach of contract, bad faith, and declaratory relief. During discovery neither plaintiff nor defendant provided information establishing a link between the policies and PORI. Plaintiff's designated agent testified that he did not know if there was link between PORI's predecessors and PORI. Defendant moved for summary judgment, claiming that plaintiff did not provide evidence that it had properly assumed the policies by assignment, and therefore was not entitled to defense of the EPA matter. Defendant argued that assignment required defendant's consent, which was not given. Plaintiff responded that defendant's consent was not required, and provided two letters purporting to establish that PORI was the successor of the policies' named insureds, and that defendant's policies provided general liability coverage to PORI. The trial court granted plaintiff's motion for summary judgment.

The Illinois appellate court affirmed, concluding that the policies were governed by Maryland law, which held that an anti-assignment clause was a valid and enforceable provision of an insurance contract. The anti-assignment clause prohibited the assignment of the policies without written consent, and defendant never gave its written consent to assignment.

It was well established under Maryland law that anti-assignment clauses were valid and enforceable,

the court observed. Although plaintiff's purchase agreement called for application of California law, the issues presented involved interpretation of the policies, not the purchase agreement. Maryland law applied to the policies because the most significant contacts were in the state of Maryland, including the address of the named insureds, the location where the policies were issued by defendant's countersignature, and the location of the environmental contamination that gave rise to the EPA investigation. In addition, a higher premium was found on premises located in Maryland, and more vehicles insured were driven in the state.

Additionally, even if the policies were properly assigned, a general liability policy did not cover a regulatory action by the EPA. Applicable Maryland law provided that liability under CERCLA was not liability for "property damage" covered under general liability policies, but rather was regulatory liability for response costs. The costs of obtaining a lawyer for representation during an EPA investigation were not covered under a standard general liability insurance policy because the government was acting as a regulator and not an injured property owner. Therefore defendant did not have a duty to defend plaintiff. // Bushnell

Liability Insurance/ Pollution Exclusion

Policy Excluded Coverage for Restaurant's Dumping of Grease into Sewer in Amounts that Obstructed Flow

Grease in Quantities Sufficient to Cause Sewer Clog Was "Contaminant"

Mountain States Mutual Casualty v. Roinestad, __ P.3d __, 2013 WL 757630 (Colo. Feb. 25, 2013)

Case at a Glance

A restaurant's liability policy excluded coverage for injuries allegedly caused when cooking grease and oil were dumped in a sewer, creating a five- to eight-foot clog that obstructed flow and caused the buildup of hydrogen sulfide gas that overcame two sewer maintenance workers. A city ordinance prohibited the discharge into sewers of "solid or viscous pollutants" in amounts that would cause obstruction to the flow, or pollutants that resulted in the presence of toxic gases within the sewer. Accordingly, cooking grease was a "contaminant" within the meaning of the policy's pollution exclusion when discharged into a sewer in quantities sufficient to create a clog. A determination that the exclusion was ambiguous and did not apply to cooking grease was according reversed.

Summary of Decision

A restaurant owner was sued by sewer maintenance workers who were injured by hydrogen sulfide gas when they attempted to clean what an investigation later revealed to be a five- to eight-foot grease clog in a manhole near the restaurant. The clog created an obstruction to the sewer flow, and the gas was formed from the water that was made stagnant by the clog. No other commercial entity's sewer fed into the sewer system upstream from the restaurant, and a restaurant employee later testified that the owner instructed employees to dump greasy water down the drain cleanout that led to the manhole.

The injured workers sued the restaurant owner in a Colorado trial court for alleged negligence, negligence per se, and off-premises liability. The negligence per se claims were based on city ordinances that restricted discharges to sewers, including one that prohibited discharge into sewers "solid or viscous pollutants" in amounts that would cause obstruction to the flow, or pollutants which resulted in the presence of toxic gases within the sewer.

The owner notified his liability insurer, who had renewed the restaurant's commercial general liability policy. The policy's pollution excluded provided that the insurance did not apply to bodily injury or property damage arising out of the discharge, dispersal, seepage, migration, release or escape of pollutants from premises owned by the insured. Pollutants included any solid or liquid irritant or contaminant. The insurer initially defended the owner under a reservation of rights. Eventually, however, it brought a declaratory judgment action in

federal court asserting that it had no duty to defend the owner, based on the pollution exclusion clause. The federal court found the insurer had no duty to defend because, under the plain meaning of the policy words, the grease and oil, in the quantities allegedly at issue, were contaminants and therefore pollutants.

The trial court found the owner liable for the workers' injuries because the restaurant dumped greasy water in the sewer in great enough amounts to cause the sewer clog, which in turn created a buildup of hydrogen sulfide gas. The workers obtained a monetary judgment against the owner, and were awarded costs. Apparently unable to collect from the owner, the workers served a writ of garnishment on the insurer. The insurer moved for summary judgment in the state court action, asserting that it had no duty to indemnify based on the pollution exclusion and the federal court ruling. The trial court granted the insurer's motion for summary judgment, determining that the pollution exclusion barred coverage.

