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The $750 Million Comma? Texas Supreme Court Rules BP Is Not Entitled to Coverage for the Gulf Oil Spill as an Additional Insured Under Policies Issued to Transocean.

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

The Supreme Court of Texas ruled on February 13, 2015, that BP is not entitled to coverage as an additional insured under insurance policies Transocean procured for the Deepwater Horizon. *In re Deepwater Horizon, Relator,* 2015 WL 674744. We previously wrote about the insurance coverage dispute concerning subsurface pollution that resulted from the 2010 oil spill in the Gulf of Mexico in the following *Insurance Litigation Reporter* articles:

IN RE: OIL SPILL BY THE OIL RIG "DEEPWATER HORIZON" IN THE GULF OF MEXICO ON APRIL 20, 2010,vol. 33,No. 20, Dec. 8, 2011

IN RE: DEEPWATER HORIZON INSURANCE LITIGATION - FIFTH CIRCUIT REVERSES IN FAVOR OF BP'S ADDITIONAL INSURED CLAIM, vol.35, No. 4, Mar. 18, 2013

IN RE: DEEPWATER HORIZON INSURANCE LITIGATION - THE FIFTH CIRCUIT REVERSES THE DISTRICT COURT'S ADDITIONAL INSURED DECISION BUT THEN WITHDRAWS ITS DECISION AND CERTIFIES ISSUES TO THE TEXAS SUPREME COURT, vol 33, no. 1 Feb 20, 2011, vol 32, no. 14, Aug. 30, 2010

Readers may recall that the federal district court in Louisiana originally ruled that the Transocean policies did not afford coverage to BP. The Fifth Circuit Court of Appeals reversed the trial court and ruled that BP was entitled to coverage, but that court then withdrew its opinion and certified two questions to the Supreme Court of Texas.

Upon certification, the principal question before the Supreme Court of Texas was whether, in deciding the scope of coverage provided to an additional insured, a trial court may look only to the insurance policy at issue or whether it may also consider other documents (in this case, the drilling contract between Transocean and BP). (The court also considered a second question as to the applicability of the sophisticated insured exception to the general rule that policies are construed in favor of insureds.)

The parties had agreed in the drilling contract that Transocean would indemnify BP for above-surface pollution regardless of fault and that BP would indemnify Transocean for subsurface pollution. The drilling contract also obligated Transocean to name BP as an additional insured under its policies.

BP was not specifically named in the policies, but the policies extended coverage to "[a]ny person or entity to whom the 'Insured' is obligated by oral or written 'Insured Contract' . . . to provide insurance such as afforded by [the] Policy." Transocean was an Insured under the policies.

After the catastrophic blow-out, BP sought insurance coverage under the Transocean policies.

The parties agreed that BP was an additional insured; thus the dispute involved only the extent of coverage afforded to BP. Transocean and its insurers argued that BP's coverage extended only to the indemnity obligations Transocean assumed in the drilling contract. BP argued that the language in the insurance policy afforded coverage that was broader than the contractual indemnity in the drilling contract and that it is improper to narrow coverage terms by referring to limitations outside the four corners of the policy.

In support of its argument, BP relied on *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008). It argued that the court previously ruled in *ATOFINA* that a court may consider only the language within the four corners of the insurance policy to determine the scope of coverage. In reply, Transocean and its insurers pointed out that BP was an additional insured under the Transocean policies only because of the status conferred to it under the

drilling contract to which the insurance policy refers, by predicating additional-insured status on the existence of an Insured Contract requiring insurance coverage. In support of their position, they relied on *Urrutia v. Decker*, 992 S.W.2d 440 (Tex. 1999), which recognized that a separate contact can be incorporated by reference into an insurance policy if it is clear that the parties intended to do so.

The court recognized that a named insured may gratuitously choose to secure more coverage for an additional insured than it is contractually obligated to provide. But, it ruled that an insurance policy may incorporate an external limitation on additional-insured coverage, which limitation effectively is an endorsement to the policy.

In this situation, had the insurance policies expressly named BP as an additional insured, the court would not have needed to consult the drilling contract or any limitation therein. However, BP would not have been afforded any coverage under the insurance policies but for the reference to the drilling contract, so it was necessary to consult that contract.

The court devoted several pages of its decision to the parties' arguments concerning the punctuation of the drilling contract insurance clause.

Transocean was required to name BP and related entities:

> as additional insureds in each of [Transocean's] policies, except Workers' Compensation for liabilities assumed by [Transocean] under the terms of [the Drilling] Contract.

Transocean argued that the proper reading of this clause is that there is a general insurance obligation that excepted only Workers Compensation coverage. BP disagreed and pointed out that there was comma before, but not after, the phrase "Workers' Compensation." BP argued that an additional comma cannot be inserted where it does not exist when that would alter the plain meaning of the contract. The court addressed this issue by stating it would "not construe the absence of a comma to produce an unreasonable construction." The court went on to observe that Transocean's argument was consistent with the allocation of liabilities in the drilling contract and noted the common practice of excepting workers' compensation from additional insured coverage.

In summary, the court held that (1) the Transocean insurance policies include language that necessitates consulting the drilling contract to determine BP's status as an additional insured; (2) under the drilling contract, BP's status as an additional insured is inextricably intertwined with limitations on the extent of coverage to be afforded under the Transocean policies; (3) the only reasonable construction of the drilling contract's additional-insured provision is that BP's status as an additional insured is limited to the liabilities Transocean assumed in the drilling contract; and (4) BP is not entitled to coverage under the Transocean insurance policies for damages arising from subsurface pollution because BP, not Transocean, assumed liability for such claims.

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Bad Faith/ Advice of Counsel Defense

Insurer's Assertion of Subjective Good Faith Defense in Bad Faith Action Does Not, by Itself, Result in Implied Waiver of Attorney-Client Privilege under Arizona Law

Evidence of Insurer's Consultation with Counsel Does Not Establish Insurer's Reliance on Counsel's Advice in Forming Subjective Belief

Everest Indemnity Insurance Co. v. Rea, et al., __ P.3d __, 2015 WL 195450 (Ariz. App., Jan. 15, 2015)

Case at a Glance

An insurance company under Arizona law does not place the advice it receives from its counsel at issue and thereby waive attorney-client privilege merely by consulting with counsel as part of the procedural handling of a claim.

Summary of Decision

This case arose out of a special action in which the insurance company, Everest Indemnity Insurance Company (Everest), challenged the trial court's order requiring the production of documents that involved privileged communications between the insurer and its counsel. The real parties-in-interest, Rudolfo Brothers Plastering and Western Agricultural Insurance Company (collectively "Rudolfo") had successfully argued in the trial court that Everest had impliedly waived the attorney-client privilege by defending against their bad faith claims on the basis of subjective good faith.

Rudolfo alleged that Everest had committed bad faith by entering into a settlement agreement that exhausted the liability coverage of an Owner-Controlled Insurance Program (OCIP) to the alleged detriment of certain insureds such as Rudolfo. Everest argued that the decision to settle was made in good faith based on its subjective belief concerning the relative merits of the various available courses of action in trying to settle the case and protect the insured. Everest acknowledged that it had communicated with counsel during the process of making that decision. The issue before the court was whether Everest had impliedly waived the attorney-client privilege regarding those communications when it asserted its subjective belief in the good faith nature of its actions and by consulting with counsel at the time.

The Arizona Court of Appeals resolved a percolating dispute under Arizona law regarding the status of waiver of attorney-client privilege in bad faith cases. A tension in Arizona law existed regarding the Arizona Supreme Court's decision in *State Farm Mut. Auto. Ins. Co. v. Lee*, 199 Ariz. 52, 13 P.3d 1169 (2000) and the Arizona Court of Appeals decision in *Mendoza v. McDonald's Corp.*, 222 Ariz. 139, 213 P.3d 288 (App. 2009). In the *Lee* decision the Arizona Supreme Court had held that it was not sufficient that the information sought was relevant or important to a claim or defense but that the party holding the privilege must take steps to place the privileged information at issue. In *Lee*, the Arizona Supreme Court explained that to waive the privilege a party must do more than simply confer with counsel and take action incorporating counsel's advice. A waiver would be implied only when, after receiving advice from an attorney, the party made an affirmative assertion that it was acting in good faith *because* it relied on counsel's advice to inform its own evaluation and interpretation of the law. In essence, reliance on advice of counsel.

