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ACCC Insurance Law Symposium
Friday, October 26, 2018 | Washington, DC | americancollegecoverage.org

AGENDA

American College of Coverage Counsel
2018 Law School Symposium:
American University Washington College of Law
October 26, 2018

Friday, October 26, 2018	
8:00-8:30 am	***Registration and Coffee***
8:30-8:45 am	***Welcoming Remarks and Introductions*** **Mary McCutcheon**, Farella, Braun + Martel LLP; President, American College of Coverage and Extracontractual Counsel **Robert Kelly**, Jackson & Campbell, P.C., **Helen Michael**, Kilpatrick Townsend, & Stockton LLP, and **Scott Godes**, Barnes & Thornburg LLP, Co-chairs, Law School Symposium Committee
8:45-9:45 am	***Estoppel by Any Other Name: The Meaning of this Doctrine in Insurance Law*** **Laura Foggan**, Crowell & Moring LLP (I) **Jodi McDougall**, Cozen O'Connor (I) **John Vishneski III**, Reed Smith LLP (P) The term "estoppel" has been employed by courts in two very distinct circumstances: (1) where an insurer controls the defense of a policyholder without providing a reservation of rights, the insurer may be "estopped" from refusing to pay a judgment or settlement if it tries to raise a coverage defense too late; and (2) where an insurer does not defend a policyholder or promptly file a declaratory judgment action to establish defenses to coverage, the insurer may be "estopped" from raising any defenses to coverage or suffer some other penalty if it is later found to have owed a duty to defend. Courts and the recent American Law Institute Restatement of the Law, Liability Insurance take varying approaches to how these two distinct "estoppel" doctrines should be applied, and in what circumstances. This presentation explores the complexities underlying this insurance law doctrine.
9:45-10:45 am	***"Stowers" and the Art of Turning the Table on an Insurer with a Policy Limits Settlement Demand***

	Robert Allen, The Allen Law Group (P) **Julia Molander**, Cozen O'Connor (I) **Vince Morgan**, Pillsbury Winthrop Shaw Pittman LLP (P) Called the Stowers doctrine in Texas, the concept of an insurer's potential liability in excess of its policy limits for failing to settle a case within policy limits is universal, although the legal standards and theories differ from jurisdiction to jurisdiction. The panel will explore and discuss the history, development, strategy, and practice involved in an insurer's duty to settle a claim against an insured within the policy limits.
10:45-11:45 am	***The Art of the Deal Doctrines: So Many Doctrines in So Little Time*** **Michael Huddleston**, Munsch Hardt Kopf & Harr, PC (P) **Meghan Magruder**, King & Spalding LLP (P) **Charles Spevacek**, Meagher & Geer, P.L.L.P. (I) This panel will conduct an examination of named doctrines for working with "deals" used to extricate an insured from a potential or actual excess judgment, including discussion of Gandy, Damron, Coblenz, Miller-Schugart, Crist/Johansson Arrangements. The discussion will cover practical, ethical and legal issues presented by such arrangements and the attacks made on them by carriers.
12:00-1:30 pm *12:15-1:15 pm*	Lunch ***How Will the ALI's New* Restatement of the Law, Liability Insurance *Shape the Future of Coverage Disputes?*** **Michael Aylward**, Morrison Mahoney LLP (I) **John Buchanan, III**, Covington & Burling LLP (P) **Harold Kim**, U.S. Chamber of Commerce **Lorelie Masters**, Hunton Andrews Kurth LLP (P) **William Shelley,** Gordon & Rees On May 22, after eight years of work, the American Law Institute approved the Restatement of Law, Liability Insurance, the first Restatement devoted specifically to a single industry. A panel of four ALI members who were active in the development and debate concerning this Restatement will discuss its most important and controversial provisions

	and forecast its implications for shaping the future of insurance coverage litigation.
1:35-2:35 pm	***From Keene to Carter-Wallace, from Boston Gas to Owens-Illinois: The Clear Winner in the "Named Doctrine" Contest*** **Georgia Kazakis**, Covington & Burling LLP (P) **Stephen Pate**, Cozen O'Connor (I) **Scott Seaman**, Hinshaw & Culbertson LLP (I) So-called "long tail" claims potentially trigger multiple years of coverage, and within each year multiple layers of insurance. The panel will describe the main themes of competing allocation doctrines, along with issues such as the impact of "prior insurance" and "other insurance" clauses, the mechanism for exhaustion of underlying layers of coverage, the differences between allocation of defense costs and allocation of indemnity payments, and responsibility for uninsured/underinsured periods.
2:35-3:35 pm	***Independent Counsel and the Tripartite Relationship: The Cumis Doctrine and Others Entitling Insureds to Pick Their Own Lawyers and Control Their Defense*** **David Anderson**, Anderson Coverage Group (P) **Troy Froderman**, FR Law Group PLLC (P) **Susan Harwood**, Kaplan Zeena LLP (I) **Mary McCurdy**, McCurdy & Fuller LLP (I) This presentation will examine the tripartite relationship that is created between the policyholder, its insurer, and defense counsel when an insurer retains defense counsel to defend its policyholder. The panel will discuss various circumstances that can create conflicts of interest for defense counsel that entitle the policyholder to select independent defense counsel with no ties to the insurer and how the states of Illinois, Florida, California, and Arizona address the respective rights and duties of the parties in this context.
3:35-3:50 pm	***Break***
3:50-4:50 pm	***Jurisdictional and Venue Considerations in Insurance Coverage Litigation: The "Colorado River" Runs Through It***

	John Heintz, Blank Rome LLP (P) **Edward Parks**, Shipman & Goodwin LLP (I) **Caroline Spangenberg**, Kilpatrick Townsend & Stockton LLP (P) **Koorosh Talieh**, Perkins Coie LLP (P) Increasingly, jurisdictional and venue considerations play a large role in determining what court will resolve (or get the first crack at resolving) insurance coverage disputes. The panel will examine the application of judicial abstention doctrines, forum non conveniens and related venue principles, and personal jurisdiction requirements in the context of competing insurance coverage actions in state and federal courts.
4:50-5:00 pm	***Closing Remarks***

PRESENTATIONS

ESTOPPEL IN INSURANCE LAW
WHAT DOES IT MEAN?

John S. Vishneski, Reed Smith LLP
Jodi A. McDougall - Cozen O'Connor
Laura Foggan – Crowell & Moring LLP

Duty to Defend Choices

- Accept coverage and pay
- Deny coverage
- Provide a defense subject to a reservation of rights to deny indemnification

Mistakes in Handling the Claim May Lead to Estoppel

- Wrongful refusal to defend
- Mistake in the defense
  - Conflict of interest
  - Fail to reserve rights

Estoppel and the Wrongful Failure to Defend

Illinois Estoppel Doctrine

- "[A]n insurer which breaches its duty to defend is estopped from raising policy defenses to coverage." *Employers Insurance of Wausau v. Ehlco Liquidating Trust,* 708 N.E.2d 1122 (Ill. 1999)
  - Even if defense may have been successful
  - Policyholder does not have to show prejudice

How to Avoid Estoppel

- Defend under a reservation of rights
- Seek a declaratory judgment that there is no coverage

Timing

- Insurer must defend or file a declaratory judgment action within "reasonable time"
  - Failure to act within 12 to 21 months – estoppel
  - Insurer acts within 6 months – no estoppel

What if the underlying cases ends?

- The insurer is estopped

Limits on the Estoppel Doctrine

- No estoppel if the insurer did not have a duty to defend or it was not properly triggered
  - Comparison of policy and complaint show that there is clearly no potential for coverage
  - Insurer not given the opportunity to defend
  - No policy in existence

Estoppel and Conflict of Interest

- Insurer who has a conflict of interest will not be estopped for failure to defend, if the insurer reimburses defense costs as they are incurred

Why Estoppel?

- Equitable remedy for the breach of the duty to defend
- Remedy in jurisdictions with no or weak bad faith laws
- Deters insurers from breaching the duty to defend
- Protects intangible benefits inherent in the duty to defend

Variations on the Estoppel Doctrine

- Connecticut: Insurer only liable for the share of the settlement related to the potentially covered claims. *Capstone Building Corp. v. American Motorists Insurance Co.*, 67 A.3d 961 (Conn. 2013).
- North Carolina: Estopped insurer could raise a late notice defense. *Home Corp. v. American S. Ins. Co.*, 647 S.E.2d 614 (N.C. Ct. App. 2007).
- California: Applies estoppel where the insurer acted in bad faith denying the defense. *Amato v. Mercury Cas. Co.*, 53 Cal. App. 4th 825 (Cal. Ct. App. 1997).

No Estoppel Doctrine

- Other jurisdictions have rejected estoppel and found that the insurer may raise coverage defenses after a breach of the duty to defend
- These courts find that the proper measure of damages is contract damages
- They also find that estoppel conflates the duty to defend with the duty to indemnify
- The courts also find that loss of control of the defense should deter insurers from wrongly refusing to defend

Estoppel When An Insurer Defends

Types of Mistakes that Lead to Estoppel

- Insurer inadequately addresses a conflict of interest created by a reservation of rights
- Failure to timely reserve rights

Reservation of Rights

- Reservations of rights advise the insureds of potential defenses to coverage
- Inform the insureds of potential conflicts
- Advise the insureds that the insurer may not have to indemnify a judgment or settlement

Covered v. Uncovered Claims

- A conflict may exist where there are covered and uncovered claims
- The insurer is benefited by a verdict based on the uncovered claims, the insured by a verdict on the covered claims
- Failure to explain this conflict may result in the insurer being liable for the uncovered claims

Defense Counsel May Not Give Coverage Advice

- Defense counsel learns of information that impacts insurance coverage
- Defense counsel must keep such information confidential from the insurer
- Insurer estopped where it relied on confidential information and coverage opinions from defense counsel to deny coverage

Right to Independent Counsel

- Illinois and California recognize the right to independent counsel when there is a "true conflict of interest"
- But, in Washington, the insurer has no duty to appoint independent counsel, even if there is a true conflict of interest

Estoppel by Failing to Reserve Rights

- An insurer who defends without reserving its rights is estopped from denying coverage
- Estoppel can apply where a ROR letter is issued, but the insurer fails to reserve specific coverage defenses that it then tries to rely on

Waiver of a Coverage Defense

- Waiver requires the insurer to intentionally relinquish its coverage defense
- It is based on the insurer's intent
- Failure to specify an exclusion in ROR letter will not waive the defense

Estoppel By Late Assertion of a Coverage Defense

- To establish estoppel, an insured much show:
  - a reasonable belief that the insurer was providing coverage; or
  - any detrimental reliance on such conduct

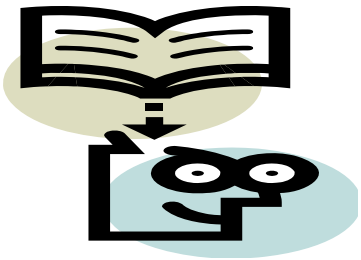
Timely ROR's

- Some jurisdictions require insurers to make all reservations fairly early
  - 10 month delay unreasonable (Arizona)
  - 1 year delay may waive rights (Ohio)

Allow Late Defenses

- Other jurisdictions allow insurers to reserve rights to defenses that they discover during litigation
- However, the insurer may not intentionally conceal a coverage defense

Estoppel Under the ALI Restatement



Estoppel As Discussed In the Restatement Drafting Process

- The first Restatement draft retained the estoppel rule that had been asserted in the Principles project.
- It proposed that estoppel (and forfeiture of the right to assert defenses to indemnity) should be an automatic consequence of any breach of the duty to defend.

Estoppel As Discussed In the Restatement Drafting Process

The first version of "Consequences of Breach of the Duty to Defend," posited that, inter alia:

An insurer that breaches the duty to defend a claim loses the right to assert any control over the defense or settlement of the claim *and the right to contest coverage for the claim*.

Damages for breach of the duty to defend *include the amount of any judgment entered against the insured or the reasonable portion of a settlement entered into by or on behalf of the insured after breach, subject to the policy limits*, and the reasonable defense costs incurred by or on behalf of the insured, in addition to any other damages recoverable for breach of a liability insurance contract.

Estoppel As Discussed In the Restatement Drafting Process

The first version of the estoppel principle in the Restatement draft was criticized:

- Majority common law view is no estoppel.
- Out of step with general analysis of the types of damages available for contractual breach (e.g., Restatement of the Law, Contracts)
- Imposes an automatic and disproportionate penalty – the forfeiture of indemnity coverage defenses
- No nexus between an automatic grant of indemnity coverage and harm allegedly sustained from a breach of the duty to defend

Estoppel As Discussed In the Restatement Drafting Process

The Reporters then revised the section, "Consequences of Breach of the Duty to Defend," to state in relevant part:

An insurer that lacks a reasonable basis for its failure to defend a legal action also loses the right to contest coverage for the action.

Estoppel As Discussed In the Restatement Drafting Process

Objectors noted that the harsh result that would be applied under an estoppel rule was not moderated in any way. For instance, the proposed rule did not have an opening phrase stating "Unless the insurer promptly seeks a declaratory judgment on its coverage obligations . . .."

Illinois' rule only imposes estoppel if an insurer fails to file a declaratory judgment action seeking court guidance on its obligations and is found to have wrongfully refused to defend.

Estoppel As Discussed In the Restatement Drafting Process

Further, the proposed rule did not tie its application to a *material* breach.

It also did not address the problem of disproportionate outcomes by stating, for instance, that "the insured bears the burden of proving that that loss of the right to contest coverage is a proportionate remedy for the actual harm demonstrated."

Nor did the Reporters' draft tie the forfeiture rule to the individual circumstances of the claim.

Estoppel As Discussed In the Restatement Drafting Process

Other criticisms included that adequate remedies already exist in the event of negligent breach of the duty to defend, so that creating a new right to indemnity coverage as a consequence of a breach was not appropriate or justified.

And, there is no empirical evidence that a reversal of the prevailing rule would be desirable, which ALI guidance states should be shown before a Restatement adopts minority position.

Estoppel In Final Draft of the Restatement

The Reporters then removed the automatic estoppel or waiver of coverage defenses based on a negligent breach of the duty to defend.

The applicable section, "Consequences of Breach of Duty to Defend," now states:

"An insurer that breaches the duty to defend a legal action forfeits the right to assert any control over the defense or settlement of the action."

The final version of this section abandons the concept of forfeiture of coverage defenses.

Estoppel in the Final Draft of the Restatement

But . . . Comments and Reporters' Notes to Section 50, Remedies for Liability Insurance Bad Faith, attempt to resuscitate an estoppel rule in the Restatement, albeit tied to bad faith.

"[T]here are some circumstances . . . in which courts have held that an insurer is estopped by its bad faith conduct from asserting a coverage defense that it would have been able to assert had it fulfilled its contractual obligations."

Estoppel In the Final Draft of the Restatement

Even as a proposed penalty for bad faith, estoppel is unsupported by the common law.

This is a place where the Restatement foregoes its role as a summary of the black-letter law in favor of assuming the role as advocate for an approach deemed to be "better."

Should it be given any more weight regarding what the law ought to be than the recommendations of any respected lawyer or scholar?

Questions

Alone In The Ditch Without The Carrier

Scenarios

- Wrongful denial of defense
- Defense subject to ROR
- Failure to settle
  - Breach of contract
  - Negligence
- Denial of Indemnity
  - Premature denial before trial—anticipatory breach
  - Same alternatives as denial of defense

Naming These Agreements

- "Sweetheart Deals"
- "Set-up"
- "Wink and nod" agreements
- Mary Carter agreements
- *Coblentz* agreements
- *Damron* agreements
- *Morris* agreements
- *Miller Schugart* agreements

Policy Favoring

- *Critz v. Farmers Ins. Group*, 230 Cal.App.2d 788, 41 Cal.Rptr. 401 (App.1965):
  - Carrier exposes the insured to "the sharp thrust of personal liability"
  - Causes an "acute change" in the relationship between PH and insurer
  - PH is not required to engage in "financial masochism"
- Encourages settlement
- Deterrence:
  - Carriers must be given a strong incentive to "give due consideration to the interests of the insured."
  - Absent such agreements the carrier has no incentive to behave

Policy Favoring

- *Dowse v. S. Guar. Ins. Co.*, 263 Ga. App. 435, 439, 588 S.E.2d 234, 237 (2003), *aff'd*, 278 Ga. 674, 605 S.E.2d 27 (2004)
  - Release/assignment agreements enforceable based on "the right of the insured to protect itself from the bad faith conduct of its insurer."
- Based on Three "Policy Considerations":
  - Upholding the intention of the settling parties
  - Ensuring availability of insurance for tort victims
  - Encouraging settlements

Public Policy Against

- Allowing such agreements perpetuates untruth
  - The PH will never pay and never suffer real harm
  - Judgment is a "sham" as a result
- Insured has no incentive to fight and thus value is increased
- Contrived judgments attempt to resolve coverage, liability and damages
- Proliferates litigation?
- Distortion (*Gandy*)
  - By assignment, molestation victim standing of the shoes of the molester/PH

Options

- **Settlement without trial**
  - **Simple settlement**
  - **Agreed judgment**
- Settlement after trial
- Insured pursues suit and plaintiff joins
- Assignment or insurance rights to claimant
- Covenant not to execute or to limit execution
- Assignment without a covenant
- ***Turnover action***
- ***Bankruptcy***

Legal Framework

- Legal obligation to pay satisfied by insured's unilateral settlement
- Judgment rule versus pre-payment rule
  - Policy requires "liability," not payment
  - Release of "right to sue" not release of "liability"
- Wrongful denial of defense or indemnity excuses anti-assignment, no action and cooperation conditions
- Damages equal the amount of the judgment (agreed or tried) as a matter of law
- Assignment to claimant
- Covenant not to execute or to partially execute
  - Right against carrier only asset left exposed
- Collateral attacks on a judgment are not permitted
  - Reasonableness and
  - Liability established

Reasonableness

- Methods of vouchsafing the amount
- Good faith determination
  - Amount in proportion to insured's potential liability
  - Amount paid
  - Allocation of settlement proceeds among plaintiffs
  - Recognition the insured actually compromised
- Some jurisdictions permit a retrial
- Shifting burdens of proof

State Farm v. Gandy

- Complete defense provided
- Independent counsel provided
- Carrier filed declaratory action to resolve coverage
- Carrier eventually prevailed—no coverage
- Not notified of the settlement and did not consent
- Not a failure to defend or settle case
  - Like a legal malpractice claim regarding behavior of independent counsel
- Damages
  - PH/molester would have been found innocent or damages would have been less
  - Submitted to the jury—found approx $200,000, not amount of the judgment

Holding

- "[W]e hold that a defendant's assignment of his claims against his insurer to a plaintiff is invalid if
  - made prior to an adjudication of plaintiff's claim against defendant in a fully adversarial trial,
  - insurer has tendered a defense, and
  - Either
    - insurer has accepted coverage, or
    - insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of plaintiff's claim.
- "In no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on insurer by plaintiff as defendant's assignee."
- Limited to facts presented
- Anti-assignment rule only applies for the "good carrier"

ATOFINA Revisits *Gandy*

- *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008)
- If an excess carrier wrongfully denies coverage, then it is ESTOPPED attacking the reasonableness of the settlement amount..
- Key factor:
  - Notice to the insurer and an opportunity to participate in the settlement discussions.
  - Rejection by the insurer.
- The insured paid its own money.
- *Gandy* narrowed—only applies to facts presented there.
  - *Here, no assignment*

Lennar

- *Lennar Corp. v. Markel American Ins. Co.*, 413 S.W.3d 750, 751 (Tex. 2013).
- PH proposed repair program to settle EIFS claims of homeowners
- Carrier refused
  - Wait til they sue

- Held:
  - Settlement satisfied
    - Legal obligation to pay requirement
    - Satisfied the loss establishment clause
    - Prejudice required to establish improper settlement
    - No prejudice shown

Yorkshire v. Seger

- Argued and pending in Supreme Court
- Carrier wrongfully denied a defense
- Principals of company dismissed prior to proceeding against the corporation.

- Held
  - "Key factor" in *Gandy*—use of an assignment
  - Assignment prolonged and proliferated litigation—the coverage suit.
    - Absurd: "Thus, the Segers obtained an assignment of Diatom's Stowers claims specifically for the purpose of initiating another suit against the CGL insurers."

Yorkshire

- Anti-assignment
  - "Key factor" in Gandy—use of an assignment
  - Assignment prolonged and proliferated litigation—the coverage suit.
  - Distortion because no damages.
  - But, other factors re anti-assignment not present

- Adversarial trial
  - Treated as a second independent holding of *Gandy*
  - Inconsistent with *Atofina, which required narrow factors to be present*
  - Refused to allow admission of judgment as evidence of damages

Supreme Court

- Inability of insured to pay
  - Amounts to fraud and collusion
- Insureds who are too poor to defend themselves must still engage in a fully adversarial trial

Dowse

- *S. Guar. Ins. Co. v. Dowse*, 278 Ga. 674, 676, 605 S.E.2d 27, 29 (2004):
  - An insurer that refuses to indemnify or defend "[does] so at its peril"
  - Insurer can deny coverage, but "if the insurer guesses wrong, it must bear the consequences, legal or otherwise, of its breach of contract."
- Three Options:
  - Accept coverage and defend
  - Defend subject to reservation of rights
  - Deny coverage, face "consequences"
- Coverage: Insured must still prove the duty to defend was breached, but insurer is estopped from challenging settlement reached by PH

Consequences

- "An insurer that denies coverage and refuses to defend an action against its insured, when it could have done so with a reservation of its rights as to coverage, waives the provisions of the policy against a settlement by the insured and becomes bound to pay the amount of any settlement [within a policy's limits] made in good faith[,] plus expenses and attorneys' fees."
- Challenge requires evidence of fraud or collusion
  - Excessive settlement amount could be evidence of bad faith
- Additional Consequences:
  - Waiver of policy conditions (consent, notice, cooperation)
  - Waiver of right to contest whether settlement was "voluntary payment"
  - Waiver of right to challenge the allocation of settlement payment to certain alleged injuries

Coblentz

- *Coblentz v. American Surety Co. of New York*, 416 F. 2d 1059 (5th Cir. 1969)
- A settlement without trial
- Elements
  - coverage;
  - wrongful refusal to defend; and
  - the settlement was objectively reasonably and made in good faith.
- Coverage: Insured must establish duty to defend and indemnify
- **Rejection of a defense subject to ROR** *Zurich v. Frankel Ent.*, 2008 WL 2787704 (11th Cir 2008)
- Reasonableness

Reasonableness

- Prima facie case made by PH or assignee
- Settlement can only be challenged for actual fraud and collusion
  - Ordinary definitions of fraud and collusion do not apply
- Standard:
  - What a reasonably prudent individual in the position of the insurance carrier would have settled for on the merits of the claimant's claim
- Methods
  - Trial court approval
  - Arbitration

Bankruptcy

- Supreme law of the land
- Trumps anti-assignment and other *Gandy* like rules
- Pre-packs

Consent to Settle

- Hammer clauses
  - Insurer wants to force settlement
- Suicide settlements by PH

Restatement Discussion Draft Sec. 19

- Wrongful refusal to defend
  - Carrier loses indemnity defenses
  - Damages
    - Amount of a judgment entered if violation of duty to settle as well or
    - The reasonable portion of any settlement up to policy limits
    - Any other damages allowed
  - May assign the claim
- Agreed or consent judgment
  - Treated like a settlement and thus subject to liability only for a reasonable amount if
    - Did PH provide a reasonable defense?
    - Was covenant not to execute anticipated?
    - Was the insured actually able to mount a defense?

How Will the American Law Institute's New Restatement of the Law, Liability Insurance Shape the Future Of Insurance Coverage Disputes?

Michael Aylward, Morrison Mahoney LLP
John Buchanan, III, Covington & Burling LLP
Harold Kim, U.S. Chamber of Commerce
Lorelie Masters, Hunton Andrews Kurth LLP
Bill Shelley, Gordon & Rees, LLP

Restatement of the Law, Liability Insurance

Topics to be addressed:

1. Brief history and status of the Restatement of the Law, Liability Insurance
2. Sturm and Drag Around the Restatement: Why All the Fuss?
3. Sections causing the greatest debate
   (a) Sections 3-4 on Policy Interpretation ("the plain meaning rule")
   (b) Section 12 on Liability of Insurers for Conduct of Defense
   (c) Sections 14-15, 19 on the Duty to Defend Reservations of Rights, Consequences for Breach
   (d) Sections 24, 27 of Duty to Make Reasonable Settlement Decisions, Settle Damages for Breach
4. (e) Other Sections Causing Debate: 41, 39, 7-9, 49-50

2

About the Restatement of Liability Insurance ("RLLI")

- Drafting process pursued for the RLLI since 2010:
  - *Numerous Meetings of Advisors, Members Consultative Group (MCG), and later Council and ALI General Membership.*
  - *Preliminary Draft(s) – many versions.*
  - *Council Draft(s) – several versions sent to Council, Advisors, MCG.*
  - *Tentative Draft(s) versus Discussion Drafts – after Council approval.*
  - *Proposed Final Draft(s), submitted to General Membership.*
- Many issues were hotly contested.
- Stated Objectives:
  - Align incentives for both policyholders/insureds on the one hand, and insurers on the other.
  - Reduce "transaction costs" and litigation over coverage.

3

Restatement of Liability Insurance: A Brief History

- Begun in 2010 as the Principles of the Law, Liability Insurance; converted to Restatement in 2014 by Council vote.
- The ALI presented Tentative Draft and Proposed Final Draft to ALI Membership in May 2016 and May 2017, with bulk of provisions approved by the general ALI membership then.
- Vote on Proposed Final Draft No. 4 vote in May 2017 deferred after deluge of motions & comments, almost all by insurer advocates.
- After significant further changes, the RLLI was approved by the ALI on May 22, 2018.
- Under ALI rules, Restatement provisions may be cited after approval by Council and ALI membership; courts and parties began citing provisions after such approvals in 2016, 2017.

4

What Sections of the Restatement Have Generated the Most Controversy?

Which Sections Have Generated the Most Controversy?

- §§ 3-4: Policy interpretation
- § 12 Insurer liability for choice/conduct of counsel.
- § 13: Avoiding the Duty to Defend
- § 19 Consequences of Failing to Defend
- § 25 Recoupment
- § 24 Duty to settle
- § 38 Number of "occurrences"
- § 39: Exhaustion of excess policies
- § 41: Allocation of liability long-tail claims
- § 46: Known Liabilities
- §§ 47-48: Fee-shifting

6

Principles of Policy Interpretation

§ 3. The Plain Meaning Rule

(1) If an insurance policy term has a plain meaning when applied to the facts of the claim at issue, the term is interpreted according to that meaning.

(2) The plain meaning of an insurance policy term is the single meaning to which the language of the term is reasonably susceptible when applied to facts of the claim at issue in the context of the entire insurance policy.

(3) If a term does not have a plain meaning as defined in subsection (2), that term is ambiguous and is interpreted as specified in § 4.

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Principles of Policy Interpretation

§ 4. Ambiguous Terms

(1) An insurance policy term is ambiguous if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the facts of the claim at issue in the context of the entire insurance policy.

(2) When an insurance policy term is ambiguous as defined in subsection (1), the term is interpreted against the party that supplied the term, unless that party persuades the court that a reasonable person in the policyholder's position would not give the term that interpretation.

8

§ 12 Liability of Insurer for Conduct of Defense

(1) If an insurer undertakes to select counsel to defend a legal action against the insured and fails to take reasonable care in so doing, the insurer is subject to liability for the harm caused by any subsequent negligent act or omission of the selected counsel that is within the scope of the risk that made the selection of counsel unreasonable.

(2) An insurer is subject to liability for the harm caused by the negligent act or omission of counsel provided by the insurer to defend a legal action when the insurer directs the conduct of the counsel with respect to the negligent act or omission in a manner that overrides the duty of the counsel to exercise independent professional judgment.

9

§ 13. Conditions Under Which The Insurer Must Defend

(1) An insurer that has issued an insurance policy that includes a duty to defend must defend any legal action brought against an insured that is based in whole or in part on any allegations that, if proved, would be covered by the policy, without regard to the merits of those allegations.

(2) For the purpose of determining whether an insurer must defend, the legal action is deemed to be based on:

(a) Any allegation contained in the complaint or comparable document stating the legal action; and

(b) Any additional allegation known to the insurer, not contained in the complaint or comparable document stating the legal action, that a reasonable insurer would regard as an actual or potential basis for all or part of the action.

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§ 13(3): When May Insurers Consider Extrinsic Facts to Eliminate Defense?

(a) The defendant in the action is not an insured under the insurance policy pursuant to which the duty to defend is asserted;

(b) The vehicle or other property involved in the accident is not covered property under a liability insurance policy pursuant to which the duty to defend is asserted and the defendant is not otherwise entitled to a defense;

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer's performance is excused under the rule stated in § 35(2);

(d) The action is subject to a prior-and-pending-litigation exclusion or a related-claim exclusion in a claims-made policy;

(e) There is no duty to defend because the insurance policy has been properly cancelled; or

(f) There is no duty to defend under a similar, narrowly defined exception to the complaint-allegation rule recognized by the courts in the applicable jurisdiction.

11

No Recoupment

- Restatement follows the majority rule: No recoupment in absence of explicit policy provision or agreement by parties.
  - Defense Costs – § 21: "Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not seek recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs."
  - Indemnity – § 25(2): "Unless otherwise stated in an insurance policy or agreed to by the insured, an insurer may not settle a legal action and thereafter demand recoupment of the settlement amount from the insured on the grounds that the action was not covered."

Proposed Final Draft No. 2, §§ 21, 25 (approved May 22, 2018).

12

Consequences of Failing to Defend

Compare:

- § 19(2): "An insurer that breaches the duty to defend without a reasonable basis for its conduct must provide coverage for the legal action for which the defense was sought, notwithstanding any grounds for contesting coverage that the insurer could have preserved by providing a proper defense under a reservation of rights pursuant to § 15."

Proposed Final Draft No. 4 § 19(2) (Mar. 28, 2017; tent. approved May 23, 2017) - REVISED.

- § 19: "An insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action."

Proposed Final Draft No. 2 § 19 (May 22, 2018).

13

Insurer's Duty to Settle

§ 24. The Insurer's Duty to Make Reasonable Settlement Decisions

(1) When an insurer has the authority to settle a legal action brought against the insured, or the insurer's prior consent is required for any settlement by the insured to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

(2) A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.

(3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

Proposed Final Draft No. 2 § 24(1)-(3) (approved May 22, 2018).

14

Damages for Breach of Duty to Settle

§ 27. Damages for Breach of the Duty to Make Reasonable Settlement Decisions

- "An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for any other foreseeable harm caused by the breach of the duty, including the full amount of damages assessed against the insured in the underlying action without regard to policy limits."

Proposed Final Draft No. 2 § 27 (approved May 22, 2018).

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Damages for Breach of Duty to Settle

Compare:

§ 27. Damages for Breach of the Duty to Make Reasonable Settlement Decisions

- An insurer that Breaches the duty to make reasonable settlement decisions is subject to liability for the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits, as well as any other foreseeable harm caused by the insurer's breach of the duty.

Proposed Final Draft No. 4 § 27 (Mar. 28, 2017; tentatively approved May 23, 2017).

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§ 38. Number of "Occurrences"

For liability insurance policies that have per-accident or per-occurrence policy limits, retentions, or deductibles, all bodily injury, property damage, or other harm caused by the same act or event constitutes a single accident or occurrence.

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§ 39. Excess Insurance: Exhaustion and Drop Down

When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the excess insurance policy:

(1) The excess insurer is not obligated to provide benefits under its policy until the underlying policy is exhausted;

(2) The underlying policy is exhausted when an amount equal to the limit of that policy has been paid to claimants for a covered loss, or for other covered benefits subject to that limit, by or on behalf of the underlying insurer or the insured; and

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide coverage in the place of the underlying insurer.

Proposed Final Draft No. 2, § 39(1)-(3) (approved May 22, 2018).

18

§ 41. Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies

(1) Except as stated in subsection (2), when indivisible harm occurs over multiple years, the amount of any judgment entered in or settlement of any liability action arising out of that harm is subject to pro rata allocation under occurrence-based insurance policies as follows:
   (a) For purposes of determining the share allocated to any occurrence-based liability insurance policy that is triggered by harm during the policy period, the amount of the judgment or settlement is allocated equally across years, beginning with the first year in which the harm occurred and ending with the last year in which the harm would trigger an occurrence-based liability insurance policy; and
   (b) An insurer's obligation to pay for that pro rata share is subject to the ordinary rules governing any deductible, self-insured retention, policy limit, or exhaustion terms in the policy.

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

(3) Defense obligations relating to multiple triggered policies are subject to the rules in § 20 [i.e., no proration of defense costs].

Proposed Final Draft No. 2, § 41 (approved May 22, 2018).

19

§ 45. Coverage for "Aggravated Fault"

(1) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for defense costs incurred in connection with any legal action is enforceable, including but not limited to defense costs incurred in connection with: a criminal prosecution; an action seeking fines, penalties, or punitive damages; and an action alleging criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(2) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for civil liability arising out of aggravated fault is enforceable, including civil liability for: criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(3) Whether a term in a liability insurance policy provides coverage for the defense costs and civil liability addressed in subsections (1) and (2) is a question of interpretation governed by the ordinary rules of insurance policy interpretation.

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§ 46. Insurance of Known Liabilities

(1) Unless otherwise stated in the policy, a liability insurance policy provides coverage for a known liability only if that liability is disclosed to the insurer during the application or renewal process for the policy.

(2) For purposes of the rule stated in subsection (1), a liability is known when, prior to the inception of the policy period, the policyholder knows that, absent a settlement, an adverse judgment establishing the liability in an amount that would exceed the amount of any applicable deductible or self-insured retention in the policy is substantially certain.

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§ 47. Remedies Available

(1) A declaration of the rights of the parties

(2) An award of damages under § 48;

(3) Court costs or attorneys' fees to a prevailing party when provided by state law or the policy;

(4) If so provided in the liability insurance policy or otherwise agreed by the parties, an award of a sum of money due to the insurer as recoupment of the costs of defense or settlement;

(5) Collection and disbursement of interpleaded policy proceeds;

(6) Payment or return of premiums;

(7) Indemnification of the insurer by the insured when state law permits recovery from highly culpable insureds; and

(8) Prejudgment interest.

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§ 48. Damages Available

The damages that an insured may recover for breach of a liability insurance policy include:

(1) In the case of a policy that provides defense coverage, all reasonable costs of the defense of a potentially covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(2) All amounts required to indemnify the insured for a covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(3) In the case of the breach of the duty to make reasonable settlement decisions, the damages stated in § 27; and

(4) Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of contracting as a probable result of a breach, which sums are not subject to any limit of the policy.

Proposed Final Draft No. 2 § 48(1)-(4) (approved May 22, 2018).

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FORECASTING THE FUTURE?

Is this Restatement likely to prove as influential as some other Restatements?

Are there particular areas of the law where it may influence the evolution of the common law?

How will courts and legislatures react to it?

Ohio Sec. 3901.82. "The Restatement of the Law, Liability Insurance that was approved at the 2018 annual meeting of the American law institute does not constitute the public policy of this state and is not an appropriate subject of notice."

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Questions

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ACCC FIFTH ANNUAL LAW SCHOOL INSURANCE LAW SYMPOSIUM

American University Washington College of Law
Washington, DC | Friday, October 26, 2018

Keene → Carter-Wallace → Boston Gas → Owens-Illinois → Viking Pump → KeySpan: The Winner of The Allocation Wars Is ~~Policyholder/Insurer~~

Georgia Kazakis, Covington & Burling LLP
Stephen Pate, Cozen O'Connor
Scott Seaman, Hinshaw & Culbertson LLP

This presentation is provided for informational purposes and does not reflect the views of any of the firms or their clients.

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Allocation: An Overview

- The determination of how losses (defense and indemnity) are divided among triggered policies
- Allocation is sometimes referred to as the "scope of coverage"
- "Trigger" and "allocation" issues generally arise in context of "long tail" claims
- Not usually an issue in "traditional claims," which are limited in time, place, and space

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Trigger Of Coverage: 4 Basic Trigger Theories

- **Exposure:** policies on risk between the first and last date that the claimant or property was exposed to harmful substance
- **Manifestation/Discovery:** policy on risk when injury or damage is discovered
- **Injury-in-fact:** policies on the risk on date that property damage or bodily injury actually happens through proof that damage was sustained
- **Continuous:** policies on risk between first exposure and manifestation

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Trigger Trends

- In the early long-tail cases (asbestos and DES) the battle was between exposure and manifestation
- The current trend of decisions is to apply a continuous or injury-in-fact trigger, with occasional manifestation rulings for property damage claims
- Compare claims-made contracts

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Allocation Methodologies & Approaches

- Two fundamental issues concerning allocation of losses:
  - The method of allocation employed ("all sums" or pro rata")
  - The extent to which losses are borne by the policyholder for periods of self-insurance and periods of unavailability of coverage
  - Defense costs or indemnity dollars

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"All Sums" Or "Joint And Several" Liability

- The policyholder can collect from any triggered policy the full amount of indemnity that is due (subject to the policy limits)
- This methodology allows the policyholder to "pick and choose" which triggered policies will pay
- The policyholder can avoid self-insured periods
- The policyholder can "spike" to reach target excess policy
- The policyholder maximizes its flexibility in settlement negotiations, but it does not necessarily ensure the policyholder of a full recovery
- Stacking and hopscotching

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Pro Rata Allocation

- Losses are prorated based upon some methodology
- The most common methods are:
  - Proration based upon “time on the risk” or
  - Proration based upon “time on the risk" and "policy limits"
- Other methods include equal shares or proration based upon premium (mostly employed with respect to contribution claims)
- Policyholder responsible for self-insured periods

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Net Differences Between “All Sums” And Pro Rata Approaches

- In all sums, selected insurers generally can seek contribution from other insurers
- This does not mean that the selected insurer will be in the same position as under a pro rata allocation because of factors such as SIR’s and insurer insolvencies
- Potential transaction costs of re-allocation
- Litigation practicalities:
  - Generally insurers defer litigating cross-claims
  - Avoid taking pro-policyholder positions
- Limited circumstances where re-allocation not permitted:
  - Illinois selective tender decisions
  - Defense (minority of jurisdictions such as Florida)

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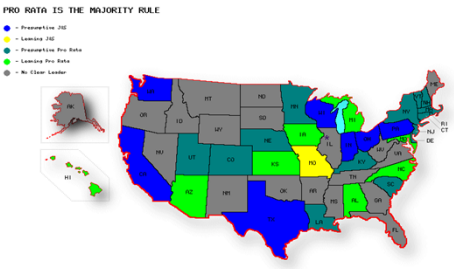
Status of Allocation



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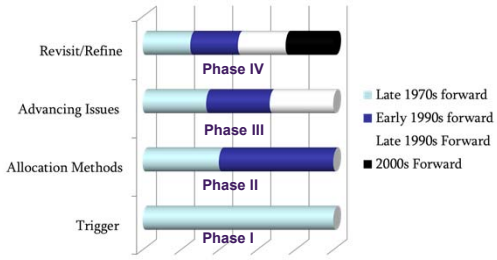
The Allocation Mix Time Line



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The Policy Language

- CGL policies "all sums" language in the insuring agreement relied upon by the policyholders
- "To which this policy applies" and "during the policy period" limitations found in the definitions of occurrence, property damage, and bodily injury generally relied upon by insurers
- "Other insurance" clauses do not necessarily address the issue
- Many excess policies written on an "ultimate net loss" basis
- In 1986, ISO changed CGL Form from "all sums" to "those sums"
- Non-cumulation and Prior Insurance provisions

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The Allocation Hydra

Acceleration/UNR
Unavailability
From "all sums" to "those sums"
Multi-Year Policies
Stubs & Extensions
Number Of Occurrences
Non-Cumulation
Vertical/Horizontal Exhaustion

SIRS/Deductibles
Actual/Functional Exhaustion

Targeted Tender
Drop Down
Guar. Funds
Defense vs. Indemnity
Reallocation (Equitable Subrogation/ Contribution)
Set-Off/Settlement Credits
Apportioned Share/Pro Tanto

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The Contemporary Allocation (Phase IV) Hydra Of Issues & Revisiting Basic Issues

- Most jurisdictions with appreciable coverage activity have law on the fundamental issues of applicable trigger and allocation methodology. In many such states it is settled, in others there is conflicting law.
- There is an increased focus on the hydra of other allocation issues.
- Insurers seek pro rata allocation in presumptive "all sums" jurisdictions based on different policy language (i.e., "those sums" vs. "all sums") – e.g., Thomson Inc.,11 N.E.3d 982 (Ind. Ct. App. 2014)
- Policyholders seek "all sums" rulings in presumptive pro rata jurisdictions based on policy language (i.e., non-cumulation clauses) – e.g., Viking Pump, 52 N.E.3d 1144 (N.Y. 2016)
- Policyholders have sought to apply "targeted tender" to consecutive policies.
- Policyholders have sought to apply the "unavailability of insurance" rule, which insurers see as an exception to the pro rata rule.

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Insurer View of "Unavailability Of Insurance" Rule

- There is no "unavailability" exception in most pro rata jurisdictions
- The notion is contrary to the fundamental and logical consequences of a pro rata allocation
- Its genesis is from a sentence in the New Jersey Supreme Court decision in Owens-Illinois, 650 A.2d 974 (N.J. 1994)
- Even where an "unavailability of insurance" exception exists, it has been limited to asbestos and environmental claims where coverage was not available in the market place
- Often insurers may show post-1986 availability of insurance for environmental and asbestos risks
- Cases largely confined to New Jersey and Minnesota
- R.T. Vanderbilt Co., is on appeal before the Connecticut Supreme Court

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Unavailability Exception Recently Rejected In New York & But Reaffirmed In New Jersey

- In March, the New York Court of Appeals rejected the unavailability rule in the KeySpan decision
- The court held that such a rule it is inconsistent with policy language mandating pro rata allocation in the first instance. The court also commented that it distorts the economics of insurance by interfering with an insurer's right to select the risks it will and will not assume and provides a policyholder with coverage for years in which it paid no premiums
- In June, the majority of the New Jersey Supreme Court decided in Honeywell to uphold the unavailability rule

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New York v. New Jersey Allocation Jurisprudence

- The thread of continuity running through the New York Court of Appeals' insurance law jurisprudence has been enforcing insurance contract language. See, e.g., General Electric (number of occurrences), Consolidated Edison (pro rata allocation consistent with but not compelled by policy language), Viking Pump (non-cumulation clause), and KeySpan (no unavailability exception)
- The difference between KeySpan and Honeywell lies in the different rationale employed by the New York and New Jersey high courts for applying a pro rata allocation. Both sides argue that their positions are rooted in policy language (or required by ambiguities therein), but in general, the New York Court of Appeals asserts that its approach is based on contract language, while the New Jersey Supreme Court asserts that it allocates based on the ambiguity of contract language and public policy considerations

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Viking Pump & Non-Cumulation Clauses

- Most of the excess policies follow form to a "non-cumulation" of liability or "anti-stacking" provision that provides: "[i]f the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, then each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by [Liberty Mutual] with respect to such occurrence, either under a previous policy or policies of which this is a replacement, or under this policy with respect to previous annual periods thereof."
- The others follow a similar two-part "Prior Insurance and Non-Cumulation of Liability" provision that provides, in part: "It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess Policy issued to the [Insured] prior to the inception date hereof[,] the limit of liability hereon ... shall be reduced by any amounts due to the [Insured] on account of such loss under such prior insurance."
- "Subject to the foregoing . . . in the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this Policy the Company will continue to protect the [Insured] for liability in respect of such personal injury or property damage without payment of additional premium."

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The New York Court Of Appeal's Ruling On Allocation & Exhaustion

- The New York high court noted – as several other courts have recognized – the non-cumulation clause is inconsistent with a pro rata allocation
- Although this inconsistency has caused some courts to refuse to enforce the clause, the New York Court of Appeals stated such cases are persuasive authority for the proposition that, in policies containing non-cumulation clauses, "all sums" is the appropriate allocation method
- The court believed that the various decisions of the Second Circuit in Olin and the other cases cited by the insurers fail to harmonize the non-cumulation clause with a pro rata allocation
- The court noted that the excess policies at issue primarily hinge their attachment on the exhaustion of underlying policies that cover the same policy period as the overlying excess policy and vertical exhaustion is more consistent than horizontal exhaustion with this language
- The court stated that vertical exhaustion is conceptually consistent with an "all sums" allocation, permitting the policyholder to seek coverage through the layers of insurance available for a specific year

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New York Allocation Law Post-Viking Pump

- In the wake of Viking Pump, parties can expect New York courts focus on contract language; practically, this likely means requiring pro rata allocation unless contract language requires another result – e.g., non-cumulation, clauses, prior insurance clauses, etc.
- Many insurance programs include policies with non-cumulation clauses and, in such instances, the allocation landscape has become more complicated, particularly when factoring in the variety of variables that come into play in allocating long-tail losses

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Olin IV

- Olin IV provides the Second Circuit's answer to a key question left unanswered by the New York Court of Appeals in Viking Pump concerning what to do where the policy at issue contains a non-cumulation clause but the underlying policy does not. The insurer argued that the underlying policy must be exhausted horizontally before its policy is impacted and subject to being exhausted vertically. The Second Circuit rejected that position saying Viking Pump provides that policies with non-cumulation clauses can be attached through vertical exhaustion
- The Second Circuit agreed with the insurer that the non-cumulation clause applies to reduce the occurrence limit for prior insurance whether that prior insurance was issued by the same insurer or another insurer. The court pointed out the provision on its face applies to "any other excess policy," and is not limited to prior policies issued by the same insurer. This construction also is consistent with the purpose of non-cumulation clauses, which were designed to prevent "stacking" by a policyholder
- The Second Circuit agreed in principle with the insurer that its limits of liability should be reduced by amounts paid by a prior insurer to settle claims with respect to the sites at issue. It reversed and remanded because the record contained no basis to calculate that amount. It placed the burden on the insurer to prove the settlement credit issue. We now have Olin V.

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Enforceability Of Non-Cum Clauses

- Several courts have enforced non-cumulation clauses often without addressing allocation methodology. See, e.g., Air Products (E.D. Pa. 1989); I-O Broadway Glass (D.N.J. 1994); Treasure Coast Travel (Fla. App. 1995); Endicott Johnson (N.D.N.Y. 1996); Treesdale (3d Cir. 2005); Nesmith (N.Y. App. 2013); Stimson Lumber (D. Or. 2004); Greene, Tweed & Co. (E.D. Pa. 2006); Westinghouse (N.J. App. 2004); Hercules, Inc. (Del. 2001); E.I.du Pont de Nemours & Co. (Del. 2010)
- Other decisions have refused to enforce non-cumulation clauses analogizing them to "escape other insurance" clauses, finding them to be ambiguous or subject to conflicting interpretations, or deferring decision on the applicability of the provision

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Impact Of Non-Cumulation Clauses On Allocation Rulings In Other States

- Some decisions, like Viking Pump, have relied upon the presence of non-cumulation clauses to support an "all sums" allocation. See, e.g., Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's London, 797 N.E.2d 434 (Mass. Ct. App. 2003); Plastics Engineering Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613 (Wisc. 2009); Riley v. United Services Auto. Ass'n, 871 A.2d 599 (Md. App. 2005)
- Other decisions have recognized the inconsistency between a pro rata allocation and non-cumulation clauses and have refused to enforce the clauses because they run counter to the state's pro rata allocation methodology. Spaulding Composites Co., Inc. v. Aetna Cas. and Sur. Co., 819 A.2d 410 (N.J. 2003); Outboard Marine Corp. v. Liberty Mut. Ins. Co., 670 N.E.2d 740 (Ill. App. 1996)

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Targeted Or Selective Tender

- Where available, policyholders often seek an "all sums" allocation to maximize flexibility/recovery
- There is a line of cases that, under certain circumstances, allows a policyholder to tender its defense to one of its primary insurers, but not another, and thereby nullify the "targeted" insurers rights of equitable contribution (as to both defense and indemnity) against the non-selected insurer
- Policyholders have attempted to expand the doctrine to long-tail claims
- Even if a policyholder obtains an "all sums" ruling, generally insurers can reallocate any disproportionate share they get saddled with through contribution claims; under certain circumstances, the net difference between an "all sums" and pro rata allocation might be de mininus, depending upon such factors as the amount of insolvent insurers within the policyholders' insurance program
- Insurers and policyholders disagree as to whether stacking flows from an "all sums" ruling

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Application of Targeted Tender

- Targeted tender (if successful) can provide a policyholder with leverage; but insurers have argued that it can be applied only in limited circumstances
- The doctrine renders "other insurance" clauses inapplicable and burdens the "targeted" insurer with defense/indemnity
- The policyholder retains some flexibility because it can "de-select" and keep other coverage available to it on a "stand-by" basis
- The origin of the doctrine was in the construction context involving concurrent coverage and a property owner and contractor or a general contractor and subcontractor. Often the construction contract/indemnity agreements between the parties are intended to shift the loss
- Illinois Supreme Court decision in Kajima Const. Services, Inc. v. St. Paul Fire and Marine Ins. Co., 858 N.E.2d 234(Ill. 2006) held:
  - Doctrine limited to concurrent, primary contracts
  - Doctrine does not override the doctrine of horizontal exhaustion
- Long tail claim disputes typically involve consecutive, not concurrent contracts
- The doctrine is typically considered an Illinois doctrine, although it has gained some traction in other jurisdictions

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The Fundamental Requirement Of Exhaustion

- Excess insurance attaches after a predetermined amount of primary insurance or self-insured retentions has been exhausted. Exhaustion is a matter of contract language and the nature and role of excess insurance
- Claims of premature exhaustion can arise under a variety of circumstances or relate to a variety of issues apart from settlement for less than policy limits
- Many times the policyholder is involved in the dispute and the issues are addressed in the coverage litigation through declaratory judgment claims and allocating the loss
- Other times the issue is presented in the context of insurer vs. insurer claims for declaratory judgment or equitable contribution/subrogation claims

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Significant Legal Issues Concerning Exhaustion

- The first issue is whether only exhaustion of the limits of insurance contracts and retentions directly underlying the subject excess insurance contract must be exhausted (vertical exhaustion) or whether all underlying limits and retentions for all periods implicated by a loss must be exhausted (horizontal exhaustion) before an excess insurance contract is obligated to respond
- There is general agreement that the attachment point of the excess contract must be reached before an excess contract is required to respond. However, a second common area of dispute concerns whether the underlying exhaustion required to reach an excess contract can be satisfied solely by payment of claims by the underlying insurer(s) or whether the policyholder can pay the difference up to the attachment point. These disputes exist with respect to both traditional and long tail claims
- The conflicting decisions cannot always be reconciled by differences in contract language

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Exhaustion Of All Underlying Limits Horizontal Exhaustion

- Horizontal exhaustion generally applies in states applying a pro rata allocation methodology
- In all sums states, the policyholder is required to exhaust the underlying coverage in the year it selects
- Self-Insurance

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The Exhaustion Debate

- Policyholders argue that, whether the policyholder pays the difference between the amount actually paid by the underlying insurer and the attachment point of the excess policy, the excess insurer is no worse off, and any other rule would disincentivize settlement.
- Insurers, on the other hand, argue this is inconsistent with the policy language According to insurers, (a) excess insurers receive only a small premium relative to the large limits of liability provided, making excess insurance available at reasonable costs, and (b) the excess insurer does not solely rely upon claims being settled for an amount in excess of the attachment point of the policy, it relies upon the claims implicating the excess contract after being subjected to the claims adjustment process of the underlying insurers such that the underlying insurers have reviewed and analyzed the claim, determined that there is coverage, and determined that the settlement is reasonable such as to pay the settlement amount

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The Zeig Line of Cases: Cases Permitting What Some Call "Functional" Exhaustion

- Zeig v. Massachusetts Bonding Ins. Co., 23 F.2d 665 (2d Cir. 1928) (old decision involved a burglary loss under a first-party insurance contract determining that the policy was ambiguous and recognizing that a different result would attain where warranted by the contract language)
- Reliance Ins. Co. v. Transamerica Ins. Co., 826 So.2d 998, 999 (Fla. Dist. Ct. App. 2001) (primary insurer paid $15,000 less than limits)
- Pereira v. National Union Fire Ins. Co. of Pittsburgh, Pa., 2006 WL 1982789 (S.D.N.Y. July 12, 2006)
- Rummel v. Lexington Ins. Co., 123 N.M. 752, 945 P.2d 970 (N.M. 1997)
- Drake v. Ryan, 514 N.W.2d 785, 789 (Minn. 1994) (policyholder settled with underlying insurers for less than the full limits of their professional liability insurance policies and agreed to "fill in the gap" by absorbing the difference between what the insurers agreed to pay and their actual policy limits)
- Maximus Inc. v. Twin City Fire Insurance Co., 2012 U.S. Dist. LEXIS 32970 (E.D. Va. 2012)
- Trinity Homes LLC v. Ohio Casualty Ins. Co., 629 F.3d 653 (7th Cir. 2010)
- Maximus Inc. v. Twin City Fire Ins. Co., (E.D. Va. March 2012)

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The *Comerica* Line of Case: Some Cases Rejecting "Functional" Exhaustion

- Comerica, Inc. v. Zurich Am. Ins. Co., 489 F.Supp.2d 1019 (E.D. Mich. 2007) (rejecting functional exhaustion by insured's payment of the difference between the amount paid by primary insurer and policy limit and holding actual payment losses by the underlying insurer is required)
- Qualcomm, Inc. v. Certain Underwriters at Lloyds, 161 Cap. App. 4th 184, 73 Cal. Rptr. 3d 770 (Cal. App. 2008) (finding language of excess contract, when read in context of function of excess contract, requires actual payment by underlying insurer of no less than the underlying limits)
- Great Am Ins. Co. v. Bally Total Fitness Holding Corp., 2012 WL 2542191 (N.D. Ill. June 22, 2010) (where, as here, policy language clearly defines exhaustion, courts tend to enforce the policy as written)
- Citigroup Inc. v. Federal Ins. Co., 649 F.3d 367 (5th Cir. 2011) (underlying insurer must make actual payment of underlying limits to constitute exhaustion)
- Federal Ins. Co. v. The Estate of Irving Gould, 2011 WL 4552381 (S.D.N.Y. Sept. 28, 2011) (policies require actual payment and noting if the insured "were able to trigger the Excess Policies simply by virtue of their aggregated losses, they might be tempted to structure inflated settlements with their adversaries… that would have the same effect as requiring the Excess Insurers to drop down…")
- Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049 (Ind. 2001)
- United States Fire Ins. Co. v. Lay, 577 F.2d 421 (7th Cir. 1978) (applying Indiana law) ("sham" settlement for less than primary limits did not trigger excess insurer's obligation)
- JP Morgan Chase & Co. v. Indiana Harbor Ins. Co., N.Y. App. Div. 2012)

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Second Circuit Decision

- Ali v. Federal Ins. Co., 719 F.3d 83, 94 (2d Cir. 2013). The excess contract language of one of the excess insurers policies provided that excess liability coverage "shall attach only after all… 'Underlying Insurance' has been exhausted by payment of claim(s)" and "exhaustion" of the 'Underlying Insurance' occurs "solely as a result of payment of losses thereunder"
- The Second Circuit agreed with the District Court that the express language "establishes a clear condition precedent to the attachment of the Excess Policies" by expressly stating that coverage does not attach until *payment* of the underlying losses
- The Second Circuit distinguished its earlier Zeig decision, noting there is nothing errant about interpreting an exhaustion clause in an excess liability policy differently than a similar clause in a first-party property policy, that the "freestanding federal common law" Zeig interpreted and applied no longer exists, and that excess insurers have good reason to require actual payment up to the attachment points of the relevant policies to deter the possibility of settlement manipulation

Generally Excess Insurers Are Entitled To Challenge Exhaustion

- Exhaustion also requires examination of the claims and facts as well as the method required or permitted in the pertinent jurisdiction
- Numerous courts have allowed excess insurers to challenge payments and settlements of claims in which the excess insurers did not participate. See, e.g., Colony Nat. Ins. Co. v. Sorenson Medical Inc., 2011 WL 6740537 (E.D. Ky. Dec. 21, 2011) (applying Utah law); Goodyear Tire & Rubber Co. v. National Union Fire Ins. Co., 694 F.3d 781 (6th Cir. 2012) (applying Ohio law); American Ins. Co. v. St. Jude Medical, Inc., 2010 WL 3733009 (D. Minn. Sept. 20, 2010); Royal Indemnity Co. v. C.H. Robinson Worldwide Inc., 2009 WL 2149637 (Minn. Ct. App. 2009) (unpublished); D.R. Horton Inc. v. American Guar. & Liab. Ins. Co., 864 F.Supp.2d 541, 548 (N.D. Tex. 2012), appeal dismissed, (5th Cir. 2012)
- Excess insurers generally do not have a duty to defend and usually are not involved in the claims handling and settlement process prior to their contacts being implicated
- Owens-Illinois and IMO cases in New Jersey prohibiting insurers from re-litigating already settled claims after refusing to settle them

The Exhausting Examination

- The policyholder generally bears the burden of proving exhaustion of underlying coverage or SIRs
- Other determinations such as assignment of date of loss (trigger), allocation, treatment of number of occurrences, multi-year policies, etc. may be involved
- The determination of exhaustion often runs deeper than an understanding of the applicable legal principles (e.g., horizontal/ vertical and actual payment/functional exhaustion), involving review of the policies, facts, and items involved
- Proper application of aggregate and per occurrence limits and treatment of costs as defense or indemnity
- The mechanics may include a full audit, a review of a sample of claims, full file reviews, reviews of invoices, cancelled checks, or loss runs
- Practical considerations: costs/benefits; the extent to which policyholders and courts will permit review and challenges; no one-size-fits-all approach to evaluating underlying exhaustion

Other Allocation Battle Fields

- Treating trigger and allocation rulings as default rules capable of being overcome by specific contract language and/or by factual proof and expert testimony demonstration when and how much injury/damage took place at various times
- Allocation between claims-made and occurrence based contracts
- Allocation among multiple lines of coverage
- The complexities and limitations associated with contribution claims

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INDEPENDENT COUNSEL AND THE TRIPARTITE RELATIONSHIP: The Cumis Doctrine & Others Entitling Insureds To Pick Their Own Lawyers And Control Their Defense

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October 26, 2018
Washington, DC

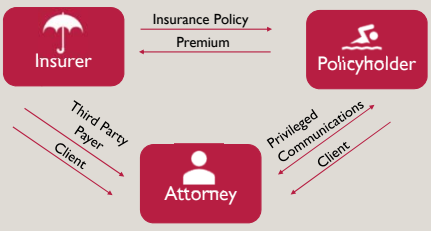
Understanding the Tripartite Relationship

Insurance Policy

Professional Responsibility Obligations

Defense Strategy

THE TRIPARTITE RELATIONSHIP



RULES OF PROFESSIONAL CONDUCT

- Who is the client?
- What limitations are expressed?
- What is defense counsel's relationship with the insurer?
- Reporting to insurer and policyholder.
- What is the scope of the engagement?

ONE CLIENT OR TWO CLIENTS?

- A majority of states (approximately 35) hold that both the insurer and the policyholder are clients of the defense attorney.
- A minority of states hold that defense counsel's sole client is the policyholder.

ABA MODEL RULE 1.7

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

(1) the representation of one client will be directly adverse to another client; or

(2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

ABA MODEL RULE 1.7 (CONTINUED)

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law;

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

(4) each affected client gives informed consent, confirmed in writing.

ABA MODEL RULE 1.6(A)

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

ABA MODEL RULE 5.4(C)

(c) A lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services.

MODEL RULE 1.2(C)

A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent.

TYPES OF POTENTIAL CONFLICTS

- When issues or facts to be decided or developed in the litigation may affect the coverage question. Maryland Cas. Co. v. Peppers, 64 Ill. 2d 187, 355 N.E.2d 24 (1976).
- When it may be advantageous for the insurer if defense counsel provides a less than vigorous defense. Nandorf, Inc. v. CNA Ins. Cos., 134 Ill. App. 3d 134, 479 N.E.2d 988 (1st Dist. 1985).

EXAMPLES OF CONFLICTS

- Negligence vs. Intentional Act
- Permission and Agency
- Punitive Damages
- Covered and Non-Covered Damages
- Damage During One Particular Policy Period vs. Another or Many Policy Periods

HYPOTHETICAL

On October 9, 2017, wannabe actress Windy Knight and her lawyer, Dan Freud, arrive at the home office of attorney Sam Rubio to discuss and possibly sign a business agreement with Rubio's client, Mari Gold, to appear in a dog food commercial.

The meeting is contentious, but the parties ultimately execute a contract. While leaving Rubio's property, Rubio's dappled dachshund, Martin, jumps from Rubio's arms and bites Knight on her left leg and heel. Unable to walk, Knight is airlifted to General's Hospital.

Later, in a comment to the local press, Rubio states that Knight "may never work again, assuming she had the talent to work before."

One year later, Knight sues Rubio for defamation, negligence (failure to warn of Martin's vicious propensities and keep him on leash), intentional assault and battery. Rubio seeks coverage under his commercial general liability policy with InsureU for all allegations.

HYPOTHETICAL (CONTINUED)

Without hiring coverage counsel, a brand new adjuster at InsureU decides to provide a defense to Rubio pursuant to a full reservation of rights ("ROR") which includes, but is not limited to, reserving its right to challenge whether Rubio is entitled to indemnity on the intentional act causes of action.

In the ROR, the insurer has selected defense counsel, Sara Goode, to defend the insured. Attorney Goode has 25 years of insurance defense experience and is an AV rated lawyer. Her hourly rate is $175 an hour. Over 80% of Sara Goode's cases are referrals from the CGL carrier, InsureU.

Rubio is not pleased with the selection of Sara Goode as defense counsel. He demands "independent counsel" and requests that his longtime business attorney, Abe Lawless, defend him in Knight's lawsuit at an hourly rate of $625 an hour.

ISSUES TO CONSIDER

- Who is (are) Goode's client(s)?
- Does Goode have a conflict?
- If Goode has a conflict, what disclosures must she make to Rubio?
- Is independent defense counsel required?
- What are InsureU's obligations to Rubio if there is a conflict?
- Are there consequences if InsureU fails to disclose the conflict to Rubio?
- Must InsureU pay Lawless's $625/hour rate?
- Who has the right to control the defense?
- May Goode reveal information to InsureU that adversely affects coverage?

Jurisdictional and Venue Considerations: *The Colorado River Runs Through It*

ACCC Insurance Law Symposium

- John Heintz, Blank Rome LLP
- Edward Parks, Shipman & Goodwin LLP
- Caroline Spangenberg, Kilpatrick Townsend & Stockton LLP
- Koorosh Talieh, Perkins Coie LLP

October 26, 2018
American University
Washington College of Law

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Introduction

- **Federal Courts have jurisdiction over insurance coverage disputes when**
  - (1) there is complete diversity of citizenship between parties and the amount in controversy is over $75,000; and
  - (2) venue is proper.
- **Insurance coverage litigants often have multiple federal and state courts to choose from when filing a coverage suit.**
  - Many coverage disputes involve multiple insurers, sometimes 20 or more.
  - Policies may have been issued in one state, the underlying loss or litigation may have occurred in another state, and the insured may be incorporated and have its principal place of business in other states.

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Introduction (continued)

- **State vs. Federal Court**: Federal courts have developed a body of case law to address how federal courts decide whether to exercise or decline to exercise jurisdiction:
  - **The *Brillhart-Wilton* Doctrine**
  - **The *Colorado River* Doctrine**
- **Federal vs. Federal Court**: Federal courts decide which venue is proper pursuant to the ***forum non conveniens*** provision of the Judicial Code, 28 U.S.C. 1404(a)
- **State vs. State Court**: State law ***forum non conveniens*** principles apply

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A Hypothetical: Parent Co. and Sub Co.

- A policyholder, "Parent Co." is currently incorporated in Delaware and its principal place of business is in Maryland. At the time Parent Co. purchased its insurance policies, Parent Co. was incorporated in and had its principal place of business in New York.
- Parent Co.'s former subsidiary, "Sub Co." was incorporated and had its principal place of business in California. Sub Co. manufactured asbestos-containing products in California until 1975.
- Actions alleging asbestos claims have been filed against Parent Co. and Sub Co. in virtually every state.

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A Hypothetical: Diverse Parties

- Both Parent Co. and Sub Co. are looking for coverage under liability policies issued by six insurers to Parent Co., as the policyholder, under which Sub. Co was an additional insured. Parent Co. and Sub Co. are running a unified defense of the asbestos claims.
- All insurance carriers are licensed to do and do business in all states, however, citizenship differs between carriers:
  - 2 carriers – incorporated and headquartered in Connecticut
  - 1 carrier – incorporated and headquartered in Pennsylvania
  - 1 carrier – incorporated in New York and headquartered in Illinois
  - 2 carriers – incorporated and headquartered in New York

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A Hypothetical: A Coverage Dispute Arises

- A standstill agreement expires on October 31, 2018 and settlement discussions between the policyholder and its insurance carriers have gone nowhere.
- Where should a coverage dispute between the policyholder and its insurers be litigated?

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What should the parties do on November 1?

- Which of the seven states is the most appropriate forum?
- Should the action be filed in state or federal court?
- Which party should file where?
- Should the parties file a declaratory judgment action or a mixed claim for relief? Does that matter?

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The Carriers won the race to the courthouse by 6 hours

- Does it matter that the insurance carriers are first-to-file in New York Federal Court?
- How should the policyholder respond?
- What effect does the first-filed action have on the policyholder's potential second-filed suit?

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Brillhart-Wilton versus *Colorado River*

- ***Brillhart-Wilton* Doctrine**
  - Federal courts have substantial discretion to abstain from parallel declaratory judgment actions
  - Only applicable to declaratory judgment actions; circuit split as to whether it is applicable to mixed claims
- ***Colorado River* Doctrine**
  - Federal courts may abstain from parallel actions only under exceptional circumstances
  - Applicable to actions seeking legal, equitable, coercive, and mixed claims for relief

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The *Brillhart-Wilton* Factors

1) **The proper allocation of decision making between state and federal courts**
   - Many circuits have a presumption in favor of pending state lawsuits – but this question is decided on the facts and circumstances of each case.
2) **Fairness**
   - District courts should discourage litigants from filing reactive declaratory actions as a means of improper forum shopping – but what is a "reactive" filing, and what is "improper" forum shopping?
3) **Efficiency**
   - District courts should avoid duplicative litigation where possible

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Additional Considerations: The *Dizol* Factors

Circuit courts have articulated additional considerations to inform the *Brillhart-Wilton* analysis. For example, the Ninth Circuit has identified the following:

- Whether the declaratory action will settle all aspects of the controversy in a single proceeding;
- Whether it will serve a useful purpose in clarifying the legal relations at issue;
- Whether it is being sought merely for the purposes of procedural fencing or to obtain a res judicata advantage at the expense of the other party;
- Whether the use of a declaratory action will result in the entanglement between federal and state court systems; and
- Convenience of the parties and the availability and relative convenience of other remedies.

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Additional Considerations: The *Trejo* Factors

As another example, the Fifth Circuit has established the following:

- Whether there is a pending state action in which all of the matters in controversy may be fully litigated;
- Whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant;
- Whether the plaintiff engaged in forum shopping in bringing the suit;
- Whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist;
- Whether the federal court is a convenient forum for the parties and witnesses;
- Whether retaining the suit would serve the purposes of judicial economy; and
- Whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

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The *Colorado River* Factors

1) Whether either court has assumed jurisdiction over a res
2) The relative convenience of the parties
3) The desirability of avoiding piecemeal litigation
4) The order in which the forums obtained jurisdiction
5) Whether state or federal law controls
6) Whether the state proceeding is adequate to protect the parties rights

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What is the likely outcome?

- Does it matter which court addresses the motion first?
- What if the policyholder filed first?
- What would the result be if the London market was involved?

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The Carriers remove the state court action to federal court

- What doctrine applies?
- Are the considerations any different?
- What role does choice of law play?

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Forum Non Conveniens

- **The First Filed Rule**
- **The Balance of Conveniences**
  - Plaintiff's choice of forum
  - The convenience of the witnesses
  - The location of relevant documents and sources of proof
  - The convenience of the parties
  - The locus of operative facts
  - The availability of process to compel attendance of witnesses
  - The relative means of the parties
  - A forum's familiarity with the governing law
- **Choice of Law**

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PAPERS

ESTOPPEL IN INSURANCE LAW – WHAT DOES IT MEAN?

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This paper is a compilation of sections prepared by different authors. Each position expressed in this paper does not necessarily represent the views of all authors, or of their law firms or clients.

ESTOPPEL IN INSURANCE LAW – WHAT DOES IT MEAN?

INTRODUCTION

When presented a request for insurance, insurers generally have the choice (i) to accept coverage and pay the claim, (ii) deny coverage and refuse to pay the claim; or (iii) provide a defense while reserving its rights under the policy to deny indemnification. "Coverage by estoppel" occurs when the court decides that the insurer may not assert coverage defenses because it made some error when handling the insured's claim. This paper examines two different situations where a court may find that an insurer is "estopped." First, it addresses estoppel when an insurer wrongfully refuses to defend. Second, it addresses the situation where an insurer defends, but inadequately responds to a conflict of interest created by the reservation of rights or fails to timely reserve rights and is precluded from raising valid coverage defenses.

ESTOPPEL AND THE WRONGFUL FAILURE TO DEFEND

Illinois has the most extensive judicial development of the estoppel doctrine that applies when an insurer breaches its duty to defend so this paper focuses on the nature and scope of the doctrine as described by Illinois courts.[1]

1. The Illinois Estoppel Doctrine

In *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, the Illinois Supreme Court found that" under the estoppel doctrine, an insurer which breaches its duty to defend is estopped from raising policy defenses to coverage." 708 N.E.2d 1122, 1133 (Ill. 1999). Describing the Estoppel Doctrine, the Court stated:

[1] Although this paper focuses on the Illinois Estoppel Doctrine, other jurisdictions apply similar estoppel rules. *See, e.g., Missionaries of the Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.,* 230 A.2d 21 (Conn. 1967); *Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co.*, 799 P.2d 1113 (N.M. 1990); *Pulte Home Corp. v. Am. S. Ins. Co.*, 647 S.E.2d 614 (N.C. Ct. App. 2007); *Farmers Union Mut. Ins. Co. v. Staples*, 90 P.3d 381 (Mont. 2004); *Se. Wis. Prof'l Baseball Park Dist. v. Mitsubishi Heavy Indus. Am., Inc.*, 738 N.W.2d 87 (Wis. Ct. App. 2007).

> The general rule of estoppel provides that an insurer which takes the position that a complaint potentially alleging coverage is not covered under a policy that includes a duty to defend may not simply refuse to defend the insured. Rather, the insurer has two options: (1) defend the suit under a reservation of rights or (2) seek a declaratory judgment that there is no coverage. If the insurer fails to take either of these steps and is later found to have wrongfully denied coverage, the insurer is estopped from raising policy defenses to coverage.

Id. at 1134-35. Under this rule, an insurer who breached the duty to defend is barred "from raising policy defenses to coverage, even those defenses that may have been successful had the insurer not breached its duty to defend." *Id.* at 1136. Additionally, the insured does not have to show that it was prejudiced by the insurer's failure to defend. *Id.*

The Estoppel Doctrine is robust, but not unlimited. For example, "[a]pplication of the estoppel doctrine is not appropriate if the insurer had no duty to defend, or if the insurer's duty to defend was not properly triggered." *Id.* at 1135. Thus, estoppel is not applicable "where the insurer was given no opportunity to defend; where there was no insurance policy in existence; and where, when the policy and the complaint are compared, there clearly was no coverage or potential for coverage." *Id.* Additionally, Illinois recognizes a narrow exception to the Estoppel Doctrine where there is a serious conflict of interest between the insurer and policyholder preventing the insurer from defending. However, to avoid estoppel in this circumstance the insurer must reimburse defense costs as incurred. *Id.* at 1137.

In applying the Estoppel Doctrine, courts have found that an insurer must act "within a reasonable time of a demand by the insured." *10 Korte Constr. Co. v. Am. States Ins.*, 750 N.E.2d 764, 770 (2001). But, what is a "reasonable time?" If the underlying case is over, because of a judgment or settlement, the answer is simple: An insurer who wrongfully refused to defend is estopped. The issue becomes murkier where significant time has passed,

but the underlying case is on-going when the insurer agrees to defend or file a declaratory judgment action. Courts have found that failure to act within periods ranging from 12 to 21 months establish estoppel as a matter of law.[2] However, where the insurer acts within a shorter period – such as six months, courts have found that there is no estoppel.[3]

Courts that apply the Estoppel Doctrine find that a breach of the policy as to the duty to defend equitably estops the insurer from asserting coverage defenses. As the Illinois Supreme Court explained, estoppel "arose out of the recognition that an insurer's duty to defend under a liability insurance policy is so fundamental an obligation that a breach of that duty constitutes a repudiation of the contract." *Id.* at 1135. Likewise, the Connecticut Supreme Court found that an insurer, "after breaking the contract by its unqualified refusal to defend, should not thereafter be permitted to seek the protection of that contract in avoidance of its indemnity provisions." *Missionaries of the Co. of Mary, Inc.*, 230 A.2d at 26. These courts recognize that the duty to defend is unique. The insured is purchasing both the insurers expertise in defending suits as well as peace of mind that it will be able to afford a defense. In this situation, normal equitable remedies such as recession or specific performance do not adequately compensate an abandoned insured. Thus, Illinois courts developed the Estoppel Doctrine to specifically address this unique situation.

There are three main justifications for the Estoppel Doctrine: (i) breach of the policy as to the duty to defend equitably estops the insurer from asserting coverage defenses (as discussed

[2] *Korte,* 750 N.E.2d at 770 (12 month delay); *W. Am. Ins. Co v. J.R. Constr. Co.*, 777 N.E.2d 610, 620 (2002) (21 months); *Electric Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 346 F. Supp. 2d 958 (N.D. Ill. 2004) (19 months).

[3] *Nautilus Ins. Co. v. Bd. of Dirs. of Regal Lofts Condo. Ass'n*, 764 F.3d 726, (7th Cir. 2014) (no estoppel where insurer filed declaratory judgment with 5 months of being notified of amended complaint which triggered the duty to defend); *Westchester Fire Ins. Co. v. G. Heileman Brewing Co.,* 747 N.E.2d 955, 965 (2001) (6 moths). It should be noted that in these cases, the court not only examined how long it too the insurers to act, but also how long after this action that the underlying case was settled or brought to judgment.

above by the Illinois and Connecticut Supreme Courts); (ii) estoppel is a needed remedy in jurisdictions with little or no bad faith liability; (iii) estoppel deters insurance companies from breaching their duties and protects the intangible benefits inherent in the duty to defend.

The Estoppel Doctrine is a necessary remedy in jurisdictions that limit bad faith damages. For example, in Illinois, an insured's bad faith damages are capped at either a percentage of the overall recovery, $60,000, or the excess amount of a settlement offer over the amount actually recovered. *See* 215 ILCS 5/155. In a case where an insured's defense costs are substantially less than the ultimate judgment against it, this bad faith remedy will fall far short of fully compensating the insured. Conversely, in jurisdictions with stronger bad faith rules, some courts have asserted that estoppel is not a necessary remedy because the insured can recover additional damages under tort law.

Limited bad faith remedies are also a factor in another basis for the estoppel doctrine, which is that the rule deters insurance companies from breaching the duty to defend. If there are minimal repercussions as a result of bad faith, then an insurer does not risk much by unreasonably refusing to defend. For example, in Illinois, if an insured faces a consequence of only a $60,000 penalty in addition to defense costs, it may view a breach as the more "efficient" option. After all, not every insured will pursue a coverage lawsuit, so there may be no risk at all in breaching. In addition, potential punitive damages will act as a deterrent only if the insurer has no reasonable basis to deny a defense. If the insurer has a reasonable basis to believe that the claim does not raise a potential for coverage, then a denial would generally not expose the insurer to bad faith liability. Thus, in a non-estoppel jurisdiction, if there is any question as to whether a duty to defend exists, then the insurer has less of an incentive to provide a defense because it would be liable only for defense costs. Courts in estoppel jurisdictions have concluded that such a result disregards the

benefit purchased by the insured. It renders the duty to defend nothing more than a duty to reimburse defense costs – and yet, these are distinctly different contractual obligations, as recognized by the fact that insurers charge different premiums for each type of coverage. By imposing an equitable remedy for the breach of the duty to defend, courts applying the estoppel doctrine have found that a further remedy is needed to make breaching more costly and to protect the intangible benefits of the duty to defend.

2. Jurisdictions with Variations and Limitations of the Illinois Estoppel Doctrine

Some jurisdictions apply a narrower or limited version of the Estoppel Doctrine. For example, in *Capstone Building Corp. v. American Motorists Insurance Co*., 67 A.3d 961 (Conn. 2013), the court held that, where the insured settled all claims in the underlying litigation, the breaching insurer was liable for only the settlement amounts proportionate to the potentially covered claims. The court reasoned that "holding an insurer liable for the settlement of claims which it had no duty to defend is per se unreasonable . . . ." *Id.* at 999. Another limitation, explicitly rejected in Illinois, is an exception for late notice. *Home Corp. v. American S. Ins. Co.*, 647 S.E.2d 614 (N.C. Ct. App. 2007) (although ultimately unsuccessful, the Court allowed an insurer who breached the duty to defend to raise late notice as a defense); *but see Ehlco,* 708 N.E.2d at 1136 (refusing to carve out an exception for late notice).

California has limited the estoppel doctrine by only applying it where there is a finding of bad faith by the insurer. Thus, while in Illinois, a refusal to defend where there is potential coverage is "wrongful," in California the insurer must have acted unreasonably or in bad faith to have "wrongfully refused to defend." Thus, estoppel will only apply if the insurer unreasonably or in bad faith denied a defense. *See e.g., Amato v. Mercury Cas. Co.*, 53 Cal. App. 4th 825 (Cal. Ct. App. 1997) (holding that insured could recover cost of underlying judgment after breach of

duty to defend even though judgment was not on a covered claim because insurer acted unreasonably and in bad faith in denying defense); *see also Mut.of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 169 P.3d 1, 10 (Wash. 2007) ("if the insured prevails on the bad faith claim, the insurer is estopped from denying coverage") (citation omitted).

3. Jurisdictions That Reject the Estoppel Doctrine

Other jurisdictions have rejected the Estoppel Doctrine and held that an insurer may raise coverage defenses even after the breach of the duty to defend.[4] Courts rejecting the Estoppel Doctrine find that prohibiting coverage defenses goes beyond the permissible damages that should be awarded as a result of a breach. According to these courts, the "proper measure of damages for breach of a contractual duty, including an insurer's duty to defend, is contract damages." *Deluna v. State Farm Fire & Cas. Co.*, 233 P.3d 12, 17 (Idaho 2008). Such damages are simply the costs incurred in providing one's own defense. *Id.* Unless specifically pled and proven, no further repercussions follow from the breach, and according to these jurisdictions, any other result would be improper.[5] *Id*

Courts also support their rejection of the Estoppel Doctrine by holding that it improperly

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[4] *See, e.g., Ala. Hosp. Ass'n Trust v. Mut. Assur. Soc. of Ala.*, 538 So. 2d 1209 (Ala. 1989); *Sentinel Ins. Co. v. First Ins. Co. of Haw.*, 875 P.2d 894 (Haw. 1994); *Hirst v. St. Paul Fire & Marine Ins. Co.*, 683 P.2d 440, 447 (Idaho Ct. App. 1984); *Lee Builders, Inc. v. Farm Bureau Mut. Ins. Co.*, 104 P.3d 997 (Kan. Ct. App. 2005); *Arceneaux v. Amstar Corp.*, 66 So. 3d 438 (La. 2005); *Elliott v. Hanover Ins. Co.*, 711 A.2d 1310 (Me. 1998); *Mesmer v. Md. Auto. Ins. Fund*, 725 A.2d 1053 (Md. 1999); *Polaroid Corp. v. Travelers Indem. Co.*, 610 N.E.2d 912, 922 (Mass. 1993); *Kirschner v. Process Design Assocs., Inc.*, 592 N.W. 2d 707 (Mich. 1999); *Shannon v. Great Am. Ins. Co.*, 276 N.W.2d 77 (Minn. 1979); *Ross v. Home Ins. Co.*, 773 A.2d 654 (N.H. 2001); *Med. Protective Co. v. Fragatos*, 940 N.E.2d 1011 (Ohio Ct. App. 2010); *Nw. Pump & Equip. Co. v. Am. States Ins. Co.*, 925 P.2d 1241 (Or. Ct. App. 1996); *Am. States Ins. Co. v. State Auto Ins. Co.*, 721 A.2d 56 (Pa. Super. Ct. 1998); *Utica Nat'l Ins. Co. v. Am. Indem. Co.*, 141 S.W.3d 198 (Tex. 2004); *Potesta v. U.S. Fid. & Guar. Co.*, 504 S.E.2d 135 (W. Va. 1998).

[5] These jurisdictions appear to leave open the possibility that an insured may recover the amount of a judgment or settlement regardless of coverage if he can show that the liability arose as a consequence of the breach of the duty to defend. *See Sentinel Ins. Co.*, 875 P.2d at 913 ("Certainly, in individual cases, the application of waiver or estoppel will be appropriate – for example, where the insured has been prejudiced in some way by the insurer's failure to provide a defense or where the insurer has taken inconsistent positions with regard to defense and coverage.") (citations omitted); *Deluna*, 233 P.3d at 17 (stating that damages for breach of the duty to defend are "attorney fees and costs for defending the claim, together with any other damages shown to be a result of the breach)..

conflates the separate and distinct duties of defense and indemnity. In *Servidone Construction Corp.,* the New York Court of Appeals emphasized that the obligation to defend is "measured against the allegations of pleadings," but the duty to indemnify is "determined by the actual basis for the insured's liability to a third person." 64 N.Y.2d at 424 (citation omitted); *see also Sentinel Ins. Co.,* 875 P.2d at 912. The Esoppel Doctrine would "in effect applied the same standard" to both the duty to defend and the duty to indemnify. *Servidone,* 64 N.Y.2d at 424.[6]

Another justification for rejecting the Estoppel Doctrine is that preventing the insurer from raising coverage defenses would violate basic contract interpretation principles. Estoppel-rejecting jurisdictions argue that imposing liability where none exists under the terms of the policy would "enlarge the bargained-for coverage . . . ." *Servidone Constr. Corp.*, 477 N.E.2d at 424. The insured would in fact obtain a "windfall" by receiving a "benefit it did not bargain for." *Sentinel Ins. Co.*, 875 P.2d at 912

A final justification commonly cited by courts is that precluding coverage defenses is improperly punitive. These courts find that prohibiting an insurer from raising coverage defenses as a result of the breach does not compensate the insured, but "serves no more than to punish the insurer for the breach of a contractual duty." *Sentinel Ins. Co.*, 875 P.2d at 912; *see also Servidone Constr. Corp.*, 477 N.E.2d at 424; *Hirst,* 683 P.2d at 447 ("We question the propriety of utilizing a form of estoppel as a punitive measure against an insurer for breach of a contractual duty to defend."). They reject the argument that estoppel acts as a deterrent to prevent insurers from disavowing their duty to defend. Instead, they argue that loss of the right to control the defense is

[6] In *Sentinel*, the Supreme Court of Hawaii rejected the Estoppel Doctrine, but it did impose some repercussion as a result of a breach of the duty to defend. The court stated that "fairness to both parties requires that the equities be balanced in each case" and held that a breach of the duty to defend results in a rebuttable presumption that the claim is covered, with the insurer bearing the burden of proof to negate coverage. 875 P.2d at 914; *see also Polaroid Corp. v. Travelers Indem. Co.*, 610 N.E.2d 912, 922 (Mass. 1993).

deterrent enough. *Sentinel Ins. Co.*, 875 P.2d at 913.

ESTOPPEL WHEN AN INSURER DEFENDS

This portion of the materials addresses the situations where an insurer defends, but made an error in handling the defense. First, it addresses the situation where an insurer inadequately responds to a conflict of interest created by the reservation of rights. It then examines the situation where an insurer fails to timely reserve rights and is precluded from raising valid coverage defenses.

1. Estoppel Where a Reservation of Rights Creates a Conflict of Interest

Insurers are well aware of the need that they reserve their rights if they wish to contest coverage. *American Eagle Ins. Co. v. Nettleton*, 932 S.W.2d 169, 174 (Tex. Ct. App. 1996) ("In an attempt to avoid this conflict of interest which gives rise to estoppel, an insurer may undertake the insured's defense and later deny coverage if it 'reserves its rights' by advising the insured that it may interpose a policy defense[.]") A reservation of rights is intended to advise the insured of potential coverage issues which, depending on how the facts develop, may limit or eliminate coverage under the policy. Thus, the reservation of rights notifies the insured of the potential conflict and ensures that the insured knows that although the insurer is defending the case, the insured may ultimately be responsible for paying any judgment. *American Safety Indemnity Co. v. Sto Corp.*, 802 S.E.2d 448, 454 (Ga. Ct. App. 2017) ("The Purpose of a reservation of rights is 'to protect both the insurer and the insured by allowing the insurer who is uncertain of its obligations under the policy to undertake a defense while reserving its rights to ultimately deny coverage following its investigation.").

Failing to issue a reservation of rights prohibits an insurer from contesting coverage after the underlying case is resolved. *See Danny's Backhoe Service, LLC v. Auto Owners Ins.*

Co., 116 So.3d 508, 509 (Fla. 1st DCA 2013) (insurer could deny coverage without issuing a reservation of rights where coverage was "expressly excluded" by the policy); *Royal Ins. Co. v. Process Design Assoc., Inc.*, 582 N.E.2d 1234, 1242 (Ill. Ct. App. 1991) (estopping insurer from denying coverage where it failed to reserve its rights). While a reservation of rights preserves the insurer's coverage defenses, it may also create conflicts. A conflict arises when the insurer potentially has no duty to pay the claim because the facts do not fall within coverage but the insurer still has the duty, and sometimes the right, to control the defense of the case.

A. The Complaint Alleges Claims Covered and Not Covered By the Policy

Conflicts of interest can arise almost immediately upon the assumption of the defense. A classic conflict of interest occurs where a complaint alleges both covered and uncovered claims; for instance, where the underlying plaintiff seeks both compensatory and punitive damages. Where punitive damages are not insurable by law or are prohibited by an exclusion in the policy, the insurer has an interest in the ultimate judgment being characterized wholly as punitive damages. The insured, on the other hand, desires to have the damages characterized as compensatory and thus covered and paid by their insurance.

Utica Mutual Ins. Co. v. David Agency Ins., Inc., 327 F.Supp. 2d 922 (N.D. Ill. 2004) illustrates just how difficult navigating such issues can be. In *Utica*, the insured—itself an insurance agency—was sued for violations of Illinois' consumer protection act and defamation. The consumer claims sought compensatory damages, but the defamation claim sought $500,000 in punitive damages (which are uninsurable as a matter of public policy in Illinois). Utica defended the insured under a reservation of rights addressing potential coverage exclusions, but failed to address the conflict created by the punitive damages

allegation. Ultimately, a nearly $1 million judgment was rendered against the insured which included $525,000 for punitive damages. Because Utica had failed to reserve its rights not to cover punitive damages, the district court estopped Utica from denying coverage. The Court reasoned that the insured was prejudiced by Utica's failure to explain the conflict created by the claim for punitive damages and therefore entitled to full coverage for the underlying Plaintiff's claims.

B. Defense Counsel May Not Give Coverage Advice

Another example of a conflict forming between an insurer and insured after a reservation of rights is issued occurs when defense counsel is aware of the coverage issues in a case and obtains information through discovery or elsewhere which would negatively impact the insured's coverage. Does defense counsel—paid by the insurer—have a duty to disclose the information to the insurer? Do they have a duty to the insured not to disclose the information to the insurer? "[A]s a general rule, a defense attorney should never share with the insurer confidential information communicated by the insured. If defense counsel learns of information suggesting coverage defenses, such information must be kept confidential." *Finley v. Home Ins. Co.*, 975 P.2d 1145, 1156 (Haw. 1998). Accordingly, "an insurer who relies on breach of confidentiality by defense counsel to assert non-coverage may be subsequently estopped from denying coverage based on policy exclusions." *CHI of Alaska, Inc. v. Employers Reinsurance Corp.*, 844 P.2d 1113, 1128 (1993).

For example, in *Parsons v. Continental Nat. Am. Group*, 550 P.2d 94 (Ariz. 1976), the Arizona Supreme Court estopped an insurer from denying coverage based on information learned from the insured's defense counsel despite the insurer having issued a reservation of rights letter. The insured, a fourteen year old boy, viciously attacked his neighbors. The

insurer appointed defense counsel under a reservation of rights and counsel obtained a confidential file from the insured's counselor's stating that the insured intentionally attacked his neighbors and knew his actions were wrong. Counsel provided this information to the insurer, along with his opinion that no coverage was owed under the policy. Accordingly, the insurer denied the coverage. However, the Arizona Supreme Court held that the insurer's engagement of an attorney to defend the insured while also "build[ing] a defense against the insured on behalf of the insurer" created a conflict of interest which estopped the insurer from denying coverage. Thus, insurers must be careful to ensure that appointed defense counsel are insulated from performing any coverage work.

C. If a True Conflict Arises, the Insured May Be Entitled to Independent Counsel

In some jurisdictions, such as Illinois and California, a conflict can result in the insured being given the right to independent counsel. *See Nandorf, Inc. v. CAN Ins. Companies*, 479 N.E.2d 988, 992 (Ill. Ct. App. 1985) (holding that where a true conflict of interest cannot be cured by defending under reservation of rights and independent counsel must be appointed); *San Diego Navy Credit Union v. Cumis Ins. Society, Inc.*, 208 Cal.App. 3d 358, 375 (Cal. Ct. App. 1984) (holding that where "an actual, ethical conflict of interest" exists between the insured and the insurer, the insurer must pay for independent counsel). As the Illinois Supreme Court explains: "the insured has a right to be defended by counsel of its own choosing. A ruling that required an insured to be defended by what amounted to his enemy in the litigation would be foolish." *Murphy v. Urso*, 430 N.E.2d 1079, 1084 (Ill. 1981).

In other jurisdictions, such as Washington, the insured has no right to independent counsel despite that the insurer is paying for the defense and may ultimately control the case.

Johnson v. Continental Cas. Co., 788 P.2d 598, 361 (Wash. Ct. App. 1990). In these jurisdictions, the view is that the insured is defense counsel's client and that the jurisdiction's rules of professional conduct are sufficient to ensure that defense counsel does not divide her loyalty between the insured and insurer. *Tank v. State Farm Fire & Cas. Co.*, 715 P.2d 1133 (Wash. 1986) (holding that part of an insurer's enhanced obligation of good faith when defending under a reservation of rights requires "[b]oth the retained defense counsel and the insurer must understand that only the *insured* is the client"). As the Supreme Court of Mississippi has recognized, the tripartite relationship between insured, defense counsel, and insurer creates problems that would "tax Socrates." *Hartford Acc. & Indem. Co. v.* Foster, 528 So.2d 255, 274 (Miss. 1988). Accordingly, insurers must be extremely diligent in treating their insured fairly when defending under reservation of rights, otherwise they seriously risk losing their coverage defenses.

2. Estoppel by Late Assertion of a Coverage Defense

A delay in issuing a reservation of rights letter can also result in estoppel or waiver of defenses. The two terms are often used interchangeably in insurance case law, but in fact are two different concepts with differing requirements. Waiver "requires the insurer to intentionally relinquish its right to deny coverage…[and] depends solely on the intent of the waiving party, and is not established merely by evidence the insurer failed to specify the exclusion in a letter reserving rights." *Ringler Associates Inc. v. Maryland Cas. Co.*, 80 Cal.App.4th 1165, 1190 (Cal. Ct. App. 2000). In contrast, under an estoppel theory, the insured must show that the insurer's conduct caused "either (1) a reasonable belief that the insurer was providing coverage or (2) any detrimental reliance on such conduct." *Id.* This technical distinction notwithstanding, the claims are similar in that they both permit the insured to reap insurance

benefits under a policy which they have somehow breached. However, waiver and estoppel typically cannot create coverage when none exists; that is they may not be used "affirmatively, to *create* a right to coverage not contained in the insuring clauses of the policy[;]" but it may be used "defensively, to *preserve* a right to coverage already acquired by preventing its forfeiture." *DeJonge v. Mutual of Enumclaw*, 843 P.2d 914, 916 (Or. 1992).

In some jurisdictions, like Arizona, an insurer must reserve its rights early in the underlying litigation; and an unreasonable delay in reserving rights, coupled with prejudice to the insured, will result in the insurer's waiver of its coverage defenses. *See Penn-American Ins. Co. v. Sanchez*, 202 P.3d 472, 478 (Ariz. Ct. App. 2008) (holding that a ten month delay in issuing a reservation of rights was unreasonable.); *Dietz-Britton v. Smyth, Cramer Co.*, 743 N.E.2d 960, 966 (Ohio Ct. App. 2000) (noting that defending a claim for nearly a year and then issuing a reservation of rights letter may waive insurers coverage defense).

However, in other jurisdictions, for instance Georgia, an insurer is not estopped from raising a coverage defense it discovers late into the litigation. "[A]n insurance company is not required to 'list each and every basis for contesting coverage in the reservation-of-rights letter before the company [can] raise such in the declaratory judgment action." *Kay-Lex Co. v. Essex Ins. Co.*, 649 S.E.2d 602, 609 (Ga. Ct. App. 2007). Generally, so long as the insurer did not intentionally conceal the coverage defense when it issued the reservation of rights, it may later assert coverage defenses it discovers. For instance, in *Federated Department Stores, Inc. v. Twin City Fire Ins. CO.*, 280 A.D.3d 32, 37 (N.Y. App. 2006), New York's intermediate appeals court held that an insurer could decline coverage twenty months after agreeing to defend an entity as an "additional insured" based on newly discovered defenses. In any event, wise insurers will reserve rights with as little delay as possible.

Whether an insurer will be deemed to be estopped from the benefit of its coverage defenses because of a late reservation of rights is a fact specific inquiry which will vary greatly from jurisdiction to jurisdiction. Courts will sometimes require a showing of prejudice and at other times hold that the delay in reserving is itself *de facto* prejudice.

ESTOPPEL UNDER THE ALI RESTATEMENT OF THE LAW.

This section of the paper discusses estoppel under the ALI Restatement of the Law, Liability Insurance ("Restatement"), including possible approaches to estoppel that were considered in the drafting of the Restatement. The American Law Institute produces Restatements of the Law, which are a series of publications which aim at clear formulations of common law and its statutory elements or variations, and reflect the law as it presently stands or might appropriately be stated by a court. In 2010, the ALI launched a project in the area of insurance law and appointed as drafters of the project law school professors Tom Baker of the University of Pennsylvania as Reporter and Kyle Logue of the University of Michigan as Associate Reporter. The insurance law Restatement project has four chapters, covering (1) Basic Liability Insurance Contract Rules; (2) Management of Potentially Insured Liability Claims; (3) General Principles Regarding the Risks Insured; and (4) Enforceability and Remedies. An official text of the Restatement has not yet been produced by the ALI, but the ALI Council and membership approved a draft and the project is now in the final stages of review prior to publication.

Restatements for the most part historically have reflected a consensus statement of established law. However, under new ALI standards adopted in 2015, modern Restatements may be different. The ALI has given Reporters more latitude to "determine the best rule" and "make the law better adapted to the needs of life." *ALI Style Manual – A Handbook for ALI Reporters and Those Who Review Their Work (2015).* Instead of codifying existing law, modern

Restatements are not compelled to follow precedent, but may "propose the better rule and provide the rationale for choosing it . . ." *Id.*

Some modern Restatements – among them the Restatement of the Law, Liability Insurance[7] - have been sharply criticized for foregoing their roles as summaries of the black-letter law in favor of assuming roles as advocates for approaches deemed to be "better." This "reform-oriented" approach prompted a strong rebuke from United States Justice Antonin Scalia, who wrote in relation to another modern Restatement that:

> Over time, the Restatements' authors have abandoned the mission of describing the law, and have chosen instead to set forth their aspirations for what the law ought to be. . . . Restatement sections such as that should be given no weight whatever as to the current state of the law, and no more weight regarding what the law ought to be than the recommendations of any respected lawyer or scholar. And it cannot safely be assumed, without further inquiry, that a Restatement provision describes rather than revises current law.

Kansas v. Nebraska, 135 S.Ct. 1042, 1064 (U.S. 2015) (Scalia, J., concurring and dissenting). Specifically with respect to the liability insurance Restatement, through legislative action, or in formal letters to the ALI from state Governors or Insurance Commissioners, officials in at least

[7] For instance, one scholar noted that the Restatement's proposals "risk significant disruption of current law with uncertain, unintended, and adverse consequences on liability insurance markets in the form of higher prices, less availability of coverage, reductions in policy limits purchased, aggravation of the judgment proof problem, and increased adverse selection and moral hazard." *Scott E. Harrington, Economic Perspectives on the Restatement of the Law on Liability Insurance Project (March 20, 2017).* Those objecting have included lawyers and insurance scholars submitting input for the Reporters' consideration in drafting the Restatement, as well as officials in several US states, who have questioned whether it properly reflects existing insurance law principles and rejected reliance on it. The Reporters and the ALI received over 200 submissions on this project, most of which – including the letters cited in this article -- are posted on the ALI website. *See https://www.ali.org.*

eleven US states have questioned the reliability of the Restatement as a reflection of existing insurance law.[8]

A. Estoppel As Discussed In the Restatement Drafting Process.

An ALI Restatement is produced through a series of drafts written by the Reporters. An Advisory Committee, made up of attorneys designated by the ALI on the basis of their knowledge of the field, and a Members Consultative Group, made up of ALI members who volunteer to participate, provide input to the Reporters on their drafts. Ultimately, the Reporters present their proposed draft for approval by the ALI Council (the ALI's governing body) and ALI membership, both of which must approve the project before it becomes the official statement of the ALI and is approved for publication.

[8] The insurance commissioners of Michigan, Idaho and Illinois have each written to the ALI to express concerns that the Restatement goes beyond codification of the law and could adversely impact the insurance system and thus matters they oversee as regulators. *See May 15, 2017 Letter to the ALI from Patrick McPharlin, Director of the Michigan Dep't of Insurance and Financial Services; April 5, 2017 Letter to the ALI from Dean Cameron, Director of the Idaho Dep't of Insurance; May 19, 2017 Letter to the ALI from Jennifer Hammer Letter, Director of the Illinois Dep't of Insurance.* The Governors of South Carolina, Maine, Texas, Iowa, Nebraska and Utah jointly wrote to the ALI to underscore their concerns about how this project alters fundamental insurance law principles. *See April 6, 2018 Letter to the ALI from Governors of South Carolina, Maine, Texas, Iowa, Nebraska and Utah.* And the legislatures of Tennessee and most recently, Ohio, have enacted new laws repudiating the Restatement's overreach into altering the common law – specifically with respect to rules giving insurance contract language its plain meaning in Tennessee and more broadly with respect to efforts to impose the Reporters' judgments about public policy on the law of Ohio. *Tennessee HB 1977/SB 1862 (providing inter alia, "[a] policy of insurance must be interpreted fairly and reasonably, giving the language of the policy of insurance its ordinary meaning"); Ohio S.B. 239, Sec. 3901.82 ("The Restatement of the Law, Liability Insurance that was approved at the 2018 annual meeting of the American law institute does not constitute the public policy of this state and is not an appropriate subject of notice.").*

The ALI Restatement of the Law, Liability Insurance is a unique project because it began as a "Principles of the Law" project of the ALI. Unlike Restatements, the ALI's Principles projects permit Reporters to propose what the law should become, and are directed to courts when an area is so new that there is little established law. Although this project was re-designated as a Restatement project, many commentators feel that the project never fully transformed from an aspirational view reflecting the Reporters' opinions of what the law should become into a project intended to reflect the existing common law.

The Restatement's treatment of the estoppel issue evolved as the project progressed through multiple drafts. The first Restatement draft retained the estoppel rule that had been asserted in the Principles project, proposing that estoppel (and forfeiture of the right to assert defenses to indemnity) should be an automatic consequence of any breach of the duty to defend.[9] The applicable section first provided that, if an insurer breaches the duty to defend, then the insurer must provide coverage for the legal action for which the defense was sought. This approach was

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[9] This Section of the draft Restatement, entitled "Consequences of Breach of the Duty to Defend," posited that:

> (1) An insurer that breaches the duty to defend a claim loses the right to assert any control over the defense or settlement of the claim and *the right to contest coverage for the claim.*
>
> (2) Damages for breach of the duty to defend *include the amount of any judgment entered against the insured or the reasonable portion of a settlement entered into by or on behalf of the insured after breach, subject to the policy limits,* and the reasonable defense costs incurred by or on behalf of the insured, in addition to any other damages recoverable for breach of a liability insurance contract.
>
> (3) The insured may assign to the claimant or to an insurer that takes over the defense all or part of any cause of action for breach of the duty to defend the claim.

RESTATEMENT OF THE LAW LIAB. INS. § 19 (AM. LAW INST., Discussion Draft 2015) (emphasis added).

criticized as being out of step with a general analysis of the types of damages available for a contractual breach (as set forth in the Restatement of the Law of Contracts), and imposing an automatic and disproportionate penalty – the forfeiture of indemnity coverage defenses.[10]

Had the Restatement adopted an estoppel rule, it would have been out of step with the majority common law rule,[11] as well as the fundamental principle that an insurance agreement is a contract, and its breach is subject to contract damages. Commentators urged that the Restatement should not award a windfall of indemnity coverage for what may be uncovered claims; it should recompense the non-breaching party for its actual losses sustained because of the breach. The lack of any nexus between an automatic grant of indemnity coverage and harm allegedly sustained from a breach of the duty to defend was a key issue with the early approach.

After substantial push back, the Reporters amended their position to state that an insurer that refused to defend "without a reasonable basis" for its conduct would be estopped from asserting coverage defenses.[12] However, this change did not resolve the concerns. It continued to advocate a punitive result for breach of a contractual duty, at odds with prevailing common law nationwide. Commentators further urged that the estoppel proposal violated the ALI's own principles for when a Restatement should adopt a minority position because there is no empirical evidence that a reversal of the prevailing rule would be desirable, which ALI guidance states should be shown

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[10] Submissions addressing the estoppel rule, and criticizing the punitive, automatic forfeiture of coverage defenses, are posted on the ALI website. *See https://www.ali.org.*

[11] *See* ALLAN D. WRIGHT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS § 4:37 (6th ed. 2013).

[12] RESTATEMENT OF THE LAW LIAB. INS. § 19 (AM. LAW INST., Council Draft No. 2, Dec. 2015). At that time, the applicable section, "Consequences of Breach of the Duty to Defend," stated in relevant part: "An insurer that lacks a reasonable basis for its failure to defend a legal action also loses the right to contest coverage for the action."

before a Restatement adopts minority position.[13] In urging that the Reporters reject an automatic estoppel of the ability to raise coverage defenses, commentators pointed out that -- in addition to the many jurisdictions finding no estoppel at all[14] -- Illinois' rule only imposes estoppel if an insurer fails to file a declaratory judgment action seeking court guidance on its obligations and is found to have wrongfully refused to defend. Objectors noted that the harsh result that would be applied under an estoppel rule was not moderated in any way. For instance, the proposed rule did not have an opening phrase stating "Unless the insurer promptly seeks a declaratory judgment on its coverage obligations . . .." Further, the proposed rule did not tie its application to a *material* breach, and did not address the problem of disproportionate outcomes but stating, for instance, that "the insured bears the burden of proving that that loss of the right to contest coverage is a proportionate remedy for the actual harm demonstrated." Nor did the Reporters' draft tie the forfeiture rule to the individual circumstances of the claim. Commentators also urged that adequate remedies already existed in the event of negligent breach of the duty to defend, so that creating a new right to indemnity coverage as a consequence of a breach was not appropriate or justified. Ultimately, the Reporters agreed and removed the provision creating an automatic estoppel or waiver of coverage defenses based on a negligent breach of the duty to defend.[15]

B. The Final Outcome: Treatment of Estoppel Under the Restatement.

The most current draft of the Restatement as of this writing is the Revised Proposed Final Draft No. 2, which was posted by the ALI in September 2018. This draft does not apply estoppel as a consequence of a breach of the duty to defend, but the issue is discussed in the Comments and

[13] *ALI Style Manual – A Handbook for ALI Reporters and Those Who Review Their Work (2015).*

[14] *See supra* Fn. 11.

[15] RESTATEMENT OF THE LAW LIAB. INS. § 19 (AM. LAW INST., Proposed Final Draft No. 2 revised, September 2018). The applicable section, "Consequences of Breach of Duty to Defend," now states: "An insurer that breaches the duty to defend a legal action forfeits the right to assert any control over the defense or settlement of the action. *Id.* It abandons the concept of forfeiture of coverage defenses.

Reporters' Notes to Section 50, Remedies for Liability Insurance Bad Faith. In Comment c to that Section, the Reporters have revived the concept of estoppel, stating that "there are some circumstances . . . in which courts have held that an insurer is estopped by its bad faith conduct from asserting a coverage defense that it would have been able to assert had it fulfilled its contractual obligations." *RESTATEMENT OF THE LAW LIAB. INS. § 19 (AM. LAW INST., Proposed Final Draft No. 2 revised, September 2018) (Section 50, Comment c).* According to the Reporters, these include where the insurer has refused to defend in bad faith, used defense counsel to collect information to deny coverage, or denied the existence of a liability insurance policy. The Reporters contend in the Reporters' Note that estoppel is appropriate where the insurer has refused to defend in bad faith, but acknowledge that "the majority rule is that an insurer that breaches the duty to defend may contest coverage" and that courts in the majority of jurisdictions have generally not held that a different rule should apply in the case of a bad faith breach. *Id. (Section 50, Reporters' Note e).* As they acknowledge, the rule the Reporters seem to be advocating – that courts should consider an estoppel rule in the event of a bad faith breach of the duty to defend -- applies only in Washington. *Id.* Because it is such as distinct minority view and there is no empirical support for that approach, the attempt to resuscitate an estoppel rule in the Restatement – albeit one tied to bad faith -- has met with substantial criticism.[16]

[16] Indeed, it is subject to the same criticisms leveled at earlier attempts to incorporate an estoppel rule, including the charge that violates the ALI's own principles for when a Restatement should adopt a minority position because there is no empirical evidence that a reversal of the prevailing rule would be desirable, which ALI guidance states should be shown before a Restatement adopts minority position. *ALI Style Manual – A Handbook for ALI Reporters and Those Who Review Their Work (2015).*

CONCLUSION

Insurers should carefully evaluate all of the claims that they receive. In doing so, the insurer should not only consider whether it has a duty, but if it does, any potential conflicts of interest or coverage defenses. Failure to correctly access and handle the claim at the beginning, could lead to estoppel down the road whether or not the insurer defends.

DON'T GO IN THE WATER

A Deep Dive into *Johansen v. California State Automobile Association*

Julia Molander, Cozen O'Connor, San Francisco

American College of Coverage Counsel Fall Symposium

October 26, 2018

American University Washington College of Law

A Deep Dive into *Johansen v. California State Automobile Association*

Julia Molander, Cozen O'Connor, San Francisco

The year 1975 seems so long ago. The internet was not yet invented; there were no fax machines, no post-its, no laptops. The personal computer was still futuristic, with the Altair 8800 just released and Microsoft a year away from licensing its name. I was in my first year of law school, the *Rocky Horror Picture Show* opened on Broadway and *Jaws* was the summer blockbuster. Watergate was still ongoing, with Attorney General Mitchell, and presidential aides Haldeman and Ehrlichman, sentenced to prison.

Women were becoming political figures in their own right in 1975, with the election of Margaret Thatcher as Prime Minister of Britain and Ella Grasso as governor of Connecticut. The Vietnam War ended with the fall of Saigon. The Golden State Warriors won their first championship. Jimmy Hoffa went missing and Patty Hearst was captured. Bruce Springsteen released "Born to Run"; Queen, "Bohemian Rhapsody"; and Elton John's album "Captain Fantastic" went number one with a bullet. Saturday Night Live televised its first episode, with now-deceased comedian George Carlin as host. New York City was bailed out of bankruptcy.

In this historical context, the California Supreme Court decided the case of *Johansen v. California State Automobile Association*, 15 Cal.3d 9, 123 Cal.Rptr. 288, 538 P.2d 744 (1975), holding that an insurer that refuses a reasonable policy limits demand violates the duty of good faith and fair dealing to its insured. This decision arguably is the most important bad faith case in California, given the long-lasting hardiness of the Court's ruling and the breadth of its impact. This paper will review the decision and its precedents; discuss the consequences of the Court's ruling in the bad faith arena; and present alternative holdings that the Court could have reached.

THE ACCIDENT FACTS

On February 26, 1963 Gary Dearing, driving a 1956 Chevy, collided with Muriel Johansen's car. How he got the car was a matter of significant dispute. The trial court found as follows. In June 1961 grandparents in Michigan lent the Chevy to their grandson. Somehow the grandson and auto made it to California. The car became inoperable because of a damaged engine. In June 1962, the grandson returned to Michigan. He left the car with a friend with instructions to sell it. Presumably for purposes of the sale, the grandson extinguished a $129 lien on the auto.

In July 1962, the grandparents transferred title to their grandson. The state of Michigan provided the grandson with a certificate of ownership and new license plates in August 1962. The car, though, was still in California sporting the old Michigan plates. The friend to whom the grandson entrusted the Chevy lived in the Dearing house. Gary Dearing tinkered with the car and put it back into working order.

In January 1963, arrangements were made for Mrs. Dearing to purchase the car because her son was a minor. On disputed facts the trial court found that a condition of sale was for Mrs. Dearing to surrender the Michigan license plates on the car. On behalf of Mrs. Dearing, a $150 money order was sent on February 4, 1963 to the grandson, three weeks before the accident, to

purchase the automobile. The old plates were never surrendered to the grandson or grandfather. The certificate of title did not arrive at the Dearing's house until May 6, more than two months after the accident. The Michigan-issued new license plates never were sent to Mrs. Dearing in California. The car was never registered in California.

The Johansens filed suit against the Dearings. California State Auto Association ("CSAA") agreed to defend and filed a declaratory relief action on the issue of whether the involved car was insured. CSAA's position was that the Chevy was a non-owned auto; the Dearings contended that the Chevy was an additionally acquired auto that was automatically covered within 30 days of purchase. After a court trial, the judge held that the Chevy was not insured under the CSAA policy issued to Mrs. Dearing. CSAA thereafter refused a policy limits demand of $10,000. The insurer offered to place the policy limits in escrow with 7% annual interest, pending resolution of the coverage action, but the plaintiffs declined. The Johansens obtained a $33,000 judgment against the Dearings.

The coverage lawsuit was appealed. The Court of Appeal reversed the judgment by the trial court, holding that the Chevy was an additionally acquired auto. CSAA paid the $10,000 policy limits plus interest and costs but refused to pay the remaining part of the judgment. The Dearings assigned their rights against CSAA to the Johansens.

THE BAD FAITH DECISION

The Johansens then commenced a lawsuit against CSAA for the remainder of the judgment. The trial court ruled in favor of CSAA on the grounds that the insurer maintained a bona fide belief that coverage did not exist. In essence this was an early effort to press the current "genuine dispute" doctrine. CSAA's bona fide belief found support in the trial court decision in the separate insurance coverage lawsuit in favor of CSAA.

However, the California Supreme Court disagreed, observing that a "wrongful" denial of coverage only required that insurer make an "erroneous" coverage decision. *Id.* at 16, n. 4. Instead, the Court held that an insurer acts in bad faith when it refuses to agree to a reasonable settlement demand within policy limits. The only fact for consideration as to the "reasonableness" of the settlement demand is "whether, in light of the victim's injuries and the probably liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer." *Id.* at 16. The size of the judgment, although not conclusive "furnishes an inference that the value of the claim is the equivalent of the amount of the judgment." *Id.* at 17.

The Court rejected a number of defenses raised by the insurer: a good faith, though erroneous, belief in no coverage; the limits imposed by the policy; a desire to reduce the amount of future settlements; the insured's purported collusion in stipulating to liability and in reaching a fee-splitting arrangement with the plaintiff's counsel.

THE SUPPORTING AUTHORITIES

The Court based its decision mainly on its previous decision in *Comunale v. Traders & General Ins. Co.*, 50 Cal.2d 654, 328 P.2d 198 (1958). *Comunale* involved an accident in which two pedestrians were injured by the insured's vehicle. The policy limits were $10,000 per person and $20,000 per accident. The insurer denied coverage because the driver did not own the vehicle

and there was controverted evidence that the truck was supplied for his regular use. The matter resulted in a judgment of $26,500, which was assigned to the plaintiff. The insurer, having been found responsible for coverage in a separate action, paid the policy limits but refused to pay the excess judgment.

In plaintiff's subsequent action, the trial court ruled for the insurer but the Supreme Court reversed. Applying the nascent doctrine of good faith and fair dealing implied in contracts, the Court in *Comunale* concluded that as a matter of contract law, the insurer wrongfully breached the contract. Under California law, the damages of a contract breach are more expansive than other states; Civil Code § 3300 provides that the measure of damages for a breach of contract is the amount that will compensate the aggrieved party for all the detriment proximately caused by the breach. Civil Code § 3358 limits the damages to full performance of the contract, which the Court construed as protecting the insured from all liability, not just liability within policy limits. The insurer therefore bore the risk of the excess judgment.

This same result was reached in a much later case, *Archdale v. American International Speciality Ins. Co.*, 154 Cal.App.4th 449, 64 Cal.Rptr. 3d 632 (2007), decided by the leading jurist on insurance law in California, Justice Walter Croskey. Justice Croskey held that as a matter of contract law, the damages that result from a failure to accept a reasonable settlement within policy limits include the full amount of the judgment, including those amounts excess of the policy limits. Following *Comunale*, the court determined that all contract damages would be available to the plaintiff.

THE CONSEQUENCES

Both *Comunale* and *Archdale* were brought as contract actions for the same reason: the plaintiffs missed the statute of limitations for a tort claim. The courts noted in both *Comunale* and *Archdale* that the claims for violation of the covenant of good faith and fair dealing (aka "bad faith") can be stated in either contract or in tort. As a contract claim, the damages included the policy limits, the amount of the judgment beyond the policy limits, and possibly pre-judgment interest at 10% per annum.

Johansen, though, was pled as a tort claim for bad faith. The damages available in California for tort bad faith are significantly greater than for contract bad faith. A successful plaintiff can recover the policy limits, the amount beyond the judgment beyond the policy limits, pre-judgment interest, attorneys' fees for obtaining the contract benefits (so-called *Brandt* fees), consequential emotional distress, consequential business losses including bankruptcy, and punitive damages.

OTHER APPROACHES TO THE SAME SITUATION

The Texas case of *Stowers v. American Indemnity Co.*, 15 S.W.2d 544 (Tex. Comm'n App.1929 – holding approved) took a different approach to the situation of an insurer's denial of a policy limits demand which results in an excess verdict. The Court rejected the insurer's argument that it was limited to face amount of the policy because that was the contractual agreement. Instead, the court framed the obligation of the insurer in terms of negligence, a fairly new concept at the

time. After all, *Palsgraf v. Long Island RR Co.*, 248 N.Y. 339, 162 N.E. 99 (1928) had been decided only one year earlier. The *Stowers* Court stated:

> The provisions of the policy giving the indemnity company absolute and complete control of the litigation, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.

Id. at 547. The insurer, having breached its duty of care by which an ordinarily prudent person would do with respect to the management of his own business, could be held responsible to the consequence of a verdict exceeding the policy limits. *Id.* The Court noted that the insurer's practice of never making a settlement for more than half of the policy limit could be admitted as bearing on the issue of negligence.

In contrast, California does not recognize negligence as a basis for liability against an insurer. An insurer cannot be sued for negligent investigation (*Benavides v. State Farm Gen. Ins. Co.*, 136 Cal.App.4th 1241, 39 Cal.Rptr.3d 1241 (2006)), negligent advisement of limits (*Schultz Steel v. Hartford Acc. & Indem. Co.*, 187 Cal.App.3d 513, 231 Cal.Rptr. 715 (1986), and negligent claims handling (*Adelman v. Associated Int'l Ins. Co.*, 90 Cal.App.4th 352, 108 Cal.Rptr.2d 788 (2001).

Had the Court in *Johansen* followed the path of *Stowers*, the Court would have found that CSAA owed a duty to accept reasonable settlements as an extension of the absolute control of the defense provided in the contract of insurance. A negligent breach of this obligation would allow the insured to recover consequential damages, including the amount of the excess judgment and other damages caused by the refusal of the policy limits demand. But it would omit two significant recoveries in California for tort-based breach of the covenant of good faith and fair dealing: *Brandt* fees and punitive damages. *Brandt* fees would not be recoverable because those fees require a finding of bad faith, as opposed to negligence (although the common law tort of another might serve as an alternative basis of recovery). Punitive damages in California cannot be awarded on the basis of negligence, even gross negligence.

THE RETROSPECTIVE TAKEAWAYS

Both *Stowers* and *Johansen* were decided in the early stages of the developing doctrines of bad faith. The *Stowers* court chose to apply negligence principles to the failure of the insurer to accept a reasonable settlement offer within policy limits. The *Johansen* court relied on the new-ish doctrine of bad faith to find a tort cause of action for the same behavior. And the earlier *Comunale* court held that there could be contract recovery for the refusal to settle within limits. Both *Comunale* and *Johansen* involved coverage issues that the insurer wanted resolved before it committed funds to a potentially uncovered claim.

The difference in the theory of recovery can make a huge difference in the amount of recovery, even based on the same circumstances. In California, an insurer rejects a demand for policy limits at its own peril; if the judgment exceeds the limits, the insurer is likely to be held liable for

the contract claim, the excessive judgment, any consequential emotional distress and business losses, and punitive damages unless it wins on the coverage issue in dispute. As the movie poster for *Jaws* said: "If you want to survive Fishing Season, don't go in the water."

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The Duty To Settle In Texas

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I. INTRODUCTION

This paper is intended to explain, and critique in some instances, the Talmudic interpretation of the duty to settle under Texas law. *Stowers* agonistes have been evolving and bedeviling parties and courts in Texas for over 85 years. Despite repeated efforts to straight-jacket the cause of action and severely limit its application, it remains a viable claim and is ever-present in connection with the handling of liability insurance claims in Texas.

II. SOURCES OF THE COMMON LAW DUTY

A. Control of Defense and Settlement

In *G.A. Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved), the court predicated the duty to settle on the "control" given to and exercised by the carrier under the policy terms:

> The provisions of the policy giving the indemnity company ***absolute and complete control of the litigation***, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.

Id.; *see also Rocor Int'l v. Nat'l Union Fire Ins. Co. of Pittburgh, PA*, 77 S.W.3d 253, 263 (Tex. 2002) (noting the *Stowers* decision is based in part "upon the insurer's control over settlement"). Stated another way, an insurer whose policy does not permit its insured to settle claims without its consent owes to its insured a common law "tort duty." *Ford v. Cimarron Ins. Co., Inc.*, 230 F.3d 828, 831 (5th Cir. 2000)(citing *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved)). It would seem that the *Stowers* doctrine is an excellent example of the rule that if a party undertakes a given duty or task, it must act reasonably in its performance.

B. Excess Carriers

Apparently, according to some authorities, the excess carrier must also have taken over the defense of the case. *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692, 701-02 (Tex. 2000). Thus, the failure of the excess carrier in *Keck* to respond to the initial

settlement demand of $3.6 million could not be used as contributory negligence where the offer came prior to tender of the primary limits and prior to takeover of the defense. *Id.*

The *Keck* court held that even if the excess carrier was negligent in failing to "explore coverage issues more diligently, reserved its rights . . . investigated the merits of the third-party claim more thoroughly, hired independent counsel to monitor the third-party claim, supervised its claim adjuster more closely, and demanded to settle the claim months before trial," it was not actionable because it was based on conduct prior to the tender of the primary limits and because in this pre-tender situation the *excess carrier has no duty to defend or indemnify*. *Id.* The court added that pre-tender, the excess carrier had no duty to monitor the defense or to anticipate that the defense was being mishandled by the primary carrier and the defense counsel selected by the insured, noting the general tort rule that a party has no duty to anticipate the negligence of another. *Id.*

In some other jurisdictions, the courts have recognized that an excess carrier has a duty to settle once the primary limits or any self-insured retention have been tendered, regardless of whether the excess carrier is defending or not. ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSUREDS, sec. 5:26 (Database updated March 2011). In Texas, however, at least some courts have recognized that the tort duty to settle under *Stowers* does not apply unless the excess carrier is defending. *Emscor Mfg., Inc. v. Alliance Ins. Group*, 879 S.W.2d 894, 909 (Tex. App.—Houston [14th Dist.] 1994, writ denied)(holding that excess insurer can never have a duty to settle). The court in *Emscor* observed: "[W]e note that ***the Stowers doctrine . . . has never been applied to an excess carrier*** . . . ." *Id.* at 901(emphasis added). The *Emscor* court added: "There is simply no authority in this State establishing a cause of action by an insured against its **excess** insurer for negligence, bad faith, or for unfair and deceptive practices in the handling of a claim brought by a third-party." *Id.* at 909; *accord West Oaks Hosp., Inc. v. Jones,* No. 01-98-00879-CV, 2001 WL 83528, at *10. The court reasoned:

> The *Stowers* doctrine has been applied in Texas in only two circumstances—to the insured's right to sue a primary carrier for wrongful refusal to settle a claim within policy limits, *see G.A. Stowers Furniture Co. v. American Indem., Co.,* 15 S.W.2d 544, 547–48 (Tex.Comm'n App.1929, holding approved), and to an excess carrier's right to sue a primary carrier, under the theory of equitable subrogation, to protect the excess carrier from

> damages for a primary carrier's wrongful handling of a claim, *see American Centennial Ins. Co. v. Canal Ins. Co.,* 843 S.W.2d 480, 483 (Tex.1992). Neither of those circumstances are present in the instant case.
>
> . . . .
>
> Under *Stowers,* the insurer's duty to the insured, extends to the full range of the agency relationship as expressed in the policy**.** *See Ranger County Mut. Ins. Co. v. Guin,* 723 S.W.2d 656, 659 (Tex.1987). [emphasis added]. That duty may include investigation, preparation for defense of the lawsuit, trial of the case, and reasonable attempts to settle. *See American Physicians Ins. Exchange v. Garcia,* 876 S.W.2d 842, 849 (Tex.1994) (opinion on motion for rehearing). Here, ***Alliance had no duty to investigate, negotiate or defend Emscor*** under the terms of the excess policy or at law, and ***never undertook those responsibilities on its own.*** *See Emscor,* 804 S.W.2d at 197–99. Therefore, Alliance had no duty under *Stowers* and Emscor has failed to state a *Stowers* cause of action.