A Colorado Court of Appeals reversed and remanded, concluding that the terms of the pollution exclusion were ambiguous, and that application of the exclusion to cooking grease, a common everyday waste product, could lead to absurd results and negate essential coverage. The appellate court directed the trial court to enter judgment for the workers and to enforce the writ of garnishment.

The Colorado Supreme Court granted certiorari and reversed the court of appeals' decision, concluding that the policy excluded coverage for the discharge of cooking grease under the circumstances of the case. "Contaminant" was not defined by the policy. The state high court concluded, however, that for purposes of construing pollution exclusion clauses, the term was commonly understood to mean a substance that contaminates by making something unfit for use or impure by the introduction of unwholesome or undesirable elements. Dictionary definitions further defined contaminant as something that soils, stains, corrupts, or infects, or renders unfit for use by the introduction of unwholesome or undesirable elements. Those definitions suggested that cooking grease becomes a contaminant when discharged into a sewer in quantities sufficient to create a clog, the court observed.

The court concluded that the term contaminant was further clarified, and rendered unambiguous, by examining the facts and circumstances of the case. The city ordinance prohibited discharge of solid or viscous pollutants in amounts that would cause obstruction to the sewer flow, or pollutants which resulted in the presence of toxic gases. The undisputed evidence showed that it was the owner's inappropriate disposal of grease and oil into the sewer that led to the sewer clog and buildup of toxic gas, a situation that exactly paralleled what the city ordinance prohibited.

The court rejected the workers' attempt to avoid this conclusion by invoking the reasonable expectations doctrine. They argued that pollution exclusion clauses were incorporated into commercial liability policies to relieve insurers of liability for clean-up and other costs associated with federal environmental protection laws. Accordingly, a reasonable insured would expect a pollution exclusion clause to exclude coverage only for traditional pollution as contemplated by laws such as the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), not cooking grease. The state high court noted that the reasonable expectations doctrine may override a policy exclusion, (1) where an ordinary objectively reasonable person would, based on the policy language, fail to understand that he or she was not entitled to the coverage, and (2) where, because of circumstances attributable to the insurer, such a person would be deceived into believing that he or she was entitled to coverage. Neither of those situations was present. The policy said nothing about federal environmental laws or "traditional" pollution, and there was no reason to believe an ordinary person would understand the clause to apply only to "traditional" pollution. Further, the court could not conclude that an ordinary reasonable person would have been deceived by the policy into thinking that there would be coverage for the dumping of cooking grease in such a great volume as to clog the sewer. // Holt

Pollution Exclusions Precluded Coverage of Claims that Village Added Polluted Well Water to Community's Tap Water

Knowing Contamination of Water Supply Met Definition of "Traditional" Environmental Pollution

Village of Crestwood v. Ironshore Specialty Insurance Co., __ N.E.2d __, 2013 WL 660496 (Ill. App., 1st Dist., Feb. 22, 2013)

Case at a Glance

"Absolute" pollution exclusions in village's excess public entity general liability insurance policies precluded coverage of claims that the village knowingly added well water contaminated with dry cleaning chemicals to the community water supply as a cost-saving measure. Knowing contamination of the water supply with chemical-laden groundwater and distribution of that water to the community was a textbook example of "traditional" environmental pollution within the scope of the exclusions. The village's argument that its liability insurance should apply because distributing municipal tap water was its "central business activity" was rejected—that activity was not to work with dry cleaning chemicals. Summary judgment for the insurers in their declaratory judgment action against the village was accordingly affirmed.

Summary of Decision

For ten years the Village of Crestwood allegedly mixed polluted well water with the community's tap water as a cost-saving measure. The well water was contaminated with a solvent used by a nearby dry cleaning facility. The village falsely stated that 100% of the water it supplied was treated water. When the water practices were discovered, Crestwood and its longstanding mayor were sued in numerous individual and class action lawsuits for negligence, fraud, failure to warn, willful and wanton misconduct, and breach of contract.

Crestwood and its mayor filed a declaratory judgment action in Illinois state court seeking a declaration that its three excess public entity general liability insurers owed duties to defend or indemnify at least 25 individual and class action lawsuits alleging that the village knowingly and routinely mixed cheap polluted water into the municipal tap water supply. Each of the policies contained an "absolute" pollution exclusion that excluded coverage for bodily injury or property damage that would not have occurred but for the discharge, dispersal, seepage, migration, release or escape of pollutants at any time. "Pollutants" included any solid, liquid, gaseous, or thermal irritant or contaminant, including chemicals. The state trial court held that the underlying claims fell within absolute pollution exclusion clauses in the insurance contracts, and that this entitled the defendant insurers to summary judgment.