Rudolfo, relying upon *Mendoza*, argued that by choosing to defend itself based on the subjective reasonableness of its actions after consulting with counsel, Everest had necessarily waived the attorney-client privilege. The Arizona Court of Appeals in *Everest* disagreed.

The court in *Everest* stated that Rudolfo had overread the *Mendoza* decision in a way that was inconsistent with *Lee*. The Supreme Court in *Lee* had expressly held that the assertion of a subjective good faith defense coupled with consultation of counsel did not, without more, waive the attorney-client privilege. In order to waive the privilege, something more was required. Under *Lee*, the privilege would be impliedly waived only when the litigant asserts a claim or defense that is dependent upon the advice or consultation of counsel, *i.e.,* advice of counsel

defense. The Arizona Court of Appeals also noted that under *Lee*, to waive the attorney-client privilege a party had to make an affirmative claim that its conduct was based on its understanding of the advice of counsel and that it was not sufficient if the party only consulted with *counsel* and received advice.

Under the facts of the case, Everest had consulted with counsel before making the decision to enter into the settlement agreement and acknowledged that counsel was involved in the settlement negotiations. The court in *Everest* found that those facts, alone, were not sufficient to suggest that Everest's subjective belief in the legality of its actions necessarily included or depended on the advice it received from counsel. The court noted that Everest had not asserted the advice of counsel defense. The court also noted that Everest had not shared the advice of its counsel with its own expert on bad faith. Everest's bad faith expert opined simply that the fact of consultation was a *procedural* indication of good faith. As such, the Arizona Court of Appeals in *Everest* held that Everest had not yet placed the advice it received from counsel at issue in the litigation and therefore had not waived attorney-client privilege.

The court in *Everest* also noted there had been no showing that Everest was in doubt as to any legal issue. Rather, Everest made decisions during the course of litigation that Everest of necessity, involved lawyers in the litigation. Everest's decision to settle the case was not necessarily the product of legal advice and Everest had not yet asserted, expressly or impliedly, that it was. // Plitt

Claims-Made Insurance/ Notice

Eighth Circuit Enforces Notice Provision in Claims-Made Liability Policy under Missouri Law

Demand for Refund Constitutes a Claim

Philadelphia Consolidated Holding Corporation v. LSi-Lowery Systems, Inc., 775 F.3d 1072 (8th Cir. 2015)

Case at a Glance

Failure to provide timely notice of a claim or potential claim precluded coverage under a claims-made liability policy for claims of breach of contract, negligence, and negligent misrepresentation arising from problems with software that the insured sold to a business. Email and other communications from the business to the insured that proposed resolution of the dispute through the refunding of all money paid by the business, and that stated the business intended to pursue all legal and equitable remedies, constituted a "claim" even though no dollar amount was specified. Summary judgment in favor of the insurer was affirmed.

Summary of Decision

LSi, a technology consulting firm, sold business software to Hodell in 2004. LSi's implementation services for the software included evaluating Hodell's hardware and software requirements and performing testing. In 2007 Hodell emailed LSi complaining that the system was unstable and slow and demanded that LSi fix the problem. Hodell discussed its intent to bring its "legal advisors" and LSi acknowledged that it could expect a legal issue if Hodell was not happy. Also in 2007, Hodell's attorneys advised LSi that Hodell would pursue all legal and equitable remedies available to it, and requested that LSi have their attorneys contact Hodell's counsel to discuss an amicable resolution. A January 2008 email from Hodell to LSi proposed a chance to resolve the situation with a refund of the money Hodell paid

related to software licenses and maintenance fees, and asked about LSi's professional liability insurance.

In November 2008 Hodell filed suit against LSi and others, asserting claims for breach of contract, negligence, and negligent misrepresentation arising from the performance issues with the software. In December 2008 LSi first notified its insurer, Philadelphia Insurance Companies (PIC) of Hodell's claims. PIC maintained that LSi had no coverage because LSi did not notify PIC of any claim or potential claim during the 2007 policy period. PIC also contended that there was no coverage under the 2008 policy period, because that policy covered claims "first made" during the policy period, and Hodell first made a claim against LSi before the 2008 policy took effect in April.

The district court granted summary judgment for PIC, concluding that there was no coverage because LSi did not give notice of a claim or potential claim to PIC within the 2007 policy period. The district court also found that there was no coverage under the 2008 policy, concluding that the communications between Hodell and LSi from 2007 to the April 2008 starting date of the policy constituted a claim.

The Eighth Circuit affirmed, agreeing that the email and other communications constituted a claim because they showed that Hodell blamed LSi for the functionality problems of the software, requested that LSi fix the issues, and expected LSi to pay the associated costs. The court rejected Hodell's and LSi's argument that the 2007 policy defined a claim solely as a demand for money, and that Hodell did not make a specific claim for money. The court reasoned that Hodell proposed a chance to resolve the situation with a refund of the money Hodell paid, and also asked LSi about its professional liability insurance, and also indicated that Hodell could not assure LSi that there would be no lawsuit. While Hodell did not make a demand for a specific dollar amount, it proposed a "settlement" in exchange for a refund of the money Hodell paid. This constituted a demand for money and amounted to a claim.

The court also rejected arguments that LSi was not required to give notice because the communications concerned LSi's performance of the contract, which would not be covered, rather than negligence. However, the evidence showed that Hodell made it clear to LSi that it intended to pursue all legal and equitable remedies, not just a suit premised on breach of contract. Finally, the court noted that PIC was not required under applicable Missouri law to show it was prejudiced by LSi's failure to give timely notice. // Holt

Compulsory Insurance

Compulsory Insurance Not Subject to Policy Conditions

Precedent from Auto Insurance Cases Applies to Aircraft Claims

Northwest Airlines, Inc. v. Professional Aircraft Line Service, 2015 WL 161610 (8th Cir. [Minn.] Jan. 14, 2015)

Case at a Glance

In an unusual case of first impression, the Eighth Circuit Court of Appeals, applying Minnesota law, has held that compulsory insurance for airplane maintenance services is not subject to notice and cooperation conditions. As with auto insurance, because the purpose of the coverage is to protect third parties, the insured's breach of the policy's conditions cannot frustrate the legislative intent underlying the required insurance.

Summary of Decision

From time to time, a lot of us have forgotten to set the parking brake on our vehicle of choice. When that vehicle is a commercial airliner, the consequences can be daunting.

Professional Aircraft Line Service, or PALS, is an aircraft maintenance company that handles planes at McCarran International Airport in Las Vegas. When a PALS technician moved a Northwest airliner and forgot to set the brake, the plane rolled down an embankment and crashed, causing Northwest some ten million dollars in repair costs and lost profits. Northwest sued PALS, which assertedly failed to tender the suit promptly to its insurer, Westchester, and Northwest recovered a default judgment that it sued Westchester to recover. The trial court held that PALS's breach of the policy's conditions did not

prevent Northwest from recovering under its policy, and the Court of Appeals agreed.

The focus of the appeal was an ordinance in Clark County, Nevada, where the airport sits. That ordinance required hanger keepers to maintain at least five million dollars of liability insurance for damage to property in their custody. Although PALS had failed to provide Westchester with timely notice of Northwest's suit as its policy required, Northwest argued that, where insurance is required by law to protect the public, an injured party cannot be barred from recovery by the failure of the insured to perform its contractual obligations—otherwise, the public policy behind the insurance requirement would be defeated. The Court of Appeals agreed, noting that the obvious purpose of the Clark County ordinance was to protect aircraft owners like Northwest. Although most of the case law on point involved compulsory auto insurance, not insurance for aircraft being maintained on the ground, Westchester had proffered no reason why the factual context should matter. Although Westchester offered a number of additional arguments for excusing it from liability, the court rejected each of them. The fact of the matter, the court noted, was that Westchester was well aware of Northwest's suit against PALS, and made a tactical decision to rest on its technical policy defenses instead of simply defending PALS. Westchester could hardly claim, having decided not to defend the underlying case, that it was prejudiced by PALS's failure to send a formal notice of the suit.