879 S.W.2d at 909 (emphasis added).

C. Appeals

As will be discussed more fully below, case authority suggests that the duty to settle does not apply once there has been a judgment in excess of limits. If no appeal is prosecuted, the special relationship between the carrier and the insured upon which the duty to settle is based no longer exists. The carrier is in that situation no longer controlling settlement or defense. Moreover, any judgment entered before a valid *Stowers* offer has been rejected is not caused by a subsequent refusal to settle within limits.

II. THE LEGAL BASICS—ACTIVATION OF THE STOWERS DUTY

A. The Garcia Test

The Fifth Circuit recently noted in *OneBeacon Insurance Company v. T. Wade Welch & Associates*, 841 F.3d 669 (5th Cir. 2016), that there are four distinct requirements for "activating" the Stowers duty to settle:

> The *Stowers* duty is ***activated*** by a settlement demand when "three prerequisites are met: (1) the claim against the insured is within the

> scope of coverage, (2) the demand is within the policy limits, and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." *Am. Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842, 849 (Tex. 1994). The demand must also offer to release fully the insured in exchange for a sum equal to or less than the policy limits. *Id*. at 848–49.[1]

It is quite difficult to organize all of the rules and restrictions surrounding *Stowers* claims within the confines of these elements. We will at least as an initial matter attempt to collect and discuss as many of these precepts as possible under these elements.

B. Element One—Coverage

1. Common Law—Debatable Coverage—A Defense?

a. Texas Decisions

A carrier has no *Stowers* duty to settle as to uncovered claims. *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994). Therefore, if there is no coverage, *Stowers* cannot apply. *Garcia, supra; American Western Home Ins. Co. v. Tristar Convenience Stores, Inc.*, 2011 WL 2412678, *4 (S.D. Tex., Jun 02, 2011)(Werlein, J.). Importantly, purely common law *Stowers* decisions, as opposed to insurance code claims for failing to settle when liability is reasonably clear, hold that **mere *uncertainty*** regarding the existence or not of coverage is not enough to prevent the application of the *Stowers* doctrine. *American Western, supra.*[2] In *American Western,* the court held: "Whether there are 'questions' about

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[1] In *American Physicians Ins. Exch. v. Garcia supra,* the court summarized the *Stowers* elements as follows:

> (1) [T]he claim against the insured is within the scope of coverage, (2) the demand is within policy limits, and (3) the terms of the demand are such that an ordinary prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Id. at 849

[2] The court cited and discussed the following decisions: *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.,* 246 S.W.3d 42, 46 (Tex.2008) (noting "the dilemma faced by both insurer and insured when a claimant presents a settlement demand within policy limits and coverage is uncertain," because, in part, "an insurer that rejects a reasonable offer within policy limits risks significant potential liability for bad-faith insurance practices if it does not ultimately prevail in its coverage contest" (citing and

coverage at the time of the settlement offer is not the equivalent of establishing as a matter of law that there is no coverage for the claim." *Id.* ***Importantly, this does not mean necessarily that questions regarding coverage cannot be considered by the jury in assessing whether a reasonable carrier would have settled.*** *Id.*[3]

b. Other Jurisdictions

Other jurisdictions have generally held that an erroneous belief regarding coverage is ***not a defense*** to a claim for failure to settle. As Professor Windt explains:

> Frequently, an insurance company will refuse to settle a case because of its erroneous belief that there is no coverage or only limited coverage under the policy. That belief, however, cannot be used to justify the company's refusal to settle in an appropriate case. As explained in *State Farm Automobile Insurance Co v Civil Service Employees Insurance Co.*:
>
> > The mere fact that an insurer has erroneously concluded that there is no coverage … cannot excuse subsequent breaches by the insurer of other provisions of the contract, including the implied obligations pertaining to settlement. To hold otherwise would result in penalizing the more prudent insurer who initially correctly recognizes [that there is coverage] …, but subsequently wrongfully refuses a settlement offer.[FN2][4]
>
> To put it in other words, when one party to a contract breaches a contract, that party is responsible for the foreseeable consequential

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discussing *Tex. Assoc. of Counties Cnty. Gov't Risk Mqmt. Pool v. Matagorda Cnty.,* 52 S.W.3d 128, 135 (Tex. 2000) and *Stowers,* 15 S.W.2d at 547)); *Am. Physicians,* 876 S.W.2d at 848 ("We start with the proposition that an insurer has no duty to settle a claim *that is not covered under its policy."* (emphasis added)).

[3] The *Tri-Star* court observed: "The contention that there was questionable coverage would be better addressed to the third ***Stowers*** liability element, which American Western also argues, namely, whether a reasonable insurer would have accepted the settlement at the time it was offered." *American Western, supra,* at *4.

[4] *State Farm Auto. Ins. Co. v. Civil Service Emp. Ins. Co.,* 19 Ariz. App. 594, 509 P.2d 725, 733 (Div. 1 1973).

> damages from that breach, whether the breach was inadvertent, negligent or intentional. Accordingly, when an insurer wrongfully denies coverage, even if its belief in the absence of coverage was merely negligent, the insurer should be liable for the foreseeable consequential damages from its denial of coverage, including the fact that there is no settlement in a situation in which a reasonable insurer affording coverage would have settled the case.

WINDT, INSURANCE CLAIMS AND DISPUTES, section 5:5 (citations omitted). This rationale is perhaps tied to the fact that jurisdictions such as California base the duty to settle on an implied contractual duty to settle within limits. *Stowers* is based on a tort duty, and it is not an implied contractual right. This is certainly the manner in which the related duty of good faith in first party cases has been interpreted as well. Thus, the California approach may be of limited applicability in Texas.

c. The Franks Odyssey—Sifting Through the Supreme Court Decisions For References to Other Jurisdictions and Logical Imperatives

As noted, the Texas Supreme Court does not appear to believe that the fact a carrier has a good faith coverage defense is in fact a defense to a *Stowers* action. In *American Physicians Insurance Exchange v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994), the Court stated that both the claimants and the carriers are at risk in determining the proper scope and limits of coverage:

> Thus, [the claimant] was informed of the insurers' position concerning the policy limits, and was advised of the demand he would have to make to trigger the *Stowers* duty. [The claimant] elected to proceed on the disputed assumption that he could aggregate the policies. Conversely, APIE elected to ***bear the risk that its point of view might have been incorrect, which could result in liability for any excess judgment.***

Id. at 850. In other words, the claimant bears the risk as to whether he or she is right in making an offer for what it believes to be the limits. If the claimant is wrong, the *Stowers* doctrine does not apply because the offer was too high. If the carrier is wrong, and the

demand is actually correct and within limits, its "bears the risk" of being wrong on coverage and thus will be fully liable for the excess judgment if it guesses wrong. *Id.*[5]

Similarly, in *Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc*., 2005 WL 1252321, at *4 (Tex., May 27, 2005)("*Frank's I* (motion for rehearing granted Jan. 6, 2006), *vacated,* 246 S.W.3d 42, 51 Tex. Sup. Ct. J. 397 (Tex. 2008), the Court followed the rationale of the California Supreme Court in *Blue Ridge Ins. Co. v. Jacobsen,* 25 Cal.4th 489, 22 P.3d 313, 106 Cal. Rptr.2d 535 (2001).

The Jacobsen shined the light of the key inquiry on whether, in light of the injuries and the probable liability of the insured, the ultimate outcome was likely to exceed the amount of the settlement offer. The court discussed the decision in *Johansen v. Cal. State Auto. Assoc. Inter-Insurance Bureau,* 15 Cal.3d 9, 123 Cal. Rptr. 288, 538 P.2d 744 (1975), noting that this decision held:

- A carrier failing to accept a reasonable offer of settlement would be held liable for amounts in excess of the policy limits.
- ***In determining whether the offer was reasonable, "an insurer may not consider the issue of coverage."***
- The only permissible consideration is whether in light of the injuries and the probable liability of the insured, the ultimate outcome is likely to exceed the amount of the settlement offer.

Id. at 541 (emphasis added). The portions of the *Jacobson* opinion relied on in *Franks I* include the following analysis:

> Under *Johansen*, if an insurer fails to accept a reasonable settlement offer within the policy limits, and the judgment exceeds the policy limits, the insurer risks liability for the entire judgment and any other damages incurred by the insured. ***Moreover, the insurer may not consider the issue of coverage in determining whether the***

[5] The Court added: "If the claimant makes such a settlement demand early in the negotiations, the insurer must either accept the demand or ***assume the risk*** that it will not be able to do so later. In cases presenting a real potential for an excess judgment, insurers have a strong incentive to accept." *Id.* at 851 n. 18 (emphasis added).

> ***settlement is reasonable.*** (Johansen, supra, 15 Cal.3d at pp. 12, 15, 16, 123 Cal. Rptr. 288, 538 P.2d 744.)
>
> In light of *Johansen*, were we to conclude insureds could, as in this case, refuse to assume their own defense, insisting an insurer settle a lawsuit or risk a bad faith action, but at the same time refuse to agree the insurer could seek reimbursement should the claim not be covered, the resulting Catch-22 would force insurers to indemnify non-covered claims. If an insurer could not unilaterally reserve its right to later assert non-coverage of any settled claim, it would have no practical avenue of recourse other than to settle and forgo reimbursement. An insured's mere objection to a reservation of right would create coverage contrary to the parties' agreement in the insurance policy and violate basic notions of fairness.

Jacobson, 22 P.3d at 321 (emphasis added).[6]

The Texas Supreme Court in *Franks I* made very clear that it found the reasoning in *Jacobson* applicable and consistent with Texas law. The *Franks* Court held:

> Whether the insurer or the insured ultimately bears the cost of a reasonable settlement with a third party should depend on whether there is coverage. As pointed out by the California Supreme Court and our own court of appeals in the present case, denying a right of reimbursement once an insured has demanded that an insurer accept a reasonable settlement offer from an injured third party can significantly tilt the playing field. ***The insurer would have only two options.*** **[1]** ***It could refuse to settle and face a bad faith claim if it is later determined there was coverage.*** **[2]** Or it could settle the third-

[6] The Court in *Johanson* reasoned: "[I]n deciding whether or not to compromise the claim, the insurer must conduct itself ***as though it alone were liable*** for the entire amount of the judgment. (*Crisci v. Security Ins. Co., supra*, 66 Cal.2d at p. 429, 58 Cal. Rptr. 13, 426 P.2d 173.) Thus, the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, and ultimate judgment is likely to exceed the amount of the settlement offer. Such factors as the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage, should not affect a decision as to whether the settlement offer in question is a reasonable one." 538 P.2d at 748-49 (emphasis added).

> party claim with no right of recourse against the insured if it is determined there was no coverage, which effectively creates coverage where there was none.

Id. Obviously, if the existence of a good faith coverage defense were an absolute defense in a *Stowers* action, then the Court's statements, which serve as the backbone of its rationale in *Garcia* and *Franks*, would be flat wrong.

Equally important, the Supreme Court in *Franks* emphasized that the *Stowers* reasonableness standard involves a test of objective reasonableness focusing on "an objective assessment ***of the insured's potential liability***." *Id.* at *3 (emphasis added). Thus, the Court reasoned that the seemingly varying standards for the *Stowers* duty were not really different:

> We have said that the duty imposed by *Stowers* is to "exercise 'that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business.'" We have also said that the *Stowers* duty is viewed from the perspective of an insurer: "the terms of the demand are such that an ordinarily prudent insurer would accept it." Both statements are correct. Whether a settlement offer within policy limits is a reasonable one is determined by an objective standard based on an assessment of the likelihood that the insured will be found liable and the range of potential damages for which the insured may be held liable, including "the likelihood and degree of the insured's potential exposure to an excess judgment." The reasonableness of a settlement offer is not judged by whether the insured has no assets or substantial assets, or whether the limits of insurance coverage greatly exceed the potential damages for which the insured may be liable. ***It is an objective assessment of the insured's potential liability.***

Id. (footnotes omitted).

Whether debatable coverage is a defense in a *Stowers* case is even more confused with the issuance of *Frank's II*, which deleted all substantive reliance on *Jacobson.* Given that the Court reasoned that the availability of declaratory actions was a sufficient protection to carriers with debatable coverage facing a *Stowers* demand, one would think

that no further protection is warranted or intended by the Court. Nevertheless, the decision in *D.R. Horton-Texas, Ltd. v. Markel Intern. Ins. Co., Ltd.*, 300 S.W.3d 740 (Tex. 2009), shows that declaratory relief is simply not a widely available as a protection. Accordingly, the potential availability of debatable coverage as a defense would appear to still be alive since the Court may find it necessary in light of the *D.R. Horton* limitations.

In *LSG Technologies, Inc. v. U.S. Fire Ins. Co.*, 2010 WL 5646054 (E.D. Tex., Sep 02, 2010)(pending before Fifth Circuit currently), the court held that a reasonable basis for contesting coverage was not a defense to a common law *Stowers* cause of action. The court reasoned that the *Stowers* action is one based in negligence, not good faith. The court did not cite *Garcia, Franks II,* or any other decisions previously touching upon this subject.

d. OneBeacon—District Court Refuses To Allow Testimony Regarding A Reasonable Basis As A Defense to A Stowers Claim

The trial court in *OneBeacon Ins. Co. v. T. Wade Welch & Associates,* Not Reported in F.Supp.3d (2014), granted the claimant/policyholder's motion in limine regarding expert testimony that the carrier had a reasonable basis for denying the claim, as a defense to a common law *Stowers* and Insurance Code claim for failure to settle when liability was reasonably clear. The court held that testimony from an attorney expert as to whether OneBeacon could consider its policy defenses in evaluating the reasonableness of DISH's *Stowers* Demand involved a pure legal question, that no witness can testify regarding legal issues, and that it is the duty of the court to instruct the jury on the law. More importantly, the court refused to allow testimony that there was a reasonable basis as to the *Stowers* claim, but it allowed it as to the Insurance Code claim, with instructions to the jury.

e. *US Metals v. Liberty*—Reasonable Basis Defense to Common Law Stowers and 541.060 Claims

Recently, the court in *American U.S. Metals, Inc., Plaintiff, v. Liberty Ins.*, --- F.Supp.3d ---- (2017), combined first party bad faith concepts, a reasonable basis or bona fide controversy defense, in a liability or third-party insurance setting. The court seized on the fact that section 541.060 requires an attempt in "good faith" to settle when liability is reasonably clear, incorporated the common law *Stowers* elements from *Garcia, supra,* and found a reasonable basis defense, even if the carrier was ultimately wrong in denying coverage. The court reasoned:

Plaintiff brings claims against Defendant under Texas Insurance Code § 541.060. This section requires insurers to "attempt in good faith to effectuate a prompt, fair, and equitable settlement of: (a) a claim with respect to which the insurer's liability has become reasonably clear." Tex. Ins. Code § 541.060.

Under Texas law, the good-faith duty is triggered where "(1) the policy covers the claim, (2) the insured's liability is reasonably clear, (3) the claimant has made a proper settlement demand within policy limits, and (4) the demand's terms are such that an ordinarily prudent insurer would accept it." *Pride Transp. v. Cont'l Cas. Co.*, 511 F. App'x 347, 354 (5th Cir. 2013). A cause of action for breach of the duty of good faith and fair dealing exists when the insurer has no reasonable basis for denying or delaying payment of a claim or when the insurer fails to determine or delays in determining whether there is any reasonable basis for denial. *Id.* Insurance carriers maintain the right to deny questionable claims without being subject to liability for an erroneous denial of the claim. *St. Paul Lloyd's Ins. v. Fong Chun Huang*, 808 S.W.2d 524, 526 (Tex. Ct. App. 1991). A bona fide controversy is a sufficient reason for failure of an insurer to incorrectly deny a claim. *State Farm Fire & Cas. Co. v. Simmons*, 963 S.W.2d 42, 44 (Tex. 1998). As long as the insurer has a reasonable basis to deny or delay payment of a claim, even if that basis is eventually determined by the fact finder to be erroneous, the insurer is not liable for breach of good faith. *Lyons v. Millers Casualty Insurance Co.*, 866 S.W.2d 597, 600 (Tex. 1993).

. . . .

At the time that Defendant denied coverage, it had a reasonable basis for its decision and there is no genuine issue of material fact that it breach its duty of good faith and fair dealing pursuant to Texas Insurance Code § 541.060. *See Lyons v. Millers Casualty Insurance Co.*, 866 S.W.2d 597, 600 (Tex. 1993).

. . . .

> In light of the Supreme Court of Texas's opinion in this case, Plaintiff is now ***covered for part*** of Exxon's third-party claim. *See* (Instrument No. 106-2 at 14). However, Plaintiff has not made a showing creating a genuine issue of material fact that Defendant ***did not have a reasonable basis*** for denying the claim.

Id. (emphasis added).

f. *Yorkshire v. Seger*—The Burdens of Proof on Coverage Are The Same In A Stowers Case As In A Breach of Contract Case

The Supreme Court in *Seger v. Yorkshire Insurance Co., Ltd.,* 503 S.W.3d 388, (2016), held:

> In a ***Stowers*** action, however, the ***burden is on the insured to prove coverage.*** *See State Farm Lloyds Ins. Co. v. Maldonado,* 963 S.W.2d 38, 41 (Tex.1998) (holding that the insured had the burden to show that the second element of his ***Stowers*** claim was met); *Garcia,* 876 S.W.2d at 848–49 (addressing coverage before moving on to the other elements of the ***Stowers*** claim); *Emp'rs Cas. Co. v. Block,* 744 S.W.2d 940, 944 (Tex.1988) (citation omitted) ("An insured cannot recover under an insurance policy unless facts are pleaded and proved showing that damages are covered by his policy.").

Id. at 396. The court explained the contractual burden of proof rules as follows:

> "Initially, the insured has the burden of establishing coverage under the terms of the policy." *JAW The Pointe, L.L.C. v. Lexington Ins. Co.,* 460 S.W.3d 597, 603 (Tex.2015) (citing *Gilbert Tex. Constr., L.P. v. Underwriters at Lloyd's London,* 327 S.W.3d 118, 124 (Tex.2010)). "To avoid liability, the insurer then has the burden to plead and prove that the loss falls within an exclusion to the policy's coverage." *Id.* "The insurer has neither a 'right' nor a burden to assert noncoverage of a risk or loss until the insured shows that the risk or loss is covered by the terms of the policy." *Ulico Cas. Co.,* 262 S.W.3d at 778. To prove coverage, the plaintiff must establish that the injury or damage is the type covered by the policy . . . The plaintiff must also establish that

> the injury or damage was incurred at a time covered by the policy. *Block,* 744 S.W.2d at 944. Finally, the plaintiff must establish that the injury or damage was incurred by a person whose injuries are covered by the policy. *See Thompson v. Travelers Indem. Co. of R.I.,* 789 S.W.2d 277, 278–79 (Tex.1990) (determining whether a jockey was an employee of a race track and therefore covered under the race track's workers' compensation insurance). Only by establishing each of these elements—that a covered injury or loss was incurred at a time covered by the policy and incurred by a person whose injuries are covered by the policy—can a plaintiff prove coverage, and only then does the burden shift to the insurer to prove that a coverage exclusion applies. *See Ulico Cas. Co.,* 262 S.W.3d at 782 ("[T]he insured bears the burden to show that a policy is in force and that the risk comes within the policy's coverage."). As such, each of these elements of coverage is a precondition to coverage, not an exception. *See Block,* 744 S.W.2d at 944 ("[T]he time of the insured's damages is a precondition to any coverage rather than an exception to general coverage.").

Id. at 400-401 (some citations omitted).

As to the burden of proof as to coverage in a *Stowers* case, the court held:

> A ***Stowers*** action is no different. A ***Stowers*** plaintiff cannot recover under a ***Stowers*** cause of action without first satisfying the precondition of establishing each element of coverage. *See Maldonado,* 963 S.W.2d at 41 (holding that the insured had the burden to show that the second element of his ***Stowers*** claim was met).

Id. at 401.

In *Yorkshire,* the policy CGL policy "expressly covered liability for injury to independent contractors." It excluded coverage for "Leased-in Employees/Workers." *Id.* at 397. The court found that there was at least an implied finding that the injured party was an independent contractor and was thus covered absent applicability of an exclusion. The court noted: "Because we hold that the Segers met their initial burden to prove coverage, the burden shifts to the ***Stowers*** Insurers to prove that the Segers' claim is excluded from coverage under the policy." *Id.* (citations omitted). The jury found that the

injured party was *not* a "leased-in" employee. The court proceeded to hold that the evidence was legally insufficient to support the jury finding, and thus judgment was rendered in favor of the carrier on coverage and on the *Stowers* claim.

2. Insurance Code—"Reasonably Clear " Distinguished

Undoubtedly, a "liability of the insurer is reasonably clear" standard, such as that set forth in section 541.060 of the Texas Insurance Code, certainly does not foreclose the consideration of coverage since a carrier would obviously consider coverage in determining whether to settle. One would expect the fact coverage was debatable would be potentially admissible under such a standard. The statutory standard certainly changes the focus from the insured's potential liability and focuses it on the "liability of the insurer."

If a close coverage question presents a defense, is it one the jury can decide? Frequently, experts in *Stowers* cases are permitted to provide such testimony. Moreover, insurers must be able to state at trial why they refused to settle even if it is not a defense.

Of course, this proposition is not with contentious debate. Some argue that Supreme Court decisions equate the *Stowers* duty with the statutory standard, suggesting there is no difference. *See Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W.3d 253 (Tex. 2002) ("There is nothing to indicate that the Legislature had in mind any standard other than the familiar ***Stowers*** standard" in enacting § 541.060(a)(2)(A); to activate an insurer's duty under that statute, the claimant must make a settlement demand within policy limits with terms that an ordinarily prudent insurer would accept; an insurer has no contractual or implied duty to settle a claim that is not covered under the policy).. The battle of "perspective," insured's versus insurer's, continues to be waged.

3. No Duty to Settle As To Uncovered Claims

A carrier is under no obligation to pay more to settle covered claims in order to have the claimant include punitive damages within the settlement. For covered claims, the carrier has complete discretion to settle and cannot commit a tort unless a demand within the limits is unreasonably refused and there is a judgment for covered damages in excess of the policy limits. *Dear v. Scottsdale Ins. Co.*, 947 S.W.2d 908, 916-17 (Tex. App. –Dallas 1997, writ denied)(Hankinson, J.). In *Rosell v. Farmers Texas County Mut. Ins. Co.*, 642 S.W.2d 278, 279 (Tex. App.–Texarkana 1982, no writ), the carrier refused to accept a

bulk offer to settle for two occurrence policy limits where one of the two claims was not, in the carrier's opinion, worth a full single limit. The court held that the carrier did not have to pay more for the weak claim in order to get a settlement of the strong claim. *Accord Pullin v. Southern Farm Bureau Cas. Ins. Co*., 874 F.2d 1055, 1056 (5th Cir. 1989) (Texas law).

In *St. Paul Fire & Marine Ins. Co. v. Convalescent Services, Inc.*, 193 S.W.2d 340, 342-43 (5th Cir. 1999, the court, quoting *American Physicians Ins. Exchange v. Garcia,* 876 S.W.2d 842, 846 (Tex. 1994, held that a carrier excluding coverage for punitive damages has no duty to settle as to such uncovered claims. The court rejected arguments that a *Stowers* duty to settle was triggered where the carrier knew that the insured had significant punitive exposure and that the insured would be willing to contribute to settlement. The court also rejected *Ranger v. Guin* arguments to the effect that the carrier was negligent in its evaluation and in communicating that evaluation to the insured. *Id.* The court held that *Guin* was subsumed within *Stowers* and was strictly subject to its elements, including coverage and the need for a verdict in excess of limits, under current Texas law as reflected in *Garcia*, *Maryland Ins. Co. v. Head*, 938 S.W.2d 27, 28 (Tex. 1996, and *State Farm Automobile Ins. Co. v. Traver,* 980 S.W.2d 625, 628 (Tex. 1998. By analogy, the court looked to *Texas Farmers Ins. Co. v. Soriano,* 881 S.W.2d 312 (1994, noting that where there are multiple claims and inadequate proceeds, the carrier may look to only the merits of the particular claim and the corresponding particular liability of the insured. *Id.* at 344. The court reasoned:

> Thus, because the Texas Supreme Court does not impose a duty upon insurers to consider other *covered* claims when faced with a settlement demand by one claimant, we believe that the Court would not impose a duty upon insurers to consider claims that are *not* covered—here, the punitive damages claims—by its policy during settlement negotiations involving one claimant.

Id. at 345. The court also rejected the argument that the court of appeals opinion in *St. Paul Surplus Lines Ins. Co. v. Dal-Worth Tank Co.,* 917 S.W.2d 29 (Tex. App.—Amarillo 1995), *aff'd in part, rev'd in part on other grounds,* 974 S.W.2d 51 (Tex. 1998), supported a claim for negligent claims handling. The court did so based on the then recent holding in *Traver, supra,* that the *Stowers* duty subsumes the duty of ordinary care in handling, investigating and evaluating the claim. Finally, the court refused to address the issue of whether the carrier could be found liable for damages not otherwise covered as a result

of some tortious conduct. Numerous courts have found such claims barred because they seek to do indirectly what is not permitted directly in those jurisdictions, provide coverage for punitive damages. *Id.* at 346 n. 13.

The courts in other jurisdictions have refused to allow tort claims for bad faith and similar theories to be made with respect to punitive damages where coverage for such damages has been found to be contrary to public policy. For example, in *Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co.*, 724 F.2d 1343 (9th Cir. 1983), the insured brought suit against the insurer alleging that the insurer breached the duty to defend and acted in bad faith in the handling/defending of a suit against the insured. The insurer provided a full defense through an outside firm. The insured also retained its own counsel. *Id*. at 1345. During the lawsuit, an offer to settle was made in the $200,000 to $250,000 range. The insured urged the insurer to settle and even offered to contribute $20,000 of its own funds. *Id*. The insurer rejected the offer, and the case was ultimately tried resulting in a verdict of $387,107 in compensatory damages and $30,000 in punitive damages. *Id*.

The insurer in *Zieman* paid the entire compensatory damages costs and defense legal fees. The insured subsequently sued the insurer for payment of the punitive damages award for failure to settle and exposing the insured to the risk of punitive damages. In response, the court stated the following:

> There is no basis whatever for that claim. [The evidence] clearly demonstrates that counsel retained for [the insured] and counsel for the other entities facing exposure to the Stewart claim conscientiously valued the same as having a jury verdict potential of no more than $100,000. They were wrong, of course, but that does not even suggest bad faith. The proposition that an insurer must settle, at any figure demanded within the policy limits, an action in which punitive damages are sought is nothing short of absurd.

Id. at 1346.

In *Soto v. State Farm Ins. Co.*, 635 N.E.2d 1222 (N.Y. 1994), a judgment for $420,000 in compensatory damages and $450,000 in punitive damages was rendered against the insured. An action was then brought against the insurer, for the full amount of the judgment alleging failure to settle within policy limits. *Id*. at 1223.

The insurer in *Soto* moved to dismiss the complaint for failure to state a claim because New York law held coverage for punitive damages was against public policy. *Id*. Both the trial court and the intermediate court accepted the argument, granting the motion and affirming respectively. *Id.* The New York Court of Appeals upheld the lower courts' decisions, stating:

> As we have noted on other occasions, since punitive damages are not designed to compensate an injured Plaintiff for the actual injury that the person may have suffered, their only real purpose is to punish and deter the wrongdoer [citations omitted]. While the deterrent value of the rule against indemnification may be somewhat attenuated in this context, the rule's equally important goal of preserving the condemnatory and retributive character of punitive damage awards remains clear and undiminished. That goal cannot be reconciled with a conclusion that would allow the insured wrongdoer to divert the economic punishment to an insurer because of the insurer's unrelated, independent wrongful act in improperly refusing a settlement within policy limits.

Id. The court added:

> Where an insurer has acted in bad faith in relation to an available pre-trial settlement opportunity, it is guilty only of placing its insured at risk that a jury will deem him or her so morally culpable as to warrant the imposition of punitive damages. Stated another way, an insurer's failure to agree to a settlement, whether reasonable or wrongful, does no more than deprive the insured of a chance to avoid the possibility of having to suffer a punitive award for his or her own misconduct. Regardless of how egregious the insurer's conduct has been, ***the fact remains that an award of punitive damages that might ensue is still directly attributable to the insured's immoral and blameworthy behavior.***
>
> Our system of civil justice may be organized so as to allow a wrongdoer to escape the punitive consequences of his own malfeasance in order that the injured plaintiff may enjoy the advantages of a swift and certain pretrial settlement. However, the benefit that a morally culpable wrongdoer obtains as a result of this system, i.e., being released from exposure to liability for punitive damages, is no more than a necessary incident of the process. It is certainly not a right whose loss need be made subject to compensation

> when a favorable pretrial settlement offer has been wasted by a reckless or faithless insurer.

Id. at 1224-25 (emphasis added).

The Supreme Court of Colorado considered similar issues in a suit entitled *Lira v. Shelter Ins. Co*., 913 P.2d 514 (Co. 1996). In Colorado, an insurer has no duty to settle the compensatory part of a suit in order to minimize the insured's exposure to punitive damages. *Id.* at 516. Therefore, the court concluded, that the insurance company's duty to settle "did not encompass a duty to protect the petitioner from exposure to punitive damages." *Id.* at 517. The court reasoned:

> The contract between the parties expressly precluded recovery for punitive damages incurred by the insured. The insured may not later utilize the tort of bad faith to effectively shift the cost of punitive damages to his insurer when such damages are expressly precluded by the underlying insurance contract.
>
> . . . .
>
> [To hold otherwise would] force insurers to settle cases involving punitive damages in order to avoid liability for the same punitive damages in subsequent bad faith actions. Such a result would be contrary to the principle that insurers have no absolute duty to settle in order to protect their insureds from punitive judgments. *See Zieman*, 724 F.2d at 1346.

Id. at 517. The court declined to extend the tort of bad faith to encompass liability for punitive damages from the underlying lawsuit. *Id.*

The California Supreme Court reached a similar conclusion in *PPG Industries, Inc. v. Transamerica Ins. Co.*, 84 Cal. Rptr. 2d 455 (1999). The court held that the insured could not recover amounts including punitive damages awarded in the underlying suit from the carrier in a bad faith case. The court concluded the insured caused this injury by its own heinous acts. Thus, the court expanded the public policy bar against indemnity for punitive damages to implied indemnity.

The leading case for the opposing point of view is *Ansonia Assoc. Ltd. v. Public Service Mut. Ins. Co.,* 257 A.D.2d 84, 692 N.Y.S.2d 5 (1999. In that case, the court found that the carrier's assertion that punitive damages were not covered was tantamount to

economic duress. *Id.* at 7. The court noted that the insured is put in the position of having to choose between going to trial and getting hit for substantial uncovered damages or having to settle the claim and potentially lose coverage for compensatory damages by settling without the consent of the carrier. The court did not address whether the insurer's cavalier indifference to its insured's exposure to potentially ruinous punitive damages, without more, constitutes bad faith. *Id.* at 7-8.

C. Within Limits

It is axiomatic that you have to have the limits correct in order to make a valid demand. It is also a basic consideration to make sure that the demand is for a definite amount within the limits.

1. Policy Controls Limits

The policy controls the determination of the policy limits applicable. Thus, a claimant may rely upon the policy to determine how much to demand. *Yorkshire Ins. Co., Ltd. v. Seger,* 279 S.W.3d 755, 769 (Tex. App.-Amarillo, Jun 20, 2007), *discussed infra* at subsection (H)(2)(c). In the context of a declining limits policy, the claimant's counsel should seek to obtain an understanding of how much of the limits are left, but the offer should be for the remaining limits according to the terms of the policy. Anything else risks the argument that the demand exceeds limits.

Garcia is a classic example of a failure to make an offer within limits. The limits are often subject to a great deal of debate from a coverage analysis standpoint. The hard work of predicting the limits applicable has to be done prior to the making of the offer.

2. Outside Factors Altering the Amount Available

The policy limits are also altered by settlement of other claims. Thus, if payment has been made to one of multiple claimants, then a demand that is for the full policy limits, without reducing the amount based on the settlement, is not an offer within limits sufficient to invoke *Stowers*. *Soriano*, 881 S.W.2d at 315. Similarly, if the policy limits are exhausted through payment under a separate section of the policy, then no *Stowers* liability can attach because any offer of settlement would be an offer in excess of the limits. *Hanson v. Republic Ins. Co.,* 5 S.W.2d 324 (Tex. App.–Houston [1st Dist.] 1999, no writ).

An error of law by the claimant in making its demand for limits will still prevent the offer from being sufficient to satisfy the elements of *Stowers*. *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 41 (Tex. 1998). Thus, the ability to discover the policy and properly interpret it is critical for the claimant. Some plaintiff's counsel suggests that the need for accuracy regarding the limits of liability also requires disclosure of reservation of rights letters under some circumstances.

3. Working With Multiple Policies And Still Hitting the Target

As will be discussed below, in subsection (H)(2), offers within the aggregate limits of multiple policies, whether primary/primary or primary/excess, are generally found to be ineffective as to primary insurers to the extent the bulk offer exceeds the individual primary limits. Thus, for example, if the offer is within the combined primary limits of two pro rata primaries, but exceeds the individual limits of any one of those policies, it is ineffective as to either. *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.,* 236 S.W.3d 765, 776 (Tex.2007). Where the offer involves combined excess and primary coverage, the offer is conditional until the primary has actually tendered. *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.,* 20 S.W.3d 692, 701-02 (Tex.2000).

4. Declining Limits Demands

Making a proper demand on a declining limits policy is particularly tricky. The best approach here would appear to be to ask for a dollar less than the remaining limits, allowing any necessary reduction for additional defense fees that must be paid to finalize settlement.

The issue of a proper declining limits offer was presented in part in *Westchester Fire Ins. Co. v. Admiral Ins. Co.,* 152 S.W.3d 172, 191-93 (Tex. App.--Fort Worth 2004, pet. pending), which is pending on petition for review before the Supreme Court. This type of policy has variously been described as exhausting, wasting, burning or eroding. In short, the costs of defense erode the policy limits. So, the limits are a moving target. In that case, the claimants orally indicated they were seeking "policy limits." A written settlement offer was made for the policy limits of the primary policy: $1 million. The letter added that the excess carrier should be apprised that the case could be settled "*at this time,* within the limits of the primary policy." *Id.* at 193. Oral testimony provided by the plaintiffs' counsel indicated he made a demand to settle for the policy limits of the primary policy, which he understood at the time to be $1 million. *Id.* The limits were actually less than $1 million because of defense cost erosion. While the letter indicated

the offer was conditioned on the limits being $1 million, the plaintiffs' counsel testified that no condition was intended. The case subsequently went to mediation, where confusion continued to reign. Again, testimony was presented in the absence of a written document, indicating the offer was to take $1 million or whatever the limits were. Additional testimony showed that the plaintiffs said they would come off $1 million if the defendant would come up to $500,000. The plaintiffs never came down from $1 million. *Id.* Added to this mess was the expert opinion of Gary Beck, indicating that he thought a *Stowers* demand had been made. *Id.* at 195. Similar testimony was presented by Rickey Brantley, the ad litem for one of the claimants. *Id.*

The court held that this evidence amounted to more than a scintilla that there was a valid *Stowers* demand. This reasoning would appear to erroneously shift to the jury the responsibility of considered legal questions.

The court also addressed whether the carrier could have settled in light of the fact that the mediation settlement discussions did not involve a communicated ***consent to settle*** from the insured. *Id.* The defense counsel did not get the consent letter until after the mediation. *Id.* Strangely, the court held that the carrier "failed to conclusively prove that it did not have an opportunity to settle the claim after receiving" the insured's consent. *Id.* The ruling seems to erroneously presuppose the existence of a valid *Stowers* offer and a duty to initiate settlement.

D. Reasonable Offer and Assessing the Likelihood of Liability and Degree of Exposure

This portion of the *Garcia* three-part test is the most complex. On first-glance, it really reflects two separate requirements: (1) the terms of the demand must be such that "an ordinary prudent insurer would accept it," and (2) the assessment of reasonableness includes as a key factor consideration of the likelihood and degree of the insured's potential exposure to an excess judgment. Note also that some courts have suggested that this element may allow consideration of whether a reasonable person would settle where there are debatable issues of coverage presented. *American Western Home Ins. Co. v. Tristar Convenience Stores, Inc.*, 2011 WL 2412678, *12-13 (S.D. Tex., Jun 02, 2011)(Werlein, J.)(holding "The contention that there was questionable coverage would be better addressed to the third *Stowers* liability element, which American Western also argues, namely, whether a reasonable insurer would have accepted the settlement at the time it was offered.")

1. Reasonable Terms

Let's begin with a list of factors that the courts have noted as being a part of the analysis of whether the offer was one a reasonable insurer would accept:

- Terms are clear and undisputed
- Written offer
- Unconditional offer
- Offer of a complete release
- Identification of party or parties released, including whether all insureds are released or only some
- Time limits provided

As the discussion which follows demonstrates, each of these considerations has multiple subparts.

a. Clear and Undisputed

In *Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W.3d 253 (Tex. 2002), the Court set forth a basic "clarity" requirement that in many ways is a touchstone for determining whether a given offer is one a reasonable carrier would refuse. The Court held:

> [A]t a minimum we believe that the settlement's terms must be ***clear and undisputed.*** That is because "settlement negotiations are adversarial and…often involve hard bargaining on both sides." *Id.* . . . Given the tactical considerations inherent in settlement negotiations, an insurer should not be held liable for failing to accept an offer when the offer's terms and scope are ***unclear or are the subject of dispute.***

Id. (emphasis added). We know that the Court in *Rocor* did not require the making of a "formal" offer. Exactly where the line is to be drawn is, therefore, not altogether clear. Comparable concepts might provide some guidance, such as the old "clear and unequivocal" rule for determining the enforceability of indemnity agreements for a

party's own negligence. Even this rule had flexibility in that you did not have to state negligence of the indemnitor was included in "so many words," but this intent had to otherwise be clear.

b. In Writing?

Some cases suggest that a "formal" demand is probably not required. *Birmingham Fire Ins. Co. v. American Nat'l Fire Ins. Co.*, 947 S.W.2d 592, 599-600 (Tex. App.–Texarkana 1997, writ denied. However, informal or "back-channel" "suggestions" regarding what the case could be settled for, coming for example from either the plaintiff's attorney or the ad litem, are ***insufficient*** to satisfy *Garcia*. *Id.* An "offer" is "'[a] proposal to do a thing or pay an amount, usually accompanied by ***an expected acceptance, counter-offer, return promise or act.***'" *Id.* at 599 n. 2 (quoting BLACK'S LAW DICTIONARY 1081 (1990)). A ***demand*** within limits must be distinguished from a "suggestion." *Id.*

In *Trinity Universal Ins. Co. v. Bleeker*, 944 S.W.2d 672 (Tex. App.- Corpus Christi), *rev'd*, 966 S.W.2d 489 Tex. 1998),[7] the court directly addressed the validity of oral offers and held that oral offers are valid in contract law to the same extent as written offers. The court rejected that argument that Rule 11 of the Texas Rules of Civil Procedure, which requires settlement offers to be in writing in order to be binding when accepted, creates a firm requirement that *Stowers* demands be made in writing. Rule 11 states:

> Unless otherwise provided in these rules, no agreement between attorneys or parties touching any suit pending will be enforced unless it is in writing, signed, and filed with the papers as a part of the record, or unless it be made in open court and entered of record.

TEX. R. CIV. P. 11. The Texas Supreme Court reversed *Bleeker* on other grounds, finding that there had not been a sufficient offer to provide release from liens. The Court did not address the issue of whether the offer must be in writing.

In his article, *Essential Requirements to Trigger a Duty Under the Stowers Doctrine and Unfair Claims Settlement* Act, Brent Cooper suggests that the *Bleeker* court of appeals was wrong in its determination that Rule 11 does not apply to settlement offers. He cites

[7] *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489 (Tex. 1998), reversed this holding by determining as a threshold issue that the settlement offer in that case was not valid because it did not provide a full release. Therefore, the Court did not confirm or reject the lower court's reasoning with respect to oral offers.

London Mkt. Cos. v. Schattman, 811 S.W.2d 550, 552 (Tex. 1991, orig. proceeding), which illustrates the role of Rule 11 when parties dispute an agreement. The Court there explained that "once the existence of such an agreement becomes disputed, it is unenforceable unless it comports with these (Rule 11) requirements." However, it appears that this turns on whether a suit is "pending." Rule 11 specifically refers to a "suit pending" and the cited case discusses this rule in reference to discovery requests. Thus, for pre-suit demands, Rule 11 on its face would be inapplicable.

Other Texas law indicates that an oral offer will be sufficient so long as both parties agree that a *Stower* offer was made and that the terms were clear. In *Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W.3d 253 (Tex. 2002), the court explained that:

> In *Garcia* we stated that the *Stowers* remedy of shifting the risk of an excess judgment onto the insurer is not appropriate unless there is proof that the insurer was presented with a reasonable opportunity to settle within the policy limits. *Garcia*, 876 S.W.2d at 849. ***We implied that a formal settlement demand is not absolutely necessary to hold the insurer liable, see id., although that would certainly be the better course.*** But at a minimum we believe that the settlement's terms must be clear and undisputed. That is because "settlement negotiations are adversarial and…often involve hard bargaining on both sides." *Id.* . . . Given the tactical considerations inherent in settlement negotiations, an insurer should not be held liable for failing to accept an offer when the offer's terms and scope are ***unclear or are the subject of dispute.***

Id. (emphasis added).

The Court determined that the oral offer was not a proper settlement demand in *Rocor* because the proposal did not clearly state the settlement's terms, nor did it mention a release. Accordingly, the court found that there was no extra-contractual liability.

No one should bank on the Supreme Court finding that a purely oral *Stowers* demand is sufficient. While the Court suggested that a "formal demand" is not absolutely necessary, the demand's terms "must, at a minimum, be 'clear and undisputed'. . . ." D. Plaut, "Stowers Update: New Aspects of An Old Claim," South Texas College of Law--Texas Ins. Law Symposium, I-8 (Jan. 26-27, 2006)(discussing and quoting *Rocor*). Oral offers are subject to dispute and are rarely likely to be "clear and undisputed."

c. Unconditional Offer

(1) General Rule

Texas courts have repeatedly held that conditional settlement offers are insufficient to impose *Stowers* liability. *Jones v. Highway Ins. Underwriters*, 253 S.W.2d 1018, 1022 (Tex. Civ. App.--Galveston 1952, writ ref'd n.r.e.). In *Insurance Corp. of Am. v. Webster*, 906 S.W.2d 77 (Tex. App–Houston [1st Dist.] 1995, writ denied), the court held that two offers that were conditioned on the insurer's representations about the limits of coverage were in fact conditional and thus failed to satisfy *Stowers*. Because other insurance was in fact in existence, the carrier could not accept the settlement offers. Thus, the court held that liability could not be imposed on that carrier.

The situation presented in *Webster* is very troubling. This author has been involved in at least one case where an interesting variation of the *Webster* problem arose. In that case, the plaintiff demanded settlement for the "carrier's policy limits." The parties disputed whether the plaintiff's attorney had ever inquired about whether there were other policies with different companies and thus whether there had been any representations regarding this issue. Certainly, if the offer does not indicate that it is contingent on there being no other such policies, then the carrier would not be able to avoid the demand for limits regardless of whether it knew of the existence of an additional policy or not.

The clear message from *Webster* is that plaintiffs need to set up a misrepresentation of limits claim as a hedge on whether there is additional coverage some place other than in their *Stowers* offer. It could be handled by using interrogatories, simply relying on disclosures, or through separate correspondence. Discovery involving the insurer should also be considered where appropriate. *In re Dana Corp.*, 138 S.W.3d 298 (Tex. 2004) (involving discovery of policies and information regarding the status of the remaining limits of liability; discussing in part Tex. R. Civ. P. 192.3(f)). Also, protection could be incorporated into the final settlement documents after acceptance of the offer. None of these methods is perfect, but they do assist in avoiding the problem of rendering the *Stowers* demand ineffective.

In *Willcox v. American Home Assurance Co.*, 900 F. Supp. 850 (S.D. Tex. 1995), the offer was conditioned on payment by two insurers whose policies could not be stacked. The court found that the offer was *conditional* in that it stated that it was for the amount stated unless the insured could demonstrate the limits were less, in which case the

demand was automatically amended to equal that lesser amount. *Id.* at 858. The court found this violated the conditional offer rule expressed in *Webster, supra.*

The determination that the offer was conditional is confusing and seems erroneous. The requirement of a "demonstration" by the insured of lower limits might be considered to be a prerequisite to the lowering of the offer to the actual limits. In any event, the offer is certainly murky and fails to meet the clarity test required by the Supreme Court.

(2) Combo Primary/Excess Offers Within the Aggregate Limits of Multiple Policies

(a) Offer In Excess of Actual Primary Limits and Conditioned on Primary Tendering

An offer including both excess and primary limits is the most typical scenario involving demands for the limits of more than one policy. It must be understood such offers generally have two critical problems:

(1) The offer is, as to the primary carrier, in excess of the policy limits;

(2) The offer is conditional as to the excess carrier unless and until the primary carrier tenders its limits of liability.

AFTCO Enterprises, Inc. v. Acceptance Indem. Ins. Co., 321 S.W.3d 65 (Tex. App.—Houston [1 Dist.] 2010, pet. denied). An offer in excess of the primary limits is unreasonable and will not activate *Stowers*. *Westchester Fire Ins. Co. v. Am. Contractors Ins. Co. Risk Retention Group*, 1 S.W.3d 872, 874 (Tex. App.-Houston [1st Dist.] 1999, no pet.).

The *AFTCO* court observed:

> This appeal requires resolution of whether a settlement offer triggers an insurer's duty to settle when the plaintiffs' settlement terms require ***funding from multiple insurers***, and ***no single insurer can fund the settlement within the limits*** that apply under its particular policy-an issue that the Texas Supreme Court has expressly left unanswered. *See Am. Physicians Ins. Exchg.,* 876 S.W.2d at 849 n. 13; *see also Birmingham Fire Ins. Co. v. Am. Nat'l Fire Ins. Co.,* 947 S.W.2d 592, 599 (Tex. App.-Texarkana 1997, writ denied) (quoting *American Physicians* in refusing to impose on primary carrier duty of care

> owed to excess carrier independent of primary insurer's duty to its insured; excess carrier could assert existing duty to insured through subrogation).

Id. at *4.

(b) Aggregation of Co-Primary Policies

The court in *AFTCO* concluded that the Supreme Court held in *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.,* 236 S.W.3d 765, 776 (Tex.2007), that where there was concurring coverage under two primary policies, an offer to settle that fell within the combined limits of those policies, but exceeded the limits of any one policy, was insufficient to invoke *Stowers* Thus, primary policies must be viewed separately in assessing whether a demand on aggregate limits is within limits of each such primary policy.

(c) Policies Involving "Several" Liability of Insurers

The court in *Yorkshire Ins. Co., Ltd. v. Seger,* 279 S.W.3d 755 (Tex. App.—Amarillo, Jun 20, 2007), held that claimants need not make proportionate demands on each of multiple underwriters/insurers combining to write an insurance policy. An aggregate demand within the stated limits is sufficient. The court reasoned:

> [W]e believe that a claimant should be entitled to rely on the specific provisions of an insurance policy in making a settlement demand that is within the coverage of the policy. That it is the policy that dictates whether a settlement demand was within policy limits is bolstered by the Texas Supreme Court's indication that a settlement demand that proposes to release the insured for "the policy limits," in lieu of a demand for a sum certain, is sufficient to satisfy the "demand within limits" element of a *Stowers* action. [*Am. Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842, 848-49 (Tex.1994).]

279 S.W.3d at 769.

(d) No Coverage Upon Which to Base Duty for Excess Until Primary Limits Are Tendered

The other key decision relied on by the court was that in *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.,* 20 S.W.3d 692, 701-02 (Tex.2000). In that case, the Supreme Court held, as noted by the *AFTCO* court, that the ***Stowers*** duty does not arise for an excess insurer until the primary carrier has tendered its limits. *Id.*

The *AFTCO* court noted that it had reached a similar conclusion in *West Oaks Hosp., Inc. v. Jones,* No. 01-98-00879-CV, 2001 WL 83528, at *10 (Tex. App.-Houston [1st Dist.] Feb. 1, 2001, pet. denied) (not designated for publication). In that case, the court held that hospital insurers did not violate their *Stowers* duty where the lowest settlement demand was $725,000, while primary insurance coverage was $500,000***. The court declined to expand the Stowers doctrine by recognizing a duty where the settlement demand fell within aggregate amount of coverage provided by available layers of coverage, but in excess of the primary coverage.*** The court in *Jones* reasoned:

> Jones provides no authority to support his contention that the *Stowers* doctrine was triggered because his lowest settlement offer ($725,000) was within the amount of the first two layers of the Hospital's insurance coverage (primary-$500,00; first excess-$1.5 million), but the amount of the verdict exceeded that amount of coverage. It should also be noted that the amount of the verdict was within the Hospital's total amount of insurance coverage, $10 million. ***We decline Jones's invitation to expand the well-recognized boundaries of the Stowers doctrine.*** *See Keck, Mahn & Cate v. National Union Fire Ins. Co. of Pittsburgh, Pa.,* 20 S.W.3d 692, 702 (Tex. 2000); *American Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842 (Tex. 1994).

Id. at *10 (emphasis added). ***Importantly, the court warned that the demand before it was within the amounts for which the carriers were in fact solvent given their shares of the loss and financial condition at the time.*** The court thus suggested that the limits could in effect be reduced where one or more of the severally liable insurers was insolvent.

Under *Garcia,* coverage is a critical prerequisite to a *Stowers* duty applying. Expanding on the observations in *AFTCO,* it should be emphasized that excess carriers generally have no coverage and thus no duty to accept a settlement within their limits until there has been a tender of the underlying limits or exhaustion of underlying limits by the primary carrier. *Employers Nat. Ins. Co. v. General Acc. Ins. Co.,* 857 F. Supp. 549, 551

(S.D. Tex. 1994) (excess insurer had no duty to act vis-à-vis a settlement until the primary carrier "'tendered' its limits, which would allow [the excess insurer] discretion to use [the primary carrier's policy limit] as it saw fit"); *Keck, Mahin & Cate v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 20 S.W.3d 692, 701 (Tex. 2000); *KLN Steel Products Co., Ltd. v. CNA Ins. Companies,* 278 S.W.3d 429, 443 (Tex. App.—San Antonio 2008, pet. denied)(holding that excess insurer does not have to contribute to settlement until primary insurance is exhausted; noting: "(T)he various insurance companies are not covering the same risk; rather, they are covering separate and clearly defined layers of risk.").

(e) Must The Excess Carrier Be Defending?

Apparently, according to some authorities, the excess carrier must also have taken over the defense of the case. *Keck, supra.* Thus, the failure of the excess carrier in *Keck* to respond to the initial settlement demand of $3.6 million could not be used as contributory negligence where the offer came prior to tender of the primary limits and prior to takeover of the defense. *Id.*

The *Keck* court held that even if the excess carrier was negligent in failing to "explore coverage issues more diligently, reserved its rights . . . investigated the merits of the third-party claim more thoroughly, hired independent counsel to monitor the third-party claim, supervised its claim adjuster more closely, and demanded to settle the claim months before trial," it was not actionable because it was based on conduct prior to the tender of the primary limits and because in this pre-tender situation the *excess carrier has no duty to defend or indemnify*. *Id.* The court added that pre-tender, the excess carrier had no duty to monitor the defense or to anticipate that the defense was being mishandled by the primary carrier and the defense counsel selected by the insured, noting the general tort rule that a party has no duty to anticipate the negligence of another. *Id.*

In some other jurisdictions, the courts have recognized that an excess carrier has a duty to settle once the primary limits or any self-insured retention have been tendered, regardless of whether the excess carrier is defending or not. ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSUREDS, sec. 5:26 (Database updated March 2011). In Texas, however, at least some courts have recognized that the tort duty to settle under *Stowers* does not apply unless the excess carrier is defending. *Emscor Mfg., Inc. v. Alliance Ins. Group,* 879 S.W.2d 894, 909 (Tex. App.—Houston [14th Dist.] 1994, writ denied)(holding that excess insurer can never have a duty to settle). The court in *Emscor* observed: "[W]e note that ***the Stowers doctrine . . . has never***

been applied to an excess carrier . . . ." *Id.* at 901(emphasis added). The *Emscor* court added: "There is simply no authority in this State establishing a cause of action by an insured against its **excess** insurer for negligence, bad faith, or for unfair and deceptive practices in the handling of a claim brought by a third-party." *Id.* at 909; *accord West Oaks Hosp., Inc. v. Jones,* No. 01-98-00879-CV, 2001 WL 83528, at *10. The court reasoned:

> The *Stowers* doctrine has been applied in Texas in only two circumstances—to the insured's right to sue a primary carrier for wrongful refusal to settle a claim within policy limits, *see G.A. Stowers Furniture Co. v. American Indem., Co.,* 15 S.W.2d 544, 547–48 (Tex.Comm'n App.1929, holding approved), and to an excess carrier's right to sue a primary carrier, under the theory of equitable subrogation, to protect the excess carrier from damages for a primary carrier's wrongful handling of a claim, *see American Centennial Ins. Co. v. Canal Ins. Co.,* 843 S.W.2d 480, 483 (Tex.1992). Neither of those circumstances are present in the instant case.
>
> . . . .
>
> Under *Stowers,* the insurer's duty to the insured, extends to the full range of the agency relationship as expressed in the policy**.** *See Ranger County Mut. Ins. Co. v. Guin,* 723 S.W.2d 656, 659 (Tex.1987). [emphasis added]. That duty may include investigation, preparation for defense of the lawsuit, trial of the case, and reasonable attempts to settle. *See American Physicians Ins. Exchange v. Garcia,* 876 S.W.2d 842, 849 (Tex.1994) (opinion on motion for rehearing). Here, ***Alliance had no duty to investigate, negotiate or defend Emscor*** under the terms of the excess policy or at law, and ***never undertook those responsibilities on its own.*** *See Emscor,* 804 S.W.2d at 197–99. Therefore, Alliance had no duty under *Stowers* and Emscor has failed to state a *Stowers* cause of action.

879 S.W.2d at 909 (emphasis added).

This approach is consistent with language utilized in the opinion adopted by the Supreme Court in *G.A. Stowers Furniture Co. v. American Indemnity Co.,* 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved). The court there predicated the duty on the "control" given to and exercised by the carrier under the policy terms:

> The provisions of the policy giving the indemnity company ***absolute and complete control of the litigation***, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.

Id.

(3) **Bulk Offers**

Bulk offers of the claims of multiple claimants are not per se ineffective. Bulk offers made involving separate limits available to separate claimants are ineffective and improperly conditional where the demand in effect asks a carrier to pay limits for a weak claim in order to get a release and settlement of a strong claim.

As discussed above, in *Rosell v. Farmers Texas County Mut. Ins. Co.,* 642 S.W.2d 278, 279 (Tex. App.–Texarkana 1982, no writ), the carrier refused to accept a bulk offer to settle for two occurrence policy limits where one of the two claims was not, in the carrier's opinion, worth a full single limit. The court held that the carrier did not have to pay more for the weak claim in order to get a settlement of the strong claim. *Accord Pullin v. Southern Farm Bureau Cas. Ins. Co.,* 874 F.2d 1055, 1056 (5th Cir. 1989) (Texas law). .

Roselle and *Pullin* present a single bulk offer conditioned on the payment of two separate limits on two separate claims. Thus, it has no application to an offer by multiple plaintiffs to settle all of their claims for a single limit. If the aggregated claims present a liability and damages exposure that a reasonable insurer would accept for a single limit, then the fact that they are made together should not make the offer unenforceable.

As usual, there is one catch. Where the plaintiffs have not reached an appropriate agreement as to how the settlement amount is to be divided, the offer may be ineffective. The plaintiff's counsel may not on his or her own make the allocation for the collective plaintiffs given the conflicting interests of those parties. The preferred manner for presenting such an offer is to actually disclose how the parties intend to allocate the funds, such as the judicial appointment of an independent party to in effect arbitrate and determine how the allocation is to be done.

Bulk offers for a single limit can actually make the *Stowers* case much stronger. The insured in such a setting obviously is given a chance of getting much more for the money. The damages exposure to be considered allows combining all of the exposure reflected in the claims being settled.

(4) Bifurcated Offers—Waiting for the Satisfaction of the Condition

A conditional offer can become valid under Stowers if the condition is satisfied in time for the carrier to respond to the offer. Thus, a so-called bifurcated offer can become valid. Offers requiring a contribution by the insured and the carrier are problematic if simply combined. In other words, if you offer to settle for $1.2 million, with $200,000 from the insured and the limits from the carrier, the insured would have to tender before the offer would be unconditional as to the carrier. The offer to the carrier is conditioned on the insured tendering their portion. Timing it so that the carrier gets time to respond once the condition is satisfied is critical. Bifurcating the offer so that the condition comes first and then the carrier portion follows once the condition is satisfied, with a separate time for responding, avoids the difficulties experienced in published cases.

Again, one cannot make a bifurcated offer without making a conditional offer. For example, if the offer to the carrier is contingent on the insured kicking in some of its own money, then the offer is conditional. Can it never be a valid Stowers demand? Yes.

The Supreme Court certainly suggested in *Maldonado* that proof that the carrier was informed of the insured's willingness to satisfy the terms of the "condition" would likely be sufficient to trigger the carrier's duty to settle. In that case, of course, the carrier did not receive sufficient notice.

One approach to this problem is to make the bifurcated offer in such a fashion that the insured is given a certain amount of time to consider whether it wishes to contribute as requested, and if the insured agrees, it then must notify the carrier, whose own duty will run a specified number of days from the date of the insured's notice to the carrier of its acceptance of the terms.

The goal is to make clear that there is in fact a conditional requirement, provide the mechanism for its satisfaction and then allow a reasonable time after the condition is satisfied for the carrier to accept. This is intended not fit the rule that even when an offer

is conditional, it will be binding when the specified conditions have occurred. *Webster*, 906 S.W.2d at 77.

A similar approach can be taken with excess carriers. In other words, the offer needs to clearly state what is expected from the primary carrier and what is expected from the excess carrier. The mechanism for the satisfaction of the condition that the primary carrier tender limits should be part of the demand. Without a tender, the excess carrier has no duty to settle, generally. For example, the following offer could be made:

Plaintiff A and B agree to provide a complete release, including the release of any liens or other encumbrances, for the following consideration:

1. $1 million paid by Slippery Rock Ins. Co. (primary);

2. $5 million paid by Mondo Excess Ins. Co. (excess).

This offer will remain open to Slippery Rock for thirty days. If Slippery Rock agrees to the tender of the designated amount as part of a total settlement of $6 million, it will then provide notice to the insured and/or Mondo Ins. Co. The offer will then remain open to Mondo to accept this offer for the additional amount of $5 million for a term of 15 days.

The thought obviously is that while the offer is initially conditional, the satisfaction of the condition sets the stage for an unconditional offer. The communication and time enlargement provisions seek to solve problems such as those in Maldonado.

A similar difficulty exists where there is a self-insured retention or sizeable deductible. A bifurcated offer may be required in such settings, particularly where the coverage above is not invoked until there is a tender or exhaustion of the deductible/SIR.

SIR's are troublesome in any event. The insured in control of its own money is often more intransigent regarding settlement than a liability insurer. Currently, Texas law holds that a self-insurer has no *Stowers* duty to settle.

d. Complete Release

(5) *Bleeker* and Hospital Liens

A split of authority has arisen after *Garcia* as to whether the demand must include a promise to provide a complete release to the insured. In *Birmingham*, *supra*, the court

held that a demand from an excess carrier that the primary carrier tender its limits did not satisfy *Stowers* because it did not propose to release the insured fully. 947 S.W.2d at 599-600 (*citing Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314 (Tex. 1994)).

In *Trinity Universal Ins. Co. v. Bleeker*, 944 S.W.2d 672 (Tex. App.–Corpus Christi 1997), *rev'd,* 966 S.W.2d 489 (Tex. 1998), the Court of Appeals held that the settlement offer did not need to specifically offer a complete release in conjunction with the demand for policy limits if the letter mentions the *Stowers* doctrine by name. Also, the fact that the settlement demand made no comment regarding how outstanding hospital liens were to be handled did not render the demand ineffective. *Id.*

The Supreme Court disagreed, stating:

> As a threshold matter, "a settlement demand must propose to release the insured fully in exchange for a stated sum of money."

Trinity Universal Ins. Co. v. Bleeker, 966 S.W.2d 489 (Tex. 1998). In *Bleeker,* the offers to settle did not indicate that certain hospital liens would be released as well. Thus, the court held that any implied release was not a full release in the context of that case. *Id.* at 491.

One question left open by *Bleeker* is whether there is any available method for proving that the offer included a full release. In other words, if the letter did not state as much, then could common practice and understanding or even subjective testimony from the plaintiff's attorney supply the missing element? The Supreme Court appears to be moving towards greater certainty as to the terms and communication of the terms of *Stowers* demands. The emerging rule appears to be that *Stowers* demands are disfavored and thus must strictly and expressly comply with the applicable rules or be found insufficient to invoke the tort remedy of an extra-contractual claim. Thus, like conditions of forfeiture, the *Stowers* demand is disfavored in part because of its drastic potential consequences. Needless to say, the *Bleeker* ruling has led to a number of malpractice claims against plaintiff's counsel based on failed *Stowers* demands.

Another issue that has not been addressed since *Bleeker* is whether that decision requires a specific reference to liens if there are in fact no liens. Can a carrier attack an otherwise valid *Stowers* demand where the plaintiff fails to state liens will be released if there are in fact no liens. Similarly, can this issue be raised if the liens are legally ineffective or unenforceable?

Since Bleeker, at least two cases have discussed *Bleeker* negatively. The first was in *Watters v. Guaranty Nat. Ins. Co.*, 300 Mont. 91 (2000). This Montana case declined to follow the holding in *Bleeker.* It also involved an automobile accident. The insurer argued that there was no valid settlement offer because there was not a full release offer. In effect, the insurer defined "settlement offer" to mean an offer within the policy limits in exchange for a full and final release. The *Guaranty* court concluded that the statutory cause of action at issue there did not include a definition of "settlement." The court held that treating a "settlement offer" as requiring an offer of a full release including liens in effect added words that the legislature did not include in the first instance. The court held that a "settlement" between the two parties was legally possible without executing full and final release of all liability.

The second case that discussing and applying *Bleeker* is *Nationwide Mut. Ins. Co. v. Chaney,* 2002 WL 31178068 (N.D. Tex. 2002). The claimant tried to rely upon an implied release of lien, urging that she never excluded a release of any pertinent lien. The court held that absent an offer to fully release that complies with section 55.007(a) of the Texas Property Code, there is no valid *Stowers* demand. The court found that the letter demand did not expressly or impliedly release the lien. The decision was affirmed by the Fifth Circuit on other grounds. 78 Fed. Appx. 348 (5th Cir. 2003).

(6) ***Home States*—Clarification Re Liens**

A significant decision regarding liens and the details surrounding them in the Stowers context was released last year. In *McDonald v. Home State County Mut. Ins. Co.,* 2011 WL 1103116 (Tex. App.-Hous. [1st Dist.] Mar 24, 2011), the demand letter stated that "full and final settlement of McDonald's claims could be made 'in exchange for payment to Edward McDonald' of the 'total amount of liability insurance available to cover your insured in this matter.'" *Id.* The court held: "To the extent the demand was intended to invoke the *Stowers* doctrine, its terms should have either made ***express reference to the liens*** or at least should not have instructed express terms for acceptance which ***left the insurer exposed to the risk of liability to the hospital***. *See Bleeker*, 966 S.W.2d at 491. McDonald's demand letter therefore failed to propose reasonable terms such that an ordinarily prudent insurer would have accepted them and assumed for itself the risk that the liens would be enforced. *See Phillips*, 288 S.W.3d at 879." *Id.* at *7 (emphasis added).

The court reached a number of important, discrete conclusions regarding the sufficiency of the demand:

(1) The court refused to find that a full release including liens was "implicit" in the offer;

(2) The carrier failed to ask for clarification and did not include liens in its own proposals regarding settlement;[8]

(3) ***The court refused to supplement the letter's terms based on the adjuster's admission that a full release including liens was standard and expected;***

(4) ***The court rejected arguments that the lien was invalid and thus irrelevant, thus justifying holding the demand was sufficient.***[9]

(5) A reference in the letter that it was intended to be consistent with the *Stowers* doctrine did not supply the missing requisites regarding liens;

The court noted that the insurer was informed by the hospital that it was seeking recovery under the lien ***before the settlement demand from the plaintiffs expired.*** *Id.* at *6. ***Query whether the carrier must actually know of the lien in order to challenge whether the demand offered a full and complete release.*** *Id.*

The court placed emphasis on the fact that the demand letter specifically instructed that payment of the settlement was to be made to the plaintiff, by and through his counsel. The letter further warned that any variation from its terms in the acceptance would be deemed to be a rejection of the demand. The court reasoned: "These express instructions in the settlement demand subjected the insurer to a risk that a settlement on the offered terms would not be a full one." *Cf. Bleeker*, 966 S.W.2d at 491."

[8] "Evidence about the insurers' claims investigation and conduct during settlement negotiations is "necessarily subsidiary to the ultimate issue" of whether McDonald's demand itself was such that an ordinarily prudent insurer would accept it. *Garcia*, 876 S.W.2d at 849. Moreover, the failure to mention hospital liens in subsequent correspondence does not indicate that the insurers would not have required protection from liens in any formal documentation of a settlement-none of the insurers' communications were framed in the take-it-or-leave-it manner of McDonald's exploding demand letter." *Id.* at *6.

[9] "The record shows that the adjuster was aware of the existence of a purported hospital lien before the settlement demand expired, but it does not indicate whether the insurers saw the actual lien. We conclude, however, that the validity of the lien itself is irrelevant to whether the demand letter triggered a *Stowers* duty." *Id.* at *7.

(7) *Pride* Transportation—All Insureds? All Claims?

In *Pride Transportation v. Continental Casualty Co.*, 511 Fed.Appx. 347 (5th Cir. 2013)(Smith, J.)(Texas Law), the parties agreed "that the insurers did not reject any demands" to settle as to either of two insureds, but, instead, the case involved "the insurers' liability for accepting a demand." *Id.* at *4. The court flatly refused "to use this case . . . to extend the *Stowers* duty to impose liability on insurers for accepting demands."

The insureds, Pride Transportation and its employee Harbin, were sued for severe injuries suffered by Wayne Hatley, including paraplegia, and for derivative damages suffered by the family. Pride had a $1 million primary automobile liability insurance policy with Continental and a $5 million excess/umbrella policy with Lexington. The same defense counsel initially represented both Harbin and Pride. His initial reports in the case indicated that attempts to seek an early settlement would be appropriate. After damaging testimony regarding falsification of records came out at Harbin's deposition, the defense counsel ceased representing Pride and continued to represent Harbin.

Just a short time after separation of the defense, the claimants made an offer to settle within the combined limits of the primary and excess policies to Harbin. The offer expressed reserved any and all claims the claimants had against Pride:

> "This demand shall in no way release Plaintiff's claims asserted against Pride Transport either for its direct negligence of for its responsibility under the *respondeat superior* or statutory employer doctrine."

Pride sought to convince Continental to tender its limits to Lexington so efforts to obtain a settlement for *both* insureds could be pursued. Continental tendered, and Lexington took control of the defense of the suit. The claimants rejected inquiries from Lexington as to a joint settlement with both insureds. Pride sought a joint counter-offer of $5 million for both insureds, but Harbin and her counsel refused to agree to this approach. Harbin demand acceptance of the demand within the total limits. Pride made clear that it had and would bring a claim for common law indemnity against Harbin even if Harbin settled. The settlement offer to Harbin did not in any way protect Harbin from common law indemnity claims made by Pride. Nevertheless, Lexington complied and exhausted the limits of both policies.

Pride eventually settled with the Hatley's for $2 million "conditioned on Pride's recovery against the product-manufacturer defendants and the insurers. " Pride filed an

indemnity claim against Harbin. The carriers refused to defend Harbin based on exhaustion of the policy limits from the settlement with the Hatley's. A default judgment was taken against Harbin. Harbin assigned her rights against the carriers to Pride, which brought suit against the carriers in federal court.

The district court in Pride granted summary judgment to the insurers. The Fifth Circuit affirmed. The court began its analysis by noting that third-party liability insurers have liability under *Stowers* for failure to settle and under breach of contract, but no other theory of tort liability is available. Id. at *11. The court treated the scenario presented as one involving multiple claimants, the Hatley's and Pride (indemnity). Accordingly, the court held that the only liability question was whether the settlement with the Hatley's was reasonable, viewing only the claims and exposure presented by the Hatley's. Id. The fact that the settlement eliminates coverage for another insured or for a second claim against the same insured may not be considered in determining if the settlement is reasonable. Id.

The Fifth Circuit in *Pride* reasoned: "'To be unreasonable, [Pride] must show that a reasonably prudent insurer would not have settled the [Harbin] claim when ***considering solely*** the merits of the [Harbin] claim and the potential liability of its insured on the claim.'" Id. at 316 (emphasis added). Pride argued that the settlement between the Hatley's and the Harbin's was unreasonable because it did not offer a complete release to Harbin since the indemnity claim was left open. Pride urged both the Hatley claim and the indemnity claim were based on the same conduct of Harbin and thus required a release of both potential claims.

The Fifth Circuit rejected Pride's arguments, noting that the indemnity claim could not affect the reasonableness of the settlement because the indemnity claim was not covered. The court noted that "the Lexington policy explicitly exempts claims or suits brought by one insured against another." *Id.* at *14. In Texas, a carrier has no responsibility under *Stowers* for accepting settlements involving claims or parts of claims that are not covered by the policy. *Id.* at *15 (citing and quoting *St. Paul Fire & Marine Ins. Co. v. Convalescent Services, Inc.*, 193 F.3d 340, 345 (5th Cir. 1999)). Thus, the court side-stepped the issue of whether the Hatley's offer to Harbin was reasonable in light of the failure to include protection from the indemnity claim. Indeed, the court stated: "Although a full release is required to trigger a Stowers demand, we need not determine whether the Settlement satisfies, or even if it is required to satisfy, that prerequisite." *Id.* at n. 15.

The court refused to address whether a prerequisite to *Soriano* protection applying is that there has to have been a completely valid *Stowers* demand that was accepted. If the release offered was not a complete release, i.e., indemnity was left open, then one would think that the offer did not satisfy *Stowers.* The simple fact of the matter is that no reasonable person would pay $6 million to get a release from the claimants, but remain exposed to precisely the same liability on an indemnity claim. Indemnity is a derivative claim. *Stowers* requires the carrier to consider the interests of the insured and not just the insurer's own interest. Thus, whether the indemnity claim was covered or not under the Lexington policy has nothing to do with whether the acceptance of an offer to settle direct liability is reasonable given the continuing exposure of the same insured to the same liability.

e. Identification of Parties

The demand letter should clearly identify who is making the offer and to whom it is being made. This author frequently sees demand letters where there is confusion over who is offering and which entities are to be released. Vagueness or confusion in the letter imperils the chances the demand will stick.

Ethical issues obviously exist regarding joint plaintiff offers by a lawyer representing a group of plaintiffs. It is unclear whether a carrier would have the right to challenge the sufficiency of a demand based on ethical considerations.

In *Home State County Mut. Ins. Co. v. Horn,* 2008 WL 2514332 (Tex. App.-Tyler, Jun 25, 2008), the demand letter offered a release of the insured, which referred to one insured. The judgment in excess of limits was taken as to a different insured. Oral testimony cannot amend or supplement the letter to make clear that both insureds were intended to be covered, even if the testimony is provided by the adjuster.

f. Timing or Buying Time

(1) Practical Thoughts

Determining when to send the demand requires careful consideration of the reasonableness standard. The carrier needs to have had a reasonable opportunity to ascertain the basic facts impacting the liability and damages exposure in the case. This will thus result in timing be varied based on the nature of the case.

Few pre-suit *Stowers* demands will succeed. Most carriers do not even hire an attorney for the insured until after suit has been filed. They have no obligation to defend until a suit has been tendered to them by the insured.

The biggest problem for claimants regarding timing is consideration of whether there are multiple claimants and limited limits. *Soriano* encourages a race to make the *Stowers* offer. This pits one plaintiff's attorney against another.

The "me first" attitude is protective, but dangerous. If there has not been time to adequately asses the financial position of the defendant/insured, settling for low limits could result create malpractice exposure for the plaintiff's counsel.

One solution is for plaintiffs' counsel to band together early and seek a joint solution. One would expect this would require some form of agreement or consent from the clients as well. This approach assures no one will take the money and run. All concerned can assess the financial condition of the insured and make intelligent choices without a time-crunch.

Another solution is to seek to include in the pre-trial scheduling order an agreement or an order barring settlement and exhaustion of funds by a single party. Where coverage issues exist, the trial court can arrange to have such issues decided in a separate declaratory action. The best approach is to confirm any such arrangement with a Rule 11 agreement that is enforceable.

Timing can also be affected by pending, important coverage decisions. The pendency of the issue of the insurability of punitive damages is one example.

(2) Reasonable Time Limits

Most plaintiffs believe that short time limits increase the pressure on the carrier. It typically does not. Remember that the time within which the offer can be accepted will be part of the determination of whether the carrier was reasonable in refusing to settle. *American Ins. v. Assicurazioni Generali*, 228 F.3d 409 (5th Cir. 2000)(Texas law); *Allstate Ins. Co. v. Kelly*, 680 S.W.2d 595 (Tex. App.-Tyler 1984, no writ)(upholding negligence finding where 14 day time limit was given). Thus, the shorter the time provided, the more likely it is that the carrier's position of reasonableness is enhanced.

Recently, in *Bramlett v. Medical Protective Ins. Co.*, 2013 U.S. Dist. LEXIS 31044 (N.D. Tex. March 5, 2013), the court held that the fact the plaintiff's expert first provided an

opinion critical of the insured five days before a *Stowers* demand was made, with a 14 day time limit, raised a fact issue as to reasonableness and could not be used as a matter of law defense. *Id.* at *19. The court reasoned:

> To begin with, the court recognizes that ***there may be cases in which an insurer has so little time to respond to a Stowers demand that no reasonable jury could find that it failed to act as a reasonably prudent insurer by rejecting the demand.*** But apart from such cases, the question whether an insurer has had a reasonable amount of time to respond to a Stowers demand will generally present a quintessential, constituent fact issue that is subsumed within the jury's application of the reasonably prudent insurer standard. In the present case, the court cannot say, as a matter of law, that MedPro had insufficient time to accept the second Stowers demand. This question is one of fact that must be resolved by the trier of fact.

Id. at *19-*20 (emphasis added).

The best philosophy is to "give them as much rope as they want." A basic thirty-day offer is standard. Freely granting extensions is also advisable. If the carrier obtains extensions and then refuses to settle, there are any number of negative implications harmful to their defense of the *Stowers* suit. Failing to give them the time again potentially gives them an out.

III. BASIC DUTIES AND DEFENSES

A. Duty

1. Impact of Sources and Nature

In *Stowers,* the court set forth the basic cause of action for the negligent failure of a carrier to accept a settlement offer within the policy limits of a liability policy. *Id.* at 547. Unlike some other jurisdictions, a carrier in Texas has no duty to initiate or make settlement offers absent a valid *Stowers* demand. *American Physicians Insurance Exchange v. Garcia,* 876 S.W.2d 842, 849 (Tex. 1994) (holding carrier has no duty to "make or solicit settlement proposals.").

Stowers is a negligence standard: "[A]n indemnity company is held to that degree of care and diligence which a man of ordinary prudence would exercise in the

management of his own business." *Stowers*, *supra*. Thus, Texas has rejected theories of strict liability for excess judgments followed in some jurisdictions.

In *Stowers*, the court held that the right to control the defense and settlement of the underlying claim supported the duty to act reasonably regarding settlement demands within limits. The Court observed:

> As shown by the above-quoted provisions of the policy, the indemnity company ***had the right to take complete and exclusive control of the suit against the assured***, and the assured was ***absolutely prohibited from making any settlement, except at his own expense,*** or to interfere in any negotiations for settlement or legal proceeding without the consent of the company; the company reserved the ***right to settle*** any such claim or suit brought against the assured. Certainly, where an insurance company makes such a contract; it, by the very terms of the contract, ***assumed the responsibility*** to act as the exclusive and absolute agent of the assured in all matters pertaining to the questions in litigation . . . .

15 S.W.2d at 547 (emphasis added). As will be discussed more fully below, a number of decisions have held that an excess carrier cannot be subject to *Stowers* unless and until it has an obligation to defend or has assumed the duty to defend.

As the quote above demonstrates, at least three critical things were found important in terms of the contract in *Stowers* and the determination that a duty to exercise due care with regard to settlement existed:

1. A duty to defend and control of that defense.

2. Control of settlement and everything related to it, including negotiations, etc.

3. The insured is prohibited from settling on his or her own, unless at his or her own expense.[10]

[10] "In Texas, an insurer whose policy does not permit its insured to settle claims without its consent [FN19] owes to its insured a common law "tort duty." *Ford v. Cimarron Ins. Co., Inc.,* 230 F.3d 828, 831 (5th Cir.2000) (citing *G.A.* ***Stowers*** *Furniture Co. v. Am. Indem. Co.,* 15 S.W.2d 544 (Tex. Comm'n App.1929, holding approved)); *see also Rocor Int'l v. Nat'l Union Fire Ins. Co. of Pittburgh, PA,* 77 S.W.3d 253, 263 (Tex.2002)

See, e.g., American Western Home Ins. Co. v. Tristar Convenience Stores, Inc., 2011 WL 2412678, *2 (S.D. Tex., Jun 02, 2011)(Werlein, J.).

In *Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.,* 77 S.W.3d 253 (Tex. 2002), the Court held that the duty to settle may attach to an excess carrier that has no duty to defend under the terms of the contract but ***which exercises or assumed control*** over the settlement process. Accordingly, a duty may arise as a result of a ***voluntary assumption of the duty***.

"A *Stowers* claim is not a "bad faith" claim. *Maryland Ins. Co. v. Head Indus. Coatings and Services, Inc.,* 938 S.W.2d 27, 28 (Tex.1996); *Garcia,* 876 S.W.2d at 847; *cf. Arnold v. National County Mut. Fire Ins. Co.,* 725 S.W.2d 165, 167–68 (Tex. 1987) (recognizing an insurer's duty, sounding in tort, to deal fairly and in good faith with its insured). However, the *Stowers* claim does sound in tort based on the negligence of the insurer in performing its obligations to its insured under the policy. *See Maryland Ins. Co.,* 938 S.W.2d at 28; *Soriano,* 881 S.W.2d at 314; *see also Universe Life Ins. Co. v. Giles,* 950 S.W.2d 48, 60 (Tex.1997) (Hecht, J., concurring)." *Southern County Mut. Ins. Co. v. Ochoa,* 19 S.W.3d 452, 466-67 (Tex. App.-Corpus Christi, Mar 02, 2000).

Of course, there is some disagreement of sorts in the case law. "The crux of the *Stowers* claim is negligence or bad faith by the insurer directed against the insured." *Foremost County Mut. Ins. Co. v. Home Indem. Co.,* 897 F.2d 754 (5th Cir. Tex., Mar 21, 1990) "The *raison d'etre* for the *Stowers* doctrine is that the insurer, when in control of the litigation, might refuse a settlement offer that its client, the insured, would want to accept if it had the option." *Id.* at 758.

Returning to the source, it would appear that *Stowers* itself focuses on due care, *not good faith.* In *American Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842 (Tex. 1994), the Supreme Court held that "the terms of the [plaintiff's settlement] demand" must be such that "an ordinary prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." Under this negligence standard, the issue is *not focused on good faith* or whether the carrier had some improper motive. Instead, it is focused on whether the carrier exercised *due care*. *Highway Ins.*

(noting the ***Stowers*** decision's basis in part "upon the insurer's control over settlement")." *American Western, supra,* at *2.

Underwriters v. Lufkin-Beaumont Motor Coaches, 215 S.W.2d 904 (Tex. Civ. App.-Beaumont 1948, no writ).

A carrier is not liable simply because the settlement determination subsequently proves to have been wrong. *Id.* at 928. Indeed, even where the plaintiff has proof that would make out a prima facie case of liability against the insured, the carrier is afforded discretion within the scope of due care to reject a demand within limits. *Id.* Thus, a *mere error in judgment* will not result in the carrier being found to have acted unreasonably; the carrier is afforded some degree of discretion in deciding whether to settle or not. *Id.* A mistake in judgment is not an absolute defense, however, and it is but one of the objective factors that makes up "due care." *Jones v. Highway Ins. Underwriters*, 253 S.W.2d 1018, 1023 (Tex. Civ. App.--Galveston 1952, writ ref'd n.r.e.). Thus, analysis of the demand and the reasonableness of accepting it depend upon consideration of the "the likelihood and degree of the insured's potential exposure to an excess judgment." *Id.* The Court has stated that an "***objective assessment of the insured's potential liability"*** is required. *Franks, supra.* In other words, one may not necessarily consider subjective factors such as whether the insured has few if any funds. The standard, even if viewed from the insured's perspective, is still one of objective reasonableness, not subjective reasonableness.

A bad result alone does not prove negligence. It is clear that the mere fact that a judgment is entered in excess of policy limits does not mean that the carrier is automatically liable for the excess amount. Thus, the fact a decision to reject an offer within limits proves to be wrong does not by itself create liability under *Stowers. Chancey v. New Amsterdam Cas. Co.,* 336 S.W.2d 763 (Tex. Civ. App.—Amarillo 1960, no writ). Only due care is required, and due care "leaves room for an error of judgment, without liability necessarily resulting." *Id.*

In *G.A. Stowers Furniture Co. v. American Indemnity Co.,* 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved), the court held that a carrier, in deciding whether to settle, must "exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances . . . ." The carrier should give the interests of the insured at least as great a consideration as the carrier's own interests.

2. Perspective

The Supreme Court has stated two different standards in its various decisions regarding the *Stowers* doctrine. In the decision in *Stowers* itself, the Supreme Court

described the standard as being a reasonable person standard measured from the ***standpoint of the insured:***

> As shown by the above-quoted provisions of the policy, the indemnity company ***had the right to take complete and exclusive control of the suit against the assured***, and the assured was ***absolutely prohibited from making any settlement, except at his own expense,*** or to interfere in any negotiations for settlement or legal proceeding without the consent of the company; the company reserved the ***right to settle*** any such claim or suit brought against the assured. Certainly, where an insurance company makes such a contract; it, by the very terms of the contract, ***assumed the responsibility*** to act as the exclusive and absolute agent of the assured in all matters pertaining to the questions in litigation, and, as such agent, it ought to be held to *that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business; and if an ordinarily prudent person, in the exercise of ordinary care,* ***as viewed from the standpoint of the assured,*** *would have settled the case, and failed or refused to do so, then the agent, which in this case is the indemnity company, should respond in damages.*

G.A. Stowers Furniture Co. v. American Indemnity Co., 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved)(emphasis added). The court added: "Where one acts as agent under such circumstances, he is bound to give the rights of his principal at least as great consideration as he does his own." *Id.* But, the court also more vaguely stated: "[A]n indemnity company is held to that degree of care and diligence which ***a man of ordinary prudence*** would exercise in the management of his own business." *Stowers*, *supra* (emphasis added).

In *Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc*., 2005 WL 1252321, at *1 (Tex., May 27, 2005), the Court noted the contrary standard:

> We have said that the duty imposed by *Stowers* is to "exercise 'that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business.'" We have also said that the *Stowers* duty is viewed from the ***perspective of an insurer:*** "the terms of the demand are such that an ordinarily prudent insurer would accept it." ***Both statements are correct.***"

Frank's, supra. Interestingly, this discussion was omitted after rehearing in the Court's second opinion in *Franks.*

Undoubtedly, the insured's perspective, if adopted as the true standard, would seem to place more emphasis on consideration of settling when liability is unlikely but the damages are potentially catastrophic. Nevertheless, it should noted that the statutory standard under Tex. Ins. Code section 541.060 is from the perspective of the carrier, was the liability of the carrier reasonably clear. Nevertheless, the Court has otherwise held that *Stowers* defines what is reasonably clear. *Rocor International, Inc. v. Patterson National Union Fire Ins. Co. of Pittsburgh, Pa.*, 77 S.W.3d 253 (Tex. 2002).

B. Reasonableness—What the Carrier Knew or Should Have Known?

In *Bramblett v. Medical Protective Ins. Co.,* 2013 U.S. Dist. LEXIS 31044 (N.D. Tex. March 5, 2013), the court held that the fact that the carrier had not yet received statutorily required medical expert reports supporting the malpractice claim as of the time of the demand time limit did not amount to a defense as a matter of law to a *Stowers* claim. *Id* at *7. The court held that where the carrier was shown to be "aware of other facts that would enable a reasonable jury to find that a reasonably prudent insurer would have accepted the first Stowers demand despite the absence of an expert report," a fact issue was presented. *Id.* at *14. Thus, the basis for the reasonableness evaluation does not appear to be limited to evidence developed and provided by the claimant or its experts. Evidence the carrier had before it or could have had before it would appear to be an antidote to any attempt to avoid *Stowers* liability as a matter of law.

C. Fleshing Out the Standard—Legal Sufficiency Decisions

1. Advice of Counsel Not Controlling

In *Highway Ins. Underwriters v. Lufkin-Beaumont Motor Coaches, Inc.,* 215 S.W.2d 904, 929 (Tex. App.--Beaumont 1948, writ ref'd n.r.e, the court held that reliance on the advice of defense counsel was *not* a complete defense to a *Stowers* claim. The court observed:

> Whether Alexander's offers should be accepted was a matter for the authorized and responsible officer of Insurer to decide; that he ***had the benefit of the opinion of the lawyers defending Insured*** is only a circumstance bearing on the issue of negligence and the standard of care required of lawyers has nothing to do with the case before us as

> was in effect held in American Indemnity Co. v. G. A. Stowers Furniture Co., Tex. Civ. App., 39 S.W.2d 956. To hold otherwise would abrogate the standard of conduct expressed in the quotations above.

Id. at 928.

2. Evidence of a Prima Facie Case of Liability Is Not Enough Alone

The court in *Lufkin* also noted that the single fact that the claimant's "proof made out a prima facie case of liability against [the] Insured did not automatically and as a matter of law subject Insurer to liability (under the applicable standard of conduct) for rejecting [the claimant's] offers." *Id.*

3. A Mere Difference of Opinion Does Not Prove Liability or the Lack of Liability—It Presents a Fact Question

The court in *Lufkin* also noted: "[T]he fact that room for a difference of opinion exists eventually makes the question one for the jury, not for this court." *Id.*

4. Material Conflicts in Testimony and Other Credibility Issues Can Impact the Reasonableness of the Decision Not to Settle

A conflict in testimony or issues affecting the credibility of witnesses is a consideration in determining the reasonableness of the refusal to settle. *Lufkin, supra.*

5. Where Damages Are Certain to Be Heavy

The decision not to settle can be made to appear less reasonable where the damages were certain to be very large and the liability suggests that it is more likely than not that the insured will be found liable. *Id.*

D. Other Factors?

In *Globe Indem. Co. v. Gen-Aero, Inc.*, 459 S.W.2d 205 (Tex. Civ. App.—San Antonio, Oct 07, 1970), the court summarized a somewhat outdated collection of factors in evaluating reasonableness:

> Certain guide lines in determining whether an insurer is negligent in failing to accept an offer to settle are set forth in an excellent comment in 38 Texas

Law Review 233, 'Insurer's Liability for Judgments Exceeding Policy Limits', supra, and in the case of *Highway Ins. Underwr. v. Lufkin-Beaumont Motor Coaches, Inc.*, 215 S.W.2d 904 (Tex. Civ. App.—Beaumont 1948, writ ref'd, n.r.e.). These may be summarized in part as follows:

(A) An opportunity to settle during the course of investigation or trial.

(B) Failure to carry on negotiations to settle or make a counter offer after receipt of an offer to settle. *See Chancey v. New Amsterdam Casualty Company*, 336 S.W.2d 763 (Tex. Civ. App.—Amarillo 1960, writ ref'd, n.r.e.); Bell v. Commercial Insurance Co. of Newark, N.J., 3 Cir., 280 F.2d 514 (1960).[11]

(C) Failure to investigate all the facts necessary to protect properly the insured against liability.

(D) Question of liability—if liability is clear, greater duty to settle may exist.

(E) Element of good faith—whether insurer acts negligently, fraudulently, or in bad faith. *See Crisci v. Security Insurance Co. of New Haven*, Conn., 66 Cal.2d 425, 58 Cal.Rptr. 13, 426 P.2d 173 (1967).[12]

(F) If there are conflicts in evidence which increase the uncertainty of the insured's defense to the injured party's claim, the possibility of the insurer being held negligent increases.

*Id.*at 208.

E. Subsidiary Considerations

In *Garcia*, the court had stated that in the context of *Stowers*, "'evidence concerning claims investigation, trial defense, and conduct during settlement negotiations is necessarily subsidiary to the ultimate issue of whether the claimant's demand was reasonable under the circumstances, such that a reasonable insurer would accept it.'" *Id.*

[11] This factor has been supplanted by the rule from *Garcia* that a carrier has no duty to initiate or move settlement negotiations forward.

[12] This factor is also outdated. As noted above, the duty under *Stowers* is one of objective reasonableness or due care, not subjective bad faith or motive.

Thus, these factors are part of the basic considerations regarding liability and damages exposure that are a part of the basic *Stowers* test.

F. Jury Instructions

1. Bad Result

In *Chancey v. New Amsterdam Cas. Co.,* 336 S.W.2d 763 (Tex. Civ. App.-Amarillo, May 31, 1960), the court upheld the following instruction given to the jury in a *Stowers* case:

> "You are instructed that under the law in Texas, an insurer is required to exercise ordinary care in considering whether an offer of settlement should be accepted, but an insurer does not necessarily become liable merely because the decision to reject an offer of settlement proves to be wrong; in other words, the duty to exercise ordinary care leaves room for an error in judgment without liability necessarily resulting therefrom."

Id. at 765. The court explained:

> As stated above in the *Stowers* case, due care is the required burden placed on the insurer in these cases. Other cases decided since the *Stowers* case have uniformly followed this basic principle. As stated in *Highway Ins. Underwriters v. Lufkin-Beaumont Motor Coaches*, Tex. Civ. App., 215 S.W.2d 904, 928: 'Only due care is required of Insurer, and therefore we agree with Insurer that Insurer did not become liable to Insured merely because a decision to reject Alexander's offers proved to be wrong. Due care leaves room for an error of judgment, without liability necessarily resulting.'

Id.

G. Varying the Elements?

In *Garcia, supra,* the court summarized the *Stowers* elements as follows:

> (1) [T]he claim against the insured is within the scope of coverage [at the time the offer is made], (2) the demand is

> within policy limits, and (3) the terms of the demand are such that an ordinary prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Id. at 849. The courts have refused to allow variations on *Stowers* that go outside of the *Garcia* elements. For example, in *Fulks v. CIGNA Lloyds Ins. Co.*, 1996 Tex. LEXIS (Tex. App.–Houston [1st Dist.], July 25, 1996, no writ), the court held that absent coverage, *Stowers* did not apply. The court rejected arguments that liability could be predicated on the failure of the carrier to communicate its position regarding coverage, thus resulting in the claimant continuing the suit and not settling for the meager available policy limits.

H. Must The Insured Demand That The Carrier Accept The Demand?

In *Lufkin, supra,* the court held that it was "not a defense to Insurer that Insured did not demand acceptance of [the claimant's] offers. Insurer must perform the duty imposed upon it ***without being activated by Insured.***" (Emphasis added.)

I. Is The Insured's Opposition To Settlement A Defense?

Undoubtedly, a forced turnover of an insured's potential *Stowers* action may not be made if the insured agreed with the carrier's refusal to settle and/or the insured did not believe the carrier did anything wrong. *Nationwide Mut. Ins. Co. v. Chaney*, 2002 WL 31178068. *4 n. 5 (N.D. Tex. 2002). *Charles v. Tamez*, 878 S.W.2d 201, 208-209 (Tex. App.–Corpus Christi 1994, writ denied)(holding that insured's right to sue insurer for failure to settle under the *Stowers* doctrine is subject to equitable subrogation and assignment; however, due to public policy concerns about the relationship between insurers and insureds, the court affirmed the judgment denying turnover of the *Stowers* claim, because the insured refused to assert the claim and denied dissatisfaction with his insurer)).

The court in *Gulf Ins. Co. v. Jones,* 2003 WL 22208551 (N.D. Tex., Sep 24, 2003), found that the insured's own evaluation that the case should not be settled for the amount demanded was a fact to be considered in determining the reasonableness of the rejection of a settlement demand within limits. The carrier will not be found to have acted unreasonably if it erroneously believed the insured's consent to settlement was required, so long as it had a basis for determining the demand was otherwise unreasonable. *Id.*

The court in *Continental Cas. Co. v. St. Paul Fire & Marine Ins. Co.*, 2007 WL 2403656 (N.D. Tex., Aug 23, 2007), held that "the *Stowers* duty exists even absent a demand by the insured that the insurer accept the offer."

The court in *American Ins. v. Assicurazioni Generali*, 228 F.3d 409 (5th Cir.(Tex.), Jul 24, 2000), indicated that consent may be a defense to a *Stowers* claim in the context of an equitable subrogation claim by an excess carrier against a primary carrier. The court noted the defense was not established as a matter of law where fact issues existed as to whether the insured was "adequately informed of settlement negotiations and trial proceedings . . . ." *Id.* at *9. Moreover, any such defense would require, the court observed, an "unequivocal decision by the insured to refuse the offer." *Id.*

In *Admiral Ins. Co., Inc. v. Arrowood Indem. Co.*, 2012 WL 1081776 (N.D. Tex., Mar 30, 2012), the court held that the failure of the insured to demand payment of additional limits under a separate, additional primary policy did not negate the duty of that primary carrier to settle. The limits and exhaustion are determined by the terms of the policy, not the insured, and the insured does not have unilateral power to determine exhaustion. Moreover, the court held that the insured's actions will not estop the excess carrier from urging the primary should have settled under *Stowers*. An "insured [cannot] decrease its primary policy limits in a way that was detrimental to its excess carrier." *Id.* (discussing *Royal Insurance Company of America v. Caliber One Indemnity Company*, 465 F.3d 614 (5th Cir.2006)).

The Fifth Circuit's opinion in *OneBeacon Insurance Company v. T. Wade Welch & Associates*, 841 F.3d 669 (5th Cir. 2016), suggested that where a company policyholder makes clear to the carrier that it only wants all claims and insureds settle, not piecemeal or partial settlements (leaving some insureds behind), the carrier cannot accept a settlement unless all insureds are included. The court held:

> Instead of following *Citgo*, OneBeacon urges us to follow a recent Texas appellate decision in which the court found no valid *Stowers* demand where only the insured employer and not the employee (an additional insured) would have been released. *Patterson v. Home State Cty. Mut. Ins. Co.*, No. 01–12–00365–CV, 2014 WL 1676931, at *10 (Tex. App.—Houston [1st Dist.] Apr. 24, 2014, pet. denied) (mem. op.).[10] However, in that case, the insured employer had explicitly indicated to its attorney that it "did not want 'any

settlement demands to be accepted that didn't involve a release of all of the claims against both [the employer and the employee.]' " *Id.*

Id.

J. If There Is Alleged Confusion or Vagueness In The Offer, Must The Carrier Ask For Clarification?

In *Nationwide Mut. Ins. Co. v. Chaney*, 2002 WL 31178068 (N.D. Tex. 2002), the court held that a carrier need not inquire from the plaintiff as to any confusing or omitted elements of the demand made by the claimants. The court observed: "That Nationwide never affirmatively demanded or required a settlement offer that included a full release does not change the result, because Nationwide, as the insurer, did not have the burden of making a valid *Stowers* settlement offer. *Garcia*, 876 S.W.2d at 851 (court concluded that public interest favoring early dispute resolution supported its decision not to shift the burden of making settlement offers under Stowers onto insurers)." *Id.* at *4

If the demand offers to answer any questions regarding any purported uncertainty, this would appear to go a long way towards solving the problem presented by *Chaney.* If a carrier is to give the interests of the insured in mind, then would that not include seeking clarification of an offer considered vague or even ambiguous? Further, would defense counsel not have an obligation to seek clarification, on behalf of the real client, regarding issues he or she knows to be considered "defects" by the carrier?

K. Can The Carrier Urge Technical Defects As Defense To A *Stowers* Claim If It Did Not Actually Rely On Those Defenses In Refusing To Accept the Offer To Settle At Issue?

Very often, carrier's counsel will come up with a vast numbers of reasons why a given *Stowers* demand is ineffective that were not the actual basis for the rejection of the demand. In fact, carriers typically do not mention in their written responses to demands the precise basis for rejection, stating opaquely that the "demand fails to satisfy *Stowers."* Should they do so? Must they do so? More precisely, is a carrier limited to the defenses to the demand that existed and that it was relying upon at the time it rejected the demand?

Post-hoc rationalization for invalidating a *Stowers* demand appears to have been rejected by the Fifth Circuit in *Am. Ins. v. Assicurazioni Generali*, 2000 WL 1056143 at *8 (5th Cir. 2000). The court there held::

> when considering whether to accept the Hinger plaintiffs' offer, Reynaud was not concerned with any future liability stemming from the structured settlement provision. *Generali's position in this litigation that the offer was conditional gives the impression of being a* ***post-hoc rationalization***. There is no evidence whatever that Reynaud or anyone else on behalf of Generali ever concluded (or was advised)-certainly not prior to the institution of this suit by the Excess Carriers-that the settlement offer might be so construed as to authorize imposition of liability on Generali in the event the annuity company defaulted in the periodic payments to the Hinger plaintiffs that presumably would be called for under a structured settlement.

Id. at *8 (emphasis added). The law generally suggests that the focus of inquiry is focused on what was believed at the time of the demand. *Westchester Fire Ins. Co. v. Admiral Ins. Co.*, 152 S.W.3d 172 (Tex. App. – Fort Worth 2004, pet. denied). *But see McDonald v. Home State County Mut. Ins. Co.*, 2011 WL 1103116 (Tex. App.-Hous. [1st Dist.] Mar 24, 2011), discussed *supra.*

IV. NO DUTY OWED TO CLAIMANTS

A liability insurance carrier owes no duty to the claimant with respect to settlement under *Stowers,* good faith and fair dealing and/or claims under the Insurance Code for failing to settle when liability is reasonably clear. *Maryland Ins. Co.*, 938 S.W.2d at 28 (quoting *Tex. Farmers Ins. Co. v. Soriano,* 881 S.W.2d 312, 318 (Tex. 1994) (Cornyn, J., concurring)); *Allstate Ins. Co. v. Watson,* 876 S.W.2d 145, 149–50 (Tex.1994) (holding insurers do not owe third party claimants statutory first party duties under article 21.21, section 16 of the Texas Insurance Code and insurance-based DTPA actions); *see also Transp. Ins. Co. v. Faircloth,* 898 S.W.2d 269, 279–80 (Tex.1995) (extending *Watson* and holding insurer does not owe third party claimant duty of good faith and fair dealing); *Coats v. Ruiz,* 198 S.W.3d 863 (Tex. App.-Dallas, Aug 14, 2006)(holding no duty owed to claimants under common law or statutory theories); *Caserotti v. State Farm Ins. Co.*, 791 S.W.2d 561, 565 (Tex. App.-Dallas 1990, writ denied) (insurers do not own third party claimants first party duties even where same insurance company insures both third party claimant and insured).

V. WHEN DOES THE DUTY START AND WHEN DOES IT STOP

A. Not Before Insured Is A Party?

The court in *Hartford Acc. & Indem. Co. v. Texas Hospital Ins. Exchange,* 1998 WL 598125 (Tex. App.—Austin, Sep 11, 1998), the court questioned whether a duty under *Stowers* was owed to an insured who had not yet been made a party to the underlying suit. The court did not decide that issue, but it did hold that the carrier had no obligation or duty to inform the insured of a settlement offer made and expired before the insured became a party, even though it may have provided a means of releasing that insured.

B. *Stowers* Duty Post-Judgment?

In *Chancey v. New Amsterdam Cas. Co.,* 336 S.W.2d 763, 766 (Tex. Civ. App.-Amarillo, May 31, 1960), the court found no authority to support the applicability of the *Stowers* to an offer coming after judgment in the underlying suit. The court refused to extend the doctrine to this setting.

VI. *SORIANO*— TOO MANY CLAIMANTS, INSUREDS AND CLAIMS (COVERED AND NOT)

A. An Introduction to Soriano

> ***"We do not address the duties of an insurer faced with <u>multiple and concurrent outstanding separate Stowers demands as to different insureds</u> where the demands in total exceed the policy limits."***

Travelers v. Citgo, infra (emphasis added).

From the outset, it must be clear that the Texas Supreme Court has simply not addressed the obligations of a carrier facing multiple, simultaneous *Stowers* demands. While the decision in *Soriano* and its progeny may provide some guidance, it must be remembered that *Soriano* was ***<u>not a Stowers</u>*** case. It was submitted on a negligent claims-handling and a breach of the duty of good faith basis. Neither theory is still available under Texas law, at least as submitted in *Soriano.* Nevertheless, as the discussion so far has already indicated, the *Soriano* approach, known in the trade as "putting on *Soriano* blinders," has been extended to a number of areas, including the recent decision in *Pride* holding that the scope of release necessary to provide a "complete release" is governed by *Soriano.*

1. Court of Appeals' Decision

In *Texas Farmers Ins. Co. v. Soriano*, 844 S.W.2d 808, 813 (Tex. App.—San Antonio 1992), *rev'd,* 881 S.W.2d 312, 315 (Tex. 1994, Soriano, the insured, negligently operated a vehicle in which Lopez was a passenger. He struck a vehicle driven by Medina, whose wife was killed in the accident. Medina himself and two of his children also suffered serious injuries. Soriano's auto policy had minimum limits of $10,000 per injury, with a $20,000 per accident aggregate. The carrier attempted to get the Medina's to settle for policy limits early on, but they refused and sought investigation into Soriano's personal assets first. Two suits were subsequently filed, one by Lopez and one by the Medina family. The Medina's counsel had made clear he would not settle for less than the full limit of $20,000. During jury selection at trial of the consolidated cases, the carrier settled with Lopez for $5,000, and subsequently offered the remaining $15,000 to the Medinas. The Medina family then obtained a judgment in excess of the policy limits against Soriano, who then assigned his rights against the carrier to the claimants.

The court of appeals affirmed judgment for bad faith and negligent claims handling against the carrier. The court rejected arguments to the effect that the jury should be required to consider only the reasonableness of the Lopez case that was actually settled. The court suggested that the carrier could have interpleaded the funds to avoid liability for amounts in excess of the limits.

The dissent by Justice Peeples lays out much of the rule structure later adopted by the Texas Supreme Court. Justice Peeples noted:

> Soriano does not contend that the Lopez settlement was made in bad faith ***when viewed alone***. He argues that it was unreasonable because the Medina cases were more serious and posed a greater threat to him. In his view, an insurer can be held liable even though the first settlement was reasonable and entered in good faith when viewed apart from the exposure in the second case. The premise of his lawsuit is that an insurer must assess the proportionate merits of each claimant that it's insured injured, and settle the cases accordingly. If its assessment is later considered wrong by a court, the insurer is liable beyond the policy limits.
>
> But Soriano's theory is contrary to the universal rule that a liability insurer can settle with some claimants in good faith even though the settlement may exhaust the insurance fund or so deplete it that a subsequent judgment

> creditor is unable to collect his judgment in full from the remaining insurance coverage.

Id. at 840-41 (omitting numerous citations).

Justice Peeples asserted that he had found no authority for the "comparative seriousness rule" urged by Soriano. *Id.* at 841. Peeples further reasoned:

> To begin with, the insurer has a duty to the insured to use care in handling *all* claims against him. An insurer that rejects any reasonable settlement offer within its policy limits-such as the Lopez $5000 offer-risks a *Stowers* suit.
>
> . . . .
>
> The general rule is also sound because it facilitates settlements. The law favors settlements.***842** *See Scurlock Oil Co. v. S* 724 S.W.2d 1, 4 (Tex. 1986); *McGuire v. C* 431 S.W.2d 347, 352 (Tex.1968). And settlements in multi-claimant cases involving underinsurance would be severely curtailed if an insurer acted at its peril by settling one of several claims

Id.

2. Supreme Court Decision

In *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 315 (Tex. 1994) (Enoch, J.), the Supreme Court held:

> We conclude that when faced with a settlement demand arising out of multiple claims and inadequate proceeds, an insurer may enter into a reasonable settlement with one of the several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims. Such an approach, we believe, promotes settlement of lawsuits and encourages claimants to make their claims promptly.

Id.

Note the use of the singular "demand." As noted, the most significant remaining issue after Soriano is what happens when there are multiple, contemporaneous demands from multiple claimants.

Under *Soriano,* an insurer is allowed to fulfill its *Stowers* duty to its insured by settling with one claimant, even though the result is to leave the insured exposed to another claim. *Id.* at 315. In *Soriano,* the insurer opted to settle a relatively minor claim for twenty-five percent of the policy limit when a formal demand was served, despite indications that a settlement with a significantly larger claimant at the policy limit might have been possible. The court held that an insurer could only be liable for settling a claim if (a) they had previously rejected a valid settlement offer within policy limits from the other claimant or (b) the settlement they reached was unreasonable "considering *solely* the merits of the" settled "claim and the potential liability of its insured on" that "claim." *Id.* at 316 (emphasis added). Neither condition was met, so the insurer was entitled to settle the initial claim. Once the first settlement was reached, the insurer had no *Stowers* duty to settle, since the major claimant did not present a settlement offer within the *remaining* policy limit.

The Court in *Soriano* placed great emphasis on the fact that the carrier should not be penalized for exercising the reasonable care required of it under *Stowers* in responding to the Lopez' demand to settle for $5,000. The Court does not clearly state that the cause of action based on an unreasonable settlement depends upon the initial offer being a valid *Stowers* offer. Such an approach would certainly not be unreasonable. The assumption in *Soriano* was that the Lopez offer had to be accepted and that the failure to do so would have visited the carrier with *Stowers* liability. *Id.* at 315.[13] As noted, the Court makes no mention of what a carrier should or must do when faced with multiple simultaneous *Stowers* demands.

The Court in Soriano appears to have only addressed whether a tort duty would apply under Stowers given the entry by the carrier into a settlement with some but not all claimants. As will be discussed below, the contractual defense of exhaustion does not apply until actual "payment." Thus, if the Stowers duty were to be controlled by whether there was coverage after exhaustion, actual exhaustion under the terms of the policy would have to be shown.

[13] Query whether the insureds acceptance of the benefits of the settlement and release would in effect concede reasonableness. *Excess Underwriters at Lloyds, London v. Frank's Casing Crew & Rental Tools,* 2005 WL 1252321, at *1 (Tex., May 27, 2005) (motion for rehearing granted Jan. 6, 2006)(suggesting that insured's demand that carrier accept demand or acquiescence in or acceptance of benefits of settlement amounted to agreement as to the reasonableness of the settlement, thus allowing the carrier to seek reimbursement of the settlement amounts upon proof of non-coverage).

A claimant may challenge the reasonableness of settlements made with other claimants. Thus, a carrier entering into unreasonable settlements with other claimants may still be subject to *Stowers* liability. Unreasonableness depends on traditional factors, such as the merits of the claim. *The mere fact that another claim may be more serious does not make the settlement with the lesser claim unreasonable. Id.* at 316. The test is whether a reasonably prudent insurer ***would not have settled the claim*** "when considering solely the merits of the" settled claim and the "potential liability of its insured on the claim." *Id.* at 316. The court noted that in any event the insured must show that claimant would in fact have accepted the actual limits if the other claim had not been settled. *Id.* at 316 n. 4.

In short, *Soriano* deals with rules applicable to a (a) negligent claims handling cause of action that does not exist under Texas law at this time; and (b) a good faith cause of action that also has been found inapplicable to liability carriers as a matter of law. *See Maryland Ins. Co. v. Head,* 938 S.W.2d 27, 28 (Tex. 1996). It is unclear how, if at all, *Soriano* would actually impact or be applied in a true *Stowers* setting.

One can, at least, imagine that the exhaustion of limits would be treated as a defense based on non-coverage or used to establish that the second offer exceeded the policy limits. The reasonableness attack would then be a method by which those limits could be reinvigorated or replenished. As noted, it is somewhat unclear from the decision as to whether a successful unreasonableness attack requires proof that the settlement would not have been entered into by a reasonably prudent carrier or whether it would have been entered for a lesser amount.

Some carriers are already urging that the multiple claimant scenario, particularly where there are concurrent or simultaneous offers (individually within limits but collectively exceeding limits), is in and of itself proof that a carrier would not be acting unreasonably in refusing to accept a single demand from the multiple demands.

3. *Soriano* as Anachronism—Some Observations on the Future

Soriano is very much an anachronism caught in the Texas Supreme Court's curtailing of duties on the part of liability carriers. Since *Stowers* is ostensibly the only true claims settlement/handling tort available, and its elements do not necessarily fit the handling of multiple claims with insufficient limits, there is no tort home for claims like

Soriano to fall.[14] If you look at the causes of action submitted in that case, they have all essentially been eliminated by the Supreme Court: (1) there is no general tort of negligent claims handling; and (2) there is no duty of good faith owed by liability carriers. These were the theories submitted. No *Stowers* issue was submitted. Indeed, no instruction was requested seeking to limit the jury's consideration of reasonableness to solely the facts of the Lopez claim that was settled. Thus, it is hard to compare other jurisdictions' treatment of the multiple claim issue since those jurisdictions invariably recognize causes of action against liability carriers under more general torts than *Stowers.*

It is indeed curious that *Soriano* was not simply decided in the first instance based on the fact that there was apparently never a proper *Stowers* demand by the Medina's to settle within the correct policy limits.[15] While there had been oral suggestions that they would do so, the Medina family made no written demand nor any made any direct communication, according to the courts, that other elements of a proper *Stowers* demand were satisfied, such as the offer to offer a full release and protection from and against all liens. If *Stowers* is the only cause of action, and the elements of *Stowers* are not satisfied, the matter is at an end and the claimant cannot recover from the carrier.

Also, a traditional *Stowers* analysis would consider whether the offers suggested for $20,000 were valid offers within the policy limits. The Lopez settlement obviously reduced the limits. There was no coverage available for $20,000 after this settlement was

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[14] In *American Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842 (Tex. 1994), the court summarized the *Stowers* elements as follows:

> (1) [T]he claim against the insured is within the scope of coverage, (2) the demand is within policy limits, and (3) the terms of the demand are such that an ordinary prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Id. at 849.

[15] Strangely, it is only in the "bad faith" discussion in the opinion that mention is even made to the failure to make an offer. Instead of referring to *Stowers,* the Court cites to *American Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842 (Tex. 1994). The Court assumes the existence of a duty of good faith, but it appears to decide there was a reasonable basis as a matter of law for the carrier's actions in rejecting an offer to settle for $20,000 by the Medina's after the settlement with the Lopez family. 881 S.W.2d at 317-18.

paid. Thus, an additional element of *Stowers* was not satisfied, the need to make an offer within limits.

The reasonableness of the settlement with Lopez is simply not a factor to even be considered in conjunction with the above-stated elements of *Stowers.* The primary factor to which reasonableness would be applicable would be in determining whether the carrier was reasonable in rejecting the Medina's offer, assuming arguendo one was made. This reasonableness is obviously much broader than simply the reasonableness of another settlement. Indeed, in determining whether the carrier unreasonably refused to settle, one would think that the jury could generally examine whether the pendency of other claims would justify refusing to settle. Remember, the Supreme Court at one time has characterized the standard as follows:

> We have said that the duty imposed by *Stowers* is to "exercise 'that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business.'" We have also said that the *Stowers* duty is viewed from the ***perspective of an insurer:*** "the terms of the demand are such that an ordinarily prudent insurer would accept it." ***Both statements are correct.***"

Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc., 2005 WL 1252321, at *1 (Tex., May 27, 2005) (motion for rehearing granted Jan. 6, 2006). Nothing in this standard excludes consideration of the pendency of other claims.

Given that the insured has the burden of proving the unreasonableness of the settlement, there will likely be an assertion by the carrier that the attorney-client and work product privileges are waived since they cannot be used as a sword and a shield. Thus, damaging information regarding the liability of the defendant insured and its actions would be potentially subject to discovery.

Soriano is ironic in a sense. The court allows for a post-hoc reasonableness challenge when the carrier unilaterally decides to settle a given claim against the insured. If an insured, however, unilaterally settles with the claimant, any resulting agreed judgment is not binding on the carrier. *State Farm Fire & Cas. v. Gandy*, 925 S.W.2d 696, 714 (Tex. 1996). The Court in *Gandy* based its holding in part on the notion that post-hoc relitigation of reasonableness was time-consuming. The Court expressed concern about the insured making unilateral settlement agreements that might be based on something other than the real value of the liability or culpability of the insured. Of course, one could

express similar concerns about unilateral settlement decisions in the multiple claimant/insufficient limits context. The carrier clearly has an interest in eliminating defense costs. Prompt exhaustion eliminates this problem. The Court in *Soriano,* however, rather than barring any recovery, has allowed a reasonableness attack, with all of its foibles.

B. Requirements for Soriano Protection

Does Soriano protection depend upon whether there was a valid *Stowers* demand made in conjunction with the settled claim? The Texas Supreme Court in *Texas Farmers Ins. Co. v. Soriano,* 881 S.W.2d 312, 314 (Tex. 1994, certainly seemed to indicate that a carrier wanting protection from multiple claims must have a duty to settle under *G.A. Stowers Furniture Co. v. American Indemnity Co.,* 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved), as to the claim/s settled. This duty is only activated by a valid *Stowers* settlement demand. The demand must at the very least identify the releasing parties, the parties to be released, be for an unconditional amount within policy limits and propose to release the insured/s fully for a stated sum of money, including a release from any outstanding liens. *Id.*; *see also Trinity Universal Ins. Co. v. Bleeker,* 966 S.W.2d 489, 491 (Tex. 1998); *Insurance Corp. of America v. Webster,* 906 S.W.2d 77, 81 (Tex. App.--Houston [1st Dist.] 1995, writ denied.

Note, however, that the recent decision of the Fifth Circuit in *Pride Transportation v. Continental Casualty Co.*, 2013 U.S. App. LEXIS 2575, (5th Cir. Feb. 6, 2013)(Smith, J.)(Texas Law), suggests that a valid demand under *Stowers* may not be required in order to invoke the protections of *Soriano.* The court stated that "this court does not need to determine whether there was a valid *Stowers* demand" in order to resolve the case under *Soriano* and *Citgo. Id.* at *15. In that case, the claimants' offer was made to an employee and made clear that claims made against the employer were not included. The employer had its own common law indemnity claim. Thus, the settlement offer by the claimants offered no protection as to this claim for precisely the same liability and damages.

An offer from a carrier is not a *Stowers* demand invoking a duty to settle under *Soriano.* A carrier has no duty to initiate or make settlement offers absent a valid *Stowers* demand. *American Physicians Insurance Exchange v. Garcia,* 876 S.W.2d 842, 849 (Tex. 1994)(holding carrier has no duty to "make or solicit settlement proposals.").

Note that some decisions, such as *Mid-Century Ins. Co. v. Childs,* 15 S.W.3d 187, 188 (Tex. App.—Texarkana 2000, no pet. hist.), suggest that a carrier may take action to avoid

Stowers in the absence of an actual, valid *Stowers* offer to settle. The court there held: "Because Mid-Century acted promptly in settling claims that, if taken to trial, would have probably resulted in an excess judgment against Childs, and because Mid-Century had the right to take action to avoid a *Stowers* claim, we conclude that it acted reasonably in exhausting the policy limits, and that because such limits were exhausted, Mid-Century's obligation to defend Childs terminated." The court notes in a footnote that the *Stowers* duty exists when "(1) the claim against the insured is within the scope of coverage; (2) the demand is within the policy limits; and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment." *State Farm Lloyds Ins. C* 963 S.W.2d 38, 41 (Tex. 1998); *G.A.* Comm'n App. 1929, holding approved)." Thus, the court's reasoning is confused. The court's discussion of the record does not indicate that a *Stowers* offer was actually made in *Childs.*

The need for a valid *Stowers* demand in connection with the first settlement is dictated by the *Soriano* Court's emphasis on the Catch-22 a carrier is placed in when facing multiple claimants with insufficient limits. Whatever it does, it will likely be facing a *Stowers* claim. Cast another way, would it be unreasonable for a carrier to settle for limits with one of many claimants if the demand made was invalid under *Stowers*?

C. Approach of Other States

Other jurisdictions have generally taken the approach that where the insured is being sued by more than one person and the limits are insufficient to resolve all claims, the "insurance company has a duty to manage the insurance proceeds in a manner reasonably calculated to protect the insured by minimizing total liability." A. Windt, Insurance Claims & Disputes, sec. 5:8, at 522 (4th ed. 2001). Most jurisdictions appear to follow a "good faith" approach, which allows for fairly open consideration of the overall liability picture. *See, e.g., Millers Mut. Ins. Assoc. of Illinois v. Shell Oil Co.,* 959 S.W.2d 864, 870 (Mo. Ct. App. 1997). Some jurisdictions discourage the carrier from seeking a comprehensive settlement, noting that it essentially should act to extinguish as much liability or potential liability as possible. *Id.* at 524. At least one jurisdiction follows a "first in time, first in right" approach to settlements with multiple claimants. *See, e.g., David v. Bauman,* 196 N.Y.S.2d 746 (N.Y. Sup. Ct. 1960). Finally, a minority of jurisdictions allows for a "pro rata" approach to settlements after the limits are tendered into the registry of the court. *See, e.g., Underwriters for Lloyds of London v. Jones,* 261 S.W.2d 686, 688 (Ky. 1953). All jurisdictions this author has reviewed indicate that it is critical to keep the insured

informed and involved in the settlement process. *See generally* Annot., "Basis And Manner Of Distribution Among Multiple Claimants Of Proceeds Of Liability Insurance Policy Inadequate To Pay All Claims In Full," 70 A.L.R.2d 416 (2006 supp.)

The basic approach suggested by the decisions in other jurisdictions to resolving multiple claimant problems is one based on simple logic. A number of practical approaches can be used to navigate these sometimes difficult waters:

- Attempt to get the attorneys for the multiple claimants together to resolve an equitable distribution on their own.
- Claimants who are dilatory may have to be cut out of the loop. If the claim is an obvious and very dangerous one, then direct contact should be attempted to get them into the loop.
- Propose a mediation or arbitration to resolve remaining disputes between the claimants or an interpleader in the alternative.
- Consider tendering the funds to the insured to use to resolve the claims or at least involve the insured in the decision-making process.

If none of this works, then the goal should be to get the most for the insured's money under the circumstances presented. Settle the worst claims first. Carriers should remain cognizant of whether any one claimant has demanded the then existing limits. Carriers should make sure that their investigation is sufficient to determine early on which claims are worst and/or to permit an accurate response to early individual *Stowers*/*Soriano* demands.

D. Exhaustion of Limits

Most liability policies contain exhaustion provisions such as the following:

> We may investigate and settle any claim or "suit" as we consider appropriate. Our duty to defend or settle ends when the Liability Coverage Limit of Insurance has been exhausted ***by payment*** of judgments or settlement.

Actual payment, not merely the entering of a settlement agreement, is required in order for exhaustion to have occurred. *See, e.g., In re Consolidated Freightways, Inc.*, 75 S.W.3d

147, 152 (Tex. App.--San Antonio 2002, orig. proceeding) (holding that settlement agreement entered into by carrier that was not funded prior to the insolvency of the carrier did not result in the exhaustion of the limits under the insolvent carrier's policy because no "payment" had been made as required by the policy terms). Settlements that result in exhaustion of policy limits excuse further performance by the insurer on behalf of the other insureds. *American States Ins. Co. v. Arnold,* 930 S.W.2d 196, 201 (Tex. App.—Dallas 1996, writ denied).