At the same time, two of the village's liability insurers filed a coverage action in federal court alleging that pollution exclusions in their contracts precluded coverage for the village. The federal district court granted summary judgment for the insurers, and the Seventh Circuit U.S. Court of Appeals affirmed.

An Illinois Court of Appeal affirmed the state trial court's grant of summary judgment for the insurers, concluding that the policies' pollution exclusions precluded coverage. The court rejected Crestwood's argument that the exclusions were properly limited to claims alleging "traditional environmental pollution," as that phrase was used in *American States Insurance Co. v. Koloms*, 177 Ill.2d 473, 1187 N.E.2d 72 (Ill. 1997). According to Crestwood, the underlying complaints must depict the village as an active polluter or an entity that could be required to pay governmental cleanup costs pursuant to an environmental law for the exclusions to apply. The court disagreed. *Koloms* and other cases made clear that the village's knowing contamination of the water supply with chemical-laden groundwater and subsequent distribution of that contaminated water to the community was a textbook example of traditional environmental pollution, the court of appeal determined. All of the underlying complaints against Crestwood were based on its contamination of the municipal tap water supply with "pollutants" and thus were within the scope of the exclusions.

The court also rejected the village's attempt to portray itself as merely a negligent distributor of groundwater contaminated by another entity. The record failed to support Crestwood's characterization of itself as an unwitting actor. Further, the absolute

pollution exclusion was not limited to intentional torts or any other particular theory of liability. Crestwood also unsuccessfully argued that its liability insurance would be meaningless if it did not encompass the village's "central business activity" of distributing municipal tap water. The village's central business activity was not to work with the dry cleaning chemicals that contaminated the well, the court pointed out. // Holt

Policy Interpretation

Iowa Supreme Court Applies "Care, Custody, and Control" Exclusion to Death of Hogs Insured Was Feeding for Another Party Despite Insured's Purchase of Custom Feeding Endorsement

Court Refuses to Apply Reasonable Expectations Doctrine

Boelman v. Grinnell Mutual Reinsurance Co., 826 N.W.2d 494 (Iowa 2013)

Case at Glance

The "reasonable expectations doctrine" did not create coverage under a farm insurance policy for the insureds' liability for the death of hogs owned by third parties but in the exclusive care, custody, and control of the insureds as part of a custom farming operation, where, despite an endorsement that increased the threshold for applicability of an exclusion arising out of custom farming operations from $2,000 to $150,000 in gross receipts, policy still expressly excluded coverage through two care, custody, or control exclusions.

Summary of Decision

Dale and Nancy Boelman (the Insureds) ran a "custom farming operation" that involved feeding "nursery hogs" for others until they were fattened and ready for market. This case concerns work the insureds performed for a customer. The agreement with the customer required that the insureds have insurance on the hogs, with specific coverage for suffocation. The insureds had exclusive "care, custody or control" over the hogs they were feeding—but their customers provided the hogs.

On October 4, 2008, 535 hogs perished of suffocation whiles the insured were cleaning out the manure basins. The insureds borrowed money and paid their customer approximately $24,000 for its loss, and the sought reimbursement under their "Farm-Guard" policy. The insurer denied coverage, and the insureds filed suit.

The Insurance Policy. The insureds' Farm-Guard policy had two relevant coverage sections: A and A-1.

Coverage A covered liability for property damage inflicted on the "general public"—perhaps damages to the tractor of another. (The phrase "general public" is not a defined phrase.) In any case, covered occurrences might included acts of negligence injuring virtually anyone (or anyone's property) who is not involved somehow in the "custom farming" operation at issue.

Coverage A-1 was different and more restricted. It covered property damage, in this case, to the owner of the hogs being raised. It "protects the insured from 'any one loss' for 'personal damage' to property owned by others in the care of any 'insured person.'"

In the absence of an endorsement expanding coverage, Coverage A would not apply to the loss in this case because the owner of the hogs did not qualify as a member of the "general public" and, in any event, the policy excluded coverage for property in the insured's care, custody, or control. Coverage A-1 did not apply because an exclusion ruled out liability "arising out of 'custom farming.'" The phrase "custom farming" was defined as, "any activity arising out of or connected with. . . [the] care or raising of livestock. . . by any 'insured person' for any other person or organization in accordance with a written or oral agreement."

Moreover, the policy contained exclusions, each of which applied generally to all coverage found in the package policy. One of them was the care, custody, or control exclusion. The other excluded coverage for custom farming operations if the "total gross receipts" from all custom farming exceed $2000 during the 12 months of the prior calendar year. (This exclusion is numbered 6a.)

