

InfoPAKSM

A Policyholder's Primer on Commercial Insurance in the United States

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A Policyholder's Primer on Commercial Insurance in the United States

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This InfoPAKSM is intended to give in-house counsel background to assist her in identifying insurance issues that may arise, participate in substantive insurance discussions relating to those issues, and assist risk managers in maximizing the protection afforded by insurance.

The information in this InfoPAK should not be construed as legal advice or legal opinion on specific facts, and should not be considered representative of the views of Blank Rome LLP or of ACC or any of its lawyers, unless so stated. This InfoPAK is not intended as a definitive statement on the subject but rather to serve as a resource providing practical information for the reader.

This material was developed by Blank Rome LLP. For more information about Blank Rome, visit their website at www.blankrome.com or see the "About the Authors" section of this document.

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I. Introduction

Insurance is a valuable corporate asset that can protect companies from man-made crises and natural disasters, but it is an asset that often is underused. The continuing development of mass tort and product liability litigation, the persistent threat of class action and derivative claims, and the property damage and business interruption (“BI”) losses caused by natural disasters are all examples of circumstances that highlight the importance of developing and maximizing the value of insurance assets. Accordingly, every in-house lawyer should have an understanding of, or at least be able to identify, basic insurance issues so that she can assist the company’s risk manager/risk management department in making sure that (1) insurance purchased by the corporation is drafted in a way to maximize coverage, (2) insurance is pursued for potentially covered claims, and (3) claims are submitted to insurers in a way that will maximize recovery. This is more crucial now than ever, as insurance companies appear increasingly determined to contest even plainly covered claims.

Risk managers tend to focus heavily on two financial aspects of insurance: the premiums charged and the limits provided. In-house counsel can provide benefits with respect to other aspects of the insurance transaction that can have a significant impact on the asset’s value, such as the legal implications of the language contained in various policy terms and whether the policyholder should accept certain provisions (e.g., arbitration and choice of law). Counsel also can assist in the submission of claims, including ensuring adherence to the notice and cooperation provisions in the policy. Counsel’s understanding of the potential underlying liability or loss that the company could suffer can also be used to maximize coverage.

This InfoPAK does not address every issue that may arise in an insurance coverage dispute. Rather, it introduces basic insurance concepts so that in-house counsel can identify those issues and assist risk managers, as well as identify those circumstances in which outside insurance coverage counsel may be helpful or necessary.

Section II is a practical guide for in-house counsel that introduces the basic structure of an insurance program, what to do when a claim comes in, and practical considerations for corporate counsel. Section III provides a discussion of the key documents that form an insurance agreement and the principal sections of an insurance policy.¹ Sections IV – VI provide a more detailed treatment of different types of third-party insurance. Section VII provides a similar discussion of first-party insurance. Sections VIII – X discuss bad faith, broker liability, and insurance and transactions. Sections XI – XIV provide a bibliography of useful insurance resources, and provide information on the authors and Blank Rome’s Insurance Recovery Practice.

II. Practical Guide for In-House Counsel

A. Types of Insurance and Structure of an Insurance Program

Insurance policies generally fall into two categories: third-party and first-party policies.

Third-party policies typically provide insurance for the policyholder's liability to third parties for damages. An important example of a third-party policy is the general liability policy, which provides broad insurance for claims against the policyholder alleging bodily injury, property damage, personal injury, and/or advertising injury. Businesses typically purchase general liability insurance through a Comprehensive General Liability or Commercial General Liability ("CGL") form.² Other types of liability insurance policies include:

- Directors and Officers ("D&O") policies, which protect corporate officers and directors against claims alleging wrongful acts in their capacity as directors and officers;³
- Errors and Omissions ("E&O") policies, designed to protect the policyholder against claims that it improperly provided (or failed to provide) professional services;⁴
- Employment Practices Liability insurance, intended to protect against various forms of employee claims;
- Fiduciary Liability insurance, intended to protect against claims that the company's pension fund has been mismanaged; and
- Professional liability insurance, intended to protect professionals who provide a service and/or advice (i.e., accountants, attorneys, physicians, healthcare organizations) against claims of failure to meet a duty of care; and
- Workers Compensation insurance, intended to protect against workers' compensation claims brought pursuant to state law.

First-party property policies typically insure against loss of, or damage to, the policyholder's property, as well as coverage for lost business revenue. First-party property policies may be issued on an "all risk"-basis, or may limit coverage to a specified "named peril" (e.g., fire). Property policies often include business interruption coverage⁵ and coverage for inventory or goods lost or damaged in transit. Other types of first-party policies include:

- Political risk policies, which protect against losses caused by "political" events in a foreign country;
- Fidelity and crime policies, which insure against, e.g., loss of the policyholder's property due to fraud or the dishonesty of an employee; and
- Automobile and homeowner's policies.

Businesses generally purchase both third- and first-party insurance in varying amounts and layers. The first so-called “layer,” referred to as a deductible or a self-insured retention (“SIR”), typically reflects the amount that the policyholder must pay before an insurance company’s obligation to pay is triggered. Although frequently confused, deductibles and SIRs operate in different ways. If the liability insurance policy has a deductible, the insurance company technically pays first-dollar coverage up to the limits of the policy, but the amount of the deductible is billed back to the policyholder for reimbursement to the insurance company. For example, if a \$1,000,000 liability policy with a \$100,000 deductible is required to pay a claim, the insurance company will pay the injured third party the \$1,000,000 policy limit; the policyholder must then reimburse the insurance company for the deductible amount, or \$100,000. Depending on the specific policy language and the circumstances, the \$1,000,000 policy may provide only \$900,000 of insurance.

On the other hand, if the insurance policy with \$1,000,000 in limits has a \$100,000 SIR, the policyholder typically is responsible for paying the first \$100,000 to the injured party. Once it has done so, then the insurance company is obligated to pay the remaining liability, up to its \$1,000,000 limit.⁶ After the deductible or SIR, the “primary policy” provides the first real layer of insurance for a covered claim. The primary policy contains the basic coverage provisions that define the scope of the particular type of insurance.

Corporations typically purchase layers of “excess insurance” to provide insurance in addition to the primary coverage. Excess insurance generally pays the amount of the loss or claim that exceeds the primary policy limit when the underlying policy is exhausted by, or has paid its limits for, a covered claim. The “first-layer excess” will pay after the primary has been exhausted. The “second-layer excess” will pay after the first-layer excess policy limits are exhausted, and so on. It is not uncommon for more than one insurance company to share a layer sold to a corporate policyholder.⁷ For instance, a \$100,000,000 layer of insurance might be shared by company X, which takes 50% of any loss in that layer, and by companies Y and Z, which each take 25% of any loss in that layer. Each company’s percentage is referred to as its “quota share.”⁸ The risk manager, often in conjunction with an insurance broker, is tasked with determining the total amount of insurance coverage a company should purchase to protect itself against a particular type of risk.

When the first layer of excess insurance contains its own terms and conditions, it is referred to as an “umbrella policy.” An umbrella policy may be broader than the underlying primary policy (or policies) and may cover certain types of losses or claims that are not covered by the primary policy. If there is no underlying policy that covers a claim within the insuring provisions of the umbrella policy, then the umbrella policy will “drop down” and pay as if it were a primary policy.

Excess policies often do not contain their own terms and conditions, but merely adopt or “follow form” to the provisions of the primary or umbrella policy/policies. They also may follow form “with exceptions” – that is, they may adopt the terms and conditions of underlying policies, except to the extent those terms conflict with specific provisions of the excess policy. Most excess policies provide that they will pay claims only when the limits of the underlying policies have been exhausted through the payment of judgments or settlements.⁹ Alternatively, the excess policies can be triggered after a retained limit has been paid for a loss that would be covered by the excess policy, but not covered by the underlying policies.

Problems can, and often do, arise when excess policies do not “follow form” to the underlying primary or umbrella policy, but contain their own terms and conditions. If layers of insurance are to work as intended, all of the policies, at least above the primary, should cover the same risks. Inconsistencies in policy language may create gaps in coverage, which may make it difficult to trigger excess policies. Disputes may arise as to whether the underlying policy limits, or the retained limit, have been properly exhausted so as to trigger the next layer of coverage.

Policyholders and brokers serving companies have multiple insurance markets that they can approach as part of building a program, including the U.S. domestic market (including both licensed insurers and excess lines insurers who are subject to less regulatory oversight), the London insurance market, as well as international insurance markets in additional countries around the globe. Additionally, there are a variety of mechanisms by which policyholders can now access reinsurance markets, also known as insurance for insurers or “stop-loss insurance,” principally through structures advertised as captives. In building any program, an insured can inquire about the availability and appetite of the various markets to insure risks. Access to these markets can provide additional flexibility and options in structuring a program. Before a U.S. domiciled entity becomes involved with any market beyond the traditional regulated U.S. domestic insurance market it will be important for the business to obtain advice and guidance about the operations of the market, the ability to address disputes, enforce policy terms, and collect on judgments.

Although it is an insurance broker’s obligation to place an insurance program that does not have inconsistencies, such errors can and do occur. Indeed, policies even within the same layer can be issued with inconsistent policy provisions if each quota share participant issues its own policy. In-house counsel can help risk managers and provide additional oversight by reviewing policy language for inconsistencies between, or within, different layers of coverage. Alternatively, counsel may suggest that the policyholder insist that the broker obtain only true “follow form” excess policies.

B. What to Do When a Claim Arises

I. Before a Claim Arises

a. Gather and Maintain Policies

Even before a claim arises, in-house counsel should review the corporation’s document retention policy to make sure that it requires the preservation of all insurance policies. Occurrence-based CGL policies – which respond to claims filed against the policyholder at any time, as long as the alleged bodily injury or property damage took place during the policy period – can provide valuable insurance for “long tail claims” where the bodily injury or property damage is the result of a process that did not manifest, or become discoverable, until years after the initial exposure. Occurrence-based policies sold 20 or 30 years ago may apply to a claim that is made against the corporation tomorrow, and may be worth tens or hundreds of millions of dollars. Thus, claims arising out of exposure to asbestos, hazardous chemicals, drugs, or medical implants may be insured under policies that were sold many years ago rather than policies issued today.

Strategic Point:

In-house counsel should work with risk management to gather and preserve the historical record on insurance purchased by the company by reviewing documents in files, contacting insurance brokers historically used by the company, and exploring any registry that might be helpful. Acquisition or merger documents also should be reviewed, because they often recite insurance that was available at the time of the corporate transaction. Professional “insurance archeologists” can help with reconstructing a historical picture of the insurance available to the policyholder. Once the material is gathered, the corporation should consider creating a coverage chart that provides a visual picture of the company’s historical insurance assets.

b. Participate in the Procurement of New Policies

Insurance policies typically are not “negotiated” in the true sense of the word. Most insurance policy language is set forth in standard forms developed by a particular insurer or an insurance industry group. Nonetheless, in-house counsel can be helpful in identifying the type of liabilities for which the policyholder needs coverage, and for reviewing the policy language offered by competing insurance companies. Often, the broker will create a chart that compares the various terms and definitions in competing policies so the policyholder can see the differences in the policy language. In-house counsel may be better trained than the risk manager to understand those differences and to recommend the policy language most favorable to the policyholder.

In-house counsel also can play a significant role in assessing how the various policies within a program fit together. If policies in different layers or different quota shares contain different language, these often will be a significant problem when a claim is submitted that requires more than one policy to respond. Inconsistencies may lead to “gaps” in coverage which must be assumed by the policyholder. Worst case, the inconsistencies may negate coverage entirely.

c. Notice of Circumstance That Might Give Rise to a Claim

Some policies, such as the specialized claims-made policies – which respond to claims made against the policyholder and reported to the insurance company during the policy period – require notice of circumstances which might give rise to a claim in the future. Examples of specialized claims-made policies are Errors and Omissions (“E&O”) and Directors and Officers (“D&O”) liability policies. Most insurance applications require the policyholder to identify potential claims. In-house counsel often is in the best position to know what claims are looming which may be filed in the future. Depending upon the language of the policy or the application, failure to identify potential future claims could result in a loss of coverage for those specific claims or, worse, result in rescission of the policy.

2. Consider Whether the Claim Is Potentially Covered

Many policyholders fail to pursue all of the insurance that is provided by their insurance policies, such as consequential damages arising out of bodily injury or property damage, or claims under the advertising injury or personal injury portions of their comprehensive general liability coverage. An insurance company's initial denial of coverage or a broker's expression of doubt regarding coverage does not mean that coverage does not exist. The insurance company obviously is biased, and the broker, as an intermediary, generally wants to avoid a disagreement between its two constituencies.

3. Be Familiar with Potentially Relevant Statutes

Most states have statutes regulating the obligations of an insurance company. For instance, in 2008, New York State enacted Section 3420 of the New York Insurance Law, which makes it harder for insurance companies to deny coverage on grounds that a policyholder failed to provide timely notice of a claim. Most states have Fair Claims Handling statutes which set forth rules that an insurance company must follow in handling a claim. Many states have specific laws governing the payment of a first-party property claim. Some jurisdictions impose specific penalties on insurance companies who fail to pay a claim that is found ultimately to be owed. In-house counsel should be aware of these statutes, rules, and regulations when a corporate policyholder submits a claim of any significance.

4. Notify All Potentially Relevant Insurance Companies

One of the most important contributions that inside counsel can make in the area of insurance is to guarantee that notice of a loss, claim, or occurrence is prompt and otherwise meets the requirements of the insurance policy. A single event can trigger several types of coverage. For example, an explosion at a plant may involve loss to the insured's property, an interruption of the insured's business, and potentially result in workers' compensation claims relating to injured employees. That same explosion may also damage third-party property or cause inhalation claims by neighbors, thus triggering general liability coverage. By way of another example, a product defect could cause third-party claims (triggering general liability policies) but also could lead to a drop in stock values and securities claims (triggering D&O coverage). If the stock is held by the company's pension fund, then the drop in stock value could lead to claims under the Fiduciary Liability policy.

Strategic Point:

All policies generally require that notice of a claim or loss must be given to the insurance company as soon as practicable. Particularly in the area of product liability under claims-made policies, if notice of a claim has already been given under a previous policy, the policyholder may have to decide whether a new claim, involving the same product, arises out of related "wrongful acts." This may determine whether the second claim is covered by the policy in the previous year because it is related to the first claim, or instead is covered under the policies currently on the risk. Attention also must be given to the amount of any potential exposure and whether excess insurance companies should be notified. The general rule is that notices should be given under all possible policies that might be triggered – regardless of type, year, or layer. The old adage "better safe than sorry" never rings more true than when it comes to a company giving notice to its insurers.

a. Prompt Notice of a Claim, Occurrence, or Loss

Regardless of what type of insurance policy is at issue, a policyholder should provide prompt notice as soon as it learns of a claim or loss, or of an occurrence that might give rise to a claim or a loss potentially covered by the policy. It is all too common for policyholders to be late in giving notice. This delay may provide the insurance company with the ability to decline coverage. If inside counsel works well with Risk Management and provides prompt notice, the policyholder will avoid coverage being denied for failure to comply with a condition precedent to coverage.

The consequences of late notice differ depending upon the type of policy and the jurisdiction. In many jurisdictions, the insurance company has the burden to show that it was prejudiced as a result of late notice under occurrence-based policies.¹⁰ For instance, it must show that evidence was lost, or there were steps that it would have taken to reduce the exposure had it been given notice of the claim earlier. In other jurisdictions, the policyholder has the burden of showing that the insurance company was not prejudiced.¹¹ In New York, it did not matter whether or not the insurance company was prejudiced; prior to the passage of N.Y. Ins. § 3420, timely notice was an absolute condition precedent to coverage.¹²

In *Century Indemnity Co. v. Brooklyn Union Gas Co.*,¹³ the court upheld a lower-court decision that denied the excess insurance company's motion for summary judgment on late-notice grounds. The Appellate Division established a standard for late notice that will make it difficult for excess insurers to escape liability on late notice grounds, despite New York law that does not require insurers to prove prejudice as a result of late notice. The court noted that:

"[u]nlike policies that require notice if an occurrence 'may result' in a claim, where the duty arises when the insured can 'glean a reasonable possibility of the policy's involvement,' the subject policies require notice if an occurrence—in this instance, hazardous waste contamination—is 'reasonably likely' to implicate the excess coverage."¹⁴

Thus, the duty to provide notice of an environmental claim could have arisen when the City of New York advised the insured that it intended to bring a federal environmental action related to one of the insured's contaminated sites. However, the court could not say as a matter of law that the insured's duty to provide notice arose from its knowledge of consultant reports which were not definitive as to the extent of the contamination or the degree of remediation needed, or instead from regulatory agency involvement that did not mandate any significant action.

Where underlying liability is uncertain or appears to be minimal, some policyholders may delay giving notice, fearing that the insurance company will raise their premium at renewal, or refuse to renew entirely. However, by waiting, policyholders open themselves up to an insurance company late notice defense if litigation later ensues or the liability increases. As a general rule, the policyholder should send notice as soon as it becomes aware of an underlying problem or claim that may trigger insurance coverage, and especially before taking any remedial steps that insurance companies later could argue

impeded their ability to adequately investigate the underlying claim adequately. If the policyholder is at the point where it is asking whether notice should be given, the answer is "yes." Giving notice promptly has the added benefit, in some jurisdictions, of triggering an insurance company's obligation to disclaim coverage within a brief, specified period of time.¹⁵

b. Notice Must Follow the Procedures Laid Down in the Policy

The notice provisions in insurance policies also may specify how, and in what form, notice should be given.¹⁶ The policies typically identify to whom notice should be addressed, and request a statement regarding all the particulars of the underlying claims.

Insurance companies have argued, and some courts have held, that notice was not adequate when it did not conform to the specific requirements in the policy. For instance, if the notice of possible claims was contained in materials submitted with a policyholder's renewal application, that notice may be held insufficient under the expiring policy.¹⁷ Notice under one policy may not be considered sufficient to provide notice under a second policy sold by the same insurance company.¹⁸ One court also has held that even when the insurance company might be aware of claims because of submissions made by the policyholder during the policy period, the policyholder nonetheless must provide the notice as required under the insurance policy.¹⁹

c. Notice Under Claims-Made Policies

Every form of insurance requires that notice be given promptly, but with claims-made and reported coverage (e.g., policies intended to protect the directors and officers), prompt notice is more than a condition of the contract. A claims-made policy typically will provide, as part of the insuring agreement, that the policy applies only to claims made against the policyholder and reported to the insurance company during the policy period. D&O policies also generally state that written notice should be given as soon as practicable or when the policyholder becomes aware of any circumstances which may reasonably be expected to give rise to a claim being made [against the policyholder]. Notice beyond the policy period may be fatal to claims-made coverage, regardless of the jurisdiction.

Several courts have found that the purpose of notice in a claims-made policy is not merely to prevent prejudice to the insurance company; therefore, late notice under such policies will void coverage even without a showing that the insurance company has been prejudiced.²⁰ A recent and thorough discussion of the importance of prompt notice in the context of a claims-made policy can be found in *Root v. American Equity Specialty Insurance Co.* ("Root").²¹ In *Root*, the policyholder, an attorney, received a telephone call from a legal publication asking about his reaction to a malpractice claim that allegedly had been filed against him. Root thought the call was a possible prank and left the next day, Saturday, February 27, for a long weekend. His claims-made malpractice policy expired on February 28. Root returned to his office on Tuesday, March 2, read an article about the malpractice claim, and notified his malpractice carrier the same day. The insurance company denied coverage because the claim had not been reported during the policy period. In the subsequent coverage action, the insurance company won summary judgment in the trial court.

On appeal, the court discussed at length the history of claims-made coverage, and the reasons why the notice/prejudice rule applicable to occurrence policies did not apply.²² The court ultimately reversed, holding that, under the facts in this case, the reporting requirement could be equitably excused. The court specifically cited the refusal of the insurance company to offer an extended reporting period to

the policyholder. Such an endorsement usually provides an extra period in which a policyholder can report a claim after the policy period has expired.

d. Notice Under First-Party Policies

First-party property policies also contain notice requirements. In addition to providing prompt notice of the loss, such policies typically will require that the policyholder file a “proof of loss” within a set period (often 60 days) after discovery of the loss. The late filing of a “proof of loss” required by a property policy may defeat coverage. The “proof of loss” must be signed and sworn to by the policyholder and generally must include certain representations.

e. Proof of Loss Checklist:

- Statements of the time and origin of the loss;
- The interest of the insured and others in the property;
- The actual cash value of the property damaged;
- All encumbrances on the property;
- All other contracts of insurance potentially covering any of the property;
- All changes in the title, use, occupation, location, and possession of the property since the policy was issued;
- By whom and for what purpose any buildings were occupied at the time of the loss; and
- Plans and specifications for all buildings, fixtures, and machinery destroyed or damaged.

Although insurance companies may agree to extend proof-of-loss filing requirements in connection with widespread losses from a common cause, such as Hurricane Katrina or Superstorm Sandy, a policyholder must get any extension agreement in writing.

5. Presentation of a Claim or Loss in a Manner That Will Maximize Coverage

After a loss or claim has occurred, the attorney should assist the risk manager in presenting the claim to the insurer in a way that will maximize coverage. A number of issues, such as trigger of coverage, number of occurrences, and allocation, can significantly affect the existence or amount of an insurance recovery. Moreover, certain causes of loss or liability may be excluded from coverage, while others are not. In addition, a number of policies provide for multiple means of calculation of the amount of the loss at the option of the

policyholder, or pay for losses that may be calculated in multiple ways, some more advantageous for the claim. These are not simple issues and require a level of legal sophistication to be understood and applied to the facts of a particular case. For instance, a policy may contain a batch clause requiring that similar claims be treated as one occurrence. Whether a claim is “similar” may not be obvious and may require a legal judgment call. A policyholder should not take a position as to whether a claim is “similar” (and thus should be batched into one occurrence) until it understands how a “single occurrence” determination affects the amount and scope of the insurance coverage it may collect and from which policies. This involves consideration of deductibles (or self-insured retentions) and limits. It also may involve the law in the applicable jurisdiction on number of occurrences.

Resolution also may depend not only on the law of a particular state that will be applied and the facts presented by a claim, but also on the way in which the facts are developed in the underlying action and presented to the insurance company – or, ultimately, to a court, if insurance litigation is necessary. A lawyer is needed to analyze how the resolution of these issues will impact the policyholder’s insurance recovery, and to help the company describe its claim in a way that will maximize its protection under the insurance program in light of the coverage issues. A lawyer also may be helpful to ensure that characterization of the claim for insurance purposes does not create any issues with respect to any underlying litigation against the company that has given rise to the insurance claim.

The original notice letter may be responded to with a request for information. Such requests may seek to have the policyholder characterize its claim in a way that will limit coverage. Before the policyholder engages in any such exchange with its insurance company, the policyholder should know what legal issues are likely to arise, and how best to describe its claim so as to maximize coverage.

6. Response to an Insurance Company’s Denial of Coverage or Reservation of Rights Letter

An insurance company must respond to notice with a statement of its coverage position.²³ A denial letter simply states the insurance companies’ position that there is no coverage for the submitted claim. A reservation of rights (“ROR”) letter is sent when the insurance company believes that it has a defense obligation, or must take some other affirmative act, but does not want to waive its rights to later deny coverage if the facts in the underlying claim eventually establish that no coverage exists. To preserve its rights, the insurance company is required in its ROR letter to state every basis on which it believes that coverage may not be available.

In-house counsel can assist the corporation in evaluating an ROR letter. Such letters are common, and often are misconstrued as a denial of coverage and the end of the insurance discussion. Rather, ROR letters should be viewed as the first step in recovery under an insurance policy. They assist in defining the issues on which the policyholder must focus to obtain insurance for the claim. At the very least, an ROR or a denial letter should be responded to with a simple “The Company does not agree with the positions on insurance coverage expressed in your letter of [X date].”

What the company decides to do next depends upon the size of the potential liability and the basis on which the insurance company has denied or reserved its rights. Some coverage disputes can be resolved by showing the insurance company that its assumption of facts or the law is incorrect. The broker sometimes can be helpful in bringing the parties together in these circumstances. However, if the potential liability is large, it is highly likely that the matter will not be resolved without mediation, arbitration, or litigation.

As already noted, the law with respect to many insurance issues varies by jurisdiction. Many insurance policies include a jurisdiction, venue and choice of law provision, but some do not. The jurisdiction in which a coverage action is filed may impact choice of law. Many insurance companies know this; when a coverage dispute is presented that suggests a potentially large exposure, the insurance company may bring a declaratory judgment action against its policyholder in a jurisdiction whose law is favorable to the insurance company. Thus, it is important for in-house counsel to assess the possibility that the policyholder might be sued by its insurance company. If that possibility exists, then the policyholder should file first in a favorable jurisdiction, have a complaint drafted so that it can file immediately if it is “jumped” by its insurance company (that is, sued in a jurisdiction with law not favorable to the policyholder), or enter into a tolling agreement with its insurance company providing that both sides agree not to file while the parties seek to resolve their differences.

7. The Policyholder's Duty to Cooperate

A policyholder has an obligation to cooperate in the defense of the underlying claim. A typical cooperation clause in a CGL policy provides:

- You and other involved insureds must:
 - Cooperate with us in the investigation, settlement, or defense of any claim or suit. No insured shall, except at her own cost, voluntarily make any payment, assume any obligation, or incur any expense.
 - Immediately send us copies of any notices or legal papers received in connection with the accident or loss.

This provision historically was interpreted to mean that the policyholder must provide information to the insurance company about the alleged occurrence by making underlying documents available, agreeing to be interviewed, and appearing at depositions and trial—in other words, to cooperate in the insurance company's defense of the claim. There should be no objection to this form of cooperation, and the policyholder should comply with these types of requests.

Even when the insurance company is not actively participating in the defense, it still has legitimate reasons for asking for information. It needs to set appropriate reserves and keep its reinsurance companies informed of potential liability. An insurer could (although it rarely does) provide advice to its insured to assist in the defense of the claims. Moreover, if the policyholder ever hopes to bring the insurance company into a settlement of the underlying claims or to resolve the insurance dispute, it needs to keep the insurance company informed. Finally, a policyholder does not want to give its insurance company the ability to claim lack of cooperation as an additional defense to coverage.

Accordingly, the policyholder should comply with the insurance company's reasonable requests for public information, or for documents that have been disclosed to the underlying claimants. Failure to provide this type of information to the insurance company can lead to a loss of coverage.

Counsel, however, must make sure that the insurance company does not abuse the cooperation clause by "turning it into a sword" to use against its policyholder in the dispute over coverage. Insurance companies may use the cooperation provision to try to compel the policyholder to produce material related to areas on which the insurer has denied coverage or reserved their rights to deny coverage. This is a misuse of the cooperation clause which must be opposed, as it creates a conflict of interest between the insurance company and the policyholder. Thus, at the earliest stage, after prompt notice has been provided, in-house counsel should analyze the underlying claims, the insurance policy, and the ROR letter. Where there is a conflict between the interests of the policyholder and those of its insurance company with respect to the defense of the underlying claims, a policyholder should resist providing the insurance company with privileged and work-product information that relate to the disputed coverage issues.

Disclosure of attorney-client or work-product documents that may contain defense counsel's analysis of issues in the underlying case – particularly if it also relates to an uncovered claim or an area of dispute in the coverage case – could result in a finding that the policyholder has waived the attorney-client privilege. Many insurance companies understand this latter concern, and their own interest, in keeping this material away from plaintiff's counsel.

Many practical solutions to these problems have been agreed to by insurance companies. At a minimum, any disclosures should be made pursuant to a confidentiality agreement. If possible, that confidentiality agreement should be "so ordered" by a court, and provide that the disclosure does not affect a broader waiver of the attorney-client or work product privileges. The confidentiality agreement and order also should provide that the documents are to be used by the insurance company solely for purposes of assisting in the defense of the underlying case, setting reserves, and keeping reinsurance companies informed, and will not be used against the policyholder in an insurance dispute.

Some insurance companies maintain a wall between those persons designated to assist in the defense of the case and those that handle the coverage dispute. In such a case, the insurance company should agree that the confidential information will not be viewed by those persons involved in the insurance-coverage dispute.

Strategic Point:

Instead of the disclosure of sensitive documents, insurers may be satisfied by meetings with defense counsel. In such situations, the defense counsel should be directed not to discuss areas related to disputed insurance issues. In-house counsel or outside coverage counsel also should participate in those meetings to further guarantee that the insurance companies do not misuse the cooperation clause to obtain information for use against the policyholder, or otherwise compromise the policyholder's ability to maintain privilege with respect to the underlying action.

8. Selection of Defense Counsel

The insurance company's duty to defend under a liability policy generally gives the insurer the right and obligation to select defense counsel, provided that it has not reserved its rights to deny coverage. Even if a policy does not require the insurance company to defend, the policyholder may have to select defense counsel from a panel approved by the insurance company; alternatively, the insurance company may reserve the right to approve defense counsel selected by the policyholder. If the policyholder knows at the time of purchase that it is likely to want to use a particular counsel, then it should add an endorsement to the policy allowing it to make that selection.

The defense mounted by the insurance company may be perfectly appropriate for the circumstances. However, the policyholder should resist the inclination to assume that if the insurance company has accepted the defense then "everything is under control." In-house counsel should receive status reports regularly, as well as copies of all pleadings, discovery demands, and correspondence with the underlying plaintiffs' counsel. The policyholder also should receive copies of all communications that defense counsel have with the insurance company regarding the matter. If the stakes are high enough, the policyholder may consider employing "shadow counsel" – a separate law firm that can monitor the conduct of defense counsel and warn the policyholder if it appears that the defense is being adversely affected by the insurance company's protection of its own interests.

If a conflict develops between the interests of the insurance company and the policyholder in the defense of the claim, and the policyholder has not contractually secured the right to control the defense in the policy or the claims-handling agreement, then the policyholder still may be able to control the defense, and select defense counsel, under the law that exists in most jurisdictions. The policyholder also may be able to negotiate control of the defense with the insurance company by agreeing to pay for the difference in billing rate between the counsel selected by the insurance company and the counsel selected by the policyholder.

Separate from any dispute over the policyholder's right to select defense counsel, the insurance company may contend that the defense costs incurred by counsel selected by the policyholder are not "reasonable and necessary." As part of the claims-handling agreement, the policyholder should seek the insurance company's consent that non-disputed items will be paid immediately, so that the dispute over the reasonableness of some fees will not be used as an excuse to withhold payment on the entire bill. Moreover, the parties should agree to a mechanism to resolve fee disputes promptly, such as through submission to a third-party arbitrator.

Strategic Point:

Many defense counsel are accustomed to insurance companies' guidelines governing claims handling and billing. In-house counsel should determine the familiarity of defense counsel with those guidelines when defense counsel is hired, and monitor defense counsel to make sure that counsel comply with those guidelines to minimize the likelihood of protracted disputes over payment of defense costs.

9. Protecting Liability Insurance Assets When Settling the Underlying Claim

Policyholders always should keep their insurance companies notified of settlement negotiations in the underlying case and invite them to participate. If there is a hearing to approve a settlement, such as when the underlying case is a class action, then the insurance company must be notified in sufficient time to attend and to voice any objection. The policyholder also should be mindful that the documents generated in connection with an underlying settlement, to the extent they describe the nature of the claim being settled, should be reviewed by the policyholder's insurance-coverage counsel so that coverage for the underlying claim is not adversely affected. From a policyholder's perspective, it is generally advisable if the settlement amount is not allocated to particular claims.

The reasons for keeping the insurance company informed are threefold. First, policies generally give the insurance company a right to participate in settlement negotiations and, ultimately, to approve settlement. Failure to provide insurance companies with the opportunity to exercise that contractual right may lead to a loss of insurance coverage for the settlement. Second, the insurance companies may be helpful in the settlement negotiations, particularly in these days of structured settlements. Third, notice and the opportunity to participate in settlement discussions prevents the insurance company from later claiming that the settlement was unreasonable. If possible, the insurance company should explicitly be asked if it believes that the settlement is unreasonable, and whether it advises that the policyholder should reject the settlement and continue litigating. The insurance company is not likely to object to the terms of the settlement at the time it is being negotiated. The most common insurance-company response to a proposed settlement is either silence or to advise that the policyholder should do what it believes is appropriate. Most courts will hold that, in those circumstances, the insurance company has waived the right to later object to the reasonableness of the settlement.

C. Practical Considerations for Corporate Counsel

I. Corporate Roles with Regard to Insurance

Although insurance policies are commercial contracts that create a valuable corporate asset, corporate legal departments often do not devote sufficient attention to that asset until a time of crisis (e.g., when a sizeable claim has been made and an insurance company denies coverage). Risk managers generally are part of the finance department and report to the treasurer. They focus on the economics of the transaction, the limits provided, and the costs of the insurance (i.e., premiums). Moreover, risk managers sometimes are not comfortable in pursuing a claim out of a belief that it may make renewal, or the acquisition of new policies, more difficult or expensive. Too often, they accept the representation of the insurance company or the broker that a given claim should not be pursued because it is not covered, rather than making an independent determination of the claim and the policy coverage.

In-house counsel always can be of assistance to the risk-management department in the purchase of insurance. They can provide valuable help in evaluating alternative policy language and the implications that language will have when and if a claim is made under

that policy or a coverage dispute arises. For example, a lawyer may be in the best position to evaluate whether a policyholder should accept certain dispute-resolution provisions, such as a choice of law or a mandatory arbitration clause.²⁴ Similarly, a lawyer may be more likely than a risk manager to check the actual policy language against the outline of coverage contained in the initial insurance binder, and to insist that inconsistencies be corrected.

Counsel should be involved in the purchase of D&O insurance in particular. An attorney may be helpful in understanding the conflict of interest between the inside individual directors and officers, the outside directors, and the corporate entity, particularly when the D&O policy contains entity coverage. Each insured is in competition with the others for the protection afforded by the policy. What may be in the interest of one may be contrary to the interests of the others. An attorney can be alert to these conflicts and better able to put the parties on notice.

2. Managing Relationships with the Broker

The broker occupies the space between the policyholder and the insurance company. Although the facts in any particular situation may differ, the broker generally fulfills many roles: agent for the policyholder for some purposes; agent for the insurance company for other purposes; or a principal in the transaction, particularly when the broker is an owner or participates in one of the entities providing insurance or has put together the policy or the facility that provides the insurance. This means that the broker may have many interests, some of which may conflict with the interests of the policyholder.

Risk managers often treat the broker as part of the “in-house” team. The broker is not an employee of the policyholder and should not be treated as such. This mistake manifests itself frequently in the dispute over the confidentiality of the broker’s files. Simply put, a policyholder should assume that the broker’s files are not confidential. The broker is not within the bubble of the attorney-client privilege. Insureds should assume that any communications they have with their broker may be discoverable by the insurance company (although certain claim-related communications may be protected by attorney work product). In this world of e-mail, a risk manager may forward an opinion of counsel on coverage and ask the broker for comments. Privileged documents may become discoverable when sent to the broker. It is also common for a risk manager to ask the broker for a written opinion on coverage. This also should be avoided. That opinion may become public, and whether or not it is correct, the insurance company will argue that the broker’s opinion somehow binds the policyholder. Meetings that a broker attends are discoverable. In-house counsel should advise risk managers that a broker must be treated as an independent third party.

Finally, an important role that the broker can fulfill is to make sure that communications are sent to all interested insurance companies. In the initial notification of loss, claim, or occurrence, it can be the broker’s job to determine all possibly implicated coverages and make sure that notice is provided to all relevant insurance companies. However, if all lines of coverage were not placed by the same broker, she may not be aware of possible coverages. The broker also may be responsible for keeping all potentially implicated insurance companies informed of developments in the underlying litigation or in the

investigation of the loss. The broker also can make sure that excess insurance companies are notified of side agreements between the primary insurance company and the policyholder, or any other act that the excess insurance companies later could claim impacts their risk, allowing them to avoid coverage.

III. Insurance Basics

A. Insurance Documents

I. The Binder

The “Insurance Binder” is the initial document that evidences that insurance was sold.²⁵ The binder typically is only a few pages long, and refers in summary fashion to the basic terms of the insurance contract, often by reference to standard policy forms. Often, the formal policy is not prepared until months after the coverage becomes effective, and sometimes may not be delivered until after the policy period has expired. The binder may be the only documented “contract” that exists during that portion of the policy period. For instance, the litigation over insurance coverage for the billions of dollars in loss and liabilities at the World Trade Center primarily concerned the wording contained in binders because, as of September 11, 2001 (“9/11”), many of the policies had not yet been issued.²⁶

2. The Policy

When the formal insurance policy eventually is delivered, it should be reviewed as soon as possible to determine whether the as-issued policy is consistent with the terms as outlined in the binder, as well as with other policies in the program. If inconsistencies are not corrected immediately, problems may arise if and when a claim for insurance coverage is made.

The formal policy generally consists of: (1) a Declarations Page; (2) a Policy Form; and (3) Endorsements. The “Declarations Page” provides a summary of the insurance provisions, including the specific type of insurance being purchased, the designation of the named insureds, the policy period, and the amount insured or limits of liability. The Declarations Page may be the only document that is customized for the individual policyholder.

The “Policy Form” generally is a preprinted document that describes:

- Who (or what) is insured;
- The insuring agreements (and definitions);
- The exclusions; and

- The conditions the policyholder must satisfy to be entitled to coverage under the policy.

For general liability policies sold today, the policy form generally has been created by the Insurance Services Office, Inc. ("ISO"), an insurance industry organization.²⁷ Other types of insurance policies (e.g., D&O, E&O, fidelity, and property policies) often are written on an insurance company's own standard forms or a broker's forms, both of which can be customized for a particular industry. For example, a Bankers Blanket Bond form is a fidelity policy customized for the financial industry.

The insurance industry uses standard language so that it can set premiums based upon prior loss experience under the same insurance provisions. Policyholders, therefore, generally have no opportunity to negotiate the language of the basic insuring provisions in the Policy Form. The negotiations that do take place principally concern the premiums and limits of coverage. Accordingly, the general rule of contract construction that ambiguities are construed against the drafter applies with particular force, and ambiguities in standard policy language are construed against the insurance company on the grounds that only the insurance company could have clarified or eliminated those ambiguities.²⁸

"Endorsements" are modifications to the Policy Form. There are standard, preprinted endorsements (e.g., nuclear energy, asbestos, or pollution exclusions) as well as customized endorsements (e.g., listing additional insureds or excluding an aspect of the policyholder's business from coverage). There may be negotiations over the language of endorsements dealing with the scope of coverage, but most often these "negotiations" are limited to a discussion over which of the insurance company's various standard endorsements will be used.

Strategic Point:

In some limited circumstances, insurance policies may be tailored for the particular policyholder. These policies are referred to as "manuscript" policies. Insurance companies often argue that manuscript policy language is negotiated between the insurance company and the policyholder, and thereby try to avoid the usual rules of policy construction that favor policyholders. However, true manuscript policies, where the language of the insuring agreements is negotiated, are rare. In most cases, "manuscript" policies merely involve standard insurance-company language that is retyped, rather than presented on a preprinted form. In this case, the pro-policyholder rules of construction still should apply. Indeed, the proper question should not be whether the insurance policy was subject to negotiation, but whether the policyholder actually *drafted* the particular language at issue.²⁹

3. Certificates of Insurance

A certificate of insurance often is given to a third-party doing business with the policyholder. Its purpose is to "certify" that the policyholder has a certain amount of insurance. Certificates generally are issued by the policyholder's broker. A certificate does not necessarily provide direct insurance rights to the third-party recipient. The Research Committee of the Risk and Insurance Management Society, Inc. ("RIMS Research Committee"), one of the largest insured associations, has stated:

A certificate of insurance is merely evidence of insurance coverage. It is not coverage itself. It is not a policy, nor can it be relied on as a policy. Some have referred to the certificate as “the illusion of protection.” Because the certificate is only evidence of in-place coverage, and not the coverage itself, many problems can arise with their use

What this means is that many insurance certificates are, as is clearly stated on the forms, “a matter of information only.”³⁰

In some instances, a certificate may include language stating the intention to name the recipient as an “additional insured” under the policy. Even in those cases, however, the certificate may be insufficient to provide insurance to the third-party recipient. Recipients of certificates of insurance should not be misled into thinking that the certificate gives them rights under the policy when it generally does not.

Many courts have recognized that a certificate of insurance, even when issued by the insurance company, may only be “evidence of a carrier’s intent to provide coverage but . . . not a contract to insure the designated party nor [as] conclusive proof, standing alone, that such a contract exists.” *Tribeca Broadway Assoc., LLC v. Mount Vernon Fire Ins. Co.*³¹ Moreover, certificates often include disclaimers such as: “[T]his certificate is issued as a matter of information only and confers no rights upon the certificate holder,” and that the “certificate does not amend, extend, or alter the coverage afforded by the policies below.”³²

In *Tribeca Broadway Assoc., LLC v. Mount Vernon Fire Ins. Co.*, the New York Appellate Division addressed the question of whether an insurance company had a duty to defend and indemnify a property owner that was the recipient of a certificate of insurance designating the property owner as an “additional insured.” However, the certificate also contained a statement that it was issued “as a matter of information only.” The court held that the certificate did not constitute conclusive proof that a contract for coverage existed between the owner and the insurance company; neither the contractor nor its broker could create rights and obligations as between the owner and the insurer.³³ Courts around the country have reached similar conclusions.³⁴

If it is important to the certificate holder to be insured under a policy, then the recipient must review the actual policy to determine if the insurance company has, in fact, issued an endorsement naming the recipient as an additional insured and the scope of that insurance. Reliance on a certificate of insurance is not sufficient.

Moreover, certificates of insurance may not adequately describe the insurance. Certificates often set forth the type (e.g., “general liability”) and limits of insurance; they often do not indicate what exclusions may apply, whether deductibles or self-insured retentions exist, or whether any erosion of limits has occurred. Certificates also do not typically address the potential for an early cancellation of the policy. The recipient of a certificate may believe that the insured has several years of coverage, only to find that the coverage was terminated early and without notice to the certificate holder.

Even if the certificate is issued by the insurance company and is deemed sufficient to include the recipient as an “additional insured,” the “additional insured” may not have the same scope of insurance as the original policyholder. It is fairly common for “additional insureds” to be protected only to the extent that their liability derives from an act or omission of the named insured. In other words, the policy may not insure the additional insured for liabilities that arise from the additional insured’s own acts or omissions, but instead only for liabilities that arise from the acts or omissions of the named insured. This gives rise to another important issue – who the “named insured” is under the policy. The named insured may be the ultimate parent, a holding company, or some other entity not directly involved with the transaction or events giving rise to suits or liability. This may mean that the additional insured will not receive any insurance coverage if the named insured did not commit the act or omission that gives rise to a potential liability.

If a third party promises to name the company as an additional insured, ask to see more than just the certificates of insurance; be sure to get a copy of the policy to see if it has an endorsement, signed by the insurance company, naming the company as an additional insured, and under what circumstances insurance will be extended.

B. Sections of the Policy Form

I. Who (or What) is Covered?

Liability policies provide insurance for specifically described persons and entities. Typically, there is a “named insured,” which will be the corporate entity. In a provision entitled “Who is an Insured,” the policy may describe other persons (e.g., employees or shareholders) or entities (e.g., vendors) who also will be considered “insureds” under the policy. “Insured” may also be a defined term in the policy, which will be located in the Definitions section. D&O policies, for example, will typically include former and current directors and officers of the corporation alike as individuals who are “insureds.”

Liability policies also may extend coverage to other categories of parties, which generally are listed in an endorsement. Often these “additional insureds” will include corporate affiliates of the “named insured,” persons or entities with whom the named insured has a close commercial relationship, or persons or entities to whom the named insured is contractually bound to provide insurance.

The equivalent provision in first-party property policies is the “Covered Property” provision, which describes the property covered by the policy. This description may list the type of property covered (e.g., inventory, goods in transit, elevators, or art) or identify property at certain defined locations. The “Covered Property” provision also may specify property that is not covered by the policy.

2. Insuring Agreements and Definitions

The insuring agreement defines the type of risk covered by the particular policy. Each type of insurance policy has its own different types of insuring agreements. For instance, a Comprehensive General Liability or Commercial General Liability (“CGL”) policy will have an insuring agreement that obligates the insurance company not only to pay the liability imposed on the policyholder (the duty to indemnify), but also to provide counsel and/or to pay the costs of litigation associated with claims that may be covered under the policy (the duty to defend). A first-party property policy will provide that it covers a loss of property from “all risks” or from a specific risk, such as fire or flood.

A policyholder cannot understand the scope of the insurance provided without reading the insuring agreement in conjunction with the Definitions section of the policy. Indeed, much of the litigation surrounding the scope of insurance coverage involves disputes over the definition of key words such as “Claim,” “Loss,” “Suit,” “Wrongful Act,” “Occurrence,” “Property,” and “Property Damage.”³⁵ The policyholder typically has the burden of proving that a loss falls within the insuring agreement to establish its right to indemnity for the claim. The insurance company seeking to deny coverage then has the burden of showing that a loss falls within an exclusion.³⁶

a. The Duty to Defend and to Pay Defense Costs

The insuring agreements of a primary general liability policy typically provide that “[the insurance company] will have the right and duty to defend any ‘suit’ seeking damages [covered by the indemnity provisions of the policy].” The end result of this standard provision is that the insurance company undertakes an obligation to defend the policyholder with respect to claims that might fall within the indemnity provisions of the policy.

The defense obligation under liability policies is broader than the duty to indemnify for a claim.³⁷ This means that the insurance company must defend, or reimburse for the costs of defense, even if the claim is only potentially covered by the policy. The “facts” which determine the duty to defend are generally limited to the language of the complaint and the insurance policy.³⁸ Moreover, an insurance company typically must defend the entire action, even if only some of the claims are covered.³⁹

In most primary general-liability policies, the costs of defense are payable in addition to, or “outside of,” the indemnity limits of the policy. The defense duty terminates only if and when the primary insurance company pays judgments or settlements in an amount sufficient to exhaust the policy limits. Therefore, the amount the insurance company pays under its defense obligation often far exceeds the policy limits. As a result, primary general-liability insurance is sometimes referred to as “litigation insurance.”⁴⁰ Litigation insurance is particularly valuable where the underlying actions involve mass torts or related product liability claims, where defense costs often equal or exceed the amount of any ultimate liability.⁴¹

Many excess general liability policies, as well as other forms of liability policies (e.g., fiduciary, D&O, and E&O policies) agree to pay defense costs “within” limits. Under such policies, each dollar paid in defense costs “erodes” the policy limit, reducing the amount

available to pay any eventual judgment or settlement. The contractual basis for the reimbursement for defense costs under these policies often is found in the definition of a covered "Loss," which includes the costs of defense. Typical provisions in a D&O policy provide that "Loss means damages, settlements, and Costs, Charges and Expenses incurred by" the insureds, and that such costs, charges, and expenses incurred by "Insureds when defending or investigating with the written consent of Insurer, shall be paid by Insurer as a part of, and not in addition to, Insurer's Limit of Liability."⁴²

Moreover, in more specialized liability policies (e.g., fiduciary, D&O, and E&O policies), the insurance company often has no "duty to defend" but, rather, has a duty to reimburse for the costs of defending a covered claim. These policies may require the policyholder to select defense counsel from a panel of lawyers approved by the insurance company, which list often is annexed to the policy. In these types of coverages, insurers often will argue that the scope of the duty to reimburse for defense costs is coextensive with, and not broader than, the duty to indemnify. However, many courts have held to the contrary.⁴³ In those cases where the insurance company must reimburse for defense costs, policyholders should ensure that those sums are reimbursed or "advanced" as they are incurred, and not held back by the insurer until after the liability dispute ultimately is resolved.

b. The Duty to Indemnify or to Pay Damages on Behalf of the Policyholder

In a general liability policy, the insurance company typically agrees:

[to] pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies⁴⁴ This insurance applies to "bodily injury" and "property damage" only if: (1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory;" (2) The "bodily injury" or "property damage" occurs during the policy period⁴⁵

A general liability policy also may have separate insuring agreements for "personal injury" and "advertising injury." Personal injury generally is defined to cover such claims as false arrest or detention, malicious prosecution, slander, libel, and violation of the right of privacy. Advertising injury generally is defined to include such claims as infringement of copyright, title, or slogan; misappropriation of advertising ideas or style of doing business; or publication of material that slanders a person or organization, or a person's or organization's goods, products, or services.

A typical insuring agreement for a D&O policy provides that the insurance company will reimburse the insured for all "Loss" that arises out of claims alleging "Wrongful Acts" committed by a director or officer in his capacity as a director or officer. The scope of coverage is dependent upon the definition of, and case law construing, the terms "Loss," "Claim," "Wrongful Act," and "Capacity."

As already mentioned, property policies come in two general categories: (1) All Risk, and (2) Named Peril policies. An "All Risk" policy provides insurance for "all risk of direct physical loss or damage to property" owned, leased, or under the control of the insured.

“Risk” refers generally to the cause of the loss. In an “All Risk” policy, a loss from a particular risk can be excluded. Property policies generally provide that the insurance company will “pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.”⁴⁶ The definitions of the terms “Covered Property” and “Covered Cause of Loss” provide the real substance of the insuring agreement.

Strategic Point:

Property policies do not just insure the value of property. They often contain other forms of coverages, including business interruption (loss resulting directly from the necessary interruption of business caused by physical damage to the policyholders’ property), contingent business interruption (“CBI”)(loss resulting directly from the necessary interruption of business to designated property owned by third parties) and extra expense (loss resulting from the increased cost of business operations above normal caused by an insured peril). Coverage may extend to losses resulting from debris removal, pollutant clean-up, orders of government or civil authority, limits on access to a business (“ingress/egress”), service interruptions, repair and replacement costs, and preventative measures to avoid imminent loss (“sue and labor”). A “Named Peril” policy insures against a particular risk, such as fire, flood, or tornado.⁴⁷

3. Exclusions

The insuring provisions must be read not only in conjunction with the definitions section of the policy, but also in conjunction with any exclusions to coverage. Indeed, it is not unusual to find an insuring provision that is a simple one-sentence declaration of coverage, followed by four pages of exclusions.

Standard exclusions vary depending upon the type of coverage involved. General liability policies, for example, typically include exclusions for, among others, property owned, operated, and leased by the policyholder; certain business risks; and pollution. Directors and Officers (“D&O”) policies may exclude coverage for, inter alia, illegal personal gain, short swing profits, and claims that should be covered by other available insurance policies. First-party property policies that include business interruption coverage may seek to exclude losses caused by, among other things, lease cancellations, interference by strikers, consequential losses, and interruption of utility services.

Many types of policies also exclude coverage for losses arising out of certain types of “intentionally” harmful conduct. D&O policies, for example, may exclude coverage for loss arising out of the directors’ and officers’ “fraud,” but only if the wrongful conduct is proved “in fact” or through a final adjudication (depending upon applicable policy language).

Similarly, general liability policies often contain an exclusion if the “bodily injury” or “property damage” was expected or intended by the policyholder. Although insurance companies try to argue that this exclusion applies whenever the policyholder’s conduct is intentional, this position has been widely rejected. Instead, courts generally have held that such exclusionary language applies only when the policyholder expected or intended the

harm that resulted from its intentional conduct.⁴⁸ Moreover, the test usually is a subjective one. It should not be sufficient that a reasonable person should have expected or intended the harm, but the actual policyholder must have expected or intended the resulting injury or damage if the exclusion is to apply.⁴⁹ In the case of a corporate insured, the intent typically must be that of senior management or the board of directors.⁵⁰

This “expected or intended” exclusion may align an insurance company's interests with those of the plaintiff asserting an underlying claim against the policyholder. For instance, the facts that may establish a claim against the policyholder for punitive damages may be the same facts on which an insurance company could deny insurance, based upon the expected or intended exclusion. This can lead to a conflict of interest and will impact whether the insurance company can control, or even participate in, the defense.

Often, exclusions are written in response to an increase in a certain type of litigation. For instance, exclusions for liability caused by asbestos, pollution, lead, or mold claims now are common in general liability policies. Exclusions for these types of liabilities were added in response to the expansion of mass tort litigation involving such claims. Similarly, in the wake of the September 11th Attacks (9/11), many first-party property insurance companies began to add exclusions for damage arising from terrorist acts. Insurers also may issue exclusions specific to a particular policyholder's experience. For instance, if a pharmaceutical company experiences a number of claims relating to a particular type of drug, it might expect to have coverage for those claims “lasered” or excluded from coverage at the next renewal. Exclusions for claims arising out of the drug Diethylstilbestrol “DES,” for example, are common.

In some instances, insurance companies have argued for what amounts to an implied policy exclusion based on the supposed “inherent nature” of insurance.⁵¹ Two of the more common examples are insurance company refusals to provide coverage based on “known loss” (sometimes inaccurately referred to as “known risk”) and “lack of fortuity.” For the most part, these fictional “exclusions” have been rejected by the courts.

Strategic Point:

The news on exclusions is not all bad. Sometimes insurance can be “revealed” through an exclusion, usually as an exception to the exclusion. For instance, in general liability policies, there is a standard exclusion for liability assumed by contract. However, that exclusion has an exception for “insured contracts.” The standard definition of “insured contracts” lists six categories of contracts where assumed liabilities are covered. More categories of “insured contracts” can be added by endorsement. This exception to an exclusion is often treated as a grant of coverage.⁵²

Finally, even if an exclusion applies to one theory of liability or loss, there may be theories of liability or loss that are not excluded. This is sometimes referred to as the “concurrent cause” doctrine.⁵³ As long as one theory of liability (in a third-party policy) or one type of peril (in a first-party policy) is covered, the resulting loss also should be covered, irrespective of whether some other, excluded cause contributed to the loss. Some jurisdictions, however, use the “efficient proximate cause” approach, and look only at the prime cause of damage.⁵⁴ Thus, a legal analysis of the potential underlying liability or loss is necessary if a policyholder is to maximize recovery under an insurance policy.

4. Conditions

Most insurance policies have a Conditions section that sets forth various duties of the policyholder and the insurance company, respectively. The most frequently litigated provision within the Conditions section relates to the policyholder's obligation to provide prompt notice of a claim made against the policyholder, or of an occurrence that might give rise to a loss or a claim under the policy. Liability insurance policies generally provide, with regard to notice:

- Duties in the Event Of Occurrence, Offense, Claim[,] or Suit
 - You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include: (1) How, when and where the "occurrence" or offense took place; (2) The names and addresses of any injured persons and witnesses; and (3) The nature and location of any injury or damage arising out of the "occurrence" or offense.
 - If a claim is made or "suit" is brought against any insured, you must: (1) Immediately record the specifics of the claim or "suit" and the date received; and (2) Notify us as soon as practicable.
 - You must see to it that we receive written notice of the claim or "suit" as soon as practicable.⁵⁵

The policies also may require the policyholder to forward a copy of any underlying complaints that have been filed:

- You and any other insured involved must . . . [i]mmediately send us copies of any demands, summonses[,] or legal papers received in connection with the claim or "suit."⁵⁶

Closely related to this notice provision is the requirement that a policyholder cooperate with its liability insurance company in the investigation of a loss or a claim under the policy or the defense of a third-party claim.⁵⁷ Often found in standard-form general liability policies, provisions requiring the policyholder to cooperate with the insurance company in the defense of underlying claims typically prohibit the policyholder from settling a covered claim, or otherwise making a "voluntary payment without the insurance company's consent.

Notice requirements are particularly important to claims-made liability policies, such as D&O and E&O policies. As noted above, these types of policies generally respond only to claims made against the policyholder and reported to the insurance company during the policy period. However, even under an "occurrence" policy – which responds to claims filed against the policyholder at any time, as long as the alleged bodily injury or property damage took place during the policy period – late notice can result in the insurance company's being able to avoid payment. Jurisdictions vary on whether an insurance company must show it was prejudiced by the timing of notice under an "occurrence" policy to escape coverage for late notice under an "occurrence" policy.

First-party policies have a requirement that a proof of loss must be filed within a specified time after notice of the loss. A failure to provide prompt notice, to file a proof of loss, or to cooperate with your insurance company may result in a forfeiture of coverage.

5. Limits of Liability

The liability limits of an insurance policy set the maximum that the insurance company will pay under certain specified circumstances. Policy limits generally are stated on the Declarations Page, but can be modified by endorsement. Insurance policies can have many types of limits. A per occurrence limit provides the total that the policy will pay per occurrence, or cause of the loss. An aggregate limit sets the most that the policy will pay under any circumstances, regardless of how many occurrences result in claims that are submitted. Some policies do not have aggregate limits, which means that they will continue to pay on liabilities or losses from each new occurrence. There also can be limits for certain types of coverages, such as a specific sublimit for product liability or completed operations coverages.

In *World Trade Center Properties L.L.C. v. Hartford Fire Insurance Co.*,⁵⁸ there were no aggregate limits in the first-party property policies, only a per occurrence limit. Thus, a key dispute in the litigation over the loss of the World Trade Center was whether the insurance companies must pay a single limit because there was one occurrence (one terrorist conspiracy) or two limits because there were two occurrences (two planes that hit two buildings).⁵⁹ Similarly, in the area of environmental insurance coverage, there typically are only per occurrence limits that apply to the premises operations insurance that responds to that type of claim. Thus, a key question for a pollution claim is how to determine the number of occurrences: Each polluting release or event? Each type of polluting operation? Each site?

Insurance companies also can use limits as a form of an exclusion. For instance, extensive litigation has surrounded the meaning and scope of various versions of the pollution exclusion. When insurance companies were frustrated in their efforts to exclude such claims, in part due to rules of contract construction (which require that exclusions be interpreted narrowly and ambiguities construed against the insurance company), some insurance companies have responded by placing a low sub-limit on coverage for pollution claims.

C. Rules of Construction

The first rule in understanding a policyholder's rights under an insurance policy is to read the policy. The second rule is to read the policy again. This may seem too obvious to mention (given that insurance policies are contracts), but policyholders often simply assume that they know what the policy says without reading the details.

Despite the importance of insurance contracts and the value of the assets which they represent, insurance policies often are poorly written and ambiguous. The rules of policy construction are a matter of state law. They are generally helpful to policyholders, and are fairly uniform across the country. The rules may be summarized as follows.

- The language in insurance policies will be given its plain meaning if it is reasonably possible to do so.⁶⁰
- In most jurisdictions, extrinsic evidence may be considered to interpret an ambiguous provision. An insurance company's testimony of its subjective understanding may not be admissible when offered by the insurance company.⁶¹ However, in some jurisdictions (e.g., Delaware), ambiguous policy language is interpreted according to what a reasonable person in the position of the policyholder would understand that language to mean, rather than the subjective understanding of the contracting parties.⁶²
- Insurance policy language should be construed to protect the reasonable expectations of the insured. If there is an ambiguity in an insurance policy, it should be resolved against the insurance carrier.⁶³
- If a term is not defined, it may be considered ambiguous and interpreted in favor of the policyholder.
- Exceptions, limitations, and exclusions to coverage should be interpreted narrowly.⁶⁴
- The insurance company has the burden of proving that an exclusion applies to a claim.⁶⁵

Insurance companies sometimes argue that the language in question was negotiated with the policyholder or that the language came from the policyholder's broker. This raises a question of fact, which requires the policyholder to prove either that the insurance companies were the source of the language, or that the broker proposed language which it knew originally was developed by insurance companies. The significance of the insurers' argument is that it may defeat summary judgment in favor of the policyholder if the language is ambiguous.