If there has in fact been a true exhaustion through payment, then there is no continuing duty to defend on the part of the carrier. *Mid-Century Ins. Co. v. Childs,* 15 S.W.3d 187, 188 (Tex. App.—Texarkana 2000)(including an exhaustion clauses similar to that quoted above). Arguments that exhaustion without resolution of all pending claims creates a conflict of interest that somehow prevents settlement with some but not all claimants have been flatly rejected. *Id.* at 189.

The decision in *Kings Park Apartments, Ltd. v. National Union Fire Ins. Co.,* 101 S.W.3d 525 (Tex. App.—Houston [1st Dist.] 2003, pet. rev. denied), present a marvelously convoluted treatment of a number of exhaustion and *Soriano*-related issues. One thing is clear, this decision stands for the proposition that an insured may certainly attempt to argue and litigate whether the monies paid were in fact for covered claims involving the claims settled against the putative insureds. There, one insured argued that payments were made for bad faith, noting that the settlement agreements allocated only a "peppercorn" as consideration for the release of bad faith claims. *Id.* at 532.

The court in *King's Park* noted that the fact that some of the underlying bodily injury claims were not released and dismissed with prejudice, thus facilitating continuing efforts to recover from the excess carrier. ***Nevertheless, the court found that these facts were not dispositive proof that the underlying agreement did not amount to a payment exhausting the policy limits of the primary policies. Id.*** Thus, despite the lack of a release, the court found that payment by the primary insurers in return for a covenant not to execute against the insureds was still sufficient to evince payment for purposes of exhaustion of the limits. *Id.*

The fact that a carrier obtains a covenant not to execute instead of a release as a basis for concluding that exhaustion has *not occurred* is an issue that was belatedly raised but not considered in *Judwin Properties, Inc. v. United States Fire Ins. Co.*, 973 F.2d 432, 436 (5th Cir. 1992)(Texas law). That court did in fact hold that a carrier commits no harmful act preventing its protection under exhaustion principles when it settles part of the claims

made against multiple insureds, noting the separation of insureds clause in the GL policy there mandated that the carrier use due care to settle on behalf of all of its insureds. *Id.*

The court in *Judwin* rejected attempts to go around the recitation of consideration in the underlying settlement agreements. The court reasoned that under Texas law the court must presume that the consideration recited is legally sufficient consideration. *Id.* at 435 n.3.

The reasoning in *King's Park* and *Judwin* would appear to be somewhat problematic in light of the heavy emphasis in Texas case law on the need for a valid *Stowers* offer to include a promise of a complete release. *Trinity Universal Ins. Co. v. Bleeker,* 966 S.W.2d 489, 491 (Tex. 1998). We do know that the failure of the carrier to obtain a release of a defense of contributory negligence to a simultaneous civil action involving the same parties is not actionable against the carrier and does not defeat *Soriano* protection. *Coats v. Ruiz,* 198 S.W.3d 863, 882-83 (Tex. App.—Dallas 2006, no pet. hist.)(Moseley, J.).

E. Attacks on Reasonableness

The focus of a reasonableness attack under *Soriano* is based solely on the settled claim. *Soriano, supra,* at 316. As noted, the *mere fact that another claim may be more serious is* ***no evidence*** *that the settlement of the lesser claim was unreasonable. Id.* at 316. The test is whether a reasonably prudent insurer ***would not have settled the claim*** "when considering [a] solely the merits of the" settled claim and the [b] "potential liability of its insured on the claim." *Id.* at 316. Thus, the Court clearly suggests that proof that the settled claim could have been settled for less money is insufficient. The decision suggests that the proof must show that a reasonably prudent carrier would not have settled the claim at all. The Court's discussion in footnote 4 is somewhat inconsistent with this language in the opinion.

In footnote 4, the Court held that the insured must offer proof that the negligent failure of the carrier to settle was a proximate cause of damages to the insured. The Court explained that even if it were shown that the carrier should have settled for a lesser amount, the non-settling insured must still show that the claimants would have settled for anything less than the full policy limits. *Id.* at 316. The Court recognized that the insurer in that case had failed to raise a point of error as to whether the insured had failed to prove proximate cause. *Id.* at n.4.

The *Soriano* Court noted that in any event the non-settled claimant would have to show that it ***would in fact have accepted the actual limits*** if the other claim had not been settled. *Id.* at 316 n. 4. In *Soriano,* evidence that the larger claimant was willing to settle within policy limits (but had not then made an offer) was deemed irrelevant in the absence of evidence that the settlement reached with the other claimant, considered alone, was unreasonable. *Id.* at 315-16. The Court emphasized that there was no evidence of a definite demand to settle within the limits of the policy. *Id.*

> The fact that the unsettled claims were more serious than the settled claims "is not evidence that the" settled claim was unreasonable. *Soriano,* 881 S.W.2d at 316.

The court of appeals in *Mid-Century Ins. Co. v. Childs,* 15 S.W.3d 187, 188 (Tex. App.—Texarkana 2000), detailed a number of facts showing reasonableness of the initial settlement/s. The court there noted that the two claimants settled had medical expenses almost equal to the available limits. The parties agreed that either of the claims settled would have exposed the insured to liability in excess of the policy limits by itself. *Id.* at 189. "In light of those facts, it was reasonable for the insurer to settle promptly for the $50,000 limit of the policy." *Id.*

F. Multiple Insureds—Can An Insured Be Left Behind and the Offer Still Activate Stowers?

1. Other Jurisdictions

The general rule in other jurisdictions is that an insurance company "cannot prefer one its insureds over another" with respect to settlement. Windt, *supra,* at 526-27. The source of this rule is the decision of the New York courts in *Smoral v. Hanover Ins. Co.,* 37 A.D.2d 23, 322 N.Y.S.2d 12 (1971). *Id.* at 527. Some states use the duty of good faith to test the carrier's actions in the context of multiple insureds and insufficient limits. *Id.* at n.3. The Fifth Circuit, interpreting Texas law, has rejected the approach in other jurisdictions, disagreeing as to the prevalence of the rule that a carrier cannot prefer one insured over another. Stated another way, the Fifth Circuit clearly believes that an offer to settle as to some but not all insureds is still sufficient under *Stowers.* In other words, a carrier can leave an insured behind.

2. *Travelers v. Citgo*

The Fifth Circuit applied *Soriano* to a situation where the carrier settled on behalf of one insured, leaving claims against another insured under the policy. *Travelers Ins. Co. v. Citgo Petroleum Corp.,* 166 F.3d 761 (5th Cir. 1999). The court held the applicable test is whether the carrier would have settled the particular claim against the particular insured when considering solely the merits of the claim and the potential liability of its insured. *Id.* at 765 (citing *American States Ins. Co. of Texas v. Arnold,* 930 S.W.2d 196 (Tex. App.–Dallas 1996, writ denied)(suit by excess carrier against primary who left the excess with defense and indemnity of additional insured after settling on behalf of another insured and exhausting limits) and *Vitek, Inc. v. Floyd,* 51 F.3d 530 (5th Cir. 1995)(involving additional insured barred by bankruptcy court permitting carrier to exhaust limits as to debtor/insured)). The court explained the carrier's dilemma as follows:

> The *Stowers* duty creates difficulties, however, when multiple parties and other potential claims in excess of policy limits are involved. In such cases, fulfillment of the *Stowers* duty will reduce the funds available to satisfy the claims of other plaintiffs or the defense of other insured parties. However, if insurers are subject to both liability for failure to settle under *Stowers* and liability for disparate treatment of non-settling insureds, insurers would find the policy limits they carefully bargained for of little utility. Under *Stowers,* they would be obliged to settle up to the limit of a policy or face a lawsuit by the covered insured as to whom the settlement within policy limits was offered. But if they in fact settled, they would leave themselves open to claims by the insureds excluded from the settlement, and any additional recovery would be in excess of the limits they had originally relied on.

Id. at 765.

The court in *Citgo* expressly rejected arguments that *Soriano* was distinguishable because it involve rights of or obligations owed by the carrier to competing claimants. The court reasoned:

> Citgo attempts to distinguish *Soriano* by pointing out that an insurer owes a higher duty to its insured than it does to claimants. Thus, Citgo argues, while the lesser "duty" (if any) to claimants may allow

> an insurer to choose which claimant to settle with, a similar discrimination is not permitted when the interests of multiple insureds are at stake. While this may be correct as far as it goes, and *Soriano* is not directly applicable, we find the case persuasive in this instance because the party complaining in *Soriano* was not the second claimant-it was the insured. The insured argued that its insurer had settled the "wrong" claim, exposing him to personal liability in the more dangerous suit. *Id.* at 314. *Soriano,* like the case before us, involved the insurer's duty to its insured.

Id.

The Fifth Circuit in *Citgo* also rejected arguments that it should focus on whether the settlement was reasonable "in light of all potential claims against all the insured parties." *Id.* The court supported its holding as follows:

> [T]he *Soriano* court made it clear that reasonableness would only be measured by looking at the initial demand for settlement in isolation. *Id.* at 316 (The test is whether "a reasonably prudent insurer would not have settled the Lopez claim when considering solely the merits of the Lopez claim and the potential liability of its insured on the claim."). In *Soriano,* evidence that the larger claimant was willing to settle within policy limits (but had not then made an offer) was deemed irrelevant in the absence of evidence that the settlement reached with the other claimant, considered alone, was unreasonable. *Id.* at 315-16.

Id.

The court noted that Texas case law in addition to *Soriano* supported its position:

> In *American States Insurance Co. of Texas v. Arnold,* a Texas court confronted a situation in which an insurer, having settled up to its policy limits and obtained a release on behalf of its named insured, refused to defend an additional insured in a separate action arising out of the same accident. 930 S.W.2d 196 (Tex.*)*(Hankinson, J.). The excess insurer of the additional insured conducted the defense and sued the primary insurer to recover its costs. The court reversed summary judgment in favor of the excess insurer and rendered

> judgment for the original insurer, finding it breached no duty in obtaining the settlement, and its duties to the additional insured terminated when the settlement exhausted the policy limits. "We conclude that, under the unambiguous policy language and circumstances of this particular case, American States' settlement of Cassady's personal injury claim against Mayes's estate for its bodily injury policy limits terminated any obligation to defend Arnold, as an additional insured, in the Cassady lawsuit." *Id.* at 202-03.

Id. The court noted that "[w]hile several out-of-state courts have found that there is a general duty not to favor one insured over another, the weight of contemporary authority is in line with *Arnold*." *Id.* at 766.

The court also rejected arguments that the purpose of *Soriano,* encouraging settlements, was not served in the multiple insured setting. The court stated:

> Citgo argues that when multiple insured parties rather than multiple claimants are involved, the *Soriano* approach will discourage settlement. This, Citgo asserts, is because the partial settlements obtained under an *Arnold* rule do not prevent continued litigation against the exposed co-insured, with the plaintiff now bankrolled by the proceeds of the settlement. Thus, according to Citgo, the encouragement of partial settlement by *Arnold* 's rule discourages true, global settlement that would keep a case out of court entirely.
>
> It is true that an *Arnold* rule may encourage a certain level of strategic behavior on the part of plaintiffs. It would encourage plaintiffs to first sue defendants with inadequate resources, or defendants that had not only a large potential exposure but also a low probability of being found ultimately liable.
>
> However, the *Soriano* court was also keenly sensitive to the plight of an insurer presented with a valid claim for settlement under *Stowers.* "Had Farmers opted not to settle . . . but, in the face of that demand, to renew its offer [to the party with the larger claim] instead, Farmers would surely face ***questions about*** liability under *Stowers* for failing to settle [with the other, lesser claimant]." *Soriano,* 881 S.W.2d at 315. Citgo's position in essence means that ***fulfilling*** the *Stowers* duty by

> exhausting policy limits (or reducing them to a level inadequate for further settlement) triggers potential liability to any other insured that is not included in the settlement. Thus under Citgo's proposal, an insurer faced with liabilities of multiple insured parties that exceed its policy limits ***would face an excess liability threat regardless of whether it attempted to create a comprehensive settlement or acted as Travelers did here***. Allowing the insurer to focus on only the claim actually before it, and rely on the bright-line test of *Soriano*, avoids this dilemma.

Id. at 766-67 (emphasis added). The court further explained:

> Moreover, while we recognize that the Travelers' position may lead to some strategic behavior on the part of plaintiffs, we are skeptical that the rule proposed by Citgo would better serve the policy goal of encouraging settlements in these cases. In essence, Citgo is asking that ***settlement holdout power be given to each insured party, regardless of whether or not it has actually been sued.*** The difficulty with this position is readily apparent when one considers the type of situations in which *Stowers* intersects with multiple insured policies to produce the dilemma seen here. A valid *Stowers* demand in the context of multiple insureds requires that the settlement offer be reasonable and the insured party reasonably fear liability over the policy limit. In other words, for the issue to come up at all there usually has to be an objective possibility that the liability of at least *one* of the insureds would ultimately exceed the policy limits.

Id. at 767. The court then added:

> If Citgo's rule were adopted, the only rational course for insurers would be to formally or informally make all their insureds parties to any settlement negotiations. No insurer would settle at its policy limits with potential excess liability to a disgruntled co-insured lurking in the background. And because the proposed "no insurer may favor one insured over another insured" rule would seem to come into play whenever any party received a larger percentage of the policy coverage than another, in practice any settlement would

> have to be backed by an agreement amongst *all* the insureds regarding liability or a judicial allocation.

Id. at n.5.

The *Citgo* court recognized that in the case before it a policy limits demand had been made as to the insured the carrier settled on behalf of and not the other insured. ***The court noted that it was not addressing the duties of a carrier faced with simultaneous Stowers demands.*** *Id.* at 767.

The court in *Citgo* also rejected arguments that there was an "independent contractual duty to act reasonably in performing the contract." *Id.* at 768. The court's response to this argument is circuitous and simply wrong. The court errs in (a) mixing and matching tort law responsibilities with contract, when they are in fact separate and distinct; and (b) confusing the duty to defend with the duty to indemnify, suggesting that ***a carrier has no duty to settle or indemnify until the insured has been sued and served in the underlying litigation***. Note that the policy there provided: ***"'We may investigate or settle any claim or suit as we consider appropriate. Our duty to defend or settle ends when the Liability coverage limit of insurance has been exhausted by payments of judgments or settlements.'"*** *Id.* n.8 (emphasis added). The court explained its rejection of Citgo's arguments as follows:

> Under *Soriano* and the explicit language of the policy, Travelers had a right to settle when it was presented with a demand within its policy limits. Indeed, Travelers apparently had a *Stowers* duty to Wright to settle as it did; Citgo does not contend to the contrary. Further, under Texas law, an insurer's duty to defend an insured is only triggered by the actual service of process upon its insured and its relay to the insurer. *See, e.g., Members Ins. C* 803 S.W.2d 462, 466-67 (Tex. App.-Dallas 1991, no writ). At the time of the settlement, this duty on Travelers' part had arisen as to Wright, a defendant in the lawsuit, but not as to Citgo, which had not then been sued. ***However, Citgo contends that the duty to defend and the duty to indemnify are separate, and the facts surrounding the case could trigger the latter, even though the duty to defend Citgo was not yet implicated.*** This is incorrect. While a party may have a duty to defend but ultimately determine there is no duty to indemnify, without a predicate triggering of the duty to defend, indemnification does not arise. *See*

> *Farmers Texas County Mutual Insurance Co. v. G* 955 S.W.2d 81, 82-84 (Tex.1997). Once this settlement had exhausted the policy limits, the provisions of the policy terminated Travelers' duties under the contract, including its duties to Citgo as a co-insured. Since Travelers was ***entitled-indeed apparently required-to settle the initial claim*** against its insured, and since Citgo has not alleged that the settlement, standing alone, was unreasonable, we find that the decision to settle on behalf of Wright constituted reasonable performance of the contract as a matter of law.

Id. at 768-69 (emphasis added). The court in *Citgo* also briefly addressed conflict of interest issues raised regarding claims against multiple insureds.

3. Inconsistency With *Citgo*—Timing of Settlement in Order to Get An Exhaustion Defense

In *Western Alliance Ins. Co. v. Northern Ins. Co.*, 176 F.3d 825 (5th Cir. 1999), the court held that exhaustion through settlement for two of multiple insureds did not provide a defense where the carrier had rejected an earlier settlement within limits that would have obtained releases for *all insureds.* The court held that there was a fact issue as to whether the rejection of that settlement was reasonable. The carrier argued in part that it refused to settle because it had good faith, although ultimately unsuccessful, coverage defenses.

4. *Davalos*—Disqualifying Conflicts of Interest Relating to Multiple Insureds?

Query whether the dilemma presented by multiple claims and insureds in *Citgo* raised a conflict of interests that disqualifies the carrier from controlling the defense and/or settlement of the underlying claims. The court in *Citgo* dismissed any such claims. The court held that since the insured was not actually served in the suit until after the exhaustion of the policy limits by payments on behalf of another insured, no harm could have been suffered by the non-settling insured. *Id.* at 769.

Since *Citgo,* the Texas Supreme Court has revisited the issue of conflicts of interest generally. In *Northern County Mut. Ins. Co. v. Davalos,* 140 S.W.3d 685, 688 (Tex. 2004), the court examined the circumstances under which an insured may reject a tender of defense by the carrier. In that case, the carrier accepted coverage. The dispute between the parties centered over whether venue should be changed and who got to make that decision.

The Supreme Court began by noting that there are defined circumstances when a carrier "may not insist upon its contractual right to control the defense." *Id.* The court noted that in *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998), it had held that where the carrier has the authority to make "defense decisions as if it were the client 'where no conflict of interest exists.'" 140 S.W.3d at 688. Not every conflict or disagreement about the defense is a conflict of interest that would invoke the right of the carrier to control the defense. To so hold would basically eliminate the carrier's right to control as set forth in the policy terms.

The court clearly held that a conflict regarding the existence or scope of coverage would amount to a disqualifying conflict. *Id.* The court added that the reservation of rights "creates a potential conflict of interest." *Id.* Importantly, the court observed that it is ***only*** when "the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends," that the conflict "will prevent the insurer from conducting the defense." *Id.* (citing 1 Allen D. Windt, Insurance Claims and Disputes, sec. 4.20 at 369 (4th ed. 2001)). Relying again upon Windt, the court observed that there are four circumstances when "the insured may rightfully refuse to accept the insurer's defense":

> (1) when the defense tendered "is not a complete defense under circumstances in which it should have been," (2) when "the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interests at the expense of the insured's," (3) when "the defense would not, under the governing law, satisfy the insurer's duty to defend," and (4) when, though the defense is otherwise proper, "the insurer attempts to obtain some type of concession from the insured before it will defend."

Id. It is hard figure out exactly what all of this means. It is clearly based on an out-of-state commentator's musings about decisions in other jurisdictions. Moreover, it is quintessential dicta to a large extent. It will, however, undoubtedly lead some to urge that a mere reservation of policy defenses does not create a "conflict" sufficient to allow the insured to select its own counsel at the expense of the carrier. One would expect that if such a change had really been considered and intended, it would have required some discussion of *Steel Erectors* and the numerous other such cases. It would also require some reconciliation of the court's holding in *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 944 (Tex. 1988), that a reservation creates a conflict sufficient to destroy privity and thus leads to the carrier not being collaterally estopped based on the judgment in the underlying

suit. How can the conflict be such as to negate privity but not be sufficient to allow the appointment of independent counsel?

5. Other Post-*Citgo* Decisions

In *Mid-Century Ins. Co. v. Childs*, 15 S.W.3d 187 (Tex. App.–Texarkana 2000, no pet. h.), the court held that the carrier acted properly by settling two claims out of multiple claims for the policy limits. Following *Soriano*, the court concluded that as long as the settlement was reasonable, the carrier violated no duty to the insured by resolving claims that would have otherwise resulted in a judgment in excess of policy limits. The court also rejected the holding of the trial court that the failure to get releases from all potential claimants created a conflict of interests and that the carrier had a duty to more fully investigate the remaining claims.

The court, in *In Re Enron Corp.*, 2006 WL 1663383, at *8 (S.D. Tex. 2006), held that under Texas law "an insurer may enter into a reasonable partial settlement that exhausts policy limits and thus leaves other insureds exposed." In short, "an insurer does not have to provide funds for all its insureds before exhausting policy limits." *Id.*

6. Pride—Indemnity or Derivative Claims

The Fifth Circuit in *Pride Transportation v. Continental Casualty Co.*, 511 Fed.Appx. 347 (5th Cir. 2013)(Smith, J.)(Texas Law), the carriers settled for an employee/insured, exhausted the limits and left the corporate/insured exposed to liability. The corporate employer insured still had a claim for common law indemnity against the employee insured. The court held that the failure of the claimants to offer protection regarding this additional claim was analogous to a situation with multiple claimants and limited insurance. The carrier, they opined, had the right to enter a reasonable settlement and thus prefer one insured to another. The only issue was whether that settlement was in and of itself reasonable.

7. *Patterson v. Home State County Mutual Ins. Co.*—Another New Twist

In *Patterson v. Home State County Mut. Ins. Co.,* 2014 WL 1676931 (Tex. App.-Hous. (1 Dist.) 2014, pet denied), the court held:

(1) An insurer does not have a *Stowers* duty to settle where multiple claims are alleged against an insured but a policy limits demand is made by only one of the claimants.

(2) An insurer does not have a *Stowers* duty to settle if the claimant's demand does not release *all* insureds covered by the policy.

In that case, the claimants consisted of (a) the husband of the, victim and (b) the children of the victim. Home States issued a policy to the (a) owner of the truck involved; (b) this policy also covered permissive users of the truck, including the driver in this claim. Claims were also made against the third-party employer of the driver.

The plaintiffs sent simultaneous demands to the Home States: (a) one on behalf of the children of the deceased, and (b) one on behalf of the father, individually and as administrator of the estate of the deceased victim. The carrier rejected the settlement demands. In subsequent litigation, it was revealed that there were several other parties claiming damages from accident. Home State then filed an interpleader, seeking protection from all the claims as a part of the court's determination of the proper allocation among the various claimants. *Id.* at *2.

A third offer was made by the original Patterson claimants. This demand sought policy limits and promised only to release the owner of the vehicle. *Id.* Shortly thereafter, the trial court in the interpleader allowed Home State to deposit the limits into the registry of the court, ordered the claimants to resolve their respective rights vis-à-vis one another, and released Home States to the extent of the funds deposited, noting that no release was being provided as to any *Stowers* claims.[16] The insureds were apparently ***not released.***

The Patterson claims proceeded to trial, but the claimants did eventually reach a settlement with the owner of the vehicle in the accident "individually" and the employer of the driver. As to the owner, the Patterson claimants exchanged a covenant not to

[16] The order stated: "This Order has no effect on, and is not intended to dispose of or absolve HOME STATE of any potential liability under the ***Stowers*** doctrine. The discharge of HOME STATE discharges their liability as to the $1,000,004 tendered to the registry but does not discharge, adjudicate, or affect any potential liability relating to any allegations of negligent failure to settle within the policy limits before the funds were deposited with the clerk." *Id.* at *2.

execute as to any judgment against the owner in its other capacities in exchange for an assignment if rights against Home States. *Id.* The settlement agreement further provided:

> . . . .
>
> 4. If there is a judgment rendered in [Patterson's] favor in the Lawsuit against Brewer, [Patterson] and [his] attorneys hereby agree, and covenant, they will seek execution of such judgment solely against any and all insurance companies which issues policies to Brewer that may or may not provide coverage to Brewer for [their] claims.
>
> 5. It is expressly understood and agreed that [Patterson] will look solely to the insurance companies covering Brewer and shall never be entitled to enforce or execute on any judgment in favor of [Patterson] against Brewer or those entities identified herein.
>
> 6. Nothing in this Agreement precludes [Patterson] from any of the following, all of which [he] intend[s] to do:
>
> . . . .
>
> D. Collect any judgment against [the owner] from Home State pursuant to an assignment and in enforcement of the almost 100 year old *Stowers* doctrine implemented by the Texas Supreme Court to protect injured people and companies from negligent insurance companies who fail to reasonably accept settlement offers within the policy limits.

The driver obtained a high/low agreement as part of the settlement with a maximum recovery of $200 and a minimum recovery of $100. *Id.*

Court approval of the settlement was obtained. The trial court then allowed counsel for the owner to withdraw. The jury was dismissed and a bench trial then held without an appearance from the owner. The court found the driver negligent and that he was the statutory employee of the vehicle owner. *Id.* The court found damages of approximately $5.8 million. *Id.*

Home States asserted an interesting package of defenses in the *Stowers* suit then filed by the assignee, Patterson claimants:

1. The insured owner had communicated that it would not accept the demands;

    a. Testimony of defense counsel that in-house counsel would not settle without releases for the driver and the owner;

2. Carrier had no duty to settle where an insured was going to be left behind without a release;

3. One of the demands was conditional;

4. Interpleader was filed before the last demand was made;

5. Failed to get a judgment after a fully adversarial trial;

6. Defended until entry of interpleader.

An incredible wrinkle in the case was that while it was pending, the claimants succeeded in overturning the underlying judgment based on fraudulent inducement by the owner, who allegedly hid the fact the driver was found to have massive amounts of cocaine in his system. The court also overturned the settlement agreement, covenant and assignment. The court of appeals held that the reversal of the judgment upon which standing and the damage claims in the *Stowers* action were predicated did not result in the appeal of the grant of summary judgment to Home States being moot.

8. *OneBeacon v. Welch*—An Insured May Be Left Behind and *Stowers* Is Still Activated

In *OneBeacon*, the *Stowers* demand offered a release to the insured law firm sued for vicarious liability for malpractice of one of its lawyers, but the offer did not offer a release to the lawyer/wrongdoer himself. The Fifth Circuit reasoned:

> OneBeacon argues that to be a "true" *Stowers* demand, the offer to settle must offer to release all insureds (here the Welch Firm and Wooten). The Texas Supreme Court has not spoken directly on this issue. However, we have. In *Travelers Indemnity Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 764 (5th Cir. 1999), we held that, when faced with a settlement demand over a policy with multiple insureds, an insurer

> fulfilling its *Stowers* duty "is free to settle suits against one of its insureds without being hindered by potential liability to co-insured parties who have not yet been sued."8 In coming to this conclusion, we were persuaded by the Texas Supreme Court's decision in Soriano. *Citgo,* 166 F.3d at 765 (citing *Soriano,* 881 S.W.2d at 314–16).9

Id. at 678. The Fifth Circuit refused to follow *Patterson, supra,* noting:

> Instead of following *Citgo*, OneBeacon urges us to follow a recent Texas appellate decision in which the court found no valid *Stowers* demand where only the insured employer and not the employee (an additional insured) would have been released. *Patterson v. Home State Cty. Mut. Ins. Co.*, No. 01–12–00365–CV, 2014 WL 1676931, at *10 (Tex. App.—Houston [1st Dist.] Apr. 24, 2014, pet. denied) (mem. op.).[10] However, in that case, the insured employer had explicitly indicated to its attorney that it "did not want 'any settlement demands to be accepted that didn't involve a release of all of the claims against both [the employer and the employee.]' " *Id.* We conclude that the district court did not err in holding that DISH's July 14, 2011, letter demanding policy limits in exchange for a full release of its claims against the Welch Firm was a valid *Stowers* demand which OneBeacon rejected.

Id. at 678-79 (footnotes omitted). Given the distinction of *Patterson,* policyholders wanting to avoid being left behind need to inform defense counsel hired by the carrier and the carrier do not want partial settlements of some insureds and not others. Of course, the policy does not require the insured's consent to settlement, but common law *Stowers* protections might require the carrier to follow the insured's clearly expressed wishes. Of course, we know from *Pride* what happens when one insured asks for any settlement, partial or otherwise, and the insured company asks for a comprehensive settlement, not a partial one.

G. First-Party Parallels

Even in the context of first-party claims under underinsured/uninsured motorists coverage ("UIM"), where there is a duty of good faith, the courts have refused to alter the rules of *Soriano* to impose extra-contractual or additional liability beyond the stated policy limits.

In *Lane v. State Farm Mut. Auto. Ins. Co.*, 992 S.W.2d 545 (Tex. App.–Texarkana 1999, pet. denied), the insured was killed in an automobile accident while riding as a passenger in a friend's vehicle. *Id.* at 548. At the time of the accident, the insured lived with his grandparents, and was covered as an additional insured under their automobile insurance policy. The grandparents notified State Farm of the death of their grandson, and presented a claim for funeral expenses they incurred as a result of the accident. *Id.* State Farm tendered the $5,000. limits of the personal injury protection provision of the policy.

State Farm also informed the grandparents that the remaining $20,000. uninsured/underinsured motorists ("UIM") coverage would be available to the insured's parents. State Farm offered to split the proceeds by giving $10,000. to each of the parents, in accordance with the intestacy provisions of the Texas Probate Code. *Id.*

Lane, the insured's mother, rejected the settlement offer and filed suit against State Farm and the driver of the vehicle in which her son was a passenger. *Id.* The claims against State Farm included breach of contract, breach of the duty of good faith and fair dealing, and violations of the insurance code. *Id.* at 548-49. The trial court granted State Farm's motion for summary judgment, from which Lane appealed. *Id.* at 549.

Because this was a first-party claim, the court noted that its first task was to determine who the covered persons were under the policy. Based on the policy's language, the policy covered both the insured and his parents. *Id.* at 551. The court determined that State Farm properly paid the insured's estate, even though the ultimate recipients were the insured's parents via intestacy.

Lane argued that State Farm breached its contract by paying one claimant over others, and the court noted that this was an issue of first impression in Texas. However, the court observed that other jurisdictions had rejected such a theory, "even when the settlement depletes or exhausts the policy proceeds." *Id.* at 552 (citations omitted). The court went on to note that:

> This analysis fits squarely within the logic outlined by the Texas Supreme Court in [*Soriano*] . . . . [W]e hold that State Farm's settlement of the UIM policy proceeds was reasonable and not a breach of contract.

Id.

As to the bad faith claim, the court noted that State Farm did not try to evaluate which claimant was more deserving of the policy proceeds. Nevertheless, the court stated:

> [State Farm] settled with an insured, Michael's estate, according to its interpretation of the Probate Code. The settlement offer exhausted the UIM proceeds, thereby effectively denying any other claim.

Id. at 553. Concluding, the court held:

> However . . . insurers will not be liable in bad faith claims for settling reasonable claims with one of several claimants under a liability policy, thereby reducing or exhausting the proceeds available to the remaining claimants. The summary judgment evidence established that State Farm reasonably settled the survival cause of action under the UIM proceeds and thus cannot, as a matter of law, be liable under the tort of breach of the covenant of good faith and fair dealing.

Id. (citing *Soriano*, 881 S.W.2d at 315).

Similarly, in *Carter v. State Farm Mut. Automobile Ins. Co.,* 33 S.W.3d 369, 372 (Tex. App.—Fort Worth 2000, no pet. hist.), the court held that "an insurance company does not breach its contract by settling with covered persons, even when the settlement depletes or exhausts the policy proceeds." A mere request to multiple UIM claimants that they "come together for a settlement conference to determine a fair division of the policy proceeds" is not a violation of the duty of good faith. The court noted that the plaintiff's attorney in that case had insisted that it would be "premature" to settle the claim, rather than unreasonably late, because his client was still being treated for injuries. *Id.* The same attorney refused to settle for less than the full limits at a subsequent settlement conference. *Id.* The court concluded:

> State Farm did not act unreasonably in settling with the two remaining claimants who were still willing to negotiate the settlement of their claims. An insurer will not be liable in had faith claims [sic] for settling reasonable claims with one of several claimants even if such settlement exhausts or diminishes the proceeds, when faced with multiple demands arising out of multiple claims and inadequate proceeds.

Id. (citing *Soriano, supra*).

H. Special *Stowers* Problems Presented by Bulk and/or Conditional Offers

For example, in *Rosell v. Farmers Texas County Mut. Ins. Co.*, 642 S.W.2d 278, 279 (Tex. App.–Texarkana 1982, no writ), the insurer refused to settle for the per occurrence policy limit on the bulk offer made on behalf of a mother and daughter. The court stated that the policy limits controlled the maximum settlement "an insurance company is required to offer each claimant." The court noted that its approach discouraged the "use of insurance policy per occurrence limits as (trust funds to divide between various plaintiffs as they see fit or requiring insurance companies to accept (package deal settlements from multiple plaintiffs." *Accord Pullin v. Southern Farm Bureau Cas. Ins. Co.*, 874 F.2d 1055, 1056 (5th Cir. 1989) (Texas law). Further, the court believed that the offers in this case were conditioned upon acceptance of settlement "in bulk," as opposed to a separate demand for individual per person limits. Texas courts have repeatedly held that conditional settlement offers are insufficient to impose *Stowers* liability. *Jones v. Highway Ins. Underwriters*, 253 S.W.2d 1018, 1022 (Tex. Civ. App.–Galveston 1952, writ ref'd n.r.e.).

In *Pullin v. Southern Farm Bureau Cas. Ins. Co.*, 874 F.2d 1055 (5th Cir. 1989). Southern Farm issued an automobile liability policy to Pullin. The policy contained limits of $100,000 per person and $300,000 per occurrence. On July 20, 1980, Pullin was involved in an automobile accident that injured seven persons. Two of the personal injury claims were settled for $34,000. The remaining five claims belonged to members of the Schlueter family. The most severe claim belonged to Lennard Schlueter, whom the accident rendered a quadriplegic with brain damage. The Schlueters' first offer of settlement called for payment of the remaining $266,000 under the policy limits. This settlement offer was broken down into $100,000 for Lennard, plus amounts ranging from $6,500 to $90,000 for the other family members. Southern Farm counter offered the $100,000 policy limits for Lennard's claim and reduced amounts for the other family members. Eventually, the other family members' claims were settled for an aggregate of $125,000. Lennard's claim went to trial, resulting in a judgment of $950,000. Following the judgment, Southern Farm Bureau paid its $100,000 policy limit.

The Pullins filed suit against Southern Farm following the judgment. The Pullins contended that the insurance company should have settled for the inflated values of the claims of the four other Schlueter family members in order to make more money available to cover Lennard's claim and in order to avoid any excess judgment. The Pullins argued that the existence of per person bodily limits should not be a defense to an insurance

company's offer to settle for less than the per occurrence limit of liability if the tender of the per occurrence limits would relieve any particular insured from exposure to a judgment in excess of the policy limits.

The Fifth Circuit Court of Appeals affirmed the trial court's summary judgment, holding that the *Stowers* doctrine does not require an insurance company to artificially inflate some claims so that the per person limit can in effect be exceeded on a more serious bodily injury claim. *Id*. at 1056. The court specifically noted that the cases cited by the Pullins in no way supported the proposition that an insurer has a duty to effect a settlement beyond its policy limits. *Id*. at 1057. (citing *Employer's Nat'l Ins. Co. v. Zurich Am. Ins. Co.*, 792 F.2d 517, 519 (5th Cir. 1986); *Texoma AG-Prods. v. Hartford Accident & Indem. Co.*, 755 F.2d 445 (5th Cir. 1985); *Ranger County Mut. Ins. Co. v. Guin*, 723 S.W.2d 656 (Tex. 1987). The court recognized in *Pullin*, 874 F.2d at 1056 that the Pullins' argument had been specifically rejected by the Texas courts in *Rosell v. Farmers Texas Mut. Ins. Co.*, 642 S.W.2d (Tex. App.–Texarkana 1982, no writ). The court concluded that the duty sought by appellants was nothing more than an attempt "at generosity with the insurance company's money," which would require ignoring the specific terms of the liability policy. *Pullin*, 874 F.2d at 1057.

I. No Duty to Settle Under *Stowers* as to Uncovered Claims

In *St. Paul Fire & Marine Ins. Co. v. Convalescent Servs., Inc.*, 193 F.3d 340 (5th Cir. 1999), the court held that a carrier has no duty under Texas law to settle as to uncovered aspects of the claim against the insured. In that case, the policy excluded punitive damages. Even though the carrier did not reserve its rights on this issue, the insured admitted it knew that such damages were not covered based on other similar claims handled under the policy. In fact, the insured had contributed to prior settlements for the punitive exposure on those claims.

The court rejected arguments that there is some form of general duty to handle liability claims with reasonable care. The court held that the only negligence duty in this setting was *Stowers. Id*. at 343. The court noted that in *American Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842 (Tex. 1994), the court held that evidence concerning improper claims handling, investigation conduct during settlement negotiations, and other such conduct were only actionable in the context of a *Stowers* claim meeting all the elements, including the fact the claim had to be covered. *Id. Garcia* clearly stated that statements suggesting the contrary in *Ranger County Mut. Ins. Co. v. Guin,* 723 S.W.2d 656, 659 (Tex. 1987), were dicta.

The court rejected arguments that *St. Paul Surplus Lines Ins. Co. v. Dalworth Tank Co.,* 917 S.W.2d 29 (Tex. App.–Amarillo 1995), *aff'd on other grounds,* 974 S.W.2d 51 (Tex. 1998), supported a finding of a general duty not to handle claims negligently. The court reasoned that the decision in that case predated the decision of the Supreme Court in *State Farm Mut. Auto. Ins. Co. v. Traver,* 980 S.W.2d 625, 628 (Tex. 1997), reaffirming the *Garcia* holding that all other claims handling conduct should be considered in the context of and as proof in a *Stowers* claim. *Id.* at 343 n. 8. *Accord Ford v. Cimarron Ins. Co.,* 1999 WL 184126 (N.D. Tex. 1999)(Solis, J.). It should be noted that *Dalworth* was a case involving an offer within limits, but the carrier was held responsible for the default judgment because it allegedly received notice of the suit and failed to answer.

The court drew analogies to *Texas Farmers Ins. Co. v. Soriano,* 881 S.W.2d 312 (Tex. 1994). The court reasoned:

> Thus, because the Texas Supreme Court does not impose a duty upon insurers to consider other covered claims when faced with a settlement demand by one claimant, we believe that the court would not impose a duty upon insurers to consider claims that are not covered . . . by its policy during settlement negotiations with one claimant.

Id. at 345.

The court determined that because it ruled as it did, it was unnecessary to address arguments presented by St. Paul that tort law should not be used to obtain coverage for punitive damages through some sort of extra-contractual claim because coverage for punitive damages is contrary to public policy. *Id.* at 343 n. 5.

J. Interpleader

Interpleaders can become a quagmire unless all concerned, the claimants and the insured, agree. Care should be taken not to admit the liability of the insured. Remember, if the interpleader is unsuccessful, the claimants may bring the insured in directly and seek a judgment on which they can then use to get at the insured's personal assets. There are serious concerns as to whether an interpleader is even legally permissible in a liability context.

A settlement offer made by one claimant to exonerate the carrier if it deposited the entire policy into the registry of the court was approved in *Trinity Universal Ins. Co. v.*

Bleeker, 944 S.W.2d 672 (Tex. App.–Corpus Christi 1997), *rev'd on other grounds*, 966 S.W.2d 489 (Tex. 1998). The carrier may not avoid liability by insisting that it would not settle until all claimants gave releases. *Id. But see Charles v. Tamez*, 878 S.W.2d 201, 208-209 (Tex. App.–Corpus Christi 1994, writ denied)(holding turnover of *Stowers* claim properly denied where insured said that he would not have accepted offer to settle without releases from all claimants and hospitals holding liens).

In *Trinity Universal Ins. Co. v. Bleeker*, *supra*, the court of appeals held that a carrier was liable where one of multiple claimants demanded that it settle by tendering the limits of liability into the registry of the court by way of interpleader. The court noted that while such action would not have prevented a direct action against the insured, it would have made sure that none of the limits were taken without submission to the interpleader proceeding. The court noted that the carrier left the "claimants no alternative but to sue [the insured] directly." The court even upheld DTPA claims of unconscionability against the carrier based on the failure to tender the limits into the registry of the court. The court strangely makes no mention of the fact that settlement practices were not actionable under the DTPA or the Insurance Code at the time of this decision, particularly after *Garcia* and *Watson*.

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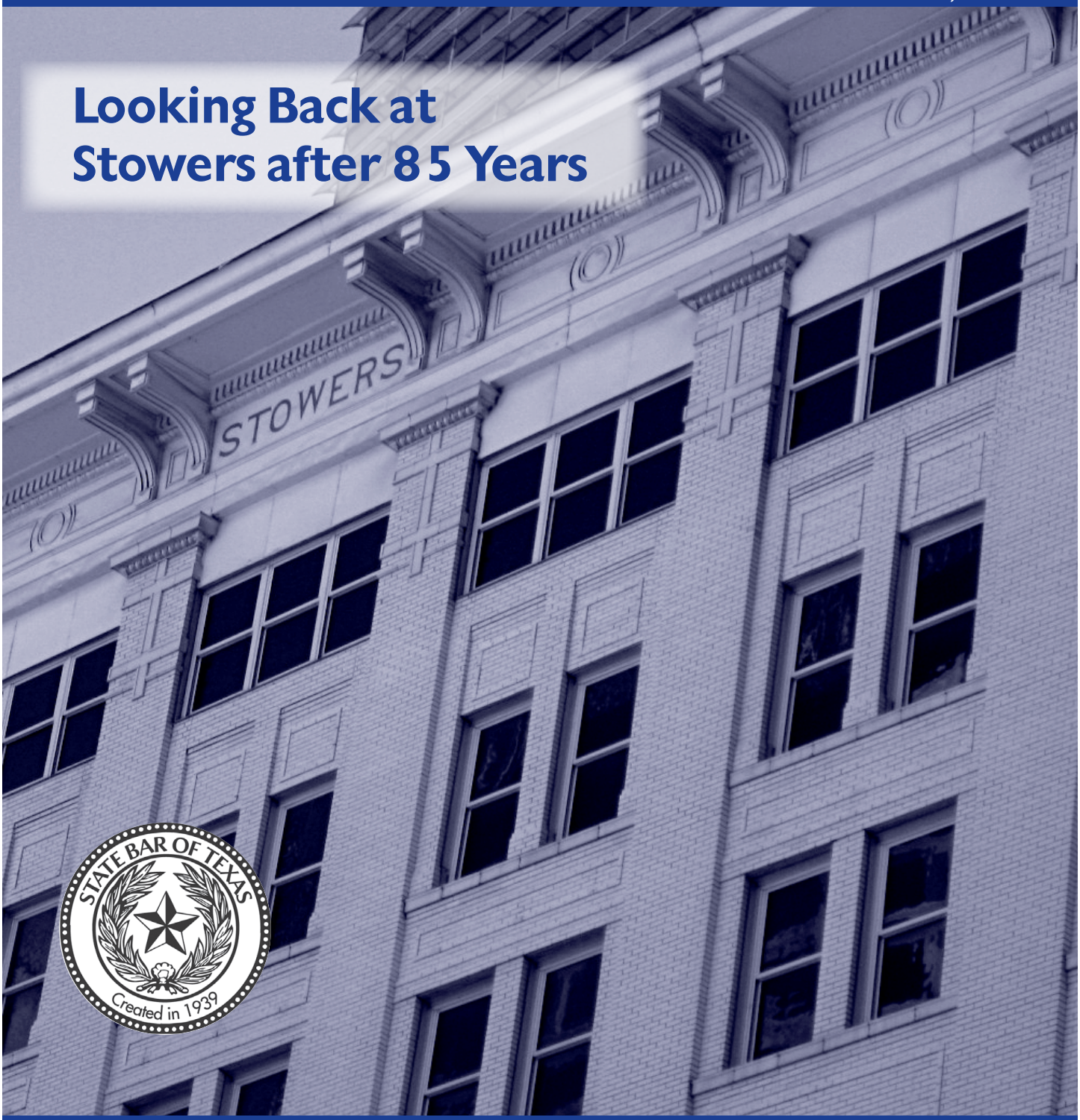
Looking Back at Stowers after 85 Years



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Journal of Texas Insurance Law

The Journal of Texas Insurance Law is published by the Insurance Law Section of the State Bar of Texas. The purpose of the ***Journal*** is to provide Section members with current legal articles and analysis regarding recent developments in all aspects of Texas insurance law, as well as convey news of Section activities and other events pertaining to this area of law.

Anyone interested in submitting a manuscript for publication should contact Bill Chriss, Editor In Chief, at 512-420-2378 or by email at wjchriss@gplawfirm.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

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FROM THE EDITOR

By William J. Chriss
Gravely & Pearson, LLP

This being my first issue as editor of the Journal, I have suffered more than a little trepidation at following in the footsteps of my predecessors, Kim Steele, and before her, Chris Martin. Fortunately, I have help from many sources, including two of the Insurance Law Section's best writers, immediate past Chair Vince Morgan and Insurance Legends Award recipient Michael Sean Quinn. Morgan reminded me that this Spring marks the 85th anniversary of the groundbreaking Stowers decision, and he offered the Journal a treasure trove of material on that subject, much of which has never been published before.

So, this issue is dedicated in its entirety to the 85th anniversary of Stowers, a precedent as influential as any in Texas jurisprudence. In this issue you will find an updated version of an article Morgan and Quinn wrote for the Journal ten years ago, on Stowers' 75th anniversary, and there is much more. Included are the following previously unpublished materials uncovered in researching that article: the "lost" dissent in the case that never made it into the West publishing system; an amicus letter predicting dire consequences from the decision ultimately reached; and the jury charge from the trial of Stowers' suit against its liability insurer, American Indemnity Company, for failing to settle the underlying personal injury claim of Mamie Bichon, a passenger in a taxi that struck a stranded G.A. Stowers Furniture Company truck. We also have included pdfs of the original typewritten opinion of the Commission of Appeals and the approval of that opinion by the Supreme Court. All these materials are reproduced from the Texas State Archives.

The Stowers doctrine handed down by the Commission of Appeals and approved by the Texas Supreme Court in 1929 continues to drive the handling of insured liability claims, and it continues to vex courts, litigants, attorneys, and commentators. Allstate v. Kelly further defined it. Ranger County Mut. Ins. Co. v. Guin extended its doctrine to require affirmative negotiations by carriers. APIE v. Garcia effectively overruled Guin and laid down specific requirements for Stowers demands. Farmers Insurance Co. v. Soriano clarified its application where there are competing Stowers demands by multiple claimants, and the Fifth Circuit's recent decision in Pride Transportation v. Continental Casualty Co. clarified its application to multiple defendant/multiple insured scenarios.

The Insurance Law Section of the State Bar of Texas was created because its founders believed that insurance law had become sufficiently nuanced to recognize it as a separate discipline with its own set of practitioners. Perhaps more than any other legal doctrine, Stowers and its ubiquity among trial practitioners proved they were right. But there are other examples and other watershed precedents, each of which would benefit from the same type of exhaustive and historical treatment Morgan and Quinn provide here. Allstate Ins. Co. v. Kelly, Arnold v. National County Mut. Fire Ins. Co., Aranda v. Insurance Co. of N.A., State Farm Fire and Cas. Co. v. Gandy, Vail v. Texas Farm Bureau Ins. Co., Viles v. Security Nat. Ins Co., Universe Life Ins. Co. v. Giles, APIE v. Garcia, and Soriano are but a few examples that instantly spring to mind.

If you are reading this, you know what I mean, and the Journal would welcome your submission of similar work for the benefit of the bench and bar. We would be happy to publish it. Email articles to me at wjchriss@gplawfirm.com. Enjoy.

William J. Chriss
Publications Editor

William J. Chriss, of counsel to Gravely & Pearson, LLP, graduated from Harvard Law School, holds graduate degrees in Theology and Political Science, and is currently a doctoral candidate in legal history at the University of Texas. He has practiced insurance law for over thirty years and currently serves as editor in chief of *The Journal of Texas Insurance Law*.

By: Vincent E. Morgan[1] & Michael Sean Quinn[2]

Pillsbury Winthrop, LLP
The Law Office of Michael Sean Quinn

"DAMN FOOLS" – LOOKING BACK AT STOWERS AFTER 85 YEARS

I. Introduction

It was a dark and rainy night.[3] When this classic story began on the evening of January 23, 1920, Mamie Bichon was a passenger in a taxi that collided with a truck owned by the G.A. Stowers Furniture Company. The legal principle resulting from this chain of events, a defending liability insurer's duty to accept reasonable settlement demands within policy limits, is known to virtually all lawyers, adjusters and other insurance professionals who routinely deal with liability issues in Texas. To think of the rule another way, it has stood as a cornerstone of Texas law for so long[4] that virtually every current practitioner (young and old alike) who knows of its existence learned the *Stowers* doctrine soon after their entry into the field.[5] While they have seen other aspects of Texas insurance law change over the course of time, this particular doctrine remains largely – or at least mostly – unaltered from its original form.[6] Because of its importance, *Stowers* and its progeny have been the subject of countless demand letters and status reports, numerous judicial decisions,[7] CLE speeches and law school classes, a host of scholarly writings,[8] and probably more than a few sleepless nights. Many of these examples have centered around the contours of the *Stowers* doctrine and its application in various scenarios.

Our focus is a bit different. This spring, *Stowers* celebrates its eighty-fifth anniversary as a landmark of Texas law.[9] In light of this occasion, we thought it might be useful to take a step back in time and revisit the original case from a number of different angles. Because *Stowers*-type cases necessarily involve "litigation about litigation," we will begin by examining the facts and people involved in both the underlying personal injury lawsuit as well as the insurance dispute. We will then review the arguments put forth by the parties, and in one instance, by a lawyer who filed an amicus brief. This topic will be followed by an analysis of the resolution of those arguments by the various courts involved. Part of this analysis will include some surprise data – there was a dissent written in the (nearly) controlling court, and we have run across no one who was aware of its existence. Thus, the primary approach will be a historical one. We wish to shed light on the case not only because it is vitally important to the insurance jurisprudence of Texas, but also because it is an interesting story that is worthy of being told. It is our hope that by engaging in this retrospective look at the case, some new insights can be gained into the legal doctrine and that interested readers can get a brief look at the colorful history of this case, not to mention the State of Texas, along the way.[10]

II. The Accident

Today, the intersection of Austin Street and Capitol Avenue[11] in Houston is unremarkable. Three corners are surface parking lots, while a nondescript low rise building of recent vintage occupies the fourth. There are two streetlights, and the intersection is very well lit. About five blocks away at the corner of Walker and Fannin sits the old Stowers building.[12]

In contrast to today, the intersection was likely very different ninety-four years ago. Again, it was raining very heavily that night. Bichon's petition described the events as follows:

> That about the 23rd day of January 1920 and about the hour eight forty five P M (8:45 P M) defendant, G.A. Stowers Furniture Company had . . . left . . . one of its large furniture vans . . . on Austin Street in . . . such a way as to obstruct a portion of said street on which it had placed no lights, that the night was dark and . . . a very heavy rain was falling which made it difficult for anyone driving on said Austin street to see said furniture van . . . .
>
> . . . .

1. Vince Morgan is with the Houston office of Pillsbury Winthrop. Since graduating from the University of Texas School of Law, his practice has concentrated on litigating insurance coverage disputes, as well as advising clients on insurance and risk management issues. He is immediate past Chair of the Insurance Law Section of the State Bar of Texas.

2. Michael Sean Quinn is the founder of his own boutique law firm in Austin. He both practices law and testifies on various subjects, including insurance coverage and professional malpractice. He is a former Chair of the Insurance Law Section of the State Bar of Texas, and has taught at the University of Texas School of Law, Southern Methodist University Dedman School of Law and the University of Houston Law Center.

> . . . [a] few minutes prior to the hour of 8:45 P M [plaintiff] left her place of business on the corner of Main Street and Congress Avenue . . . and entered [a] rent car [presumably something like a taxi], belonging to defendant, Jamail, for the purpose of going to her home in the southern portion . . . of Houston.
>
> . . . .
>
> Plaintiff would further show that the driver of defendant, Jamail, was going in a southerly direction on Austin Street and that about the 700 block on said street the said driver . . . was going at a tremendous rate of speed, being some twenty or thirty miles an hour,[13] and that while so running at said tremendous rate of speed he drove into and came into collision with the said furniture van . . . hitting the said van with tremendous force, throwing this plaintiff from said rent car . . . under the said furniture van thereby injuring this plaintiff
>
> . . . .

Bichon's Original Petition, at 1-3. Clearly, "tremendousness" was thought of differently in 1920 and was very important to Bichon, or her lawyer.

The liability theory against Stowers had two basic components: (a) the truck's obstruction of the road; and (b) the fact that the truck had no operating warning lights or watchman at the time of the accident, as we shall presently see.

In her Original Petition, Bichon made only brief remarks concerning the truck. In her Amended Petition, she alleged:

> [The truck] had no lights upon it of any character and especially had no red light in the rear thereof and was left without anyone being in charge thereof and without any warning or signal of any character around the same to warn approaching vehicles of the presence of such automobile truck.

Bichon's Amended Petition, at 4. Like many lawsuits, however, the plaintiff's petition told only part of the story. In responsive pleading, Stowers:

> [a]nswered by a general demurrer and general denial, and further specifically pleaded that . . . the driver[14] of its truck, while driving his truck in a careful manner, ran into a wagon that had been left by its owner on the streets without a light on it of any sort; that [the] force of the collision with the wagon damaged the defendant's truck so that the motor was disabled to such an extent that the engine could not run and that the fender was bent down upon the tire so that it was impossible for the driver to move the truck; that the truck in question was a Ford truck, with the lights connected directly to the motor, and that the electricity that furnished the lights to the truck was generated by the motor, and therefore, since the engine or motor was disabled so that it could not run, the lights would not burn;[15] that the driver of the truck, as soon as he discovered the condition, went as quickly as possible to the nearest telephone for help, and, although gone from the truck only a few minutes, the rent car in which plaintiff was riding ran into the truck which was still standing immediately behind and against the wagon in question. The defendant further pleaded that the fact that the truck was on the streets without a light at the time and place in question was not due to any act of this defendant, but to the act of the unknown owner of the wood wagon. [S]towers Furniture Company further pleaded that the rent car in which plaintiff was riding would have struck the wagon in question if the defendant's truck had not previously hit it, and on account of the damages received remained immediately behind the wagon.

Bichon, 254 S.W. at 608. Stowers's answer set up the key factual dispute in the case. Bichon pleaded that Stowers was negligent for abandoning the truck and not leaving a watchman at the scene to warn oncoming traffic of the hazard. As set forth in its answer, however, Stowers maintained that its driver "went as quickly as possible to the nearest telephone for help," and was "gone from the truck only a few minutes."[16] Note that Stowers also pleaded causation, arguing that the taxi would have hit the wagon anyway had the truck not done so beforehand.

III. Bichon's Injuries

As for damages, Bichon pleaded that her back and kidneys were injured, and that she received abrasions to her face and head. More importantly, it was also alleged that she:

> [s]uffered a bad wound which cut and lacerated her throat, injuring the thyroid glands and [that] some sharp instrument cut or penetrated her throat to a depth of nearly an inch, cutting some arteries, which caused her a great loss of blood[17] .
>
> . . .

7.

> She further shows that she is informed by her physician and charges the truth to be that the force with which she was thrown from said automobile was such that it inflicted either a strain or rupture on one of the valves of her heart and said injury is very dangerous as it is liable to prove fatal at nearly any time and she fears the same is incurable.

Bichon's Original Petition, at 3-4. Thus, Bichon alleged cuts, bruises, arterial bleeding of the neck, and heart damage, at least some of which was a consequence of being thrown from the cab.

Her medical expenses, including a one week stay in St. Joseph's hospital along with a surgical procedure and follow-up visits by two doctors, amounted to $174.[18] Additionally, she claimed to suffer swelling, heart palpitations, and chest pains. Lastly, she alleged that the accident resulted in a heart murmur that ultimately led to valvular disease. Bichon's Amended Petition, at 6. In her prayer, she sought $20,000 as damages for the injuries, $174 in medical expenses, and $33 for her clothes that were destroyed. She did not specifically seek lost wages, although they probably occurred. Hence, most of the damages she sought would today be categorized as compensation for pain and suffering.

Unfortunately, while his business may have "changed [San Antonio's] skyline," Mr. Stowers did not live long enough to see his business change the landscape of Texas insurance law…

IV. The Players

A. The Parties

1. Mamie Bichon

Mamie Bichon worked at Cockrell's Drug Store, located on the corner of Main Street and Congress Avenue in Houston. In her First Amended Original Petition, she was referred to as a "feme sole."[19] She was repeatedly described in the pleadings and testimony as a pleasant woman and a "respectable white business lady."[20] There is no question that she sustained injuries in the accident, although just how severe they actually were remains unclear.

2. The G.A. Stowers Furniture Company

George Arthur Stowers founded the G.A. Stowers Furniture Company. Mr. Stowers died in 1917 at the age of 50, about three years before Ms. Bichon's accident. Born in Georgia just after the close of the Civil War, he was a remarkably successful businessman. The Handbook of Texas Online, published by the Texas State Historical Association, has this biography:

> Out of his savings from a two-dollar-a-week job in a candy company he was able at seventeen to start his own furniture store in Birmingham, Alabama, with $500 capital. By the time he was twenty-three he was operating ten stores in Alabama, Tennessee, and Texas; San Antonio, Dallas, Waco, and Fort Worth were the Texas outlets. Stowers moved his business from Birmingham to Dallas in 1889, but soon thereafter he located in San Antonio, where his business succeeded to the extent that it eventually changed the city's skyline. His first furniture stores were on West Commerce Street; by 1910 he had one of the largest retail businesses in San Antonio and had built a ten-story building (a "skyscraper" at that time) at the corner of Main and Houston streets. He also opened furniture stores in Houston and Laredo. Stowers's ranch holdings outside San Antonio were extensive.[21]

Unfortunately, while his business may have "changed [San Antonio's] skyline," Mr. Stowers did not live long enough to see his business change the landscape of Texas insurance law.[22]

3. American Indemnity Company

Based in Galveston, the American Indemnity Company was incorporated in 1913 by Joseph F. Seinsheimer. His son, Joseph F. Seinsheimer, Jr. took over the company in 1951.[23] During the 1990's, Joseph F. Seinsheimer III ran the company until its acquisition by the United Fire & Casualty Company in 1999.[24] Thus, it lasted seventy-six years as an independent entity.

B. The Lawyers

There were many lawyers involved, but a handful in particular played key roles.

1. Norman Atkinson

Mr. Atkinson, along with his father (who later became a Harris County judge), represented Ms. Bichon in the personal injury lawsuit. Subsequently, he served as co-counsel with John Freeman in the lawsuit against American Indemnity following the final resolution of Bichon's case.

2. John H. Freeman

Freeman was a partner in Campbell, Myer & Freeman, and was regular counsel to the Stowers Furniture Company. In 1924, he became the third partner in the law firm of Fulbright, Crooker & Freeman, which is still well-known in Houston and now elsewhere.[25] He later served as city attorney for Houston in 1928-1929 and also prepared the legal documents setting up the M.D. Anderson Foundation, which funded the beginnings of the Texas Medical Center.[26]

3. Ben Campbell

Born in 1858, Ben Campbell was mayor of Houston from 1913-1917. Given the seriousness of the case, Freeman turned over the lead role of defending Stowers to Campbell, who was the senior litigator in their firm. Campbell tried Bichon's case alongside Mr. Patterson, who was engaged by the insurer. During his tenure as mayor, Houston's first parks were established and Campbell's administration was credited with paving the way for the development of the Port of Houston.[27] In fact, his daughter christened the port during its opening ceremony on November 10, 1914.[28] Campbell died in 1942, survived by his wife and six children.

4. R.C. Patterson

Robert Clendening Patterson was appointed by American Indemnity to defend the underlying case for Stowers. Once Stowers brought suit against American Indemnity, he was again engaged by American Indemnity to defend the carrier in the insurance lawsuit. Prior to forming the firm of Fouts & Patterson, he was an attorney with Baker Botts (then known as Baker, Botts, Parker & Garwood). Educated at Vanderbilt, Patterson was a distinguished lawyer. After practicing with Elwood Fouts for about fifteen years, he finished his career as a solo practitioner from 1935 until his retirement in 1951. Patterson died in 1952.[29]

C. The Jurists

1. Judge Monteith

Walter E. Monteith, who presided over the trial of the *Stowers* case as judge of the 61st Judicial District Court of Harris County, was quite an extraordinary fellow. Born in 1877, he served in the Boer War and ran rubber and banana plantations in Nicaragua.[30] Attending both college and law school at The University of Texas, he played football on the first undefeated Longhorn team. Monteith even took a leave of absence from the bench to serve as a private in field artillery in World War I. *Id.*[31] He went on to become mayor of Houston from 1929-1933.[32] Later, he served on the First District Court of Civil Appeals from 1939 until his death in 1953.[33]

2. Justice Critz

Richard Critz, the author of the key opinion, spent much of his legal career in public service. Born in Mississippi, he worked as a farmhand and teacher before becoming a lawyer. He held various positions such as city attorney in Granger and judge in Williamson County, where he was instrumental in the construction of a new courthouse.[34] Critz also assisted Georgetown district attorney Daniel Moody in prosecuting members of the Ku Klux Klan in the 1920's.[35] In 1927, Moody became governor and appointed him to the Commission of Appeals.

Critz served in that capacity until 1935 when Justice William Pierson was brutally murdered by his son.[36] Governor Allred appointed him to succeed Pierson on the Texas Supreme Court.[37] During his tenure, Critz wrote hundreds of opinions and was considered both industrious and influential.[38] He left that bench in 1944 and returned to private practice in Austin with Lloyd Mann, Emmett L. Bauknight, F.L. Kuykendall, and Pierce Stevenson.[39] Dying on April 1, 1959 at the age eighty-one, Critz was survived by his wife of fifty-three years and three of his four children.[40]

3. Judge Nickels

Born in 1882,[41] Nickels went to law school at The University of Texas. He served as a member of the Texas House of Representatives and Assistant Attorney General. Before and after his service on the Commission of Appeals from 1925 until 1929, Nickels was in private practice in Dallas with former U.S. Senator Joseph W. Bailey and his son, U.S. Congressman Joseph W. Bailey, Jr., at Bailey, Nickels & Bailey. Nickels died relatively young in 1933 at the age of 51, but like Justice Critz, he also passed away on April 1. *Id.*

He served on the Commission of Appeals with Richard Critz and J.D. Harvey.[42] Collectively, these three judges comprised Section "A" of the Commission of Appeals in the year that *Stowers* was decided. Judge Nickels wrote the dissenting opinion in the *Stowers* case that, for reasons unknown to us, never made it into the *South Western Reporter*. The reporter contains no dissenting opinion; neither do the online versions available from Westlaw and Lexis. The majority opinion gives no hint of a dissent. It was only through reviewing the files of the Texas State Archives that this opinion was discovered, and it will be discussed below.

V. The Outcome of the Underlying Lawsuit

Bichon sought a total of $20,207 in her lawsuit. Her lawyers extended two settlement offers. The first was for $5,000, and the second was for $4,000. Neither offer was accepted. Settlement negotiations having failed, the case went to trial. On appeal, the court held that the evidence was sufficient for the jury to conclude:

> This truck, the motor of which had been so damaged by a collision with a broken-down wagon, which had been left in the street by some unknown person, that the truck could not be moved and its lighting system could not be operated, was left in this condition by its driver for more than an hour before the car in which appellee was riding collided therewith.[43]

Therefore, the Court upheld the jury's factual findings and apparently their decision to disregard the driver's testimony concerning the length of time he was gone. The jury awarded Bichon $12,207.[44] With costs of suit and interest, the judgment came to $14,103.15.[45] Following an unsuccessful appeal and denial of review by the Supreme Court, Stowers paid Bichon and then brought suit against American Indemnity for the full amount of the judgment.

VI. The *Stowers* Case[46]

A. The Policy

Interestingly, this was a "lost policy" case, as the original was "misplaced."[47] Using the following year's policy, Stowers proved up the contents of the missing one. In exchange for a premium of $607, Stowers obtained an "Automobile Public Liability and Property Damage Policy."[48] Although there are some differences from modern policies, the basic structure is largely the same. It began with the insuring agreements, followed by certain conditions (including the exclusions), and then concluded with a number of schedules and endorsements. The relevant defense obligation stated:

> AMERICAN INDEMNITY COMPANY
>
> * * * *
>
> DOES HEREBY AGREE
>
> * * * *
>
> Defense.(A) TO DEFEND in the name and on behalf of the Assured any suits even if groundless, brought against the Assured to recover damages on account of such happenings as are provided for by the terms of the preceding paragraphs.[49]

The policy also spoke to the rights and obligations of the parties concerning settlements:

> [T]he Assured shall not voluntarily assume any liability, settle any claim or incur any expense, except at his own cost, or interfere in any negotiation for settlement or legal proceeding without the consent of the Company previously given in writing. The Company reserves the right to settle any such claim or suit brought against the Assured.[50]

It was against this backdrop that the insurance case unfolded.

B. The Pleadings

Worth remembering is the fact that this case arose prior to the onset of "notice pleading." Consequently, the pleadings on both sides were fairly elaborate.[51] One interesting point is that Stowers said its truck hit the wagon "at about the hour of seven o'clock p.m." Stowers's Second Amended Petition, at 3. It also stated that Jamail's car hit the truck "at about 8:30 or 8:40 p.m. . . ." *Id.* at 4. Stowers got to the heart of the case with the following allegation:

> [D]efendant[,] who was conducting plaintiff's defense in said underlying cause, had to rely for this defense upon the naked statement of this plaintiff's said servant who was a *Negro boy*[52] and interested in clearing or showing himself guilty of no wrong, whereas the said Mamie Bichon had *two reputable white witnesses* who were in nowise interested in the suit who testified in their behalf that they saw the truck standing where it had collided with the wagon at about seven o'clock that night . . . and the undisputed evidence showed that the accident did not occur until more than an hour later — all of which facts were well known to defendant long prior to said trial, or could have been known by it by the exercise of ordinary care and diligence.

Stowers's Second Amended Petition, at 8 (emphasis added).[53] By way of legal allegations, Stowers stated:

> [I]t became the duty of the defendant . . . on taking charge of plaintiff's defense in the aforesaid suit to conduct same in good faith and for this plaintiff's interest as well as for the defendant's own interest and without negligence on the part of said defendant; and that it further became the duty and obligation of said defendant to conduct said suit and to make such settlement with . . . Miss Bichon or her attorneys as the reasonably prudent person would have made under the same or similar circumstances for the protection of this plaintiff's interest . . . .

Id. at 9.[54] This position, modified and narrowed somewhat, became the *Stowers* doctrine.

American Indemnity responded with its own lengthy and elaborate pleading. As to the legal duty, it argued that the petition failed to state a claim. With respect to the relative worth of the testimony of the driver versus the two disinterested witnesses, American Indemnity pleaded:

> Defendant specially excepts to that part . . . for the reason that this court will not consider that white witnesses are more truthful than black or that a negro boy was interested, as he was not a party to the suit, or that a negro boy may not be as reputable as a white witness, and that said allegations are prejudicial and inflammatory and improper . . . .

American Indemnity's Second Amended Original Answer, at 2. Thus, the insurer "accused" Stowers's lawyers of racism. In addition to failure to state a claim, American Indemnity also pleaded that the case did not justify a settlement of $4,000. Further, American Indemnity claimed that even if it did breach a duty, it was a contractual one, and hence, Stowers was put to the election of either kicking the insurer out of the defense and suing it or continuing to allow performance through trial and appeal. Since Stowers allowed American Indemnity to continue to defend the case through trial and the appellate process, American Indemnity contended that Stowers had therefore waived, or was estopped from asserting, what in American Indemnity's view was at most a breach of contract claim. At its core, American Indemnity's position was that it did all that it was required to do by faithfully and reasonably defending its insured until the Supreme Court's denial of review and then offering to pay the full limits of its policy. Freeman testified that he argued with Patterson on this issue, pointing out the unfairness of this position to the insured. Unfortunately, the testimony makes no other reference to this point.[55]

C. The Trial

Six witnesses testified at the trial. Stowers called Norman Atkinson, I.P. Walker (the manager of its Houston store), and John Freeman. American Indemnity called Ben Campbell, R.C. Patterson, and W.L. Hartung, the last of whom was the head of American Indemnity's claims department. Seven witnesses were excluded, including Bichon, her employer, the two witnesses who first saw the truck at the accident site, the doctor who examined her for life insurance before and after the accident, and her treating physicians at the hospital. These witnesses were the "Irrelevant Seven." Although the trial court and the Court of Civil Appeals held their testimony was irrelevant, the Commission of Appeals later reversed this ruling.[56]

Mr. Atkinson was the first witness. While testifying, he recalled discussing the case with Patterson and Freeman many times prior to the trial of Bichon's suit:

> Mr. Patterson's contention was that the Stowers Furniture Company's truck had been disabled, . . . a few minutes before the accident by running into a wagon that had been left there, and that the negro driver had gone to secure assistance by telephone; and that the truck at the time of the accident had only been there just a few minutes, some ten, fifteen or possibly twenty minutes, the accident having taken place at about eight or eight twenty. I told Mr. Patterson we had two reputable white men who would testify they had seen that truck there at around or just before seven o'clock, about an hour and a half before the accident.

SOF at 15-16. Thus, the length of time the truck sat unattended was a key factual dispute in the underlying case. The defense contended it was only a short time, just long enough to go and summon help via telephone. Bichon, on the other hand, contended that the truck was there for more than an hour, giving the driver ample time to summon help and return to the truck to warn oncoming traffic. Not only was this an important factual dispute, but the racial backdrop was a constant issue in both the underlying case and the subsequent insurance case.

Atkinson also testified about Bichon's injuries, stating that Dr. Alvis E. Greer conducted an independent medical evaluation of Bichon. Dr. Greer's report, which was introduced into evidence,[57] indicated that she told him she was rendered unconscious for about forty-five minutes after the accident. Ultimately, he concluded that she had pre-existing valvular disease, but that the accident may have aggravated the condition. *Id.* at 18-19. Bichon had her own doctor, though, who examined her for a life insurance policy before the accident and re-examined her after the accident. It was expected that this doctor would have testified that he detected a heart murmur in the subsequent examination that was not present prior to the accident. *Id.* at 19-20. Thus, there was a conflict in the medical opinions.

As noted before, Bichon's lawyers made two offers of settlement. The first, of $5,000, was summarily rejected. Subsequently, a $4,000 offer was made and rejected. Atkinson testified:

> It is true that the American Indemnity Company was not willing to pay as much as we demanded in settlement, leaving a difference between what it was willing to pay and what we were willing to accept.

> Mr. Patterson's attitude was that he was going to put it up to Stowers, and if Stowers wanted to pay the balance they would be able to put the settlement over, otherwise not.[58]

Mr. Walker, the manager of Stowers's Houston store, testified next. He explained that, the morning after the accident, Stowers gave notice of the matter to its insurance agent, and Patterson was engaged "the next day or two after the accident." *Id.* at 48-49. After suit was filed, the insurance company gave Stowers the opportunity to have its counsel assist with the defense, and at that point, Freeman and Campbell became involved.[59] SOF at 50. Walker testified that "the first communication I had with Mr. Patterson was when he wrote me a letter, telling me that he was representing the American Indemnity Company." *Id.* at 54. As for the $4,000 settlement offer, Walker stated:

> Mr. Patterson . . . came by the store one morning and discussed with me a proposition of settlement, claiming that Atkinson & Atkinson had come to him and offered to settle for $4,000.00, and asked if we would be willing to put up fifteen hundred dollars of that amount, stating that the American Indemnity Company was willing to pay twenty-five hundred dollars,[60] but would not go any further than that. I discussed it with Mr. Patterson quite a bit, and he impressed on me that this was going to be a pretty serious case . . . .

SOF 26-27. Walker then testified as follows:

> I told Mr. Patterson that I thought we had insured with a pretty good company, and that they should take care of us without bringing us into court, in as much as it could be settled for less than the amount of the policy, and that we would not put up any part of it in settlement. Mr. Patterson said if the case was not settled it would go to trial, and they were only liable for five thousand dollars and that it was so near the amount of their policy they were willing to take a chance on it.

SOF at 27. On redirect, he testified about the following exchange:

> I told Mr. Patterson I thought his company should go ahead and settle this claim without bringing us in to any kind of litigation; that it was a crime for us to carry insurance and pay for it, and then they would not pay what little claims we might have. He told me he thought that was a fair settlement, a good settlement, and the thing should be settled, but they would not put up over twenty-five hundred dollars.

SOF at 64. He also testified that Patterson said "the case was dangerous, and he thought [the insurer] ought to settle . . ." *Id.* at 28.[61] Interestingly, in a letter to Jamail's attorneys, Walker had previously stated a somewhat different view of the matter:

> The night of this accident the police were called to the scene and they immediately exonerated our driver, stating that he was not to blame under the circumstances, and if there is really anybody who is to blame . . . it should be the man who left his wagon in the street without a light of any kind . . . .

SOF at 52. If the police did indeed exonerate Stowers, it is curious to us why the defense did not make this a central point of their case. Nevertheless, it is also interesting that Stowers's manager found fault with the wagon on the same basis that Bichon found fault with Stowers.[62]

Finally, Walker testified that after the conclusion of Bichon's case:

> [The insurance company] offered to pay the five thousand dollars with interest on it up to that time, providing we would give them a release. I refused to give them a release and they would not pay me. I would not give them a full release of their liability under this policy in connection with this accident because we were figuring on suing them; immediately after the case was affirmed we figured on doing that.[63]

Freeman was the next witness. As to the conflict in the testimony, he stated:

> [T]he facts as contended by our negro driver and the plaintiff's facts supported by their two witnesses; we were conscious there was going to be a conflict there. In discussion [of the matter] we took into consideration the fact that the plaintiff's witnesses were reputable white men.

Id. at 76. Continuing, Freeman also noted that if the plaintiff's witnesses were correct, "then our defense simply was not a defense." *Id.* at 79. After discovering what the testimony of these witnesses was expected to be, "[Mr. Patterson and I] went to work a little more seriously trying

to get a settlement of the case." *Id.* at 80.

Ultimately, he characterized the case as one:

> [I]n which there probably would be no recovery, or else a recovery very considerably in excess of the five thousand dollars that had been discussed as the limit of this insurance policy, dependent upon how the jury viewed this conflicting testimony, and based further upon how the jury considered the injuries that this young lady had received.

Id. at 81. Freeman and Patterson each went back to their respective counterparts to inquire about the prospect of putting together a settlement fund for the plaintiff. Stowers's position was that it should not pay any amount of a settlement less than five thousand dollars, and they were of the "impression that it was the duty of the insurance company to make settlement of that case if it could be settled for less than five thousand dollars, and relieve them of any liability of loss over five thousand dollars." *Id.* at 83. Freeman then stated:

> To be perfectly frank, Mr. Patterson and I told each other that both of our clients were damn fools . . . [T]hat his insurance company was foolish in not coming up a little above twenty-five hundred dollars, and that [Stowers] was foolish if it could get rid of a law suit with the potentialities this one had by putting up some amount not to do it. Just as a broad proposition, that a suit of this kind had potentialities and I think our language was that they were damn fools not to do it.[64]

American Indemnity's first witness was Stowers's lead trial lawyer, Ben Campbell. He thought Stowers had a good case below. He believed Perry's story, and he doubted that Bichon was as injured as she had claimed. Nevertheless, he was cognizant of the disadvantage a corporation had when defending itself against the claims of an injured woman who was faultless. Remember that Bichon was merely a passenger in what was essentially a taxi-cab. In fact, Campbell went on to state that he "knew that [the underlying action] was a dangerous case." SOF at 100. He knew this before it went to trial.

Perhaps the most telling indicator of Campbell's view of the case was given at the close of his cross-examination. Here is what he said:

> Assuming that a suit was brought by a young lady against a corporation, and that the principal defense of the corporation was based on the testimony of a colored boy in their employ; and assuming that the evidence of the colored boy was that it was only fifteen minutes from the time of the collision between the truck and the wagon, and the accident, and that the testimony of two reputable white men was that they saw that truck in the position where it was at the time of the accident from an hour to an hour and a half before the accident could have occurred, they saw it there at about seven o'clock at that place and the accident didn't occur until about eight twenty, *I would say under those circumstances there would be* [*a*] *very serious danger of losing the case, because it was a negro, and the circumstances detailed.*

SOF at 101-02 (emphasis added). Race thus played a significant role in this lawyer's thinking. How else might it have been relevant?

The head of American Indemnity's claims department, W.L. Hartung, testified as the last witness in the case. On cross-examination, the Stowers attorneys[65] pressed him to identify cases in which the company paid more than fifty-percent of the limit of a given policy. In response to this line of questioning, he testified:

> It is pretty hard for me to recall the particular instances and the style of a case where the company paid the full limit of their policy without anybody contributing anything, because in handling claims for the company for a period of ten years I could not recall that . . . .
>
> . . . .
>
> I don't know that I can name you a single case where my company paid the full limit of their liability under the policy without trial and without somebody else contributing something to that settlement. I said there was such a case but I could not give you the name of it. I will state here under my oath that to the best of my recollection there have been such instances but I cannot recall a specific case now.
>
> . . . .
>
> I cannot give you the name of any specific case where the company paid more than half, I could not tell you in what town it happened or when it happened. I could not tell you the name of the assured nor the agent who handled it. All I can tell you about that matter is that such a case

> happened. I don't know the place where it occurred, what court it was in, the name of the fellow that got the money nor the company to whom the policy was issued in any single instance. Instead of my having a recollection about such an instance it may be an impression.

SOF at 168-69.[66] This, from the head of the insurance company's claims department. Today, most lawyers would find such testimony shocking. Viewed under current standards, Hartung is probably admitting that American Indemnity violated Tex. Ins. Code Ann,. Section 541.060(a)(2)(A), and perhaps in every case in the company's history until that point.

Following the closing of the evidence, Judge Monteith withdrew the case from the jury and rendered judgment in favor of American Indemnity. Thus, the insurer won the trial handily, as a matter of law. Stowers appealed.

VII. The Appeals

A. The Court of Civil Appeals

As we shall see, an intermediate appellate court ruled twice on this case. We turn now to the first ruling.

1. Stowers's Arguments

Stowers put forth two propositions in the beginning of its opening appellate brief. When taken together, these propositions form the basis of the *Stowers* doctrine. They were:

> FIRST PROPOSITION
>
> Where an insurance company for a valuable consideration to it in hand paid undertakes to insure one against loss and stipulates that it is to have the sole settlement of any cases, if any settlement is made, and also stipulates that it has the sole right to appear and defend on the behalf of the assured, then such insurance company is held to that reasonable degree of care and diligence which a prudent man would exercise in the management of his own business.
>
> SECOND PROPOSITION
>
> Where it is manifest to the insurance company during the progress of the litigation that a trial of the cause is practically certain to result in a verdict and judgment against the assured in excess of the liability of the policy, it is the duty of the insurance company to make a settlement of said cause, if the same can be done within the limits of the amount of its liability as fixed in its policy.

Stowers's Brief, at 7-8. The first proposition focuses upon the key element of control of the defense and settlement, and it speaks in terms of negligence. The second proposition addresses the potential for excess judgments that may be avoided where settlement can be had for an amount within the limits of the policy. It does not, however, formulate the standard by which that duty should be judged. Thus, only when these two propositions are taken together can the full contours of the *Stowers* doctrine be seen.

After setting out its view of the case, Stowers went through a lengthy summary of the testimony from the trial to paint a picture of Bichon's case as well as the events surrounding the defense and failure to settle. It began its arguments with this:

> To hold that one, who, for a valuable consideration, enters into a contract with another by which he has exclusive control of all litigation that may arise and which litigation he agrees to defend on behalf of the person with whom he has contracted, has a right to disregard the interest of the one with whom he has made a contract and consult his own interest only, seems to us to be utterly abhorrent to the plainest principles of justice.[67]
>
> For the present, we confine this discussion to the question of whether the acts of the Indemnity Company in this litigation fulfilled its obligation to the Stowers Furniture Company or constituted a fraud upon said company.

Id. at 44. Both sides took liberties with the facts, as litigants occasionally do. Stowers argued:

> The evidence of Mr. Hartung also authorizes the conclusion that it was the fixed policy of defendant company not to pay more in any case than one-half of the amount of liability on its policy.

Id. at 46. This was a fair inference from Hartung's testimony, but it was only an inference. Stowers varied between arguing that the evidence supported this conclusion and that it established it as a fact, which was central to its pleading of fraud. In other words, Stowers argued that American Indemnity had an unwritten settlement sublimit of half of the policy limits.

Stowers then cited a handful of cases from around the country (since none existed in Texas at the time) with similar facts and in which the insurers were held liable for failing to make reasonable settlements within the limits of their respective policies, as well as an A.L.R. annotation. It then concluded with a brief argument:

> The meaning of the policy in controversy may be a little obscure where in effect it provides that the insurance company shall pay where lawfully liable. We think a fair interpretation of the meaning of this provision of this policy is that if under all the circumstances, it is the duty of the insurance company to settle the loss, it is certainly lawfully liable to do so.

Stowers's Brief, at 51. Note the insured's use of the word "fair." Its final paragraph stated:

> In this cause, the defendant insurance company has, by its conduct, inflicted on the Stowers Furniture Company, a loss of thousands of dollars. It did this rather than pay Fifteen Hundred Dollars for which it was legally liable or at least the evidence of its legal liability was certainly sufficient to go to a jury to be heard and determined by them.

the defendant insurance company has, by its conduct, inflicted on the Stowers Furniture Company, a loss of thousands of dollars. It did this rather than pay Fifteen Hundred Dollars for which it was legally liable…

Id.

2. American Indemnity's Response

American Indemnity began with a number of counter arguments. The first three in particular are noteworthy:

FIRST COUNTER PROPOSITION

> In a policy of indemnity insurance against loss resulting from liability imposed by law, such as is involved in this suit, the undertaking of the insurance company in the contract is to defend and pay a judgment, and, in the absence of fraud, there can be no liability on the part of the insurance company for refusing to settle a case, the company never having agreed . . . to settle the same in the contract.

SECOND COUNTER PROPOSITION

> The provision for settlement involved in this case is a mere option to be exercised by the insurer, should it elect to do so for its own benefit, as distinct from that of the assured and the insurance company is under no obligation to exercise it otherwise than for its own benefit.

THIRD COUNTER PROPOSITION

> As long as there is even a remote chance of recovering a verdict or securing a judgment for less than the amount of the policy, there can be no duty upon the insurance company to settle upon the policy.

American Indemnity's Brief, at 4.[68] In contrast to Stowers's negligence approach, American Indemnity took the position that this was a contractual issue. Its argument began:

> Every case must be tried upon some legal theory that will support a recovery. The relation of the parties is wholly governed by the contract. If plaintiff has a case and if there has been any breach of any duty, it must be of an express or implied contractual duty resulting from the relations of the parties, as evidenced by the contract or read into the contract by operation of law because of the relation of the parties resulting therefrom. In other words, the duty must be a contractual one, or what is legally termed a quasi-contractual one.

Id. at 16. Noting that it agreed to defend any suit but did not agree to settle every suit, it stated:

> Naturally, having undertaken the defense in the contract and having contracted to defend, there are duties in connection with the defense of a law suit to use care,[69] but there is no such duty in connection with the settlement under the policy, there having been no agreement, either express or implied, to settle.

Id. at 17. American Indemnity then argued:

> If an insurance company has such duties as appellants claim, they would necessarily settle all cases, for they would have no hope of convincing a jury after judgment that they had acted with reasonable care.[70]

By characterizing it as a contractual issue,[71] American Indemnity set up the defenses of waiver and estoppel. It correctly noted that, by virtue of Stowers having its own

lawyers in the case, the insured knew all the facts surrounding Bichon's lawsuit. It also correctly noted that Stowers did not sue at the time of the failure to settle, but instead allowed American Indemnity to continue performing under the contract by paying Patterson to defend the case through trial and even through the appellate process. Of course, the insurer pleaded these defenses below.

As a result of these facts, American Indemnity argued:

> [T]he G.A. Stowers Furniture Company is attempting, and, if successful in this case, will have done two things. First: It will have reaped the benefit of the representation in the defense of the case by the insurance company and its lawyers and the other services in the way of investigation, payment of costs, and all other matters. Secondly: In addition to securing the full performance of the contract, it will secure damages for a breach thereof. In other words, if their position is good law, the G.A. Stowers Furniture Company can sit idly by and await final outcome of their lawsuit. If the Insurance Company is successful in its defense, or does not have to pay more than $5,000.00, it gets off scot free.[72] If, on the other hand, the suit is ultimately lost, although the contract of defense has been carried to completion, yet the insurance company must pay a sum of money far in excess of the amount it agreed to pay, and the Stowers Furniture Company in addition to having secured the performance of the agreements of the company recovers in addition for a supposed breach of the contract.

American Indemnity's Brief, at 54-55. Continuing, it made the following analogy:

> [I]f an insurance company undertakes the defense of a policy it would waive the fact that the accident was not covered by the policy or that there had been some prior breach of it by the insured. Why is it not equally true that when the insured goes ahead with the performance of the contract and permits the insurance company to do so and by its actions permits it to defend said insured has not waived any breach that existed and is it not also estopped from asserting it?

American Indemnity's Brief at 56-57. In sum, American Indemnity's position was that no duty was owed, no duty was breached, and even if a duty was owed and breached, then Stowers had waived the right to complain about it.

3. The Court's Opinion

In the Court of Civil Appeals, American Indemnity again won outright. After thoroughly stating Stowers's position, the court held:

> We do not think the Indemnity Company was, by the terms of the policy, under any obligation to do more than faithfully defend the suit. [I]t had not agreed to settle the suit, but had reserved the right to do so.

Stowers I, at 261. Continuing, the court went on to state:

> Under the facts shown, the Indemnity Company had the right to refuse the proffered settlement and to defend the suit against a larger recovery or any recovery whatever, no matter how slender its chances of success. It was not under obligation to abandon what it believed to be a defense to the suit because there was a strong probability that a refusal of a settlement would result in the rendition of a judgment in excess of its liability under its policy, and settle the suit for $4,000 so as to assure the Furniture Company against loss.

Id.[73] Thus, the judgment of the trial court was affirmed. *Id.* at 261-62.

B. The Commission of Appeals

Before continuing, a short discussion of the history of the Commission of Appeals is worthwhile. It was first created by the Legislature in the late 1870's to assist the Supreme Court.[74] As the Supreme Court had only three members at the time, the Commission was designed to help relieve an ever-increasing caseload. After being revived in 1918, the Commission took the form it was in when *Stowers* was decided, having two sections with three judges each.[75] All decisions by the Commission required approval or adoption by the Supreme Court. The court was effectively disbanded in 1945, when an amendment to the Texas Constitution increased the number of Supreme Court justices from three to nine, and the Commissioners then in office were automatically elevated to fill the new places on the Supreme Court. *Id.*

1. Stowers's Brief

Stowers first filed a petition for writ of error, with a thirty-

odd page brief in the Supreme Court. Later, it filed a comparatively short brief in the Commission of Appeals, at less than ten pages. It repeated most of its original points, but it also expressed its arguments in new ways. For instance, Stowers summarized its position as follows:

> [The insurance company] was bound to do two things by its contract: one was to defend on behalf of the Company and the other was its implied obligation to make a settlement if that seemed to be the wise and prudent thing to do. When the Indemnity Company bound itself by its contract to defend against any suit or claim on behalf of the insured, it certainly obligated itself to do something more than to permit the insured to be dragged into a hopeless lawsuit or one in which there was great danger of losing.

Stowers's Brief, at 3. Continuing, Stowers argued:

> Of course, if the agreement to defend in behalf of the insured does not mean anything and is merely a delusion and a snare, then the decisions of the trial court and of the Court of Civil Appeals are right, but if that agreement means that good faith should be exercised by the Indemnity Company in protecting the insured and that the Indemnity Company will not knowingly pursue a course by which it will lose the insured many thousands of dollars in order to save itself a few hundred dollars, then the decisions of the lower courts are wrong.

Id. at 5.

2. American Indemnity's Response

Unfortunately, we were unable to locate a copy of American Indemnity's response to Stowers's principal brief. One can guess what it probably said, given the success of the insurer's brief in the Court of Civil Appeals.

3. The Majority Opinion

Justice Critz's majority opinion began by noting:

> This case involves issues that are questions of first impression in this court, and are so important to the jurisprudence of this state that we deem it advisable to make a very full and complete statement of the issues involved.[76]

Stowers, at 544. After reciting the facts, the court held:

> We are of the opinion that the plaintiff's petition states a cause of action against the defendant for the amount sued for, and that the evidence in the case raised an issue of fact to be submitted to the jury by the trial court under proper instructions.

Id. at 546. Continuing, it adopted Stowers's position, stating:

> Certainly, where an insurance company makes such a contract; it, by the very terms of the contract, assumed the responsibility to act as the exclusive and absolute agent of the assured in all matters pertaining to the questions in litigation, and, as such agent, it ought to be held to that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business; and if an ordinarily prudent person, in the exercise of ordinary care, as viewed from the standpoint of the assured, would have settled the case, and failed or refused to do so, then the agent, which in this case is the indemnity company, should respond in damages.
>
> . . . .
>
> The provisions of the policy giving the indemnity company absolute and complete control of the litigation, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.

Id. at 547. After discussing various cases from other jurisdictions, the court concluded:

> In our opinion the other authorities . . . sustain the rule announced by us, and, while there are authorities holding the contrary rule, we are constrained to believe that the correct rule under the provisions of this policy is that the indemnity company is held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business.

Id. at 548. The court agreed with Stowers on the evidentiary

points as well, noting that "all the facts and circumstances surrounding [Bichon's] injury, are material as bearing on the question of negligence on the part of the indemnity company in failing and refusing to make the settlement." *Id.* Lastly, the court held that the testimony concerning American Indemnity's "rule" of never making a settlement for more than half the amount of the policy should have been admitted as bearing on the issue of negligence on the part of the insurer. *Id.* All of these holdings were in turn approved by the Supreme Court.[77]

4. The Lost Dissent

Countless lawyers, scholars, adjusters and other insurance professionals have read Justice Critz's opinion and thought this was all there was to the case. As previously noted, however, Judge Nickels wrote a dissenting opinion. Beginning as many opinions do by stating the case and the relevant facts, Judge Nickels did so succinctly:

> Accident transpired; suit followed; defense was conducted by the Company and the assured; "trial of the issue" was had; final judgment declaring liability in excess of "indemnity" stipulated resulted. The Company's obligation to pay $5,000, plus interest from "entry of judgment" and costs, matured and payment thereof is required in the judgment before us.

Dissenting Opinion, at 3.

Continuing, the opinion addressed the heart of the case by noting that the insurance company's "obligation . . . is sought to be extended . . ." because of the facts involved in the handling of the underlying lawsuit.[78] After reciting these facts, Judge Nickels responded:

> But the very gamble which was made by the Company and by the assured in declining the offer was by them left open when their contract was made. The possibility that a judgment in any suit for damages for personal injuries (especially internal ones) may be for a sum either more or less than the amount of indemnity named affords a probable reason for lack of contractual terms specifically requiring a settlement by either party.

Id. The dissent argued that, "for aught that appears," the contract was negotiated at arm's length, and "its terms cannot be re-cast so as to impose that liability sought to be established in this case." *Id.* Next, the dissent went through each case Stowers cited as authority for its position, painstakingly distinguishing them from the instant case. Following this analysis, Judge Nickels seized on a distinction between a duty to pay "upon ascertainment of liability" and a duty to pay after liability is established at trial. He felt that the *Stowers* case was more like the latter type rather than the former, and for this reason he recommended that the Court of Civil Appeals be affirmed. We will not dwell on it further, but as it was left out of the published reporter and lost to history, this dissenting opinion is at least worth a passing discussion.

5. Subsequent Developments

Following the decision, American Indemnity filed a Motion for Rehearing in the Commission of Appeals, and then filed a motion directly with the Supreme Court asking it to withdraw the motion from the Commission of Appeals and decide the matter itself.

In support of this Motion for Rehearing, J.W. Gormley filed an amicus brief. A lawyer at the Dallas firm of Touchstone, Wight, Gormley & Price,[79] he was very interested in the outcome of the *Stowers* case, and asked the Clerk of the Texas Supreme Court to:

> [P]lease remind [the Chief Justice] for me that if the Court adheres to the opinion as written by Judge Critz, it will put us insurance lawyers out of business.

Gormley letter, at 1. Continuing, he stated:

> In this case the Commission [of Appeals] simply elected to follow a line of minority decisions without carefully examining their *rationes decidendi*. This is a pardonable error, but if it is not corrected, a new and intolerable burden will be placed upon us Texas lawyers, – a burden that will take all the fight out of us; and a lawyer without courage, yea, without even daring, is of little help, either to clients or to courts.

Id. He concluded:

> [W]e are really fighting for our bread and butter as lawyers in this matter, as well as for the interests of several clients, who will be very much embarrassed if the original opinion in this case is suffered to stand.

Id. In contrast to Gormely's prediction that the decision would "put us insurance lawyers out of business," American Indemnity's motion for direct review by the Supreme Court

argued it was:

> A matter of so much importance to the people of this State and involves untold sums of money and will cast upon the Courts of this State great volumes of litigation hitherto not tried . . .

Motion to Withdraw, at 2. Where Gormley saw a drought, American Indemnity saw a flood.[80]

As for his amicus brief, Gormley wrote it on behalf of Standard Accident Insurance Company, which was subsequently merged into Reliance Insurance Company in 1963.[81] Like his letter, Gormley's brief is filled with sensational prose. It is an entertaining read, filled with quotations from Cardozo and Lord Westbury.[82] In it, Gormley advances two main points. First, the duty is based in terms of the "reasonable person," when, according to Gormley, it should be couched in terms of the "reasonable lawyer."[83] His second point is that a case with uninsured exposure is really two lawsuits – one below the limit and one above it. Thus, Gormley suggests that a contribution scheme like the one American Indemnity proposed to Stowers is proper in such cases. Gormley's first point is incorrect because the duty really should be measured from the standpoint of a reasonable person, as lawyers can only recommend to clients that settlements be accepted or rejected, but ultimately the decision is the client's to make (or the insurer's, in the case of most liability policies). Either way, it is not a lawyer's decision. Gormley's second point is unworkable, as even back then parties knew that the vast majority of all lawsuits settled for amounts less than their true potential.[84] Furthermore, after seventy-five years of *Stowers*, parties have come to rely on it.[85] By way of example, insureds rely on it when determining the amount of liability limits they should purchase, how closely they should monitor cases with excess exposure, and sometimes how a corporation should report such lawsuits in public filings. Even excess carriers have come to rely on it when dealing with cases that should be settled by underlying carriers.[86] Gormley's arguments were untenable back then, and this is even more true eighty-five years later.

After the case was remanded to the trial court following the decision in *Stowers II*, and now that it was deemed a negligence action by the Commission of Appeals, American Indemnity filed another Second Amended Answer. In its second Second Amended Original Answer, American Indemnity changed its contract defenses of waiver and estoppel into a negligence defense of contributory fault. It alleged that Stowers, having had its lawyers working side by side with the insurance company's lawyers, knew all the facts of Bichon's lawsuit as well, and if the underlying case were as bad as Stowers later made it out to be (*i.e.* one that should have been settled), then Stowers was itself guilty of negligence for not capping the exposure by settling within policy limits. Thus, it set up a contributory fault/failure to mitigate defense.[87]

VIII. The Final Chapter

More than ten years after Bichon's accident, Stowers finally got the chance to take its case to a jury. Here is what happened.

A. "Gentlemen of the Jury"[88]

Following retrial in the 11th Judicial District Court of Harris County, the judgment recited the sole special issue and the jury's answer, which were:

> "Special Issue No. 1.
>
> Would a person in the exercise of ordinary care in the management of his own business under the facts and circumstances known to the American Indemnity Company or its counsel in charge of the case, prior to the trial of the suit of *Mamie Bichon v. Stowers Furniture Company*, have settled said suit for Four Thousand Dollars? Answer Yes or No as you may find."
>
> To which Special Issue the jury answered: "Yes."

Judgment, at 1.[89] The jury submission raises at least three interesting questions.

First, it refers to "facts and circumstances known . . . ." In Bichon's case, the facts were very well known. What about cases in which certain key facts are unknown? Should the carrier treat unknowns as if they would be adverse to the insured in the underlying lawsuit? Can the carrier disregard unknowns altogether? Can it guess as to what it thinks the truth really is?

Second, it refers to facts "known to the American Indemnity Company or its counsel." What if counsel knew of certain problems but failed to inform the carrier? Under this formulation, the carrier would be responsible in any event because "its counsel" was aware.[90]

Third it speaks only in terms of "prior to the trial . . . ." Suppose a case looks defensible prior to trial, and then a surprise witness comes forward in the middle of trial who brings new evidence to light that completely negates the defense's theory. Does the duty to settle apply then? Or can the carrier rest comfortably, knowing that it did not need to

settle it "prior to the trial"?

Some of these questions are obvious and have already been answered, but some remain open to this day. In any event, Stowers prevailed at the retrial, and it ultimately obtained a judgment for $19,309.85.[91]

B. One Last Appeal

American Indemnity appealed when it lost this time, re-urging its arguments from before. This time, the Court of Civil Appeals rejected American Indemnity's position, noting that the jury verdict in the second trial "finally settled this controversy." *Stowers III*, at 956. As they have been amply discussed, we do not repeat these arguments here. We note only one item worth mentioning from Stowers's Reply Brief – its response to American Indemnity's "have your cake and eat it too" argument:

> The appellant attempts . . . to set up some kind of waiver by appellee . . . on the ground that the appellant did certain things after the breach complained of, from which the appellee received benefits. We have sought earnestly to see what benefits appellee has received from the so-called performance of appellant in the trial of the Bichon case, and the only thing that we find is that the case was so managed by the appellant, (American Indemnity Company) that appellee had to pay out some $14,000.00. A few more performances like that and appellee would cease to exist. It is a new proposition for a party to a lawsuit to so conduct it as to cause its clients to be mulcted in a sum in excess of $14,000.00, and then claim it has acquired merit . . . .[92]

the case was finally at an end, more than a decade after Bichon's accident…

Following its unsuccessful appeal, American Indemnity's writ of error was refused.[93] Thus, the case was finally at an end, more than a decade after Bichon's accident.

IX. Vistas in Research[94]

In the course of our work on this project, a number of issues appeared worthy of further exploration. While there are many, we identify only a handful of possibilities:

1. A thorough treatment of the racial issues involved in this case and others of this type. Our space limitations did not permit us to examine the topic beyond this article's scope, but these issues clearly warrant careful study.

2. An investigation of the evolution of the *Stowers* doctrine from the "ordinarily prudent *person*" standard set forth in the original opinion, to more recent formulations that occasionally speak in terms of an "ordinarily prudent *insurer* . . . ."[95] Was this evolution purposeful, or simply accidental?

3. A discussion of the various perspectives from which the duty can be measured. An ordinarily prudent person? An ordinarily prudent attorney? An ordinarily prudent insurer? Although we touched on this point, a more thorough analysis of each position would be worthwhile in our view.

4. An analysis of the roles of the lawyers in this case. From all we have seen, they were lawyers of eminent skill, reputation and integrity. Nevertheless, they switched clients and testified at trials where their firms were acting as counsel. On top of these points, there is always the thorny issue of the tripartite relationship, a problem that continues to vex lawyers, litigants and courts even to this day.[96] Exploring this in connection with the evolution of modern professional responsibility rules would be interesting.

5. An analysis of Patterson's role in particular is enough for a short paper. Walker testified that at ". . . the trial of the case . . . Mr. Patterson [was] representing the insurance company and working with Mr. Campbell who represented us, and the[y] cooperated with each other in the trial of the case." SOF at 62. Freeman testified that "Mr. Patterson was representing the insurance company . . . ." *Id.* at 78. Campbell remarked that he "took part in the defense of that Bichon case, Mr. Patterson and I together; I represented the Stowers Furniture Company and Mr. Patterson represented the insurance company." *Id.* at 98. Patterson even thought he represented the insurer, stating that "I do not remember how many letters I wrote to my client, the American Indemnity Company . . . ." *Id.* at 146. Later, however, Patterson went on to blur the line, stating that "the insurance company undertook to and did furnish the lawyers, my firm, to contest the case and represent the Stowers Furniture Company, in conjunction with their

lawyers." *Id*. at 150.

6. An empirical analysis of the accuracy of American Indemnity's prediction that if the *Stowers* duty exists, then insurance companies "would necessarily settle all cases, for they would have no hope of convincing a jury after judgment that they had acted with reasonable care."[97]

7. Similar studies of other landmark insurance cases. Our own insights into the *Stowers* doctrine have deepened because of this process, and we hope it will encourage like ventures with other important cases. *Tilley*[98] may be an appropriate candidate for the next such project.

X. Conclusion

As eighty-five years have passed since the *Stowers* doctrine was first laid down, now seemed like a good time to step back and review this historic case. In light of what we learned, we wondered who among the parties involved in the case are left standing today. Of course, Fulbright & Jaworski has merged into Norton Rose Fulbright, a multi-national law firm, [99] and American Indemnity, though it has since been sold, is still licensed to sell insurance in Texas. The Stowers Furniture Company remains in business today, noting on its website that it has been "creating beautiful homes in San Antonio since 1890."[100] We found nothing current on Fouts & Patterson. No word on Gormley's firm, either.

We have seen how the case came about by examining the facts surrounding both the personal injury lawsuit and the subsequent insurance litigation. We also discussed the arguments put forth by the parties and the resolution of the competing positions by the courts involved. While those who deal with *Stowers* know its doctrine well, hopefully the readers of this article will come away with a deeper appreciation of the case itself.

1 Vince Morgan is with the Houston office of Pillsbury Winthrop. Since graduating from the University of Texas School of Law, his practice has concentrated on litigating insurance coverage disputes, as well as advising clients on insurance and risk management issues. He is immediate past Chair of the Insurance Law Section of the State Bar of Texas.

2 Michael Sean Quinn is the founder of his own boutique law firm in Austin. He both practices law and testifies on various subjects, including insurance coverage and professional malpractice. He is a former Chair of the Insurance Law Section of the State Bar of Texas, and has taught at the University of Texas School of Law, Southern Methodist University Dedman School of Law and the University of Houston Law Center.

3 It literally was. *G.A. Stowers Furniture Co. v. Bichon*, 254 S.W. 606, 609 (Tex. Civ. App.—Galveston 1923, writ dism'd w.o.j.) ("That appellee was injured . . . on a dark, rainy night . . . is shown by the undisputed evidence."). In fact, it was the heaviest rainfall in Houston's recorded history for a 24 hour period in January at the time. *Expect Cold Wave to Follow Heavy Downpour of Rain,* Houston Chronicle, Jan. 24, 1920 at 1. As an aside, the newspaper had another article reporting the accidents that resulted from the storm. Notably, Ms. Bichon's accident was not among them. *Slippery Streets Cause Accidents*, Houston Chronicle, Jan. 24, 1920 at 8.

4 The first judicial reference to the "*Stowers* doctrine" that we found was in 1960. *F.M. Chancey v. New Amsterdam Cas. Co.*, 336 S.W.2d 763, 766 (Tex. Civ. App.—Amarillo 1960, writ ref'd n.r.e.). It was referred to as a "landmark case in this state" as early as 1963. *Bostrom v. Seguros Tepeyac, S.A.*, 225 F. Supp. 222, 224 (N.D. Tex. 1963).

5 Sometimes it is learned sooner than that. The case is regularly studied in courses on insurance law, and it is even discussed in some first-year tort classes.

6 So-called "*Stowers* demands" may now have to be slightly more explicit than they did in the past.

7 A search performed using Westlaw's Keycite program on October 6, 2004, showed that *Stowers* has been cited in 216 cases, with 445 references in total. Candidly, we expected this figure to be higher. One possible explanation could be that courts now cite to more recent expositions of the *Stowers* doctrine, such as *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 847 (Tex. 1994). There is some breadth to the citations, though, with decisions from more than two dozen jurisdictions, including courts in Alabama, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Montana, New York, Ohio, Oklahoma, Oregon, Rhode Island, Utah, Washington, Wisconsin, Vermont, the Virgin Islands, and the U.S. Courts of Appeals for the 5th, 7th, 8th, and 10th Circuits. *Id.*

8 The Journal of Texas Insurance Law routinely publishes significant articles on this important subject. *See*, *e.g.* Brent Cooper, *Essential Requirements to Trigger a Duty under the Stowers Doctrine and Unfair Claims Settlement Practices Act*, 4:2 J. Tex. Ins. L. 7 (June 2003); Randall L. Smith & Fred A. Simpson, *The Liability Insurer's Dilemma: Should a Good Faith But Mistaken Belief There is No Coverage Absolve an Insurer of "Stowers" Liability?*, 4:3 J. Tex. Ins. L. 2 (November 2003).

9 To be precise, the decision was handed down on March 27, 1929, making its seventy-fifth anniversary March 27, 2004. As an aside, March 27 is a particularly significant date in Texas history generally. On that day in 1836, the Mexican army executed hundreds of Texas revolutionaries at Goliad, *available at* http://www.historychannel.com/tdih/tdih.jsp? month=10272955&day=10272992&cat=10272948 (last visited Apr. 21, 2004).

10 A brief note about the conventions we will use is in order. This article discusses four key decisions (which comprise a total of five opinions with the "lost" dissent included), including the appeal of the underlying lawsuit and the three appeals in the insurance action. We refer to the appeal of the underlying lawsuit, reported in *G.A. Stowers Furniture Co. v. Bichon*, 254 S.W. 606, 609 (Tex. Civ. App.—Galveston 1923, writ dism'd w.o.j.), simply as *Bichon*. We refer to the first appeal of the insurance suit, reported in *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 295 S.W. 257, 261 (Tex. Civ. App.—Galveston 1927), as *Stowers I*. The second appeal of

the insurance suit, which is the opinion cited for the *Stowers* doctrine and reported in *G.A. Stowers Furniture Co. v. Am. Indem. Co*., 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved), is referred to as either *Stowers* or *Stowers II*. Finally, there was a third appeal after the re-trial of the insurance lawsuit, reported in *Am. Indem. Co. v. G.A. Stowers Furniture Co*., 39 S.W.2d 956 (Tex. Civ. App.—Galveston 1931, writ ref'd), and this decision is referred to as *Stowers III*. Also, we will draw heavily from the testimony at the trial of the *Stowers* case, and our citations to the Statement of Facts will be prefaced with the abbreviation "SOF." Pleadings, briefs or other papers from the cases are identified as appropriate. As these pleadings were prepared on typewriters for the most part, we have taken the liberty of editing typographical errors in the passages we quoted. Thus, while some excerpts were not reproduced quite verbatim, they are substantively the same and any changes are purely cosmetic.

11 When we began this project, we thought the accident occurred at the corner of Austin and Leeland, some nine blocks southwest of Austin and Capitol. In preparation for the 2003 Annual State Bar Meeting, *Texas Lawyer* provided a map of noteworthy points of interest for attendees who might be so inclined. Among these was the "*Stowers* Case Accident Scene," listed as being at the corner of Austin and Leeland. Kelly Pedone, *Get Ready for Hot Hip History: Houston State Bar's Annual Meeting Offers Sightseer's Plenty to Do*, Texas Lawyer, June 9, 2003 at 20. However, after reading the trial transcript and other materials we obtained in researching this article, we later became convinced that the accident actually took place at the corner of Austin and Capitol. The amended petition in the underlying lawsuit lists the accident scene as happening at the 700 block of Austin, which is the corner of Austin and Capitol. Bichon's Amended Petition, at 4. Further, the bill of exceptions filed by Stowers in response to the exclusion of Bichon's testimony states that she would have testified the accident happened "near the corner of Austin Street and Capitol Avenue." Transcript, at 29.

12 This ten-story building, located at 820 Fannin, still has the word "Stowers" emblazoned on it. Long vacant, it is currently undergoing renovation and seeking occupants, *available at* http://www.stowersbuilding.com (last visited Nov. 30, 2004). Perhaps an enterprising mediator with a flair for irony will move in and use history as an extra incentive to encourage reluctant parties into settling.

13 At the time of the accident, the applicable speed limit was 10 miles per hour. Bichon's Original Petition, at 2.

14 The truck driver's name was Otis Perry. SOF at 64. Mr. Perry was about twenty years old at the time. *Id*. at 101. We have discovered nothing else about his life.

15 Consequently, the issue was not that the truck was missing the required lights, but that the lights were disabled because the engine was rendered inoperable as a result of the collision with the wagon. The tongue on the back of the lumber wagon went through the truck's radiator and disabled the motor. SOF at 77. Though attempts were made to determine the identity of the wagon's owner, they were unsuccessful. *Id*. at 88, 104. An interesting question is whether, at any time in Texas legal history, Bichon might have had a cause of action against Ford for say, strict liability? The rule laid down in *MacPherson v. Buick Motor Co*., 111 N.E. 1050 (N.Y. 1916), was in existence at the time of Bichon's accident. However, it was not cited by a Texas court until 1922. *Tex. Drug Co. v. Caldwell*, 237 S.W. 968, 976 (Tex. Civ. App.—Dallas 1922, writ ref'd).

16 At the trial of Bichon's lawsuit, the driver testified that he went two to three blocks to the nearest telephone, and that he was gone for only 10 to 15 minutes. *Bichon*, 254 S.W. at 609. There was even a possibility that the driver was within earshot of the accident, and that he may have actually heard Bichon's crash. Finally, there was at least some speculation that the driver lived near the accident scene, and that he might have gone home or gone to visit a lady friend while he went to seek help. SOF at 139. These alternative theories are possible explanations for the time discrepancy.

17 She later alleged that because of this cut, she "came very nearly bleeding to death . . . ." Bichon's Original Petition, at 4.

18 Among these expenses, we note that the doctor charged $3 for a weekday visit, and $5 for a Sunday visit. *Id*.

19 Bichon's First Amended Original Petition, at 1. Interestingly, the archives of the Harris County courts also contained a file in an action for divorce filed by Leon Bichon against "Mammie J. Bichon" in 1918, two years before the *Stowers* accident. The defendant's answer spells the name as "Mamie," which is consistent with the spelling of the first name of the plaintiff in *Bichon*. Whether this is the same person is speculation, but interesting nonetheless. In any event, the marriage apparently was an unsuccessful one, as the plaintiff-husband alleged that she was "a woman of a high and ungovernable temper and disposition . . .," that she "made most indecent remarks about the plaintiff's dead mother . . .," and that she "almost constantly nagged and found fault with every thing that the plaintiff did . . . ." Ultimately, the plaintiff alleged that the "constant ill treatment and abuse of the defendant . . . keeps [the plaintiff] . . . in such [an] unsettled state of mind that his life [is] a Hell on Earth . . . ." *Bichon v. Bichon*, Original Petition, at 1. (Perhaps Stowers felt the same way about the plaintiff suing it.).

20 *Stowers I*, 295 S.W. at 261. But consider the immediately preceding note.

21 Handbook of Texas Online (Ron Tyler et al. eds., 1996), *available at* http://www.tsha.utexas.edu/handbook/online/articles/view/SS/fst69.html (last visited Feb. 6, 2004). As for his ranch holdings, they remain in the hands of his grandchildren and great-grandchildren to this day. The ranch is about 25 miles west of Kerrville, in Hunt, Texas. It is open to guests for recreational usage such as hunting, hiking, and wildlife observation, *available at* http://www.stowersranch.com (last visited Apr. 26, 2004).

22 Ironically, it turned out that Stowers left a more permanent mark on Texas insurance law than he did on the San Antonio skyline. The "skyscraper" he built in San Antonio was apparently dynamited in 1981. San Antonio Conservation Society's "Milestones," *available at* http://www.saconservation.org/about/milestones_4.htm (last visited Oct. 22, 2004). Perhaps it is more fitting that only the Houston building now remains.

23 Handbook of Texas Online (Ron Tyler et al. eds., 1996),

available at http://www.tsha.utexas.edu/handbook/online/articles/view/AA/djatk.html (last visited Apr. 22, 2004). The middle Seinsheimer graduated from Tulane University in 1936 with a bachelor of business administration degree. He later became a generous supporter of Tulane's business school and endowed a professorship, *available at* http://www.tulane.edu/~akc/seins.html (last visited Oct. 18, 2004). Continuing the family tradition, the youngest Seinsheimer graduated from Tulane in 1962, *available at* http://www.freeman.tulane.edu/freemanmag/summer04/gwded.pdf (last visited Oct. 23, 2004).

24 United Fire Group, *available at* http://www.unitedfiregroup.com/investorrelations/news/19990304.asp (last visited Apr. 22, 2004).

25 Of course, this firm ultimately became what became known as Fulbright & Jaworski and is now Norton Rose Fulbright.

26 Handbook of Texas Online (Ron Tyler et al. eds., 1996), *available at* http://www.tsha.utexas.edu/handbook/online/articles/print/FF/ffr29.html (last visited Feb. 23, 2004).

27 *Memorials*, 5 Tex. B.J. 134 (1942).

28 *The Port's Past*, *available at* http://www.portofhouston.com/geninfo/overview2.html (last visited Oct. 23, 2004).

29 *Memorials*, 16 Tex. B.J. 609 (1953).

30 *Id*.

31 *Id*. That he would leave his job on the bench in order to volunteer for combat duty speaks volumes about his patriotism, or perhaps the job satisfaction of the judiciary during that era, or possibly both.

32 L. Patrick Hughes, *Beyond Denial: Glimpses of Depression-era San Antonio*, *available at* http:// www.austin.cc.tx.us/lpatrick/denial.htm (last visited Feb. 23, 2004).

33 Justice Robert W. Calvert, *Judicial System of Texas*: *The Appellate Courts of Texas – History*, *in* 361-362 S.W.2d 1-18 (1963).

34 These facts were drawn from a biography prepared by Critz's surviving daughter, Genevieve. Genevieve Critz Atkin & Brenda A. Rice, A Biographical Sketch of Richard Critz, Texas Judge (Dec. 1959) (unpublished manuscript, on file with the Austin History Center).

35 Ken Anderson, *How Dan Moody*, *'14 Destroyed the Klan in Texas*, The Alcalde (July/August 2000), *available at* http://www.texasexes.org/alcalde/issue-2000.07.html#feature (last visited May 4, 2004).

36 Justice Pierson and his wife were beaten and shot to death by their son Howard just outside of Austin. Howard even shot himself in the arm in an effort to cover up his crime, although he later confessed and offered a number of conflicting reasons behind the gruesome killings. Declared insane, he did not stand trial initially and was instead sent to the Austin State Hospital, from which he twice escaped. Twenty eight years after the slayings, he was pronounced medically sane and the case was later reopened for trial. Jerry Pillard, *Motive Still Obscure in Pierson's Slayings*, Houston Post, Sept. 8, 1963 at 10. Prior to the confession, a young Walter Cronkite reported Howard's original story in the student newspaper for the University of Texas. Walter Cronkite, The Daily Texan, April 25, 1935 at 1.

37 At the time, the Court had only three members. It was physically located in the Capitol building, and the justices wore suits rather than robes. As a young attorney, Joe Greenhill clerked for the Supreme Court during Critz's tenure. Justice Greenhill later quipped:

> To say we served under Justice Critz is a slight exaggeration. He would have nothing to do with a law clerk. He didn't want any "boy" telling him what the law was. (laughter) He could have used the help. (laughter)

Salute to the Honorable Clarence A. Guittard, February 27, 1987, *in* 741-742 S.W.2d at XLVI, LII.

38 The memorial services held in his honor at the Supreme Court were chronicled in the Texas Bar Journal. 22 Tex. B.J. 557-58, 586 (1959).

39 *Memorials*, 22 Tex. B.J. 545 (1959).

40 Handbook of Texas Online (Ron Tyler et al. eds., 1996), *available at* http://www.tsha.utexas.edu/handbook/online/articles/view/CC/fcr22.html (last visited Feb. 6, 2004). His fourth child, Ella Nora (known as "Sugar"), married J.J. "Jake" Pickle before dying of cancer in 1952. He and Critz remained friends after her death, and a touching biographical piece can be found in Congressman Pickle's book, "Jake." Jake Pickle & Peggy Pickle, Jake 197-200 (1997).

41 *Struck Down by Heart Attack*, *Luther Nickels Dies Suddenly*, Dallas Morning News, Apr. 2, 1933 at 1.

42 Judge Harvey was the presiding judge of Section "A." Born in Austin County in 1873, Harvey served on the Commission of Appeals from 1925 until 1943. As an aside, Leon Bichon's 1918 divorce petition mentioned in note 19, *supra*, was filed in the 80th J.D. of Harris County, Texas and was addressed to "the Hon. J.D. Harvey, Judge of said Court." *Bichon v. Bichon*, Original Petition at 1. Harvey is listed as having served as "District Judge, 80th Judicial District, 1915-1925" in the 1937 edition of the Bench and Bar of Texas. Bench and Bar of Texas, Vol. 1 (Horace Evans 1937). While we can only speculate, it appears that Judge Harvey may have had the opportunity to be associated with two cases involving Ms. Bichon.

43 *Bichon*, 254 S.W. at 609.

44 The judgment was against all defendants jointly and severally. Unfortunately, Jamail and his surety company were insolvent. Interestingly, at some point during this case, the name of Patterson's firm changed from Fouts & Patterson to Fouts, Amerman, Patterson & Moore. Patterson's partner, Mr. A.E. Amerman, served as mayor of Houston from 1918 until 1921. In that capacity, he approved the very bond that later turned out to be worthless. *See* Exhibit "A" to Bichon's Original Petition.

45 *Stowers I*, 295 S.W. at 258. In 2004 dollars, this figure would be worth $147,570.95. *See* Federal Reserve Bank of Minneapolis, *available at* http://woodrow.mpls.frb.fed.us/research/data/us/calc

(last visited Apr. 22, 2004).

46 Adjusters, lawyers and judges instantly recognize the issues involved in a *Stowers*-type case, including whether an underlying lawsuit should be settled instead of tried. However, juries tend to view things through a different prism. Accordingly, it is important to keep in mind the difficulty insureds sometimes face in winning over the jury in this type of case. An excellent trial lawyer once observed that the trouble with trying to recover under a liability policy is that the insured has to prove its wrongdoing was bad enough to warrant settlement with the plaintiff(s) but not so bad that it should not be covered. There is a distinction, of course, between conduct that is *very injurious* as opposed to that which is *quite intentional*.

47 SOF at 29. To recover on a lost or missing policy, the Fifth Circuit has held:

> Where the actual policy is not available, the terms of the contract can also be shown by secondary evidence. This alternative requires evidence of the policy terms, not just evidence of the existence of the policy.

Bituminous Cas. Corp. v. Vacuum Tanks, *Inc*., 975 F.2d 1130, 1132 (5th Cir. 1992). Notably, the opinion from the Commission of Appeals mentions but does not discuss this issue. *Stowers*, 15 S.W.2d at 545-46.

48 SOF at 47, 30.

49 *Id*. at 31.

50 *Id*. at 38.

51 In addition to the pleadings, the lawyers spoke with a certain eloquence as well. For example, when asked about his experience as a trial lawyer, Campbell responded:

> My experience has been largely that of a trial lawyer in all kinds of litigation. [I] couldn't tell you how many such cases I have tried, but I suppose about the average number that a lawyer tries who has been in the practice as long as I have.

SOF at 98.

52 Regrettably, the racial composition of the people involved in this case was an issue during this litigation. As a result, the briefs, opinions and other materials we reviewed in researching this article contain racial epithets of this type. While we do so with much reluctance, we repeat these terms only in the quotations in order to maintain historical accuracy.

53 The petition thus laid bare the more sinister aspect of the case lurking in the background. The Court of Civil Appeals also categorized the individuals by race. *Stowers I*, 295 S.W. at 261 (referring to Perry, Bichon, and her liability witnesses by their respective races). The other courts, though, did not. *See*, *e.g. Stowers*, 15 S.W.2d at 545 (referring to Perry simply as one of the ". . . furniture company's servants . . . .").

54 Stowers mixed bad faith and negligence together in its pleadings. For example, it stated that it was compelled to pay Bichon's excess judgment "by reason of said defendant's lack of good faith and negligence in refusing to make settlement of said suit for $4,000 . . ." Stowers's Second Amended Original Petition, at 11. Although both are torts, one is pure negligence, the other is bad faith. In part because of *Stowers*, the Texas Supreme Court has held that there is no common-law duty of good faith duty and fair dealing in the third party context. *Maryland Ins. Co. v. Head Indus. Coatings & Servs*., *Inc*., 938 S.W.2d 27, 28-29 (Tex. 1996) (per curiam).

55 SOF at 85.

56 This was one of the points of dispute on appeal, but it was not a central part of Stowers's initial brief. American Indemnity's brief argued that the exclusion of these witnesses was proper because the only relevant testimony was what the lawyers and parties knew at the time the settlement was refused, which of course was prior to trial. However, since the *Stowers* doctrine is designed to avoid excess judgments, it should not be limited only to pre-trial settlement offers. Thus, if settlement at a certain sum appeared unwise before trial, but became reasonable as the trial progressed, there is no reason to think that the *Stowers* doctrine should not apply. Consequently, any evidence up to the entry of an excess judgment should be relevant. Ultimately, this position prevailed. *Stowers*, 15 S.W.2d at 548 ("[W]e are of the opinion that the serious nature of Miss Bichon's injuries and all the facts and circumstances surrounding her injury, are material as bearing on the question of negligence on the part of the indemnity company in failing and refusing to make the settlement.").