The insured, however, claimed coverage under a special "Custom Feeding Endorsement." It indicated

(i) that there would be coverage for the care and feeding of the livestock of another if done "in accordance with a written or oral contract[,]" and (ii) that "total gross receipts" from such feeding "do not exceed the amount of gross receipts as stated on 'your' declaration page," or are [in this case] "not more than $150,000," a number checked off on the dec page]. In other words, the endorsement expanded coverage for custom farming operations by increasing the threshold for application of the exclusion 6a, the custom farming exclusion, from $2,000 to $150,000. However, nothing in endorsement altered the applicability of the care, custody, and control exclusion.

Iowa Supreme Court's Ruling. The critical issue in the case was whether the Custom Feeding Endorsement trumped the applicability of the care, custody, and control exclusion. The trial court ruled that it did, and granted summary judgment for insureds. The intermediate appellate affirmed, reasoning that the reasonable expectations of coverage engendered when the insured's purchased the Endorsement overrode the care, custody and control exclusion. The Iowa Supreme Court, however, disagreed and reversed.

The Ambiguity Argument. The insureds argued that the Custom Feeding Endorsement was ambiguous because it appeared to override all the relevant exclusions and therefore provide coverage. The court pointed out that it did no such thing but only overrode one of them, 6(a)—the custom farming exclusion—and said nothing about any other, including the care, custody, and control exclusion. It also indicated that the endorsement was not ambiguous at all and this was especially true since the endorsement announced in large, dark letters that the endorsement, "MODIF[IED] THE POLICY[,]" and asked that insureds "PLEASE READ THIS ENDORSEMENT CAREFULLY."

The court relied on all the usual rules regarding dealing with alleged ambiguities in contracts and emphasized several points. First, courts will not interprete a term to be ambiguous if doing so would render another part of the contract superfluous, or if doing so would render other terms of the policy to be in conflict with the allegedly ambiguous term. Second, interpretations of courts will attend to the reasonable and not to the hypertechnical. And, finally, the tiny premium paid for the endorsement did not suggest the expansion of coverage urged by the insureds.

The court therefore, and for another reason to be discussed in the "Comment" section below, held that the language of endorsement was not ambiguous.

The Reasonable Expectation Argument. Iowa, like some other states, permits insureds to recover in spite of certain coverage-defeating language of an insurance policy, if the insured has a reasonable expectation that it should recover. *Clark-Peterson Co. v. Assocs., Ltd.,* 492 N.W.2d 675 (Iowa 1992). The doctrine pertains to exclusions only when an exclusion "(1) is bizarre or oppressive, (2) eviscerates terms explicitly agreed to, or (3) eliminates the dominant purpose of the transaction." The expectation must be objectively reasonable, and the evidence must come from "underlying negotiations, the inferences, or the inferences arising from the circumstances of when the parties entered the contract. Only representations made by the insurer at the time of policy negotiation and issuance are relevant." *Vos v. Farm Bureau Life Ins., Co.,* 667 N.W. 2d 36, 50 (Iowa 2003). The objectively reasonable expectations of a policyholder will be honored "even though painstaking study of the policy provisions would have negated those expectations."

The court held that the insureds failed to carry their burden of proving any of these elements.

Comment

The policy at issue in *Boelman* is way, way, way too complicated for a regular Joseph-&-Josephine. At the same time, it must be conceded that at least two other courts have reached the same conclusion as reached by the Iowa Supreme Court, and neither of them complained about the policy being overly complex and on that basis raising issues of reasonable expectations. See *Grinnell Mut. Reinsurance* Co. *v. Schwieger,* 685 F.3d 697 (8th Cir. 2012) and *Gaza Beef Inc. v. Grinnell Mutual Reinsurance Co.,* 2011 WL 3654533 (Minn. App. 2011). // Quinn

Procedure/Anti-SLAPP Statutes

Filing Insurance Claims and Alleged Capping Were Not Protected Prelitigation Conduct

Subjective Intent That Litigation Would Follow Filing of Claims Did Not Support Motion to Strike

People ex rel. Fire Insurance Exchange v. Anapol, 211 Cal.App.4th 809, 150 Cal.Rptr.3d 224 (2d Dist. 2012)

Case at a Glance

Attorneys who allegedly filed false insurance claims, and used cappers to procure insureds willing to pursue such claims, were properly denied a motion to strike a qui tam action brought against them by insurers. The attorneys' bald assertion that they submitted the insurance claims with the subjective intent that litigation would follow was not sufficient, without more, to establish that the attorneys were engaged in prelitigation conduct protected by the anti-SLAPP law. Submission of contractual claims in the regular course of business was not an act in furtherance of the right of petition.