IV. Comprehensive General Liability Policies

A. Executive Summary of GCL Coverage

Comprehensive General Liability ("CGL") policies are purchased by companies to protect them from claims seeking to hold them liable for alleged bodily injury or property damage to others. Many CGL policies also extend coverage to allegations of personal or advertising injury. CGL policies typically cover both the defense of actions alleging such liability, and indemnify the policyholder for any judgments or settlements.

The "duty to defend" policyholders under primary CGL policies is a particularly valuable aspect of the coverage. This duty exists from the beginning of the underlying action, as long as a comparison of the policy with the underlying allegations establishes even the potential for coverage. The duty extends to groundless, false, or fraudulent underlying actions whose allegations would fall within coverage if true, and doubts about the underlying allegations

are resolved in favor of coverage. In most jurisdictions, there is a full duty to defend the entire underlying action if *any* part of the underlying allegations falls within coverage.

An insurance company may defend the policyholder while reserving rights to deny coverage for any judgment or settlement. If the coverage position of the insurance company creates a conflict of interest between it and the policyholder as to the underlying defense, then the insurance company may lose its right to defend the policyholder, with its duty to defend converted into a duty to reimburse the cost of an independent defense by attorneys selected by the policyholder.

Some of the most significant disputes over coverage under CGL policies have involved coverage for mass torts and particularly long-term latent injuries (e.g., those alleged in actions for asbestos bodily injury or environmental harm). Long-term injuries raise questions as to the “trigger of coverage,” that is, what event must take place during the policy period to require coverage to respond, as well as the allocation of loss if more than one policy period is triggered. Most courts have held that typical CGL coverage is triggered by injury, even if not yet manifested during the policy period, and that a long-term injury process may trigger multiple policy periods. Courts have split on whether each triggered policy period is fully and independently liable for “all sums” the policyholder is liable to pay from a long-term occurrence, or whether the insurance companies can reduce their coverage obligation under some theory that prorates the loss by time on the risk.

CGL coverage may also be sold on a “claims-made” basis, where coverage is triggered only under the policies that were in place when the claim was actually made against the policyholder and reported to the insurance company. Another issue that arises prominently in the context of coverage for mass torts is the number of “occurrences” involved in a loss, which affects the amount of coverage limits and deductibles that apply to a particular liability.

Disputes also arise under the language in CGL policies barring coverage for injury or damage that is expected or intended from the standpoint of the policyholder. Insurance companies often attempt to argue that this language excludes any harm that was reasonably foreseeable to the policyholder—a standard that, if applied literally, would eviscerate almost all coverage because most tort-liability theories under which a policyholder could be held liable require a showing that the harm was reasonably foreseeable. Most jurisdictions instead apply a subjective test, and bar coverage only if the policyholder actually intended the harm or knew that it was substantially certain to take place.

One major area of dispute under CGL policies in recent decades has been coverage for long-term environmental harm, particularly under the Comprehensive Environmental Response, Compensation, and Liability Act (“CERCLA”)⁶⁶ and state law equivalents that impose cleanup liability against companies that owned, operated, or had other involvement with contaminated environment sites. At such sites, there may be allegations of environmental harm (e.g., leaching of contaminants through soil and groundwater) taking place over many decades, potentially triggering CGL coverage under many policy periods. In addition to those issues previously discussed, environmental coverage disputes raise a number of particular issues. Insurance companies typically dispute whether a letter from a government agency

naming a policyholder a potentially responsible party at a site is a “suit” triggering the insurance company’s defense obligation. Insurance companies also have asserted, usually unsuccessfully, that CERCLA cleanup liability is equitable in nature, and so does not constitute “damages because of property damage” as required for coverage under typical CGL language. Disputes also arise as to whether the cost of measures taken on the policyholder’s own property, designed to mitigate the effect of harm to offsite property, is excluded by the own property exclusion.

As environmental coverage disputes have arisen over the years, the insurance industry has responded by introducing and revising pollution exclusions. The earliest version of the exclusion, introduced in policies dating from the early 1970s, excluded pollution damage except if caused by a “sudden and accidental” release. Courts addressing coverage for long-term environmental harm split over whether the “sudden and accidental” language required that the release be abrupt, or whether it was merely a restatement of the language barring expected or intended harm, as the insurance industry represented at the time. Starting in the mid-1980s, the exception for “sudden and accidental” releases was removed, and various versions of so-called “absolute” and “total” pollution exclusions were included in policy language. Disputes have arisen under these exclusions as to whether they are limited to excluding pollution from traditional environmental releases, or whether they also bar coverage for indoor workplace exposures to chemicals, products liability claims involving alleged contaminants, and other liabilities that are not traditional “pollution” claims.

Asbestos liability is another area where coverage disputes can and have implicated decades of historic insurance CGL policies. The disputes over trigger and allocation of coverage for long-term injuries received the first sustained attention from courts in this context. A particularly significant area of dispute for some policyholders facing liability from their role as asbestos installers is whether their potential liability arises under the “products hazard” (and thus subject to the aggregate products-liability limits in many policies), or whether the loss is outside the products hazard (and, thus, as many separate limits apply as a court finds there are separate occurrences).

Other product liability claims can lead to coverage disputes under CGL policies. One area of dispute is the reach of certain so-called “business risk” exclusions, intended to bar coverage for harm to the policyholder’s product itself or the need to recall similar products. These exclusions generally do not apply to allegations that the policyholder’s products have caused harm to other property or to persons.

Many CGL policies extend coverage to personal or advertising injury, which the policies define to include certain listed torts and wrongful acts. Personal injury coverage often includes such causes of action as defamation, malicious prosecution, and wrongful eviction. Advertising injury coverage responds to claims alleging such wrongs as defamation, use of another’s advertising idea, or infringement of copyright in the policyholder’s advertisements. One area of dispute has been the extent to which advertising injury coverage is available for actions alleging intellectual property infringement. The results have depended on the precise language of the coverage grants, as well as the closeness of the connection between the alleged infringement and the advertising activities of the policyholder.

B. Basics of the Insuring Agreement

For businesses, the most common type of liability insurance is CGL insurance coverage. Until the 1940s, the insurance industry typically sold policies that provided coverage only for specific risks. However, in the late 1940s, the “comprehensive” general liability policy was introduced. This policy was intended to insure all risks not specifically excluded.⁶⁷ The coverage has been described as follows:

The primary purpose of a comprehensive general liability policy is to provide broad comprehensive insurance. Obviously, the very name of the policy suggests the expectation of maximum coverage. Consequently, the comprehensive policy has been one of the most preferred by businesses and governmental entities over the years because that policy has provided the broadest coverage available. All risks not expressly excluded are covered, including those not contemplated by either party.⁶⁸

Over the years, CGL policies largely have been standardized by various insurance industry organizations, including the Insurance Services Office, Inc. (ISO).⁶⁹ Until 1966, standard-form CGL policies typically provided coverage for claims alleging either “bodily injury” or “property damage.” After 1966, CGL policies also provided coverage for “personal injury” and “advertising injury.” Since at least the early 1980s, standard-form CGL policies have included coverage for all four types of injuries.

In addition to obligating the insurance company to pay those sums that the policyholder becomes legally obligated to pay as damages because of bodily injury, personal injury, property damage, or advertising injury to which the policy applies, it also typically obligates the insurance company to defend any “suit” seeking those damages. CGL policies are, by far, the most important form of insurance available to most policyholders. It is also the type of insurance that has generated the most extensive coverage disputes. Some of the key issues raised by those disputes are discussed in the following sections.

To fully understand the scope of a CGL policy’s insuring agreements, they must be read in conjunction with the policy’s definitions and exclusions. Each of the insurance agreements in a CGL policy typically is followed by a standard set of exclusions. The exclusions relate to, for example, bodily injury and property damage stemming from expected or intentional injury, certain liquor liabilities, and pollution. Exclusions can be added or modified by endorsement.

Strategic Point:

It is important to remember that the exclusions applicable to bodily injury and property damage are *only* applicable to those coverages. Similarly, the exclusions listed in connection with personal and advertising injury do not apply to bodily injury and property damage. Thus, the exclusions in one coverage part should not bar coverage for claims falling under another coverage part.

In addition, although this chapter addresses some of the more common CGL policy exclusions, it does not address every exclusion that could potentially apply. As always, insureds are advised to carefully read all of the exclusions in their policies to determine whether any of them could potentially bar coverage.

C. Managing an Insurance Company's Defense Obligation

Liability policies potentially impose a number of duties on insurers arising out of complex insurance claims. Of the insurer's obligations, one of the most critical (and therefore most often litigated) is the insurer's duty to defend.

The insuring agreements of a primary general-liability policy typically provide that "[the insurer] will have the right and duty to defend the insured against any 'suit' seeking damages [covered by the indemnity provisions of the policy]." Standard-form general liability policies also contain provisions that require the insured to cooperate with the insurer in the defense of underlying claims, and prohibit the insured from settling a covered claim or otherwise making a "voluntary" payment, without the insurer's consent. The end result of these standard liability insurance policy provisions is that the insurer undertakes an obligation to defend the insured with respect to claims that could fall within the indemnity provisions of the policy.

With respect to the insurer's defense duty, an insurer typically must defend, or reimburse its insured for the costs of defense, if any aspect of the claim is potentially covered under the terms of the policy. The insurer must defend against the entire action, even if only some of the claims are covered.⁷⁰

I. The Scope of the Duty to Defend

The vast majority of liability-insurance policies require the insurer to defend its insured in lawsuits on a mere showing that the allegations are potentially covered under the policy. Accordingly, the duty to defend is recognized as one of the most important obligations owed by an insurer to its insured. As the California Supreme Court has explained:

Imposition of an immediate duty to defend is necessary to afford the insured what it is entitled to: the full protection of a defense on its behalf.

The insured's desire to secure the right to call on the insurer's superior resources for the defense of third-party claims is, in all likelihood, typically as significant a motive for the purchase of insurance as is the wish to obtain indemnity for possible liability. As a consequence, California courts have been consistently solicitous of insureds' expectations on this score.⁷¹

Determining whether an insurer in fact has a duty to defend requires an initial analysis and comparison of the allegations in the underlying lawsuit with the terms, conditions, exclusions, and endorsements of the policy. That analysis was discussed in *Manzarek v. St.*

*Paul Fire & Marine Insurance Co.*⁷² A founding member of the classic rock music group The Doors sought a defense from his liability insurer against two lawsuits. The underlying lawsuits alleged trademark infringement in connection with the band members' use of The Doors name and logo in promoting a new band. The United States Court of Appeals for the Ninth Circuit analyzed the allegations in the underlying complaints and compared them against the insured's policy. The court concluded that the allegations sounding in trademark infringement and breach of contract were sufficient to trigger the insurer's duty to defend. The court reached this conclusion on the basis that an allegation of injury to reputation at least raised the potential that the claim was covered under the policy's bodily injury coverage.⁷³

Accordingly, an insured must have a working understanding of any applicable insurance policies – and, in particular, whether and to what extent the insurer actually has a potential duty to defend. For example, some policies give the insurer the right to defend, but do not impose upon it the duty to do so. If the policy does not explicitly provide for an insurer's defense obligation, or if the policy only confers on the insurer the right to defend should it elect to do so, then a court may find that no duty to defend exists.⁷⁴ This generally is not something that an insured should be investigating for the first time after a lawsuit has been commenced.

2. The Duty to Pay Defense Costs

In most primary general liability policies, the costs of defense are payable in addition to, or "outside of," the indemnity limits of the policy. The obligation to defend terminates only if and when the primary insurer pays judgments or settlements in an amount sufficient to exhaust the policy limits. As a result, the amount the insurer pays under its defense obligation often far exceeds the policy limits.⁷⁵ Thus, primary general-liability insurance is sometimes referred to as "litigation insurance."⁷⁶ Litigation insurance is particularly valuable where the underlying actions involve mass torts or related product liability claims, where defense costs often equal or exceed the amount of any ultimate liability.

Strategic Point:

Because policy language can vary, insureds should pay close attention to how their particular liability coverage functions with respect to defense costs and policy limits. If defense costs burn policy limits, then it is important for the insured – and its defense counsel – to know it.

3. An Insured's Potential Liability Triggers the Duty to Defend

It is well established nationally that an insurer's duty to defend exists with respect to any suit that "potentially seeks damages within the coverage of the policy."⁷⁷ In fact, courts have recognized that the duty to defend arises whenever the insurer "is informed of [an] accident and learns of even the potential for liability under its policy."⁷⁸ To the extent there is an arguable doubt about the existence of that duty, or the allegations in the complaint otherwise raise a question of fact that potentially impacts the existence and applicability of coverage, the issue must be resolved in favor of the insured, and a duty to defend will be imposed on the insurer.⁷⁹ Additionally, as long as even one claim or cause of action in an

underlying suit is potentially covered, the duty to defend typically will be imposed with respect to the entire action and all of the claims asserted therein.⁸⁰ Moreover, the duty to defend typically continues even after a judgment has been rendered on the covered claims, obligating the insurer to continue defending the insured through appeal.⁸¹

Strategic Point:

Because of the broad scope of a duty to defend, insureds should not accept a liability insurer's offer of a partial or incomplete defense. If the insured is entitled to a defense for even one allegation in an underlying complaint, then it is entitled to a defense for the entire lawsuit.

4. Determining the Potential for Liability

As a general matter, the facts pleaded or asserted are what govern the availability of coverage and the imposition of the duty.⁸² However, even claims or causes of action not specifically alleged in an underlying complaint can ultimately lead to the imposition of the duty. For example, in *Travelers Property Insurance Co. v. Charlotte Russe Holding, Inc.*,⁸³ a California Court of Appeal held that an insurer's duty to defend is not conditioned upon the sufficiency of the underlying pleading in setting forth a particular cause of action, rather "[t]he underlying claims may trigger a duty to defend if the conduct for which the policies provide coverage is charged by implication, as well as by direct accusation."⁸⁴ Most courts recognize that, even if the allegations of a complaint do not trigger the duty to defend, the duty can be triggered by information outside of the complaint, provided that it is reasonably available to the insurer.⁸⁵

An insurer can escape the duty to defend only if there is absolutely no single legal theory or factual allegation in the complaint upon which the insurer may eventually or ultimately be required to indemnify its insured.⁸⁶ In other words, to avoid its defense obligation, the insurer must conclusively negate even the potential for coverage.⁸⁷ Consequently, insurers typically seek a judicial determination as to the existence and scope of the duty based upon facts, circumstances, or extrinsic proof, beyond that which is alleged in the underlying complaint. However, most states do not permit an insurer to escape its duty to defend by pointing to extrinsic evidence showing that the allegations in the complaint are untrue.⁸⁸

Indeed, the duty to defend extends to false, fraudulent, and frivolous claims. It is well established that a liability insurer must defend its insured against a lawsuit regardless of how false or groundless those allegations may ultimately prove to be.⁸⁹ As the California Supreme Court explained:

An insured buys liability insurance in large part to secure a defense against all claims potentially within policy coverage, even frivolous claims unjustly brought If [the claimants'] claims were indeed so insubstantial as not to warrant any damages, [the insurer] should have raised that defense in the underlying action for [the insured's] benefit, rather than in this declaratory relief action to his detriment

By way of illustration, we note that when the underlying action is a sham, the insurer can demur or obtain summary judgment on its insured's behalf and thereby obviate the necessity of further defense. And a declaratory relief action remains available when the facts of the underlying lawsuit are indeed not of the nature and kind covered by the policy.⁹⁰

Accordingly, when served with a complaint or when litigation appears imminent (provided the policy imposes a duty to defend), that duty will be triggered upon a demonstration by the insured that the claims are potentially covered. Such a showing is sufficient to trigger the duty, regardless of the merits (or lack thereof) in the complaint. In other words, the fact that the insured may ultimately be exonerated – or that many, if not all, of the allegations prove to be untrue – is of absolutely no consequence when analyzing the existence of an insurer's duty to defend.⁹¹

Strategic Point:

Insureds and their counsel should remember that liability insurers must defend potentially covered claims even where it is clear that the underlying lawsuit lacks merit in all respects. So long as the underlying complaint includes allegations that, if proven, would potentially trigger the duty to indemnify, the liability insurer must defend the lawsuit. It is entirely immaterial that the insured is likely or even certain to be exonerated of all liability.

5. Duty to Defend When a Conflict of Interest Exists Between the Insurer and Its Insured

As already mentioned, general liability policies provide that the insurer has the right and/or duty to defend. Thus, the insurer will argue that it has the right to control the defense. This is not a problem when the insurer has accepted coverage. When the underlying claim is fully covered, the insurer will bear the entire consequence if judgment is obtained against the insured. As a consequence, the insurer is motivated to provide a sufficient defense, and the insured is fully protected if it fails to do so.

Unfortunately, there are many circumstances where the entire risk of an adverse result in the underlying claim has not been shifted to the insurer. In these circumstances, insureds and their insurance companies often find themselves in conflict on any number of issues regarding management of the defense. This conflict will arise with respect to areas in which the insurer has reserved its rights, and there are additional sources of conflict.

For example, the parties may have a very different view of the quality of the defense that is appropriate. Insurance companies may want to hire an “insurance defense” firm – a firm that has a long-standing relationship with the insurer from whom it receives a significant portion, or sometimes all, of its business.⁹² The insurance defense firm's handling of the underlying claims can be characterized as economical and efficient, or inadequate, depending upon one's standards and perspective. That is not to say that such a firm will not do an adequate job. However, a firm recommended by an insurer needs to be investigated, rather than rejected out of hand, by the insured. Insureds, on the other hand, generally want “the best defense that money can buy,” particularly when the costs of that

defense are borne by the insurer. These differing views as to the quality of the defense often arise when there are non-insurable consequences from the underlying action, such as damage to reputation or interference with future business prospects.

These differences can lead to a variety of disagreements, particularly when an insurer rejects defense expenditures that the insured believes are necessary to protect its interests. Moreover, conflict may arise when the insurer imposes limitations on the work defense counsel can do, which the insured believes will negatively affect the quality of the defense. For example, an insured facing a series of lawsuits in different jurisdictions – such as mass tort or products-liability suits – may believe that national defense counsel is necessary to ensure that the positions and strategies undertaken in each individual action are consistent, and to determine the overall strategy of defense to be followed in those actions. Insurance companies may object to the added expense of hiring national defense counsel.⁹³

The unlimited defense obligation contained in many general liability policies also can create a conflict between the interests of the insurer and those of the insured in the outcome of the underlying claim. It may be in the financial interest of the insurer to reach early settlements – or even suffer early losses – so that the policy’s indemnity limits can be exhausted and the insurer’s defense obligation extinguished. However, the insurer’s interest in promoting quick “nuisance settlements” can be devastating to the insured’s interests in many ways. Not only may there be a portion of the loss not covered by the insurance (e.g., damage to reputation), but word of quick settlements in a few early actions can lead to the filing of many more claims against the insured, as well as increasing the “war chest” available to underlying plaintiffs’ counsel to fund additional claims. Thus, the insurer’s financial interest in exhausting its indemnity limits and exiting the case quickly may be in direct conflict with the insured’s interest in vigorously defending each underlying claim.

For example, in *Emons Industries, Inc. v. Liberty Mutual Insurance Co.*,⁹⁴ the insured was sued in several underlying actions relating to its manufacture and sale of the drug DES. The court found that there were “substantial conflicts of interest” between the insured and the insurer, because the insurer had “a strong interest in reducing the defense costs it must pay by quickly settling these cases irrespective of whether they are reasonable or are within the per claim limit,” while it was in the insured’s best interest to vigorously defend these suits and obtain the smallest possible settlement or judgment. In the face of that conflict, the court enjoined the insurer from interfering with the insured’s choice of counsel.

Strategic Point:

Even if no conflict of interest presently exists, it does not necessarily follow that one will not arise during the course of underlying litigation. If the stakes are high enough, insureds might consider employing “shadow counsel,” a separate law firm that can monitor the conduct of defense counsel and warn the insured if it appears that the insured’s defense is adversely affected by the insurer’s interests.

Insurance companies often respond to notice of an underlying action by agreeing to defend under an ROR. A letter from an insurer in which it agrees to defend while setting forth various defenses to indemnity coverage is commonly referred to as an ROR letter. Often the strength of the insurer’s defenses to coverage will depend upon the facts developed in the

underlying action. Sometimes the Reservation of Rights (ROR) letter also will attempt to preserve the insurer's right to recoup any money spent in defense of the action if the insurer is successful in establishing that there was no indemnity coverage.

Strategic Point:

Although they may have a duty to identify conflicts of interest and disclose them to insureds, liability insurers do not always do so in practice. Consequently, insureds should also be on the lookout for actual and potential conflicts of interest.

The insurer may take a position in the ROR letter that is similar to the position taken by the underlying plaintiffs asserting claims against the insured. As already mentioned, the insurer may reserve its right to deny coverage on the grounds, for example, that the insured expected or intended to cause bodily injury or property damage. Based upon those facts, the insurer will argue that there is no occurrence, or that the claim arose out of a "known loss." These insurance defenses are based upon an alleged factual premise that is similar, if not identical, to what the underlying plaintiffs allege against the insured to support their claims for an intentional tort or for punitive damages. If the insurer seeks to deny coverage based upon a factual argument that is similar to what is asserted against the insured in the underlying claims, there is a conflict of interest between the insured and insurer in the defense of that claim. Under these circumstances, allowing the insurer to control the defense is akin to "sending the fox to guard the chicken coop."

Strategic Point:

One coverage defense that will almost always lead to conflicts of interest is reliance on an exclusion for willful or intentional acts. Such exclusions generally bar coverage only if facts developed in the course of underlying litigation or elsewhere point to the insured's willfulness or intent. Therefore, if a liability insurer reserves the right to argue that an insured's actions were willful or intentional, and the underlying complaint does not allege intentional conduct as the sole basis for any liability, then a conflict of interest with respect to the defense of the underlying action will likely result.

It is also typical for an underlying action to involve both covered and non-covered claims. For example, many product liability claims are based upon negligence (which are generally covered claims), but also include punitive damage claims, or contract and warranty claims (which often are uncovered claims). As discussed, an insurer's defense obligation is triggered whenever the underlying complaint contains allegations that are arguably within the policy coverage; in most states, the law requires that the insurer defend the entire action as long as even one potentially covered claim is at issue. A conflict is thus created to the extent that the insurer's primary interest is to defeat only the *potentially covered* claim—thereby ending its duty to defend and reducing or eliminating its indemnity obligation. The insured's interest, however, is in defeating *all* claims filed against it and, if unsuccessful in defeating the claims, maximizing coverage for any eventual settlement or judgment.

For example, in *Lockwood International, B.V. v. Volm Bag Co.*,⁹⁵ after spending four years defending its insured, the insurer entered into a settlement agreement with the underlying plaintiff, pursuant to which the insurer settled the underlying claim, but only with respect to covered claims. The appellate court, reversing the trial court's entry of final judgment

dismissing the covered claims, recognized that the insurer's actions arose directly from the conflict of interest created when the insurer controlled the defense of both covered and not covered claims:

We have difficulty imagining a more conspicuous betrayal of the insurer's fiduciary duty to its insured than for its lawyers to plot with the insured's adversary a repleading that will enable the adversary to maximize his recovery of uninsured damages from the insured while stripping the insured of its right to a defense by the insurer. The limits of coverage, whether limits on the amount to be indemnified under the policy or, as in the present case, on the type of claims covered by the policy, create a conflict of interest between insurer and insured. The insurer yielded to the conflict, in effect paying its insured's adversary to eliminate the insured's remaining insurance coverage.⁹⁶

The law provides insureds with certain protections when there is a conflict between the interests of the insurer and those of the insured.⁹⁷ For instance, the ethical rules governing an attorney's conduct typically require that defense counsel's sole loyalty be to the insured client, and not to the insurer, merely because the insurer is funding the defense.⁹⁸ Insurance companies contend that this ethical rule solves the problems that arise when there is a conflict of interest between the insurer and the insured.

This "protection," however, may be insufficient. First, such ethical rules are binding only on the attorney, not on the insurer. They may not, for example, prevent the insurer from attempting to interfere with the management of the case through enforcement of its claims-handling guidelines or through a dispute over what is reimbursable under the billing guidelines. Moreover, the defense counsel's ethical rules do not prevent the insurer from initiating settlement discussions directly with an underlying plaintiff, despite the insured's objections.

Second, insurance companies often do not agree that, when there is a conflict, the right to control the defense shifts to the insured. For instance, in a brief filed in Montana related to the use by insurance companies of claims-handling guidelines to control the defense of claims, the insurance companies argued: "[D]efense counsel represents both the insured and the insurer. Insurance companies, like any other client, are thus entitled to define the objectives of the representation."⁹⁹

Third, whatever the rules formally state about the loyalty required of defense counsel, that loyalty can be sorely tested when a significant portion of the attorney's practice depends upon receiving continued defense assignments from the insurer's claims handlers.

As a result, the vast majority of courts addressing the conflict issue have held that, when a conflict of interest exists, the insured must be allowed to select defense counsel and to manage the defense of the underlying action, even in the face of express policy provisions granting the insurer the right to control the defense.¹⁰⁰ If independent counsel is retained, the liability insurer then generally forfeits the right to control the defense of its insured.¹⁰¹ For example, in *Mundry v. Great American Insurance Co.*,¹⁰² the Second Circuit held that under both Connecticut and New York law, an insurer must notify its insured if it disputes

insurance coverage, to allow the insured to exercise its right to “retain independent counsel and to take over the defense, and either settle the case or conduct the defense more vigorously than the insurer would after announcing an intention to disclaim.”

In *San Diego Naval Federal Credit Union v. Cumis Insurance Society, Inc.*,¹⁰³ the defendant appealed a judgment requiring it to pay for independent counsel to defend its insureds. The insurer had retained defense counsel for the underlying action and instructed the attorney to defend all causes of action, including those which sought punitive damages. However, when the insurer subsequently told defense counsel it was denying coverage for any claims seeking punitive damages, and reserving its right to deny coverage on other grounds and on some future date, the insured hired independent counsel.

The insurer initially agreed to fund the payments to the insured’s counsel, but ceased doing so after concluding that a conflict of interest existed. The California Court of Appeal noted that, when an insurer reserves its right to deny coverage under a policy, there may be little commonality of interest between the insurer and the insured.¹⁰⁴ In affirming the trial court’s directive that the defendant pay for its insureds’ independent counsel, the court stated as follows:

[T]he Canons of Ethics impose upon lawyers hired by the insurer an obligation to explain to the insured and the insurer the full implications of joint representation in situations where the insurer has reserved its rights to deny coverage. If the insured does not give an informed consent to continued representation, counsel must cease to represent both. Moreover, in the absence of such consent, where there are divergent interests of the insured and the insurer brought about by the insurer’s reservation of rights based on possible noncoverage under the insurance policy, the insurer must pay the reasonable cost for hiring independent counsel by the insured. The insurer may not compel the insured to surrender control of the litigation.¹⁰⁵

Recently, in *Schaefer v. Elder*,¹⁰⁶ the California Court of Appeal reaffirmed the insured’s absolute right to independent counsel in a conflict situation and affirmatively disqualified the defense counsel previously appointed by the insurer from any further involvement in the case.

As a leading authority on insurance coverage states: “Where the insurer lacks an economic motive for vigorous defense of the insured, or the insurer and insured have conflicting interests, the insurer may not compel the insured to surrender control of the litigation.”¹⁰⁷ Neither the theoretical “sole-client” rule nor the policy provision that the insurer has the “right and duty to defend” the insured justifies exposing the insured to the risk that the insurer will advance its own interests at the expense of the defense to which the insured is entitled.

Strategic Point:

Disputes over the insured's choice of independent counsel and (as will be discussed in more detail) the rates that the insurer deems "reasonable" for independent counsel can be an unwanted distraction during the defense of underlying litigation. For this reason, insureds should ask the insurer to pre-approve a list of preferred independent counsel and their rates should a conflict arise during the policy period. Such foresight can simplify the appointment of independent counsel, should such appointment become necessary.

6. Payment of Defense Costs, Including Billing Guidelines Disputes

Liability insurers are obligated to pay reasonable rates for independent counsel.¹⁰⁸

However, if a liability insurer disputes the reasonableness of fees of independent counsel incurred in connection with the insured's defense, a court (or jury) may be called upon to consider various factors in assessing the reasonableness of fees. The factors that courts often consider include, among others:

- the nature and complexity of the litigation;
- the amount of money at issue;
- the skill and experience required to handle the litigation;
- the attention given to the litigation by defense counsel; and
- the education and experience level of defense counsel.

Similarly, liability insurers have a duty to pay those costs reasonably incurred in connection with the defense of a potentially covered lawsuit. As noted by the court in *Dowdell v. City of Apopka, Florida*,¹⁰⁹ fees and costs are inseparable, holding that "[l]itigation expenses such as supplemental secretarial costs, copying, telephone costs and necessary travel, are integrally related to the work of an attorney and the services for which outlays are made may play a significant role in the ultimate success of litigation"¹¹⁰ Indeed, courts have consistently required liability insurers to pay reasonable costs associated with:

- photocopying;
- postage;
- telephone charges;
- attorney travel costs; and
- computerized legal research.¹¹¹

Liability insurers often attempt to impose billing guidelines on independent counsel in an effort to keep costs down. These billing guidelines may unreasonably attempt to limit or restrict certain types of discovery and legal research. Such restrictions can, for obvious reasons, hamper the effectiveness of independent counsel. As a result, courts and several state bar associations alike have stated that unreasonable billing guidelines, assessed on a case-by-case basis, may violate the insurer's duty to defend if they interfere with the defense and/or impact defense counsel's ethical responsibilities to exercise their independent professional judgment in rendering legal services.¹¹²

Strategic Point:

To avoid issues regarding billing guidelines, insureds should seek to obtain any such guidelines during the underwriting process to determine whether they are, in fact, reasonable. Once the policy has been purchased and the coverage has been bound, the insured may no longer have the bargaining power to make such demands upon its insurer.

7. Insurance Companies' Claim of Recoupment for Defense Costs When There Is a Finding of No Coverage

An issue of disagreement among the states is whether an insurer may recoup the costs paid to the insured to defend certain claims after a court makes a finding of no coverage, particularly when the policy language is ambiguous in this regard. The California courts, for example, have recognized that an insurer may have a right to receive reimbursement with respect to defense costs incurred in defending uncovered claims. In *Buss v. Superior Court*,¹¹³ the court reaffirmed that insurance carriers have a duty to defend an entire action as long as a single claim is potentially covered.¹¹⁴ However, the court also recognized that an insurer has the right to seek reimbursement of defense costs and fees paid with respect to uncovered claims. This right, however, is severely limited. The *Buss* court ruled that, as to "claims that are at least potentially covered, [a carrier] may not seek reimbursement for defense costs."¹¹⁵ It also ruled that the only defense costs recoverable by an insurer are those "that can be allocated *solely* to the claims that are not even potentially covered."¹¹⁶

A number of courts that have recently addressed the "reimbursement" issue have soundly rejected an insurer's effort to avoid its duty to pay for defense fees incurred by insureds, even after a court rules that there is no duty to defend. Indeed, "[i]n contrast to *Buss* and the courts relying on its rationale, the 'most recent decisions'" reject the *Buss* approach.¹¹⁷ One commentator makes clear that the views expressed by these most recent decisions reflect the actual "majority" view.¹¹⁸ Courts disallowing claims for reimbursement generally reason that an insured is not unjustly enriched when an insurer agrees to defend against uncovered claims under a reservation of rights.¹¹⁹

For example, in *General Agents Insurance Co. of America, Inc. v. Midwest Sporting Goods Co.*,¹²⁰ the court flatly rejected the insurer's argument under *Buss* that the insured would be unjustly enriched if the court did not find a right of "reimbursement":

We agree that when an insurer tenders a defense or pays defense costs pursuant to a reservation of rights, the insurer is protecting itself at least as much as it is protecting its insured. Thus, we cannot say that an insured is unjustly enriched when its insurer tenders a defense to protect its own interests, even if it is later determined that the insurer did not owe a defense. Certainly, if an insurer wishes to retain its right to seek reimbursement of defense costs in the event it later is determined that the underlying claim is not covered by the policy, the insurer is free to include such a term in its insurance contract. Absent such a provision in the policy, however, an

insurer cannot later attempt to amend the policy by including the right to reimbursement in its reservation of rights letter.¹²¹

Most recently, in *National Surety Corp. v. Immunex Corp.*,¹²² the Washington Supreme Court followed the recent trend articulated in *General Agents*, and refused to follow the outmoded reasoning of *Buss* and its progeny: “More recently, however, courts deciding in the first instance whether Insurers can recover defense costs have generally concluded that they cannot. These decisions provide valuable guidance.”¹²³ Then, after analyzing the arguments both for and against recoupment, the Court rejected the “all reward, no risk” proposition espoused in *Buss*, and held that “insurers may not seek to recoup defense costs incurred under a reservation of rights defense while the insurer's duty to defend is uncertain. Accordingly, National Surety may be held responsible for the reasonable defense costs incurred by its insured until the trial court determined National Surety had no duty to defend.”¹²⁴

In *American & Foreign Insurance Co. v. Jerry's Sports Center, Inc.*,¹²⁵ the court reached the same conclusion. In that action, the insurers agreed to defend the insured in an underlying lawsuit pursuant to the reservation of a claimed right to seek reimbursement. In a declaratory judgment action, the court concluded that (1) there was no duty to defend and (2) the insurer was entitled to “reimbursement” of previously expended defense costs. The Appellate Court subsequently reversed, finding that the insurer was not entitled to reimbursement despite having reserved its right to recoup defense costs. On appeal to the Pennsylvania Supreme court, the insurer argued that Pennsylvania should follow the *Buss* approach and order the insured to reimburse the defense costs arguing that the insured had been unjustly enriched by the insurer's coverage of defense costs for claims that were subsequently determined to not be within the coverage provided by the policy.¹²⁶ The Pennsylvania Supreme Court, however, rejected this theory. Instead, the Court elected to follow the “growing number of courts” expressly rejecting *Buss* and adopting *General Agents*.¹²⁷ Specifically, the Court held “that an insurer may not obtain reimbursement of defense costs for a claim for which a court later determines there was no duty to defend, even where the insurer attempted to claim a right to reimbursement in a series of reservation of rights letters.”¹²⁸

Other courts have reached the same result as *General Agents*, *Westchester*, and *American & Foreign*.¹²⁹

D. Common Issues Under CGL Policies

I. Trigger of Coverage

“Trigger of coverage” means the event that takes place during the policy period that requires the policy to respond. For example, as noted, a “claims-made” policy must respond if the claim is made against the policyholder during the policy period. Many claims-made policies also require that the claim must be reported to the insurance company during the policy period. These are sometimes referred to as “double-anchor” policies. Other types of policies or particular coverages specify triggering provisions. For instance, CGL policies are triggered by bodily injury or property damage happening during the

policy period, or, in the case of personal injury and advertising liability coverage, a wrongful act taking place during the policy period.

“Trigger” is most often litigated in “latent” injury claims submitted under the bodily injury or property damage coverage of CGL policies.¹³⁰ Although the policy is triggered if the alleged bodily injury or property damage takes place during the policy period, “latent” claims often involve an unknown ongoing condition, injury, or damage. For instance, environmental claims often involve a single claimant (usually a governmental entity), but the environmental damage is usually widespread and not detected until years after the activity that caused the problem. Moreover, damage from contamination can continue to accumulate before it is detected. Perhaps the most important characteristic of latent injury claims is that, in addition to being typically difficult to evaluate, they usually involve substantial damages. The issue of “trigger” addresses the question of what policies that cover property damage must respond to such a claim.

Strategic Point:

There are four general theories of “trigger”:

- Exposure;
- Manifestation;
- Injury-in-fact; and
- Continuous.

Generally, the continuous trigger is the most favorable for a policyholder, but every situation is factually unique and must be analyzed independently.

The CGL policy language providing for the trigger of coverage is generally a combination of the insuring agreement and the definitions of bodily injury and property damage. Typical definitions provide that:

“bodily injury” means bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom;

* * *

“property damage” means (1) physical injury to or destruction of tangible property which occurs during the policy period including the loss of use thereof at any time resulting therefrom, or (2) loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period.¹³¹

The references to “during the policy period” in the definitions of bodily injury and property damage provide the trigger of coverage.

In the late 1970s and early 1980s, litigation concerning asbestos-related bodily injury claims resulted in significant disputes over the proper trigger of coverage between policyholder and insurer, as well as among insurers themselves. Insurance companies took different positions on the issue, arguing that: (1) only policies on the risk at the time when the claimant was exposed to asbestos were triggered; (2) only policies on the risk at manifestation or discovery of the asbestos disease were triggered; or (3) only policies on the risk when the injury could have been discovered were triggered. Not surprisingly, the trigger position advocated by each insurance company tended to minimize its exposure, either in the context of the particular claim presented or in the context of the insurance company's entire book of business.

These coverage-limiting theories were rejected in *Keene Corp. v. Insurance Co. of North America*,¹³² which held that all policies on the risk from first asbestos exposure to manifestation of the disease were triggered, because the asbestos caused bodily injury in each policy year during that period. The *Keene* theory is referred to as the "continuous trigger." It imposes a presumption that latent injury claims trigger multiple policies in successive years because of ongoing continuous injury, but allows the insurance company to prove, as a matter of fact, that injury or damage did not take place during any particular policy period.

Closely related to the *Keene* decision is the "injury-in-fact trigger" adopted by *American Home Products Corp. v. Liberty Mutual Insurance Co.*¹³³ Under this theory, the policyholder has the burden of proving, as a matter of fact, that injury or damage took place during each policy period.

The injury-in-fact and continuous trigger theories often lead to the same result, particularly in toxic tort cases; all policies from first exposure to manifestation are triggered. The difference is one of burden of proof: whether the policyholder has the burden of proving injury during each policy period ("injury-in-fact trigger") or whether the burden shifts to the insurance company to disprove injury in its particular year or years ("continuous trigger"). Although most jurisdictions appear to be moving towards either an injury-in-fact¹³⁴ or continuous trigger¹³⁵ of coverage, there still are exceptions, and some courts have applied an exposure¹³⁶ or manifestation¹³⁷ trigger to certain types of claims.

Strategic Point:

One area relating to trigger of coverage that currently causes disputes in coverage litigation is how to determine trigger in the mass-tort context, where coverage often is sought for thousands, or tens of thousands, of claims. An inquiry into each claim effectively precludes coverage because of the cost and procedural difficulties inherent in such an inquiry. Accordingly, courts have allowed the factual issues surrounding trigger of coverage to be resolved using exemplar claims,¹³⁸ a statistical sample,¹³⁹ the testimony of a series of independent experts that provides an opinion of a particular fact,¹⁴⁰ or summary testimony of a fact witness who has reviewed all or a statistically valid sample of the universe of claims.¹⁴¹ In-house counsel (who are involved with defending underlying claims as well as pursuing coverage) should gather the facts on the timing of injury or damage at an early stage in the litigations so that the most beneficial trigger theory can be pursued in the most efficient manner.

Strategic Point:

How do you determine trigger if the underlying action settled with no determination as to the existence or timing of any injury or damage? This is an issue of particular significance in underlying mass-tort litigation because the policyholder often contends that no bodily injury or property damage actually occurred. If the underlying case is settled, there may be no factual determination as to whether, much less when, bodily injury or property damage actually took place.¹⁴² In many jurisdictions, the policyholder need establish only that it had potential liability based upon the facts known at the time of the settlement, and that the settlement was reasonable.¹⁴³

The case of *Dow Corning Corp. v. Continental Casualty Co.*,¹⁴⁴ which concerned insurance coverage for breast implant liabilities, demonstrates this point. All of the parties in the coverage litigation, including the court, believed that the implants did not cause bodily injury. Dow Corning settled the underlying claims because, regardless of the medical evidence, Dow Corning believed it could lose its case on the underlying claims if it were tried by a jury. Nonetheless, the court held that, despite the absence of actual bodily injury, the underlying implant claims still could trigger coverage.

The insurers argued that Dow Corning was required to prove when actual injury occurred for each underlying plaintiff in order to receive coverage. Despite their protestations to the contrary, the insurers were merely attempting to re-litigate the underlying breast implant claims. The insurers even offered opinions from experts regarding the underlying plaintiffs' claims of a progressive, continuous disease process beginning upon implantation, which had nothing to do with the reason for imposition of liability against Dow Corning in the underlying actions. Under these circumstances, the trial court properly concluded that, for coverage purposes, injury occurred beginning on the date of implant and progressed continuously thereafter.¹⁴⁵

2. Number of Occurrences

The insuring agreements in general-liability, umbrella, and excess policies generally provide coverage for bodily injury and property damage resulting from an "occurrence." Generally, that term is defined as follows:

"Occurrence" means an accident, including continuous or repeated exposure to conditions, which results in personal injury, property damage or advertising injury neither expected nor intended from the standpoint of the insured.¹⁴⁶

That standard definition of "occurrence" was introduced in 1966. Prior to that time, liability insurance policies typically provided coverage for liabilities arising from "accidents" during the policy period. The change in the standard policy language from "accident" to "occurrence" required that the term "occurrence" be interpreted "from the standpoint of the insured," not from the standpoint of the injured person. Insurance provided by other forms of coverage, such as first-party property policies, also can be provided on an occurrence basis.

The question of the number of occurrences at issue under a policy can affect:

- the number of deductibles or SIRs the policyholder must pay;
- the number of per occurrence limits the policy must pay; and
- whether the loss will be borne principally by the primary layer of coverage (in the case of multiple occurrences) or shifted to the excess layers (in the case of one occurrence).

The number of occurrences also may impact whether it is appropriate to allocate the entire loss over many years (if occurrence is considered synonymous with loss) and whether a “non-cumulation clause” (present in some policies) applies, requiring that all loss be paid from a single policy. Accordingly, a determination of the number of occurrences can have an enormous impact on which layer of insurance responds to a claim and for how much.

Strategic Point:

There is no simple answer to whether a finding of a single occurrence or multiple occurrences is more beneficial to a policyholder. Because the number-of-occurrences issue affects many aspects of how the policy works, and often affects how the loss is spread among multiple insurance companies, it is an issue on which insurance companies and policyholders take different positions, depending upon how their interests are affected in a particular case. It also can be an intensely factual issue that must be determined on a case-by-case basis. This allows for creativity in the dispute over the number of occurrences, in addition to diversity (or inconsistency) in the results.

Strategic Point:

Insurance companies that principally write primary coverage are likely to argue that multiple claims arise from a single occurrence. If this argument is accepted, the insurance company can confine its payments to a single occurrence limit and cut off its duty to pay defense costs. Insurance companies that principally write excess coverage tend to argue that each claim is a separate occurrence, in an attempt to confine the loss to the primary layer. Insurance companies that write both primary and excess coverage may take inconsistent positions depending upon their exposure on a particular claim. Knowledgeable policyholders and their counsel can and should exploit these differences, arguing that the language is imprecise and, therefore, ambiguous.

The “number of occurrence” issue is an area in which counsel should identify the facts in the underlying case that may impact on the amount of coverage. At an early stage, counsel must determine whether the policyholder is benefited by a single or multiple occurrence finding, and present a coverage-maximizing position to the insurers.

The vast majority of courts hold that the number of occurrences will be determined by the “the cause or causes of damage, rather than . . . the number of individual claims or injuries.”¹⁴⁷ Cases that have considered the change from accident-based to occurrence-based coverage have recognized that, in determining the “cause” of the loss, the analysis must focus on the policyholder’s conduct and not the resulting individual injury.¹⁴⁸ Nevertheless, a minority of cases look to the effect, or resulting injury, to determine the number of occurrences.¹⁴⁹

Courts applying the cause test may, depending upon the circumstances of the particular case, reach different conclusions on the number of occurrences. In *Metropolitan Life Insurance Co. v. Aetna Casualty & Surety Co.*,¹⁵⁰ for example, the issue was the number of occurrences that were involved in thousands of asbestos claims arising out of an alleged failure to warn of asbestos dangers. Although the court adopted a cause test, it found that the cause of the alleged bodily injury was each claimant's exposure to asbestos, not the alleged conduct of the policyholder. Thus, it held that each claim presented a separate occurrence. A Third Circuit case declined to follow the reasoning in *Metropolitan Life*, and held that the asbestos liabilities arose out of a single occurrence.¹⁵¹

In *Uniroyal, Inc. v. Home Insurance Co.*,¹⁵² the court held that hundreds of thousands of Vietnam veterans' exposures to Agent Orange, as a result of multiple sprayings, all arose from a single occurrence: the policyholder's delivery of Agent Orange to the military.¹⁵³ The *Uniroyal* court rejected the insurance company's argument that the number of occurrences should be determined "by reference to the time and place of the ultimate injury," and instead looked at the underlying conduct for which the policyholder was being held liable.¹⁵⁴

Strategic Point:

The difficulty and uncertainty surrounding the number-of-occurrences issue is demonstrated by Dow Chemical Company's pursuit of insurance coverage on two separate claims. In *Dow Chemical Co. v. Associated Indemnity Corp.*,¹⁵⁵ a federal court in Michigan held that multiple claims based upon the sale of a building product should be treated as multiple occurrences. The same court, a few years later, interpreting the same policies in a subsequent case, *Associated Indemnity Corp. v. Dow Chemical Co.*,¹⁵⁶ held that the sale of defective resin used to make pipes that failed, resulting in multiple claims of property damage, constituted a single occurrence. The only way to harmonize these apparently conflicting decisions is through the court's belief that the policy language was ambiguous. Accordingly, in each case, the court interpreted the language in a manner that favored Dow Chemical for that particular claim.

Strategic Point:

An issue related to the number of occurrences involves interpretation of the so-called "batch" clause, which some policies also include in their definition of "occurrence." Such a provision may (there are different versions) provide:

For purposes of determining the limit of the company's liability and the retained limit, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

This type of provision is referred to as a "batch" clause because it is intended to combine, or "batch," all related claims emanating from substantially the same conduct into a single occurrence. Under a batch clause, only one occurrence arises when the insured's conduct creates conditions leading to similar injuries and multiple claimants.

Disputes over the meaning of a batch clause may arise with respect to the interpretation of the phrase “exposure to substantially the same general conditions.” Parties have argued that claims should be “batched”:

- only when multiple exposures are suffered by the same injured party;
- only when similar exposures are suffered by multiple bodily injury claimants (e.g., in the case of asbestos);¹⁵⁷
- when multiple waste dumpings at a single environmental site cause property damage;¹⁵⁸
- when multiple claims arise out of the sale of the same product;¹⁵⁹ or
- when multiple claims arise out of a similar course of conduct.¹⁶⁰

Strategic Point:

Albeit in the context of a first-party claim, the Second Circuit’s decision on the number-of-occurrences issue in *World Trade Center Properties LLC v. Hartford Fire Insurance Co.*,¹⁶¹ provides insight into the way that courts will analyze the number of occurrences issue. The issue there was whether the planes colliding into the two towers of the World Trade Center constitute one or two occurrences under various definitions of the term “occurrence.” A single occurrence vs. a multiple occurrence has a significant financial impact upon Silverstein, the lessee of the World Trade Center, because a single occurrence made available only \$3.5 billion in total per occurrence limits, whereas a finding of two occurrences made available up to \$7 billion in insurance proceeds. The Court held that, with respect to the language in certain policies, the terrorist attack was a single occurrence. With respect to other policies with a different and ambiguous definition of occurrence, the Court remanded for a jury trial. The jury subsequently found two occurrences with respect to many of the policies at issue. Thus, the number-of-occurrences issue was resolved independently for each layer of the tower of insurance.

3. Allocation

The issue of allocation refers generally to how a large loss will be shared by multiple insurance policies that are triggered. The loss may be spread horizontally over multiple triggered policies or may be assigned to a single triggered policy year. Traditional general liability policy language defines an insurance company’s obligation as follows:

[The insurance companies will pay] on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage

Policyholders frequently argue that, once a policy year is “triggered” by injury or property damage during the policy period, each of the individual insurance policies in that year must indemnify the policyholder for “all sums” for which the policyholder becomes liable,

subject to each policy's limits, regardless of when the bodily injury or property damage occurred. "All sums" allocation divides the loss among policies "vertically." Each triggered policy is liable for "all sums" until the policy's limits are exhausted, and then the policies that sit above the exhausted policy are called upon in the same manner. After the policyholder is paid for its loss, the paying insurance companies then may be able to pursue contribution claims against the other non-paying insurance companies whose policies are triggered in different policy years.

Insurance companies, in contrast, generally argue for "pro rata allocation" or "pro rata by time on the risk allocation," which may take multiple forms but generally refers to dividing a loss "horizontally" among all triggered policy periods, with each insurance company paying only a share of the policyholder's total damages. When courts adopt proration, they tend to rely upon general principles of equity, rather than policy language, ruling that, given the facts in a particular case, it is fair to spread the loss over several years rather than require one insurer or one policy year with liability for "all sums."¹⁶²

Cases at the level of state supreme courts are divided between these two theories of allocation.¹⁶³ The highest courts of California, Delaware, Indiana, Illinois, Ohio, Pennsylvania, Texas, Wisconsin, and Washington,¹⁶⁴ as well as several federal courts,¹⁶⁵ have refused to imply a pro rata limitation in policies where no express limitation exists. For example, the Washington Supreme Court, in *American National Fire Insurance Co. v. B & L Trucking & Construction Co.*,¹⁶⁶ rejected an insurance company's argument for proration based upon purported "fairness" considerations, emphasizing that the policy language controls:

[The insurance company] drafted the policy language; it cannot now argue its own drafting is unfair. Further, because insurance policies are considered contracts, the policy language, and not public policy, controls. We will not add language to the policy that the insurance company did not include. Instead, [the insurance company] agreed to pay "all sums" arising out of an "occurrence" which, by its own policy definition, may take place over a period of time.

Other state supreme or appellate courts have adopted pro rata allocation.¹⁶⁷ These cases often reached their results based upon considerations of the particular equities in their cases, not upon the policy language. Thus, if a court is to adopt pro rata allocation, it must weigh the particular equitable factors in its case before deciding to what time period or periods a loss should be assigned.

For instance, in *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*,¹⁶⁸ the Second Circuit, applying a pro rata allocation to injuries from asbestos, refused to allocate to years beyond 1985, although injuries continued after that date, because of the factual finding that the policyholder had not voluntarily assumed the risk of asbestos liability after 1985, when no coverage for asbestos liability was available in the marketplace.¹⁶⁹ Stonewall thus stands for the proposition that proration to the policyholder is appropriate only if there is a finding (i) that liability insurance was available and (ii) that the policyholder consciously decided to underinsure or assume the risk for that period. Similarly, the court in *State of N.Y. Ins. Dep't*

Liquidation Bureau v. Generali Ins. Co.,¹⁷⁰ found no basis to require proration to the insured for years in which there was no coverage.

On the other hand, in *Plastics Engineering Co. v. Liberty Mutual Ins. Co.*,¹⁷¹ the Wisconsin Supreme Court adopted the all sums allocation method. The insurer contended that it had no obligation to pay toward injury that took place outside its policy periods and sought a declaration that Plastics Engineering was obligated to make a pro rata contribution for the periods when it was uninsured. The court concluded that once a policy is triggered, the insurer is required to defend the lawsuit in its entirety, and was responsible for “all sums” up to policy limits, regardless of whether the compensation was for damage that occurred “partly before and partly within the policy period.”¹⁷² In addition, “[g]iven Liberty Mutual’s definition of ‘occurrence,’ which includes ‘continuous or repeated exposure,’ Liberty Mutual contemplated a long-lasting occurrence that could give rise to bodily injury over an extended period of time; nonetheless, it failed to specifically include a pro rata clause.”¹⁷³

Strategic Point:

As noted, the particular language of the policies at issue affects the allocation issue. In *Viking Pump, Inc. v. Century Indemnity Co.*,¹⁷⁴ the court held that certain “non-cumulation” clauses in the policies were inconsistent with a pro rata approach. The Delaware Court of Chancery ruled that non-cumulation provisions permit the policyholder to recover all of its defense costs and liabilities under an all sums allocation method, even if the controlling state law would require the application of pro rata allocation in the absence of the non-cumulation provisions. The court reached its decision under the law of New York, which generally follows pro rata allocation for continuous injury claims. Accordingly, policyholders in pro rata jurisdictions, or jurisdictions that have not decided the issue, should determine whether their general liability policies include non-cumulation provisions or incorporate such provisions by reference from other policies. If so, the policyholder may have a viable claim for all sums coverage, even if the applicable state law mandates application of a different allocation method for policies that do not include non-cumulation provisions.

The generally controlling state law may also be inapplicable under the particular facts of a case, such as where the policyholder is uninsured for large periods during the risk. In *State of New York Insurance Department, Liquidation Bureau v. Generali Ins. Co.*,¹⁷⁵ also decided under New York law, the court refused to allocate defense and indemnity costs incurred based solely on the insurer’s “time on the risk.” Instead, the court allocated defense costs evenly between the insurers, and it allocated the indemnity amounts between the insurers based upon their respective time on the risk without any amount being allocated to the policyholder for uninsured periods. The insured was sued for damages caused by exposure to lead paint, but was uninsured for much of the risk period. After one insurer failed to defend and a second insurer became insolvent, the state liquidation bureau bore almost the entire cost of the defense and the insured’s share of the settlement. The court noted that New York courts have used “time-on-the-risk” to prorate insurers’ respective obligations.¹⁷⁶ However, no authority, prior to *Generali*, involved settlements pertaining to risks extending over uninsured periods or supported strict pro rata allocation when there are lapses in coverage.¹⁷⁷ Thus, where the first insurer unjustifiably failed to defend and the liquidation

bureau covered lengthy periods for which there was no applicable coverage, the court's allocation formula was "manifestly fair and should stand."¹⁷⁸

Policyholders also support the "all sums" theory of allocation by citing to the language related to the issue of exhaustion of underlying policies. Excess policies contain a "Schedule of Underlying Insurance" specifying the particular policies that must be satisfied before the relevant policy must pay. The schedule typically refers only to the policies directly "underneath" the excess policy for that particular policy year. The "Schedule of Underlying Insurance" does not require that all other available insurance across all horizontal policy periods be exhausted before an excess policy must respond. It requires only vertical exhaustion.

In *Westport Ins. Corp. v. Appleton Papers, Inc.*,¹⁷⁹ the court held that the "all sums" language of the insurance policies permitted the insured to select policies in a particular year to respond first to the insured's CERCLA liability under a "vertical exhaustion" method. Under recently decided Wisconsin law requiring all sums allocation,¹⁸⁰ the court held that horizontal exhaustion, like pro rata allocation, was inconsistent with the policy language requiring indemnification for all sums for which the insured is liable as a result of an occurrence during that policy year.¹⁸¹ The court noted that "[h]orizontal exhaustion would create as many layers of additional litigation as there are layers of policies."¹⁸²

a. Coverage for Consequential Damages Because of Bodily Injury or Property Damage

General liability policies provide insurance for claims seeking damages "because of" bodily injury or property damage. Insurance companies often argue that the damages sought in the underlying case are not in direct compensation for the bodily injuries or property damage, but rather are compensation for economic loss that is not covered. There is no exclusion in general liability policies for so-called "economic loss." Policyholders should object when the insurance companies seek to deny coverage on this basis. The pertinent question under the standard policy language is whether the damages sought are "because of" bodily injury or property damage.

Strategic Point:

Policyholders must remember that the standard commercial general-liability policy language does not only cover damages awarded for bodily injury or property damage. The policy broadly covers all damages that are "because of" bodily injury or property damage, including consequential losses.

First, whether damages are "because of" bodily injury or property damage is a question of causation. Causation issues traditionally are questions of fact, which should be resolved by the jury or the finder of fact at trial. Policyholders should be wary of insurers attempting to characterize factual issues to the court as legal ones under the so-called economic loss doctrine.

Second, courts have held that economic losses that flow from bodily injury or property damage¹⁸³ can be covered under a standard form comprehensive general liability policy. For example, in *Reinsurance Ass'n of Minnesota v. Timmer*,¹⁸⁴ the court held that, although

lost profits or other consequential damages do not constitute property damage, the insurance company in question was obligated to defend and indemnify its policyholder against claims for lost profits based upon physical injuries to the cows of the underlying plaintiff farmer:

[The insurance company] argues that the district court erred [in finding coverage] because the [underlying plaintiffs] seek damages for economic losses, including lost profits, which are not “property damage” under the policy It is true that the term “property damage” does not include economic losses As noted by the district court, however, it appears that the specific language of the RAM policy enlarges coverage to include damages in addition to “property damage.” Coverage “L” states: “We pay***all sums for which an insured is liable by law because of***property damage***.”

(Emphasis omitted and emphasis added). Thus, the district court concluded, coverage is not limited to property damage, but includes other damages that flow from property damage.

In *Aetna Casualty & Surety Co. v. Pintlar Corp.*,¹⁸⁵ the Ninth Circuit held that costs incurred to clean up environmental contamination were covered under a liability policy, as those costs were “imposed ‘because of . . . property damage.’”¹⁸⁶ The court expressly rejected the argument that cleanup costs were not recoverable under the policy because they did not compensate directly for the property damage. The environmental contamination itself constituted the property damage that triggered coverage under the policies. “The sums the insureds are legally obligated to pay the EPA are because of that contamination.”¹⁸⁷ The court looked to the “plain meaning” of the policies and found that “cleanup costs constitute damages incurred ‘because of . . . property damage’ as that term is used in the policies.”¹⁸⁸

In *Charles F. Evans Co. v. Zurich Insurance Co.*,¹⁸⁹ a contractor was sued by a building owner after a subcontractor built a roof that leaked. The leaks caused the building owner’s employees to suffer bodily injuries when they slipped and fell on the wet floor. The claims in the underlying action were not brought by the employees, but instead by the building owner who suffered economic losses arising from lost employee time at work and the costs of workers’ compensation claims. The court concluded that allegations of “consequential” harm resulting from bodily injury triggered coverage because the policy’s insuring agreement was broadly written to cover liability for all damages awarded “because of” bodily injury.

The policy, providing coverage for “those sums that the insured becomes legally obligated to pay as damages because of ‘bodily injury,’” is at least ambiguous as to whether the claims in question are covered, and must be construed against the insurance company. The claims arising from slip-and-fall injuries thus allege “facts or grounds which bring the action within the protection purchased,” and “trigger [the insurance company’s] duty to defend [the policyholder].”¹⁹⁰

In *Marley Orchard Corp. v. Travelers Indemnity Co.*,¹⁹¹ the policyholder installed an irrigation system in the underlying claimant’s orchard that failed. The property damage was the stress to the claimant’s trees. In the insurance coverage action, the court found that the

“policy language covers consequential damages, i.e., damages causally related to the property damage.”¹⁹² Because the costs of modifying the irrigation system were reasonably related to the stressed trees (i.e., the property damage), those consequential damages were covered by the policy as damages because of property damage.¹⁹³

Strategic Point:

Business losses may be covered by commercial general liability policies if those losses are causally connected to bodily injury or property damage. There is no “economic loss” rule that bars such recovery. For instance, courts routinely have found that business losses are covered damages.¹⁹⁴

A line of cases arising from litigation by municipalities against handgun manufacturers supports the broad interpretation of the “because of” language. In *Scottsdale Insurance Co. v. National Shooting Sports Found.*,¹⁹⁵ municipalities alleged that they suffered damages, such as increased costs of police and emergency medical care, arising out of National Shooting Sports Foundation’s (“NSSF”) marketing of handguns. NSSF’s insurance company brought a declaratory judgment action against NSSF, seeking a declaration that the underlying claims were not covered because they did “not allege damages ‘because of’ an injury to body or property.”¹⁹⁶ The court rejected that argument and stated:

The complaint alleges that, because of the bodily injuries to its citizens, the City of New Orleans had to incur additional costs. This allegation is arguably covered by the policies. We reject Scottsdale’s contention that the “because of bodily injury” provision requires the plaintiff seeking damages to be the one who suffered the bodily injury. At best, the provision is ambiguous and should be construed against Scottsdale. Scottsdale could have explicitly limited coverage to “claims for damages incurred because of bodily injury to the plaintiff seeking damages,” but it did not.