57 It is curious to us why the report was admitted if the witnesses were excluded. Perhaps no objection was made.

58 SOF at 21.

59 Freeman testified that Patterson "said . . . that there was sufficient question in the case that there might possibly be a judgment over and above the five thousand dollars, and that it would be wise for Stowers Furniture Company to be in the case with attorneys of their own selection in addition to the attorneys representing the insurance company." SOF at 71.

60 The limit was $5,000. Thus, American Indemnity was willing to pay no more than half of the limit in settlement.

61 Patterson denied that this conversation ever took place. SOF at 116.

62 Apparently, the distinction between "no lights" and "non-working lights" worked for Walker, but not the jury.

63 SOF at 63.

64 SOF at 83. At trial, Patterson testified first that "I don't remember who said it." *Id.* at 127. Later, he testified that he had "no recollection of making that statement." *Id.* at 144.

65 Although it is not expressly clear, it appears that Freeman's partner, John H. Crooker, tried the case on behalf of the Stowers Furniture Company. Crooker was the co-founder of the Fulbright firm.

66 There was some discussion about one other case in particular where the company paid 75% of its limits to settle, but it was reinsured for half of the limit of the policy, so American Indemnity's

net out of pocket was no more than half of the policy's limit. Hartung also testified concerning other cases about which he could not identify the particulars, but was certain that they had paid more than half of the limits of the policy.

67 At one point, Stowers argued that, when it issued the policy, American Indemnity Company "created the relation of attorney and client . . . ." Stowers's Brief, at 44.

68 This last point makes little sense as virtually any case can draw an adverse jury verdict, a directed verdict, or other similar outcome that results in no recovery. Thus, if this were the standard, then the duty would likely never be triggered. It occurs to us that a duty which is almost never triggered is worth very little.

69 Curiously, American Indemnity acknowledged that it would be liable for botching the defense, stating:

> We do not contend for a second that in proper cases negligence in the defense of a suit, the failure to plead proper defense, etc., will not make the [insurer] liable under a policy of this nature.

American Indemnity's Brief, at 18. Contrast this view with *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998) (prohibiting recovery against the insurer for the conduct of an independent attorney it selects to defend the insured.).

70 *Id.* at 19. Obviously, this prediction is not absolutely true. Nevertheless, as the jury verdict in Stowers's favor shows, there is probably at least some merit to this contention. This could partially explain why there has been a large amount of litigation as to whether the duty was properly triggered. *See*, *e.g. Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 853-55 (Tex. 1994) (whether demand was within policy limits); *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489 (Tex. 1998) (whether demand offered to fully release insured). Nevertheless, there are many cases where the insured has difficulty in convincing a jury that it should be indemnified for its own culpable conduct. An interesting empirical study would be to analyze the reported cases involving the *Stowers* duty to determine what percentage of jury verdicts is won by insurers and what percentage is won by policyholders. This would only be a rough estimate at best given the small fraction of cases that actually reach the appellate process, and this limitation is particularly relevant here since the very purpose of *Stowers* is to encourage settlement.

71 Why did it ultimately evolve as an action in tort instead of one in contract? It might be that because Stowers pleaded it that way, and since it ultimately prevailed, perhaps the court naturally adopted Stowers's approach. It might also be that since the standard is couched in terms of "ordinary care," the logical response is to call it a negligence claim. Interestingly, if the duty sounds in contract, then a breach would subject the insurer to liability for attorneys' fees. But, since the duty ultimately was couched as a tort, then there is no exposure to attorneys' fees under Tex. Civ. Prac. & Rem. Code Ann. § 38.001 as a result of a breach of the duty to settle. However, since it is a tort, it theoretically opens an insurer up to the possibility of exemplary damages. Accordingly, the nature of the evolution of this doctrine both narrowed and broadened the available remedies in this context. Fortunately (or unfortunately), this issue has now been resolved by the Texas Supreme Court's decision in *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 255 (Tex. 2002) (allowing recovery under Tex. Ins. Code Ann. art. 21.21 for breach of the *Stowers* duty). Thus, in a proper case, an insured would be allowed to recover attorneys' fees *and* exemplary damages under art. 21.21.

72 Of course in this situation, the insured would not "get off scot free" as American Indemnity claimed. Instead, it would receive exactly what it paid for – indemnity up to the policy limits, if necessary.

73 Curiously, it seems that the court found significance in the fact that Stowers itself refused to put up $1,500 to settle the suit. Apparently, the court felt that this was evidence of Stowers's belief in the strength of the defense. Stowers took issue with this point in its Motion for Rehearing, noting that the testimony revealed that Stowers simply believed it was not obligated to contribute anything to a settlement below the limits of its insurance. In effect, Stowers was unwilling to insert a deductible or self-insured retention into the policy after it was issued, as American Indemnity was trying to force it to do.

74 Catherine K. Harris, *A Chronology of Appellate Courts in Texas*, 67 Tex. B.J. 668, 671 (2004).

75 Justice Robert W. Calvert, *Judicial System of Texas*: *The Appellate Courts of Texas – History*, *in* 361-362 S.W.2d 2-3 (1963).

76 At the time, there were only a handful of other states that had considered the matter. Thus, this was not only an issue of first impression in Texas, it was one in which there was very little guidance from other jurisdictions as well. In its briefing, Stowers reported the decisions to be more or less evenly split as to whether the insured should be allowed to recover in claims of this type.

77 Chief Justice Cureton signed the order approving of the holding of the Commission of Appeals. Aside from Chief Justice of the Supreme Court of Texas, Cureton held other public posts, including state legislator and attorney general. He was appointed to the Court in 1921 by Governor Pat M. Neff, and served continuously until his death in 1940, *available at* http://www.tsha.utexas.edu/handbook/online/articles/print/CC/fcu26.html (last visited Nov. 14, 2004).

78 Interestingly, Judge Nickels referred to these as "facts." Among the facts identified were that a reasonable offer within the policy limits was extended, an excess judgment was possible if not probable, and the insurer refused to contribute more than $2,500.

79 Gormley's firm provided the founding partners of what is today known as Strasburger & Price, *available at* http://www.strasburger.com/nav/directory.htm (last visited May 5, 2004). Gormley's prediction may have turned out correct after all, at least with respect to his own firm going out of business. With the defection of the lawyers who formed Strasburger & Price in 1939, the firm dissolved. Gormley then became a partner in the new firm of Touchstone, Wight, Gormley & Touchstone, where he practiced until his retirement in 1945. Gormley passed away in 1949, at the age of 74. *Memorials*, 12 Tex. B.J. 482 (1949).

80 Contrast American Indemnity's position here with its earlier

prediction that if the *Stowers* duty remained, insurance companies "would necessarily settle all cases . . . ." American Indemnity argued both extremes, despite the inconsistency. In a motion for additional time to file an extra brief, American Indemnity suggested that the effect of the case "will be so drastic and cause such losses as to put out of business many companies, and to make it unprofitable to write this character of policy for many companies . . ." Motion for Additional Time, at 1. Of course, American Indemnity still has a current license to sell insurance in Texas to this day, and thankfully, liability insurance remains widely available as well.

81 Texas Department of Insurance, *available at* https://wwwapps.tdi.state.tx.us/pcci/pcci_how_profile.jsp? tdiNum=3808&companyName=Standard+Accident+Insurance+Company&sysTypeCode=CL&optCaller=Caller+Info&optExplanation=Explanation (last visited May 4, 2004). The struggles of Reliance are well known. A simple summary of this complex case is *available at* http://www.relianceinsurance.com (last visited May 4, 2004).

82 Apparently Gormley was known for being widely read in literary classics and history, and for quoting such works in his arguments. He was very proud of his membership in the Texas Philosophical Society. *Memorials*, 12 Tex. B.J. 482 (1949).

83 Whether the term "reasonable lawyer" is an oxymoron is a question best left for another day.

84 In its Motion for Rehearing in the Court of Civil Appeals, Stowers argued that "[i]n our modern time . . . the statistics show that more than ninety per cent of all disputes are . . . settled." Motion for Rehearing, at 8.

85 *See*, *e.g. Bawcom v. State*, 78 S.W.3d 360, 363 (Tex. Crim. App. 2002) (noting that *stare decisis* fosters reliance on judicial decisions, and that under the doctrine, it is often "better to be consistent than right.").

86 *See Am. Centennial Ins. Co. v. Canal Ins. Co*., 843 S.W.2d 480, 482-83 (Tex. 1992) (referring to the *Stowers* doctrine as a "clear right" of the insured, and extending this right to allow excess carriers to pursue equitable subrogation claims against primary carriers for mishandling a claim).

87 The pleading made clear that the mitigation defense was directed only to that portion of the judgment in excess of the limits, so it would not apply to the difference between the $4,000 demand and the $5,000 limit, but it would apply to every dollar in excess of the $5,000 policy limit. While Stowers had the financial resources to make such a settlement (it did pay the judgment in full), this creative argument fails when one considers insureds without such resources. Certainly an insurance company should not obtain a windfall for its own negligence simply because its insured has sufficient resources to pay where the insurance company refuses. Perhaps this was merely a throw-away claim back in the days when contributory negligence was still a complete bar to recovery. S*ee Signal Oil & Gas Co. v. Universal Oil Prods*., 572 S.W.2d 320, 327 n.12. (Tex. 1978) ("Contributory negligence no longer bars recovery in a negligence cause of action in Texas since Texas enacted Article 2212a, Texas Revised Civil Statutes Annotated, which became effective on September 1, 1973.").

88 The jury charge begins with this salutation. It appears, therefore, that the jury was all-male. We do not know if it was also all-white, although we suspect it may have been.

89 It is important to note that, on the second appeal, the Court of Civil Appeals expressly approved of this submission. *Stowers III*, at 936-37.

90 Again, there is an interesting question as to the impact, if any, of *Traver* on this point.

91 This was the $14,103.15 paid to Bichon, plus interest during the pendency of the suit against American Indemnity.

92 Stowers's Reply Brief, at 6.

93 That the writ was refused means the opinion in *Stowers III* has precedential value equal to a decision from the Texas Supreme Court. *See* Appendix "A" to the *Texas Rules of Form* (10th ed. 2003).

94 The title for this section of the paper comes from Judge Posner's excellent biography of Justice Cardozo, wherein he suggests alternative areas for further study on one of the towering figures in American law. Richard A. Posner, Cardozo: A Study in Reputation 144 (1990). Posner's treatment of Cardozo's life and work is scholarly, engaging and insightful. In short, it is worth the reader's time.

95 *See*, *e.g. Rocor*, 77 S.W.3d 253, 264-65 ("To establish liability, the insured must show that . . . (4) the demand's terms are such that an ordinarily prudent insurer would accept it."). In truth, recent cases can be found on both sides. To compound the problem further, *Garcia* uses both formulations, and even in the very same paragraph. There are other cases using both as well, including *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314 (Tex. 1994), and *St. Paul Fire & Marine Ins. Co. v. Convalescent Servs*., *Inc*., 193 F.3d 340, 342 (5th Cir. 1999). In *Garcia*, the court first stated that the carrier "was required to exercise 'that degree of care and diligence which an ordinarily prudent *person* would exercise . . . .'" *Garcia*, 876 S.W.2d at 848 (emphasis added). In the same paragraph, it then stated that the *Stowers* duty "is not activated . . . unless . . . the terms of the demand are such that an ordinarily prudent *insurer* would accept it . . . ." *Id*. at 849 (emphasis added). Adding to the mystery, its second formulation cites a law review article written by Judge Keeton in 1954. This issue was raised in both *Rocor* opinions from the San Antonio Court of Appeals and, after determining that that the Texas Supreme Court had not addressed which formulation was more appropriate and that *Stowers* remained good law, the court found no error with the use of "person" instead of "insurer" in the jury charge. In the first opinion, the court also relied on the use of "person" by the Corpus Christi Court of Appeals in *Trinity Universal Ins. Co. v. Bleeker*, 944 S.W.2d 672, 680 (Tex. App.—Corpus Christi 1997). *See Rocor*, 1998 WL 9505 (Tex. App.—San Antonio Jan. 14, 1998). Curiously, the *Bleeker* citation is absent from the substituted opinion following rehearing *en banc*. *Rocor*, 995 S.W.2d at 814-15.

96 S*ee*, *e.g. State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d

625, 627 (Tex. 1998); *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 558 (Tex. 1973); *American Home Assurance Co., Inc. v. Unauthorized Practice of Law Committee*, 121 S.W.3d 831 (Tex. App.—Eastland 2003, pet. filed); *Safeway Managing Gen. Agency v. Clark & Gamble*, 985 S.W.2d 166, 168 (Tex. App.—San Antonio 1998, no pet.); *Bradt v. West*, 892 S.W.2d 56, 77 (Tex. App.—Houston [1st Dist.] 1994, writ denied).

97 As we noted previously, American Indemnity's dire prediction is not literally true. Regardless, it reminds us of the words of Justice Holmes:

> [F]or the rational study of the law the black-letter man may be the man of the present, but the man of the future is the man of statistics . . . .

Oliver Wendell Holmes, Jr., Collected Legal Papers 187 (Harcourt, Brace & Co. 1921). Here, we have analyzed the black-letter law (as well as the facts of the case that led to its creation). We leave it to others to analyze the statistics in order to evaluate the true accuracy of American Indemnity's prediction.

98 *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973).

99 We would like to express our sincere thanks to the many individuals who assisted us in preparing this article. In particular, however, we are grateful to U.S. District Judge Gray Miller, formerly of Fulbright & Jaworski (now Norton Rose Fulbright) for searching that firm's archives several years ago and locating several briefs that served as the inspiration for this paper. Interestingly, the firm's former website identified a number of engagements involving the *Stowers* doctrine in describing its insurance expertise, but the *Stowers* case itself was not among them. See http://www.fulbright.com/index.cfm?fuseaction=local.detail site_id= 334&link_name=Experience (last visited Apr. 27, 2004).

100 Stowers Furniture Company, http://www.stowersfurniture.com/index.php (last visited Apr. 27, 2004).

COMMISSION OF APPEALS
OF TEXAS
AUSTIN

No. 1021-4915.
COMMISSION OF APPEALS.
SECTION A.

G.A.STOWERS FURNITURE COMPANY,	)	
PLAINTIFF IN ERROR,	)	FROM HARRIS COUNTY,
vs.	)	FIRST DISTRICT.
AMERICAN INDEMNITY COMPANY,	)	
DEFENDANT IN ERROR.	)	

This case involves issues that are questions of first impression in this court, and are so important to the jurisprudence of this state that we deem it advisable to make a very full and complete statement of the issues involved.

This suit was originally filed by the G.A. Stowers Furniture Company, plaintiff in error, hereinafter styled plaintiff, against American Indemnity Company, defendant in error, hereinafter styled defendant, for $14,103.15, together with interest, and for cause of action the petition states in substance:

That defendant was a private corporation in the city of Galveston and was engaged during the years 1919 and 1920 in the business of writing and issuing insurance policies and bonds to indemnify the assured against loss by reason of liability imposed by law upon the assured for injuries on account of bodily injuries, etc., and that the said Indemnity Company issued to said Stowers Furniture Company a policy of insurance for the sum of Five Thousand Dollars which proposed to indemnify the said Furniture Company against loss by reason of injuries accidentally suffered by any person or persons if such loss or damage so sustained was by reason of the said Furniture Company's ownership of the automobiles described in said policy.

It was further charged that defendant, Indemnity Company, agreed in said policy and had reserved the right to defend any suit in the name and behalf of said named assured for such damage or loss sustained if same was by reason of said plaintiff's ownership.

It was further provided that the Furniture Company should immediately, in the case of an accident, give notice to defendant, Indemnity Company, at Galveston and should forward to said Indemnity Company any summons or other process served upon them and when requested by said Company, the assured should aid in effecting settlement, etc.

It was further stipulated in said policy that the assured, meaning said Furniture Company, should not voluntarily assume any liability, settle any claim or expense except at its own cost and should not engage in any negotiations of such settlement or legal proceedings without the consent of said Insurance Company and the said Insurance Company reserved the right to settle any and all claims or suits brought against the plaintiff.

It was further alleged that the premiums were all paid on said policy and the same was valid and subsisting and in full force and effect, that said policy had been mislaid and that proof would be offered of its contents.

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It was further charged in said petition that on the 23rd day of January, 1920, a truck belonging to said Furniture Company and covered by said policy of insurance, which was hauling and delivering furniture and being operated by one of the said Furniture Company's servants and was being driven on Austin Street in the City of Houston, Texas, at about the hour of 7:00 p.m., came in contact with a wagon standing on the side of Austin Street and was thereby disabled and so crippled that said servant could not longer operate it and that it was left by the servant of said Furniture Company, without a light and without any one to watch it, and that shortly thereafter Miss Mamie Bichon, who was an employee in a drug store, left for her home at about 8:30 p.m. and was driven by Jamail in a Ford Coupe very rapidly along said street and came in collision with said truck; that the coupe was turned over and that she was very seriously injured; and that about the 3rd day of March, 1920, the said Miss Bichon brought suit for damages against said Stowers Furniture Company for Twenty Thousand Dollars.

It was further charged that defendant herein took charge of the defense of said suit for this plaintiff in accordance with the terms of said policy.

It was further charged that defendant herein employed counsel and proceeded to trial in said cause of Miss Bichon against the plaintiff, Furniture Company, and that after hearing the evidence and the charge of the court, the jury returned a verdict for Miss Bichon for the sum of Twelve Thousand Two Hundred Seven and No-100 ($12,207.00) Dollars besides cost; that there was an appeal by the defendant herein from said judgment; that the same was affirmed and that this plaintiff paid to Miss Bichon the sum of Fourteen Thousand One Hundred Seven and 15-1000 ($14,107.15) Dollars, including interest and costs of court.

It was further charged that during the pendency of this suit, and before the trial, Miss Bichon offered to accept Four Thousand Dollars in full settlement for the damages due her; that defendant herein refused to pay more than Twenty-five Hundred Dollars, although its policy bound it to pay Five Thousand Dollars; that the defendant herein knew that the case which Miss Bichon had against this plaintiff was a very dangerous one and that she was likely to get a judgment for far more than Five Thousand Dollars and that a person of ordinary prudence would have settled said cause for said sum of Four Thousand Dollars; that defendant admitted that said offer of settlement was a good one and should be accepted; that it wilfully and negligently refused to make such settlement knowing at the time it did so that it was jeopardizing the interests of this plaintiff in a very large amount; that in refusing to make such settlement it did not act in good faith; and it did not act like a prudent person would have done under like circumstances and that by reason of such conduct of said Indemnity Company the Furniture Company had been compelled to pay the said sum of more than Fourteen Thousand Dollars.

The material portion of the defendant's answer as shown in the opinion of the Court of Civil Appeals is as follows:

"That after the happening of the said accident made the basis of this suit the defendant investigated it, and after suit was filed and after citation was forwarded to it by plaintiff herein, it made defense of said suit and defended it through all the courts. That under the terms and provisions of said contract it was to have control of the defense of said suit and no settlement was to be made without its consent, it having the option of settling or defending the suit as it might deem best, and it was under no duty to settle said suit, and it elected to and did defend the said suit. That after making investigation in reference to said accident and the extent of the injuries suffered by Mamie Bichon, this defendant reached the conclusion that the facts of the accident were of such nature that it could and did reasonably suppose that judgment would ultimately result in a verdict for the defendant, and that the injuries suffered by Mamie Bichon as

a result of the accident were not of a permanent nature or of such seriousness as to justify a settlement of this case for $4,000.* * *

"For further and special answer herein, defendant says that by the terms of said contract of indemnity its liability was limited, as hereinbefore alleged, to $5,000, with interest thereon at 6 per cent. from the date of the judgment to the affirmance thereof. This defendant says that it has already carried out the terms and provisions of said contract except the payment of $5,000 and interest thereon, which immediately upon the affirmance of this case by the Supreme Court was tendered to the plaintiff herein and plaintiff was notified that defendant was ready and willing to pay the same, but was notified by the plaintiff that plaintiff would not release this defendant from liability, which it was entitled to be released from if it complied with its contract, and stated it was useless to tender the actual money because plaintiff would not accept it; that this defendant has always been ready and willing to pay the limit of its liability, to wit, $5,000, with interest at 6 per cent. until plaintiff's notice it would not be accepted, and is now ready and willing to pay the same, which amount next above mentioned represents principal of $5,000, interest thereon to the date of the notification that tender would not be effective, together with court costs, which are also tendered, which notification to the plaintiff and the understanding that a complete release from liability would not be effected was within ten days of the affirmance of said case by the Supreme Court."

The policy mentioned in the petition contains, among others, the following provision:

"AMERICAN INDEMNITY COMPANY
"Home Office: Galveston, Texas.

"In consideration of the premium of this Policy, as expressed in Statement 5, and of the other statements which are set forth in the Schedule of Statements herein made, and which the Assured warrants to be true by the acceptance of this Policy, and also subject to the conditions of this Policy as hereinafter set forth:

DOES HEREBY AGREE

"TO INDEMNIFY the Assured named and described in Statement 1 of the Schedule of Statements forming part hereof:

"AGAINST LOSS BY REASON OF THE LIABILITY imposed by law upon the Assured for damages on account of bodily injuries, including death at any time resulting therefrom, accidentally suffered or alleged to have been suffered while this Policy is in force by any person or persons except employes of the Assured while engaged in operating, riding in or on, or caring for automobiles covered hereby."

****

"AND IN ADDITION THE COMPANY AGREES:

"(A)TO DEFEND in the name and on behalf of the Assured any suits even if groundless, brought against the Assured to recover damages on account of such happenings as are provided for by the terms of the preceding paragraphs.

"(B) TO PAY irrespective of the limits of liability expressed in Condition 8 (Limits) hereof, all costs taxed against the Assured in any legal proceeding defended by the Company, all interest accruing after entry of judgment upon such part thereof as shall not be in excess of said liability and the expense incurred by the Assured for such immediate medical or surgical relief as is imperative at the time of the accident, together with all the expense incurred by the Company growing out of the investigation of such an accident, the adjustment of any claim or the defense of any suit resulting therefrom."

The policy further provides:

"This policy does not cover Injuries and / or Death, or Loss, Damage and / or Expense:"

* * * * * * * * * * *

"Assumed by the Assured under any Contract or

The policy further provides:

"The Company's Liability is Limited:
"Under Clause One (Liability) regardless of the number of Assured involved, the Company's liability for the loss from an accident resulting in bodily injuries to or in/death of one person is limited to FIVE THOUSAND DOLLARS ($5,000.00), and, subject to the same limit for each person, the Company's total liability for loss from any one accident resulting in bodily injuries to or in the death of more than one person is limited to TEN THOUSAND DOLLARS ($10,000.00). "

The policy further provides:

"No action shall lie against the Company to recover for any loss, Damage and or Expense, under this Policy, unless it shall be brought by the Assured for Loss, Damage and / or Expense actually sustained and paid by him in money in satisfaction of a judgment after trial of the issue, and no such action shall lie to recover under any other agreement of the Company herein contained unless brought by the Assured himself to recover money actually expended by him. In no event shall any such action lie unless brought within ninety days after the right of action accrues, as herein provided.
"The Assured shall upon the occurrence of an accident give immediate written notice thereof to the Company's Home Office, at Galveston, Texas, or its Agent duly authorized by law to receive the same, with the fullest information obtainable. He shall give like notice with full particulars of any claim made on account of such accident. If, thereafter, any suit is brought against the Assured he shall immediately forward to the Company every summons or other process served upon him. The Assured, when requested by the Company, shall aid in effecting settlements, securing evidence, the attendance of witnesses and in prosecuting appeals. The Assured shall not voluntarily assume any liability, settle any claim or incur any expense, except at his own cost, or interfere in any negotiation for settlement or legal proceeding without the consent of the Company previously given in writing. The Company reserves the right to settle any such claim or suit brought against the Assured."

At the close of the testimony in the district court the trial court withdrew the case from the jury, and entered judgment for the defendant. This judgment was, on appeal, affirmed by the Court of Civil Appeals. 295 S.W. 257.

The case is now before this court on writ of error granted on application of the plaintiff.

We are of the opinion that the plaintiff's petition states a cause of action against the defendant for the amount sued for, and that the evidence in the case raised an issue of fact to be submitted to the jury by the trial court under proper instructions.

The Court of Civil Appeals in passing on the issues of this case holds:

"We do not think the indemnity company was, by the terms of the policy, under any obligation to do more than to faithfully defend the suit. As before stated, it had not agreed to settle the suit, but had reserved the right to do so. It had the unquestioned right to defend the suit to the

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end that it might not be called upon to pay a judgment which might be rendered in favor of Miss Bichon."

As stated in the beginning, the matters involved in this litigation are of first impression in this state, and the holding of the Court of Civil Appeals is in the main supported by the authorities cited by that court.

We, however, are of the opinion that the Court of Civil Appeals was in error in the above holding, and that the better and sounder authorities, and those more in harmony with the spirit of our laws, support a contrary rule. Douglass vs. United States Fidelity & Guaranty Co. (Sup.Ct.N.H.) 127 Atl, 708; Mendota Electric Co.vs.New York Indemnity Co., (Sup.Ct. Minn.) 211 N.W. 317; Cavanaugh vs.General Accident, etc., Assurance Corporation, 106 Atl., 604; Attleboro Mfg. Co.vs. Frankford, etc., Ins.Co. 240 Fed. 573; Brown vs.Guaranty Co., 232 Fed. 298.

As shown by the above quoted provisions of the policy, the Indemnity Company had the right to take complete and exclusive control of the suit against the assured, and the assured was absolutely prohibited from making any settlement, except at his own expense, or to interfere in any negotiations for settlement, or legal proceeding without the consent of the company, the company reserved the right to settle any such claim or suit brought against the assured. Certainly where an insurance company makes such a contract, it, by the very terms of the contract, assumed the responsibility to act as the exclusive and absolute agent of the assured, in all matters pertaining to the questions in litigation, and as such agent, it ought to be held to that degree of care, and diligence, which an ordinarily prudent person would exercise in the management of his own business; and, if an ordinarily prudent person, in the exercise of ordinary care, as viewed from the standpoint of the assured, would have settled the case, and failed or refused to do so, then the agent, which in this case is the Indemnity Company, should respond in damages.

It is true that the policy is for $5000.00, so far as this accident is concerned, but when the liability arose

against plaintiff, the Indemnity Company was in duty bound to exercise ordinary care to protect the interest of the assured up to the amount of the policy, for the reason that it had contracted to act as his agent, and assumed full and absolute control over the litigation arising out of the accident covered by the policy. The provisions of the policy giving the Indemnity Company absolute and complete control of the litigation, as a matter of law, carried with it a corresponding duty and obligation, on the part of the Indemnity Company, to exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the Indemnity Company.

It is the duty of the court to give effect to all the provisions of the policy, and it would certainly be a very harsh rule to say that the Indemnity Company, in a case such as this, owed no duty whatever to the insured further than the face of the policy, regardless of whether it was negligent in discharging its duties as the sole and exclusive agent of the assured, in full and complete control. Such exclusive authority to act in a case of this kind does not necessarily carry with it the right to act arbitrarily. Douglas vs.United States, etc.Guaranty Co., supra.

In the Douglas case, supra, the Supreme Court of New Hampshire lays down the law, which we think applies to the issues of the case at bar, as follows:

"The fundamental question is, Does or does not the insurer owe to the insured a duty in the matter of a settlement? If it does not owe such a duty, it is not liable either for a failure to act or for the manner of action. It may refrain from completing a settlement for any reason, however essentially dishonest, and still there would be no liability. If, as the cases roundly state, it has an exclusive and absolute option, no one can question its motives for the exercise or nonexercise of the privilege. No case has gone that far. All acknowledge a liability for fraudulent conduct, or lack of good faith, in refusing to settle. But they are silent as to any reasoning which would sustain such liability and at the same time deny responsibility for negligent conduct.

"The whole question of insurance against loss may be laid out of the case, and still the defendant would be accountable for negligence. It had contracted to take charge of the defense of this claim. That contract created a relation out of which grew the duty to use care when action was taken. The insurer entered upon the conduct of the affair in question.

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It had and exercised authority over the matter in every respect, even to negotiating for a settlement. It is difficult to see upon what ground it could escape responsibility when its negligence resulted in damage to the party in had contracted to serve. Attleboro Manufacturing Company v.Company, 240 F. 573, 153 C.C.A. 377.

"Denial of agency upon the part of the insurer is put upon the ground that, if there were such a relation the insurer would be bound to consider the interests of the insured, when in conflict with its own. It is then said that, when there is such conflict, the insurer may consult its own interests solely. Therefore, it is concluded there can be no agency.

"This reasoning seems to imply that one party cannot be the agent of the other party. But the law is plainly otherwise. The parties may make that sort of an agreement if they see fit. The result of such a compact is not to leave the promissor free to act as though he had made no promise. On the contrary, his conduct will be subject to closer scrutiny than that of the ordinary agent, because of his adverse interest. The fact that here the insurer stood to lose but a part of the claim, and that as to the balance the chances of loss growing out of mismanagement of the defense were upon the insured, is an added reason for holding the defendant to the use of reasonable care in the exercise of its exclusive control over the negotiations. Where one acts as agent under such circumstances, he is bound to give the rights of his principal at least as great consideration as he does his own. Colby v. Copp. 35 N.H., 434, and cases cited; Richards v.Insurance Company, 43 N.H.263. The insurer cannot betray the trust it has undertaken nor be relieved from the usual rule that in such a case an agent must serve as he has promised to serve."

In the Cavanaugh case, supra, the same court announces the same rule as is announced in the Douglas case.

In our opinion the other authorities above cited sustain the rule announced by us, and while there are authorities holding the contrary rule, we are constrained to believe that the correct rule under the provisions of this policy, is that the Indemnity Company is held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business.

The Court of Civil Appeals holds that the trial court did not err in refusing to permit Miss Bichon, and others, all witnesses for plaintiff, to testify as to the serious nature of her injuries. We think this holding is error. Further, we are of the opinion that the serious nature of Miss Bichon's injuries and all the facts and circumstances surrounding her injury, are material as bearing on the question of negligence on the part of the Indemnity Company in failing and refusing to make the settlement.

Of course knowledge on the part of the Indemnity Company is also an issue. The facts and circumstances surrounding

the original injury, and the extent of same, would not raise the issue of negligence on the part of the Indemnity Company unless it had knowledge thereof, or by the exercise of ordinary care could have had such knowledge.

We think further that the testimony offered by plaintiff to the effect that it was a rule of the Indemnity Company never to make a settlement for more than one-half the amount of the policy should have been admitted as bearing on the issue of negligence on the part of the Indemnity Company.

What we have said disposes of all the assignments.

We recommend that the judgments of the Court of Civil Appeals, and of the District Court, be both reversed, and the cause remanded to the District Court for a new trial.

Richard Critz

Judge.

C/p

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SUPREME COURT
AUSTIN

No. 4915.

G. A. Stowers Furniture Co., Plaintiff in Error,

vs.

American Indemnity Co., Defendant in Error.

Judgments of the District Court and Court of Civil Appeals reversed, and cause remanded to the District Court.

We approve the holdings of the Commission of Appeals on the questions discussed in its opinion.

O. M. Cureton

Chief Justice.

March 27, 1929.

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COMMISSION OF APPEALS
OF TEXAS
AUSTIN

Dissenting Opinion
by
Luther Nickels

NO. 1021-4915,
COMMISSION OF APPEALS,
SECTION A.

G. A. STOWERS FURNITURE CO.,		
PLAINTIFF IN ERROR,		FROM HARRIS COUNTY,
-Vs.-		
AMERICAN INDEMNITY CO.,		FIRST DISTRICT.
DEFENDANT IN ERROR.		

The case is generally stated in the opinion of the Court of Civil Appeals, 295 S. W. 257.

In terms, the insurer agreed "to indemnify" the "assured" to the extent of $5,000

> "AGAINST LOSS BY REASON OF THE LIABILITY imposed by law upon the Assured for damages on account of bodily injuries, including death at any time resulting therefrom, accidentally suffered or alleged to have been suffered while this policy is in force by any person or persons except employes of the Assured while engaged in operating, riding in or on, or caring for automobiles covered hereby."

But, it was stipulated,

> "No action shall lie against the Company to recover for any Loss, Damage and/or Expense, under this Policy, unless it shall be brought by the Assured for Loss, Damage and/or Expense actually sustained and paid by him in money in satisfaction of a judgment after trial of the issue, and no such action shall lie to recover under any other agreement of the Company herein contained unless brought by the Assured himself to recover money actually expended by him. In no event shall any such action lie unless brought within ninety days after the right of action accrues, as herein provided."

In the provision last quoted, it will be marked, there is definition of "liability imposed by law" mentioned in the provision first quoted. "Liability imposed by law", as stipulated, is that declared in final judgment "after

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Indemnity thus declared is conditioned, amongst other things, upon notice by "assured" of "accident" and of "claim on account of such accident", transmission by "assured" of "every summons or other process served" in a suit, "aid" by assured (when requested) "in effecting settlements, securing evidence * * * attendance of witnesses and in prosecuting appeals". In the paragraph embodying those conditions are two others:(a) "The Company reserves the right to settle any such claim or suit brought against the assured"; (b) "The assured shall not voluntarily assume any liability, settle any claim, or incur any expense, except at his own cost, or interfere in any negotiation for a settlement or legal proceeding without the consent of the Company previously given in writing".

The "Company" agreed further:

> "(A) TO DEFEND in the name and on behalf of the Assured any suits even if groundless brought against the Assured to recover damages on account of such happenings as are provided for by the terms of the preceding paragraphs.
> "(B) TO PAY irrespective of the limits of liability expressed in Condition 8 (Limits) hereof, all costs taxed against the Assured in any legal proceeding defended by the Company, all interest accruing after entry of judgment upon such part thereof as shall not be in excess of said liability and the expense incurred by the Assured for such immediate medical or surgical relief as is imperative at the time of the accident, together with all the expense incurred by the Company growing out of the investigation of such an accident, the adjustment of any claim or the defense of any suit resulting therefrom";

The basic elements of the praesenti agreement may be thus re-stated: (a) Indemnity "against loss by reason of liability imposed by law" as pronounced in a final "judgment after trial of the issue". That definition of "liability imposed by law", as noted, is to be found in the excerpt secondly given above; and it is given some effect in the provision against 'voluntary assumption' of liability and in the stipulation for "interest accruing after judgment". (b) Right of the Company to "settle any * * * claim or suit", and its duty to "defend" if it do not use the right to

"settle". (c) Right of the assured to "settle" at its own expense.

What was left to futuro agreement, in virtue of the liberty of contract inhering in those of able-minds and by way of prophetic stipulation, was this: (d) Settlement by the assured at expense, in whole or part, of the Company; (e) "Settlement" by the Company for an amount in excess of "indemnity" named in the policy; (f) conduct of the "defense" in whole or part by the assured, - 'settlement' absent.

Accident transpired; suit followed; defense was conducted by the Company and the assured; "trial of the issue" was had; final judgment declaring liability in excess of "indemnity" stipulated resulted. The Company's obligation to pay $5,000, plus interest from "entry of judgment" and costs, matured and payment thereof is required in the judgment before us.

The obligation, however, is sought to be extended in virtue of these facts: (a) Prior to judgment the injured party offered to settle for $4,000; (b) result of the trial demonstrates that was a good offer for acceptance by the Company; (c) the nature of the case, as developed in previous investigations and in communications about the offer to settle, was such as to make it plain that judgment for more than $5,000 was possible, if not probable; (d) the offer was for a sum less than the "indemnity" named; (e) the Company refused to contribute more than $2500 or to "settle" unless the assured would contribute $1500. But the very gamble which was made by the Company and by the assured in declining the offer was by them left open when their contract was made. The possibility that a judgment in any suit for damages for personal injuries (especially internal ones) may be for a sum either more or less than the amount of indemnity named affords a probable reason for lack of contractual terms specifically requiring a settlement by either party. And the conduct of the Company and of the assured in declining the offer made

demonstrates the value which each of them originally put upon that reservation of liberty. For aught that appears, the insurer and the insured dealt at arm's length in making the contract, and its terms cannot be re-cast so as to impose that liability sought to be established in this case. For adjudications more or less in point, see: Wisconsin Zinc Co. vs. Fidelity & Deposit Co., 155 N. W. 1081; Auerbach vs. Maryland Casualty Co., 140 N. E. 577; Rumford Falls Paper Co. vs. Fidelity & Casualty Co., 43 Atl. 503, C. Schmidt & Sons Bruen vs. Travelers Ins. Co., 90 Atl. 653.

Plaintiff in error has cited Attleboro Mfg. Co. vs. Frankfort, etc., Ins. Co., (C.C.A.), 240 Fed. 573, Brown vs. Guaranty Co., (Dist.Ct.), 232 Fed. 298, Mendota El. Co. vs. N. Y. Ind. Co., (Minn.), 211 N.W. 317, Cavanaugh vs. Corporation, 79 N.H. 186, 106 Atl. 604, and Douglas vs. United States Fid. & G. Co., (N.H.), 127 Atl. 708.

Amongst the "counts" in Attleboro Mfg. Co. vs. Frankfort, etc., Ins. Co. were these: (a) The insurer, by the contract, was required to take charge of the defense in the former case; it had done so, but was negligent in the manner of performance of that duty because of inadequate preparation for trial, improper conduct of trial, etc. (b) The insurer, for a consideration, had agreed to, and had, undertaken "the task of settling" without judgment. In the trial (of the case brought by the insured against the insurer) it was ruled: (a) The insurer was confined to the right of action pleaded in the first "count". (b) Since the insurer (in the former case) had employed an attorney and to him committed the defense, it was not liable for negligence occurring after that employment. (c) Evidence proffered by the insured tending to establish that subsequent negligence was improper. The insured had judgment, but less in amount than that to which it might have been entitled and which it might have received but for the rulings mentioned. The case

was taken to the Circuit Court of Appeals by each party; that court found error against the insured in the rulings mentioned and remanded the cause. In the course of the opinion a contention by the insurer that cause of action was not stated in either of the "counts" was overruled; in respect to each it was held that the insurer would be responsible for negligent performance of the duty for which it had contracted and which it had, in fact, undertaken to perform.

Brown vs. Guaranty Company arose on demurrer to allegations, inter alia, that the insurance company "investigated the claim, ascertained that there was a liability and that the injured party would settle for $3,000.00 ($2,000.00 less than the face of the policy)" and thereupon: (a) Notified the insured of the offer of settlement; (b) demanded that the insured pay $1500.00; (c) stated that unless the insured did contribute that much to the settlement "it would permit the pending action to proceed to trial and it would necessarily result in a judgment in excess of the face of the policy so that the assured would ultimately be compelled to pay more than the $1500.00". The insured refused to accede, it was averred, the case proceeded to trial and judgment for $12,000.00. The policy stipulations are not disclosed, except that the insurer was bound to defend any "suit or action * * * or settle same as it might deem advisable" and except that the assured might settle at its own expense or at the insurer's expense with its consent.

A demurrer was sustained in the trial court (in Mendota El. Co. vs. N. Y. Ind. Co.) in respect to a complaint which included averments: (a) That the insurance company "undertook the defense of the action" (brought by an injured employe) in behalf of the insured and "agreed * * * that if it were possible to satisfy" the insured's liability "it would pay the amount required * * * to effect a settlement provided it did not exceed $5,000.00" (the amount of the policy); (b) "while the trial was in progress" the injured employe agreed to accept

$18,000.00; (c) in the opinion of the attorneys for the insured and the insurer "the proposed settlement was advisable"; (d) that suit was against the insured and two other defendants, and those three paid the $18,000.00 in consummation of settlement, of which amount the insured paid $4750.00; (e) the insurer "repudiated its previous agreement" with the insured "and refused to contribute more than $3625.00". Suit was brought by insured against insurer for $1125.00, the difference between what it had 'previously agreed' to pay and the amount paid. When all proper inferences were drawn in favor of the complaint, it was held on appeal, a cause of action was stated.

"The action" in Cavanaugh vs. Corporation was "brought to recover from the defendant the sum of $3,000.00, which the plaintiffs claim(ed) they paid because of the negligence of the defendant in the preparation and manner of conducting the defense" in a former suit brought on injury within the indemnity contract. Terms of the policy, etc., are not disclosed except as in this statement: "The defendant insured the plaintiffs against liability for accidents, and, when one of their horses kicked one Blais, it assumed the defense of his claim". After suit brought, the claim was settled for $6000.00, but the circumstances under which the settlement was made are not definitely shown. There was evidence that the claim might have been settled before suit was filed and within the amount of the policy. So far as we can judge, the basic question on appeal was 'whether the insurer owed the insured the duty of settling with Blais before suit, if that was the reasonable thing to do', and as to that "duty", it was decided, 'there could be no question', for "when the defendant assumed control of the Blais claim it then and there became its duty to do what the average man would do in a similar situation". It will be noted that the insurer "assumed control" of the claim originally and before suit and that (according to the opinion) it made no "serious attempt to settle with Blais until matters were in

such shape there was nothing else to do".

Amongst the obligations definitely assumed by the insurer, in the policy before the court in Douglas vs. United States Fid. & Guar. Co., was that of "service" to the assured "by investigation" upon notice of "injury" "and by settlement of any resulting claims in accordance with the law" and by defense of suits. The insurer received notice of injury within the contract; the injury (according to evidence) was a "serious" one for "which a common law recovery would probably exceed the $5,000.00 insurance"; the injured person offered to settle for $1,500.00, and the insurer "failed to accept the offer"; suit was brought by the injured party and a final judgment against the insured for $13,500.00 resulted. Suit was then brought by the insured to recover the excess of judgment and because of negligence in "failing to settle" the claim. The insurer made no defense upon the ground that the contract did not impose a duty to settle, nor (in view of the stipulation noted) could it well have done so. The defense, pre-supposing a contract duty to settle in a proper case, rested upon the ground, first, "that it had no reason to believe" the insured was liable when settlement was proffered and, second, that a "binding settlement" could not have been made with the injured party because of his lack of mental capacity. In respect to the first ground of defense it was held there was "a clear and plain issue for the jury" about the insurer's "knowledge of such facts as would at once inform any one" that the insured "was probably liable", and a like ruling was made about the evidence bearing on mental condition. The decision in the appellate court was that motion for involuntary non-suit was properly overruled in the trial court, and what was said in the opinion on subjects other than those already disclosed would appear to have an obiter character; it is the latter discussion to which plaintiff in error here refers.

That part of the opinion (of the New Hampshire court)

must be read, however, with the existence of the stipulation for "service" "by settlement of any resulting claims in accordance with the law" in mind. In respect to that stipulation (as the basis of duty) the court said:

> "The whole control of negotiations is taken from the insured and given to the insurer. * * The argument that the latter ~~clause~~ refers to the payment of judgments, and not to adjustments, is plainly untenable. The promise of indemnity is contained in another and independent paragraph."

In resume, it may be said: (a) Negligent defense per se is not presented in the instant case, as it was in Attleboro Mfg. Co. vs. Frankfort Ins. Co.; (b) contractual duty of 'defending or settling' "as it might deem advisable", with the implied duty of making good faith selection as between ordinary defense and settlement and with what amounts to admission of bad faith in the election, present in Brown vs. Guaranty Co., is absent here; (c) entrance upon the "task of settling", pursuant to agreement to do so (as in Attleboro Mfg. Co. vs. Frankfort Ins. Co.), special 'agreement to settle within the amount of the policy' and repudiation of that agreement (as in Mendota El. Co. vs. N. Y. Ind. Co.), actual settlement after suit brought "when matters were in such shape there was nothing else to do" and lack of "serious attempt to settle" before suit brought on the part of an insurer undertaking defense of the "claim" and of the suit, (as in Cavanaugh vs. Corporation) and expressed agreement to perform "service" by "investigation" and by "settlement of any resulting claim" (as in Douglas vs. United States Fid. & Guar. Co.) are elements foreign to this record. It may be noted, further, that the form of indemnity stipulation in the policy considered in Mendota El. Co. vs. N.Y. Ind.Co. apparently exerted force toward the decision made, for (unlike that here) there was no contractual definition of "liability imposed by law", for which indemnity was provided, and it was held that "liability" arose co-incidently with the "accident"; and in this respect the policy involved in Douglas vs. United States Fid. & Guar. Co. was like that in

Mendota El. Co. vs. N. Y. Ind. Co. This, we think, has some importance, for where liability arises, under a contract, and with a general stipulation for defense, there is more reason in saying that right performance of the duty includes settlement, if that appears proper, than there is for saying that one who has contracted to pay only after judgment resulting from "trial of the issue" and who has contracted for defense must "settle", and therefore pay before the time stipulated, if facts appear which might signify danger to the insured if settlement be not made. In the one case, the contract is for payment upon ascertainment of the amount due, which includes ascertainment in any proper method (St.Louis, etc. Co. vs. Maryland Cas. Co., 201 U.S. 173, 26 Sup.Ct. 400, 50 L. Ed. 712; Mendota El. Co. vs. N. Y. Ind. Co., supra); in the other case, the stipulation is for payment after fixing of the liability and amount thereof in a way specified, i.e. by judgment, unless an additional method be provided, in futuro, by exercise of the reserved right to settle.

We recommend that the judgment of the Court of Civil Appeals be affirmed.

Nichols

Judge.

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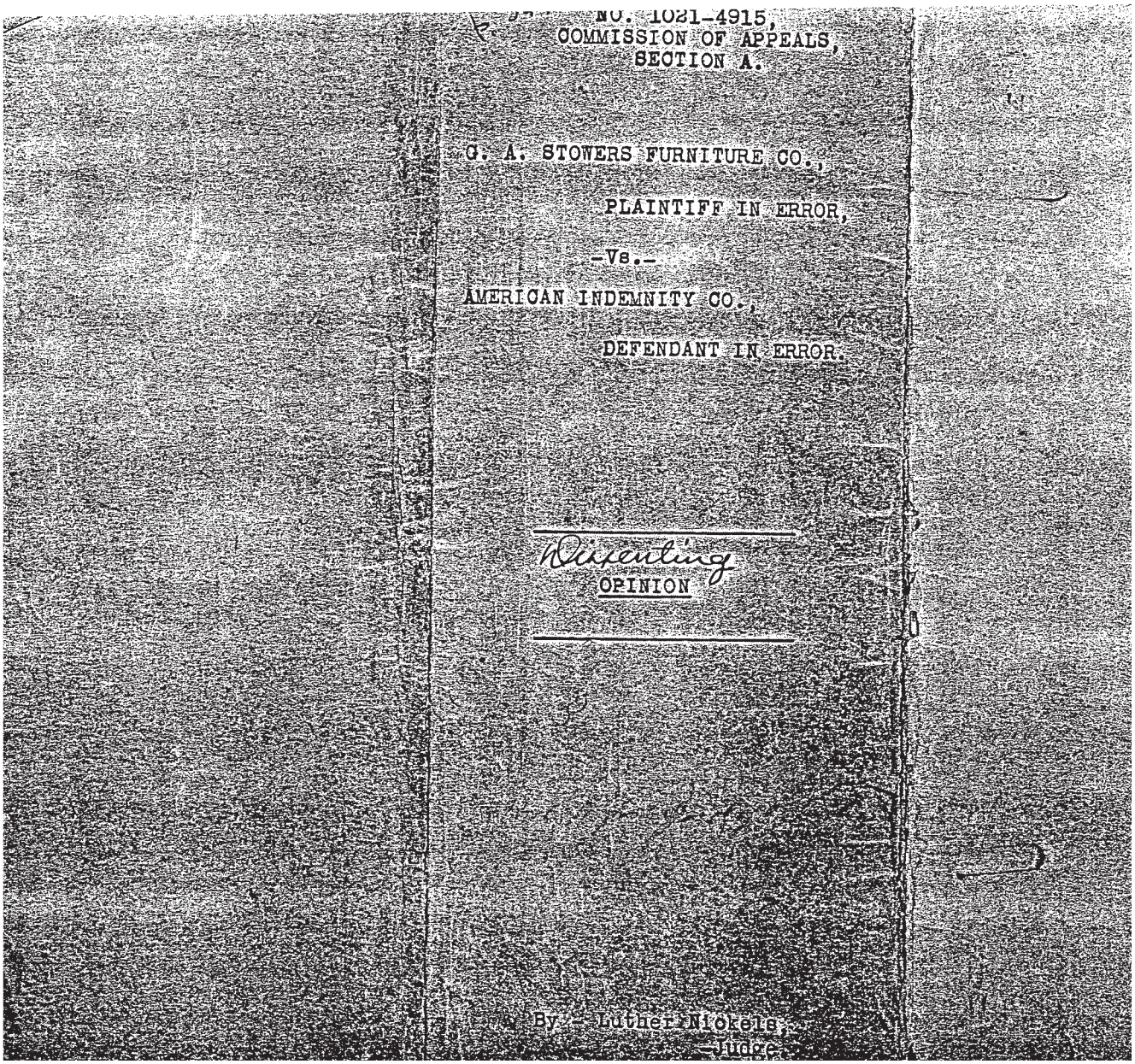

NO. 1021-4915,
COMMISSION OF APPEALS,
SECTION A.

G. A. STOWERS FURNITURE CO.,

PLAINTIFF IN ERROR,

-Vs.-

AMERICAN INDEMNITY CO.,

DEFENDANT IN ERROR.

Dissenting
OPINION

By:- Luther Nickels,
Judge.

TOUCHSTONE, WIGHT, GORMLEY & PRICE
ATTORNEYS AND COUNSELORS
MAGNOLIA BUILDING
DALLAS, TEXAS

O. O. TOUCHSTONE
JOHN N. TOUCHSTONE
ALLEN WIGHT
J. W. GORMLEY
HOBERT PRICE
HENRY W. STRASBURGER
THOMAS F. NASH
PHILIP L. KELTON
ROBERT B. HOLLAND

APRIL 29, 1929

Hon. F. T. Connerly,
Clerk Supreme Court of Texas,
Austin, Texas.

Dear Mr. Connerly:

Re: No. 1021-4915
G.A.Stowers Furniture Co.
vs. American Ind. Co.

Herewith I hand you three copies of a so-called amicus curiae argument, in support of Motion for Rehearing in the above styled and numbered cause. Prayer for permission to file it appears in the proem of the argument.

I do not know what the proper procedure is in these extraordinary matters. In any event I presume you will have to call the attention of the Chief Justice to the prayer that the argument be filed and abide by his judicial action in the matter. If he hesitates to grant the prayer, will you please remind him for me that if the Court adheres to the opinion as written by Judge Critz, it will put us insurance lawyers out of business. In this case the Commission simply elected to follow a line of minority decisions without carefully examining their rationes decidendi. This is a pardonable error, but if it is not corrected, a new and intolerable burden will be placed upon us Texas lawyers, - a burden that will take all the fight out of us; and a lawyer without courage, yea, without even daring, is of little help, either to clients or to courts.

Kindly advise me whether the enclosed will be filed, and if not what further procedure is necessary to prevail upon the Court to consider it, because we are really fighting for our bread and butter as lawyers in this matter, as well as for the interests of several clients, who will be very much embarrassed if the original opinion in this case is suffered to stand.

Very truly yours,

Gormley

JWG:D

Stowers Furniture Company,	*	In the District Court of
	*	
vs	*	Harris County, Texas.
	*	
American Indemnity Company.	*	11th Judicial District.

Gentlemen of the Jury:

This case will be submitted to you upon a special issue which you will answer as you find the fact to be, from a preponderance of the evidence, that is to say, the greater weight of credible testimony.

"Ordinary care", as used in this charge, means such care as an ordinarily prudent person would have exercised under the same or similar circumstances.

You are the exclusive judges of the facts proved, the credibility of the witnesses and the weight to be given their testimony, but the law you receive from the charge of the court as herein given and be governed thereby.

Chas E. Fuller
Judge.

Special Issue No. 1.

Would a person in the exercise of ordinary care in the management of his own business, under the facts and circumstances known to the American Indemnity Company, or its counsel in charge of the case, prior to the trial of the suit of Mamie Bichon vs Stowers Furniture Co. have settled said suit for four thousand dollars?

Answer Yes or No, as you may find.

No. 110139

Stowers Furniture Co.,
versus
American Indemnity Co.

In the District Court
Of Harris County, Texas,
11th Judicial District,

January Term, A. D., 192___

We, the jury, answer the special issues submitted to us by the court, as follows:

No. 1: yes

No.

No.

No.

No.

No.

No.

No.

No.

No.

F. L. McGinnis
Foreman.

110139

Charge

Dec 1930

Filed

O. H. FLOYD

Clerk District Court

HARRIS COUNTY, TEXAS

Deputy

The Art of the Deal Doctrines:
So Many Doctrines in So Little Time

American College of Coverage Counsel
2018 American University Washington College of Law
Symposium

Washington, DC
October 26, 2018

Michael W. Huddleston
Munsch Hardt Kopf & Harr, P.C.

Meghan Magruder
King & Spalding

The Art of the Deal Doctrines:
So Many Doctrines in So Little Time

I. Coverage and Settlement

The courts have long-struggled with settlements by insureds with underlying claimants where the carrier has (a) wrongfully refused to defend the insured, (b) wrongfully denied the existence of a duty to indemnify, and/or (c) breached its duty to settle by rejecting a reasonable settlement offered by the underlying claimant. Insureds and claimants have used a number of approaches to settling without the carrier in these circumstances. A few of the more common examples is set forth below:

(1) Settling before trial of the underlying suit for an agreed amount with the source of funding being limited to an action against the liability insurer brought by either the insured or by the claimant after an assignment of the insured's rights against the carrier;

(2) The entry of an agreed judgment, without a trial, with an amount set by the parties, an agreement that the sole funding source would be an action against the liability insurer (usually with a covenant not to execute on any other assets), and an assignment of rights of the insured against the insurer;

(3) The entry of judgment after trial of the underlying suit has determined the (a) bases of liability and (b) the amount owed, joined with an assignment and a covenant limiting execution to the rights against the carrier;

(4) A settlement after trial or after the entry of a judgment after trial including some form of assignment and limitation of execution.

Because of the peculiarities of damages law in this area of insurance, some claimants will refuse to limit execution and will simply agree to seek satisfaction first from the carrier.

The courts have generally allowed insureds to have some form of settlement approach that allows them to be extricated from a situation where the carrier has wrongfully refused to defend or settle. The courts have struggled with carrier concerns as to whether the (a) amount of the settlement is reasonable, and (b) whether the liability or damages have been distorted or manipulated. The courts have also explored other solutions to the difficult situation where coverage is being contested by the carrier, but the issues of coverage cannot be finally determined until after trial or resolution of the underlying case.

This paper will focus on the Texas experience with these issues. The Texas Supreme Court currently has before it a case before it which again raises these scenarios and concerns and presents the opportunity for reconsideration of the appropriate solution/s. Next, we will turn to Georgia law relating to these agreements and issues by comparison. Finally, we will review some of the approaches taken by other jurisdictions in dealing with these issues.

II. The Texas Experience

A. Groundwork—The Danger

1. Damages Law

In Texas, the existence of a ***judgment*** against the insured is a critical element of establishing damages against an insurer. It is evidence of the damages. The fact that an insured did not, had not and would not ever actually pay the judgment has never been a defense to the damages claim. Texas rejected the so-called "pre-payment" approach as a condition of finding damages against the carrier because

liability policies impose liability on the carrier based on a settlement or judgment against the insured, not on actual payment. *Hernandez v. Great American Insurance Co. of N.Y.,* 464 S.W.2d 91 (Tex. 1971). Liability policies are different from indemnity policies, which in fact require payment to establish harm.

The Texas Supreme Court adopted the "judgment rule." Under that rule, the Court held that the mere entry and existence of a judgment against the insured is "some evidence" that the insured was exposed to the entire amount of the judgment and thus satisfaction of the judgment was required to extinguish that harm. *Hernandez v. Great American Insurance Co. of N.Y.,* 464 S.W.2d 91 (Tex.1971); *accord Montfort v. Jeter,* 567 S.W.2d 498 (Tex.1978). "Under the judgment rule of *Hernandez* and *Montfort*, when there is an existing adverse judgment offered into evidence in a suit against the tortfeasor who caused that judgment to be entered, the existing judgment is some evidence of actual damages, whether it is paid or unpaid. The basis of the judgment rule is that when there is a judgment against a person, his credit is affected, a lien attaches to his land, and his nonexempt property is constantly subject to sudden execution and sale." *Woods v. William M. Mercer,* 717 S.W.2d 391, 399 (Tex. App.—Texarkana 1986), *aff'd on related grounds,* 769 S.W.2d 515 (Tex. 1988).

Some Texas courts have held that the underlying judgment proved damages *against a liability insurer* in the amount of the judgment as a matter of law. *See, e.g., YMCA of Metro. Fort Worth v. Commercial Standard Ins. Co.,* 552 S.W.2d 497 (Tex. Civ. App.—Fort Worth 1977, writ ref'd n.r.e.); *see also Ridgway v. Gulf Life Ins. Co.,* 578 F.2d 1026 (5th Cir.1978); *Allstate Ins. Co. v. Kelly,* 680 S.W.2d 595 (Tex. App.—Tyler 1984, no writ); *Ranger Ins. Co. v. Rogers,* 530 S.W.2d 162 (Tex. Civ. App.—Austin 1975, writ ref'd n.r.e.). The Texas Supreme Court appeared to endorse so-called "Sweetheart" deals and the concept of damages in the amount of the judgment as a matter of law in its initial opinion in *American Physicians Ins. Exchange v. Garcia*, 36 TEX. SUP. CT. J. 406 (Dec. 31. 1996). The Court subsequently vacated this opinion and issued a new opinion, leaving the issue open.

2. Binding Effect Of Judgment—Liability and Amount/Reasonableness

Carriers were barred in Texas from making collateral attacks on the judgment against the insured, even if the judgment was entered after a non-adversarial proceeding or an agreed judgment. *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 943 (Tex. 1988). Thus, the carriers raised concern about the fact that there were simply no limits on the amount of damages that could be agreed upon by the claimant and the insured, at least in the context of an agreed judgment.

In *Block,* 744 S.W.2d at 943, the Supreme Court held that an agreed judgment was binding on a carrier in terms of the fact and quantum of liability. The Court reasoned:

> [W]e agree with the court of appeals' conclusion that Employers Casualty was barred from collaterally attacking the agreed judgment by litigating the reasonableness of the damages recited therein, *Ranger Insurance Co. v. Rogers,* 530 S.W.2d 162 (Tex. Civ. App.—Austin 1975, writ ref'd n.r.e.), and *St. Paul Insurance Co. v. Rahn,* 641 S.W.2d 276 (Tex. App.—Corpus Christi 1982, no writ) . . . .

Id. at 943. The Court relied on the decision of the court of appeals in *Hargis v. Maryland American General Ins. Co.,* 567 S.W.2d 923 (Tex. Civ. App.—Eastland 1978, writ ref'd n.r.e.):

> The court in *Hargis* held that the question of liability and of coverage are separate and distinct, and that the prior judgments establishing liability were not binding on Maryland as to the issue of coverage. *Hargis*, 567 S.W.2d at 927. Although *Hargis* dealt with *judgments resulting from litigation*, it is apparent that the reasoning of the court applies as much, if not more, to *agreed judgments*.

Id. Thus, the Court concluded that the "question of liability," and hence the fact of it and the amount of liability, were in fact determined by either a litigated or agreed judgment and ***could not be collaterally attacked by the carrier.*** *Id.*[1] What remained unanswered by the courts was whether a judgment, agreed or otherwise, procured as a result of so-called collusion was admissible as evidence of the fact of liability and damages and the reasonableness of those damages.

3. Contractual Anti-Assignment Clauses

"[A]n insurer who first 'wrongfully refuses to defend' an insured is precluded from insisting on the insured's compliance with other policy conditions." *Quorum Health Res., L.L.C. v. Maverick Cnty. Hosp. Dist.,* 308 F.3d 451, 468 (5th Cir.2002); *Enserch v. Shand Morahan & Co., Inc.,* 952 F.2d 1485, 1496 n. 17 (5th Cir.1992) (applying Texas law); *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 943 (Tex.1988); *Gulf Ins. Co. v. Parker Prods., Inc.,* 498 S.W.2d 676, 679 (Tex. 1973).*St. Paul Ins. Co. v. Rahn,* 641 S.W.2d 276, 278 (Tex. App.—Corpus Christi 1982, no writ); *see also OneBeacon Ins. Co. v. Welch*, No. CIV.A. H-11-3061, 2014 WL 2931933, at *10 (S.D. Tex. June 30, 2014). This includes the no-action clause of the policy. In *Gulf, supra,* the carrier wrongfully refused to defend and denying coverage. The insured then unilaterally settled the claim against it. The court reasoned and concluded:

> The insurance company may ordinarily insist upon compliance with this condition [no action] for its own protection, but it may not do so after it is given the opportunity to defend the suit or to agree to the settlement and refuses to do either on the erroneous ground that it

[1] The *Block* Court explained: "A collateral attack is an attempt to avoid the effect of a judgment in a proceeding brought for some other purpose." *Ranger Insurance Co. v. Rogers,* 530 S.W.2d 162, 167 (Tex. Civ. App.—Austin 1975, writ ref'd n.r.e.). Collateral estoppel refers to issue preclusion because it bars relitigation of any ultimate issue of fact actually litigated and essential to the judgment in the prior suit. *Bonniwell v. Beech Aircraft Corp.,* 663 S.W.2d 816, 818 (Tex. 1984). Insofar as the coverage issue is concerned, both of these doctrines are inapplicable in the present case." *Id.*

has no responsibility under the policy. *See Womack v. Allstate Insurance Company,* 156 Tex. 467, 296 S.W.2d 233 (1956).

Id. (some citations omitted).

"Anti-assignment clauses that interfere with the operation of a statute are not enforceable. *Choi v. Century Surety Co.,* 2010 WL 3825405, *4 (S. D. Tex. Sept. 27, 2010); *see also Tex. Dev. Co. v. Exxon Mobil Corp.,* 119 S.W.3d 875, 880 (Tex. App.—Eastland 2003, no pet.) (citing *Reef v. Mills Novelty Co.,* 126 Tex. 380, 89 S.W.2d 210, 211 (1936)).

Anti-assignment clauses are inconsistent with and interfere with the federal Bankruptcy Code. *See* 11 U.S.C. §541(c)(1)(A), §1123(a)(5)(B). The Bankruptcy Code pre-empts the application of the anti-assignment clause in liability insurance policies to transfers to a trust under a Chapter 11 bankruptcy plan. *In re Federal-Mogul Global Inc.*, 684 F.3d 355, 377-78 (3d Cir. 2012) (§1123); *In re Thorpe Insulation Co.*, 671 F.3d 1011, 1026 (9th Cir. 2012) (§541); *In re Thorpe Insulation Co.*, 677 F.3d 869, 889 (9th Cir. 2012) (Congress expressly pre-empted liability insurance anti-assignment clauses through §541; even without that section, anti-assignment clauses impliedly pre-empted); *In re Combustion Eng'g, Inc.*, 391 F.3d 190, 219 n. 27 (3d Cir. 2004) (§§541, 1123); *In re W. R. Grace & Co.*, 475 B.R. 34, 197-99 (D. Del. 2012), *aff'd*, 729 F.3d 332 (3d Cir. 2013) (§1123).

4. Covenant—Release Or Not?

In Texas and other jurisdictions, a covenant not to execute is treated under general contract law as a release. *Woods v. William M. Mercer,* 717 S.W.2d 791 (Tex. App.—Texarkana 1986), *aff'd on related grounds,* 769 S.W.2d 515 (Tex. 1988). The courts have reasoned that if a covenant is breached, treatment of it as a release prevents any recovery. This avoids the "circuity of action" presented by requiring a suit showing damages from the breach.

Apparently as a result of public policy concerns, the discharging or release aspect of a covenant not to execute is ignored in certain liability insurance contexts. In *Woods,* the court explained:

> Normally, a covenant not to execute is treated as discharging a judgment so that there are no damages caused by the judgment. *Panhandle Gravel Co. v. Wilson,* 248 S.W.2d 779 (Tex. Civ. App.-Amarillo 1952, writ ref'd n.r.e.); RESTATEMENT (SECOND) OF CONTRACTS § 285(2), comment a (1981). Ordinarily, however, a covenant not to execute will not obviate the existence of damages when there is proof that an *insured was forced to assign his rights against the insurer or other responsible parties to obtain that covenant*.

717 S.W.2d at 398.

The timing of the covenant is important. Pre-judgment covenants or releases would appear to prevent any subsequent judgment from actually imposing a "legal obligation to pay" as required by the insuring agreement. *Empire Indem. Ins. Co. v. N/S Corp.,* 571 Fed. Appx. 344, 347 (5th Cir. 2014)(discussing *U.S. Fire Ins. Co. v. Lay,* 577 F.2d 421, 423 (7th Cir.1978)). Strangely, the court in *Woods* expressly held that "the agreement contained in the covenant not to execute was reached prior to the actual date of the execution of the covenant and, in fact, was entered into informally before judgment was rendered in federal court." *Woods, supra,* at 399. It should be noted that the claim in *Woods* was *not* against an insurer, but instead it was against an insurance agent which allegedly failed to procure professional liability insurance for the insured nurse anesthetist in that case. The court concluded that in this setting Texas law did not support a finding of damages as a matter of law in the amount of the judgment. *Id.* Instead, the question of damages presented a fact issue.

5. Inability To Resolve Coverage Disputes When Demand Within Policy Limits Was Made

At the time of the initial *Garcia* opinion, carriers had no ability to determine the duty to indemnify prior to trial of the underlying suit. The courts considered an indemnity coverage action premature because the insured might not even be found liable. Texas had also not recognized that insurers could settle and seek reimbursement from the insured if coverage was later found not to exist. Thus, pre-trial, insurers had to make an educated, unilateral determination regarding coverage, and if they were wrong, the existence of a good faith defense to coverage, albeit a wrong one, did not excuse a failure to settle within policy limits.

B. *Gandy*—A Most Peculiar Set of Facts

Many considered the decision in *State Farm Fire & Cas. v. Gandy*, 925 S.W.2d 696, 714 (Tex. 1996), to presage the death of any form of "sweetheart" deal involving an assignment and/or agreed judgment. As subsequent decisions have revealed, it is a decision limited to its very peculiar facts and circumstances.

In *Gandy*, the insured was alleged to have molested his own step-daughter. The insurer importantly:

(a) Did not wrongfully refuse to defend,

(b) Did not wrongfully deny coverage,

(c) Did not dictate the choice of counsel and provided a defense through independent counsel.

(d) Sought and eventually obtained a declaratory judgment that there was in fact no duty to defend or indemnify owed by the insurer.

(e) Was not notified of the settlement and did not consent to the settlement.

Moreover, liability in *Gandy* ***was not predicated on a wrongful failure to settle***. Instead, the allegation was that the insured somehow did not know that he could change counsel after he had initially selected counsel himself, and thus he allowed incompetent counsel the insured himself selected to continue in the case, resulting in the imposition of judicial sanctions in the underlying suit. In short, the suit against the carrier alleged that if the insured had had competent counsel, he would have been exonerated or liability would have been substantially less. The case was akin to a legal malpractice claim for an incompetent defense.

Insurance policies provide a battery of potential contractual defenses to a unilateral settlement entered by the insured or the use of an agreed judgment:

(a) The requirement of a "legal obligation to pay" as damages by the insuring agreement.

(b) The no-action clause, barring any action against the carrier in the absence of a settlement consented to by the insured or a judgment after an "actual trial."

(c) The anti-assignment clause, barring assignment of claims against the carrier absent consent of the carrier.

None of these defenses was actually at issue in *Gandy* because the action was based on negligence and statutory theories and because the court found that there was in fact ***no contractual duty to defend or indemnify*** **owed under the policy.** Contract defenses were not relevant to such claims.

After so-called discovery abuse by the insured's independent counsel, of which the carrier was not informed by the insured or his lawyer, the insured replaced his previously selected counsel. Again, no notice was given to the carrier. New counsel entered into an agreed judgment for in excess of $6 million dollars, $2 million of which involved punitive damages. The judgment itself included numerous false recitals intended to make it look as though there was some form of adversarial

proceeding leading to the judgment. The insurer was provided no opportunity to object to the judgment.

The controlling holding in *Gandy* was that the assignment in that case was invalid. The Court expressly limited its holding:

> Balancing the *various considerations we have mentioned*, we hold that a defendant's *assignment* of his claims against his insurer to a plaintiff is *invalid if*
>
> (1) it is made *prior to an adjudication* of plaintiff's claim against defendant in a *fully adversarial trial*,
>
> (2) defendant's insurer has tendered a defense, and
>
> (3) either
>
> (a) defendant's insurer has accepted coverage, or
>
> (b) defendant's insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of plaintiff's claim.

Id. at 714.[2]

The *Gandy* Court overruled the holding in *Block, supra*, that a challenge to the amount of an agreed judgment was an improper "collateral attack" on the judgment. The Court stated:

[2] The Court observed: "The settlement arrangement we have examined has three elements: [1] an assignment [to the plaintiff] of a defendant insured's claims against his insurer, [2] a covenant by the plaintiff to limit recovery from the defendant personally, and [3] a judgment for plaintiff against defendant." *Id.* at 715.

> In no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on defendant's insurer by plaintiff as defendant's assignee.

Id. The *Gandy* court expressly disapproved of language in its own opinion in *Block* and that of the Fifth Circuit in *United States Aviation Underwriters, Inc. v. Olympia Wings*, 896 F.2d 949, 954 (5th Cir. 1990), to the contrary. The Court's statement that under no circumstances would a judgment entered without a fully adversarial proceeding be binding upon the carrier was, according to subsequent decisions, obiter dictum.

In any event, the reference to a judgment resulting from a fully adversarial proceeding appears to involve the issue of when and/or whether the judgment can be used as evidence of damages. The Court did not directly address whether "collusion" was a defense to an agreed judgment or a judgment without a full trial. The Court also did not address whether a covenant not to execute agreed to prior to the entry of judgment was in reality a release, thus negating the existence of damages and effectively throwing the baby out with the bath-water. In fact, the covenant in *Gandy* was a covenant to limit execution to the insurance policy and related extra-contractual rights.

C. The *Gandy* Court of Appeals Focuses On Damages Rule

The central complaint of the Court of Appeals in *Gandy* was the rule that the judgment in the underlying suit sets damages as a matter of law, even where there is an agreed judgment with a covenant not to execute. As the court explained, and as quoted by the Supreme Court in *Gandy*, the central distortion of the litigation process was the notion that damages were actually being suffered in the face of an agreed judgment from which the insured was fully protected:

> The amount of the judgment in a case like this, where a covenant not to execute is given contemporaneously with and as a part of a settlement and agreed judgment, cannot constitute damage to the

judgment debtor. Allowing an assignee of the named judgment debtor in such a case to collect all or part of the judgment amount ***perpetrates a fraud on the court***, because it ***bases the recovery on an untruth***, i.e., that the judgment debtor may have to pay the judgment. *See Whatley v. City of Dallas,* 758 S.W.2d 301 (Tex. App.—Dallas 1988, writ denied); *Garcia v. American Physicians Ins. Exch.,* 812 S.W.2d 25 (Tex. App.—San Antonio 1991) (Peeples, J. dissenting), *rev'd,* 876 S.W.2d 842 (Tex. 1994). Such a result should be against public policy, because it allows, as here, parties to take a ***sham judgment*** [n.5] [The judgment is a sham because it is not what it is represented to be. It cannot be collected from the judgment debtor, and that was the parties' intention when the judgment was taken.] by agreement, without any trial or evidence concerning the merits, and then collect all or a part of that judgment from a third party. Allowing recovery in such a case encourages fraud and collusion and corrupts the judicial process by basing the recovery on a fiction . . . But the fact remains that the courts are being used to perpetrate and fund an untruth—that Pearce was damaged by the bare amount of the judgment. [n.6] [Prohibiting this type of arrangement would not inhibit settlements. The insurance company would still have an incentive to settle because it would face potential liability for damage to credit, reputation, property, and for mental anguish. Allowing recovery for the amount of the judgment is not necessary to encourage insurance companies to give careful consideration to the interests of their insureds.]

. . . .

To the extent that our Supreme Court would hold that the bare amount of the judgment constitutes damage in a case like this, we believe it is wrong, and we urge it to correct the matter when it has the opportunity. Until it does so, however, we defer to what we believe is the stated law and hold that the judgment here is some evidence of

> damage to Pearce, even though the judgment can never be collected from him, and is sufficient evidence to support the jury's finding.

Gandy, 925 S.W.2d at 705.

The court of appeals failed to recognize that the insured was in fact contributing to payment or satisfaction of the judgment. The insured was assigning valuable contractual rights to the claimant. The insurance policy and related extra-contractual rights unquestionably had value. The court also ignored the fact that a judgment debtor such as the claimant has the right to sue up to the policy limits without the necessity of an assignment.

The court of appeals complained about the unfairness of three judicially created rules: (1) damages were set by the underlying judgment as a matter of law, (b) the insured was damaged by the judgment and thus prepayment of the judgment was not required, and (c) a covenant not to execute would not be treated as a release as a matter of public policy in order to aid the insured left in the ditch by its insurer. The insured and the claimant in *Gandy* can hardly be said to have engaged in fraud and collusion, distorting the judicial process, by following then existing law. In fact, it was a set of rules endorsed in *Garcia* by the Supreme Court in its initial opinion.

D. The Backdrop of *Garcia I*—Public Policy In Favor Of Assignment/Covenant Arrangements

In the original opinion in *Garcia*, which has been completely erased from any published source, the court, as described by the dissenting opinions in *Garcia*, expressly held that "that an injured plaintiff, as the assignee of the insured, is not precluded from recovering damages from the insurer by the existence of a covenant between the plaintiff and the insured to seek relief only from the insurer." (Hightower, J.). The dissent provides a very solid explanation of the public policy behind the damages and covenant rules:

Insurance companies will at times inappropriately refuse to settle a case, thereby exposing their insureds to liability in excess of policy limits. *See* Kent Syverud, *The Duty to Settle,* 76 VA.L.REV. 1113, 1120 n. 15 & 1126 (1990). *See also* Bob Roberts, *Agreements Between Claimants and Insureds After Misconduct By Insurers,* STATE BAR OF TEXAS—SUING, DEFENDING AND NEGOTIATING WITH INSURANCE COMPANIES B–24–26 (1991) (hereinafter Roberts). To remedy this problem, many states, including Texas, allow an insured to assign any claim against the insurer in exchange for a covenant not to execute. *See Foremost County Mut. Ins. Co. v. Home Indem. Co.,* 897 F.2d 754, 759–60 (5th Cir.1990); *Young Men's Christian Ass'n (YMCA) v. Standard Ins. Co.,* 552 S.W.2d 497, 504–05 (Tex.Civ.App.—Fort Worth 1977), *writ ref'd n.r.e. per curiam,* 563 S.W.2d 246 (Tex.1978); Reagan M. Brown, *Defending Against the Sweetheart Deal,* STATE BAR OF TEXAS—SUING, DEFENDING AND NEGOTIATING WITH INSURANCE COMPANIES I–18 (1991) (hereinafter Brown); *Ranger v. Superior Coach Sales and Service of Arizona,* 110 Ariz. 188, 516 P.2d 324, 327 (1974); *Ivy v. Pacific Automobile Ins. Co.,* 156 Cal.App.2d 652, 320 P.2d 140, 147 (1958).

The use of a covenant not to execute provides insurers with a strong incentive to give due consideration to the interests of its insureds. *See YMCA,* 552 S.W.2d at 504–05; *Rawlings v. Apodaca,* 151 Ariz. 149, 726 P.2d 565, 575–76 (1986). The necessity of such covenants is particularly apparent when an insurer has ***refused to provide a defense***:

> In such a situation, the *YMCA* rule is needed to protect the insured adequately. Where the insurer refuses to tender a defense, the insured often can protect himself only with a covenant not to execute. Without such a covenant, the insured either would have to pay the

> plaintiffs enough to settle their claim or would have to incur defense costs himself, even though the insurer is contractually responsible for payment of such costs. *Were a covenant not to execute to absolve the insurer of liability, plaintiffs would have no incentive to enter into such a covenant.*
>
> *Foremost County Mut. Ins. Co.,* 897 F.2d at 759 (citations omitted). Without the availability of such a covenant, there may be nothing to deter an insurer from failing to give due regard to its insured's interests. *See YMCA,* 552 S.W.2d at 504–05; *Foremost County Mut. Ins. Co.,* 897 F.2d at 760.

Garcia II, supra, at 867-68 (emphasis added) Quoting *Samson v. Transamerica Insurance Co.,* 30 Cal.3d 220, 178 Cal. Rptr. 343, 636 P.2d 32 (1981), the dissent in *Garcia* recognized "When the insurer 'exposes its policyholder to the sharp thrust of personal liability' by breaching its obligations, the insured 'need not indulge in financial masochism . . . "[B]y executing the assignment, he attempt[ed] only to shield himself from the danger to which the company.... exposed him." In short, the dissent noted that ***deterrence*** was yet another public policy in favor of the use of assignment/covenants. The dissent observed that "[i]f there were no recovery for the excess judgment, there would be more of an incentive for breach of the contract than its performance . . . Pretrial covenants not to execute should be encouraged as a matter of *public policy favoring settlements and minimizing the insured's potential damages. See Rainbo Baking Co. v. Stafford*, 787 S.W.2d 41, 42 (Tex.1990). Public policy considerations are better served by allowing an injured claimant to collect from the party who engaged in false, misleading and deceptive acts and caused those damages—the insurance company—rather than the victim of those acts—the insured." *Garcia II, supra,* at 868-69 (emphasis added). The dissent noted a large number of other jurisdictions permitted the use of assignment/covenant arrangements based on the idea that when an insurer has

"'refused to defend its insured, it is in no position to argue that the steps the insured took to protect himself should inure to the insurer's benefit.'" *Id.* (quoting *Greer v. Northwestern Nat'l Ins. Co.,* 109 Wash.2d 191, 743 P.2d 1244, 1251 (1987)).

E. *Gandy*—Rationale For Anti-Assignment

Instead of focusing on the "distorting" damages rule and the corollary that a covenant is not a release, the Supreme Court in *Gandy* turned to assignability, picking up the complaint of the court of appeals that the distorting effect of the damages/covenant rule was inconsistent with the Supreme Court's rejection of Mary Carter agreements because they "skew the trial process, mislead the jury, promote unethical collusion among nominal adversaries, and create the likelihood that a less culpable defendant will be hit with the full judgment." *Elbaor v. Smith*, 845 S.W.2d 240 (Tex.1992).

The court recognized that it had rejected alienation of legal malpractice actions because of the "reversal of roles" sometimes caused by such transfers. 925 S.W.2d. at 708. The Court also noted its decision in *Elboar* regarding the distorting effect of Mary Carter agreements. Both situations also increased litigation rather than ending it. The Court also emphasized that the jury would be confused where the claimant was standing in the shoes of the defendant/insured in the insurance litigation. *Id.* at 710-11.

A number of the distortions found by the *Gandy* Court are convoluted and unfounded:

1. The *Gandy* assigment caused a proliferation of litigation rather than ending it.

a. A carrier breaching its contract and failing to act reasonably can should be sued in a separate action. Because of justiciability concerns, it is almost always after resolution of the underlying suit.

b. Unless the insured abandoned its legal rights against the carrier, there was always going to be a second suit against the carrier, at the very least for the policy limits.

2. "Without the assignment and covenant not to execute, the agreed judgment would never have been rendered." It was a sham and distorted the litigation.

a. The parties entered into an agreement sanctioned by Texas law and sought damages as a matter of law based on prior decisions allowing such a damage fiction in order to provide protection to insureds left in the ditch by their carrier.

b. Julie Gandy argued her father was liable in the tort suit, but she argued as an assignee that he would have been found innocent or less culpable if he had a proper defense. This situation involved what was in effect a legal malpractice claim, not a claim for the failure to settle a covered claim.

3. *Gandy* Agreements Alter the Natural Incentives of Insureds To Claims

a. Once the insurer fails to handle the claim properly and/or wrongfully denies a defense or indemnity, the insured rightfully wants to settle and place the liability on the insurer which acted improperly.

b. The carrier forced the insured into this situation, and it has no right to complain.

4. The Settlement Did Not Resolve The Parties' Disputes

a. The insurance dispute could not be settled earlier.

b. Absent a carrier acknowledging coverage, the insured and the claimant have no ability to settle their claims without a subsequent insurance case being brought.

Strangely, the Court recognized that some insureds need to have the ability to assign rights with a covenant, depending on the circumstances. Those circumstances form the framework of the Court's non-assignability ruling. The damages/covenant fiction will be entertained and the assignment held valid if the carrier did not attempt to resolve coverage issues early in the case. It will not be entertained if the carrier is in fact providing a defense. And/or the carrier has accepted coverage.

Finally, the Court recognized its decision was narrow:

> As we have said, we do not address whether an assignment is invalid when any element of the rule is lacking, such as when an insurer has not tendered a defense of its insured. Adjudication of an insurer's obligations before determination of the defendant insured's liability to the plaintiff removes the justification for a settlement like the one in this case in most instances.

925 S.W.2d at 719.

F. Narrowing of *Gandy*—Wrongful Denial Of Coverage—Pure Settlement Without Judgment

1. Evanston Ins. v. Atofina

In *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.,* 256 S.W.3d 660 (Tex. 2008), the Court narrowed the scope of *Gandy*. *Atofina* was presented to the lower courts as a summary judgment case. Evanston urged that Atofina was barred

from recovery alternatively because it failed to at least create a fact issue as to whether the settlement agreement it had entered into was *reasonable*. The Supreme Court held that where the insurance carrier has ***wrongfully denied coverage***, it is estopped from urging the settlement was *unreasonable*. *Id.* at 671-72.[3] The Court certainly suggests that other breaches, such as a wrongful refusal to defend, would have a similar impact.

The *Atofina* Court resurrected *Employers Casualty Co. v. Block*, 744 S.W.2d 940 (Tex. 1988), which was clearly overruled by Gandy. The Court ignored the fact that *Block* involved the issue of whether a carrier could collaterally attack an agreed judgment entered into by the insured. *Atofina* involved a reasonableness attack on a settlement with no agreed judgment required as part of that settlement. The Court sidestepped the fact that the law regarding the sanctity and need to avoid collateral attacks on judgments does not apply to determining the recoverability of a settlement agreement that is not formalized into a judgment. *Id.* at 673-74.

The Court by implication is would appear to be suggesting that even an agreed judgment may be entered and not subject to attack if a carrier is wrong about coverage. The Court noted numerous decisions had interpreted *Block* as binding a carrier who wrongfully denied a defense from challenging (a) the fact of liability and (b) the reasonableness of the amount. *Id.* at 671 n.58 (citing *W. Alliance Ins. Co. v. N. Ins. Co. of N.Y.,* 176 F.3d 825, 830 (5th Cir.1999) (citing *Block*, 744 S.W.2d at 943) ("If an insurer breaches the duty to defend, it may not contest a determination that its insured was liable in the underlying settlement or verdict (or the amount of either)."); *Enserch Corp. v. Shand Morahan & Co.,* 952 F.2d 1485, 1495-96 (5th Cir.1992) ("Texas law denies insurers like these a collateral attack on the settlement itself . . . . Recent opinions of both this Court and the Texas Supreme Court have confirmed that, unlike a request for allocation, an attempt to contest the

[3] *Block* involved a failure to defend by a primary carrier. It did not involve an excess carrier, as did *Atofina*. An excess carrier has no duty to defend. After *Atofina*, the simple fact is that excess carriers certainly should not prematurely deny coverage.

reasonableness of a *consent judgment* entered into between the insured and an injured third party is unavailable to an insurer who has wrongfully breached its duty to defend.")(emphasis added)). The Court's decision potentially presages a new age of settlements with assignments that can once again bind a carrier to an agreed judgment.

Note the following discussion by the Court as to the conduct of Evanston that it found critical in invoking the protections of *Block*:

> On multiple occasions before the settlement, Evanston explicitly rejected Atofina's claim for coverage under the policy. Evanston first denied Atofina's request for coverage by letter, and then consistently asserted the same in its pleadings throughout the coverage suit. Even if this conduct does not amount to an anticipatory breach of the contract, which it very well might, *see Murray v. Crest Constr., Inc.,* 900 S.W.2d 342, 344 (Tex. 1995); *Johnson & Higgins of Tex., Inc. v. Kenneco Energy, Inc.,* 962 S.W.2d 507, 515 (Tex. 1998), this kind of explicit, unqualified rejection of coverage surely operates to trigger the equitable principles in Block.

Id. at 672 n. 60.

Importantly, the *Atofina* Court observed:

> [N]either the difference in policy claims nor the absence of a judgment memorializing the parties' settlement disrupts the *Block* principles here because *Block's* rule is not derived from the nature of the violated policy term or the formality of agreed judgments. The cases barring insurers' challenges rest on principles of estoppel and waiver; what is most important in this context is *notice to the insurer and an opportunity to participate in the settlement discussions*.

Id. (emphasis added). This was a critical missing element in *Gandy,* where the insured failed to inform the carrier or numerous developments in the litigation and failed to involve the carrier or notify it of the settlement offer/s and discussion.

The inability to attack the reasonableness of the insured's settlement is particularly stinging for carriers. In *Excess Underwriters at Lloyds, London v. Frank's Casing Crew & Rental Tools, Inc., supra,* the Court held that reasonableness concerns with respect to a carriers settling and seeking reimbursement were so substantial that no cause of action for reimbursement would be recognized. The message is that this Court does not appear to like litigation about reasonableness.

In *Atofina,* the Court noted that some cases had found that a carrier wrongfully denying coverage was also *estopped to assert policy defenses*. The Court admitted that this was not the situation presented in the case before it. Nevertheless, the Court certainly seems to give it importance in dismissing the distinction that a difference in the type of coverage, excess versus primary, should result in *Block* not applying. But, in a footnote, the Court held that even a carrier wrongfully denying coverage or a defense ***could still contest coverage***:

> The denial does not bar Evanston from challenging coverage. *See Utica Nat'l Ins. Co. of Tex. v. Am. Indem. Co.,* 141 S.W.3d 198, 203 (Tex. 2004) ("Even if a liability insurer breaches its duty to defend, the party seeking indemnity still bears the burden to prove coverage if the insurer contests it."); *Block,* 744 S.W.2d at 943–44.

Id. n. 74.

The *Atofina* Court sidesteps the fact that Block was obviously overruled by Gandy. The Court recognized that *Gandy* held:

> "In no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on defendant's insurer or admissible as evidence of damages in an action against defendant's

> insurer by plaintiff as defendant's assignee. We disapprove the contrary suggestion in dicta in *Employers Casualty Company v. Block,* 744 S.W.2d 940, 943 (Tex. 1988), and *United States Aviation Underwriters, Inc. v. Olympia Wings, Inc.,* 896 F.2d 949, 954 (5th Cir. 1990)."

Id. (quoting Gandy, supra). The Court concludes that *Gandy* only overruled *Block* to the extent the next case at issue involves precisely the factual and legal situation presented in *Gandy.* Undoubtedly, *Gandy* has been narrowed.

Gandy was initially recognized as having two distinct holdings. The first dealt with assignability. It depended on a list of factors, which were not found to be exclusive or always mandatory, and evidence of distortion. The second holding of Gandy involved the evisceration of *Block*. It was seemingly not dependent on proof of the factors or anything similar to them. In limiting *Gandy,* the *Atofina* Court observed:

> *Gandy* does not disrupt the application of Block to this case for two reasons. First, this case does not fall within *Gandy's* holding. *Gandy's* holding was explicit and narrow, ***applying only to a specific set of assignments with special attributes. By its own terms, Gandy's invalidation applies only to cases that present its five unique elements***. Here, *Gandy's* key factual predicate is missing: ATOFINA made ***no assignment*** of its claim against Evanston; ATOFINA sued Evanston directly.

Id. (emphasis added.) The Court added:

> *Gandy's* rationale does not require disapproving *Block* in this setting. ***Gandy's reason for invalidating assignments was simple: Those assignments made evaluating the merits of a plaintiff's claim difficult by prolonging disputes and distorting trial litigation motives.*** But not all cases implicate *Gandy's* concerns. "We should not invalidate a settlement that is free from this difficulty [of fairly

evaluating a plaintiff's claims] simply because it is structured like one that is not."

Barring Evanston's challenge here does not implicate *Gandy's* concerns. ***Preventing insurers from litigating the reasonableness of a settlement does not extend disputes***; by definition, it shortens them. ***Nor is there a risk of distorting litigation or settlement motives here.*** ATOFINA settled without knowing whether or not it would be covered by the policy, ***leaving in place its motive to minimize the settlement amount in case it became solely responsible for payment.***

Id. (emphasis added).

2. *Lennar v. Markel Ins.*—Unilateral Settlements By The Insured

In *Lennar Corp. v. Markel American Ins. Co.,* 413 S.W.3d 750, 751 (Tex. 2013), the insured homebuilder determined that homes built with an exterior insulation and finish system ("EIFS") were suffering serious water damage that worsens over time. The insured "undertook to remove the product from all the homes it had built and replace it with conventional stucco." "The homebuilder's insurers refused to cooperate with this remediation program, preferring instead to wait until homeowners sued, and denied coverage of the costs." *Id.* The insurers all denied coverage. All of the underlying claims eventually settled, with only three ever getting to litigation. *Id.*

The Court held that legal liability sufficient to invoke coverage under the insuring agreement and Loss Establishment Clause can be established by a unilateral settlement to which the insurer has not consented, so long as the settlement did not prejudice the insurer. The policy obligated Markel to pay Lennar's "'ultimate net loss'—defined as 'the total amount of [property] damages for which [Lennar] is legally liable'—and states that such loss 'may be established by adjudication, arbitration, or a compromise settlement to which we have previously

agreed in writing.'" *Id.* at 756. The policy also included a condition barring settlement without consent, and it also included similar language in the insuring agreement. *Id.* at 751. The Court also reasoned that repeating the consent requirement in the insuring agreement did not mean that the absence of consent was a material breach that obviated the need to show prejudice. *Id.* at 756.

The Court rejected arguments that Lennar prejudiced the insurer as a matter of law by actively "soliciting claims which might otherwise never have been brought contacting of potential claimants rather than waiting for them to assert a claim somehow prejudiced the insurer." *Id.* at 755-56. Strategic use of the Court's ruling could assist policyholders with a new tool to encourage carriers to participate and initiate settlement. While carriers in Texas have traditionally not had a tort duty to initiate settlement, the decision in Lennar strongly suggests that is they take a wait and see approach, the insured can take preemptive action, solve the impasse and send the bill back to the carrier.

Critics of the decision in Lennar fear that the Court has set the stage for policyholders to exclude liability insurers from settlement discussions. As noted, the Court has previously emphasized that carriers who are given the opportunity to participate in settlement and refuse to do so will suffer. *Evanston, supra.* The Court in *Lennar* clearly desired to reward responsible corporate insureds seeking to limit and solve problems, noting that "Lennar's responsible efforts to correct defects in its home construction did not absolve [the liability insurer] of responsibility for the costs under its liability policy." *Id.* at *6.

G. *Yorkshire v. Seger*—The Saga—Denial Of Defense And Coverage

Litigation over a variety of issues involving *Gandy* and so-called sweetheart deals have been played out over a long period of time in *Yorkshire Ins. Co., Ltd. v. Seger,* 407 S.W.3d 435 (Tex. App.—Amarillo 2013, review granted March 13, 2015). The court of appeals addressed the *Atofina* reading of *Gandy*, and reasoned:

> Relying on *ATOFINA,* the Segers contend that, because Insurers did not provide Diatom a defense and denied coverage, Insurers are barred from challenging the reasonableness of the underlying judgment. However, we conclude that the arrangement between Diatom and the Segers does not meet *ATOFINA*'s exception to *Gandy.* First, because the Segers are asserting their *Stowers* claims as assignee of Diatom, "*Gandy*'s key factual predicate" is present. *Id.* at 673; *see Gandy,* 925 S.W.2d at 713. Second, the agreement between Diatom and the Segers implicates both of *Gandy*'s concerns. The very point of the assignment was to prolong the litigation. Before the underlying judgment was obtained, Diatom was judgment-proof and each of the individual principals of Diatom had been nonsuited. *See Transp. Ins. Co. v. Heiman,* No. 05–95–00482–CV, 1999 WL 239917, at *9–10, 1999 Tex.App. LEXIS 3083, at *27–28 (Tex.App.-Dallas Apr. 26, 1999, no pet.) (it is the insured's insulation from any personal liability, such as from a covenant not to execute, that makes these sorts of arrangements "so highly suspect."). Thus, the Segers obtained an assignment of Diatom's *Stowers* claims specifically for the purpose of initiating another suit against the CGL insurers. *See First Gen. Realty Corp. v. Md. Cas. Co.,* 981 S.W.2d 495, 499 (Tex. App.-Austin 1998, pet. denied).

Id. at 439-40. The court added:

> Likewise, the assignment distorted the litigation. Because neither Diatom nor its principals had any financial exposure in the underlying trial, unlike ATOFINA, Diatom had no incentive to contest its liability or to attempt to limit the assessment of damages after it was found liable. *See ATOFINA*, 256 S.W.3d at 674 (*ATOFINA* "settled without knowing whether or not it would be covered by the policy, leaving in place its motive to minimize the settlement amount in case it became solely responsible for payment."); *see also First Gen. Realty Corp.*, 981 S.W.2d at 500. Further, as assignee of Diatom's claims against Insurers, the

> Segers, in their *Stowers* action, are forced to take the position that they would not have recovered more than policy limits against Diatom if Insurers had only provided Diatom a defense. In the underlying action against Diatom, the Segers sought and obtained a judgment awarding them a combined $15,000,000 in actual damages. However, as assignee of Diatom, in the present action, the Segers are forced to argue that they would have recovered no more than the $500,000 CGL policy limits had Insurers provided Diatom a defense. In fact, the Segers argued to the trial court in their *Stowers* action that admission of the amount of damages recovered by them in the underlying proceeding would be "completely prejudicial."

Id. at 440.

The court of appeals next turned to the "adversarial trial" requirement of *Gandy.* Applying the *Atofina* approach, the court concluded the assignment was valid:

> In the present case, (1) the Segers obtained their assignment of Diatom's claims against Insurers after the underlying proceeding, (2) Insurers refused to tender a defense of Diatom, and (3) Insurers neither accepted coverage nor made a good faith effort to adjudicate coverage prior to the adjudication of the Segers' claims. Thus, under *Gandy*, Diatom's assignment of its claims against Insurers to the Segers is valid.

Id. at 441. The court held that the underlying judgment may not be used as evidence of damages whenever it is rendered without a fully adversarial trial. Of course, if this is what *Gandy* intended, then why would there be a need for the anti-assignment rule?

The court reasoned that "any evidence of pre-trial collusion between Diatom and the Segers would only be relevant to the validity of the post-judgment

assignment of Diatom's claims against Insurers. *See Gandy*, 925 S.W.2d at 714. The determination of the reliability of the underlying judgment's assessment of damages depends entirely on the extent of Diatom's participation in the underlying proceeding. *See Gandy*, 925 S.W.2d at 713–14; *Seger I,* 279 S.W.3d at 772 n. 25." *Id.* at 443 n. 7.

The court characterized the "trial" as follows:

> The record reflects that Diatom was not represented by counsel, did not announce ready at the start of trial, made no opening or closing statements, offered no evidence, and did not cross-examine any of the Segers' witnesses.
>
> . . . .
>
> The record reflects that the Segers offered a significant amount of evidence during the underlying proceeding, however, it is noteworthy that the only evidence of actual damages offered during this proceeding was that Randall's death cost his estate $570,278 as the value of his expected future earnings, and that funeral expenses were $4,881.76. There was no evidence offered that would support awards of $7,500,000 to both Roy Seger and Shirley Hoskins. However, because Diatom was not acting as an adversary, this lack of evidentiary support for the trial court's award of actual damages was not challenged during the trial, by post-judgment motion, or on appeal. Further, this lack of evidentiary support for the trial court's award of damages in the underlying case evinces that the value of the Segers' claims against Diatom were not "fairly determined" by that proceeding. *See Gandy*, 925 S.W.2d at 713–14 (a settlement or judgment that follows an adversarial trial "fairly determine[s]" the value of the plaintiff's claims).

Id. at 442. The court added: "[T]he 'fully adversarial trial' determination is a legal one, as a mixed question of law and fact, the trial court's factual determinations

underlying its legal conclusion must be properly supported by the record. *See Remington Arms Co. v. Luna*, 966 S.W.2d 641, 643 (Tex. App.—San Antonio 1998)." *Id.* at 443 n. 4. Thus, the court concluded that the judgment could not be admitted into evidence as proof of damages, and no other proof was provided.

The issues were teed up for the Supreme Court to revisit *Gandy* with *Yorkshire.* Instead, the Court went to great lengths to find coverage existed, thus avowing any contractual or extra-contractual liability and thus the *Gandy* issues presented by the decision of the Court of Appeals.

H. Course Correction—*Hamel*

The Supreme Court corrected the course of *Gandy* in 2017 with its decision in *Great American Insurance Company v. Hamel*, 525 S.W.3d 655 (Tex. 2017). In that case, the underlying plaintiffs sued the Builder/insured for breach of implied warranty, negligence, Deceptive Trade Practices Act violations, and Residential Construction Liability Act violations, alleging that the Builder failed to perform its services in a good and workmanlike manner. *Id.* at 659. Initially, the plaintiffs alleged Exterior Insulation and Finish System ("EIFS") was improperly used or installed, resulting in water damage to the home. They amended the suit to alternatively allege (a) water damage from improper construction or (b) from use of EIFS.

Great American had five years of CGL coverage for the Builder. The last two years included EIFS exclusions. Great American determined that the damage was discovered during the last policy. Great American denied a defense based on the EIFS exclusion in the discovery policy period. Great American admitted on appeal that it erroneously selected the "discovery" policy and failed to follow the actual injury or injury-in-fact rule, and thus it admitted it erroneously denied the Builder a defense. *Id.* at 659-60.

Before trial, the plaintiffs and the Builder entered into a Rule 11 agreement. In that agreement, plaintiffs agreed:

(1) To protect the Builder's owner from any claim seeking to pierce the corporate veil;

(2) If a judgment was obtained against the Builder, they would only enforce it against assets in the company's name, excepting tools of the trade and truck (the only assets possessed by the company).

The Builder's owner agreed to appear at trial and not seek a continuance.

A week before trial, the parties agreed to a stipulation in lieu of responding to admissions in which the Builder confessed to having a duty to inspect the work of the prior builder and the subcontractors, that Builder failed to do so, that this was a failure to complete the home in a good and workmanlike manner and water damage resulted. Builder stipulated that none of the water damage was related to EIFS. The Builder had previously contended in discovery responses that the areas where there was a problem were to areas for which Builder was hired and paid. *Id.* at 660. The stipulation was not admitted into evidence, but the owner of the Builder testified to the same facts. The plaintiffs expert also testified to basically the same facts. "The trial court rendered judgment in the Hamels' favor and adopted their proposed findings without modification, awarding them $365,089 in damages—composed of $169,089 in repair costs, $100,000 in loss of market value due to stigma, $50,000 in mental-anguish damages, $15,000 in costs to repair landscaping that would be damaged during the home repair, $24,000 in temporary housing costs, and $7,000 in moving costs—plus prejudgment interest and court costs." *Id.* at 661. The Builder assigned most of its rights against Great American to the plaintiffs.

The trial of the insurance case was to the bench. The trial court entered findings of fact and conclusions of law that tracked the liability findings in the underlying suit. Additionally, the court in the insurance suit found:

- Great American waived its right to control the Builder's defense.

- The evidence and testimony admitted at the underlying trial was truthful.
- The Builder defended itself at the underlying trial in good faith.
- The Builder's and the plaintiffs' trial strategies and actions were reasonable and were not collusive or fraudulent.
- The underlying trial "was a genuine contest of issues resulting in an adversarial proceeding."
- The damage judgment and findings were supported by the evidence adduced at trial and were binding on Great American.
- Great American breached its duties to defend the Builder in the underlying suit and to indemnify the Builder from the judgment.

Great American urged that *Gandy* requires the underlying judgment to be the product of a "fully adversarial trial" and that absent such a trial the judgment may not be enforced by assignees against the insurance company. *Id.* at 663.

The Supreme Court began with a review of *Gandy,* noting it issued two rules: (a) one dealing with assignability, and (b) the other dictating that no judgment would be binding against the insurer without a fully adversarial trial. *Id.* Great American urged that the underlying trial was a sham and the insured had no real stake in the outcome. The plaintiffs/assignees urged there was no evidence of fraud and collusion.

The Supreme Court explained that assignability was not an issue in the case before it because:

(1) the assignment was after trial, not before;

(2) unlike *Gandy,* the insurer breached the duty to defend;

(3) Great American did not accept coverage and did not make a good faith effort to litigate the coverage issue before the underlying claims were resolved.

The Court observed: "Great American took a significant risk by refusing to defend, or at least litigate its duty to the Builder." *Id.* at 664. The Court noted that declaratory actions are available to help resolve coverage disputes, observing that insurers will often "'assume the burden of having the issues resolved' to prevent undue burden on the insured." *Id.* (quoting in part *Gandy*).

The Court noted tension and some confusion existed regarding how the holdings in *Block, Gandy* and *Atofina* apply outside of their specific fact patterns. The court described the apparent holdings as follows:

(1) *Block*: The insurer's "breach of its duty to defend necessarily renders *any covered judgment* binding on the breaching insurer. 744 S.W.2d at 942–43." (Emphasis added.)

(2) After *Gandy,* the formula changed from focusing on the denial of a defense to whether there was a "fully adversarial trial" that resulted in a "judgment that accurately reflects the plaintiff's damages and thus the insured's covered loss. 925 S.W.2d at 714."[4]

(3) *Atofina* held an insurer is bound to a judgment arising from a settlement agreement rather than a trial "because the defendant retained a stake in the litigation even upon settlement."

[4] The Court in *Hamel* explained in a footnote that the "adversarial trial" requirement was not an issue in *Gandy* and thus was apparently dicta: "our holding in Gandy that the plaintiff could not enforce the judgment against the insurer was based solely on the assignment's invalidity. As a result, we did not have the opportunity to expound on the meaning of the phrase 'fully adversarial trial.'" *Id.* at 671 n. 7.

The Supreme Court recognized the Court of Appeals in effect assess "fully adversarial" by looking back to what happened at the trial. The Supreme Court reasoned:

> The court of appeals' approach necessarily requires courts to retroactively evaluate and thus second-guess trial strategies and tactics, which—as we have noted in other circumstances—often produces an inaccurate and unreliable result. *C.f., e.g., Cantey Hanger LLP v. Byrd*, 467 S.W.3d 477, 481 (Tex. 2015) (noting the general rule that "attorneys are immune from civil liability to non-clients for actions taken in connection with representing a client in litigation" (citations and internal quotation marks omitted)); *In re JFC,* 96 S.W.3d 256, 283 (Tex. 2002) (noting the difficulty of overcoming the presumption that trial counsel's acts and omissions are based on strategy in claims of ineffective assistance of counsel). ***Every trial presents unique challenges, requiring subjective judgment calls that may seem in hindsight to have been ill-advised. But determining whether and when those calls destroy the "adversarial" nature of the proceeding is simply not possible***. Great American's criticism of the Builder's trial strategy here is particularly troubling given that it ***had the opportunity to control the defense in the first instance and wrongfully refused to do so.***

Id. at 666. The Court clarified:

> Today we clarify that the controlling factor is whether, at the time of the underlying trial or settlement, ***the insured bore an actual risk of liability for the damages awarded or agreed upon***, or had some ***other meaningful incentive*** to ensure that the judgment or settlement accurately reflects the plaintiff's damages and thus the defendant—insured's covered liability loss.

Id. Importantly, the Court added:

> When the parties reach an agreement before trial or settlement that deprives one of the parties of its incentive to oppose the other, the proceeding is ***no longer adversarial***. Stated another way, proceedings lose their adversarial nature when, by agreement, ***one party has no stake in the outcome and thus no meaningful incentive to defend itself.*** When a plaintiff agrees to forgo execution of a judgment against a defendant's assets, whether in conjunction with a settlement or before trial, the defendant no longer has a financial stake in the outcome and thus likely has no interest in either avoiding liability altogether or minimizing the amount of damages. ***We believe adversity turns on the insured defendant's incentive to defend (or lack thereof), and an after-the-fact evaluation of the parties' trial strategies therefore has no place in the analysis.*** Stated another way, proceedings lose their adversarial nature when, by agreement, one party has ***no stake in the outcome*** and thus no meaningful incentive to defend itself. When a plaintiff agrees to forgo execution of a judgment against a defendant's assets, whether in conjunction with a settlement or before trial, the defendant no longer has a financial stake in the outcome and thus likely has no interest in either avoiding liability altogether or minimizing the amount of damages. We believe adversity turns on the insured defendant's incentive to defend (or lack thereof), and an after-the-fact evaluation of the parties' trial strategies therefore has no place in the analysis.

The Court noted that the Builder's only assets were a pickup truck and some tools. One wonders whether an insured would ever have an interest in defending under such circumstances. Strangely, the Court also noted that the plaintiffs agreed not to attempt to pierce the corporate veil and go after the actual owner of the Builder. How could these assets, which ostensibly belong to the owner and not the insured, provide an "incentive" for the insured to defend? The Court concluded:

> In sum, the parties' pretrial agreement removed the Builder's stake in the outcome and any corresponding incentive to defend itself. After the agreement was executed, the Damage Suit no longer involved opposing parties, and the trial that followed was not fully adversarial. Accordingly, under *Gandy*, the Damage Judgment is not binding against Great American in the present suit brought by the Hamels as judgment creditors and assignees. *See* 925 S.W.2d at 714.

The Court added:

> We do not suggest that a formal, written pretrial agreement that eliminates the insured's financial risk will always be either necessary or sufficient to disprove adversity. We hold instead that the presence of such an agreement creates a strong presumption that the judgment did not result from an adversarial proceeding, while the absence of such an agreement creates a strong presumption that it did.

Id. at 668.

The Court next addressed whether the insurance coverage trial could somehow remedy the lack of adversity at the damages trial. Evaluating and assessing a defendant's liability after settlement is avoided by the courts except where there are "compelling reasons to the contrary." The Supreme Court in *Hamel* held that "an insurer's wrongful refusal to defend presents a compelling reason to engage in this endeavor despite its difficulty." *Id.* at 668. The *Hamel* Court noted:

> An insurer's refusal to defend or to even attempt to litigate its duties while the underlying suit is pending carries significant risks, and for good reason. *See id. [Gandy]* at 714. It places the burden on the insured to defend itself, often without adequate resources to do so. . . To some degree, the parties' conduct is simply an attempt to make the best of a situation that Great American created by refusing to defend. .

> . By declining to defend or litigate its duties early, an insurer plays a key role in making such a complicated endeavor necessary. Certainly, relitigation of underlying liability and damages issues is not a perfect solution, but it is necessitated by the circumstances. The insurer should not benefit from the problem that it helped create, as Great American's proposed solution—rendition of judgment in its favor—would allow. Rather, under the approach we adopt today, the insurer will have the opportunity to challenge its insured's underlying liability and the resulting damages, the abandoned insured is protected, and the burden on the plaintiff is fair. And of course, the insurer has every incentive to assert a strong defense during the Insurance Trial.

Id. at 670. Finally, the Court concluded that the Insurance Coverage Trial did not solve the issue in the case before it. Accordingly, the Court remanded in the interests of judgment. Thus, in the Court's own words, the mission on retrial is to provide "the opportunity to litigate any disputed underlying issues with the benefit of full adversity." *Id.* at 671.

I. CBX—Default Judgment

The court in *CBX Resources, LLC v. Ace American Insurance Company,* 320 F.Supp.3d 853 (2018), applied *Hamel* to a case in which the underlying suit was resolved by a default judgment in the amount of $105 million. The insured was compelled to assign its rights against ACE as a result of the entry of a post-verdict turnover order. It was undisputed that the insured was insolvent prior to the default.

Focusing on the insolvency of the insured, the court concluded the underlying judgment was not binding on the carrier because the insured had no financial interest to contest the suit. *Id.* at 859. The court emphasized the insured did not show up. The court seemed to give little protection to an insured who is too poor to defend itself and as to whom the carrier has denied a defense. Moreover, the court

rejected the arguments of the claimant the insured still had an adequate stake in the outcome:

> CBX also argues that at the time of trial, Espada still had a meaningful stake in the outcome of the underlying litigation because (1) it held the right to receive a fee in exchange for making several different wells produce and it did not want to have a judgment against it if it wanted to continue its business; (2) it attempted to hire counsel to sue Ace to force Ace to continue its defense in the underlying litigation, but the law firm declined to take the case; (3) to this day, Espada remains a going concern in that the business has never been dissolved and it still presently files tax returns; and (4) as an operating company, Espada did not need any assets to generate revenue because "its assets were the people that were running it as managers," and that it was designed to be insolvent as a result of "incurring liabilities like for these plugging of wells." (Dkt. # 47 at 19–20; Ex. U at 52:20–53:9.)

Id. at 860. The court noted that summary judgment evidence was presented by the carrier that the insured sought to get coverage counsel but it made no effort to get a defense counsel to defend it against the attempts to seek a monstrous judgment. *Id.*

The court concluded:

> Based on the foregoing, the Court finds that Ace has produced sufficient evidence that Espada did not have a meaningful incentive to ensure that CBX's default judgment accurately reflected its damages. *See Hamel,* 525 S.W.3d at 668. Accordingly, the Court finds that the underlying judgment was not the result of a fully adversarial proceeding, and thus it is not binding on Ace in this suit. *See id.* ("The defendant's insurer is often the plaintiff's only real source of recovery, but without the insurer's involvement in the lawsuit the likelihood of a

> fully adversarial trial diminishes substantially."). The Court will therefore grant Ace's motion for partial summary judgment on this issue, and deny CBX's motion on the same.

Id. at 861. It is unclear whether the second phase of *Hamel* would be available in *CBX.* The court noted that in contrast to *Hamel,* it had found that the carrier was correct in denying a defense and did not owe a duty to defend the insured. *Id.* at n. 5.

III. The Georgia Approach

A. The Bedrock Principle—An Insurer That Fails to Provide a Defense "Does So At Its Peril"

The Supreme Court of Georgia has held: "An insurer that refuses to indemnify or defend based upon a belief that a claim against its insured is excluded from a policy's scope of coverage "[does] so at its peril, and if the insurer guesses wrong, it must bear the consequences, legal or otherwise, of its breach of contract." *S. Guar. Ins. Co. v. Dowse*, 278 Ga. 674, 676, 605 S.E.2d 27, 29 (2004) (quoting 49 A.L.R.2d 694 at (I)(2b)). One of these "consequences" is that the insurer can no longer enforce consent and cooperation conditions in the policy. This rule is predicated on the finding that "[t]hese provisions enable insurers to control the course of litigation concerning such claims, and also serve to prevent potential fraud, collusion and bad faith on the part of insureds," but that an insurer also "has a correlative duty to defend its insured against all claims covered under a policy, even those that are groundless, false, or fraudulent." *Dowse*, 278 Ga. at 676. Thus, under Georgia law, the duty to defend and duty to obtain consent to settle are inextricably intertwined.

Pursuant to these principles, "an insurer that denies coverage and refuses to defend an action against its insured, when it could have done so with a reservation of its rights as to coverage, 'waives the provisions of the policy against a settlement by the insured and becomes bound to pay the amount of any settlement [within a

policy's limits] made in good faith[,] plus expenses and attorneys' fees.'" *Id.* Put another way, an insurer that abandons its policyholder on the side of the road is responsible for the full fare paid by the policyholder to get home safely.

1. "Sweetheart Deals" Under *Dowse*—Substance Over Form

In *Dowse*, the claimants in the underlying action released the policyholder from all liability for damages in exchange for an assignment of the policyholder's right to pursue a claim against the insurer. *See id.*, at 675. "Because the settlement agreement release[d] Cutter, Inc. [the policyholder] of any obligation to pay damages, SGIC [the insurer] argue[d] that it, too, [was] relieved of that obligation." *Id.* The Supreme Court of Georgia rejected this argument and held:

> The settlement agreement provides that the Dowses [the claimants in the underlying action] would not seek to recover or collect from Cutter, individually, or from Cutter, Inc., "except [the Dowses] may seek to recover any funds available to [Cutter, Sr., and Cutter, Inc.,] as indemnity under [SGIC's insurance policy] .... it being the express intent of all parties hereto to enter into an agreement providing [the Dowses] shall limit their recovery to whatever [they] may recover under the [SGIC policy] ... whether as assignee of the benefits of this policy or as judgment creditor of [the insureds]." Thus, it is clear that the Dowses specifically reserved their claims against Cutter, Inc., to the extent that coverage is provided under the SGIC policy. Accordingly, there has not been a full and complete release of Cutter, Inc., as claimed by SGIC, and its argument to the contrary fails.

Id.

In so holding, the Supreme Court of Georgia affirmed the opinion of the Georgia Court of Appeals, which relied on precedent from other jurisdictions holding "that an insurer may be liable to an injured party when the insured before judgment is protected by an agreement not to execute, basing their holdings . . . on the right

of the insured to protect itself from the bad faith conduct of its insurer." *Dowse v. S. Guar. Ins. Co.*, 263 Ga. App. 435, 439, 588 S.E.2d 234, 237 (2003), *aff'd*, 278 Ga. 674, 605 S.E.2d 27 (2004) (citing *Metcalf v. Hartford Accident &c. Co.*, 176 Neb. 468, 126 N.W.2d 471 (1964); *Coblentz v. American Surety Co. of New York,* 416 F.2d 1059 (5th Cir. 1969)). Importantly, the Georgia Court of Appeals distinguished its holding from an "alternative line of reasoning in holding that a covenant not to enforce against a party does not release that party's insurance carrier" because a "covenant not to execute is simply a contract, not a release, so that the underlying tort liability remains and a breach of contract action lies if an injured party seeks to execute on its judgment." *Id.* at 441. Thus, while the court implied that the same result would be reached under this "alternative" approach based on the distinction between contract and tort rights, it also affirmed that in Georgia substance rules over form. The insurer will not avoid the "consequences" of breaching its duty to defend simply because the "sweetheart deal" is structured a certain way. *See id.* at 438 (finding "distinction between a covenant not to execute and a covenant not to sue" is "a distinction without a difference").

Indeed, the Georgia Court of Appeals' decision was predicated on three fundamental "policy considerations":

1) ***Enforcing the Intention of the Settling Parties***: As the court explained, "holding that SGIC is not released from its obligations under the policy by the Dowses' settlement agreement with Cutter, Inc. forwards the important goal of enforcing the intentions of the parties to the agreement. . . In this case, our holding enforces the parties clear intention that SGIC not be released."

2) ***Ensuring the Availability of Insurance for Tort Victims*:** The court also noted that its holding "advances the strong public policy favoring the availability to injured persons of the liability insurance of those whose negligence is the cause of their plight. Cutter, Inc. secured insurance and paid premiums to cover instances of liability such as the one

damaging the Dowses, both Cutter, Inc. and the Dowses are entitled to the protection of that insurance coverage, and SGIC should not be permitted to refuse to supply it."

3) ***Encouraging Settlements***: Finally, the court held that Georgia courts have "long recognized that it is sound public policy to encourage parties to engage in settlement negotiations to the end that litigation may be avoided."

Id. at 442 (internal citations omitted).

2. Other Consequences—Waiver of Defenses

The Supreme Court of Georgia subsequently reaffirmed *Dowse* in *Owners Ins. Co. v. Smith Mech. Contractors, Inc.*, 285 Ga. 807, 683 S.E.2d 599 (2009). In *Smith Mechanical*, the Georgia Supreme Court held there was a waiver of the provisions of the insurance policy against settling without the insurer's consent when there is a denial of coverage and refusal to defend. In that case, the court went on to hold that the insurer's decision not to defend its policyholder estopped the insurer from re-litigating the merits of the underlying disputes and, consequently, from arguing that the policyholder's settlement was a "voluntary payment." *Id.* Similarly, in *Hoover v. Maxum Indem. Co.*, the Supreme Court of Georgia reaffirmed that an insurer that "den[ies] coverage and refuse[s] to defend" faces consequences, including the waiver of coverage defenses not asserted with its initial coverage denial. 291 Ga. 402, 405, 730 S.E.2d 413, 416 (2012).

Moreover, several Georgia Court of Appeals have relied on *Dowse* to hold insurers responsible for the "consequences" of its refusal to defend its policyholder. *See, e.g., Occidental Fire & Cas. of N. Carolina v. Goodman*, 339 Ga. App. 427, 431, 793 S.E.2d 606, 610 (2016) ("In this case, rather than defend the action with a reservation of rights as to coverage, [the insurer] simply denied coverage and refused the request to provide a defense to the lawsuit based on its incorrect belief

that the claim against [the policyholder] was not covered by the policy. Under these circumstances, [the insurer] ***must bear the consequences*** of its decision not to defend the suit and must pay for its breach of the contract.") (emphasis added); *McGregor v. Columbia Mat. Ins. Co.,* 298 Ga.App. 491, 494, 680 S.E.2d 559, 562 (2009) ("Georgia law is clear that by refusing to defend its insured in litigation, an insurer ***loses all opportunity to contest the negligence of the insured or the injured person's right to recover***, and exposes itself to a charge of and penalty for breach of contract.") (internal citations omitted) (emphasis added); *Yeomans & Assocs. Agency, Inc. v. Bowen Tree Surgeons, Inc.*, 274 Ga. App. 738, 747, 618 S.E.2d 673, 681 (2005) ("Under these circumstances, [the insurer] is ***estopped from arguing that the plaintiffs violated the insurance policy by settling a claim without [the insurer's] consent***, when it was [the insurer] who breached the policy and left [the policyholder] unprotected in the [underlying] suit.")(emphasis added).

One Georgia court has applied the *Dowse* rule where the insurer did not have duty to defend under the policy and held the insurer's attempt to rescind the directors and officers liability policy at issue precluded the insurer from subsequently challenging the allocation of the settlement payment. *Exec. Risk Indem., Inc. v. AFC Enterprises, Inc.*, 510 F. Supp. 2d 1308, 1333 (N.D. Ga. 2007), *aff'd*, 279 F. App'x 793 (11th Cir. 2008) ("[The insurer] had the opportunity to protect the interests of its insureds and its own interests. It chose instead to stand by its rescission of the Policy. It cannot now insist that its insureds should have, in some fashion suitable to [the insurer], allocated the settlement they reached to comply with an insurance policy [the Insurer] has insisted does not exist.")

Thus, the *Dowse* holding and bedrock principle upon which it is based—*i.e.*, that an insurer that abandons its policyholder "does so at its peril"—has not only been reaffirmed, but has been expanded by subsequent decisions to impose additional consequences beyond the waiver of the right to contest a settlement.

B. Exception for Bad Faith or Collusive Settlements

Under the *Dowse* holding and its progeny, the only means for an insurer to challenge a settlement made after refusing to provide a defense is to prove the settlement was entered into in bad faith. *See, Dowse,* 278 Ga. at 676; *see also Lee v. Universal Underwriters Ins. Co.*, No. 1:12-CV-3540-CAP, 2014 WL 11858159, at *3 (N.D. Ga. June 25, 2014), aff'd, 642 F. App'x 969 (11th Cir. 2016) ("Under Georgia law, [the insurer] may challenge the underlying consent judgment only by establishing that it was not made in good faith.") The burden of proving such bad faith conduct is on the insurer. *See AFC Enterprises, Inc.*, 510 F. Supp. 2d at 1332 ("[The insurer offered no evidence at trial that [policyholder's] settlement of the Underlying Actions was collusive or in bad faith."). However, the insurer may not need to show additional evidence of collusion if the settlement amount is grossly excessive. *See Georgia Southern & C. R. Co. v. U.S. Cas. Co.*, 97 Ga.App. 242, (1958); ("Where an insurer refuses to defend an action against an insured on the ground that the policy does not require it to do so under the policy coverage, the insurer is bound by a settlement of the action made by the insured in good faith, and may not question the reasonableness of the amount if the settlement otherwise was in good faith, *unless the excessiveness of the amount alone is sufficient to show bad faith*.")

IV. Other Jurisdictions

A. Florida and The *Coblentz* Agreement

1. Mary Carter Agreements

The term "Mary Carter" agreement is derived from the name of one of the earliest cases involving such an agreement, *Booth v. Mary Carter Paint Company*, 202 So. 2d 8 (Fla. 2d DCA 1967). Four features characterize Mary Carter agreements: (1) the settling defendant and the plaintiff usually agree to keep the agreement secret; (2) the settling defendant remains a party to the litigation and agrees to aid the plaintiff's recovery; (3) the settling defendant guarantees the plaintiff a minimum recovery, and in return, the plaintiff agrees not to enforce a judgment against the

settling defendant; and (4) the settling defendant gains a financial interest in the plaintiff's recovery.

The argument in favor of Mary Carter agreements: they promote settlement . . . but with only one of the defendants. The arguments against Mary Carter Agreements:

> Settling parties may cooperate during the discovery process; cooperate during voir dire and share their strategic peremptory challenges; coordinate courtroom strategy, support each other's motions, vigorously challenge the non-settling defendant's motions; and persuade the jury to render a judgment that serves the settling parties' interests. Additionally, it can increase the likelihood of post-trial attacks on verdicts alleged to have been unfairly obtained as a result of such agreements. Bottom line, they prevent fair trials, and obscure the search for the truth.