Summary of Decision

Plaintiffs Fire Insurance Exchange and Mid Century Insurance alleged that an insurance fraud ring engaged in submission of false and/or inflated claims for smoke and ash damage arising from several California wildfires. Plaintiffs brought a qui tam action against several members of the alleged fraud ring, including two attorneys who submitted purportedly false insurance claims on the part of plaintiffs' insureds. The complaint alleged that the attorneys submitted false claims and used cappers to obtain insureds willing to pursue such claims.

The attorney defendants brought motions to strike the complaint under California's anti-SLAPP (strategic lawsuit against public participation) statute, Code of Civil Procedure § 425.16. They argued that their pursuit of insurance claims and acts in obtaining clients constituted prelitigation conduct protected by their First Amendment right to petition. The trial court denied the motions on the basis that the attorneys had failed to establish protected conduct, specifically relying on authority holding that the submission of insurance claims does not constitute protected conduct under the anti-SLAPP law (*People ex rel. 20th Century Ins. Co. v. Building Permit Consultants, Inc.*, 86 Cal.App.4th 280, 103 Cal.Rptr.2d 71 (2000) ("*BPC*"). The attorneys appealed, arguing that *BPC* was wrongly decided, or should be distinguished when the underlying insurance claim was submitted in expectation of litigation against the insurance company for the anticipated bad faith denial of the claim.

The court of appeal affirmed, concluding that the attorneys' bald assertions that the insurance claims were submitted with the subjective intent that litigation would follow were insufficient, without more, to constitute prima facie evidence that the claims constituted prelitigation conduct. As the attorneys submitted no additional evidence in the case, they failed in their burden to show that the anti-SLAPP statute applied, and their motions were properly denied.

The anti-SLAPP law protected communications or conduct in furtherance of a person's right of speech or petition, including a statement made before a judicial proceeding or in connection with an issue under consideration or review by a judicial body. The court rejected the attorneys' argument that the submission of an insurance claim constituted protected petitioning conduct under the anti-SLAPP law as both a necessary prerequisite to litigation and a prelitigation demand letter. In *BPC* the court concluded that submission of documents to an insurer in support of a claim was not prelitigation conduct when the reports were sent to the insurer to demand performance. Thus submission of contractual claims in the regular course of business was not an act in furtherance of the right of petition. However, if a claim was instead submitted merely as a necessary prerequisite to expected litigation or was submitted as the equivalent of a prelitigation demand letter, it could constitute protected petitioning activity.

The first attorney's initial declaration in support of his anti-SLAPP position stated that his claims were good faith pre-litigation negotiations that could have settled the claims without the need of a lawsuit. He also declared that most of the claims were in fact

settled without litigation. His subsequent contrary declaration that his conduct was prelitigation conduct could not constitute prima facie evidence of anticipation of litigation, the court determined. The second attorney declared that the insurers had made an institutional decision in mid-2009 to deny virtually all smoke and ash claims, and that as a result all claims submitted after that date were submitted with the expectation that they would be denied and litigation was inevitable. However, there was no evidence that the attorney informed the insurers of his belief that any post-mid-2009 claim would be denied, or that the insureds anticipated litigation at the time the claims were filed. There was also no admissible evidence that the insurers informed the attorney that their claims would be denied. The attorney's subjective intent in submitting the claim did not transfer the claim from a simple claim for payment in the usual course of business into protected prelitigation conduct, the court concluded.

The court also rejected the attorneys' alternative arguments that the submission of the claims constituted protected petitioning activity. The alleged capping and submitting of false claims formed the basis of the insurers' complaint, based on the attorneys' acts, regardless of the motive for which the complaint may have been brought. Similarly, the attorneys' conduct in obtaining clients also did not constitute petitioning activity. The attorneys failed to establish that the clients were contacted for anything other than filing claims.

Procedure/Intervention

Liability Insurer May Be Denied Intervention in Underlying Suit When It Reserves Right to Deny Coverage

Insurer Failed to Establish Required Interest in Suit

Granite State Insurance Co. v. Lodholtz, 981 N.E.2d 563 (Ind. App. 2012)

Case at a Glance

A trial court did not abuse its discretion in denying an employer's liability insurer's motion to intervene in a tort suit against the employer when the insurer had offered to defend the employer only under a reservation of rights, and maintained its right to deny coverage. Because of the reservation of rights, the insurer failed to establish the requisite interest in the underlying suit. When the insurer reserved the right to deny coverage, the insurer's asserted interest was not cognizable but was contingent on the acceptance of coverage before it could become colorable for purposes of intervention.

Summary of Decision

Robert Lodholtz was seriously injured while working in a facility operated by his employer, Pulliam Enterprises. Granite State was Pulliam's commercial general liability insurer at the time. Lodholtz sued Pulliam, and the employer contacted Granite State's claims administrator. The claims administrator requested and received extra time to answer Lodholtz's complaint. Neither the administrator nor Granite State secured counsel for Pulliam, advised the employer to retain counsel, or followed up concerning the claim prior to the date for answering the complaint.