Id.; see also *SIG Arms Inc. v. Employers Ins.*, 122 F. Supp. 2d 255, 260 (D.N.H. 2000); *Beretta, U.S.A., Corp. v. Fed. Ins. Co.*, 117 F. Supp. 2d 489 (D. Md. 2000), *aff’d*, 17 Fed. App. 250 (4th Cir. 2001). See also *Spirco Envtl., Inc. v. Am. Int’l Specialty Lines Ins. Co.*, 555 F.3d 637, 645-46 (8th Cir. 2009) (“there is no language in the policy excluding economic loss or economic harm from the definition of ‘Loss;’” “the indemnification award for the surety’s fees was ‘reasonably apparent’ and a ‘natural and reasonable incident or consequence’ of the underlying property damage claim.”); *Wausau Underwriters Ins. Co. v. United Plastics Group, Inc.*, 512 F.3d 953, 958 (7th Cir. 2008) (“Tort liability for . . . consequential damages is limited by the principles of tort causation, but whatever liability the court imposed in a tort suit would, as consequential damages from tortuously inflicted property damage, be within the ‘because of property damage’ coverage of the Comprehensive General Liability policy.”).

4. Additional Insured Coverage

In many instances, a third party will be entitled to coverage under an insurance policy that was purchased by another entity. Common situations where this arises include contractors designated as “additional insureds” under a subcontractor’s insurance policy, the lessor or owner of real property that is designated as an “additional insured” under a tenant’s insurance policy, or a vendor that is added as an “additional insured” under a policy purchased by the manufacturer of goods.

Typically, an “additional insured” is added to a policy via an endorsement that amends the “Who Is an Insured” section of the policy. The designation as an “additional insured” typically is limited in purpose based upon the nature of the relationship between the Named Insured on the policy and the party being added to the policy.

The added party often already has indemnification rights with regard to the Named Insured based upon the business relationship between the parties. The “additional insured” endorsement makes clear that the added party not only has indemnification rights with regard to the Named Insured, but also has rights to recovery under the Named Insured’s policy.

Strategic Point:

A party added as an additional insured is entitled to an immediate defense under the policy, rather than being indemnified for defense costs at a later date by the named insured. Defense costs also should be paid to the “additional insured” in addition to, and not out of, the policy limits.

Additional insured coverage is different from the contractual liability coverage afforded the named insured to help fund its contractual obligation to indemnify a third party.

Contractual liability coverage protects the named insured; it does not extend insurance coverage to the third party. Additional insured coverage protects the third party, and allows that third party a direct right under the insurance policy. Moreover, the rights of additional insureds are determined based upon the policy language, not the language of any contract between the additional insured and the named insured.

For example, when a landlord leases premises to the tenant, the lease may provide that the tenant agrees to indemnify the landlord for any liabilities arising out of the leased premises. To provide a measure of security for the tenant’s indemnification obligation, the lease can be defined as an “insured contract” that falls within an exception to the contractual liability exclusion. As a result, if the landlord incurs any liability arising out of the leased premises, the insurance company will pay on behalf of the named insured tenant the monies owed to the landlord under the indemnification agreement contained in the lease. Further, if the landlord is named as an “additional insured” under the tenant’s insurance policy, and if the landlord is sued because of an injury on the premises, then the landlord can obtain a defense and indemnity directly from the tenant’s insurance policy.

Strategic Point:

Insurers will frequently try to narrow the breadth of the coverage afforded to additional insureds. Some commercial general liability policies contain limiting language that restricts the protection provided to an additional insured. Careful analysis of the policy language is needed to determine whether additional insured coverage will provide protection from the relevant business risks.

For instance, insurance companies may argue that additional insured status covers only the vicarious liability that the additional insured may have for the negligence of the named insured. For instance, a recent case, *Raymond Corp. v. National Union Fire Insurance Co.*,¹⁹⁷ held that a vendor's endorsement adding a vendor as an additional insured only extended coverage for liabilities arising out of defects in the named insured's products, and did not extend coverage for the vendor's own negligence. Two other cases, however, reached a result directly contrary to *Raymond*: *Pep Boys v. Cigna Indemnity Insurance Co.*,¹⁹⁸ and *Sportmart, Inc. v. Daisy Manufacturing Co.*,¹⁹⁹. Some new additional insured endorsements will limit coverage only "with respect to liability . . . caused in whole or in part by [the named insured's] acts or omissions or the acts or omissions of those acting on behalf [of the named insured] in the performance of the ongoing operations [of the named insured] for the additional insured."²⁰⁰ The new language tries to limit the additional insured's coverage to vicarious liability, and may not provide insurance when the additional insured's independent act of negligence is the sole cause of the loss.

Strategic Point:

Insurers have also attempted to use the terms of the contractual relationship between a named insured and an additional insured as a basis to limit the additional insured coverage provided by a liability policy.²⁰¹ The insurance policy is a separate integrated contract, and only the terms and conditions of the policy should govern.

Situations where additional insured coverage is implicated almost inevitably involve multiple lines of coverage because the additional insured is likely to have its own insurance policies where it is the named insured. Courts generally look to "other insurance" provisions in liability policies when determining the priority of payment between concurrent and overlapping insurance policies.

Other insurance clauses often provide that the insurance policy is excess to any other insurance available to an insured. If competing "other insurance" clauses cancel each other out, a court generally requires each insurance policy, or each line of insurance, to share the liability on a proportional basis.²⁰² Alternatively, a court may hold that the later-issued policy should pay first, on the assumption that the insurance companies who sold the later policy were in a position to make their insurance excess of earlier policies, if that was intended. Additionally, policyholders should consider *Argonaut Ins. Co. v. U.S. Fire Ins. Co.*,²⁰³; *United Nat'l Ins. Co. v. Lumbermens Mut. Cas. Co.*,²⁰⁴ advancing arguments based upon the purpose behind additional insured coverage, as it would be reasonable to find that specific insurance coverage for liabilities arising from a designated business relationship must pay first. Taking advantage of additional insured coverage in this way preserves a policyholder's own insurance limits in case it needs them in the future.

The most recent ISO insurance forms appear to take this factor in consideration, noting that the policy is excess to “[a]ny other primary insurance available to you covering liability for damages arising out of the premises or operations, or the products and completed operations, for which you have been added as an additional insured.”²⁰⁵ There is not a large amount of case law deciding this issue. Careful evaluation of the facts of each case, the language of the policy at issue, and the law of the governing jurisdiction will be needed in order to determine how payment will be divided between insurers with concurrent and overlapping coverage obligations.

E. Issues Concerning Coverage for Environmental Liabilities

Environmental claims present some of the most complex insurance coverage issues. Many of the areas of difficulty already discussed in this InfoPAK will be involved when an environmental claim is presented. For instance, because environmental property damage takes place over time, policies in many consecutive policy years will be triggered.²⁰⁶ In addition, environmental property damage often triggers policies sold many years, if not decades, earlier, requiring counsel to find or reconstruct “lost policies.” Because many policy periods are triggered, the problems associated with allocating a loss over multiple policies also will be implicated.²⁰⁷ There also may be a dispute over how to determine the number of occurrences presented by an environmental property damage claim.²⁰⁸ However, many insurance disputes are unique to environmental property damage claims. Moreover, as can be seen from the following discussion, the law on these issues varies by jurisdiction. Thus, the choice of law that will be applied often is critical in determining whether the policyholder will be able to obtain insurance.

I. Whether a “PRP” Letter Is a “Suit”

As explained, standard CGL policies require a primary insurance company to defend any “suit” seeking “damages.” However, a party typically is notified that it is the subject of an environmental proceeding commenced by the federal Environmental Protection Agency (“EPA”) under CERCLA, or by a state agency under an equivalent state statute, when such agency sends a potentially responsible party (“PRP”) letter advising the party that it may be liable to investigate and remediate a contaminated site.

Therefore, a threshold issue is whether a PRP letter is the equivalent of a “suit.” The clear majority of courts addressing this issue have determined that a PRP letter constitutes a “suit” as that term is used in the standard CGL policy.²⁰⁹ In doing so, those courts have noted that “suit” is not a defined term, and therefore should be understood under a functional, less rigid definition. These courts have emphasized that a PRP letter commences an administrative action, that the letter carries immediate and severe implication for the PRP, that a PRP’s actual liability is established at this stage, and that judicial review of the administrative proceeding is appellate in nature and greatly circumscribed. As one court held, “The consequences of the EPA letter [are] so substantially equivalent to the commencement of a lawsuit that a duty to defend arises immediately It would be naïve to characterize the [PRP] letter as a request for voluntary action. [The policyholder] had no practical choice other than to respond actively to the letter.”²¹⁰

On the other hand, a minority of courts have interpreted “suit” rigidly to only include the commencement of a judicial proceeding. Those courts consequently have held that a PRP letter is not a suit that implicates an insurer’s duty to defend.²¹¹

2. Are Cleanup Costs and/or Injunctive Relief “Damages”?

A number of courts have addressed the question of whether the costs of remediating contaminated property (i.e., “cleanup costs”) are “damages” within the meaning both of the duty to defend and the duty to indemnify. A minority of courts, relying primarily on traditional distinctions between actions at law and actions at equity, have held that remedial costs are equitable in nature, and thus are not “damages.”²¹² Most courts, however, view the meaning of “damages” from the perspective of a lay policyholder, and hold that the costs of cleaning up a contaminated site constitute “damages” within the meaning of a CGL policy.²¹³

A related question is whether the cost of complying with other forms of injunctive relief, including orders to modify existing facilities to reduce future contamination, are covered as “damages.” This issue is particularly relevant in connection with EPA proceedings under the Clean Air Act, where much of the relief typically sought by the EPA involves such prospective relief. Courts are again split with some characterizing such claims as not seeking damages while others have held that such claims at least trigger an insurer’s duty to defend.²¹⁴

3. Categorization of Investigation Costs

Prior to the cleanup of an environmental site, a policyholder typically investigates a site in phases, either voluntarily as part of its defense or at the request of the EPA or state agency. In the initial phase, which may involve multiple investigations, the extent of contamination is determined. This investigation often is termed a remedial investigation (RI). In the second phase, which is typically called a feasibility study (FS) a plan of remediation is developed. Together, both phases are often referred to as “RI/FS.” Because primary CGL policies typically provide that covered “defense costs” are paid in addition to (and thus do not erode) those policies’ limits of liability, the question of whether both or either of the RI/FS should be considered “defense costs” greatly impacts the amount of insurance available to the policyholder. To the extent that some of the RI/FS is considered “defense costs,” those costs will not reduce, and therefore not exhaust, policy limits, thereby leaving additional policy limits to pay for the ultimate remediation of the contaminated property.

Courts are divided not only on the issue of which, if any, investigation costs should be treated as “defense costs,” but also on the proper methodology for making this decision. For example, in *Hi-Mill Manufacturing Co. v. Aetna Casualty & Surety Co.*,²¹⁵ the court determined that all RI/FS costs were covered defense costs, including those reimbursed to the EPA, because they were necessary costs in order for the policyholder “to participate in the development of the administrative record” and thereby “‘put forth a theory that [it was] not liable’ for contamination.”²¹⁶ In *American Bumper & Manufacturing Co. v. Hartford Fire Insurance Co.*,²¹⁷ the Michigan Supreme Court modified the standard from *Hi-Mill* by drawing a distinction between (1) costs incurred to defeat or limit the scope of liability,

(2) costs incurred to remediate or make a party whole, and (3) costs incurred as part of normal business operations. Under the *American Bumper* analysis, “RI/FS are defense costs, rather than indemnification costs, if they were expended in order to disprove or limit the scope of liability for cleanup under the CERCLA and if they do not represent an ordinary cost of doing business.”²¹⁸ The California Supreme Court placed even more restrictions on coverage for investigation costs in *Aerojet-General Corp. v. Transport Indemnity Co.*²¹⁹. In *Aerojet*, the court adopted a similar standard to that used in *American Bumper*, but added that only RI/FS conducted by the insured “within the temporal limits of the insurer’s duty to defend” qualifies as defense costs.²²⁰ Finally, in *Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*,²²¹ the Northern District of New York has held that RI/FS costs must be allocated between those expenses “primarily attributable to remedial investigations” (which are defense costs), and those expenses “primarily attributable to feasibility studies” (which are to be considered indemnity).

Different jurisdictions use different methodologies and require a number of different prerequisites for coverage. Nevertheless, policyholders can typically maximize their recoveries by characterizing their investigation costs aimed at defeating or limiting the scope of its liability, while simultaneously minimizing any feasibility or normal business expenses. To the extent possible, policyholders should perform any RI/FS after providing notice to their insurer and before any resolution of the underlying proceeding or litigation.

4. Natural Resource Damages

In addition to the “cleanup costs” often sought in environmental actions, environmental defendants may also face claims — often very large claims — seeking recovery of “natural resource damages” (“NRD”), including the “loss of use” of allegedly contaminated natural resources. In the case of *New Jersey Department of Environmental Protection v. Exxon Mobil Corp.*,²²² the Appellate Division of the New Jersey Superior Court held that companies can be held strictly liable under the Spill Act for these types of “loss of use” damages. In a time of constrained budgets, NRD claims are a potential source of new funding for many state environmental protection agencies. Accordingly, it is expected that NRD claims will continue to become more prevalent, especially for situations like the *Deepwater Horizon* oil spill in the Gulf of Mexico, where BP agreed to provide \$1 billion toward natural resource damages restoration projects.

In addition to the potentially large damages awards available, coverage lawsuits involving NRD are significant because they can raise unique coverage issues, including the scope of prior releases that were negotiated in connection with earlier “clean-up” proceedings. To date, NRD coverage issues have been lightly litigated. Although insurance companies are likely to raise their usual – and often rejected – litany of coverage defenses, policyholders should still assume, in the first instance, that coverage remains available for NRD lawsuits. In many instances, NRD claims fall even more naturally within the scope of coverage of CGL policies than cases involving remedial cleanup costs. For example, although considerable case law holds that cleanup costs constitute insured “damages” within the meaning of CGL policies,²²³ the “loss of use” component of NRD claims closely track the typical definition of “property damage” in the standard-form CGL policy. Finally, while insurers routinely assert that releases from prior insurance settlements extend to include claims for NRD that may be asserted in a subsequent litigation, such arguments are often

misplaced. Many releases in earlier settlements are narrowly tailored to include only known claims or cleanup costs. Therefore, companies should not assume that they do not have any coverage for NRD claims simply because they have entered into prior coverage settlements with their insurers.

5. The Pollution Exclusion

Beginning in 1970, the insurance industry adopted an exclusion that precluded coverage for environmental contamination, unless the discharge of pollutants was “sudden and accidental” (i.e., the so-called “pollution exclusion”). This standard pollution exclusion provides that:

This insurance does not apply to:

Bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapor, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste material or other irritant, contaminants . . . ; but this exclusion does not apply if such discharge . . . is sudden and accidental.

The most significant litigated issue raised by the pollution exclusion is whether “sudden” only means “abrupt,” — and thus excludes gradual pollution from coverage under the policy, as the insurance companies argue — or whether “sudden” also can mean “unexpected,” in which case unexpected gradual contamination is not excluded. The insurance companies’ argument focuses on the “common meaning” of sudden, while policyholders rely both on alternative dictionary definitions and representations about the exclusion’s meaning that the insurance industry made to state regulators when seeking approval for the exclusion.²²⁴ Courts have split fairly evenly on this issue.²²⁵

In response to this conflicting case law, beginning in the mid-1980s, the insurance industry developed the so-called “absolute” pollution exclusion, which precludes coverage for contamination, with a narrow, “hostile fire” exception. This revised standard pollution exclusion provides that:

This insurance does not apply to:

(1) “Bodily injury” or “property damage” arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of “pollutants”:

(a) At or from any premises, site or location which is or was at any time owned or occupied by, or rented or loaned to, any insured. However, this subparagraph does not apply to:

* * *

(iii) “Bodily injury” or “property damage” arising out of heat, smoke or fumes from a “hostile fire.”

With the adoption of the so-called “absolute” pollution exclusion, a new battleground issue began to emerge: What constitutes a “pollution” claim subject to the exclusion? Insurance companies, for example, have attempted to extend the exclusion’s reach beyond traditional environmental pollution claims to such areas as injuries from carbon monoxide fumes inside a residence,²²⁶ lead-paint exposure,²²⁷ and worker exposure to chemicals or fumes in the workplace.²²⁸

Some courts have held that the absolute pollution exclusion bars coverage for such claims.²²⁹ Nevertheless, an increasing number of courts have refused to expand the reach of the exclusion beyond “traditional” environmental claims.²³⁰ In large measure, that refusal is based on the breadth of the exclusion’s wording. As the Seventh Circuit noted in *Pipefitters Welfare Educational Fund v. Westchester Fire Insurance Co.*, “[w]ithout some limiting principle, the pollution exclusion clause would extend far beyond its intended scope, and lead to some absurd results.”²³¹

In addition, courts have recognized that both the drafting history of the pollution exclusion, and its use of environmental “terms of art” such as “discharge, dispersal, release or escape” — terms and phrases drawn directly from environmental legislation and regulations — demonstrate that “the industry’s intention was to exclude only environmental pollution damage from coverage.”²³² For example, Maryland’s highest court in 2006 firmly established that the pollution exclusion applies only to traditional environmental liability claims, and did not bar coverage for personal injury suits arising from workplace exposure to manganese welding fumes.²³³ The court examined the historical purpose of the pollution exclusion, and its “development and refinement over time” to support its conclusion that “the insurance industry intended the pollution exclusion to apply only to environmental pollution.”²³⁴

Finally, certain courts around the country have rejected application of any pollution exclusion to claims arising out of an insured’s principal or primary product unless that product is specifically identified as a pollutant. By finding the exclusions ambiguous, these courts often have refused to characterize a company’s main product as a pollutant because to do so would render much of the policy’s coverage illusory.²³⁵

6. The Owned Property Exclusion

The owned property exclusion precludes coverage for damage to the policyholder’s own property, which presumably would be covered by first-party coverage. This exclusion generally provides that:

This insurance does not apply to:

- Property owned or occupied by or rented to the insured;
- Property used by the insured; or
- Property in the care, custody, or control of the insured or as to which the insured is for any purpose exercising physical control.

Based on this language, many CGL policies do not provide coverage for environmental remediation unless the relevant contamination has migrated onto, or is threatening, a neighboring third party’s property.

This exclusion raises two significant issues. Since environmental contamination often affects groundwater, one issue is whether the property owner or the state owns the groundwater under the contaminated property. In many states, the state owns groundwater, and, thus, groundwater contamination is not implicated by the exclusion.²³⁶ However, even in states where the groundwater is owned by the property owner, courts have recognized that groundwater typically flows off site, thereby causes property damage to neighboring property, and have not enforced the owned property exclusion. *Allstate Ins. Co. v. Dana Corp.*²³⁷; *Rubenstein v. Royal Ins. Co. of Am.*²³⁸

The second issue is whether remedial action by a policyholder on its own property to prevent imminent contamination to offsite property is subject to the exclusion. Many courts have held that such activity is not subject to the exclusion.²³⁹ New Jersey courts agree, but only if contamination already has occurred to offsite property. *State v. Signo Trading Int'l, Inc.*²⁴⁰

7. Exclusion for Intentional Damage

Among other things, insurance covers the unintended results of intentional conduct. In CGL policies, the language embodying this concept generally is found in the definition of “occurrence” included in the standard form policy at least since 1966. Pursuant to that definition, “occurrence” means:

An accident including injurious exposure to conditions which results, during the policy period, in bodily injury neither expected nor intended from the standpoint of the insured.²⁴¹

Most courts hold that this language does not bar coverage for intentional acts unless the resulting damage was also intentional. As Judge (later Justice) Cardozo wrote in 1921, in finding the policyholder entitled to insurance: “A driver turns for a moment to the wrong side of the road, in the belief that the path is clear and deviation safe. The act of deviation is willful, not the collision supervening.” *Messersmith v. Am. Fid. Co.*²⁴²

Two major issues arise from the “occurrence” definition. The first is whether the issue is analyzed from an objective, “reasonable person” standard, in which case industry-wide knowledge may be relevant, or whether the issue is judged only from the policyholder’s subjective intent. Not surprisingly, insurance companies typically prefer the objective test, while policyholders prefer the subjective test. Most courts have applied a subjective test.²⁴³ In support, many of those courts have emphasized the “from the standpoint of the insured” language in the standard definition of “occurrence.”²⁴⁴

The second issue is which party (i.e., the policyholder or the insurer) bears the burden of proof of establishing that the damages were “expected or intended.” Because the “expected or intended” language serves as a limitation on coverage, many courts have found the placement of the clause in the “occurrence” definition irrelevant and instead treated the relevant language as an exclusion.²⁴⁵ By doing so, those courts have placed the burden of proof for establishing the requisite intent on the insurance company. Other courts, however, apply a rigid analysis and place the burden of proof on the policyholder.²⁴⁶

The intentional damage issue is inherently factual, and thus not often subject to resolution by summary judgment motion. Moreover, expert testimony often is required to demonstrate the cause of existing contamination, as well as the state of knowledge about the hazards of contamination at the time of the release of the contaminants.

8. Coverage for Global Climate Change Claims

For coverage to exist under CGL policies for lawsuits alleging climate change damages, a policyholder must establish that such suits allege an “occurrence” causing “property damage” during the policy period. As noted, “occurrence” is typically defined to be “an accident, including continuous and repeated exposure to conditions.”²⁴⁷ Therefore, the continuing release of carbon dioxide and other greenhouse gases that lead to rising temperatures could be considered an “occurrence.” However, in *AES Corp. v. Steadfast Insurance Co.*,²⁴⁸ the Supreme Court of Virginia interpreted the allegations of *Native Village of Kivalina v. ExxonMobil Corp.* as only alleging harm that was either intentional or a “natural and probable consequence of” intentional acts.²⁴⁹ As a result, the court held that the plaintiffs had failed to allege a covered “occurrence” under applicable Virginia law. While *Steadfast* is the first case to analyze coverage for a public nuisance climate change lawsuit, many other states have favorably interpreted the definition of “occurrence” to provide coverage for the unintended results of intentional acts.²⁵⁰

In addition to identifying an occurrence, CGL policies typically require that there be property damage or bodily injury during the policy period to trigger coverage for that policy.²⁵¹ Arguably, the global climate change injury is a continuous and progressive injury for which coverage for every policy period in which carbon dioxide buildup and resulting temperature change occurred will be triggered. Indeed, the global climate change litigation today typically alleges that there is substantial impact on property as part of a process that began decades ago. For example, there are suggestions that weather patterns—including the historic 2005 hurricane season (e.g., hurricanes Katrina, Rita, and Wilma)—and their resulting damage are a direct result of a continuous multi-year process.

a. Personal Injury Coverage for Global Climate Change Lawsuits

As noted, most of the pending climate change lawsuits focus on public nuisance as the theory of recovery. Besides implicating a CGL policy’s “property damage” provisions, such lawsuits also may be covered under the policy’s coverage for “personal injury,” which was incorporated into the standard CGL policy form on a uniform basis starting in the mid-1960s.²⁵²

There are significant differences between personal injury coverage and the coverage afforded for bodily injury or property damage. To begin with, “personal injury,” in the context of insurance, “is a term of art that describes coverage for certain enumerated offenses that are spelled out in the policy.”²⁵³ Unlike bodily injury or property damage coverage, the key to determining the applicability of personal injury coverage “is not . . . the nature of the damages sought in the action against the insured, but . . . the *nature of the claims* made against the insured in that action.”²⁵⁴

The particular personal injury “offenses” that may afford coverage for climate change liability claims is coverage for “wrongful entry or eviction, or other invasion of the right of private occupancy.”²⁵⁵ Wrongful entry or violation of occupancy coverage applies to rights applicable to real property interests.²⁵⁶ Nuisance claims, including public nuisance claims, are torts that relate to the interference with real property rights.²⁵⁷ Thus, courts have specifically found that “personal injury coverage” applies to claims sounding in trespass and nuisance.²⁵⁸ Similarly, a physical invasion or even a non-invasive form of interference with the enjoyment of property can fall within coverage for “other invasion of the right of private occupancy.”²⁵⁹

Which policy period is triggered is also calculated differently when considering personal injury coverage. “Offense” coverage is triggered by the wrongful act taking place during the policy period, not the resulting injury taking place during the policy period. Personal injury insurance covers “offenses committed” during the policy period, even if the injury or damage takes place later.²⁶⁰ Thus, emission of the carbon dioxide and other greenhouse gases would arguably be the triggering offense for successive policies even if climate change occurs later.

Additionally, personal injury coverage for “offenses” also provides coverage throughout the period of potential nuisance or trespass. In the context of contamination, a “continuing trespass” or a “continuing nuisance” may be deemed to take place from the first contamination by a hazardous substance through abatement.²⁶¹ An “offense” for coverage purposes should be deemed to be taking place as long as the offending substance or action is alleged to be present.

b. Product Liability Coverage for Global Climate Change Lawsuits

Many global climate change lawsuits allege liability because of the emission of carbon dioxide and other greenhouse gases from manufactured products. Such allegations may implicate the separate policy limits available in most CGL policies for “product liability.” This coverage typically extends to “goods or products . . . manufactured, sold, handled, distributed or disposed of by [the insured].”²⁶² Therefore, coverage extends only to products that are no longer in the possession of the insured.²⁶³

The primary benefit of the “product liability” coverage is the availability of a second set of policy limits for global climate change lawsuits. In addition, many insurance policies’ pollution exclusions only apply where the alleged pollution is released from property owned or operated by the insured. Therefore, such exclusions would not be applicable to claims alleging that the policyholder was liable for emissions from a product no longer in its possession.

Finally, the formality of the claim brought against the insured does not dictate or exclude the availability of coverage, particularly in connection with the duty to defend. The fact that a global climate change complaint chooses public nuisance as the legal theory being pursued does not affect the possibility of products coverage. The facts pled or asserted are what govern the availability of coverage.²⁶⁴ What is important is a comparison to the facts

and the scope of coverage. If any of the allegations fit within the product liability coverage, that coverage may apply, without regard to the theory of liability or the causation alleged.²⁶⁵

c. Umbrella Policies

Umbrella policies, as the name implies, were designed to provide additional, broader coverage than that provided by an insured's primary CGL policies.²⁶⁶ And, when they provide coverage that is broader, umbrella policies actually serve as an insured's first line of defense. As one court noted,

[u]mbrella policies differ from standard excess insurance policies in that they are designed to fill gaps in coverage both vertically (by providing excess coverage) and horizontally (by providing primary coverage) Moreover, this interpretation is consonant with the broader function served by umbrella policies — extending coverage even to unanticipated 'gaps.'"²⁶⁷

Westview Associates v. Guaranty National Insurance Co.,²⁶⁸ provides an example of the gap filling with respect to pollution coverage. In that case, the primary policy contained a specific exclusion regarding lead paint, while the umbrella policy contained only a general pollution exclusion. The umbrella policy was required to cover the liability for lead paint in a form of gap filling. The obligation of an umbrella insurance carrier to respond if a primary policy will not can also be seen in the decision by the California Supreme Court obligating umbrella insurers to defend administrative claims when the underlying policies provided for defense only of the formal "suits." *Powerine Oil Co. v. Superior Court*.²⁶⁹

Because their wording may not be standardized, and because they may also provide broader coverage to which a duty to defend may attach, umbrella policies are an important potential asset. Each policy must be examined to determine if it is potentially unique, and possibly broader coverage language gives rise to a separate duty to defend that may not be found in any other policy.

d. Environmental or Pollution Liability Policies

Another source of possible coverage for environmental liabilities may be specialized Pollution Legal Liability ("PLL") coverage purchased by the insured. These policies are sold for an additional (often high) premium, and may be limited to one or more specific sites enumerated in the policy. Because of variations in policy terms and conditions, the specific language of these policies must be consulted to determine the scope of coverage provided.

PLL insurance can cover third-party and first-party risks. In other words, these policies can cover a company's liabilities based on pollution claims made by third parties, as well as costs that the company itself incurs for cleanup or similar costs. Some examples of insurance that can be provided under a PLL policy are coverage for bodily injury, property damage, or cleanup costs that happen both on and off the insured company's property. Emergency response costs can also be included. This coverage can also be referred to as Environmental Impairment Liability ("EIL") insurance. PLL policies are typically written on a "claims-made" basis, meaning that they are not triggered by an injury or offense during

the policy period like typical CGL coverage. Instead, coverage is applicable when a potentially covered claim is actually made against the insured, seeking some form of monetary relief.

These specialized policies also are often limited by a retroactive date that excludes coverage for pollution that occurs before that date. Thus, historical contamination that existed prior to the retroactive date, even if first discovered during the policy period, may not be covered by such policies.

F. Coverage for Product Liability Claims

In the past several decades, products liability lawsuits have increased exponentially. The most well-known example involves asbestos claims. While it is unlikely that any future products liability lawsuits will have the long-term financial and legal impact of asbestos claims, new products liability claims are being filed every day, and CGL insurance policies have been marketed specifically to provide coverage for such claims.

Other high-profile recalls relate to bacteria and other contaminants found in food and beverage. Examples over the past few years include:

- An outbreak of E. coli tied to bagged spinach, causing the deaths of several people;
- Sickness caused by salmonella-tainted tomatoes in 21 states and Canada;
- Warnings issued by a juice provider when frozen strawberries were discovered to have been contaminated by *Listeria monocytogens*;
- A salmonella outbreak in October 2006, which sickened 200 people in 18 states; and
- A March 2007 recall of allegedly contaminated dog food and cat food, which reportedly resulted in the deaths and illnesses of more than 100 pets in multiple states.

The following sections identify some of the coverage issues pertinent to products liability claims.

I. Coverage Territory

Some CGL policies contain coverage territory provisions limiting the territorial scope of coverage. Such provisions come into play when products manufactured or sold in one country cause harm in another country. Domestic CGL policies often require an occurrence to take place in the coverage territory (typically including the United States and globally) “if the damage or injury arises out of . . . products made or sold in the United States.” A Seventh Circuit Court of Appeals case involved a designer and marketer of toys seeking coverage for US class action lawsuits arising out of allegations of lead-paint contamination in the components.²⁷⁰ The court considered all of the factors leading to the injury, including where the injury was inflicted. The court held that customers were ultimately exposed to lead paint in the United States, and then denied coverage on the grounds that the domestic coverage contained a lead-paint exclusion.

2. Expected or Intended Harm Exclusion

CGL policies do not afford coverage for liabilities arising out of third-party damage or injuries that were “expected or intended” by the policyholder.²⁷¹ In raising this defense, insurers usually align themselves with the underlying claimants who typically allege that the policyholder acted with knowledge of the harmful effects of its product.

In *Sherwin-Williams Co. v. Certain Underwriters at Lloyd’s London*, a case involving lead poisoning, the court held:

Although Sherwin-Williams allegedly acted with a knowledge of the risks posed by lead-based paint, [the claimant] does not allege that the company acted with the intent of injuring consumers or their children. If knowledge of certain risks posed by a product were sufficient to infer intent by a manufacturer to injure consumers, then no manufacturer would ever be able to seek coverage from an insurer because every product has certain known dangers and risks.²⁷²

Strategic Point:

CGL policies cover the unintended results of even intentional acts. Mere knowledge of a risk is not the same as knowledge of a loss. If it were, such knowledge of potential risks would undermine the entire rationale for purchasing insurance.

3. Contractual Liability Exclusion

In product liability matters involving multiple defendants, claims for indemnification and contribution can greatly complicate an insured’s access to insurance coverage. CGL policies typically contain an exclusion that precludes coverage for bodily injury and property damage for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. The contractual liability exclusion has a built-in exception for an “insured contract.” An insured contract provision is basically an indemnification provision in which the insured assumes the tort liability of another party.

Although an agreement might fall within the definition of insured contract, issues have arisen about whether the insured is entitled to coverage for the indemnified parties’ defense costs.²⁷³ Moreover, cross-indemnities among parties can create an issue about which parties’ insurers are required to pay any liabilities first. In all events, it is important to take steps to preserve any indemnification or contribution rights to avoid impairing any subrogation rights the insurers might have.

4. “Business Risk” Exclusions

In products liability matters, insurers frequently raise a set of exclusions found in CGL policies known as the “business risk exclusions.” These include the “your product” exclusion, the “impaired property” exclusion, and the “sistership” exclusion. In cases involving injury to persons or physical damage to property, however, these exclusions should have a limited impact unless there is a product recall or claims among the defendants related to the removal of allegedly defective parts.

a. The “Your Product” Exclusion

The “Your Product” exclusion bars coverage for “property damage” to “your product arising out of it or any part of it.” This exclusion has been interpreted to bar coverage for the repair and replacement of a defective product itself but not injury to persons or other property.²⁷⁴ In *Reliance National Insurance Co. v. Hatfield*, for instance, a court applied the “your product” exclusion to bar coverage for defective airplane engines.²⁷⁵ The court, however, acknowledged that this might not have been the result had the engines caused damage to third-party property.

In *L. D. Schreiber Cheese Co. v. Standard Milk Co.*,²⁷⁶ a wholesaler sought payment from the insured producer for costs incurred when the wholesaler was required to test for the presence of contaminants in its entire inventory of cheese. A small percentage of the cheese was contaminated; the rest was sold. The court held that the commingling of the uncontaminated cheese with the contaminated cheese constituted an accident separate from the contamination itself, and thus the “good” cheese was not the excluded “product” out of which the accident arose.²⁷⁷

b. The Impaired Property Exclusion

The impaired product exclusion, which concerns defective products incorporated into another product, has been limited to situations that do not involve physical injury or property damage.²⁷⁸ The impaired product exclusion states as follows:

“Property damage” to “impaired property” or property that has not been physically injured, arising out of:

- (1) A defect, deficiency, inadequacy or dangerous condition in “your product” or “Your work”: or
- (2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to “your product” or “your work” after it has been put to its intended use.

This exclusion only applies to damage to “impaired property,” which is defined as:

“Tangible property, other than “your property” or “your work,” that cannot be used or is less useful because:

(a) it incorporates “your product” or “your work” that is known or thought to be defective, deficient, inadequate or dangerous...

if such property can be restored to use by the repair, replacement, adjustment or removal of “your product” or “your work” or your fulfilling the terms of the contract or agreement.

By its terms, the impaired property exclusion does not apply when a product causes damages to other property. Nor, by its terms, does it apply to bar coverage for bodily injury. Also, the impaired property exclusion contains a built-in exception, providing that it does not apply damage arising out of “sudden and accidental physical injury to ‘your product’ or ‘your work’ after it has been put to its intended use.”

c. The Sistership Exclusion

The “sistership exclusion” bars coverage for the repair or replacement of a product when it has been withdrawn from the market. A typical sistership exclusion may exclude:

“Damages” claimed for any loss, cost or expense incurred by the insured or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal, or disposal of:

- “Your Product;”
- “Your Work;” or
- “Impaired Property.”

If such product, work, or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy, or dangerous condition in it.

The sistership exclusion should not apply unless there is a withdrawal of a policyholder’s products, and it does not exclude coverage for the actual damage caused by the product.²⁷⁹

Despite its seeming breadth, the trend is for courts to find that the sistership exclusion does not bar all coverage when there is a product recall. Many courts have interpreted the sistership exclusion to bar coverage only for preventative measures that are undertaken before actual harm is discovered. In the words of one court, “[t]he ‘product recall’ or ‘sistership’ exclusion ‘operates to exclude coverage for the cost of “preventative or curative action” when the insured withdraws a product in situations in which a danger is merely apprehended.’ ‘It does not, however, operate to exclude coverage for actual damage caused by the very product giving rise to such an apprehension.’” *Centillum Commc’ns, Inc. v. Atl. Mut. Ins. Co.*²⁸⁰

5. Product Recall Insurance

Businesses facing allegations of product contamination or product defects often are under significant pressure to quickly recall a product and avoid negative publicity. Such recalls can be extremely expensive. For this reason, insurers developed product impairment lines of insurance. These coverages generally reimburse an insured for expenditures incurred in connection with a determination to recall a product or in responding to a request for a recall.

Though not as common as more traditional lines, product recall coverage has been gaining in popularity, and thus has increasingly been offered by insurers.²⁸¹ Wider availability should encourage companies with potential recall liability to consider this coverage, but companies also must be attuned to potential coverage disputes.

Product recall insurance covers costs that may not be covered by more typical CGL and first-party policies. A standard form for product recall insurance has been approved by the ISO.²⁸² It provides two independent coverages.²⁸³ First, it provides coverage for “product withdrawal expenses” incurred by the insured because of a “product withdrawal.” “Product withdrawal” is defined as:

The recall or withdrawal from the market; or from use by any other person or organization; of “your products,” or products which contain “your products,” because of known or suspected “defects” in “your product,” or known or suspected “product tampering,” which has caused or is reasonably expected to cause “bodily injury” or physical injury to tangible property other than “your product.”²⁸⁴

“Product withdrawal expenses” are a specifically enumerated and limited list of expenses including the cost of replacing or repairing the product; the cost of notification; overtime costs to non-salaried employees; costs of transportation and storage space; and disposal costs of the insured’s products or products containing the insured’s products that cannot be reused.²⁸⁵

There are also exclusions about which the insured should be aware. For example, coverage is excluded for the failure of products to accomplish their intended purpose. Also excluded are the costs of regaining goodwill, market share, revenue or profit, or the costs of redesigning the insured’s product. Damages, fines, or penalties imposed upon the insured may also be excluded.

By comparison, “Product Withdrawal Liability” coverage operates similarly to a typical liability policy given that the insurer must pay “sums that the insured becomes legally obligated to pay as damages” for product withdrawal expenses. The insurer also must defend the insured against any suits seeking such damages. This coverage is limited by many of the same exclusions as the Product Recall Expense coverage, but also contains other exclusions specific to the liability context. As in a standard form CGL policy, damages claimed for loss of use of other property are excluded. The two policies’ exclusions therefore could exclude damages for loss of use and, in combination, create a potential hole in coverage for damages claimed for loss of use of property. To ultimately ensure full

coverage for product recalls, insureds must understand not only what is covered and excluded from a product recall policy, but also how the policy interacts with other policies in the company's insurance program.

Finally, damages claimed for bodily injury and property damage are excluded from the Product Withdrawal Liability coverage. This exclusion demonstrates that Product Withdrawal Liability coverage is not designed to cover the same type of liability as typical CGL policies. Rather, the Product Withdrawal Liability coverage targets expenses appurtenant to the withdrawal of a product and not, for example, the negative health effects of a defective beverage upon a consumer.

G. Coverage for Advertising Liability and Intellectual Property Claims

I. CGL Insurance Coverage

One valuable component of standard-form CGL insurance is the coverage afforded for risks that fall within "advertising injury" coverage. In addition to the well-known coverage provided for "bodily injury" and "property damage," a standard form CGL policy also insures against "personal and advertising injury" that offers protection for a variety of "offenses" including a number of commercial actions and business torts. This coverage often is overlooked by insureds who face commercial disputes and business tort claims. It should not be. For example, companies have successfully obtained coverage for a variety of commercial disputes under the "advertising injury" coverage, including alleged:

- Antitrust violations²⁸⁶
- Violations of Robinson-Patman Act²⁸⁷
- Discriminatory pricing practices²⁸⁸
- Disparagement by implication²⁸⁹
- Lanham act violations²⁹⁰
- Patent infringement,²⁹¹ and inducing patent infringement²⁹²
- Selling counterfeit products²⁹³
- Selling cloned products that allegedly dilute brand strength²⁹⁴
- Trade dress infringement²⁹⁵
- Tortious interference²⁹⁶
- Unfair competition²⁹⁷

2. Relevant CGL Policy Provisions

CGL policies typically obligate insurance carriers to pay “those sums that the insured becomes legally obligated to pay as damages because of ‘personal and advertising injury.’”²⁹⁸ The policies also typically obligate carriers to “defend any ‘suit’ seeking those damages.”²⁹⁹ Id. “Personal and advertising injury” is defined in standard forms to include the “offenses” of “[o]ral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services,” “[t]he use of another’s advertising idea in [the insured’s] advertisement,” and “[i]nfringing upon another’s copyright, trade dress or slogan in [the insured’s] advertisement.”³⁰⁰ Some CGL policies also define “personal injury” to include “discrimination,”³⁰¹ “piracy,”³⁰² and “unfair competition”³⁰³ within the covered “offenses.” A standard definition of “advertisement” is:

1. “Advertisement” means a notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters. For the purposes of this definition:
 - a. Notices that are published include material placed on the Internet or on similar electronic means of communication; and
 - b. Regarding websites, only that part of a website that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement.³⁰⁴

The standard form CGL contains exclusions applicable to “personal and advertising liability” that seek to limit the breadth of coverage. The exclusions, however, are subject to exceptions that preserve important protections for insureds. For example, “personal and advertising injury” coverage typically contains:

- An exclusion for Contractual Liability, but the exclusion does not apply to “liability for damages that the insured would have in the absence of the contract or agreement”:
- An exclusion for “Breach of Contract,” but the exclusion does not apply to claims of “an implied contract to use another’s advertising idea in your ‘advertisement’;” and
- An exclusion for “Infringement of Copyright, Patent, Trademark or Trade Secret,” but the exclusion does not apply to infringement in the policyholder’s “‘advertisement’, of copyright, trade dress or slogan.”

Insurers may seek to deny coverage by citing exclusions in the “personal and advertising injury” coverage section. As with all exclusions, however, the insurer bears the burden of proving the exclusion, which must be narrowly construed. Policyholders should scrutinize insurers’ purported reliance on an exclusion, and review the exceptions that may preserve the insurance coverage notwithstanding the exclusions.

3. Specific Intellectual Property Issues

a. Coverage for Alleged Trademark and Trade Dress Infringement

A majority of jurisdictions have found coverage for trademark, trade dress, or service mark infringement because such claims qualify as the covered offense of “misappropriation of advertising ideas,” “the use of another’s advertising ideas in your ‘advertisement’” or “infringement of . . . title or slogan.”³⁰⁵ The causal nexus requirement is met because trademarks either are used in advertising, or are advertisements themselves; therefore, the use of an allegedly infringing trademark or trade dress will necessarily occur in the course of the policyholder’s advertising activities.³⁰⁶

Several courts have held that a trademark infringement claim falls under the “infringement of title” offense found in the coverage in many policies.³⁰⁷ The word “title” is undefined in the policies, so courts often apply a dictionary definition, finding that title may mean a “distinguishing name” or “a descriptive or distinction appellation,” or that the definition of “title” may include a reference to the term trademark.³⁰⁸ Because a trademark is a distinctive mark used to distinguish products, a trademark acts as a “title” to a product and the “infringement of title” offense includes trademark infringement.

A trademark may also be a slogan. Because “infringement of . . . slogan” often is an expressly covered offense, courts have held that an insurance company must defend and indemnify if its policyholder faces a claim that it is infringing another’s slogan.³⁰⁹

Finally, many courts also have held that claims of trademark or trade dress infringement are a “misappropriation of advertising ideas or style of doing business.”³¹⁰ Policies that use the phrase “copying . . . advertising ideas or advertising style” should also provide coverage for trademark or trade dress infringement claims.³¹¹

Although the majority of courts have held that claims of trademark or trade dress infringement are a covered advertising injury, some courts have not.³¹² A few courts have held that trademark or trade dress infringement does not constitute a “misappropriation of advertising ideas,” on the grounds that a trademark or trade dress is not an “advertising idea.”³¹³

Some courts have also held that trademark or trade dress infringement does not qualify as an “infringement of . . . title or slogan” because the courts reason that a “title” refers only to names of literary or artistic works.³¹⁴

“Prior publication” exclusions, which exclude coverage for alleged wrongful behavior if any part of it occurred before the beginning of the policy period, have also been held to bar coverage for trademark infringement claims that would otherwise have been covered as “advertising ideas.”³¹⁵

b. Copyright Infringement

The 2013 ISO form policy has an exclusion for personal and advertising injury arising out of copyright infringement, except for infringement of copyright, trade dress, or slogan, in the insured's advertisement.³¹⁶ Under prior ISO forms, a number of courts have held that copyright infringement claims qualify as a covered offense under a CGL policy.³¹⁷ Again, the underlying copyright infringement claim should be causally related to the policyholder's advertising activities to be covered. A claim that the policyholder's advertisement itself infringes because it contains copyrighted material in the advertisement would clearly be covered.³¹⁸ An advertisement that is not a direct copyright infringement, but which simply advertises an infringing product, might not be covered.³¹⁹

c. Trade Secret Claims

Older ISO CGL forms contained a defined term of "advertising injury." One of the definitions of advertising injury included the offense of "misappropriation of advertising ideas or style of doing business." There has been litigation under the older policy forms on the question of whether trade secrets meet that defined offense. Because trade secrets are confidential, however, they often have been viewed as lacking the necessary causal nexus to a policyholder's advertising activities. Most courts have held that confidential customer lists are not an advertising idea, and that a policyholder's misappropriation or use of such lists to target its competitor's customers is not an "advertisement."³²⁰ And if the trade secret that was allegedly misappropriated is simply information about the manufacture of a product and service itself, the requisite causal nexus is lacking, even if the policyholder subsequently used that information in its own advertisements.³²¹ In addition, the disclosure of a trade secret may also constitute a breach of contract.³²² CGL policies may contain exclusions for breach of contract claims.³²³ The current 2013 ISO form does not include a separate definition of "advertising injury" and no longer uses the definition of "misappropriation of advertising ideas or style of doing business."

d. Patent Infringement

Patent infringement claims may qualify as "injury aris[ing] out of . . . piracy [or] unfair competition," and may be covered under the Broad Form Endorsement that appeared in certain older CGL policy forms.³²⁴ Under most CGL policy forms, however, the majority of courts have found no coverage for patent infringement claims.³²⁵ First, policies may contain an "IP Exclusion" for advertising injury "arising out of the infringement of . . . patent."³²⁶ Second, even if the policy does not contain an IP Exclusion, policyholders must show a causal nexus between the alleged patent infringement and the policyholder's advertising activities. Most courts have held that a claim of patent infringement does not occur in the course of advertising activities (even though the policyholder advertises the infringing product) if the claim of infringement is based on the manufacture, sale, or importation of the product rather than its advertisement.³²⁷ Often, claims for patent infringement do not depend on advertisements, but rather the product, method, or process itself. If the patented invention is itself an advertising technique, then a claim for patent infringement may be covered as a "misappropriation of an advertising idea."³²⁸ Companies in certain industries, such as "broadcasting" or "telecasting," should be cautious of exclusions that can bar coverage for patent infringement claims that might otherwise be covered.³²⁹ Separate, non-

CGL insurance policies are available to both pursue and defend against patent infringement claims, but such policies often come with high premiums and stringent terms.

V. D&O Liability Insurance Policies

One important protection available to directors, officers, and companies is directors' and officers' liability ("D&O") insurance. Although the extent of coverage provided varies considerably among D&O policies and the nature of the entity purchasing the coverage, D&O policies often provide valuable protection for a wide range of corporate cases, including mismanagement claims, fraudulent conveyance suits, and antitrust cases. This section explores some of the common features of these policies, and the common areas of dispute once a claim is made.

A. Basics of D&O Insurance —Insuring Agreements

D&O insurance is not sold on any one common form used by the entire insurance industry. Rather, each insurance company has developed its own set of forms. Moreover, as circumstances have evolved in recent years, each insurance company has continued to modify its policy language. There is, however, considerable consistency between the various insurers' forms, including a number of common features as well as coverage enhancements that should be available upon request. Although policyholders are not always in a strong bargaining position, they should be aware that D&O insurance is often subject to negotiation, with a number of basic enhancements available at little or no additional premium. Accordingly, policyholders should be aware of certain key issues relevant to the purchase of D&O insurance so that they can inquire about whether favorable language is offered in the marketplace.

I. Side A, Direct or Liability Insurance

The fundamental coverage provided by all D&O insurance policies is Side A Coverage, which provides insurance to protect directors and officers for claims made against them. It does not provide insurance for claims either indemnified by the corporate policyholder or asserted directly against the corporate policyholder. Under a typical D&O insurance policy, the insurance company agrees to indemnify, or to pay on behalf of, the individual directors or officers for all "Loss" that those individuals become legally obligated to pay arising out of a "Claim" alleging a "Wrongful Act" committed in those individuals' capacity as a director or officer. One typical provision states:

This policy shall pay the Loss of any Insured Person arising from a Claim made against such Insured Person for any Wrongful Act of such Insured Person, except when and to the extent that an Organization has indemnified such Insured Person.

“Loss” generally is defined to include amounts that the policyholder is legally obligated to pay, including damages, settlements, and defense costs. Definitions of “Claim” vary, but all D&O policies include at least “a written demand for monetary or non-monetary relief.” “Wrongful Acts” are defined generally to include “any act, error, misstatement or omissions, neglect or breach of duty” committed by the individual in his capacity as an officer or director. Although some insurance companies argue that intentional conduct is not a “wrongful act” covered by a D&O policy, this argument generally has been rejected.³³⁰ However, this issue can and does arise in connection with the various “conduct exclusions” as will be discussed in Section V.G.1 of this InfoPAK.

Generally, the individuals covered under a D&O policy include past, present, and future directors and officers, although more modern D&O policies generally provide coverage for all of the corporate policyholder’s employees. The “insured” individuals are covered only for claims that allege wrongdoing performed by the director or officer while acting in her capacity as a director or officer.³³¹ Where the acts of misconduct were not performed in such a capacity, claims under the D&O policy may be denied. Some D&O policies provide limited coverage for directors and officers serving in “outside entities,” including when individuals serve as outside directors of other corporations at the request of their corporate employer or work for non-profits affiliated with the corporate policyholder. When the corporate policyholder is a private equity fund, REIT, or other entity that invests in third party entities, this “insured capacity” issue can become particularly salient, especially when individuals may be wearing “multiple hats” at different entities. Such corporate policyholders should ensure that their D&O coverage is broad enough to coverage situations where liability may arise from responsibilities at multiple entities, especially when some of those entities may not meet the D&O policies’ insured “Organization” definition.

2. Side B, Reimbursement or Indemnity Insurance

Under Side B Coverage, sometimes referred to as “corporate reimbursement” coverage, the insurance company agrees to reimburse the corporate entity for all “Loss” for which the company is required to indemnify, or has legally indemnified, the directors or officers for a claim alleging a Wrongful Act. A common Side B insuring agreement states:

[T]he Insurance company shall pay on behalf of ABC Corp. or any Subsidiary, Loss for which ABC Corp. or any Subsidiary is required, or has determined as permitted by law, to indemnify the Insured Persons and which results from any Claim first reported by the ABC Corp. Insureds to the Insurance company during the Policy Period or Extended Reporting Period, if applicable, and made against the Insured Persons for a Wrongful Act.

As with Side A, Side B does not provide insurance for claims asserted directly against the corporate policyholder. It merely reimburses the corporation for monies spent to protect the individual directors and officers.

State indemnification laws typically delineate the types of liabilities for which indemnification by the corporate employer to its directors and officers is permitted. Many state statutes permit full indemnification for judgments, fines, settlement costs, and expenses in third-party actions where the director or officer (a) acted in good faith, (b) in a manner that reasonably could be construed to have been in the best interests of the corporation, and (c) where there was “no reasonable cause to believe the person’s conduct was unlawful.”³³² Where, however, the officer or director causes loss because of willful misconduct or has been found guilty of acts of deliberate dishonesty, state statutes may prohibit corporate indemnification.³³³

3. Side C or Entity Insurance Coverage

Side C, or “entity” coverage, describes the insurance company’s promises to reimburse the corporate policyholder for liability arising out of a defined group of claims filed directly against the corporation. A typical provision that provides entity coverage states as follows:

The Insurer will pay on behalf of the Company, Loss resulting from Claims first made during the Policy Period or the Discovery Period against the Company for which the Company is legally obligated to pay for Wrongful Acts.

For corporate policyholders that are publicly traded, Coverage C is often limited to providing coverage for the entity’s “Wrongful Acts” arising out of “Securities Claims.” A typical “Securities Claims” definition states as follows:

“Securities Claim” means any Claim alleging a violation of any statutory or common law which in whole or in part is: (i) brought by one or more securities holders of the Company, in their capacity as such, or (ii) based upon, arising out of or attributable to the purchase or sale of, or offer or solicitation of an offer to purchase or sell, any securities issued by the Company

Therefore, the scope of coverage for public corporate policyholder is generally limited to claims either concerning securities (which includes both the company’s equity and debt) or brought by a securities holder (which includes both shareholder class actions, derivative actions, and other lawsuits brought by one or more securities holders).

For corporate policyholders that are privately held (including non-profits), Coverage C generally provides considerably broader coverage. In such situations, the label “D&O insurance” is a misnomer because such coverage is better characterized as “all risk” insurance that provides coverage for any “claim” alleging a “Wrongful Act” that is not explicitly excluded by the policy. For private corporation or non-profits, this means that their directors’ and officers’ liability (D&O) insurance is often the coverage that should be first pursued for any business-related liabilities stemming from a lawsuit or investigation.

B. A Claim Triggers Coverage

D&O coverage is written typically on a “claims-made” basis, which means that the policy is implicated or “triggered” when the potentially covered “Claim” is first asserted against the insureds during the policy period.³³⁴ Most D&O policies are “claims made and reported” policies, meaning that not only must the claim be made against the insured during the policy period, but the claim also must be reported to the insurance company during the policy period, or during a short extended reporting period. These are sometimes referred to as “double trigger” or “double anchor” D&O policies, because they require both the claim and notice to take place during the policy period. Most D&O policies include a “retroactive date,” which means that the “Claim” must arise out of conduct subsequent to that specified date. As a result, a D&O policy’s “retroactive date” is one of its most significant terms, and should correspond to the first date on which the corporate policyholder purchased D&O insurance. Purchasers of D&O insurance should therefore ensure that they maintain their “retroactive date” at renewal, even if they elect to change their D&O insurer.

There are two common exceptions to the “claims-made” basis of D&O insurance. First, most D&O policies contain language deeming multiple claims arising out of “Interrelated Wrongful Acts” to be the same claim that occurs at the time the first such claim was made. Therefore, if a lawsuit filed against a policyholder is based on the same or similar “Wrongful Acts” as a previous lawsuit that was first filed during the preceding policy year, then both lawsuits are covered, if at all, under the earlier policy year. The insurer of the current policy year will disclaim coverage based on its policy’s interrelated claims or interrelated wrongful acts language. Therefore, all “Claims” potentially covered by D&O insurance should be noticed, even if the first claim is likely to be resolved within a self-insured retention or deductible, because the availability of coverage for future “related” claims may be contingent on the first claim being properly noticed to the D&O insurer.

The second common exception to the “claims-made” basis of D&O insurance is the potential for providing a “notice of circumstances” before an actual “Claim” is asserted. Most D&O policies permit the insured to provide notice of circumstances of which it becomes aware that might in the future give rise to a “Claim.” In providing such a notice, coverage is “locked in” from the policy period in effect at the time of the notice of circumstances. This permits the policyholder to reserve a potentially expiring limit of liability for future claims and preserve future limits of liability for claims unrelated to the identified circumstance. An additional reason to provide a notice of circumstances is that many D&O insurance applications contain language requiring an applicant to disclose all known circumstances that might give rise to a claim in the future. A failure to disclose a known circumstance may be used as a basis to deny coverage under the first policy. Therefore, “locking in” coverage with a notice of circumstance may be the best way of preserving coverage for a “Claim” that might be asserted years into the future. However, there often is litigation regarding the sufficiency of the notice of potential circumstances that may give rise to a claim. Although some courts merely require substantial compliance with a policy’s notice requirements, other courts have required strict compliance.³³⁵ “Substantial compliance” is a less onerous standard that simply requires an insured to provide enough information for a D&O insurer to identify a claim that may be asserted in the future. “Strict compliance,” if applicable, requires an insured to have addressed all of what may be numerous requests for information in the D&O policy’s notice of potential

circumstances provision. Therefore, it is important to review any policy requirements regarding notice of potential circumstances and review the case law in the applicable jurisdiction.

One question that often arises regarding the trigger of the claims-made policy is what constitutes a “claim.” One common policy provision defines a “Claim” to mean:

- A written demand for monetary or non-monetary relief;
- Any civil proceeding in a court of law or equity, including any appeal there from, which is commenced by the filing of a complaint, motion for judgment, or similar proceeding;
- Any criminal proceeding which is commenced by the return of an indictment;
- Any administrative or regulatory proceeding which is commenced by the filing or issuance of a notice of charges, formal investigative order, subpoena, or similar document; and
- Any written demand or notice to an Insured describing circumstances that are likely to give rise to the commencement against an insured of any proceeding described above.

In civil cases, courts have found the existence of a claim, for example, when the underlying plaintiffs file suit;³³⁶ when the underlying plaintiffs file an administrative charge of discrimination;³³⁷ when a client asked its attorney to work without pay to correct errors in legal work (i.e., when insured was aware that work was inadequate);³³⁸ when the policyholder “first learned of an event that could reasonably be expected to result in the eventual filing of a claim”;³³⁹ when the Federal Home Loan Bank Board sent a further letter directive imposing severe operating restrictions on a bank “for the protection of the Federal Savings and Loan Insurance Corporation [FSLIC]”;³⁴⁰ when the FSLIC conducted an investigation and entered a Supervisory Agreement with the directors and officers of a defunct savings and loan business;³⁴¹ when a policyholder became aware of potential liability to the state under its environmental protection laws;³⁴² when demand was made on an employer to restore an employee’s insurance coverage;³⁴³ when subpoenas and other demands were made in an antitrust investigation;³⁴⁴ and when a policyholder received an E.E.O.C. notice of charge of discrimination.³⁴⁵

Courts also have found that no claim existed where a demand did not “necessarily result in a loss.”³⁴⁶

Strategic Point:

A D&O policy’s definition of “Claim” may be one of the provisions that can be modified during the underwriting process. Such potential modifications include extending the definition to include requests for tolling agreements, demands for arbitration or mediation, and governmental investigations of the corporate policyholder. Generally, a broader “Claim” definition is preferable because it extends coverage to additional events and permits coverage for legal fees at an earlier period. However, it is important for policyholders to remember that a broader “Claim” definition comes with a more extensive obligation to provide notice—i.e., the more events that satisfy the definition, the more events that must be timely noticed to the insurer.

C. Extended Reporting Period Coverage

Most claims-made policies, including directors' and officers' liability (D&O) policies, contain a provision requiring the insurance company to sell the policyholder extended reporting period ("ERP") coverage if the insurance company does not renew the policy. Such coverage extends the life of the policy so that it will continue to cover claims made and reported during the extended reporting period, but only if the claims arise out of wrongful acts which occurred prior to the original termination date of the policy.

The availability of extended reporting coverage is a critical aspect of claims-made coverage. The New York Insurance Department has recognized that "claims-made coverage tends to provide less protection," and is "a more complicated and confusing method of coverage," than traditional "occurrence"-based coverage, which generally "protect[s] against injury or damage that occurs during the policy period" without regard to the timing of the claim against the policyholder.³⁴⁷

Equally to the point – and as the New York Insurance Department also has recognized – claims-made coverage poses a clear potential for "coverage gaps."³⁴⁸ The court in *CheckRite Ltd. v. Illinois National Insurance Co.*,³⁴⁹ identified some of the potential perils for claims-made policyholders:

A gap can occur where an insured switches to an occurrence policy because there will be no coverage for claims based on acts that happened during the claims-made policy but before the occurrence policy. A gap can occur where the insured switches to another claims-made policy because the subsequent carrier might impose a retroactive date that limits coverage for prior acts. An extended reporting period option gives the insured the ability to protect itself in these situations.³⁵⁰

ERP coverage is intended to avoid these coverage gaps.