Florida attempted to ameliorate the inherent unfairness of Mary Carter Agreements. In 1973, Florida held the Agreement must be disclosed and admitted into evidence. Even admitting the agreement into evidence, however, can be a double-edged sword to the extent that it conveys a message to the jury that at least one of the defendants felt that the plaintiff's claim was meritorious. *Ward v. Ochoa,* 284 so. 2d 385 (Fla. 1973) *abrogated by Dosdourian v. Carsten*, 624 So. 2d 241 (Fla. 1993).

In 1993, the Florida Supreme Court held that it would no longer recognize Mary Carter agreements between plaintiff and one of multiple defendants, including any agreement which requires the settling defendant to remain in the litigation, regardless of whether there is a specified financial incentive to do so. The court noted that Mary Carter Agreements were invalid for (1) encouraging an unfair trial, (2) promoting unethical practices by attorneys, (3) adding to litigation and appeals to the Florida courts, and (4) undermining the integrity of the judicial system. *Dosdourian v. Carsten*, 624 So. 2d 241 (Fla. 1993).

2. Policyholder Settlements

Policyholder settlements without involvement of the carrier have been drawn into the world of Mary Carter agreements, as Gandy shows. The majority of jurisdictions permit a policyholder to enter into a stipulated judgment with the underlying claimant, under certain circumstances, without the consent of the insurer in exchange for an agreement that the underlying claimant will not execute the judgment against the policyholder. There are important limitations, though, in every jurisdiction.

3. *Coblentz* Agreement:

Coblentz v. American Surety Co. of New York, 416 F. 2d 1059 (5th Cir. 1969) coined the term "Coblentz Agreement." As a general matter, one who is not a party to a settlement agreement cannot be bound by its terms. An exception to this rule occurs when an insurer refuses to defend its insured. Absent fraud or collusion, a liability insurance carrier will be bound to the settlement agreement between the insured and the claimant if the insurance carrier wrongfully refused to defend its insured. Florida courts have extended the reasoning of *Coblentz* to allow agreements by the insured to a judgment *in excess of the policy limits* against an insured who wrongfully refuses to defend and acts in bad faith. *Perera v. U.S. Fid. and Guaranty Co.,* 35 So.3d 893, 900 (Fla.2010).

As in most jurisdictions, under Florida law, "when an insurer unequivocally denies coverage that actually exists, the insurer has breached the contract and therefore cannot rely on a contractual provision prohibiting the insured from settling the claim without its consent." *U.S. Fire Ins. Co. v. Mikes*, 576 F.Supp.2d 1303 (M.D. Fla. 2007). "Likewise, when an insurer improperly fails or refuses to defend an insured's claim, the insurer has breached the insurance contract and an insured is entitled to enter into a reasonable settlement even though the policy purports to avoid liability for a settlement made without the insurer's consent." *Id.* (citing

Gallagher v. Dupont, 918 So.2d 342 (Fla. Dist. Ct. App. 2005) and *Steil v. Fla. Physicians' Ins. Reciprocal*, 448 So.2d 589, 591 (Fla.Dist.Ct.App.1984)).

The recent decision in *Bioscience West, Inc. v. Gulfstream Property and Cas. Ins. Co.,* 2016 WL 455723, --- So.3d --- (Fla. 2d Dist. Ct. App. 2016), the court held that the policy in that case barred assignment of the entire policy without consent of the carrier, but it did not bar assignment of benefits derived from the policy. The policy stated: "Assignment. Assignment of this policy will not be valid unless we give our written consent." *Id.* at *2. The court also held:

> A review of the "loss-payment" provision provides support for our interpretation that the "Assignment" provision of the insurance policy was not intended to apply to assignments of benefits derived from the policy but instead to assignments of the entire policy. See *Cespedes*, 161 So.3d at 584 (noting construction of an insurance contract as a whole). Specifically, an examination of the loss-payment provision demonstrates that Gulfstream contemplated the need to pay third parties who were "legally entitled" as follows: "[Gulfstream] will pay you unless some other person ... is legally entitled to receive payment." (Emphasis added). In sum, Gulfstream anticipated the need to pay those "legally entitled to receive payment" under the policy, which, pursuant to Ms. Gattus's "Assignment of Insurance Benefits" agreement with Bioscience, entitled Bioscience to receive any payments due under the policy.

Id. Importantly, the court also held that anti-assignment clauses do not apply to assignments made *after* a loss:

> Even if an insurance policy contained a specific, articulate provision precluding an insured's post-loss assignments of benefits without the insurer's consent, Florida case law yields deep-rooted support for the conclusion that post-loss assignments do *not* require an insurer's

> consent. *See One Call Prop. Servs. Inc.,* 165 So.3d at 755 ("Even when an insurance policy contains a provision barring assignment of the policy, an insured may assign a post-loss claim."). Nearly 100 years ago, the Florida Supreme Court recognized that provisions in an insurance policy requiring consent to assignment of that policy do not apply to assignments after a loss. *W. Fla. Grocery Co. v. Teutonia Fire Ins. Co.,* 77 So. 209, 210–11 (Fla.1917) ("The policy was assigned after loss, and it is a well-settled rule that the provision in a policy relative to the consent of the insurer to the transfer of an interest therein does not apply to an assignment after loss."). This principle was reaffirmed in 1998, when our supreme court explained that "an insured may assign insurance proceeds to a third party after a loss, even without the consent of the insurer." *Lexington Ins. Co. v. Simkins Indus., Inc.,* 704 So.2d 1384, 1386 n. 3. (Fla.1998).

Id. at *4.

In Florida, a party seeking coverage under a *Coblentz* agreement must prove: (1) coverage; (2) a wrongful refusal to defend; and (3) that the settlement was objectively reasonably and made in good faith. There are two prongs to the coverage element:

- the facts alleged in the underlying complaint must state a claim that fealls within the coverage of the policy (i.e., that the insurer had a duty to defend); and

- notwithstanding the allegations in the underlying complaint or stipulated facts in the consent judgment, the plaintiff's underlying claims must actually come within the coverage of the policy (i.e., on the merits, the insurer has a contractual duty to indemnify).

How the duty to indemnify is determined is a narrow enquiry, based on what liabilities were settled and why. Again, a claimant seeking coverage must not only

prove a wrongful refusal to defend but also that the claim was ultimately within the policy's coverage. *Steil v. Florida Physicians Ins. Reciprocal,* 448 so. 2d 589, 592 (Fla. 2d DCA 1984).

A covenant not to execute given in connection with a consent judgment does not affect the insurer's responsibility under the policy or release it from liability. *Shook v. Allstate Ins. Co.*, 498 So. 2d 498 (Fla. 4th DCA 1984).

Insurer needs to have breached the insurance policy before the insured may enter into assignment agreement. If an insurance company breaches its contractual duty to defend, the insured can take control of the case, settle it, and then sue the insurance company for damages it incurred in settling the action. *MCO Environmental Inc. v. Agricultural Excess & Surplus Ins. Co.*, 689 So. 2d 1114 (Fla. 3d DCA 1997)

In *Zurich American Insurance Company v. Frankel Enterprises*, 2008 WL 2787704 (11th Cir. 2008), the insurer agreed to provide defense under reservation of rights. The insured never rejected the assigned defense counsel and never rejected the defense offered by Zurich. Zurich never withdrew its defense of the case, even after reserving its rights. The insured settled with the claimant, consented to a judgment against it, and assigned its rights against Zurich to the claimant. Zurich did not authorize or consent to the settlement. The court upheld the trial court's order granting summary judgment in favor of the Insurer. The trial court noted that an insurer is not bound by an unauthorized settlement unless: the insurer refuses to defend, not merely denies coverage; or if the insurer defends under a reservation of rights, and the ***insured rejects the defense***. *Zurich American Insurance Company v. Frankel Enterprises*, 2008 WL 2787704 (C.A. 11 July 18, 2008). This is a very touchy subject, wed as it is to reservation of rights law, such as the existence of true conflicts between the insured and insurer, when can a defense be rejected once accepted, consent to settle and no voluntary assumption clauses.

In *Zurich,* the court explained:

> When a defense is offered under a reservation of rights, the insured has a right to reject the conditional defense, retain control over the defense, and effect a reasonable settlement, despite a contract term forbidding settlement without the insurer's consent and thus without releasing the insurer's obligation to pay for covered losses. *See Taylor v. Safeco Ins. Co.*, 361 So.2d 743, 744, 746 (Fla. 1st DCA 1978) (insured rejected the defense at the outset of the case); see also *W. Heritage Ins. Co. v. Montana*, 8:13cv1116, 2014 WL 3057393, at *5 (M.D. Fla. July 7, 2014) (citing *Taylor,* 361 So.2d at 746). "However, the insured must actually reject the conditional defense to be entitled to take control of the defense." *Montana*, 30 F.Supp.3d at 1372, 2014 WL 3057393, at *5 (citing *Aguero v. First Am. Ins. Co.*, 927 So.2d 894, 898 (Fla. 3d DCA 2005)).

Id. The court also noted that even if the insured accepts the defense initially and thus does not "reject" the conditional defense, circumstances may change, allowing the insured to unilaterally settle:

> Florida law also provides that an insured who does not reject a conditional defense at the outset may nonetheless ***subsequently reject*** it "if the insurer changes the terms of the defense in a material way." *Am. Pride,* 601 F.3d at 1150 (internal marks omitted) (finding a question of fact on this issue where, although the insured had accepted the conditional defense for over a year before rejecting it, there was evidence that the insurance company had changed the conditions of the defense by seeking attorney's fees and costs).

Id. (emphasis added).

The initial burden of making a prima facie showing of reasonableness and lack of bad faith rests with the claimant. Once that initial burden is met, the burden of pleading and persuasion regarding unreasonableness, bad faith or collusion shifts

to the Insurer. The ordinary standard of collusion or fraud is inappropriate. *Steil v. Florida Physicians Ins. Reciprocal,* 448 so. 2d 589 (Fla. 2d DCA 1984). All agreements are collusive by definition. True fraud must be proven.

The Florida test as to whether a settlement of a claim against an insured is reasonable and prudent is what a reasonably prudent individual in the position of the insurance carrier would have settled for on the merits of the claimant's claim. *Wrangen v. Pennsylvania Lumbermans Mut. Ins. Co.*, 593 F. Supp. 2d 1273 (S.D. Fla. 2008). Florida courts consider *objective factors* (the extent of the claimant's injuries) and *subjective factors* (the degree of certainty of the tortfeasor's subjection to liability, risks of going to trial, chances that the jury verdict might exceed the settlement offer, etc.). Insurance carrier can only challenge a settlement if the parties settled in bad faith, fraudulently, collusively or without any effort to minimize the insured's liability. *U.S. Auto Ass'n v. Hartford Ins. Co.*, 468 So. 2d 545 (Fla. 5th DCA 1985).

The stipulated judgment between the insured and the claimant may affix damages at a larger figure than the case's actual value. *Florida Physicians Ins. v. Reciprocal c. Avila, M.D.*, 473 So. 2d 756 (Fla. 4th DCA 1985). Similarly, a settlement is sufficient to satisfy the policy requirement that there be a legal obligation to pay as damages. *U.S. Fire Ins. Co. v. Mikes*, 576 F.Supp.2d 1303 (M.D. Fla. 2007).

If the insured is completely released from liability *before* it assigns any rights to the claimant, then the Consent Judgment cannot be binding on the insurer. *Fidelity & Cas. Co. v. Cope*, 462 So.2d 459, 461 (Fla. 1985) (the release has the effect of extinguishing the insured's liability, and therefore, all of the insured's rights against the insurer that subject to assignment). In Florida, the Supreme Court distinguished its earlier decision in *Cope* and held that the courts must look to the intent of the parties, and if the settlement between plaintiff and the insured was intended to continue liability rather than end it, it would be treated as a covenant not to execute, rather than a release. *Rosen v. Florida Ins. Guar. Ass'n*, 802 So.2d 291, 297-298 (Fla. 2001)(Agreement that plaintiff would accept consent judgment

against defendant, but the judgment "would never be recorded, would create no liens and could not be executed," was a covenant not to execute, not a release). In 2008, the court reaffirmed this rule, allowing it to be used in a case involving assignment of claims against an insurance agent for failure to procure insurance and breach of fiduciary duty. *Wachovia Ins. Services, Inc. v. Toomey,* 994 So.2d 980 (Fla. 2008).

B. Arizona and *Damron* and *Morris* Agreements

"A Damron agreement is one initiated when an insurer ***refuses to defend*** a policyholder in a lawsuit. Faced with the risk of personal liability, the policyholder/defendant settles the case for a specific amount and assigns to the plaintiff whatever claims the policyholder has against the insurer for failing to defend the lawsuit. In consideration, the plaintiff enters a covenant not to execute against the policyholder. *Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969)." *Cunningham v. Goettl Air Conditioning, Inc.,* 194 Ariz. 242, 246, 980 P.2d 495, 499 (1997). Such agreements are intended to allow the insured to protect itself from personal liability when the insurance company has left the insured "high and dry." *Id.* as explained by one court:

> In a *Damron* agreement, a policyholder may settle with a claimant only if the insurer first has breached a contractual duty to the policyholder. 105 Ariz. 151, 460 P.2d 997; *see Arizona Property and Casualty Ins. Guar. Fund v. Helme,* 153 Ariz. 129, 735 P.2d 451 (1987); *State Farm Mutual Auto. Ins. Co. v. Paynter,* 122 Ariz. 198, 200-01, 593 P.2d 948, 950-51 (App.1979). On the other hand, if an insurer performs its contractual obligation to defend the policyholder against any claim potentially covered by the policy, the policyholder must cooperate and aid the insurer in the defense. *United Services Auto. Ass'n v. Morris,* 154 Ariz. 113, 117, 741 P.2d 246, 250 (1987) . . . In this context, a policyholder defended by its insurer under a "reservation of rights"2 can enter a *Damron* agreement without breaching the policy's

> cooperation clause if the agreement is "made fairly, with notice to the insurer, and without fraud or collusion on the insurer."

460 P.2d at 999 (some citations omitted).

The Arizona Supreme Court, in *Safeway Ins. Co., Inc. v. Guerrero*, 210 Ariz. 5, 106 P.3d 1020 (2005)(en banc), noted that in circumstances involving wrongful conduct by the insurer other than denial of a defense, so-called *Morris* agreements are used. The court explained:

> The term "*Morris* agreement" is generally used to describe a settlement agreement in which an insured defendant [a] admits to liability and [b] assigns to a plaintiff his or her rights against the liability insurer, including any cause of action for bad faith, [c] in exchange for a promise by the plaintiff *not to execute* the judgment against the insured. *See United Servs. Auto. Ass'n v. Morris,* 154 Ariz. 113, 741 P.2d 246 (1987). Such an agreement can be prompted by a number of circumstances. *See, e.g., id.* at 115, 741 P.2d at 248 (involving an agreement entered into *after reservation of rights* by insurer); *Ariz. Prop. & Cas. Ins. Guar. Fund v. Helme,* 153 Ariz. 129, 735 P.2d 451 (1987) (involving an agreement entered into after alleged ***anticipatory breach of insurer's duty to indemnify***); *Miel v. State Farm Mut. Aut. Ins. Co.,* 185 Ariz. 104, 912 P.2d 1333 (App.1995) (involving an agreement entered into after alleged ***bad faith failure to settle*** by insurer). An agreement with these same characteristics entered in response to an insurer's ***refusal to defend*** the insured is generally referred to as a *Damron* agreement. *See Damron v. Sledge,* 105 Ariz. 151, 460 P.2d 997 (1969). We recognize that the cases sometimes use the terms "*Morris* agreement" and "*Damron* agreement" interchangeably. *See Himes v. Safeway,* 205 Ariz. 31, 34 n. 2 ¶ 1, 66 P.3d 74, 77 (App.2003). We refer to the agreement at issue in this case as a "*Morris* agreement" because it does not involve a refusal to

defend.

Id. at n. 1. The court found that a bad faith refusal to settle would permit such an agreement to be entered without it violating the cooperation clause. *Id.* But, in the case before it, there was a finding that the carrier did not mishandle the claim.

C. California

In *Critz v. Farmers Ins. Group,* 230 Cal.App.2d 788, 41 Cal.Rptr. 401 (App.1965), the California Supreme Court held:

> When the insurer breaches its obligation of good faith settlement, it exposes its policyholder to the ***sharp thrust of personal liability***. At that point, there is an acute change in the relationship between policyholder and insurer. The change does not or should not affect the policyholder's obligation to appear as defendant to testify to the truth. He need not indulge in financial masochism, however. Whatever may be his obligation to the carrier, it does not demand that he bare his breast to the continued danger of personal liability. By executing the assignment, he attempts only to shield himself from the danger to which the company has exposed him.

Id. at 153, 460 P.2d at 999.

In 1981 the California Supreme Court held that "an insured breaches no duty to the insurance company when he assigns his rights against the company to the injured plaintiffs in return for a covenant not to execute." *Samson v. Transamerica Ins. Co.*, 30 Cal.3d 220, 178 Cal.Rptr. 343, 356, 636 P.2d 32, 45 (1981). In *Isaacson v. California Ins. Guarantee Assn.*, 44 Cal.3d 775, 244 Cal.Rptr. 655, 750 P.2d 297 (1988), the Supreme Court acknowledged the rule that if an insurance company "'erroneously denies coverage and/or improperly refuses to defend the insured' in violation of its contractual duties, 'the insured is entitled to make a reasonable settlement of the claim in good faith and may then maintain an action against the

insurer to recover the amount of the settlement.'" *Id.* at 791, 244 Cal.Rptr. 655, 750 P.2d 297, quoting *Clark v. Bellefonte Ins. Co.,* 113 Cal.App.3d 326, 335, 169 Cal.Rptr. 832 (1980)). The court added that where the insurer *wrongfully refuses to defend* and the insured settles, the insured is entitled, in later litigation, to the following *evidentiary presumption*: "In a later action against the insurer for reimbursement based on a breach of its contractual duty to defend the action, a reasonable settlement made by the insured to terminate the underlying claim against him may be used as presumptive evidence of the insured's liability on the underlying claim, and the amount of such liability." *Isaacson, supra,* at 791, 244 Cal.Rptr. 655, 750 P.2d 297.

Isaacson did not consider whether a settlement or stipulated judgment containing a covenant not to execute would raise a presumption of the insured's liability and the amount of such liability. That issue was addressed in *Pruyn v. Agricultural Insurance Co.,* 36 Cal. App.4th 500, 42 Cal. Rptr.2d 295 (1995), in which the court observed:

> [C]ourts focus on whether the facts have been adjudicated independently in a process that does not create the potential for abuse, fraud or collusion . . . To be sure, a stipulated or consent judgment which is coupled with a covenant not to execute against the insured brings with it a high potential for fraud or collusion . . . An insurer which has wrongfully abandoned its insured should not be heard to complain or allowed to relitigate the trial court's judgment merely because the default or uncontested proceedings followed, and were related to, an agreement between the insured and the claimant.

Id. at 304. The court added:

> We . . . hold that when, as plaintiff alleges happened here, a liability insurer ***wrongfully denies coverage or refuses to provide a defense,*** then the insured is free to negotiate the best possible settlement consistent with his or her interests, including a stipulated judgment

> accompanied by a covenant not to execute. Such a settlement will raise an ***evidentiary presumption*** in favor of the insured (or the insured's assignee) with respect to [a] the existence and [b] amount of the insured's liability. The effect of such presumption is to *shift the burden of proof* to the insurer to prove that the settlement was [a] unreasonable or [b] the product of fraud or collusion. If the insurer is unable to meet that burden of proof then the stipulated judgment will be binding on the insurer and the policy provision proscribing a direct action against an insurer except upon a judgment against the insured after an "actual trial" will not bar enforcement of the judgment.

Id. 42 Cal.Rptr.2d at 299. The court explained that the presumption required the insured

> to establish . . . [that] (1) the insurer wrongfully failed or refused to provide coverage or a defense, (2) the insured thereafter entered into a settlement of the litigation which was (3) reasonable in the sense that it reflected an informed and good faith effort by the insured to resolve the claim . . . .
>
> The insured can satisfy its prima facie burden of showing that the settlement was reasonable by presenting . . .evidence which would support a determination of good faith . . . "Good faith" . . . requires "the trial court to inquire, among other things, whether the amount of the settlement is within the reasonable range of the settling tortfeasor's proportional share of comparative liability for the plaintiff's injuries . . . . [A] number of factors [must] be taken into account including a rough approximation of plaintiffs' total recovery and the settlor's proportionate liability, the amount paid in settlement, the allocation of settlement proceeds among plaintiffs, and a recognition that a settlor should pay less in settlement than he would if he were found liable after a trial. Other relevant considerations include the financial

> conditions and insurance policy limits of settling defendants, as well as the existence of collusion, fraud, or tortious conduct aimed to injure the interests of nonsettling defendants."

Id. at 312 (quoting *Tech–Bilt, Inc. v. Woodward–Clyde & Assocs.,* 38 Cal.3d 488, 213 Cal. Rptr. 256, 698 P.2d 159, 170 (1985)). The court in *Pruyn* concluded that the risk of collusion and inflation of claims was acceptable given that "the presumption only arises in those cases where the insurer has breached the underlying insurance contract " and that "[i]n no other way can the courts give any ***meaningful protection to an insured who is abandoned by a liability insurer*** wrongfully denying coverage or refusing a defense and at the same time provide to the insurer some measure of procedural due process in order to protect against the consequences of a fraudulent or collusive settlement." *Id.* at 530, 42 Cal.Rptr.2d 295 (emphasis added).

In *Fluor Corp. v. Superior Court*, 61 Cal.4th 1175, 191 Cal.Rptr.3d 498, 354 P.3d 302 (2015), the California Supreme Court addressed whether California Insurance Code section 520 prevented enforcement of a consent to assignment or anti-assignment clause in a liability policy. Prior to the adoption of this provision, the court had held in *Henkel Corp. v. Hartford Accident & Indemnity Co.* 29 Cal.4th 934, 129 Cal.Rptr.2d 828, 62 P.3d 69 (2003), that a "consent-to-assignment clause was enforceable and precluded the insured's transfer of the right to invoke coverage without the insurer's consent even after the coverage-triggering event . . . had already occurred." 354 P.3d at 303. Section 520 provides: "An agreement not to transfer the claim of the insured against the insurer ***after a loss has happened***, is void if made before the loss except as otherwise provided in Article 2 of Chapter 1 of Part 2 of Division 2 of this code." *Id.* (emphasis added).

The *Fluor* court concluded that a "loss has happened" for liability insurance purposes when the claimant is injured, not when a judgment against the insured for those damages has been entered. The court resoned and held:

> [W]e conclude that the phrase "after a loss has happened" in section

> 520 should be interpreted as referring to a loss sustained by a third party that is covered by the insured's policy, and for which the insured *may be liable*. We conclude that the statutory phrase *does not contemplate that there need have been a money judgment or approved settlement* before such a claim concerning that loss may be assigned without the insurer's consent. Only this interpretation of the statute's language barring veto of assignment by an insurer honors the clear intent demonstrated by the history of section 520 to avoid any "unjust" or "grossly oppressive" enforcement of a consent-to-assignment clause.

Id. at 329. The court added: "In light of the relevant language and history of section 520, we conclude the statute applies to third party liability insurance, and that, properly construed in light of its relevant language and history, section 520 bars an insurer from refusing to honor an insured's assignment of policy coverage regarding injuries that predate the assignment." *Id.* at 315.

D. Minnesota—*Miller Shugart* Agreements

In Minnesota, the courts have adopted and enforced so-called "Miller-Shugart" agreement. *Chalmers v. Kanawyer*, 544 N.W.2d 795 (Minn. Ct. App. 1996). Minnesota refers to assignment/covenant agreements as nonexecution or "by-pass" agreements. Under Minnesota law, such agreements are not per se fraudulent or collusive. Following *Critz, supra,* the courts recognize that as a matter of fairness an insured "deserted" by his insurer is entitled to enter an agreement that allows it to personal liability and avoid litigation expense. *Miller v. Shugart,* 316 N.W.2d 729 (Minn. 1982).[5]

[5] In *Buysse v. Baumann–Furrie & Co.*, 481 N.W.2d 27, 29 (Minn.1992), the court observed:

> In an authentic Miller–Shugart settlement, the insurer has denied all coverage, and the abandoned insured, left on its own, agrees with the plaintiffs that judgment in a certain sum may be entered against it in return for the plaintiffs releasing the insured from any personal liability.

In *Miller,* the court reasoned:

> [The insurer] says there has never been a trial on the merits, that the purported judgment, insofar as it is concerned, is still an "unliquidated tort claim," and that, consequently, the sum due plaintiff is not "due absolutely," and so garnishment does not lie. Minn. Stat. § 571.43 (1980). [The insurer] overlooks, however, that as between plaintiff and the defendants the tort claim has been liquidated and reduced to a judgment. So long as this has occurred, the basis for garnishment exists.
>
> What [the insurer] is really saying is that the judgment does not liquidate the claim because it obligates the defendants to pay nothing. While it is true that defendants need not pay anything, it is also true that the judgment effectively liquidates defendants' personal liability. We hold, therefore, that plaintiff may seek to collect on that judgment in a garnishment proceeding against the insurer.

Id. at 732. The court refused to find a breach of cooperation as a result of the agreement:

> What we have, then, is a question of how should the respective rights and duties of the parties to an insurance contract be enforced during the time period that application of the insurance contract itself is being questioned. Viewed in this context, Milbank's position, really, is that it has a superior right to have the coverage question resolved before the plaintiff's personal injury action is disposed of either by trial or settlement. It is unlikely plaintiff could have forced defendants to trial before the coverage issue was decided. Put this way, the question becomes: Did the insureds breach their duty to cooperate by not waiting to settle until after the policy coverage had been decided? In

Buysse v. Baumann–Furrie & Co., 481 N.W.2d 27, 29 (Minn.1992).

> our view, the insureds did not have to wait and, therefore, did not breach their duty to cooperate.
>
> . . . .
>
> While the defendant insureds have a duty to cooperate with the insurer, they also have ***a right to protect themselves*** against plaintiff's claim. The attorneys hired by Milbank to represent them owe their allegiance to their clients, the insureds, to best represent their interests. If, as here, the insureds are offered a settlement that effectively relieves them of any personal liability, at a time when their insurance coverage is in doubt, surely it cannot be said that it is not in their best interest to accept the offer. ***Nor, do we think, can the insurer who is disputing coverage compel the insureds to forego a settlement which is in their best interests.***

Id. at 733-34 (emphasis added).

Minnesota also appears to base the rule first on a wrongful denial of coverage, which then permits the insured to agree to the entry of a judgment against him in a reasonable amount and limit the source of payment to the insurance policy and carrier. This type of agreement may also be enforceable where the carrier has not denied a defense, but it has been put on notice of the settlement situation and circumstances. *Insurance Co. of North America v. Spangler,* 881 F. Supp. 539, 545 (D. Wyo. 1995); *Brownsdale Co-op. Ass'n v. Home Ins. Co.,* 473 N.W.2d 339 (Minn. Ct. App. 1991); *The Rivers v. Richard Schwartz/Neil Weber, Inc.,* 459 N.W.2d 166 (Minn. Ct. App. 1990). The insurer is given the opportunity to show that the judgment is not conclusive as to it and this does not bind it. *Economy Fire & Cas. Co. v. Iverson*, 426 N.W.2d 195 (Minn. Ct. App. 1988), *judgment aff'd in part, rev'd in part on other grounds,* 445 N.W.2d 824 (Minn. 1989) (overruled on other grounds by, *American Standard Ins. Co. v. Le,* 551 N.W.2d 923 (Minn. 1996)).

I AM KNOWN BY MANY NAMES, BUT YOU MAY CALL ME…

LITIGATING THE CONFESSED JUDGMENT CASE

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With increasing frequency, coverage disputes are being litigated in the context of significant confessed judgments. This paper examines how the 50 states view confessed judgments and offers practice tips for litigating the confessed judgment coverage case.

I. Confessed Judgments – A 50 State Survey.

Alabama –

In *Bendall v. White*, 511 F. Supp. 793 (N.D. Ala. 1981), a United States District Court looked to Oregon law (*Stubblefield v. St. Paul Fire & Marine Ins. Co.*, 267 Or. 397, 517 P.2d 262 (1973)), and gave effect to the "legally obligated to pay" language in the policy, thus holding that because the covenant not to execute released the defendant/driver, the insurer was also released.

In a more recent decision, the Alabama Supreme Court held the insurers were bound by the consent judgment. In *Liberty Mutual Insurance Co. v. Wheelwright Trucking Co.*, 851 So. 2d 466 (Ala. 2002), the insurers denied coverage and refused to defend. The consent judgment was for $2.5 million. The court found that the consent judgment was only applicable to the extent the policies provided coverage, and valid to the extent it was reasonable and entered into in good faith. The court rejected the insurers' claim that the consent judgment was "per se" collusive: the insurers had been informed of the settlement and its terms, and had ample time to contest the terms before the settlement was approved by the bankruptcy court. The court further found that the lower court's ruling that the settlement was not collusive was supported by the record, and that the facts permitted an inference that the insurers expressly consented to the terms of the consent judgment. Thus, the Alabama Supreme Court affirmed the lower court's determination that the insurers were precluded from challenging the validity or amount of the judgment.

Alaska –

In a 2011 case, the Ninth Circuit Court of Appeals, applying Alaska law, upheld a confessed judgment in the amount of $1,937,500. In *Allstate Insurance Company v. Herron*, 634 F.3d 1101 (9th Cir. 2011), Allstate had brought a declaratory judgment action claiming that Herron, its insured, breached the insurance contract and voided coverage under the policy by entering into the consent judgment. After finding that the district court did not abuse its discretion by

retaining jurisdiction over the declaratory judgment action, the court discussed the distinction between a material breach of the policy's cooperation clause and a material breach of the insurance contract itself. The court stated that there would have to be a material breach of the insurance contract itself to relieve Allstate of its liability under the policy. The court concluded that Allstate remained liable to its insured within the policy limits, and therefore the insured retained assignable rights to the extent of those limits.

In a 2003 state court decision, the Alaska Supreme Court held that the focus should be on whether there has been a material breach by the insurer, *i.e.*, a bad faith failure to settle. If there is such a violation, the insurer cannot escape liability just because the insured has taken control of the defense and settled the case in a manner that, but for the insurer's material breach, would otherwise violate the cooperation clause. *See Great Divide Ins. Co. v. Carpenter*, 79 P.3d 599 (Alaska 2003).

Six years earlier, the Alaska Supreme Court had reached a contrary decision in *Grace v. Insurance Co. of No. America*, 944 P.2d 460 (Alaska 1997), where the insured was found to have breached the policy's cooperation clause by settling without the insurer's consent. However, there was a genuine issue of material fact as to whether INA repudiated its obligations. If INA was not in breach, there were issues of fact as to the reasonable and non-fraudulent nature of the settlement. At note 19, Alaska's Supreme Court cited its own decision from the previous year, describing the test for determining the reasonableness of a consent settlement combined with a covenant not to execute against the insured. *See Washington Insurance Guaranty Ass'n v. Ramsey*, 922 P.2d 237 (Alaska 1996). That test considered the following factors: "[t]he releasing person's damages; the merits of the releasing person's liability theory; the merits of the released person's defense theory; the released person's relative faults; the risks and expenses of continued litigation; the released person's ability to pay; any evidence of bad faith, collusion, or fraud; the extent of the releasing person's investigation and preparation of the case; and the interests of the parties not being released." Id. at 247-48 (citing *Glover v. Tacoma Gen. Hosp*., 98 Wash.2d 708, 658 P.2d 1230, 1236 (1983)).

Arizona –

One of the seminal and oft-cited cases on the topic of consent judgments is the Arizona Supreme Court decision, *Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969). *Damron* involved a personal injury action stemming from an automobile accident. The insurers refused to defend so the driver settled with and assigned to plaintiffs any claims he had against the insurance companies for their bad faith failure to defend. The court found the settlement was not collusive.

The Arizona Court of Appeals subsequently held that a covenant not to execute was just a contract and not a release. The tortfeasor was still "legally obligated to pay," so the insurer was also liable. *See Globe Indem. Co. v. Blomfield*, 115 Ariz. App. 5, 562 P.2d 1372 (1977).

The covenant judgment was upheld in *State Farm Mutual Automobile Insurance Co. v. Paynter*, 122 Ariz. App. 198, 593 P.2d 948 (1979). In *Paynter*, the court found that the covenant not to execute was not a release. The tortfeasor was still "legally obligated to pay" the injured party. Thus, the insurer must make good on its contractual promise to pay.

Another leading Arizona case on this issue is *United Services Automobile Ass'n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987), where the court upheld the consent judgment even though the insurer defended under a reservation of rights. The court found that the entering into a settlement agreement was not a breach of the policy's cooperation clause. The insurer could assert coverage defenses, and if it prevailed, it would only be liable for the settlement if it was reasonable and prudent under the circumstances.

An insurer's claim for intentional interference in contractual relations against the attorneys who negotiated a Morris agreement in a personal injury action was dismissed in *Safeway Insurance Co., Inc. v. Guerrero*, 210 Ariz. 5, 106 P.3d 1020 (2005).

An insurer that does not defend an underlying wrongful death action is not permitted to intervene to challenge the reasonableness of a *Damron* agreement entered into between the injured party and the insured. *American Fam. Ins. Grp. v. Milo Bergeson*, No. 2 CA-CV-2010-0144, 2011 WL 1207622 (Ariz. Ct. App. Mar. 31, 2011).

Arkansas –

The Supreme Court of Arkansas refused to uphold a consent judgment because it was not a "true barometer" of the extent of damages. The court stated the circumstances surrounding the consent judgment were "highly questionable and smacked of subterfuge." *Hartford Ins. Co. of the Midwest v. Mullinax*, 336 Ark. 335, 984 S.W.2d 812 (1999).

California –

The insurer defended and was not obligated to pay the stipulated judgment between the insured and the plaintiff in *Hamilton v. Maryland Casualty Co.*, 27 Cal. 4th 718, 117 Cal. Rptr. 2d 318, 41 P.3d 128 (2002). *Hamilton* involved an assigned claim for breach of the covenant of good faith and fair dealing. The court found that the stipulated judgment was not sufficient proof that the insured suffered damages from the breach, and the insurer had not agreed to or participated in settlement.

Applying the "Hamilton rule," which states that an insurer is not obligated by the duty of good faith and fair dealing to pay a stipulated judgment between its insured and the injured party when the insurer is defending, the Ninth Circuit Court of Appeals found that the assignee's pre-trial tort claim for bad faith refusal to settle was not allowed until an excess judgment was rendered after trial. Mercado v. Allstate Ins. Co., 340 F.3d 824 (9th Cir. 2003) (applying California law).

Where the insurer refused to defend, assignments were upheld in *Samson v. Transamerica Insurance Co.*, 30 Cal. 3d 220, 178 Cal. Rptr. 343, 636 P.2d 32 (1981); *Pruyn v. Agricultural Insurance Co.*, 36 Cal. App. 4th 500, 42 Cal. Rptr. 2d 295 (1995); and *Consolidated American Insurance Co. v. Mike Soper Marine Services*, 951 F.2d 186 (9th Cir. 1991) (applying California law).

In *Zander v. Texaco Inc.*, 259 Cal. App. 2d, 66 Cal. Rptr. 561 (1968), the California Court of Appeals adopted the rule that if the insurer fails to fulfill its obligation to defend, the insured, in the absence of fraud, may enter into a settlement and covenant not to execute with the plaintiff without forfeiting his right to indemnity.

In *Critz v. Farmers Insurance Group*, 230 Cal. App. 2d 788, 41 Cal. Rptr. 401 (1964), the insurer defended. The court stated that the validity of the assignment depended on whether the insurer acted in good faith when it rejected the offer to settle at the policy limit.

The court found collusion in connection with the settlement in *Andrade v. Jennings*, 54 Cal. App. 4th 307, 62 Cal. Rptr. 2d 787 (1997).

In *Wright v. Fireman's Fund Ins. Cos.*, 11 Cal. App. 4th, 14 Cal. Rptr. 2d 588 (1992), the insurer defended. The court found that the insurer was not bound by the stipulated judgment entered into without the insurer's consent or participation.

The plaintiff/assignee cannot bring a tort claim for bad faith refusal to settle against the insurer until an excess-of-limits judgment was rendered after trial. *Safeco Insurance Co. v. Superior Court*, 71 Cal. App. 4th 782, 84 Cal. Rptr. 2d 782 (1999).

Colorado –

A pretrial stipulated judgment was not binding on the insurer in *Old Republic Insurance Co. v. Ross*, 180 P.3d 427 (Colo. 2008).

In *Nunn v. Mid-Century Insurance Co.*, 244 P.3d 116 (Colo. 2010), after the insurer rejected a policy limits settlement demand, the insured driver settled with the passenger injured in a car accident for an amount exceeding the insurance coverage by $3.9 million. The passenger took an assignment of the insured's bad faith claim against the insurer and entered into a covenant not to execute. The passenger brought a bad faith claim against the insurer. The court held that despite the covenant not to execute the judgment against the insured, the insured suffered actual damages when he entered into the stipulated judgment for an amount in excess of the policy limits.

Connecticut –

In *Black v. Goodwin*, 681 A.2d 293 (Conn. 1996), the insurer denied coverage and did not defend. The court upheld the stipulated judgment; it was not contrary to public policy because

the judgment provided that the insured would assign to the injured party all rights the insured would otherwise have against his insurer in exchange for an agreement that the injured party would only seek to satisfy the judgment against the insurer.

District of Columbia –

The insurer did not defend leading to a default judgment against the insured. The insured's assignment to claimant of his rights against the insurer coupled with the claimant's release of the insured's legal obligation to pay the judgment was not the result of fraud or collusion and was enforceable. *Gray v. Grain Dealers Mutual Insurance Co.*, 871 F.2d 1128 (D.C. Cir. 1989) (applying North Carolina law).

In *Antal's Restaurant v. Lumbermen's Mutual Casualty Co.*, 680 A.2d 1386 (D.C. Cir. 1996), the anti-assignment clause in the policy did not bar the post-loss assignment of insured's claim.

Delaware –

The Delaware Supreme Court, applying California law, upheld an assignment where the insurer did not defend. In *AT&T Corp. v. Clarendon American Insurance Co.*, 931 A.2d 409 (Del. 2007), the court found that the insured directors of At Home Corporation had suffered a "loss" under the Directors and Officers policy, and therefore the directors had a legally cognizable claim against their insurers, which the assignee, AT&T, was entitled to enforce.

Florida –

In Florida, consent judgments are valid and binding on an insurer if the damages are covered under the policy, the insurer wrongfully fails to defend, and the settlement is reasonable and entered into in good faith. *See Ahern v. Odyssey Re (London), Ltd.*, 788 So.2d 369 (Fla. Ct. App. 2001). The court found for the insurer where it had no duty to defend but tendered what it believed to be its limit of liability. The insured rejected the tender and entered into a settlement agreement and assignment with the plaintiff.

In *Steil v. Florida Physicians' Insurance Reciprocal*, 448 So.2d 589 (Fla. 1984), the insured doctor entered into a settlement of a malpractice claim with the injured plaintiff, pursuant to which he assigned plaintiff his rights against his insurance carrier, and was then discharged him from liability to the plaintiff. The court found that the settlement was unenforceable because of the concern that the amount was unreasonable or tainted by bad faith.

The facts in *Coblentz v. American Surety Co. of New York*, 416 F.2d 1059 (5th Cir. 1969), involved the insurer's refusal to defend, thus leaving the insured to his own devices. The court held that the insurer was bound by the terms of a final consent judgment entered against the insured.

In *United States Fire Insurance Co. v. Hayden Bonded Storage Co.*, 930 So.2d 686 (Fla. Ct. App. 2006), the parties agreed that the insurer had no duty to defend. The insurer tendered what it

believed to be its limit of liability, but the insured rejected the tender and entered into a settlement agreement and assignment with the plaintiff. The court found that there was no legal basis to impose liability on the insurer for more than the amount it tendered. Therefore, the insurer was not in breach of the duty to indemnify and not bound by the *Coblentz* settlement/consent judgment.

Georgia –

There was no defense and the agreement was upheld in *Southern Guaranty Insurance Co. v. Dowse*, 605 S.E.2d 27 (Ga. 2004), but the Georgia Supreme Court stated that the insurer could still challenge the insured's assertion of coverage.

Hawaii –

A pre-trial stipulated judgment and covenant not to execute the judgment were valid and enforceable in *Weber v. Indemnity Insurance Co.*, 345 F. Supp. 2d 1139 (D. Haw. 2004) (applying Hawaii law). In *Weber*, the insurer defended but breached its duty to by rejecting a reasonable offer to settle within policy limits. A similar assignment had been upheld in *McLellan v. Atchison Insurance Agency, Inc.*, 81 Haw. App. 62, 912 P.2d 559 (1996).

Idaho –

Post-loss assignments are valid, but stipulated judgments entered into without full adjudication must be reasonable in amount and non-collusive. *Hartman v. State Farm Fire & Cas. Co.*, No. CV-03-06793 (D. Ct. 1st Jud. Dist., Kootenai County, Oct. 12, 2004) (Luster, J.) (Order on Def.'s Mot. Summ.J).

Illinois –

In *Guillen v. Potomac Insurance Co. of Illinois*, 785 N.E.2d 1 (Ill. 2003), the insurer did not defend. The Illinois Supreme Court considered the effect of the "legally obligated to pay" language in the policy. The court sided with the majority view that when an insurer breaches the duty to defend and abandons its insured, the insured should be afforded a liberal construction of the policy's "legally obligated to pay" language. *See also La Rotunda v. Royal Globe Ins. Co.*, 87 Ill. App. 3d 446, 42 Ill. Dec. 219, 408 N.E.2d 928, (1980) (no defense); *Maneikis v. St. Paul Ins. Co. of Ill.*, 655 F.2d 818 (7th Cir. 1981) (applying Illinois law) (no defense).

A covenant not to execute where the insurer did defend was held valid in *Bishop v. Crowther*, 101 Ill. App. 3d 933, 57 Ill. Dec. 341, 428 N.E.2d 1021 (1981). But see *Nat'l Union Fire Ins. v. Continental Ill. Corp.*, 673 F. Supp 267 (1987) (applying Illinois law) (settlement agreement did not expose insureds to personal liability, so plaintiff, as assignee, could not enforce agreement).

In Illinois, an insurer can challenge the reasonableness of the confessed judgment amount even on a finding of a breach of the duty to defend. *See Stonecrafters, Inc. v. Wholesale Life Ins. Brokerage,* 915 N.E.2d 51 (Ill. Ct. App. 2009).

Indiana –

In American Family Mutual Insurance Co. v. Kivela, 408 N.E.2d 805 (Ind. Ct. App. 1980), the insurer did not defend. The court stated the insurer may not hide behind "legally obligated to pay" language in the insuring agreement when it abandons its insured.

The assignment was also upheld in *Cincinnati Insurance Co. v. Young*, 852 N.E.2d 8 (Ind. Ct. App. 2006) (no defense); *Midwestern Indemnity Co. v. Laikin*, 119 F. Supp. 2d 831 (S.D. Ind. 2000) (applying Indiana law) (no defense); and *Frankenmuth Mut. Ins. Co. v. Williams*, 690 N.E.2d 675 (Ind. 1997) (no defense). *But see American Fam. Mut. Ins. Co. v. C.M.A. Mortgage, Inc.*, 682 F. Supp.2d 879 (S.D. Ind. 2010) (applying Indiana law) (an insurer that defends, is not bound by settlement where it does not consent to confessed settlement).

Iowa –

In *Red Giant Oil Company v. Lawlor*, 528 N.W.2d 524 (Iowa 1995), the insurer did not defend and the consent judgment, assignment and covenant not to execute were upheld. The court stated the covenant not to execute was a contract, not a release, and the insured's liability remained if there was insurance coverage. The court stated the settlement must also be reasonable and prudent. But see *Freeman v. Schmidt Real Estate & Ins., Inc.*, 755 F.2d 135 (8th Cir. 1985) (applying Iowa law) (giving "legally obligated to pay" language practical construction: if insured is not "legally obligated to pay," neither is insurer).

For other cases addressing the issue, *see Roach v. Estate of Ravenstein*, 326 F. Supp. 830 (S.D. Iowa 1971) (applying Iowa law) (collusion); *Kelly v. Iowa Mut. Ins. Co.*, 620 N.W.2d 637 (Iowa 2000) (insurer defends but unreasonably rejects settlement demand); *Clock v. Larson*, 564 N.W.2d 436 (Iowa 1997) (insurer defends but court distinguishes *Red Giant Oil* where insurer defended and settlement was full release, not mere covenant not to execute).

Kansas –

In *Wade v. Emasco Insurance Co.*, 483 F.3d 657 (10th Cir. Apr. 10, 2007) (applying Kansas law), the court held the insured may assign contractual rights under the policy. Thus, the assignee was the real party in interest regarding the contract claims but the insured remained the real party in interest regarding the fraud claim.

For other cases addressing the issue, see *AKS v. Southgate Trust Co.*, 844 F. Supp. 650 (D. Kan. 1994) (applying Kansas law) (upheld if reasonable in amount and made in good faith); *Glenn v. Fleming*, 247 Kan. 296, 799 P.2d 79 (1990) (insurer defends but breaches implied good faith settlement obligation; covenant not to execute valid and enforceable if reasonable and made in

good faith); *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 261 Kan. 806, 934 P.2d 65 (1997) (could be enforceable if insurer's denial of coverage was in bad faith and settlement amount is unreasonable); *Shawnee Auto Svc. Center, Ltd. v. Continental Cas. Co.*, 782 F. Supp. 1503 (D. Kan. 1992) (applying Missouri law) (insurer denied defense and coverage; insurer held bound by allocation in a settlement agreement absent showing of fraud or collusion).

Kentucky –

The assignment and covenant were upheld in *Liberty Mutual Fire Insurance Co. v. Harris*, 2011 WL 1157745 (W.D. Ky. Mar. 28, 2011); *see also Ayers v. C & D Gen'l Contractors*, 269 F. Supp. 2d 911 (W.D. Ky. 2003) (applying Kentucky law) (insurer denied defense and coverage; consent judgment enforceable if plaintiff makes prima facie showing of reasonableness, and insurers unable to show amount is unreasonable or product of collusion or bad faith); *Steedly v. London & Lancashire Ins. Co.*, 416 F.2d 259 (6th Cir. 1969) (applying Kentucky law) (insurer not liable for refusing to settle claim).

Louisiana –

In *New England Insurance Co. v. Barnett*, Civ. A. No. 06-555, 2011 WL 933970, slip copy (W.D. La. 2011) (applying Louisiana law), the insurer defended. The court held the "no action" and "consent to settle" clauses barred the assignee's rights to enforce the consent judgment and incorporated settlement and assignment. But see *In Re Combustion, Inc.*, 960 F. Supp. 1051 (W.D. La. 1997) (applying Louisiana law) (assignment valid; no participation by insurers; settlement did not contemplate release of insurers).

Maine –

In *Patrons Oxford Insurance Co. v. Harris*, 905 A.2d 819 (Me. 2006); *see also* M.R.S. 24-A § 2904 (2005)), the insurer defended under a reservation of rights. The settlement was binding on the insurer to the extent the insured or claimant could show it was reasonable, and only after coverage was determined to exist.

Maryland –

In *Medical Mutual Liability Insurance Society of Maryland v. Evans*, 330 Md. 1, 622 A.2d 103 (1993), the court followed the majority rule that a claim for bad faith refusal to settle was assignable. *See also Fireman's Fund Ins. Co. v. Rairigh*, 59 Md. App. 305, 475 A.2d 509 (1983) (excess insurer that did not provide concurrent defense in underlying litigation bound by consent judgments in underlying phase of litigation if coverage is established); *Benway v. Resource Real Estate Svcs, LLC*, Civ. A. No. WMN-05-3250, 2011 WL 1045597 (D. Md. Mar. 16, 2011) (undecided; remanded for state court determination of viability of "Miller-Shugart" Agreement). *See* Minnesota, *infra*.

Massachusetts –

Campione v. Wilson, 422 Mass. 185, 661 N.E.2d 658 (1996), involved the assignment of negligence claims against an insurance broker. The court recognized the assignment of negligence claims, noting the majority rule that a judgment in excess of the policy limits, along with a release or covenant not to execute in favor of the insured "does not invalidate an accompanying assignment of the right to sue the insurer for negligence." *Id.* at 191.

Michigan –

In *J & J Farmer Leasing, Inc. v. Citizens Insurance Co. of America*, 472 Mich. 353, 696 N.W.2d 681 (2005), the insurer defended a wrongful death action, but the jury returned a verdict for $3.2 million which exceeded the $750,000 policy limits. The insured assigned to the plaintiff/personal representative its cause of action for bad faith refusal to settle. The court distinguished between a covenant not to sue and a release, finding the agreement was not a release.

Minnesota –

The leading Minnesota case on this issue is *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982). In that case, the insurer defended the insured against a liability claim, subject to a reservation of rights. The Minnesota Supreme Court held the judgment was not obtained by fraud or collusion and that the insurer could contest coverage. In a very recent decision, *Nelson v. American Home Assurance Co.*, No. 11-1161 (D. Minn. Oct. 5, 2011) (Order on Mot. for Summ. J.) (Kyle, Richard H., J.) (applying Minnesota law), the court held the "Miller-Shugart" agreement by itself was not conclusive proof of coverage, and the burden to establish coverage was still on the claimants. *But see Koehnen v. Herald Fire Ins. Co.*, 89 F.3d 525 (8th Cir. 1996) (applying Minnesota law) (settlement collusive as a matter of law).

Mississippi –

The insurer did not defend, the settlement was reasonable and the assignment was upheld in *Mississippi Insurance Guaranty Association v. Byars*, 614 So.2d 959 (Miss. 1993). The court noted the long-established rule that "when an insurer breaches its duty to defend an insured, the insurer is liable and bound by any settlement agreements made by the insured as a result of this breach." *Id*. at 964; *but see Nichols v. State Farm Mut. Auto. Ins. Co.*, 345 F. Supp. 212 (N.D. Miss. 1972) (insurer defends; failure to settle within policy limits; assignment appeared to release insured as condition of assignment, and insured had also released State Farm prior to assignment).

Missouri –

In *Cologna v. Farmers & Merchants Insurance Co.*, 785 S.W.2d 691 (Mo. Ct. App. 1990), the insurer defended under a reservation of rights and denied coverage. The parties entered into a settlement agreement pursuant to Missouri Stat. § 537.065, titled "Claimant and tort-feasor may contract to limit recovery to specified assets or insurance contract – effect." The court found the settlement was statutorily authorized under Section 537.065.

Montana –

A stipulation to judgment or confession of judgment is enforceable against an insurer absent fraud. *Nielsen v. TIG Ins. Co.*, 442 F. Supp. 2d 972, 980 (D. Mont. 2006) (applying Montana law) (no defense); *see also Farmers Union Mut. Ins. Co. v. Staples*, 2004 MT 108, 321 Mont. 99, 90 P.3d 381 (2004) (no defense; judgment not obtained through fraud); *Sec. Nat'l Ins. Co. v. Wink*, CV 02-121-M-DWM, 33 Mont. Fed. Rep. 389 (D. Mont. 2005) (Order) (Molloy, Donald W., J) (citing June 1, 2004 ruling in which court found that insurer had obligation to defend and indemnify for injuries, and settlement agreement between injured party and insured was non-collusive).

Nebraska –

The assignment was upheld and the insurer was liable when it refused to defend in *Metcalf v. Hartford Accident & Indemnity Co.*, 176 Neb. 468, 126 N.W.2d 471 (1964). The court rejected the insurer's claim of non-liability, stating, "having declined to defend the action when called upon to do so, the defendant is in no position to attack the judgment in the absence of fraud, collusion or bad faith." *Id*. at 476; *see also Frazier, Inc. v. 20th Century Bldrs.*, 188 Neb. 618, 198 N.W.2d 478 (1972) (no defense; settlement and covenant not to execute entered into on day of trial did not evidence fraud or collusion and was valid).

New Hampshire –

Tort claims are generally assignable as choses in action. *Dumas v. State Farm Mut. Ins. Co.*, 111 N.H. 43, 274 A.2d 781 (1971). Thus, in *Dumas*, where the insurer defended, the assignment to recover the excess judgment was upheld. *See also Stateline Steel Erectors, Inc. v. William Shields*, 150 N.H. 332, 837 A.2d 285 (2003) (claim against insurance agent).

New Jersey –

In *Griggs v. Bertram*, 88 N.J. 347, 443 A.2d 163 (1982), the insurer did not defend. The settlement and consent judgment were upheld, and the insurer was estopped from relying on the "no-action" clause. The court quoted from an earlier opinion, "[w]here an insurer wrongfully refused coverage and a defense to its insured, so that the insured is obliged to defend himself in an action later held to be covered by the policy, the insurer is liable for the amount of the judgment obtained against the insured or of the settlement made by him. The

only qualifications to this rule are that the amount paid in settlement be reasonable and that the payment be made in good faith." *Id*. at 364 (citations omitted). Thus, the insurer in *Griggs* was estopped from denying coverage and insisting the insured comply with the policy's "no action" provision. In summary, the court held that a settlement was enforceable if it was reasonable in amount and entered into in good faith.

New Mexico –

"[I]nsurers that improperly refuse to defend their policyholders may face serious consequences, including the loss of the right to claim that the insured has breached the policy provisions and has not cooperated. *Continental Cas. Co. v. Hempel*, 4 Fed. Appx. 703, 715, 2001 WL 173662, at **10 (10th Cir. Feb. 22, 2001) (citation omitted). "[A]n insured whose insurer has refused to defend him may enter into a settlement of the claims that have been asserted against him." *Id*. at 716. While an insurer that wrongfully fails to defend will be liable for a judgment and good faith settlement entered into against the insured, the settlement must be reasonable. *Id*.; *see also Rummel v. Lexington Ins. Co.*, 945 P.2d 970 (N.M. 1997) (remanded to trial court for finding regarding allegations of collusion, bad faith).

New York –

The bad faith claim against the insurer survived an assignment and release (as opposed to a covenant not to execute) in *Pinto v. Allstate Insurance Co.,* 221 F.3d 394 (2nd Cir. 2000). The court explained that New York courts have ignored the formal distinction between a release and a covenant not to sue or covenant not to execute so as to avoid an unjust result. *Id*. Thus, the bad faith claim in *Pinto* was preserved. *See also*
Westchester Fire Ins. Co. v. Utica First Ins. Co., 40 A.D.3d 978, 839 N.Y.S.2d 91 (2007).

North Carolina –

North Carolina follows the minority view. *See Terrell v. Lawyers Mut. Liab. Ins. Co. of No. Car.*, 131 N.C. App. 655, 507 S.E.2d 923 (1998) (contract claims against insurer not assignable; tort claims are personal to insured and not assignable as against public policy); *Huffman v. Peerless Ins. Co.*, 17 N.C. App. 292, 193 S.E.2d 773 (1973), *cert*. *denied* 283 N.C. 257, 195 S.E.2d 689 (1973) (per terms of consent judgment, insureds were not "legally obligated to pay" plaintiff, thus neither was insurer); *Lida Mfg. Co., Inc. v. United States Fire Ins. Co.*, 116 N.C. App. 592, 448 S.E.2d 854 (1994) (no defense; "legally obligated to pay" language in policy extinguishes insurer's obligation to injured party when insured is protected by covenant not to execute).

North Dakota –

Assignments with covenants not to execute have been upheld in North Dakota. *See Wangler v. Lerol*, 2003 ND 164, 670 N.W.2d 830 (2003) (insurer defended, then withdrew; "Miller-Shugart" agreement enforceable against insurer but not insurance agent); *Fisher v. American Family Mut. Ins. Co.*, 1998 ND 109, 579 N.W.2d 599 (1998) (no defense). *Medd v. Fonder*, 543 N.W.2d 483

(N.D. 1996) (no defense; insurer may still contest coverage); *D.E.M. v. Allickson*, 555 N.W.2d 596 (N.D. 1996) (no defense; settlement reasonable; no notice to insurer required when insurer refuses to defend and abandons insured); *Sellie v. North Dakota Ins. Guar. Ass'n*, 494 N.W.2d 151 (N.D. 1992) (no defense; insurer may contest coverage).

Ohio –

The umbrella insurer, National Union, was not obligated to defend and was therefore not estopped from asserting the consent clause as a bar to coverage in *Castronovo v. National Union Fire Insurance Co. of Pittsburgh*, 571 F.3d 667 (7th Cir. 2009) (applying Ohio law). A condition precedent to coverage was breached by failing to obtain National Union's consent before entering into the consent judgment. Thus, National Union was not obligated to indemnify.

The insurer was never requested to defend and therefore did not refuse to defend in *Novak v. State Farm Insurance Cos.*, 2009-Ohio-6952, 2009 WL 5174078 (2009) (Carr, J.) (Decision and Journal Entry). Therefore, the settlement agreement was found to be in breach of the insurance agreement when it was entered into without the insurer's consent.

Oklahoma –

The insurer's actions forced the insured to settle, and the insurer was estopped from denying payment on the grounds that the insured's entering into a covenant not to sue abrogated the insurer's right to subrogation in *Buzzard v. Farmers Insurance Co., Inc.*, 1991 Okla. 127, 824 P.2d 1105 (1992). The insurer had no subrogation rights where the covenant not to sue released the tortfeasor, reserving no rights to the insurer in *Frey v. Independence Fire & Casualty Co.*, 1985 Okla. 25, 698 P.2d 17 (1985).

Oregon –

In *Groce v. Fidelity General Insurance Co.*, 252 Or. 296, 448 P.2d 554 (1968), the court found that the policy's anti-assignment clause only prohibited pre-loss, not post-loss assignments.

The "legally obligated to pay" language in the policy was enforced in *Stubblefield v. St. Paul Fire & Marine Insurance Co.*, 267 Or. 397, 517 P.2d 262 (1973) and in
Far West Federal Bank v. Transamerica Title Insurance Co., 99 Or. App. 340, 781 P.2d 1259 (1989), the insurer did not defend and the court ruled that the settlement extinguished the insured's liability to plaintiff, and thus the insurer's liability was also extinguished.

In *Holloway v. Republic Indemnity Co. of America,* 341 Or. 642, 147 P.3d 329 (2006), the Oregon Supreme Court held the assignment was invalid, finding that the anti- assignment clause was unambiguous and included both pre-loss and post-loss assignment rights.

In a recent Ninth Circuit case, the court held that the policy's anti-assignment clause was ambiguous, and thus construed it against the insurer, finding that the clause did not preclude the post-loss assignment in that case. *See Alexander Mfg. Inc. Employee Stock Ownership Plan and Trust v. Ill. Union Ins. Co.*, 560 F.3d 984 (9th Cir. 2009) (applying Oregon law).

Pennsylvania –

The insured's assignee's claim against the insurer was upheld in *Gray v. Nationwide Mutual Insurance Co.*, 422 Pa. 500, 223 A.2d 8 (1966) (disagreeing that such a result will foster fraud and collusion between the claimant and the insured). A post-verdict assignment was upheld in *Greater New York Mutual Insurance Co. v. North River Insurance Company*, 85 F.3d 1088 (3rd Cir. 1996) (applying Pennsylvania law).

Rhode Island –

In *DeMarco v. Travelers Insurance Co.*, 26 A.3d 585 (R.I. 2011), a release was not construed to render an assignment ineffective, as such a finding would lead to what the New York court in *Pinto*, *see* New York, *infra*, called "an unjust result." Thus, the court looked to the intention of the parties to determine whether the release was, in effect, a covenant not to sue. The court concluded that the release document did not extinguish the assignee's right to bring claims against the insurer. The assignments were also upheld in *Mello v. General Insurance Co. of America*, 525 A.2d 1304 (R.I. 1987) and *Etheridge v. Atlantic Mutual Insurance Co.*, 480 A.2d 1341 (R.I. 1984).

South Carolina –

"A Covenant Not To Execute is a promise not to enforce a right of action or execute a judgment when one had such right at the time of entering into the agreement." *Poston by Poston v. Barnes*, 294 S.C. 261, 363 S.W.2d 888 (1987) (quoted in *Ackerman v. Travelers Indem. Co.*, 318 S.C. App. 137, 456 S.E.2d 408, 413 (1995)). "The intention of the parties governs in determining whether an instrument is a covenant not to execute or a release." *Id*. Thus, the court in *Ackerman* held that the covenant not to execute was not a release, preserving the right to underinsured motorist benefits. *But see Cobb v. Benjamin*, 325 S.C. 573, 482 S.E.2d 589 (1998) (upheld as to recovery of UIM benefits only; agreement expressly stated claimant could only collect against UIM carrier; thus, no recovery from driver's liability insurer).

South Dakota –

A pre-judgment assignment was upheld in *Kobbeman v. Oleson*, 1988 SD 20, 574 N.W.2d 633 (1998) (claim against insurance agent). *But see Wolff v. Royal Ins. Co. of Am.*, 472 N.W.2d 233 (S.D. 1991) (applying Nebraska law) (collusion).

Tennessee –

The insurer denied any duty to defend or indemnify in *Tip's Package Store, Inc. v. Commercial Insurance Managers*, 86 S.W.3d 543 (Tenn. Ct. App. 2001). Based on the language of the agreement at issue, the court, citing with approval *Red Giant Oil v. Lawlor*, *see* Iowa, *infra*, found the agreement did not extinguish the underlying liability of Tip's Package Store, but did operate as a full release of any claims against its shareholder, officer and director, individually.

Texas –

In Texas, assignments are invalid if made pre-adjudication in a fully adversarial trial, the insurer defends, and the insurer has either accepted coverage or made a good faith attempt to adjudicate coverage issues before adjudication of plaintiff's claims. *See State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996) (assignment void as against public policy); *see also Willcox v. American Home Assur. Co.*, 900 F. Supp. 850 (S.D. Tex. 1995) (applying Texas law) (no defense; enforceable up to policy limits if reasonable and not product of fraud and collusion); *Employers Cas. Co. v. Block*, 744 S.W.2d 940 (Tex. 1988), *rehearing denied*, February 24, 1988) (insurer allowed to contest coverage); *First Nat'l Indem. Co. v. Mercado*, 511 S.W.2d 354 (Tex. Ct. App. 1974) (judgment upheld where insurer refused to defend, thus entitling insured to protect himself).

Utah –

The primary insurers defended and a pre-trial assignment was upheld in *Rupp v. Transcontinental Ins. Co.*, 627 F. Supp. 2d 1304 (2008) (applying Utah law). Rejecting the insurers' argument that the plaintiff must first obtain a judgment on the merits through trial, the court predicted the Utah Supreme Court "would hold that an insured facing the likelihood of an excess judgment is not required to take the case to trial before a cause of action for bad faith accrues." *Id*. at 1324.

Vermont –

In a 2006 decision, the Vermont Supreme Court, while not expressly ruling on the validity of the assignment, addressed some interesting procedural issues – standing, relation back, and statute of limitations – in the context of an assignment and covenant not to execute. *See Korda v. Chicago Ins. Co.*, 180 Vt. 173, 908 A.2d 1018 (2006).

Virginia –

The settlement was a contract and not a release and the insurer was "legally obligated to pay" in *Beckner v. Twin City Fire Insurance Co.*, 58 Va. Cir. 544 (2002). *But see Spence-Parker v. Maryland Ins. Grp.*, 937 F. Supp. 551 (1996) (applying Virginia law) (not upheld because of collusion); *French v. Assur. Co. of Am.*, 2006 WL 2975651 (E.D. Va. Oct. 16, 2006) (applying Maryland law) (insurers defend; policy's "no action" clause valid and insurers did not waive

right to consent); *Jones v. Nationwide Mut. Ins. Co.*, 2010 WL 5211479 (E.D. Va. Dec. 14, 2010) (applying D.C. law) (agreement violated consent clause of policy; insured released and not "legally obligated to pay." Thus, neither was insurer).

Washington –

In *Chaussee v. Maryland Casualty Co.*, 60 Wash. App. 504, 803 P.2d 1339 (1991), the Washington Court of Appeals set out the factors to be used in determining the reasonableness of a settlement and consent judgment in a bad faith action. In that case, there was insufficient proof that the settlement was reasonable.

In *Besel v. Viking Insurance Co. of Wisconsin*, 49 P.3d 887 (Wash. 2002), the court found the agreement was a contract, not a release, and the amount of the covenant judgment was the presumptive measure of the insured's harm caused by the insurer's bad faith, if the covenant judgment was reasonable. In *Bird. v. Best Plumbing Group*, LLC, ___ Wash. ___, P.3d ___ (2012), No. 86109-9 (Oct. 25, 2012), the insurer defended but refused a pre-trial $2 million, policy limits demand, offering instead $350,000. In response, the plaintiff and the insured entered into a covenant judgment for $3.75 million. The Supreme Court upheld the use of a statutory reasonableness hearing to presumptively establish the damages for a bad faith claim for refusal to settle. More significantly, the court held that the insurer is not entitled to a jury trial on the issue of reasonableness at either the reasonableness hearing or during the bad faith trial. The covenant not to execute was not a release against the insurer in *Kagele v. Aetna Life & Casualty Co.*, 40 Wash. App. 1994, 698 P.2d 90 (1985). *See also Greer v. Nw. Nat'l Ins. Co.*, 109 Wash.2d 191, 743 P.2d 1244 (1987) (no defense; agreement not to execute did not extinguish insurer's liability for judgment); *Mutual of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 161 Wash.2d 903, 169 P.3d 1 (2007) (insurer defended and did not raise a fact issue regarding reasonableness of underlying settlement). But in *Water's Edge Townhome Ass'n v. Water's Edge Associates*, 152 Wash. App. 572, 216 P.3d 1110 (2009), the agreement was not upheld because the settlement was unreasonable.

West Virginia –

The insurer defended and a pre-trial assignment was not upheld in *Strahin v. Sullivan*, 220 W. Va. 329, 647 S.E.3d 765 (2007). *But see Johnson v. Acceptance Ins. Co.*, 292 F. Supp. 2d 857 (N.D.W.Va. 2003) (applying West Virginia law) (agreement valid but no recovery in excess of policy limits).

A consent judgment was not binding on a general liability insurer because the insurer was not a party to the lawsuit and did not expressly agree to the judgment. *Penn-America Ins. Co. v. Osborne,* 2017 WL 878716 (W. Va. 2017).

Wisconsin –

The agreement was valid but case was remanded for a hearing on the reasonableness of the settlement in *Deminsky v. Arlington Plastics Machinery*, 259 Wis.2d 587, 657 N.W.2d 411 (2003).

Wyoming –

The assignee's bad faith suit against the insurer was allowed in *Gainsco Insurance Co. v. Amoco Production Co.*, 53 P.3d 1051 (Wyo. 2002) and in *Crawford v. Infinity Insurance Co.*, 64 Fed. Appx. 146, 2003 WL 1909286 (10th Cir. Apr. 22, 2003), the agreement was also upheld: the jury had found the amount of the settlement unreasonable and adjusted it.

II. Litigating the Confessed Judgment Case.

A. Attacking the Confessed Judgment *Before* It Becomes a Confessed Judgment.

The majority of states that allow the insured to enter into a confessed judgment also require notice be given to the insurer before that judgment is entered. If a judgment is about to be entered in a case where liability is weak, or in an amount far in excess of the claim's value, and insurer may want to try to intervene in the underlying action before the entry of the confessed judgment so as to contest liability, damages, or both, rather than wait to challenge the judgment after it has been entered. In cases involving the settlement of class actions, it is also helpful for an insurer to intervene for the purpose of challenging the certification of a settlement class, or the mechanics of class administration, including the required proof for participation in the class, the amount of class counsel's fee, and the disposition of unclaimed settlement fund assets through a *cy pres.*

Intervention is by rule and is either of right or permissive. To intervene as of right, the applicant must generally demonstrate that: (1) it has a recognized interest in the subject matter; (2) this interest might be impaired by the disposition of the case; and (3) the interest will not be adequately protected by the existing parties. *See* F.R.C.P. 24 (a)(2); *Chiglo v. City of Preston*, 104 F.3d 185 (8th Cir. 1997) (permissive intervention is allowed, at the court's discretion, to anyone who has a claim or defense that shares with the main action a common question of law or fact).

Intervention as of right has been allowed to insurer in the damages phase of a trial following entry of default against its insured. *E.g., Bridge v. Air Quality Technical Services, Inc.,* 194 F.R.D. 3 (D. Me. 1999); *Campbell v. Plank,* 133 F.R.D. 175 (D. Kan. 1990). Some states allow an insurer to challenge and litigate issues of liability. *See, e.g., United Servs. Auto. Ass'n v. Morris,* 741 P.2d. 246 (Ariz. 1987).

B. Choosing your Forum.

In most instances the vehicle for collecting a confessed judgment against an insurer will be garnishment, and in some state courts the garnishment action of an eight-figure confessed judgment will be heard on the same cattle call docket as an endless list of $1,000 unlawful detainers. To avoid having the garnishment action heard in an unfavorable forum, or in an action that may not allow for a jury trial where one might be needed, there are a number of tactics available to an insurer, including starting a preemptive declaratory judgment action and then moving to stay the later commenced garnishment action. *See, e.g., Medical Assur. Co., Inc. v. Hellman*, 610 F.3d 371 (7th Cir. 2010) (declaratory judgment action allows for full resolution of coverage issues and for trial by jury); *Stonewall Ins. Co. v. Asbestos Claims Management Corp.,* 73 F.3d 1178 (2d Cir. 1995).

In addition, in most jurisdictions garnishment actions are removable to Federal Court, so long as the requisites for Federal jurisdiction can be met. *See, e.g., Allstate Ins. Co. v. Herron,* 634 F.3d 1101 (9th Cir. 2011); *Coblentz v. American surety Company of New York,* 416 F.2d 1059 (5th Cir. 1969); *Hairrel v. Wintervile Marine Services, Inc.,* 2004 WL 2931273 (N.D. Ill. 2004); *Stewart v. EGNEP*, 581 F. Supp. 788 (C.D. Ill. 1983); *but see Liberty Mut. Ins. Co. v. Wheelwright Trucking,* 851 So.2d 466 (Ala. 2002).

C. Defenses to the Consent Judgment Action beyond "There is no Coverage."

In addition to the defense of no coverage, additional defenses are available to the confessed judgment case, including:

- **The amount of the judgment is unreasonable.** Here, however, the test is typically not what any given jury would have awarded on the claim were it presented with the case, but what was reasonable at the time of the "settlement" given the vicissitudes of litigation. *See, e.g., Guillen v. Potomac Ins. Co. of Ill.,* 785 N.E.2d 1 (Ill. 2003); *Miller v. Shugart,* 316 N.W.2d 729 (Minn. 1982); *but see, e.g., Evanston Ins. Co. v. ATOFINA Petrochems. Ins.,* 256 S.W.3d 660 (Tex. 2008).

- **There wasn't a complete denial of coverage.** Not every coverage denial will free the insured to enter into a confessed judgment. Generally, the denial must be a complete denial of coverage. A denial as to the amount of coverage (a limits dispute), for example will not justify a confessed judgment. *See, e.g., Buysse v. Bauman-Furrie & Co.,* 448 N.W.2d 865, 873 (Minn. 1989).

- **There was a failure to allocate between covered and non-covered claims.** In *Corn Plus Cooperative v. Continental Casualty Co.,* 516 F.3d 674 (8th Cir. 2008), the court held it was unreasonable as a matter of law for a policyholder to stipulate to a judgment recoverable from its insurer where the policyholder

failed to allocate the recoverable damages between covered and non-covered claims.

- **Failure to allocate between multiple defendants.** *United Servs. Auto. Ass'n v. Morris,* 741 P.2d. 246 (Ariz. 1987).

- **The judgment was a product of fraud or collusion.** Because confessed judgments are, by definition, inherently collusive, the courts have said that the ordinary standard of collusion or fraud is inappropriate. Instead, the collusion must be tainted by "bad faith," with the insured assuming the burden of initially going forward with the production of sufficient evidence to make a prima facie showing of reasonableness and lack of bad faith. *See, e.g., Steil v. Florida Physicians Ins. Reciprocal,* 448 So.2d 589 (Fla. Ct. App. 1984); *Miller v. Shugart,* 316 N.W.2d 729 (Minn. 1982).

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UNCOMMON LAW:
How Will the American Law Institute's New Liability Insurance Restatement Shape The Future of Coverage Disputes

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Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firm's complex insurance claims resolution group. For the past four decades, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He has also advised various medical malpractice insurers concerning professional liability claims and consults frequently on bad faith and ethics disputes. He has also served as an arbitrator in numerous insurance coverage matters and has testified as an expert in matters involving coverage and reinsurance issues arising out of such claims.

Mr. Aylward is a leading member of the defense bar, including roles as:

American Bar Association Section of Insurance Litigation
--Umbrella Issues Subcommittee Co-Chair (2009-present).
--CLE Co-chair (2004-2006).

American College of Coverage and Extra-Contractual Lawyers
--Founding Member (2012)
--Board of Directors (2012-18)
--President-Elect (2017-18)

Defense Research Institute
--Board of Directors (2000-2003)
--Insurance Law Committee Chair (2000-2002)
--Law Institute (2004-2015, Chair—2012-2014)

Federation of Defense and Corporate Counsel
--Reinsurance Excess Surplus Lines Committee Chair (2016-2017)
--Amicus Committee (2010 to present)

International Association of Defense Counsel
--Reinsurance, Excess and Surplus Lines Committee (2005-2007)
--Board of Editors, *Defense Counsel Journal* (2005-2015).

In 2002, he was honored by the Defense Research Institute as its Outstanding Committee Chair for his leadership of DRI's Insurance Law Committee. In 2006, he received DRI's G. Duffield Smith Award for Outstanding Publications for his article analyzing post-*Campbell* trends in punitive damages jurisprudence.

Mr. Aylward has lectured and written frequently on insurance issues and has contributed chapters to the *New Appleman* insurance treatise (2007 and 2010); the Law and Practice of Insurance Litigation (West 2005) and Emerging Issues in the CGL (National Underwriter 2008); the ABA's *Environmental Liability and Insurance* treatise (2012) and Thompson Reuters' 2015 *Reinsurance Desk Handbook*.

In 2014, he was elected to the American Law Institute and served from 2015 to 2018 as one of the several dozen Advisors to the Reporters on the ALI's *Restatement of the Law, Liability Insurance.*

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By
Michael F. Aylward

I. Introduction

On May 22, 2018, the membership of the American Law Institute voted to give final approval to the *Restatement of Law, Liability Insurance.* Eight years in the making, the RLLI is the first Restatement devoted solely to a single industry. Perhaps due to that focus or the difficulty of finding consensus with respect to an area of the law that differs so markedly among the fifty states, the debate over the RLLI was quite contentious and resulted in an unprecedented amount of comments from outside interests in the last few years of the project.

In fact, this Restatement was originally supposed to have been approved a year earlier. In the weeks leading up to the scheduled vote on May 23, 2017, however, the ALI was deluged with objections and letters of concern from a broad spectrum of institutions and individuals who stood to be affected by its provisions. In the face of this firestorm of criticism, the ALI announced on May 22 that, while a debate would go forward on May 23, no final vote on this project would occur until the next Annual Meeting in May 2018. In the interim, the Reporters were asked to reconsider their existing text in light of the comments expressed by ALI members at the 2017 Annual Meeting and the criticisms leveled by outsiders in the weeks leading up to the meeting.

Now that the RLLI has received final approval, it remains to be seen how widely accepted this *Restatement* precepts will be and whether insurers and other groups that criticized many of its provisions over the past several year will come to terms with the Restatement as a whole or make use of certain provisions that are favorable to them while continuing to be critical of others that seem inconsistent with established law.

II. The American Law Institute Tackles Insurance Law

Founded in 1923 by eminent judges and scholars such as Benjamin Cardozo and Learned Hand, the ALI takes as its mission the goal of promoting "the clarification a simplification of the law and its better adaptation to social needs, to secure the better administrative of justice and to encourage and carrying out scholarly insights of legal work." Its membership includes hundreds of prominent state and federal appellate judges, leading legal scholars and practicing attorneys.

Over the past century, the ALI has had a profound impact on American law through model statutes such as the Uniform Commercial and Penal Codes as well as its various Restatements of the law in areas as diverse as torts, conflicts of law and the law of lawyering.

In 2010, the American Law Institute embarked on an analysis of legal issues presented by liability insurance disputes. This project was originally envisioned as a "Principles of the Law." Unlike the ALI's more familiar "Restatements," "Principles" projects are geared more towards regulators and legislatures and set forth "best practices" that the Reporters feel should be adopted, whether they currently reflect the way that most courts address such issues or not. In short, *Principles* forecast the law as it might become, whereas *Restatements*, for the most part, describe the law as it presently exists.

ALI projects proceed through a slow iterative process. First, ALI-appointed Reporters circulate Memoranda and Preliminary Drafts. These initial drafts are reviewed by appointed Advisors and the volunteer Members Consultative Group, ALI members who provide feedback to the Reporters. With this input, the Reporters produce so-called Tentative Drafts. When these drafts are approved, a so-called Council Draft is submitted to the ALI Council, a small group of senior members that vet all proposed sections before they are submitted to the full membership for final approval at the ALI's annual meetings in Washington, D.C.

Professors Thomas Baker and Kyle Logue of the Universities of Pennsylvania and Michigan agreed to serve as the Reporters for the Liability Insurance project and duly drafted several preliminary sections that were debated and approved by the American Law Institute at the annual meetings of its membership in Washington, D.C. in 2012 and 2013. In 2014, however, the new executive director of the ALI decided that it should be a Restatement. As a result, and despite the fact that Chapters One and Two had already by then been debated and approved by the full ALI membership, the Reporters were obliged to pull back Chapters One and Two at the end of 2014 and reassess these sections to eliminate aspirational provisions that were not rooted in the common law or that were otherwise inappropriate for inclusion in a Restatement.

The transition of this project to a Restatement did not eliminate the controversy concerning its provisions. Indeed, between 2015 and 2018, the Reporters advanced a number of proposals that were vigorously opposed by the insurance industry. Although many of these proposals were ultimately eliminated or scaled down by the time that the final text was approved in 2018, some remain in the final text:

- Section 3: Should the "plain meaning" rule be abandoned in favor of a rebuttable "presumption of plain meaning" allowing unambiguous policy provisions to be interpreted in favor of coverage based upon drafting history and other extrinsic evidence of meaning.

- Sections 7-9: Should insureds be excused for "innocent misrepresentations"?

- Section 12: Should insurers be automatically liable for the misconduct of defense counsel or for failing to ensure that defense counsel have reasonable amounts of malpractice insurance?

- Section 13: Under what circumstances may an insurer's duty to defend be negated by facts that are not alleged in the underlying complaint?

- Section 19: Is an insurer automatically estopped to dispute indemnity if it is found to have wrongfully refused to defend?

- Section 24: Do insurers have a duty to make settlement offers even if no demand has been made?

- Section 27: Do the damages recoverable against an insurer for failing to settle include a verdict for punitive damages that would otherwise not be covered?

- Section 38: Should the number of "occurrences" be determined based on the "cause" of the underlying claimants' injuries or the insured's legal liability?

- Section 41: Should long-tail losses be allocated on a "pro rata" or "all sums" basis? Should insureds bear responsibility for shares allocable to years in which insurance was "unavailable"?

- Section 46: Are losses uninsurable because the litigation pre-dates an insurer's issuance of its policy?

- Section 47-48: Are insureds that prevail in coverage litigation always entitled to be reimbursed for their DJ fees?

III. *The Restatement of the Law, Liability Insurance*

The *Restatement of Law, Liability Insurance* is divided into four chapters. Chapter One addresses basic principles of insurance contract interpretation; the doctrines of waiver and estoppel and the effect of misrepresentations made by policyholders during the application process. Chapter Two focuses on the obligation of a liability insurer to defend (or pay defense costs), as well as the duty to settle and cooperation issues. Chapter Three addresses the scope of insured risks and topics such as trigger, allocation, and issues related to exclusions and conditions, while Chapter Four covers remedies, bad faith, and enforceability.

A. Chapter One (Basic Liability Insurance Contract Principles)

Following an opening definitional section, Chapter One consists of three topics: (1) Interpretation (Sections 2-4); (2) Waiver and Estoppel (Sections 5-6) and (3) Misrepresentations (in Section 7-9).

--Topic 1: Interpretation

Section 3 was perhaps the most controversial section in the entire RLLI. Instead of adopting "plain meaning" as a fixed rule, the Reporters proposed a theory of their own creation whereby there would only be a *presumption* of plain meaning that could be refuted by extrinsic evidence of contractual intent. Furthermore, even if a policy term is unambiguous on its face, that plain meaning could have been overcome if a judge "determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence."

Comment d. in Preliminary Draft No. 1 (2014) stated that "plain-meaning" is assumed to be the understanding that "an ordinary reasonable person would have, if that person took the time to read all of the relevant parts of the policy in the context of the claims at issue." Section 3 diverged from the common law in its assessment of where courts can search for meaning. Whereas

most courts have found that meaning derives from the policy wording itself, as late as 2017 the Reporters were insisting through Section 3 that even policy language that is plain on its face could be given a different meaning that favored coverage extrinsic evidence supported an interpretation that was different from what the text itself would suggest.

The Reporters explained at the time that their "presumption of plain-meaning" approach was a pragmatic compromise between the overly rigid "plain-meaning rule" and the overly flexible "contextual" approach to policy interpretation. Nevertheless, the "presumption" approach proved highly controversial given the near ubiquity of the "plain meaning rule."

In the weeks leading up to what was to have been the final vote on the RLLI in the Spring of 2017, the ALI was showered with letters of criticism from outside interests, including DRI; state insurance regulators from Illinois, Michigan, New York and South Dakota; several trade industry groups (American Insurance Association, National Association of Mutual Insurance Companies, National Conference of Insurance Legislators and the Property Casualty Insurance Industry Association) as well as commentary from several insurers and over a dozen law firms. Additionally, the general counsel of seven non-insurance corporations, including Brunswick, Eli Lilly, Johnson & Johnson, Novartis and Shell Oil, submitted a letter on May 19, 2017, expressing concern that the Reporters abandonment of "plain-meaning" would have consequences for contract law that went far beyond insurance contracts.

Faced with this avalanche of criticism, the ALI announced on the very eve of the May 23, 2017 vote that while it would allow the ALI membership to debate PFD No. 1 as originally agreed, but would delay the vote on final approval until the ALI's next annual meeting in May 2018. Meanwhile, the Reporters were instructed to reassess their earlier drafts in light of these comments and criticisms.

The revised text that the Reporters released in August 2017 disputed that U.S. courts were agreed on single "plain meaning" rule, observing about half used strict "plain-meaning", a third followed "latent ambiguity" and a "respectable minority" used a contextual approach. The Reporters also made a concerted effort in this draft to set forth case law support for their novel approach and to minimize the extent to which it diverged from strict "plain meaning." They explained that their proposed approach is a compromise between "strict plain meaning" and the "contextual" approach favored by the *Restatement of Contracts* that construes terms in accordance with the circumstances and context of the contract that because a determination of ambiguity is to be made without regard to extrinsic evidence, this section did not recognize the concept of "ambiguity in context."

While essentially adopting the "latent ambiguity" cases as the doctrinal basis for this "presumption" approach, the Reporters argued that their compromise was more favorable to insurers than the result in most "latent ambiguity" cases. As they noted, most courts that have recognized a latent ambiguity have automatically found coverage, whereas the Reporters' proposal would only require coverage if the latent meaning is more reasonable than the patent meaning evident from the policy's text.

The Reporters also emphasized that extrinsic evidence may not be used to "manufacture" an alternative meaning. Rather, a plausible basis must already exist for arguing that an alternative

meaning exists before courts should allow discovery of extrinsic evidence to determine the relative reasonableness of the proposed latent meaning.

The revised text of Section 3 survived a vigorous debate within the project's Adviser and Members Consultative Groups in the Fall of 2017 but fell afoul of the ALI Council in January 2018. Several members of the ALI Council were critical of Section 3 at their January 2018 and demanded further revisions. In the face of this criticism, the Reporters finally gave way and abandoned their "presumption of plain meaning" approach.

While the final text of Section 3 that was approved on May 22, 2018 purports to adopt a traditional "plain meaning" approach, it also stated for the first time that courts could consider "custom, trade and usage" evidence to interpret policies. As revised, Comment c., states that:

> Many courts that follow a strict plain-meaning rule also consider custom, practice, and usage when determining the plain-meaning of insurance policies entered into between parties who can reasonably be expected to have transacted with knowledge of that custom, practice, or usage. This is the better approach because informed insurance market participants conduct their business in light of custom, practice, and usage in the insurance market and in the trade of the business being insured.

A motion to delete Comment c. was defeated on a floor vote during the May 22 debate. The Reporters did, however, accept a suggestion by John Buchanan of Covington & Burling that the legal authority that they had deleted after abandoning the "presumption of plain meaning" approach be restored to the Reporters' Notes for Section 3 as reflecting the "spectrum" of views in this area. Under ALI rules, the Reporters' Notes reflect the private opinions of the Reporters and are not deemed to be a statement of the ALI's views.

Section 4 sets forth rules for determining whether policy language is ambiguous. In most states, when standard-form policy language is involved, a finding of ambiguity automatically results in coverage ("tie goes to the insured"). Thus, even if an insurer's proposed interpretation is reasonable, coverage will be found so long as the insured's proposed interpretation is also reasonable. As set forth in Comment c., the RLLI rejects this "tie breaker" approach to *contra proferentem* and allows insurers to present extrinsic evidence to show that the "coverage-promoting interpretation of the ambiguous term is unreasonable in the circumstances" because "a reasonable person in the policyholder's position would not give the term that interpretation."

Section 4 is not even handed in its approach to what sort of evidence insureds and insurers may present. As set forth in Comment h., whereas policyholders are free to present a wide-range of extrinsic evidence in support of their proposed interpretation, including evidence of a policy's drafting history; regulatory filings with state insurance departments; other versions of the policy available on the market and expert testimony regarding custom and practice in the insurance industry, the history, purpose, and functions of policy terms and forms of insurance coverage, insurers may only present extrinsic evidence that the insured would or should have had knowledge of at the time of contracting.

Comment e. to Section 4 rejects any exception to these general rules for so-called "sophisticated policyholders." Comment h. does acknowledge, however, that a broader spectrum of evidence may be presented by insurers in cases where the insured is a large corporation advised by brokers and other insurance experts and thus would be expected to have a broader knowledge of various sources of policy meaning than a small business would likely have had access to.

Sections 5 and 6 set forth the general rules governing the application of the doctrines of waiver and estoppel to insurance coverage disputes. For the most part, the principles enunciated in these sections follow the common law in most jurisdictions both as regards the distinction between waiver and estoppel and the general principle that an insurer cannot "waive into coverage." Section 6 does state, however, that an insurer's post-loss conduct can estop it to dispute coverage if the insured reasonably relies on it to their detriment.

Misrepresentation is the subject of **Sections 7, 8 and 9.** The RLLI's analysis of misrepresentation issues was one of the most contentious issues during the *Principles* phase of this project (2010-14). In particular, insurers objected to Section 7's use of a "fraud" standard of proof as well as a requirement that insurers accept coverage, albeit at the cost of additional premium to the insured, in cases of "innocent misrepresentation." Both of these provisions were eliminated in the 2015 Council Draft, along with any distinction between negligent and intentional misrepresentations. Even as revised, however, certain provisions of Sections 7 and 8 do not track the rules in most states with respect to intent, materiality and reliance. For instance, Comment d. in Section 7 requires an insurer to demonstrate reliance if a misrepresentation is intentional. Likewise, Comment j. acknowledges that most states do not excuse "innocent misrepresentations" but states that courts should permit insureds to assert a "fairness objection" in these circumstances.

There was controversy during the May 22, 2018 floor debate with respect to Section 8's statement in Comment a. that a misrepresentation is "material" only if the insurer would have refused to issue the policy had it known the truth or would have issued the policy on "substantially different terms. " A motion by Allstate's Vanita Banks to delete the "substantially different terms" language was defeated on a floor vote after the Reporters' explained that it was needed to avoid insurers from rescinding a policy based on a trivial misstatement

B. Chapter Two: Management of Potentially Insured Liability Claims (Sections 10-30)

Chapter Two is divided into three topics: (1) defense; (2) settlement, and (3) cooperation. According to the Reporters, these three Topics have "engendered much confusion in the case law" and there is a "real opportunity to clarify and improve the law. . . . ." The Reporters go on to assert that Chapter Two is an attempt to "clarify and unify existing law" and that it largely sets forth rules that already apply in most jurisdictions. Indeed, the *Principles* version of Chapter Two was generally less controversial than Chapter One and thus was changed less in drafts hat were issued after this became a *Restatement* project.

--Topic 1: Defense

Sections 10-23 analyze the right and duty of insurers to defend.

Section 10 acknowledges the right of insurers to defend and states in Subsection (2) that insurers have the right to receive information from defense counsel. **Section 11** expands on this analysis, declaring that such disclosures do not result in a waiver of the attorney-client privilege with respect to the subject matter of such communications. Section 11(2) states, however, that insurers do not have the right to demand privileged information "if that information could be used to benefit the insurer at the expense of the insured."

Section 12 addresses when an insurer may be liable for its conduct of the insured's defense and was one of the most controversial sections of this Restatement. During the *Principles* phase of the project, this section declared that insurers should always be vicariously liable for the misconduct of defense counsel, in the apparent belief that imposing liability would cause insurers to more vigorously police the conduct of appointed defense counsel. In light of the absence of any common law support for this sweeping proposition, however, the Reporters abandoned this approach after 2014 but continued to impose liability for the negligent selection of counsel, as by failing to ensure that the firm had adequate malpractice coverage. Insurers could also still be liable for the acts of their employees, such as staff counsel.

Numerous ALI Advisers and outside bar associations, notably DRI, noted the impracticability of determining whether counsel had "adequate" E&O coverage as well as the lack of any case support for this proposition. In light of this criticism, this language was softened in the Revised Proposed Final Draft released by the Reporters on September 7, 2018. As revised, Comment c. now merely states that a court "could find" that an insurer was negligent for failing to ensure that defense counsel did not have adequate insurance but that this Restatement would not take a position on this topic owing to the lack of any case law to support this contention.

Concerns were expressed during the floor debate on Section 12 that the illustrations used by the Reporters, many of which involved an insurer's knowledge of substance abuse or other personal problems, were problematic or would place insurers in the position of intruding into the privacy of defense counsel. A motion to delete Subsection (1) by Brackett Denniston of Goodwin LLP and Harold Kim on the Chamber of Commerce was defeated. Nevertheless, the references to "substance abuse" have been eliminated Revised Proposed Final Draft released by the Reporters on September 7, 2018.

Section 13 proposes a "four corners plus" approach to the duty to defend that would require insurers to consider not only the facts alleged but also facts that become known through the insurer's investigation. However, extrinsic facts will only defeat a duty to defend that otherwise exists in five defined circumstances or any similar exception acknowledged by a state court, as where the issue concerns whether the claimant is an insured or the policy was cancelled before the accident. Insurer advocates argued during 2015-2017 that there is no case support for codifying these specific situations as being the only instances where extrinsic facts might eliminate a duty to defend. Although the Reporters did initially agree to set forth a broader rule that created a general exception in all cases where the extrinsic facts showing a lack of coverage were undisputed, this language was abandoned by the Reporters in 2016 in favor of enumerating these specific examples instead.

Section 14 sets forth certain basic principles governing the insurer's right to defend, including the insurer's duty to defend the entire law suit, even if only some of the claims were

covered. Subsection (1) also reinforces Section 11's statement that the insurer cannot compel defense counsel's duty to disclose confidential information that would harm the insured's interests. Subsection (2) affirms the insurer's right to conduct the defense with staff counsel unless independent counsel are required. Finally, Subsection (3) states that, unless the policy provides otherwise, defense costs do not count against limits.

Section 15 addresses reservation of rights letters. It requires the insurer to give timely notice to its insured of any coverage defense that it is aware of or to issue a supplemental letter when additional facts bring new defenses to its attention of which it was previously unaware. Such letters must identify the specific policy wordings at issue and explain the issue in language that is understandable to a reasonable person in the position of the insured. Subsection (4) does allow insurers to undertake the defense of a case pursuant to a generic reservation of rights letter if exigent circumstances prevent them from completing their investigation of a claim at the time. However, the insurer must act diligent to complete its investigation and issue a detailed RoR once the investigation is completed.

Section 16 addresses the circumstances in which an insured may insist on its own defense counsel. Section 16 adopts the California *Cumis* approach wherein independent counsel is only required if the insurer is raising a coverage defense that could affect how the case is defended to the prejudice of the insured.

Section 17 states that an insurer's determination of the hourly rate for independent counsel may not be determined solely based on what the insurer pays to its panel counsel. An earlier provision requiring the insurer to front the full amount charged subject to a right to sue defense counsel at the conclusion of the litigation to recoup excessive fees was eliminated in 2016.

Section 18 sets forth the specific circumstances that permit an insurer to terminate its defense, including a voluntary relinquishment by the insured; a final adjudication or settlement of the underlying claim or a successful coverage suit by the insurer. Comment c. makes clear, however, that an interlocutory order will not terminate the duty to defend and that the insurer must defend against any appeal that the plaintiff may bring from a lower court's dismissal of the claims against the insured. Subsection (5) provides that an insurer may terminate its defense duty by entering into a settlement with the underlying claimant to dismiss the covered claims, but only with the insured's express consent. Subsection (8) also states that an insurer may only terminate its duty to defend through coverage litigation if there has been a "final adjudication" that the insurer did not owe a defense.

Section 19 provides that "an insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action." Along with Sections 3 and 12, Section 19 was a flashpoint for insurer opposition to this Restatement. It originally provided that an insurer that failed to defend lost the right "to contest coverage for the claim." After vehement opposition by insurer advocates, the Reporters initially agree to scale back Section 19 so that insurers would only lose the right to raise defenses to indemnity if their failure to defend lacked a "reasonable basis." As there was no common law basis for even this compromise proposal, however, the final text of this section merely states that an insurer that fails to defend loses the right to exercise any control over how the insured's defense is conducted. Comment a. further states that the insurer is bound by the outcome of any case that it fails to defend and can

only re-litigate the issue of the insured's liability or any resulting damages by showing fraud or collusion.

Section 20 states that if multiple insurers have a duty to defend, the insured may target a single insurer to handle its defense. This is very much a minority view, followed only in states like Illinois. Unlike the Illinois "targeted tender" approach, however, Section 20 provides that the insurer that the insured selects to defend is entitled to contribution from other insurers that shared a similar obligation.

Section 21 states that insurers may not retroactively recoup their costs of defense, absent explicit policy wordings allowing such recovery. The Reporters are at pains to reconcile this finding with Section 35 of the *Restatement (Third) of Law, Restitution and Unjust Enrichment*, which does allow for equitable restitution under analogous circumstances.

Section 22 addresses so-called "defense cost indemnification policies" that require insurers to pay for an insured's defense but do not do so pursuant to any "duty to defend."

Section 23 discusses the insurer's right to associate in the insured's defense, including the right to receive reports from defense counsel (as limited by Sections 11 and 14) and to participate in "major decisions in the defense of the action that is consistent with the insurer's level of engagement with the defense of the action." "Level of engagement" appears to mean that an insured is not required to continue to follow up with its insurer if the insurer refuses to respond to earlier notices.

--Topic 2: Settlement

Section 24 concerns the obligation of insurers to make "reasonable settlement decisions." A "reasonable settlement decision" is "one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending a claim." Subsection (3) provides that this duty extends to accepting reasonable settlement demands made by plaintiffs with a proviso that the insurer's liability is "never greater than policy limits." The duty also includes the "duty to contribute its policy limits . . . if that settlement exceeds those policy limits."

Comment a. describes the rationale for these rules as follows:

> The objective is to encourage liability insurers to make efficient and equitable settlement decisions. In addition, because insureds are generally more risk adverse than insurers, this rule maximizes the joint well-being of the parties by shifting the risk of excess judgments from insureds to insurers.
>
> The purpose of the duty to make reasonable settlement decisions is to align the interest of insurer and insured in cases that expose the insured to damages in excess of the policy limits. Therefore, the duty is owed only with respect to cases that expose the insured to such damages.

It is interesting that the Reporters are treating the failure to make reasonable settlement decisions as a contractual issue and not "bad faith." Comment m. observes that the issue of whether an insurer has failed to make a reasonable settlement decision is not the same as whether an insurer has acted in bad faith or breached the implied duty of good faith and fair dealing as liability for failing to make a reasonable settlement decision does not require proof of bad intent. The issue is one of "reasonableness" and not a question of "good faith." Accordingly, a failure to settle is only bad faith if the insurer does so without a reasonable basis for its conduct or with reckless disregard to that lack, as required by Section 49 in Chapter 4 of the RLLI.

Comment b. observed that the Reporters use the term "duty to make reasonable settlement decisions" instead of the more common term "duty to settle," to emphasize their view that insurers do not have a duty to settle every claim but, rather, "to make reasonable settlement decisions." It emphasized that insurers "may reject unreasonable settlement demands," as defined in Section 27(2) of the black-letter rule. The reasonableness standard is "flexible," permitting the finder of fact "to take into account the whole range of reasonable settlement values." This range includes consideration of whether an insurer made reasonable offers and counteroffers.

Comment f. specifically distinguishes between an insurer's rejection of a reasonable settlement demand and its failure to make a reasonable offer at all:

> A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer's decision not to make a reasonable offer, or counter-offer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

Comment f. also makes plain that this difference rises from differences in proof of causation. When an insurer rejects a reasonable settlement demand leading to an excess judgment against the policyholder, causation is plain. It is less clear when an insurer fails to make any offer or counter-offer. This rule applies to both duty to defend and defense costs indemnification policies.

Comment f. proposes a "reasonableness" standard, not a "hard and fast rule" and that whether an insurer owes the duty to make an offer depends on the particular circumstances as where the facts known to the insurer make clear that the policy limits are significantly less than the reasonable settlement value of the underlying case given the severity of the claimant's damages and the likelihood of liability being found. The Reporters acknowledge, however, that there may be strategic value in not making an offer early on.

Comment g. acknowledges the argument that these rules may "hamper negotiation strategies by liability insurers in settlement discussions, to the detriment of policyholders as a whole." The Reporters stated, however, that "minimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions. Rather, the primary objective is to protect insureds from the conflict of interest inherent in the standard less-than-full-coverage case where the insurer has the sole settlement discretion." In any event,

insurers remain free to reject settlement offers. "Rather, the rule simply imposes on insurers (and, thus, the insurance pool) the risk of being wrong in making that determination in individual cases."

There was vigorous debate within the ALI with respect to the circumstances in which liability would be imposed for failing to accept a "reasonable" offer of settlement. Prior to the 2016 Annual Meeting, Robert Cusamano of Crowell & Moring (former general counsel to ACE) submitted a lengthy letter to the Reporters urging them to delete language holding insurers liable for excess judgments in any case where they fail to accept a reasonable offer of settlement. As Cusamano observed, Comment d. did not reflect the reality of how cases settle and would impose unrealistic and costly obligations on insurers:

> In tort actions, one can say that ranges of reasonable are often several hundred percent of each other or more. Indeed, in many cases where liability itself is questionable, or where the law is disputed, that ratio may rise to infinity as a perfectly reasonable defendant concludes that a given action has no merit at all. Once again, to force an outcome at the highest point in such a wide range is incompatible with the mandate to negotiate as if one "bears sole financial responsibility" for a potential judgment. And, once again, "reasonableness" is very much in the eye of the beholder and there are beholders (plaintiff, defendant, mediator, judge, jury and the main tort case, appellate bench, jury in the second case against the insurer for failure to settle) and they all have different cognitive apparatus, wants, needs and exigencies.

Cusamano criticized the treatment of this issue in Comment d. as representing "an existential change in the nature of settlement talks, and entail a dramatic, perhaps virtually total, shift in bargaining power among litigants" and as supplanting the existing framework of settlement negotiations "with a system that requires payment of any reasonable amount requested."

As Cusamano observed, "the current approach, while reflected in the black letter text of Section 24, certainly encourages a dialogue structure around policy limits and the duties of good faith, as it centers on the insurer's duty to act carefully and reasonably." By contrast, the new regime set forth in Comment d. "will center not on good faith, and will not even center on the insurer's course of conduct. Rather, it will center on predictions about how a later adjudicator will assess the reasonableness of a plaintiff's unilaterally selected settlement demand" based on valuation factors that are "hardly knowable and probably not even roughly predictable."

Adviser William Barker of Denton also proposed striking the final sentence of Comment d., which stated that an insurer is liable "even if the rejected settlement was at the high end of the reasonable range" and substituting in its place the following text:

> While reasonableness may be seen as a range, a reasonable person evaluating a demand will look towards the center of that range to evaluate the probable verdict value of the case, which would reflect

> the average result if the case were tried many times. Hypothetical verdicts at the high and low end of the range of reasonableness would average out.

While neither proposal was adopted at the 2016 ALI Annual Meeting, these criticisms clearly had an effect on the Restatement Reporters. In particular, in advance of the 2017 Annual Meeting, the Reporters softened Comment d. so that instead of being liable if they rejected "any" reasonable settlement demand, the liability of an insurer would only arise if the insurer rejected "a settlement offer that a reasonable insurer would accept …"

Furthermore, the Reporters adopted Cusamano's standard of a "reasonable insurer." Following the 2017 Annual Meeting, the Reporters added language to Comment d. to state that their conception of a "reasonable insurer" includes not only an average ordinary insurer but also "a more aspirational concept that protects against circumstances at which average conduct is objectively unreasonable." They have clarified, however, that the duty to make reasonable settlement decisions only extends to excess judgments that are otherwise covered by the policy, language that was lacking in earlier drafts.

While the amelioration of the standards of liability are an improvement over earlier drafts of this Secton, concerns remain that insurers will face increased liability for failing to accept a "reasonable" settlement offer even where their efforts to settle have otherwise been reasonable. Additionally, although the Reporters are at pains to distinguish such claims from bad faith litigation, the inclusion of "procedural factors" as a basis for imposing liability muddies the waters and certainly introduces bad faith evidentiary elements into failure to settle litigation. Finally, while the revised text of Section 24 omits prior language imposing an affirmative duty to make settlement offers, echoes of this earlier language continue to resonate in the Comments to this Section.

Section 25 concerns the effect of an insurer's reservation of rights on its rights and duties with respect to settlements. Subsection (a) states that the insurer has no duty to settle non-covered claims. However, Subsection (b) also states that the insurer cannot recoup a settlement payment from its policyholder on the basis that the underlying claims were not covered in whole or in part.

Most of the controversy concerning Section 25 related to Subsection (3), which addressed the circumstances in which an insured may enter into a settlement over the objections of its insurer. The black letter rule requires the insured to alert the insurer to the proposed settlement and to give the insurer the opportunity to withdraw its reservation of rights. Finally, any such agreement must be one "that a reasonable person who bears the sole financial responsibility for the full amount of the potential covered judgment would make."

Prior to the May 22, 2018 floor debate, the RLLI Reporters accepted a proposal by Malcolm Wheeler of Wheeler Trigger to amend Sections 25(3) and 27 to require that insureds give full notice and information to insurers before being permitted to enter into settlements over the insurer's objection in cases where the insurer is defending under a reservation.

Section 26 addresses situations in which there are more claimants than policy limits. Such circumstances can present difficult questions of timing and entitlement to the policy proceeds, particularly when an insurer has not paid defense costs as they are incurred. Courts have struggled to identify appropriate rules to govern such situations. Does the insurer in such cases act in bad faith if it pays its full limit to settle some of the cases but not all? Alternatively, if the insurer is unable to settle all of the claims, does the insurer nonetheless have a duty to settle such claims as it can?

The answer, according to Section 26, is interpleader. Thus, the Reporters state that an insurer has a duty to make "a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure." The insurer may satisfy this duty by "joining all affected claimants in the underlying action and tendering its policy limits to the court" with a motion to allocate the limits "among the claimants on the basis of the relative value of their claims."

If a claimant in such a situation rejects a portion of the policy limits offered in full satisfaction of its claim, the insurer's duty to defend remains in effect until the claim is settled, the claim is finally adjudicated, or a court finds that the insurer does not have a duty to defend.

Section 27 provides that an insurer that fails to make a reasonable settlement decision is liable for the entire amount of the judgment, not just the amount within its policy limits. Furthermore, the insurer may be liable for "any other reasonably foreseeable harms." If there is an excess judgment, this liability may include the insured's emotional distress. This rule applies only if there is an excess judgment, however.

Comment e. states that an insurer that fails to effectuate a reasonable settlement is liable for all damages flowing from that failure even if the resulting excess judgment may include elements, such as punitive damages, that would not otherwise have been covered. This is contrary to the view of cases such as *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999), and *Lira v. Shelter Insurance Co.*, 913 P.2d 514 (Colo. 1996). Despite this lack of common law authority for this aspect of Section 27, a motion by Victor Schwartz of Shook Hardy & Bacon to strike Comment e. was defeated at the 2018 Annual Meeting.

Section 28 recognizes that an excess insurer may pursue a right of equitable subrogation against a primary insurer for failing to effectuate a reasonable settlement. This appears to reflect the emerging majority view on this issue, although it is not one that is universally accepted.

--Topic 3: Cooperation

Section 29 provides that policyholders have a duty to cooperate with their insurers in:

(i) "the investigation and settlement of a claim for which the insured seeks coverage;

(ii) the insurer's defense of a claim, "when applicable"; and

(iii) situations in which the insurer associates in the defense.

As the Comments note, the duty to cooperate "serves to align the incentives of insurer and insured," helping to ensure that the insured has the incentive to aid the insurer in its defense and management of the claim. The duty requires the insured to render "reasonable assistance," with reasonableness assessed depending on the complexity of the claim, the insurer's ability to obtain information from other sources, the extent to which the insurer needs the policyholder's cooperation, etc. Comment c. explicitly states that the duty to cooperate is not intended to "become a trap for the insured," and states that an insurer "may not unilaterally withdraw from the defense of a claim based on non-cooperation." Instead, an insurer must follow the procedure set forth for reserving rights and pursuing a declaratory judgment action in such situations. Similarly, Comment d. states that the duty to cooperate does not obligate the insured to comply with unreasonable requests.

Section 30 states that, where an insured has failed to cooperate with its insurer, the insurer may avoid coverage only if the insured's actions have substantially prejudiced the outcome of the case. Further, if the insurer can show that its policyholder colluded with the claimant, the insurer is excused from coverage unless the insured proves that the collusion "if undetected, would not have caused substantial prejudice to the insurer in the outcome of the claim." "Prejudice" is also defined by reference to the outcome of the case and does not take into account additional expense or difficulty that an insurer may suffer in defending the case due to the insured's tardiness.

C. Chapter Three: General Principles Regarding the Risks Insured (Sections 31-45)

Chapter Three represents a comprehensive effort to analyze and apply the building blocks of all liability insurance policies, including (1) the scope of coverage; (2) conditions to coverage; (3) terms affecting the amount that an insurer must pay.

--Topic 1: Coverage

Section 31 provides that meaning of a policy term does not depend on where it appears or what label is attached to it, although "insuring clauses" should be interpreted "broadly."

Section 32 states that exclusions are to be read narrowly. Exclusions requiring proof of intent will generally be interpreted as requiring proof of subjective intent, although Comment d. confirms that insurers may draft around this requirement, as homeowners form exclusions commonly do. Comment d. also points out that subjective intent must be proved by objective evidence and may sometimes be inferred as a matter of law, as in cases of sexual assault.

Section 33 describes the role that "trigger of coverage" clauses play, whether in the context of "occurrence"-based policies or "claims made" policies. Comment f. adopts the "injury in fact" approach as the default solution for long-tail claims, while acknowledging that "injury in fact" may implicate multiple years of coverage depending on the causal circumstances of loss. Comment g. assigns the burden of proof in such cases to insureds, although the burden appears to be light and an insured may be able to compel coverage based on mere evidence of injurious exposure, subject to each insurer's ability to show that no harm actually occurred in its policy period.

Section 34 defines a "condition" as an event that "unless excused, must occur, or must not occur, before performance under the policy becomes due." Whether a term is a "condition" or not does not depend on where it is placed in a policy. Subsection (3) states that a failure to satisfy a condition will generally only defeat coverage if it results in prejudice to the insurer. Earlier language requiring "substantial prejudice" was removed, although Comment e. confirms the Reporters' view that the prejudice must be "material."

Having articulated a general requirement of prejudice for notice conditions in Section 34, the Reporters proceed to carve out an exception for "claims made" policies in **Section 35** in light of the different role that such terms play in "claims made" coverage. Section 35 does insist, however, that policyholders be given a "reasonable" amount of time within which to report claims that are received at the end of the policy period if the policy otherwise lacks an Extended Reporting Period (ERP) endorsement.

--Topic 2: Application of Limits, Retentions and Deductibles

Section 36 distinguishes between the assignment of a specific claim and rights under a policy generally. As to the former, Section 36 states that insureds are free to assign individual claims. As to the latter, an insured may only enter into an assignment as part of a merger or other corporate transaction that also transfer financial responsibility, the policy has already expired and the transfer does not materially increase the risk insured by the carrier. Comment c. also confirms that these rights only extend to liabilities that were already insured under the policy; successor entities may not obtain coverage for pre-merger liabilities.

Section 37 defines the function and role of policy limits, including "per occurrence," "per claim" and aggregate limits.

Section 38 analyzes the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate "occurrence" limits and adopts the majority "cause" approach and have made the further important determination that "cause" is based on the source of the insured's liability and not the process or processes that are the physical cause of the underlying injuries.

Section 39 addresses two issues of consequence to excess insurers: (1) what event triggers an excess insurer's duties and (2) whether insurers must "drop down" following the insolvency of a primary insurer. Section 39(1) provides that an excess insurer's duties are not triggered until the underlying limits are exhausted, although Section 39(2) adopts the so-called *Zeig* rule that allows those limits to be exhausted through a combination of sums paid by the underlying insurers and the policyholder. Comment d. states that this is only a default rule and that an excess insurer can draft around the *Zeig* rule by adopting language stating that "liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits," or (2) "coverage under this policy shall attach only after the full amount of the underlying limits have been paid by the underlying insurers."

Section 40 states that, in most cases, "when more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy." Insurers may, however, internally allocate

their obligations through the use of "other insurance" clauses or similar terms so long as they do not conflict with each other and do not operate to eliminate coverage altogether.

Despite the preceding section's adoption of "joint and several" liability as the default rule where two policies insure the same risk, **Section 41** carves out an exception for "continuing or repeated harm" that causes injury in successive policies. For these "long-tail" cases, insurer's coverage obligations are pro-rated on a "time on the risk" basis by dividing their years of coverage by the overall duration of the underlying injury or damage. While recognizing the division of authority on the issue, the Reporters have concluded that "pro rata by years" is the most consistent, simplest, and fairest solution to this problem."

There was considerable debate following the 2016 Annual Meeting with respect to whether Section 41 should include an "unavailability" exception to "pro rata" liability. Under this proposed exception, the denominator for calculating each party's share of loss in asbestos cases would omit years after 1985, when asbestos exclusions became prevalent. By contrast, under a pure "pro rata" rule, the insured is responsible for all years when there is no coverage, without distinction as to exclusions, insolvency or a simple failure to purchase insurance. Following an intense debate within the ALI, the Reporters merely note in Comment h. that "some courts" have recognized an "unavailability" exception but do not endorse this approach.

Section 42 permits an insurer that has paid more than its share of a judgment or settlement to recover from another insurer that has not paid its fair share so long as the other insurer has not, in the interim, entered into a settlement and obtained a release from the insured. Note that this right of contribution only applies to indemnity claims and does not apply in the not uncommon situation where a carrier settles out early for a small amount.

Section 43 concerns the impact of earlier settlements on an insurer's indemnity duties. It provides that the judgment recovered against the non-settling insurer shall be reduced "by the amount paid for those losses by an insurers that settled with and were released by the insured respect to that legal action." Comment b. notes that this rule does not apply in long-tail cases where liability is allocated on a "pro rata" basis as, in such cases, "a settlement agreement has no bearing on the pro rata liability of insurers in other policy periods." Where liability is concurrent, however, Section 43 adopts the so-called *pro tanto* rule rather than the competing approach that gives the non-settling insurer a credit in proportion to the amount of liability that the settled insurers had. Section 43 does not discuss the practical problem of how credits should be apportioned in cases where multiple claims were involved and whether the judgment against the non-settling insurer overlaps with the settled claims.

D. Chapter Four: Enforceability and Remedies (Sections 44-49)

--Topic 1: Enforceability

Section 44 proposes that certain terms be "implied in law" even if they do not appear in the policy. Thus, subsection (1) states that a term that is required by statute will be deemed a part of the policy even if it does not appear in the text. Conversely, an express contractual term will be voided under Subsection (2) if it is prohibited by statute or "clearly outweighed in the circumstances" by public policy.

Section 45 was among the more controversial provisions at the 2016 ALI Annual Meeting. As originally drafted, it declared that it is not against public policy for insurers to pay to defend cases involving aggravated fault, as where an insured acted with intent to cause injury, nor are insurers precluded from paying judgments or settlements in such cases. Insofar as the law forbids insurers from indemnifying cases of aggravated fault, this Section proposed that insurers pay such losses in the first instance but be allowed to obtain reimbursement from their policyholders.

In the face of harsh criticism from insurer advocates, the Reporters walked back this construction of this Section prior to the 2016 Annual Meeting. The proposed "claw back" provision was eliminated after counsel pointed out that it was inconsistent with other sections of the Restatement that prohibit recoupment. Finally, the Reporters agreed to re-write this Section so that coverage for punitive damages is not allowed if "contrary to public policy."

The final text of Section 45 that was approved at the 2018 ALI Annual Meeting allows policies to cover anti-social claims such as criminal proceedings unless prohibited by "legislation or judicially declared public policy" as is true in states such as California. On the other hand, the Reporters will not permit insurers to avoid coverage for such claims on the basis of public policy. According to Comment d. "moral hazard" is not a realistic or appropriate basis for precluding coverage on the basis of public policy. The Comments also argue that insurers already provide coverage for intentional acts, although these claims seem to conflate provisions found in certain D&O policy that do not mirror general liability insurance terms.

Section 46 addresses the so-called "known loss" doctrine. A "known liability" is defined as one that "a policyholders know that, absent a settlement, an adverse judgment establishing the liability in an amount that would reach the level of coverage provided under the policy is substantially certain."

Section 46 reflects something of a compromise between those courts have that ruled that losses are uninsurable if the policyholder is already aware that a loss is occurring and those such as California and Massachusetts that have found that even prior litigation may be insurable so long as the outcome of the claims is uncertain.

In short, Section 46 focuses on whether, prior to the issuance of a policy, an insured knows to a substantial certainty that it faces a liability that will affect its insurer. This would appear to be an absolute defense to coverage for primary insurers where a claim is already in suit. Excess insurers or primary insurers with large SIRs may only avail themselves of this defense if they can establish that the scope of the insured's defense costs will exceed the applicable SIR or is otherwise likely to penetrate the excess layer of coverage.

Section 46 is not limited to situations in which litigation is already pending. As policyholder advocates complained during ALI Adviser debates about this Section of the Restatement, Section 46 might arguably restrict coverage in cases such as environmental liability claims or other actions where the insured faced "strict liability." In such cases, the issue would be the degree of damages that the insured faced, rather than the possibility that it would face liability for some hypothetical judgment against it. In all of these cases, however, the issue is

whether the insured is aware of some liability that is presently certain to trigger an obligation on the part of an insurer, whether for defense or indemnity.

Following the 2017 Annual Meeting, the Reporters added language to Section 46(a)(2) clarifying that insurers had no duty to defend law suits that were already pending before their policies were issued. As Comment e. to this August 2017 draft explained "unless the insurance policy provides to the contrary, the no-liability default rule applies to exclude coverage for a legal action when the policyholder is substantially certain, prior to the policy period, that a person insured under the policy will incur otherwise covered defense costs."

The August 2017 draft also deleted an earlier statement that the doctrine was inapplicable to claims made policies. This is a correct statement of the law although it must be said that "known loss" issues almost never appear in the context of "claims made policies, since these policies typically contain language that expressly limits coverage to claims that are first made during the policy period and exclude coverage for claims arising out of circumstances of which the insured was aware prior to the policy period. As before, this limitation did not apply to excess insurers or primary insurers with self-insured retentions.

In the course of the May 2018 Annual Meeting, however, the Reporters reversed course and accepted a "friendly" motion by policyholder advocate David Goodwin of Covington & Burling to delete language from the black letter rule addressing defense costs. Comment e. now merely states that this Restatement is not taking a position on whether insurers can apply the known liability doctrine to defense costs because courts have not "squarely addressed" this question. It is a pity that this rigorous "squarely addressed" standard was not also applied to some of the Reporters' proposals that largely lack common law support.

--Topic 2: Remedies

The concluding sections of the Restatement deal with fee awards and bad faith. In the months leading up to the release of Chapter 4 in September 2016, there was great uncertainty and anticipation with respect to the approach that the Reporters would follow in addressing bad faith law. Given the ambitious innovations that Professors Baker and Logue had experimented with during the *Principles* phase of this project and the broad scope of the project as a whole, insurers feared, with some justice, that Chapter 4 would set forth broad and controversial rules seeking to transform the terrain upon which bad faith claims would be litigated in the years to come.

In the event, the discussion of bad faith in Chapter 4 is something of an anti-climax, consisting of only Section 49 (what is bad faith) and Section 50 (bad faith damages). The brevity of this analysis may have reflected fatigue on the part of the Reporters after seven years of labor on this project or, more likely, the Reporters' sense that some of the more complex issues presented by extra-contractual lability claims are not susceptible to a *Restatement*. For instance, this *Restatement* does not address the nature of the duty that liability insurers owe to their policyholders and whether there is some sort of actual or quasi-fiduciary obligation that insurers take on.

It is also clearly the case that many of the topics that are commonly viewed as involving "bad faith" are dealt with elsewhere in Chapter 2 ("Management of Potentially Insured Liability Claims") and Chapter 3 ("General Principals Regarding the Risks Insured"). In particular, the

issue of whether and when insurers may be liable for failing to settle within policy limits is separately dealt with in Section 24 of Chapter 3. Similarly, the problem of how insurers should act when there are more claimants than limits is dealt with in Section 26.

Other topics that often engender bad faith disputes are likewise addressed as non-bad faith topics and discussed in the claims management sections of Chapter 2, including whether insurers can be sued for the misfeasance of appointed defense counsel (Section 12); the insured's right to independent counsel (Section 16) and the consequences of wrongfully failing to defend (Section 19).

Sections 47 and 48 set forth the remedies available to policyholders and, in particular, the circumstances in which policyholders can recover their fees for litigating coverage disputes. Section 47 states that insurers that substantial prevail in coverage suits commenced by insurers seeking to terminate a defense obligation may recover their fees, whereas Section 48 allows fees if the insurer has declined to defend and the insured obtains a ruling finding a duty to defend. At the September 7, 2018 Advisers meeting, insurer advocates protested that Section 47, while consistent with the *Mighty Midgets* rule in New York, unfairly penalized insurers for bringing DJs to clarify their obligations, especially in states like Illinois where the failure to bring a DJ may estop the insurer from contesting its indemnity obligations.

Section 49 defines when insurers may be liable for "bad faith." It provides that:

> An insurer is subject to liability to the insured for insurance bad faith when it fails to perform its duties under a liability insurance policy:
>
> (a) Without a reasonable basis for its conduct; and
>
> (b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

The Reporters observe in Comment a. that the rule that they are proposing contains both an objective and a subjective element. The objective element is the requirement that insurers have a "fairly debatable" basis for their coverage position. Instead of merely relying on this element, however, the reporters have also required that the insurer act "with knowledge or reckless disregard" of a lack of a good faith basis for its position.

Policyholder advocates criticized the Reporters for setting the bar too high and requiring them to prove both subjective and an objective elements of liability in order to recover. In response, the Reporters defended their position in Comment a., setting forth three reasons why they chose not to adopt a purely objective standard. First, they felt that the objective approach was already embodied in other insurance law rules requiring that the insurer act reasonably as set forth in Sections 19, 24 and 27. Second, they take the viewpoint that the insured's right to attorney's fees as set forth in Sections 49 and 50 mean that the insured will already be receiving fees when their rights to a defense are denied or threatened without regard to whether the insurer's failure to do so is bad faith. Finally, they note that many of the cases in which courts have adopted a purely objective standard involve types of conduct that this Restatement treats as not involving bad faith such as the insurer's failure to settle or defend.

Comment a. to Section 49 identifies the "objective" element as the familiar requirement that the insurer's coverage position be "fairly debatable." Comment a. explains that the Reporters mean to use the same standard for Section 49 as they adopted in 2016, when in compromising the issue of whether insurers are estopped to contest indemnity when they fail to defend, they revised Section 19 of Chapter 2 to limit estoppel to cases in which insurers lack of "reasonable basis" for failing to defend.

In contract to this objective "fairly debatable" element, the subjective element is whether the insurer failed to perform when it knew it was obligated to perform or without regard to whether it had a reasonable basis for not performing. Comment a. observes that a "reckless disregard" may be found (1) because of lack of investigation of the relevant facts; (2) a failure to conduct the necessary state-specific legal research to evaluate the coverage position or (3) some other circumstance that placed the insurer on notice that it had not done what it needed to do in order to evaluate whether it had a reasonable basis for its position.