Comment

Ostensibly, the holding of the *Northwest* case is that, where liability insurance is made compulsory to protect a third party, the legislative intent in requiring the insurance cannot be subverted by the insured's failure to perform its obligations under the policy. After all, the coverage is required to protect the third party. The more practical point of the case may be that, if an insurer is going to defend a claim based on based on lack of notice, it should think twice about doing so where it had actual notice of a suit and simply decided not to get involved. // Barnes

Disability Insurance/ Regulation

California Insurance Code Requires Commissioner to Review Disability Policy Forms Prior to Approval

Plaintiff Who Alleged Failure to Review Stated Claim for Mandamus

Ellena v. Department of Insurance, 230 Cal.App.4th 198, 178 Cal.Rptr.3d 435 (1st Dist. 2014)

Case at a Glance

The California Insurance Commissioner had a duty under the Insurance Code to review a disability policy form to ensure that it complied with California law prior to approving it. A trial court erred in finding that a plaintiff who challenged the commissioner's alleged approval of a form without review failed to state a claim for mandamus, and approval of a demurrer of her claims against the Department of Insurance was reversed. Statutes allowing the commissioner to explicitly approve a policy with a writing or implicitly approve it by not objecting to it did not relieve the commissioner from the obligation to approve a disability policy before insurers were allowed to use it.

Summary of Decision

Plaintiff filed a complaint against Standard Insurance and the California Department of Insurance, alleging that Standard failed to provide disability benefits to her under a group disability policy issued to her employer. According to plaintiff, Standard denied her claim for disability based on the language of a policy form entitled "Definition of Disability" that she claimed was deceptive and violated settled California law. Plaintiff asserted that the DOI approved the policy without complying with its mandatory duty to review the policy form in accordance with established criteria. She sought a writ of mandamus against the DOI for violating its mandatory duties.

According to plaintiff, Standard's policy allowed

the insurer to redefine plaintiff's "Own Occupation" as an occupation other than the one she actually performed, and to deny her claim based on its determination that she was able to perform an occupation that was not her own. She asserted that the "California Settlement Agreement" approved by the DOI in an agreement negotiated with another insurer defined total disability as a disability that rendered one able to pursue his or her usual occupation in the usual and customary way. Plaintiff alleged that DOI never actually exercised its discretion or performed its mandatory duties under the Insurance Code to determine whether the Standard policy complied with California law or qualified for approval under the Insurance Code.

The DOI demurred to plaintiff's complaint, and the trial court sustained the demurrer without leave to amend. The court ruled that plaintiff had not sufficiently alleged a violation of a specific mandatory duty and that a writ of mandate could not be based on general enforcement provisions or statutes involving the DOI's exercise of discretion. The court dismissed the DOI from the lawsuit with prejudice.

The court of appeal reversed the order entering a judgment of dismissal in favor of the DOI and remanded, directing the trial court to enter a new order overruling the demurrer. The court first determined that plaintiff's appeal was not moot on the ground that plaintiff could not personally benefit from a mandamus proceeding, reasoning that the DOI's interpretation of the Insurance Code was a matter of great public interest. Insurance Code § 10291.5(b) provided that the insurance commissioner "shall not approve any disability policy" unless it met a number of requirements. The plain meaning was that the commissioner had a mandatory duty to review the policy prior to approving it and the commissioner must review the disability policy to ensure it met the statutory requirements.

The court rejected DOI's claim that § 10291.5 contained a statement of legislative intent and goals, but did not force the commissioner to take a particular action. Plaintiff's suit was not directed towards forcing the commissioner to comply with the part of the statute setting forth legislative goals and intent, the court reasoned. Other statutes relied on by the DOI, Insurance Code §§ 10290 and 10291, provided the commissioner with the power to approve a policy explicitly with a writing or to approve it implicitly by failing to act within a specified time. Those sections did not relieve the commissioner from the obligation to approve a disability policy before insurers are allowed to use it, the court concluded. The court also determined that the fact that the commissioner's authority to revoke approval of a policy was discretionary had no bearing on the commissioner's authority to approve a policy without reviewing it.

The court concluded that the Insurance Code required that the commissioner review a disability policy form prior to approving it. The trial court therefore erred in finding that plaintiff failed to state a claim for mandamus against the DOI based on her allegations that the commissioner did not review the policy to ensure that it complied with California law prior to approving the policy for distribution in California.

Duty to Defend

Denial of Insurer's Summary Judgment on Duty to Defend Does Not, Itself, Establish Existence of Defense Duty

Denial Based on Insurer's Failure to Meet Evidentiary Burden, Not Existence of Factual Dispute

McMillin Companies, LLC v. American Safety Indemnity Co., ___ Cal.App.4th ___, ___ Cal.Rptr.3d ___, 2015 WL 270034 (4th Dist., Jan. 22, 1015)

Case at a Glance

A liability insurer's failure to satisfy its initial burden, in moving for summary judgment, of producing evidence showing the absence of potentially covered claims did not establish that the insurer owed a duty to defend. In order for the denial of an insurer's motion for summary judgment regarding its duty to defend to establish a duty to defend, the denial must be based on the existence of an unresolved factual dispute.

An insured's settlement of claims against other

insurers from which it sought a defense did not preclude the insured from proving damages resulting from a non-settling insurer's breach of its duty to defend. The settlements offset recoverable damages but did not eliminate the damages element of a cause of action for breach of the duty to defend.

Summary of Decision

McMillin Companies, LLC, a general contractor for a series of residential construction projects, was insured as an additional insured under liability policies issued to the projects' subcontractors. After the projects were completed, McMillin was named in a construction defect lawsuit that arose out of the projects. McMillin tendered its defense to all the subcontractors' insurers, including American Safety Indemnity Company (ASIC). The insurers all denied coverage.

McMillin sued all the insurers for breach of contract and bad faith failure to defend. By the time the coverage litigation was ready for trial, McMillin had settled with all the insurers except ASIC. ASIC moved for summary judgment on the ground that its policy covered ASIC only for liability arising out of its named insured's "ongoing operations" which had ceased prior to the occurrences alleged in the litigation. Finding ASIC had failed to meet its initial burden of producing evidence showing the absence of triable issues of fact regarding whether McMillin was an additional insured, the trial court denied the motion.

At trial, both McMillin and ASIC submitted motions in limine. McMillin moved to exclude argument disputing ASIC's duty to defend. The trial court granted McMillin's motion, finding the prior denial of ASIC's motion for summary judgment necessarily established the existence of potentially covered claims and thus a duty to defend.

ASIC moved to preclude McMillin from arguing that the settlement proceeds were not an offset to the alleged damages for breach of the duty to defend or that the proceeds were allocated to damages for breach of the implied covenant of good faith and fair dealing. The trial court granted ASIC's motion. The parties agreed that the effect of the ruling was to preclude McMillin from proving contract damages. Accordingly, judgment was entered in favor of ASIC, and both parties appealed.

The California Court of Appeal, Fourth District, reversed, holding the trial court erred in granting the motions in limine. With respect to the duty to defend, the court acknowledged that the very existence of the factual dispute regarding the potential for coverage necessarily establishes a potential for coverage and thus a duty to defend. Here, however, the trial court denied ASIC's motion for summary judgment on the duty to defend because ASIC had failed to meet its initial burden of production, not because there was an unresolved factual dispute. Accordingly, the appeals court held the trial court erred in precluding ASIC from providing additional evidence at trial showing there was no duty to defend.

With respect to the effect of the settlements on McMillin's ability to establish the damages element of a cause of action for breach of the contractual duty to defend, the court ruled that the settlement amounts did not affect the amount of damages that McMillin suffered as a result of ASIC's breach of the duty to defend, but only McMillin's recovery of such damages. The court held that at trial, McMillin must be allowed to present evidence of its contract damages and of ASIC's bad faith in denying coverage. While any damages awarded would be subject to offset by the settlement amounts McMillin had received, the court found that McMillin has the right to prove its damages at trial.

In so ruling, the court distinguished *Emerald Bay Community Assn. v. Golden Eagle Ins. Corp.*, 130 Cal.App.4th 1078, 31 Cal.Rptr.3d 43 (2005), where a policyholder was provided a complete defense at all times by another insurer. In that situation, the policyholder generally cannot assert a breach of contract claim, because an essential element of that claim—damages—is lacking. // DiMugno

Insurer Must Defend Groundless Suit Even If Extrinsic Facts Know to Both Insurer and Insured Establish Absence of Coverage

Illinois Law Applied

Illinois Tool Works, Inc., et al. v. Travelers Casualty and Surety Co., __ N.E.3d __, 2015 IL App. (1st) 132350, 2015 WL 165941 (Ill. App. Jan. 13, 2015)

Case at a Glance

In this multi-district litigation involving alleged exposure to toxic materials, connected with a welding company that was acquired by the insured after expiration of the insurers' policy periods, the court found several grounds to impose the duty to defend on the insurers. First, the court held that regarding complaints where the time period of exposure to toxic materials was ambiguous or unstated that ambiguity or pleading silence had to be resolved in favor of finding a duty to defend. In those lawsuits where the insured's direct liability was alleged as well as successor-in-interest liability, the insurers had a duty to defend. However, where the complaints only alleged a successor-in-interest liability theory against the insured, the insurers were not obligated to defend.