Pulliam did not file an answer to the complaint, and Lodholtz moved for default judgment. The trial court granted the motion and set the case for trial on the issue of damages. Separately, the claims administrator, apparently unaware of the default

judgment, advised Pulliam that the Granite State policy did not appear to cover the loss. When the administrator learned of the default judgment he sent a letter to Pulliam's private counsel urging that Pulliam take immediate action to vacate the default judgment and defend itself in Lodholtz's suit.

Instead of seeking to vacate the judgment, Pulliam and Lodholtz settled. The settlement agreement provided that Pulliam would not move to vacate the judgment or dispute the amount of damages, and would assign all of its claims against Granite State and the claims administrator to Lodholtz. For his part, Lodholtz agreed not to proceed against Granite State and the claims administrator to collect any damages.

Granite state offered to defend Pulliam under a reservation of rights, including the right to deny coverage. Pulliam rejected the offer. Granite State then moved to intervene as of right and to vacate the default judgment. In its motion, Granite State denied that it owed Pulliam coverage. The trial court denied Granite State's motion to intervene, heard evidence on damages, and entered judgment in favor of Lodholtz for $3,866,462. Granite State appealed, contending that the trial court abused its discretion in denying the insurer's motion to intervene.

The Indiana Court of Appeals affirmed, concluding that when an insurer attempts to intervene in the action between its insured and the injured party but reserves the right to deny coverage, the insurer's asserted interest is not cognizable but is rather contingent upon the acceptance of coverage before it becomes colorable for purposes of intervention. Granite State had consistently reserved the right to deny coverage, had offered to defend Pulliam only under a reservation of rights, and maintained the right to deny coverage in its motion to intervene, the court noted. The court relied on *Cincinnati Ins. Co. v. Young*, 852 N.E.2d 8 (Ind. App. 2006) which upheld denial of intervention by an insurer that denied coverage. *Young* set out four factors that intervenors are required to show: (1) an interest in the subject of the action, (2) disposition of the action may impede the protection of that interest, (3) representation of the interest by existing parties is inadequate, and (4) timeliness. The court of appeals rejected the insurer's attempt to distinguish *Young* on the basis that the insurer in *Young* explicitly denied coverage, while Granite State only reserved the right to do so. The *Young* court upheld denial of intervention based on the fact that an insurer who reserves the right to deny coverage has failed to establish a direct interest in the underlying suit, the appellate court reasoned.

One judge dissented, arguing that Granite State had demonstrated that its interest in the tort suit was sufficient to support information, that its interest was in danger barring intervention, and that its interest was not currently being protected, thus satisfying the requirements for intervention. // Holt

Professional Liability Insurance

Architect's Notice of Troubled Project Triggered Coverage Under "Claims Made" Policy

Takeover Surety Sued for Overcertification

Liberty Ins. Underwriters, Inc. v. Perkins Eastman Architects, P.C., 101 A.D.3d 650, 958 N.Y.S.2d 90 (2012)

Case at a Glance

An architect's notice of a troubled project triggered coverage under a "claims made" policy, even though the notice concerned the ongoing project, and the claims were brought by a surety that had entered into a takeover agreement after the policy had expired.

Summary of Decision

This factual recitation is derived from the trial court decision, *Liberty Ins. Underwriters, Inc. v. Perkins Eastman Architects, P.C.*, 31 Misc.3d 1223(A), 2011 WL 1744218 (2011).

In July 1998, an owner hired the insured architectural firm to provide design and project administration on a project to build a 700-room nursing home. The owner hired the general contractor in 2001.

Liberty Insurance Underwriters, Inc. (Liberty) issued to the insured a "claims made" professional liability policy for the period of January 16, 2003 to January 16, 2004, extended by endorsement to

February 16, 2004. Of relevance here, the policy allowed for coverage of claims made within 60 days after expiration of the policy period under the following conditions: "If during the Policy Year you become aware of a Circumstance that may reasonably be expected to give rise to a Claim against you, and if you report such Circumstance to us during the Policy Year in writing, then any Claim subsequently arising from such Circumstance duly reported in accordance with this paragraph shall be deemed under the Policy to be a Claim made during the Policy Year."

On February 13, 2004, three days before the Liberty policy expired, the insured faxed Liberty a one-page "Loss Prevention Notice" in which the architect reported that the contractor on the nursing home project "is looking to pursue major claims and is alleging some design errors." In response to Liberty's request, the insured on March 17, 2004 sent Liberty a three-page, single-spaced letter, stating that: the project "has been beset by problems throughout the course of the construction," the contractor had been terminated and rehired twice, the owner was suffering financial problems, the owner was in negotiations with the surety, and the contractor was attempting to deflect responsibility for the project's problems by blaming the owner, the engineering firm, and the insured architect and its consultants "for purported delays and material defects in the drawings that have caused them damages." The March 17 letter listed *seven design items* which the contractor was claiming caused the project to suffer delays. Finally, in the letter the insured listed potential claimants as the owner, contractor and its surety, and that these claims stemmed from the insured's role as "Contract Administrator of the project."