Section 50 sets forth the damages that are recoverable in bad faith cases: (1) the attorney's fees and other costs incurred by the insured in the legal action establishing the insurer's breach; (2) any other loss to the insured proximately caused by the insurer's bad-faith conduct; and (3) if the insurer's conduct meets the applicable state-law standard, punitive damages.

IV. Conclusion

Although the membership of the American Law Institute voted to give approval to the text of Proposed Final Draft No. 2 at the May 22, 2018 ALI Annual Meeting, the final text of the Restatement remains to be determined. Not only were a few final compromises agreed to between the release of PFD No. 2 on April 13, 2018 and the May 22 vote but the Reporters also retain discretion under the ALI's so-called "Boskey Rule" to make limited editorial revisions to previously-approved sections. Accordingly, the final text of the *Restatement of Law, Liability Insurance* will not appear until it is finally published by the American Law Institute, which is unlikely to occur before the Fall of 2018 or later.

This *Restatement* is already creating waves, however. In Delaware, a state court ruled in *Catlin Specialty Ins. Co. v. CBL & Assocs. Props.*, 2018 Del. Super. LEXIS 342 (Del. Super. Ct. Aug. 9, 2018) that its conclusion that an insurer could not recoup already-paid defense costs from its policyholder was consistent with Section 17's treatment of the issue.

On the other hand, this Restatement faces political opposition in several states that may limit the ability of courts to follow it. Prior to the 2018 Annual Meeting, the ALI received letters from several state insurance commissioners; the National Conference of Insurance Legislators and a joint letter from Governors of Iowa, Maine, Nebraska, South Carolina, Texas and Utah, all expressing this Restatement ignores common law rules, will destabilize insurance markets and may necessitate legislative action.

In apparent response to the perceived shortcomings of Section 3, Tennessee adopted HB 1977/SB 1862 in early 2018, requiring that "[a] policy of insurance must be interpreted fairly and reasonably, giving the language of the policy of insurance its ordinary meaning."

A few weeks after the ALI's vote to approve the RLLI, Ohio Governor John Kasich signed a public works funding bill in July (SB 239) that contained an amendment that seemed to have little to do with infrastructure funding:

> Sec. 3901.82. The Restatement of the Law, Liability Insurance that was approved at the 2018 annual meeting of the American law institute does not constitute the public policy of this state and is not an appropriate subject of notice.

In short, while the debate over this Restatement is now concluded within the American Law Institute, the debate over its long-term future and implications for the future shape of American insurance law may have only just begun.

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WRITTEN MATERIALS FOR PANEL PRESENTATION

"Keene →Carter-Wallace →Boston Gas → Owens-Illinois →Viking Pump →KeySpan: The Name of the Winner of the Allocation Wars Is ~~Policyholder/Insurer~~?"

ATTACHMENT A

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Why Pro Rata Allocation Is The Majority Rule

Law360, New York (October 16, 2014, 9:38 AM ET) --


Scott M. Seaman

Many jurisdictions with a substantial volume of insurance coverage litigation have already decided the fundamental allocation issue of whether losses are allocated under the all sums approach generally advocated by policyholders or pursuant to one of the pro rata allocation methods (e.g., time on the risk or time and limits)[1] often advocated by insurers. It is the numerous — and often significant — nuances associated with allocation that dominate many of today's coverage disputes.[2]

However, some jurisdictions have not addressed the issue of which allocation method applies to defense costs and/or indemnity payments and others are subject to conflicting decisions. Even in those jurisdictions with established case law, it is often worthwhile to consider the allocation methodology applied by the courts as well as their rationale for selecting the method in distinguishing the facts or policy language in your case, formulating arguments concerning the more subtle allocation issues and evaluating the coverage claims.

In their recent Law 360 column, "How To Argue An All Sums Approach To Long-Tail Claims" David Elkind and Daniel Streim capably outline the policyholders' strongest case for an all sums allocation, also known as the joint and several liability, pick and choose or vertical spike approach. As they point out, the high courts of several states have adopted the all sums approach.

Nonetheless, pro rata allocation has emerged as the allocation method of choice in the majority of jurisdictions that have addressed the issue. Most courts have recognized that insurance contract language, rules of contract interpretation, principles of consistency, equity and fair apportionment, and notions of efficiency and judicial economy all strongly favor a pro rata allocation.

See generally S.M. Seaman & J.R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (2d Thomson Reuters 2013) at Chapter 4 and Appendix "A" (50 State Survey of Allocation Decisions). We highlight below some of the arguments against an "all sums" allocation.

Policy Language Supports a Pro Rata Allocation, Not All Sums

Occurrence-based liability policies cover only damages or injuries that take place during the policy

period. Although pre-1986 commercial general liability policies often contain the all sums language Elkind and Streim reference, the policies expressly qualify the all sums phrase to "damages to which this policy applies." Further, the policies provide coverage only for the damages that take place "during the policy period." Most courts adopting a pro rata allocation approach recognize that coverage is provided only for damage or injury taking place during the policy period.

Indeed, the all sums or joint and several liability theory is based upon an erroneous and selective reading of the all sums language to the exclusion of other relevant contract language. Such an interpretation violates the fundamental and nearly universal rule of construction that insurance contracts must be read as a whole. Accordingly, an all sums allocation is not supported by the policy language even with respect to policies containing all sums language.

To be sure, most liability insurance contracts do not specify a particular mathematical formula for allocating damages. One could readily understand why it would be neither appropriate nor prudent to mandate a particular formula without consideration of the type of loss and claim type (keeping in mind that most claims are not "long-tail" claims), the claim-specific facts and the controlling law. Instead, the policies provide the standard — injury or damage during the policy period — and properly leave it to the claims adjustment process in the first instance and to the courts, if coverage litigation ensues, to determine the quantum of injury or damage taking place during the policy period.

Further, many policies do not even contain all sums language. Historically and currently, many excess contracts are written on an ultimate net loss or loss basis, and do not contain all sums language. Moreover, for the past 28 years, all sums language does not appear in primary general liability policies. The Insurance Services Officereplaced the all sums language with "those sums" language in the 1986 commercial general liability form, completely undercutting any language-based argument supporting an all sums allocation. Insurers with policies that do not contain all sums language generally should point out the absence of such language in opposing attempts by policyholders to saddle them with joint and several liability.

The all sums language serves as the sole or primary basis for the minority of courts rendering all sums rulings. Even where a state has existing law adopting an all sums allocation, insurers may be well-served by emphasizing the lack of such language in their policies. For example, in Thomas Inc. v. Ins. Co. of North America, 11 N.E.3d 982 (Ind. Ct. App. 2014), the policyholder instituted a declaratory judgment action against its primary and excess insurers seeking defense and indemnity for class actions filed against it by persons allegedly sustaining injury from exposure to organic solvents at the policyholder's premises. The court held that a pro rata allocation, rather than an all sums allocation, was applicable for apportioning liability, notwithstanding the Indiana Supreme Court's all sums ruling in Allstate Ins. Co. v. Dana, 759 N.E.2d 1049 (Ind. 2001).

The appellate court reasoned that the policies at issue had markedly distinct language from that at issue in Dana. Specifically, the subject policy language was those sums as opposed to all sums and expressly limited coverage for damages during the policy period. The court did not adopt a specific means for apportioning liability on a pro rata basis. Rather, it concluded that "the trial court will be best situated to select (and customize, if necessary) the fairest method of apportioning liability" in view of the factual complexities of the case. A petition to transfer to the Indiana Supreme Court is pending, but the case does illustrate the importance of policy language. See also Irving Materials Inc. v. Zurich Am. Ins. Co., 2007 WL 1035098 (S.D.Ind. 2007), reconsideration denied, 2008 WL 687126 (S.D. Ind. 2008).

All Sums Allocation is Inconsistent with Multiple Policy Trigger Theories

Policyholders often advocate, and many courts apply, the injury-in-fact or the continuous injury triggers in the context of long-tail claims.[3] It is axiomatic that policyholders are required to prove that a policy is triggered and, to do so, they must demonstrate when the subject property damage or bodily injury took place. The injury-in-fact and continuous trigger theories as applied by many courts to long-tail claims often benefit policyholders.

First, such trigger theories may enable policyholders to meet their burden of proof in many instances in which they otherwise would be utterly unable to do so.[4] Simply stated, if policyholders were required to prove precisely what injury or damage took place during particular periods, often they would be unable to trigger policies and be unable to obtain coverage. Second, such trigger theories often enable policyholders to trigger multiple policies. Thus, policyholders receive a considerable benefit from these trigger theories as applied by many courts.

Many policyholders, in their quest to have their cake and eat it too, claim that the "during the policy language" limitation addresses the issue of trigger, but not the allocation issue. They argue it is the all sums language that addresses the issue of allocation. The policy language, however, does not support such compartmentalization. In reality, both trigger and allocation are addressed by the policy requirement of bodily injury or property damage during the policy period. Trigger concerns the issue of whether there was any bodily injury or property damage during the respective policy periods and allocation focuses on how much injury or damage took place in the respective periods.

Accordingly, many courts recognize the need to address these issues in tandem. See, e.g., Owens-Illinois Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994) ("courts must adapt common-law doctrines 'to the peculiar characteristics of toxic-tort litigation.' Ibid. We advert to those principles because we believe that common-law resolution of the trigger-of-coverage issue requires that we consider, at the same time, the issue of scope of coverage if a policy is triggered."); Northern States Power Co. v. Fidelity and Casualty Co. of New York, 523 N.W.2d 657 (Minn. 1994) ("[T]he choice of trigger theory is related to the method a court will choose to allocate damages between insurers").

As the New Jersey Supreme Court recognized in Owens-Illinois Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994), the all sums allocation method is inconsistent with the continuous trigger often advocated by policyholders. It is also incompatible with an injury-in-fact trigger. See, e.g., EnergyNorth Natural Gas Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517 (N.H. 2007); Uniroyal Inc. v. Home Ins. Co., 707 F. Supp. 1368 (E.D. N.Y. 1988). It is disingenuous to argue for an expansive reading of "during the policy period" for purposes of triggering coverage and then to turn around and ask the court to artificially truncate or collapse all of those same damages.

All Sums Allocation is Unfair and Constitutes Bad Public Policy

The majority of courts to consider the issue recognize that an all sums allocation is not a fair way to apportion losses. For example, it may result in an insurer being liable for the entire loss even when it was on the risk for one day. See, e.g., Public Service Co. of Colorado v. Wallis & Cos., 986 P.2d 924 (Colo. 1999) ("We do not believe that those policy provisions can reasonably be read to mean that one single-year policy out of dozens of triggered policies must indemnify the insured's liability for the total amount of pollution caused by events over a period of decades, including events that happened both before and after the policy period.").

In contrast, it is hardly unfair for the policyholder to bear the consequences of its decisions concerning the purchase of insurance and the managing of its liabilities (e.g., decisions relating to self-insurance, the amount of limits purchased, the years it did and did not purchase insurance, its purchase of insurance from insurers that become insolvent or prior exhaustion based on other claims against the policyholder). See, e.g., EnergyNorth Natural Gas Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517, 522 (N.H. 2007) (finding that joint and several liability method was inferior to pro rata allocation because it "permitted a policyholder who chooses not to be insured for part of the long-tail injury period to recover as if the policyholder has been fully covered for that period.").

In fact, allocating damages to policyholders reflecting these factors as part and parcel of a pro rata allocation promotes public policy by providing incentives for them to acquire insurance to cover their risks, engage in responsible conduct, price their products in accordance with the attendant risks, and cease production of products or activities that have or may give rise to claims.

The imposition of joint and several liability produces inequitable results. With respect to a claim where the extent of damage can be readily determined in any particular period, the damages would be allocated accordingly. Policyholders should not be able to transform their failure or inability to prove the extent of injury or damages in various periods into a windfall in the form of joint and several liability. Instead, equity requires that a pro rata allocation be applied as a proxy — rather than the imposition of joint and several liability — under such circumstances. Similarly, it is entirely proper to expect a policyholder to shoulder the burden of losses or portions of losses where it failed to comply with a contract condition (e.g., late notice) or where an exclusion applies to bar or limit coverage. See Public Service Co. of Colorado v. Wallis & Cos., 986 P.2d 924, 940 (Colo. 1999) ("At the time [the policyholder] purchased each individual insurance policy, we doubt that [it] could have had a reasonable expectation that each single policy would indemnify [it] for liability related to property damage occurring due to events taking place years before and years after the term of each policy.")

All Sums Allocation is Inefficient and Wastes Judicial Resources

The lesson most parents teach their children about doing something right the first time applies with full force to the issue of allocation. In most states applying an all sums allocation, insurers saddled with a disproportionate share of the loss may seek contribution from other insurers to reallocate the loss. Thus, an all sums allocation is likely to spawn additional claims and more litigation.

A pro rata approach, in contrast, eliminates the need for reallocation among insurers through cross-claims in the coverage action or in separate litigation. Indeed, one court has labeled the all sums approach as "improvident" since it "does not solve the allocation problem; it merely postpones it." EnergyNorth Natural Gas Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517 (N.H. 2007) (citation omitted). See also Boston Gas Co. v. Century Indem. Co., 454 Mass. 337, 364-65, 910 N.E.2d 290, 311 (Mass. 2009).

All Sums Allocation Often Does Not Yield Results Sought by Policyholders

Although an all sums allocation may unjustly enrich policyholders and unfairly impoverish insurers, an all sums allocation standing alone often does not provide the policyholder with the results it desires. In many instances, allowing the policyholder to "pick and choose" a year of coverage does afford the policyholder flexibility in avoiding insolvencies, retentions or policy exclusions. However, depending on the coverage program and magnitude of the loss, an all sums allocation may not provide the policyholder with a full recovery and may even limit a policyholder to recovering the limits available in a

single policy year. In such instances the policyholder must convince the court to compound an improvident all sums ruling with a ruling permitting the policyholder to "stack" limits. Some all sums decisions permit stacking, others prohibit it, and many do not address the issue. However, even allowing stacking may not appease the policyholder. Sometimes policyholders seek to "hopscotch" around the coverage chart in pursuit of recovery. Such an approach amounts to an unabashed effort to reach a result at the expense of contract language, insurance law principles and fundamental notions of fairness and consistency.

Notwithstanding the general ability to assert contribution claims, an insurer may be disadvantaged by an all sums ruling because it may not be able to reallocate the entire loss for which it was over-assessed where, for example, insurer insolvencies are involved. Additionally, there are transaction costs associated with pursuing a claim for contribution and an insurer's portfolio interests may cause it to be disinclined to take some positions or to pursue some recoveries. Nonetheless, the reality of reallocation properly makes insurers resistant to settling with policyholders based on the assumption that the insurer is liable for the entire loss and insurers generally refuse to pay disproportionate amounts. Many times, the threat of an all sums allocation hinders, rather than facilitates, the settlement of complex coverage actions.

A common threat hurled by policyholders in settlement negotiations and mediations with insurers is that the policyholder intends to "select" the year or years of coverage in which the insurer's contracts were issued. Policyholders often make the same threat to every insurer. The threat is without muster, of course, where the applicable law requires pro rata allocation.

Where an all sums allocation is a possibility, in addition to pointing out the potential reallocation of the loss, the threatened insurer may point out the reasons why the policyholder would not select its contract period to "spike," and it may point out that the policyholder is making the same indiscriminate threat to its other insurers. In appropriate cases where an all sums allocation is threatened, the insurer may attempt to have the court require the policyholder to "pick and choose" the year of coverage from which it seeks recovery at the earliest possible stage. If successful, the policyholder may lose considerable bargaining power and some of the insurer-hostages may be released from the litigation.

For these and other reasons, a pro rata allocation represents the superior approach for allocating losses.

—By Scott M. Seaman, Meckler Bulger Tilson Marick & Pearson LLP

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The opinions expressed are those of the author(s) and do not necessarily reflect the views of the firm, its clients, or Portfolio Media Inc., or any of its or their respective affiliates. This article is for general information purposes and is not intended to be and should not be taken as legal advice.

[1] There are a variety of pro rata allocation methods applied by courts, but the most common are prorating based upon time-on-the-risk or by considering time-on-the-risk and limits. In some jurisdictions, trial courts are afforded discretion to come up with an equitable allocation under the particular facts of the case. These allocation methods serve as proxies in continuous or progressive injury or damage cases due to the inability or impracticality of determining the degree of injury or the amount of damage taking place during each policy period. Some courts have recognized that a fact-based allocation — one that allocates damages based upon the actual damage or injury taking place

during each period — should be employed where such a determination is capable of being made. Properly viewed, having the policyholder bear responsibility for periods of no insurance, underinsurance or where insurance is "unavailable" for any reason is a cornerstone of any pro rata allocation. See S.M. Seaman & J.R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (2d Thomson Reuters 2013) at Chapter 4.

[2] Most of the allocation-related activity now is focused on the various elements comprising the "allocation mix," including treatment and impact of: number of occurrences; "unavailability" of coverage; multiyear and stub policies; coordination of lines of coverage; insurer settlements and credits; policyholder bankruptcies; ascertaining applicable policy limits; exhaustion-related issues (including functional exhaustion); characterization of costs and payment of defense costs; retentions and deductibles; targeted tender; reallocation; and other policy provisions. For comprehensive treatment of these and other issues, see S.M. Seaman & J.R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (2d Thomson Reuters 2013).

[3] The application of three of the four principle "trigger of coverage" theories employed by courts (exposure, continuous and injury-in-fact) often result in potential impact to multiple policy periods. In contrast, most manifestation trigger rulings implicate a single policy period. See S.M. Seaman & J.R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (2d Thomson Reuters 2013) at Chapter 2 and Appendix "C" (50 State Survey of Trigger of Coverage Decisions).

[4] There is variance among courts applying an injury-in-fact trigger as to the quantum of proof required for the policyholder to trigger a policy, but under some decisions it is not automatic that a policyholder will satisfy the burden of proof. See, e.g., D.R. Sherry Const., Ltd. v. American Family Mut. Ins. Co., 316 S.W.3d 899 (Mo. 2010); Continental Cas. Co. v. Employers Ins. Co. of Wausau, 871 N.Y.S.2d 48 (N.Y. App. Div. 2008).

ATTACHMENT B

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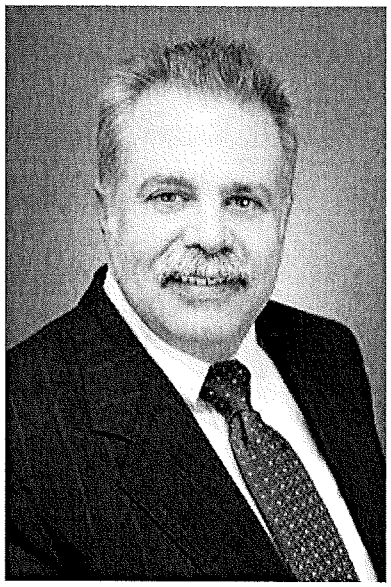
The Tiring Terrain Of Insurance Contract Exhaustion

Law360, New York (June 12, 2015, 11:25 AM ET) --



Scott M. Seaman

Exhaustion is a fundamental requirement that generally is discussed in connection with excess insurance. However, exhaustion is important to primary insurers in determining when they have satisfied their obligations, to policyholders seeking to extract the maximum value from their primary insurance assets and to policyholders and excess insurers alike in determining when excess insurance coverage begins and ends.

Horizontal Versus Vertical Exhaustion

The method of exhaustion is the threshold exhaustion issue presented. More specifically, the issue is whether only exhaustion of the limits of insurance contracts and retentions directly underlying the subject excess insurance contract must be exhausted (vertical exhaustion) or whether all underlying limits and retentions for all periods implicated by a loss must be exhausted (horizontal exhaustion) before an excess insurance contract is obligated to respond. By way of illustration, assume an excess policy it sitting above $1 million in underlying limits for its sole year of coverage in an insurance program that affords $20 million in underlying limits for all years implicated by the loss. The subject excess policy could be impacted by a loss of over $1 million if vertical exhaustion is permitted, while a loss of more than $20 million would be required to impact the subject excess policy if horizontal exhaustion is required.

From the perspective of the excess insurance contract, the issue often turns on whether phrases such as "underlying insurance" refers only to the schedule of underlying insurance listed in the excess contract or to all underlying layers of coverage and retentions in years implicated by the loss. Many times, however, the issue is resolved at least to some extent by the jurisdiction's rules regarding allocation methodology. See generally S. Seaman, J. Schulze Allocation of Losses in Complex Insurance Coverage Claims 3d (Thomson Reuters2014) at Chapter 4 and Appendix A.

Horizontal exhaustion is the rule in jurisdictions applying a pro rata allocation. In fact, horizontal exhaustion and pro rata allocation go together like bread and butter, though there may be differences among jurisdictions concerning whether the horizontal exhaustion is accomplished by layer or by means of a rising bathtub approach.

Even in jurisdictions with some law supporting an "all sums" allocation — which also is commonly referred to as a "pick and choose" or "vertical spike" approach — some courts recognize that the fundamental distinctions between primary and excess insurance require horizontal exhaustion. See, e.g., Kajima Const. Services Inc. v. St. Paul Fire and Marine Ins. Co., 879 N.E.2d 305 (Ill. 2007); John Crane Inc. v. Admiral Ins. Co., 991 N.E.2d 474 (Ill. App. 2013), appeal denied, 996 N.E.2d 11 (Ill. 2013) and appeal denied, 996 N.E.2d 14 (Ill. 2013) (requiring policyholder to prove exhaustion of all primary policies prior to any excess or umbrella insurer being required to contribute to any settlement or judgment notwithstanding "all sums" allocation ruling and holding that policyholder must prove that the primary polices were exhausted as those limits were written); Kaiser Cement And Gypsum Corp. v. Insurance Company of the State of Pennsylvania, 155 Cal. Rptr. 3d 283 (Cal. App. 2d Dist. 2013).

Actual Verses Functional Exhaustion

Another major issue presented is how exhaustion may be accomplished. There is general agreement that the attachment point of the excess contract must be reached before an excess contract is required to respond. There often are disputes, however, as to whether the underlying exhaustion required to access an excess contract can be satisfied solely by payment of claims by the underlying insurer or insurers or whether some type of "functional" exhaustion will be permitted. In fact, this has been one of the hottest excess insurance issues in recent years.

Assume for the examples to follow that the policyholder has a primary liability insurance policy with $1 million in per occurrence limits and an excess policy sitting above the primary with $3 million in per occurrence limits in the single year of coverage implicated by a loss.

Sometimes the alleged functional exhaustion may take the form of the policyholder specifically paying the sum representing the gap between the amounts paid on a claim by the underlying insurer. In this example, if the claim is settled for $1.2 million, with the primary insurer paying only $800,000 of its $1 million in applicable limits, the policyholder may ultimately seek to pay $200,000 representing the difference between the amount paid by the primary insurer and the primary insurance limits. The policyholder then may seek to pursue the excess insurer for the remaining $200,000 claiming that, by paying the difference, the primary policy limits were functionally exhausted. Other times, the policyholder alleges functional exhaustion by virtue of the total amount of the loss exceeding the underlying limits. In our example, the policyholder might argue that the $1.2 million settlement exceeds the primary limits by $200,000 and seek that amount from the excess insurers.

Functional exhaustion disputes exist with respect to both traditional and long-tail claims. Fundamentally, like many coverage issues, exhaustion requirements are a matter of interpretation and application of the contract requirements. Review of the entire contract language is required as multiple provisions may address the issue and, of course, there are differences in the language employed from excess contract to excess contract. Many of the functional exhaustion decisions purport to turn on whether or not the court determines the language of the contract to be clear with respect to exhaustion requirements. Yet, the conflicting decisions cannot always be reconciled by differences in contract language.

Cases allowing "functional" exhaustion generally rely upon Zeig v. Massachusetts Bonding & Insurance Co., 23 F.2d 665 (2d Cir. 1928). This old decision involved a burglary loss under a first-party insurance contact, was predicated upon the court's determination that the policy was ambiguous and expressly recognized that a different result would attain where warranted by the contract language.

Several recent decisions have not permitted "functional" exhaustion, holding that exhaustion of the underlying limit must be accomplished by the actual payment of the amount of limits by the underlying insurer. See, e.g., Comerica Inc. v. Zurich American Ins. Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007) (rejecting functional exhaustion by policyholder's payment of the difference between the amount paid by primary insurer and policy limit and holding actual payment of losses by the underlying insurer is required); Qualcom Inc. v. Certain Underwriters at Lloyd's, London, 73 Cal. Rptr. 3d 770 (Cal. App. 2008) (finding language of excess contract, when read in context of function of excess contract, requires actual payment by underlying insurer of no less than the underlying limits).

Recently, the United States Court of Appeals for the Second Circuit held that the policyholder must establish actual exhaustion by payment of claims. Ali v. Federal Ins. Co., 719 F.3d 83, 94 (2d Cir. 2013). The contract language of one of the excess insurers policies provided that excess liability coverage "shall attach only after all ... 'underlying insurance' has been exhausted by payment of claim(s)" and "exhaustion" of the underlying insurance occurs "solely as a result of payment of losses thereunder." The other excess insurer's policy stated the excess coverage "shall attach only after all such underlying insurance has been exhausted," and that exhaustion occurs "solely as a result of payment of losses thereunder." The Second Circuit agreed with the district court that the express language "establishes a clear condition precedent to the attachment of the excess policies" by expressly stating the coverage does not attach until payment of the underlying losses.

The Second Circuit noted that the district court did not hold that the underlying insurers must make payments before the obligations under the excess policies are reached, as the court did not specify which party was obligated to make the requisite payments. The district court noted that the maintenance clause did not relieve the insurers from coverage even if underlying coverage was not maintained, but rather the insurer shall not be liable to a greater extent than if the condition had been complied with. The policyholders simply sought a declaration that the excess policies' coverages are triggered once the respective attachment points are reached. The Second Circuit distinguished its earlier Zeig decision, noting there is nothing errant about interpreting an exhaustion clause in an excess liability policy differently than a similar clause in a first-party property policy, that the "freestanding federal common law" Zeig interpreted and applied no longer exists and that excess insurers have good reason to require actual payment up to the attachment points of the relevant policies, thus deterring the possibility of settlement manipulation. For a more detailed discussion and listing of cases, see S. Seaman, J. Schulze Allocation of Losses in Complex Insurance Coverage Claims 3d (Thomson Reuters 2014) at Chapter 10.

Where functional exhaustion is not permitted a policyholder that settles with an underlying insurer for less than limits may find itself without any coverage from higher level excess contracts. Accordingly, apart from arguing ambiguity, policyholders often argue that, where the policyholder pays the difference between the amount actually paid by the underlying insurer and the attachment point of the excess policy, the excess insurer is no worse off by reason of functional exhaustion by settlement and it would be unjust to limit the policyholder's ability to settle.

Contrary to policyholder contentions, requiring actual exhaustion is not a trap or "got you" argument. Rather, it reflects the realities of excess insurance. Excess insurers receive only a small premium relative to the large limits of liability provided, making excess insurance available at a reasonable cost. The excess insurer does not solely rely upon claims being settled for an amount in excess of the attachment point of the policy, it relies upon the claims implicating the excess contract after being subjected to the claims adjustment process of the underlying insurers such that the underlying insurers have reviewed and analyzed the claim, determined that there is coverage and determined that the settlement is reasonable such that the underlying insurers agree to pay the settlement amount.

The Tiring Examination Of Exhaustion

Having a good grasp of the exhaustion terrain — whether it is vertical or horizontal under the controlling law and whether or not functional exhaustion is permitted — is required. However, much of the exhaustion battle is fought in the weeds. Examination of proper exhaustion may involve multiple considerations depending upon the facts of the claim and coverage issues presented. We will highlight a couple of common issues for illustrative purposes.

Application Of Payments Against Proper Limits

A determination of proper exhaustion requires an understanding and application of the various limits of liability. Insurance contracts may contain a host of applicable limits of liability: per occurrence; per claimant; per accident; per claim; and aggregate limits. The limits may apply separately to property damage, bodily injury or personal injury. Alternatively, contracts may contain "combined single limits," such that payments made on bodily injury and property damage combine to reduce the limits of liability. Some contracts contain aggregate limits, while others do not. Aggregate limits may apply to all losses under the contract or only to some types of losses such as operations, premises or products/completed operations claims. Aggregates may apply on a policy basis or an annual basis.

Accordingly, one consideration relevant to analyzing exhaustion is determining whether the claims and payment are, and historically have been, applied properly against the limits. For instance, where the insurance contract only contains product aggregates, payments made on ongoing operation claims should not be applied against the aggregate. Similarly, payments made on workers' compensation claims should not be charged against general liability contract limits. Many times the determination is straightforward, but that is not always the case. In recent years, the issue of characterizing asbestos-related bodily injury claims against asbestos defendants who installed (as well as manufactured or distributed) asbestos containing products as products/completed operations claims or nonproduct (ongoing operations) claims has been vigorously litigated in several cases.

Proper Cost Characterization

Sometimes cost items must be reviewed to determine whether the dollars involved are defense costs or indemnity dollars. Under most commercial general liability policies defense costs are payable on a supplementary basis (i.e., they do not erode or impair the limits of liability). Thus, treating defense costs as indemnity costs may result in premature exhaustion of the primary policies and adversely impact the timing of impact or ultimately the extent of impact to excess policies. Many excess contracts do not provide coverage for defense costs, in which case defense costs should not be used to impair the excess contract limits. When defense costs are covered under excess policies, under some policies defense costs are payable within limits (i.e., erode limits) and under others policies they are payable in addition to limits. Usually, it is easy to identify whether costs are defense costs (e.g., counsel fees) or indemnity (e.g., settlement payments or payments made to satisfy a judgment against the policyholder). Other times, such as in the case of evaluating environmental remedial investigative and feasibility study costs, the answer requires reference to the law in the controlling jurisdiction as well as analysis of the costs themselves to determine whether they are defense costs or indemnity. In some instances, the application and impact of deductibles and self-Insured retentions also must be considered.

The review of specific items may establish that some components of an otherwise covered claim are improperly included. Many corporate policyholders are aggressive in the costs for which they seek

recovery from their insurers and may include items that are not covered or rely upon highly inflated future cost estimates to maximize their recovery. Costs of doing business, maintenance, regulatory compliance, economic loss, civil fines and facility improvements, for example, may not be covered damages under third party liability contracts.

Cutting The Weeds

Although the exhaustion examination may require a lot of work on the part of insurers, it is important to remember that policyholders generally bear the burden of establishing proper exhaustion. Sophisticated policyholders recognize that, to reach higher layers of coverage, exhaustion must be established. They also recognize that lack of cooperation in providing proof of exhaustion jeopardizes their insurance recovery and sends the message to their insurers that they have concerns as to whether there has been proper exhaustion.

Where issues of proper impairment or exhaustion are presented, insurers often require an audit or file review to determine the proper status of underlying impairment or exhaustion. Often an examination of the specific costs allegedly exhausting or impairing underlying coverage is undertaken to determine whether payments have been properly applied to the applicable limits. Invoices, canceled checks and documents showing the application of payments may be among the items reviewed. Sometimes review of loss runs or other documents of the primary or underlying insurers is part of the process either to confirm or supplement the information provided by the policyholder or because the policyholder lacks some of the information.

Practical considerations confronting the insurer, such as the costs of reviewing documents and the extent to which policyholders and courts will permit review and challenges to exhaustion — also come into play. Numerous courts have allowed excess insurers to challenge payments and settlements of claims in which the excess insurers did not participate. See, e.g., Colony Nat. Ins. Co. v. Sorenson Medical Inc., (E.D. Ky. Dec. 21, 2011) (applying Utah law); Goodyear Tire & Rubber Co. v. National Union Fire Ins. Co., 694 F.3d 781 (6th Cir. 2012) (applying Ohio law); American Ins. Co. v. St. Jude Medical Inc., (D. Minn. Sept. 20, 2010) (applying Minnesota law); Royal Indemnity Co. v. C.H. Robinson Worldwide Inc., (Minn. Ct. App. 2009) (unpublished opinion); D.R. Horton Inc. v. American Guar. & Liab. Ins. Co., 864 F.Supp.2d 541, 548 (N.D. Tex. 2012) (applying Texas law), appeal dismissed, (5th Cir. 2012). New Jersey courts have been somewhat less accepting of efforts to challenge prior payments in the long tail claims context based upon Owens-Illinois Inc. v. United Ins. Co., 138 N.J. 437, 650 A.2d 974 (N.J. 1994) and its progeny.

Though court intervention is sometimes required, in most instances, insurers and policyholders are able to work through issues of exhaustion. Sophisticated policyholders and proactive insurers understand the advantages of periodic monitoring of impairment.

—By Scott M. Seaman, Hinshaw & Culbertson LLP

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[1] In the above examples, the policyholder has been advocating for "functional exhaustion" often after having resolved any disputes with the primary or underlying insurers. However, another situation is presented where the primary insurer attempts to "tender limits" in an effort to terminate its defense obligation. These efforts generally are resisted by policyholders and, in the absent of express policy language permitting the primary insurer to do so, courts generally hold that such "cutting and running" is not permitted.

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Door Closing On 'Unavailability' Insurance Exception: Part 1

By **Scott M. Seaman, Hinshaw & Culbertson LLP**

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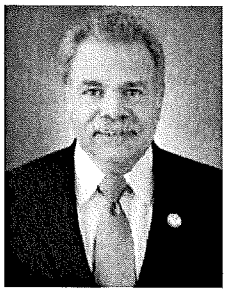

Scott M. Seaman

Although several states employ an "all sums" allocation, the trend of decisions and the distinct majority rule is that long tail losses are allocated on a pro rata basis. There are a variety of ways in which losses may be prorated, but the time-on-the-risk and time-and-limits methodologies are the most commonly followed at least where an allocation cannot be made based upon evidence showing the amount of injury or damage taking place during the respective time periods. As we pointed out in our prior expert analysis, a pro rata allocation offers several advantages over the "all sums" fiction. See "Why Pro Rata Allocation Is The Majority Rule." Law360 (October 16, 2014).

One important feature of a pro rata allocation is that policyholders are required to participate in the allocation by accepting the consequences associated with periods of self-insurance. Specifically, courts require policyholders to bear the financial responsibility for those periods of no insurance, self-insurance, insufficient insurance, insurance issued by insolvent insurers or insurance that does not respond because of noncompliance with policy conditions or application of policy exclusions. Overwhelmingly, courts applying a pro rata allocation have recognized that the responsibility for uninsured periods rests squarely on policyholders regardless of whether or not insurance for the particular risk was available for purchase in the market at the time.

A distinct minority of courts in pro rata jurisdictions recognize a limited exception in the context of asbestos and environmental claims and absolve policyholders from participating in the allocation in later years where insurance coverage was unavailable for such risks in the market. This limited exception for periods in which insurance is "unavailable" has its genesis in a sentence from the New Jersey Supreme Court's landmark decision in Owens-Illinois.[1]

Over the past 20 years, policyholders across the country have sought fervently to use an "unavailability of insurance" exception to undo the logical consequences of a pro rata allocation for the purpose of limiting policyholders' participation in the allocation. Notwithstanding their extensive efforts, the "unavailability of insurance" exception has not garnered much support from courts in pro rata

jurisdictions. Nor have courts expanded the scope of this very limited exception to the general rule requiring policyholders to bear responsibility for periods of self-insurance whatever its cause.

Many believe that the application of an "unavailability of insurance" exception has proven to be improvident. Recent activity suggests that the "unavailability of insurance" exception may be losing support even in the couple of jurisdictions with decisions that have recognized the exception. First, in New York, the recent Keyspan case[2] — which marks the first time a New York state appellate court has addressed the issue — held there is no "unavailability of insurance" exception under New York law to allow the policyholder to avoid responsibility for uninsured periods. Second, a recent Sixth Circuit decision[3] demonstrates the limited utility of the exception to policyholders. Finally, on Dec. 12, 2016, the New Jersey Supreme Court granted review in Continental v. Honeywell[4]. Although there is little reason to suspect the court will abandon the "unavailability of insurance" exception altogether, the case affords the court an opportunity to clarify the circumstances under which a policyholder may avoid the consequences of its risk retention and transfer decisions even where insurance may be unavailable in the market. At this point, it is fair to ask whether the door is closing on the "unavailability of insurance" exception.

In Part I of this article we discuss the general rule in pro rata jurisdictions that the unavailability of insurance coverage in the market does not absolve policyholders of responsibility for self-insuring and explore the genesis of the limited "unavailability of insurance" exception. Part II will address the limited nature of the "unavailability of insurance" exception and consider the prospect of the exception being even further limited.

The General Rule: The Unavailability Of Insurance Does Not Absolve Policyholders Of Responsibility For Self-Insuring

The vast majority of decisions applying a pro rata allocation methodology require policyholders to contribute for "bare" periods regardless of whether applicable insurance was "available" or "unavailable." Stated differently, most pro rata decisions simply do not consider whether or not insurance coverage was available to cover particular risks after any point in time — where there is no insurance for any reason the policyholder bears the financial responsibility. S. M. Seaman & J. R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (5th Ed. Thomson Reuters 2016) at Chapter 4 (collecting and discussing cases). [5]

When urged by policyholders to carve out an "unavailability of insurance" exception to limit the period in time in which losses are allocated to policyholders, courts applying a pro rata allocation generally have declined to do so. A couple of decisions illustrate the point.

The first decision is Sybron Transition Corp. v. Security Insurance of Hartford, 258 F.3d 595 (7th Cir. 2001), which involved a single asbestos bodily injury claim for which one of Sybron's insurers, Security Insurance Company, paid $1.3 million to resolve. Applying New York law, the Seventh Circuit held that the claim implicated periods of coverage from 1969 through 1988. Security issued coverage to Sybron for the period of 1969 through 1971. Because Sybron self-insured after 1971, the issue presented in the

case was how much of the $1.3 million settlement could be spread on a pro rata basis to the policyholder for years after 1971 and, in particular, the period of 1986 to 1988 when Sybron argued that insurance for asbestos-related risks was "unavailable."

In refusing to interpose an "unavailability of insurance" exception, the Seventh Circuit noted "we do not know what it means (or could mean) to say that coverage for a particular risk is "unavailable." Unavailable at what price?" 258 F.3d at 599 (emphasis in original). After analyzing the various options available to Sybron to acquire some form of insurance coverage for its asbestos-related liabilities, the Seventh Circuit concluded that the "availability" analysis is inherently flawed and unworkable. The court found that, instead of using such terms, "it is better to say that Sybron did not in the late 1980s have an economically attractive opportunity to participate in a pool in which the risks of asbestos-related casualties were spread among similar firms." Id.

In concluding that Sybron should contribute for periods through 1988, the court stated:

> To require Security to pay extra because Sybron did not find it cost-effective to purchase coverage during 1986 to 1988 would be the economic equivalent of requiring Security to furnish free coverage during 1986-88 (for Sybron does not propose to pay for the going premium retroactively). Why an underwriter who furnishes low-price coverage during a period before the magnitude of the risk became apparent should be required to furnish, for nothing, an additional period of high-price coverage escapes us. After all, it was Sybron, not Security, that created the risk of loss. And the consequences of that risk should fall on its creator, not on an underwriter unlucky enough to insure an early slice of the risk.

258 F.3d at 600.

The second illustrative case is Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290 (Mass. 2009). In this case, the Massachusetts Supreme Judicial Court declined to adopt the "unavailability" exception because to do so would contravene the limitations in the subject policies to liability attributable to property damage during the policy periods. The Massachusetts high court reasoned:

> [T]he unavailability exception 'effectively provides insurance where insurers made the calculated decision not to assume risk and not to accept premiums. In effect, because the policyholder could not buy insurance, it is treated as though it did by passing those uninsurable losses to insured periods.' This would not be equitable to insurers if the insured purchased coverage for only a few years where there was protracted damage.

910 N.E.2d at 315. [6]

The Genesis Of The "Unavailability" Exception

Policyholders seeking refuge in the "unavailability" exception invariably point to the New Jersey Supreme Court decision in Owens-Illinois Inc. v. United Insurance Co., 650 A.2d. 974 (N.J. 1994). In Owens-Illinois, the court rejected the "all sums" or "joint and several" approach and adopted pro rata allocation. The New Jersey Supreme Court expressly recognized "when periods of no insurance reflect a

decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable." Id. at 995. It is the "when coverage for a risk is not available" language that policyholders cease upon.

The New Jersey Supreme Court, unlike most courts determining that a pro rata allocation represents the proper allocation method, did not base its decision in whole or in part upon policy language. Indeed, the court flatly stated it "was unable to find the answer to allocation in the language of the policies." Instead, it relied upon "public interest factors" to guide its determination that a pro rata allocation is required.

The New Jersey Supreme Court explained that the theory of insurance is one of "transferring risks" and any allocation rule must take this into account:

> Our job, however is not just to solve today's problems, but to create incentives that will tend to minimize their recurrence. "[T]o send the correct signals to the economic system, a judge must appreciate the consequences of legal decisions on future behavior"... Future actors would know that if they do not transfer to insurance companies the risk of their activities that cause continuous and progressive injury, they may bear that untransferred risk.

Id. at 992.

The court also noted:

> [M]anufacturers and distributors of defective products can best allocate the costs or injuries resulting from those products. The premise is that the price of the product should reflect all its costs, including the cost of injuries caused by the product. Those manufacturers and distributors can incorporate the cost in the price of the product. The cost of the product will thus be borne by all those who profit from it, including manufacturers and distributors who profit from its sale, and buyers who profit from its use. The policy considerations underlying those principles include the relative bargaining power of the parties and the allocation of the loss to the better risk-bearer in a modern marketing system.

Id.

Additionally, the court placed primary importance on other considerations such as efficient use of resources. Id.

In some circumstances, it is possible to apply a limited "unavailability of insurance" exception in a manner that does not do violence to the other policy considerations articulated by the court. However, the text of the Owens-Illinois decision as well as the public interest factors and rationale for the Owens-Illinois decision provide solid support for insurers to argue that the "unavailability of insurance" exception must yield in particular factual contexts. The New Jersey high court has not yet had occasion to address circumstances in which absolving a policyholder of responsibility for years in which insurance is not available encourages irresponsible behavior and otherwise undermines the public interest factors the court recognized. As discussed below, such a case may now be before the court.

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[1] Owens-Illinois Inc. v. United Insurance Co., 650 A.2d 974 (N.J. 1994).

[2] Keyspan Gas East Corp. v. Munich Reinsurance America Inc., 143 A.D.3d 86 (N.Y. App. Div. 2016).

[3] Continental Casualty Co. v. Indian Head Industries Inc., 2016 WL 7321362 (6th Cir. Dec. 16, 2016) (applying Michigan law).

[4] Continental Insurance Co. v. Honeywell International Inc., 2016 WL 3909530 (App. Div. July 20, 2016), certification granted (Dec. 12, 2016).

[5] See, e.g., In re Wallace & Gale Co., 385 F.3d 820, 832-33 (4th Cir. 2004), as amended, (Nov. 15, 2004) (applying Maryland law) (holding that "it is neither equitable nor fair to require an insurance company to pay for coverage during a period for which no effective coverage is in force"); Pennsylvania Nat. Mut. Cas. Insurance Co. v. Roberts, 668 F.3d 106, 118-19 (4th Cir. 2012), cert. denied, 133 S. Ct. 191 (2012) (applying Maryland law) (affirming that an insurer is obligated to pay no more than its pro rata share of a judgment because "[t]o place the entire judgment on the insurer would be chaotic, rewarding those who decline to purchase adequate coverage and ultimately punishing those who do"); Porter v. American Optical Corp., 641 F.2d 1128 (5th Cir. 1981) (applying Louisiana law); Ray Industries Inc. v. Liberty Mut. Insurance Co., 974 F.2d 754, 23 Envtl. L. Rep. 20145 (6th Cir. 1992) (applying Michigan law); Commercial Union Insurance Co. v. Sepco Corp., 918 F.2d 920 (11th Cir. 1990) (applying Alabama law) (finding the policyholder must share in defense costs allocated to years in which it lacked coverage); Uniroyal Inc. v. Home Insurance Co., 707 F. Supp. 1368 (E.D.N.Y. 1988) (applying New York law) ("A firm that fails to purchase insurance for a period ... is self-insuring for all the risk incurred in that period; otherwise it would be receiving coverage for a period for which it paid no premium. Self-insurance is called 'going bare' for a reason"); Insurance Co. of North America v. Forty-Eight Insulations Inc., 451 F. Supp. 1230 (E.D. Mich. 1978), aff'd, 633 F.2d 1212 (6th Cir. 1980), decision clarified on reh'g, 657 F.2d 814 (6th Cir. 1981) (holding that the policyholder "must bear its share of the liability risk for those years in which it had no insurance"); H.B. Fuller Co. v. U.S. Fire Insurance Co., 2011 WL 2884711 (D. Minn. 2011) (holding that policyholder must be allocated its share of losses attributable to periods in which policies are unable to respond because they were issued by insurers that are now insolvent); IMCERA Group Inc. v. Liberty Mut. Insurance Co., 50 Cal. Rptr. 2d 583 (App. 2d Dist. 1996), as modified on denial of reh'g, (Mar. 29, 1996), review granted and opinion superseded, 917 P.2d 1164 (Cal. 1996) and review dismissed, and cause remanded, 939 P.2d 746 (Cal. 1997); Security Insurance Co. of Hartford v. Lumbermens Mut. Cas. Co., 826 A.2d 107, 127 (Conn. 2003) (ruling that, for "long latency loss claims that implicate multiple insurance policies, the pro rata method of allocating defense costs applies for purposes of allocating costs to the insured for periods during which it was uninsured or has 'lost or destroyed its policies'"); AAA Disposal Systems Inc. v. Aetna Cas. & Sur. Co., 821 N.E.2d 1278, 1290 (Ill. App. 2005), appeal denied, 829 N.E.2d 786 (2005) (holding that "it would be unfair to allocate the damages occurring during the uninsured period to an insurer that did not agree to provide coverage during that time"); Outboard Marine Corp. v. Liberty Mut. Insurance Co., 670 N.E.2d 740 (Ill. App. 1996), as modified on denial of reh'g, (Sept. 16, 1996) (holding that the policyholder is responsible for uninsured years); Norfolk Southern Corp. v. California Union Ins. Co., 859 So. 2d 167, 198 (La. Ct. App. 2003), writ denied, 861 So. 2d 579 (La. 2003) (requiring the policyholder to contribute to the pro rata allocation for any "period in which no insurer is on the risk"); Mayor & City Council of Baltimore v. Utica

Mut. Insurance Co., 802 A.2d 1070, 1101-02 (Md. 2002) (holding that "an insured who elects not to carry liability insurance for a period of time, either by electing to be self-insured, or by purchasing a policy which withholds coverage pursuant to a particular exclusion ... will be liable of the prorated share that corresponds to periods of self-insurance or no coverage"); Boston Gas Co. v. Century Indem. Co., 910 N.E.2d 290, 315–16 (Mass. 2009) ("the policyholder is responsible for any periods that it went without insurance."); Domtar Inc. v. Niagara Fire Insurance Co., 563 N.W.2d 724 (Minn. 1997) ("Policyholders who chose to 'go bare' or underinsure must sustain the burden of those choices. Likewise, policyholders are required to underwrite the risk of insurer insolvency or bankruptcy.").

[6] See also Crossmann Communities of North Carolina Inc. v. Harleysville Mut. Insurance Co., 717 S.E.2d 589 (S.C. 2011) (holding that employing an "unavailability" exception would "exceed the trial court's authority, as the effect is to shift losses from one policy period to another in order to create coverage where none was purchased"); Midamerican Energy Co. v. Certain Underwriters at Lloyd's London, 2011 WL 2011374 (Iowa Dist. Ct. 2011) (ruling "the availability of coverage is not to be a factor in allocating damage; the plaintiff will be responsible for those years in which damage has found to have occurred in which there is no insurance coverage, regardless of the reason that no coverage was obtained or available"); Bradford Oil Co., Inc. v. Stonington Insurance Co., 54 A.3d 983 (Vt. 2011) (rejecting the unavailability exception and determining that "the reason for the absence of effective insurance is not determinative" and that such an exception "is not consistent with a pure time-on-the-rise methodology"); AAA Disposal Systems Inc. v. Aetna Cas. & Sur. Co., 821 N.E.2d 1278, 1290 (Ill. App. 2005), appeal denied, 829 N.E.2d 786 (Ill. 2005) ("Because the policy periods contained in the American Employers' insurance policies do not include the years plaintiffs went uninsured, we fail to understand why American Employers should have to bear the costs from that period ... We understand that insurance coverage was not available for the period at issue, but intervenors cannot shift responsibility for the uninsured years to American Employers.")

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Door Closing On 'Unavailability' Insurance Exception: Part 2

By **Scott Seaman, Hinshaw & Culbertson LLP**

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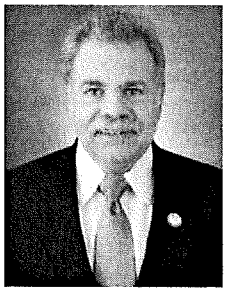
The Limited Nature Of The "Unavailability Of Insurance" Exception



Scott M. Seaman

To be sure, decisions applying New Jersey law post-Owens-Illinois have applied the "unavailability of insurance" exception in the context of asbestos and environmental coverage claims by ending the coverage block (the allocation end-date) at the time when coverage for asbestos or pollution losses was unavailable in the market.

Outside the Garden State, however, very few decisions applying the law of a pro rata jurisdiction have recognized any "unavailability of insurance" exception. Some (but not all) federal court decisions purporting to apply New York law have applied the "unavailability of insurance" exception[8] as has the Minnesota Supreme Court.[9] But the tried and true requirement of policyholders bearing responsibility for uninsured periods has otherwise held firm in pro rata jurisdictions across the country.

Further, it bears emphasizing that, even in the couple of jurisdictions with decisions recognizing the "unavailability of insurance" exception, policyholders still bear responsibility where risks were not transferred for any other reason, including earlier self-insured periods, periods in which policyholders failed to obtain sufficient limits, purchased insurance from insolvent insurers, had deductibles, failed to comply with policy conditions, and otherwise.

Policyholders have not been hesitant in attempting to play the unavailability card. Courts, however, have repeatedly rejected efforts by policyholders to effectively undermine the consequences of a pro rata allocation by expanding the limited exception. See, e.g., Benjamin Moore & Co., v. Aetna Cas. and Sur. Co., 843 A.2d 1094, 1103, 1106 (N.J. 2004) (holding that the policyholder was responsible for the deductible on each triggered policy as agreed to in the insurance contract and recognizing policyholders "who chose to 'go bare' or underinsure must sustain the burden of those choices. Likewise, policyholders are required to underwrite the risk of insurer insolvency or bankruptcy."); H.B. Fuller Co. v. U.S. Fire Insurance Co., (D. Minn. 2011) (rejecting policyholder's argument that insurance was "unavailable" to it because the insurers had become insolvent); Crown Cork & Seal Co. Inc. v. Travelers Cas. & Sur. Co., No. 0074568-88 (N.J. Super. Ct. Aug. 11, 1997) (ruling that the inability to purchase insurance on same terms and rates does not equate to unavailability for purposes of allocation); NL Industries Inc. v. Commercial Union Insurance Co., 926 F. Supp. 446 (D. N.J. 1996) (applying New York law) (holding that the policyholder was responsible for injuries in years where lead paint coverage was

unavailable and for periods of missing insurance contracts); Fulton Boiler Works Inc. v. American Motorists Insurance Co., 828 F. Supp. 2d 481 (N.D. N.Y. 2011) (holding that policyholder is required to contribute to the allocation of asbestos-related losses for the period between 1949 and 1976 because the policyholder was unable to establish that it purchased liability insurance for that period) Olin Corp. v. Insurance Co. of North America, 986 F. Supp. 841 (S.D.N.Y. 1997), aff'd, 221 F.3d 307 (2d Cir. 2000) (holding that the policyholder must contribute for period of 1971 through 1985, the period of time in which coverage was barred by pollution exclusions in the subject general liability contracts, because the policyholder could have purchased Environmental Impairment Liability policies that would have been required to respond to the loss at issue); Foster Wheeler LLC v. Affiliated FM Insurance Co., 27 Misc. 3d 1223(A), 910 N.Y.S.2d 762 (Sup. Ct. 2010) (applying New Jersey law) (unreported decision) (holding that period of 1982 to 1985 was to be included in the allocation of asbestos liabilities even though coverage may not be collectible because of policyholder's misrepresentations/non-disclosures; the question for allocation to those years was not whether insurance was collectible but, rather, whether insurance was available); Domtar Inc. v. Niagara Fire Insurance Co., 563 N.W.2d 724 (Minn. 1997) (holding the policyholder responsible for impacted years where the policyholder's contracts were missing).

By deviating from the straightforward consequences of a pro rata allocation, the limited number of courts letting policyholders off the hook based upon the limited "unavailability of insurance" exception have added another phase to complex coverage litigation. The additional issues presented in litigating the "unavailability of insurance" exception include: (1) determining the proper standard governing unavailability (i.e., whether the standard of unavailability is "subjective" or "objective;" whether the inquiry is availability of insurance to a particular policyholder, a particular type of policyholder, or any policyholder); (2) who bears the burden of proof (i.e., whether the policyholder must prove unavailability or whether the insurer must prove availability); (3) what constitutes available insurance (i.e., whether claims-made coverage such as environmental impairment liability insurance constitutes available insurance; whether foreign markets as well as domestic markets may be considered; whether captives and alternative risk transfer devises may be considered; and (4) the date upon which insurance became "unavailable." Courts have reached different conclusions on each of these issues. In short, the "unavailability of insurance" exception has embroiled litigants and courts in expensive and time-consuming discovery, motion practice, and fact-finding. Court rulings on the issue of when insurance became "unavailable" in the context of asbestos and environmental losses have varied with results ranging from the mid-1980s to well into the 2000s.

The Potential Further Limiting Of The "Unavailability Of Insurance" Exception

As shown above, federal courts applying New York law have reached different conclusions as to whether there is any "unavailability of insurance" exception. The first recent development with respect to the exception was the September 2016 decision in Keyspan Gas East Corp. v. Munich Reinsurance America Inc., 143 A.D.3d 86 (N.Y. App. Div. 2016). In the first New York state appellate court decision to address the issue, the court flatly rejected the exception, holding there is no "unavailability of insurance" exception under New York law to allow the policyholder to avoid responsibility for uninsured periods. Id. at 95.

Keyspan sought coverage for its remediation costs at various former manufactured gas plants. Century issued 16 successive years of general liability insurance policies from 1953 to 1969. Keyspan's claim for indemnification by Century implicated not only the 16–year period that the policies were in effect, but also periods of time, both before 1953 and after 1969, when insurance covering this risk could not be purchased in the marketplace. The trial court, on Century's motion for summary judgment, held that a pro rata time-on-the-risk allocation formula is appropriate to determine the parties' respective

obligations for the loss; for periods when Keyspan did not purchase insurance that was otherwise available in the marketplace, Keyspan is responsible for a share of liability attributable to that period of time; and Keyspan is allocated liability for the time period between 1971 and 1982 when the New York Insurance Law expressly prohibited insurers from covering liability arising out of pollution or contamination (reasoning this result was consistent with the purpose of the insurance law to have companies, such as Keyspan, bear the full burden of their own actions affecting the environment). These holdings were not challenged on appeal.

The trial court's holding that Century, not Keyspan, should be allocated the other periods of time when insurance was unavailable in the marketplace was challenged on appeal. The appellate court noted that pro rata allocation typically includes apportioning some part of the risk to the policyholder in connection with periods of no insurance, self-insurance, insufficient limits, etc. The appellate court reversed the trial court and flatly refused to create an exception based upon unavailability of insurance.

We find that the policy language supports a conclusion that the unavailability exception to proration to the insured does not apply. As with the policies in Con. Edison, the "all sums" policy language in the policies at bar is qualified by other language. Each policy, despite some minor variations, provides the insured with coverage for occurrences, accidents and continuous and repeated exposure to conditions that result in damage "during the policy period." While none of the policies expressly address how to allocate liability in a situation where the underlying damage is long-term, continuous and indivisible, the fact that the policies require Century to indemnify Keyspan for occurrences, accidents, etc., 'during the policy period' is consistent with allocation for time on the risk. Unavailability is an exception to time on the risk, since it allocates responsibility for periods of time when no insurance was purchased and it is, therefore, inconsistent with policy language restricting coverage to the policy period. There is no other or additional contractual language in the policy justifying this exception. There are no express contract provisions requiring the insurer to cover damages outside of the policy period when insurance is otherwise unavailable in the marketplace.

Id. at 95 - 96.

The appellate court also rejected Keyspan's public policy arguments, noting that the court will not rewrite the terms of an insurance policy. The court aptly pointed out that "the spreading of industry risk through insurance is accomplished through the setting and payment of premiums for insurance, consistent with the parties' forward looking assessment of what that risk might entail. In the absence of a contract requiring such action, spreading risk should not by itself serve as a legal basis for providing free insurance to an insured." Id. at 97.

The second recent development illustrates the potential limited utility of the "unavailability of insurance" exception to the policyholder. In Continental Casualty Co. v. Indian Head Industries Inc. (6th Cir. Dec. 16, 2016) (applying Michigan law), the Sixth Circuit affirmed the district court's pro rata time-on-the-risk allocation of defense and indemnity costs for asbestos bodily injury claims.

The insured, Indian Head, argued that it was not required to reimburse Continental for damages and defense costs for years in which asbestos-related insurance was unavailable. It asserted that, once its insurer Continental barred asbestos-related claims from its coverage, it could no longer obtain coverage for such suits. The Sixth Circuit relied upon the district court decision in Decker Mfg. Corp. v. Travelers Indem. Co., 106 F.Supp.3d 892, 898 (W.D. Mich. 2015), which recognized an exception to the requirement that the policyholder bear responsibility for uninsured periods has to hold a policyholder liable for its own damages "where insurance is not available in the marketplace."

As a threshold matter, it is doubtful that any "unavailability of insurance" exception actually exists under Michigan law. The district court, in Decker, did not cite to a single case decided under Michigan law recognizing such an exception. Instead, the district court relied solely upon the Second Circuit decisions in Stonewall and Olin (neither of which purported to apply Michigan law) and the court decision in Keyspan, applying New York law, that subsequently was reversed. Keyspan Gas E. Corp. v. Munich Reinsurance Am. Inc., 46 Misc.3d 395 (N.Y. Sup. 2014), rev'd 143 A.D.3d 86 (N.Y. App. Div. 2016).

However, even if Michigan law recognized an "unavailability of insurance" exception, the Sixth Circuit imposed upon the policyholder the burden of proving that insurance was not reasonably available to it. Moreover, the court further explained that it is not enough that the "same policy type" was not available, but that the policyholder could not purchase coverage of any policy type that would have "provided similar coverage." Id. According to the Sixth Circuit,

> Indian Head has only asserted that asbestos-related coverage was no longer available to it after Continental added asbestos exclusions to its policies. We find this insufficient. Continental has pointed to instances where asbestos-related coverage continued to be available to companies until at least 2001. See John Crane, Inc. v. Admiral Ins. Co., 991 N.E.2d 474, 478 (Ill. App. Ct. 2013) (noting the insured had asbestos coverage through 2001). Based on this information, Indian Head has failed to show that asbestos-related coverage from any insurer was unavailable after 1987. The district court, therefore, did not err in allocating to Indian Head its share of damages incurred after 1987.

Id. at * 9.

Though accepting (perhaps wrongfully) the "unavailability exception," the court placed the burden of proof on the policyholder and ruled asbestos coverage was available through 2001.

The third significant recent development is the New Jersey Supreme Court's decision to grant the insurers' petition for certification in Continental Insurance Co. v. Honeywell International Inc.

Under New Jersey law, at a minimum, the policyholder is responsible for years in which insurance coverage for asbestos risks was available in the market. The appellate division's decision in Continental Insurance Co. v. Honeywell International Inc., (App. Div. July 20, 2016) is instructive on the minimum end point of the allocation point. In Honeywell, the appellate division affirmed the trial court's determination that excess insurance coverage was "reasonably available for purchase" well into 1987. Id. at *12-13. Properly viewed, Honeywell demonstrates the minimum (not the maximum) end date for the availability of coverage for asbestos risks.

In granting review, the New Jersey Supreme Court will have the opportunity to consider whether a policyholder may bear responsibility for periods beyond which insurance is "available" for a risk based upon principles articulated by the court in Owens-Illinois and its progeny, including assumption of risk, incentivizing responsible conduct by companies, simple justice and exceptional circumstances.

In seeking review, the insurers argued that Honeywell should be held liable regardless of whether the plaintiffs' claims involve pre-1987 exposures because Bendix (the Honeywell predecessor manufacturing and selling asbestos-containing brake and clutch parts) continued to manufacture and sell asbestos-containing products until 2001 knowing that it did not have insurance coverage. By inflexibly relieving

the policyholder of responsibility post-1987 when asbestos coverage ceased to be available to Honeywell, the insurers contend the appellate division violated other principles articulated in Owens-Illinois such as incentivizing responsible conduct, discouraging irresponsible risk taking and pricing products to reflect their true costs.

According to the insurers:

> Rather than encouraging responsible conduct, the Appellate Division has implicitly encouraged risk-taking and irresponsible conduct, and would signal to manufacturers that they can continue to engage in activities alleged to cause continuous and progressive injury without insurance coverage knowing they will be able to transfer losses to their prior insurers.

The insurers also point to the New Jersey Supreme Court decision in Carter-Wallace Inc. v. Admiral Insurance Co., 712 A.2d 1116 (N.J. 1998) in which the court indicated a departure from Owens-Illinois would be warranted under "exceptional circumstances" and argue that continuing to manufacture asbestos-containing products 14 years after commercial asbestos insurance was available constituted "exceptional circumstances."

Honeywell resisted review arguing that it seeks coverage for only pre-1987 exposures to asbestos and there is no evidence to support the proposition that its post-1987 conduct increased its pre-1987 claims. Further, it claims nothing in Owens-Illinois or its progeny supports holding a policyholder responsible for periods in which insurance is unavailable. Argument and decision are likely several months away.

The hallmark of the New Jersey Supreme Court's jurisprudence on allocation issues has been its recognition of the need for flexibility and its desire to interpose innovative approaches. It will be interesting to see what the court does in the Honeywell case.

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[1] Compare Stonewall Insurance Co. v. Asbestos Claims Management Corp., 73 F.3d 1178 (2d Cir. 1995), opinion modified on denial of reh'g, 85 F.3d 49 (2d Cir. 1996) (no proration to the insure for years after 1985, the "point at which asbestos liability insurance ceased to be available.") and Olin Corp. v. Insurance Co. of North America, 986 F. Supp. 841 (S.D. N.Y. 1997), aff'd, 221 F.3d 307 (2d Cir. 2000) (the "unavailability" exception is to be interpreted in the generic sense to mean insurance not being available in the marketplace to policyholders of the same kind as opposed to insurance not being available to the particular policyholder or for the particular risk) with Sybron Transition Corp. v. Security Insurance of Hartford, 258 F.3d 595 (7th Cir. 2001) (holding that the policyholder must contribute to the pro rata time-on-the-risk allocation for periods without insurance, regardless of whether coverage for the risk at issue was available).

[2] Woodale Builders Inc. v. Maryland Cas. Co., 722 N.W.2d 283, 297-98 (Minn. 2008).

ATTACHMENT E

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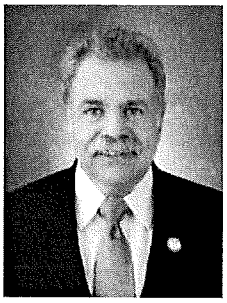
NY Slams Door On 'Unavailability Of Insurance' Exception

By **Scott Seaman** (March 28, 2018, 3:24 PM EDT)



Scott Seaman

The New York Court of Appeals delivered a significant victory to insurers in the latest battle in the long-tail insurance coverage wars. On March 27, the New York Court of Appeals issued a unanimous decision in the KeySpan case rejecting the so-called "unavailability of insurance" exception to the general rule that policyholders are responsible for periods of time that insurance is unavailable for purchase in the marketplace under a pro rata allocation. This victory comes on the heels of what most consider to be a policyholder victory before the New York Court of Appeals in the Viking Pump case.[1]

In this article, we examine the New York Court of Appeals decision in KeySpan rejecting the "unavailability of insurance" exception. In essence, this is Part III of our expert analysis on "Door Closing On 'Unavailability' of Insurance Exception." In Part I, we discussed the general rule in pro rata jurisdictions that the unavailability of insurance coverage in the market does not absolve policyholders of responsibility for self-insuring and explored the genesis of the limited "unavailability of insurance" exception.[2] In Part II, we addressed the limited nature of the "unavailability of insurance" exception and considered the prospect of the exception being even further limited.[3] We now discuss how the New York Court of Appeals slammed the door shut on policyholders seeking to hoist upon their insurers losses for periods in which insurance is unavailable in the marketplace.

The Issue of "Unavailability Of Insurance" Placed in Context

Although several states employ an "all sums" allocation, the trend of decisions and the distinct majority rule continues to be that long-tail losses are allocated on a pro rata basis. There are a variety of ways in which losses may be prorated, but the time-on-the-risk and time-and-limits methodologies are the most commonly followed at least where an allocation cannot be made based upon evidence showing the amount of injury or damage actually taking place during the respective time periods. A pro rata allocation offers several advantages over the "all sums" fiction.[4]

One important feature of a pro rata allocation is that policyholders are required to participate in the allocation by accepting the consequences associated with periods of self-insurance. Specifically, courts require policyholders to bear the financial responsibility for those periods of no insurance, self-insurance, insufficient insurance, insurance issued by insolvent insurers or insurance that does not respond because of noncompliance with policy conditions or application of policy exclusions.

Overwhelmingly, courts applying a pro rata allocation have recognized that the responsibility for uninsured periods rests squarely on policyholders regardless of whether or not insurance for the particular risk was available for purchase in the market at the time.[5] However, resourceful policyholders continue their quest for a "second bite" at the allocation apple in pro rata allocation jurisdictions and the "unavailability of insurance" exception is a way for policyholders to attempt to mitigate the adverse financial consequences they may experience from a pro rata allocation.

The New York High Court Rejects the "Unavailability of Insurance" Exception

The New York Court of Appeals added its imprimatur to the issue of the impact on insurance unavailability on allocation of long-tail losses in its March 27, 2018, decision in KeySpan v. Munich Re. Although the court referred to the unavailability "rule," we refer to it in this analysis as the "unavailability of insurance exception" because, when applied, it actually operates as a limited exception to the logical consequences of a pro rata allocation that the policyholder bears responsibility for any period in which it does not have insurance for whatever reason.

The New York Court of Appeals began its decision by noting "we once again venture into the complex realm of long-tail insurance claims," and concluded that the policyholder, not the insurer, "bears the risk for those years during which such coverage was unavailable."

The liability underlying the coverage dispute in KeySpan emanates from environmental contamination caused by coal tar constituents from three manufactured gas plants owned and operated by KeySpan's predecessor, Long Island Lighting Company, dating back to the late 1800s. The court opinion states that, between 1953 and 1969, Century issued multiple excess liability insurance policies to Long Island Lighting Company covering property damage.

KeySpan did not dispute that it is responsible for damages in years in which property damage insurance was available, but not purchased by its predecessor. KeySpan argued, however, that Century's pro rata share should not be reduced by factoring in the years in which property damage liability insurance was unavailable in the market for pollution risks. Accordingly to KeySpan, such insurance was not available in the market for utilities prior to 1925 or after 1970 when the "sudden and accidental pollution exclusion" was generally included in general liability policies.

The trial court granted Century's motion for summary judgment in part, holding that liability should be allocated to KeySpan for the years in which it elected to self-insure and from 1971 to 1982 (the period during which the legislature mandated inclusion of a pollution exclusion in liability policies under former New York Insurance Law § 46 [13], [14]). However, the trial court denied the motion with respect to those years in which insurance coverage was otherwise unavailable in the marketplace. This essentially absolved the policyholder for the years before 1953 and after 1986. The Appellate Division reversed in part, holding that Century was not obligated to indemnify KeySpan for losses that are attributable to time periods when liability insurance was unavailable in the marketplace. The Appellate Division certified the question of whether its order was correct to the New York Court of Appeals.

The New York Court of Appeals described New York Law on allocation as follows:

> In New York, we have not adopted a strict pro rata or all sums allocation rule. Rather, the method of allocation is governed foremost by the particular language of the relevant insurance policy (see Matter of Viking Pump, 27 NY3d at 257). Thus, applying principles of contract interpretation, we held in Consolidated Edison Co. of N.Y. v Allstate Ins. Co. that policy language restricting an

> insurer's liability to all sums incurred and occurrences happening "during the policy period" generally supports a pro rata allocation (98 NY2d at 224). As we explained, the policies at issue there contained such language providing "for liability incurred as a result of an accident or occurrence during the policy period, not outside that period," and we concluded that "[p]roration of liability ... acknowledges the fact that there is uncertainty as to what actually transpired during any particular policy period" (id.). We subsequently distinguished the policy language in Consolidated Edison from that presented in Matter of Viking Pump, Inc. and held, in the latter case, that the presence of noncumulation and prior insurance provisions "plainly contemplate that multiple successive insurance policies can indemnify the insured for the same loss or occurrence" and, therefore, require all sums allocation (27 NY3d at 261). Such provisions are inconsistent with pro rata allocation because "the very essence of pro rata allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period," such that no two insurance policies indemnify the same loss or occurrence absent overlapping or concurrent policy periods.

The summary serves as useful guidance on New York allocation law and reinforces the reality that New York remains a presumptive pro rata allocation.

The New York Court of Appeals recognized that courts applying a pro rata allocation require the policyholder to participate in the allocation to some extent with respect to periods of noncoverage. It noted courts are divided with regard to whether a policyholder should be held responsible for those periods of time when the relevant coverage was not offered for sale on the market. The court pointed out that the applicability of the unavailability of insurance exception is a matter of first impression in New York.

Importantly, the New York high court agreed with Century that: (1) the unavailability rule is inconsistent with the policy language that mandates pro rata allocation in the first instance; and (2) the imposition of liability on an insurer for damages resulting from occurrences outside the policy period would contravene the very premise underlying pro rata allocation.

The court reiterated its holding in Consolidated Edison that, although the insurance policies do not speak directly to allocation in the context of long-tail claims, each of the policies contains language limiting the insurer's liability to losses and occurrences happening "during the policy period" and that pro rata allocation — rather than all sums allocation — was more consistent with such policy language because "the policies provide indemnification for liability incurred as a result of an accident or occurrence during the policy period, not outside that period."

The court pointed out the utter lunacy of the "unavailability of insurance" exception. First, it is inconsistent with the very notion of a pro rata allocation. As the court stated:

> The unavailability rule is inconsistent with the contract language that provides the foundation for the pro rata approach – namely, the "during the policy period" limitation – and that to allocate risk to the insurer for years outside the policy period would be to ignore the very premise underlying pro rata allocation ... . Indeed, such an approach could, once a policy is triggered, impose liability in perpetuity (or retroactively to periods prior to coverage) on an insurer who issued insurance coverage for only a limited number of years, thereby eviscerating much of the distinction between pro rata and all sums allocation. In the context of continuous harms, where the contamination attributable to each policy period cannot be proven and we draw from the

> contract language to distribute the harm pro rata across the policy periods, it would be incongruous to include harm attributable to years of noncoverage within the policy periods.

Second, the court recognized that the "unavailability of insurance" exception distorts the economics of insurance. As the court aptly stated, the application of such an exception:

> to an insurance policy that directs pro rata allocation, either expressly or under our interpretation in Consolidated Edison would effectively provide insurance coverage to policyholders for years in which no premiums were paid and in which insurers made the calculated choice not to assume or accept premiums for the risk in question. Fundamentally, an insurer "is free to select its risks" and to exclude certain risks. Vander Veer v Continental Cas. Co., 34 NY2d 50, 52 [1974]).

Third, the court noted the unavailability exception contravenes the reasonable expectations of the average policyholder that would not expect to receive coverage without regard to the number of years for which it purchased applicable insurance.

The thread of continuity running through the New York Court of Appeals' insurance law jurisprudence in general and on allocation-related issues in particular has been reliance upon enforcing insurance contract language and not using notions of public policy to override insurance contract language.

In evaluating decisions that address the "unavailability of insurance" exception, the court stated that those courts that have adopted the unavailability exception in the pro rata context have relied heavily on public policy concerns and a desire to maximize resources available to claimants against the policyholder. By contrast, courts rejecting the unavailability exception generally focus on the policy language that serves as the foundation for pro rata allocation.

Not surprisingly, the New York Court of Appeals sided with the reasoning of the Seventh Circuit in Sybron Transition Corp., [6] and the Massachusetts Supreme Court of Appeals in Boston Gas [7] in rejecting the unavailability exception. It noted the Seventh Circuit "declined to require an insurer who furnished coverage during a specific period of time before the magnitude of a risk was recognized "to furnish, for nothing, an additional period of high-price coverage" outside of the policy period because the insured, not the insurer, created the risk of loss and there was no contractual basis to impose the consequences of that risk "on an underwriter unlucky enough to insure an early slice of the risk." Likewise, the Massachusetts Supreme Court of Appeals rejected the unavailability exception as contravening the limitation of coverage for damage during the policy periods.

The New York Court of Appeals expressly concurred with the Appellate Division decision that the spreading of risk through insurance is accomplished through the setting and payment of premiums for insurance, consistent with the parties' forward-looking assessment of what that risk might entail. In the absence of a contract requiring such action, spreading risk should not by itself serve as a legal basis for providing free insurance to a policyholder.

The court rejected KeySpan's argument that it is inequitable to allocate the risk to the policyholder for years when coverage was unavailable. It noted that, even those courts that have adopted the unavailability of insurance exception have recognized that, "[f]rom an equitable standpoint, either party can justifiably be assigned responsibility for ongoing [injuries arising after policy exclusion]. The policyholder is the one who allegedly caused the injury and, therefore, who ultimately will be financially responsible should insurance prove insufficient."[8]

The New York Court of Appeals stood resolute in resisting the re-writing of insurance policies based upon policy concerns, noting:

> this [C]ourt may not make or vary the contract of insurance to accomplish its notions of abstract justice or moral obligation" (Breed v Insurance Co. of N. Am., 46 NY2d 351, 355 [1978]). Ultimately, because "the very essence of pro rata allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period" (Matter of Viking Pump, 27 NY3d at 261; see Consolidated Edison, 98 NY2d at 224), the unavailability rule cannot be reconciled with the pro rata approach. We, therefore, reject application of the unavailability rule for time-on-the-risk pro rata allocation."

The unanimous decision sends a strong message that unavailability of insurance regardless of whether in the early years or later years of a coverage block does not provide the policyholders with an opportunity to hoist upon insurers responsibility for injuries or damages taking place outside their respective policy periods.

The Door Appears to be Closing on the "Unavailability of Insurance" Exception

The New York Court of Appeals' decision in KeySpan represents a significant victory for insurers. It also lends muster to the proposition that the door appears to be closing more generally on the "unavailability of insurance" exception to the general rule in pro rata jurisdictions that policyholders are responsible for periods of no insurance regardless of whether or not insurance of particular risks is available for purchase in the marketplace.

There are a couple of cases pending before state supreme courts that may address the "unavailability of insurance" exception. The New Jersey Supreme Court, which gave birth to the "unavailability of insurance" exception through its decision in Owens Illinois [9], may address the scope of the exception in Continental Insurance Co. v. Honeywell International Inc. In granting review in that case, the New Jersey Supreme Court will have the opportunity to consider whether a policyholder may bear responsibility for periods beyond which insurance is "available" for a risk based upon principles articulated by the New Jersey Supreme Court in Owens-Illinois and its progeny, including assumption of risk, incentivizing responsible conduct by companies, simple justice and exceptional circumstances.

In seeking review, the insurers argued that Honeywell should be held liable regardless of whether the plaintiffs' claims involve pre-1987 exposures because Bendix (the Honeywell predecessor manufacturing and selling asbestos-containing brake and clutch parts) continued to manufacture and sell asbestos-containing products until 2001 knowing that it did not have insurance coverage. By inflexibly relieving the policyholder of responsibility post-1987 when asbestos coverage ceased to be available to Honeywell, the insurers contend the appellate division violated other principles articulated in Owens-Illinois such as incentivizing responsible conduct, discouraging irresponsible risk taking and pricing products to reflect their true costs.

The Connecticut Supreme Court will have the opportunity to address the "unavailability of insurance" exception adopted by the intermediate appellate court in the R.T. Vanderbilt case.[10] The battle over the impact of insurance unavailability wages on.

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[1] In re Viking Pump, Inc., 52 N.E.2d 3d 1144 (N.J. 2016)

[2] "Door Closing on "Unavailability of Insurance" Exception: Part 1," Law360, New York (January 9, 2017)

[3] "Door Closing on "Unavailability of Insurance" Exception: Part 2," Law360, New York (January 10, 2017)

[4] "Why Pro Rata Allocation Is The Majority Rule." Law360 (October 16, 2014).

[5] S. M. Seaman & J. R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims (6th Ed. Thomson Reuters 2017-2018) at Chapter 4 (collecting and discussing cases).

[6] Sybron Transition Corp. v. Security Insurance of Hartford, 258 F.3d 595 (7th Cir. 2001.

[7] Boston Gas Co. v. Century Indem. Co., 910 NE2d 280, 315 (Mass. 2009).

[8] R.T. Vanderbilt Co., Inc., 171 Conn App at 134, 156 A3d at 579-580.

[9] Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d. 974 (N.J. 1994).

[10] R.T, Vanderbilt Co., Inc. v. Hartford Acc. and Indem. Co., 156 A3d 539, 577 (Conn App Ct 2017), cert granted 171 A3d 63 (Conn. 2017).

Independent Defense Counsel: A 50-State (and D.C.) Survey

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For additional commentary on this topic, s*ee also*, *Duty of insurer to pay for independent counsel when conflict of interest exists between insured and insurer*, 50 A.L.R.4TH 932 (originally published 1986, updated through 2017); John E. Zulkey, *Contesting the Costs of Independent Counsel: Using Regional Fee Scales as Evidence of Reasonable Rates*, 58 DRI FOR THE DEFENSE 46 (2016); Jeffrey W. Stempel, *Policyholder Rights to Independent Counsel: Issues Remain Regarding Compensation, Supervision of Counsel*, 23 NEV. L. 12 (Dec. 2015); Douglas R. Richmond, *Reconnoitering Reservations of Rights in Liability Insurance*, 51 TORT TRIAL & INS. PRAC. L.J. 1 (Fall 2015); Gary L. Gassman, Seth D. Lamden, Le G. Trieu, *Potential Consequences of Breaching the Duty to Defend: Key Considerations for Insurers and their Attorneys*, 45 BRIEF 30 (Fall 2015); Gary L. Gassman, *Reservation of Rights Letters: A Primer*, 43 BRIEF 51 (Summer 2014).

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In Alabama, the mere fact that an insurer is defending under a reservation of rights does not entitle a policyholder to independent counsel, nor is the insurer obligated to pay for policyholder's independent counsel. *L & S Roofing Supply Co., Inc. v. St. Paul Fire & Marine Ins. Co.*, 521 So. 2d 1298, 1303 (Ala. 1987).

A policyholder *is* entitled to control the litigation through his or her own counsel with the insurer paying reasonable attorney's fees *only if* the insurer breaches certain specific conditions set out by the court. *Strength v. Alabama Dept. of Finance, Div. of Risk Management*, 622 So. 2d 1283, 1291 (Ala. 1993). The Alabama Supreme Court describes these conditions as an "enhanced obligation" and also mentions "other specific criteria" to be met by the defense counsel in a reservation-of-rights case. *L & S Roofing Supply Co., Inc.*, 521 So. 2d at 1303.

The "enhanced obligation" includes thoroughly investigating the cause of the insured's accident and the plaintiff's injuries, retaining competent defense counsel for the insured, making sure both counsel and the insured know that the insured is the client, fully informing the insured with respect to all coverage issues, disclosing all settlement offers made by the company, and refraining from engaging in any action that would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk. *Id.*

Even though the insured is not entitled to independent counsel, the insured may pay for his or her own defense, and the insurance company must reimburse for defense costs if an adverse final judgment establishes the company's liability. *See, e.g., L&S Roofing Supply Co., Inc.,* 521 So. 2d at 1304, citing to *Waite v. Aetna Cas. & Sur. Co.*, 77 Wash. 2d 850, 467 P.2d 847 (1970). However, if the insured chooses to hire its own counsel and does not allow the carrier's counsel to participate, the insured risks losing the insurer's "enhanced obligation of good faith." *Aetna Cas. & Sur. Co. v. Mitchell Bros., Inc.*, 814 So. 2d 191, 197 (Ala. 2001).

The case law concerning independent counsel and "enhanced obligation of good faith" was most recently affirmed in 2009 by a federal district court applying Alabama law. *State Farm and Cas. Co. v. Myrick,* 611 F. Supp. 2d 1287, 1299 (M.D. Ala. 2009). In this case, the court found that the mere refusal to settle *for* the insured was precisely what a reservation of rights permits and not a breach of its enhanced obligation of good faith.

But see MetLife Auto & Home Ins. Co. v. Reid, Civil Action No. CV-09-S-01762-NE, 2013 WL 6844109 (N.D. Ala. Dec. 23, 2013), which followed the holding of *L & S Roofing*, but nevertheless found that the insurer was not obligated to provide a defense in the first instance.

For one commentator's analysis, *see* William E. Shreve, Jr., *Determining An Insurer's Duty to Defend*, 74 ALA. LAW. 238 (July 2013).

ALASKA

A. Parameters of Insured's Right to Independent Counsel

The right to independent counsel was originally a creature of case law. *CHI of Alaska, Inc. v. Employers Reinsurance Corp*., 844 P.2d 1113, 1118 (Alaska 1993); a*ccord Attorneys Liability Protection Soc., Inc. v. Ingaldson & Fitzgerald, P.C.*, No. 3:11-cv-00187-SLG, 2012 WL 6675167 (D. Alaska Dec. 21, 2012) (following *CHI of Alaska, Inc.*, and finding the insurer's position in this case in conflict with AS § 21.96.100).

The District Court case was reversed in party by *Attorneys Liability Protection Soc., Inc. v. Ingaldson Fitzgerald, P.C. f/k/a Ingaldson, Maassen & Fitzgerald, P.C.*, 838 F.3d 976, 980 (9th Cir. 2016), which held that the Liability Risk Retention Act ("LRRA"), 15 U.S.C. § 3902(a)(1) preempts subsection (d) of Alaska Statute ("AS") § 21.96.100. Section 3902(a)(1) broadly preempts "any State law, rule, regulation,

or order to the extent that such law, rule, regulation, or order would . . . make unlawful, or regulate, directly or indirectly, the operation of a risk retention group." 838 F.3d at 980 n.2.

In connection with its consideration of the *Ingaldson* case, the Ninth Circuit had certified two questions to the Alaska Supreme Court:

1. Does Alaska law prohibit enforcement of a policy provision entitling an insurer to reimbursement of fees and costs incurred by the insurer defending claims under a reservation of rights, where (1) the insurer explicitly reserved the right to seek such reimbursement in its offer to tender a defense provided by independent counsel, (2) the insured accepted the defense subject to the reservation of rights, and (3) the claims are later determined to be excluded from coverage under the policy?

2. If the answer to Question 1 is "Yes," does Alaska law prohibit enforcement of a policy provision entitling an insurer to reimbursement of fees and costs incurred by the insurer defending claims under a reservation of rights, where (1) the insurer explicitly reserved the right to seek such reimbursement in its offer to tender a defense provided by independent counsel, (2) the insured accepted the defense subject to the reservation of rights, and (3) it is later determined that the duty to defend never arose under the policy because there was no possibility of coverage?

Ingaldson, 838 F.3d at 979-80. The Alaska Supreme Court answered "yes" to each question. *Attorneys Liability Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 370 P.3d 1101, 1112 (Alaska 2016). Accordingly, any provision entitling insurers to reimbursement—even if the duty to defend never arises—is unenforceable under Alaska law. *Id.* [2]

When and under what circumstances, however, an insurer must provide independent counsel to its insured is governed by statute in Alaska (*see* AS § 21.96.100[3]), subject to the Ninth Circuit's holding in *Ingaldson*, *supra*, which appears limited on its facts to risk-retention groups.

This statute came into effect on July 1, 1995, and provides:

> (a) If an insurer has a duty to defend an insured under a policy of insurance and a conflict of interest arises that imposes a duty on the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to the insured unless the insured in writing waives the right to independent counsel.…

The statute then specifies the parameters of this obligation. In particular, it explains that claims for punitive damages; claims for damages in excess of the policy limits; and claims or facts in a civil action for which the insurer denies coverage, do not constitute a conflict of interest. (*Id.* subsection (b)). If, however, an insurer reserves rights on an issue for which coverage is denied, then the insurer must provide independent counsel to the insured.

Whether the statute in any way limits the right to independent counsel established in the prior case law has not yet been tested in the courts, but it appears that the statute was essentially enacted to codify the existing case law. *See Great Divide Ins. Co. v. Carpenter ex rel. Reed*, 79 P.3d 599, 604 (Alaska 2003). Although the statute has been in existence for nearly a decade and a half, there has been very little interpretation in published case law. However, there are cases which further illuminate the right to independent counsel.

For example, a case that postdates the statute, but does not directly address it, further explains the duties of an insurer in this context. The court in *Lloyd's & Institute of London Underwriting Co. v. Fulton*, 2 P.3d 1199 (Alaska 2000), explained that an insurer has a duty to advise its insured that a potential conflict exists

[2] *See, also, Ingaldson*, (D.Alaska, 2017).

[3] Formerly AS § 21.89.100. As noted *supra*, subsection (d) of AS § 21.96.100 has been preempted by 838 F.3d 976 (9th Cir. 2016).

as soon as its investigation reveals that grounds to dispute coverage exist, not on "the insurer's final decision on coverage." Moreover, the insured need not continue to provide information to the insurer once the insurer has a reason to believe that there are coverage issues: "to allow the insurer to attempt to obtain information from the insured in order to bolster an undisclosed policy defense would, in effect, allow the company to take advantage of its fiduciary relationship with the insured in order to strengthen its position against the insured." *Id.* at 1205.

As noted, although the insured has an automatic right to independent counsel under the circumstances specified, the insured may waive its right to independent counsel by signing a statement which describes this intention (an exemplar of such a statement exists in the statute at subsection (f)).

B. Additional Requirements and Duties Under Statute[4]

In addition to explaining when an insured has a right to independent counsel, AS § 21.96.100[5] sets forth other requirements to which the insured and insurer must both adhere. In particular, subsection (d) discusses the minimum qualifications of the independent counsel, and the rates that an insurer may be obligated to pay when such counsel is retained.[6]

The statute also explains the obligations the insured and insurer have vis-à-vis one another if independent counsel is retained: "the independent counsel and the insured shall consult with the insurer on all matters relating to the civil action and shall disclose to the insurer in a timely manner all information relevant to the civil action, except information that is privileged and relevant to disputed coverage." The statute also explains that it does not eliminate the insured's duty to cooperate as required by the terms of an insurance policy. (*Id.* subsection (g)).

Finally, the statute provides that when an insured is represented by independent counsel, the insurer may settle directly with the plaintiff if the settlement includes all claims based upon the allegations for which the insurer previously reserved its position as to coverage or accepted coverage, regardless of whether the settlement extinguishes all claims against the insured. (*Id.* subsection (h)).

Interestingly, this statute is almost identical to California *Civil Code* § 2860. Case law interpreting and applying the California statute may serve as possible guidance for questions not answered by or yet decided under the Alaska statute. (Indeed the *CHI* court cited heavily to California cases that predated the California statute).

C. Statute:

Alaska Stat. § 21.96.100. Appointment of independent counsel; conflicts of interest; settlement[7]

(a) If an insurer has a duty to defend an insured under a policy of insurance and a conflict of interest arises that imposes a duty on the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to the insured unless the insured in writing waives the right to independent counsel. An insurance policy may contain a provision that provides a method of selecting independent counsel if the provision complies with this section.

[4] See Appendix.

[5] Formerly AS § 21.89.100.

[6] Note, however, that subsection (d) has been preempted, apparently with respect to risk-retention groups, by *Attorneys Liability Protection Soc., Inc. v. Ingaldson Fitzgerald, P.C. f/k/a Ingaldson, Maassen & Fitzgerald, P.C.*, 838 F.3d 976, 980 (9th Cir. 2016).

[7] Formerly AS § 21.89.100.

(b) For purposes of this section, the following do not constitute a conflict of interest:

(1) a claim of punitive damages;

(2) a claim of damages in excess of the policy limits;

(3) claims or facts in a civil action for which the insurer denies coverage.

(c) Notwithstanding (b) of this section, if the insurer reserves the insurer's rights on an issue for which coverage is denied, the insurer shall provide independent counsel to the insured as provided under (a) of this section.

(d) If the insured selects independent counsel at the insurer's expense, the insurer may require that the independent counsel have at least four years of experience in civil litigation, including defense experience in the general subject area at issue in the civil action, and malpractice insurance. Unless otherwise provided in the insurance policy, the obligation of the insurer to pay the fee charged by the independent counsel is limited to the rate that is actually paid by the insurer to an attorney in the ordinary course of business in the defense of a similar civil action in the community in which the claim arose or is being defended. In providing independent counsel, the insurer is not responsible for the fees and costs of defending an allegation for which coverage is properly denied and shall be responsible only for the fees and costs to defend those allegations for which the insurer either reserves its position as to coverage or accepts coverage. The independent counsel shall keep detailed records allocating fees and costs accordingly. A dispute between the insurer and insured regarding attorney fees that is not resolved by the insurance policy or this section shall be resolved by arbitration under AS 09.43.

(e) If the insured selects independent counsel at the insurer's expense, the independent counsel and the insured shall consult with the insurer on all matters relating to the civil action and shall disclose to the insurer in a timely manner all information relevant to the civil action, except information that is privileged and relevant to disputed coverage. A claim of privilege is subject to review in the appropriate court. Information disclosed by the independent counsel or the insured does not waive another party's right to assert privilege.

(f) An insured may waive the right to select independent counsel by signing a statement that reads substantially as follows:

> I have been advised of my right to select independent counsel to represent me in this lawsuit and of my right under state law to have all reasonable expenses of an independent counsel paid by my insurer. I have also been advised that the Alaska Supreme Court has ruled that when an insurer defends an insured under a reservation of rights provision in an insurance policy, there are various conflicts of interest that arise between an insurer and an insured. I have considered this matter fully and at this time I am waiving my right to select independent counsel. I have authorized my insurer to select a defense counsel to represent me in this lawsuit.

(g) If an insured selects independent counsel under this section, both the counsel representing the insurer and independent counsel representing the insured shall be allowed to participate in all aspects of the civil action. Counsel for the insurer and insured shall cooperate fully in exchanging information that is consistent with ethical and legal obligations to the insured. Nothing in this section relieves the insured of the duty to cooperate fully with the insurer as required by the terms of the insurance policy.

(h) When an insured is represented by independent counsel, the insurer may settle directly with the plaintiff if the settlement includes all claims based upon the allegations for which the insurer previously reserved its position as to coverage or accepted coverage, regardless of whether the settlement extinguishes all claims against the insured.

ARIZONA

Whether an insured has a right to independent counsel is determined by reference to case law in Arizona. Although the first case addressing this issue was in 1976, there has been little significant development on the principals governing the question in the years since, and the specific requirements and process that must be followed remain unresolved.

A. Parameters of Insured's Right to Independent Counsel

Arizona appears to have first addressed whether an insured has a right to independent counsel in *Joseph v. Markovitz,* 551 P.2d 571 (Ariz. App. 1976), in which the Arizona Court of Appeal explained that when a conflict of interest exists between an insurer and its insured, "public policy" demands that the insured be able to "choose his own attorney without relieving [the insurer] of its contractual obligation under the policy to pay for the defense." *Id.* at 577. However, the *Markovitz* court did not elaborate on this obligation beyond this general statement. In a case decided that same year, *Fulton v. Woodford*, 545 P.2d 979 (Ariz. App. 1976), an Arizona Court of Appeal explained that an insurer's reservation of rights to seek reimbursement of payments created a conflict of interest.

Three decades later, however, the Arizona courts provided additional guidance. In *Pueblo Santa Fe Townhomes Owners' Ass'n v. Transcontinental Ins. Co.,* 178 P.3d 485 (Ariz. App. 2008), the Court of Appeal explained that a conflict of interest is created when an insurer "reserves rights to contest indemnification liability." When this happens, the court explained, "[a]n insured … is on notice of the conflict of interest and is free, upon proper notice to the insurer, to act to protect its rights in the litigation with the claimant." *Id.* at 491. The court further warned that, if an insurer fails to advise the insured that it is reserving rights to contest coverage, an insurer may be estopped from asserting its coverage defenses.

But see Nucor Corp. v. Employers Ins. Co. of Wausau, 975 F. Supp. 2d 1048, 1055, (D. Ariz. 2013), holding that "there is no support in Arizona case [law] for the blanket proposition that an insurer defending under a reservation of rights loses its right to appoint defense counsel for its insured. Although the courts in *Morris* and *Pueblo Santa Fe* indicated that an insurer defending under a reservation of rights loses some of its contractual rights to control the defense of an insured, neither of those opinions, nor any other Arizona case that the Court has found, addressed the specific issue of whether an insurer loses its right to appoint defense counsel." [¶] Thus, in the absence of any authority in support of Nucor's claim that it has a right to appoint its own defense counsel, the Court finds that Wausau has a contractual right under the insurance policies to appoint defense counsel in the underlying RID action."

In *Navigators Specialty Ins. Co. v. Nationwide Mut. Ins. Co.*, 50 F. Supp. 3d 1186, 1198 (D. Ariz. 2014), the federal district court held that, under Arizona law, an insurer's retained lawyer for an insured cannot be used as an agent of the company to supply information detrimental to the insured, such as information designed to deny coverage (citing to *Parsons v. Cont'l Nat'l Am. Group*, 113 Ariz. 223, 227, 550 P.2d 94, 98 (1976) (a lawyer retained by an insurer to defend an insured owes an undeviating and singular allegiance to the insured). [8]

B. Additional Requirements and Duties?

Thus, it appears the basic principle in Arizona is that an insured is entitled to seek independent counsel when a conflict of interest exists with the insurer, and that a conflict exists whenever an insurer reserves

[8] *Admiral Ins. Co. v. Cmty, Ins. Grp. SPC Ltd.*, (D.Ariz,, 2016) and *Nat'l Fire Ins. Co. of Hartford v. James River Ins.*, (D.Ariz, 2016) (both cases discussing duty in relation to competing policies of insurance).

rights to contest coverage. Beyond this, there is no Arizona authority defining what happens when independent counsel is selected.[9]

It is important to note, however, that the issue of right to independent counsel may be subsumed by *Morris* (*United Services Automobile Ass'n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987)), and *Damron* (*Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969)) in which the Supreme Court held that where there is a reservation of rights, "an insured may protect itself … by assigning the claimant the insured's coverage rights under the policy." *Pueblo Santa Fe*, 178 P.3d at 491. Such protection can include a stipulated judgment and covenant not to execute.

For further commentary on *Damron* and its progeny, *see*, *e.g.*, Myles P. Hassett & Jamie A. Glasser, *Damron Agreements in the 21st Century: Sword or Shield?*, ARIZ. ATTY. 20 (March 2016); Wm. Sandweg III & John Ager, *A Primer on the Cooperation Clause:* Damron v. Sledge *and Its Progeny*, ARIZ. ATTY. 11 (March 2016).

ARKANSAS

No Arkansas state court has directly addressed the issue of whether a policyholder has a right to choose its own counsel under circumstances in which its insurer has reserved its rights. However, numerous federal courts applying Arkansas law have recognized the right of a policyholder to choose its own counsel and be reimbursed *reasonable* fees when the insurer has accepted the defense under a reservation of rights. *Northland Ins. Co. v. Heck's Service Co., Inc.*, 620 F. Supp. 107 (E.D. Ark. 1985), *Union Ins. Co. v. Knife Co., Inc.*, 902 F. Supp. 877, 879 (W.D. Ark. 1995) (includes a lengthy discussion on "relevant data" and the majority rule among the states on this issue).

A United States District Court applying Arkansas law also held that the insurer must either provide an independent attorney to represent the insured *or* pay the costs incurred by the insured in hiring counsel of its own choice, not both. *Bituminous Cas. Corp. v. Zadeck Energy Group, Inc.*, 416 F. Supp. 2d 654, 660 - 61 (W.D. Ark. 2005).

But the Eighth Circuit appears to have limited that holding to situations where the appointed lawyer's conflict of interest is more apparent.

> PNC argues Hortica *assigned* Cross Gunter to represent PNC, despite PNC's "absolute right" to choose its own counsel. Appellant/Cross-Appellee's Br. 35. Hortica counters it had no prior relationship with Cross Gunter and the firm was well qualified to represent PNC. Arkansas law does not directly address this question, but two federal courts have held the insured has a right to select is own counsel in cases where an insurer-appointed counsel would face a conflict of interest. *Union Ins. Co. v. The Knife Co.*, 902 F. Supp. 877, 881 (W.D. Ark. 1995); *Northland Ins. Co. v. Heck's Serv. Co.*, 620 F. Supp. 107, 108 (E.D. Ark. 1985). But even assuming Arkansas law provides PNC the right to choose its own counsel, PNC presents no evidence Hortica chose Cross Gunter out of malice or dishonesty. Nor does PNC explain how its inability to choose proximately caused its harm. We are not anxious to infer bad faith or negligence in such speculative circumstances. *See Wheeler v. Bennett*, 312 Ark. 411, 849 S.W.2d 952, 958 (1993) (declining to award recovery where cause of damages was conjectural).

[9] There is Arizona case law explaining that when a liability insurer assigns an attorney to represent an insured, the lawyer owes a duty to the insurer arising from the understanding that the lawyer's services are intended to benefit both insurer and insured when their interests coincide, even if the insurer is a nonclient. *See Paradigm Ins. Co. v. Langerman Law Offices P.A.*, 24 P.3d 593 (Ariz. 2001). Because the ruling rests on the premise that the parties' "interests coincide," it does not speak to the situation of when independent counsel is retained for an insured because its interests diverge from the insurer's.

Hortica-Florists' Mut. Ins. Co. v. Pittman Nursery Corp., 729 F.3d 846, 855 (8th Cir. 2013) (emphasis in original).

CALIFORNIA

A. Parameters of Insured's Right to Independent Counsel

In *Executive Aviation, Inc. v. National Insurance Underwriters*, 16 Cal. App. 3d 799, 810 (1971), the court held that in a conflict-of-interest situation, "[t]he insurer's desire to exclusively control the defense must yield to its obligation to defend its policyholder," allowing the insured to control the defense. Subsequently, *San Diego Federal Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App. 3d 358 (1984), confirmed that when an insurer reserves rights on issues critical to the defense of the case, a conflict of interest arises for the attorney appointed by the insurer to defend and gives rise to the right of an insured to hire independent counsel at the insurer's expense. The right to independent counsel set forth in *Cumis* was codified in 1987 by California *Civil Code* § 2860,[10] which now sets forth the basic ground rules for rights and obligations with respect to independent counsel. And, although the statute sets forth those basic ground rules, there also is case law that guides the parties' conduct.

To summarize, *Civil Code* § 2860 provides:

(a) If a conflict of interest arises which creates a duty on the part of the insurer to provide the independent counsel, the insurer shall *provide* independent counsel to represent the insured unless the insured is informed and expressly waives in writing its rights to independent counsel or the insurance contract itself provides a different method of selecting counsel consistent with § 2860.

(b) A conflict of interest does not arise under all circumstances; it arises when the outcome of a coverage issue upon which a reservation of rights is based can be controlled by the defending counsel. No conflict of interest exists by reason of claims for punitive damages or the potential for a judgment in excess of policy limits.

(c) The insurer has the right to require certain "minimum qualifications" of the independent counsel. The insurer's obligation to pay fees for the independent counsel is limited "to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim is being defended." Again, the policy can provide other methods for setting fees. Any dispute concerning attorneys' fees is to be resolved by "final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute."

(d) When independent counsel has been selected by the insured, that counsel and the insured must disclose "all information concerning the action except privileged materials relevant to coverage disputes" to the insurer and keep the insurer informed and "consult" in a timely manner on "all matters relating to the action." Privilege claims are subject to an *in camera* review and information disclosed by the insured or independent counsel to the carrier does not create a waiver of any privilege.

(e) The insured may waive its rights to independent counsel by a signed writing in conformance with the Code.

(f) If independent counsel is selected, the insurer may also provide counsel and such counsel "shall be allowed to participate in all aspects of the litigation."

[10] See Appendix.

B. Additional Requirements and Duties

Not every conflict of interest requires independent counsel. According to case law, the conflict must be "significant, not merely theoretical, actual, not merely potential." *Dynamic Concepts. Inc. v. Truck Insurance Exchange*, 61 Cal. App. 4th 999 (1998). A reservation of rights itself is not the trigger of independent counsel. The outcome of the coverage issue upon which the reservation is based must be such as can be controlled by counsel first retained by the insurer. Thus, where the reservation of rights is based on coverage disputes that have nothing to do with the issues being litigated in the underlying case, there is no right to independent counsel. *See, e.g., McGee v. Superior Court*, 176 Cal. App. 3d 221 (1985) (reservation of rights regarding resident relative exclusion does not give rise to rights to independent counsel); *James 3 Corp. v. Truck Ins. Exchange*, 91 Cal. App. 4th 1093 (2001) (insurer's refusal to fund prosecution of affirmative claims does not give rise to right to independent counsel); *Blanchard v. State Farm Fire & Casualty Co.*, 2 Cal. App. 4th 345, 347 (1991) (reservation of rights that certain types of construction-related damages were not covered by the insurance policy does not give rise to right to independent counsel). *Accord with Dynamic Concepts and Blanchard*, *Fed. Ins. Co. v. MBL, Inc.*, 219 Cal. App. 4th 29, 42, (6th Dist. 2013). *Accord with James 3 Corp.*, *Park Townsend, LLC v. Clarendon Am. Ins. Co.*, 916 F. Supp. 2d 1045 (N.D. Cal. 2013).

See also, e.g., Bank of America, N.A. v. Superior Court of Orange County, 212 Cal. App. 4th 1076 (4th Dist. 2013); *Park Townsend, LLC v. Clarendon Am. Ins. Co.*, 916 F. Supp. 2d 1045 (N.D. Cal. 2013).

California courts have made clear that the arbitration provision of *Civil Code* § 2860 applies only to fee-related disputes and no other disputes. Issues relating to the duty to defend and the right to independent counsel are not properly arbitrable. *See, e.g., Handy v. First Interstate Bank*, 13 Cal. App. 4th 917, 927 (1993). Further, for example, *Gray Cary Ware & Freidenrich v. Vigilant Ins. Co.*, 114 Cal. App. 4th 1185 (2004) held that *Civil Code* § 2860 did not require arbitration of a dispute concerning "defense expenses" (*e.g.*, investigative computer litigation support, travel expenses, meals, etc.). In *Compulink Management Center, Inc. v. St. Paul Fire & Marine Ins. Co.*, 169 Cal. App. 4th 289 (2008), however, the court held that *Civil Code* § 2860 required arbitration of "any issues concerning the amount of *Cumis* fees allegedly owed by [the insurer] including any disputed issues regarding independent counsel's hourly rate or number of hours billed." 169 Cal. App. 4th at 301. *Accord with Gray Cary Ware & Freidenrich*, *Wallis v. Centennial Ins. Co.*, 982 F. Supp. 2d 1114 (E.D. Cal. 2013). *Accord with Compulink*, *Arrowood Indem. Co. v. Bel Air Mart*, No. 2:11-CV-00976-JAM-DAD, 2013 WL 2434830 (E.D. Cal. June 4, 2013); *Swanson v. State Farm Gen'l Ins. Co.*, 219 Cal. App. 4th 1153, 1163-66 (2d Dist. 2013).

See also Behnke v. State Farm Gen'l Ins. Co., 196 Cal. App. 4th 1443 (4th Dist. 2011) (where insurer was not a party to a fee agreement between the insured and independent counsel, insurer was not contractually obligated to pay the full amount of independent counsel's fees billed under that agreement).

The insurer's obligation to pay the independent counsel rates is limited to the rate the insurer pays counsel it retains (*i.e.*, panel counsel) to defend similar cases in the relevant community. Importantly, the rate is not a rate to be paid for each individual insurer which may be defending. California courts have held that when multiple insurers are obligated to provide *Cumis* counsel, the statute limits the attorney to a single fee based on billing rates paid by one of the insurers (who must thereafter share such costs). Also *Civil Code* § 2860 applies to policies issued before its enactment. *See, San Gabriel Valley Water Co. v. Hartford Accident & Indemnity Co.*, 82 Cal. App. 4th 1230 (2000).

Although *Civil Code* § 2860 references a conflict of interest created for counsel "first retained by the insurer," in *Long v. Century Indem. Co.*, 163 Cal. App. 4th 1460 (2008), the court made clear that the duty arises "when the potential conflict arises, whether or not the insurer has—or will—retain its own counsel."

New cases:

- *Hartford Cas. Ins. Co. v. J.R. Marketing, LLC*, 61 Cal. 4th 988 (2015). Among the significant holdings are the following:
    - Unless the insured agrees otherwise, in a case where, because of the insurer's reservation of rights based on possible noncoverage under a CGL policy, the interests of the insurer and the insured diverge, the insurer must pay reasonable costs for retaining independent counsel by the insured (citing to Cal. Civ. Code § 2860). *Id.* at 998.
    - The statute requiring an insurer to provide independent counsel for an insured in the event of a conflict of interest is not triggered simply because an insurer defends under a reservation of rights, the underlying litigation alleges facts under which the insurer would deny coverage, or the litigation includes claims for punitive damages or damages in excess of policy limits; rather, the statute comes into play only when there exists a real and significant disjuncture between the interests of an insurer and its insured (citing to Cal. Civ. Code § 2860). *Id.* at 1003.
    - Independent *Cumis* counsel representing an insured, due to a conflict of interest on the part of the insurer, must be free to represent the insured as they see fit, subject only to generally applicable legal provisions and professional standards (citing to Cal. Civ. Code § 2860). *Id.* at 1006.
    - The proper test for any hindsight claim of excessive billing by independent *Cumis* counsel representing an insured due to a conflict of interest with the insurer is the same as for a contemporaneous challenge—i.e., whether the charges were objectively reasonable at the time they were incurred, under the circumstances then known to counsel (citing to Cal. Civ. Code § 2860). *Id.*

See also John DiMugno, Hartford Casualty Insurance Company v. J.R. Marketing: *New Questions about California's Independent Counsel Statute*, CAL. INS. L. & REG. RPTR 1, Vol. 28 Issue 4 (May 2016).

- *Dorroh v. Deerbrook Ins. Co.*, No. 1:11-cv-02120-DAD-EPJ, 2016 WL 7209808, __ F. Supp. 3d __ (E.D. Cal. Dec. 12, 2016) (because an attorney retained by an insurer to defend its insured is an independent contractor, a liability insurer cannot be held liable for the attorney's tortious conduct under California law).
- *Hollyway Cleaners & Landry Co. v. Central Nat'l Ins.*, No. 2:13-cv-07497-ODW(E), 2016 WL 6602544 (C.D. Cal. Nov. 7, 2016) (citing to Cal. Cv. Code § 2860, under California law, in some types of conflict-of-interest situations, an insurer must provide not only a defense for its insured, but an independent attorney selected by the insured; the scope of the conflict of interest requiring the provision of independent counsel to insured under California law is narrow, and where a reservation of rights is based on coverage disputes that have nothing to do with the issues being litigated in the underlying action, there is no conflict of interest requiring independent counsel). In this case, the court held that a conflict of interest arising from a CGL's reservation of rights concerning the policy's chemical-discharge exclusion did not require appointment of independent counsel to defend the insurer dry-cleaning establishment, and its owners, in an underlying environmental-contamination lawsuit, where the insurer's efforts to demonstrate that the subject contamination was intentional and, therefore, excluded from coverage did not undermine the insureds' defense in the underlying lawsuit, since the causes of action in said lawsuit were not restricted to deliberate or intentional acts. And the insurer's assertion of a fraud defense did not create a conflict of interest requiring appointment of independent counsel where insurer did not reserve its rights as to its fraud defense.

- *St. Paul Mercury Ins. Co. v. McMillin Homes Construction, Inc.*, No. 15-cv-1548 JM(BLM), 2016 WL 5464553 (S.D. Cal. Sept. 29, 2016) (not every conflict gives rise to the right of an insured to independent counsel).

- *Travelers Cas. Ins. Co. v. Hirsh*, 831 F.3d 1179 (9th Cir. 2016) (insurer's claims of unjust enrichment, violation of state governing independent counsel, and concealment against independent counsel for an insured arose from counsel's post-settlement conduct, and not counsel's communications with insured in settling a lawsuit, and thus, insurance company's claims were not barred by California's litigation privilege, where insurer alleged that independent counsel unjustly retained received funds received from settlement of insured's claims without providing insurer a setoff in fees insurer owed counsel, and that counsel failed to disclose material, nonprivileged information regarding amendment of settlement of insured's lawsuit).

- *Centex Homes v. St. Paul Fire & Marine Ins. Co.*, 237 Cal. App. 4th 23 (4th Dist. 2015) (*Centex I*) (contractor, subcontractor, and subcontractor's insurer did not currently have a conflict of interest in connection with underlying construction-defect litigation, which required appointment of independent counsel for general contractor, which was a named insured under subcontractor's insurance policy; while insurer's and general contactor's interests were slightly different because insurer's liability was limited to subcontractor's work and insurer claimed a right to reimbursement against general contractor for all defense fees unrelated to property damage caused by subcontractor, general contractor's liability was merely derivative of all of its subcontractors' liability such that the parties had the same interest in defending against the underlying claim). *See also Differing Interests of Developer and Subcontractor's Insurer, Which Covered Developer as an Additional Insured, Did Not Entitle Developer to Independent Counsel at Insurer's Expense*, 36 CAL. TORT REP. 8, No. 7 (July-Aug. 2015).

- *Centex Homes v. St. Paul Fire & Marine Ins. Co.*, 19 Cal. App. 5th 789 (3d Dist. 2018) (*Centex II*) (contractor, subcontractor, and subcontractor's insurer—who agreed to defend contractor as additional insured—did not have a conflict of interest requiring appointment of independent counsel in connection with underlying construction-defect litigation where: (1) Rule 3-310(C)(1) of the Rules of Professional Conduct, which governs representation of more than one client in which interests of clients potentially conflict, was inapplicable because insurer's interest was only as an indemnity provider and not as a direct party to the action; (2) there was no evidence that insurer defending claim under a reservation of rights could control outcome of coverage dispute of the underlying construction defect litigation for which insured was strictly liable; and (3) there was no evidence that insurer controlled both sides of the construction defect litigation).

- *Celerity Educational Group v. Scottsdale Insurance Company*, No. CV 17-03239-RSWL-JC, 2018 WL 2585231 (C.D. Ca. Apr. 11, 2018) (educational group under federal investigation for theft of government property, theft or bribery of federal funds, wire fraud, and mail fraud was not entitled to independent counsel as a matter of law because there was no evidence that insurer made a reservation of rights as to an issue that would be controlled by counsel selected by the insurer. In the same action, one of the five board members of the educational group, who was identified as a "person of interest" in connection with the federal investigation, was entitled to independent counsel as a matter of law, while the remaining four board members were not entitled to independent counsel).

C. *KPC Healthcare, Inc. v. Hudson Specialty Ins. Co.*, No. SACV1601483AGDFMX, 2017 WL 5642305 (C.D. Cal. Apr. 10, 2017) (where insured is being defended by independent counsel and must satisfy a self-insured retention, the self-insured retention erodes at independent counsel's reasonable billing rate, not at the so-called "*Cumis* rate." Statute:

§ 2860. Conflict of interest; duty to provide independent counsel; waiver; qualifications of independent counsel; fees; disclosure of information

(a) If the provisions of a policy of insurance impose a duty to defend upon an insurer and a conflict of interest arises which creates a duty on the part of the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to represent the insured unless, at the time the insured is informed that a possible conflict may arise or does exist, the insured expressly waives, in writing, the right to independent counsel. An insurance contract may contain a provision which sets forth the method of selecting that counsel consistent with this section.

(b) For purposes of this section, a conflict of interest does not exist as to allegations or facts in the litigation for which the insurer denies coverage; however, when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist. No conflict of interest shall be deemed to exist as to allegations of punitive damages or be deemed to exist solely because an insured is sued for an amount in excess of the insurance policy limits.

(c) When the insured has selected independent counsel to represent him or her, the insurer may exercise its right to require that the counsel selected by the insured possess certain minimum qualifications which may include that the selected counsel have (1) at least five years of civil litigation practice which includes substantial defense experience in the subject at issue in the litigation, and (2) errors and omissions coverage. The insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended. This subdivision does not invalidate other different or additional policy provisions pertaining to attorney's fees or providing for methods of settlement of disputes concerning those fees. Any dispute concerning attorney's fees not resolved by these methods shall be resolved by final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute.

(d) When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action. Any claim of privilege asserted is subject to in camera review in the appropriate law and motion department of the superior court. Any information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.

(e) The insured may waive its right to select independent counsel by signing the following statement: "I have been advised and informed of my right to select independent counsel to represent me in this lawsuit. I have considered this matter fully and freely waive my right to select independent counsel at this time. I authorize my insurer to select a defense attorney to represent me in this lawsuit."

(f) Where the insured selects independent counsel pursuant to the provisions of this section, both the counsel provided by the insurer and independent counsel selected by the insured shall be allowed to participate in all aspects of the litigation. Counsel shall cooperate fully in the exchange of information that is consistent with each counsel's ethical and legal obligation to the insured. Nothing in this section shall relieve the insured of his or her duty to cooperate with the insurer under the terms of the insurance contract.

COLORADO

No Colorado state court has yet addressed this issue.

But a recent federal court analyzed the applicable Colorado Rules of Professional Conduct and Colorado Ethics Opinions in determining that, in the case at bar, no conflict of interest existed to require the insurer

to relinquish control of the defense to independent counsel. *Weitz Co., LLC v. Ohio Cas. Ins. Co.*, No. 11-cv-00694-REB-BNB, 2011 WL 2535040 (D. Colo. June 27, 2011).

CONNECTICUT

There is no Connecticut statute or reported opinion addressing the insured's right to select independent counsel. However, in *Aetna Life & Casualty v. Gentile,* 15 Conn. L. Rptr. 451, 1995 WL 779102 (Conn. Super. Dec. 12, 1995), an unpublished opinion addressing a declaratory judgment action filed by the insurer seeking a declaration that it had no duty to defend or indemnify its insured, the Court noted:

> Where an insurer perceives a conflict of interest between itself and its insured prior to or during the course of trial, it is customary, legally appropriate, and often legally necessary for the insurer to provide independent counsel to the insured, so as to not jeopardize the insured's rights under the terms of the contract.

Id. In *Gentile,* the Court found in favor of the insured and ordered the insurer to defend. In addition the Court ordered that the insurer reimburse the insured for the reasonable costs and fees it had incurred to date in defending the action, but did not elaborate on any standard for determining such reasonable costs and fees.

Gentile was abrogated by *ACMAT Corp. v. Greater N.Y. Mut. Ins.*, 282 Conn. 576 (2007), holding that the insured was not entitled to attorney fees as the prevailing party in an action against its liability insurer for declaratory judgment regarding the existence of a policy issued in the 1960s; no finding of bad faith conduct by the insurer was made, and no statutory or contractual provision authorized such an award.

Similarly, in *Hartford Fire Ins. Co. v. Rivers*, 19 Conn. L. Rptr. 183, 1997 WL 162750 (Conn. Super. Mar. 27, 1997), a case involving a declaratory judgment action initiated by the underlying plaintiff (as opposed to either the insurer or insured), the Court, noted, *inter alia,* that the insurer had provided the insured with independent counsel and, in doing so, had satisfied its contractual obligations to the insured.

See also Nationwide Mut. Ins. Co. v. Pasiak, No. X08FSTCV084015401, 2011 WL 6413817 (Conn. Super. Nov. 30, 2011).

Finally, in *King v. Guiliani*, 9 Conn. L. Rptr. 527, 1993 WL 284462 (Conn. Super. July 27, 1993), the Superior Court was called upon to consider the propriety of an insurance company's practice of engaging a "captive" law firm to defend its insureds. The case arose from a dispute involving a former insurance company staff counsel who sought to continue to represent his insured clients after his employment was terminated by the insurer. In considering the issue, the Court concluded that, absent a conflict, such a practice was appropriate. However, the Court pointed out:

> I can only observe that anyone who believes that in conflict of interest situations, a salaried employee of [the insurer] would not place the welfare of the corporation above that of the policyholder, who theoretically he represents, probably also believes in the tooth fairy and the Easter bunny.

Id. (citations omitted).

Although it appears that Connecticut would conclude that an insured is entitled to separate counsel when a conflict of interest exists, there is no reported opinion on this issue and the few unreported opinion that touch on this issue do not elaborate upon an insurer's obligations under these circumstances.

DELAWARE

The Delaware courts have not addressed the issue of an insured's right to select independent counsel. However, in *Baio v. Comm'l Union Ins. Co.,* 410 A.2d 502 (Del. 1979), the Supreme Court recognized that

an insurance company had a duty to act "equitably" towards its insured. There, an insurer sought to recover for its subrogated interest against a third party for funds it had paid out on a worker's compensation claim. The insurer subsequently discovered that it also insured the defendant tortfeasor, whom the insurer was obligated to defend. The Court suggested that the insurer's equitable conduct might include maintenance of separate files or "the employment of separate counsel . . . and so on," but did not address the issue any further. *Id.* at 508 n.6. Likewise, in *Corrado Bros., Inc. v. Twin City Fire Ins. Co.*, 562 A.2d 1188 (Del. 1989), the court commented that an insured might need independent counsel when a claim exceeds policy limits.

DISTRICT OF COLUMBIA

No District of Columbia court has yet addressed this issue. A Federal court, however, has found an insurance policy ambiguous on the question of when an insured is entitled to select independent counsel where the insurer defends under a reservation of rights. *See O'Connell v. Home Ins. Co.*, CIV. A. No. 88-3523, 1990 WL 137386 (D.D.C. Sept. 10, 1990).

A federal district court sitting in New York, applying D.C. law, relied on *O'Connell* in support of insured's right to select independent counsel. *Wallace v. Nat'l Railroad Passenger Corp.*, 5 f. Supp. 3d 452 (Mar. 18, 2014) (D.C. law).

FLORIDA

Florida has a Claims Administration Statute, §627.426(2), Fla. Stat. ("CSA") which applies in liability cases. It is important to note, however, that in *AIU Insurance Company v. Block Marina Investment Co*., 544 So. 2d 998 (Fla. 1989), the Florida Supreme Court held that the CSA only applied to a "coverage defense." In other words, §627.426(2) "by its express terms applies only to a denial coverage based on a particular coverage defense" such as late notice. The Court held in pertinent part as follows:

> Therefore, we hold that term "coverage defense" as used in section §627.426(2), means a defense to coverage that otherwise exists. We do not construe the term to include a disclaimer of liability based on a complete lack of coverage for the loss sustained.

Id. At 1000. See also Grigby, Andrew E., "The Dance of the Porcupines: Defense Under a Reservation of Rights," *The Florida Bar Journal*, Vol. 83, No. 2 (Feb. 2009)

Pursuant to §627.426(2)(b)3,[11] where a "coverage defense" is raised, Florida law requires that the *insurer* retain "independent counsel which is mutually agreeable to the parties." To be mutually agreeable, the insured must actually approve the selected counsel. *See Cont'l Ins. Co. v. City of Miami Beach*, 521 So. 2d 232, 233 (Fla. App. 3d Dist. 1988); *Am. Empire Surplus Lines Ins. Co. v. Gold Coast Elevator, Inc.,* 701 So. 2d 904, 906 (Fla. App. 4th Dist. 1997).

When an insurer defends under a reservation of rights, the insured may reject the carrier's defense and retain its own attorneys without jeopardizing its right to seek indemnification from the insurer for liability. *See Travelers Indem. Co. of Ill. v. Royal Oak Enterprises, Inc.,* 344 F. Supp. 2d 1358, 1370 (M.D. Fla. 2004). [12]Under Florida law, however, the policyholder is required to take several steps before he or she can actually retain his or her own attorney. First, the insured must actually *reject* the defense that the carrier offers before the insured is allowed to select his or her own counsel. *See Aguero v. First American Ins. Co.*, 927 So. 2d 894, 898 (Fla. App. 3d Dist. 2005). An unreported federal court decision indicates that, to reject the insurer's counsel, the policyholder may have to show "harm or prejudice" as to why counsel provided by the insurer is not "mutually agreeable." *See Prime Ins. Syndicate, Inc. v. Soil Tech Distributors, Inc.,*

[11] See Appendix.

[12] This case can also be cited for the proposition that an insurer does not have to seek "mutually agreeable counsel" where no "coverage defense" has been raised by the insurer. *Id*. at 1272.

2006 WL 1823562, *6 (M.D. Fla. 2006) (rebutting arguments that counsel was not "mutually agreeable" on an estoppel theory with the argument that counsel did not harm or prejudice the insured).

See also:

Mid-Continent Cas. Co. v. Am. Pride Building Co., 601 F.3d 1143 (11th Cir. 2010) (while an insurer must defend its insured, and may tender its defense subject to a reservation of rights, Florida law does not require an insured to accept such a defense; when an insurer agrees to defend under a reservation of rights or refuses to defend, the insurer transfers to the insured the power to conduct its own defense and, under Florida law, if the insurer offers to defend under a reservation of rights, the insured has the right to reject the defense and hire its own attorneys and control the defense).