An important issue with claims-made coverage in general, and D&O coverage in particular, is whether the insurance company has refused to renew the policy, and thus is required to sell extended reporting period coverage. Often the "renewal" policy offered by the insurance company is markedly different from the original and is far more restrictive. The insurance company may try to insert or expand exclusions that wipe out many of the protections afforded by the policy, or insert huge deductibles or retentions that change the nature of the insurance provided. Whether a particular bundle of terms constitutes a "renewal" or a refusal to renew is likely to be a litigated issue.

Strategic Point:

Exercise of the extended reporting option should be considered whenever a new policy provides narrower coverage than an existing policy that is about to expire, when a corporation changes D&O insurance companies, or when a significant corporate transaction occurs. Under these circumstances, the purchase of ERP coverage for the original policy will allow directors and officers to report new claims under the old policy arising out of conduct going back to the old retroactive date. It also provides valuable “tail coverage” for potential pre-merger liabilities of an acquired company. Without such ERP coverage, the post-merger insurer may disclaim coverage for liabilities asserted against the non-surviving corporate entity and its directors and officers.

D. The Insurance Company’s Defense Obligation

Under many D&O policies, the insurance company is required to reimburse for the costs of a defense. The defense costs often times diminish the limits of the policy. The insurer's obligation to pay defense costs is judged by the duty-to-defend standard – whether there is a potential that the claim will fall within coverage.³⁵¹ While the standard for implicating coverage for defense costs remains the duty-to-defend standard, the responsibilities of the insurer and insured under D&O policies are often different than policies, such as CGL policies, that contain an actual duty to defend.

For example, D&O insurers generally are required to “advance” defense costs under a D&O policy, including when an insurance company has brought an action to declare that there is no coverage.³⁵² However, this obligation to advance defense costs is often limited to the share of such costs that are related to a potentially “covered” claim or portion of a claim. This “allocation” issue is explained in greater detail below. If a claim or portion of a claim ultimately is not covered by the D&O policy, the insurance company may seek recoupment of any monies that have been advanced for that claim or portion of a claim.

In addition, under D&O policies, the insurer generally retains the right to select defense counsel and manage the defense of the claim. The right to select defense counsel, however, often is limited by requiring the policyholder to select an attorney pre-approved by the insurance company, referred to as the “Panel Counsel.” The identity of pre-approved attorneys often is appended to the policy. If there are outside counsel that the insured entity or directors and officers anticipate they may want to use, they should negotiate at the time the policy is issued for those attorneys to be on the Panel Counsel list.

Strategic Point:

D&O policies issued to private companies and non-profit entities often contain broader defense obligations for the D&O insurer. Some such policies permit the insured to delegate all responsibility to the insurer to select and manage the defense of the Claim. Many such policies also expand the duty to pay defense costs to 100% of the defense costs incurred, rather than simply the potentially covered portion of the claim.

E. The “Loss” Issue

D&O policies require the insured to suffer “loss” to obtain coverage, and many coverage disputes have resulted from questions regarding whether the policyholder has suffered “loss.” For example, the question of whether fines and penalties are “losses” under D&O policies often is disputed in coverage cases, with insured officers and directors contending that the fines or penalties are in lieu of more traditional damages. In some instances, the insureds may also argue that, because the fines and penalties are insurable as a matter of law (i.e., that state law allows for corporate indemnification thereof), they also are covered under a D&O policy. Some policies explicitly provide that punitive and exemplary damages are included within the definition of “loss.”

Whether restitution or disgorgement of ill-gotten gain is recoverable under a D&O policy also is a highly disputed issue. In *Level 3 Communications, Inc. v. Federal Insurance Co.*,³⁵³ the court denied coverage, stating: “An insured incurs no loss within the meaning of the insurance contract by being compelled to return property that it had stolen, even if a more polite word than ‘stolen’ is used to characterize the claim for the property’s return.”³⁵⁴ However, this rule, if applied, should be limited to situations where a party is being asked to return just what was taken wrongfully, and does not apply in situations where the insured is assessed statutory or treble damages that exceed the amount wrongfully withheld. In *Bank of the West*, the court specifically recognized that, “[a]lthough the concept of ‘restitution’ may have a broader meaning in other contexts, we limit our reference to it here to situations in which the defendant is required to restore to the plaintiff that which was wrongfully acquired.”³⁵⁵ Thus, in *Nutmeg Insurance Co. v. East Lake Management & Development Corp.*,³⁵⁶ where statutory damages were awarded of two times the amount wrongfully withheld, the award “thus provide[d] more than restitution.”³⁵⁷ Similarly, in *Unified Western Grocers, Inc. v. Twin City Fire Insurance Co.*,³⁵⁸ the Ninth Circuit considered whether coverage would apply to claims that the insureds had funneled money out of a company, forcing the company into bankruptcy. Although the claimants sought to recover the funds that allegedly had been funneled out of the company wrongfully, the court determined that the action was not for restitution alone, and refused to deny coverage.³⁵⁹ In so ruling, the court cited *Bank of the West* and rejected the insurance company’s argument that all of the damages sought were uninsurable restitution.³⁶⁰ Several recent cases have more directly rejected the “public policy” considerations underlying *Level 3 Communications* and similar cases finding that disgorgement and restitution should not be insurable. For example, in *U.S. Bank National Association v. Indian Harbor Insurance Co.*,³⁶¹ a United States District Court applying Delaware law rejected the public policy argument that restitution is uninsurable as a matter of public policy, finding that the freedom of contract should permit the insurability of such damages if the language of the policy so permits.

In *J.P. Morgan Securities, Inc., et al. v. Vigilant Insurance Company, et al.*,³⁶² the New York Court of Appeals denied an insurer's motion to dismiss a lawsuit brought by Bear Stearns seeking coverage for \$160 million in “disgorgement” damages it paid to settle a Securities and Exchange Commission (“SEC”) claim. The insurers argued that the disgorgement payment was not covered based upon New York public policy, but the Court of Appeals held that the insurers were not entitled to dismiss Bear Stearns’ complaint because Bear Stearns was “not pursuing recoupment for the turnover of its own improperly acquired profits”³⁶³ According to the court, because the so-called disgorgement was linked to

gains that went to others and “not revenue that Bear Stearns itself pocketed,” Bear Stearns would not have been unjustly enriched if it recovered the loss from its insurers.³⁶⁴ More recently, a subsequent appellate division decision in the *J.P. Morgan*³⁶⁵ case has held that the \$160 million disgorgement settlement is excluded for an alternative reason, namely that it should be considered a “penalty” under the United States Supreme Court’s decision in *Kokesh v. SEC*.³⁶⁶ Therefore, the law remains unsettled in this area as policyholders and their insurers hotly contest the availability of coverage for certain types of “Loss” under D&O policies. It would appear, however, that the specific factual circumstances of each case may have a significant bearing on the availability of coverage.

F. The Allocation Dispute

I. Between Insured and Uninsured Liability

A D&O insurer typically only has the obligation to reimburse the costs of defending covered claims. Thus, an allocation dispute may arise when the litigation involves both covered and uncovered claims. It is well settled that an insurance company is obligated to pay all defense costs that are “reasonably related to the defense of the covered claims,” whether or not those costs also are related to non-covered claims or events. *Cont’l Cas. Co. v. Bd. of Educ.*;³⁶⁷ accord *Bordeaux, Inc. v. Am. Safety Ins. Co.*;³⁶⁸ *HLTH Corp. v. Agric. Excess & Surplus Ins. Co.*;³⁶⁹ *Safeway Stores, Inc. v. Nat’l Union Fire Ins. Co.*;³⁷⁰ *Nordstrom, Inc. v. Chubb & Son, Inc.*;³⁷¹ *Fed. Realty Inv. Trust v. Pac. Ins. Co.*;³⁷² *Nodaway Valley Bank v. Cont’l Cas. Co.*;³⁷³ see also *Harristown Dev. Corp. v. Int’l Ins. Co.*;³⁷⁴ *City of Burlington v. Ass’n of Gas & Elec. Ins. Servs., Ltd.*³⁷⁵ Some newer D&O policy forms, however, obviate such allocation issues as to defense costs, by deeming 100% of defense costs for actions alleging both covered and non-covered matters to be covered loss.

When an action is brought against a director or officer, the corporate entity is almost always named as a defendant. Unless all of the claims fall within the scope of entity coverage, a dispute over allocation may arise. Moreover, directors’ and officers’ liability (D&O) claims are often the subject of parallel proceedings. For instance, the same conduct, allegedly in violation of the federal securities laws, can give rise not only to shareholder lawsuits, but also to grand jury investigations, investigations by the SEC, and Congressional inquiries. D&O claims not involving violations of the securities laws (such as the sale of a defective product, infringement of intellectual property rights, or unfair trade practices) can also be the subject of governmental investigation or otherwise require a response to a regulatory agency.

As a result, even with the presence of entity coverage, the same alleged wrongful conduct can generate many claims, some covered by the insurance policy and others not. The defense of these parallel claims often overlaps. These circumstances still may lead to a dispute over allocation—what percentage of the “Loss” is attributable to a covered claim and should be reimbursed by the insurance company.

Some policies include a provision requiring that the parties will use their “best efforts” to allocate between covered and non-covered claims. Other policies may have a provision that contains a pre-set allocation percentage. In that circumstance, if and when a dispute arises

over what portion of the loss is covered, that dispute will be resolved according to a fixed percentage. Allocation provisions should be reviewed carefully prior to purchasing a D&O policy.

Strategic Point:

The broader the coverage and the narrower the exclusions, the less likely it is that a dispute over allocation will arise. The addition of entity coverage has significantly reduced the frequency of allocation disputes. One way to reduce further the allocation disputes arising out of parallel proceedings is to obtain the broadest possible definition of “Claim” in the D&O policy. That term can, and often is, defined to include investigations by the SEC and the Department of Justice.

2. Among Insureds

Because D&O policies generally contain a single aggregate limit, any payment by the insurance company (whether under liability (Coverage A), reimbursement (Coverage B), or entity (Coverage C) coverage) reduces, and can ultimately exhaust, the limits of the policy. If a payment is made for the benefit of one insured, fewer funds are available to protect the other insureds. As a result, the corporation may be in conflict with the individual directors and officers, and the individual directors and officers may be in conflict among themselves, over the limits of the policy. For example, it is not uncommon for the outside “innocent” directors to be able to settle shareholder claims against them at an early stage in the litigation. They will demand that the insurance companies fund that settlement. That payment, however, may significantly deplete, or even exhaust, the D&O policy, leaving the inside directors with little or no insurance to pay for their ongoing defense.

The issue of allocating fixed limits among multiple covered parties can arise with any form of insurance policy, but arises with particular frequency with D&O insurance. In general, an insurance company must act in good faith,³⁷⁶ but may pay a settlement or judgment that is first in time.³⁷⁷

Some insurers include language in the insurance policy that specifically deals with how the limits of the policy will be paid to competing insureds, particularly if the entity declares bankruptcy. For instance, a policy can contain an “order of payments” provision, which specifically provides that, if individual directors and officers and the entity are competing for the limits of the policy, then the individual directors and officers are paid first. There is insufficient case law to give an individual director or officer comfort as to how a bankruptcy court, which tends to be pro-debtor, will apply such language. The issue was addressed in *In re Enron Corp.*³⁷⁸ In that case, the court allowed payment of substantial sums for the individual directors’ and officers’ defense costs under a D&O policy with an order of payments provision. In *In re Downey Financial Corp.*, 428 B.R. 595 (Bankr. D. Del. 2010), the court applied an “order of payments” provision to prioritize coverage for the directors and officers over the trustee’s interest in the policy, and thus held that the policy proceeds were not property of the bankrupt estate.³⁷⁹

G. Exclusions

I. Conduct Exclusions

D&O policies include exclusions for liability that arises from a director's or officer's fraud, self-dealing, or dishonesty. Typically, those provisions exclude coverage for loss arising out of:

- Illegal personal gain (although such exclusion may not apply if the insured's dishonesty has not been clearly established);
- Illegal or unauthorized remuneration;
- Short-swing profits gained in violation of Section 16(b) of the Securities Exchange Act of 1934, or similar state statutory provisions; and
- Final adjudication of fraudulent or dishonest acts.

Usually, these provisions require a final judicial determination of the excluded conduct for these exclusions to apply.³⁸⁰ In *AT&T Corp. v. Clarendon America Ins. Co.*,³⁸¹ AT&T secured a summary judgment ruling that a fraud exclusion did not bar coverage for a settlement of a shareholder lawsuit because there was no judicial finding of fraudulent conduct. The court reasoned that the settlement "did not 'adjudicate' anything" and agreed "with AT&T that '[i]t would seem obvious that there has been no adjudication or finding of deliberate, dishonest, fraudulent or criminal conduct in a case whose merits *no finder of fact has ever decided.*'"³⁸²

Other policies exclude coverage for dishonesty, but only where the allegations are finally adjudicated against the officer or director, and the wrongful conduct was determined to be deliberate and material.³⁸³ The insurance company must advance defense costs until a determination of fraud or dishonesty is made. *Sun-Times Media Grp., Inc. v. Royal & Sunalliance Ins. Co. of Canada*.³⁸⁴ Moreover, given that most claims are settled, the insurance company is obligated to fund a reasonable settlement despite the possible application of these exclusions, provided there has been no finding of wrongdoing.

Strategic Point:

The specific language used in a D&O policy's "conduct" exclusions can be dispositive of coverage. Some such exclusions leave open the question of whether the necessary "final adjudication" must occur in the underlying action or whether it can be established in a subsequent coverage litigation with the D&O insurer. Accordingly, insureds should carefully review their "conduct" exclusions at the time of renewal, and request the most narrow language available.

The "innocent" director who did not participate in the wrongdoing should not be precluded from obtaining coverage under the policy. D&O policies may explicitly limit the applicability of the conduct exclusions to protect "innocent directors" with a severability clause. Such clauses typically provide that "the Wrongful Act of an Insured shall not be imputed to any other Insured for the purposes of determining the applicability of relevant exclusions." See discussion of severability in Section V.J of this InfoPAK.

2. “Insured vs. Insured” Exclusion

The “insured vs. insured” exclusion was designed by insurance companies in response to collusive “disputes” between or among companies and directors and officers (companies with losses would sue willing directors and officers, alleging mismanagement, in an attempt to pass the loss onto insurance). The exclusion rectified this issue and also provided insurance companies with the ability to exclude so-called “family disputes” arising between officers and directors of an institution and to address claims brought, for example, against former management where there has been a change in corporate control.

In bankruptcy, the insurance company may argue that a claim brought by the trustee in bankruptcy against a director or officer is not covered by the policy, because the trustee stands in the shoes of the corporation. Whether a claim against the directors and officers by a bankruptcy trustee, creditors committee, or debtor in possession falls within the “insured v. insured” exclusion is an issue about which the courts have disagreed.³⁸⁵ Directors and officers will be better off if the D&O policy explicitly provides that a trustee in bankruptcy is not deemed to be the corporation for the purpose of this exclusion. While recent modifications to the standard “insured v. insured” exclusion has eliminated much of the disputes arising from bankruptcy proceedings, it remains important that policyholders review their existing “insured v. insured” language to ensure that only potentially collusive activities are excluded. This remains particularly true in privately held companies who are often more likely to have intra-shareholder disputes that may give rise to coverage claims.

3. Interrelated Wrongful Acts Exclusion

Many D&O policies contain “related acts” or “interrelated wrongful acts” exclusions. A typical interrelated wrongful acts provision provides as follows:

All Claims arising from Interrelated Wrongful Acts shall be deemed to constitute a single Claim and shall be deemed to have been made at the time at which the earliest such Claim is made or deemed to have been made, regardless of whether such time is during the Policy Period or prior thereto.

“Interrelated Wrongful Acts” may be defined as “Wrongful Acts that are logically, causally, or otherwise based upon, arising from, resulting from, or in consequence of the same or related facts, circumstances, situations, transactions, causes, or events.”

As a result of such provisions, “related claims” issues are increasingly prevalent with D&O policies. Insurers may attempt to use such provisions to argue that coverage is excluded for claims that purportedly relate back to claims made before the policy period. In essence, the insurers’ argument is that the claim was made outside of the effective policy period. Such provisions may result in claims being excluded from a particular policy and pushed back, if at all, into another policy period.³⁸⁶

The circumstances where related claims questions arise, and the answers courts provide, vary greatly. As many courts have noted, the relatedness of multiple claims is a fact-intensive inquiry that does not lend itself to “bright line” rules and easy characterizations. Comparison to and among cases is further complicated by the significant variation in policy.

Accordingly, the benefits of different policy formulations may depend largely on the factual circumstances a policyholder confronts, rendering pre-claim predictions difficult. One aspect of the problem that *policyholders* can control is the giving of notice; as appropriate to their specific situations, policyholders should be vigilant in giving timely notice and giving notice across multiple policy periods, if any question exists concerning the proper policy period that might apply.

4. Other Exclusions

D&O policies typically exclude coverage for claims that generally are covered, or could be covered, under other forms of insurance. For instance, claims for bodily injury, property damage, libel, and slander will be excluded because such claims are covered under typical general liability policies. Claims for violations of the Employee Retirement Income Security Act³⁸⁷ are excluded because coverage is available under a fiduciary liability policy. Claims alleging the breaching of a “professional liability” are often excluded because of the availability of “errors and omissions” coverage. Other exclusions may deny *coverage* for, among other things, (1) failure to maintain insurance, (2) punitive damages, and (3) terrorist acts.

Many D&O policies, but not all, contain a severability provision that treats each individual director or officer separately with regard to certain or all of the D&O policy’s exclusions, especially those exclusions that include a subjective knowledge requirement. This language protects coverage for “innocent” insureds who were unaware of alleged intentional wrongdoing or were unaware prior to the inception of the policy of circumstances that later gave rise to a “Claim.” For purposes of coverage for the insured organization, the subjective knowledge of certain identified executives are usually imputed to the organization. Therefore, restricting this list of executives is generally advisable.

H. Checklists for D&O Insurance

I. Checklist for Procuring a D&O Insurance Policy:

- Obtain quotes from several financially sound insurance companies.
- Consider key policy definitions to assure proper breadth of coverage, including definitions of “Company,” “Insured,” “Claim,” “Loss,” and “Wrongful Act.”
- Consider provision regarding the insurer’s obligation to defend (e.g., does the insurer have the duty to defend or to advance defense costs; does the policyholder have the right to choose its defense counsel; is policyholder’s preferred defense counsel approved by the insurer).

- Review the language of key exclusions and consider application of exclusions to the primary risks of the company (e.g., does insured v. insured exclusion carve out claims by bankruptcy trustee; do conduct exclusions contain a final adjudication requirement).
- Carefully review clauses relating to allocation or priority of payment, and consider requesting a provision that allocates 100% of defense costs to the covered portion of any claim.
- Seek severability language that makes it clear the bad acts of some directors and officers will not be imputed to “innocent” directors and officers.

2. Checklist of Actions to Take After a Claim or Circumstances Which May Give Rise to a Claim:

- Ensure that notice is provided in a timely manner and that any specific requirements are met.
- Provide notice to potentially responsible insurers.
- Be careful in communications regarding your insurance claim, keeping detailed notes of any oral communications and maintaining copies of communications with the insurer.
- Promptly communicate any offers to settle, especially any offer to settle within limits
- Consult with outside counsel when necessary.

I. Misrepresentation/Rescission

D&O applications typically request many different types of information, including financial statements, information relating to the applicant's operations or activities, information relating to other insurance presently owned by the potential policyholder, details of employment, and information regarding past and pending claims against the applicant. Applicants also often are asked to provide copies of their by-laws and/or articles of incorporation, annual reports of CPA audits, SEC filings, and a schedule of their directors and officers. The company's chief executive officer (“CEO”), chief financial officer (“CFO”), or another corporate representative must sign the application.

With increasing frequency, D&O insurance companies are trying to avoid liability for claims based on allegations that there was a material misrepresentation in the application. Indeed, some policies provide that the policy is void if there are material misrepresentations in the application or other materials submitted.³⁸⁸ For instance, given that the companies' financials generally are incorporated into the application, an underlying claim based upon a financial restatement likely will be denied on the grounds of rescission.

An issue is presented where one corporate director or officer makes a misrepresentation on the policy application and another so-called “innocent” director, who had no knowledge of the misrepresentation, brings a claim under the D&O policy. Some cases hold that neither knowledge of the misrepresentation nor an intent to misrepresent on the *part* of the policyholder are elements that the insurance company must prove to support a defense of misrepresentation. Thus, an innocent director may be denied coverage because the corporate officer or director who signs the insurance application made a misrepresentation on it.³⁸⁹

An insurance company seeking to avoid coverage based on an alleged misrepresentation or omission generally must show that the *alleged* misstatement was “material” to its decision to sell or price the policy.³⁹⁰ Most US jurisdictions hold that the insurance company can base rescission only on information specifically requested in the application.³⁹¹

The insurance policy or application may contain language limiting the insurance company’s ability to rescind. There may be language limiting rescission to intentional misrepresentations,³⁹² or barring rescission against an innocent co-insured who was unaware of the misstatements.³⁹³ A court may also find that an insurance company has waived the right to avoid coverage based on a purported omission or misrepresentation, if, for example, the insurance company ignored an obvious incompleteness in the application;³⁹⁴ failed to assert rescission promptly after learning of a basis to do so;³⁹⁵ or failed to return, or continued to accept, premium payments.³⁹⁶

Courts have held that an insurance company asserting rescission of a liability policy nevertheless must continue to honor its obligations to defend the policyholder or reimburse defense costs, until such time as the court determines the rescission *issue* in the insurance company’s favor.³⁹⁷

J. Severability

Because of the growing frequency of rescission claims, severability is a current key issue with directors’ and officers’ liability (D&O) insurance. The severability issue *refers* to whether, and in what circumstances, the wrongdoing or false statements of one director or officer can be imputed to the other directors or officers, or to the corporation. A severability provision will limit the ability of the insurance company to deny coverage under one of the conduct exclusions, or to rescind an entire policy solely on the basis of false statement or intentional wrongful act committed by a single insured.

The issue of severability typically arises in two circumstances. The first circumstance is when statements made in the insurance application are false. In such event, the insurance company may try to rescind the entire policy on the grounds of misrepresentation. If the responsibility for the statements in the application is severable, then the insurance company can rescind the policy only as to the individual director or officer who signed the *application* or was aware of the false statement. A typical severability clause in an insurance application states:

In granting coverage under this policy to any of the Insureds, the Company has relied upon the declarations and statements in the written application for coverage. All such declarations and statements are the basis of such coverage and shall be considered as incorporated and constituting part of the policy.

The written application for coverage shall be construed as a separate application for coverage by each of the Insured Persons. With respect to the declarations and statements contained in such written application for coverage, no statement in the application or knowledge possessed by any Insured Person(s) shall be imputed to any other Insured Person(s) for the purpose of determining the availability of coverage with respect to claims made against any Insured Person(s) whether or not the Insured Organization grants indemnification.

Such a *clause* precludes an insurance company from rescinding the entire policy solely on the basis of misrepresentations by a single insured.³⁹⁸

The second circumstance where severability becomes important is in the application of the “conduct” exclusions. For instance, an insurance company may seek to deny insurance based on the fraud exclusion if the president of the company pleads guilty or is convicted of fraud, arguing that the wrongdoing of the president is imputable to the corporation.³⁹⁹ Many policies have a non-imputation, clause which provides:

The Wrongful Acts of a Director or Officer shall not be imputed to any other Director or Officer for the purpose of determining the applicability of [intentional act exclusions].

The term “Director and Officer” can be defined to include the corporate entity. Thus, a policy with a non-imputation clause specifically provides that the wrongful acts of a director or officer may not be imputed to *either* individuals or the corporation for purposes of determining the applicability of the intentional act exclusions. In such a case, the wrongdoing of each insured must be looked at separately.

In *SEC v. Credit Bancorp, Ltd.*,⁴⁰⁰ a case involving a Bankers’ Blanket Bond, the court held that a policy’s exclusion for losses arising out of dishonesty did not apply to persons other than the individual dishonest actor, and that barring coverage for other insureds for losses arising out of related but non-dishonest conduct would render the non-imputation clause meaningless. In *Alstrin v. St. Paul Mercury Insurance Co.*,⁴⁰¹ executives sued the corporation’s D&O liability insurance company, seeking coverage for both a securities fraud class action and a bankruptcy adversary proceeding. The insurance company sought to exclude coverage to all insureds, under a provision that excluded coverage for claims arising out of profit or advantage to which an insured was not legally entitled. The court held that to exclude coverage based on illegal profit or gain, the insurance company must prove guilt separately for each insured.⁴⁰²

Finally, in *Shapiro v. American Home Assurance Co.*,⁴⁰³ the insurance companies argued that the policies were void ab initio as to all officers and directors, because the insurance was procured by means of fraudulent financial statements. The court disagreed:

I interpret the policy to mean that each insured must be treated separately with respect to a defense of fraud as well as in other respects. If the insured making the particular claim of coverage willfully defrauded, then the exclusion applies and coverage for that insured is defeated. But if only some other insured willfully defrauded, the exclusion and severability clauses taken together plainly say the insured who is not guilty of the willful fraud is covered. The exclusion clause itself indicates that each insured must be treated separately.⁴⁰⁴

Accordingly, policy provisions requiring severability, both in connection with the policy application and the “conduct” exclusions, are critical to the purchase of D&O insurance, particularly for outside directors.

K. Protection of the Outside Director, Including Independent Director Liability Policies

Outside directors who are most concerned about exposing their assets to liability based upon the conduct of the inside management team should consider requiring their corporation to obtain non-rescindable “Side A” excess policies that insure only their own liability. The purchase of these policies will resolve many of the problems mentioned in this InfoPAK. This insurance can be written to cover the independent directors when the underlying primary D&O policy is rescinded or commuted or has its limits exhausted. This policy is not cancelable (except for non-payment of premiums), defines “securities claim” to include claims brought by a bankruptcy trustee, and does not exclude coverage because of a financial reporting restatement or insider wrongdoing.

“Side A” coverage for outside directors can be written to provide that the insurance company will respond if the insured corporation itself does not honor its indemnification obligations, particularly for defense costs, within a defined period of time (30 to 90 days) after the outside director has made a written demand on the *corporation* (or debtor in possession or bankruptcy trustee). Although this coverage will increase premium expense, it does address one of the problems presented in the new world of Sarbanes-Oxley – the reluctance of independent outside individuals to join the board of directors and sit on the audit committee.

VI. Other Third-Party Coverages

A. Errors and Omissions and Professional Liability Coverage

E&O coverage is intended to insure against liability arising out of an act, error, or omission of the named insured in rendering or failing to render services. Professional Liability Insurance is a form of E&O insurance designed to protect the professional activities of those who possess specialized knowledge and skills through special education and experience in a particular field. The professions that typically fall within this category are accountants, architects, attorneys, engineers, physicians, and veterinarians. This type of insurance often is referred to as malpractice insurance.

E&O policies, however, are not limited to those specialized professions. They can apply to “non-professionals” who require coverage for their wrongful acts that cause harm to others. Insurance agents, brokers, consultants, real estate agents, and stockbrokers are examples of individuals in less-specialized fields who often purchase E&O insurance. Indeed, any company that provides a service may seek to purchase E&O insurance.

Although E&O and Professional Liability policies used to be considered two separate lines of insurance, over time the distinctions have blurred. It is now more common for an insurance company to develop policy wording tailored for whatever business area the insurance company decides to underwrite.

A generic insuring agreement for an E&O policy provides that the insurance company agrees:

To pay on behalf of the Insured Damages and Claims Expenses which the Insured Shall become legally obligated to pay because of any Claim or Claims first made against the Insured . . . and reported to the Underwriters during the Period of Insurance or Extended Reporting Period arising out of any act, error or omission of the Insured in rendering or failing to render Professional Services.

A few points to note about the standard insuring agreement. First, E&O coverage is sold on a claims-made basis. The Claim must be made against the insured and reported to the insurance company during the policy period. Second, defense costs (Claim Expenses) are within limits.

E&O policies cover only “Damages,” which usually are defined to exclude the return or reimbursement of fees, costs, and expenses to the Insured for Professional Services. Thus, if a client sues the policyholder for the return of fees, that lawsuit is not covered. If the client sues for damages, and the claim is settled by the return of fees, the insurance company may pay defense costs, but not the settlement amount. If the policyholder sues the client for non-payment of fees, and is met with a counterclaim based on the policyholder’s negligent performance of services, the defense of the counterclaim may not be covered.

The insuring provision may or may not require that the “act, error or omission” be “negligent.” Thus, intentional acts that lead to damages may be covered, provided they are not excluded elsewhere in the policy. Even if the policy covers only negligent acts, the policy may provide coverage for negligence resulting from decisions that were intentionally made. In *Stinker Stores, Inc. v. Nationwide Agribusiness Ins. and Order Co.*,⁴⁰⁵ the court held that the insurance company had a duty to defend a lawsuit alleging intentional conduct by an employer who decided to terminate an employee benefit plan and deny benefits to plan participants. The court concluded “that the reasonable interpretation of the language ‘negligent acts, errors or omissions’ in the policies at issue in this action is conduct that may include decisions which are discretionary and intentionally made, but may also nonetheless be negligent decisions.”⁴⁰⁶

It is also critical to check the definition of Professional Services in the policy. This definition often will be found in an endorsement tailored to the policyholder’s specific business. The policyholder must be careful to make sure that the definition is sufficient to cover the conduct that could give rise to a claim. Another issue of frequent dispute is whether the conduct “arises out of” acts of rendering or failing to render Professional Services. The recent case of *Navigators Specialty Ins. Co. v. Scarinci*,⁴⁰⁷ is one example. The court held that fraudulent conduct by lawyers “arose out” of the rendering of professional services because “had Defendants not been acting as attorneys . . . they would not have been able to commit the alleged fraudulent acts.”⁴⁰⁸ While the insurance company was “correct that the definition of legal services typically does not (and should not) include the commission of fraud, the acts alleged in the underlying complaint qualif[ied] as ‘professional services’” because they bore a “substantial nexus” to professional services sought.⁴⁰⁹

E&O policies typically contain many exclusions. Some of these exclusions are intended to exclude those liabilities that should be covered by the CGL policy. It is important to verify that there are no gaps between the two lines of insurance, leaving areas of liability unprotected.

If an in-house counsel serves as a director or officer of the company, he may be covered under the company’s D&O policy, but D&O insurance will not provide sufficient coverage. D&O policies typically cover individuals only when acting in the scope of their duties as a director or officer, which insurers would argue do not include “attorney” duties. Additionally, many D&O policies now go further and exclude coverage altogether for professional services claims.

Strategic Point:

As a provider of professional services, in-house counsel should make sure they are protected by E&O insurance. Various insurers sell professional liability insurance policies to employed lawyers. These policies vary considerably, so it is important to review and compare available coverages. Coverages offered by some, but not all, employed lawyers professional liability insurance policies include coverage for:

- Claims brought by the company or its directors and officers (which would be excluded under the insured vs. insured exclusion of a D&O policy);
- Ethics and licensure proceedings, in addition to the more customary demands and suits; and
- Claims arising out of moonlighting and pro bono activities.

B. Employment Practices Liability Coverage

I. Scope of Coverage

Employment Practices Liability (“EPL”) insurance covers many traditional employment-related claims, such as those alleging “sexual harassment,” “discrimination,” and “wrongful termination.” EPL policies typically provide insurance on a claims-made basis.⁴¹⁰ However, many EPL policies have broader coverage that applies to “wrongful employment practices,” “employment claims,” or similar catch-all terms. These terms typically are defined to include a laundry list of possible offenses. For example, one policy form defines an employment practices “Injury” to include:

- Work-related harassment . . . [or] verbal, physical, mental or emotional abuse arising from “discrimination,” [meaning] violation of a person’s civil rights with respect to such person's race, color, national origin, religion, gender, marital status, age, sexual orientation or preference, physical or mental condition.
- Demotion or failure to promote, negative evaluation, reassignment or discipline of your current employee or wrongful refusal to employ;
- Wrongful termination . . . [i]n violation . . . of applicable law;
- Wrongful denial of training, wrongful deprivation of career opportunity, or breach of employment contract;
- Retaliatory action against an employee because the employee has [d]eclined to perform an illegal or unethical act, . . . [or] filed a complaint with a governmental authority or a suit against you . . . ;
- Coercing an employee to commit an unlawful act or omission
- Negligent hiring or supervision which results in any of the other offenses listed in this definition.⁴¹¹

EPL insurance also typically protects insureds from a broad range of monetary awards or judgments. For example, EPL insurance typically obligates the insurance company to pay all “Loss” for any employment claim. “Loss” may be defined as damages; “settlements; judgments; back and front pay; . . . prejudgment and post-judgment interest,” and defense expenses.⁴¹²

2. Coverage for Wage-Hour Class Action Lawsuits

Over the past few years, many purported class-action lawsuits have been filed against employers⁴¹³ regarding an alleged failure to pay overtime and other alleged violation. Many of these lawsuits are premised, at least in part, on the federal Fair Labor Standards Act ("FLSA"). Some are premised solely on state wage-hour laws or on state law in addition to the FLSA. The state laws often have a different method for determining when employees are exempt from overtime requirements. These lawsuits present a potential exposure of hundreds of thousands, or even tens of millions, of dollars for an employer. In fact, there have been settlements or judgments in such cases of \$20 million, \$30 million, or more. Protection for employers may be found in some EPL insurance policies, as many so-called called "wage-hour" or "overtime" lawsuits contain allegations that may fall within the broad coverage provided by such policies.

For example, the plaintiffs may claim that they were discriminated against because they were placed in positions that allegedly were exempt from overtime requirements, when those positions were not in fact exempt from overtime requirements. Others may argue that they were "retaliated" against by being deprived of overtime to which they were due because of some complaint they made about another subject. Others may claim that they were wrongfully deprived of a career opportunity because their particular employment positions were treated as exempt from overtime requirements, thereby depriving them of the opportunities that should have come with those positions. Other plaintiffs may accuse a corporate employer of having inadequate or inconsistent corporate policies with respect to overtime, or failing to honor their corporate policies (in particular, broadly worded policies that state that an employer will "comply with the law").

Many EPL insurance policies contain exclusions for wage-hour lawsuits including those premised on the FLSA. These policies attempt to exclude some or all coverage for wage-hour lawsuits, including "any federal, state, or local law or regulation governing or related to the payment of wages including the payment of overtime, on-call time, minimum wages, meals, rest breaks or the classification of employees for the purpose of determining employees' eligibility for compensation under such law(s)."⁴¹⁴ Other EPL insurance policies provide coverage for defense costs limited to the sum certain for defense. For example, one insurer offers an EPL insurance policy that provides that the insurer shall have no duty to pay for loss, other than defense expenses, for any Wage and Hour Law Claim. The policy imposes a \$100,000 wage-hour sublimit on defense costs.⁴¹⁵

Even if there is a question as to whether a wage-hour lawsuit gives rise to coverage, there may be a strong argument that coverage is implicated in most wage-hour suits because of the very nature of the lawsuits. Some of these lawsuits allege that employers misclassified or improperly designated the status of their employees as "exempt" from overtime laws, failed to enforce adequate wage-hour policies, or coerced employees into working excessive hours. In fact, many "wage-and-hour" lawsuits allege that employees were told that they were "exempt" from overtime requirements when they were, in fact, not exempt.

Such allegations should constitute "misrepresentations" covered by an EPL policy. "Misrepresentation" has been defined as "[a]ny manifestation by words or other conduct by one person to another that, under the circumstances, amounts to an assertion not in accordance with the facts." *A.P. Landis, Inc. v. Mellinger*, 175 A. 745, 746 (Pa. Super Ct. 1934);

see also *Everson v. Lorenz*,⁴¹⁶ see also *Fireman's Fund Ins. Co. v. Orient Overseas Container Line Ltd.*⁴¹⁷ A “misrepresentation” also can involve the concealment of the truth. *United States v. Sterling Salt Co.*⁴¹⁸; see also *Stewart v. Thrasher*.⁴¹⁹ The *Black's Law Dictionary* definition of “misrepresentation” shows the broad scope of the term:

A misrepresentation, being a false assertion of fact, commonly takes the form of spoken or written words. Whether a statement is false depends on the meaning of the words in all the circumstances, including what may fairly be inferred from them. An assertion may also be inferred from conduct other than words. Concealments or even non-disclosure may have the effect of a misrepresentation . . . [A]n assertion need not be fraudulent to be a misrepresentation. Thus a statement intended to be truthful may be a misrepresentation because of ignorance or carelessness, as when the word “not” is inadvertently omitted or when inaccurate language is used.⁴²⁰

Given this breadth, it is not surprising that courts have recognized that a misclassification of employees can constitute a “misrepresentation.” Thus, the term “misrepresentation” in an EPL policy reasonably can be interpreted to include a representation contrary to fact, or a concealment, relating to the nature of an employee’s job, such as whether the employee is “exempt” from overtime requirements.

Coverage also should be triggered when an EPL policy applies to claims for breaches of express or implied contracts. Courts have recognized that employment contracts “must be held to . . . incorporate[] the provisions of existing law. Hence, upon violation of [a Labor Code] section, an employee has a right of action for damages for breach of his employment contract.” *Lockheed Aircraft Corp. v. Super. Ct*⁴²¹. Therefore, because wage-hour actions often allege a failure to comply with state labor laws, such a claim may be a breach of implied contract covered by EPL provisions. See, e.g., *Hortica-Florists' Mut. Ins. Co. v. Pittman Nursery Corp.*⁴²²

C. Coverage for Cybersecurity Risks

I. Cybersecurity Risks

Modern businesses face increasing exposure to cybersecurity risks. Major data breaches at Yahoo!, Marriott, Equifax, Target, Home Depot, and Sony have grabbed headlines. According to a survey by the Ponemon Institute, which tracks data breaches, only 13 percent of senior management said their concern about a data breach was extremely high before the breach at Target.⁴²³ That figure jumped to 55 percent after the incident.⁴²⁴ In addition to damaging a company’s reputation, data breaches can lead to significant costs and liabilities, such as myriad reporting obligations that vary by state and federal law; potential civil lawsuits by customers, banks, and clients whose data was exposed; and investigations and lawsuits from state attorneys general, the Federal Trade Commission, and the Department of Health and Human Services and the Office for Civil Rights. Data

breaches have also received attention from state attorneys general.⁴²⁵

Businesses face an increasingly complex web of regulations, both domestically and overseas, that exposes them to increased compliance risks. In the European Union, the General Data Protection Regulation (“GDPR”), which went into effect in May 2018, created one of the strictest data privacy regimes in the world, with heavy penalties for non-compliance. GDPR extends to all companies processing the personal data of data subjects residing in the European Union, regardless of the company’s location. Organizations in breach of GDPR can be fined up to 4% of annual global turnover or €20 Million (whichever is greater). In the United States, the California Consumer Privacy Act (“CCPA”), whose requirements take effect in January 2020, likewise increases the data privacy regulatory requirements that companies face.

In addition to data privacy and regulatory and compliance risks, cybersecurity risks include computer system and business interruptions. A denial of service attack, for instance, can shut down a company’s website, preventing its customers from accessing its services via its website. But a business need not be completely web-based to be vulnerable to cyber-related business interruptions. In 2012, for instance, a virus introduced through an act of employee sabotage erased data on three quarters of Saudi Aramco’s computers and caused Aramco to shut down the company’s internal corporate network, disabling employees’ e-mails and Internet access to contain the virus.⁴²⁶ More recently, major companies in diverse industries reported substantial business interruption losses due to 2017’s “NetPetya” virus attack.

An emerging cybersecurity concern relates to the potential for cybersecurity breaches to cause property damage and bodily injury. Such risks are illustrated by the demonstrated ability of security experts to hack into computer systems in automobiles.⁴²⁷ If computer systems that in vehicles are vulnerable to cyber risks, it stands to reason that computer systems used to operate industrial processes are vulnerable to cyberattacks intended to cause damage or injury.

In addition, those companies that are publicly reporting should be cognizant of the SEC’s Corporation Finance’s Disclosure Guidance regarding cybersecurity. That guidance, released on October 13, 2011, states that “appropriate disclosures may include: . . . Description of relevant insurance coverage.”⁴²⁸ Insureds would be advised to discuss the scope of their insurance coverage (whether it be under cyber insurance policies or others, for cybersecurity risks, and cyber incidents) with insurance coverage counsel experienced in analyzing coverage for such events and risks.

Companies can find protection against these risks in new forms of cybersecurity insurance policies. But companies should not overlook traditional forms of insurance, such as commercial property policies, commercial general liability policies, and other types of coverage, which, depending on wording and circumstances, can cover cyber-related losses.

Strategic Point:

Companies facing cybersecurity and data privacy risks should consider the following tips.

- Determine what the company's risks are in relation to cybersecurity and data privacy. Understanding the risks will allow the company to procure an insurance program that is best suited to the company's particular risks
- Consider investing in a standalone "cyber insurance" policy that is specifically marketed as protecting against first- and third-party risks related to a broad range of cybersecurity and data privacy risks. For companies that provides services, consider specialized error or omissions coverage that provides protection for liability arising from services.
- Compare cyber insurance policies from several insurers to find one that best fits the company's needs and request modifications to better tailor the coverage to company's needs.
- When considering cyber insurance proposals, pay attention to the coverage grants and key definitions, such as confidential information, to confirm that the coverage is sufficiently broad. At the same time, beware of exclusions for unduly broad wording.
- Review the company's entire portfolio of insurance to determine any overlapping coverage for cybersecurity and data privacy risks. Recent cases have demonstrated that certain policies can and do provide coverage for cybersecurity and data privacy risks.

2. Specialized Insurance Policies for Cybersecurity Risks

Insurance companies have introduced specialized insurance policies designed to address cybersecurity and data privacy risks. Such policies are intended to fill gaps left by other types of policies that may limit or exclude coverage for cybersecurity and data privacy risks. These policies are not standardized and their wording varies widely from one insurer to another. Despite the great variation among cybersecurity insurance policies, they typically offer some combination of third-party and first-party coverages for risks and liabilities arising out of data breaches and cybersecurity failures. Common cyber coverages include third-party liability, regulatory, media liability, event management costs, business interruption and contingent business interruption, professional liability, and extortion. The types of losses that may be covered include:

- Public-relations costs after a data breach;
- Loss of and loss of use of data, networks, and the cloud;
- Liability-based losses, such as the costs to defend suits and to pay judgments and settlements;
- Investigation and mitigation cost coverage; costs to evaluate state and federal law regarding notification after a data breach;

- Costs of notification after a data breach and the cost of “voluntary” notification after a data breach that exposed information, but did not require notification under state or federal law;
- Data breach-based class actions; business partners alleging breach of contract, negligence, or other causes of action, or demanding contractual defense and indemnity;
- Professional negligence;
- Demands from card brands, banks, and card processors; and
- Coverage for exposure or theft of intellectual property, trade secrets, or other proprietary information.

3. Cyber Insurance Checklist:

When purchasing cyber insurance policies, insureds should keep the following considerations in mind:

- Does the cyber insurance policy provide coverages corresponding to the business’s cyber exposures? Often, cyber insurance policies are offered “cafeteria style,” where the insured can choose which coverages to purchase or not purchase. For instance, an insured that relies on vendors or cloud service providers to handle data should ensure that the policy covers cyber-related risks involving such third parties. Insureds concerned about business interruption should carefully consider the scope of the BI, extra expense, and other time element losses. If the Insured accepts credit cards, consider whether the policy includes card industry fines as in the definition of loss.
- Are the definitions of key terms, such as “personal information,” “computer system,” and “privacy event” or “cybersecurity event” sufficiently broad? Does the term “personal information” correspond to the type of data that the insured handles? Is the definition of “personal information” commensurate with the scope of information regulated by the privacy laws that apply to the insured? Does the definition of “computer system” reflect the insured’s computer system and include, for instance, services hosted by vendors and other service providers? Do the definitions of “privacy event” and “cybersecurity event” encompass the types of risks to which the insured is exposed?
- What exclusions appear in the policy? Some policies contain exclusions that are triggered by the failure of the insured to maintain minimal security standards. Some policies contain broadly worded contractual liability exclusions that could limit coverage for contractual liabilities.⁴²⁹ Some policies contain loosely worded war exclusions that could be construed to encompass a state sponsored cyberattack. The war exclusions in other policies lack exceptions for cyberterrorism. Many policies contain exclusions for fraudulent and dishonest acts committed by employees, but some lack exceptions for the acts of rogue employees.

- Even if coverage for a particular risk is not excluded, it may be subject to sublimit. For example, certain cyber insurance policies contain sub limits for costs related to regulatory investigations or risks related to the cloud.

4. Insurance Coverage for Cybersecurity Losses and Liabilities Under First-Party Property Policies and CGL Policies

Insureds should review their insurance policies (to which they are named insureds or additional insureds) closely to determine whether there may be coverage for cybersecurity losses. These include first-party property and CGL insurance policies.

a. Defining Coverage for “Property Damage”

A key point to keep in mind when seeking insurance coverage for a data breach or other cybersecurity incident under a non-cyber insurance policy is whether the incident caused “property damage.” Under both first-party property insurance and third-party Commercial General Liability (CGL) policies, several of the coverage grants are dependent on whether there is “property damage” as that term is used and defined within the insurance policies. (CGL policies also provide, among other coverages, personal and advertising injury coverage that is not dependent on a finding of property damage, the application of which to cybersecurity claims is discussed in this section.)

First-party property policies may define “property damage,” or may promise to pay for direct physical loss of, damage to, or loss of use of covered property. Standard form CGL policies typically define property damage; ISO’s 2013 CGL form defines “property damage,” in part, as meaning “[p]hysical injury to tangible property” and resulting “loss of use of the property,” or “loss of use of tangible property not physically injured.”⁴³⁰ The definition states that “electronic data is not tangible property.”⁴³¹

Several issues critical to coverage arise in light of these definitions. Policyholders should work closely with information technology and forensics experts after a data breach or cybersecurity incident to determine whether there has been any property damage. Most persuasive to insurance companies that sold CGL or first-party property insurance policies will be evidence of physical damage to hardware. Loss of use of hardware also should be persuasive. Loss of or damage to software, data, and other electronically stored information should be considered “property damage” as well, but insurance companies rarely will agree to such an interpretation without significant effort or litigation.

Courts have been willing to find that computer hardware itself is tangible property, and that damage to hardware constitutes property damage. In addition to direct physical damage, both first-party and third-party insurance policies may provide coverage for occurrences that result in a “loss of use” of tangible property. Because of such coverage, even if lost or damaged data is considered intangible, there is still a possibility that data-related losses will be covered. Considering the “loss of use of tangible property” definition of “property damage,” a leading appellate decision has found that the inability to use computers as intended, after a cybersecurity incident, was “property damage.”⁴³² Loss of function of a computer, such as by corruption of data or virus, may be significant enough to extend coverage to the loss of data as well.⁴³³ Policyholders should determine whether the

facts support an argument that the data was stored on media or affects property in a way such that the property is unavailable for use as a result of corresponding data damage, and that there was “property damage” as a result.⁴³⁴

b. Loss of or Damage to Data as Injury to “Tangible Property”

Whether data, computer software, or other cybersecurity-related materials are considered physical, tangible property is less clear, with a split in authority.⁴³⁵ Notwithstanding favorable case law, policyholders should be aware that many CGL insurance policies sold after 2000 contain an exclusion stating that electronic data is not tangible property.⁴³⁶ Not every insurer’s CGL policy contains this language, and brokers may be able to persuade underwriters to change that language for particular policyholders.⁴³⁷

Strategic Point:

For those insurance policies that do not define data to be tangible property, or for which there are endorsements that eliminate any such exclusion, policyholders should be aware of a split in authority on the question of whether software and data constitute tangible property. Specific to the insurance coverage context, certain courts have interpreted CGL insurance policies and first-party property insurance policies, and have determined that damage to or complete loss of data, software, or computer settings constitutes physical damage to tangible property.⁴³⁸ Other courts addressing this issue have found that data and computer software do not constitute tangible property.⁴³⁹ These courts assert that computer data is not “tangible” on the grounds that “[a]lone, computer data cannot be touched, held, or sensed by the human mind. . . .”⁴⁴⁰ Other cases have recognized that data and computer software should be considered tangible property that can be physically damaged.⁴⁴¹ If data is not considered tangible property, then it is unlikely that claims based on the loss of or damage to data alone, without loss of use of, or other physical damage to tangible property, meet the requirements of “property damage” under a policy.⁴⁴²

c. Relevant Coverage Provisions Under CGL Policies

Basic CGL policy terms may provide coverage for data breaches and cyber risks through two coverage provisions: (1) protection from liability to third parties resulting from bodily injury or property damage and (2) protection from liability to third parties resulting from personal or advertising injury. As the result of ever-increasing cyber risks, however, insurance companies have begun including exclusions specifically related to cybersecurity issues in CGL policies.⁴⁴³ Nonetheless, the CGL policy provides robust protection and may provide an opportunity for coverage against cyber risks.

Beyond the property damage coverage discussed above, CGL policies also provide coverage for personal and advertising injury claims that may extend to cybersecurity claims, particularly data breach claims. For cybersecurity purposes, the key provisions of personal and advertising injury are those providing coverage for alleged publication of material that invades another’s privacy. Under these provisions, a threshold issue is whether a publication exists. In one case in which computer tapes containing personal

information of employees fell off a truck, the court found that there was no publication because there was no evidence that the information on the tapes was accessed.⁴⁴⁴ Fortunately, emerging law suggests that personal and advertising injury is appropriate for data breach claims if the data is likely to have been accessed or viewed.⁴⁴⁵ In addition, decisions interpreting personal and advertising injury in the context of coverage for alleged violations of the Telephone Consumer Protection Act ("TCPA") and the Fair Credit Reporting Act ("FCRA") claims are analogous to many of the issues that arise in the cybersecurity context. Those decisions also favor the application of personal and advertising injury for cybersecurity claims, because they hold that the viewing of confidential or private information is publication for purposes of personal and advertising injury; such decisions cut in favor of finding that a data breach, hacking, or phishing incident constitutes publication for purposes of coverage.⁴⁴⁶

One question that has arisen in connection with the publication requirement in the context of cybersecurity and data breach claims is whether the insured must perform the publication. A recent trial court decision ruled that Sony was not entitled to coverage for a data breach because hackers, not Sony itself, disclosed confidential data.⁴⁴⁷ However, nothing in the wording of the personal and advertising injury coverage provisions requires a publication to be performed by the insured; rather, it merely requires that the insured become legally obligated to pay damages for an action that constitutes a personal or advertising injury.

The insurance industry introduced a series of endorsements for CGL policies intended to eliminate coverage for cybersecurity risks. One endorsement eliminates coverage for personal and advertising injury arising out of the disclosure of confidential and personal information, while the other two also exclude coverage for both bodily injury and property damage or bodily injury only.⁴⁴⁸ Insureds should be wary of attempts by insurers to add such endorsements to their CGL policies. In addition to taking away coverage for data breaches, the endorsements may create gaps in coverage for bodily injury and property damage. The purchase of a cybersecurity policy may not fill such gaps, as cybersecurity policies typically exclude coverage for bodily injury and property damage.

Strategic Point:

Insureds should also pay close attention to recent policy endorsements and the language contained within the body of the Insurance Services Office (ISO) 2013 CGL policy form that contain exclusions styled "Recording and Distribution of Material and Information in Violation of Law." That exclusion often relates to certain statutorily based claims, such as the TCPA, and other laws, statutes, regulations, that address, prohibit, or limit the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating, or distribution of material or information.⁴⁴⁹ To the extent that cybersecurity claims against the insured allege such violations, insureds should be aware that their insurance companies will seek to deny coverage, in whole or in part, because of that exclusion. Nonetheless, such exclusions should not apply to common-law claims.

d. First-Party Policy Coverages for Cybersecurity Losses

The first-party property policies noted above provide coverages in addition to insurance for damage to or loss of use of insured properties. First-party property insurance policies often also protect a company's income from insured risk, as well as covering extra expenses resulting from covered losses. Cybersecurity losses may cause covered BIs, extra expense, or CBI losses.⁴⁵⁰ First-party property insurance policies also may provide coverage for lost or deleted data.⁴⁵¹

5. Other Policy Coverages Available for Cybersecurity Losses

After analyzing the company's CGL and first-party policies, it is worthwhile to analyze any remaining policies. Coverage from other policies may be available, depending on the facts of the cybersecurity incident. For example, a policyholder's crime policy may provide coverage for hacking, data breaches, and the theft of consumer data. Crime policies may also contain endorsements for computer fraud, computer theft, or other data extraction which may cover data breaches and other cybersecurity losses.⁴⁵²

E&O insurance may provide coverage for alleged errors and omissions that result in a cybersecurity loss.⁴⁵³ An E&O policy is intended to insure against liability arising out of an act, error, or omission of the named policyholder in rendering or failing to render services, and may cover cybersecurity or computer-related claims.⁴⁵⁴

Directors' and officers' liability (D&O) insurance policies typically provide coverage for losses suffered by directors or officers and by the company for certain claims. In the context of cybersecurity losses, policyholders should consider carefully the resulting potential liability, and the definitions of "Wrongful Act" in their D&O policies.⁴⁵⁵ Moreover, private company D&O insurance policies often contain broad coverage for "entity claims," and privately-held insureds should consider whether such coverage could apply to claims based on alleged data privacy violations.⁴⁵⁶

Commercial crime policies may include coverages such as computer fraud coverage that afford coverage for computer-related fraudulent schemes such as business email compromise fraud. Such schemes typically entail a fraudulent email sent by a third party impersonating a vendor or high-level company officials that trick the recipient into wiring money to the third party. Insurers frequently contend that computer fraud coverage does not apply to such losses on the basis that they do not involve a computer hacking and/or are not directly caused. Although several courts have found that crime policies do not cover such risks, others have found that such policies do cover such risks.⁴⁵⁷

Strategic Point:

Insureds facing certain cybersecurity claims may consider whether kidnap, ransom, and extortion ("KR&E") policies could provide coverage for their claims. In the area of cybersecurity, a growing number of threats of extortion have been made relating to data that was obtained by hacking, a data breach, or other type of cybersecurity incident⁴⁵⁸. KR&E coverage, which often includes coverage for extortion, including threats of abduction or damage to or loss of covered property, might apply in such an incident, depending on the terms used in the form purchased.

VII. First-Party Policies

A. Executive Summary of Property Coverage

First-party policies are designed to provide insurance for a loss to the policyholder's property. Examples of personal first-party policies include automobile and homeowners' policies. Commercial first-party policies protect a business' place of operations and inventory. For instance, if a factory is damaged by fire or explosion, the loss of the building and inventory can be covered under first-party property insurance. Lost profits caused by the interruption of the company's operations can be covered by business interruption ("BI") insurance that typically is included within first-party property policies.

A first-party policy is often a combination of various different but overlapping coverages, with both common and distinct definitions, conditions, and exclusions. Its application to any particular loss is very fact-intensive. Traditionally, the issues under commercial first-party insurance were ones of quantification, and to a lesser extent, causation. Adjusters were, and to a great extent still are, the first professionals called when such a loss occurs. However, traditionally rare catastrophic events, such as terrorist attacks, hurricanes and tornados, have become more commonplace, giving rise to an increased focus on the nature and scope of first-party property coverage. Millions, if not billions, of dollar losses could be suffered by businesses in connection with such events. Thus, understanding the manner in which first-party coverage applies can be critical to businesses at risk of such losses.

Basic issues surrounding first-party insurance are discussed in this section.

B. Property Coverages Generally

Commercial property insurance generally falls into one of two categories: "named perils" and "all risk." Named-perils insurance covers losses to property only if they result from one of the specific causes, or perils, listed in the policy. Typical named perils include fire, lightning, windstorm, and hail. "All-risk" insurance, on the other hand, covers losses from all causes, other than those expressly excluded.⁴⁵⁹ Courts tend to interpret liberally the losses that all-risk policies cover.⁴⁶⁰

I. Value of Property Lost or Damaged

First-party property policies generally provide insurance for "direct physical loss or damage to property." Traditional losses under first-party property policies involve tangible property: buildings, machinery, or inventory. Insurers often will argue that such insurance generally does not cover losses that are "intangible."⁴⁶¹ However, as was discussed in Section VI.C of this InfoPAK regarding coverage for cybersecurity losses, depending on the relevant factors, insureds facing such arguments can cite to authority from around the

country to support the applicability of coverage. Given the uncertainties as to how a court ultimately may rule regarding property damage coverage for claims involving claimed intangible property (e.g., those regarding whether lost information or the breakdown in a computer system constitutes covered property damage), in-house counsel should help risk managers evaluate the corporation's insurance needs and, if necessary, obtain endorsements that expand the meaning of the term "property damage," as used in the insurance policy.

2. Business Interruption and Contingent Business Interruption

BI insurance most often is found not in a separate policy, but as an additional endorsement that supplements the policyholder's first-party property insurance. An exemplar provision provides that:

Coverage is afforded against loss resulting directly from necessary interruption of business caused by direct physical loss or damage to, or destruction of, from the perils insured against, real or personal property insured hereunder.

In general terms, the first-party property policy indemnifies the policyholder for the value of the covered property that has been lost or damaged. The BI coverage indemnifies the policyholder for the income that is lost when, as a result of the lost or damaged property, there is a disruption to the policyholder's business. The time period for which the insured may recover its BI typically is limited by the specific terms of the policy. For example, in some instances, recovery may be limited to the income lost while the property at issue was being repaired or replaced. Contingent business interruption ("CBI") is the loss that results when loss or damage to property of another causes an interruption in the policyholder's business.

The decision in *Zurich American Insurance Co. v. ABM Industries Inc.*⁴⁶² is instructive regarding the availability and potential benefits of BI and CBI insurance. That action arose out of the 9/11 terrorist attack, and addresses the possible scope of BI and CBI insurance. The policyholder, ABM, provided janitorial, lighting, and engineering services at the World Trade Center. ABM serviced the common areas of the complex, had office space and storage space in the complex, and had access to janitorial closets and slop sinks located on every floor.

Its policy covered loss or damage to property "owned, controlled, used, leased or intended for use by" ABM (Insurable Interest provision). The policy provided BI insurance against "loss resulting directly from the necessary interruption of business caused by direct physical loss or damage, not otherwise excluded, to insured property at an insured location." The policy also provided CBI insurance, which read:

due to the necessary interruption of business as a result of the direct physical loss or damage . . . to properties not operated by the Insured which . . . wholly or partially prevents any direct receiver of goods and/or services for the Insured from accepting the Insured's goods and/or services.

The CBI coverage had a \$10 million sublimit.

The District Court granted Zurich's motion declaring that ABM was not entitled to BI insurance on the grounds that the common areas and tenants' premises serviced by ABM, but not owned or leased by ABM, were not "Insured Property" as that term was defined in the policy. The Second Circuit Court of Appeals reversed, holding that ABM "used" the WTC in its business, thus creating an insurable interest in the property.⁴⁶³ However, a policy exclusion barred CBI coverage for losses to premises "operated by the insured." Because ABM provided upkeep and maintenance to the common areas of the WTC, it effectively "operated" the WTC, and was barred from receiving CBI coverage.⁴⁶⁴

Strategic Point:

Given the variations in the language in the basic insuring agreement, each BI claim can present its own set of issues. Whether coverage will attach for that claim will depend not only upon the underlying facts, but also upon the particular bundle of provisions and endorsements that make up the insuring agreement. The following four elements often are involved in a BI claim:

- A covered peril;
- That results in a loss of covered property;
- That results in an interruption of the policyholder's business operations; and
- That occurred during the "period of restoration" (if such a period applies), while the covered lost or damaged property is restored or replaced.