In a March 11, 2005 letter, the insured informed Liberty that the owner had terminated the contractor (upon the insured's recommendation) and entered into a takeover agreement with the surety. The insured prepared a list of nonconforming work (either improperly done or not completed), and the surety hired a replacement contractor to complete the project. The letter also warned the insurer: "It has also become clear that the Surety itself is trying to disingenuously back away from a firm completion date based on misrepresentations regarding the scope of the completion work and their understanding of 'nonconforming work.'"

On November 3, 2005, the surety sued the owner and insured. It alleged that, upon commencing work, it discovered more nonconforming work than the insured had declared in its list of nonconforming work and also that the insured had overcertified payments to the original contractor. The insured forwarded the surety's complaint to Liberty.

Liberty denied coverage on the ground that the surety's action was a separate and distinct claim which was first made after expiration of the Liberty policy. The insurer distinguished between the claims of potential litigation arising out of the seven design items that the insured had noticed in its February 13, 2004 and March 17, 2004 letters. The surety's claim, by contrast, arose not out of the design items but from the insured's role as contract administrator. The insured sued Liberty for denial of coverage and the parties moved for summary judgment.

Trial Court Decision

Ruling in favor of the insured, the New York Supreme Court held that the insured timely advised Liberty of a "Circumstance that may reasonably be expected to give rise to a Claim against" the architect within the meaning of the policy's 60-day extension on coverage of claims. In New York, notice requirements are liberally construed in favor of the insured, such that substantial (rather than strict) compliance is adequate.

The policy defines "Circumstance" as "an event reported during the Policy Year from which you reasonably expect a Claim may be made" and "Claim" as "a demand for money or services, naming you and alleging a Wrongful Act[.]" According to the motion court, Liberty's error was in equating the terms "circumstance" and "claim." The court pointed out that while the insured was not aware of the exact claims that the surety ultimately asserted, the correspondence between the insured and insurer during 2004 and 2005 provided notice of events during the policy period of problems with the nursing home project from which the insured reasonably expected that a demand for money or damages could be made by the surety. The court added that Liberty never objected to either the March 17, 2004 letter or the March 11, 2005 letters as beyond the scope of what Liberty now contends was merely notice of potential design defect claims.

Moreover, an examination of the insured's letters

revealed that the insured provided notice beyond the alleged design errors. The original email referred to the contractor looking to "pursue major claims" against the insured in addition to "alleging some design errors." The March 17, 2004 letter described a severely-troubled construction project where the contractor was looking to blame everyone else for its own problems. The owner was reported as negotiating with the surety. Indeed, the court found that the March 11, 2005 letter "actually predicted with a fair degree of accuracy the eventual claims that were asserted" by the surety.

Liberty is wrong in alleging that the surety's claims are distinct because they arose out of the takeover agreement. The surety's claim in fact arose out of the insured's role in inspecting and certifying payment for the contractor's work. The contractor's work, in turn, implicated many of the alleged design errors referred to in the March 17, 2004 letter. The court concluded that the insured "provided the best notice the firm could of a problematic construction project until a specific complaint was actually filed."

Appellate Court Decision

Liberty appealed and the New York Supreme Court, Appellate Division, affirmed with reasoning limited to a single paragraph:

> In correspondence with plaintiff from 2004 to 2005, defendant identified specific problem areas, as well as delays and coordination issues, in the course of the subject nursing home construction project. It identified the owner, contractor, and contractor's surety as potential claimants for millions of dollars. It noted that the owner was litigious, that the contractor was looking to deflect blame, and that negotiations with the surety over honoring its performance bond were proceeding slowly. Nowhere in any of the notices and letters to plaintiff did defendant limit the potential claim to design errors.

Comment

The *Perkins* decision illustrates the importance not only of timely notice, but of also of including in the notice articulation of an insured's observations and concerns with regard to the project. Parties should be mentioned (not just the contractor and owner, but the surety as well), suspicions voiced (the contractor "is looking to pursue major claims") and possible claims listed (the seven design items). Policyholders ideally would include counsel in drafting the notice letter, to help draw out the relevant facts that should be brought to the insurer's attention. It was the tie between the facts listed in the notice letters and the factual basis for the surety's claim that allowed the court to rejected Liberty's defense: that there was no coverage because the surety's claims arose out of the takeover agreement which was entered into after expiration of the policy. // Schneier

Uninsured Motorist Coverage

Uninsured Motorist and Personal Injury Protection Benefits Reduced by Unreimbursed Workers' Compensation Payments

Intent to Reimburse Workers' Compensation Was Not Sufficient to Avoid Reduction

TravCo Insurance Co. v. Williams, __ A.3d __, 2013 WL 656615 (Md. Feb. 25, 2013)

Case at a Glance

Auto policy uninsured motorist and personal injury protection payments to an employee injured in a work-related collision were required by Maryland law to be reduced by the amount of unreimbursed workers' compensation benefits received by the employee. The employee's intent to reimburse the workers' compensation insurer for her benefits in the future was not sufficient to avoid the statutory reduction. Under the plain meaning of the statute, reimbursement must have occurred in the past or present.