U.S. Specialty Ins. Co. v. Burd, 833 F. Supp. 2d 1348 (M.D. Fla. 2011) (under Florida law, an economic conflict occurs, precluding an attorney from representing both the insurer and the insured, when the financial interests of the insurer and insured diverge; this typically happens when the insured, facing an excess claim, wants the policy limits offered in order to head off an excess judgment, but the insurer is reluctant to do so in the belief that the claim is not worth the policy limit; and when the insurer that has hired an attorney to represent its insured raises coverage defenses to the insured's claim, the interests of the insured and the insurer are in conflict, and the insurer normally issues a reservation of rights letter informing the insured that he might want to obtain independent counsel).

U. of Miami v. Great Am. Assur. Co., 112 So. 3d 504 (3d Dist. Ct. App. 2013) (conflict in legal defenses raised by university and operator of summer swim camp held on university campus required insurer to appoint separate independent counsel for university in a third-party negligence action falling under camp operator's general liability policy, which covered university as an additional insured; complaint alleged that each of the co-defendants was directly liable, camp operator alleged that plaintiff's injury was caused by the fault of university for which it was entitled to indemnification and contribution, university alleged that plaintiff's injury was caused by the fault of camp operator, and single defense counsel was put in the position of arguing that each of its clients was not at fault, and the other was).

Embroidme.com v. Travelers Cas. & Sur. Co. of Am., 992 F. Supp. 2d 1259 (S.D. Fla. 2014) (insurer was not foreclosed under Fla. Stat. § 627.426 from raising defense that insured had incurred disputed defense costs without insurer's knowledge and not at insurer's request in violation of plain language of policy, on insured's claim that insurer had breached CGL insurance policy by not reimbursing it for full cost of defending underlying legal action; although law firm was "mutually agreeable" independent counsel and insurer did not retain that firm until 133 days after notice of claim, the statute did not apply if there was no coverage).

Petro v. Travelers Cas. & Sur. Co. of Am., 54 F. Supp. 3d 1295 (N.D. Fla. 2014) (insured had timely actual knowledge of reservation of rights and policy exclusions potentially applicable to the facts, and timely accepted the retained counsel, and thus insurer fulfilled its duty under Fla. Stat. § 627.426 to select mutually agreeable counsel; insurer thus fulfilled its duty under the statute to select mutually agreeable counsel; although insurer unilaterally retained independent counsel and reservation-of-rights letter did not explicitly mention that counsel had to be "mutually agreeable," insured had been consulted and agreed to counsel within requisite 60 days, and retained counsel then proceeded to represent insured for almost five years without objection).

Maronda Homes, Inc. of Fla. v. Progressive Express Ins. Co., 118 F. Supp. 3d 1332 (M.D. Fla. 2015) (although Florida law requires an insurer to provide an adequate defense of a claim against its insured that is covered by a policy and that if such defense is not adequate and it is reasonable for an insured to retain its own counsel, then an insured may recoup attorney fees from the insurer because it has, in effect, forced the insured to retain its own counsel, and although under Florida law the right to manage claims and defenses by an insurer can be overridden only when the insurer's interest interferes with the independent

representation by counsel provided by the insurer, insured was not entitled to recoup because insured precluded insurer's efforts to provide a defense from the start of the underlying lawsuit by rejecting first defense counsel due to alleged conflict of interest and second defense counsel because insured disagreed with his litigation strategy; there was no showing that any aspect of insurer's defense was inadequate).

Traci K. Stevenson, as Ch. 7 Trustee for Ayyoub v. Corporation of Lloyd's, et al., No. 8:15-cv-2745-T-30, 2016 WL 524735 (M.D. Fla. Feb. 10, 2016) (bankruptcy trustee failed to establish that a conflict of interest existed; debtors not entitled to appointment of independent counsel).

EmbroidMe.com, Inc. v. Travelers Prop. Cas. Co. of Am., No. 14-10616, 2017 WL 74694, __ F.3d __ (11th Cir. Jan. 9, 2017) (under Florida law, if an insurer offers to defendant insured under a reservation of rights, the insured has the right to reject the defense and hire its own attorneys and control the defense, without jeopardizing its right to later seek indemnification from the insurer for liability; and, further, an insured must actually reject the insurer's defense, which it offered under a reservation of rights, before the insured may hire its own attorneys and control the defense without jeopardizing its right to seek indemnification from the insurer for liability).

Houston Specialty Ins. Co. v. Vaughn, No. 8:15-cv-2165-T-17AAS, 2017 WL 990581 (M.D. Fla. Mar. 14, 2017) (insurer failed to comply with § 627.426(2)(a), rendering its reservation-of-rights letter untimely).

Statute:

627.426. Claims administration

(1) Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(a) Acknowledgment of the receipt of notice of loss or claim under the policy.

(b) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(c) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

(2) A liability insurer shall not be permitted to deny coverage based on a particular coverage defense unless:

(a) Within 30 days after the liability insurer knew or should have known of the coverage defense, written notice of reservation of rights to assert a coverage defense is given to the named insured by registered or certified mail sent to the last known address of the insured or by hand delivery; and

(b) Within 60 days of compliance with paragraph (a) or receipt of a summons and complaint naming the insured as a defendant, whichever is later, but in no case later than 30 days before trial, the insurer:

1. Gives written notice to the named insured by registered or certified mail of its refusal to defend the insured;

2. Obtains from the insured a nonwaiver agreement following full disclosure of the specific facts and policy provisions upon which the coverage defense is asserted and the duties,

obligations, and liabilities of the insurer during and following the pendency of the subject litigation; or

3. Retains independent counsel which is mutually agreeable to the parties. Reasonable fees for the counsel may be agreed upon between the parties or, if no agreement is reached, shall be set by the court.

GEORGIA

In reservation-of-rights cases, the insurance company seeking to defend must obtain the consent of the insured. *Richmond v. Georgia Farm Bureau Mut. Ins. Co.*, 140 Ga. App. 215, 219, 231 S.E.2d 245, 248 (1976). "Where the insured refuses to consent to a defense offered subject to a reservation of rights, the insurer must thereupon (a) give the insured proper unilateral notice of its reservation of rights, (b) take necessary steps to prevent the main case from going into default or to prevent the insured from being otherwise prejudiced, and (c) seek immediate declaratory relief including a stay of the main case pending final resolution of the declaratory judgment action." *Id.* Consent can be express or implied. *Jacore Systems, Inc. v. Central Mut. Ins. Co.*, 194 Ga. App. 512, 390 S.E.2d 876 (1990).

Although Georgia law does not directly address the hiring of entirely independent counsel nor the payment thereof, it does discuss joint counsel. An Eleventh Circuit case applying Georgia law states the following:

> Where an insured hires co-counsel instead of rejecting the defense offered by the insurance company after an insurance company denies coverage but offers to provide a defense, it does not seem to us misplaced to put the burden on the insurance company to choose between denying a defense and providing a defense in cooperation with co-counsel retained by the insured.

Am. Family Life Assur. Co. of Columbus, Ga. v. U.S. Fire Co., 885 F.2d 826, 832 (11th Cir. 1989).

HAWAII

A. Insured's Right to Independent Counsel?

The Hawaii Supreme Court directly addressed the question of whether an insured is entitled to the appointment of independent counsel in *Finley v. Home Ins. Co.*, 975 P.2d 1145 (Haw. 1998). There, the court rejected the requirement that that the insurer must fund a separate "independent" counsel of an insured's choice when an insurer reserves rights. The court specifically explained:

> [W]e are convinced that the best result is to refrain from interfering with the insurer's contractual right to select counsel and leave the resolution of the conflict to the integrity of retained defense counsel. Adequate safeguards are in place already to protect the insured in the case of misconduct. If the retained attorney scrupulously follows the mandates of the Hawaii Rules of Professional Conduct (HRPC), the interests of the insured will be protected.

Id. at 1152. The *Finley* court explained that if the insured is concerned about the situation, it is free to reject the appointed counsel. However, if it does so, it waives the right to defense fees:

> If the insured chooses to conduct its own defense, the insured is responsible for all attorneys' fees related thereto. The insurer is still potentially liable for indemnification for a judgment within the scope of insurance coverage. However, having refused the contractual terms of the policy, the insured foregoes its right to compensation for defense fees.

The Supreme Court reaffirmed this approach in the case of *Delmonte v. State Farm Fire & Cas. Co*., 975 P.2d 1159 (Haw. 1999), elaborating that the insured may refuse the counsel offered but is responsible for the attorney's fees incurred if it does so.

B. Additional Requirements or Duties

Although independent counsel need not be provided merely because a potential conflict exists, as subsequent cases have explained, the *Finley* case nonetheless adopted an "enhanced" standard of good faith when an insurer defends subject to a reservation of rights.

> [T]he potential conflicts of interest between insurer and insured inherent in this type of defense mandate an even higher standard: an insurance company must fulfill an enhanced obligation to its insured as part of its duty of good faith.... This enhanced obligation is fulfilled by meeting specific criteria. First, the company must thoroughly investigate the cause of the insured's accident and the nature and severity of the plaintiff's injuries. Second, it must retain competent defense counsel for the insured [subject to rejection by the insured].... Third, the company has the responsibility for fully informing the insured not only of the reservation-of-rights defense itself, but of all developments relevant to his policy coverage and the progress of his lawsuit.... Finally, an insurance company must refrain from engaging in any action which would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk.

See CIM Ins. Corp. v. Masamitsu, 74 F. Supp. 2d 975, 989 (D. Hawaii 1999).

Although under Hawaii law, an insurer need not provide separate counsel if a potential conflict exists with the insured, such as if the insurer has reserved rights, and the insurer is subject to an enhanced standard of good faith under this circumstance to ensure that its ethical obligations are met, case law does not address the question of what obligations an insurer has if an *actual conflict* develops.

IDAHO

A. Parameters of Insured's Right to Independent Counsel

Although the Idaho courts have not directly considered the question of whether an insured is entitled to independent counsel when a conflict of interest exists, in 1941 the Supreme Court indirectly considered this question in the case of *Boise Motor Car Co. v. St Paul Mercury Indem. Co.*, 112 P.2d 1011 (Idaho 1941). There, the court briefly discussed the consequences that flow from an insurer reserving rights in connection with a matter, explaining that if the insured did not consent to the reservation, and the insurer nevertheless continued to assert a right to withdraw[13], the insurer was in breach of the insurance contract such that it was appropriate for the insured to protect itself by employing its own counsel. The court concluded that under this circumstance, "[a] fee paid the attorneys is … properly chargeable against respondent." In other words, if an insurer reserves right, the insured may retain separate counsel funded by the defense.

B. Additional Requirements and Duties?

It appears that the *Boise* case is still relied on today for the general notion that an insurer must pay for separate counsel for its insured when it reserves rights. Since that time, however, there has been no elaboration on this requirement, such as the rate that must be provided or if there are any limitations on this requirement.

[13] By right to withdraw, the court here means the insurer maintains the position that it does not have duty to defend, but nevertheless continues to defend under a reservation of rights.

ILLINOIS

If there is an actual conflict of interest between the insurer and insured, the Illinois Supreme Court has held that the insured has the right to obtain independent counsel at the insurer's expense. *Murphy v. Urso*, 430 N.E.2d 1079, 1084 (Ill. 1981) (holding that insurer could not appoint counsel to defend insureds with diametrically opposed interests); *Thornton v. Paul*, 384 N.E.2d 335, 343 (Ill. 1978), *overruled on other grounds*, *Am. Family Mut. Ins. Co. v. Savickas*, 739 N.E.2d 445 (Ill. 2000); *Maryland Cas. Co. v. Peppers*, 355 N.E.2d 24, 31 (Ill. 1976) (holding that conflict existed between insurer and insured where insured in underlying lawsuit could be held liable on either negligent or intentional act claims and only negligence claim was covered under policy). In order to determine whether an actual conflict exists, the court must determine whether the resolution of the factual issues in the underlying lawsuit would allow insurer-retained counsel to lay the groundwork for a later denial of coverage. *Am. Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc.*, 843 N.E.2d 492, 498 (Ill. Ct. App. 2d Dist. 2006) (holding that an actual conflict existed between the insurer and the insured because the date on which the property damage began in the underlying construction defect lawsuit was disputed and would affect coverage); *but see National Cas. Co. v. Forge Indus. Staffing, Inc.,* 567 F.3d 871 (7th Cir. 2009) (applying Illinois law) (holding that an actual conflict did not exist merely because of the hypothetical possibility that the plaintiffs could amend their complaint to add uncovered punitive damages claims). "The insurer must underwrite the reasonable costs incurred by the insured in defending the action with counsel of his own choosing." *Ill. Masonic Medical Center v. Turegum Ins. Co.*, 522 N.E.2d 611, 613 (Ill. App. Ct. 1st Dist. 1988).

See also:

Santa's Best Craft, LLC v. Zurich Am. Ins. Co., 941 N.E.2d 291 (Ill. App. Ct. 1st Dist. 2010) (when a conflict of interest exists between insured and insurer that prevents insurer from defending insured in an underlying suit, the insurer must permit the insured to be represented by counsel of its own choosing, and must reimburse the insured for the reasonable cost of defending the action).

Am. Fam. Mut. Ins. Co. v. Westfield Ins. Co., 962 N.E.2d 993 (Ill. App. Ct. 4th Dist. 2011) (same; and, additionally, a reservation of rights must adequately inform the insured of the rights the insurer intends to reserve, because it is only when the insured is adequately informed of the potential policy defense that the insured can intelligently determine whether to retain his or her own counsel or accept the tender of defense counsel from the insurer).

Econ. Premier Assur. Co. v. Faith in Action of McHenry County, Nos. 1-11-2329, 1-11-2457, 2013 IL App (1st) 112329-U, 2013 WL 1227118 (1st Dist. Mar. 26, 2013) (trial court did not err in granting insured's motion on the issue of the appointment of counsel; appellate court agreed that the conflict outlined by the insured at the beginning of the case, and repeated by appointed counsel during the case, is akin to *Peppers*, *supra*, because it created an unresolved conflict between the interests of the insured and the insurer as it would be in the insurer's interest to keep the insured in the case).

Standard Mut. Ins. Co. v. Lay, No. 4-11-0527, 2013 IL App (4th) 110527-UB, 2013 WL 6199952 (4th Dist. Nov. 25, 2013) ("Where a conflict exists, an insurer's obligation to defend is satisfied by reimbursing the insured for the cost of defense provided by independent counsel selected by the insured. *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 198-99, 355 N.E.2d 24, 31 (1976). Under these circumstances, the insured is entitled to assume control of the defense. *Id.* When an insurer surrenders control of the defense, it also surrenders its right to control the settlement of the action and to rely on a policy provision requiring consent to settle. *Myoda Computer Center, Inc. v. Am. Fam. Mut. Ins. Co.*, 389 Ill. App. 3d 419, 425, 909 N.E.2d 214, 220 (2009). Standard had no right to require Lay to obtain permission to settle the underlying suit or to object to it itself."). *Order withdrawn*, 2 N.E.3d 1253, 2014 IL App (4th) 110527-B (Jan. 21, 2014).

First Mercury Ins. Co. v. Nationwide Security Services, Inc., 2016 IL App (1st) 143924 (2016) (where liability insurer surrenders defense to independent legal counsel because of a conflict of interest, it thereby

relinquishes control over the litigation, and a reasonable settlement by the insured should not prevent an action for or in opposition to indemnification).

Rainey v. Indiana Ins. Co., 2016 IL App (1st) 150862-U (May 11, 2016) (unpublished) (absent a conflict of interest in the underlying litigation, insurer was not obligated to pay for independent counsel and did not breach its duty to defend by failing to do so; because insured cannot show that insurer breached its duty, insured cannot satisfy his contention that insurer was estopped from denying its obligation to provide independent counsel).

DHR Int'l v. Travelers Cas. & Sur. Co. of Am., No. 15 C 4880, 2016 WL 561914 (N.D. Ill. Feb. 12, 2016) (insurer was under no obligation to appoint independent counsel or to advise insured of its right to independent counsel because no conflict of interest existed).

Essex Ins. Co. v. RHO Chem. Co., et al., 145 F. Supp. 3d 780 (N.D. Ill. 2015) (insureds not prejudiced by potential conflict of interest resulting from insurer's representation of insureds, under reservation of rights, in underlying lawsuit, and thus insurer was not estopped under Illinois law from asserting policy exclusion as defense to coverage; although insurer opined in its reservation-of-rights letter that a material conflict of interest did not exist, it specifically identified the potential conflict of interest, insureds did not raise any such conflicts until five months after the letter was sent, and when insurer was informed that its letter created conflict of interest, it permitted insureds to hire their own defense counsel at insurer's expense).

Central Mut. Ins. Co. v. Tracy's Treasures, Inc., 2014 IL App (1st) 123339, 19 N.E.3d 1100 (2014) (insurer may cede control of the defense thus allowing insured to enter into reasonable settlement agreement without insurer's consent under two scenarios: (1) when a conflict of interest exists such that insured becomes entitled to control the defense through counsel of its own choosing or (2) when the insurer breaches its duty to defend thereby requiring the insured to assume its own defense; when a conflict of interest arises between insurer and insured the insured has the right to reject the defense offered by insurer and select counsel of insured's choosing and control the defense of the case and recover its defense costs from the insurer; CGL insurer retained its ability to contest both the reasonableness of settlement insured entered into in underlying class action after obtaining independent counsel and whether the claims giving rise to the settlement were covered under its policies; insurer never breached its duty to defend nor controlled the defense of the underling case to insured's detriment since it allowed insured to obtain substitute counsel and continued to pay for insured's independent counsel; lack of notice to CGL insurer of settlement agreement of underlying class action against insured was not determinative of the reasonableness of the settlement; at the time of settlement, insured had independent counsel whose sole obligation was to represent insured's interests, and insurer made no attempt to assign counsel to monitor case on insurer's behalf).

Perma-Pipe, Inc. v. Liberty Surplus Inc. Corp., 38 F. Supp. 3d 890 (N.D. Ill. 2014) (pursuant to an insurer's duty to defend under Illinois law, if there is a conflict between the interests of the insurer and the insured, the insurer must pay for independent counsel selected by the insured; a conflict of interest does not arise between and insured and an insurer merely because the insurer has an interest in negating coverage nor is a conflict absent simply because both parties would benefit from the insured's exoneration in the underlying suit; under Illinois law, there was a nontrivial probability that there would be a judgment in excess of limits of the CGL policy in the underlying suit against the insured and, thus, a conflict of interest existed that obligated insurer to pay for independent counsel selected by insured in the underlying action—insured was being sued for more than $40 million and the policy limit was $1 million per occurrence).

Indiana Ins. Co. v. CE Design Ltd., 6 F. Supp. 3d 858 (N.D. Ill. 2013) (under Illinois law, an insurer that fails to disclose conflicts of interests in connection with appointment of independent counsel for insured is not estopped from raising coverage defenses unless the insured has been prejudiced by the conflict of interest or appointed counsel; insurer was not estopped from contesting coverage in action seeking declaration that it had no duty to defend or indemnify insured based on its failure to disclose alleged conflict

of interest or offer independent counsel to insured in reservation-of-rights letter absent evidence that insured was prejudiced by its representation in the underlying action).

For one commentator's views, *see* Scott O. Reed, *Conflicts and the Use of Independent Counsel*, 25 DCBA BRIEF 26 (July 2013).

INDIANA

Generally, under Indiana law, where there is a coverage dispute, the insurer must either hire independent counsel for the insured and defend under a reservation of rights or file a declaratory judgment action. *Nat'l Union Fire Ins. Co. v. Standard Fusee Corp*., 917 N.E.2d 170, 187 (Ind. Ct. App. 2009), *vacated on other grounds*, 940 N.E.2d 810 (Ind. 2010). Where a conflict of interest arises, an insurer "must" either retain independent counsel or choose to reimburse the insured for its choice of independent counsel. *All-Star Ins. Corp. v. Steel Bar, Inc.*, 324 F. Supp. 160, 165 (N.D. Ind. 1971) (holding that conflict existed necessitating retention of independent counsel where liability for underlying case and coverage dispute turned on whether injury was the result of an accident or insured's intentional conduct). While this rule of law seems to imply an insured may select counsel only if the insurer does not retain counsel itself, subsequent cases provide otherwise. In *Snodgrass v. Baize*, 405 N.E.2d 48, 51 (Ind. Ct. App. 1980), the court stated that in instances where a conflict of interest arises, "the insurer should not defend, but, rather, [] should reimburse the insured's personal counsel." In *Armstrong Cleaners, Inc. v. Erie Ins. Exch.*, 364 F. Supp. 2d 797, 808 (S.D. Ind. 2005), a federal district court similarly stated that "the conflict may be sufficient to require the insurer to pay for counsel of the insured's choice." A conflict of interest exists where there is a "*significant risk* that an attorney selected by and under the control [of the insurer] would be materially limited in the representation" as a result of the relationship with the insurer and the reservation of rights. *Id.* at 817 (emphasis added). In *Armstrong Cleaners*, an environmental pollution coverage matter, the district court denied the insurer's motion for summary judgment and granted a cross motion in favor of the insureds, holding that the insureds had the right to select defense counsel where the insurer's reservation of rights included coverage defenses concerning whether the pollution was the result of an "occurrence" or whether the insureds expected or intended to cause the alleged property damage. *Id*. at 815–16.

See also:

Am. Fam. Mut. Ins. Co. v. C.M.A. Mortgage, Inc., 682 F. Supp. 2d 879 (S.D. Ind. 2010) (under Indiana law, where insurer, in response to insured's tender of defense, reserves it rights to deny coverage based on a policy exclusion, thus creating a conflict of interest, the insurer is required to reimburse the insured's independent counsel as part of its duty to defend).

Auto-Owners Ins. Co. v. Lake Erie Land Co., Cause No. 2:12-CV-184 JD, 2013 WL 4401834 at *7 (N.D. Ind. Aug. 13, 2013) (citing *Armstrong* extensively, court stated: "Indiana has intentionally adopted the wider 'significant risk' approach reflected in [Indiana] Rule [of Professional Conduct] 1.7(a)(2), see *Armstrong Cleaners*, 364 F. Supp. 2d at 808, but even under the narrower standard advocated by the Plaintiff Insurers, [Lake Erie Land] would carry the day. The simple fact is that, by deciding the claims raised in the Hite Lawsuit, a jury must also necessarily decide the question of intent. The question of intent, in turn, goes a long way towards deciding the question of coverage. That clearly satisfies the *National* [*Cas. Co. v. Forge Indus. Staffing, Inc.*, 567 F.3d 871 (7th Cir. 2009)] test, and that creates a conflict of interest.").

Valley Forge Ins. Co. v. Hartford Iron & Metal, Inc., et al., 148 F. Supp. 3d 743 (N.D. Ind. 2015) (under Indiana law, insurer created conflict of interest that prevented it from controlling the defense by filing breach of contract action against insured that sought recovery of same environmental remediation costs that insured said CGL insurance policies covered; attorney could not represent both insured's and insurer's interests consistent with his or her ethical obligations due to risk of misaligned incentives as result of insured complaining that insurer's selection of remediation company contributed to further discharge issues and insurer maintained that discharge issues were due to insured's bad faith failure to cooperate (citing Ind.

Code Ann. § 13-30-9-5 and Ind. R. Prof. Conduct 1.7(a)); insurer created conflict of interest that prevented it from controlling environmental remediation by filing breach of contract action against insured that sought recovery of same remediation costs that insured said CGL insurance policies covered; although policies prohibited voluntary payments, insurer did not dispute coverage, defense and remediation activities were inextricably intertwined, and insurer and insured blamed each other for further discharge issues that prevented attorney from representing both insured's and insurer's interests).

IOWA

Although no state or federal court has squarely addressed the issue, the Iowa Supreme Court has stated in *dicta* that where "there is an 'inherent conflict of interest' between [the insurer] and [the insured], [the insurer] can simply allow the [insured] to retain its own counsel and then reimburse it for the cost of the entire defense." *First Newton Nat. Bank v. General Cas. Co. of Wisconsin*, 426 N.W.2d 618, 630 (Iowa 1988) (citing *Howard v. Russell Stover Candies, Inc.,* 649 F.2d 620, 625 (8th Cir. 1981)).

KANSAS

The Kansas Supreme Court stated that when a conflict of interest arises between an insured and insurer, the insurer must hire independent counsel to defend the insured in the action and notify the insured of the reservation of rights. *Patrons Mut. Ins. Ass'n v. Harmon*, 732 P.2d 741, 745 (Kan. 1987). No case law has addressed whether an insured has a right to select its own counsel absent a designation by the insurer. *See also*, *Hackman v. W. Agric. Ins. Co.*, 275 P.3d 73 (Ct. App. Kans. 2012).

Eye Style Optics, LLC v. State Farm Fire & Cas. Co., No. 14-2118-RDR, 2014 WL 2472096 (D. Kan. June 3, 2014) (where underlying lawsuit involved covered and uncovered claims of negligent and intentional misconduct, insured did not allege any other facts from which the court could find that the insurer's appointed counsel was not "independent" or able to defend all claims asserted against insured).

KENTUCKY

Kentucky case law states that "an insured is not required to accept a defense offered by the insurer under a reservation of rights." *Med. Protective Co. of Fort Wayne, Ind. v. Davis,* 581 S.W.2d 25, 26 (Ky. App. 1979); *see Cincinnati Ins. Co. v. Vance*, 730 S.W.2d 521, 524 (Ky. 1987). Kentucky courts, however, have not addressed whether the insured may hire its own defense counsel or whether an insurer would be obligated to pay for such expense.

See also Lee v. Med. Protective Co., 858 F. Supp. 2d 803 (E.D. Ky. 2012) (if a conflict of interest arises for the attorney retained by the insurer to defend the insured against an underlying claim, the insured typically retains her own attorney due to the conflict, such as receipt of an offer to settle within the policy limits in a case where an excess verdict is possible; the attorney must advise the insured of the conflict and advise her further about the possibility of an excess verdict and of her right to retain her own attorney).

LOUISIANA

A 1936 Louisiana appellate case was the first case in the state to recognize a policyholder's right to independent counsel and award payment to such counsel of *reasonable* attorney fees. *Shehee-Ford Wagon & Harness Co. v. Cont'l Cas. Co.*, 170 So. 249 (La. App. 2d Cir. 1936). The court did state that it would generally not order payment of insured's attorney fees but for the fact that the counsel provided by the insurer so "directly opposed" the policy. *Id* at 252 (insurer's counsel denied the validity of the policy as part of the "defense" of the insured)

See also, *Emery v. Progressive Cas. Ins. Co.*, 49 So. 3d 17 (Ct. App. La. 1st Cir. 2010) (if insurer chooses to defend the insured but deny coverage, it must employ separate counsel).

Since the 1936 case, a state appellate court has held that "if the insurer chooses to represent the insured but deny coverage it must employ separate counsel. If it fails to do so, the insurer is liable for the attorney fees and costs the insured may incur for defending the suit." *Dugas Pest Control of Baton Rouge, Inc. v. Mut. Fire, Marine and Inland Ins. Co.*, 504 So. 2d 1051, 1054 (La. App. 1st Cir. 1987); *but cf. Trinity Universal Ins. Co. v. Stevens Forestry Service, Inc.*, 335 F.3d 353, 356 (5th Cir 2003) (Louisiana law) (not requiring reimbursement for the insured's *additional* counsel as long as insurer provided *competent* defense counsel).

For one commentator's views, *see* Melissa Claire Scioneaux, *Louisiana Recognizes the Insurance Policyholder's Entitlement to Select Independent Counsel, Now What?" A Legislative Proposal*, 81 TUL. L. REV. 537 (Dec. 2006).

See also J. S. Holliday, Jr., H. B. Shreves & D. R. Baringer, *Insurance coverage and independent counsel*, LA. PRAC. CONSTRUCTION L. § 16:6 (2016).

See also:

Lynch-Ballard v. Lammico Ins. Agency, Inc., 176 So. 3d 651 (Ct. App. La. 5th Cir. 2015) (professional liability insurer had no conflict of interest with insured physician objecting to settlement of malpractice case and, therefore, was not required to appoint new, separate counsel for physician since insurer had the right to settle case within policy limits without insured's consent).

Belanger v. Gabriel Chemicals, Inc., 787 So. 2d 559 (Ct. App. La. 1st Cir. 2001) (insured was entitled to select independent counsel to defend itself against claims of employees, where insurer denied coverage under the CGL and excess policies; the two attorneys offered by insurer had a potential conflict of interest between insurer's duty to defend the insured and insurer's right to contest coverage, and the insured's act of hiring independent counsel evinced a lack of consent to representation by insurer-selected attorneys with a potential conflict of interest, citing La. R. Prof. Cond. 1.7 and LSA-R.S. foll. 37:221; if an insurer chooses to represent the insured but deny coverage, separate counsel must be employed, and failure to do so subjects the insurer to the attorney fees and costs the insured may incur for defending the suit; in cases where the insurer and insured have a conflict of interest, the insured, rather than the insurer, is entitled to assume control of the defense of the underlying action, and select its own attorney; however, the insurer must underwrite the reasonable costs incurred by insured in defending the action with counsel of insured's own choosing).

Smith v. Reliance Ins. Co. of Ill., 807 So. 2d 1010 (Ct. App. La. 5th Cir. 2002) (insured allowed to select own counsel and insurer ordered to pay for all present and future defense costs where insurer attempted to deny coverage in effort to avoid providing a defense to insured; claims against insured and insurer's claim that exclusions applied served to create a conflict of interest that entitled insured to assume control of defense and to select own counsel; insurer's coverage denial is an event that entitles insured to select independent counsel to represent insured at insurer's expense).

Vargas v. Daniell Battery Mfg. Co., Inc., 648 So. 2d 1103 (Ct. App. La. 1st Cir. 1995) (if insurer chooses to represent insured but deny coverage it must employ separate counsel).

MAINE

In *Travelers Indem. Co. v. Dingwell*, 414 A.2d 220 (Me. 1980), the Supreme Judicial Court of Maine recognized in *dicta* the insurer's obligation to provide independent counsel when a conflict arises between insurer and insured:

> Of course, the insurers' obligation to defend can lead to a serious dilemma for the insurer. In some cases, the parties may agree that the insurer hire independent counsel for the insured. . . . The difficulties which these cases may pose will have to be addressed as they arise. For the case at bar, it is sufficient for us to hold that the complaint here does generate

> a duty to defend, because it discloses a potential for liability within the coverage and contains no allegation of facts which would necessarily exclude coverage.

414 A.2d at 227 (citing *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964)).[14]

The Supreme Judicial Court next addressed the issue in *Patrons Oxford Ins. Co. v. Harris*, 905 A.2d 819 (Me. 2006). There, in the context of reviewing a settlement entered by appointed counsel on behalf of an insured which was being defended under a reservation of rights, the Court commented that when an insurer defends subject to a reservation of rights—irrespective of the basis for the reservation and whether it creates an actual conflict of interest—it gives up its right to control the defense. *Id*. at 826.

See also, *Kohl's Dep't Stores, Inc. v. Liberty Mut. Ins. Co.*, No. BCD-CV-12-13, 2012 WL 6650619 (Me. Super. Oct. 11, 2012) (Trial Order), at § I.A. "Identification of the Correct Client."

MARYLAND

The Maryland state courts have concluded that, in the case of an actual conflict of interest, the insured is entitled to retain independent counsel to defend the claim and that the insurer is required to pay the reasonable cost of that defense. *See Brohawn v. Transamerica Ins. Co.*, 276 Md. 396, 414-15, 347 A.2d 842 (1975); *So. Md. Agric. Assoc., Inc. v. Bituminous Cas. Corp*., 539 F. Supp. 1295 (D. Md. 1982); *Allstate Ins. Co. v. Campbell*, 334 Md. 381, 392, 639 A.2d 652, 657 (Md. App. 1994) ("We have recognized an obligation by the insurer to assume the reasonable costs of the defense provided by an independent attorney where independent counsel is necessary because there exists a conflict of interest between the insurer and the insured.").

In *Brohawn*, an insurer brought a declaratory judgment action against its insured, seeking a declaration that it had no obligation to defend or indemnify its insured in an action brought by third parties based on alternative allegations of negligence and assault. The policy expressly excluded from coverage liabilities arising from any intentional acts committed by the insured, and the insured had pleaded guilty to assault in a criminal action arising out of the same incident. The Court concluded that the insurer's obligation to defend is determined by the allegations in the complaint and if the complaint alleges a claim potentially covered by the policy, the insurer has a duty to defend. *Id.* at 407, 347 A.2d 842. In order to fulfill this duty, the *Brohawn* Court concluded that the insurer must permit the insured to select independent counsel to defend the entire case and pay that independent counsel a reasonable fee:

> We hold that an insured is not deprived of his contractual right to have a defense provided by the insurer when a conflict of interest between the two arises under circumstances like those in this case. When such a conflict of interest arises, the insured must be informed of the nature of the conflict and given the right either to accept an independent attorney selected by the insurer or to select an attorney himself to conduct his defense. If the insured elects to choose his own attorney, the insurer must assume the reasonable costs of the defense provided.

Id. at 414-15, 347 A.2d at 854.

At least one Maryland federal court, however, appears to differ. In *Cardin v. Pac. Employers Ins. Co.,* 745 F. Supp. 330 (D. Md 1990), the Court concluded the insured was not entitled to select independent counsel of his own choosing when the counsel retained by the carrier is instructed to defend all claims. In *Cardin,* the insurer hired a private attorney from a noncaptive law firm to represent its insured subject to a reservation of rights in which the insurer asserted that it would not pay any judgment against the insured

[14] Of interest, in the *Magoun* case cited by the *Dingwell* Court, the Massachusetts Court concluded that absent a separate agreement on the issue, when an insurer issues a reservation of rights and thereafter "acquiesces" in the insured's selection of counsel, the insurer must pay the "reasonable charges" of that counsel.

based on any "non-covered or excluded grounds." The insured asserted that he was entitled to select his own counsel at the insurer's expense because there was a conflict between his interests and that of the insurer in light of the fact that claims were made for both negligent and intentional acts and because there were claims for punitive damages. The District Court held that because appointed counsel: (1) was instructed by the insurer to represent *only* the interests of the insured; (2) was at no time also representing the insurer in the case; and (3) had an ethical responsibility to work only on behalf of the insured, his client, that no actual conflict of interest was created. The Court held, therefore, that the insurer had no duty to pay for independent counsel selected by the insured.

> [The insured] asserts that he was entitled to independent counsel in the defense of the [claim] due to the conflict of interest that arose from [the insurer's] reservation of rights based on the presence of covered and uncovered claims in the underlying suits. In addition, [the insured] alleges that unusual circumstances in this case, including the claim for compensatory damages far in excess of policy limits (with a provision for allocation of counsel fees if there were a recovery in excess of coverage), the claim for punitive damages and the related criminal investigation and prosecution, justified [his] right to select his own counsel and have that counsel paid by the insurer. Finally, Cardin argues that because [the law firm selected by the insurance company] receives referrals frequently from [the insurer], the lawyer might appear to have an incentive to steer his defense of [the insured] in a direction favorable to [the insurer].
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> * * *
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> [T]he potential existence of such different objectives cannot, *per se,* warrant requiring the insurer to pay the fees of the insured's criminal defense counsel even if there could be an allocation of fees between the civil and criminal defense functions.

Id. at 335-36.

MASSACHUSETTS

In *Magoun v. Liberty Mutual Insurance Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964), the Massachusetts Supreme Judicial Court was called upon to discuss the "dilemma confronting an insurance company, when it discovers in the course of defence [*sic*] of an action that it has a probable basis for disclaiming liability." In *Magoun,* the insurer issued a reservation of rights to the insured, who rejected the insurer's offer and selected its own counsel to defend the litigation. The insurer did not insist that it maintain control of the defense and merely cooperated with its insured's chosen counsel. Ultimately, the insured prevailed in its defense of the underlying claim and thereafter filed suit against the insurer to recover the fees and expenses incurred in defending the litigation. The Court ruled that under such circumstances the insurer was required to pay the "reasonable charges" of the insured's counsel, but did not elaborate.

More recently, in *N. Sec. Ins. Co. v. Sandpiper Village Condominium Trust*, 24 Mass. L. Rptr. 500, 2008 WL 4514515 (July 3, 2008), the Superior Court was called upon to address the insurer's obligation to reimburse its insureds for costs and fees paid by the insured to independent counsel who successfully defended the insured after the carrier issued a reservation of rights. In *Sandpiper*, the insurer argued that it should not be required to pay more than $150.00 per hour for counsel since this was the rate it paid counsel it typically retained. The insured's selected counsel, however, billed at a higher hourly rate and the insured argued that it was entitled to be reimbursed for the full amount it had incurred. Although the Court concluded that the insured was entitled to be reimbursed for "reasonable fees" and outlined the parameters for making this determination, the Court declined to decide the issue in the context of the summary judgment motion before it because the Court concluded that the determination was a factual issue:

> Next, the Court considers the defendants' argument on summary judgment that the Court should require Northern Security to pay the $15,563.00 in attorney's fees incurred by

> Marcus Errico Emmer & Brooks in the underlying case. The question of reasonable attorneys fees is a question left up to the sound discretion of the judge. . . In making that determination the Court considers, "the nature of the case and issues presented, the time and labor required, the amount of damages involved, the result obtained, the experience, reputation and ability of the attorney, the usual price charged for similar services by other attorneys in the same area, and the amount of awards in similar cases." . . . The defendants point to Marcus Errico Emmer & Brooks' experience representing condominium associations and note that they successfully obtained a rare motion for reconsideration in the underlying case. In the instant case, however, the issue of "reasonableness," is a genuine issue of material fact inappropriate on summary judgment.

Id.[15]

While the *Sandpiper* Court did not elaborate on which party bore the burden of establishing the reasonableness of counsel fees, this issue was addressed by the United States Court of Appeals in *Liberty Mut. Ins. Co. v Cont'l Cas. Co*., 771 F.2d 579 (1st Cir. 1985), which held that the insured, as the party claiming attorney's fees, has the burden of proving that the fees are reasonable. *Id.* at 582.

In a recent case, the Massachusetts Appeals Court in *OneBeacon Am. Ins. Co. v. Celanese Corp.*, 92 Mass. App. Ct. 382 (2017), *review denied*, 479 Mass. 1107 (2018) determined whether the insured was entitled to independent counsel even though the insurer agreed to defend without a reservation of rights. The insured argued it was entitled to independent counsel because it opposed insurer-appointed counsel's defense strategy which sought to settle the asbestos and chemical product injury claims. *Id*. at 391-392. The insured, placing a high priority on its business reputation, sought to publicly defend and to rebut any and all claims. *Id*. The Court found the insurer was entitled to control the defense over the insured's objections; the covered risks solely concerned claims of bodily injury or property damage against the insured, and the insured's desire to protect its reputation was not something that the insurer was required to insure or defend. *Id*. at 392.

OneBeacon also clarified Massachusetts law on when a conflict of interest arises which entitles an insured to independent counsel. The Court held that circumstances in which a conflict of interest may arise other than a dispute over the scope of coverage include: (1) when the defense tendered is not a complete defense under circumstances in which it should have been; (2) when the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interests at the expense of the insured's; (3) when the defense would not, under the governing law, satisfy the insurer's duty to defend; and (4) when, though the defense is otherwise proper, the insurer attempts to obtain some type of concession from the insured before it will defend. *Id*. at 388-389.

See also:

Mount Vernon Fire Ins. Co. v. VisionAid, Inc., 875 F.3d 716 (1st Cir. 2017) (insured's embezzlement counterclaim against former employee in employee's age discrimination suit did not generate a disqualifying conflict of interest under Massachusetts law. Therefore, insured was not entitled under an employment practices liability insurance policy to separate independent counsel to prosecute the counterclaim, even if the insurer had an interest in devaluing the embezzlement

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[15] The Court added the following footnote to its discussion:

> The Court declines to reach the argument regarding whether the Court should only consider the usual price charged for similar services by other attorneys in the same area in place of the usual price paid by insurance companies to other attorneys for similar services in the same area.

Id. at n.6.

counterclaim. The Court further found that insurer-appointed counsel did not have an automatic conflict of interest with the insured simply because counsel could get multiple case assignments from the insurer).

N. Sec. Ins. Co., Inc. v. R.H. Realty Trust, 78 Mass. App. Ct. 691, 941 N.E.2d 688 (2011) (when an insurer seeks to defend its insured under a reservation of rights, and the insured is unwilling to allow the insurer do so, the insured may require the insurer either to relinquish its reservation of rights or relinquish its right to defend the insured and reimburse the insured for its defense costs; in such an instance, the insurer must pay the reasonable charges of the insured's retained counsel); *Vicor Corp. v. Vigilant Ins. Co.*, Civil Action No. 07-10517-RGS, 2012 WL 4469084 (D. Mass. Sept. 28, 2012) (same); *Citation Ins. Co. v. Newman,* 80 Mass. App. Ct. 143, 951 N.E.2d 974 (2011) (same); *Norfolk & Dedham Mut. Fire Ins. Co. v. Cleary Consultants, Inc.*, 81 Mass. App. Ct. 40, 958 N.E.2d 853 (2011) (same).

Riva v. Ashland, Inc., Civil Action Nos. 09-cv-12074-DJC, 11-cv-12269-DJC, 11-cv-12277-DJC, 2013 WL 1222393 (D. Mass. Mar. 26, 2013) (following *Magoun* in an indemnitor-indemnitee situation).

MICHIGAN

The Michigan Supreme Court has not specifically addressed the issue of whether an insured, upon receipt of a reservation-of-rights letter, may insist upon independent counsel at the insurer's expense. The federal district courts in Michigan, however, repeatedly have addressed that question. Those courts have held that where a conflict of interest between the insured and insurer arises—*i.e.* when the insurer "reserves its rights"—the insurer's duty to defend is discharged when it selects independent counsel to represent the insured, as long as the insurer exercises good faith in its selection and the attorney selected is truly independent. *Central Mich. Bd. of Trustees v. Employers Reinsur. Corp.*, 117 F. Supp. 2d 627, 633-35 (E.D. Mich. 2000) (insured could not recover costs of retaining counsel it selected in the absence of evidence that counsel selected by insurer could not be independent); *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 44 F. Supp. 2d 847, 860-61 (E.D. Mich. 1997) (insured has the right to select counsel where there is a conflict of interest between the insurer and the insured, but denying insured's motion for partial summary judgment on recovery of pretender defense costs because there was a genuine issue of material fact as to whether a conflict-of-interest situation existed); *Fed. Ins. Co. v. X-Rite*, *Inc.*, 748 F. Supp. 1223, 1226 (W.D. Mich. 1990) (policyholder was not entitled to recovery of defense costs incurred by law firm it selected in the absence of evidence that the law firm selected by the insurer could not act independently). Should the insurer fail to provide independent counsel, the insured is at liberty to hire its own defense counsel, and the insurer is then liable for all reasonable attorney fees. *See Fireman's Fund Ins. Cos. v. Ex-Cell-O Corp.*, 790 F. Supp. 1339, 1346 (E.D. Mich. 1992). "Reasonable" is measured by what a typical defense lawyer would have done under same or similar circumstances. *Id.*

But see, *Lapham v. Jacobs Technology, Inc.*, Nos. 295482, 295489, 2011 WL 2848802 (Ct. App. Mich. July 19, 2011) (in case where issue was whether counsel selected by insurer on account of a conflict of interest necessitating the need for independent counsel truly was "independent," court held that "communications between the [law] firm and [the insurer] is not enough to show that the [law] firm acted against [the insured's] interests.").

See Brooks Kushman P.C. v. Cont'l Cas. Co., No. 15-12351, 2016 WL 5661577 (E.D. Mich. Sept. 30, 2016) (under Michigan (as well as California) law, there is no attorney-client relationship between an insurer and a law firm that has been retained by the insured party as independent counsel).

MINNESOTA

The insurer retains the right to appoint counsel even after the issuance of a reservation of rights absent the showing of "actual conflict." *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368 (Minn. Ct. App. 1991); *see also Hawkins, Inc. v. Am. Int'l. Specialty Lines Ins. Co.*, 2008 WL 4552683 at *7 (Minn. Ct.

App. Oct. 14, 2008). Where such conflict is shown to exist, an insurer must pay for independent defense counsel selected by the insured. *Prahm v. Rupp Constr. Co.*, 277 N.W.2d 389, 391 (Minn. 1979); *see also Chicago Title Ins. Co. v. F.D.I.C.*, 172 F.3d 601, 605 (8th Cir. 1999).

See also:

Cont'l Cas. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 940 F. Supp. 2d 898, 928 (D. Minn. Mar. 29, 2013, as amended and op. denying reconsideration, Aug. 9, 2013) ("Generally, in the absence of an actual conflict of interest between the insured and the insurer, the insured has no right to choose independent defense counsel to provide the insured with a defense. *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368 (Minn. Ct. App. 1991). When a conflict of interest exists—such as when an insurer accepts the tender of defense but also disputes coverage—the insurer's duty to defend is transformed into a 'duty to reimburse [the insured] for reasonable attorneys' fees.' *Prahm v. Rupp Constr. Co.*, 277 N.W.2d 389, 391 (Minn. 1979).").

Select Comfort Corp. v. Arrowood Indem. Co., No. 13-2975 (JN3/FLN), 2014 WL 4232334 (D. Minn. Aug. 26, 2014) (insurer's reservation of rights created a conflict of interest that converted insurer's duty to defend into a duty to reimburse insured for the reasonable costs of defending itself using separate, independent counsel).

MISSISSIPPI

Where only a part of the claim against the insured, or only one (or less than all) of the underlying plaintiff's multiple theories of recovery from the insured, is subject to potential coverage, the insurer is obligated only to provide a defense with respect to the potentially-covered claim and the insured must retain its own counsel, at its own expense, to defend the remaining noncovered claims. If, however, the insurer, at its election, agrees to provide a defense as to the entire action, encompassing both covered and noncovered claims, subject to a reservation of rights, the resulting potential conflict of interest entitles the insured to retain additional counsel with respect to the noncovered claims at the insurer's expense. *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1070-71 (Miss. 1996); *see also Twin City Fire Ins. Co. v. City of Madison, Miss.*, 309 F.3d 901 (5th Cir. 2002); *Scottsdale Ins. Co. v. Bungee Racers, Inc.*, 2006 WL 2375367 (N.D. Miss. Aug. 14, 2006); *Hartford Acc. & Indem. Co. v. Foster* 528 So. 2d 255 (Miss., 1988) (discussing in detail the ethical dilemmas of an attorney selected by the insurer and noting that coverage, not policy limits, creates a conflict).

See also:

PIC Group, Inc. v. LandCoast Insul., Inc., 795 F. Supp. 2d 459 (S.D. Miss. 2011) (under Mississippi law, attorney fees incurred by the insured in retaining its own counsel to defend it against claims falling outside coverage of policy, after insurer chose to defend insured under a reservation of rights, were reasonable and, thus, were encompassed within the indemnity provision of a subcontractor's agreement requiring the subcontractor to indemnify the insured for any "costs" or "expenses" in any matter "arising out of, resulting from, caused by or in connection with" the agreement. Further, under Mississippi law, when an insurer undertakes the defense of its insured while reserving its right to deny coverage, the insurer must permit the insured to select its own counsel for those claims outside the coverage of the policy, and is responsible for the reasonable legal expenses incurred in defense of such claims). *Compare with U.S. Liab. Ins. Co. v. Goldin Metals, Inc.*, 2012 WL 130254 (S.D. Miss. June 17, 2012), holding that the insurer is not entitled to depose insured's counsel on issue of reasonableness of fees.

Fed. Ins. Co. v. Singing River Health System, No. 15-60774 consolidated with No. 15-60876, 850 F.3d 187 (5th Cir. March 1, 2017) (under Mississippi law, insurer must pay for the insured's separate counsel where a conflict of interest exists).

Deviney Constr. Co., Inc. v. Ace Utility Boring & Trenching, LLC, et al., Nos. 3:11cv468-DPJ-FKB, 3:13cv60-DPJ-FKB, 2014 WL 2932169 (S.D. Miss. June 30, 2014) (Deviney, an additional insured under a policy issued by Penn National, was entitled to independent counsel because of potential conflicts between Deviney and Penn National).

James L. Warren III, Maggie Nasif & Erin D. Guyton, *Defending Under a Reservation of Rights: Mississippi Insurance Defense in the Wake of* Moeller *and its Progeny*, 83 MISS. L.J. 1219 (2014).

MISSOURI

The Missouri Supreme Court recently explained that where an insurer offers its insured a defense subject to a reservation of rights, the insured, in turn, may elect to allow the insurer to defend or refuse the insurer's offer. If the insured rejects the defense offered the insurer subject to reservation, the insurer has one of three options: (1) represent the insured without reservation; (2) withdraw from representing the insured altogether; or (3) file a declaratory judgment action to determine the insurer's obligations under the policy. *Kinnaman-Carson v. Westport Ins. Corp*., 283 S.W.3d 761, 765 (Mo. 2009) (citing *Truck Ins. Exch. v. Prairie Framing, LLC*, 162 S.W.3d 64, 88 (Mo. Ct. App. 2005)). If the insurer selects the first option, it may maintain control of the defense; if, however, it selects the second or third options, it necessarily relinquishes control of the defense to the insured. Federal courts applying Missouri law have further held that where a conflict of interest arises, the carrier must provide independent counsel or pay the costs incurred by the insured in securing counsel of its choosing. *Howard v. Russell Stover Candies, Inc.*, 649 F.2d 620, 625 (8th Cir. 1981) (applying Missouri law) (quoting *U.S. Fid. & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932, 939 n.6 (8th Cir. 1978)).

See also Heubel Materials Handling Co., Inc. v. Universal Underwriters Ins. Co., 704 F.3d 558 (8th Cir. 2013) ("Under Missouri law, a 'reservation of rights' refers to an insurer's offer 'to defend its insured but reserve the right to later disclaim coverage.' " citing *Truck Ins. Exch. v. Prairie Framing, LLC*, 162 S.W.3d 64, 88 (Mo. Ct. App. 2005)) (per curiam). The insured may reject an insurer's offer to defend with a reservation of rights, and if the insurer refuses to withdraw the reservation of rights, the insured is then free to hire independent counsel to defend the underlying suit and obtain compensation from the insurer if the underlying suit later is held to be covered by the policy. *Id.*.

MONTANA

A. Parameters of Insured's Right to Independent Counsel

Montana has not directly addressed the question of whether an insured is entitled to independent counsel if a reservation of rights is asserted and/or when a conflict of interest exists. Montana appears to have concluded indirectly, however, that an insurer is obligated to pay for separate counsel for its insured when an actual conflict has developed. *See St. Paul Fire & Marine Ins. Co. v. Thompson,* 433 P.2d 795 (Mont. 1967). In *Thompson*, an employee of a company was in an auto accident during the course and within the scope of his employment, but while driving his own vehicle. After resolution of the underlying action, the employer's insurer, St. Paul, sued the employee as a subrogee because the company's liability was based on respondeat superior. The employee's own insurer, State Farm, defended the first action, however it refused to defend the indemnity action by St. Paul (it initially accepted, but then withdrew). In analyzing whether State Farm had a duty to defend this second action, the Court stated:

> State Farm argues that it should be allowed to defend rather than paying counsel to defend the action. There can be no question of the good faith and sincere defense by counsel for State Farm in the Welch suit nor here. However, the inconsistent and yes, antagonistic positions that have developed make it clear that Thompson was required to hire his own counsel.

Id. at 799. In other words, the insured was entitled to retain separate counsel, apparently of his own choosing, because a conflict exited, and the insurer was obligated to fund it.

It should also be noted that in *In the Matter of the Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures,* 2 P.3d 806 (Mont. 2000)—a declaratory relief action challenging insurer-imposed billing guidelines—the Supreme Court ruled that an insured is the sole client of defense counsel appointed by the insurer, and thus, the insurer is not a co-client of defense counsel. Nevertheless, the court explained that a potential conflict of interest may exist where an insurer provides a defense under a reservation of rights. Given the *Thompson* case, it appears an insured may retain separate counsel whenever an insurer reserves rights under Montana law, although, as indicated, no Montana court has directly considered this issue.

See also, *Mid-Century Ins. Co. v. Windfall, Inc., et al.*, No. CV 15-146-M-DLC, 2016 WL 2992114 (D. Mont. May 23, 2016) ("Under Montana law, an insurer has a duty to provide independent counsel due to 'inconsistent and yes, antagonistic positions that have developed[.]' *St. Paul Fire & Marine Ins. Co. v. Thompson*, 433 P.2d 795, 799 (Mont. 1967). The Montana Supreme Court has not specifically addressed when a potential conflict is sufficiently antagonistic to trigger an insurer's duty to provide independent counsel." In this case, insured failed to show any inconsistent or antagonistic positions between the insured and her co-defendants.)

B. Additional Requirements and Duties?

It appears that no case since *Thompson* has addressed this issue, and thus there has been no elaboration on the scope of this requirement or accompanying duties.

NEBRASKA

The Nebraska Supreme Court explained in *Hawkeye Cas. Co. v. Stoker*, 48 N.W.2d 623 (Neb. 1951) that while an insurer may defend its insured under a reservation of rights with its insured's consent, the insurer may not continue to defend the insured if it initiates a declaratory judgment action or other denies coverage under the policy. The existence of a conflict of interest between the insurer and the insured is not a basis upon which the insurer can refuse to defend the insured. *Babcock & Wilcox Co. v. Parsons Corp*., 430 F.2d 531, 537-38 (8th Cir. 1970) (applying Nebraska law).

NEVADA

A. Right to Independent Counsel?

The state courts of Nevada have not yet considered the issue of whether an insured is entitled to independent counsel when a conflict of interest arises between the insurer and insured. A federal district court in Nevada has touched upon this issue, but did not reach a determination on the subject. In particular, in the case of *Crystal Bay Gen'l Improvement Dist. v. Aetna Cas. & Sur. Co.,* 713 F. Supp. 1371 (D. Nev. 1989) , an insurer reserved rights on a claim tendered by its insured because of the possible application of the sudden and accidental pollution exclusion. The insurer, acknowledging the presence of a conflict, suggested the insured retain independent counsel, at its own expense. The court analyzed this conduct in the context of bad faith and in particular, in terms of the whether the insurer had given consideration to its insured's interests equivalent to its own. The court explained:

> The result is that … the insurer must conduct itself with that degree of care which would be used by an ordinarily prudent person in the management of his own business, with no policy limits applicable to the claim.

Id. at 1379. The court stated that some courts have found this standard to require the insurer to provide its insured with independent counsel, but expressly declined to address this issue since it had not been briefed.

In a more recent Federal district court case, however, the Court held that "Nevada law requires that independent *Cumis* counsel must be appointed when a conflict of interest arises between the insured and insurer." *Hansen v. State Farm Mut. Auto. Ins. Co.*, No. 2:10-cv-01434-MMD-RJJ, 2012 WL 6205722 at *7 (D. Nev. Dec. 12, 2012).

See also:

USF Ins. Co. v. Smith's Food & Drug Center, Inc., 921 F. Supp. 2d 1082, 1092 n.3 (D. Nev. 2013) ("Notwithstanding the admission of its claims officer, USF erroneously argues that Smith's' demand for separate counsel destroyed the conditions for USF's representation of Smith's. First, the Policy designated Smith's as an insured regardless of the supplementary payments section. Second, USF may have been under an obligation to provide its insured with independent counsel when a conflict with Smith's arose. *See Hansen v. State Farm Mut. Auto Ins. Co.*, No. 2:10-cv-1434-MMD-RJJ, 2012 WL 6205722, at *8-9 (D. Nev. Dec. 12, 2012) (interpreting Nevada law to adopt requirement that insurers must provide independent counsel to insureds when conflict arises, per *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App. 3d 358, 364, 208 Cal. Rptr. 494 (1984)).").

State Farm Mut. Auto. Ins. Co. v. Hansen, 357 P.3d 338 (Nev. 2015) (as matters of first impression and in answer to certified questions from the federal district court for the District of Nevada, the Nevada Supreme Court held that when an actual conflict of interest exists between an insurer defending its insured under a reservation of rights to determine coverage and the insured, the insurer is required to satisfy its contractual duty to provide representation by permitting the insured to select independent counsel and by paying the reasonable costs of such counsel; and an insurer defending under a reservation of rights is obligated to provide independent counsel of the insured's choosing only when an actual conflict of interest exists, and courts must inquire, on a case-by-case basis, whether there is an actual conflict of interest; a reservation of rights does not create a *per se* conflict of interest).

Accord, Dogra v. Liberty Mut. Ins. Co., No. 2:14-cv-01841-GMN-GWF, 2016 WL 5419418 (D. Nev. Sept. 27, 2016); *Andrew v. Century Sur. Co.*, 134 F. Supp. 3d 1249 (D. Nev. 2015) (citing *Hansen* but finding no conflict)

See also, Sarah J. Odia, *Venada Supreme Court: Insurers Must Provide Independent Counsel for their Insureds*, 23 NEV. L. 8 (Dec. 2015).

B. Further Requirements and Duties?

As the above discussion notes, the insurer must give the same degree of consideration to the interests of the insured as it does to its own, and this may include provision of independent counsel to defend the insured if a conflict develops. Except for the federal court's decision in the *Hansen* case, however, there has been no further elaboration on this principle in connection with whether an insured has a right to independent counsel if a conflict of interest exists under Nevada law.

C. Statute

§ 41A.085. Recommendation of settlement for amount of limits of policy of insurance: When authorized; insurer to pay for opinion of independent counsel upon request

1. In an action for damages for professional negligence in which the defendant is insured pursuant to a policy of insurance covering the liability of the defendant for a breach of the defendant's professional duty toward a patient:

(a) At any settlement conference, the judge may recommend that the action be settled for the limits of the policy of insurance.

(b) If the judge makes the recommendation described in paragraph (a), the defendant is entitled to obtain from independent counsel an opinion letter explaining the rights of, obligations of and potential consequences to the defendant with regard to the recommendation. The Insurer shall pay the independent counsel to provide the opinion letter described in this paragraph, except that the insurer is not required to pay more than $1,500 to the independent counsel to provide the opinion letter.

2. The section does not:

(a) Prohibit the plaintiff from making any offer of settlement.

(b) Require an insurer to provide or pay for independent counsel for a defendant except as expressly provided in this section.

Eff. June 9, 2015.

NEW HAMPSHIRE

In *White Mountain Cable Constr. Co., Inc. v. Transamerica Ins. Co.*, 137 N.H. 478, 631 A.2d 907 (1993), the New Hampshire Supreme Court held that where there is a conflict between the insurer and the insured, the insurer is not relieved of its duty to defend and, although the insurer must defend, it is precluded from controlling the defense. The Court appears to hold that independent counsel must be provided:

> Having a duty to defend, and faced with a conflict of interest, the [insurer] could have hired independent counsel to defend the [insured] while intervening on its own behalf. In the alternative, the [insurer] could have provided the defense but reserved its right to later deny coverage.

Id. at 913.

NEW JERSEY

Under New Jersey law, if an actual conflict exists between the insured and the insurer as a result of the issuance of a reservation of rights with respect to mutually exclusive covered and noncovered claims, the insured is permitted to select independent counsel at the expense of the insurer. Under such circumstances, the insurer is required to pay independent counsel for the reasonable costs incurred in defending the entire action.

Burd v. Sussex Mut. Ins. Co., 56 N.J. 383, 267 A.2d 7 (1970), is the earliest reported New Jersey case addressing this issue. In *Burd*, the Court recognized that in circumstances where there is a conflict of interest between the carrier and the insured over coverage and where "the case may be so defended by a carrier as to prejudice the insured thereafter upon the issue of coverage," the carrier is not permitted to control the defense.

The issue was next addressed in *Yeomans v. Allstate Ins. Co.*, 130 N. J. Super. 48, 324 A.2d 906 (1974). In *Yeomans* the carrier insured two codefendants who had antagonistic defenses, and selected separate counsel to defend each insured. In holding that the carrier had fulfilled its duty to both insureds by retaining separate counsel for each, the Court distinguished this situation, (*i.e.* a conflict between two insureds), from that presented in *Burd*, *supra*, where an actual conflict existed between insurer and insured. The Court pointed out that only in the later situation is the insured entitled to select independent counsel to defend the action.

> We must, however, disassociate ourselves from that portion of the trial court's opinion holding that under the circumstances [the insurer] should not have selected defense counsel, but should have permitted the [insured] to do so, subject to [the insurer's] approval and at its expense. Two of the cases cited in support of this theory . . . are not pertinent. They involved the issue of the company's right to control the defense of pending tort

> litigation where the company disputed its obligation to pay any adverse judgment that might be rendered.

Id. at 53-54.

The issue of what billing rate an insurer is required to pay independent counsel retained to defend an insured when an actual conflict exists was addressed in *Aquino v. State Farm Ins. Co.*, 349 N.J. Super. 402, 793 A.2d 824 (2002). There, the Court concluded that independent counsel was not able to dictate the rate the carrier was required to pay, and concluded that the insurer was only required to pay a "reasonable fee" for work performed after counsel entered his appearance in the case. While the Court declined to decide what a "reasonable fee" would be, the Court did outline factors which should be considered in making this determination.

> It does not follow, however, that [independent counsel] is entitled to be compensated by the carriers for that defense work on the same basis that he is entitled to be compensated for work performed in connection with the declaratory judgment action. While *Aquino* may have been entitled to an attorney of his selection to handle the claim of intentional conduct, he does not have the right to dictate to the insurers the hourly rate they must pay. The trial court here should have determined a reasonable hourly rate for defense work of this nature and set a fee accordingly. Published material indicates, for example, that lawyers who perform insurance defense work may bill at a significantly lower hourly rate than do lawyers rendering other legal services. [Citation omitted.]
>
> Nor does it follow that counsel is entitled to an award of fees for all the work he has performed. We have conducted our own cursory review of the affidavit of service in *Faison v. Aquino*. It commences with his initial meeting with Aquino in December 1997 and his background investigation. He did not formally enter the case until he was granted that limited relief in March 1999. Clearly, much of the earlier work was entirely unrelated to the conflict of interest confronting Travelers and we are unable to perceive any basis why the carriers should be required to assume responsibility for those fees.
>
> Moreover, it has not escaped our notice that [the insured's independent] counsel was unhappy with the nature of the defense efforts put forth by the firm selected by [the insurer], and spent at least a portion of his time monitoring that work. Again, we see no basis to charge such work to the carriers at all, at least to the extent it was not specifically designed to protect [the insured] against the conflict of interest.
>
> * * *
>
> We are satisfied that with the limitations we have set forth, the result which we have reached is fair and appropriate in the context of this case. [The insurer], in essence, undertook, according to its letter of December 17, 1997, to defend [its insured] against allegations of intentional conduct, as well as negligence, and assured him his "rights and interests [would be] protected." Having undertaken that responsibility, we cannot consider it unfair to charge it with the reasonable cost of defending against allegations of intentional conduct when the attorneys it selected had an inherent conflict of interest which precluded them from handling both aspects of the defense. It will, in substance and effect, be responsible for that which it originally agreed to provide, no more and no less.

Id. at 349 N.J. Super. at 415-16; 793 A.2d at 832-33.

In a more recent unpublished opinion, *Township of Readington v Gen'l Star Ins. Co.*, 2006 WL 551404 (N.J. Super. March 3, 2006), the Superior Court held that in a matter involving nonmutually exclusive claims against an insured, an insurer was permitted to defend the entire action under a reservation of rights

and to select and retain counsel. The Court further held that under such circumstances, if the insured rejects the proffered defense and retains its own counsel, it is precluded from recovering the fees it incurs.

Most recently, a federal district court summarized the current state of New Jersey law as follows:

> An insurer who owes its insured a duty to defend is not permitted to control the defense if there is a conflict of interest between the two parties. *See*, *e.g.*, *Schmidt v. Smith*, 294 N.J. Super. 569, 590, 684 A.2d 66 (App. Div. 1996) (citing *Burd v. Sussex Mau. Ins. Co.*, 56 N.J. 383, 389, 267 A.2d 7 (1970)). In such a situation, some method must be devised for the insurer to fulfill its duty other than by retaining its own counsel to represent the insured. *Morrone v. Harleysville Mut. Ins. Co.*, 283 N.J. Super. 411, 421, 662 A.2d 562 (App. Div. 1995) (citing cases). *Burd* and subsequent cases indicate that the usual course of action is for the insured to select its own attorney and for the insurer to reimburse the insured. *See*, *e.g.*, *Morton Int'l, Inc. v. Gen'l Accident Ins. Co. of Am.*, 266 N.J. Super. 300, 341-43, 629 A.2d 895 (App. Div. 1991). Of course, this does not mean that the insurer is required to pay whatever fee the insured's retained attorney happens to charge; rather, the insured is required to pay a reasonable fee for those services reasonably related to the defense of any covered claims. *Aquino v. State Farm Ins. Co.*, 349 N.J. Super. 402, 415-16, 793 A.2d 824 (App. Div. 2002).

Szelc v. Stanger, Civ. No. 08-4782, 2010 WL 2925847 at *2 (D.N.J. July 21, 2010).

In *YA Global Investments, L.P. v. Mandelbaum, Salsburg, Gold, Lazris & Discenza, P.C.*, No. 2:12-cv-219 (WJM), 2014 WL 2737894 (D.N.J. June 17, 2014), the court faced plaintiff's motion to disqualify McCarter & English LLP from representing Wiss & Co., a defendant in this lawsuit. In the lawsuit, plaintiffs alleged that, but for the alleged acts, omissions and purported conflicts of interest of the named defendants, YA would never have consummated a $14 million loan transaction with Global Outreach. Wiss, a named defendant, notified and requested coverage from its professional liability insurer, Liberty Mutual. Liberty reserved its rights and appointed one of its panel firms to represent Wiss. Wiss objected to Liberty's offer to appoint panel counsel, and Wiss informed Liberty that it would retain McCarter & English as independent counsel. Later, Liberty sued Wiss and certain employees for declaratory judgment. In the declaratory, McCarter & English represented Wiss, and Ropes & Gray represented Liberty. In Plaintiff's motion to disqualify, they argued that as a consequence of Liberty paying McCarter to provide a defense to its insured, Wiss, in this lawsuit, "McCarter represents two clients—Liberty Mutual and Wiss." Plaintiffs then argue that McCarter should be disqualified from representing Wiss in this action because a conflict of interest arose when Liberty brought its declaratory action against Wiss. The court denied the motion, saying:

> The arrangement at issue here is distinctly different from situations "wherein an attorney selected by the insurer was assigned to represent the insured in the defense of a covered claim. More is required to establish a lawyer-client relationship than, as appears here, merely that the insurer ultimately absorbs the cost of the insured's legal representation." *Historic Smithville Dev. Co. v. Chelsea Title & Guar. Co.*, 190 N.J. Super. 567, 572, 464 A.2d 1177 (App. Div. 1983). In the instant matter, Wiss refused Liberty Mutual's appointment of counsel, and Wiss specifically hired McCarter as independent counsel. Liberty Mutual did not even pay McCarter directly for their services, but rather McCarter submitted invoices directly to Wiss. [Citation to record omitted.] Where, as here, the policyholder retains its own independent counsel, no conflict of interest exists because the independent counsel does not represent the carrier. *See Cay Divers Inc. v. Raven*, 812 F.2d 866, 870 (3d Cir. 1987) ("We … hold that when … an action against an insured is arguably within the scope of the insurance coverage, an insurer's discharge of its duty to defend by providing independent counsel, even though reserving the right to contest coverage, relies it of control over the litigation."); *Cf. Illinois Masonic Medical Ctr. v. Turegum Ins. Co.*, 168 Ill. App. 3d 158, 163, 118 Ill. Dec. 941, 522 N.E.2d 611 (1st Dist. 1988) ("[W]here a

> conflict of interests exists the insured, rather than the insurer, is entitled to assume control of the defense of the underlying action; but by reason of its contractual obligation to furnish a defense, the insurer must underwrite the reasonable costs incurred by the insured in defending the action with counsel of his own choosing.").
>
> Plaintiffs have not met the high burden of proving that a conflict of interest exists in McCarter representing Wiss. Liberty Mutual's mere agreement to pay some of McCarter's fees for representing Wiss did not create an attorney-client relationship between McCarter and Liberty Mutual.

YA Global, 2014 WL 2737894 at *3-4.

NEW MEXICO

The New Mexico Supreme Court has held that when an insurer perceives a conflict of interest, it may demand that the policyholder obtain independent counsel, or the insurer may satisfy its duty to defend by employing two sets of attorneys, one to represent the insured and one to represent the insurer. *Am. Employers Ins. Co. v. Crawford*, 533 P.2d 1203, 1209 (N.M. 1975) (citing *Employers' Fire Ins. Co. v. Beals*, 240 A.2d 397 (R.I. 1968), abrogated on other grounds by *Peerless Ins. Co. v. Viegas*, 667 A.2d 785 (R.I. 1995)).

NEW YORK

While there is no New York statute pertaining to an insured's right to select independent counsel, under New York case law, an insured is permitted to select independent counsel when there is an actual conflict of interest between the interests of the insured and the insurer concerning the defense of a liability claim. Under such circumstances, the insurer is required to pay independent counsel a "reasonable fee". *Prashker v. U.S. Guar. Co.*, 1 N.Y.2d 584, 136 N.E.2d 871 (1956); *Public Service Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 425 N.E.2d 810 (1981).

Accord, Pac. Employers Ins. Co. v. Troy Belting & Supply Co., No. 1:11-CV-912, 2014 WL 2805312 (N.D.N.Y. June 20, 2014) n.5.

The *Prashker* case involved a claim brought by the personal representative of a deceased passenger who was killed in a private airplane crash against the estate of the pilot. It was alleged that the pilot operated the aircraft in violation of his license, which allegation could serve as a basis for the pilot's insurer to deny coverage. The Court held that the insurer had a duty to defend the claim and, when it was presented with the suggestion that counsel appointed by the carrier to defend might have divided loyalties, responded as follows:

> The objection taken by the insurance company is without substance that it would subject to divided loyalty any attorneys who might defend the action, in that their duty to the assureds would be to endeavor to defeat recovery on any ground, whereas their duty to the insurance company would be to defeat recovery only upon such grounds as might render the insurance company liable. If any such conflict of interest arises, as it probably will, the selection of the attorneys to represent the assureds should be made by them rather than by the insurance company, which should remain liable for the payment of the reasonable value of the services of whatever attorneys the assureds select.

In *Goldfarb*, *supra*, New York's highest court addressed the conflict situation and the right to select independent counsel in the context of a case where the plaintiff asserted mutually exclusive alternative claims for negligence and intentional tort in a case alleging that a dentist had sexually abused a patient during the course of treatment. Relying on the *Prashker* decision, the Court concluded that because "the insurer's interest in defending the lawsuit is in conflict with the defendant's interest—the insurer being

liable only upon some of the grounds for recovery asserted and not upon others—[the defendant] is entitled to defense by an attorney of his own choosing, whose reasonable fee is to be paid by the insurer." 53 N.Y.2d at 427, 425 N.E.2d 815. The Court clarified, however, that not every conflict requires the appointment of independent counsel:

> That is not to say that a conflict of interest requiring retention of separate counsel will arise in every case where multiple claims are made. Independent counsel is only necessary in cases where the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable. When such a conflict is apparent, the insured must be free to choose his own counsel whose reasonable fee is to be paid by the insurer. On the other hand, where multiple claims present no conflict—for example, where the insurance contract provides liability coverage only for personal injuries and the claim against the insured seeks recovery for property damage as well as for personal injuries—no threat of divided loyalty is present and there is no need for the retention of separate counsel. This is so because in such a situation the question of insurance coverage is not intertwined with the question of the insured's liability.

53 N.Y.2d at 427 n.1, 425 N.E.2d 815 n.1; *see also 69th Street and 2nd Avenue Garage Assocs., L.P. v. Ticor Title Guar. Co.,* 207 A.D.2d 225, 622 N.Y.S.2d 13 (1995) (crucial conflict of interest gave policyholder the right to select independent counsel).

See also:

Sea Tow Services Int'l, Inc. v. St. Paul Fire & Marine Ins. Co., No. 09-CV-5016 (PKC)(GRB), 2016 WL 6092486, __ F. Supp. 3d __ (E.D.N.Y. Sept. 29, 2016) (Under N.Y. law, insured franchisor was not entitled to independent counsel in underlying action against insured and its franchisee brought by one of franchisee's employees who had sustained injuries in work-related accident at franchisee's site; franchisor's insurer had accepted coverage of vicarious liability and direct liability claims asserted against insured at all times, and even though its position was that franchisee's insurance carrier's coverage was primary, insurer continued to have a vested interest in defending insured because insurer, and not insured, would be stuck with the defense costs in the event franchisee's insurance carrier later prevailed with respect to its coverage position. Under N.Y. law, independent counsel is only necessary in cases where defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable).

Landon v. Austin, 129 A.D.3d 1282, 11 N.Y.S.3d 721, 2015 N.Y. Slip Op. 04911 (3d Dep't 2015) (Although law firm was retained by insured's CGL insurer to provide a defense for insured, the paramount interest that counsel represented was that of insured, and insurer was precluded from interference with counsel's independent professional judgments in the conduct of the litigation on behalf of its client. Where law firm has been retained by liability insurer to provide a defense for insured, a conflicting interest exists, for example, when defense attorney's duty to the insured would require that he or she defeat liability on any ground and his or her duty to the insurer would require that he or she defeat liability only upon grounds which would render the insurer liable.)

Sabre, Inc. v. Ins. Co. of State of Pennsylvania, 149 A.D.3d 589, 52 N.Y.S.3d 355 (N.Y. App. Div. 2017) (In coverage action commenced by insured, the Court found that a conflict of interest existed which precluded the insurer from controlling the defense because the facts to be adjudicated in the underlying actions were the same facts upon which coverage depended. The Court further found that although the insured's selected counsel did not bill by the hour as required by the policy at issue, the insurer was not relieved of its duty to defend because the insurer specifically approved the insured's selected counsel)

Med-Plus, Inc. v. Am. Cas. Co. of Reading, PA, No. 16CV2985NGGJO, 2017 WL 3393824 (E.D.N.Y. Aug. 4, 2017) (After insured selected its own defense counsel, insurer agreed to defend and attempted to appoint new, insurer-appointed counsel; insured objected on grounds that a claim for punitive damages created a conflict of interest entitling the insured to select its own independent counsel. The Court held for the insured, finding that the potential for punitive damages in the underlying action created a conflict of interest because under New York law, insurers are prohibited from indemnifying punitive damages assessed against insured entities.

NORTH CAROLINA

In a case where the insurance company as reserved its rights, a North Carolina appellate court has held that a policyholder may refuse the insurance company's defense, select its own counsel, and seek indemnification of its legal expenses. *Nat'l Mortg. Corp. v. Am. Title Ins. Co.* 41 N.C. App. 613, 622-23, 255 S.E.2d 622, 629 (1979) reversed on other grounds, 299 N.C. 369, 261 S.E.2d 844 (1980). The Supreme Court reversed this case on other grounds, stating that the policy did not cover the insured. The Court, however, made no mention of independent-counsel or attorney's-fees issues.

NORTH DAKOTA

A trial court may require an insurer, in instances where a conflict of interest is present, to "furnish independent counsel to represent the insured on the insurer's claims and defenses, or by requiring reimbursement of the insured's reasonable attorney fees for those services." *Fetch v. Quam*, 530 N.W.2d 337, 341 (N.D. 1995).

OHIO

The Ohio Supreme Court has stated that an insurer's issuance of a reservation of rights letter, by itself, does not automatically obligate the insurer to pay for an insured's independent counsel. *Socony-Vacuum Oil Co. v. Cont'l Cas. Co.*, 59 N.E.2d 199 (Ohio 1945). Only when the interests of the insurer and insured are "mutually exclusive" does an obligation on the part of the insurer to pay the cost of the insured's private counsel arise. *Id.* Therefore, the test in determining whether an insured can secure its own counsel at the expense of the insurer "is whether the insurer's reservation of rights renders it impossible for the company to defend both its own interests and those of its insured." In *Socony-Vacuum*, the Supreme Court held that interests of the insurer and the insured were mutually exclusive, as both the liability in the underlying case and the coverage questions turned on whether the alleged tortfeasor was a Socony-Vacuum employee acting within the course and scope of his employment at the time of the incident. Intermediate appellate courts, however, have held that conflicts of interest of lesser magnitude do not require the insurer to pay for the insured's independent or private counsel. *See*, *e.g.*, *Lusk v. Imperial Cas. & Indem.*, 603 N.E.2d 420, 423 (Ohio Ct. App. 1992) (holding that insured was not entitled to reimbursement for private counsel where two insurers had offered to defend insured under reservations of rights and the insurers' reservations concerned only which insurer's policy had a duty to indemnify the insured in event of adverse judgment); *see also Red Head Brass, Inc. v. Buckeye Union Ins. Co.*, 735 N.E.2d 48, 55 (Ohio Ct. App. 1999) (holding that the insured was not entitled to reimbursement for cost of private counsel hired to prosecute compulsory counterclaims or for defense costs incurred after covered claims had been dismissed by court on summary judgment). Where the insurer's interest and the insured's interest are mutually exclusive, an insurer that offers the insured the option to hire private counsel must bear the expense for reasonable attorney fees. *Socony-Vacuum*, 59 N.E.2d at 205.

OKLAHOMA

The only Oklahoma case that has addressed this issue stated the following:

> From our review of these decisions and others, we discern a common theme: not every perceived or potential conflict of interest automatically gives rise to a duty on the part of the insurer to pay for the insured's choice of independent counsel. Independent counsel is only necessary in cases where the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds that would render the insurer liable. Conversely, absent a threat of divided loyalty between the insured and insurer, no need for retention of independent counsel arises because the issue of coverage is then separate from the issue of liability. However, an insurer may demand their insured obtain independent counsel when the *insurer* perceives a conflict of interest.

Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490 & n.1 (Okla. App. 1996) (emphasis added; citations omitted).

OREGON

A. Parameters of Insured's Right to Independent Counsel

Oregon law does not require the insurer to provide the insured with separate counsel, even when a clear conflict of interest arises.[16] The Oregon courts first considered this issue in the case of *Ferguson v. Birmingham Fire Ins. Co.*, 460 P.2d 342 (Or. 1969), in which an insurer reserved rights after its insured tendered a complaint alleging willful trespass. The insured refused the defense offered by the insurer under reservation, and retained separate counsel. In analyzing whether the insurer had acted inappropriately, the *Ferguson* court concluded that the danger that an insurer would not provide the insured with an adequate defense because it could later assert a defense of noncoverage was minimal. In particular, the court explained that "[t]he insurer knows that when it is the defendant in a lawsuit brought by one of its policy holders the jury's sympathy for the insured frequently produces a plaintiff verdict even when the insurer's case is strong. Knowing this, the insurer is not likely to relax its efforts in defending the action against the insured. If the insurer feels certain that it can successfully defend an action brought against it by the insured, it is not likely to accept the insured's tender of the defense in the first place." This analysis was reiterated in the subsequent case of *Home Indem. Co. v. Stimson Lumber Co.,* 229 F. Supp. 2d 1075 (D. Or. 2001).

The *Ferguson* court did find that if the insured prevailed in the coverage dispute on remand, the insurer would have to pay for the defense costs incurred in the underlying lawsuit. Thus, in effect, an insurer risks having to pay for separate counsel if it concludes no defense is owed and its coverage evaluation is incorrect. *Ferguson, supra*, 460 P.2d at 349-50.

See also:

Siltronic Corp. v. Employers Ins. Co. of Wausau, 176 F. Supp. 3d 1033 (D. Or. 2016) (under Oregon law, as predicted by the federal district court, insurer was obligated to pay some or all of the attorney fees incurred by insured corporation's independent counsel to protect its interest adverse to insurer on coverage issues involving the Portland Harbor Superfund Site, citing to O.R.S. § 465.483). This case is interesting for its compare-and-contrast analysis comparing the Oregon statute to Cal. Civ. Code § 2860.

Accord, Century Indem. Co. v. The Marine Group, LLC, No. 3:08-CV-1375-AC, 2016 WL 2730675 (D. Or. May 10, 2016), *but see* n.4 ("Third-Party Plaintiffs also argue [O.R.S. §] 465.483 requires independent

[16] It should be noted that despite the case law cited herein, certain treatises and authorities have concluded that Oregon does not have case law directly considering this question.

counsel for the insured in part so the insured can control what type of defense material is disclosed to the insurer. While the statute requires the insurer to provide independent counsel under certain circumstances, nothing in the statute compels the conclusion the independent counsel requirement is intended to allow the insured to control the information to which the insurer has access. To the contrary, the statute envisions cooperation between insured and insurer, as it specifically states the insured has a duty to cooperate with the insurer under the terms of the parties' insurance contract. [O.R.S. §] 465.483(4). The court therefore finds this argument unpersuasive.")

And see, Century Indem. Co. v. The Marine Group, LLC, No. 3:08-CV-1375-AC, 2015 WL 810987 (D. Or. Feb. 25, 2015) ("With regard to independent counsel financed by Argonaut [intervenor insurer] for Marine, Argonaut is entitled to rely on the statutory presumption found in [O.R.S. §] 465.483(3)(a) that amounts paid to independent counsel and environmental consultants as defense costs at the regular and customary rates charged for environmental claims similar to the one at hand are reasonable. Marine is not entitled to recover pre-tender defense costs.

B. Additional Requirements and Duties?

It does not appear that any Oregon statute or case law has established any additional requirements on insurers or insureds in connection with this issue.

C. Statute

O.R.S. § 465.483. Defense of environmental claim; provision of independent counsel by insurer

(1) If the provisions of a general liability insurance policy impose a duty to defend upon an insurer, and the insurer has undertaken the defense of an environmental claim on behalf of an insured under a reservation of rights, or if the insured has potential liability for the environmental claim in excess of the limits of the general liability insurance policy, the insurer shall provide independent counsel to defend the insured who shall represent only the insured and not the insurer.

(2) (a) (A) Independent counsel retained by the insurer to defend the insured under the provisions of this section must be experienced in handling the type and complexity of the environmental claim at issue.

(B) If independent counsel who meet the requirements specified in this paragraph are not available within the insured's community, then independent counsel from outside the insured's community who meet the requirements of this paragraph must be considered.

(b) (A) An insurer may retain environmental consultants to assist an independent counsel described in subsection (1) of this section. Any environmental consultants retained by the insurer must be experienced in responding to the type and complexity of the environmental claim at issue.

(B) If environmental consultants who meet the requirements specified in this paragraph are not available within the insured's community, then environmental consultants from outside the insured's community who meet the requirements of this paragraph must be considered.

(c) As used in this subsection, "experienced" means an established environmental practice that includes substantial defense experience in the type and complexity of environmental claim at issue.

(3) (a) The obligation of the insurer to pay fees to independent counsel and environmental consultants is based on the regular and customary rates for the type and complexity of environmental claim at issue in the community where the underlying claim arose or is being defended.

(b) In the event of a dispute concerning the selection of independent counsel or environmental consultants, or the fees of the independent counsel or an environmental consultant, either party may request that the other party participate in nonbinding environmental mediation described in ORS 465.484(2).

(4) The provisions of this section do not relieve the insured of its duty to cooperate with the insurer under the terms of the insurance contract.

Added by Laws 2013, c. 350, § 7, eff. June 10, 2013.

PENNSYLVANIA

Before 2013, no state appellate court had addressed the issue of an insured's right to select independent counsel, although at least one trial court has concluded that the issuance of a reservation of rights letter does not automatically create a conflict and the insurer's appointed counsel has only one client: the insured. *Bedwell Co. v. D. Allen Bros. Inc.,* 2006 WL 3692592, at *2 (Pa. Com. Pl. Dec. 6, 2006).

On July 10, 2013, the Superior Court affirmed a lower-court decision, holding that, as a matter of first impression, when an insurer tenders a defense subject to a reservation of rights to contest coverage, the insured may choose to accept the defense or decline the insurer's tender of a qualified defense and furnish its own defense. *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 2013 PA Super 174, 76 A.3d 1 (Pa. Super. Ct. 2013), *reversed* 131 A.3d 445 (Pa. 2015) (in which the Pa. S. Ct. held that, as a matter of first impression, the insured did not forfeit the right to coverage when it reasonably settled a lawsuit without the insurer's consent, where the insurer had defended the suit subject to a reservation of rights and, further concluding, that the Superior Court erred by requiring an insured to demonstrate bad faith when the insured accepts a settlement offer in a reservation of rights case).

Alternatively, Pennsylvania's federal courts have held that if there is an actual conflict of interest between the insurer and the insured, that the insured is permitted to select counsel of its choosing whose reasonable fee is to be paid by the insurer.

In *Krueger Assocs. Inc., v. ADT Sec. Systems*, No. CIV.A. 93-1040, 1994 WL 709380 (E.D. Pa. Dec. 20, 1994), the Court concluded that "[i]t is settled law that 'where conflicts of interest between an insurer and its insured arise, such that a question as to the loyalty of the insurer's counsel to that insured is raised, the insured is entitled to select its counsel, whose reasonable fee is to be paid by the insurer.' " *Id.*, at *5 (quoting *Emons Industries, Inc. v. Liberty Mut. Ins. Co.,* 749 F. Supp. 1289, 1297 (S.D.N.Y. 1990)). The *Krueger* Court did not elaborate on what a reasonable fee is or the factors which should be considered in making this determination.

More recently, in *Rector, Wardens and Vestryman of St. Peters Church v. Am. Nat'l Fire Ins.*, No. CIV.A. 00-2806, 2002 WL 59333 (E.D. Pa. Jan. 14, 2002), the Court elaborated on this principal:

> "It is clear that in Pennsylvania, as in most other jurisdictions, if an insurance company breaches its duty to defend, it is liable to reimburse the [insured] the costs the latter incurred in conducting its own defense." *St. Paul Fire & Marine Ins. Co. v. Roach Bros. Co.*, 639 F. Supp. 134, 138-39 (E.D. Pa. 1986). An insurance company breaches its duty to defend when a conflict of interest arises between the insurer and its insured "such that the company's pursuit of its own best interests in the litigation is incompatible with the best interests of the [insured]." *Id.* at 139. A conflict of interest between an insurer and its insured will not relieve insurer of its duty to provide a defense. *See Consolidated Rail Corp. v. Hartford Acc. & Indem. Co.*, 676 F. Supp. 82, 86 (E.D. Pa. 1987). Rather, courts have concluded that one appropriate resolution in this circumstance "is for the insurer to obtain separate, independent counsel for each of its insureds, or to pay the costs incurred by an insured in hiring counsel." *Id.*
>
> In support of its contention that it is entitled to remuneration for the procurement of conflict-free counsel, [insured] cites to *Cay Divers, Inc. v. Raven*, 812 F.2d 866 (3d Cir. 1987) (applying law of the Virgin Islands). In *Raven*, the Third Circuit found that the

> Provision of independent counsel or reimbursement for the insured's choice of counsel and expenses ordinarily fulfills the duty to defend, and is particularly appropriate where, as here, there is a conflict of interest between the insurer and the insured.... Indeed, where there is a conflict of interest, ethical considerations may even require that the insurer provide independent counsel rather than participate in the defense.
>
> *Id.* at 870 n.3.

Rector, Wardens and Vestryman, 2002 WL 59333 at *9.

The insured's right to select independent counsel at the expense of the insurer only applies, however, if there is an actual conflict, and at least one Pennsylvania federal court has concluded that the fact that an insured is sued for both covered and noncovered claims does not, in itself, create an actual conflict. In *St. Paul Fire & Marine Ins. Co. v. Roach Bros. Co.*, 639 F. Supp. 134 (E.D. Pa. 1986), the Court explained:

> In the present case, there were at least two potential sources of conflict between [insurer] and its insureds, the defendants: [insurer's] policy did not cover intentional acts of wrongdoing or claims for punitive damages, and the [plaintiffs'] claims greatly exceeded the policy limits. But, since the [plaintiffs] would be entitled to prevail even if they did not prove intentional wrongdoing on the part of the defendants, but merely negligence (for example, a genuine but erroneous belief that the [plaintiffs] had abandoned the project, or a genuine but unfound belief that the [plaintiffs] had consented to defendant's activities, or lack of communication within defendant's organization concerning their representation of the [plaintiffs], it was the obligation of the [insurer] to provide a defense. Moreover, that obligation extended to *all* claims asserted by the [plaintiffs], regardless of the limited nature of [insurer's] obligation to indemnify. *Gedeon v. State Farm Mut. Auto. Ins. Co.*, 410 Pa. 55, 188 A.2d 320 (1963); *Wilson v. Md. Cas. Co.*, 377 Pa. 588, 105 A.2d 304 (1954); *Cadwallader v. New Amsterdam Cas. Co.*, 396 Pa. 582, 152 A.2d 484 (1959).
>
> With respect to the policy limits, no actual conflict of interest arises except in connection with possible settlement negotiations (for example, an opportunity to settle within the policy limits, favored by the insured but not by the company); although a very great disparity between exposure and policy limits may suggest that the uninsured portion of the claim is what is really at stake in the litigation. But where a claim is settled for the full policy limits, with the consent of the insured, there is obviously neither conflict nor the potential for conflict.
>
> With respect to the existence of both covered and uncovered claims or theories of liability, the potential for conflict is much greater, but actual conflict is not inevitable. In some circumstances, the company might be tempted to save money by urging that the insured was guilty of intentional wrongdoing or wanton recklessness, rather than mere negligence. At the least hint of such a development, an obligation to provide independent counsel would be triggered, and the company's unwillingness to protect the full interests of its assured would probably also trigger a reimbursement obligation.
>
> But I am aware of no case, from any jurisdiction, which has held that the mere theoretical possibility of such a conflict requires the company to pay for the assured's separate representation. The [insureds] place principal reliance upon the California case of *San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984). That case, however, held merely that where punitive damages (not covered) and compensatory damages (covered) are sought against the assured, and the exposure is in excess of the policy limits, and there is an opportunity to settle the entire case within the

> policy limits, the company is obligated either to settle within the policy limits, or to pay the reasonable expenses of independent counsel to represent the interests of the assured. It is unnecessary for me to essay a prediction as to whether the Pennsylvania Supreme Court would agree with the *Cumis* decision; for even under the holding of that case, [insureds] would not prevail here.

Id. at 139.

See also:

Eckman v. Erie Ins. Exch., 2011 PA Super 87, 21 A.3d 1203, 1208-09 (2011) (fact that any attorney appointed by insurer to represent insureds in underlying defamation action would be compensated by insurer did not require per se disqualification of the attorney on the grounds of conflict of interest, relying on Pa. R. Prof. Conduct 1.7(a)(2)).

Am. & Foreign Ins. Co. v. Jerry's Sport Center, Inc., 606 Pa. 584, 616, 2 A.3d 526, 545 (2010) (an insurer faced with uncertainty about its duty to indemnify offers a defense under a reservation of rights to avoid the risks to which it might be exposed if an inept or lackadaisical defense of the underlying action results in the imposition of liability for which it ultimately turns out there was a duty to indemnify).

Yaron v. Darwin Nat'l Ins. Co., No. 502, 2011 WL 3027835 (Pa. Com. Pl. July 5, 2011) (Trial order) (liability insurer's issuance of a reservation of rights letter, warning insureds that the claims asserted against them could trigger an exclusion of coverage, did not automatically create a conflict of interest between insurer and insureds, so as to entitle insureds to select their own defense counsel to be paid for by insurer subject to its reservation of rights; reservation of rights presented only the possibility of a conflict, and some evidence of an actual conflict would be required before requiring insurer to pay for insured's chosen counsel).

Erie Ins. Exch. v. Lobenthal, 2015 PA Super 78, 114 A.3d 832 (2015) (homeowner's insurer's reservation-of-rights letter was untimely sent more than seven months after filing of complaint alleging that insured permitted and encouraged use of controlled substances at a party from which impaired driver caused automobile accident and, thus, insurer was estopped from relying on controlled-substances exclusion, even though case was not yet listed for trial and insurer had duty to defend until dismissal of allegations regarding furnishing of alcohol to driver; over three months had passed from disposition of preliminary objections limiting claim to alleged furnishing of controlled substances, and insured could have declined insurer's defense, engaged separate counsel, managed her own defense, and was prejudiced; and further holding that where liability insurer fails to clearly communicate a reservation of rights to an insured, prejudice may be fairly presumed).

Mine Safety Appliances Co. v. N. Riv. Ins. Co., 73 F. Supp. 3d 544 (W.D. Pa. 2014) (under Penn. law, co-client exception to attorney-client privilege did not apply as would allow selective waiver of attorney-client privilege for insured's documents submitted in support of summary judgment motion and discussing how insured defended, valued, or settled underlying lawsuits advancing asbestos, silica, and coal-workers' pneumoconiosis personal-injury and wrongful-death claims against insured and reflecting attorney-client communications with insured's underlying defense counsel, where insured and insurer did not hire separate counsel and then direct their counsel to engage in joint defense against common adversary as would create co-client relationship, but instead insurer denied all insured's claims for coverage, under umbrella commercial general liability policy, for losses arising from underlying lawsuits).

RHODE ISLAND

The Rhode Island courts have concluded that in the case of a conflict of interest between insurer and insured, the insured is permitted to reject the insurer's selected counsel and retain independent counsel of its own

choosing at the reasonable expense of the insurer. But Rhode Island's court have yet to provide guidance as to how this "reasonable fee" is to be determined.

In *Employers' Fire Ins. Co. v. Beals*, 103 R.I. 623, 240 A.2d 397 (1968), *abrogated on other grounds by Peerless Ins. Co. v. Viegas*, 667 A.2d 785 (R.I. 1995), the Court concluded:

> If, however, an insured, after having been apprised of the conflicting interests existing between him and his insurer, declines to be represented by the insurer's attorney, we have a different situation. Concerned as we are that the public's trust in the judicial processes be maintained, this court cannot stand idly by in such circumstances. We are as conscious of an insurer's concern that it control the defense of any action brought against one of its insureds as we are of an insured's expectations that his rights will be properly protected. In our opinion, however, an insured, when faced with the quandary posited by the facts of the instant case, has a legitimate right to refuse to accept the offer of a defense counsel appointed by the insurance company; and when an insured elects to exercise this prerogative, the insurer's desire to control the defense must yield to its obligation to defend its policyholder.
>
> There is, therefore, a discernible need to discover a solution to this dilemma which will, at the same time, be mutually protective and satisfactory to the parties.

Beals, 103 R.I. 633-34; 240 A.2d at 403.

More recently, the Supreme Court, in *Labonte v. National Grange Mut. Ins. Co.,* 810 A.2d 250 (R.I. 2002) re-affirmed the *Beals* holding, but declined to extend the insurer's obligation to provide independent counsel to a presuit coverage investigation:

> In *Beals,* the insurer found itself in a situation in which it was simultaneously suing the insured in a declaratory judgment action and defending the insured in a tort suit. In the declaratory judgment action, the insurer attempted to demonstrate that the insured's actions were intentional, a position it certainly did not want to advance in the tort action. In face of the clear conflict, this Court required the insurer to provide the insured with an independent attorney in the tort action and held that "the insurer's desire to control the defense must yield to its obligation to defend its policyholder." . . . Here, in contrast, plaintiff had not yet been sued when he requested independent counsel. Moreover, defendant had not yet brought a declaratory action against plaintiff at the time it sought to examine him.
>
> Therefore, on the basis of the facts of this case, we decline to extend *Beals* to require an insurer to provide independent counsel to an insured on each occasion that the insurer initiates a coverage investigation.

Labonte, 810 A.2d at 254-55.

See also Quality Concrete Corp. v. Travelers Prop. Cas. Co. of Am., 43 A.3d 16, 20-22 (R.I. 2012) (insured not entitled to have insurer—which issued CGL policy—subsidize engagement of independent counsel to represent insured in addition to law firm that insurer had hired to represent insured in connection with death of trespasser, even though insurer reserved right to deny coverage for punitive damages; there was no actual conflict between prime interests of insurer and those of insured given that no complaint was ever filed by trespasser's estate and, as a general rule, the engagement of an independent counsel to represent the insured due to a conflict of interest between the insured and the liability insurer should be approved by the insurer).

And see, Andromeda Real Estate Partners, LLC v. Commonwealth Land Title Ins. Co., No. 15-224-M-LDA, 2016 WL 715777 (D.R.I. Feb. 19, 2016), *vacated* June 23, 2016, but included here for its holding in conformity with *Beals*.

SOUTH CAROLINA

In South Carolina, a case defended under a reservation of rights only gives rise to a "potential," not actual, conflict of interest. *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., LP,* 336 F. Supp. 2d 610, 621 (D.S.C., 2004). Thus, an insured does not have an automatic right to select and retain his or her own counsel. *Id.*

Ben Arnold was affirmed at 433 F.3d 365 (4th Cir. 2005) (under S.C. law as predicted by federal court, CGL insurer's reservation of rights letter disclaiming coverage as to some claims asserted against insured, but not as to others, did not create per se conflict of interest; thus, insurer was not required to cover legal fees of counsel that insured appointed to replace insurer's chosen counsel, after insured had rejected insurer's counsel on conflict grounds and excluded insurer from litigation. Further, under S.C. law, no actual conflict of interest arose when CGL insurer sent reservation of rights letter disclaiming coverage as to some sexual harassment claims asserted against insured, but not as to others, and thus insured was not entitled to reimbursement from insurer of legal fees and costs of settling cases using insured's own counsel; there was no inherent conflict since claims turned largely on credibility determination and thus fact that only some claims were covered would not divide insurer and insured, and further more insured ousted insurer from defense before any hypothetical conflict could materialize).

See also:

Cincinnati Ins. Co. v. Crossmann Communities of North Carolina, Inc., No. 4:09-CV-1379-RBH, 2013 WL 1282017 (D.S.C. Mar. 27, 2013) (" 'Under South Carolina law, an insurer's duty to defend is triggered if any cause of action in a complaint seeks damages covered by the policy.' *Liberty Mut. Fire Ins. Co. v. J.T. Walker Ind., Inc.*, C.A. No. 2:08-2043-MBS, 2012 WL 3292973 at *16 (D.S.C. Aug. 10, 2012). Similarly, in *Twin City Fire Ins. Co. v. Bear Arnold-Surebelt* [sic] *Beverages*, 433 F.3d 365, 366 (4th Cir. 2010), the Court held that when a policyholder notifies its insurer of a potentially covered suit, the 'insurance company, in turn, typically chooses, retains, and pays private counsel to represent the *insured as to all claims in that suit*.' *Id.* at 366." [emphasis added by *Crossmann* court]).

Episcopal Church in S.C. v. Church Ins. Co. of Vt., 53 F. Supp. 3d 816 (D.S.C. 2014) (court held: (a) CGL insurance policy gave right to insurer under S.C. law to select defense counsel and control defense in underlying action, where policy provided that insurer had "the right and the duty to defend a suit seeking damages which may be covered under the Commercial Liability Coverage"; (b) insurer that wrongfully refused to defend insured in underlying action forfeited its right to defend insured under CGL insurance policy after it reversed its position and acknowledged its obligation, and thus insured was entitled to continue to be represented by its chosen attorney, as predicted by federal court; insured's attorney had been working on case for over one year, and insured would have suffered material harm if forced to relinquish control of its defense).

SOUTH DAKOTA

A. Parameters of Insured's Right to Independent Counsel

South Dakota considered the issue of what duties an insurer has when a conflict of interest arises between itself and its insured in the case of *Connolly v. Standard Cas. Co.,* 73 N.W.2d 119 (S.D. 1955). The insurer defended under a reservation of rights.

The insured argued that, by assuming defense of the underlying case, the insurer was estopped from denying liability. However, the court explained that it was a well-settled rule that an insurer is not so estopped as

long as timely notice is given to the insured that it has not waived the benefit of its coverage defenses under the policy, *i.e.*, reserved rights. The court found the insured here had impliedly consented to defense under these circumstances. If it had not, however, the court suggested that the insurer could not retain control of the defense and at the same time reserve the right to disclaim liability. Thus, while the court does not explicitly set forth a requirement, it suggests that under these circumstances, separate counsel for the insured is warranted. *Id.* at 122. The Supreme Court reaffirmed this approach in *St. Paul Fire and Marine Ins. Co. v. Engelmann,* 639 N.W.2d 192, 201 (S.D. 2002).

The South Dakota federal district court and the Eight Circuit have reached the same conclusion, specifically finding that a reservation of rights can create a conflict of interest. *See State Farm Mut. Auto. Ins. Co. v. Armstrong Extinguisher Service, Inc.,* 791 F. Supp. 799 (D.S.D. 1992); *Kansas Bankers Sur. Co. v. Lynass,* 920 F.2d 546 (8th Cir. 1990). The *Lynass* Court explained: "It is clear how a conflict of interest can develop in a situation like this. Kansas Bankers could conceivably offer only a token defense if it knows that it can later assert non-coverage. If an insurer does not think that the loss on which it is defending will be covered under the policy, the insurer may not be motivated to achieve the best possible settlement or result." *Id.* at 549.

B. Additional Requirements and Duties?

Although South Dakota appears to have concluded that an insured may retain separate counsel when a conflict of interest exists, and that a reservation of rights alone can create a conflict, South Dakota has not elaborated upon an insurer's obligations under these circumstances.

TENNESSEE

The Tennessee Supreme Court has held that the insured is the sole client of an attorney hired by an insurer pursuant to its contractual duty to defend. *Givens v. Mullikin ex rel. Estate of McElwaney*, 75 S.W.3d 383, 396 (Tenn. 2002). Although the primary issue addressed in the *Givens* case was whether an insurance company and an insured may be held vicariously liable for the alleged tortious actions of an attorney hired to defend the insured, the implication of the court's holding that Tennessee is a one-client state is that the insurer likely is permitted to select defense counsel even where it is defending under a reservation of rights.

TEXAS

A. When The Right Arises

Prior to guidance from the Texas Supreme Court, Texas courts routinely allowed the insured to choose independent counsel—at the insurer expense—when an insurer offered a defense under a reservation of rights. *See Rhodes v. Chicago Ins. Co.,* 719 F.2d 116, 120 (5th Cir. 1983) (applying Texas law); *Britt v. Cambridge Mut. Fire Ins. Co*., 717 S.W.2d 476, 481 (Tex. App.—San Antonio 1986, writ ref'd n.r.e. May 6, 1987); *Steel Erection Co. v. Travelers Indem. Co*., 392 S.W.2d 713, 716 (Tex. Civ. App.—San Antonio 1965, writ ref'd n.r.e. Nov. 3, 1965).

The Texas Supreme Court refined this rule in *N. County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685 (Tex. 2004). This case arose from a car accident in Dallas County. Davalos, the insured, was injured in the accident and sued the driver of the other car in Matagorda County. *Id.* at 687. The other driver then sued Davalos in Dallas County, which suit Davalos tendered to his insurer for a defense. Before insurer-appointed counsel appeared in the case, Davalos, through his Matagorda County counsel, moved to transfer venue of the Dallas case to Matagorda County. *Id.* The insurer informed Davalos that it opposed the transfer of venue. Davalos advised the insurer that its opposition to the transfer of venue created a conflict, which Davalos believed gave him the right to choose his own independent counsel. *Id.* Davalos refused to accept the insurer-appointed defense counsel and demanded that the insurer pay for his independently retained lawyer. The case centered around whether the insurer's disagreement with Davalos, its insured, over the

proper venue of the case created the type of conflict that triggered the insured's right to independent counsel (and the insurer's obligation to pay that lawyer's fees).

The Texas Supreme Court initially accepted the proposition that the carrier may be precluded from insisting on its contractual right to control the defense where there is a "conflict of interest" between the carrier and the insured. The most common situation giving rise to such a conflict, the Court acknowledged, is where there is a dispute between the carrier and the insured as to the existence or scope of coverage. "When the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends, the conflict of interest will prevent the insurer from conducting the defense." *Id.* at 689. Under those circumstances, the insured has the right to select defense counsel and send the bill to its carrier.

The *Davalos* Court listed other types of conflicts that may justify an insured's refusal of a defense offered by the carrier:

- When the defense tendered "is not a complete defense under circumstances in which it should have been."
- When "the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interest at the expense of the insured's."
- When "the defense would not, under the governing law, satisfy the insurer's duty to defend."
- When, although the defense is otherwise proper, "the insurer attempts to obtain some type of concession from the insured before it will defend."

The conflict alleged by Davalos, however, concerned a disagreement over the appropriate venue for the defense of a third-party claim, not Davalos's independent right to pursue his own remedy. According to the Court, the insurer's actions did not actually deprive Davalos of the defense attorney's independent counsel on any issue and, thus, did not amount to a disqualifying conflict of interest. Because Davalos rejected the insurer's defense in the absence of a qualifying conflict, he lost his right to recover the costs of that defense.

See also:

Mid-Continent Cas. Co. v. Petroleum Solutions, Inc., No. 4:09-0422, 2016 WL 5539895 (S.D. Tex. Sept. 29, 2016) ("an insured is entitled to independent counsel at the insurer's expense if a conflict of interest precludes the insurer from controlling the insured's defense" and n.233 ("*See, e.g., Hous. Auth. Of City of Dallas v. Northland Ins. Co.*, 333 F. Supp. [2d] 595, 600-02 (N.D. Tex. 2004) (Lindsay, J.). Under Texas law, '[a] conflict of interest exists that prevents the insurer from insisting on its contractual right to control the defense when the insurer has reserved its rights and the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage defends.' *Allstate Cnty. Mut. Ins. Co. v. Wootton*, No. 14-14-00657-CV, 2016 WL 1237872, at *9 (Tex. App.Houston [14th Dist.] Mar. 29, 2016) ((citing *N. Cnty. Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685, 688 (Tex. 2004)))").

Graper v. Mid-Continent Cas. Co., 756 F.3d 388 (5th Cir. 2014) ((a)under Texas law, if a conflict of interest actually exists it may be disqualifiable, giving the insured the privilege of rejecting limited representation under an insurer's reservation of rights and hiring a lawyer of its own choosing and looking to the insurer for the payment of the attorney's fees; (b) with regard to the duty to defend, a reservation of rights does not, by itself, create a conflict between the insured and insurer, but only recognizes the possibility that such a conflict may arise in the future; the test to apply is whether the facts to be adjudicated in the underlying lawsuit are the same facts upon which coverage depends; (c) adjudication of accrual date in underlying lawsuit that claimed copyright infringement did not create disqualifying conflict of interest between insurer and insureds, thus weighing in favor of insurer's right under Texas law to appoint counsel to defend insureds, since adjudication of accrual date in support of insureds' state of limitations defense did not require judicial ruling on whether insureds' infringement occurred outside of CGL policy period which

would relieve insurer of duty to defend in that infringement could have occurred long before it was discovered and thus occurred within limitations period but outside of policy period; (d) insured is not entitled to select its own counsel merely because the potential for a conflict of interest exists; (e) adjudication of willfulness in underlying lawsuit that claimed copyright infringement did not create disqualifying conflict of interest between insurer and insureds, thus weighing in favor of insurer's right under Texas law to appoint counsel to defend insureds under CGL policy, since adjudication of willfulness in support of underlying plaintiff's claim for upward adjustment of statutory damages would not require proof of knowing conduct that violated the rights of another person, as required for policy exclusion to apply, in that violation could amount to reckless conduct and still be willful under the statue).

And see 46 TEX. JUR. 3D INSURANCE CONTRACTS AND COVERAGE § 944. Care required in exercising duty to defend—Where conflict of interest arises (Jan. 2017 update).

B. When A Reservation Of Rights Might Not Be Sufficient To Create A Conflict

Texas case law provides very few examples of reservation-of-rights letters that are insufficient to create an independent-counsel-triggering conflict of interest. Clearly, a disagreement over the venue of the lawsuit will not create such a conflict. *See Davalos, supra.* If in doubt about whether an insurer's reservation of rights is of such nature as to create a conflict of interest, one might look to the general rule provided by United States District Judge Lee Rosenthal in *Rx.com, Inc. v. Hartford Fire Ins. Co.,* 426 F. Supp. 2d 546, 559 (S.D. Tex. 2006): "[a] conflict of interest does not arise unless the outcome of the coverage issue can be controlled by counsel retained by the insurer for the defense of the underlying claim."

C. How Much Does The Insurer Have To Pay The Independent Counsel?

It is not unusual for an insurance carrier to concede the insured's right to select its own counsel, but then refuse to pay the insured's selected lawyer a rate higher than those charged by the carrier's local "panel counsel." These "panel counsel" rates are typically the lowest rate that an insurer can contractually impose on particular firms in particular regions. Most of the "panel counsel" firms are willing to charge lower rates because of the high volume of business provided by the insurer. According to one insurance commentator, defense attorneys who serve as "panel counsel" or "captive counsel" are paid 15% to 50% less per hour than the hourly rate of outside counsel selected by the insured. *See* Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 TEX. L. REV. 1583, 1597-98 n.72 (1994).

Absent an express provision in the insurance policy, an insurer does not have the right under Texas law to impose its "panel counsel" rates on its insured and the insured's independent counsel. Once the insured exercises its right to select its own defense counsel to defend the claim, the insurer must then pay the legal fees ***reasonably incurred*** in the defense. *See, e.g.,* "Chapter V Insurance Defense," 50 BAYLOR L. REV. 671, 679 (1998) ("The insurer has to pay only the reasonable expenses of independent counsel"). A determination of the reasonableness of attorneys' fees should be guided by the following factors (not the insurer's "panel counsel rates"):

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill required to perform the legal service properly;

(2) The likelihood that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the relevant locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the service; and

(8) Whether the fee is fixed or contingent on results obtained or uncertainty of collection before the legal services have been rendered.

See, TEX. DISCIPLINARY R. PROF. CONDUCT 1.04(b). *See also Arthur Andersen & Co. v. Perry Equip. Corp.,* 945 S.W.2d 812, 818 (Tex. 1997).[17]

There are no Texas statutes addressing this issue (unlike the *Cumis* statute in California), but two Texas courts—both federal courts in the Northern District of Texas—have rejected an insurer's attempt to limit fees to panel counsel rates. In *Housing Auth. of the City of Dallas, Texas v. Northland Ins. Co.,* 333 F. Supp. 2d 595 (N.D. Tex. 2004) (Lindsay, J.), the insured retained its own counsel to defend against a lawsuit involving covered claims because the insured was dissatisfied with the insurer-appointed defense counsel. The insurer disagreed that there was an independent-counsel-triggering conflict, and also argued that it should only have to pay the insured's defense counsel the same rates that it paid its panel counsel. At the most senior lawyer level, the panel counsel rates were less than half of the rates charged by the insured's chosen counsel. Finding that the insurer created a conflict that allowed the insured to choose its own defense counsel, Judge Lindsay ordered that the insurer pay the "reasonable attorney's fees" incurred by the insured in the defense of the lawsuit.

Shortly thereafter, the parties submitted the attorney's fees issue to Judge Lindsay by way of written submissions. The Judge made his determination in an eleven-page order issued on January 27, 2005. *Housing Auth. of the City of Dallas, Texas v. Northland Ins. Co.,* Case No. 3:03-cv-00385 (N.D. Tex. January 27, 2005) (unpublished). In his ruling, Judge Lindsay applied the two-step process for determining a reasonable fee award in the Fifth Circuit ("lodestar" plus the *Johnson* factors) and found that the rates charged by the insured's counsel were reasonable. In one instance the court noted that the insured's lawyer's rate "is on the low end of reasonableness for an attorney of [the lawyer's] experience." Significantly, the court expressly rejected the insurer's proffer of its panel counsel's rates as ***any evidence*** of reasonableness of the hourly rates charged by the insured's counsel.

Additionally, in *Kirby v. Hartford Cas. Ins. Co.,* 2003 WL 23676809, at *2 (N.D. Tex. June 9, 2003) (Stickney, M.J.), the court stated as follows:

> In addition to its failure to offer any evidence to support its assertion that $135.00 per hour represents the only "reasonable and customary" rate for defense counsel in a matter like the Underlying Lawsuit (MPSJ ¶ 9), Hartford cites no authority for its conclusion that Kirby is obligated to accept defense counsel "appointed" by Hartford or be limited to any rate the insurer is able to negotiate with such counsel. Hartford cites one case confirming that the insurer is obligated to pay "reasonable and necessary" defense costs. (MPSJ ¶ 19, citing *Travelers Ins. Co. v. Chicago Bridge & Iron Co.,* 442 S.W.2d 888, 900 (Tex. Civ. App.—Houston [1st Dist.] 1969, writ ref'd n.r.e.)). Neither that case nor any other authority establishes, as Hartford contends, that "any rate above [$135 per hour] simply cannot be deemed as necessary." *See Ripepi v. Am. Ins. Cos.,* 234 F. Supp. 156, 158 (W.D. Pa. 1964) (insured "was not required to employ the cheapest lawyer he could get, or solicit competitive bids" after insurer failed to defend), aff'd, 349 F.2d 300 (3rd Cir. 1965).

[17] These factors are closely associated with the federal appellate decision in *Johnson v. Georgia Highway Express, Inc.*, 488 F.2d 714 (5th Cir. 1974), and have come to be referred to as "the *Johnson* factors." They are commonly considered in the resolution of disputes regarding attorneys' fee awards arising in federal court actions decided under fee-shifting statutes.

D. Recent Cases

Partain v. Mid-Continent Specialty Ins. Services, Inc., 838 F. Supp. 2d 547, 566-67 (S.D. Tex. 2012):

- Insurer's right of control, pursuant to its defense of the insured under a liability policy, generally includes the authority to make defense decisions as if it were the client.
- Insurer's right to appoint counsel to defend insured in an underlying suit gives way when a disqualifying conflict of interest exists; in such a situation, the insured may select its own, independent counsel, thus protecting the insured from an insurer-hired attorney who may be tempted to develop facts or legal strategy that could ultimately support the insurer's position that the underlying lawsuit fits within a policy exclusion.
- Reservation of rights letters do not necessarily create a conflict between the insured and the liability insurer; rather, a reservation of rights letter only recognizes the possibility that such a conflict may arise in the future.
- Disqualifying conflict of interest exists under Texas law, such that a liability insurer's right to appoint counsel to defend insured in an underlying suit gives way to the insured's selection of its own, independent counsel, where the facts to be adjudicated in the underlying suit are the same facts upon which coverage depends.

Partain v. Mid-Continent Specialty Ins. Services, Inc., Civil Action No. H-10-2580, 2012 WL 524130 (S.D. Tex. Feb. 15, 2012) (insurer's remaining argument—that insureds are no longer entitled to defense and indemnity on grounds that: (i) by refusing to accept insurer's counsel and allowing insured's counsel to assume the defense, insured's repudiated the insurance contract and prevented insurer from performing under it; (ii) by failing to cooperate with insurer, insureds breached a condition precedent to coverage; and (iii) because insurer was prejudiced by insured's acts, insureds have forfeited their rights under the insurance policies—are rejected and remaining portion of insurer's Motion for Summary Judgment is denied).

Downhole Navigator, LLC v. Nautilus Ins. Co., 686 F.3d 325, 328-31 (5th Cir. 2012) (under Texas law, potential conflict of interest created by insurer's reservation of rights letter did not disqualify counsel offered by insurer to represent insured or entitle insured to reimbursement for cost of hiring independent counsel absent any demonstrated overlap between the facts implicated in the underlying negligence action and the facts determinative of the coverage defenses upon which the insurer's reservations were based).

Coats, Rose, Yale, Ryman & Lee, P.C., v. Navigators Specialty Ins. Co., 830 F. Supp. 2d 216, 219 (N.D. Tex. 2011) (under Texas law, if attorney appointed by insurance company would have incentive to act for insurance company's interest rather than insured's interest and, therefore, deprive insured of its right to independent counsel, conflict of interest exists triggering insured's right to select counsel; but only *actual* conflict of interest will trigger insured's right to select independent counsel).

UTAH

A. Parameters of Insured's Right to Independent Counsel

Although Utah has not directly addressed the question of whether an insurer must provide independent counsel to its insured when a conflict of interest exists, the courts have commented on this issue in *dicta*. In particular, in two cases, the Supreme Court indicated that an insured should be allowed to choose independent counsel to be funded by the insurer when there is a conflict. *Lima v. Chambers*, 657 P.2d 279, 285 (Utah 1982), *superseded by rule on other grounds by State v. Bosh,* 266 P.3d 788 (Utah 2011); and *Foster v. Salt Lake County,* 712 P.2d 224, 228 (Utah 1985).

Although it is not binding, the Eighth Circuit evaluated this issue at length under Utah law. *See U.S. Fid. & Guar. Co. v Louis A. Roser Co*., 585 F.2d 932 (8th Cir. 1978). Because, as indicated, no Utah court had directly considered this question, the Eighth Circuit predicted how Utah would rule based on its law on conflict of interest more generally and concluded that when a conflict of interest between insurer and insured exists, an insurer must provide independent counsel to its insured. Because the Utah cases cited above echo this conclusion, it is reasonable to conclude that, in Utah, an insured is entitled to independent counsel, funded by its insurer, when a conflict of interest exists.

B. Additional Requirements and Duties?

Although Utah appears to have concluded that an insured is entitled to separate counsel when a conflict of interest exist, Utah has not elaborated upon an insurer's obligations under these circumstances.

VERMONT

The Vermont courts have not directly addressed the issue of an insured's right to independent counsel. In *Am. Fid. Co. v. Kerr*, 138 Vt. 359, 416 A.2d 163 (1980), the court noted generally that an insurer needs consent from the insured in order to control the defense when a reservation of rights is issued. While one could conceivably argue that implicitly, in the absence of such consent an insurer must cede control by hiring independent counsel, this issue was not addressed. Additionally, in a concurring opinion filed in the case of *Orleans Village v. Union Mut. Fire Ins. Co*., 133 Vt. 217, 335 A.2d 315 (1975), it was noted that notwithstanding the existence of a conflict of interest triggering the right of the insured to select its own defense counsel, there may be a duty for the company to reimburse an insured's legal costs.

More recently, the Supreme Court held that a homeowner's liability insurer had a duty to pay attorney fees and costs incurred in an appeal from a judgment in an underlying defamation lawsuit against its insured, where the underlying judgment exposed the insured to both covered and uncovered damages such that a reversal would have served the insured's interests, and the appeal raised at least reasonable, if ultimately unsuccessful, grounds for challenging the judgment. *Pharmacists Mut. Ins. Co. v. Myer*, 2010 VT 10, 187 Vt. 323, 993 A.2d 413 (2010).

See also:

Jonathan M. Dunitz, *Insurer's Duty to Defend: A Compendium of State Law—Vermont*, 2016 DRI-INSDD 233 (2016):

> **When is there a right to independent counsel?**
>
> There is no Vermont Supreme Court case on point. However, in *Northern Security Insurance Co. v. Pratt*, No. 838-11-10 Wncv, 2011 WL 8472930 (Vt. Super. May 19, 2011), the superior court determined that "under Vermont law, the lack of an insured's assent to a reservation of rights alone appears to be sufficient to require the insurer to relinquish control over the defense and appoint independent counsel." In the decision, the court quoted the following " 'classic' rule for determining whether a conflict exists such that independent counsel is necessary:
>
> > The most widely employed criterion appears to be whether the nature of the divergent interests is such that, under the facts of the dispute between insurer and insured, contrasted with the dispute between the insured and the third-party claimant, the insured's attorney would have an incentive to steer the facts of the latter litigation to a conclusion which would benefit the insurer by avoiding or minimizing coverage, while prejudicing the insured in some manner, usually by rendering it necessary for the insured to pay a judgment which the insurer might otherwise have been required to pay.

> *Id.* (quoting 14 Couch on Ins. § 202:23). The court further determined that the insurer has the right to select independent defense counsel *Id.*

Sharon Academy, Inc. v. Wieczorek Ins., Inc., No. 442-7-13 Wncv., 2015 WL 5176793 (Vt. Super. Feb. 25, 2015) (following *Pratt*, *supra*).

VIRGINIA

In Virginia, the insurer has the right to select counsel to defend its insured. In reaching this conclusion, the Supreme Court, in *Norman v. Ins. Co. of N. Am.*, 218 Va. 718, 239 S.E.2d 902 (1978), reasoned that the ethical obligations of an attorney to act in the interest of his or her client were sufficient to protect the insured:

> No one questions the fact that the standards of the legal profession require undeviating fidelity of a lawyer to his client, and no exceptions can be tolerated. A client may presume that his attorney has no interest which will interfere with his devotion to the cause confided in him. And an insurer's attorney, employed to represent an insured, is bound by the same high standards which govern all attorneys, and owes the insured the same duty as if he were privately retained by the insured.
>
> There is no allegation by Norman, and no intimation in the record, that in defending Norman in the [subject] case, his attorneys safeguarded the interest of INA and neglected that of Norman. This is not an action by Norman against his attorneys and INA for negligent representation, or one against INA for negligent employment of incompetent attorneys.

Id. at 727-28, 239 S.E.2d at 907. *See also State Farm Fire & Cas. Co. v. Mabry*, 255 Va. 286, 497 S.E.2d 844 (1998).

WASHINGTON

A. Right to Independent Counsel

Under Washington law, the insurer may retain the right to select defense counsel even where it reserves rights. However, Washington law essentially strips control of the defense from the insurer and places other heightened obligations on the insurer when it reserves rights.