Demonstrating that the covered peril interrupted the policyholder's business operations often presents two issues for resolution. The first issue is one of causation — did the damage to covered property actually cause the BI? The facts in *Harry's Cadillac-Pontiac-GMC Truck Co. v. Motors Insurance Corp.*⁴⁶⁵ illustrate how this issue can arise. In *Harry's Cadillac*, a snowstorm caused the roof of the automobile dealership to collapse. The storm also blocked access to the dealership for one week. The damage to the roof was covered by the first-party property policy. The dealership sought coverage for the week of lost sales under the BI provisions of the policy. The court held that the property damage, the collapsed roof, did not cause the lost sales. Rather, the lost sales were due solely to the storm. Accordingly, the court held that the policy did not cover the loss.⁴⁶⁶

Another issue that often arises in connection with this element is whether the level of "interruption" to the business has been sufficient under the policy language. BI insurance commonly uses the phrase "necessary suspension of operations." The issue is whether a "slowdown" in operations is sufficient, or whether the policy requires a total "shutdown." For instance, in *Home Indemnity Co. v. Hyplains Beef, L.C.*,⁴⁶⁷ the court held that the "common understanding of the term 'suspension' [is] a temporary, but complete, cessation of activity." However, other courts have held to the contrary and have held that BI coverage applies when a business continues to operate but at a diminished capacity.⁴⁶⁸

As a result, policyholders should submit their claims in a form that maximizes the chance of recovery. A “slowdown,” or a reduction in productivity, might accurately be described as a partial “shutdown” of some of the operations. Moreover, policyholders often are required to mitigate damages by resuming operations at the covered location or elsewhere. Performance of this duty to mitigate, by resuming some operations when possible, should not be used by insurers to void or reduce coverage. In *American Medical Imaging Corp. v. St. Paul Fire & Marine Insurance Co.*,⁴⁶⁹ a fire rendered the policyholder’s business premises unusable. The policyholder rented an alternative site and resumed operations, albeit at reduced capacity. The court in *American Medical Imaging* rejected the insurance company’s argument that coverage should be denied because the policyholder’s business operations were not totally suspended, reasoning that the policyholder’s compliance with the mitigation provisions should not be used as a basis to deny coverage.⁴⁷⁰

C. Elements of a Business Interruption or Contingent Business Interruption Claim

I. Covered Peril

Pursuant to a “Named Peril” policy, the policyholder must prove that the cause of the loss falls within the “peril”⁴⁷¹ for which the insurance policy provides protection. If the insurance is provided under an “All Risk” policy, to avoid coverage, the insurance company will have the burden of showing that one or more of the exclusions applies.

For instance, after 9/11, there was significant discussion as to whether the “war risk” exclusion found in many first-party policies excluded the losses that resulted from the destruction of the World Trade Center. Insurance companies concluded that the terms of the “war risk” exclusion did not apply because the exclusion required that the act of war be committed by a hostile government. Many “All Risk” policies now include a separate terrorist exclusion, along with separate “Named Peril” coverage that provides coverage for a loss caused specifically by a terrorist act.

An example of coverage that has drawn particular attention in the context of catastrophic environmental disasters, such as hurricanes and flooding, is coverage that applies when “ingress” or “egress” to a business has been prohibited by a civil authority. This form of coverage can be found under “all risk” language or grafted onto a BI insurance policy through a separate endorsement or otherwise. Thus, if a governmental entity orders an area closed or otherwise denies access to the premises, the BI coverage could be triggered. Some of the civil authority or ingress/egress coverages still require physical damage to the premises of the policyholder or at adjacent locations, but others do not.⁴⁷²

There are many other forms of “named peril” coverages that may be relevant to BI claims. For instance, “service interruption” coverage specifically indemnifies the policyholder for a loss to the policyholder’s business that results from an interruption of utility services, such as electricity, gas, sewer, or telecommunications. These “service interruption” policies also may be viewed as a form of CBI insurance.

2. Covered Property

"Covered Property" typically is defined to include all property at certain specified locations (or premises), or within a certain number of feet of the listed locations. For instance, "All Risk" policy language may provide insurance "against all risks of direct physical loss or damage to the property described [elsewhere in the policy] from any external cause." Some courts find coverage for an insured where a covered peril caused damage to the building containing the insured's business, even though the peril did not cause physical damage to the insured's business property.⁴⁷³

To recover under CBI coverage, a policyholder does not need to show actual physical damage to its property. As already noted, CBI insurance explicitly covers the policyholder for losses that arise in its operations because of damage to the property of a business or individual upon which the policyholder depends. In the case of CBI coverage, the third-party property generally is referred to as "contributing" or "dependent" property.

In some circumstances, the third-party property is specifically described on a schedule annexed to the policy. An exemplar insuring provision provides:

We will pay for the actual loss of Business Income you sustain because of the necessary suspension of your "operations" during the "period of restoration." The suspension must be caused by direct physical loss of or damage to "dependent property" at a premise described in the Schedule caused by or resulting from any covered Cause of Loss.

"Dependent property" often is limited to property at the following four types of businesses:

- A business that provides goods or services needed for the policyholder's operations;
- A business that purchases the policyholder's goods or services;
- A business that manufactures products that the policyholder sells; and
- A business that attracts customers to the policyholder's business (e.g., popular "anchor" stores that draw customers to a shopping center) or related businesses (e.g., a neighboring hotel and casino).

Some CBI policies can be broader in scope and can extend to the interruption of business "caused by damage to or destruction of real or personal property . . . of any supplier of goods or services which results in the inability of such supplier to supply an insured location[s]." ⁴⁷⁴ For instance, in *Archer-Daniels-Midland Co. v. Phoenix Assurance Co.*,⁴⁷⁵ the court held that there was CBI coverage when a flood of the Mississippi River disrupted transportation on the river, requiring the policyholder to obtain substitute transportation and supplies for its farm product manufacturing operation. When the policy contains the more generalized reference to "dependent property," however, a dispute may arise over whether the particular loss triggers coverage.

3. Covered Loss

A policyholder also generally should establish that, but for the interruption of its operations, it would have earned income. In other words, insurers often will require the policyholder to show not just that it suffered lost sales, but that those sales would have resulted in a profit.⁴⁷⁶ If the interruption is to an ongoing business, with a history of sales and profits, then the calculation of loss may be straightforward. However, proving “lost profits” is not always a simple task. Challenges in calculating lost income generally warrant the early involvement of an accounting expert.

A significant and common coverage that often is included within BI coverage that can affect the scope of the insurable loss is “extra expense” coverage. This coverage typically extends the BI insurance to those expenses necessary to continue operating the business while the property is being repaired and the operations’ capacity is brought back to “normal.” The most obvious example of these mitigation costs would be the costs of renting alternative space.

4. Period of Restoration

The “period of restoration” or “extended period of indemnity” often is described as the period that it takes to repair the damaged property and return the business back to its “normal” level of operation. Ordinarily, but not always, only the losses incurred during the period of restoration (or extended period of indemnity) are reimbursable under a business interruption policy.

Two issues often arise regarding how to calculate the period of restoration. Destroyed property or premises often are not replaced as they were, but instead are modernized or improved. Thus, there often is a dispute over whether the actual time of restoration includes additional time to improve or modernize the property facility. The insurance company often will contend that some portion of the lost income is attributable to the additional time period and is not reimbursable. However, insureds should not necessarily acquiesce. Indeed, if it is necessary to “modernize” or “improve” the property to return to “normal” operations, then the period of restoration should include the time necessary to modernize.

The second issue arises when loss that otherwise would be covered by the policy takes place after the period of restoration. For instance, if, during the period of restoration, the policyholder makes sales out of inventory, the depleted inventory may result in reduced sales after the period of restoration, when the business is operational. Courts have reached different results as to whether losses incurred in the post-restoration period are covered.⁴⁷⁷

Some of these potential issues can be resolved through the purchase of an extended BI coverage.⁴⁷⁸ This provision allows coverage for losses that occur after the period of restoration. However, the losses still usually must be caused by the initial BI.⁴⁷⁹

Since 9/11 and Hurricane Katrina, first-party property insurance in general, and BI insurance in particular, have been the subject of intense judicial scrutiny. Policyholders have become painfully aware of the perils that can lead to a BI, and the types of policies that are being offered by the insurance industry to cover those risks. Additional litigation will

result in further examination of the language used in these types of policies. In-house counsel should become aware of the package of insuring provisions that are available to protect against these risks and how to prosecute BI claims to most effectively serve their clients.

D. Exclusions

Insurers frequently respond to claims for coverage by arguing that various exclusions apply to bar or limit coverage. Whether exclusions apply may depend in substantial part on what the cause of loss is determined to be and on whether the applicable law follows the “efficient proximate cause” doctrine. This will be particularly important when multiple causes (*e.g.*, wind, flood, government order, looting) may contribute to a loss. If the efficient proximate cause doctrine applies, then coverage may depend on a single cause, with exclusions applicable to other causes having no or limited impact.⁴⁸⁰ If the “concurrent causation” doctrine applies, then coverage may apply to the extent that any cause or peril not expressly excluded contributes to causing the loss.⁴⁸¹

I. Common Disputes Related to Flood or Water Exclusion

The “flood” exclusion provides an example of how insurers can seek to limit coverage by focusing on one excluded “cause of loss” and seeking to avoid others. A common dispute with regard to the application of the flood exclusion arises when policies cover one common cause of hurricane-related loss and exclude another. For example, policies may cover the peril of wind but not the peril of flood, or vice versa.⁴⁸² These and similar issues have been addressed by several courts, particularly in the context of Hurricane Katrina and Superstorm Sandy coverage litigation. The phrase “whether driven by wind or not” in the flood exclusion in a policy may affect whether an insurer will be responsible for water-related damage.⁴⁸³

Strategic Point:

Depending on the degree of flood risk faced by the business, it may be possible to purchase flood coverage as an endorsement to the business’s commercial property policy or by purchasing a separate supplemental policy.⁴⁸⁴ When flood coverage is purchased – either as an endorsement or as a separate, supplemental policy – it may be subject to a separate deductible and may contain a sublimit on coverage. In the wake of Superstorm Sandy and the ensuing re-mapping and re-rating of flood zones by the federal government, many businesses may find themselves priced out of insurance through the private market. If a business is exposed to a moderate to severe flood hazard, such as businesses along the Gulf Coast and the Eastern Seaboard, it may have to purchase coverage from the National Flood Insurance Program (“NFIP”). The NFIP is a federally funded program that provides limited flood insurance in certain communities. Non-residential buildings are eligible for up to \$500,000 in building coverage and \$500,000 in contents coverage.⁴⁸⁵ If additional insurance is needed above the amount provided through the NFIP, then a business may be able to purchase flood insurance in excess of the amount provided by the NFIP policy.

2. Land and Water Exclusions

Many property policies contain land and water exclusions, which explicitly provide that land, “including land on which the property is located,” and water are not included as “covered property.”

Other policies, however, provide coverage for land improvements and betterments, such as graded or filled land, plants and shrubs, retaining walls, and paved surfaces. Such land and water exclusions could be relevant in a variety of contexts, including, for example, the oil spill in the Gulf of Mexico.

According to insurer arguments, since the oil spill has damaged or will damage land and water, such damage is not covered because there has been no damage to covered property. Courts addressing similar arguments in different contexts have sided with the insurance companies. In *Horning Wire Corp. v. Home Indemnity Co.*,⁴⁸⁶ for example, the Seventh Circuit Court of Appeals found that a land exclusion unambiguously excluded coverage for the costs of removing contaminated soil. The court ruled that the exclusion was not inconsistent with the fact that the policy covered the broader concept of real property, noting that land is merely an excluded subset of that category.⁴⁸⁷

Strategic Point:

Policyholders have several responses to this insurer argument against coverage. First, some courts have found that the land exclusion applies only to land in its natural state. Accordingly, the exclusion should not apply to damaged land that has been graded, paved, or improved upon. In one case, a Minnesota federal district court found in favor of coverage for damaged excavated land that had been used in the construction process, despite a land exclusion in the policy. The court distinguished between land in its “natural” state and land that had been altered through construction. See *M.A. Mortenson Co. v. Indem. Ins. Co. of N. Am.*⁴⁸⁸ In another case, a court found a land exclusion was ambiguous as to whether it applied to altered or excavated land, and denied an insurer’s motion for summary judgment on the applicability of the exclusion. See *Klockner Stadler Hurter Ltd. v. Ins. Co. of Pa.*⁴⁸⁹

At least one court has found that man-made bodies of water were not excluded from coverage under the water exclusion. The Ninth Circuit Court of Appeals found that a water exclusion did not exclude coverage for a man-made channel that had become clogged with debris after a large storm. *Abbey Co. v. Lexington Ins. Co.*⁴⁹⁰ The water exclusion in Abbey purported to apply “[w]ater, except water which is normally contained within any type of tank, piping system or other process.”⁴⁹¹ The court read this exception to the exclusion to indicate that the exclusion only applied to “the substance water, which, unlike bodies of water,” can be contained in a pipe system.⁴⁹² Noting “‘water’ can sometimes encompass ‘bodies of water,’” the court decided that, in this case, bodies of water were not excluded by the policies.⁴⁹³ It did, however, rely in part on the fact that the water was not damaged, “as by, for example, pollution or contamination;” rather, the canal itself was damaged.⁴⁹⁴

In addition, some cases hold that if the property is rendered unusable, such as by a landslide that destabilizes a building foundation, a property policy may provide coverage. See, e.g., *Pfeiffer v. Gen. Ins. Corp.*⁴⁹⁵ Similarly, policyholders may argue that their home or

business is rendered unusable by the contamination of oil, and thus coverage applies.

Another policyholder argument relies on additional coverages for debris removal, which is often included via rider or endorsement in a property policy.⁴⁹⁶ Policyholders may argue that the removal of oil-contaminated soil or water is covered under the debris removal provision. There is no way to effect the removal of oil without the removal of the contaminated land or water. Thus, even if the debris removal process entails the removal of contaminated soil, the costs incurred for such a process may be covered. At least one court has applied this reasoning to a land exclusion and found in favor of coverage. *Farrell v. Royal Ins. Co. of Am.*⁴⁹⁷

E. Additional Coverages

In addition to the basic coverage for damage to property, most first-party policies include several related coverages. These additional coverages may be labeled as “supplemental coverages,” “coverage extensions,” or “additional coverages,” depending on the form used by a particular insurer. There are also “premises” pollution policies available to cover first-party cleanup of environmental issues at specific properties listed in the policy.

In addition, certain policies are designed to cover a particular type of property, such as Boiler and Machinery insurance and Aircraft or Watercraft insurance. Other coverages protect the property of the policyholder when it is in the hands of a third person, often in transit. These types of policies are sometimes referred to as “Inland Marine” policies. Marine insurance was the first type of insurance designed to protect goods in transit. However, this coverage ended when the ship landed. Inland Marine insurance was developed to protect goods while they continued their journey “inland,” thus, the generic reference to “Inland Marine” for transit insurance.

I. Sue and Labor Coverage

Policyholders often spend substantial sums to prevent future damage. For example, if a hurricane is predicted, the policyholder might spend money sandbagging its buildings and boarding up windows to prevent damage to the buildings from the anticipated hurricane. Traditional property insurance policies frequently cover such preventive measures pursuant to the “sue and labor”⁴⁹⁸ provision and, in many instances, expect the policyholder to take such measures to avoid “imminent” loss.

Sue and labor policy provisions may read as follows:

In the case of actual or imminent loss or damage by a peril insured against, it shall, without prejudice to this insurance, be lawful and necessary for the insured . . . to sue, labor, or travel for, in, and about the defense, the safeguard, and the recovery of the property or any part of the property insured hereunder . . . This Company shall contribute to the expenses so incurred according to the rate and quantity of the sum herein insured.

The sue and labor clause once was considered an archaic policy provision not frequently discussed among insureds and insurance companies. However, this provision continues to be included in property policies today. The insurance essentially applies when policyholders spend money to protect otherwise covered property from damage or destruction by a covered peril. By encouraging policyholders to protect threatened property, insurance companies hope to protect themselves from the far greater liability they would incur under their policies should the covered property be damaged or destroyed. The key to the coverage typically revolves around the level of “imminence” of the event likely to lead to loss. Whether the potential loss-causing event was sufficiently imminent to trigger coverage often is a question of fact and quite circumstance specific.

It has been widely observed that the sue and labor clause is a separate contract of insurance. In *White Star Steamship Co. v. North British & Mercantile Insurance Co.*, the court explained the supplementary and independent character of the sue and labor clause:

The law is well settled that the sue and labor clause is a separate insurance and is supplementary to the contract of the underwriter to pay a particular sum in respect to damage sustained by the subject matter of the insurance. Its purpose is to encourage and bind the assured to take steps to prevent a threatened loss for which the underwriter would be liable if it occurred, and when a loss does occur, to take steps to diminish the amount of the loss. Under this clause, the assured recovers the whole of the sue and labor expense which he has incurred, subject to the expense having been proper and reasonable in amount under all the circumstances, and without regard to the amount of the loss or whether there has been a loss or whether there is salvage, and even though the underwriter may have paid a total loss under the main policy.⁴⁹⁹

As a separate contract of insurance, the exclusions applicable to other coverages should not apply to prevent payment under the sue and labor provisions. Were it otherwise, the insured would be forced to act at its peril unless (1) the loss was not totally averted and (2) the peril giving rise to the loss, regardless of what was anticipated, must in fact be a covered peril. The only way for the “sue and labor” clause to work is as a separate coverage whose provisions are triggered by the reasonable anticipation of a potentially covered cause of loss.

In *Witcher Construction Co. v. St. Paul Fire & Marine Insurance Co.*, the court construed policy language that was similar to a “sue and labor clause.”⁵⁰⁰ The court found that the provision was a separate coverage, not subject to exclusions which, in effect, merely stated an implied duty to mitigate damage. The court emphasized that as long as the steps are reasonable and calculated to mitigate, the insurance company should be held accountable for its share of such costs: “Because this provision primarily benefits the insurance company by limiting its exposure to liability, the insurance company must reimburse the insured for the costs of mitigation, even if the policy would not otherwise cover those expenses.”⁵⁰¹

2. Debris Removal

Coverage under the “debris removal” provision, which often has a sublimit, pays for the expenses associated with removing debris of covered property when the debris was caused by or resulted from a covered cause of loss. Courts have held that such a provision may provide coverage for the removal of oil-contaminated soil. *See, e.g., Farrell v. Royal Ins. Co. of Am.*⁵⁰² Some debris removal provisions explicitly exclude coverage for the removal of pollutants or decontamination of land and water. Thus, it is important to review the provision carefully to determine its applicability.

3. Civil Authority

“Civil authority” coverage typically protects the policyholder from losses caused by the inability to access its premises when a civil authority denies such access because of covered damage to, or destruction of, property belonging to third parties. Some civil authority coverages require physical damage to the policyholder’s own premises; others do not.

A common civil authority provision, providing coverage for damage to property belonging to third parties, reads:

When a Covered Cause of Loss causes damage to property other than property at the described premises, we will pay for the actual loss of Business Income you sustain and necessary Extra Expense caused by action of civil authority that prohibits access to the described premises, provided that both of the following apply:

- Access to the area immediately surrounding the damaged property is prohibited by civil authority as a result of the damage, and the described premises are within that area but are not more than one mile from the damaged property; and
- The action of civil authority is taken in response to dangerous physical conditions resulting from the damage or continuation of the Covered Cause of Loss that caused the damage, or the action is taken to enable a civil authority to have unimpeded access to the damaged property.⁵⁰³

A “civil authority” may be a federal agency or a state government. A Virginia court found for coverage under a civil authority provision when the policyholder airline had to suspend operations because of the closure of Washington’s Reagan National Airport after the 9/11 terrorist attacks. *US Airways, Inc. v. Commonwealth Ins. Co.*⁵⁰⁴ The court found that the policy covered civil authority closures issued as a “direct result of risk of damage or loss” to the policyholder’s property.⁵⁰⁵

4. Ingress/Egress Coverage

“Ingress/egress” coverage protects the policyholder against lost business income and extra expense when the policyholder’s premises are inaccessible for reasons other than an order of a civil authority. This type of coverage typically requires that the property damage be located within a certain radius of the policyholder’s premises. By way of example, such coverage could be implicated by a marine oil spill. In the areas where the oil spill reaches land, for example, business owners along the shoreline may be affected by cleanup operations that require the closure of coastal areas. Business owners may be able to obtain coverage for related business losses and additional expenses they incur.

5. Extra Expense

“Extra expense” coverage indemnifies the policyholder for any increased cost of business operations above normal because of a peril insured against. For example, in *American Medical Imaging Corp. v. St. Paul Fire & Marine Insurance Co.*⁵⁰⁶ a fire forced the policyholder to relocate its business headquarters for six weeks. In addition to claiming lost profits during that time period under its BI coverage, the policyholder also received reimbursement for the costs associated with relocating its business to a temporary building under the policy’s extra expense coverage.⁵⁰⁷ Another example of such expense would be increased costs of raw materials and transportation occurring as a result of a marine oil spill. In that situation, a restaurant along the coast near such a spill might be forced to spend additional sums to keep its business operating by obtaining seafood from Asia or Latin America, because of a lack of supply from the coastal area in which the restaurant is located.

F. Additional Issues

I. Calculation of Limits

Commercial property insurance policies contain limits (e.g., the maximum amount to be paid in the event of a loss) that may be provided on a “scheduled” or “blanket” basis. When the policy contains limits based on a scheduled basis, a separate limit of liability will apply for each type of property at each location. When the policy contains limits based on a “blanket” basis, a single limit of liability typically will apply for all types of property at all locations covered by the policy. In some instances, the policy may contain blanket limits that exclude certain locations or that apply to only certain types of property.

Coverage disputes involving calculating limits often arise in situations where multiple insurers cover a loss, such as a shared program of insurance, or an insurance program with umbrella and/or excess carriers. In some instances, the different policies involved in the same program do not have consistent limits, leading to disputes regarding how to calculate the limits. For example, in *Maryland Casualty Co. v. W.R. Grace & Co.*⁵⁰⁸ the policyholder argued that a multi-year quota share policy had an annual aggregate limit of \$5 million per year, while the insurance company argued that this same multi-year policy had a single aggregate limit of \$5 million for the entire multi-year policy period. The court granted the

insurance company's partial summary judgment motion on this issue because the policy provided for a \$5 million aggregate limit and did not mention the term "annual."⁵⁰⁹ The court disregarded other quota share policies within the same layer, which contained the term "annual" in their policy limits provisions.⁵¹⁰

2. Measuring Business Interruption Losses

Insurance policies typically contain provisions stating how BI losses are to be measured. They often address the issue in terms of "actual loss sustained," which frequently is measured in terms of either (i) the net reduction in gross earnings minus expenses that do not necessarily continue or (ii) the net profit that is prevented from being earned plus necessary expenses that continue during the period of interruption. Because of the complexities involved in measuring BI losses, a policyholder may need to hire an expert to assist in preparation of the claim, including measuring the BI losses. Early loss calculations should be qualified, since the actual amount of loss may change as the policyholder gathers and analyzes additional information regarding its losses. Indeed, in some instances it may take years to properly assess the BI losses caused by a disaster.

Strategic Point:

One question that should be asked relates to how the lost earnings or profits are measured – against past performance, against budget, pursuant to a specified formula, or through some other method. This frequently will depend on policy language. However, when policies indicate that the measurement is the difference between actual earnings or profits and, in essence, what otherwise would be expected, a policyholder frequently measures its losses by comparing the income it would have generated absent the covered risk to the income it actually generated. This may result in a lower insurance recovery than the law permits. A policyholder should consider measuring its losses not based on what it would have made if there had been no loss event, but rather on what it would have made had its facilities and operations not been affected by the event, while other businesses were negatively impacted by the event. As one court has explained, the policy "does not exclude profit opportunities due to increased consumer demand created by" an insured peril. *Levitz Furniture Corp. v. Houston Cas. Co.*⁵¹¹ The court further explained that "business interruption loss earnings may include sales [the policyholder] would have made in the aftermath of the [peril] had it been open for business during that period."⁵¹²

G. Political Risk Insurance

Political risk insurance is a specialty insurance designed to protect a company's assets, investments, or contractual rights in a foreign country from losses caused by "political" events in that foreign country. Depending on the type of policy, covered "political" events commonly include civil unrest, vandalism, riots, wars, terrorism, expropriation, confiscation of assets, or the enactment of new laws. Companies operating in foreign countries – particularly those with a history of instability and civil unrest – should consider political risk insurance as a means to guard against financial losses from such events. The various types of political risk insurance, the markets for political risk insurance, and certain issues unique to political risk insurance are discussed below.

I. Types of Political Risk Insurance

While there are variations, five basic types of political risk insurance are typically available in the marketplace.

- **Contract Frustration Insurance:** Contract frustration insurance protects a company's trade or sales contract with a foreign company from an action by the foreign government. This type of policy may protect against losses from confiscation, nationalization, expropriation, changes in the foreign country's law, embargo or license cancellation, war, political violence, insurrections, strikes, riots, and other specified events that prevent the performance of the contract in question. These policies typically require that the government's action or inaction result in the termination of the contract, prevent the performance of the contract, or result in the foreign company having a valid discharge of its duties under the contract.
- **Currency Inconvertibility Insurance:** Currency inconvertibility insurance protects a company doing business in a foreign country from losses caused by the inability to convert the foreign currency into US dollars. This type of policy typically applies when a foreign government enacts new currency restrictions or otherwise prevents the conversion or transfer of a company's funds generated in connection with its foreign business pursuits from local currency into US dollars.
- **Expropriation Insurance:** Expropriation insurance protects a company from a foreign government's unlawful confiscation, nationalization, or expropriation of the company's investment or assets. This type of coverage may insure against both direct and indirect interference with the company's ownership rights.
- **Political Violence Insurance:** Political violence insurance protects a company against losses incurred due to certain politically charged events in the foreign country. Covered events may include war, civil unrest, revolution, military coups, riots, and politically motivated terrorism. This type of policy typically covers the loss of or damage to physical assets and property, resulting lost profits and earnings, and evacuation costs.
- **Terrorism Insurance:** Stand-alone terrorism insurance protects a company from losses caused by violent acts, such as acts involving chemical, biological, or other weapons of mass destruction, by individuals or groups. This type of coverage is typically much narrower than political violence coverage.

2. Insurers Providing Political Risk Insurance

Political risk insurance can be obtained from “official” insurers, such as the Overseas Private Investment Corporation (“OPIC”) (United States), the Multilateral Investment Guarantee Agency (“MIGA”) (World Bank), or the Export Credits Guarantee Department (“ECGD”) (United Kingdom). The coverage also is available from private-market insurers, including the London market, ACE, Zurich North America, and the AIG group of insurers. The nature of the coverage and the policy forms and terms vary between the “official” and private markets, creating advantages and disadvantages for both.

For example, political risk insurance provided by OPIC, MIGA, and ECGD typically provide longer policy terms (15–20 years). Additionally, OPIC and ECGD insurance is backed by the US and UK governments, respectively, which may in and of itself deter a foreign government from interfering with a company’s investments or contracts. Likewise, MIGA insurance is backed by the World Bank and the foreign country in which the company is doing business must be a member. This arrangement may also deter harmful acts by the foreign government. That said, OPIC, MIGA, and ECGD have the following eligibility requirements that may limit their availability:

- OPIC requires that:
 - the company must be a US company,
 - the investment or project must be registered with OPIC before the company starts the investment or project,
 - the company must obtain the foreign government’s approval of the insurance,
 - the project must take place in one of the countries that OPIC services, and
 - the project must not fall into one of OPIC’s categorically prohibited sectors.
- MIGA requires that:
 - the company making the investment be in a MIGA “member country,”
 - the investment be made in a MIGA “member country,” and
 - the proposed investment project must be economically viable, environmentally sound, and consistent with the labor standards and development objectives of the host country.
- ECGD requires that:
 - the company be conducting business in the United Kingdom, and
 - the investment must be made in an enterprise outside of the United Kingdom.

Even though it is not backed by the United States government, the United Kingdom government, or the World Bank, the private market may offer certain advantages. The private market is not subject to the strict eligibility requirements listed above. Additionally,

the private market generally can provide political risk insurance faster than OPIC, MIGA, or ECGD, which can be a major advantage if a project or risk requires quick placement of insurance. Private market insurers also have greater flexibility, allowing them to tailor a policy to a company's specific needs or offer coverage for risks that the "official" insurers will not insure. However, policies purchased from the private market are usually subject to confidential provisions limiting the disclosure of their terms and even existence. Given the advantages and disadvantages of both the "official" and private markets, companies can sometimes combine political risk insurance policies from both markets to achieve the level of protection they need.

3. Arbitration Clauses

In many instances, political risk policies contain a mandatory arbitration provision applicable to any dispute arising under the policy. Policies containing an arbitration provision will often provide detail regarding the following aspects of the arbitration:

- The location of the arbitration;
- The law to be applied to the dispute;
- The process for the selection of the arbitration tribunal;
- The arbitration rules and procedures to be applied; and
- Other factors regarding the manner in which the arbitration will be conducted.

Insureds should not purchase a political risk policy with a mandatory arbitration provision without first considering all of the positives and negatives of such a provision. Advocates of arbitration claim that it is a more streamlined and economical process to resolve insurance disputes than litigation. The parties can have the dispute resolved by arbitrators who have expertise regarding insurance coverage disputes and political risk issues rather than a judge who may not have such experience. However, there are aspects of arbitration – particularly international arbitration – that can diminish these benefits for insureds.

Unlike in traditional litigation, parties to an arbitration typically must pay the hourly rates of the arbitrators for their hearing, reading, deliberation, and drafting time, the costs of the hearing facilities, travel-related costs to an international location, as well as administrative costs in the case of an institutional arbitration. A successful insured may be able to recover some or all its expenses in an award of costs, but an unsuccessful insured may find itself paying these costs in addition to those of the insurer.

Additionally, in international arbitrations, the insurer may have a home field advantage because it regularly arbitrates coverage disputes and, consequently, may have existing relationships with counsel and arbitrators that an insured does not. Procedurally, an international arbitration provision – coupled with an unfavorable choice of law – may preclude the insured from obtaining certain types of damages, such as bad faith damages, that may be available through traditional litigation. Also, the narrow scope of discovery in arbitration can limit the insured's ability to prove its claim in some instances.

Insureds would do well to consider each of these positive and negative attributes before purchasing a political risk policy with a mandatory arbitration provision and should also factor them into the cost/benefit analysis associated with arbitrating a claim under a political risk policy.

4. Notice Provisions

Most political risk policies contain a provision requiring that the insured immediately provide notice to the insurer upon the occurrence of any event likely to give rise to a claim under the policy. Because notice is typically listed as a condition precedent to coverage – either explicitly in the notice provision itself or by the placement of the provision in the conditions section of the policy – political risk insurers often will attempt to deny coverage if the insured does not fully comply with a notice provision. For this reason, it is crucial that insureds provide notice as soon as possible and comply with the explicit terms of their policies provisions, including providing notice in the proper medium and through the designated party.

Strategic Point:

A common issue in any dispute regarding a notice provision is when an occurrence is “likely to give rise to a claim” triggering a notice obligation. The test to determine whether an insured was aware of a circumstance likely to give rise to a claim is partly subjective and partly objective. The subjective component refers to what information the insured in fact has in its possession. Clearly, an insured cannot provide notice of that which it does not know. The objective component is used to gauge whether the facts the insured is aware of are those which are likely to give rise to a claim. For this component, the “mere possibility” of a claim may not trigger the notice obligation. Rather, there must be a reasonable likelihood that the occurrence will result in a claim under the policy, as determined by the insured after responsible investigation and consideration of the relevant events.⁵¹³ Although this determination is highly factual in nature, insureds should endeavor to provide notice whenever a claim is likely so as to avoid potential pitfalls down the road.

However, an insured that delays in providing notice is not necessarily without arguments in favor of coverage. Although courts may enforce notice provisions as a condition to coverage, in some jurisdictions an insured’s failure to give timely notice may not bar coverage if the insurer is not prejudiced by the late notice.⁵¹⁴ In California, for instance, a delay in notice typically will not bar coverage unless the insurer proves that it actually and substantially is prejudiced by the delay.⁵¹⁵ Thus, an insured should be mindful of its notice obligations, but also understand that delayed notice might not necessarily be fatal to coverage.

5. Disclosure Requirements

Political risk insurance policies also typically impose a continuing obligation on the insured to disclose certain information to the insurer not only prior to the policy's inception but also on a continuing basis. For example, a typical political risk policy provides:

The Insured represents, warrants and/or covenants that: (a) it had no knowledge, at the inception of the Policy Period, of any circumstance which could give rise to a loss under this Insurance Policy; (b) all the information that the Insured has provided in the Application for Insurance and that the insured will provide to the Underwriter, whether in written form or verbal, is true and correct and that no material information has been or will be withheld⁵¹⁶

If an insured breaches its disclosure obligations, the insurer may be entitled to void the policy *ab initio*.⁵¹⁷

Accordingly, it is important for an insured to communicate clearly and openly with its insurer during the negotiation of any political risk policy to ensure that any disclosure obligations are being met. For example, there may be some ambiguity in whether the insurer requires simply the final report that compiles and provides an overview or summary of all of the research concerning the underlying transaction or the commercial circumstances surrounding the investment, or if it instead requires the more detailed underlying data and other information encapsulated in that final report.⁵¹⁸ At the same time, it would be unreasonable for an insurer to expect its insured to provide “a daily document dump” to satisfy its continuing disclosure duty.⁵¹⁹ The scope of an insured's disclosure obligation is therefore an appropriate topic for discussion between an insured and its insurer before the negotiation of a political risk policy is finalized.⁵²⁰

6. Mitigation or “Due Diligence”

An insured also should be aware that many political risk policies contain a “due diligence” clause requiring the insured to do everything “reasonably practicable” to protect or remove the insured property and to avoid or diminish any potential loss in the event of a political situation.⁵²¹ Other policies may require the insured to take steps to mitigate its loss. Such requirements echo the established rule that an insured may not recover damages it may have avoided through reasonable efforts.

Specifically, a typical due diligence provision requires

that [the insured] will act at all times with due diligence, and as if uninsured, and use all reasonable efforts to avoid or minimize Loss, *including, but not limited to, (i) prior to any claim payment and thereafter, pursuing in consultation with the Company [insurer] all reasonable diplomatic, legal, administrative, judicial, and informal means which may be reasonably available for the minimization or recovery of any Loss including the application for any injunctive or peremptory relief*⁵²²

In other words, a policy may require – as a condition to receiving any claim payment – that the insured attempt to resolve or minimize the claim through diplomatic, legislative, or other means. Additionally, an insured may be obligated to consult with its insurer in the course of pursuing such efforts. In the event of a potential claim under a political risk policy, an insured should consult counsel for advice on “due diligence” or mitigation efforts, including, for example, negotiating with the foreign government, ambassadors, intermediaries, and representatives and departments of the US government.⁵²³

The due diligence requirement in a political risk policy requires the insured to take only “reasonable” efforts to minimize the loss. Thus, an insured is not required to undertake measures that are impractical, beyond the insured’s financial means, or otherwise unreasonable under the circumstances.⁵²⁴ Beyond this general reasonableness standard, however, policies typically do not clearly delineate precisely what an insured must do in pursuing its “due diligence” or mitigation efforts. Because of the room for debate about whether an insured did everything “reasonably practicable” under the circumstances and whether the mitigation was appropriate, it is prudent for an insured to document what it did – and why – to show that mitigation expenses incurred were reasonable.

Mitigation expenses also may be recoverable, even if the political risk policy does not explicitly provide for such coverage.⁵²⁵ That said, it is important for an insured to be aware of and comply with any due diligence obligations under its political risk policy so that it knows the appropriate steps to take following a loss. Additionally, an insured should be mindful that some policies may require the insurer’s approval or consent prior to any settlements with third parties that may have contributed to the loss. Therefore, the insured may need to keep the insurer informed and give it an opportunity to approve, or object to, any proposed resolution.

H. Crime/Fidelity Insurance

Commercial fidelity and crime policies, including financial institutions bonds, are purchased by companies to protect against a wide array of first-party losses, not simply theft in its most typical sense.

I. Types of Fidelity/Crime Coverage

Fidelity and crime policies may contain a number of different insuring agreements, depending on the nature of the insured's business and the coverages selected. Common coverages include the following:

- Employee dishonesty coverage: for loss resulting directly from dishonest or fraudulent acts committed by an employee acting alone or in collusion with others. Such dishonest or fraudulent acts must be committed by the employee with the manifest intent (a) to cause the insured to sustain such loss and (b) to obtain financial benefit for the Employee or another person or entity.
- “On Premises” and “In Transit” coverage: for robbery or theft by a non-employee or disappearance of property on the policyholder’s premises or in transit.

- Forgery or Alteration coverage: often only for specified types of written instruments.
- Securities coverage: for losses resulting from the insured having acquired or sold one of various security instruments that is forged, altered, or stolen.
- Counterfeit money coverage
- Computer fraud coverage
- Workplace violence coverage
- Kidnap, Ransom and Extortion (“KR&E”) coverage

These various coverages are typically set forth in separate insuring agreements, and often have separate sub-limits of liability applicable to claims asserted under those agreements.

2. Common Fidelity/Crime Coverage Issues

Timing is always an important consideration when dealing with insurance issues. This is particularly so for fidelity and crime claims. It is important for a policyholder to notify its insurer as soon as reasonably possible after discovering a fidelity loss because (1) fidelity and crime policies typically apply only to claims “discovered” during the policy period (or any extended tail purchased by the insured); (2) like other policies, fidelity and crime policies have notice provisions (with varying language concerning what triggers the notice requirement); and (3) fidelity and crime policies sometimes include provisions terminating coverage as to a particular employee as soon as the insured discovers (or should have discovered) a dishonest act by that employee.

Fidelity and crime claims may also raise a number of substantive issues. For employee dishonesty claims in particular, coverage may turn on whether the person who committed the acts leading to the insured’s loss is an “employee.” Policy definitions of “employee” vary, but they often tie “employee” status to whether an individual is compensated in the form of wages or salary, and whether the individual is subject to the direction and control of the insured. Independent contractors, for example, may be expressly or impliedly excluded from the scope of coverage for “employee” conduct.⁵²⁶ Policy endorsements may be used, however, to extend the scope of “employee” coverage to include persons who do not fall within the standard definition of an “employee” (e.g., agents of the insured and data processing organizations while acting on behalf of the insured in processing payments to and from the insured).

Another oft-contested issue concerns whether a claimed loss resulted “directly” from dishonest or fraudulent acts. Although the net result to the insured is the same whether an employee takes money directly from her employer or the employee causes a third party to sustain a loss for which the employer must reimburse the third party, some courts treat those situations very differently for purposes of fidelity coverage. Courts applying a rigid causation standard have found that a fidelity policy is not triggered where an insured must reimburse a third party for losses the third party suffered as a result of misconduct by the insured’s employee.⁵²⁷ Many other courts apply the more practical “proximate cause” standard to determine whether a loss results “directly” from an employee’s dishonest or fraudulent acts, and do not find the involvement of a third party to be dispositive.⁵²⁸

Additionally, the nature of fidelity losses creates some added wrinkles. An employee who has committed a dishonest or fraudulent act may face criminal charges. The employee is not likely to cooperate with any investigation by the insured or the insurer. It can be difficult to prove that an employee acted with “manifest intent” to cause a loss where an employee fails to cooperate and/or invokes Fifth Amendment privilege. When an insured conducts an investigation into a fidelity or crime loss, the insured may be able to recover those investigation costs expressly under the policy (depending on its terms), or via recovery/restitution from the dishonest employee prior to reimbursing the insurer for any loss paid.

I. Representation & Warranty Policies

Buyer and seller side Representation & Warranty (“R&W”) insurance policies have been available in the insurance marketplace for more than a decade, however, due to trends in mergers and acquisitions R&W policies are being increasingly utilized as part of corporate acquisitions. R&W insurance is written to provide protections and payment of “Loss” as defined in the policies for a “Breach” of Representations and Warranties in the corporate purchase agreement. The policies typically are written with the ability to provide both first-party protection and also insurance in the event of a “Third-Party Claim” resulting in “Loss” from a “Breach.”

There is a growing pool of insurers who offer R&W insurance. Each of these insurers utilize forms that are specific to that insurer, however, there are common elements to the coverage. Typically, R&W coverage pays “Loss” that will provide for the payment of certain Defense Costs and Prosecution Expenses, however, the insurer does not have any duty to defend. The policies are often subject to retentions that can be set as high as 2% of the acquired company’s enterprise value. The policies provide some differentiation between Fundamental and General Representations with respect to the period of coverage, and sometimes the limits and applicable retention.

The policies should be tailored to correspond to the specific purchase deal and policyholders would be wise to pay special attention to aligning the definition of “Loss” in the policy with the definition of loss in the purchase agreement. In addition, deal lawyers and companies should focus on how the retentions erode and whether there is any gap between the deductible, basket, escrow, or retention in the purchase agreement and the erosion in the policy retention. Frequently these policies are utilized as a substitute for a large escrow and to achieve that end, policyholders will want to work through the interaction between the policy and purchase agreement escrow. A significant takeaway for policyholders is that the form policy provisions should be revised to align with the terms of the underlying purchase deal.

During the underwriting and purchase of these policies, the insurers will be actively involved in reviewing the due diligence for the deal and will engage counsel for the insurer to review the materials and engage with deal counsel about any questions. Issues that are not addressed to the satisfaction of the insurer will be addressed in deal specific exclusions to the policy. There can be a significant back and forth during this process to permit the addition and removal of these types of deal specific exclusions.

Strategic Point:

There are several specific areas that have become the focus of negotiations between policyholders and the insurers. These include, among others:

- The definition of Loss;
- The percentage of the retention;
- Negotiated retention drop down dates;
- The erosion of the retention simultaneously with the erosion of retentions in the purchase agreement;
- Treatment of the materiality scrape;
- Coverage for prosecution costs;
- Treatment of breaches during the interim period between signing and closing;
- The specific wording of the no claims and no knowledge letters;
- Coverage for loss of value;
- Protection of privilege for materials exchanged with the insurer; and
- Limitations on subrogation rights against the Sellers or customers of the purchased company.

1. The Coverage

Buyer Side R&W insurance frequently provides that “Subject to the terms and conditions of the Policy” the insurer shall indemnify or pay Insureds, or “on their behalf” for “Loss” in excess of the “retention,” or Policies provide coverage based on functionally equivalent language. The definition of “loss” will by necessity be tied to the definition of “loss” in the “Acquisition Agreement” and also connect in the definition of “breach” under the “policy”.

2. Exclusions

Each insurer has developed a list of specific exclusions that the insurer writes into its policies, although the R&W insurers retain greater flexibility to reduce and limit the scope of exclusions. Exclusions frequently written into R&W policies include:

- Breach of which any Deal Team Members had Actual Knowledge prior to Inception;
- Interim Breaches (when applicable for a non-simultaneous sign and close);
- Material inaccuracies in No Claims Declarations;
- Purchase Price Adjustments
- Covenants or breaches of estimates or forward-looking statements;
- The monetary amount of unfunded or underfunded benefit plans; and
- The efficacy or usability of certain Net Operating Losses.

These are only examples, and each Representation & Warranty (R&W) insurer has its own list of Exclusions for their policy forms.

In addition to the initial Exclusions, R&W insurers will write “Deal Specific Exclusions” into their Policies to address diligence items that raise loss concerns for the insurers. As with the Exclusion language, and other R&W language, policyholders, brokers, and deal counsel all may propose language variations that the insurers may accept to address the application and breadth of the Exclusion (or whatever provision is at issue). In addition, “Deal Specific Exclusions” are frequently proposed by the insurer and then can be removed if further diligence satisfies the insurer’s concerns.

3. Customization

One of the differentiating aspects of R&W insurance, at least for most policyholders, is the customization that is performed on the Policy to align the insurance with the specific brokers, counsel, and the Acquisition Agreement for the deal. R&W insurers modify these Policies substantially and accept proposals from the broker and deal counsel on specific wording to ensure that the Policy works with the structure of the Acquisition Agreement. The insurers continue to dictate the ultimate terms of the Policies and retain the power to refuse certain changes or refuse the sale of insurance altogether, however, the customization process for most policyholders offers their first experience in modifying the terms of an insurance policy to enhance the workability of the insurance. Indeed, the customization begins early in the process, with the insurer frequently adopting a recently used template form from a prior transaction with the policyholder, broker, deal counsel, or any or all of the above.

Specific items frequently addressed in the customization of the Policy include:

- Definitions of Acquisition Agreement, Actual Knowledge, Affiliates, Insured(s), Breach, Loss, Interim Breach, Deal Team Members;
- R&W insurers frequently agree to abide by the “materiality scrape” such that “materiality,” “material adverse effect,” or similar terms shall be disregarded in determining whether a Breach or Loss has occurred;
- The terms of how any “offsetting recoveries” are applied is addressed in the Policies and language can be proposed to customize the Policy to fit the specific purchase;
- Selection of governing law; and
- Dispute resolution terms in R&W policies frequently provide for Arbitration, however, variations that make arbitration optional (along with resolution through the courts) have been offered by various insurers.

These specific items are only examples. R&W insurance policies offer buyers the opportunity to engage in far more active and substantial customization than casualty insurance policies (general liability insurance, property coverage), with which policyholders may be more familiar.

VIII. Bad-Faith Claims Against an Insurer

Like all other contracts, insurance policies contain an implied covenant of good faith and fair dealing.⁵²⁹ The implied covenant of good faith and fair dealing permeates all aspects of an insurer's relationship with its insured, and it obligates the insurer to perform its contractual duties fairly and in good faith, mandating that the insurer refrain from doing "anything which will injure the right of the [insured] to receive the benefits of the agreement."⁵³⁰ A failure to comply with this covenant generally either is called a lack of good faith or "bad faith," and the remedies that apply to breaches of the covenant vary among states. An insurer may be liable for both contract and tort damages for bad faith conduct.

Good faith and fair dealing have been found to be central to the important relationship between insurer and insured. In fact, insurers have been held to have heightened responsibilities to their insureds, as opposed to the parties to a typical commercial contract.⁵³¹ This is generally so because: (1) insurance contracts usually are standardized contracts of adhesion;⁵³² (2) the insurance business is fundamentally important to the public's interest;⁵³³ and (3) an insurer and its insured have a fiduciary relationship.⁵³⁴ To recover on a bad-faith claim, a policyholder need not necessarily establish intentional misconduct. Instead, it may be sufficient that the policyholder simply show that the insurer did not act consistently with applicable customs, practices, and standards.⁵³⁵ An insurer must give the interests of the insured at least as much consideration as it gives its own interests.

In addition to other common law causes of action for a breach of the covenant, policyholders also may have statutory bases for redress against an insurer that does not comply with applicable customs and practices in the handling of claims. For instance, in *ABT Building Products Corporation v. National Union Fire Insurance Company of Pittsburgh*,⁵³⁶ the United States Court of Appeals for the Fourth Circuit affirmed an \$18 million jury verdict against National Union, which had breached its duty to defend and engaged in bad faith. The jury found that National Union violated North Carolina's Insurance Unfair Trade Practices Act by failing to effectuate a prompt, fair, and equitable settlement with ABT when its liability to provide coverage under the policy became reasonably clear:

National Union failed to account for its utter lack of response to ABT's settlement demands. National Union could have acted reasonably under the circumstances--for example, it could have conducted an independent analysis of what the third-party property damages might be, or it could have advised ABT to wait for the actual costs of the claims in the underlying actions to be ascertained. National Union did neither--nor anything else--it instead simply closed its file on ABT without rendering a coverage decision. Viewed in the proper light, this evidence provides ample support for the jury's finding that National Union's indemnification liability was "reasonably clear" and that National Union nonetheless failed to attempt in good faith to effectuate a settlement with its insured.⁵³⁷

The court rejected National Union's argument that it was permitted to wait to settle with the insured until the insured was legally obligated to pay a third party by way of a final judgment or a settlement.⁵³⁸ The court also affirmed the jury's finding that National Union violated the unfair trade practices statute by misrepresenting policy terms to ABT, thereby inducing ABT to negotiate and to buy a subsequent insurance policy on unfavorable terms.⁵³⁹

This section discusses four common subjects of bad faith litigation: (1) breach of the insurer's duty to investigate claims; (2) failure to settle actions against policyholders in good faith; (3) post-litigation bad faith; and (4) whether there is bad faith liability in the absence of a finding of coverage for the claim. In addition, we discuss consequential and punitive damages, which may be recoverable if an insurer acts in bad faith.

A. The Insurer's Duty to Promptly and Properly Investigate a Claim

The extent of the "duty to investigate" claims varies by state. Different courts consider different factors when determining whether the insurer adequately investigated a claim. The factors that have been considered include:

- the extent to which the insurer sought out multiple sources of information about the claim;
- whether the insurer had legitimate reason to believe the claim was fraudulent and required a heightened investigation;
- whether the insurer unreasonably delayed making a coverage decision while waiting for the policyholder to respond to unnecessary information requests; and
- the degree of cooperation and assistance provided by the policyholder throughout the investigation.

Performing a biased investigation also may be bad-faith.⁵⁴⁰

Pennsylvania courts, for example, have interpreted a Pennsylvania bad faith statute to allow a bad faith claim to "encompass the insurer's settlement and investigative practices."⁵⁴¹ In *Cher-D, Inc. v. Great American Alliance Insurance Company*, a Pennsylvania court determined that a reasonable jury could find that the insurer acted in bad faith by failing to take any action to investigate or pay a claim for a 10-month period.⁵⁴² The court explained that this delay only would have been reasonable had there been "red flags" indicating that the claim may be fraudulent, and thus required further investigation. Absent such "red flags," the insurer had no reasonable basis to delay its investigation, and the court determined that a jury could be permitted to consider an award of punitive damages.⁵⁴³

Strategic Point:

Delays in an investigation, or a failure to investigate in a timely fashion, have been held to be a basis for bad faith in other jurisdictions as well. Some states, like Florida, have a statute setting out the periods during which an investigation must be completed.⁵⁴⁴ The United States Court of Appeals for the Ninth Circuit, applying California law, also reversed a summary judgment decision in which the lower court had accepted an insurer's argument that its 15-month delay in investigating and settling a claim was reasonable on the ground that it needed information regarding the policyholder's ongoing medical treatment.⁵⁴⁵ The facts demonstrated that the insurer had obtained the policyholder's medical records prior to the 15-month delay, and understood that its coverage obligation would exceed the policy limits.⁵⁴⁶ "Delayed payment based on inadequate or tardy investigation . . . may breach the implied covenant because [it] frustrates the insured's right to receive the benefits of the contract [promptly]."⁵⁴⁷ New Jersey courts similarly find that delay in investigation or claim processing can support a finding of bad faith.⁵⁴⁸

B. Insurer's Duty to Settle Third-Party Actions in Good Faith

Insurers may commit bad faith if they do not comply with their duty to effect reasonable settlements of claims against their insureds, especially where the policyholder faces the risk of a judgment against it in excess of the policy limits. For instance, courts in California, Illinois, Georgia, and Florida, among other states, each have imposed bad faith liability on insurers for failing to settle claims against policyholders that potentially expose policyholders to excess verdicts.⁵⁴⁹

In a Utah case, *Beck v. Farmers Insurance Exchange*,⁵⁵⁰ an insured motorist sued his insurer for refusal to settle his claim for uninsured motorist benefits. The underlying plaintiff had offered to settle for the amount of the policy limit, \$20,000, even though there was evidence that his claim was worth twice that. The trial court granted summary judgment to the insurer on the ground that the insured had no cause of action. The Utah Supreme Court reversed, finding that an insurer's duty of good faith toward its insured requires "at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim."⁵⁵¹ The court also found that an insurer that breaches this duty is liable to its insured for any foreseeable damages caused by the breach, even if they exceed the policy limit.⁵⁵² Such damages are not limited to contractual damages, and may extend to emotional suffering in certain circumstances.⁵⁵³

Even an excess carrier may owe its insured a duty of good faith in participating in settlement negotiations.⁵⁵⁴ The California Court of Appeals has held that the fact that an insurer "occupied the position of a secondary or excess carrier and took no active part in the defense of the [underlying] action" did not relieve the insurer of its duty to exercise good faith toward the insured in considering any offer of compromise within the limits of its policy.⁵⁵⁵ Further, in *Kelley v. British Commercial Insurance Company*,⁵⁵⁶ an action against an excess liability insurer to recover the amount by which plaintiff's judgment against the insured exceeded the total insurance coverage, the court focused on the excess insurer's participation in the settlement: "Since [the excess insurer] alone had the authority to agree

to a settlement in excess of [the primary limits], it was obviously under a duty to exercise good faith toward its insured in considering any offer of compromise within the limits of its policy.”⁵⁵⁷

C. Insurer's Duty of Good Faith in Post-Litigation Conduct

A frequent issue in bad faith coverage actions is whether an insurer's actions taken after the initiation of a coverage lawsuit may be used to support the policyholder's bad faith claims. Does the duty of good faith and fair dealing end with the filing of a coverage complaint? Courts vary widely on whether, and in what circumstances, an insurer's behavior after being sued is admissible evidence of bad faith, and whether the duty of good faith and fair dealing survives the onset of litigation. Courts that have considered this question often balance several competing factors, such as:

- the extent of the insurer's litigation privilege versus the continuing duty of good faith and fair dealing;
- whether the conduct at issue relates directly to the actual litigation;
- the relevance and probative value of the conduct; and
- whether the consideration of post-litigation behavior will deter insurers from denying claims of bad faith in the future.

Some jurisdictions cite the “litigation privilege” as a ground to bar admission of an insurer's post-litigation conduct in support of a bad faith claim. However, when an insurer's post-litigation actions are not directly related to the conduct of the coverage litigation itself, courts are more likely to consider the insurer's actions as proof of bad faith.⁵⁵⁸ For instance, in *Estee Lauder, Inc. v. OneBeacon Insurance Group, LLC*, a New York Court held that documents prepared by attorneys acting as claims handlers and created after coverage litigation was filed “could not be considered attorney work product simply because they were created during midstream of a litigation.”⁵⁵⁹ Further, the Court found that internal communications documenting the deliberations underlying the insurer's payment delay were “substantially necessary” to the policyholder's bad faith claim.⁵⁶⁰

Strategic Point:

Some courts employ statutes to sanction insurers for acting in bad faith after litigation is initiated. For example, in *Dufrene v. Gauthreau Family LLC*, the Louisiana Court of Appeals upheld a lower court decision to impose sanctions pursuant to Louisiana statutes LSA C.C.P. art. 863, 1471, and LSA-R.S. 22:1220.⁵⁶¹ The *Dufrene* court found that, because LSA-R.S. 22:1220 provided penalties for an insurer's breach of its duty of good faith and fair dealing, and LSA C.C.P. art. 863 and 1471 penalized, respectively, a party's actions in its litigation conduct, and failure to comply with orders compelling discovery, the three statutes “do not deal with the same subject matter” and sanctions could be awarded for an insurer's bad faith after litigation is filed pursuant to all three statutes.⁵⁶²

D. Bad Faith Without Coverage

Insurers frequently argue that a bad faith claim cannot be successful unless there is a ruling that the policy at issue covers the loss. Some states follow that rule.⁵⁶³ Insurers also argue that, if the coverage issue was subject to reasonable debate, the insurer should be immune from bad faith liability. However, bad faith liability may be based upon the insurer's conduct leading up to its coverage determination, regardless of the merits of the coverage decision. Beyond owing a duty of good faith and fair dealing in its ultimate coverage determination, an insurer also owes a duty of good faith and fair dealing in the post-loss or post-occurrence claims handling process, as well as in the investigation, defense, and negotiation of any settlement of claims. These duties are separate from the duty to promptly make a coverage determination and, thus, many courts have found that bad faith claims based on these duties survive, even where no coverage is found to exist, or where reasonable minds could differ on whether coverage exists. This distinction incentivizes insurers to properly investigate and handle all claims, regardless of the ultimate coverage decision.⁵⁶⁴

In *Enoka v. AIG Hawaii Insurance Company*,⁵⁶⁵ the policyholder alleged that the defendant AIG had handled her claim for no-fault benefits in bad faith by denying it for an invalid reason. Defendant AIG argued that, because it had no contractual duty to pay no-fault benefits, there was no implied covenant of good faith and fair dealing in the contract and, therefore, no action for bad faith could exist. The court disagreed with AIG and found that, because a claim for the tort of bad faith turns on the conduct of the insurer in handling the claim, the policyholder "was not precluded from bringing her bad faith claim even where there is no coverage liability on the underlying policy."⁵⁶⁶

E. Consequential and Punitive Damages

When a policyholder pursues a bad faith claim, one important question is the nature of the damages that may be recovered. The amount recoverable may include not only the value of the claim up to the policy limits, but also other damages, including tort and consequential damages. If the insurer cannot be liable for more than the claim amount, there is an incentive for the insurer to deny or delay payment, and force the insured into litigation. An insurer, thus, could employ a strategy of delay because its liability is, in effect, capped. An award of damages in excess of the policy limits for the insurer's bad faith breach remedies the imbalance that exists between the insurer and its insured. The threat of being subjected to damages in excess of contractual limits provides an insurer with incentive to perform its contractual obligations promptly and in good faith.

Recognizing this inequity, in 2008, the New York Court of Appeals decided two groundbreaking cases permitting policyholders to seek consequential damages based on their insurers' breach of their implied duties of good faith and fair dealing. The rulings, *Bi-Economy* and *Panasia*,⁵⁶⁷ involved the insurers' failure to adjust and pay first-party property insurance claims in a timely manner. In *Bi-Economy*, the insurer's failure to pay the policyholder's BI claim resulted in a complete loss of its business enterprise. In *Panasia*, the insurer's failure to promptly investigate and adjust the policyholder's claim resulted in additional lost rents and interest than the policyholder owed on a construction loan.

Consequential damages were warranted in those cases because “limiting an insured’s damages to the amount of the policy, i.e., the money which should have been paid by the insurer in the first place, plus interest, does not place the insured in the position it would have been in had the contract been performed.”⁵⁶⁸

Representing a significant evolution in New York insurance coverage jurisprudence toward the majority of states’ recognition of the availability of consequential damages for wronged policyholders, the Court of Appeals held in *Bi-Economy* and *Panasia* that the policyholders could maintain their respective claims for damages against their insurers beyond the limits of the insurance policies. Consequential damages are available to policyholders in insurance coverage actions, if these damages are reasonable and foreseeable.

With respect to Business Interruption (BI) coverage, the Court of Appeals stated that such coverage is designed “to ensure . . . the financial support necessary to sustain . . . business operation[s] in the event disaster occurred.”⁵⁶⁹ To be effective, BI insurers must promptly, honestly, and adequately evaluate claims “so that in the aftermath of a calamitous event, as *Bi-Economy* experienced here, the business could avoid collapse and get back on its feet as soon as possible.”⁵⁷⁰

The *Bi-Economy* and *Panasia* decisions also are important because the Court of Appeals distinguished “consequential losses” (which typically are excluded under property policies) from “consequential damages.” Although “consequential losses” stemming from a third party’s failure to perform an obligation might be excluded from coverage, “consequential damages” that result from the insurer’s failure to perform under the insurance contract are not. In *Panasia*, the Court of Appeals held that a policyholder may recover damages beyond the limits of its policy for consequential damages resulting from a breach of a duty to investigate, bargain for, and settle claims in good faith.