Summary of Decision

The declaratory judgment action in this case involved a multitude of cases brought by individuals that were allegedly injured as a result of exposure to harmful materials while welding or engaging in other building or maintenance activities. Plaintiffs Illinois Tool Works, Inc. and ITW Finishing, LLC (collectively, Illinois Tool) were companies that engaged in the manufacture and distribution of tools, equipment, finishing systems, and consumables. Illinois Tool was insured by Travelers Casualty and Surety Company and Century Indemnity Company (collectively, Insurers) with policies issued as early as 1971, but no later than 1987. The facts indicated that in the late 1980s, Illinois Tool expanded its product line through a series of corporate acquisitions. One of the markets entered by Illinois Tool was the distribution of welding products which began for the first time with its acquisition of Miller Electric in 1993. It was undisputed by the parties that Illinois Tool was not involved in the welding product market prior to its acquisition of Miller Electric.

In the declaratory judgment action, the parties submitted a sampling of the various complaints filed in the toxic tort cases. From 1971 to 1987, the Insurers issued 10 policies to Illinois Tool. The Insurers argued that they could not be liable to the plaintiffs because the last policy they issued to Illinois Tool expired in 1987 and Illinois Tool had not entered the welding product market prior to the expiration of those policies.

The Illinois Court of Appeals analyzed the duty to defend issues which were in dispute by dividing the representative complaints into four broad categories for purposes of determining whether the duty to defend attached. The complaints were grouped into categories based on whether they contained allegations of: (1) direct liability with exposure dates during a policy period; (2) direct liability with unstated injury or exposure dates; (3) pure successor-in-interest liability claims; and (4) a combination of direct liability and successor-in-interest claims.

Regarding the complaint allegations involving direct liability claims with exposures during a policy period, the court held that the Insurers had a duty to defend. This grouping of complaints alleged direct liability against Illinois Tool during at least some portion of the relevant policy periods. Therefore, the Insurers had a duty to defend that group of cases even though the allegations may have, in fact, been groundless. Regarding this group of cases, the Insurers argued that they had no duty to defend because it was unlikely that Illinois Tool would actually be found liable in the underlying suits. The court rejected this approach, noting that the court's inquiry had to focus on whether the facts pled by the underlying plaintiffs, if true, would potentially bring the claims within coverage. Therefore, the Insurers' knowledge that extrinsic facts not pled in the complaint would ultimately defeat any coverage obligation did not negate the Insurers' duty to defend in the first place if the complaint, on its face, presented a claim potentially within the insurance policies' coverage.

At the heart of the Insurers challenge were the allegations which grouped together all of the

defendants without differentiating any specifics regarding Illinois Tool's alleged responsibilities in producing the overall liability event. In addressing this concern, the court acknowledged that the majority of the underlying complaints in this grouped category used "group pleading" or "shotgun pleading" which implicated Illinois Tool. Nevertheless, the court held that the Insurers bore the burden of the underlying plaintiffs' broad drafting, that the allegations had to be liberally construed in favor of a duty to defend, and that any ambiguities in the underlying Complaint needed to be resolved in favor of the duty to defend. Irrespective of whether or not Illinois Tool ultimately could be found liable in the underlying cases, the insurers had agreed in their policy to bear the burden of defending against the putative groundless allegations. It was only with knowledge of the extrinsic facts that it became apparent that, contrary to the express allegations in the underlying complaints, Illinois Tool was not in the business of manufacturing or distributing welding products before 1993.

The second grouped category of complaints addressed by the court involved direct liability claims with unstated exposures or injury dates. In resolving the duty to defend in favor of Illinois Tool, the court began its analysis by noting that vague and ambiguous allegations against an insured should be resolved in favor of finding a duty to defend. Therefore, the ambiguous or unstated time periods needed to be resolved in favor of the duty to defend. The bear allegations of the underlying complaints left open the possibility that the plaintiffs' exposure or injuries occurred during the policy periods. Therefore, the underlying allegations did not foreclose coverage. The court noted that the time of injury was a factual question. The allegations brought against Illinois Tool in this grouped category of cases gave rise to a duty to defend because the time of the injury was a factual uncertainty that, until resolved, required a defense.

The third grouped category of complaints involved pure successor-in-interest claims. In this grouping of complaints it was alleged that Illinois Tool was liable as a successor-in-interest to the predecessor welding companies that Illinois Tool later acquired which engaged in the manufacture and distribution of the various products in question. In essence, these complaints alleged that Illinois Tool was liable for the conduct of other companies that Illinois Tool acquired after the Insurers policy periods had expired. Regarding this grouping of complaints, Illinois Tool had essentially conceded that it was not entitled to a defense. The underlying allegations for this grouping of cases made it clear that Illinois Tool could not be found liable for its own conduct and that it was only alleged to be liable based on its affiliation with the companies it acquired after the policy periods. The Illinois Court of Appeals held that the underlying plaintiffs had essentially pled the Insurers out of any duty to defend by making it clear that their claims were only directed at predecessor companies or activities beginning in 1993. In that situation, Illinois Tool did not bargain for a defense for claims made against it by way of any after-acquired companies or for conduct occurring after 1987. Therefore, the court held that Illinois Tool was not entitled to a defense in this category of cases.

The final grouping of complaints addressed by the court involved a combination of both direct liability and successor-in-interest claims. In these cases Illinois Tool was named individually as well as a successor-in-interest to Miller Electric Manufacturing Company and Hobart Brothers Company. In the underlying multi-district litigation, the trial court held that Illinois Tool was entitled to summary judgment because, despite claiming that Illinois Tool should be individually liable, the plaintiffs could not produce any evidence that there was a causal connection between anything done by Illinois Tool and the plaintiffs injuries. The predominate shortfall in the underlying plaintiffs direct claims against Illinois Tool was that Illinois Tool was not in the welding product industry or any of the relevant trade associations prior to 1993. Therefore, the District Court held that the direct liability claims could not succeed against Illinois Tool because there was no evidence that plaintiffs were harmed by any Illinois Tool product or that Illinois Tool had a duty to plaintiffs. However, regarding the duty to defend, as opposed to indemnity, the court noted that Illinois Tool was alleged to be directly liable and in each complaint there was, based on the allegations, the possibility that Illinois Tool could be found directly liable. Where there were allegations of direct liability against Illinois Tool and the bare allegations left open the possibility that the loss could be covered, the court held that the Insurers had a duty to defend those claims. Because, under Illinois law, when an insurer has a duty to

defend against one claim in a suit its duty to defend exists against all claims even if some of the claims standing alone were beyond the scope of the policy, the court found that for this category of claims the Insurers were required to provide a defense for the direct claims against Illinois Tool, as well where successor liability (not covered) had been alleged in the same complaint. // Plitt

Liability Insurance/Coverage B

"Failure to Conform" Exclusion Upheld in New York

Defense Reimbursement Claim Rejected

General Star Indem. Co. v. Driven Sports, Inc., __ F. Supp. 3d __, 2015 WL 307017 (E.D.N.Y. Jan. 23, 2015)

Case at a Glance

A federal judge construing New York law has applied the "failure to conform" exclusion in a CGL policy to an unfair competition suit. The court declined, however, to make the insured return its defense costs.

Summary of Decision

The decision in *Driven Sports* addressed the tension between the Coverage B insuring clause in a CGL policy and the exclusion for a product's "failure to conform." In this ongoing war over the limits of Coverage B, the insurer won this round.

Driven Sports is a manufacturer of an athletic nutritional supplement called "Craze," which it advertises as a "natural" product. Driven's competitors and customers took umbrage at the claim, arguing that Craze contained synthetic substances similar to methamphetamine and was hardly "natural." When Driven was sued in three class actions, General Star accepted its defense under a reservation of rights and sought declaratory relief and reimbursement of its defense costs. It got half the relief it was looking for.