Unreimbursed workers' compensation "write-downs" of an injured employee's medical bills were to be deducted from uninsured motorist and personal injury protection payments made by the employee's auto insurer. Under Maryland law, if the write-downs

were treated as workers' compensation benefits by the employer, and the employee had not reimbursed the workers' compensation insurer, the auto insurer was required to reduce its uninsured motorist and personal injury protection payments to the employee by the amount of the write-downs.

Summary of Decision

Crystal Williams, an employee of the District of Columbia government, was injured when she was a passenger in a government vehicle driven by her supervisor that was rear-ended by an unknown driver. The other driver left the scene and no information about him was known. Williams missed nine weeks of work and her loss of earning capacity was $10,476. She also incurred medical expenses of $13,096, after workers' compensation (WC) "write-downs" applied by her medical providers that totaled at least $3,591.

Williams had a personal auto policy with TravCo Insurance that included uninsured motorist (UM) coverage and personal injury protection (PIP) benefits. The UM coverage provided that any amounts payable for damages would be reduced by sums paid because of bodily injury under WC laws, provided the insurer had not been reimbursed for amounts paid under WC. A similar provision applied to PIP coverage.

The District's WC third-party administrator asserted a subrogation right in the amount of $11,043 against any PIP or UM recovery by Williams. Williams stated that she intended to reimburse the District, but the amount that she would reimburse could not be determined before the settlement or judgment with TravCo, and Williams had no funds to reimburse the District out of pocket.

A dispute arose as to the interpretation of Maryland Code § 19-513(e) of the Insurance Article, which provided that benefits due under UM and PIP provisions would be reduced to the extent that the recipient had recovered benefits under the WC laws for which the provider of WC benefits had not been reimbursed. TravCo contended that the law required it to reduce Williams's insurance benefits because she had received WC benefits from the District and had not reimbursed them. Williams contended that she should not incur a reduction because she would reimburse the District for her WC benefits. The insurer brought an action in federal district court concerning the amount of UM and PIP benefits to which Williams was entitled. The district court certified three questions of Maryland law to the Maryland Court of Appeals:

> Does Section 19–513(e) apply where the insured has not to date reimbursed the WC provider but the WC provider claims that the insured will need to reimburse it from any UM or PIP recovery?
>
> If the answer to the first question is "yes," what is the appropriate means to resolve a dispute between the insurer and insured as to the validity and extent of a WC provider's subrogation right?
>
> If the law applicable to the underlying automobile accident and to the WC claim treats "write-downs" of medical bills as WC benefits, do such "write downs" reduce the benefits payable under Section 19–513(e)?

The Maryland high court concluded as to question 1 that under the plain meaning of the statute "reimbursement" to the WC provider must have occurred in the present or past for the previously-compensated insured to avoid the statutory PIP and/or UM reduction by the insurer. The facts of the case indicated that Williams had recovered WC benefits, and her WC provider had not been reimbursed for those benefits. As such, under the plain meaning of § 19-513(e), the insurer was required to reduce UM and PIP benefits to the extent of the recipient's unreimbursed WC benefits. The court limited its response to an interpretation of the Maryland statute, and did not resolve what the District was entitled to recover under its right of subrogation. In light of its answer to question 1, the Maryland court found it unnecessary to reach question 2.

Addressing question 3, the Maryland court concluded with respect to "write-downs" that: (1) assuming the District of Columbia treated such "write-downs" as WC benefits; (2) Ms. Williams received such benefits; and (3) the WC provider had not been reimbursed, TravCo was required to reduce the UM benefits payable to Williams. The court based this determination on the unambiguous language of the statute, specifically, that "[b]enefits payable under the coverages described in [PIP] and [UM] ... shall be

reduced to the extent that [Williams] has recovered benefits under the [WC] laws of a state ... for which the provider of the workers' compensation benefits has not been reimbursed." Assuming, that the "write-downs" were the actual benefits paid out by the WC provider and recovered by Williams under the District's WC laws, the UM benefits, which Williams was entitled to receive, were to be reduced to the extent that the "write-downs" were un-reimbursed. // Holt

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