Other states similarly allow consequential, punitive, and other damages for bad faith conduct. In Pennsylvania, for instance, if there is a finding of bad faith, a court may award interest on the amount of the claim from the date the claim was made by the insured, in an amount equal to the prime rate of interest plus 3%, as well as award punitive damages against the insurer.⁵⁷¹ Further, in many other states, if an insurer acts with “oppression, fraud, or malice,” then the policyholder also may be entitled to recover punitive damages.⁵⁷² Indeed, “punitive damages may be recovered upon a proper showing of malice, fraud or oppression even though the conduct constituting the tort also involves a breach of contract.”⁵⁷³

Strategic Point:

The amount of a punitive damages award generally is determined by considering three factors: “(1) the degree of reprehensibility of the defendant’s misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury” and comparable civil penalties where available.⁵⁷⁴ These factors long have been used by many courts, with courts also considering the impact of an award upon the defendant.⁵⁷⁵

Of these various factors, the first — deterrence — often is viewed as a factor that increases the size of the award. The other factors often are viewed as limiting the amount of the award by prohibiting awards that might bankrupt a defendant and by requiring that there be some reasonable relationship between the size of the punitive damage award and the damages inflicted.⁵⁷⁶ It is important to keep in mind that, when punitive damages are available for an insurer's tortious bad faith, the constitutional limitations on awards of punitive damages also must be considered.

IX. Broker Liability

When purchasing insurance, companies generally rely on the advice and assistance of their insurance brokers. The relationship between the policyholder company and the broker can include not only the negotiation of coverage terms and rates, but also the rendering of advice regarding the appropriate types and amount of coverage to purchase, the completion of forms and notices, and the rendering of advice and assistance in how best to handle claims for coverage.

A. The Difference Between an Insurance Agent and Broker

While the terms often are used interchangeably, "agents" and "brokers" may have different legal functions. An insurance agent usually offers insurance from a single insurance company or family of insurance companies. Insurance agents tend to owe "duties" to the insurance company. An insurance agent also can bind the insurance company by his/her actions. The scope of the agent's authority to bind the insurance company can range from merely accepting paperwork, and providing it to the company, to determining premiums for coverage and settling claims. When an insurance agent does not adequately comply with his/her obligations to the policyholder, the insurance company on whose behalf the agent acted will be answerable for any damages sustained. See *R & B Auto Ctr., Inc. v. Farmers Group, Inc.*⁵⁷⁷

An insurance broker, on the other hand, is typically free to place insurance with any insurance company. Insurance brokers also generally have broader duties to the policyholder company. The identity of a broker's client in a particular relationship is sometimes subject to dispute, and a broker can be a dual agent for both the insured and the insurer. If the broker acts on behalf of the insurance company, the insurance company will be liable for damages sustained by the client, because of the broker's performance. See *Pan-Am. Life Ins. Co. v. Roethke*;⁵⁷⁸ *Branscum v. Am. Cmty. Mut. Ins. Co.*⁵⁷⁹ The broker also may be liable to its policyholder client if the broker fails to adequately perform his/her duties in connection with the procurement of insurance.

B. Services Generally Provided by Insurance Agents and Brokers

Insurance agents and brokers provide a broad range of services to their clients, including:

- Advice about the adequacy of the client's insurance (both in relation to coverage terms and amount of coverage);
- Advice and assistance in submitting information to the insurance companies in connection with the underwriting of the insurance coverage;
- Negotiation of the terms and rates of the insurance coverage;
- Review of the insurance binder or insurance policy to ensure that the coverage afforded comports with the client's needs and requests; and
- Assisting the client in pursuing coverage for any claims (including providing notice to the insurance company of any claims).

C. The Duties of an Insurance Broker

In procuring an insurance policy for the client, an agent or broker has a duty to (i) understand the client's needs; (ii) attempt to meet those needs by canvassing the insurance marketplace; and (iii) advise the client whether or not he succeeded in obtaining the necessary coverage and of any potential gaps in coverage or grounds on which the insurer might dispute coverage under the policy.⁵⁸⁰

In general, "the duty of [an insurance] broker . . . is to use reasonable care, diligence, and judgment in procuring the insurance requested by its client." *Kotlar v. Hartford Fire Ins. Co.*⁵⁸¹ An insurance broker has a duty to advise her client to obtain different or additional coverage when (i) the policyholder client requests a particular type or extent of coverage, (ii) the broker assumes an additional duty by "holding himself out" as having expertise in a given field of insurance being sought by the policyholder client, or (iii) the broker misrepresents the nature, extent, or scope of the coverage being offered or provided. *Fitzpatrick v. Hayes*.⁵⁸²

D. Potential Claims Against an Insurance Broker or Agent

If the broker does not comply with one or more of its duties to the policyholder client, the policyholder can pursue claims against the broker for breach of contract, negligence, and other tort claims. See, e.g., *Chase Scientific Research, Inc. v. NIA Group, Inc.*;⁵⁸³ *Saunders v. Cariss*.⁵⁸⁴

An insurance broker may be liable to its client if the broker failed to procure the type, scope or amount of insurance coverage the policyholder client requested. A broker's "failure to deliver the agreed-upon coverage may constitute actionable negligence and the proximate cause of an injury."⁵⁸⁵

An insurance broker also may be liable to the policyholder client for the advice he gives to the client, including failing to advise the client to procure a type of coverage. See *Kurtz*,

Richards, Wilson & Co. v. Ins. Communicators Mktg. Corp., 12 Cal. App. 4th 1249, 1257–58 (1993); *Clement*, 16 Cal. App. 4th 39, 44 (1993) (insurance agent held liable for misrepresenting extent of contractual liability coverage to its client/insured who incurred loss in real estate transaction); *Eddy v. Sharp*, 199 Cal. App. 3d 858, 866 (1988) (where court found evidence that agent misled insureds into believing that policy covered damage from backed-up sewers, summary judgment for agent barred).

An insurance broker also may be liable to its client when the insurance broker actually obtains the coverage that is promised if the insurer denies coverage and the insured incurs costs or fees in challenging that denial.⁵⁸⁶ In *Third Eye Blind*, the broker contended that it could not be liable because the trial court had found that the policy provided coverage. The court disagreed. It held that the broker should have warned the insured of the possibility of a gap in its coverage – or at least that the insurer might dispute coverage: “The point is that [the broker] failed to alert [the insured] that the [exclusion] would give [the insurer] a viable basis for refusing coverage under some circumstances and, consequently, failed to recommend that [the insured] purchase errors and omissions insurance to ensure complete, uncontestable coverage.”⁵⁸⁷

A broker may also face exposure if it fails to provide adequate guidance with respect to the policyholder’s insurance coverage application. After a claim is made under a policy, if the insurer seeks to avoid coverage based upon alleged problems with the insurance application (depending upon the broker’s involvement in the application process and level of knowledge), then the broker may have exposure.

In general, an insurance broker cannot avoid liability to its policyholder client by arguing that the policyholder client had a duty to read its insurance policies.⁵⁸⁸

Brokers may be liable for the policy limits that would have been available to satisfy a loss or liability had the broker not failed to satisfy its obligations. Brokers also might be liable for their clients’ attorneys’ fees and costs incurred in pursuing coverage with their insurer.

Strategic Point:

Brokers recently have begun inserting limitation clauses in their fee agreements with policyholders that purport to limit their liability to the policyholder to a certain amount. Therefore, it is important that policyholders review their agreements with their brokers carefully to determine if the agreements contain a limitation clause and, if so, whether the limitation clause should be narrowed or eliminated.

E. Statute of Limitations in a Broker Dispute

If a policyholder believes that it might have a possible claim against its insurance broker, then the policyholder should carefully assess the potentially applicable law to determine the relevant statute of limitations and negotiate a tolling agreement with the insurance broker as soon as possible to preserve its claims.

The statute of limitations may vary depending on a number of factors, including the applicable jurisdiction and the nature of the claims against the insurance broker (i.e., breach of contract or negligence). In California, for example, the statute of limitations for a suit against an agent or broker is two years, whether the claim is for negligence or breach of oral contract. *Hydro-Mill Co. v. Hayward, Tilton & Rolapp Ins. Assocs., Inc.*⁵⁸⁹ In New York, the statute of limitations for a negligence claim against an insurance broker is three years following accrual of the cause of action, whereas breach of contract claims are subject to a six-year limitations period. *See Mauro v. Niemann Agency, Inc.*⁵⁹⁰

Jurisdictions also may differ with regards to when a policyholder's claim against its broker accrues. Many courts hold that the cause of action against a broker accrues when (i) the insured actually discovers, or reasonably should have discovered, the broker's failure to procure the proper insurance coverage, and (ii) the insured is damaged by the broker's failure. *See, e.g., Roger E. Smith, Inc. v. SHN Consulting Eng'rs & Geologists, Inc.*⁵⁹¹; *Filip v. Block*.⁵⁹² This may mean that the cause of action does not accrue until the insurer has denied coverage, when the insured actually is damaged by the lack of coverage even though it knew of the problem earlier, or even later, when the insured's lawsuit against the insurer to secure coverage benefits fails.

In *Williams v. Hilb, Rogal & Hobbs Insurance Services of California, Inc.*,⁵⁹³ the insured "did not request any specific type of insurance (and did not know enough about what kind of insurance was needed to make a specific request), instead asking [the broker] for whatever insurance was needed to operate the business"⁵⁹⁴ The broker procured coverage that did not include workers compensation coverage. Subsequently, an employee was injured in a fire. When the insured reported the fire, he learned that he had no workers' compensation insurance. The employee later filed a civil action. The insured was defended in that action by another insurer. However, only part of the resulting judgment was insured. Therefore, the insured filed a lawsuit against his broker.

The broker contended that the lawsuit was time-barred by the statute of limitations. It argued that the statute began to run when the employee was seriously injured "because on that date [the insured] incurred liability to [the employee] that was 'inescapable,' and only the amount of [the insured's] liability, not the fact of his liability, remained to be determined"⁵⁹⁵ The court rejected this argument. It acknowledged that the insured "became aware of his exposure shortly after the fire, and knew of his potential liability when [the employee] filed his lawsuit."⁵⁹⁶ However, it pointed out there "no actual injury occurred until judgment was entered against him."⁵⁹⁷ It reasoned that until judgment was entered against the insured in excess of the coverage provided by another insurer, "other litigation results were possible: a settlement or verdict under the [other policy's] limit, greater comparative liability on [a] codefendant . . . , or a defense verdict."⁵⁹⁸

However, other jurisdictions have found that causes of action against insurance brokers accrue when the inadequate policy is procured.⁵⁹⁹

X. Insurance and Corporate Transactions

Various types of transactions raise insurance issues that often are overlooked. Corporate transactions such as mergers and acquisitions raise issues as to which of the entities existing after the transactions succeeds the insurance rights of the pre-transaction entities. Corporate transactions, as well as many types of more routine transactions, also may contain provisions expressly requiring the purchase or maintenance of insurance. These should be reviewed carefully to ensure that they do not create unintended conflicts with other insurance or indemnification rights the parties may have. Finally, insurance products are available to cover various aspects of transactions themselves.

In merger and acquisition transactions, the disposition of insurance rights is sometimes overlooked, and can lead to disputes both among the parties and with their insurance companies. Insurance coverage for losses going forward often is expressly dealt with in the policies themselves; parties involved on both sides of such acquisitions should review their policies carefully to determine what reporting and other requirements are triggered by such deals. More challenging issues often arise, however, as to the treatment of insurance rights under the parties' existing or historic insurance coverage for losses that may already have taken place, but of which the policyholder and the insurance company may be unaware (e.g., long-term latent injury claims under general liability coverage).

The disposition of insurance rights in such situations may depend on the type of transaction involved. In a statutory merger, for example, most courts hold that the surviving corporation succeeds to the insurance rights of the predecessors as a matter of law. The case law is less certain as to the treatment under other types of transactions, such as a sale of assets, and the parties should be sure to consider the impact of the form of the transaction on the disposition of insurance rights.

A key issue in the transfer of any insurance rights is the anti-assignment clause found in many insurance policies, prohibiting assignment of coverage rights without the consent of the insurance company — consent that is often difficult to obtain if the attempted transfer involves years of historic coverage for long-term liabilities. In the case of a statutory merger, most courts hold that the merger statute overrides any anti-assignment language in the policies. In other forms of transactions that purport to transfer insurance rights, courts may apply the well-established rule that such clauses do not bar transfer of rights to coverage for losses that already have taken place. In other words, the clauses do not bar the assignment of claims for existing losses, only the assignment of rights to coverage for future losses. In the case of long-term latent exposure liability, where the claimant allegedly had been exposed to the injurious conditions prior to the policyholder's attempted transfer of insurance rights, but its injuries have not yet been manifested or reported, courts have split on whether the attempted transfer should be considered a post-loss or pre-loss transfer.

Many types of transactions contain provisions under which one party agrees to indemnify or maintain insurance for the other party, or to add that other party as an additional insured to its own policies. The parties should be careful that their intent as to how such provisions are to operate is expressly stated in the agreement—for example, if there is both an indemnification agreement between the parties as to certain types of losses, but also an agreement that insurance be maintained for such losses, disputes may arise as to whether the insurance or the indemnity should respond first. Transactions providing “additional insured” status to another party in the transaction give that party direct rights to the coverage. The party being made an additional insured should make sure that it has, in fact, been added to the policy, and that the additional coverage does not create unintended conflicts with the additional insured’s own coverage. Both parties should make sure that the limits of the coverage—taking into account the existence of additional insureds under the same policy—are sufficient for the exposures being insured against.

There are also various types of insurance available to cover some of the risks of a transaction itself. “Representations and Warranties” (“R&W”) insurance, as discussed in section VII.I of this InfoPAK, may be available to cover losses arising from breach of certain of the representations and warranties in the deal documentation of a corporate transaction. Policyholders engaged in transactions involving international operations may purchase “Political Risk” insurance against the risks of interference from or instability in the host country. Insurance may also be available to protect against losses from failure of a transaction to receive the expected tax or regulatory treatment.

A. Mergers, Acquisitions, and Insurance

In mergers and acquisitions, the acquiring company (the “successor”) frequently wants to obtain rights under the insurance policies of the company it is acquiring or the company selling assets (the “predecessor”). Therefore, transaction documents often state that the insurance policies are being assigned to the acquiring party. Unfortunately, as stated earlier in this section, most insurance policies contain clauses specifically barring assignment unless the insurer consents. These clauses typically are enforced as to current policies with respect to losses that have not yet taken place. As a result, unless the insurers consent, the assignments may be invalid—and parties to mergers and acquisitions almost never ask for the required consent.

However, there is the possibility that coverage can be found without an express assignment of insurance policies. Rights under insurance often flow, by operation of law, to the successor in certain circumstances. A successor may be able to take advantage of the predecessor’s insurance when the transaction is a consolidation or merger of the two corporations or the successor is a continuation of the predecessor. Moreover, “no assignment” clauses are often not enforced if the transfer of the rights to insurance proceeds was made after the covered loss, though as later subsections demonstrate, courts vary on their interpretation of when a loss has taken place for purposes of this rule.

I. Insurance Coverage Under Predecessor's Pre-Acquisition Policies

When a transaction involves the complete merger of one entity into another, the surviving company may be entitled to the insurance coverage rights under the policies of insurance that were purchased by the predecessor before the merger. In the context of a statutory merger, all corporate assets and liabilities of the merging entities are combined. Thus, in that context, a company's insurance "asset" transfers to the new entity. See *Elliott Co. v. Liberty Mut. Ins. Co.*;⁶⁰⁰ *Chatham Corp. v. Argonaut Ins. Co.*⁶⁰¹

Questions exist in the case law, however, as to the impact on a company's insurance coverage when a corporate transaction does not constitute a technical statutory merger, but instead only certain assets or liabilities are transferred from one entity to another. In that circumstance, an asset purchase agreement may expressly provide for the transfer of rights to insurance coverage as one of the transferred assets. When an asset purchase agreement discusses the transfer of "all assets" and "all liabilities" of the predecessor, the successors can argue that the rights to insurance coverage for injury or damage taking place prior to the date of the acquisition is an asset that is transferred along with all of the other assets transferred under the agreement.

Even if the asset purchase agreement does not expressly acknowledge the intent to transfer rights to insurance coverage, absent language in the agreement to the contrary, such rights can be argued to transfer by "operation of law." In fact, based upon the theory that the insurance "follows the liability," some courts have found that the technical nature of the corporate transaction should be irrelevant to a determination of coverage. For example, in *P.R. Mallory & Co. v. American States Insurance Co.*,⁶⁰² the court recognized that "it has been well-settled for decades that the right to recover under an insurance policy transfers by operation of law when the liability for which the coverage is sought also transfers by operation of law. The right to recover under an insurance policy follows the liability that the insurer underwrote." See also *B.S.B. Diversified Co. v. Am. Motorists Ins. Co.*;⁶⁰³ *Total Waste Mgmt. Corp. v. Commercial Union Ins. Co.*⁶⁰⁴

However, certain courts have sought to narrow this line of cases where the liability at issue does not automatically transfer to the successor entity, but instead is transferred by contract. In that circumstance, these courts have concluded that insurance coverage will "follow the liability" only where the parties expressly transferred rights to the coverage. See, e.g., *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*;⁶⁰⁵ *Glidden Co. v. Lumbersmens Mut. Cas. Co.*⁶⁰⁶

2. The “No Assignment” Clause

Standard form liability policies contain a “no assignment” clause that provides that no assignment of the policy will be effective unless the insurer consents to the assignment. A predecessor’s insurers may argue that a seller’s assertion of coverage under the predecessor’s policies, under a theory either of express assignment or of transfer by operation of law, is precluded unless the insurer consented in writing to an assignment of its policies.

Such an argument should be rejected; in fact, several courts have addressed this argument and rejected it. These courts have based their decisions on one of two lines of reasoning. Under one line of reasoning, courts have looked to the time of the insured injury or damage, reasoning that if the assignment took place after the injury or damage, then the obligation of the insurer is fixed and therefore is a mere debt or chose in action, which may be freely assigned by the insured (the predecessor) without the consent of the insurer.⁶⁰⁷ Under another line of reasoning, courts look to the effect of the assignment on the nature of the risk insured, holding that where the assignment does not result in a material increase in risk to the insurer, the “no assignment” clause will not be applied so as to result in a forfeiture of coverage.⁶⁰⁸ Both rules logically flow from the recognition that the purpose of the “no assignment” clause is to protect the insurer from an increase in risk to which the carrier has not consented. Where the injury or damage occurs prior to the assignment, there often is no increase in risk because the injury or damage taking place during the policy period is fixed before the assignment.

The *Ocean Accident* line of cases⁶⁰⁹ holds that a transfer of rights under a liability policy is “post loss” and avoids the no-assignment clause, if the transfer takes place after the injury or damage has taken place. The Supreme Court of California recently held that California would follow the *Ocean Accident* majority, in a decision that overruled a previous California Supreme Court decision that was much narrower. *Fluor Corp. v. Superior Court*⁶¹⁰ (overruling *Henkel Corp. v. Hartford Accident & Indemnity Co.*⁶¹¹). The court in *Fluor* held that, after a loss covered by an insurance policy has taken place, an insurer may not enforce a “no assignment” clause in the policy.⁶¹² *Fluor* also clarified that a “loss” occurs for purposes of this analysis when property damage or bodily injury happens to a third party that may later advance claims against the policyholder—in *Fluor*, when a third party was exposed to asbestos resulting in personal injury.⁶¹³ This overruled the rule in *Henkel*, which had allowed an insurer to enforce its “no assignment” clause until the claims against the insured were “reduced to sum of money due or to become due under the policy.”⁶¹⁴

In *Fluor*, a unanimous decision, the Supreme Court of California reconsidered and overruled its 2003 decision in *Henkel* for several reasons. Among those reasons, the most important was that a section of California’s Insurance Code cut directly against its result.⁶¹⁵ “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 situations involving life insurance and disability insurance].⁶¹⁶ As the court in *Fluor* noted, this section had not been argued or considered in *Henkel*. The court in *Fluor* found that the statutory language of Insurance Code Section 520 did not allow the result reached in *Henkel*.⁶¹⁷

In interpreting the statutory language “after a loss has happened,” the court in *Fluor* reviewed historical decisions concerning the duty to indemnify under a third party liability policy, and held that that duty arises “when personal injury or property damage results during the term of the policy, even though the dollar amount of the liability continues to be unascertained until later established.”⁶¹⁸ Thus, an insurer’s duties under an insurance policy are predictable and definable at this point, justifying the court’s decision that after that point, an insurer cannot assert the “no assignment” clause.⁶¹⁹

In its decision in *Fluor*, the Supreme Court of California also acknowledged that, since the time *Henkel* was decided, several courts in other jurisdictions had declined to follow its approach, and instead held that a loss has taken place under a liability policy, and may be freely transferred once the covered injury has occurred, and that the claim need not have been fixed as a sum certain.⁶²⁰ The court noted that *Ocean Accident* has become “an accepted part of the legal landscape”⁶²¹ and that the court was aware of “only one out-of-state exception to this line of authority” that had “not been followed by any other jurisdiction.”⁶²²

Finally, the court noted that following the *Ocean Accident* majority would further California’s public policy interest in favor of “contributing to the efficiency of business by minimizing transaction costs and facilitating economic activity and wealth enhancement.”⁶²³

3. Coverage for Successor Liability Under Policies of Insurance Purchased by the Successor Prior to the Date of the Acquisition or Merger

In addition to seeking coverage under the predecessor’s pre-acquisition policies, a successor also might be able to obtain coverage under its own pre-acquisition policies for claims brought against it relating to injury or damage caused by or attributable to the predecessor’s operations. This insurance coverage principle has been called “pre-merger” coverage.

Standard-form liability policies often do not state that the insured must cause the injury or damage at issue, and typically do not state that liability for covered injury or damage must be imposed upon the insured during the policy period. Indeed, standard-form liability policies customarily furnish coverage to an insured for liabilities “imposed upon” it or “assumed” by it for injury or damage occurring during the policy period of the policies, regardless of who actually causes that injury or damage and regardless of whether liability for that injury or damage could not have been imposed upon the insured until after the expiration of the policy. In other words, although policies typically require that the insured be held liable to pay damages and that the damages be for injury or property damage that occurs during the policy period, they usually do not require that the insured itself have engaged in the injury-causing activities or that it even own the business or operations that gave rise to the injury.

This concept was applied to *National Union Fire Insurance Co. v. Liberty Mutual Insurance Co.*⁶²⁴ In *National Union*, the O’Brien Corporation acquired Napko Corporation in 1979. Thereafter, its several plaintiffs filed a lawsuit against O’Brien, alleging that products manufactured and sold by Napko prior to its acquisition by O’Brien injured them. The insurance policies at issue insured O’Brien for time periods which preceded its acquisition by O’Brien’s.⁶²⁵

However, O'Brien sought coverage under those policies. The court summarized O'Brien's arguments as follows:

Pursuant to [the insuring agreements and definitions of "occurrence" and "bodily injury"], [O'Brien claims that] the policies cover those sums that O'Brien becomes legally obligated to pay as a result of bodily injuries occurring during the policy period.

Due to the merger acquisition of Napko, O'Brien contends that it has become legally obligated to pay plaintiffs for the damages they sustained from exposure to the products manufactured and sold by Napko. The Complaint in the underlying action alleges that the plaintiffs were exposed to the products and sustained bodily injuries over an extended period of time, which includes those time periods encompassed by the . . . policies. Therefore, O'Brien argues there are bodily injuries occurring during the policy periods for which O'Brien is legally obligated to pay.

O'Brien points out that the language of the provisions does not require that the legal obligation to pay damages must arise during the policy period in order for coverage to attach. Rather, the only limitation imposed in the relevant provisions is that coverage liability can only result from "bodily injury" which occurs during the policy period. In sum, O'Brien contends that although bodily injury must occur during the policy period, the time when a legal obligation to pay damages for such injury arises is not so limited to the policy period.⁶²⁶

The court accepted this argument. It denied the insurers' motion for summary judgment on the issue of "premerger" coverage and granted O'Brien's cross-motion in favor of such coverage.

The majority of courts, however, have rejected the premerger doctrine. In *Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co.*,⁶²⁷ for example, GAF Corporation argued that policies that it had purchased before it acquired Ruberoid (a manufacturer of asbestos-containing products), insured it against liabilities caused by Ruberoid's premerger activities. The court had no difficulty in recognizing that Ruberoid's premerger policies applied to protect GAF against suits filed after the merger regarding Ruberoid products. As the court explained:

The insurers rely upon *Aetna Life & Cas. v. United Pac. Rel. Ins.* (Utah 1978) 580 P.2d 230, but that case holds that insurance coverage survives a corporation's merger and passes to the surviving corporation along with the liabilities. . . . Application of that principle here means that upon GAF's secession to Ruberoid's liabilities, GAF became entitled to insurance coverage by Ruberoid's insurers.⁶²⁸

However, the court did not accept the argument that GAF's premerger policies applied to cover exposure to Ruberoid's asbestos-containing products, at least with respect to policies that expired before the merger took place. As the court explained:

A liability insurance policy has a finite duration. The period of time during which the insurance policy is effective is an essential element of a liability insurance contract . . . , and the reason is obvious: the insurer's obligation to indemnify is limited to insurable events occurring during the coverage period. Unless coverage has been triggered during the policy period, there is no coverage once the policy period has ended. Logically, then, neither is there a named insured once the policy period has ended. Thus, a corporate acquisition taking place after the policy has expired can have no retroactive effect on the identity of the named insured during the policy period.⁶²⁹

However, the court did recognize the coverage would be afforded under a policy in effect at the time of the merger. The court held:

In the present case, Ruberoid had no relationship with GAF during the 1961-1967 policy periods. The merger of Ruberoid and GAF took place after the . . . policies had expired. The fact that the companies became affiliated later is not enough to give Ruberoid the status of a named insured under the premerger policies.⁶³⁰

B. Insurance and Indemnification

In many types of transactions, the agreement between the parties will contain provisions relating both to insurance and to indemnification. It is important for the parties to review such provisions carefully, to make sure there are no unintended conflicts among the various insurance and indemnification provisions, and that the arrangements intended by the parties are reflected in the documentation.

Courts may enforce an indemnification to allocate loss between the parties, before determining which entity's insurance will apply. *See, e.g., St. Paul Fire & Marine Ins. Co. v. Am. Int'l Specialty Lines Ins. Co.*⁶³¹ If the same agreement, however, contains both a requirement that insurance be purchased to cover a particular type of loss and an indemnification provision for the same type of loss, then the court may find that the parties intended the required insurance to apply before the indemnification. *See, e.g., Southside River Rail Terminal, Inc. v. CSX Transp., Inc.*⁶³² To avoid disputes over these issues, contracting parties should spell out in the agreement whether any indemnification provisions are intended to be set at any particular insurance.

A contract may also require one party to add another party to the first's insurance coverage as an "additional insured" for liabilities arising from the parties' transactions. For example, a manufacturer may have its distributors added as additional insureds to its policies by means of vendor endorsements. A landlord may require engineers performing work on its premises to list the landlord as an additional insured under the engineers' liability policies for liability arising out of the work being done.

Parties with additional insured status should also require that they be provided with copies of the policies to which they have been added. As discussed *supra* in Section III.A.3 of this InfoPAK, the “certificates of insurance” that are exchanged pursuant to many such agreements may not be considered sufficient evidence to establish coverage.

Additional insureds also want to review their own coverage to determine whether language should be added to one or both policies to minimize any disputes created by overlapping coverage—for example, commonly available language can clarify that coverage under which a policyholder is an additional insured responds prior to the policyholder’s own coverage. In addition, the additional insured should review both sets of policies to avoid unintended consequences, such as the additional coverage rendering the policyholder liable for additional deductibles or retentions. The additional insured also should take into account the limits to which it is entitled as an additional insured; in the case of a party being added to a policy that already has many additional insureds, there may be many claims on these same limits, which may not go far, particularly if they are aggregate limits. In addition, additional insured endorsements vary in the link required between the liability in question and the work being performed by the policyholder; the policyholder should make sure the language is broad enough to protect against the intended exposure.⁶³³

Another common type of insurance requirement is a provision that an indemnity provision be backed by insurance. In contrast to a requirement of additional insured status, insurance of an indemnification does not provide the indemnified party with direct rights to the insurance coverage as an insured; instead, it ensures that there is a source of funds backing up the other party’s indemnification obligations.

C. Insurance for the Deal Itself

In many deals, the buyer relies on R&W made by the seller with respect to the asset being purchased. R&W insurance may be available for purchase to cover losses arising from a breach of an insured representation or warranty. This insurance generally will not apply, however, to inaccuracies known to the buyer prior to the inception of the policy. Other types of insurance may also be available to protect other aspects of particular transactions, including insurance protecting against losses from the failure of a transaction to qualify for the expected tax regulatory treatment.

D. Insurance Issues in the Bankruptcy Context

This section discusses common insurance issues that arise when a corporation files for bankruptcy protection. The section focuses on issues in the Chapter 11 reorganization context, although many of the same principles will apply to Chapter 7 and other types of bankruptcy proceedings. The first subsection focuses on the treatment of the corporation’s insurance policies in the bankruptcy context. The second subsection addresses issues that frequently arise when a debtor’s directors and officers seek insurance coverage under D&O policies after a bankruptcy filing.

I. Treatment of the Corporation's Insurance Policies

In some bankruptcy cases, such as those prompted by mass tort liabilities, the debtor's insurance policies will be a significant part of the bankruptcy estate and a central focus of the debtor's reorganization efforts. In those cases, debtors should retain insurance counsel early in the process to ensure that the insurance assets are appropriately protected and maximized. However, even in bankruptcy cases where insurance is not a central focus, counsel should understand how insurance is treated under the Bankruptcy Code, and should consider consulting with insurance counsel, to ensure that provisions in a reorganization plan (or related agreement) that address insurance policies are valid and do not inadvertently jeopardize coverage under the policies.

Two of the most common insurance problems that arise out of bankruptcy proceedings are (1) disputes that arise when the parties do not adequately evaluate which entity or entities should have insurance rights post-reorganization and (2) challenges by insurers to the validity or effect of a transfer of insurance. As will be discussed, these risks can be minimized with careful planning.

The next section provides a general overview of how bankruptcy policies are treated under the Bankruptcy Code, and then discusses the two problems identified.

a. Insurance Policies are Property of the Bankruptcy Estate

When a petition for bankruptcy is filed, an estate is automatically created that contains all of the debtor's legal and equitable interests in property. A debtor's insurance policies, including liability insurance policies, are considered property of the debtor's estate. Accordingly, suits or other actions that seek to void a policy or otherwise negate coverage are subject to the automatic stay under Bankruptcy Code section 362, which generally stays the commencement or continuation of litigation or other acts seeking to obtain or control property of the estate after a bankruptcy petition is filed.

Although courts generally have held that a debtor's insurance policies are assets of the estate, the proceeds of those policies do not necessarily constitute estate assets. For policies indemnifying a debtor for its own losses (e.g., first-party property and casualty policies), proceeds are clearly treated as property of the estate. For liability policies, some attempts have been made by creditors whose claims are insured under the debtor's liability policies to argue that they should be entitled to any proceeds on account of their claim. Most courts have rejected such arguments, holding that the proceeds of a liability policy in such circumstances are also property of the estate. The law governing D&O policy process is more complex, and will be discussed separately in the next section.

b. Practical Considerations in Bankruptcy Transactions

Although careful attention is typically paid to how a debtor's assets and liabilities are handled in a reorganization, the same level of care is not always paid to how insurance policies and rights are handled. Bankruptcy plans frequently treat insurance policies like any other commercial contract, and focus on ensuring that the policies in force are transferred to the reorganized entity. This approach can result in the inadvertent release of coverage (i.e., coverage for which premiums were paid) and the acquisition of liabilities without corresponding insurance protection.

For example, in most corporate families, the parent corporation will purchase insurance policies that insure the parent as well as all of the other entities in the corporate family. If a reorganization involves the spin-off of subsidiaries, counsel should carefully consider how the rights under these policies are treated. Policies that the subsidiaries procure after the spin-off typically will insure the subsidiaries only for events or claims made after the new policies incept. If claims are made against the subsidiary for events that occurred prior to the spin-off, the newly procured policies may not provide coverage for the claims. To protect the subsidiaries, and to ensure that the policies purchased in the past continue to provide coverage for the risks they were purchased to insure, the parties should address the extent to which the transferred entity will retain rights under the policies for events that occurred prior to the transaction.

The same concerns can arise when a debtor (or other party) transfers assets and liabilities to another entity as part of a reorganization. Typically, parties intend insurance rights to follow the liabilities. However, this is not always clarified in the relevant agreements. As a result, the insurers may deny coverage under the pre-transaction policies on the ground that the acquiring entity does not have rights under the policies. Although some courts have held that insurance rights follow liabilities as a matter of law, taking steps to ensure that the parties' intent is carefully spelled out in the relevant agreements can help avoid or minimize disputes.

Strategic Point:

These problems can be avoided or minimized with careful planning. Because many policies provide coverage for events that occurred during the relevant policy period regardless when the claim is made (and therefore can provide coverage long after the policy period has expired), planning should encompass all policies that may potentially provide coverage for claims, not only those policies in effect at the time of the bankruptcy filing. For historic policies that insure on an occurrence basis, the parties should specify in the relevant transaction documents which entities have which rights under the policies. For example, in the subsidiary example, the parent corporation would likely retain the policies but the transaction documents may specify that the subsidiary retains all rights to coverage under the policies that it had prior to the transaction. For policies that are still in effect (i.e., where the policy period has not expired), the parties may want to negotiate with the insurer to enter into a novation agreement that ensures that both the parent corporation and the subsidiary remain insureds under the policy.

c. Insurer Challenges to Insurance Transfers

Where a bankruptcy plan (or related agreement) transfers an insurance policy or insurance proceeds to another entity, disputes can arise as to the validity of the transfer. If the transfer occurs without the insurer's consent, insurers have frequently argued that the transfer violates the "anti-assignment" provisions commonly found in policies. These anti-assignment provisions typically prohibit the assignment of a policy to another entity without the insurer's consent. In the bankruptcy context, insurers have argued that an assignment of a policy or its proceeds without their consent voids the policy or invalidates the transfer.

The good news for debtor-insureds is that courts have generally rejected objections to such transfers asserted by insurers. These courts have based their decisions on both bankruptcy preemption principles and general insurance law principles. With respect to disputes over the transferability of insurance policies and proceeds pursuant to a plan of reorganization, courts generally find that sections 1123 and 541(c) of the Bankruptcy Code supersede any conflicting contractual provisions in the policies. Section 1123 requires that reorganization plans "provide adequate means for a plan's implementation," and courts have interpreted this section to preempt non-bankruptcy law that inhibits the plan, like contractual anti-assignment provisions. Section 541(c)(1), which prohibits restrictions on the interests of a debtor, also has been interpreted to preempt contractual provisions limiting a debtor-insured's ability to transfer or assign insurance policies in a bankruptcy proceeding.

Additionally, courts in the majority of jurisdictions have held that anti-assignment provisions do not prevent a debtor-insured from assigning the policy or proceeds if the transfer does not increase the insurer's risk under the policy. This rule is premised on the purpose of anti-assignment clauses, which is to ensure that insurers are not held liable for more risk than they agreed to insure. As such, courts in the majority of jurisdictions have found that a debtor-insured may transfer insurance rights even if the policy contains an anti-assignment provision and the insurer does not consent, so long as the insurer's risk under the policy is not affected. Similarly, many courts have held that once the event occurs that gives rise to the insurer's liability under the policy, the policy can be assigned or transferred because the insurer's risk of liability will not increase. Thus, the transfer of insurance rights in as part of a reorganization plan should be valid and enforceable, provided the transfer does not increase or materially change the insurer's risk under the policy. If the transfer will increase or change the insurer's risk, then the debtor should consider negotiating with the insurer to obtain consent to the transfer or to obtain an endorsement or novation ensuring that the insurance will continue in force.

2. Director and Officer Rights Under D&O Policies

Individual directors and officers can become the target of lawsuits or other civil liability when a corporation files for bankruptcy. Frequently, the circumstances that give rise to the bankruptcy simultaneously give rise to derivative suits or other legal proceedings against individual directors and officers based on alleged securities or fiduciary violations. Corporations purchase directors' and officers' liability (D&O) policies to defend and indemnify directors and officers against such liability.

As explained in Section V.A.i of this InfoPAK, some D&O policies provide coverage only for the corporation's directors and officers (commonly called "Side A Only" policies). However, many D&O policies insure not only the entity's directors and officers, but also provide coverage to the corporate entity itself. Where the corporation has a D&O policy with shared coverage, the filing of a bankruptcy petition can give rise to difficult issues over the ownership of and right to payment under the policies. These issues are attributable to the conflicting interests of the directors and officers – who may need immediate coverage under the policy – and the goal of bankruptcy, which is to preserve the debtor's assets for creditors.

Faced with this dilemma, most courts have held that D&O policies that also provide coverage for the corporation are property of the bankruptcy estate. However, many courts have drawn a distinction between the policies themselves (which are estate assets) and the *proceeds* of the policies (which may not belong to the estate). Giving priority to the contractual rights of the directors and officers, some courts have held that the proceeds of D&O policies are not assets of the estate and instead belong to the debtors' directors and officers, who are the intended beneficiaries of the policies. In light of these cases, D&O policies in certain circumstances have been deemed to fall outside the scope of the automatic stay of section 362(a)(3), which in turn allows the debtor's directors and officers to obtain coverage for defense costs and liabilities during the pendency of the bankruptcy proceeding.

In some cases, courts have drawn a distinction between policies that insure the corporation only for amounts it pays to indemnify its directors and officers (called "Side B coverage"), and policies that also insure the corporation for direct claims made against it (called "entity coverage"). Where the policy does not provide entity coverage, the policy is more clearly intended as a vehicle for the protection of the directors and officers, which supports the conclusion that the proceeds of those policies should not be considered property of the debtor's estate. The presence of entity coverage, on the other hand, has been used in some cases as justification for treating the policy's proceeds as estate property. These courts reason that because "entity coverage" provides an alternative source of proceeds for certain types of claims asserted against the debtor, courts have found that D&O policies with "entity coverage" satisfy the test for "whether or not property belongs to the estate," which is "whether 'the debtor's estate is worth more with them than without them.'"

Strategic Point:

In light of the risk to directors' and officers' coverage under D&O policies when a corporation files for bankruptcy, directors and officers should review and understand their D&O policies. If the policies include Side B or entity coverage, the directors and officers should be cognizant of the challenges that may arise in the context of a bankruptcy filing. These directors and officers may want to consider whether a Side A Only policy, which provides coverage only for the directors and officers and therefore should not be subject to claims that the policy or its proceeds belong the debtor's estate, would provide more appropriate protection.

XI. Dispute Resolution

A. Dispute-Resolution Provisions in Insurance Policies

Insurance companies commonly try to limit the dispute-resolution options available to policyholders by inserting various provisions in an insurance policy that require arbitration, select a venue, or select the appropriate law to be applied. When possible, these efforts should be resisted.⁶³⁴

Arbitration, generally, is not a favorable forum for policyholders. The pro-policyholder rules of policy interpretation, and the option of raising a bad faith claim generally, are less available in arbitration. A jury is generally a more favorable fact-finder for a policyholder than an arbitrator. The belief that arbitrations are a more expeditious and less costly alternative to litigation is not always well deserved, and is totally inaccurate if the requirement is arbitration in London, a favorite venue for many insurance companies, particularly those in the London, European, or Bermuda markets. Similarly, insurance companies often suggest a choice-of-law provision designating New York or English law. Those jurisdictions have law that is favorable to insurance companies. Not surprisingly, that is why the insurance companies urge their adoption. Additionally, insurance companies are "repeat players" in insurance coverage litigation, and thus are much more fearful of having bad precedent set than are their insureds. Arbitrations resulting in confidential, non-precedential decisions remove this incentive for insurers to settle.

Strategic Point:

Policyholders are best served if the policy is silent on these issues. If and when a dispute arises, a policyholder can always agree to arbitrate if it feels that is desirable under the circumstances. Policyholders should not give up their right to bring an action in the jurisdiction of their choice, subject to applicable jurisdictional and venue requirements. At that point, each side can argue what law should govern the insurance claim.

B. Choice of Law and Choice of Forum

As already noted, construction of a contract (in this case, an insurance policy) is a matter of state law. Although the general rules of construction in different jurisdictions are similar, the choice of law that will govern interpretation of specific policy provisions is critical because courts in various states have interpreted the same policy provisions differently. An insurance company will sometimes argue that its policy language should be interpreted according to the law of the jurisdiction where the insurance company is located or from where it issued the policy. This approach is generally not advantageous to policyholders, because insurance companies tend to be located in jurisdictions where the law is favorable to them.

In the case of an insurance program comprised of multiple policies sold by insurance companies in different jurisdictions, interpreting each policy according to the laws of the jurisdiction where the insurance company is located can be disastrous. Policyholders should consider a provision in each policy comprising part of a multi-policy program, providing that the law of a single jurisdiction will govern, usually where the policyholder's principal place of business is located or in a policyholder favorable jurisdiction where the policyholder has a reasonable tie.

If choice of law is not designated at the time of purchase, the policyholder should be prepared for a dispute over choice of law. Because courts are disposed to apply their own law to any dispute presented to them, the jurisdiction in which the case is litigated often impacts the law that will be applied. In *In re Helicopter Crash Near Weaverville, California 8/5/08 ("Carson")*,⁶³⁵ Carson Helicopter sought coverage for losses arising out of the crash of a Carson helicopter involved in firefighting efforts on behalf of the U.S. Forest Service. Carson initially brought suit in the Eastern District of Pennsylvania, but the case was transferred to the District of Oregon to be centralized with the underlying wrongful death and bodily injury cases in multi-district litigation. In its ruling on choice of law, the court held that because no conflict exists between the law of Oregon and the law of Pennsylvania regarding the admissibility of extrinsic evidence to interpret an ambiguity in an insurance policy, the court would "follow the specific principles as described in the Oregon line of cases, with which this court has more experience."⁶³⁶ However, the court agreed that the choice of law issues should be resolved on an issue-by-issue basis, and granted Carson's motion to apply Pennsylvania law to Carson's bad faith claim. The court found that Pennsylvania has a strong interest in protecting its resident insureds against insurance company bad faith, whereas Oregon has little or no interest in a nonresident insurance company that sold an insurance policy to a nonresident insured.⁶³⁷ The ruling was favorable to the policyholder because Oregon law does not recognize a separate tort claim for bad faith refusal to pay.

Because courts are usually inclined to apply their own laws absent a conflict, as in *Carson*, insurance coverage litigation often involves a dispute over the forum in which the case will be litigated. Despite the fact that the policyholder is the "true" plaintiff (by seeking money damages for breach of contract), in an effort to win this dispute over forum, the insurance company often "jumps" its policyholder by filing an initial litigation seeking a declaration of the parties' rights and obligations under the policy in a jurisdiction whose law the insurance company believes is favorable to its position. The "first round" of motion practice in insurance coverage litigation often concerns a dispute over the forum in which the case should proceed.

Thus, the choice of law that will be applied is critical in determining whether the policyholder will be able to obtain insurance. For example, in *Frontier Oil Corp. v. RLI Insurance Co.*,⁶³⁸ an oil and gas plant sought coverage under a pollution liability endorsement for personal injury lawsuits resulting from releases of toxic chemicals. Coverage would have been denied under Texas law, where the policy was issued, because Texas law typically denies a duty to defend under pollution liability endorsements like Frontier Oil's. However, the court applied California's choice-of-law statute governing the interpretation of contracts to determine that California law applied, and under California law, the insurer had a duty to defend.⁶³⁹

The complexity of choice of law is compounded in the environmental context when a policyholder seeks concurrent insurance for multiple environmental sites located in different states. The first steps for counsel faced with a potential environmental claim include determining:

- Whether the corporation's overall environmental exposure involves sites in multiple jurisdictions;
- What the law is with respect to the key issues in each of these jurisdictions; and
- What the facts are with respect to each of the sites on each of the key issues.

Only after "profiles" of each site (including this information) are prepared will counsel be able to assess the likelihood of insurance recovery, and to develop a strategy that will maximize that recovery.

C. Bringing an Action Against the Insurance Company

The law with respect to the issues surrounding a policyholder's right to insurance varies by jurisdiction. Although it should not matter in what jurisdiction an action is filed, it does have an impact on the outcome. A court is most likely to apply, or be influenced by, the laws of the forum. Accordingly, the forum in which the insurance coverage action is filed can be outcome-determinative. Therefore, if a dispute arises with an insurance company, the first step is to identify the key legal issues that will arise, and to research the law in the various possible jurisdictions to determine which forum is most favorable to the policyholder.

The insurance company will be performing the same analysis. If a significant difference in the law of the potentially applicable jurisdictions exists, some insurance companies (part of whose business is litigation) will file a preemptive law-suit against the policyholder, seeking a declaration of no coverage. Accordingly, the policyholder may want to consider filing a coverage action first in the appropriate forum, or have a complaint ready to file in case the insurance company commences an action, making both actions essentially simultaneous. In that case, the first round of motions will concern transfer, dismissal, or stay on the grounds of *forum non conveniens*.

Strategic Point:

An alternative is to negotiate a “standstill agreement” with the insurance company, whereby both sides agree not to file a lawsuit during settlement discussions. Because merely asking an insurance company for a standstill agreement can trigger the filing of a lawsuit, it is possible for outside counsel to contact the insurance company on behalf of a non-disclosed policyholder client and obtain a standstill agreement without revealing the client’s name. Once the standstill agreement is in place, the policyholder is protected and settlement discussions can take place without fear of being sued.

D. Litigation, Mediation, or Arbitration with the Insurance Company

Although litigation with the insurance company is not an option that most policyholders relish, it may be the only way to protect a policyholder’s rights. Trying an insurance coverage case requires the same skills as trying any other civil matter. However, a few items are worth noting:

- Always ask for, and try to obtain at the earliest possible date, a trial by jury.
- Be a plaintiff’s lawyer, not a defense lawyer. Corporate policyholders are used to being defendants. By disposition and habit, they bring their desire for delay to insurance coverage litigation. Change your posture. Be aggressive. Move the case. Get a firm trial date from the judge as soon as possible, and do not, through a delay in discovery, give the insurance companies an excuse to delay the trial.
- Try the insurance case, not the underlying liability case. The tactic of the insurance company is to put its policyholder on trial, and seek to prove that its policyholder acted maliciously, intentionally, fraudulently, or in another standard of conduct that will exclude coverage. The policyholder must focus on the insurance company’s promise to pay, and its wrongful refusal to do so. Do not let the jury’s attention be distracted from the insurance company’s conduct. Motions in limine can be a helpful tool for limiting insurance company distractions.
- The insurance company has a fiduciary duty to its policyholder; it has a duty to act in good faith and to look for coverage, rather than look for ways to avoid coverage. If a need for litigation has arisen, then the insurance company likely has failed in these duties. Become familiar with the state’s unfair claims handling statutes and regulations, as well as the other statutory and industry guidelines that articulate the standards insurance companies are supposed to meet in handling a claim. Hold the insurance company to those standards in prosecuting your case.

I. Dispute Resolution Checklist:

- Become familiar with the state's bad faith law, and use it when appropriate.
- Keep it simple. Juries can understand that your client paid money in return only for the insurance company's promise that it would defend and protect their policyholder when a claim is made. Emphasize the special nature of the insurance relationship. Unlike other transactions (in which a person gets a product or immediate service), when a policyholder pays a premium, all it gets is a promise. When the policyholder needs that insurance company to keep its promise, the insurance company may run "for cover, rather than coverage" — or, worse, turn on its policyholder and open a "second front" of conflict at a time when its policyholder needs help.
- Insurance companies' websites typically promote their efficient and fair claims handling (for everyone, it seems, except the policyholder). Check the insurer's Form 10-K and other filings to find out what it is telling regulators about claims against it by other policyholders.
- As a general matter, if the underlying case is still pending, try to stay the coverage litigation with respect to a determination of indemnity until the underlying case is resolved. It is difficult to fight a battle on two fronts at the same time.
- If the insurance company has a duty to defend (or to reimburse for defense costs), then move early for summary judgment on the duty to defend. On that motion, the insurance company has the heavy burden to prove that there is no possibility of coverage. Typically, little or no discovery is necessary in order to obtain a ruling on the duty to defend.
- Mediation is merely a structured settlement negotiation with a third-party mediator serving as a go-between. Many courts require mediation, with mediators appointed by the court. There also are a variety of private organizations that supply mediators who often are retired judges.

Strategic Point:

Mediation is not necessarily an alternative to litigation, but is a method of dispute resolution that may be pursued in conjunction with litigation. It will be effective only if both sides want to settle. It also can be particularly helpful if the problem on one or both sides is an adversary posture, or even antagonism between counsel. Mediations also can be helpful if the realities of each side's strengths and weaknesses are not reaching the client(s) because they are being filtered by counsel. Principals (who generally must be present at the mediation) may be able to find a business resolution of the dispute when litigation counsel cannot. Even if the mediation does not result in a settlement, the process can be a useful mechanism to learn the strengths and weaknesses of the other side's case.

Arbitration is a form of private litigation, a trial outside of the public court system. Discovery and the rules of evidence may or may not be available, depending upon the agreement of the parties. A key factor is the selection of the arbitrator(s). Some organizations (e.g., the American Arbitration Association) will appoint an arbitrator, but it is preferable for the parties to agree upon their own. One common practice is for each side to pick an arbitrator (the "Party Arbitrators"), and for the Party Arbitrators to pick a third neutral arbitrator.

As previously mentioned, in the insurance coverage context, arbitration often is not the quick and inexpensive method of dispute resolution that it is reputed to be. The negotiations with respect to the procedure to be used in the arbitration, and the selection of the arbitrator(s), can be time-consuming. Because the arbitration sessions must accommodate the schedule of the parties, witnesses, and arbitrators, an arbitration often takes place over many months, if not years, with the trial days not consecutive. Once the arbitrators reach a decision, it is generally final and cannot be challenged or appealed except on very limited grounds (e.g., fraud).

E. Settling with the Insurance Company

An insurance settlement can take many forms. There are at least three general categories. First, a settlement can be limited to an individual claim for a fixed amount, either with a single payment by the insurance company or a structured payment over time. Such a settlement does not affect the availability of the policy (or policies) for other claims, except through the reduction in limits and a release of the specific claim. Such settlements are common with claims-made coverages. By the time of settlement negotiations, the policy period is usually over, so there is little risk that unknown future claims covered by the policy would arise.

Second, a settlement can result in a full or partial buyout of the policy, where the policyholder gives up the right to submit all or a defined set of future claims under the settled coverage. Such buyouts often are limited to a certain type of coverage provided by the policy(ies). For instance, such buyouts can exhaust only the bodily injury coverage, or the product liability coverage. Such partial buyouts are particularly common in settlements under general liability policies, which often contain many types of coverage with separate limits (e.g., product liability, premises operations, completed operations).

If the parties are unable to agree to the amount of the settlement, sometimes they can agree to a coverage-in-place agreement. This third type of settlement is particularly applicable to occurrence policies that provide insurance for repeated types of claims (e.g., asbestos, product liability claims). In such a settlement, the insurance company agrees to accept coverage for a defined set of claims, but will do so based upon a reduced percentage of the liability or under reduced limits.

There are several variations in these three general categories. In negotiating with insurance companies, it is helpful to know what kinds of settlements a particular insurance company has agreed to in the past. It also is necessary to be aware of a number of side issues that are important to the settlement. For instance, although an insurance company will require a release from the policyholder, the policyholder also should require a release from an insurance company. This will prevent the unfortunate surprise that may occur when an insurance company tries to bill back to the policyholder a portion of the settlement as a deductible or retrospective premium.

Assignment of the loss is another issue that policyholders often overlook. In the situation where the settlement affects multiple policies sold by the same insurance company, the policyholder may have an interest in deciding to what policy, or to what types of coverage, the loss is assigned. This impacts exhaustion and is particularly important if the policy remains available for other claims.

Insurance companies also will want the policyholder to indemnify them for any claims arising out of the settled loss. If policyholders cannot prevent such a provision, then they should be careful to limit any such indemnity as much as possible. For instance, the indemnity should be limited to only (1) direct action claims by underlying claimants and (2) claims or cross-claims for contribution by other specific insurance companies on the policyholder's program. The indemnity should be further limited to claims arising out of the subject of the settlement.

Strategic Point:

The indemnity provisions also should include the following, if possible:

- A limitation of the policyholder's indemnification obligation to a dollar amount, often the amount that the insurance company pays in settlement.
- Exclusions to the indemnity provision, including claims of bad-faith against the settling insurance company, or claims for punitive or exemplary damages, fines, sanctions, and similar awards.
- Exclusions for claims relating to disputes with the settling insurance companies' reinsurance companies
- The Settlement Agreement should provide that any claim for which indemnity is not specifically granted should be excluded.
- The conditions governing defense of indemnity claims should be spelled out. A settling policyholder will want the same type of terms that an insurance company requires in an insurance policy with respect to a claim covered by the indemnity, such as notice, cooperation, the right to control or participate in the defense, the selection or approval of counsel, and consent to settlement.

Once a settlement is reached and the settlement price agreed to, the insurance company will draft the papers to make the settlement as broad as possible. Similarly, the policyholder should seek to narrow the scope of the settlement. The following additional matters should be considered:

- Limit the definition of the parties to the Agreement. Insurance companies often will seek to broaden those definitions to all affiliates. A policyholder who is not careful may inadvertently release policies sold by an affiliate of the settling insurance company, or release policies purchased from the settling insurance company by one of its subsidiaries.
- Limit the definition of policies being released. It is prudent to have the settlement cover only the policies listed on an exhibit to the settlement, rather than all policies sold by the insurance company or its affiliates. A less desirable alternative is to have the insurance company warrant that it knows only of the policies listed on an exhibit to the agreement as the subject of the settlement.

- Narrow the definition of the type of claims being released. “Released claims” generally should be limited to the specific claims noticed to the insurance company, or to the underlying claims at issue in the coverage action. To eliminate ambiguity, a policyholder may want to specify in an appendix what claims, or types of claims, are not being released.
- The release, which runs in favor of the policyholder, should be broad enough to include any claim brought by the settling insurance company, or its affiliates, for additional premiums, such as retrospective premiums; reimbursement of deductibles or self-insured retentions; any reinsurance obligations; liability for misrepresentation or material omissions in the underwriting; and liability for reverse bad faith, improper claims handling, or fraud.
- Be specific on the time, place, and manner of the settling insurance company’s payment.
- If the insurance company is required to make payments over time, yet requires dismissal of the coverage action before all payments are made, then the policyholder should request that the terms of the settlement be incorporated into a consent judgment.
- The settling insurance company should waive its right of contribution, indemnity, and subrogation with respect to the monies it has paid in settlement, particularly its claim against other insurance companies that sold insurance to the policyholder. The settling insurance company also should give a warranty that it has not already transferred its rights of contribution, indemnity, and subrogation.
- Both sides may want confidentiality, but the insurance company probably will want it more. The Settlement Agreement must allow the policyholder to disclose the settlements to its accountants and to regulatory authorities such as the SEC. The policyholder may want to specifically prohibit the insurance company from disclosing the amount of the settlement to other insurance companies with whom the policyholder seeks to settle.
- Settlement with the London Market (Underwriters at Lloyd’s as well as London Market Companies), has its own set of issues, given the manner in which their policies are subscribed to by multiple syndicates and companies. Hiring a specialist in such settlements who is familiar with the workings of the London Market may be wise.

F. Impact of Settlement on the Claims Against Other Insurance Policies

As discussed, a single claim can trigger:

- Various layers of insurance, if the amount of the claim exceeds the limits of the primary insurance company;
- Concurrent policies, if more than one type of insurance, or more than one line of insurance, is implicated; or
- Consecutive policies spanning several years. A settlement of one policy, or with one insurance company, will give rise to issues regarding the policyholder's ability to access other triggered policies.

I. Impact on Excess Policies

Most settlements are made for an amount less than the limits of that policy. This gives rise to the claim by excess policies that the settled underlying policies have not been properly exhausted, and therefore the excess policies never will have to pay. The law in most jurisdictions is that an excess insurance company's duty to indemnify the policyholder for an otherwise covered loss arises when that covered loss exceeds the underlying limits, regardless of whether the primary insurance company has actually paid its entire limits toward the claim.⁶⁴⁰ Any other conclusion would effectively allow an insurance company whose policies provide excess coverage to avoid forever their obligation to pay for covered losses in excess of the primary limits of a settled policy, on the grounds that the primary insurance company has not "exhausted" its coverage by actual payment of claims. Such a rule would deter settlements that (almost by definition) fall short of the maximum amount of coverage. Insurance companies have a legitimate interest in not being required to pay for indemnity that does not reach the attachment point of their policies; they have no legitimate interest in how those underlying limits are exhausted.

Despite this, certain courts have held that a settlement with an underlying policy for less than limits results in the inability of the policyholder ever to exhaust the underlying policy by payment of losses, thereby preventing the policyholder from accessing excess coverage even for the portion of the loss that exceeds the underlying coverage. *See Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*⁶⁴¹

A court addressing this issue may look to whether the excess policy at issue contains a "maintenance of underlying insurance" clause, which states that in the event the policyholder fails to maintain the underlying coverage, the excess policy will still respond, but only as it would if the underlying coverage had been maintained. *See, e.g., Johnson v. Milgo Industrial, Inc.*⁶⁴² Such a clause, merely requiring the policyholder to make up the difference if it fails to maintain underlying coverage, sets out a remedy for this failure directly contrary to the remedy of excusing the excess policy of any coverage imposed by the *Qualcomm* and *Comerica* courts for the policyholder's failure to maintain the underlying coverage by settling for less than the limits.

In light of this case law, policyholders considering settlement with lower layers of coverage for less than full limits must carefully consider their policy language, the applicable case law, and the structure of the proposed settlement to assess the settlement's impact on the ability to access excess policies.

2. Impact on Consecutive or Concurrent Policies

When multiple policies respond to a loss, and provide concurrent or consecutive coverage, a settlement with one insurance company can impact recovery against the others. The non-settling insurance companies likely will argue that they are entitled to either contribution from the settling insurance company, or a set-off from their liability equal to an amount of the settling insurance companies' allocated share. For instance, if 10 years of CGL coverage are triggered for a \$100 million environmental loss, and the policyholder settles for \$2 million with the insurance company that sold one year of insurance, then the non-settling insurance companies will contend either (1) that they have an \$8 million contribution against the settling insurance company (which probably must be indemnified by the policyholder as part of its settlement agreement) or (2) that the claim against the non-settling insurance companies must be reduced by the settling insurance companies' \$10 million share, not the \$2 million that the policyholder actually received in settlement.

Non-settling insurance companies will rely, primarily, on *Koppers Co. v. Aetna Casualty & Surety Co.*,⁶⁴³ but also may cite *Olin Corp. v. Insurance Co. of North America*,⁶⁴⁴ and *Keene Corp. v. Insurance Co. of North America*,⁶⁴⁵ in support of their contribution and set-off claims. The situation usually is complicated by the fact that most settlements in complex coverage disputes are not for an isolated claim, but instead are in the form of buyouts where the settlement payment is for the release of several known – and also other unknown – future claims.