The focus of the court's analysis was the standard exclusion in Coverage B of General Star's CGL policy, which applied to personal and advertising injury "arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your 'advertisement.'" After reviewing Second Circuit precedent, the court had no difficulty agreeing the class actions all fell within the "failure to conform" exclusion, because each rested on the premise that "Craze" was not, in fact, "natural." Although the suits raised a variety of statutory and common law claims, each of those claims "arose out of"—that is, had its origin in—the failure of "Craze" to conform to the advertised representation that it was "natural." The court further indicated grave concerns about the validity of cases exemplified by *E.piphany, Inc. v. St. Paul Fire & Marine Ins. Co.*, 590 F. Supp. 2d 1244 (N.D. Cal. 2008), which held that boasting about one's own product is tantamount to disparaging a competitor's product. Rather, the court suggested, making false claims about the quality of one's own product is simply an excluded event under the "failure to conform" exclusion.

At least Driven had better luck with General Star's claim for reimbursement of its legal fees. In predicting the New York Court of Appeals would not allow recoupment of noncovered defense costs, the District Court noted that equity generally steps in only where a contract could not have provided a remedy. Because the policy obligated General Star to bear the costs of suits it defended, and nowhere reserved a recoupment remedy, the court was disinclined to create a term the insurer itself had foregone. Moreover, even if it reached the "equities" of the dispute, the court would not have found it equitable to restore the defense costs to General Star. General Star suffered no injustice by paying Driven's defense costs: it avoided any risk of incurring bad faith liability for wrongfully denying coverage. The court did throw General Star a small bone, however, by agreeing that its defense payments eroded the policy's limits, a point on which the policy itself was clear and unambiguous.

Comment

The case law addressing coverage for unfair competition and competitive injury litigation under Coverage B of a CGL policy is a rapidly-moving target that, in some ways, mirrors the early environmental

coverage litigation of a generation ago. At this point, to paraphrase Winston Churchill, it is unclear whether we are at the end of the beginning or the beginning of the end, but the rediscovery of the "failure to conform" exclusion is likely to add an interesting new chapter to an ongoing saga that is anything but dull. // Barnes

Loss Payees/Full Credit Bids

Full Credit Bid at Foreclosure Sale Extinguished Insurance Claims on Property

First and Second Mortgages Not Aggregated to Show Bid on Second Was Not "Full Credit"

Najah v. Scottsdale Insurance Company, 230 Cal.App.4th 125, 178 Cal.Rptr.3d (2nd Dist. 2014)

Case at a Glance

The right to recover insurance benefits under mortgagee insurance was foreclosed by plaintiffs' full credit bid at a foreclosure sale. Making a full credit bid equal to the unpaid debt and expenses of foreclosure precluded the lender from later claiming that the property was worth less than the bid. The lender's only interest in the property, repayment of the debt, was satisfied, and any further payment by the insurer would be double recovery. All liens held by the mortgageholder could not be aggregated to determine whether a full credit bid was made. Having deprived the insurer of the benefit of a bona-fide mortgage foreclosure auction, plaintiffs could not then reasonably contend that they were entitled to insurance proceeds in an amount between what they freely paid to secure the property and the amount they now claimed the property was worth.

A trial court did not abuse its discretion in finding an insurer's $30,000 settlement offer to mortgageholders for property damage was made in good faith. Although the mortgageholders alleged that the property needed repairs in excess of $500,000, nothing precluded the trial court from concluding that the $30,000 offer was reasonable based on its determination that the insurer had no liability because any damage or removal of property done on behalf of the property owner was not recoverable under the policy.

Summary of Decision

Plaintiffs sold a property to Orange Crest Realty in 2006. Orange Crest borrowed $2.021 million from a family trust in return for a promissory note secured by a first deed of trust on the property. Plaintiffs took back a promissory note and a second deed of trust for an additional $2.55 million. There was structure on the property at the time of sale. Plaintiffs' promissory note stated that there would be no remodeling or construction on the property until the first mortgage and the note were paid in full. The second deed of trust similarly required Orange Crest to keep the property in good condition, to not remove or demolish any building, and to restore any building that might be damaged or destroyed.

Plaintiffs' note also provided that Orange Crest would furnish full all risk insurance for the property. Orange Crest obtained an insurance policy from Scottsdale Insurance, listing the family trust and plaintiff as mortgageholders. The policy covered "vandalism," but not theft.

Orange Crest stopped making payment on the loans in 2008. The family trust began foreclosure under its first deed of trust. To stop the foreclosure plaintiff purchased the family trust's interest in the property for the balance due on the family trust note, $1.749 million, and the family trust assigned its first trust deed to plaintiffs. The assignment stated that it assigned to plaintiff "all beneficial interest" under the first deed of trust. Plaintiffs then foreclosed on the second deed of trust. At the foreclosure sale, plaintiff acquired the property by bidding $2.878 million, the amount of the unpaid debt on the second promissory note.

Plaintiffs had visited the property before the foreclosure and observed severe damage to the building. After purchasing the family trust's interest plaintiffs submitted a claim to Scottsdale that the insurer did not pay. Plaintiffs sued Scottsdale for breach of its insurance contract and of the implied covenant of good faith and fair dealing. The complaint alleged that damage had occurred to the property due to theft and/or vandalism that would cost at least

$500,000 to repair. Scottsdale contended that plaintiffs had extinguished the debt and any claim to insurance proceeds by acquiring the property at the foreclosure sale with a full credit bid, and that the damage was not covered by the policy.

After a trial the court found in favor of Scottsdale on the issue of insurable interest and coverage. The court ruled that under California law an owner cannot vandalize or steal his own property, and that any damage done on behalf of Orange Crest was not recoverable under the policy. In addition, any claim plaintiffs had to insurance proceeds as mortgagee under the second deed of trust was extinguished by their full credit bid at the foreclosure sale. With respect to the first deed of trust, plaintiffs' full value purchase in a private transaction extinguished the debt and any right to insurance proceeds. Prior to trial, Scottsdale offered to settle for $30,000. After judgment was entered, Scottsdale sought $86,022 in costs. The trial court denied the motion to tax with respect to $41,317 expert witness costs, but found the offer to compromise was made in good faith and plaintiffs failed to show the expenses were unreasonable.

The court of appeal affirmed, concluding that plaintiffs' right to recover insurance benefits under the mortgagee insurance provided by Scottsdale was foreclosed by their full credit bid at the foreclosure sale. Under the full credit bid rule, when the lienholder obtains property by making a full credit bid equal to the unpaid debt and expenses of foreclosure, it is precluded from later claiming that the property was worth less than the bid. The lender is also not entitled to insurance proceeds payable for prepurchase damage to the property, because the lender's only interest in the property, repayment of the debt, has been satisfied, and any further payment would be double recovery. Plaintiffs agreed that their full faith bid at the foreclosure sale on the second trust deed extinguished that debt, but contended that because they held two separate deeds of trust securing two separate debts, they should be entitled to pursue any remedy that would have been available to a third party holding the first separate trust deed.

Plaintiffs proposed a rule under which all liens held by the mortgageholder be aggregated to determine whether a full credit bid was made. The court rejected this approach, determining that the effect of plaintiffs bidding the full amount of the second lien, notwithstanding their belief that the property was worth less than the combined amount of the first and second liens, was to block other interested parties from participating in setting the price of the property. Having thus deprived Scottsdale of the benefit of a bona-fide mortgage foreclosure auction, plaintiffs could not then reasonably contend that they were entitled to insurance proceeds in the amount between what they freely paid to secure the property and the amount they later claimed the property was worth. Adopting plaintiffs' proposed aggregation rule would lead to the end of the effectiveness of the full credit bid rule, the court observed.

Finally, the court concluded that the trial court did not abuse its discretion in finding Scottsdale's $30,000 settlement offer to have been made in good faith. Plaintiffs argued that evidence showed the property needed repairs in excess of $500,000. However, nothing precluded the trial court from concluding that the $30,000 offer was reasonable based on its determination that Scottsdale had no liability. The trial court had ruled that an owner cannot vandalize or steal his owner property, and that any damage or removal of property on behalf of Orange Crest was not recoverable under the policy. // Jordan

Pollution Exclusion

Wisconsin Supreme Court: Manure and Septage Spread on Farm Fields Become "Pollutants" When They Contaminate Neighbors' Wells

Context Is Relevant to Whether Substance Is a "Pollutant"

Wilson Mutual Insurance Co. v. Falk, 857 N.W.2d 156 (Wis. 2014)

Preisler v. General Casualty Insurance Co., 857 N.W.2d 136 (Wis. 2014)

Case at a Glance

The absolute pollution exclusion in liability policies issued to dairy farmers unambiguously precludes coverage for lawsuits alleging that cow

manure and septage the farmers spread on farm fields contaminated neighbor's wells. Cow manure and septage both qualify as "pollutants" when found in a well, even if they may not so qualify in other contexts.