The seminal case is *Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 715 P.2d 1133 (Wash. 1986), in which the Supreme Court declared that an insurer has an "enhanced obligation" to its insured when defending under a reservation of rights. The insurer can fulfill its enhanced obligation by meeting four criteria: (1) the company must thoroughly investigate the claim; (2) it must retain competent defense counsel for the insured, and both retained defense counsel and the insurer must understand that only the insured is the client; (3) the company must inform the insured of the reservation of rights defense and all developments relevant to policy coverage and progress of the lawsuit; and (4) the company must refrain from any activity that would show a greater concern for its monetary interest than for insured's financial risk. *Tank*, 105 Wash. 2d at 388. *But see, Phila. Indem. Ins. Co. v. Olympia Early Learning Center*, No. C12-5759 RLB, 2013 WL 6174480 (W.D. Wash. Nov. 21, 2013) (following *Tank* but nevertheless finding that insured did not establish that, as a matter of law, the insurer's assertion of its policy limits or its defense of the underlying claims amounted to bad faith or unclean hands).

Additionally, defense counsel retained by insurers to defend an insured under a reservation of rights must also recognize that his or her ethical duties of loyalty and disclosure run solely to the insured. This means that counsel must understand that she or he represents the insured, not the insurer, and must not allow the fact that she or he is being paid by the insurer to influence her or his professional judgment. It also means that potential conflicts of interest between insurer and insured must be fully disclosed and resolved in favor

of the insured; that all information relevant to the insured's defense must be communicated to the insured; and that the insured, not the insurer, has the ultimate choice regarding settlement. *Id*. In other words, the insured is the client, so counsel's obligations run to the insured and the insured can control the defense.

In *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598 (1990), the Court of Appeals rejected an insured's contention that a conflict of interest automatically arises requiring that the insurer pay for independent counsel chosen by the insured anytime an insurer defends under a reservation of rights; the Court noted, however, that an insurer, defending under a reservation of rights, has an "enhanced obligation of fairness towards its insured. . . .." The obligation comes about because of "[p]otential conflicts between the interests of insurer and insured, inherent in a reservation of rights defense. . . ."

B. Additional Matters

While insurers may agree to counsel selected by the insured, there are strong arguments that they are not required to pay such counsel more than they would pay counsel they selected. There is no case directly addressing this, but *Griffin v. Allstate Ins. Co.*, 108 Wash. App. 133, 29 P.3d 777 (2001) supports the argument by implication.

C. Recent Cases

Weinstein & Riley, P.S. v. Westport Ins. Corp., No. C08-1694JLR, 2011 WL 887552 (W.D. Wash. Mar. 14, 2011). Insureds were not entitled to "independent counsel" under Washington law because they did not establish that insurer's reservation of rights created an actual, rather than merely a potential, conflict of interest, with the result that the insurer retained the right to select defense counsel. *Id.* at *21. Elaborating, the court said:

> In several states, including California, the law provides that where there are divergent interests between the insured and the insurer brought about by the insurer's reservation of rights, and where the insured does not consent to joint representation, the insured is entitled to select its own independent counsel at the expense of the insurer. *See San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984) (superseded by statute as stated in *Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 61 Cal. App. 4th 999, 101, 71 Cal. Rptr. 2d 882 n.1 (Cal. Ct. App. 1998)); Cal. Civ. Code § 2860.
>
> Washington does not recognize an entitlement to "independent counsel" as it is understood under the *Cumis* model. In Washington, an insured is not entitled by law to choose independent counsel to represent it where there is a potential conflict with the insurer in a reservation of rights situation. *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598, 601 (Wash. Ct. App. 1990) ("In Washington, there is simply no presumption . . . that a reservation of rights situation creates an automatic conflict of interest. Therefore, the insurer has no obligation *before-the-fact* to pay for its insured's independently hired counsel." (emphasis in original)). Instead, the insured is entitled to a defense provided by a lawyer selected by the insurer, and the appointed lawyer owes an enhanced obligation of fairness to the insured. *Id.* At 600; *see Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 715 P.2d 1133 (Wash. 1986). Thus, in contrast to *Cumis*, "any breach of the 'enhanced obligation of fairness' in a reservation of rights situation might lead to *after-the-fact* liability of the insurer, retained defense counsel, or both." *Johnson*, 788 P.2d at 601 (italics added).

Weinstein & Riley, 2011 WL 887552, at *19.

JACO Environmental, Inc. v. Am. Int'l Specialty Lines Ins. Co., No. C09-0145JLR, 2010 WL 415067 (W.D. Wash. Jan. 26, 2010) ("By contrast, under Washington law, 'the insurer selects a lawyer for the insured who then has an obligation to represent only the insured.' [*San Diego Navy Fed. Credit Union v. Cumis*

Ins. Soc'y, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984) (citing *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598, 600 (Wash. Ct. App. 1990)).] Thus, 'the prerequisite for the clause to apply, that "the insured is entitled by law to select independent counsel," is absent here.' (*Id.*) The court also noted that 'the advent for JACO's hiring of its own defense counsel was not the creation of a potential conflict created by AISLIC's agreement to defend JACO under a reservation of rights, but rather AISLIC's outright rejection of its duty to defend at the time it was initially notified of the suit by JACO.'").

In a subsequent ruling in the same case, however, it was held that the insured was entitled to reimbursement for the costs of hiring independent counsel because the insurer refused to defend. *JACO Environmental, Inc. v. Am. Int'l Specialty Lines Ins. Co.*, No. C09-0145JLR, 2010 WL 807441 (W.D. Wash. Mar. 9, 2010) ("In sum, because AISLIC breached its duty to defend as established in the insurance contract, JACO is entitled to recover the reasonable attorneys' fees it incurred in defending itself in the *ARCA* suit. Whether JACO was entitled to independent counsel under the Truck policy is not relevant to JACO's rights under the AISLIC policy.")

Nat'l Surety Corp. v. Immunex Corp., 176 Wash. 2d 872, 297 P.3d 688 (Wash. 2013) (holding that: (1) an insurer may not seek to recoup defense costs incurred under a reservation of rights defense while the insurer's duty to defend is uncertain; abrogating *Holly Mountain Resources, Ltd. v. Westport Ins. Corp.*, 130 Wash. App. 635, 104 P.3d 725 (Wash. Ct. App. 2005); (2) for late notice of claim by insured to relieve insurer of duty to defend, insurer must show that the late notice actually and substantially prejudiced its interests; and (3) genuine issue of material fact as to whether insurer was prejudiced by insured's late notice of claim, as could relieve insurer of duty to defend, precluded summary judgment).

Weinstein & Riley PS v. Westport Ins. Corp., Nos. 11-35324, 11-35341, 484 Fed. App'x 121, 2012 WL 2024770 (9th Cir. June 6, 2012) (Ninth Circuit predicted that, under Washington law, professional liability insurer was required to reimburse insured law firm for 100% of its litigation costs in legal malpractice action that included covered and uncovered claims, where there was no reasonable basis for allocating costs between covered and uncovered claims).

Arden v. Forsberg & Umlauf, P.S., 193 Wash. App. 731, 373 P.3d 320 (Div. 2 2016) (holding: (a) at attorney who represents an insurer in coverage cases is not automatically prohibited on conflict-of-interest grounds from representing that insurer's insured when the insurer reserves its right to deny coverage; (b) law firm hired by homeowners' insurer to defend its insureds under a reservation of rights, in connection with a lawsuit alleging that they were liable for willful conversion of their neighbor's dog, did not have fiduciary duty to disclose to insureds the firm's longstanding relationship with the insurer; firm's undertaking of a reservation-of-rights defense even when it represents the insurer in other cause did not automatically create a conflict of interest; (c) one requirement for attorneys handling a reservation-of-rights defense of an insured is that potential conflicts of interest between insurer and insured must be fully disclosed and resolved in favor of the insured; (d) an attorney handling a reservation-of-rights defense of an insured generally must explain the "reservation of rights" process; i.e., that the insurer could refuse to indemnify the insured even though it was providing a defense and that the attorney represents only the insured and not the insurer; (d) law firm hired by insurer to defend insureds did not breach its fiduciary duty to disclose potential conflicts of interest between insureds and insurer, where firm's attorney met with insureds and discussed the relationship between insurer, firm, and insureds, including that attorney's duties were "solely" to insureds, and insureds had personal counsel who was engaged in the reservation-of-rights process and who presumably provided insureds with information and legal advice about the process; (e) if insurer defends its insured under a reservation of rights, the insured under certain circumstances has the ability to settle the case at his or her own expense without defeating coverage, even when the insurer does not consent; (f) if an insurer defends its insured under a reservation of rights, under certain circumstances the insured can enter into an agreement with the plaintiff to execute a stipulated judgment; and (g) when the insurer ends its insured under a reservation of rights, the insured has the ability, under certain circumstances, to settle the case without the insurer's involvement or consent; this means that when the

claimant makes a settlement demand, defense counsel must consult with the insured before that demand is rejected or allowed to expire).

Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Coinstar, Inc., 39 F. Supp. 3d 1149 (W.D. Wash. 2014) (under Washington law, insurer was responsible under CGL policy for reasonable defense costs incurred by its insured after relinquishing its right to choose attorney to defend underlying suits; insurer did not have power to unilaterally set rates it would pay for defense of lawsuit, without any restrictions, and regardless of unreasonableness of its rates, in absence of policy provision limiting rates or reservation of rights letters alerting insured to attorney fee rates; and under Washington law, insureds may not freely conduct their own litigation and then seek reimbursement where the policy obligates the insurer only to defend through counsel of its own choosing).

Nat'l Fire Ins. Co. of Hartford v. Commerce & Industry Ins. Co., No. 14-1398 RAJ, 2017 WL 468575 (W.D. Wash. Feb. 3, 2017):

> At issue, then, is whether CIIC is responsible for the cost of Mr. Jager, the attorney that Hartford hired while waiting for CIIC to accept the tendered defense. In the context of a reservation of rights agreement [footnote 1 says that "[t]he parties agree that there is no reservation of rights agreement in this matter"], insurers are not required to provide insureds with separate defense attorneys. *See, e.g., Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 388 (1986). Instead, the insurer has an enhanced obligation to (1) thoroughly investigate the claim, (2) retain competent defense counsel for the insured with the understanding that the insured is the only client, (3) fully inform the insured about a reservation of rights agreement and any relevant issues that arise with respect to this coverage, and (4) refrain from acting in a way that "would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk." *Id.* at 388. In addition, defense counsel retained by insurers in these instances must meet their own distinct criteria. *Id.* If an insurer meets the *Tank* standard, then it "has no obligation before-the-fact to pay for its insured's independently hired counsel," though the insurer may be liable after-the-fact for any breach of the enhanced obligation of fairness. *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 363 (1990) (finding that the insurer did not face after-the-fact liability because it met its enhanced obligation in defending and settling the underlying claim).

2017 WL 468575, at *3.

Accord, *Berkshire Hathaway Homestate Ins. Co. v. SQI, Inc.*, 132 F. Supp. 3d 1275 (W.D. Wash. 2015) (citing *Tank*).

WEST VIRGINIA

The West Virginia courts have not addressed an insured's right to independent counsel. However, at least two published opinions indicate that counsel hired by an insurer to defend the insured owes a duty of loyalty solely to the insured client. In *Haba v. Big Arm Bar and Grill, Inc.*, 196 W. Va. 129, 468 S.E.2d 915 (1996), the Supreme Court of Appeals noted that:

> We sanction the view that "an insurer's attorney, employed to represent an insured, is bound by the same high standards which govern all attorneys, and owes the insured the same duty as if he were privately retained by the insured." *Norman v. Ins. Co. of N. Am.,* 218 Va. 718, 727, 239 S.E.2d 902, 907 (1978). In the absence of any claim to the contrary, it appears that the counsel employed by [the insurer] to represent [the insured] in the [underlying] action adequately discharged that duty.

196 W. Va. at 136, 468 S.E.2d at 922.

More recently, in *Barefield v. DPIC Cos., Inc*., 215 W.Va. 544, 600 S.E.2d 256 (2004), the Supreme Court of Appeals reiterated this position:

> Arguably, the language of both Rules 1.7 and 1.8(f) might allow an attorney hired and paid by an insurance company to protect the insurance company's interests, and comply with the insurance company's directives and restrictions, in the representation of an insured if the insured "consents after consultation." However, the Rules also require that there must also be "no interference with the lawyer's independence of professional judgment," Rule 1.8(f)(2), and the attorney must reasonably believe that "the representation will not be adversely affected" by the joint representation. Rule 1.7(b)(1). More specifically, Rule 5.4(c) prohibits a third-party who pays for an attorney's services from "direct[ing] or regulat[ing] the lawyer's professional judgment in rendering such legal services."
>
> In sum, our *Rules of Professional Conduct* compel us to the conclusion that when an insurance company hires a defense attorney to represent an insured in a liability matter, the attorney's ethical obligations are owed to the insured and not to the insurance company that pays for the attorney's services. *In accord*, *In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures*, 299 Mont. 321, 333, 2 P.3d 806, 814 (2000); *Higgins v. Karp*, 239 Conn. 802, 810, 687 A.2d 539, 543 (1997); *Petition of Youngblood*, 895 S.W.2d 322, 328 (Tenn. 1995); *Atlanta Int'l Ins. Co. v. Bell*, 438 Mich. 512, 520, 475 N.W.2d 294, 297 (1991); *First Am. Carriers, Inc. v. Kroger Co.*, 302 Ark. 86, 89-91, 787 S.W.2d 669, 671 (1990).
>
> Because a defense attorney is ethically obligated to maintain an independence of professional judgment in the defense of a client/insured, an insurance company possesses no right to control the methods or means chosen by the attorney to defend the insured. As one court stated, an insurance company "cannot control the details of the attorney's performance, dictate the strategy or tactics employed, or limit the attorney's professional discretion with regard to the representation [of the insured]." *Petition of Youngblood*, 895 S.W.2d at 328. Accordingly, "an attorney hired by an insurer to defend an insured must be considered, at least initially, to enjoy the status of an independent contractor." *Givens v. Mullikin ex rel. Estate of McElwaney*, 75 S.W.3d 383, 392 (Tenn. 2002).

215 W.Va. at 558, 600 S.E.2d at 270.

WISCONSIN

The independent-counsel issue has not been addressed by the Wisconsin Supreme Court. There is a slight split of opinion between the federal district courts in Wisconsin that have addressed this issue. The U.S. District Court for the Eastern District of Wisconsin, citing various Wisconsin appellate court cases, has held that upon the insurer's issuance of a reservation-of-rights letter, the insured is allowed to control its own defense. *Nowacki v. Federated Realty Group, Inc.*, 36 F. Supp. 2d 1099, 1109 (E.D. Wis. 1999) (citing *Jacob v. W. Bend Mut. Ins. Co.*, 553 N.W.2d 800 (Wis. Ct. App. 1996)); and *Grube v. Daun*, 496 N.W.2d 106 (Wis. Ct. App. 1992) (*overruled on other grounds by Marks v. Houston Cas. Co.*, 2016 WI 53, 369 Wis. 2d 547, 881 N.W.2d 309 (Wis. 2016)). The rule of law reached in *Fireman's Fund Ins. Co. v. Waste Management, Inc.*, 777 F.2d 366 (7th Cir. 1985) (apparently applying Wisconsin law), which provides that an insurer is liable for the insured's attorney fees only if a mutual agreement with defense counsel is reached between the parties, is not to be interpreted to add an additional requirement. *Nowacki*, 36 F. Supp. 2d at 1109.

A subsequent unpublished opinion, however, reasoned that the insurer may still be entitled to a role in the selection of defense counsel even if, because of a conflict of interest, it may not control the defense. *HK Systems, Inc. v. Admiral Ins. Co.*, 2005 WL 1563340 (E.D. Wis. June 27, 2005). In that case, the district

court stated (in *dicta*) that the insurer was still entitled to appoint defense counsel if the appointed counsel were truly independent of the insurer. *HK Systems*, 2005 WL 1563340, at *16. The district court also denied the insured's motion for summary judgment that it was entitled to reimbursement for the expense of its much higher-priced law firm, holding that the insured was only entitled to reimbursement for reasonable defense costs and that fact questions existed as to whether the rates charged by its selected firm were reasonable. *Id*. at *18-19.

The U.S. District Court for the Western District of Wisconsin, citing an Eighth Circuit opinion, stated that the insurer, when confronted with a conflict of interest, must either provide an independent attorney to represent the insured or pay the costs incurred by the insured in hiring counsel of the insured's own choice. *Am. Motorists Ins. Co. v. Trane Co.*, 544 F. Supp. 669, 686 (W.D. Wis. 1982) (citing *U.S. Fid. & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932, 939 (8th Cir. 1978)).

In a relatively recent state appellate decision, the court addressed the issue of an insurer's obligation with respect to attorney's fees:

> Depending on the fact finder's determination on remand, the issue of attorney fees may be resolved. However, if the fact finder determines that the rate schedule was only temporary, the court will have to determine Liberty's obligation for attorney fees from the time of tender until the resolution of litigation. Whether the requested compensation for attorney fees is reasonable is a question of fact to be addressed by the trial court following consideration of the factors in SCR 20:1.5 (2010), which includes the fees customarily charged in the locality for similar service, SCR 20:1.5(a)(3). [Footnote omitted.] *See Wright v. Mercy Hosp. of Janesville, Wis., Inc.*, 206 Wis. 2d 449, 470, 557 N.W.2d 846 (Ct. App. 1996); *Fireman's Fund Ins. Co. v. Bradley Corp.*, 261 Wis. 2d 4, ¶ 67, 660 N.W.2d 666; *see also HK Sys., Inc. v. Admiral Ins. Co.*, 2005 WL 1563340 at *18, 19 (E.D. Wis. 2005) (applying Wisconsin law, holding that an insurer's responsibility for defense costs extends only to a reasonable charge and the market standard for attorney rates for a particular type of litigation in a particular geographic area is a question of fact preventing the grant of summary judgment); *see also* 14 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INS. § 202:35, at 202-87 (3d ed. 1999) ("An insurer's obligation to reimburse independent counsel is limited to reasonable attorney's fees and disbursements.").

Lakeside Foods, Inc. v. Liberty Mut. Fire Ins. Co., 329 Wis. 2d 270, 789 N.W.2d 754 (Table) (2010).

A federal district court in Wisconsin cited to *Lakeside Foods* and other cases in grant an insurer's motion for summary judgment on an insured's claims for bad faith and breach of the duty to defend, stating:

> With respect to bad faith, defendant [insured] acknowledges that a claim for bad faith requires a showing that the insured [read "insurer"?] lacked any reasonable basis for its decision. [Citation to record omitted] (quoting *Lakeside Foods*, 2010 WI App 120 at ¶ 44). Although I sided with defendant regarding the right to choose counsel in the April 1, 2015 order, I also acknowledged that there is a split in authority regarding whether the insurer or the insured has the right to choose counsel when the insured [should read "insurer"] provides a defense under a reservation of rights. *Compare HK Systems*, 2005 WL 1563340 (insurers who defend under reservation of rights retain right to choose "independent" counsel) with *Nowacki v. Federated Realty Group, Inc.*, 36 F. Supp. 2d 1099 (E.D. Wis. 1999) (insured has right to choose counsel when insurer provides a defense under reservation of rights). The parties cited no cases in which any court had considered the circumstances under which an insurer could be estopped from choosing counsel. Thus, although defendant may have incurred additional costs by hiring separate counsel to litigate the dispute over the choice of counsel, I cannot say that the law on that issue was so clear as to justify a finding of bad faith by United States Fire. Accordingly, I am granting United

> States Fire's motion for summary judgment on defendant's claims for bad faith and breach of the duty to defend.

Haley v. Kolbe & Kolbe Millwork Co., Inc., No. 14-cv-99-bbc, 2015 WL 6669395 (W.D. Wis. Nov. 2, 2015), at *4.

Two months later, however, the same court ruled that the insurers were estopped from requiring insured to switch counsel:

> When an insurer agrees to defend and indemnify an insured in a lawsuit, the general rule is that the insurer gets to control the defense. *HK Systems, Inc. v. Admiral Insurance Co.,* No. 03 C 0795, 2005 WL 1563340, at *4 (E.D. Wis. June 27, 2005) (citing ERIC MILLS HOLMES, APPLEMAN ON INSURANCE 2D § 136.1, at 4 (2003)). This makes sense because, under those circumstances, it is the insurer rather than the insured that will have to pay a potential judgment. However, when, as in this case, an insurer agrees to defend an insured under a reservation of rights to contest its obligation to indemnify, a conflict of interest may arise because the insured has a greater interest in having the best possible defense while the insurer has a greater interest in keeping costs down. The parties assume in their briefs that a conflict of interest exists between defendant and its insurers in this case because the insurers agreed to defend defendant under a reservation of rights and that, as a result of the conflict, defendant rather than its insurers has the right to control its counsel. Accordingly, I need not consider those issues.
>
> The key question raised by the parties' motions is the extent to which defendant's right to *control* counsel includes the right to *choose* counsel in a case such as this one in which the policies at issue give the insurer the "right and duty" to defendant its insured. The parties assume that Wisconsin law governs this question, so I will do the same. *RLI Insurance Company v. Conseco, Inc.,* 543 F.3d 384, 390 (7th Cir.2008). However, neither side cites case law from the Wisconsin Supreme Court or the Wisconsin Court of Appeals that addresses the right to choose counsel when an insurer provides a defense under a reservation of rights. Defendant says that "there are a number of Wisconsin Court of Appeals decisions holding that the insured has a right to choose counsel" when the insurer defends under a reservation of rights, [citation to record omitted], but the cases defendant cites say only that the insured has the right to "control" counsel in that situation, *Jacob v. West Bend Mutual Insurance Co.,* 203 Wis. 2d 524, 536, 553 N.W.2d 800, 805 (Ct. App.1996); *Grube v. Daun,* 173 Wis. 2d 30, 75, 496 N.W.2d 106, 123 (Ct. App.1992), a proposition that the insurers do not deny in their motion. Rather than citing controlling precedent, the parties cite opposing district court decisions from the Eastern District of Wisconsin. *Compare HK Systems,* 2005 WL 1563340 (insurers who defend under reservation of rights retain right to choose "independent" counsel) *with Nowacki v. Federated Realty Group, Inc.,* 36 F. Supp. 2d 1099 (E.D. Wis.1999) (insured has right to choose counsel when insurer provides defense under reservation of rights).
>
> The insurers also cite *American Motorists Insurance Co. v. Trane Co.,* 544 F. Supp. 669 (W.D. Wis.1982), in which I stated that, "[w]here there is a conflict [of interest between the insurer and insured], the insurer must *either* provide an independent attorney to represent the insured *or* pay the costs incurred by the insured in hiring counsel of the insured's own choice." *Id.* at 686 (citing *U.S. Fidelity and Guaranty Co. v. Louis A. Roser Co.,* 585 F.2d 932, 939 (8th Cir.1978)) (emphasis added). However, the relevant issue in that case was whether the insurer had breached its contract with the insured by refusing to defend the insured because of a conflict of interest. I did not need to decide the extent to which the insurer or the insured has the right to choose counsel when there is a conflict. Outside Wisconsin, jurisdictions are split on the question whether the insurer or the insured

has the right to select counsel when the insurer agrees to defend the insured under a reservation of rights. ARNOLD P. ANDERSON, WISCONSIN INSURANCE LAW vol. II, ch. 7, § 7.96 (6th ed.2010).

For the sole purpose of deciding the parties' cross motions for summary judgment, I will assume that insurers have a right to choose counsel even when they defend the insured under a reservation of rights. Even making that assumption, however, I conclude that defendant is entitled to summary judgment because the insurers lost whatever right they had through their own inaction.

It is undisputed that defendant tendered its defense to the insurers the day after plaintiffs filed their complaint. After that, the insurers did not object or otherwise place any restrictions on defendant with respect to counsel over the course of four months when defendant took the following actions:

- on February 19, 2014, when defendant informed its insurers that it was seeking counsel;
- on February 21, 2014, when defendant informed its insurers that it had chosen Foley & Lardner as counsel;
- on February 24, 2014, when counsel from Foley & Lardner held a conference call with the insurers and informed them of the firm's experience and rates;
- on March 4, 2014, when defendant informed the insurers that Foley & Lardner was preparing an answer (which was due by March 10, 2014); defendant stated that it was "await[ing] [the insurers] responses with regard to [their] coverage positions";
- on March 28, 2014, when defendant informed the insurers that it had received its first invoice from Foley & Lardner and again asked the insurers for their coverage positions.

It was not until June 18, 2014, four months after defendant tendered its defense, that the insurers informed defendant that they did not want defendant to use Foley & Lardner as counsel, but instead wanted defendant to choose one of two different law firms. Even then, the insurers provided no information to defendant about those firms except for their names. Although the insurers referred to the firms as "independent," the insurers did not provide any foundation for that statement.

Defendant argues that insurers' conduct prohibits them from arguing now that they have a right to choose counsel. Defendant characterizes this argument in several ways: (1) the insurers "allowed" defendant to choose Foley & Larder or "consented" to defendant's choice; (2) the insurers should be estopped from requiring defendant to switch counsel because defendant relied on the insurers' failure to object; (3) the insurers did not act in good faith; and (4) the insurers did not choose "truly" independent counsel for defendant because Wilson Elser has an ongoing relationship with intervenor Fireman's Fund. Of these arguments, I believe that estoppel is the strongest.

As defendant points out, the Supreme Court of Wisconsin has applied the doctrine of equitable estoppel to disputes about insurance coverage. *Mercado v. Mitchell,* 83 Wis. 2d 17, 26-27, 264 N.W.2d 532, 537 (1978). Although the parties do not cite any cases in which a Wisconsin court has considered whether estoppel may apply to the selection of counsel, numerous courts in other states have applied estoppel to the analogous issue whether an insurer may reverse a decision to provide a defense after the insurer already started

providing that defense. *E.g., Underwriters at Lloyds v. Denali Seafoods, Inc.,* 927 F.2d 459, 463-64 (9th Cir.1991); *Pacific Indemnity Co. v. Acel Delivery Service, Inc.,* 485 F.2d 1169, 1173 (5th Cir.1973); *Zurich Insurance Co. v. Continental Insurance Co.,* 101 Wash. App. 1023, 2000 WL 789861 (2000); *Providence Washington Insurance Co. v. A & A Coating, Inc.,* 30 S.W.3d 554, 556-57 (Tex. Ct. App.2000); *Safeco Insurance Co. v. Ellinghouse,* 223 Mont. 239, 725 P.2d 217, 220-21 (1986); *Maryland Casualty Co. v. Peppers,* 64 Ill. 2d 187, 355 N.E.2d 24, 29 (1976). In any event, the insurers do not deny that estoppel may apply in this context, so I need not resolve that issue. Instead, the insurers argue that defendant cannot meet the requirements of estoppel.

Estoppel applies when a party's action or inaction induces reliance by another party and prejudices the relying party as a result. *Mercado,* 83 Wis. 2d at 26–27, 264 N.W.2d at 537. The insurers argue that defendant could not have relied reasonably on anything the insurers did or did not do because "from the outset, [the insurers] informed [defendant] that [they were] exercising [their] right to select independent counsel pursuant to the policy and Wisconsin law." [Citation to record omitted].

The insurers' argument is not persuasive for two reasons. First, the insurers do not cite any evidence that they gave defendant any indication that they wanted to select different counsel until April 22, 2014, when Fireman's Fund wrote that it "is in contact with [the] other carriers to coordinate the defense and discuss the retention of independent counsel." However, that was two months after defendant tendered its defense and, even in the letter, the insurers simply say that they are "discuss[ing]" the retention of independent counsel; they did not suggest that they had reached any decisions and they did not tell defendant that Foley & Lardner would be expected to withdraw in the future.

Second, even if the April 22, 2014 letter qualifies as notice that Foley & Lardner may need to be replaced, that does not defeat an argument of reliance by defendant. Regardless when the insurers *told* defendant that they may be selecting their own counsel, there was little that defendant could do to ready itself until the insurers actually *provided* counsel. In other words, the prejudice to defendant was not simply a matter of not knowing that the insurers might choose another firm, but rather that the insurers failed to make a selection until defendant's counsel had already invested significant time and resources into the case. Under the insurers' view, if they had informed defendant that they were considering whether to choose different counsel the day defendant tendered its defense, the insurers would be free to take as much time as they wished *1054 to make a decision regarding counsel, up until the day of trial, regardless of the disruption that it would cause to the defense.

By June 18, 2014, Foley & Lardner had already begun engaging in extensive discovery and formulating a litigation strategy, including conducting interviews, reviewing a large number of documents, retaining an expert and inspecting plaintiffs' homes. Thus, forcing defendant to switch counsel at that stage could have jeopardized the work that defendant's counsel had done up to that point or at least caused significant delays as new counsel attempted to get up to speed. Particularly because defendant would have no way of knowing whether the court would grant extensions of time while new counsel attempted to catch up, it is not surprising that defendant resisted the insurers' efforts to make the switch. Further, because the insurers did not provide defendant any information about the law firms it chose, defendant was not in a position to accept the insurers' offer as of June 18.

The insurers argue that they were not simply sitting on their hands doing nothing before June 18. Rather, they say that they were investigating coverage, which was complicated by the number of policies involved and the breadth of plaintiffs' claims. It is difficult to

evaluate the merit of the insurers' allegation that they were investigating coverage diligently because they provide few details about what they were doing during the relevant time. Further, even if the insurers' conduct might have been reasonable under some circumstances, they should have known that time was of the essence under the circumstances of this case. When defendant notified the insurers of plaintiffs' claims, defendant already had been served with the complaint, so expedited consideration was required. Every day that passed without a decision from the insurers was a day in which the case progressed further and defendant's counsel invested more resources in the defense. Particularly because the insurers should have known that this court sets a tight schedule, they also should have known that a decision on counsel could not wait four months.

The insurers cite *American Design & Build, Inc. v. Houston Casualty Co.,* No. 11-C-293, 2012 WL 719061, at *11 (E.D. Wis. Mar. 5, 2012), and *Lakeside Foods, Inc. v. Liberty Mutual Fire Insurance Co.,* 2010 WI App 120, ¶ 13, 329 Wis. 2d 270, 789 N.W.2d 754 (nonprecedential opinion), for the proposition that there was no undue delay. However, the insurers' reliance on those cases is misplaced because the question in both cases was whether an insurer breached its duty to defend by waiting too long to accept the defense. The parties were *not* disputing the choice of counsel. This is important because the prejudice to the insured may be different in both situations. Although a four-month delay in deciding whether to defend an insured may not cause prejudice so long as the insurer agrees to make its decision retroactive and pay the costs of litigation from the time the insured tendered its defense, the same conclusion does not necessarily follow regarding the choice of counsel. Regardless whether the insurer promises to foot the bill for litigation expenses occurred before the insurer selected counsel, changing counsel after the lawsuit has progressed is more likely to be disruptive and prejudicial. Because the courts in *American Design* and *Lakeside Foods* emphasized that the insured in those cases had not made any showing that the insurer's delay had resulted in any prejudice, those cases actually support a view that an insurer should be estopped from requiring an insured to make a prejudicial change in the middle of a lawsuit.

In this case, not only did the insurers delay in choosing counsel, they delayed in seeking relief from the court when defendant rejected their offer. The insurers waited more than four more months after defendant rejected the insurers' offer to file a motion to intervene in this case so that the court could resolve the issue. The insurers' only explanation for that delay is that they were trying to resolve the issue without court assistance. However, that argument is disingenuous in light of the fact that the insurers waited more than three weeks to even *respond* to defendant's rejection. Further, although making every effort to settle a dispute out of court is a laudable goal in most situations, it makes little sense simply to spend months exchanging letters at a leisurely pace in the context of an ongoing lawsuit when it is clear that a prompt resolution of a decision is needed to avoid further prejudice to the insured. Finally, defendant was clear in its June 24, 2014 letter to the insurers that it believed it had the right to keep Foley & Lardner as counsel. After that point, any further attempt to resolve the issue through mere persuasion was not an efficient use of time.

By the time that the insurers filed their motion for summary judgment on the selection of counsel issue, the case had been proceeding for more than ten months. (Although the insurers sought to stay the case while the coverage issue was pending, I denied this motion in accordance with this court's consistent practice in recent years. [Citation to record omitted] (citing *Neri v. Monroe,* No. 11-cv-429-bbc (W.D. Wis.2011); *Biewer–Wisconsin Sawmill, Inc. v. Fremont Industries, Inc.,* 2007 WL 5517466, *1 (W.D. Wis.2007); *Solofra v. Douglas County,* 2005 WL 3059488 (W.D. Wis.2005); *Wimmer v. Rental Service Corp.,* 2005 WL 949328 (W.D. Wis.2005)).) The motion for summary judgment was not fully

briefed until two months later, in part because of extensions of time sought by the insurers. By that time, defendant had filed a 70-page motion for partial summary judgment. Thus, at this point, it would be impossible to grant the insurers' motion without causing substantial prejudice to defendant or completely resetting the schedule in this case, which is already on a slower track than the vast majority of cases in this court. Under these circumstances, it would not be fair to defendant (or plaintiffs) to allow the insurers to stall the proceedings by substituting new counsel. The insurers' insouciance regarding the developments in a pending lawsuit in a fast-paced court is simply not justified.

Fireman's Fund Insurance Co. v. Waste Management of Wisconsin, Inc., 777 F.2d 366 (7th Cir.1985), is instructive. In that case, after the insured was sued, it retained counsel and tendered its defense to its insurer. The insurer agreed to defend the insured under a reservation of rights and then made no objection to the insured's choice of counsel and did not suggest retaining other counsel until a few months later. *Id.* at 368. At that point, the insured refused to accept the new counsel. Both the district court and the Court of Appeals for the Seventh Circuit concluded that the insurer was not entitled to impose its own choice of counsel on the insured after not objecting for several months. *Id.* at 369.

The insurers in this case point out that in *Fireman's Fund,* the court directed the parties to choose new independent counsel. However, this was only because counsel for the insured chose had a conflict of interest with the insurer. *Id.* at 370. As a result of that conflict, the court "adopted the equitable suggestion of permitting [the insured] to select new independent counsel ... but subject to the approval and at the expense of" the insurer. *Id.* Because the insurers have not identified any conflicts they have with Foley & Lardner, I see no reason to require the selection of new counsel.

The insurers object to Foley & Lardner on the ground that the law firm has been "uncooperative," but the only example of this the insurers discuss in their briefs is that Foley & Lardner did not inform them of a settlement conference until after the conference occurred. The insurers cite no authority for the view that they are entitled to participate in every settlement discussion, but even if I assume that they are, the insurers have not shown that a single slight is a sufficient ground to remove Foley & Lardner from the case. The insurers do not dispute defendant's statement that since the one oversight, defendant has asked for the insurers' input on settlement offers. [Citation to record omitted].

The insurers also object to Foley & Lardner on the ground that its rates are higher than the law firm the insurers chose. However, neither side develops an argument on the question whether there should be a "reasonable rate" cap on defendant's choice and, if so, whether Foley & Lardner's rates are reasonable. *HK Systems,* 2005 WL 1563340, at *18 (concluding that "the insurer's responsibility for defense costs extends only to a reasonable charge"). Accordingly, I conclude that it would be premature to resolve that issue in the context of this order.

Haley v. Kolbe & Kolbe Millwork Co., Inc., 97 F. Supp. 3d 1047, 1051-56 (W.D. Wis. 2015)

Wis. Pharmacal Co., LLC v. Neb. Cultures of Cal., Inc., 2016 WI 14, 367 Wis. 2d 221, 876 N.W.2d 72 (Wis. 2016) (liability insurer may avoid breaching the duty to defend by requesting a bifurcated trial on the issues of coverage and liability and moving to stay any proceedings on liability until the issue of coverage is resolved; however, insurer may need to provide a defense to its insured when the separate trial on coverage does not precede the trial on liability and damages).

WYOMING

Wyoming has not yet considered the issue of whether an insured is entitled to independent counsel if a conflict of interest develops between insurer and insured. Two Wyoming cases mention that an insurer provided independent counsel under such circumstances in their recitations of facts, but the courts did not comment on whether or not this was required. *See Gainsco Ins. Co. v. Amoco Prod. Co.,* 53 P.3d 1051, 1059 (Wyo. 2002), and *Crawford v. Infinity Ins. Co.,* 64 Fed. App'x 146 (10th Cir. 2003). Accordingly, it appears that whether an insurer must fund separate counsel in a conflict of interest situation remains an open question under Wyoming law. However, note that an insurer cannot defend under a reservation of rights and later seek reimbursement of defense costs in the event no coverage is owed. Rather, it must either deny the defense or seek declaratory judgment. *See Shoshone First Bank v. Pacific Employers Ins. Co*., 2 P.3d 510 (Wyo. 2000).

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Jurisdictional and Venue Considerations in Insurance Coverage Litigation:
The "Colorado River" Runs Through It
(John Heintz, Edward Parks, Caroline Spangenberg, Koorosh Talieh)

I. Introduction

a. Federal Courts have jurisdiction over insurance coverage disputes when (1) they have jurisdiction over the action and (2) venue is proper.

i. State courts are courts of general jurisdiction; federal courts are courts of limited jurisdiction, as defined by Article III, section 2 of the United States Constitution.

1. Federal courts have jurisdiction over disputes involving federal questions, disputes between states, and disputes between citizens of different states (diversity jurisdiction). A federal court exercising diversity jurisdiction will apply the law of the state in which it sits, including with respect to choice of law questions. *Erie v. Tompkins*, 304 U.S. 64 (1938); *Klaxon v. Stentor Elec. Mfg. Co.*, 313 U.S. 487 (1941). States' local laws differ substantially with respect to the ways in which many important insurance policy provisions are interpreted and applied. They also differ with respect to choice of law – i.e., how to determine which state's law applies. Accordingly, the outcome of an insurance coverage dispute will sometimes turn on which court hears and decides it.
2. Insurance coverage disputes and policy interpretation are governed by state law. As a general matter, coverage disputes can be litigated in federal court only if there is diversity jurisdiction. To establish diversity jurisdiction, federal courts must have complete diversity of citizenship between all parties on one side and all parties on the other side, and the amount in controversy must

exceed $75,000. 28 U.S.C. § 1332; *see Strawbridge v. Curtiss*, 7 U.S. (3 Cranch) 267 (1806).

3. A corporation's citizenship is based on state of incorporation and its principal place of business. *Louisville, Cincinnati & Charleston Railroad Co.* v. *Letson*, 43 U.S. (2 How.) 497 (1844) (holding that a corporation is to be deemed a citizen of the state where it is chartered for the purpose of suing and being sued.).

ii. Establishing citizenship for the purpose of demonstrating diversity jurisdiction in coverage disputes can be particularly difficult where LLCs and other entities or organizations that are not corporations are involved.

1. If an insured is a limited liability company or a partnership, as a general rule, the organization has the citizenship of each of its "members," and one must go "up the chain" and establish that all members at all levels are diverse. *See, e.g.*, *Carden v. Arkoma Assoc.*, 494 U.S. 185 (1990) (holding that a limited partnership has the citizenship of each of its partners, whether general or limited); *Americold Realty Trust v. ConAgra*, 136 S. Ct. 1012 (Mar. 7, 2016) (because *Americold* was organized under a statute enabling it to sue and be sued in its own name, the rule of *Carden* was applied, and the citizenship of every beneficial owner in the trust was attributed to it for purposes of diversity jurisdiction); *Mut. Assignment & Indem. Co. v. Lind-Waldock & Co.*, 364 F.3d 858, 861 (7th Cir. 2004) ("Lind-Waldock is a limited liability company, which means that it is a citizen of every state of which any member is a citizen; this may need to be traced through multiple levels if any of its members is itself a partnership or LLC."). *But see Americold*, 136 S. Ct. at 1016 (recognizing that the citizenship of a traditional trust that lacks the capacity to sue and be sued in its own name and can only bring suit through its trustee is determined

by the citizenship of the trustee, not the trust's members); *Navarro Savs. Assn. v. Lee*, 446 U.S. 458 (1980) (business trust could not sue or be sued in its own name so only citizenship of trustee mattered for diversity purposes).

2. Establishing diversity jurisdiction in coverage disputes that involve syndicates of Lloyd's of London is also made difficult by courts that require a showing that each member of the syndicate is diverse. *See Indiana Gas Co. v. Home Ins. Co.*, 141 F.3d 314 (7th Cir. 1998) (holding that a syndicate procures the citizenship of each of its subscribing members); *accord Underwriters at Lloyd's, London v. Osting-Schwinn*, 613 F.3d 1079 (11th Cir. 2010) *and E.R. Squibb & Sons, Inc. v. Acc. & Cas. Ins. Co.*, 160 F.3d 925 (2d Cir. 1998). *But see Certain Interested Underwriters at Lloyd's v. Layne*, 26 F.3d 39 (6th Cir. 1994) (holding that a Lloyd's insurance syndicate acquires strictly the citizenship of the agent of the syndicate).

iii. In insurance coverage actions, the amount in controversy requirement is usually met if the amount potentially recoverable under the policy at issue exceeds $75,000. *First Mercury Ins. Co. v. Excellent Computing Distributors, Inc.*, 648 Fed App'x 861, 865 (11th Cir. April 20, 2016) (citing *Stonewall Ins. Co. v. Lopez*, 544 F.2d 198, 199 (5th Cir. 1976)) (concluding the amount in controversy included both the insurance company's potential indemnity liability and attendant costs associated with defending an underlying action against the insured).

iv. In addition to establishing jurisdiction, venue must be proper under 28 U.S.C. § 1391(b). Venue may be changed "for the convenience of the parties and witnesses, in the interest of justice." 28 U.S.C. § 1404(a).

b. Insurance coverage litigants often have multiple federal and state courts to choose from when filing a coverage suit. Many coverage disputes involve multiple

insurers, sometimes 20 or more. Even if only one insurer is involved, litigants may still have multiple possibilities among federal and state courts from which to choose. This is particularly true if the policy was issued in one state, the underlying loss or litigation occurred in another state, and the insured is incorporated and has its principal place of business in other states.

c. Federal courts have developed a body of case law that addresses how federal courts decide whether to exercise or decline to exercise jurisdiction, known as *Colorado River* and *Brillhart-Wilton* doctrines. *See Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 817 (1976); *Brillhart v. Excess Ins. Co. of Am.*, 316 U.S. 491-494-95 (1942); *Wilton v. Seven Falls Co.*, 515 U.S. 277, 288 (1995). There is also a body of case law that has evolved to address venue disputes.

   i. Coverage disputes generally involve one or two core causes of action: one seeking a declaration of coverage (by the policyholder) or of no coverage (by an insurer); the other for breach of contract seeking damages by the policyholder. If an insurer files in federal court, it files under the Declaratory Judgment Act.

   ii. The issues addressed here arise in a few different contexts:

      1. An insurer files a federal court declaratory judgment action, and a policyholder files a state court declaratory judgment and breach of contract action.
      2. A policyholder files a federal court declaratory judgment and breach of contract action, and an insurer files a state court declaratory judgment action.
      3. An insurer files a federal court declaratory judgment action, and a policyholder files a federal court declaratory judgment and breach of contract action.

   iii. The federal case law governing the first context flows from the Supreme Court's decisions in *Brillhart* and *Wilton*. The case law governing the

second flows from the Supreme Court's decision in *Colorado River*. The case law governing the third context flows from the forum non conveniens provision of the Judicial Code, 28 U.S.C. § 1404(a). The factors considered under these lines of cases overlap.

II. The *Brillhart-Wilton* Doctrine – Federal district courts have discretion to abstain from duplicative parallel declaratory judgment actions.

a. Introduction

i. Courts apply the *Brillhart-Wilton* doctrine when deciding whether to abstain from a parallel declaratory judgment action.

ii. The *Brillhart –Wilton* doctrine establishes that the district court has broad discretion to determine "whether and when to entertain an action under the Declaratory Judgment Act, even when the suit otherwise satisfies subject-matter jurisdictional prerequisites." *Wilton,* 515 U.S. at 288.

iii. The *Brillhart-Wilton* doctrine stands for the proposition that district courts are not compelled to entertain parallel actions seeking declaratory relief because the Declaratory Judgment Act grants them discretion in deciding whether to hear such claims. *Id.*

b. Substantial Discretion to abstain from parallel declaratory judgment actions – District courts are afforded "substantial discretion" to decline to exercise jurisdiction over parallel federal declaratory judgment actions because the Declaratory Judgment Act allows a court to decline jurisdiction on the basis of practicality and wise judicial administration. *Wilton*, 515 U.S. at 288.

i. The authority of the federal courts to issue declaratory judgments derives from the Declaratory Judgment Act. 28 U.S.C. § 2201 ("any court of the United States, upon the filing of an appropriate pleading, *may* declare the rights and other legal relations of any interested party seeking such

declaration, whether or not further relief is or could be sought ….") (emphasis added).

1. Under the Declaratory Judgment Act, a lawsuit seeking federal declaratory relief must present two things:
    a. An actual case or controversy within the meaning of Article III, section 2, of the United States Constitution. *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 239-40 (1937).
    b. Statutory jurisdictional prerequisites. *Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 672 (1950).
2. Even if an action passes the statutory hurdle, the district court must also be satisfied that entertaining the action is appropriate. *Governmental Emps. Ins. Co. v. Dizol*, 133 F.3d 1220, 1223 (9th Cir. 1998).
    a. "The normal principle that federal courts should adjudicate claims within their jurisdiction yields to considerations of practicality and wise judicial administration." *Wilton*, 515 U.S. at 288.
3. Parallel Action – The existence of a parallel action in state court is a threshold factor for federal abstention.
    a. A state proceeding is parallel to a federal declaratory relief action when (1) the actions arise from the same factual circumstances; (2) there are overlapping factual questions in the actions; or (3) the same issues are addressed by both actions.
    b. Courts construe "parallel action" liberally. Underlying state actions need not involve the same parties or the same issues to be considered parallel: it is enough that the state proceedings arise from the same factual circumstances. *See, e.g.*, *N. Pac. Seafoods, Inc. v. Nat'l Union Fire Ins.*

Co., 2008 U.S. Dist. Lexis 1714 at *11 (W.D. Wash. Jan. 3, 2008).

i. The parallel action standard is generally satisfied when an insurer seeks a coverage determination in the federal court, and a policyholder seeks an opposite coverage determination in the state court. *State Auto. Mut. Ins. Co. v. Reed*, 2008 U.S. Dist. LEXIS 29712, at *2 (S.D. Ind. Mar. 28, 2008).

ii. Declaratory judgment suits by insurers have been held "parallel to the underlying state court action against the policyholder that gives rise to the coverage dispute" when fact issues overlap. *Emp'rs Reinsurance Corp. v. Karussos*, 65 F.3d 796 (9th Cir. 1995) (district court abused its discretion when it retained jurisdiction over an insurance coverage dispute because the resolution of coverage issues "turn[ed] on factual questions that overlap[ed] with those at issue in the underlying state court litigation," despite that fact questions were non-identical.)

c. Courts may exercise their discretion to dismiss a federal declaratory relief action in circumstances where state and federal actions involve different parties and legal theories. *See, e.g.*, *Am. Nat'l Fire Ins. Co. v. Hungerford*, 53 F.3d 1012, 1017 (9th Cir. 1995), overruled on other grounds.

i. In *Dizol*, the district court refrained from exercising jurisdiction even though the federal action did not "parallel a state court action arising from the same facts in the sense that different legal issues are

presented by the pleadings" because there was a sufficient "parallel" "in the sense that the ultimate legal determination in each depends upon the same facts." 133 F.3d at 1227.

ii. Thus, a federal court may decline to exercise jurisdiction over a parallel declaratory judgment even when the suit satisfies subject matter jurisdictional prerequisites because the Declaratory Judgment Act is "deliberately cast in terms of permissive, rather than mandatory, authority." *Public Serv. Comm'n v. Wycoff Co.*, 344 U.S. 237, 250 (1952) (Reed, J., concurring). *See also Public Affairs Ass'n v. Rickover*, 369 U.S. 111, 112 (1962) (the Act "gave the federal courts competence to make a declaration of rights; it did not impose a duty to do so").

c. In *Brillhart*, the Supreme Court outlined considerations for deciding whether to hear or abstain from hearing a case. Recognizing that the Declaratory Judgment Act increased the potential for "uneconomical as well as vexatious" parallel actions in state and federal courts, the Court urged avoidance of "gratuitous interference with the orderly and comprehensive disposition of a state court litigation." 316 U.S. at 495. The Court found that the question for a district court presented with a suit under the Declaratory Judgment Act is "whether the questions in controversy between the parties to the federal suit, and which are not foreclosed under the applicable substantive law, can better be settled in the proceeding pending in the state court." *Id.*

d. *Brillhart* did not set out an exclusive list of factors governing the district court's exercise of discretion in deciding whether and when to entertain an action under the Declaratory Judgment Act. *See Wilton*, 515 U.S. at 282-83. The circuits have developed their own multi-factor tests to guide the district courts. Each circuit's expression of the *Brillhart* factors, though stated differently, encompasses three main aspects: (1) "the proper allocation of decision-making between state and

federal courts"; (2) fairness; and (3) efficiency. *Sherwin-Williams Co. v. Holmes County*, 343 F.3d 383, 390 (5th Cir. 2003).

i. The proper allocation of decision-making between state and federal courts.

1. Many circuits have a presumption in favor of a pending parallel state lawsuit.

a. There is a presumption that an entire suit should be heard in state court when there are parallel state proceedings involving the same issues and parties pending at the time a federal declaratory action is filed. *Dizol*, 133 F.3d at 1225.

b. *See also Chamberlain v. Allstate Ins. Co.*, 931 F.2d 1361, 1366 (9th Cir. 1991), overruled on other grounds by *Smith Mailer Mfg. v. Lib. Mut. Ins. Co.*, 1997 WL 407862 (9th Cir. July 21, 1997) (citing *Brillhart*). ("Ordinarily it would be uneconomical as well as vexatious for a federal court to proceed in a declaratory judgment suit where another suit is pending in a state court presenting the same issues, not governed by federal law, between the same parties. . . . [T]here exists a presumption that the entire suit should be heard in state court.").

c. *But see, e.g.*, *Evanston Ins. Co. v. Jimco, Inc.*, 844 F.2d 1185, 1193 (5th Cir. 1988) (internal quotation marks and alterations omitted) ("The presence of a federal law issue must always be a major consideration weighing against surrender of jurisdiction, but the presence of state law issues weighs in favor of surrender only in rare circumstances.").

2. Whether or not such a presumption applies, the question of which court is better positioned to decide a particular declaratory judgment action is ultimately decided based on the facts and

circumstances of the case. For example, in *Great American Insurance Company v. ACE American Insurance Company*, the court declined to abstain from hearing the insurer's first-filed declaratory judgment action in deference to the insured's competing New Jersey lawsuit because, among other reasons, the court determined that Texas rather than New Jersey state law governed the construction of the relevant policies. 2018 WL 1916567, *3-5 (N.D. Tex. April 20, 2018); *see, also, e.g.*, *Crum & Forster Specialty Ins. Co. v. Explo Sys. Inc.*, 2013 WL 1869099, *5 (W.D. La. May 2, 2013) ("*Explo*") (declining to abstain in part because "federal courts frequently decide cases involving liability insurance coverage"); *Sherwin-Williams*, 343 F.3d at 396 (finding that the absence of novel questions of state law weighed in favor of retaining federal jurisdiction).

3. A needless determination of state law may involve an ongoing parallel state proceeding or an area of law expressly reserved to the states. *Continental Cas. Co. v. Robsac Indus.*, 947 F.2d 1367, 1370 (9th Cir. 1991).
    a. "[A] district court's discretion to grant relief under the Declaratory Judgments Act ordinarily should not be exercised where another suit is pending in a state court presenting the same issues, not governed by federal law, between the same parties." *Id.*
    b. In *Robsac*, the insured (Robsac) brought a state court action against its insurer, Continental Casualty, and certain other non-diverse parties, for breach of contract related to Continental's denial of coverage. Because Robsac's action lacked diversity, and thus, could not be removed to federal court, Continental filed its own action in federal court,

seeking a declaration that it had no coverage obligation under its policy. Applying the *Brillhart* factors, the Court found that three facts created a likelihood that the parallel federal action would result in a needless determination of state law issues:

i. "[T]he precise state law issues at stake [in the federal action] are the subject of a parallel proceeding in state court." *Id.*

ii. "In the federal case, a diversity action, California law provides the rule of decision for all the substantive questions. Moreover, this case involves insurance law, an area that Congress has expressly left to the states through the McCarran-Ferguson Act." *Id.*; and

iii. "[W]here, as in the case before us, the sole basis of jurisdiction is diversity of citizenship, the federal interest is at its nadir. Thus, the *Brillhart* policy of avoiding unnecessary declarations of state law is especially strong here." *Id.*

4. Area of state law

a. Abstention is more appropriate where state law is unclear and there is no strong federal interest in the matter. *Mitcheson v. Harris*, 955 F.2d 235, 238 (4th Cir. 1992).

i. Absent a strong countervailing federal interest, federal court should not attempt to render what may be an "uncertain and ephemeral" interpretation of state law. *Allstate Ins. Co. v. Davis*, 230 F. Supp. 2d, 1112, 1120 (D. Haw. 2006).

b. Conversely, abstention is less appropriate where "the issues involved are standard ones" and "[a] federal court [applying state law] would be unlikely to break new ground or be faced with novel issues of state interest." *United Capitol Ins. Co. v. Kapiloff*, 155 F.3d 488, 494 (4th Cir. 1998).

c. Because the McCarran-Ferguson Act leaves the substantive law of insurance to the states, there is no compelling federal interest in resolving disputes concerning insurance coverage.

    i. States have a free hand in regulating the dealings between insurers and their policyholders. *Karussos*, 65 F.3d at 799

    ii. Federal interest in coverage disputes is minimal because the insurance industry is wholly state regulated. *Dizol*, 133 F.3d at 1232

    iii. Where the sole basis of federal subject matter jurisdiction is diversity, the federal interest is "at its nadir." *Robsac*, 947 F.2d at 1371.

d. However, courts have rejected assertions that questions of liability insurance coverage—which are frequently decided by federal courts—necessarily present the sort novel questions of state law that weigh in favor of abstention. *See Explo*, 2013 WL 1869099 at *5; *see also Dizol*, 133 F.3d at 1225 ("[T]here is no presumption in favor of abstention in declaratory actions generally, nor in insurance coverage cases specifically. We know of no authority for the proposition that an insurer is barred from invoking

diversity jurisdiction to bring a declaratory judgment action against an insured on an issue of coverage.").

ii. Fairness: The district court should discourage litigants from filing declaratory actions as a means of improper forum shopping.

1. "Although many federal courts use terms such as 'forum selection' and 'anticipatory filing' to describe reasons for dismissing a federal declaratory judgment action in favor of related state court litigation, these terms are shorthand for more complex inquiries. The filing of every lawsuit requires forum selection. . . . The courts use pejorative terms such as 'forum shopping' or 'procedural fencing' to identify a narrower category of federal declaratory lawsuits filed for reasons found improper and abusive, other than selecting a forum or anticipating related litigation." *Sherwin-Williams*, 343 F.3d at 391.
2. Federal courts generally decline to entertain declaratory actions that appear to have been brought to gain an unfair advantage. Courts apply a variety of different tests in determining whether a plaintiff's choice of forum is improper or abusive.
3. Courts "generally decline to entertain reactive declaratory actions." *Dizol*, 133 F.3d at 1225.
4. A number of courts have characterized an insurer's declaratory relief action filed during the pendency of parallel underlying proceedings as reactive and found abstention proper in order to discourage forum shopping.
    a. "A declaratory judgment action by an insurance company against its insured during the pendency of a non-removable state court action presenting the same issues of state law is an archetype of what we have termed 'reactive'…." *Robsac*, 947 F.2d at 1372-73.

5. Courts have reached different results in analyzing whether a first-filed federal court action should be considered "reactive" or otherwise improper.
    a. In *Robsac*, the court took the view that a federal court action is improperly "reactive" when an insurer "anticipate[s] that its insured intends to file a non-removable state court action, and rush[es] to file" a declaratory judgment action in federal court in hopes of "preempt[ing] any state court proceeding." *Id.* The court concluded that "[w]hether the federal declaratory judgment action regarding insurance coverage is filed first or second, it is reactive, and permitting it to go forward when there is a pending state court case presenting the identical issue would encourage forum shopping in violation of the second *Brillhart* principle." *Robsac*, 947 F.2d at 1372-73. *See also Chamberlain*, 931 F.2d at 1367 ("[T]here is a concern that parties could attempt to avoid state court proceedings by filing declaratory relief actions in federal court. This kind of forum shopping could be avoided by requiring district courts to inquire into the availability of state court proceedings to resolve all issues without federal intervention."); *Federated Servs. Ins. Co. v. Les Schwab Warehouse Ctr., Inc.*, 2004 U.S. Dist. Lexis 9252, at *11-14 (D. Or. Feb. 9, 2004); *Great Am. Assur. Co. v. Bartell*, 2008 U.S. Dist. Lexis 38720, at *11-12 (D. Ariz. Apr. 28, 2008); *AMCO Ins. Co. v. AMK Enters*., 2006 U.S. Dist. LEXIS 50806, at *12 (N.D. Cal. July 13, 2006) (exercising jurisdiction would encourage forum shopping because

insurer could have brought action in state court where underlying action was pending.).

b. However, in *Sherwin-Williams*, the court emphasized that "[d]eclaratory judgment actions often involve the permissible selection of a federal forum over an available state forum, based on the anticipation that a state court suit will be filed." *Sherwin-Williams*, 343 F.3d at 398. *See also, e.g.*, *Kapiloff*, 155 F.3d 488 at 495 (finding that although the plaintiff-insurer may have predicted that the insured would file suit in state court, thus making the federal suit "anticipatory," "without more, we cannot say that [the insurer's] action is an instance of forum-shopping instead of a reasonable assertion of its rights under the declaratory judgment statute and diversity jurisdiction"); *Chubb Custom Ins. Co. v. Prudential Ins. Co. of Am.*, 195 N.J. 231, 242 (2008) ("The case law has overwhelmingly rejected the notion that an insured has the right to choose the forum in all instances and to avoid participation in a first-filed action by the insured.").

iii. Efficiency: The district court should "avoid duplicative litigation" where possible.

1. Resolving the coverage dispute in the context of the more comprehensive action may promote judicial economy and conservation of judicial resources—results that may not be achieved through piecemeal litigation.

a. In *Robsac*, the court determined that the insurers' federal declaratory relief action was sufficiently "duplicative" of the insureds' state court action: "The federal declaratory suit is virtually the mirror image of the state suit. All of the

issues presented by the declaratory judgment action could be resolved by the state court. [Indeed, the state court can also resolve the additional claims involving the non-diverse defendants.] Hence, permitting the present action to go forward would waste judicial resources in violation of the third *Brillhart* factor." 947 F.2d at 1373.

b. However, where either suit would fully resolve the parties' dispute, this factor does not support disregarding the first-filing plaintiff's choice of forum. *See Great Am. Ins. Co.*, 2018 WL 1916567 at *5.

2. A stay may be indicated where state and federal claims are "inherently intertwined[.]" *Burlington Ins. Co. v. Panacorp, Inc.*, 758 F. Supp. 2d 1121, 1142 (D. Haw. 2010); *see also Phoenix Assur. PLC v. Marimed Found. for Island Health Care Training*, 125 F. Supp. 2d 1214, 1222 (D. Haw. 2000) (avoidance of duplicative litigation favored stay where district court would have to decide many of the same issues pending in state court litigation).
3. Where duplicative litigation runs the risk of providing inconsistent factual findings and judgments, a stay or dismissal of proceedings is particularly appropriate. *See One Beacon Ins. Co. v. Parker, Kern, Nard & Wenzel*, 2009 U.S. Dist. LEXIS 88043 *15 (E.D. Cal. Sept. 9, 2009).
    a. There is the clear potential that allowing this action to continue will lead to state and federal appellate courts reviewing claims and rulings, perhaps inconsistent rulings, arising from the same set of facts." *Hungerford*, 53 F.3d at 1018.
4. Courts also recognize that it may be inefficient to litigate in a forum that is inconvenient to the parties and witnesses. Depending

on the facts presented, it may be more appropriate to address concerns of duplicative litigation and inconsistent factual findings and judgments through a stay of the later-filed state court action, rather than the first-filed federal court action. *See Great Am. Ins. Co.*, 2018 WL 1916567, at *5.

e. Additional Factors – Circuit courts have articulated additional considerations that a district court should address in considering whether to abstain.
    i. Ninth Circuit – The *Dizol* Factors
        1. whether the declaratory action will settle all aspects of the controversy in a single proceeding;
        2. whether it will serve a useful purpose in clarifying the legal relations at issue;
        3. whether it is being sought merely for the purposes of procedural fencing or to obtain a res judicata advantage at the expense of the other party;
        4. whether the use of a declaratory action will result in the entanglement between federal and state court systems; and
        5. convenience of the parties and the availability and relative convenience of other remedies.
    ii. Fifth Circuit – The *Trejo* Factors – *St Paul. Ins. Co. v. Trejo*, 39 F.3d 585, 590-91 (5th Cir. 1994).
        1. whether there is a pending state action in which all of the matters in controversy may be fully litigated;
        2. whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant;
        3. whether the plaintiff engaged in forum shopping in bringing the suit;
        4. whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist;

5. whether the federal court is a convenient forum for the parties and witnesses;
6. whether retaining the lawsuit would serve the purposes of judicial economy; and
7. whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

f. Utility

i. The Court will only apply the "substantial discretion" standard when the action is for declaratory judgment; the inclusion of claims for damages or injunctive relief may render the *Brillhart-Wilton* doctrine inapplicable. There is a circuit split as to whether the discretionary *Brillhart-Wilton* standard, or the exceptional circumstances *Colorado River* standard, applies when the federal case presents mixed claims for relief. *See State Farm Mut. Auto. Ins. Co. v. Physicians Grp. of Sarasota, L.L.C.*, 9 F. Supp. 3d 1303, 1308 (M.D. Fla. 2014) (summarizing circuit split).

1. Second, Fourth, Fifth, and Tenth – The *Brillhart/Wilton* standard does not apply where non-declaratory claims are joined with declaratory ones; any abstention decision must be reached by reference to the exceptional cases standard of *Colorado River*. *New England v. Barnett*, 561 F.3d 392, 395 (5th Cir. 2009); *United States v. City of Las Cruces*, 289 F.3d 1170, 1181-82 (10th Cir. 2002); *Vill. of Westfield v. Wlech's*, 170 F.3d 116, 125 n. 5 (2d Cir. 1999).

a. The Fourth Circuit has held that when a complaint states claims for both non-declaratory and declaratory relief, the *Colorado River* "exceptional circumstances" standard, rather than the *Brillhart/Wilton* "discretionary" standard,

always applies to determine whether abstention is appropriate. *VonRosenberg v. Lawrence*, 781 F.3d 731 (4th Cir. 2015), *as amended* (Apr. 17, 2015).

i. The *Colorado River* standard applies to all mixed claims—even when the "claims for coercive relief are merely 'ancillary' to [a party's] request for declaratory relief." *Id.*

ii. Indeed, "the only potential exception to this general rule arises when a party's request for injunctive relief is either frivolous or is made solely to avoid application of the *Brillhart* standard." *Id.*

b. Claims for declaratory and injunctive relief "are so closely intertwined that judicial economy counsels against dismissing the claims for declaratory judgment relief while adjudicating the claims for injunctive relief." *Chase Brexton Health Servs., Inc. v. Maryland*, 411 F.3d 457, 463, 466-67 (4th Cir. 2005).

2. Ninth and Seventh Circuits – declined to apply *Brillhart* where the coercive claims are "independent of any claim for purely declaratory relief." *Dizol*, 133 F.3d at 1225 ("Because claims of bad faith, breach of contract, breach of the fiduciary duty and rescission provide an independent basis for federal diversity jurisdiction, the district court is without discretion to remand or decline to entertain these causes of action"); *R.R. St. & Co. v. Vulcan Materials Co.*, 569 F.3d 711,716-17 (7th Cir. 2009).

a. The Ninth Circuit has held "when [monetary] claims are joined with an action for declaratory relief . . . the district court should not, as a general rule, remand or decline to entertain the claim for declaratory relief." *United Nat'l Ins.*

Co. v. R&D Latex Corp., 242 F.3d 1002, 1009 (9th Cir. 2001)

i. But subsequent cases interpreting *R&D* have held that "the presence of claims for monetary relief does not require the district court to accept jurisdiction where the action is primarily declaratory in nature." *Keown v. Tudor Ins. Co*., 621 F. Supp. 2d 1025, 1030 (D. Hawaii 2008) (citing *R&D* and remanding action to state court).

3. Eighth Circuit and certain district courts look to the "essence" of the lawsuit: if the essence of the lawsuit is a declaratory judgment action, *Brillhart* applies. *See Royal Indem. Co. v. Apex Oil Co.*, 511 F.3d 788, 793-94 (8th Cir. 2008); *see also Nissan N. Am., Inc. v. Andrew Chevrolet, Inc.*, 589 F. Supp. 2d 1036, 1040 (E.D. Wis. 2008).

a. "If the outcome of the coercive claim hinges on the outcome of the declaratory ones, *Wilton's* standard governs; conversely, if the opposite applies, *Colorado River's* standard controls." *Coltex Indus., Inc. v. Continental Ins. Co*., 2005 WL 1126951, *2 (E.D. Pa. May 11, 2005).

III. The *Colorado River* Doctrine - Abstention from duplicative parallel action seeking legal, equitable, and coercive relief.

a. Introduction

i. Courts apply the *Colorado River* doctrine when deciding whether to abstain from a parallel action for damages or equitable relief.

ii. The *Colorado River* doctrine stands for the proposition that federal courts should abstain because of pending parallel and duplicative state court litigation in a limited number of cases. *Colorado River*, 424 U.S. at 817 (1976).

iii. The *Colorado River* doctrine's "exceptional circumstances" standard is more narrowly applied than the *Brillhart* doctrine's "substantial discretion" standard.

b. Exceptional Circumstances Standard

i. The pendency of a parallel state proceeding should not generally bar federal court proceedings. *Moses H. Cone Memorial Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 25- 26 (1983). In light of the "virtually unflagging obligation of the federal courts to exercise the jurisdiction given them," notably "[o]nly the clearest of justifications will warrant dismissal." *Colorado River*, 424 U.S. at 817-18.

ii. A federal court may decline jurisdiction in deference to a contemporaneous parallel proceeding pending in state court "only in the exceptional circumstances where the order to the parties to repair to the state court would clearly serve an important countervailing interest." *Id.* (citing *Cty of Allegheny v. Frank Mashuda Co*., 360 U.S. 185, 188-189 (1959)).

iii. Courts have rejected the argument that "a liability insurance coverage question is [necessarily] a 'rare circumstance warranting abstention." *Explo*, 2013 WL 1869099, at *5.

c. *Colorado River* Factors

i. Four Factor Test – The Supreme Court examined four factors to determine whether staying proceedings was appropriate under the Exceptional Circumstances standard:

1. whether either court has assumed jurisdiction over a res;

2. the relative convenience of the forums;
3. the desirability of avoiding piecemeal litigation; and
4. the order in which the forums obtained jurisdiction. *Colorado River*, 424 U.S. at 818.

ii. Additional Factors – In *Moses H. Cone*, the Supreme Court articulated two more considerations:

5. whether state or federal law controls; and
    a. "[T]he presence of federal-law issues must always be a major consideration" for a federal court in deciding whether to surrender jurisdiction.
    b. "[I]n some rare circumstances the presence of state-law issues may weigh in favor of that surrender . . . ."
6. whether the state proceeding is adequate to protect the parties' rights.

460 U.S. at 25- 26 (1983).

ii. "These factors are to be applied in a pragmatic and flexible way, as part of a balancing process rather than as a 'mechanical checklist.'" *Am. Int'l Underwriters, (Philippines), Inc. v. Continental Ins. Co.*, 843 F.2d 1253, 1257 (9th Cir. 1988) (quoting *Moses H. Cone*, 460 U.S. at 16).

b. Utility

i. *Colorado River* abstention is only applicable to situations of parallel litigation. Circuits differ as to whether the involvement of different parties is enough to preclude abstention.

1. The Seventh Circuit requires parallel suits, not identical suits.
    a. In *Interstate Material Corporation v. City of Chicago*, the Court held a suit was parallel when "substantially the same parties are contemporaneously litigating substantially the same issue in another forum." 847 F.2d 1285, 1288 (7th Cir. 1988).

2. The Second Circuit may require identical parties.
    a. In *Zemsky v. City of New York*, the court refused to apply Colorado River when the parties were not identical because the stay of federal action would not necessarily avoid piecemeal litigation. 821 F.2d 148 (2d Cir.), *cert. denied*, 484 U.S. 965 (1987)
3. The Eighth Circuit has held a suit is parallel when it is substantially similar such that disposition of the state proceeding will dispose of the claims presented in a federal court. *Fru-Con* Constr. Corp. *v. Controlled Air, Inc.*, 574 F.3d 527, 535 (8th Cir. 2009).
    a. "The pendency of a state claim based on the same general facts or subject matter as a federal claim and involving the same parties is not alone sufficient. Rather, a substantial similarity must exist between the state and federal proceedings."
    b. A substantial similarity "occurs when there is a substantial likelihood that the state proceeding will fully dispose of the claims presented in the federal court…. Moreover, in keeping with the Supreme Court's charge to abstain in limited instances only, jurisdiction must be exercised if there is any doubt as to the parallel nature of the state and federal proceedings."

ii. The *Colorado River* doctrine is only relevant when "a federal case duplicates *contemporaneous* state proceedings." *Haak Motors LLC v. Arangio*, 670 F. Supp. 2d 430, 434 (D. Md. 2009) (*quoting Vulcan Chem. Techs., Inc. v. Barker*, 297 F.3d 332, 341 (4th Cir. 2002)). If a parallel state court action is removed to federal court such that both parallel actions are in federal court,

neither the *Colorado River* doctrine nor the *Brillhart-Wilton* doctrine applies to determine the appropriate forum.

1. Federal abstention does not apply in a dispute between two federal court forums. *Allstate Ins. Co. v. Longwell*, 735 F. Supp. 1187, 1191–92 (S.D.N.Y. 1990) ("[Defendant's] arguments were premised on the principles set forth in *Colorado River* …. These doctrines of abstention, however, are predicated on the existence of pending state litigation on parallel issues, and, thus, are inapposite since there is no longer anything pending in the state courts—both lawsuits are now [in federal court]." (citations omitted)).
2. To determine a dispute between federal court forums, district courts consider the first-filed rule and factors of forum convenience.

IV. Forum Non Conveniens

a. Introduction

i. The forum non conveniens provision of the Judicial Code provides that "[f]or the convenience of parties and witnesses, in the interest of justice, a district court may transfer any civil action to any other district or division where it might have been brought." 28 U.S.C. § 1404(a).

ii. Through transfer after removal, a movant may obtain its preferred forum, a more convenient federal court, or a federal court that already has before it one or related matters.

iii. Courts typically apply the first-filed rule to determine which federal court is the appropriate forum for a duplicative action, however, the rule is not to be applied mechanically. *Orthmann v. Apple River Campground Inc.,* 765 F.2d 119, 121 (8th Cir. 1985). Importantly, there are exceptions under which a court will defer to a second-filed action over the first filed suit.

1. In the insurance coverage context, special circumstances such as forum shopping, procedural fencing and fundamental unfairness will often lead a court to defer to the second-filed suit.
2. Additionally, courts may be persuaded to defer to a second-filed suit or transfer the action to a more appropriate venue based on factors of convenience.

iv. When parallel federal actions exist, the court where the first-filed lawsuit is pending decides which court should hear the case.

1. *Congregation Shearith Israel v. Congregation Jeshuat Israel*, 983 F. Supp. 2d 420, 422 (S.D.N.Y. 2014) ("*Shearith*") (citing *Factors Etc., Inc. v. Pro Arts, Inc.*, 579 F.2d 215, 218 (2d Cir.1978)) ("The Southern District of New York has laid down a bright-line rule for situations such as this: The court before which the first-filed action was brought determines which forum will hear the case.") (citations omitted)); *accord Nutrition & Fitness, Inc. v. Blue Stuff, Inc.*, 264 F. Supp. 2d 357, 360 (W.D.N.C. 2003) ("[W]here parallel federal litigation has been filed, the court in which the litigation was first filed must decide the question of where the case should be heard.").

b. First-filed rule

i. The first-filed rule provides that, as between parallel actions in federal courts with concurrent jurisdiction, the "first suit should have priority, absent the showing of balance of convenience in favor of the second action." *Volvo Const. Equip. N. Am., Inc. v. CLM Equip. Co.,* 386 F.3d 581, 595 (4th Cir. 2004) (quoting *Ellicott Mach. Corp. v. Modern Welding Co., Inc.*, 502 F.2d 178, 180 n. 2 (4th Cir. 1974)); *see, e.g.*, *First City Nat'l Bank and Trust Co. v. Simmons*, 878 F.2d 76, 79 (2d Cir. 1989); *Orthmann v. Apple River Campground Inc.,* 765 F.2d 119, 121 (8th Cir. 1985); *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Haydu,* 675 F.2d 1169, 1174

(11th Cir. 1982). Insurance carriers typically rely on the first-filed rule to argue that the court with the second-filed action should defer to the previously filed suit.

1. The standard for determining whether lawsuits are parallel for purposes of the first-filed rule is relevantly consistent with the standard for abstention motions, as both are based on the shared nexus of facts and do not require exact identity of parties. *See, e.g.*, *Harleysville Mut. Ins. Co. v. Hartford Cas. Ins. Co.*, 2012 WL 1825331, at *4 (E.D.N.C. May 18, 2012) (applying first-filed rule to defeat insurance company's second-filed suit where "the parties to the two suits are *nearly* identical) (emphasis added); *see also Allied-Gen. Nuclear Servs. v. Commonwealth Edison Co.*, 675 F.2d 610, 611 (4th Cir. 1982) ("Ordinarily, when multiple suits are filed in different Federal courts upon the *same factual issues*, the first or prior action is permitted to proceed to the exclusion of another subsequently filed.") (emphasis added).

ii. However, the first-filed rule "is not intended to be rigid, mechanical, or inflexible[.]" *Orthmann*, 765 F.2d at 121. Instead, the first-filed rule is discretionary, and only to be applied in a manner best serving the interests of justice. *Affinity Memory & Micro, Inc. v. K&Q Enters*., 20 F. Supp. 2d 948, 954 (E.D. Va. 1998) (citing *Brierwood Shoe Corp. v. Sears, Roebuck & Co.*, 479 F. Supp. 563, 567 (S.D.N.Y. 1979)). Thus, deference may be given to the court where the second-filed action is pending when there are "special circumstances," or where a "balance of conveniences" favors the second-filed action. *See Ill. Union Ins. Co. v. NRG Energy, Inc.*, 2010 WL 5187749, at *1 (S.D.N.Y. Dec. 6, 2010) ("It is within the sound discretion of the Court "to determine whether substantive factors, including the balance of convenience, weigh against proceeding in the forum of the first

filed action"); *Adam v. Jacobs*, 950 F.2d 89, 92 (2d Cir. 1991); *Oleg Cassini, Inc. v. Serta, Inc.*, 2012 LEXIS 33875, *5-*6 (S.D.N.Y. 2012).

c. Special Circumstances – Anticipatory Filing and Forum Shopping

i. Special circumstances may overcome the first filed rule. *See, e.g.*, *Affinity Memory*, 20 F. Supp. 2d at 954 (noting that district courts have always retained discretion to depart from the first-filed rule given appropriate circumstances); *Carbide & Carbon Chems. Corp. v. U.S. Indus. Chems.*, 140 F.2d 47, 49 (4th Cir. 1944). Exceptions to the "first-filed" rule are sometimes granted when "justice or expediency requires." *Samsung Elecs. Co. v. Rambus, Inc.,* 386 F. Supp. 2d 708, 724 (E.D. Va. 2005). *But see Learning Network, Inc. v. Discovery Commc'ns*, Fed. Appx. 297 at 301 n. 2 (4th Cir. 2001) ("The Fourth Circuit has not stated explicitly that special circumstances may warrant an exception to the first-filed rule.").

ii. This is especially true in some jurisdictions where "the filing date difference between [the] parallel actions is de minim[i]s." *NRG*, 2010 WL 5187749, at *1. In those cases, the first-filed rule is often not determinative. *Id.* (holding the first-filed rule not determinative where an insurance carrier filed for declaratory relief eleven days before Defendants filed their competing complaint). *But see, e.g.*, *Bass v. DeVink*, 336 N.J. Super 450, 457 (App. Div. 2001) (holding one-day priority sufficient to invoke the first-filed rule, and rejecting "a nebulous 'meaningfully first-filed' test" that "would needlessly complicate a straightforward principle of sound judicial administration").

iii. The "special circumstances" exception may apply where the first-filed case was an "anticipatory filing" or the result of forum shopping. *E.g.*, *Cassini*, *2012* LEXIS 33875 at *5-*6; *Aetna Cas. & Sur. Co. v. Quarles,* 92 F.2d 321, 324 (4th Cir.1937) (Courts should decline jurisdiction over declaratory judgment actions filed "for the purpose of anticipating the trial of an issue in a court of coordinate jurisdiction."); *Remington Arms Co., Inc. v. Alliant*

Techsystems, Inc., 2004 WL 444574, at *3 (M.D.N.C. Feb. 25, 2004) ("Other courts that have considered exceptions to the first-filed rule have, for example, refused to apply the first-filed rule when the party that files first does so with notice that the other party is about to file ... This court agrees that an improper anticipatory filing is one of the 'special circumstances' that may indicate a departure from the first-filed rule is appropriate.").

iv. The question of whether a first-filed suit is anticipatory often arises when an insurance carrier, which has a dispute with its policyholder, files a declaratory judgment action seeking a declaration that it has no coverage obligations. In response, the policyholder will often argue that the court should not give deference to the insurer's first-filed suit because the insurer (i) knew about or should have anticipated a lawsuit by the policyholder and (ii) engaged in improper forum shopping by filing suit somewhere outside of the policyholder's preferred state.

v. It may be improper for one party to file an anticipatory suit if on notice of the opposing party's intention to do the same. *See, e.g.*, *Family Dollar Stores, Inc. v. Overseas Direct Imp. Co.*, 2011 WL 148264, at *3 (W.D.N.C. Jan. 18, 2011). However, courts also note that the other party's anticipated suit must be "imminent," and that "[a] suit is 'anticipatory' for the purposes of being an exception to the first-to-file rule if the plaintiff in the first-filed action filed suit on receipt of specific, concrete indications that a suit by the defendant was imminent." *EEOC v. Univ. of Pa.*, 850 F.2d 969, 976 (3d Cir. 1988), *aff'd on other grounds*, 493 U.S. 182 (1990); *see, e.g.*, *Pittsburgh Logistics Sys. v. C.R. Eng., Inc.*, 669 F.Supp.2d 613, 623 (W.D. Pa. 2009) (recognizing that a filing may also be anticipatory if one party has set a deadline after which it will file suit, and the other files preemptively in advance of the deadline); *Sinclair Cattle Co. v. Ward*, 80 F.Supp.3d 553, 561 (M.D. Pa. 2015); *Salaman v. United Capital Funding*

Corp., 2017 WL 616549, at *3 (E.D. Pa. Feb. 14, 2017); *Mitek Sys., Inc. v. United Servs. Auto. Ass'n*, 2012 WL 3777423, at *3 (D. Del. Aug. 30, 2012).

vi. What constitutes an anticipatory filing is a highly fact-dependent inquiry. *See Schnabel v. Ramsey Quantitative Sys.,* 322 F. Supp. 2d 505, 511-512 (S.D.N.Y. 2004).

1. An improper anticipatory filing is "one made under the apparent threat of a presumed adversary filing the mirror image of that suit is in another court." *Citigroup Inc. v. City Holding Co.*, 97 F.Supp.2d 549, 557 (S.D.N.Y.2000). As noted above, some courts hold that a filing is only anticipatory for purposes of disregarding the first-filed rule where it follows specific, concrete indications of an imminent suit by the other party. *See, e.g.*, *EEOC v. Univ. of Pa.*, 850 F.2d 969, 976 (requiring specific, concrete indications of an imminent suit); *Koresko v. Nationwide Life Ins. Co.*, 403 F. Supp. 2d 394, 403 (E.D. Pa. 2005) ("[T]he party at the receiving end of a financial ultimatum is not required to unilaterally disarm and allow the party asserting the demand to control the choice of forum. This is particularly so, given that [the plaintiff insurer's] choice of forum is reasonable and will not unduly vex or burden plaintiffs' ability to litigate this matter.").

2. Some courts have found that where a declaratory judgment was "triggered by a notice letter, this equitable consideration may be a factor in the decision to allow the later-filed action to proceed to judgment in the plaintiff's chosen forum." *Emplrs. Ins. v. Fox Entm't Grp., Inc*., 522 F.3d 271, 276 (2d Cir. N.Y. 2008); *see also Northwest Airlines, Inc. v. American Airlines, Inc.*, 989 F.2d 1002, 1007 (8th Cir. 1993).

3. Courts have also found that a departure from the first-filed rule may be warranted where an action was filed in the midst of settlement negotiations. *Family Dollar Stores, Inc. v. Overseas Direct Imp. Co.*, 2011 WL 148264, at *3 (W.D.N.C. Jan. 18, 2011) (citing *Remington,* 2004 WL 444574 at *2; *EMC Corp. v. Norand Corp.*, 89 F.3d 807, 814 (Fed. Cir. 1996)). *But see, e.g.*, *Zelenofske Axelrod Consulting, L.L.C. v. Stevenson*, 1999 WL 592399, at *3 (E.D. Pa. Aug. 5, 1999) ("A party by virtue of engaging in settlement discussions is not obligated to provide notice to his adversary that he has decided to sue to allow the adversary to commence suit first.").

d. The Balance of Conveniences

i. A balance of the conveniences may overcome the first-filed rule. *See, e.g.*, *Ellicott Machine Corp. v. Modern Welding Co., Inc.*, 502 F.2d 178, 180 (4th Cir. 1974) ("A departure from application of the 'first-filed' rule is warranted where convenience weighs in favor of the second action."); *see also Carbide*, 140 F.2d at 49 ("[O]rdinarily, the court first acquiring jurisdiction of a controversy should be allowed to proceed with it without interference from other courts under suits subsequently instituted" unless convenience weighs in favor of the second-filed action.); *Allied-Gen.*, 675 F.2d at 611.

ii. Convenience Factors: Federal courts have articulated a variety of factors that are derived from, and in some cases, identical to, those considered on a motion to transfer venue under 28 U.S.C. § 1404(a). For example, the Eleventh Circuit balances the following private and public factors: "(1) the convenience of the witnesses; (2) the location of relevant documents and the relative ease of access to sources of proof; (3) the convenience of the parties; (4) the locus of operative facts; (5) the availability of process to compel the attendance of unwilling witnesses; (6) the relative means of the

parties; (7) a forum's familiarity with the governing law; (8) the weight accorded a plaintiff's choice of forum; and (9) trial efficiency and the interests of justice, based on the totality of the circumstances." *Manuel v. Convergys Corp*., 430 F.3d 1132, 1135 n. 1 (11th Cir. 2005). Of these factors, considerations that are particularly relevant to the insurance coverage context include the following:

1. Plaintiff's choice of forum.
    a. There is a presumption in favor of the plaintiff's choice of forum. *See, e.g.*, *Collins v. Straight, Inc.*, 748 F.2d 916, 921 (4th Cir. 1984) ("[U]nless the balance is strongly in favor of the defendant, the plaintiff's choice of forum should rarely be disturbed.") (quoting *Gulf Oil v. Gilbert*, 330 U.S. 501, 508 (1946)); *Prod. Grp. Int'l, Inc. v. Goldman*, 337 F. Supp. 2d 788, 799 (E.D. Va. 2004). Courts have held that "[t]he plaintiff's choice of forum should not be disturbed unless it is clearly outweighed by other considerations." *Robinson v. Giarmarco & Bill, P.C.*, 74 F.3d 253, 260 (11th Cir. 1996) (quoting *Howell v. Tanner*, 650 F.2d 610, 616 (5th Cir. 1981)); *SME Racks, Inc. v. Sistemas Mecanicos Para Electronica, S.A.*, 382 F.3d 1097, 1100 (11th Cir. 2004) (there is a "strong presumption against disturbing plaintiffs' initial forum choice.").
    b. Policyholders often argue that the presumption in favor of the plaintiff's chosen forum only applies to a "natural plaintiff." A natural plaintiff is an aggrieved party with a claim for damages, such as a policyholder that sues its insurer for breach of contract. *Cf. Andritz Hydro Corp. v. PPL Montana, LLC*, 2014 WL 868750, at *7 (W.D.N.C.

Mar. 5, 2014) ("[Plaintiff] was a natural plaintiff insofar as they filed a suit for contract damages in their home district and promptly served Defendants."); *see also Hipage Co. v. Access2Go, Inc.*, 589 F. Supp. 2d 602, 616 (E.D. Va. 2008) (holding the forum presumption is in favor of the aggrieved party with a claim for damages).

i. Many policyholders argue that requests for declaratory judgment cannot be used to allow a traditional defendant, such as an insurer, to choose the time and place of litigation. *Klingspor Abrasives, Inc. v. Woolsey*, 2009 WL 2397088, at *4 (W.D.N.C. July 31, 2009).

ii. The presumption in favor of the natural plaintiff can overcome the first filed rule. *See Hipage*, 589 F. Supp 2d at 616 ("[Plaintiff] filed for declaratory judgment in Virginia after [Defendant] filed suit for breach of contract in Illinois. Thus, [Plaintiff] attempted to 'wrest [ ] the choice of forum from the 'natural' plaintiff,' which runs directly contrary to the prevailing view, which is 'not to give the alleged wrongdoer a choice of forum.'") (citations omitted) (open brackets in original)).

c. In response, insurers often point to cases holding that the concepts of "natural plaintiff" and "natural defendant" have no meaning in insurance coverage disputes and do not impact operation of the first-filed rule. *See, e.g.*, *Biotronik, Inc. v. Lamorak Ins. Co.*, 2015 WL 3522362, *10 (D. N.M. June 3, 2015) (collecting cases).

2. The intent of resolving localized controversies at home and the appropriateness of having the trial of a diversity case in a forum that is at home with state law.
3. The avoidance of conflict of laws.
    a. Forum Selection Clause – When the parties express a preference for a particular venue in an insurance policy, that forum is determinative of the convenience to the parties. *See Priz Credit Alliance, Inc. v. Mid-South Materials Corp.*, 816 F. Supp. 230, 234 (S.D.N.Y. 1993). 28 U.S.C. 1404(a) may be used to transfer a case to the forum identified in an insurance policy's forum selection clause. *Union Elec. Co. v. Energy Ins. Mutual Ltd.*, 2014 WL 4450467, at 82 (E.D. Mo. Sept. 10, 2014); *Atlantic Marine Constr. Co. v. U.S. District Court for the Western District of Texas*, 134 S. Ct. 568 (2013) (a proper application of 1404(a) requires that a forum selection clause be "given controlling weight in all but the most exceptional cases.").
    b. However, an insurer that files a declaratory judgment action against its policyholder in a forum other than the forum specified in policy may be deemed to have waived its choice of forum. *See NRG*, 2010 WL 5187749, at *1 (holding that an insurance carrier abandoned its arguments on the basis of a forum selection clause when it filed its suit in a forum (the Southern District of New York) other than the one provided for in the policy (the "State of New York")).
    c. Absent a valid forum selection clause, conflicts of law analyses may be unavoidable absent agreement of the

parties regarding the governing law; the issue of what law applies may therefore exist in either action, albeit that it may be decided under different standards depending on which forum is ultimately chosen.

e. Utility
    i. The first-filed party can move to dismiss or stay a second-filed action based on the first-filed rule.
    ii. The movant may also ask for injunction of the second filed case to give effect to the first-filed rule. *See Learning Network*, 11 F. App'x at 298 (affirming injunction issued by trial court after determining that the pending action had priority over a later-filed New York action); *accord City of New York v. Exxon Corp.*, 932 F.2d 1020, 1025 (2d Cir. 1991) (holding that courts hearing a first-filed action have the authority to enjoin "a later action embracing the same issue").

V. Conclusion – Summary and Practical Tips
    a. Forum battles are fairly common in insurance coverage disputes.
        i. Federal versus state court preference.
            1. Insurers typically favor federal court actions.
                a. Insurers wish to avoid "home-cooking" in policyholder's backyard.
                b. Federal courts generally offer a more conservative bench, more resources and quicker resolution.
            2. Policyholders typically favor state court actions.
                a. Many policyholders believe they will receive a better shake in own backyard, where state court judges (and often a less conservative bench) are better able to construe their own state law.
                b. Policyholders filing in state court must consider strategies to avoid removal to federal court. For example, they can

add the insurers as third-parties in the underlying litigation, or add non-diverse defendants to defeat diversity jurisdiction.

ii. Applicable law

1. The law applicable to a coverage dispute may include the law of any jurisdiction that has a colorable connection to the parties or dispute.
2. Because insurance law is an area left to the states, applicable law can vary greatly between states and parties have an incentive to ensure that they are not litigating in a forum that will apply unfavorable law.

b. Practical Tips

i. Parties to insurance coverage disputes should research all potentially applicable laws on key issues of the case and determine which jurisdiction has the most favorable law.

ii. Parties should also assess the possibility that their adversary will "jump" them by filing first in an unfavorable jurisdiction. If that possibility is real, parties should prioritize filing first in their preferred jurisdiction so that they may take advantage of the first-filed rule.

iii. Parties should maximize their chances of remaining in their preferred jurisdiction by filing the broadest action possible.

1. Bring suit against all relevant parties, including all insurers.
2. Allege more or different facts and issues than competing action.
3. Present mixed claims for relief: legal, equitable and coercive (certainly more than a declaratory judgment action).
4. Attempt to conduct discovery as soon as possible after the initiation of an action.


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BOB ALLEN founded the Dallas Texas based The Allen Law Group on March 1, 2013 after spending nearly 30 years with top firms, including Meckler Bulger Tilson Marick & Pearson, Baker & McKenzie and Vial, Hamilton, Koch & Knox.

Mr. Allen's practice is primarily focused in representing parties in trial court and appellate proceedings in insurance, commercial and tort litigation in Texas and other regions of the United States. This includes complex insurance coverage, bad faith, fraud, and reinsurance disputes. Mr. Allen also serves as a mediator, arbitrator, umpire, and expert witness in insurance, reinsurance, commercial and tort disputes.

Bob Allen is active in several Professional Associations, including the ABA and State Bar of Texas Insurance Law Section. He was a founder and a past Chair of the Dallas Bar Association's Tort & Insurance Practice Section. He is a Fellow in the American College of Coverage and Extra Contractual Counsel.

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David represents policyholders in insurance coverage disputes. He has a wide-ranging practice involving counseling, mediation, arbitration, and litigation in state and federal courts throughout the United States. David regularly represents policyholders in coverage matters involving construction, directors' & officers' liability, professional errors & omissions, first-party property and business interruption, insurance brokers' errors & omissions, environmental, products liability, and employment practices liability matters. David also counsels clients regarding insurance renewals, policy wording, notice issues, risk management issues, and the drafting of insurance requirements and indemnity clauses in client contracts.

David has significant prior insurance industry experience, having previously worked as a primary commercial underwriter and casualty facultative reinsurance underwriter. He holds the Chartered Property Casualty Underwriter (CPCU) and Associate in Risk Management (ARM) professional designations. David is a frequent writer and speaker on insurance coverage-related issues. In 2014, David was elected a Fellow of the American College of Coverage and Extracontractual Counsel.

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Michael is a partner in the Boston office of Morrison Mahoney, where he chairs the firm's complex insurance claims resolution group. For the past four decades, he has represented insurers and reinsurers in disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation as well as bad faith claims arising out of such disputes. Michael has also served as an AAA-certified arbitrator in numerous insurance coverage matters and has testified as an expert in matters involving coverage and reinsurance issues arising out of such claims. He has taken a leading role in the major defense bar associations, including DRI, FDCC and IADC and is the President-Elect of the American College of Coverage and Extra-Contractual Counsel.

Michael has delivered over a hundred papers over the past four decades on issues relating to insurance coverage, bad faith, emerging liability topics and, most recently, cognitive issues involving the reading of digital briefs by appellate judges; cyber-threats to the U.S. energy grid and the potential impact of the American Law Institute's Restatement of Law, Liability Insurance on the scope and prosecution of bad faith claims in the United States.

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John Buchanan, senior counsel in Covington's Washington office and the firm's first Insurance Practice Group Coordinator, has represented policyholders in insurance coverage advocacy, dispute resolution and counseling for over three decades. His career has ranged from the early DES and asbestos coverage litigation to claims for some of the largest cyber losses in history. Mr. Buchanan has litigated, arbitrated or negotiated a wide variety of complex property and casualty insurance claims, from railroad derailment claims to satellite-in-orbit claims, and from silver-theft claims to cyber claims. *Chambers USA* ranks him as Band 1 for Insurance Dispute Resolution - Policyholder, both in DC and nationally, and he is listed in *Best of the Best USA* and numerous other attorney rating guides.

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Laura Foggan is a partner in Crowell & Moring's Washington, D.C. office, and chair of the firm's Insurance/Reinsurance Group. She is described by *LawDragon 500 Magazine* as "one of the most successful advocates for the insurance industry to ever practice" and recently was recognized as a Thought Leader for Insurance & Reinsurance by *Who's Who Legal* (2018) and named Washington DC Insurance "Lawyer of the Year" by *Best Lawyer*s (2017). Laura represents clients in a variety of litigation and counseling matters.

In addition to her litigation and counseling work described above, Laura represents insurers in arbitrations, as well as Alternative Dispute Resolution (ADR) and mediation proceedings. She handles multi-party negotiations involving private claimants, multiple carriers, and insureds. Laura also assists in drafting insurance policy forms and endorsements, offering strategic suggestions and form language to meet product goals and regulatory requirements.

Laura served as the insurance industry liaison to the American Law Institute's Restatement of the Law on Liability Insurance Project, a first-of-its-kind project commissioned to reaffirm the most sound legal rules on a wide range of insurance liability issues. A former co-chair of the Insurance Coverage Litigation Committee of the American Bar Association (ABA) Litigation Section, Laura is praised by *Chambers USA* as "a highly experienced appellate lawyer" who frequently handles "novel and ground-breaking cases" and "knows coverage issues A-Z" (2016). Laura is regularly rated by *Chambers USA* as one of Washington's "Leading Lawyers" for insurers in commercial insurance work, is included in the *Best Lawyers in America* directory for insurance law, and has been named one of Washington's "Top 100 Lawyers" (2012-2017), "Top 50 Women Lawyers" (2009, 2011-2017), "Top 10 Lawyers" (2015), and "Super Lawyers" for Insurance Coverage (2008-2017), among many other honors.

Troy Froderman
FR Law Group PLLC

Troy is a trusted and experienced trial lawyer with over 75 jury trials under his belt. For over 29 years, he has represented clients in state and federal courts throughout the United States. This breadth of experience makes him one of the nation's leading lawyers for insurance coverage disputes. He has also been named Benchmark Litigation Star (2012-present), one of Arizona's Finest Lawyers (2014-present), and Super Lawyers (2011-present).

After graduating cum laude from DePauw University in Greencastle, Indiana, Troy continued to Vanderbilt University Law School in Nashville, Tennessee - graduating with a Juris Doctorate Degree in May 1989. Having been an equity shareholder in both regional and national Am Law 100 law firms like Polsinelli PC and Bryan Cave LLP, Troy has seen a wide cross-section of the legal landscape. While he enjoyed the high energy environment of large corporate firms, he wanted to build deeper relationships with his clients. This is one of the driving forces behind Troy's partnership with Scott and the formation of FR Law Group PLLC.

Troy also serves on the Board for the American College of Coverage and Extracontractual Counsel, the Maricopa County Volunteer Lawyers' Program, and the Pinewood Country Club.

Susan Harwood
Kaplan Zeena LLP

Susan B. Harwood is Of Counsel at the Miami, Florida law firm of Kaplan Zeena LLP. Before joining Kaplan Zeena LLP, Ms. Harwood was a partner at the insurance coverage firm of Boehm Brown Harwood, P.A. in Maitland, Florida for 25 years. She continues to concentrate her practice in the areas of first and third party insurance coverage disputes, bad faith and third party liability matters. She is "AV" rated by Martindale-Hubbell. Ms. Harwood is also a certified circuit and appellate mediator in Florida.

From 2017 – 2018, Ms. Harwood served as president of the Windstorm Insurance Network (WIND), an organization dedicated to promoting awareness of windstorm insurance issues through the application of educational initiatives. She continues on WIND's Board of Directors.

Ms. Harwood has also been a member of the Federation of Defense and Corporate Counsel (FDCC) since 2001. Ms. Harwood was chair of the FDCC's Property Insurance Section in 2007-2009, and she has served on the FDCC's Admissions, Amicus, Membership and Visibility committees. Involved with the FDCC's Leadership Institute in 2010 and 2011, Ms. Harwood also served as Dean of the FDCC's Litigation Management College's Graduate Program from 2012-2013.

Ms. Harwood is also a member of the American College of Coverage and Extra-Contractual Lawyers.

A past member of the Tort Trial and Insurance Practice Section of the American Bar Association ("TIPS"), Ms. Harwood has served on the Women and Minority Involvement Committee, as chair of the Property Insurance Law Committee and on the editorial board of The Brief, a TIPS publication.

A frequent speaker on insurance coverage topics, Ms. Harwood was honored to give the keynote speech at the Australian Insurance Law Association's 2009 Annual Conference in Melbourne, Australia on recent catastrophic losses in the United States. Ms. Harwood has also presented at several conferences held by the Property Loss Research Bureau on various insurance topics such as appraisal in property loss claims and claim handling best practices.

Ms. Harwood currently volunteers at the Hope CommUnity Center in Apopka, Florida where she assists immigrants who are seeking U.S. citizenship.

John Heintz
Partner
Blank Rome LLP

John Heintz is a partner in Blank Rome's policyholder-only insurance recovery practice, formerly the insurance practice of Dickstein Shapiro LLP. He is a veteran in the fields of corporate insurance coverage and complex litigation. With more than 40 years of experience, John has recovered billions of dollars in coverage for his clients. He has handled major cases in every area of insurance coverage, including several that rank among the largest in coverage litigation history. Many of his cases have involved issues of first impression, resulting in landmark trial and appellate rulings for his clients at the state and federal levels. John's grasp of the legal issues and his ability to direct large-scale litigation have earned him praise from clients and opponents alike.

He has represented numerous clients in the chemical, petrochemical, petroleum, auto, hotel, and technology industries, in securing coverage for asbestos, lead, public nuisance, environmental contamination, professional liability, class-action employment discrimination, directors and officers liabilities, political risk, and medical product liability claims.

John has also represented clients in securing coverage for property and business interruption losses arising out of the 9/11 attacks, hurricanes, and other catastrophic events. He has litigated and secured favorable resolutions of insurance coverage disputes and related bankruptcy issues arising in several asbestos-related bankruptcies. He has tried numerous cases and argued before the U.S. Courts of Appeals for the Second, Third, Fourth, Fifth, and Sixth Circuits and numerous state appellate courts, U.S. district courts, and state trial courts across the country.

Michael W. Huddleston
Shareholder, Dallas
Munsch Hardt Kopf & Harr, PC

Mike's practice focuses on commercial insurance, risk management, litigation management and appeals. He routinely represents corporate and professional policyholders and assists claimants in insurance recovery involving commercial insurance, including director and officer, general liability, excess/umbrella, commercial automobile and trucking, commercial property, cyber-liability, technology errors and omissions, pollution and environmental coverages, professional liability (including coverages for health care providers and medical equipment manufacturers, architects/engineers), specialty health coverages (including Medicare fraud, FLSA, etc.) aviation, reinsurance, fidelity, etc. He is often hired to manage large scale and complex litigation, particularly claims involving multiple claimants and/or excess and super-excess coverages, including providing advice on assisting the carriers to properly evaluate the case, assisting in the development of defense issues, particularly involving technical legal defenses, appellate issues and related insurance coverage issues.

He works closely with transactional and corporate counsel in the review and drafting of risk management provisions regarding insurance, indemnity, disclaimers, waivers and exculpatory clauses in a wide variety of commercial agreements, including commercial real estate contracts, construction contracts and leases, agreements with municipalities and other service contracts. He also provides advice regarding insurance options such as owner and/or contractor controlled insurance programs, project specific professional liability, contractor's professional liability plus indemnity, etc. He also assesses insurance and liability exposure and alternative options such as representation and warranty coverage in connection with mergers and acquisitions.

Mike is a leader in the insurance law field. He is a fellow and Board Member of the American College of Coverage and Extra-Contractual Counsel. He was recently awarded the 2017 Thomas Segalla Service Award for his creativity, persistence, volunteerism and leadership in the practice of law as a policyholder counsel. He was selected the "Go-To Lawyer" in Insurance Law by *Texas Lawyer* in 2012, and has been named a "Top Ranked" Leader in Their Field, Band 1 in Insurance Law by *Chambers USA* since 2004. He was one of the founding officers and is a past-Chair of the State Bar of Texas Insurance Section. He is a frequent speaker at insurance and business law seminars in Texas and nationally.

Georgia Kazakis
Partner
Covington

Georgia Kazakis uses innovative and creative litigation and non-litigation solutions to obtain successful outcomes for her policyholder clients in complex insurance coverage disputes. She has represented policyholders in coverage disputes before federal and state courts involving a variety of underlying claims, including environmental, asbestos, construction defect, advertising injury, employment practices, errors and omissions, defamation, and securities claims. She has particular expertise in environmental and construction defect coverage disputes; coverage issues affecting government contractors; coverage disputes arising from natural disasters and other perils, including coverage for physical damage, extra expense, business interruption and contingent business interruption losses; and disputes under crime/fraud, fidelity bond, and professional liability policies.

By combining creative strategic vision, litigation and trial experience, zealous advocacy, and an understanding of the practical considerations affecting insurance dispute resolutions, Ms. Kazakis has successfully resolved substantial coverage disputes for clients in a variety of industries, including aerospace, industrial products, hospitality, energy/utilities, pharmaceutical companies, private equity groups, and hedge funds.

Ms. Kazakis also has an active non-litigation practice assisting clients with policy placements, renewals, and wording modifications; advising clients on the use of surety bonds and surety bond facilities; and negotiating and mediating favorable insurance settlements. She also represents clients in underlying CERCLA allocation disputes.

Harold H. Kim
Executive Vice President, Legal Reform Initiatives
U.S. Chamber of Commerce Institute for Legal Reform

Harold H. Kim serves as the executive vice president of the U.S. Chamber Institute for Legal Reform. He is responsible for providing strategy, policy guidance, programmatic management, and leadership support for ILR's comprehensive program aimed at improving the nation's litigation climate.

Before joining ILR, Kim was special assistant to the President in the White House Office of Legislative Affairs. In that position, he served as former President George W. Bush's liaison to the Senate on matters involving national security, the judiciary, civil justice reform, intellectual property, and criminal law enforcement. During his tenure, he helped win confirmation for several of President Bush's judicial and executive nominees and worked closely with Congress to advance the administration's policy priorities.

From 2003 to 2007, Kim served as counsel to the Senate Judiciary Committee, as deputy chief counsel to ranking member Arlen Specter, and as senior committee counsel for then-Chairman Orrin Hatch. During the passage of the 2005 Class Action Fairness Act, Kim was the committee's chief civil counsel and advised Republican members during the bill's committee markup and Senate floor action. He also advised the committee members in the areas of asbestos, class action, medical malpractice, and bankruptcy litigation reform.

Prior to government service, Kim was a senior litigation associate at the Washington D.C.-based law firm of Patton Boggs, LLP. Kim is a graduate of the University of California, Irvine. He earned a J.D. from the Catholic University of America.

Meghan Magruder
Partner
King & Spalding

Meghan Magruder is a Partner in King & Spalding's Atlanta office and a member of the Business Litigation Practice Group. She has more than thirty-five years of experience handling complex litigation matters. Ms. Magruder is regularly listed in *The Best Lawyers In America, Georgia Super Lawyers,* and *Top Women Attorneys in Georgia*.

In addition to being a fellow and Board member for ACCEC, Meghan is a fellow in the Litigation Counsel of America, an invitation-only trial lawyer honorary society representing one-half of one percent of American lawyers. Fellows are selected based upon excellence and accomplishments in litigation, trial work and superior ethical reputation. Meghan is also a member of the American Law Institute and was an officer of the American Bar Association Section of Litigation for several years. She was both President and Vice President of the Environmental Commission for the Union Internationale des Avocats.

Meghan advises her policyholder clients on all types of insurance issues and claims. She also has substantial experience advising clients on corporate governance and risk management issues. She serves as general counsel for the Institute of Nuclear Power Operations and the North American Transmission Forum.

Meghan is active in *pro bono* work and community activities. In 2013, she was honored as one of "Georgia's Most Powerful and Influential Female Lawyers" by Looking Ahead Publications. In 2001, she was awarded ABC News "Toyota Working Woman Award" for outstanding contributions to her profession and community. She is a member of Leadership Atlanta and currently serves on the Board of Directors for the Atlanta Symphony Orchestra, Rabun-Gap Nacoochee School, and United Way of Greater Atlanta. She is a past member of the Board of Directors for the Atlanta Women's Foundation, the Board of Directors of the Atlanta Children's Shelter, and the Board of Visitors for Emory University. She received her B.A. from Emory College and her J.D. from Emory University School of Law.

Lorelie S. Masters
Partner
Hunton Andrews Kurth LLP

Lorie Masters is a partner at Hunton Andrews Kurth LLP's Insurance Coverage Group in Washington, D.C. She has written two well-respected treatises on insurance law and is a nationally recognized insurance coverage litigator. She handles all aspects of complex, commercial litigation and arbitration. Lorie is a member of the American Bar Association's Board of Governors, serves as Treasurer for the DC Bar Foundation, and is a co-founder and former President of the American College of Coverage and Extracontractual Counsel.

Mary McCurdy
Founding Partner
McCurdy & Fuller LLP

Mary P. McCurdy is a founding partner of McCurdy & Fuller. Ms. McCurdy has extensive experience in representing insurance carriers in complex insurance coverage matters, including construction, public entity, employment practices, bad faith, toxic tort and environmental issues.

Ms. McCurdy was born and raised in California and attended college at Santa Clara University where she received a B.S. in economics. She attended law school at Santa Clara University School of Law and graduated cum laude in 1984. Ms. McCurdy is president of the Santa Clara University School of Law Alumni Association and a member of the Santa Clara University Law Advisory Board.

Ms. McCurdy has served as a guest lecturer on many insurance related topics and taught at Santa Clara University. She has been selected as a Super Lawyer for 2009 through 2018.

Ms. McCurdy is admitted to practice in California and works in the Northern California office of McCurdy & Fuller.

Jodi McDougall
Office Managing Partner
Cozen O'Connor

Jodi represents insurers in complex insurance coverage disputes and maritime matters. She enjoys working together with her clients to help them avoid and solve problems. Jodi has extensive experience defending bad faith claims. She primarily practices in Washington and Oregon, two venues that are notoriously difficult for insurers to operate. She handles all types of coverage disputes including environmental, professional liability, maritime, and general liability. She has successfully litigated hundreds of cases, including two of the largest coverage cases in Washington state history.

Jodi is serving her second term on the board of directors for Cozen O'Connor and has been the managing partner of the Seattle office for the past 12 years. She is a fellow in the American College of Coverage Counsel and has been recognized as one of the top 50 women attorneys in Washington by Super Lawyers. She was named to the Best Lawyers in America list for commercial litigation and awarded the AV Preeminent rating by Martindale-Hubbell.

Jodi enjoys pro bono work and is involved in a wide array of matters. She recently obtained asylum for an African national based on persecution in his native country due to his sexual orientation. She has also represented asylum seekers who are fleeing their native country because of persecution for their democratic political beliefs. Jodi has represented numerous Holocaust survivors and obtained reparations for them from the German government. She actively participates in the firm's COVET project and has fought for veterans to obtain broader benefits. She is currently working with several women veterans to assist them in obtaining benefits for military sexual trauma that they have endured.

Jodi received her Bachelor of Arts, *magna cum laude*, in 1989 from the University of Southern California, where she was elected to Phi Beta Kappa. She earned her law degree, *cum laude*, in 1992 from the Seattle University School of Law. She studied the Law of the Sea and International Law at Cambridge University in England. Prior to joining private practice, Jodi worked as a prosecutor in both King and Pierce counties.

Julia Molander
Member
Cozen O'Connor

Julia A. Molander represents the insurance industry in virtually all aspects of their business, including insurance coverage litigation, insurance counseling, extracontractual (bad faith) liability, insurance fraud, underwriting matters, policy drafting, regulatory compliance, brokerage and agency liability, insurance insolvency and legislative issues. She has served as first-chair in more than 20 bench trials, jury trials and arbitrations.

Julia has more than 30 years experience in strategically managing insurance risk, on an enterprise-wide basis (state, regional and national), in areas such as construction defects, class actions, cyber risks, trucking and cumulative trauma. Julia was elected a fellow of the American College of Coverage and Extracontractual Counsel in 2014 and the Insurance Litigation Institute of America, where she currently serves as chair. She is rated AV Pre-eminent by her peers and has been recognized as a “Super Lawyer” since 2005.

Julia has lectured at major professional conferences sponsored by the American Bar Association, Association of Defense Counsel, Defense Research Institute, Association of California Insurance Companies, the California Continuing Education of the Bar, the American Conference Institute, the Property Law Research Bureau, the Insurance Risk Management Institute and the Practising Law Institute. She is a contributing editor the CEB publication *California Liability Insurance Practice: Claims and Litigation*. She has published numerous articles and scholarly discussions on a variety of insurance topics.

Julia earned her Bachelor of Science with distinction from Northwestern University in 1974 and her J.D. from Stanford Law School in 1978.

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Vincent Morgan
Partner, Houston
Pillsbury Winthrop Shaw Pittman LLP

Vincent Morgan, managing partner of the firm's Houston office, has helped clients obtain billions in insurance proceeds and other recoveries, including eight-, nine- and ten-figure recoveries for catastrophic claims. Vince has a proven track record representing corporate policyholders in complex disputes. His litigation and arbitration successes span many coverage areas, including commercial property and business interruption, commercial general liability, professional and fiduciary liability, directors' and officers' liability, and intellectual property. Vince advises clients regarding complicated risk management issues, such as placement of cyber insurance policies and contractual indemnity structures. He also handles internal investigations and other matters such as construction disputes, ERISA claims, and insolvencies.

Edward Parks
Partner
Shipman & Goodwin

Edward Parks focuses principally in the areas of trial and appellate litigation involving general commercial, bankruptcy, and insurance coverage litigation. He practices actively in federal and state courts around the country.

Prior to joining Shipman & Goodwin, Edward was a partner at Hogan & Hartson LLP. He also served as Assistant U.S. Attorney for the District of Columbia.

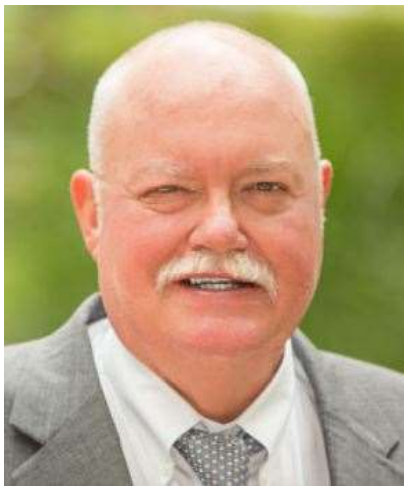
Distinctions

- Fellow, American College of Coverage and Extracontractual Counsel
- AV Preeminent® Rated, Martindale-Hubbell
- *Benchmark Litigation*, Local Litigation Star: Bankruptcy, Commercial Litigation, Insurance (2012-2016)
- *Chambers USA*, America's Leading Lawyers: Insurance: Insurer (2007-2008; 2014-2018)
- Listed as a Washington, D.C. Super Lawyer®: *Insurance Coverage* (2014-2018)

Professional Affiliations

- D.C. Bar Association
- Virginia Bar Association

Stephen P. Pate
Member
Cozen O'Connor



Stephen Pate focuses his litigation practice on property insurance matters, Directors and Officers insurance matters, business interruption issues, CGL insurance matters, builders risk matters, commercial general liability insurance disputes, fraud, and various other extracontractual litigation matters. Over a 30 year career in coverage work, he has tried more than 45 first-party extracontractual cases to verdict. Prior to joining the firm, Stephen had been partner in the Houston office of an international law firm since 1994.

A fellow of the American College of Coverage and Extracontractual Counsel, in May 2017 Stephen was elected to a three-year term on the Board of Regents. ACCEC was established in 2012 and is composed of preeminent lawyers representing both insurers and policyholders involved in coverage and extracontractual matters. Since 2006 he has also been recognized by *Chamber and Partners USA* in Insurance-Texas. Stephen is also a member of the American Board of Trial Advocates and the American Law Institute.

Stephen received his bachelor's degree, *magna cum laude*, from Vanderbilt University. Stephen earned his law degree from Vanderbilt University Law School. While in law school, he was research editor for the *Vanderbilt Journal* and he is a member of Phi Beta Kappa.

Scott Seaman
Partner, Chicago, Illinois Office
Hinshaw & Culbertson LLP

Scott Seaman is Co-Chair of the firm's National Insurance Services Practice Group. The group has earned a Band 1 ranking in 2018 Chambers USA: America's Leading Lawyers for Business, Insurance: Dispute Resolution Illinois and a National Tier 1 rating in the 2018 Best Law Firms list published by *U.S. News – Best Lawyers* as well as Tier 1 regional ratings in Chicago, Los Angeles, and Miami.

As a commercial litigator and trial lawyer with more than 30 years of experience, Mr. Seaman has had the privilege of working with some of the most dedicated and talented senior management, legal counsel, and insurance and reinsurance claims and litigation professionals in the world and of serving as counsel in precedent setting cases involving some of the most challenging contemporary coverage and reinsurance issues confronting the insurance industry.

Mr. Seaman has a long track record of successfully representing companies before trial courts, appellate courts, and arbitration panels across the country in a variety of high stakes cases and matters involving general liability coverage (primary, umbrella, and excess), professional liability coverage, first-party property coverage, bad faith and extra-contractual matters, fee disputes, and facultative and treaty reinsurance contracts. He has served as national coverage counsel as well as trial and appellate counsel. Scott also provides advice to companies on emerging issues and on a wide-range of case specific and portfolio issues. He has drafted contract language, trained insurance and reinsurance professionals, and assisted companies in evaluating and resolving issues in the claims stage. Scott also has handled a variety of challenging international, professional liability, director and officer liability, tort and product liability, and business and commercial cases.

Scott is widely regarded as one of the leading attorneys in the United States representing insurers and reinsurers in property and casualty matters.

William Shelly
Founding and Office Managing Partner
Gordon & Rees

William Shelley is the founding and managing partner of the firm's Philadelphia office, which opened in 2013.

Bill's practice primarily involves complex contract litigation and business tort actions. His contract and business experience includes service as an Assistant General Counsel at Sony Corporation of America.

Bill is an elected member of the American Law Institute, is listed in Chambers (2012-2017) and has been listed in Best Lawyers in America since 2006.

Bill earned his undergraduate degree from Rutgers College (B.A., *summa cum laude*) and his law degree from Rutgers School of Law (J.D. 1979). He is admitted to practice in Pennsylvania, New Jersey and New York and before all the federal district courts in those states, together with the United States Supreme Court and the Second, Third and D.C. Circuit Courts of Appeal.

Caroline Spangenberg
Senior Counsel
Kilpatrick Townsend & Stockton LLP

Caroline Spangenberg is a member of and the former Team Leader of Kilpatrick Townsend & Stockton LLP's Insurance Recovery Team. She has more than thirty years' experience advising and representing policyholders in insurance coverage matters throughout the United States and abroad.

Ms. Spangenberg was recognized by *The Best Lawyers in America*® for Insurance Law in 2019 and the 11 years immediately preceding. She was also named the 2017 "Atlanta Lawyer of the Year" in the area of Insurance Law by *The Best Lawyers in America*®. Since 2011, Ms. Spangenberg has been recognized as a Georgia "Super Lawyer" in Insurance Coverage by *Super Lawyers* magazine.

Ms. Spangenberg has also been named a Top Attorney in Georgia by *Atlanta* magazine and a Top Lawyer by *Corporate Counsel* magazine. She has been selected a Top Rated Lawyer in "Commercial Litigation" by Martindale-Hubbell and American Lawyer Media in *The American Lawyer* & *Corporate Counsel* magazine. She has been recognized among the world's leading insurance lawyers in *Who's Who Legal: Insurance & Reinsurance 2017*. Ms. Spangenberg is AV® Preeminent™ rated by Martindale-Hubbell.

She is a member of the American College of Coverage Counsel (ACCC), an organization of preeminent coverage and extra-contractual lawyers, representing the interests of both insurers and policyholders dedicated to promoting the creative, ethical and efficient adjudication of insurance coverage and extra-contractual disputes. She was graduated from Harvard Law School (J.D., *magna cum laude*) and from Wellesley College (A.B., Wellesley Scholar, Phi Beta Kappa).

Charles Spevacek
Partner
Meagher & Geer PLLP

Chuck has over 30 years of experience litigating complex commercial cases, with particular emphasis on the trial and appeal of insurance coverage disputes, including breach of contract, declaratory judgment and bad faith actions. Chuck was named in both 2019 and 2014 by The Best Lawyers in America as its Minneapolis Insurance Law "Lawyer of the Year." He was also named as its 2016 Minneapolis Mass Tort Litigation/Class Action – Defendants "Lawyer of the Year." He has twice been recognized by Minnesota Lawyer as an "Attorney of the Year", in 2013 and in 2006. He was chosen as one of Minnesota's 10 best appellate lawyers and has been recognized since 2003 as a Minnesota Super Lawyer, earning Top 100 distinction in fourteen of those years. Since 2013, he has been identified by Chambers USA as one of America's Leading Litigation Lawyers for Business. Chuck is the national coordinating claims counsel for the cyber-liability program of a major commercial insurer. He has shared his expertise on insurance issues in testimony before the Minnesota Legislature. He is a member of the Board of Directors of Center of the American Experiment having previously served as Chair. Chuck also served on the Board of Directors of Ridgeview Hospital Foundation, and is a Past-Chair, and he has served on the Board of Directors of The Purdue Alumni Association.

Representative clients include American Financial Group, AIG, Bituminous Insurance Company, Certain Underwriters at Lloyds of London, CNA Insurance Companies, Federated Mutual Group, The Guilford Specialty Group, Hartford Casualty Insurance Company, Liberty Mutual Insurance Companies, OneBeacon Insurance Group, Ltd., Riverstone Claims Management Services, Inc., Swiss Re Reinsurance Company, The Travelers Companies, Inc., and Westfield Insurance Companies.

Chuck's experience includes work on several major cases whose decisions have been cited as significant precedent in over 300 published opinions and scholarly papers.

Koorosh Talieh
Partner
Perkins Coie

Koorosh Talieh (“KT”) is a partner at Perkins Coie’s Insurance Recovery group. He has a national practice representing corporate policyholders in complex insurance coverage and bad faith disputes against their insurers. His wide-ranging experience includes pursuing insurance coverage for underlying liabilities involving products and environmental claims, directors and officers, errors and omissions, employment, and other types of professional liability claims, cyber and computer-based claims, and a wide-array of first-party property and business interruption losses. His experience includes all phases of dispute resolutions from pre-complaint investigation and advice through high-value mediation and first-chairing arbitrations and trials, appeals and negotiating complex cost-sharing agreements and settlements.

Koorosh has extensive experience in analyzing coverage under various types of insurance policies, including general liability, directors and officers, errors and omissions, employers’ professional liability, cyber, fiduciary liability, bankers’ professional liability, crime, first-party property, builder’s risk, multimedia and other types of specialized insurance products. He also provides risk management consulting services to clients during procurement process and renewal for virtually all risks and lines of coverage.

Koorosh is recognized by *Chambers USA* as one of the leading insurance coverage practitioners in the District of Columbia. *Chambers USA* referred to Koorosh as "client favorite" and stated that "[c]lients describe him as a 'go-to guy for insurance coverage issues big or small. He has been an extremely effective advocate for us and we have gotten great results in a number of high-exposure cases.'" Koorosh is a Fellow of the American College of Coverage and Extracontractual Counsel and the co-chair of the College’s Membership Committee. He is “AV Peer Review Rated” by Martindale-Hubbel, which is Martindale-Hubbels’ highest peer recognition for legal ability and ethical standards.

John Vishneski
Partner
Reed Smith

John focuses his practice on complex insurance coverage litigation. His experience is broad and includes coverage disputes concerning toxic torts liability, mortgage defaults, real property title defects, environmental liability, intellectual property liability, commercial property damage and business interruption. He is both a trial lawyer and an advisor. John has litigated insurance coverage disputes involving diverse types of insurance, including First Party Property policies, Title Insurance policies, General Liability policies, Directors & Officers Liability policies, Mortgage Insurance policies, Credit Insurance policies and Employment Practices Liability policies and has extensive knowledge of insurance policy drafting history. John advises clients regarding negotiation of new and renewal policies with respect all coverages purchased by commercial businesses. He has represented clients in many jurisdictions, including the Supreme Court of Illinois and the Supreme Court of Connecticut. His practice is nationwide and also involves Lloyds and the London Market. John also acts as both neutral and party-appointed arbitrator in complex insurance coverage disputes.