In jurisdictions that have imposed liability on an insurance company based upon an “all sums” or “joint and several” method of allocation, any right to contribution or a set-off or credit against monies owed to the policyholder should be limited to the extent necessary to prevent the policyholder from recovering more than its total loss.⁶⁴⁶ In the previous example, a set-off would be allowed only for the \$2 million actually received by the policyholder, provided that the \$2 million was in settlement of the disputed claim (as opposed to additional or future claims).

First, public policy in all jurisdictions favors settlement and repose, and disfavors continuation of the coverage dispute through contribution claims against insurance companies who have reached earlier settlements.⁶⁴⁷ Second, true “all sums” allocation (which does not allocate damages to an insured for periods where no collectible insurance is available) should preclude the insurance companies from shifting responsibility through contribution claims to policies that have been extinguished through settlement, or back to the policyholder through set-off. Third, both parties to a settlement (i.e., the policyholder and settling insurance company alike) want finality. That finality cannot be achieved if either the policyholder or settling insurance companies are forced to submit to subsequent litigation with the non-settling insurance company regarding the settlement.

Case law supports finality and rejects the reallocation efforts of the non-settling insurance companies. In *Eli Lilly & Co. v. Aetna Casualty & Surety Co.*,⁶⁴⁸ the policyholder facing an environmental liability settled with some, but not all, of its insurance companies. In the insurance coverage action, when faced with the non-settling insurance companies' argument regarding reallocation to other years of coverage, the court phrased the issue as follows: "can [Lexington] by a contribution action against settling insurance companies obtain 'pro rata' reallocation where that would leave the policyholder with less than a full recovery for its losses."⁶⁴⁹

The court, relying on Indiana "all sums" decisions, rejected Lexington's argument that Eli Lilly's claim should be spread across all years triggered by the environmental property damage.⁶⁵⁰ "If Lexington were to prevail on this issue, it would enable Lexington to spread Lilly's claims across all triggered years, pro-rata, a result with resounding consequences and one which has been firmly rejected by our state's Supreme Court."⁶⁵¹ Additionally, the court relied on the public policy arguments that Lexington's contribution theory would discourage settlements.⁶⁵² Policyholders and insurance companies would have little incentive to settle if they could be forced to pay more or contribute a pro-rata share in response to a contribution claim by a non-settling insurance company. Additionally, the court reasoned that no contribution rights even existed against a settled policy. A non-settling insurance company had only the same rights as the policyholder and, because Eli Lilly had released the settling insurance company, there were no contribution rights against a released policy.⁶⁵³ In *Westport Insurance Corp. v. Appleton Papers Inc.*,⁶⁵⁴ the court also rejected an insurance company's argument to spread a loss into years with settled policies, holding that such an approach is inconsistent with "all sums" allocation.

Similarly, courts generally have limited the non-settling insurance companies' claim of set-off to an amount that was actually paid on the disputed claim. The purpose is to prevent the policyholder from recovering more than its actual loss. Indeed, a set-off may not be allowed where there is uncertainty as to whether all or a portion of the prior settlement is attributed to the disputed claim, or to a bundle of existing and future claims.

For instance, in *Weyerhaeuser Co. v. Commercial Union Insurance Co.*,⁶⁵⁵ the policyholder faced liabilities and incurred damages at 42 environmental sites. It sought insurance coverage from its insurance companies, and ultimately settled with all but one. After a judicial determination that the non-settling insurance company owed \$8 million, the non-settling insurance company argued that it was entitled to a set-off equal to the amount of the prior settlements. The court disagreed.⁶⁵⁶ The *Weyerhaeuser* court emphasized that "the insured must first be fully compensated for its loss before any setoff is allowed."⁶⁵⁷ It determined that, because the policyholder's past environmental costs greatly exceeded the amounts of earlier policy settlements, there was no evidence of a double recovery. The court noted that the prior settlements were for "far more than a simple release of liability at specific sites."⁶⁵⁸ Accordingly, the insurance company was not entitled to any set-off.⁶⁵⁹

Like the policyholder in *Weyerhaeuser*, the policyholder in *Insurance Co. of North America v. Kayser-Roth Corp.*,⁶⁶⁰ faced damages arising out of environmental contamination. In the insurance coverage action, after the policyholder settled with several carriers, it obtained a \$9 million judgment against First State Insurance Company. In support of a motion to amend the judgment to reflect the amounts received in the prior settlements, First State attempted to subpoena the confidential settlement agreements, arguing that it was entitled to discovery to support its claim for a set-off. The trial court quashed the subpoena.⁶⁶¹

The Rhode Island Supreme Court affirmed, relying heavily on public policy: “[A]lthough public policy mitigates against [the policyholder] receiving a windfall, public policy mitigates more strongly against [the non-settling insurance company] receiving a windfall.”⁶⁶² The *Kayser-Roth* court also reviewed the settlement agreements in camera and found that “the settlements were so generalized that the court could not discern how the parties came to the settlement amounts or whether they intended to allocate any particular dollar [amount] paid in settlement toward the Environmental Protection Agency (EPA) loss.”⁶⁶³ Considering equitable principles favoring settlements, and against an insurance company paying less than the limits of its triggered policy, the court concluded that, unless it was likely that the policyholder would receive a double recovery, First State was not entitled to a set-off.⁶⁶⁴

In *Pederson's Fryer Farms, Inc. v. Transamerica Insurance Co.*,⁶⁶⁵ after settling with one of its insurance companies, the policyholder sued another insurance company, seeking coverage for environmental property damages. Ultimately, it settled with two insurance companies. After a judgment was entered against the non-settling insurance company for the full amount of the policyholder's environmental liability, that company sought a set-off for the amount the policyholder had obtained in the prior settlement. The court concluded that the earlier settlement agreement was not a “mere payment for [the policyholder's] clean-up costs; it was in exchange for a release of liability for all past, present and future environmental claims.”⁶⁶⁶ Because the settlement agreement was not attributable to cleanup costs at a particular site, there was no showing of a double recovery. No set-off was allowed.⁶⁶⁷

Strategic Point:

A policyholder must be aware of these issues when it decides to settle with some, but not all, of its insurance companies. In jurisdictions that adopt a pro-rata allocation, a policyholder probably will have to absorb the difference between the settlement amount and the settling insurance companies' pro-rata share of the loss. In a jurisdiction which applies an “all sums” or “joint and several” allocation, a non-settling insurance company's right of contribution or set-off may be limited only to the extent that the policyholder would recover more than its insured loss. The language used to release the settling insurance company may be a factor in determining whether and to what extent contribution or a set-off will be allowed.

XII. Conclusion

Insurance is one of the most important assets of the corporate policyholder. In-house counsel can play an important role in assisting the risk management department in all stages of the insurance process – acquisition, maintenance, and claims – to help maximize the corporation’s insurance recovery.

XIII. About the Authors

A. Blank Rome’s Insurance Recovery Practice

Blank Rome’s premier Insurance Recovery Practice, recognized by *Law360* as a Practice Group of the Year, has one overarching objective: to maximize your bottom line. Our practice represents policyholders, taking a creative and business-minded approach to insurance. Finding coverage where others are not able to is our strength and we break new ground, making new law for our clients and shaping it for others with precedent-setting litigation, mediation, arbitration, and settlement strategies that lead to landmark rulings, new types of coverage, and major advances. And, our novel legal theories are widely recognized by both the courts and commentators.

Attorneys in our national Insurance Recovery Practice have been industry leaders for more than 30 years. Our substantial team, with decades of insurance experience and deep trial bench strength, offers comprehensive services to clients – from *Fortune* 500 companies to private businesses and entrepreneurs facing bet-the-company losses. We have successfully represented clients in a wide range of industries, including chemical, energy, financial services, health care, manufacturing, pharmaceutical, professional services, and technology.

Our attorneys represent clients in matters ranging from policy audits to risk assessments to litigation for coverage recoveries to complex resolution options that include strategic settlements and other options. With decades of proven success in recovering billions on innovative theories, our clients turn to us for our analysis, experience, reputation, and record of success.

There is no type of policy, loss, or claim that we have not dealt with on behalf of clients. We have several unique areas of practice that are dedicated to developing specialized solutions for specific industries and policy types. The practices include:

- Bad faith
- Bankruptcy insurance
- Business conduct liabilities
- Cargo/storage/commodities insurance
- Credit risk insurance
- Directors & officers/errors & omissions
- Employment insurance

- Energy insurance
- Entertainment
- Fidelity/crime
- General liability
- Insurance broker liability
- Intellectual property insurance
- Political risk insurance
- Property & business interruption
- Representation & warranty
- Sports
- Transactional & private equity insurance

Our ability to achieve successful outcomes on behalf of our clients has earned us recognition by industry observers. Notable practice recognitions include:

- *Benchmark Litigation* and *Benchmark Plaintiff*
- *Chambers USA*
- *Law360*
- *Legal 500*
- *U.S. News and Best Lawyers "Best Law Firms" Guide*

Comprised of leaders in the insurance coverage bar who are top-tier ranked by *Chambers USA*, Fellows of the American College of Trial Lawyers and the American College of Coverage Counsel, and *Law360* MVPs, our attorneys are frequently sought for their in-depth industry knowledge and are routinely invited for speaking engagements, media commentary, and educational seminars. They also host seminars and roundtables; moderate panels; and publish legal articles, handbooks, and treatises.

B. About the Blank Rome Primary Author & Editor

John A. Gibbons is a Washington, DC-based partner in Blank Rome's Insurance Recovery Practice. John's national practice focuses on advising corporate policyholders about their insurance policy rights and recovery insurance assets, either through negotiation or trial. He maintains a particularly active trial practice that includes serving as trial counsel for a *Fortune* 100 pharmaceutical company in a four-month trial, a *Fortune* 500 regulated utility in two separate multiweek jury trials, and a large multinational engineering services corporation in a three-judge panel arbitration. John is ranked in *Chambers USA* and *Legal 500* recommended John for his "subject-matter expertise and business-focused approach." *Benchmark Litigation* also recognized John as a local (Washington, DC) "Plaintiff Litigation Star" and ranked him in the National Tier 1 level (one of only 11 for insurance nationally). He is also recognized in *Best Lawyers in America*.

C. About the Blank Rome Contributing Authors

Omid Safa is a partner in Blank Rome's policyholder-only Insurance Recovery Practice. He has been named to the *Washington Business Journal's* "40 Under 40," a "Rising Star" by *Law360*, *The National Law Journal*, and *Super Lawyers*, and has been recognized in *Benchmark Litigation's* "40 & Under Hot List" and *Legal 500's* "Next Generation Lawyer." Omid has successfully represented policyholders across industries in a broad range of insurance disputes across the United States. In the last five years alone, he has helped clients secure insurance recoveries and judgments worth nearly \$500 million.

Justin F. Lavella is a partner in Blank Rome's Insurance Recovery Practice. He represents corporate policyholders, debtors' and creditors' committees, professional partnerships, federal employees, and other parties in insurance coverage disputes relating to the full spectrum of insurable losses, including mass tort liabilities, directors' and officers' liabilities, professional errors and omissions liabilities, employee theft, product contamination and recall, and first-party property damage. Justin represents companies in all aspects of risk management and insurance recovery, including litigation, arbitration, mediation, and bankruptcy proceedings, as well as counseling clients regarding prospective insurance placement. He is ranked in *Legal 500* and listed by *Best Lawyers in America* for Insurance Law in Washington, D.C.

James S. Carter is Of Counsel in Blank Rome's policyholder-only Insurance Recovery Practice. He exclusively litigates on behalf of corporate policyholders to preserve and maximize the value of their insurance assets, and has helped clients obtain millions of dollars in insurance recoveries. Jim also leverages his coverage litigation experience and his pro-policyholder perspective to help companies improve their cyber insurance, D&O, E&O, and other policies and lay the foundation for successful claims. He has been listed in *Euromoney's Rising Stars Expert Guide*, as an "LMG Rising Star" in *Expert Guide*, and as a Washington, D.C. "Rising Star" in *Super Lawyers*.

Kyle P. Brinkman is an associate in Blank Rome's Insurance Recovery Practice. He focuses his practice on representing corporate policyholders or their directors and officers in complex insurance coverage matters, from preemptive analysis of coverage for potential risks to advocacy, dispute resolution, litigation, and appeals. Kyle's clients have included regulated utilities, hospitality and entertainment industry companies, logistics companies, private equity firms, chemical, pharmaceutical, and other manufacturers, and individual directors and officers. He has been named a "Rising Star" by *Legal 500*, listed as a Washington, D.C. "Rising Star" in Insurance Coverage by *Super Lawyers*, and has twice been named to the Capital Pro Bono Honor Roll by the District of Columbia Courts.

Dominique A. Meyer is an associate in Blank Rome's policyholder-only Insurance Recovery Practice. She focuses her practice on insurance recovery matters and complex commercial litigation, with particular experience in federal and state court insurance coverage disputes, contract actions, and business tort matters. Dominique advises policyholders on the resolution of complex coverage disputes under various lines of insurance, including commercial general liability, directors' and officers' liability, professional liability, and title policies.

XIV. Additional Resources

A. ACC Docket Articles

John DeGroote and Wendy Toolin Breau, “Bet the Company’ Litigation From a Policyholder’s Perspective” 27 No. 4, *ACC Docket* 24 (May 2009),
<https://www.accdocket.com/articles/resource.cfm?show=206899>

John C. Tanner, Rebecca M. Lamberth, Kelly Wilcove and Alex Reed, “Does the Gatekeeper Lawyer Need Insurance?” 26 No. 7, *ACC Docket* 94 (September 2008),
<https://www.accdocket.com/articles/resource.cfm?show=1501017>

John C. Tanner and Anthony P. Tatum, “10 Issues to Consider When Negotiating Your Company’s D&O Coverage” 25 No. 6, *ACC Docket* 92 (July/August 2007), <https://www.accdocket.com/articles/resource.cfm?show=1501019>

John C. Tanner, Rebecca M. Lamberth and Scott N. Sherman, “Your Company’s D&O Policy, Will the Insured v. Insured Exclusion Surprise You?” 24 No. 8, *ACC Docket* 46 (September 2006), <https://www.accdocket.com/articles/resource.cfm?show=14632>

Kathy Barlow and Kirk Pasich, “Disasters & Insurance: Lessons for Businesses from Katrina and Rita” 24 No. 2, *ACC Docket* 34 (February 2006),
<https://www.accdocket.com/articles/resource.cfm?show=14723>

John C. Tanner and David E. Howard, “Blowing Whistles and Climbing Ladders: The Hidden Insurance Issues” 23 No. 4, *ACC Docket* 32 (April 2005),
<https://www.accdocket.com/articles/resource.cfm?show=16990>

James D. Prendergast, “UCC Insurance: Cost-Effective Alternative to Borrowers Counsel Legal Opinion” 22 No. 1, *ACC Docket* 82 (January 2004),
<https://www.accdocket.com/articles/resource.cfm?show=17062>

Lori L. Siwik, “The Crashing Wave of Asbestos Claims: Practical Suggestions for Staying Afloat” 20 No. 4, *ACCA Docket* 42 (April 2002),
<https://www.accdocket.com/articles/resource.cfm?show=1501015>

B. Treatises

Appleman on Insurance 2d by Eric M. Holmes (LexisNexis 2002) or *Couch on Insurance 3d* by Lee R. Russ and Thomas F. Segalla (West Group 1997). These are multi-volume collections. Although expensive, they can be useful in helping both lawyers and lay people understand the basics of insurance law for any number of different types of insurance policies.

Insurance Claims and Disputes by Allan D. Windt (5th ed. Thomson/West 2007). This two-volume treatise provides a good substantive overview of insurance coverage issues. It has a particularly useful index.

Handbook on Insurance Coverage Disputes by Barry R. Ostrager and Thomas R. Newman (15th ed. Aspen Law & Business). This two-volume treatise has many helpful charts that provide state-by-state overviews of the law on specific coverage issues. A new edition is published every other year. Policyholder counsel should be aware, however, that the authors represent insurance companies in their private practice, and that this treatise, not surprisingly, tends to have a pro-insurance company slant.

C. Other Research Books

Miller's Standard Insurance Policies by S. Miller and P. Lefebvre (5th ed. Legal Research Systems, Inc. 2007). A good policy forms book which contains copies of insurance industry-drafted, standard form property and casualty insurance policies. It is annotated and regularly updated.

Best's Insurance Reports: Property/Casualty. *Best's Insurance Reports* is considered the "Bible" of the insurance industry. It provides background information on insurance companies, including their principal place of business, state of incorporation, corporate history, and references to determine a company's solvency.

Dictionary of Insurance Terms by Harvey Rubin (4th ed. Barron's 2000). This is a basic insurance dictionary, which defines more than 3,000 terms. It includes a separate list of abbreviations and acronyms.

D. Periodicals

Business Insurance ("BI"). BI provides up-to-date coverage of insurance issues from both a legal and a risk management perspective.

Mealey's Litigation Reports – Insurance. *Mealey's* is a good weekly loose-leaf service. *Mealey's* tracks insurance coverage actions and publishes the most recent decisions (in slip opinion form) and pleadings in coverage cases nationwide. *Mealey's* also offers a myriad of specialty publications on various other subjects.

E. Online

There are innumerable insurance-related sites. For example, trade associations, insurance companies, state insurance commissioners, and publishers are all on the Internet. You also can subscribe to one of the legal services providers, LEXIS/NEXIS or WESTLAW, to aid with legal research. These services include major insurance trade publications, reported and unpublished court decisions, statutes, regulations, jury verdicts, settlements, law reviews, and insurance law texts.

F. Glossary

Glossary for "A Policyholder's Primer on Commercial Insurance in the United States"

- BI: Business Interruption
- CCPA: California Consumer Privacy Act
- CEO: Chief Executive Officer
- CFO: Chief Financial Officer
- CERCLA: Comprehensive Environmental Response, Compensation, and Liability Act
- CGL: Comprehensive General Liability/Commercial General Liability
- CBI: Contingent Business Interruption
- DES (a drug): Diethylstilbestrol
- D&O (policies/liability): Directors and Officers
- EPL: Employment Practices Liability
- EIL: Environmental Impairment Liability
- EPA: Environmental Protection Agency
- EEOC: Equal Employment Opportunity Commission
- E&O (policies): Error and Omissions
- ECGD: Export Credits Guarantee Department
- ERP: Extended Reporting Period
- FCRA: Fair Credit and Reporting Act
- FLSA: Fair Labor and Standards Act
- FSLIC: Federal Savings and Loan Insurance Corporation
- GDPR: General Data Protection Regulations
- IP: Infringement Patent/Patent Infringement
- ABM: Insurable Interest provision
- ISO: Insurance Services Office, Inc.

- KRE: Kidnap, ransom, and extortion
- MIGA: Multilateral Investment Guarantee Agency
- NFIP: National Flood Insurance Program
- NSSF: National Shooting Sports Foundation
- NRD: Natural Resource Damages
- OPIC: Overseas Private Investment Corporation
- PLL: Pollution Legal Liability
- PRP: Potentially Responsible Party
- RAM: Reinsurance Association of Minnesota
- RI: Remedial Investigation, FS: Feasibility Study, (RI/FS)
- R&W: Representation & Warranty
- RIMS: Research Committee Research Committee of the Risk and Insurance Management Society, Inc.
- ROR: Reservation of Rights
- SEC: Securities and Exchange Commission
- SIR: Self-insurance Retention
- TCPA: Telephone Consumer Protection Act
- 9/11: September 11, 2001 Terrorist Attacks

XV. Endnotes

¹ An insurance policy is simply a specialized form of commercial contract. Although the general statements in this Primer should be helpful to an understanding of a policyholder's rights and an insurance company's obligations, the specific language of the individual policy at issue is the most important factor to consider in assessing those rights and obligations.

² Coverage for products liability claims generally is included within CGL policies.

³ In recent years, D&O insurance often has been expanded to protect the corporation directly against claims based on the federal securities laws.

⁴ E&O insurance is particularly important for those corporations that sell services, as opposed to products. Professional malpractice insurance is a form of E&O coverage.

⁵ See 1 Linda G. Robinson & Jack P. Gibson, *International Risk Management Institute, Inc., Commercial Property Insurance* (2009).

⁶ If the insurance policy has a duty to defend, as well as a duty to indemnify, separate deductibles or SIRs can apply to the insurance company's defense and indemnity obligations.

⁷ This practice is particularly common for insurance bought in the London insurance market.

⁸ A loss that falls within that layer is borne by the insurance companies according to their quota share. For instance, a \$50 million loss in the \$100 million layer described in the text is paid for by \$25 million from company X and \$12.5 million each from companies Y and Z.

⁹ Some policies have "drop-down" language under which the excess insurance company must pay, even without the payment of the entire limits in the underlying coverages. This is particularly important if the underlying coverage is unavailable because the underlying insurance company is insolvent.

¹⁰ *Arrowood Indem. Co. v. King*, 304 Conn. 179, 203, 39 A.3d 712, 727 (2012) ("we now join the overwhelming majority of our sister states in adopting a rule that facilitates informed determinations of prejudice by incentivizing insurers to bring evidence of prejudice, should it exist, to the court's attention"); *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630 (Tex. 2008). See also *Axis Surplus Ins. Co. v. Lake CDA Dev. LLC*, 2008 WL 4238966 (D. Idaho 2008) (late notice barred coverage under builder's risk policy where notice given after damaged wall was repaired); *Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wash. 2d 411, 191 P.3d 866 (2008) (genuine issue of material fact as to whether non-participating insurer was prejudiced by late notice of claims against insured precluded summary judgment); *Steelcase, Inc. v. Am. Motorists Ins. Co.*, 907 F.2d 151, 1990 WL 92636, at *2 (6th Cir. 1990) (unpublished); *Falcon Steel Co. v. Md. Cas. Co.*, 366 A.2d 512, 514 (Del. Super. Ct. 1976); *Johnson Controls, Inc. v. Bowes*, 409 N.E.2d 185, 188 (Mass. 1980); *Alcazar v. Hayes*, 982 S.W.2d 845, 853 (Tenn. 1998);

13 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 193.30 (1997).

¹¹ *Buckeye Ranch, Inc. v. Northfield Ins. Co.*, 839 N.E.2d 94, 110 (Ohio Ct. Com. Pl. 2005) (“The onus falls on the insured to demonstrate that unreasonably late notice caused no prejudice to the carrier.”); *Harris Specialty Chems., Inc. v. United States Fire Ins. Co.*, 2000 U.S. Dist. LEXIS 22596, at *34 (M.D. Fla. July 7, 2000) (“The pertinent policy language provides that notice of an ‘occurrence’ which might result in a claim must be made ‘as soon as practicable.’ Timely notice is required to ‘. . . enable the insurer to evaluate its rights and liabilities, to afford . . . an opportunity to make a timely investigation’ Prejudice is presumed; the burden is on the insured to show that the late notice did not cause prejudice to an insurance company.”); See also *Bankers Ins. Co. v. Macias*, 475 So. 2d 1216, 1217-18 (Fla. 1985); *Ormet Primary Aluminum Corp. v. Emp’rs Ins. Co. of Wausau*, No. 808, 1998 WL 774997 (Ohio Ct. App. Oct. 30, 1998), *aff’d*, 725 N.E.2d 646 (Ohio 2000); 13 *Couch on Insurance* 3d § 193.30.

¹² *Argo Corp. v. Greater N.Y. Mut. Ins. Co.*, 827 N.E.2d 762, 765 (Ct. of Ap. 2005); *Transp. Ins. Co. v. AARK Constr. Group Ltd.*, 526 F.Supp. 2d 350, 358-59 (E.D.N.Y. 2007). With the passage of Section 3420, the law in New York has changed. For policies issued after Jan. 17, 2009, if notice is less than two years late, the insurance company must prove that it has been prejudiced to avoid coverage. If notice is more than two years late, the policyholder has the burden of proving that the insurance company has not been prejudiced. If notice is given after the underlying liability has been determined, coverage is forfeited.

¹³ 872 N.Y.S.2d 444 (App. Div. 2009).

¹⁴ *Id.* at 445 (internal citations omitted).

¹⁵ See *Pav-Lak Indus., Inc. v. Arch Ins. Co.*, 56 A.D.3d 287, 866 N.Y.S.2d 671 (1st Dep’t 2008) (insurer’s 45-day delay in disclaiming coverage was unreasonable); *Adames v. Nationwide Mut. Fire Ins. Co.*, 55 A.D.3d 513, 866 N.Y.S.2d 210 (2d Dep’t 2008) (notice of disclaimer must promptly apprise the claimant with the highest degree of specificity of the grounds upon which the disclaimer is predicated and insurer’s reliance on homeowner’s policy’s definition of “insured location” is not a valid basis for denying coverage).

¹⁶ E.g., *Resolution Trust Corp. v. Artley*, 24 F.3d 1363, 1367-68 (11th Cir. 1994).

¹⁷ E.g., *FDIC v. Mijalis*, 15 F.3d 1314, 1333-37 (5th Cir. 1994); *LaForge v. Am. Cas. Co.*, 37 F.3d 580, 583 (10th Cir. 1994); *Am. Cas. Co. v. Continisio*, 17 F.3d 62, 69 (3d Cir. 1994); *Am. Cas. Co. v. RTC*, 845 F. Supp. 318, 322 (D. Md. 1993).

¹⁸ *Sorbara Constr. Corp. v. AIU Ins. Co.* 897 N.E.2d 1054 (N.Y. 2008).

¹⁹ E.g., *FDIC v. Booth*, 82 F.3d 670, 676-77 (5th Cir. 1996) (transmittal of general financial and regulatory material from FDIC to the insurance company during time of coverage did not constitute notice of a claim against bank directors for breach of duty in managing loans).

²⁰ E.g., *Manufactured Housing Communities of Washington v. St. Paul Mercury Ins. Co.*, 660 F. Supp. 2d 1208, 1213-14 (W.D. Wash. 2009) (the notice/prejudice rule did not apply in the

context of claims-made and reported policies); *Am. Auto. Ins. Co. v. Marlow*, 666 F. Supp. 2d 1209, 1215 (D. Colo. 2009) (“Based on the structure of the claims-made insurance contract, the court in *St. Paul Fire & Marine Ins. Co. v. Hunt* stated that notice is ‘a basic term of the insurance contract which expresses the parties’ agreement’ and, thus, the notice period should not be extended even if an insurer would suffer no prejudice by an insured’s tardy report of a claim.”); *Gargano v. Liberty Int’l Underwriters, Inc.*, 572 F.3d 45, 51 (1st Cir. 2009) (“We reject out of hand Gargano’s assertion that the insurance companies must demonstrate prejudice from his untimely notice to escape liability. To require the insurer of a ‘claims made and reported’ policy to demonstrate prejudice from the insured’s failure to report a claim within the relevant policy period ‘would defeat the fundamental concept on which claims-made policies are premised,’ with the likely result ‘that claims-made policies, which offer substantial benefits to purchasers of insurance as well as insurance companies, would vanish from the scene.’”); *Venoco, Inc. v. Gulf Underwriters Ins. Co.*, 175 Cal. App. 4th 750, 760, 96 Cal. Rptr. 3d 409, 416 (Cal. App. 2 Dist., 2009) (“Where the policy provides that special coverage for a particular type of claim is conditioned on express compliance with a reporting requirement, the time limit is enforceable without proof of prejudice.”); *McCullough v. Fid. & Deposit Co.*, 2 F.3d 110, 112 (5th Cir. 1993) (“Notice, as provided in the policy, is required in a claims-made policy to trigger coverage. Notice in a claims-made policy therefore serves a very different function than prejudice-preventing notice required under an ‘occurrence’ policy.”); *DiLuglio v. New England Ins. Co.*, 959 F.2d 355, 359 (1st Cir. 1992) (malpractice insurance company not required to establish actual prejudice from attorney’s late notification); *Nat’l Union Fire Ins. Co. v. Talcott*, 931 F.2d 166, 167 n.4 (1st Cir. 1991) (finding that while prejudice is “justly required” in occurrence policies, no showing of prejudice is required with claims-made policies); *Harbor Ins. Co. v. Cont’l Bank Corp.*, 922 F.2d 357, 369 (7th Cir. 1990) (“The insurance company wants to know whether there is a possibility that it will be receiving a claim after the policy period, but of course it also wants to receive notice of that claim when and if it materializes. It can enforce this vital condition without proving that it was harmed by violation of it.”); *Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422, 425 (8th Cir. 1989); *Empl’rs Reinsurance Corp. v. Sarris*, 746 F. Supp. 560, 563 (E.D. Pa. 1990) (“a claims-made policy is of such a different nature from an occurrence policy that the ‘notice-prejudice’ rule . . . should not apply”); *MGIC Indem. Co. v. Cent. Bank*, 838 F.2d 1382, 1388 (5th Cir. 1988) (no coverage because of failure to give notice pursuant to terms of policy regardless of whether policyholder could demonstrate prejudice); *Civic Assocs., Inc. v. Sec. Ins. Co.*, 749 F. Supp. 1076, 1082 (D. Kan. 1990); see also *Winkler v. Nat’l Union Fire Ins. Co.*, 930 F.2d 1364 (9th Cir. 1991); *Burns v. Int’l Ins. Co.*, 929 F.2d 1422 (9th Cir. 1991); *Pac. Empl’rs Ins. Co. v. Super. Ct.*, 270 Cal. Rptr. 779, 784 (Cal. Ct. App. 1990). Not all courts agree, however. See, e.g., *Nw. Title Sec. Co. v. Flack*, 85 Cal. Rptr. 693, 698 (Cal. Ct. App. 1970).

²¹ 30 Cal. Rptr. 3d 631 (Cal. Ct. App. 2005).

²² The court cited at length from *Works, Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case* (1999) 5 Conn. L.J. 505.

²³ Many states have statutes that require a timely response by the insurance company. See Alaska Statutes § 21.36.125; Arizona Statutes § 20-461; Arkansas Statutes § 23-66-206;

California Insurance Law § 790.03; Colorado Statutes § 10-3-1104; Connecticut Statutes § 38a-816; Delaware Statutes, Title 18 § 2304; Florida Statutes § 626.9541; Georgia Statutes § 33-6-34; Hawaii Statutes § 431:13-103; Idaho Statutes § 41-1329; Illinois Statutes, CH 215 § 5/154.6; Indiana Statutes § 27-4-1-4.5; Iowa Statutes § 507B.4; Kansas Statutes § 40-2404; Kentucky Statutes § 304.12-230; Louisiana Revised Statutes § 22:1214; Michigan Statutes § 500.2026; Minnesota Statutes § 72A.20; Missouri Statutes § 375.936; Montana Statutes § 33-18-201; Nevada Statutes § 686A.310; New Jersey Statutes § 17:29B-4; New Mexico Statutes § 59A-16-20; North Carolina Statutes § 58-63-15; Oregon Statutes § 746.230; 40 Pennsylvania Statutes § 1171.5; South Dakota Statutes § 58-33-67; Texas Insurance Art. 21.21; Utah Statutes § 31A-26-303; Vermont Statutes, Title 8 § 4724; Virginia Statutes § 38.2-510; West Virginia Statutes § 33-11-4; Wyoming Statutes § 26-13-124.

²⁴ As already mentioned, a choice-of-law provision should designate the law of a jurisdiction favorable to the policyholders. Arbitration is a form of dispute resolution that generally is less favorable to a policyholder than an action in court.

²⁵ For insurance sold in the London insurance market, the initial contracting document is called a “Slip,” and serves a similar function as a binder for U.S.-based insurance companies. The Slip outlines the coverage to be provided, and each syndicate or London market company is bound to insure its quota share of the risk when its underwriter subscribes to, or signs onto, the Slip.

²⁶ *World Trade Ctr. Props. L.L.C. v. Hartford Fire Ins. Co.*, 345 F.3d 154 (2d Cir. 2003) (concerning first-party property policies), *overruled on other grounds by Wachovia Bank v. Schmidt*, 546 U.S. 303 (2006); *In re September 11th Liab. Ins. Coverage Cases*, 333 F. Supp. 2d 111 (S.D.N.Y. 2004) (concerning third-party liability policies).

²⁷ For additional discussion regarding the development of standard-form language in CGL policies, see the discussion in *Am. Home Products Corp. v. Liberty Mutual Insurance Co.*, 565 F. Supp. 1485, 1500-02 (S.D.N.Y. 1983), *aff’d as modified*, 748 F.2d 760 (2d Cir. 1984).

²⁸ *Shaw Mortg. Corp. v. Peerless Ins. Co.*, 615 F. Supp. 2d 1172, 1176 (S.D. Cal. 2009) (“A policy provision is ambiguous only if it is susceptible to two or more reasonable constructions despite the plain meaning of its terms within the context of the policy as a whole.” Only then does the court “invoke the principle that ambiguities are generally construed against the party who caused the uncertainty to exist (i.e., the insurer) to protect the insured’s reasonable expectation of coverage.” (quoting *La Jolla Beach & Tennis Club, Inc. v. Indus. Indem. Co.*, 884 P.2d 1048, 1053 (Cal. 1994))); *G-I Holdings, Inc. v. Reliance Ins. Co.*, 586 F.3d 247, 254 (3d Cir. 2009) (“Under New Jersey law, an insurance policy that has been unilaterally drafted by the insurer (such as this one) will typically be treated as a contract of adhesion. As such, New Jersey courts ‘constru[e] contracts of insurance to reflect the reasonable expectations of the insured in the face of ambiguous language and phrasing, and[,] in exceptional circumstances, [even] when the literal meaning of the policy is plain.” (citations omitted)); *Drake v. Town of Mansfield*, 652 F. Supp. 2d 236, 240 (D. Conn. 2009) (“However, ‘[a]s with contracts generally, a provision in an insurance policy is ambiguous when it is reasonably susceptible to more than one reading. . . . Under those circumstances, any ambiguity in the terms of an insurance policy must be construed in favor of the insured because the insurance company drafted the policy.” (quoting *Nat’l Grange Mut. Ins. Co. v.*

Santaniello, 961 A.2d 387, 393 (Conn. 2009)); see also *Am. States Ins. Co. v. Natchez Steam Laundry*, 131 F.3d 551, 553 (5th Cir. 1998); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538-39 (9th Cir. 1990); *O'Brien v. U.S. Fid. & Guar. Co.*, 669 A.2d 1221, 1224-25 (Conn. 1996); 2 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 22:14 (1997).

²⁹ *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F. Supp. 2d 376, 390 (D. Del. 2002) ("Delaware and Illinois courts continue to strictly construe ambiguities within insurance contracts against the insurer and in favor of the insured in situations where the insurer drafted the language that is being interpreted regardless of whether the insured is a large sophisticated company. The rationale behind this application of the rule is that ambiguities in contracts are generally interpreted against the drafter. Moreover, in the insurance policy context, such a rule reduces an insurance company's incentive to construct a policy where certain provisions purport to give coverage while other clauses take that very coverage away." (citations omitted)); see *id.* ("Thus, in determining whether to apply the contra-insurer rule and construe ambiguities against National Union, the court must determine whether National Union unilaterally drafted the ambiguous portions of the policy or whether CTFG, acting jointly with National Union, was responsible for drafting the ambiguous provisions of the policy. While there certainly may be instances where applying the contra-insurer rule would be inappropriate, this is not such an instance. It is clear from the documentary record before the court that CTFG had no substantial role in drafting the National Union policy form, on which the four exclusions relied upon by National Union to deny coverage were standard boilerplate terms."); *Morgan Stanley Grp. Inc. v. New England Ins. Co.*, 225 F.3d 270, 279-80 (2d Cir. 2000) ("It is unsettled in New York whether contra proferentem applies if the policyholder is a sophisticated entity that negotiated contract terms. But we need not decide this issue because Morgan Stanley (although sophisticated) did not negotiate its coverage terms. A New England insurance agent who participated in the insurance transaction testified that it was a 'standard policy' that New England 'didn't amend for anybody.'" (citations omitted)); *Wakefern Food Corp. v. Liberty Mut. Fire Ins. Co.*, 968 A.2d 724, 734 (N.J. Super. Ct. App. Div. 2009) ("These principles apply to commercial entities as well as individual insureds, so long as the insured did not participate in drafting the insurance provision at issue."); *Benjamin Moore & Co. v. Aetna Cas. & Sur. Co.*, 843 A.2d 1094, 1103 (N.J. 2004) ("When there is doubt . . . regarding the existence of coverage, that doubt is ordinarily resolved in favor of the insured. An exception to that rule exists for sophisticated commercial entities that do not suffer from the same inadequacies as the ordinary unschooled policyholder and that have participated in the drafting of the insurance contract." (emphasis added) (citations omitted)); *ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 973 (3d Cir. 1985); *Ogden Corp. v. Travelers Indem. Co.*, 681 F. Supp. 169, 173 (S.D.N.Y. 1988). But see *In re September 11th Liab. Ins. Coverage Cases*, 458 F. Supp. 2d 104, 118 n.11 (S.D.N.Y. 2006) ("Silverstein argues also that where a term in an insurance contract is found to be ambiguous and its meaning cannot be ascertained through reliance on extrinsic evidence, such ambiguities 'should be resolved in favor of the insured.' However, application of this rule 'is generally inappropriate if both parties are sophisticated.' Further, it is inappropriate to rely on this rule when the intent of the parties can be discerned through reliance on extrinsic evidence." (citations omitted)).

³⁰ RIMS Research Committee, *Certificates of Insurance* 7-8 (2000).

³¹ 774 N.Y.S.2d 11, 13 (App. Div. 2004).

³² *Tribeca*, at 12.

³³ See also *McKenzie v. N.J. Transit Rail Operations, Inc.*, 772 F. Supp. 146 (S.D.N.Y. 1991). But see *B.T.R. E. Greenbush Inc. v. Gen. Accident Co.*, 615 N.Y.S.2d 120 (App. Div. 1994) (holding that a certificate issued by the insurance company, not the broker, was sufficient to grant summary judgment holding that the third party was an additional insured).

³⁴ *Am. Hardware Mut. Ins. Co. v. BIM, Inc.*, 885 F.2d 132, 139 (4th Cir. 1989) (“[T]he general rule [is] that ‘a certificate of insurance is not a contract of insurance but is merely the evidence that a contract has been issued’” (citation omitted)); *Atlas Assurance Co. v. Harper, Robinson Shipping Co.*, 508 F.2d 1381, 1386 (9th Cir. 1975) (“A certificate of insurance is not a substitution of parties. It ‘is not, and does not purport to be, a policy, but states that a policy . . . is in existence . . . and refers to the terms and conditions of the underlying policy.’” (citation omitted)); *U.S. Pipe & Foundry Co. v. U.S. Fid. & Guar. Co.*, 505 F.2d 88, 89 (5th Cir. 1974) (“A certificate issued to a lessor indicating that liability insurance has been acquired by the lessee does not constitute a contract between the lessor and the insurer”); *G.E. Tignall & Co. v. Reliance Nat’l Ins. Co.*, 102 F. Supp. 2d 300, 304 (D. Md. 2000) (“Ordinarily, the presentation of a certificate alone does not create coverage or legal duties.”); *Bradley Real Estate Trust v. Plummer & Rowe Ins. Agency, Inc.*, 609 A.2d 1233, 1235 (N.H. 1992) (“In effect, the certificate is a worthless document; it does no more than certify that insurance existed on the day the certificate was issued.”).

³⁵ If a term is not defined or the definition is not clear, the policy may be considered ambiguous and the interpretation most favorable to the policyholder adopted. See *Gen. Mills, Inc. v. Gold Medal Ins. Co.*, 622 N.W.2d 147, 153 (Minn. Ct. App. 2001) (“Here we have two opposing interpretations reasonably based on policy language, particularly in the absence of any definition of material terms. We conclude that this exclusion is open to more than one interpretation and thus is ambiguous. Therefore, although the district court did not find this clause to be ambiguous, we agree with its conclusion in favor of coverage.”); *Vt. Mut. Ins. Co. v. Petit*, 613 F. Supp. 2d 154, 158 (D. Mass. 2009) (“A court must enforce an insurance contract according to its plain language, unless that language is ambiguous. A contract term is ambiguous if ‘its language is “reasonably prone to different interpretations” or “susceptible to differing, but nonetheless plausible, constructions.”’ The court is to read the insurance contract ‘according to the fair and reasonable meaning of the words in which the agreement of the parties is expressed,’ construing the insurance contract terms ‘in their usual and ordinary sense’ and ‘in the context of the Policy as a whole.’ The court must resolve any contract ambiguity against the insurer.” (citations omitted)); *Alexander Mfg., Inc. Emp. Stock Ownership Plan & Trust v. Ill. Union Ins. Co.*, 560 F.3d 984, 987 (9th Cir. 2009) (“The court held that, if the insurance policy explicitly defines the phrase in question, the court applies that definition. If the policy does not define the phrase in question, the court must consider whether the phrase has a plain meaning. If the phrase in question has a plain meaning, the court must apply that meaning and no further analysis is needed. If the phrase in question has more than one plausible interpretation, the court must then examine the context in which the phrase is used and the broader context of the policy as a whole. It is only after this full contextual examination that any remaining ambiguity

should be construed against the drafter." (citations omitted)); *Liverpool & London & Globe Ins. Co. v. Kearney*, 180 U.S. 132, 136 (1901); *Gulf Ins. Co. v. Edgerly*, 107 Cal. Rptr. 246, 250-51 (Cal. Ct. App. 1973); *State Farm Mut. Auto. Ins. Co. v. Seeba*, 433 S.E.2d 414, 416 (Ga. Ct. App. 1993); *Thornton v. Ill. Founders Ins. Co.*, 418 N.E.2d 744, 747 (Ill. 1981).

³⁶ *Bianchi v. Florists Mut. Ins. Co.*, 660 F. Supp. 2d 434, 436 (E.D.N.Y. 2009) ("That law provides that a plaintiff bears the initial burden of showing: (1) existence of an insurance contract with the defendant and, (2) that the policy potentially covers the loss asserted."); *New Fed Mortg. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 543 F.3d 7, 11 (1st Cir. 2008) ("The insured has the initial burden of proving that a loss falls within the policy's description of covered risks."); *Tower Auto., Inc. v. Am. Prot. Ins. Co.*, 266 F. Supp. 2d 664, 668 (W.D. Mich. 2003) ("Even with an all risk policy, the burden is on the policyholder to demonstrate that the loss falls within the terms of the policy. The burden is on the insurer, however, to clearly state any exclusions." (citations omitted)); *Walla Walla Coll. v. Ohio Cas. Ins. Co.*, 204 P.3d 961, 963 (Wash. Ct. App. 2009) ("The party asserting coverage bears the burden of proving the loss is a covered occurrence within the policy period. The insurer bears the burden of showing an exclusion applies." (citation omitted)); see also *Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 89 F.3d 976, 983-84 n.6 (3d Cir. 1996); *Colonial Gas Co. v. Aetna Cas. & Sur. Co.*, 823 F. Supp. 975, 979 (D. Mass. 1993); *Allstate Ins. Co. v. Morgan*, 806 F. Supp. 1460, 1463 (N.D. Cal. 1992); *State Farm Fire & Cas. Co. v. Hiermer*, 720 F. Supp. 1310, 1314 (S.D. Ohio 1988), *aff'd*, 884 F.2d 580 (6th Cir. 1989); *Sentinel Ins. Co. v. First Ins. Co. of Haw., Ltd.*, 875 P.2d 894, 909 & n.13 (Haw. 1994); *Wexler Knitting Mills v. Atl. Mut. Ins. Co.*, 555 A.2d 903, 905 (Pa. Super. Ct. 1989).

³⁷ See, e.g., *United Nat'l Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 214 P.3d 1260, 1269 (Mont. 2009) ("And the duty to defend is independent from and broader than the duty to indemnify created by the same insurance contract."); *Solvent Underwriters Subscribing to Energy Ins. Int'l, Inc. Cover Note No. EII-3824 v. Furmanite Am., Inc.*, 282 S.W.3d 661, 667 (Tex. App. 2009) ("The duty to defend is distinct from, and broader than, the duty to indemnify."); *Ohio Gov't Risk Mgmt. Plan v. Harrison*, 874 N.E.2d 1155, 1159-60 (Ohio 2007) ("An insurer's duty to defend is broader than and distinct from its duty to indemnify."); see also *U.S. Fid. & Guar. Co. v. Armstrong*, 479 So. 2d 1164, 1167 (Ala. 1985); *Missionaries of the Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 230 A.2d 21, 24 (Conn. 1967); *Tropical Park, Inc. v. U.S. Fid. & Guar. Co.*, 357 So. 2d 253, 256 (Fla. Dist. Ct. App. 1978); *Wolford v. Wolford*, 662 S.W.2d 835, 838 (Ky. 1984); *Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272, 274-75 (N.Y. 1984) ("Gillette"); *Sanderson v. Ohio Edison Co.*, 635 N.E.2d 19, 23 (Ohio 1994).

³⁸ In some jurisdictions, the policyholder may establish the potential for coverage by relying on facts outside these two documents. *Fitzpatrick v. Am. Honda Co.*, 575 N.E.2d 90, 92-93 (N.Y. 1991).

³⁹ See, e.g., *Barkan v. N.Y. Sch. Ins. Reciprocal*, 886 N.Y.S.2d 414, 418 (App. Div. 2009) ("If any of the claims against the insured arguably arise from covered events, the insurer is required to defend the entire action."); *J.G. v. Wangard*, 753 N.W.2d 475, 482 (Wis. 2008) ("When an insurance policy provides coverage for even one claim made in a lawsuit, the insurer is obligated to defend the entire suit."); *Padilla Constr. Co. v. Transp. Ins. Co.*, 58 Cal. Rptr. 3d 807, 816 (Cal. Ct. App. 2007) ("As the Supreme Court explained in *Buss v. Superior Court*,

supra, 16 Cal. 4th at page 49, an insurer must defend an entire action when there is at least one claim that is potentially covered—including the balance of the action, which may press claims that are not even potentially covered.”); *Gillette*, 476 N.E.2d at 275.

⁴⁰ See, e.g., *Avondale Indus., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1204 (2d Cir. 1989); *City of W. Haven v. Liberty Mut. Ins. Co.*, 639 F. Supp. 1012, 1020 (D. Conn. 1986) (stating that one of the “basic purposes of the defense provision is protection of the insured from the expenses of litigation”).

⁴¹ See 7C John Alan Appleman, *Insurance Law and Practice* § 4682, at 34 (1979). An oft-cited 1983 RAND report on the costs of asbestos litigation advises that the underlying plaintiffs received, on average, only thirty-seven cents of every dollar spent by defendants and insurance companies on asbestos litigation. Thomas E. Willging, Federal Judicial Center, *Appendix C: Mass Torts Problems & Proposals: A Report to the Mass Torts Working Group* 3 (Jan. 1999), available at <http://www.fjc.gov> (literature review examining problems related to mass torts and discussing proposals for resolving those problems). This same study explains that mass tort litigation tends to have higher defense costs than other types of litigation.

⁴² *Alexander Mfg., Inc. v. Ill. Union Ins. Co.*, 666 F. Supp. 2d 1185, 1193 (D. Or. 2009).

⁴³ *Turner Constr. Co. v. Am. Mfrs. Mut. Ins. Co.*, 485 F. Supp. 2d 480, 491 (S.D.N.Y. 2007) (“However, under New York law, defense costs are separate and apart from an insurer’s duty to indemnify.”); see also *Valassis Commc’ns, Inc. v. Aetna Cas. & Sur. Co.*, 97 F.3d 870, 876 (6th Cir. 1996); *Kenai Corp. v. Nat’l Union Fire Ins. Co. (In re Kenai Corp.)*, 136 B.R. 59, 64 (S.D.N.Y. 1992); *Harristown Dev. Corp. v. Int’l Ins. Co.*, 1988 WL 123149, at *11 (M.D. Pa. Nov. 15, 1988); *Faulkner v. Am. Cas. Co.*, 584 A.2d 734, 749-50 (Md. Ct. Spec. App. 1991).

⁴⁴ The words in quotation marks are separately defined.

⁴⁵ ISO Commercial General Liability Coverage Form, CG 00 01 04 13 (2013).

⁴⁶ ISO Building and Personal Property Coverage Form, CP 00 10 10 12 (2012).

⁴⁷ See Section VII, *infra*.

⁴⁸ *St. Paul Fire & Marine Ins. Co. v. Brother Int’l Corp.*, 319 F. App’x. 121, 127 (3d Cir. 2009) (“Because the property damage here is the depletion of paper and toner, and because Brother knew that this damage would occur as a result of its unsolicited advertisements, we hold that Brother expected or intended to cause the injury.”); *Liebovich v. Minn. Ins. Co.*, 751 N.W.2d 764, 779 (Wis. 2008) (“However, we have resolved the ambiguous meaning of intentional acts exclusions in previous cases, in which we have explained that intentional act exclusions preclude coverage where some alleged harm or injury, in addition to the act causing injury, was intended by or should have been anticipated by the insured.”); *Allstate Ins. Co. v. Sanders*, 495 F. Supp. 2d 1104, 1109 (D. Nev. 2007) (“Frauenknecht threw a sign at or in the general direction of Edington in the context of some plainly careless and senseless horseplay. Nevertheless, Frauenknecht testified that he did not subjectively intend to hit or injure Edington, and the evidence does not indicate that Edington’s injuries would have

been 'reasonably expected to result from' Frauenknecht's actions."); *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 194 P.3d 167, 182 (Or. Ct. App. 2008) ("An insured's subjective intent to inflict harm can be established as a matter of law if the insured 'engaged in an act so certain to cause a particular kind of harm that the court will say that the insured intended the harm.' 'In other words, the court should only infer that the insured had a subjective intent to cause harm or injury as a matter of law when such subjective intent is the *only* reasonable inference that may be drawn from the insured's conduct.'" (citations omitted)); see also *Allstate Ins. Co. v. Sparks*, 493 A.2d 1110, 1112 (Md. Ct. Spec. App. 1985); *SL Indus., Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266, 1276 (N.J. 1992); *Cont'l Cas. Co. v. Rapid-American Corp.*, 609 N.E.2d 506, 510 (N.Y. 1993); *Vt. Mut. Ins. Co. v. Singleton*, 446 S.E.2d 417, 420-21 (S.C. 1994).

⁴⁹ *Chem. Leaman Tank Lines*, 89 F.3d at 983-86, 987; *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 28 F. Supp. 2d 421, 427-29 (E.D. Mich. 1998); *MAPCO Alaska Petroleum, Inc. v. Cent. Nat'l Ins. Co. of Omaha*, 795 F. Supp. 941, 947 n.14 (D. Alaska 1991); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 719-21 (Cal. Ct. App. 1996); *U.S. Fid. & Guar. Co. v. Wilkin Insulation Co.*, 550 N.E.2d 1032, 1038-40 (Ill. App. Ct. 1989), *aff'd*, 578 N.E.2d 926 (Ill. 1991); *State v. CNA Ins. Cos.*, 779 A.2d 662, 670 (Vt. 2001).

⁵⁰ See, e.g., *Dart Indus., Inc. v. Liberty Mut. Ins. Co.*, 484 F.2d 1295 (9th Cir. 1973) (coverage for damages in a libel action was not barred by statutory intentional conduct exclusion, even though the libel was the result of the willful act of the corporate president, because there was no showing that the board of directors or other senior management either authorized or ratified the libelous acts).

⁵¹ Robert E. Keeton & Alan I. Widiss, *Insurance Law* § 5.3(a) (Practitioner's ed. 1988).

⁵² *McGinnis v. Union Pac. R.R. Co.*, 612 F. Supp. 2d 776, 805 (S.D. Tex. 2009) ("As urged by UP, the indemnity agreement contained in the Lease Agreement is an 'Insured Contract' for purposes of the Umbrella policy."); *Capital Envtl. Servs., Inc. v. N. River Ins. Co.*, 536 F. Supp. 2d 633, 641 (E.D. Va. 2008) ("Specifically, the policy covers Capitol for liability Capitol assumes in an 'insured contract,' which is any 'part of any other contract or agreement pertaining to your business . . . under which you [Capitol] assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization. Capitol did precisely this in its subcontract with Earth Tech; in this contract, it assumed the tort liability of another (FCI) to pay for bodily injury to a third person (the Careys)." (alterations in original) (footnote omitted)); *Soo Line R.R. Co. v. Brown's Crew Car of Wyo.*, 694 N.W.2d 109, 113 (Minn. Ct. App. 2005) ("There is no dispute that Brown's assumed Soo Line's tort liability in its indemnity agreement with CTS. The contract indemnified Soo Line against 'any other loss incurred by . . . [Soo Line] . . . regardless of the nature of the claim or the theory of recovery.' Rather, Progressive argues that the insured-contract exception is not applicable because Soo Line's complaint for declaratory relief characterized its dispute with Brown's as a breach-of-contract claim, alleging that Brown's had not fulfilled its obligations under the indemnity agreement. Noting that the definition of an insured contract under the policy refers to 'that *part* of any other contract or agreement pertaining to your business . . . *under which you assume the tort liability,*' Progressive contends that the only portion of the CTS/Brown's indemnity agreement

qualifying under the insured-contract exemption is the portion that assumed liability for damages paid pursuant to a judgment in tort. We disagree.”); *Gibson & Assocs., Inc. v. Home Ins. Co.*, 966 F. Supp. 468, 476 (N.D. Tex. 1997).

⁵³ *State v. Allstate Ins. Co.*, 201 P.3d 1147, 1161-68 (Cal. 2009); *Burgess v. Allstate Ins. Co.*, 334 F. Supp. 2d 1351, 1359-64 (N.D. Ga. 2003); *Shelter Mut. Ins. Co. v. Maples*, 309 F.3d 1067, 1071 (8th Cir. 2002). See generally Francis J. MacLaughlin, Brief, *Third-Party Liability Policies: The Concurrent Causation Doctrine And Pollution Exclusions*, 24-SPG Brief 20 (Spring 1995) (discussing the doctrine and providing a state survey of cases addressing the doctrine).

⁵⁴ See *Jussim v. Mass. Bay Ins. Co.*, 610 N.E.2d 954, 955-58 (Mass. 1993). In this case, Massachusetts’ highest court applied the efficient proximate cause test and found that coverage was available for damage due to oil-contaminated property under a homeowner’s policy that contained a pollution exclusion. The court reasoned that the efficient proximate cause of the damage was the negligence of a third party when pumping oil, rather than the release of a pollutant, and coverage was available. *Id.*

⁵⁵ ISO Commercial General Liability Coverage Form, CG 00 01 04 07, Section IV(2)(a)-(b) (2013).

⁵⁶ *Id.*, Section IV(2)(c)(1).

⁵⁷ *Id.*, Section IV(2)(c)(3).

⁵⁸ 345 F.3d 154 (2d Cir. 2003) , *overruled on other grounds by Wachovia Bank v. Schmidt*, 546 U.S. 303 (2006).

⁵⁹ The Second Circuit ruled that the definition with respect to certain policies required a single occurrence as a matter of law. The court found the language of other policies ambiguous. Accordingly, the number of occurrences issue was resolved by a jury.

⁶⁰ *Buckeye State Mut. Ins. Co. v. Carfield*, 914 N.E.2d 315, 318 (Ind. Ct. App. 2009) (“If the language is clear and unambiguous, we give the language its plain and ordinary meaning.”); *Mass. Prop. Ins. Underwriting Ass’n v. Gallagher*, 911 N.E.2d 808, 810 (Mass. App. Ct. 2009) (“In the first instance, we construe the policy language in accordance with its plain meaning.”); *AIU Ins. Co. v. Superior Court*, 799 P.2d 1253, 1264 (Cal. 1990) (Insurance policy terms “should be interpreted according to their plain, ordinary, and accepted sense in common speech.”); *First Ins. Co. of Haw., Inc. v. State*, 665 P.2d 648, 655 (Haw. 1983).

⁶¹ *Amerisure Mut. Ins. Co. v. Carey Transp. Inc.*, 578 F. Supp. 2d 888, 900 (W.D. Mich. 2008) (“The jury would ascertain what the parties intended by interpreting the contract’s terms in light of the apparent purpose of the contract as a whole, the rules of construction, and extrinsic evidence of intent and meaning. The jury would be allowed to consider extrinsic evidence as to the parties’ contemporaneous understanding of the agreement and its terms, including ‘the parties’ conduct, the statements of its representatives, and past practice to aid in interpretation.’” (citations omitted)); *Nat’l R.R. Passenger Corp. v. Lexington Ins. Co.*, 445 F. Supp. 2d 37, 41 (D.D.C. 2006) (“When that language is ambiguous, ‘[e]xtrinsic evidence of the parties’ subjective intent may be resorted to,’ and any doubts are resolved in a manner

'consistent with the reasonable expectations of the purchaser of the policy.'" (alteration in original) (citation omitted)), *aff'd*, 249 F. App'x 832 (D.C. Cir. 2007); *Maritz Holdings, Inc. v. Fed. Ins. Co.*, 298 S.W.3d 92, 102 (Mo. Ct. App. 2009) ("Maritz in particular has presented extensive extrinsic evidence of the parties' intent, most especially with respect to their prior dealings. In the past, the parties have not used one standard-form D & O policy, but rather have changed and added terms over the course of their relationship. While we do not consider extrinsic evidence on review of a grant of summary judgment, such evidence will be relevant on remand insofar as it evinces the parties' intent."); *Whittier Props., Inc. v. Alaska Nat'l Ins. Co.*, 185 P.3d 84, 91 (Alaska 2008) ("Thus, with regards to liability policies, the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations. Under this doctrine, we examine the language of the disputed provisions, other provisions, and relevant extrinsic evidence."); *Bird v. State Farm Mut. Auto. Ins. Co.*, 165 P.3d 343, 347 (N.M. Ct. App. 2007) ("When an ambiguity exists in the pertinent language of a policy, we look first to other terms of the policy to resolve the issue. If the ambiguity cannot be resolved by examining the other policy provisions, we look to extrinsic evidence, such as the premiums paid, the circumstances surrounding the agreement, the parties' conduct, and the parties' oral expressions of intent."); *WTC Properties*, 345 F.3d at 170; *September 11 Liab. Ins. Coverage Cases*, 333 F. Supp. 2d at 122. However, a policyholder may be able to offer statements of the insurance company (for instance, in manuals or in claims handling guidelines) against the insurance company as an admission under Federal Rule of Evidence 801(d)(2) and similar state rules of evidence.

⁶² *Mentis v. Del. Am. Life Ins. Co.*, 1999 Del. Super. LEXIS 419, at *14-*15 (July 28, 1999) ("In determining the meaning of a contract, 'the true test is not what the parties to the contract intended it to mean, but what a reasonable person in the position of the parties would have thought it meant.' If a contract is deemed ambiguous, extrinsic evidence is admissible to help determine the proper construction of the contract. This policy is ambiguous and falls painfully short of placing a reasonable insured on notice that the premium rates would drastically increase if the policy's rate of return faltered." (citations omitted)).