Summary of Decision

In both *Falk* and *Preisler,* the insured dairy farmers used cow manure (Falk) or septage (Preisler) to fertilize farm fields, a common practice among farmers. The insureds in *Preisler* also processed septage for use on their fields and sale to other farmers. In both cases, neighbors alleging that their well water had become contaminated by the manure or septage sued the insured.

The insureds sought coverage under the commercial general liability portions of their farm insurance packages. The policies insured against liability for bodily injury or property damage caused by an "occurrence" and defined an occurrence as "an accident, including . . . repeated exposures to" similar harmful conditions. The policies also contained similarly worded pollution exclusions that excluded harm "arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants.'" The policies defined "pollutants" as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed."

The trial courts in both cases ruled that the pollution exclusion precluded coverage for the neighbors' lawsuits. The intermediate appellate court affirmed in *Preisler* but reversed in *Falk.* The *Falk* appellate court reasoned that a reasonable farmer would consider cow manure to be "liquid gold" and not a pollutant when applied to a farm field. For a farmer, "manure is an everyday, expected substance … that is not rendered a pollutant under the policy merely because it may become harmful in abnormally high concentrations or under unusual circumstances."

The Wisconsin Supreme Court reinstated the trial court rulings. After finding that the contamination of the wells qualified as an occurrence within the meaning of the policies' insuring agreements because the seepage was neither expected nor intended, the supreme court focused on whether the pollution exclusions precluded coverage. In *Preisler,* the court opined that "a reasonable insured would understand decomposing septage to be a contaminant when it seeps into a water supply" such as plaintiffs' wells. The court further noted that state and federal regulations of septage handling supported the conclusion that the insureds should have been aware of the health risks connected with hauling, storing and applying septage.

In *Falk*, the court adopted a two part test for determining the pollution exclusion's applicability to a given set of facts. First, a substance is a pollutant if it is "largely undesirable and not universally present in the context of the occurrence [for which] the insured seeks coverage." Second, a substance is a pollutant when "a reasonable insured would consider the substance causing the harm involved in the occurrence to be a pollutant." The court found both elements satisfied here because cow manure in well water is undesirable, it is commonly understood to be harmful, and it is not universally present in well water.

Lastly, in *Falk*, the court held that the insurer had an obligation to defend and indemnify under a separate incidental coverage, with indemnity limits of $500 per occurrence, for "Damage to Property of Other." The court found that each of five contaminated wells constituted a separate occurrence.

Chief Justice wrote strongly worded dissents to both decisions in which she focused on the insureds' reasonable expectations in light of the nature of their businesses. In *Preisler,* observed that the insureds would not consider "septage a pollutant under the pollution exclusion clause of general liability policies they purchased to cover liability for damage caused by their septic business operations." In *Falk,* she reasoned that farmers covered under a farmowner's liability policy, would not consider manure a pollutant. // DiMugno

Completed Operations Hazard Exception to Pollution Exclusion Did Not Apply to Ongoing Operations

Insurer Not Required to Cover Damages Caused by Leakage of TCE into Soil

Visteon Corp. v. National Union Fire Insurance Co. of Pittsburgh, PA, __ F.3d __, 2015 WL 294384 (7th Cir. Jan. 23, 2015)

Case at a Glance

The operations hazard exception to a pollution exclusion in a manufacturer's liability policy did not apply to ongoing manufacturing operations of the insured. The operations hazard exception was narrowly construed to apply to accidents caused by defective workmanship that arose after completion of work by the insured on construction or services contracts. Judgment in favor of the insurer in the manufacturer's suit seeking coverage for damages resulting from leakage of TCE into the soil and groundwater from the manufacturer's plant as a result of ongoing operations was affirmed.

Summary of Decision

Visteon operated a manufacturing plant in Indiana in which the toxic solvent TCE was used to clean machinery. In 2001 it was discovered that TCE had leaked into the soil and groundwater. Neighboring landowners sued Visteon for damages caused by the leakage. Visteon spent millions of dollars to settle the suits and additional millions to clean up the pollution.

Visteon had bought a liability insurance policy from National Union. The policy contained an exclusion for liability resulting from pollution caused by Visteon, but the exclusion was inapplicable to liability arising from a "completed operations hazard." National Union refused to indemnify or defend Visteon from the suits arising from pollution caused by the plant. Visteon filed suit in Indiana state court, and National Union removed the case to federal district court in Indiana.

Indiana law required that for a pollution clause to be enforceable, the policy must specify what falls within the exclusion. TCE was not specified in the National Union policy. Michigan law, on the other hand, enforced the more general kind of pollution exclusion found in the policy. The district court ruled that Michigan law governed, but that Visteon was not entitled to coverage under the completed operations clause exception to the pollution exclusion. The court dismissed Visteon's suit.

The Seventh Circuit affirmed. The court upheld application of Michigan law, because the state had more insured facilities than Indiana, and Michigan was the state where Visteon had its headquarters and where the personnel who administered and negotiated the contract with National Union were stationed. Interpreting the pollution exclusion, the court agreed that the completed operations hazard exception did not apply. The exception was not to be interpreted so broadly as to swallow the entire pollution-exclusion clause, and the court rejected Visteon's argument that work was completed each time a contract to supply products made at the polluting plant was performed. Pollution arising from ongoing operations, such as manufacturing, was not covered by the completed operations hazard clause, even though Visteon was completing the performance of particular sales contracts with customers, the court reasoned. The clause instead was narrowly construed to refer to accidents caused by defective workmanship that arose after completion of work by the insured on construction or services contracts. Because TCE was a pollutant excluded from coverage under the policy, and because the completed operations hazard exception did not apply to Visteon's ongoing manufacturing operations, judgment in favor of National Union was affirmed. // Holt

Property Insurance/ Forced Placed Insurance

Insurance Companies Face Liability Exposure When Offering Insurance Policies for Forced Placement by Lenders

In a Lengthy Opinion, a Federal District Judge Examines Lender Force-placed Insurance Issues

Wilson v. Everbank, N.A., ___ F. Supp. 3d ___, 2015 WL 265648 (S.D. Fla. January 6, 2015)

Case at a Glance

The case of *Wilson v. Everbank, N.A.*, ___ F. Supp. 3d ___, 2015 WL 265648 (S.D. Fla. Jan. 6, 2015), was filed as a class action arising out of Lender Force-Placed Insurance practices in residential mortgages. The homeowner-borrower pays the premium charged on every force-placed insurance policy, including in this case. The original complaint contains eleven (11) claims or causes of action against four defendants, two lenders and two insurance companies which offered insurance policies that were force-placed on the plaintiffs. Some of the named plaintiffs' claims invoked Federal law and the rest invoked the law of three State jurisdictions in addition: Florida, New York, and Illinois. The District Court dismissed some claims and declined to dismiss others, leaving several claims intact as alleged against the lender and both insurance company defendants.

Summary of Decision

To an audience of readers of *Insurance Litigation Reporter*, the claims (or, as the Federal Judge described them, the "causes of action") of greatest interest are those alleged against the insurance companies in this case. The plaintiffs sued American Security Insurance Company ("ASIC") and Standard Guaranty Insurance Company ("SGIC") for alleged unjust enrichment, tortious interference, Racketeer Influenced and Corrupt Organizations Act ("RICO") violations, and for alleged violations of the New York Deceptive Trade Practices Act ("NYDPA").

Tortious Interference Claims Against the Insurance Company Defendants. The tortious interference counts or claims were not the first ones alleged against ASIC and SGIC in the plaintiffs' complaint, but the court's disposition of them is remarkable: In every lender force-placed insurance case that the author has found, including this one, every single claim alleged against an insurance company which provides insurance policies to be placed on borrowers by force, has survived a motion to dismiss based on alleged tortious interference with the borrower's business relationship with a lender.

To date, each of these cases has been filed in South Florida, specifically, in the United States District Court for the Southern District of Florida. The decision in the present case joins that lineup; in this case, too, the court denied the force-placing insurance companies' motion to dismiss the tortious interference claim alleged against them. Simply put, the insurance company defendants in this and other lender force-placed insurance cases allegedly paid "kickbacks" and compensation by other names, in exchange for a lender adding their names to an approved list used by the lender to force-place insurance on residential mortgagors. The lender thereafter selects the pay-to-play insurance company's policy when the lender force-places the insurance and the premium on the borrower. "Because Plaintiffs have adequately pled that EverBank [their lender-mortgagee] breached their mortgage agreements and that the Insurer Defendants intentionally and unjustifiably induced such breaches, Plaintiffs have stated valid tortious interference claims." *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *26 (S.D. Fla. Jan. 6, 2015).

At times, the court's summary of the insurance company defendants' arguments against tortious interference in this case almost seemed to include an argument that tortious interference should not lie here, because the insurance companies did not induce *the plaintiffs* to breach their mortgage contracts whether by failing to make payments on the mortgage or by allowing their homeowner's policies to lapse, or in some other, unspecified way. That has nothing to do with the tort of tortious interference with a business relationship in a lender force-placed insurance case, of course. The tort is directed toward

the mortgage contract relationship existing between the plaintiffs-borrowers and the lender-mortgagee. When the plaintiffs plead and, ultimately, if the plaintiffs prove that the insurance companies paid kickbacks to the lender in order to be able to charge the borrower a higher premium for force-placed insurance, the cost of which is added to the borrowers' monthly mortgage payments as they alleged here, then the tort of tortious interference with a business relationship will lie, again as it did here and as it has done in every case found to date.

If a legal counter to pleading a tortious interference claim exists for force-placing insurance companies, their challenge is to find it. They have not countered these alleged claims as yet. In the *Wilson* case, the insurance companies attempted to argue that tortious interference claims against them should be dismissed because the insurance companies' actions were privileged. The court refused to consider the issue of a privilege in conjunction with the insurance companies' motion to dismiss. Rather, privilege is an affirmative defense which must be proven. Besides, the court also noted, there is no privilege where the defendants asserting the privilege acted "in bad faith," including actions taken with malice or with conspiratorial motives. In the eyes of this court, "Plaintiffs have certainly alleged intentional and conspiratorial conduct by the Insurer Defendants here." *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *27 (S.D. Fla. Jan. 6, 2015). For all these reasons, the court in this case denied the insurer defendants' motion to dismiss the plaintiffs' tortious interference claim whether alleged under Florida, New York, or Illinois law.

Unjust enrichment claims. Unjust enrichment seems on its face to be the best fit for claims based on kickbacks and other illegal compensation. Just the sound of those two words—"unjust enrichment"—seems to describe the situation completely. The law does not see—or hear—it that way, however.

In lender force-placed insurance cases in particular, unjust enrichment claims do not have much success, although as in this case, the courts' discussions of these claims produce a lot of paper. In brief, unjust enrichment or quasi contract will not lie where there is a valid express contract. For that reason, unjust enrichment claims alleged against lenders-mortgagees have pretty uniformly been dismissed, just as the court in this case dismissed the plaintiffs' claims against their lender-mortgagee here. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *8-*9 (S.D. Fla. Jan. 6, 2015).

Some States also allow *nonparties* to a valid express contract to raise the existence of the contract as a bar to unjust enrichment claims against *them*. So it was in this case, as to the unjust enrichment claim alleged against the insurance company defendants under New York law, because New York unjust enrichment law—unlike Florida law or Illinois law—allows even defendants who were not parties to the express contract in the situation to raise the existence of the contract as a bar to the claim. In this case, of course, there was a valid and express contract, the mortgage, and even though the insurance companies were not parties to the mortgage, they were permitted to raise the mortgage contract as a bar to unjust enrichment claims against them under New York law. The court accordingly granted the insurance companies' motion to dismiss the plaintiffs' unjust enrichment claim, to the extent that one plaintiff from New York raised the claim under New York law. The Florida and Illinois plaintiffs' unjust enrichment claims in this case were left intact. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *23 (S.D. Fla. Jan. 6, 2015).

RICO Claims Against All Defendants. The plaintiffs alleged RICO claims "based on mail and wire fraud," which require allegations of "a scheme to defraud" and that the defendants intentionally participated in the scheme in order to state a claim upon which relief can be granted under 18 U.S.C. § 1962(c). The plaintiffs also alleged a RICO conspiracy which would have been actionable under 18 U.S.C. § 1962(d). However, the plaintiffs failed to allege actionable RICO claims and so the court granted all defendants' motions to dismiss them.

In this case, the court followed the majority view and held that alleged RICO violations have to be pled with the specificity required for allegations of fraud. Here, the plaintiffs failed to meet not only "the heightened pleading requirement" under Federal Rule of Civil Procedure 9(b) for claims of fraud, but in part they also failed to meet the standard of "requisite plausibility". Simply put, the plaintiffs did not present an actionable RICO claim based on allegations that EverBank mailed them notices which effectively "consisted of urging Plaintiffs to adhere to their obligations," and to obtain coverage other than the

coverage force-placed by the lender, thereafter including a small charge for "unearned commissions masked as authorized costs." Under such allegations, there was no plausible allegation that the plaintiffs were caused injury by these actions. The court dismissed the plaintiffs' RICO claims as to all defendants, including the conspiracy claims alleged by the plaintiffs under RICO. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *13-*14 (S.D. Fla. Jan. 6, 2015).

New York Deceptive Practices Act Claim Against All Defendants. One of the named plaintiffs in this case, Mr. Jesus A. Avelar-Lemus, alleged a claim against all defendants under the New York Deceptive Practices Act ("NYDPA"), New York General Business Law § 349. This is the last of the claims alleged in *Wilson* to be considered here which included the insurance company defendants.

The NYDPA in basic terms exists to prohibit all deceptive acts or practices in any business, trade, commerce, or service in New York State. The court in this case dismissed Mr. Avelar-Lemus's NYDPA claim here because it suffered from the same defect as all the plaintiffs' alleged RICO claims, in the eyes of the court: Legally insufficient allegations of proximate cause of the claimed injury. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *15 & *27 (S.D. Fla. Jan. 6, 2015).

Claims Allowed Against the Lender, EverBank: Claims Alleged for Breach of Contract; for Breach of the Covenant of Good Faith and Fair Dealing; and for Alleged Violations of the Truth-in-Lending Act ("TILA").

The motion to dismiss filed on behalf of the Lender Defendant in this case, EverBank, was denied as to certain claims. First, EverBank's motion was denied as to its alleged breach of the mortgage contract. Although the mortgage authorized EverBank to force-place insurance, the mortgage contained no express provision allowing EverBank to include the cost of kickbacks and other alleged costs in the price of premiums paid by borrowers for insurance force-placed by the lender. The claim for breach of the mortgage contract was accordingly sufficient to withstand EverBank's motion to dismiss in this case. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *6 (S.D. Fla. Jan. 6, 2015).

The court clearly grasped the nature of force-placed insurance by describing the policies at issue as "master policies" previously obtained by the lender even before there was any valid opportunity to force-place insurance on a particular borrower. In particular, the court showed unusual insight into the nature of these policies by pointing out that the plaintiffs were complaining of more than the fact or amount of their lender's unauthorized addition of costs including kickbacks and other remuneration, to their, the borrowers'-plaintiffs', premium bills. This court recognized that such costs are "truly associated with insuring an ***entire loan portfolio*** and ***not*** the ***individual*** mortgaged property, and risk-free insurance costs." *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *6 (S.D. Fla. Jan. 6, 2015). [Emphasis added.]

The court slipped a little, without harming its thoughtful analysis of this particular issue in this case, by elsewhere in its opinion describing the force-placed insurance policies as "umbrella" policies just as they were described in the complaint. Complaint, Dkt. No. 1, ¶ 36, substantially quoted and cited by the court. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *3 (S.D. Fla. Jan. 6, 2015)("the coverage comes through the master or umbrella policy already in place."). There is a master policy already in place in a case of force-placed insurance, but insurance practitioners know very well of course that it is incorrect to call it an "umbrella" policy. An "umbrella" policy is a type of excess policy, not a type of force-placed insurance policy.

In declining to dismiss the claims for alleged breach of the implied covenant of good faith and fair dealing, the court stumbled but did not fall when it lumped together the law of Florida, New York, and Illinois governing this claim. The court's discussion of this claim seemed shaky from the beginning. For example, this court referred to the contracting party which brings an action for alleged breach of the implied covenant as "the contract counterparty." *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *6 (S.D. Fla. Jan. 6, 2015). This is the language of finance, not the language ordinarily used by a Judge presiding over a lawsuit involving a contract and covenants implied in it.

In each State whose law was implicated in the implied covenant claims of the named plaintiffs in this case—Florida, New York, and Illinois—the implied covenant must relate to some express provision of the contract but the implied covenant will not be allowed

to alter it. Thus, the court recognized that New York law in particular will not recognize an implied covenant where there is an express contract provision that governs the matter, although the court held that the Federal Rules of Civil Procedure which allow alternative pleading trump State law on this question. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *7 (S.D. Fla. Jan. 6, 2015). Inexplicably, the court treated Illinois law as somehow standing in "contrast" to New York law because Illinois law does not permit a separate claim for breach of the implied covenant but permits such a claim "within" a breach of contract claim.

The court was apparently distracted by the particular features of Illinois law, for the court actually wrote that since the plaintiffs alleged the violation of "an *express* contract term," that this "substantiates" their *implied* covenant claim. The court regained its focus, however, on the gist of the plaintiffs' implied covenant claim and on why the court sustained that claim against EverBank's motion to dismiss in this case:

> Further, Plaintiffs' claim for breach of the implied covenant is not duplicative of their breach of contract claim. The former focuses on EverBank's charging Plaintiffs for costs beyond the cost of coverage and not permitted under their mortgage agreements, while the latter focuses on EverBank's exercise of the discretion afforded it under Plaintiffs' mortgage agreements to select and impose insurance coverage. Therefore, Plaintiffs' claim for breach of the implied covenant of good faith and fair dealing survives. The court interprets the Crosses claim for breach of the implied covenant [under Illinois law] as a claim for breach of contract.

Wilson v. Everbank, N.A., No. 14-CIV-22264, 2015 WL 265648, *7 (S.D. Fla. Jan. 6, 2015).

The court also denied EverBank's motion to dismiss the plaintiffs' TILA (Truth-in-Lending Act) claims in this case. The court held the plaintiffs' allegations sufficient to state a claim for failure to disclose what were allegedly new terms of the lender's extension of credit. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *10 (S.D. Fla. Jan. 6, 2015). In this decision, the *Wilson* court joined the majority view that TILA claims are sustainable in lender force-placed insurance cases.

Claims Denied Against the Lender, EverBank: Claims Alleged for Asserted Violations of the Florida Deceptive and Unfair Trade Practice Act ("FDUTPA") and Breach of Fiduciary Duty.

In granting EverBank's motion to dismiss two claims alleged solely against EverBank as the plaintiffs' lender, the court in the *Wilson* case joined the majority view in both respects. First, this court denied the plaintiff Mr. Wilson's claim alleged under FDUTPA principally because that Act, by its own terms, simply does not apply to Federally regulated banks or savings and loan associations like EverBank. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *9 (S.D. Fla. Jan. 6, 2015).

Second, the court granted the lender defendant's motion to dismiss the plaintiffs' alleged breach of fiduciary duty claims. In general there is no fiduciary duty between a lender and a borrower. Although in special circumstances a lender accepts an actionable fiduciary relationship with a borrower, no such special circumstances appeared in this complaint to this court and so EverBank's motion to dismiss was granted in this regard. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *11-*12 (S.D. Fla. Jan. 6, 2015).

Other Issues Decided by the Court in Wilson: *Whether a Subsidiary of the Lender is a Proper Party (Held: Negative); Whether Plaintiff Avelar-Lemus Failed to Perform Presuit Notice Conditions to Sue His Mortgagee, EverBank (Held: Negative); Whether Failure to Join Plaintiff Wilson's Spouse Was Failure to Join a Necessary Party (Held: Negative); Whether the Florida Plaintiff, Mr. Wilson, Failed to Undertake Administrative Remedies Under Fla. Stat. § 627.731 (Held: Negative); and Two Remaining Issues Worthy of a Little Further Comment, Below.* The heading of this part of the *Wilson* Case Summary concisely summarizes the court's disposition of several ancillary issues. Two, however, draw a little further comment: ASIC's and SGIC's Motion to Dismiss for Lack of Subject-Matter Jurisdiction, and the two Insurer Defendants' Motion to Dismiss Based on the "Filed Rate Doctrine".

The two insurance company defendants in the *Wilson* case filed what the court called "the 'Motion on Jurisdiction'." ASIC and SGIC argued in this motion

that the *Wilson* plaintiffs could not proceed on their claims as a nationwide class, because the *Wilson* plaintiffs "lack Article III standing to assert state common law claims for unjust enrichment and tortious interference under the laws of the states in which they do not reside and in which they do not claim to have been injured." *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *16 (S.D. Fla. Jan. 6, 2015).

This argument has great appeal to lawyers who litigate constitutional questions. On its face, this argument even has appeal to lawyers who do not necessarily litigate constitutional questions so much as they litigate questions involving subject-matter jurisdiction. There are cases holding that an alleged nationwide class cannot be certified in a given case because the claims asserted by the named plaintiffs are too diverse under varying State laws to be common to the class. Taking this line of cases one step further, the courts in such cases arguably do not have jurisdiction over the subject matter, or, at the least, lack jurisdiction over those claims which cannot be presented on behalf of a nationwide class of people.

The *Wilson* court's response to this argument is instructive. The court spent several pages discussing class action procedures, knowledge of which is helpful in understanding the issue. The *Wilson* court's opinion explaining class action procedures is extremely understandable. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *16-*19 (S.D. Fla. Jan. 6, 2015).

Ultimately, however, the court ruled that it would not confront this issue at the pleading stage but would confront it instead when and if the plaintiffs' action is certified as a class. Dismissal of nationwide claims is no substitute for considering class certification under Federal Rule of Civil Procedure 23, the Federal class action rule, said this court: A contrary ruling "would in effect impose a requirement that, in a multistate class action involving state common law claims, there be a named plaintiff from every state…. [T]hat is contrary to established practice and highly inefficient." The issues of standing and Rule 23 are not the same. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *18 (S.D. Fla. Jan. 6, 2015).

The Filed Rate Doctrine is an Affirmative Defense. It is extremely common to find a filed rate doctrine defense raised at the pleading stage in lender force-placed insurance cases. Since the filed rate "doctrine" defense applies in other insurance-related cases, it too merits a little further discussion here. Parenthetically, I put the word "doctrine" in quotes just now because the filed rate doctrine argued in the *Wilson* case by the insurance company defendants does not look anything like the actual filed rate doctrine worked out in the decided cases.

The filed rate doctrine originated in utility rate-making proceedings. The idea behind the defense is that if a regulatory authority of competent jurisdiction, i.e., a regulatory authority charged with approving or denying rate requests, has already approved a given rate charged by the utility (or by the defendant claiming to be clothed as a utility in this respect), then the judiciary may not alter the rate approved by the rate-making authority.

There are problems with that defense in insurance cases, including in lender force-placed insurance cases like *Wilson*. The doctrine is an affirmative defense. Therefore the filed rate doctrine is legally insufficient to defeat a claim unless the doctrine appears from the face of the allegations in the complaint. That was not the case in *Wilson*, and so the *Wilson* court declined to rule on the efficacy of this affirmative defense at the pleading stage of this case. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *19 (S.D. Fla. Jan. 6, 2015).

In addition, the filed rate defense is available only to those who pay the rates in question. In *Wilson*, as in most lender force-placed insurance cases and as in most insurance cases of any kind, the plaintiffs were not the ratepayers. The plaintiffs' *lender* procured "the group master policies" that were sold by the defendant insurance companies. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *21 (S.D. Fla. Jan. 6, 2015).

Finally, the *Wilson* court held that the filed rate doctrine could not defeat the plaintiffs' claims at the pleading stage because the plaintiffs did not challenge the defendant insurance companies' rates: The plaintiffs took exception to *additional* charges which the defendant insurance companies allegedly added on to their rates. In short, the plaintiffs' objection was not to being charged rates for force-placed insurance but rather to being charged for kickbacks allegedly paid by the insurers to the plaintiffs' lender. *Wilson v. Everbank, N.A.*, No. 14-CIV-22264, 2015 WL 265648, *20-*21 (S.D. Fla. Jan. 6, 2015).

In sum, Wilson v. Everbank, N.A. is a decision

which Westlaw prints out at 54 pages, and which runs to 52 pages in the court file. Given the length of this opinion, at times during the writing of this Case Summary (and undoubtedly also during the reading of any summary of the *Wilson* case), it has seemed that the issues confronting the court in this case would never stop. All told, the court's disposition of these issues is masterful and well worth reading in order to begin to understand the many issues presented. // Wall

[Editor's Note: Dennis J. Wall is the author of "Lender Force-Placed Insurance Practices" to be published by the American Bar Association in Spring, 2015).]

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