⁶³ *Bos. Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, 305 (Mass. 2009) ("If in doubt, we 'consider what an objectively reasonable insured, reading the relevant policy language, would expect to be covered.'" Finally, '[a]ny ambiguities in the language of an insurance contract are interpreted against the insurer who used them and in favor of the insured.'" (citations omitted)); *S & K Motors, Inc. v. Harco Nat'l Ins. Co.*, 213 P.3d 630, 633 (Wash. Ct. App. 2009) ("Courts construe insurance policies as a whole, giving them a fair, reasonable, and sensible construction. Insurance policies are construed liberally, to provide coverage whenever possible. Terms that are defined within a policy should be interpreted in accordance with the policy definition. An undefined term is interpreted according to its ordinary meaning, unless there is a legal, technical meaning that both parties clearly intended to apply. Ambiguities are construed in favor of the insured." (citations omitted) (internal quotation marks omitted)); *Mega Life & Health Ins. Co. v. Pieniozek*, 585 F.3d 1399, 1406 (11th Cir. 2009) ("Ambiguity in an insurance contract is to be strictly construed against the drafter and liberally in favor of the insured."); *Toffler Assocs., Inc. v. Hartford Fire Ins. Co.*, 651 F. Supp. 2d 332, 341 (E.D. Pa. 2009) ("If the policy language is ambiguous, the meaning

must be construed in favor of the insured.”); *Int’l Bus. Machs. Corp. v. Liberty Mut. Fire Ins. Co.*, 303 F.3d 419, 424 (2d Cir. 2002) (“It is well settled that ‘[w]here there is ambiguity as to the existence of coverage, doubt is to be resolved in favor of the insured and against the insurer.’” (quoting *Handelsman v. Sea Ins. Co.*, 647 N.E.2d 1258, 1260 (N.Y. 1994))); *Penn Mut. Life Ins. Co. v. Ogelsby*, 695 A.2d 1146, 1149-50 (Del. 1997); *Ace Wire & Cable Co. v. Aetna Cas. & Sur. Co.*, 457 N.E.2d 761, 764, (N.Y. 1983) (“The ambiguities in an insurance policy are, moreover, to be construed against the insurance company, particularly when found in an exclusionary clause.”); *Royal Coll. Shop, Inc. v. N. Ins. Co.*, 895 F.2d 670, 674 (10th Cir. 1990); *AIU Ins.*, 799 P.2d at 1264-65; *Bank of the West v. Superior Court*, 833 P.2d 545, 552 (Cal. 1992) (“‘[I]f the terms of a promise are in any respect ambiguous or uncertain, it must be interpreted in the sense in which the promisor believed, at the time of making it, that the promisee understood it.’ . . . Only if this rule does not resolve the ambiguity do we then resolve it against the insurer.” (citations omitted)).

⁶⁴ *State Auto Prop. & Cas. Ins. Co. v. Boardwalk Apartments, L.C.* 572 F.3d 511, 516 (8th Cir. 2009) (“‘As a general rule, exceptions, limitations, and exclusions to insurance policies are narrowly construed.’” (citation omitted)); *Caribbean I Owners’ Ass’n, Inc. v. Great Am. Ins. Co. of N.Y.*, 600 F. Supp. 2d 1228, 1246 (S.D. Ala. 2009) (“Exceptions to coverage are interpreted as narrowly as possible to maximize coverage, and are construed strongly against the insurer.”); *Gen. Cas. Co. of Wis. v. Wozniak Travel, Inc.*, 762 N.W.2d 572, 575 (Minn. 2009) (“Because most insurance policies are preprinted forms drafted solely by insurance companies – basically contracts of adhesion – policy words of inclusion will be broadly construed, and words of exclusion are narrowly considered.”); see also *Traders State Bank v. Cont’l Ins. Co.*, 448 F.2d 280, 283 (10th Cir. 1971); *Garvey v. State Farm Fire & Cas. Co.*, 770 P.2d 704, 710 (Cal. 1989); *Chi. Title Ins. Co. v. Resolution Trust Corp.*, 53 F.3d 899, 905 (8th Cir. 1995); *Am. Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952, 953 (Colo. 1991); *Aetna Ins. Co. v. Weiss*, 416 A.2d 426, 428 (N.J. Super. Ct. App. Div. 1980) (“Weiss”); *Borg-Warner Corp. v. Ins. Co. of N. Am.*, 577 N.Y.S.2d 953, 958 (App. Div. 1992); *Bebber v. CNA Ins. Cos.*, 729 N.Y.S.2d 844, 845-46 (Sup. Ct. 2001); *City of Burlington v. Glens Falls Ins. Co.*, 340 A.2d 89, 90 (Vt. 1975); 13 John Alan Appleman & Jean Appleman, *Insurance Law and Practice* § 7405 (1976); 2 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 22:31 (1997).

⁶⁵ *Garvey*, 770 P.2d at 710; *Diamond Shamrock Chems. Co. v. Aetna Cas. & Sur. Co.*, 609 A.2d 440, 464 (N.J. Super. Ct. App. Div. 1992); *Weiss*, 416 A.2d at 429; *Am. States Ins. Co. v. Md. Cas. Co.*, 628 A.2d 880, 887 (Pa. Super. Ct. 1993); *Am. Reliance Ins. Co. v. Mitchell*, 385 S.E.2d 583, 585 (Va. 1989); see also 17 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 254:12 (1997).

⁶⁶ 42 U.S.C. §§ 9601-9675

⁶⁷ See J.M. Campbell, *Specific Policies on the Way Out – Comprehensive Takes Over*, The Local Agent 16 (Mar. 1949) (“Today we have come to the point when separate coverages must give way to . . . comprehensive policies for all industrial and mercantile risks.”).

⁶⁸ *James Graham Brown Found., Inc. v. St. Paul Fire & Marine Ins. Co.*, 814 S.W.2d 273, 278 (Ky. 1991).

⁶⁹ ISO and the role it plays with respect to CGL policies have been described as follows:

ISO is a nonprofit trade association that provides rating, statistical, and actuarial policy forms and related drafting services to approximately 3,000 nationwide property or casualty insurance companies. Policy forms developed by ISO are approved by its constituent insurance carriers and then submitted to state agencies for review. Most carriers use the basic ISO forms, at least as the starting point for their general liability policies.

Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 891 n.13 (Cal. 1995).

⁷⁰ See, e.g., *U.S. Fid. & Guar. Co. v. Armstrong*, 479 So. 2d 1164, 1168 (Ala. 1985); *Missionaries of the Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 230 A.2d 21, 24 (Conn. 1967); *Tropical Park, Inc. v. U.S. Fid. & Guar. Co.*, 357 So. 2d 253, 256 (Fla. Dist. Ct. App. 1978); *United States Fidelity & Guaranty Co. v. Wilkin Insulation Co.*, 578 N.E.2d 926, 930 (Ill. 1991); *Wolford v. Wolford*, 662 S.W.2d 835, 838 (Ky. 1984); *Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272, 274-75 (N.Y. 1984); *Sanderson v. Ohio Edison Co.*, 635 N.E.2d 19, 23 (Ohio 1994).

⁷¹ *Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1158 (Cal. 1993) (citations omitted).

⁷² 519 F.3d 1025 (9th Cir. 2008).

⁷³ *Id.* at 1032-33.

⁷⁴ See, e.g., *E. Fla. Hauling, Inc. v. Lexington Ins. Co.*, 913 So. 2d 673, 676-78 (Fla. Dist. Ct. App. 2005); *Alexander v. CNA Ins. Co.*, 657 A.2d 1282 (Pa. Super. Ct. 1995).

⁷⁵ See 7C John Alan Appleman, *Insurance Law and Practice* § 4682, at 34 (1979). An oft-cited 1983 RAND report on the costs of asbestos litigation advises that the underlying plaintiffs received, on average, only thirty-seven cents of every dollar spent by defendants and insurance companies on asbestos litigation. Thomas E. Willging, Federal Judicial Center, *Appendix C: Mass Torts Problems & Proposals: A Report to the Mass Torts Working Group* 3 (Jan. 1999), available at <http://www.fjc.gov> (literature review examining problems related to mass torts and discussing proposals for resolving those problems). This same study explains that mass tort litigation tends to have higher defense costs than other types of litigation.

⁷⁶ See, e.g., *Avondale Indus., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1204 (2d Cir. 1989); *City of W. Haven v. Liberty Mut. Ins. Co.*, 639 F. Supp. 1012, 1020 (D. Conn. 1986) (stating that one of the “basic purposes of the defense provision is protection of the insured from the expenses of litigation”); *Servidone Constr. Corp. v. Security Ins. Co.*, 477 N.E.2d 441, 444 (N.Y. 1985) (“[t]he insured's right to representation and the insurer's correlative duty to defend suits, however groundless, false or fraudulent, are in a sense “litigation insurance” expressly provided by the insurance contract”).

⁷⁷ See, e.g., *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 176 (Cal. 1966) (Liability insurers “must defend a suit which potentially seeks damages within the coverage of the policy.”); accord *McCostis v. Home Ins. Co.*, 31 F.3d 110, 112 (2d Cir. 1994) (“An insurer can escape the duty to defend only if there is no legal or factual basis in the complaint upon which the insurer might eventually have to indemnify the insured.”); *Wilkin Insulation Co.*, 578 N.E.2d at 930 (“If the underlying complaints allege facts within or *potentially* within policy coverage, the

insurer is obliged to defend its insured even if the allegations are groundless, false, or fraudulent.”) (emphasis in original); *Ross v. Briggs & Morgan*, 540 N.W.2d 843, 847 (Minn. 1995) (insurer has “duty to defend if any part of the claims asserted against [insured] in the underlying case ‘arguably’ falls within the scope of coverage”); *Frontier Ins. Co. v. State*, 662 N.E.2d 251, 253 (N.Y. 1995) (insurer has no duty to defend “only if it can be concluded as a matter of law that there is no possible factual or legal basis on which the insurer will be obligated to indemnify the insured”); *Geico General Ins. Co. v. Austin Power Inc.*, 357 S.W.3d 821, 823-24 (Tex. App. 2012) (“insurer has a duty to defend when a third party sues the insured on allegations that, if taken as true, potentially state a cause of action within the coverage terms of the policy”).

⁷⁸ See, e.g., *Samson v. Transamerica Ins. Co.*, 636 P.2d 32, 44 (Cal. 1981); *Cincinnati Cos. v. W. Am. Ins. Co.*, 701 N.E.2d 499, 504-05 (1998).

⁷⁹ See, e.g., *United Nat’l Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 214 P.3d 1260, 1269 (Mont. 2009) (“any doubt as to the existence of a duty to defend must be resolved in the insured’s favor”); *Legacy Vulcan Corp. v. Superior Court*, 110 Cal. Rptr. 3d 795, 806 (Cal. Ct. App. 2010); *Lawyers Title Ins. Corp. v. JDC (Am.) Corp.*, 52 F.3d 1575, 1580-81 (11th Cir. 1995) (“If an examination of the allegations of the complaint leaves any doubt regarding the insurer’s duty to defend, the issue is resolved in favor of the insured.”); *Chantel Assocs. v. Mount Vernon Fire Ins. Co.*, 656 A.2d 779, 786 (Md. 1995) (“[A]ny doubt as to whether there is a potentiality of coverage under an insurance policy is to be resolved in favor of the insured”); *State Farm Mut. Auto. Ins. Co. v. Wertz*, 540 N.W.2d 636, 638 (S.D. 1995) (When “doubt exists [as to] whether the claim against the insured arguably falls within the policy coverage, such doubts must be resolved in favor of” the duty to defend); *Mirpad, LLC v. Cal. Ins. Guar. Ass’n*, 34 Cal. Rptr. 3d 136, 143 (Cal. Ct. App. 2005) (“If coverage depends on an unresolved dispute over a *factual* question, the very existence of that dispute would establish a possibility of coverage and thus a duty to defend.”); *Westfield Ins. Co. v. Kroiss*, 694 N.W.2d 102, 106 (Minn. Ct. App. 2005) (“Generally where questions of fact need to be discovered to determine if an insurer has a duty to indemnify, a duty to defend exists.”); *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 187 (Tex. 2002) (“we resolve all doubts regarding the duty to defend in favor of the duty”).

⁸⁰ See *Horace Mann Ins. Co. v. Barbara B.*, 846 P.2d 792, 797-98 (Cal. 1993) (once defense duty attaches, carrier must defend all claims in the action, even if the “dominant factor” in the action is an uncovered claim); *Maryland Cas. Co. v. Peppers*, 355 N.E.2d 24, 28 (Ill. 1976) (“duty to defend extends to cases where the complaint alleges several [***8] causes of action or theories of recovery against an insured, one of which is within the coverage of a policy while the others may not be”); *Philadelphia Indemn. Ins. Co. v. Chi. Title Ins. Co.*, 871 F. Supp. 2d 744, 751 (N.D. Ill. 2012) (recognizing “the well-settled Illinois rule that if an insurer ‘has a duty to defend as to at least one count of the lawsuit, it has a duty to defend in all counts of that lawsuit’”).

⁸¹ See, e.g., *Wells' Dairy, Inc. v. Travelers Indem. Co.*, 336 F. Supp. 2d 906, 911 (N.D. Ia. 2004); *Pritchard v. Liberty Mut. Ins. Co.*, 101 Cal. Rptr. 2d 298, 305-07 (Cal. Ct. App. 2000); *Harrington Haley LLP v. Nutmeg Ins. Co.*, 39 F. Supp. 2d 403, 409 (S.D.N.Y. 1999).

⁸² *U.S. Fid. & Guar. Co. v. Saddle Ridge, L.L.C.*, 1999 WL 1072905, at *5-*6 (D. Kan. Sept. 27,

1999) (although “personal injury” was defined to include only malicious prosecution claims, insurer had duty to defend underlying action alleging abuse of process); *CNA Cas. v. Seaboard Sur. Co.*, 222 Cal. Rptr. 276, 280-81 (Cal. Ct. App. 1986) (even though underlying action was labeled as uncovered antitrust claim, the facts alleged created potential for coverage).

⁸³ 144 Cal. Rptr. 3d 12 (Cal. Ct. App. 2012); *but see Hartford Cas. Ins. Co. v. Swift Distribution, Inc.*, 148 Cal. Rptr. 3d 679, 686-87 (Cal. Ct. App. 2012), *petition for review granted* 294 P.3d 73 (2013).

⁸⁴ *Id.* at 20.

⁸⁵ *See Am. Motorists Ins. Co. v. Sw. Greyhound Lines, Inc.*, 283 F.2d 648, 649 (10th Cir. 1960); *Barbara B.*, 846 P.2d at 795 (duty to defend may be deemed to exist based on allegations in the complaint or on facts extrinsic to the complaint that “reveal a possibility that the claim may be covered by the policy”); *El-Com Hardware v. Fireman's Fund Ins. Co.*, 111 Cal. Rptr. 2d 670, 675-76, 679 (Cal. Ct. App. 2001); *Associated Indem. Co. v. Ins. Co. of N. Am.*, 386 N.E.2d 529, 536 (Ill. App. Ct. 1979).

⁸⁶ *McCostis*, 31 F.3d at 112 (“An insurer can escape the duty to defend only if there is no legal or factual basis in the complaint upon which the insurer might eventually have to indemnify the insured.”); *Frontier Ins.*, 662 N.E.2d at 253 (insurer has no duty to defend “only if it can be concluded as a matter of law that there is no possible factual or legal basis on which the insurer will be obligated to indemnify the insured”).

⁸⁷ *Montrose Chem.*, 861 P.2d at 1161 (“[T]he insured need only show that the underlying claim *may* fall within policy coverage; the insurer must prove it *cannot*.”); *see also Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.* 495 Fed. Appx. 830, 831 (9th Cir. 2012) (“insurer must defend its insured if it is even ‘conceivable,’ based on the factual allegations in a third-party's complaint, that the third-party could state a claim covered by the insured's policy”); *Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 89 F.3d 976, 983 n.6 (3d Cir. 1996); *Wexler Knitting Mills v. Atl. Mut. Ins. Co.*, 555 A.2d 903, 904-05 (Pa. Super. Ct. 1989).

⁸⁸ *See, e.g., W. World Ins. Co. v. Hartford Mut. Ins. Co.*, 784 F.2d 558, 562 (4th Cir. 1986); *Consol. Rail Corp. v. Liberty Mut. Ins. Co.*, 416 N.E.2d 758, 762 (Ill. App. Ct. 1981); *Truchinski v. Cashman*, 257 N.W.2d 286, 288 (Minn. 1977). *But see Montrose Chem.*, 861 P.2d at 1161 (insurer may rely on extrinsic evidence to defeat duty to defend, but must prove that the claim against the insured cannot be covered).

⁸⁹ *Reese v. Travelers Ins. Co.*, 129 F.3d 1056, 1061 (9th Cir. 1997) (“The question is not whether the allegations of the underlying complaint are meritorious, but rather whether [the insurer's] policy terms require it to provide a defense against such claims. . . . [The insurer] has a ‘duty to defend . . . as long as the complaint contains language creating the potential of liability under an insurance policy.’ . . . Thus, we must determine whether the underlying complaint alleges a covered claim, not whether the facts alleged in the complaint are true.” (citations omitted)); *Avemco Ins. Co. v. Acer Enters., Inc.*, 796 F. Supp. 343, 346 (N.D. Ill. 1992) (“The duty to defend hinges on a liberal reading of the underlying complaint: to the extent that a single cause of action is potentially within the policy coverage, the duty to defend is

triggered, even if the insurer discovers that the allegations are groundless, false or fraudulent.”); *Gray*, 419 P.2d at 174 (recognizing that carrier must defend insured against groundless, false, or fraudulent claims, the nature and kind covered by the policy, because the policy language “would lead the insured reasonably to expect defense of *any* suit regardless of merit or cause”); *A-H Plating, Inc. v. Am. Nat’l Fire Ins. Co.*, 67 Cal. Rptr. 2d 113, 121 (Cal. Ct. App. 1997) (“The duty to defend does not evaporate simply because the insurer has decided that the insured will ultimately be exonerated (or because evidence supporting that conclusion has been introduced in a declaratory relief action over coverage); *Wilkin Insulation Co.*, 578 N.E.2d at 930 (“the insurer is obliged to defend its insured even if the allegations are groundless, false, or fraudulent.”); . As one commentator has explained: “Insurers, as a general rule, are not allowed to refuse to defend on the grounds that they are in possession of information establishing that the allegations of the complaint giving rise to coverage are untrue.” Allan Windt, *Insurance Claims & Disputes*, § 4.4, at 4-79 (5th ed. 2007).

⁹⁰ *Barbara B.*, 846 P.2d at 799 (citations omitted).

⁹¹ *Garriott Crop Dusting Co. v. Superior Court*, 270 Cal. Rptr. 678, 686 (Cal. Ct. App. 1990) (duty to defend exists “regardless of *potentially* meritorious defenses to [underlying] claims’); *Essex Ins. Co. v. T-Birds Nightclub & Rest., Inc.*, 645 N.Y.S.2d 218, 219 (App. Div. 1996); *Mary Kay Cosmetics, Inc. v. N. River Ins. Co.*, 739 S.W.2d 608, 612 (Tex. App. 1987) (“In determining the duty of a liability insurer to defend a lawsuit brought against the insured, the allegations of the complainant should be considered in the light of the policy provisions without reference to the truth or falsity of such allegations, and without reference to what the parties know or believe the true facts to be, or without reference to a legal determination thereof.”).

⁹² Frequently, these firms agree to charge the insurer a below-market rate for their services, and agree to abide by all aspects of the insurer’s billing or claims-handling guidelines.

⁹³ Many courts have found national coordinating counsel fees to qualify as covered defense costs reimbursable by the insurer. *See, e.g., Caterpillar, Inc. v. Century Indemnity Company*, No. 3-09-0456, 2011 Ill. App. LEXIS 60, *33-34 (Ill. App. Ct. Feb. 1, 2011); *Watts Water Techs., Inc. v. Fireman’s Fund Ins. Co.*, No. 05-2604-BLS2, 2007 Mass. Super. LEXIS 266, *22-24 (Mass. Super. Ct. July 10, 2007); *Emons Indus., Inc. v. Liberty Mut. Ins. Co.*, 749 F. Supp. 1289, 1292, 1298 (S.D.N.Y. 1990); *Dart Indus., Inc. v. Commercial Union Ins. Co.*, No. B1296601, 2003 Cal. App. Unpub. LEXIS 57, *9-12 (Cal. Ct. App. Jan. 6, 2003).

⁹⁴ 749 F. Supp. 1289, 1297 (S.D.N.Y. 1990).

⁹⁵ 273 F.3d 741, 744 (7th Cir. 2001).

⁹⁶ *Id.* (citations omitted).

⁹⁷ The relationship among the insured, the insurer, and the defense counsel is often referred to as the triangular, or tripartite relationship.

⁹⁸ *See* Michael F. Aylward, The American Law Institute, *Insurance Ethics: The Future of the*

Tripartite Relationship, SG004 ALI-ABA 217, 223-24 (2001); Ronald D. Rotunda, The American Bar Association, *Legal Ethics – The Lawyer's Deskbook On Professional Responsibility* § 8-6.13.1 (2002-03 ed.). See generally Laura A. Foggan, Practicing Law Inst., *Ethics and Professional Responsibility Issues: The Tripartite Relationship*, 673 PLI/Lit 479 (2002) (recent survey of each state's view on who defense counsel represents).

⁹⁹ Joint Brief of Respondents, In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures, No. 98-612 (Mont. filed May 17, 1999).

¹⁰⁰ See, e.g., *Am. Family Life Assurance Co. v. U.S. Fire Co.*, 885 F.2d 826, 831 (11th Cir. 1989) (interpreting Georgia law); *CHI of Alaska, Inc. v. Emp'rs Reinsurance Corp.*, 844 P.2d 1113, 1121 (Alaska 1993); Alaska Stat. § 21.96.100 (2012); *Union Ins. Co. v. Knife Co., Inc.*, 902 F. Supp 877, 880-81 (W.D. Ark. 1995); *Ill. Masonic Med. Ctr. v. Turegum Ins. Co.*, 522 N.E.2d 611, 614 (Ill. App. Ct. 1988); *Nandorf, Inc. v. CNA Ins. Cos.*, 479 N.E.2d 988, 992 (Ill. App. Ct. 1985) (insurer that issued reservation of rights meets its defense obligation "by reimbursing the insured for the costs of independent counsel," including costs of counsel selected by insured); *Snodgrass v. Baize*, 405 N.E.2d 48, 51 (Ind. Ct. App. 1980); *Belanger v. Gabriel Chems., Inc.*, 787 So. 2d 559, 565-67 (La. Ct. App. 2001); *Patrons Oxford Ins. Co. v. Harris*, 905 A.2d 819, 825-26 (Me. 1980); *Hartford Cas. Ins. Co. v. A&M Assocs., Ltd.*, 200 F. Supp. 2d 84, 90 (D. R.I. 2002 (applying Massachusetts law)); *Cent. Mich. Bd. Of Trustees v. Employers Reinsurance Corp.*, 117 F. Supp. 2d 627, 634-35 (E.D. Mich. 2000); *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1071 (Miss. 1996); *Cunniff v. Westfield, Inc.*, 829 F. Supp. 55, 57 (E.D.N.Y. 1993); *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 425 N.E.2d 810, 815 n.* (N.Y. 1981); *Nat'l Mortg. Corp. v. Am. Title Ins. Co.*, 255 S.E.2d 622, 629-30 (N.C. Ct. App. 1979), *rev'd on other grounds*, 261 S.E.2d 844 (N.C. 1980); *Socony-Vacuum Oil Co. v. Cont'l Cas. Co.*, 59 N.E.2d 199, 205 (Ohio 1945).

¹⁰¹ See, e.g., *Cay Divers, Inc. v. Raven*, 812 F.2d 866, 870 (3d Cir. 1987) (by reserving the right to deny coverage and providing insured with independent counsel, insurer "renounced control of the litigation and thereby thrust the responsibility for the litigation wholly upon the insured and its counsel"); *Grand Cove II Condo. Ass'n Inc. v. Ginsberg*, 676 A.2d 1123 (N.J. Super. Ct. App. Div. 1996); *Steel Erection Co. v. Travelers Indem. Co.*, 392 S.W.2d 713, 716 (Tex. App. 1965).

¹⁰² 369 F.2d 678, 681-82 (2d Cir. 1966).

¹⁰³ 208 Cal. Rptr. 494 (Cal. Ct. App. 1984), *superseded by statute*, 1987 Cal. Stat. Ch. 1498 (codified at Cal. Civ. Code § 2860).

¹⁰⁴ *Id.* at 498.

¹⁰⁵ *Id.* at 506 (citations omitted).

¹⁰⁶ 2013 Cal. App. LEXIS 461 (Cal. Ct. App. May 16, 2013), __ Cal. Rptr. 2d __ (Cal Ct. App. 2013).

¹⁰⁷ 7C John Alan Appleman, *Insurance Law and Practice* § 4681, at 5 (1979).

¹⁰⁸ See, e.g., *Aquino v. State Farm Ins. Cos.*, 793 A.2d 824, 832-33 (N.J. Super. Ct. App. Div. 2002); see also Cal. Civ. Code § 2860.

¹⁰⁹ 698 F.2d 1181 (11th Cir. 1983).

¹¹⁰ *Id.* at 1190 n.13.

¹¹¹ See *LeBlanc-Sternberg v. Fletcher*, 143 F.3d 748, 763 (2d Cir. 1998); *Hall v. Harleysville Ins. Co.*, 943 F. Supp. 536, 546 (E.D. Pa. 1996) (charges such as telephone charges, photocopies and reasonable costs stemming from computer research should be compensated); *United Nuclear Corp. v. Cannon*, 564 F. Supp. 581, 592 (D.R.I. 1983) (“Denial of reimbursement for Lexis charges in a proper case would be an open invitation to law firms to use high-priced attorney time to perform routine research tasks that can be accomplished quicker and more economically with Lexis.”).

¹¹² See, e.g., *Dynamic Concepts v. Truck Ins. Exch.*, 71 Cal. Rptr. 2d 882, 889 (Cal. Ct. App. 1998); *In re The Rules of Professional Conduct*, 2 P.3d 806 (Mont. 2000); Rhode Island Supreme Court Ethics Advisory Panel Opinion No. 99-18 (Oct. 1999); Utah Ethics Opinion 02-01, 2002 WL 340262 (Utah State Bar 2002); West Virginia Office of Disciplinary Counsel L.E.I. 2005-01 (2005).

¹¹³ 939 P.2d 766 (Cal. 1997).

¹¹⁴ *Id.* at 774.

¹¹⁵ *Id.* at 775.

¹¹⁶ *Id.*

¹¹⁷ *Westchester Fire Ins. Co. v. Wallerich*, 563 F.3d 707, 715 (8th Cir. 2009).

¹¹⁸ Carole E. Cheney, *Recoupment Revisited: Why the Majority Should Adopt the Minority Position*, Ins. Cov. L. Bull., July, 2005.

¹¹⁹ *Gen. Star Indem. Co. v. V.I. Port Auth.*, 564 F. Supp. 2d 473, 477-78 (D. V.I. 2008).

¹²⁰ 828 N.E.2d 1092 (Ill. 2005).

¹²¹ *Id.* at 1103.

¹²² 297 P.3d 688 (Wash. 2013).

¹²³ *Id.* at 693.

¹²⁴ *Id.* at 694 and 695.

¹²⁵ 2 A.3d 526 (Pa. 2010).

¹²⁶ *Id.* at 597-98.

¹²⁷ *Id.* at 605-09 (citing and discussing numerous recent decisions denying an insurer reimbursement of defense costs).

¹²⁸ *Id.* at 618.

¹²⁹ See, e.g., *Westchester Fire Ins. Co. v. Wallerich*, 563 F.3d 707 (8th Cir. 2009); *Am. Modern Home Ins. Co. v. Reeds at Bayview Mobile Home Park, LLC*, 176 Fed Appx. 363 (4th Cir. 2006); *Liberty Mut. Ins. Co. v. FAG Bearings Corp.*, 153 F.3d 919 (8th Cir. 1998); *Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213, (3rd Cir. 1989); *Gen. Star Indem.*, 564 F. Supp. 2d at 480 (insurer could not “reserve any right to reimbursement for defense costs because no such right existed in the Policies.”); *St. Paul Fire & Marine Ins. Co. v. Holland Realty, Inc.*, 2008 WL 3255645, at *8 (D. Idaho Aug. 6, 2008) (court rejected application of “principle of unjust enrichment to find a reimbursement right” as set forth in *Buss* and found persuasive those decisions refusing to allow reimbursement absent agreement to the contrary in insurance policy); *Pekin Ins. Co. v. TYSA, Inc.*, 2006 WL 3827232, at *19 (S.D. Iowa Dec. 27, 2006) (court rejected those cases that permitted an insured to recover defense costs on an unjust enrichment theory because “examination of the long-standing Iowa jurisprudence regarding the breadth of the duty to defend and the reasonable expectations of the insured” convinced court that “the Iowa Supreme Court would be more persuaded by the Illinois, Minnesota, and Pennsylvania decisions finding that using a reservation of rights to permit recovery of defense costs amounts to a unilateral modification of the policy terms and that . . . the insured is not unjustly enriched when the insurer provides a defense for claims that are at least possibly within the coverage terms”); *Emp’rs Mut. Cas. Co. v. Indus. Rubber Prods., Inc.*, 2006 WL 453207, at *6 (D. Minn. Feb. 23, 2006) (rejecting a Minnesota decision relying on California law, court held “an insurer is not entitled to the reimbursement of defense costs expended prior to the determination of coverage, unless specifically provided for in the insurance policy”); *Shoshone First Bank v. Pacific Empls. Ins. Co.*, 2 P.3d 510 (Wyo. 2000).

¹³⁰ A “latent injury claim” or “long tail claim” refers to a claim where the bodily injury or property damage goes on for many years while remaining undetected. Examples of such latent injury bodily injury claims are those arising from exposure to asbestos or harmful drugs. The activity causing the claims typically involves exposure to a hazardous substance over a long period of time. The alleged injury or damage often is widespread. Such claims often involve multiple plaintiffs and can give rise to mass tort litigation and class actions. Latent injury claims also can involve multiple defendants, multiple insurance companies, multiple coverage layers, and many policy periods.

¹³¹ International Risk Management Institute, Inc., *Commercial Liability Insurance*, 1973 Policy Jacket Specimen (2002) (emphasis added).

¹³² 667 F.2d 1034, 1048 (D.C. Cir. 1981) (“*Keene*”).

¹³³ 565 F. Supp. 1485 (S.D.N.Y. 1983), *aff’d as modified*, 748 F.2d 760 (2d Cir. 1984).

¹³⁴ *Am. Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 748 F.2d 760 (2d Cir. 1984); *Avondale Indus., Inc. v. Travelers Indem. Co.*, 774 F. Supp. 1416 (S.D.N.Y. 1991); *Sentinel Ins. Co. v. First Ins. Co. of Haw., Ltd.*, 875 P.2d 894 (Haw. 1994).

¹³⁵ *Keene*, 667 F.2d 1034; *New Castle Cnty. v. Cont'l Cas. Co.*, 725 F. Supp. 800 (D. Del. 1989), *aff'd in part, rev'd in part on other grounds sub nom. New Castle County v. Hartford Accident & Indem. Co.*, 933 F.2d 1162 (3d Cir. 1991); *Lac D'Amiante du Quebec, Ltee. v. Am. Home Assurance Co.*, 613 F. Supp. 1549 (D.N.J. 1985).

¹³⁶ *Commercial Union Ins. Co. v. Sepco Corp.*, 765 F.2d 1543 (11th Cir. 1985); *Ducre v. Exec. Officers of Halter Marine, Inc.*, 752 F.2d 976 (5th Cir. 1985); *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980); *Burroughs Wellcome Co. v. Commercial Union Ins. Co.*, 632 F. Supp. 1213 (S.D.N.Y. 1986); *Allstate Ins. Co. v. Colonial Realty Co.*, 121 Misc. 2d 640, 468 N.Y.S.2d 800 (Sup. Ct. Kings County 1983).

¹³⁷ *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982).

¹³⁸ *Celotex Corp. v. AIU Ins. Co. (In re Celotex Corp.)*, 152 B.R. 661, 665 (Bankr. M.D. Fla. 1993).

¹³⁹ *UNR Indus., Inc. v. Cont'l Cas. Co.*, 942 F.2d 1101, 1107 (7th Cir. 1991); *see also Manual for Complex Litigation – Third* § 21-493 (1995).

¹⁴⁰ *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 829 F.2d 227, 242 (1st Cir. 1987).

¹⁴¹ *See* Fed. R. Evid. 1006.

¹⁴² Moreover, often there are additional underlying claims on the horizon, so that if the policyholder were required to prove its own liability to obtain insurance, that would invite more underlying tort claims to be filed.

¹⁴³ *See Luria Bros. & Co. v. Alliance Assurance Co.*, 780 F.2d 1082, 1091 (2d Cir. 1986); *Uniroyal, Inc. v. The Home Ins. Co.*, 707 F. Supp. 1368, 1378-79 (E.D.N.Y. 1988).

¹⁴⁴ Nos. 200143-54 1999 WL 33435067 (Mich. Ct. App. Oct. 12, 1999).

¹⁴⁵ *Id.* at *6.

¹⁴⁶ *See generally* 9 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 126:29 (1997); 12 Am. Jur. 3d *Proof of Facts* § 3 (1991); James L. Rigelhaupt, Annotation, *Construction and Application of Provisions of Liability Insurance Policy Expressly Excluding Injuries Intended or Expected by Insured*, 31 A.L.R.4th 957, 971-72 (1984).

¹⁴⁷ 2 Allan D. Windt, *Insurance Claims & Disputes* § 11.24, at 559 (5th ed. 2007); *see Newmont Mines Ltd. v. Hanover Ins. Co.*, 784 F.2d 127, 135-36 (2d Cir. 1986) ("*Newmont Mines*"); *Mich. Chem. Corp. v. Am. Home Assurance Co.*, 728 F.2d 374, 379-80 (6th Cir. 1984); *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, 61 (3d Cir. 1982); *Greaves v. State Farm Ins. Co.*, 984 F. Supp. 12, 16-17 (D.D.C. 1997), *aff'd*, 172 F.3d 919 (D.C. Cir. 1998); *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, 707 F. Supp. 762, 772-73 (E.D. Pa. 1989), *aff'd in part, vacated in part on other grounds*, 25 F.3d 177 (3d Cir. 1994); *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1380-81 (E.D.N.Y. 1988) ("*Uniroyal*"); *Champion Int'l Corp. v. Liberty Mut. Ins. Co.*, 701 F. Supp. 409, 412-13 (S.D.N.Y.), *amended by* 758 F. Supp. 127 (S.D.N.Y. 1988); *Transcont'l Ins. Co. v. Wash. Pub. Utils. Dists.' Util. Sys.*, 760 P.2d 337, 345-46 (Wash. 1988); *see also* 12 Lee R. Russ

& Thomas F. Segalla, *Couch on Insurance* 3d § 172:12 (1997); 46 C.J.S. *Insurance* § 1129 (1993); 44 Am. Jur. 2d *Insurance* § 1552 (1982).

¹⁴⁸ In *Uniroyal*, the court recognized that the insurance industry developed the “occurrence” policies to make clear its intent to provide insurance for “gradual, continuous, and prolonged events that might have been excluded by the instantaneous connotation of ‘accident.’” 707 F. Supp. at 1381 (citing *Am. Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485, 1501 (S.D.N.Y. 1983), *aff’d as modified*, 748 F.2d 760 (2d Cir. 1984)); *see also Newmont Mines*, 784 F.2d at 135-36 (“occurrence” provides broader coverage than “accident”); *Burroughs Wellcome Co. v. Commercial Union Ins. Co.*, 632 F. Supp. 1213, 1216-17, 1219 n.2 (S.D.N.Y. 1986) (same); *Am. Motorists Ins. Co. v. E. R. Squibb & Sons, Inc.*, 406 N.Y.S.2d 658, 659-60 (Sup. Ct. N.Y. County 1978) (same).

¹⁴⁹ *Lombard v. Sewerage & Water Bd.*, 284 So. 2d 905, 915-16 (La. 1973); *Gibbs v. Armovit*, 452 N.W.2d 839, 840-41 (Mich. Ct. App. 1990).

¹⁵⁰ 765 A.2d 891 (Conn. 2001). Several courts in New York have adopted an “unfortunate events” test, which looks to the “unfortunate event” from which the claim or claims arose to determine the number of occurrences. Under this test, there may be more than one cause for purposes of determining the number of occurrences. *See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1213 (2d Cir. 1995), *modified on other grounds on denial of reh’g*, 85 F.3d 49 (2d Cir. 1996); *DiCola v. Am. S.S. Owners Mut. Prot. & Indem. Ass’n (In re Prudential Lines Inc.)*, 158 F.3d 65, 81 (2d Cir. 1998); *see also Consol. Edison Co. of N.Y., Inc. v. Employers Ins.*, 1997 WL 727486, at *3 (S.D.N.Y. Nov. 21, 1997).

¹⁵¹ *Liberty Mut. Ins. Co. v. Treesdale Inc.*, 418 F.3d 330, 334-39 (3rd Cir. 2005).

¹⁵² 707 F. Supp. 1368, 1379-87 (E.D.N.Y. 1988).

¹⁵³ *Id.* at 1382.

¹⁵⁴ *Id.* at 1380.

¹⁵⁵ 727 F. Supp. 1524 (E.D. Mich. 1989).

¹⁵⁶ 814 F. Supp. 613, 622-23 (E.D. Mich. 1993).

¹⁵⁷ Numerous courts have held that multiple claims resulting from exposure to asbestos must be considered a single occurrence under liability insurance policies containing a batch clause. *Air Prods. & Chems.*, 707 F. Supp. at 772-73; *Owens-Illinois, Inc. v. Aetna Cas. & Sur. Co.*, 597 F. Supp. 1515, 1527-28 (D.D.C. 1984); *U.S. Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1258-59 (Ill. App., Ct. 1994).

¹⁵⁸ *See, e.g., Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*, 928 F. Supp. 176, 180-81 (N.D.N.Y. 1996) (court focused on the batch clause to consolidate many waste disposals over many years into a single occurrence at each of two separate waste sites).

¹⁵⁹ *Champion Int’l Corp. v. Cont’l Cas. Co.*, 546 F.2d 502, 505-06 (2d Cir. 1976).

¹⁶⁰ See, e.g., *Chemstar, Inc. v. Liberty Mut. Ins. Co.*, 797 F. Supp. 1541, 1545-48 (C.D. Cal. 1992) (involving underlying allegations of a policyholder's "failure to warn" over an extended period), *aff'd*, 41 F.3d 429 (9th Cir. 1994).

¹⁶¹ 345 F.3d 154 (2d Cir. 2003).

¹⁶² *Carter-Wallace Inc. v. Admiral Ins. Co.*, 712 A.2d 1116, 1124 (N.J. 1998); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 993 (N.J. 1994).

¹⁶³ See, e.g., *Plastics Eng'g Co. v. Liberty Mut. Ins. Co.*, 514 F.3d 651, 659 (7th Cir. 2008) (noting a fairly even split in authority).

¹⁶⁴ E.g., *Aerojet-Gen. Corp. v. Transp. Indem. Co.*, 948 P.2d 909, 931-32, (Cal. 1997) ("*Aerojet*"); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 489-94 (Del. 2001); *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30, 33-35 (Del. 1994); *Zurich Ins. Co. v. Raymark Indus., Inc.*, 514 N.E.2d 150, 165 (Ill. 1987) ("the appellate court did not err insofar as it declined to order the *pro rata* allocation of defense and indemnity obligations among the triggered policies"); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 769 N.E.2d 835, 841-42 (Ohio 2002); *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 507-08 (Pa. 1993); *Am. Nat'l Fire Ins. Co. v. B & L Trucking & Constr. Co.*, 951 P.2d 250, 256-57 (Wash. 1998); *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994); *Plastics Eng'g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613 (Wis. 2009); *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001).

¹⁶⁵ See, e.g., *ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 974 (3d Cir. 1985); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1048 (D.C. Cir. 1981) ("There is *nothing* in the policies that provides for a reduction of the insurance company's liability if an injury occurs only in part during a policy period."); *Fed. Ins. Co. v. Susquehanna Broad. Co.*, 727 F. Supp. 169, 175 (M.D. Pa. 1989), *aff'd*, 928 F.2d 1131 (3d Cir.).

¹⁶⁶ 951 P.2d 250, 257 (Wash. 1998) (footnote omitted) (rejecting the argument that an insurance company on the risk for a short period would be unfairly burdened by having joint and several liability imposed on it for the indemnification of expenses to remediate pollution spanning several years).

¹⁶⁷ See, e.g., *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1224-25 (6th Cir. 1980), *clarified on reh'g*, 657 F.2d 814 (6th Cir.); *Mayor of Balt. v. Utica Mut. Ins. Co.*, 802 A. 2d 1070 (Md. Ct. Spec. App. 2002); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 995 (N.J. 1994); *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, 774 N.E.2d 687, 693-696 (N.Y. 2002); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 140-42 (Utah 1997). These cases were criticized by *Aerojet* for failing to adhere to a stricter contract analysis, and for instead relying upon "vague" notions of "fairness" and "rough justice," when they determined that the policyholder should be liable for a *pro rata* portion of the liability for those years that the policyholder was self-insured. *Aerojet*, 948 P.2d at 930-31 & nn.22-24.

¹⁶⁸ 73 F.3d 1178 (2d Cir. 1995), *modified on other grounds on denial of reh'g*, 85 F.3d 49 (2d Cir. 1996).

¹⁶⁹ *Id.* at 1203-04.

¹⁷⁰ 844 N.Y.S.2d 13, 15 (App. Div. 2007).

¹⁷¹ 759 N.W.2d 613 (Wis. 2009).

¹⁷² *Id.* at 625.

¹⁷³ *Id.* at 626.

¹⁷⁴ 2009 WL 3297559 (Del. Ch. Oct. 14, 2009).

¹⁷⁵ 844 N.Y.S.2d 13 (App. Div. 2007).

¹⁷⁶ *Id.* at 15.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ 2010 WL 2265638 (Wis. Ct. App. Jun. 8, 2010).

¹⁸⁰ *See Plastics Engineering, supra.*

¹⁸¹ *Id.* at ¶ 77.

¹⁸² *Id.* at ¶ 78.

¹⁸³ *See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1194, 1208-09 (2d Cir. 1995) (rejecting insurance company assertion that underlying asbestos claims asserted non-covered “economic loss;” “[s]uch claims are for ‘property damage,’ not economic loss.”); *Indep. Petrochem. Corp. v. Aetna Cas. & Sur. Co.*, 654 F. Supp. 1334, 1359 (D.D.C. 1986).

¹⁸⁴ 641 N.W.2d 302 (Minn. App. 2002), *aff’d*, 944 F.2d 940 (D.C. Cir. 1991).

¹⁸⁵ 948 F.2d 1507, 1515 (9th Cir. 1991).

¹⁸⁶ 948 F.2d at 1515.

¹⁸⁷ *Id.* at 1514 (emphasis added).

¹⁸⁸ *Id.* at 1515.

¹⁸⁹ 731 N.E.2d 1109, 1110 (N.Y. 2000),

¹⁹⁰ 731 N.E.2d at 1110.

¹⁹¹ 750 P.2d 1294 (Wash. Ct. App. 1988).

¹⁹² *Id.* at 1297.

¹⁹³ *Id.* at 1298.

¹⁹⁴ See, e.g., *Great Am. Ins. Co. v. Lerman Motors, Inc.*, 491 A.2d 729 (N.J. Super. Ct. App. Div. 1984); *Broadhead v. Hartford Cas. Ins. Co.*, 773 F. Supp. 882 (S.D. Miss. 1991), *aff'd*, 979 F.2d 209 (5th Cir. 1992).

¹⁹⁵ No. 99-90 (J3), slip op. at 2 (E.D. La. Sept. 15, 1999), *aff'd*, 226 F.3d 642 (5th Cir. 2000),

¹⁹⁶ *Id.* at 4.

¹⁹⁷ No. 3, 95, 2005 WL 1523565 (N.Y. Jun. 29, 2005).

¹⁹⁸ 692 A.2d 546 (N.J. Super. App. Div. 1997).

¹⁹⁹ 645 N.E.2d 360 (Ill. App. Ct. 1994)

²⁰⁰ 2013 ISO Form CG 20 10 04 13.

²⁰¹ See, e.g., *Old Republic Ins. Co. v. Concast, Inc.*, 588 F. Supp. 616 (S.D.N.Y. 1984).

²⁰² See *Allstate Ins. Co. v. Farmers Ins. Group*, 488 N.Y.S.2d 703, 704 (App. Div. 1985).

²⁰³ 728 F. Supp. 298, 303 (S.D.N.Y. 1990).

²⁰⁴ No. 89 Civ. 3869 (SWK) 1994 WL 259820, at *6 (S.D.N.Y. June 8, 1994), *aff'd*, 48 F.3d 1212 (2d Cir. 1994).

²⁰⁵ ISO CG 00 02 04 13, Section IV(4)(b)(1)(b) (2013); *see also* ISO CG 00 01 04 13, Section. IV(4)(b)(1)(b) (2013).

²⁰⁶ See Section IV.D.1, *supra*.

²⁰⁷ See Section IV.D.3, *supra*.

²⁰⁸ See Section IV.D.2, *supra*.

²⁰⁹ See, e.g., *Aetna Cas. and Sur. Co., Inc. v. Pintlar Corp.*, 948 F.2d 1507 (9th Cir.); *Boardman Petroleum, Inc. v. Federated Mut. Ins. Co.*, 926 F. Supp. 1566 (S.D. Ga. 1995), *rev'd on other grounds*, 150 F.3d 1327 (11th Cir. 1998); *Travelers Cas. & Sur. Co. v. Ala. Gas Corp.*, No. 1110346, 2012 Ala. LEXIS 174, at *17-18 (Ala. Dec. 28, 2012) ("*Alabama Gas*"); *Compass Ins. Co. v. City of Littleton*, 984 P.2d 606 (Colo. 1999); *R.T. Vanderbilt Co. v. Cont'l Cas. Co.*, 870 A.2d 1048 (Conn. 2005); *Hazen Paper Co. v. U.S. Fid. & Guar. Co.*, 555 N.E.2d 576 (Mass. 1990) ("*Hazen Paper*"); *Mich. Millers Mut. Ins. Co. v. Bronson Plating Co.*, 519 N.W.2d 864 (Mich. 1994), *overruled on other grounds by Wilkie v. Auto-Owens Ins. Co.*, 664 N.W.2d 776 (Mich. 2003); *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305 (Minn. 1995), *overruled on other grounds by Bahr v. Boise Cascade Corp.*, 766 N.W.2d 910 (Minn. 2009); *Dutton-Lainson Co. v. Cont'l Ins. Co.*, 778 N.W.2d 433 (Neb. 2010); *Coakley v. Me. Bonding & Cas. Co.*, 618 A.2d 777 (N.H. 1992); *Johnson Controls, Inc. v. Emp'rs Ins. of Wausau*, 665 N.W.2d 257 (Wis. 2003); *State v. CNA Ins. Cos.*, 779 A.2d 662 (Vt. 2001). See also *Aetna Cas. & Sur. Co. v. Com.*, 179 S.W.3d 830 (Ky. 2005) (CERCLA administrative proceedings constituted "suit"); *C.D. Spangler Constr. Co. v. Indus. Crankshaft & Eng'g Co.*, 388 S.E.2d 557 (N.C. 1990) ("*C.D. Spangler*")

(state environmental compliance orders “were an attempt by the State to ‘gain an end by legal process’” and therefore constituted a “suit”); *A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am.*, 475 N.W.2d 607 (Iowa 1991) (same).

²¹⁰ *Hazen Paper*, 555 N.E.2d at 581; see also *Alabama Gas*, 2012 Ala. LEXIS 174, at *37 (“Given the severe penalties for failure to cooperate and other enforcement tools available to the EPA, a decision by the EPA to designate an insured as a PRP cannot on any practical level be understood as anything less than the initiation of a “legal action” constituting a “suit” within the contemplation of the insurance contract at issue.”)

²¹¹ See, e.g., *Harleysville Mut. Ins. Co. v. Sussex County*, 831 F. Supp. 1111 (D. Del. 1993), *aff’d*, 46 F.3d 1116 (3d Cir. 1994); *Joslyn Mfg. Co. v. Liberty Mut. Ins. Co.*, 836 F. Supp. 1273 (W.D. La. 1993), *aff’d*, 30 F.3d 630 (5th Cir. 1994); *Foster-Gardner, Inc. v. Nat’l Union Fire Ins. Co.*, 959 P.2d 265 (Cal. 1998); *Lapham-Hickey Steel Corp. v. Protection Mut. Ins. Co.*, 655 N.E.2d 842 (Ill. 1995); *Patrons Oxford Mut. Ins. Co. v. Marois*, 573 A.2d 16 (Me. 1990); *Profl Rental, Inc. v. Shelby Ins. Co.*, 599 N.E.2d 423 (Ohio Ct. App. 1991).

²¹² See, e.g., *Parker Solvents Co. v. Royal Ins. Cos. of Am.*, 950 F.2d 571 (8th Cir. 1991); *Argonaut Ins. Co. v. Atl. Wood Indus., Inc.*, No. 87-0323-R (E.D. Va. June 20, 1988); *City of Maple Lake v. Am. States Ins. Co.*, 509 N.W.2d 399 (Minn. Ct. App. 1993); *Braswell v. Faircloth*, 387 S.E.2d 707 (S.C. Ct. App. 1989).

²¹³ See, e.g., *Anderson Dev. Co. v. Travelers Indem. Co.*, 49 F.3d 1128 (6th Cir. 1995); *Briggs & Stratton Corp v. Royal Globe Ins. Co.*, 64 F. Supp. 2d 1346 (M.D. Ga. 1999); *Douglas Ridge Rifle Club v. St. Paul Fire & Marine Ins. Co.*, 2010 WL 98942 (D. Or. Jan 8, 2010); *Hazen Paper*, 555 N.E.2d at 576; *C.D. Spangler*, 388 S.E.2d at 557.

²¹⁴ *Compare Cinergy Corp. v. Associated Elec. & Gas Ins. Servs., Ltd.*, 915 N.E.2d 524 (Ind. Ct. App. 2009) (finding that prospective relief under the Clean Air Act was not covered under a CGL policy) with *La. Generating LLC v. Ill. Union Ins. Co.*, No. 12-30651, 2013 U.S. App. LEXIS 9837, *12-14 (5th Cir. May 15, 2013) (finding coverage for Clean Air Act claim under environmental liability policy).

²¹⁵ 884 F. Supp. 1109 (E.D. Mich. 1995).

²¹⁶ 884 F. Supp. at 1117. See also *Wells Cargo, Inc. v. Transport Ins. Co.*, No. 08-cv-491, 2011 U.S. Dist. LEXIS 123916, *12-13 (D. Id. Oct. 26, 2011).

²¹⁷ 550 N.W.2d 475 (Mich. 1996).

²¹⁸ 550 N.W.2d at 486.

²¹⁹ 948 P.2d 923 (Cal. 1997).

²²⁰ 948 P.2d at 922.

²²¹ 928 F. Supp. 176 (N.D.N.Y. 1996).

²²² 923 A.2d 345 (N.J. Super. Ct. App. Div. 2007).

²²³ See *Aetna Cas. & Sur. Co. v. Com.*, 179 S.W.3d 830, 838-39 (Ky. 2005), as modified on reh'g (Jan. 19, 2006); *Johnson Controls Inc. v. Employers Ins. of Wausau*, 665 N.W.2d 257, 270-81 (Wis. 2003); *Bausch & Lomb Inc. v. Utica Mut. Ins. Co.*, 625 A.2d 1021, 1032 (Md. 1993); *Morton Int'l, Inc. v. Gen. Accident Ins. Co. of Am.*, 629 A.2d 831 (N.J. 1993); *AIU Ins. Co. v. Superior Court*, 799 P.2d 1253 (Cal. 1990).

²²⁴ *Morton Int'l, Inc. v. Gen. Accident Ins. Co. of Am.*, 629 A.2d 831 (N.J. 1993) ("Morton Int'l") (relying on the doctrine of regulatory estoppel to preclude insurers from adopting coverage positions contradictory to their original regulatory filings explaining the intent of newly introduced standard-form policy language).

²²⁵ See, e.g., *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 693 A.2d 1059 (Del. 1997); *Dimmitt Chevrolet, Inc. v. Se. Fid. Ins. Corp.*, 636 So. 2d 700 (Fla. 1993); *Upjohn Co. v. N.H. Ins. Co.*, 476 N.W.2d 392 (Mich. 1991); *Waste Mgmt. of Carolinas, Inc. v. Peerless Ins. Co.*, 340 S.E.2d 374 (N.C. 1986) (holding that "sudden" only means "abrupt"). But see, e.g., *Ala. Plating Co. v. U.S. Fid. & Guar. Co.*, 690 So. 2d 331 (Ala. 1996); *Hecla Mining Co. v. N.H. Ins. Co.*, 811 P.2d 1083 (Colo. 1991); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204 (Ill. 1992); *Morton Int'l*, 629 A.2d at 871 (holding that "sudden" can mean "unexpected").

²²⁶ See, e.g., *Bernhardt v. Hartford Fire Ins. Co.*, 648 A. 2d 1047 (Md. Ct. Spec. App. 1994); *Assicurazioni Generali, SpA v. Neil*, 160 F.3d 997 (4th Cir. 1998) ("*Assicurazioni Generali*").

²²⁷ See, e.g., *Sullins v. Allstate Ins. Co.*, 667 A.2d 617 (Md. 1995) ("*Sullins*").

²²⁸ See, e.g., *Hastings Mut. Ins. Co. v. Safety King, Inc.*, 778 N.W.2d 275 (Mich. Ct. App. 2009) (use of pesticide during air duct cleaning services performed in a home); *Baughman v. U.S. Liability Ins. Co.*, 662 F. Supp. 2d 386 (D.N.J. 2009) (mercury contamination at a daycare); *Nat'l Union Fire Ins. Co. v. Am. Re-Insurance Co.*, 351 F. Supp. 2d 201 (S.D.N.Y. 2005) ("*Nat'l Union Fire*") (workplace exposure to metalworking fluids); *Roofers' Joint Training, Apprentice Educ. Comm. v. Gen. Accident Ins. Co. of Am.*, 713 N.Y.S. 2d 615 (App. Div. 2000) ("*Roofers' Joint Training*") (exposure to toxic fumes emitted by roofing materials); *Bituminous Cas. Corp. v. Advanced Adhesive Tech. Inc.*, 73 F.3d 335 (11th Cir. 1996) ("*Bituminous Cas. Corp.*") (injury from exposure to vapors emitted by policyholder's adhesive); *Meridian Mut. Ins. Co. v. Kellman*, 197 F.3d 1178 (6th Cir. 1999) ("*Meridian Mut. Ins.*") (injuries from exposure to policyholder's floor sealant); *Sargent Constr. Co. v. State Auto. Ins. Co.*, 23 F.3d 1324 (8th Cir. 1994) ("*Sargent Constr. Co.*") (exposure to muriatic acid used in policyholder's construction work); *Nat'l Elec. Mfrs. Ass'n v. Gulf Underwriters Ins. Co.*, 162 F.3d 821 (4th Cir. 1998) ("*Nat'l Elec. Mfrs.*") (workplace exposure to welding fumes).

²²⁹ *Nat'l Elec. Mfrs.*, 162 F.3d at 825; *Assicurazioni Generali*, 160 F.3d at 1000.

²³⁰ See, e.g., *Sullins*, 667 A.2d at 623; *Nat'l Union Fire*, 351 F. Supp. at 210; *Roofers' Joint Training*, 713 N.Y.S.2d at 617; *Nautilus Ins. Co. v. Jabar*, 188 F.3d 27, 30-31 (1st Cir. 1999) ("*Jabar*"); *Bituminous Cas. Corp. v. Advanced Adhesive Tech.*, 73 F.3d 335, (11th Cir. 1996); *Meridian Mut.*, 197 F.3d at 1181-82; *Sargent Constr. Co.*, 23 F.3d at 1326.

²³¹ *Pipefitters Welfare Educational Fund v. Westchester Fire Insurance Co.*, 976 F.2d 1037 (7th Cir. 1992) at 1043.

²³² *Sullins*, 667 A.2d at 622; *see also Jabar*, 188 F.3d at 30.

²³³ *See Clendenin Brothers, Inc. v. United States Fire Ins. Co.*, 889 A.2d 387 (Md. 2006).

²³⁴ 889 A.2d at 397.

²³⁵ *See, e.g., Am. States Ins. Co. v. Kiger*, 662 N.E.2d 945, 948-49 (Ind. 1996) (gasoline leak from commercial gas station not excluded, finding it odd to characterize gasoline as a pollutant when it was the gas station's principal product). *See also State Auto. Mut. Ins. Co. v. Flexdar, Inc.*, 964 N.E.2d 845 (Ind. 2012) (reaffirming *Kiger* by ruling that pollution exclusions are *per se* ambiguous and therefore only enforceable as to pollutants named explicitly in the exclusion).

²³⁶ *See, e.g., N. States Power Co. v. Fid. & Cas. Co.*, 504 N.W.2d 240 (Minn. Ct. App. 1993), *aff'd as modified*, 523 N.W.2d 657 (Minn. 1994).

²³⁷ 759 N.E.2d 1049, 1055 (Ind. 2001).

²³⁸ 694 N.E.2d 381, 389 (Mass. App. Ct. 1998), *review granted*, 707 N.E.2d 367 (Mass. 1998) (Table), *aff'd*, 708 N.E.2d 639 (Mass 1999).

²³⁹ *See, e.g., Savoy Med. Supply Co. v. F&H Mfg. Corp.*, 776 F. Supp. 703, 708-09 (E.D.N.Y. 1991).

²⁴⁰ 612 A.2d 932 (N.J. 1992).

²⁴¹ The same concept arises under older liability policies that require that the property damage be caused by an "accident," which often is undefined. More recent policies move the language precluding coverage for expected or intended harm to a separate exclusion.

²⁴² 133 N.E. 432, 433 (N.Y. 1921).

²⁴³ *See, e.g., Capano Mgmt. Co. v. Transcon. Ins. Co.*, 78 F. Supp. 2d 320 (D. Del. 1999); *Nationwide Mut. Ins. Co. v. Grady*, 502 S.E.2d 648 (N.C. Ct. App. 1998).

²⁴⁴ *See, e.g., Lane v. Worcester Mut. Ins. Co.*, 430 N.E.2d 874, 875 (Mass. App. Ct. 1982).

²⁴⁵ *See, e.g., Boston Gas Co. v. Century Indem. Co.*, 529 F.3d 8, 18 (1st Cir. 2008); *Clemco Indus. v. Commercial Union Ins. Co.*, 665 F. Supp. 816 (N.D. Cal. 1987), *aff'd*, 848 F.2d 1242 (9th Cir. 1988); *Fireman's Fund Ins. Cos. v. Ex-Cell-O Corp.*, 750 F. Supp. 1340 (E.D. Mich. 1990).

²⁴⁶ *See, e.g., Consol. Edison Co. of N. Y., Inc. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 219-20, 774 N.E.2d 687, 691-92, 746 N.Y.S.2d 622 (N.Y. 2002); *JC Penney Life Ins. Co. v. Baker*, 33 S.W.3d 417 (Tex. App. Fort Worth 2000).

²⁴⁷ *See* Section IV.D.2, *supra*; *see also*, Commercial General Liability Coverage Form, section I, Coverage A, Para. 1.b(1) & (2).

²⁴⁸ 725 S.E.2d 532 (Va. 2012).

²⁴⁹ 725 S.E.2d at 537.

²⁵⁰ See, e.g., *Armstrong World Indus. Inc. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 76 (1996) (“[G]eneral knowledge of the hazards of asbestos is not equivalent to knowledge that asbestos bodily injuries [for which coverage is sought] were practically certain to occur.”); *Sherwin-Williams Co. v. Certain Underwriters at Lloyd’s London*, 813 F. Supp. 576, 585 (N.D. Ohio 1993) (“If knowledge of certain risks posed by a product were sufficient to infer intent by a manufacturer to injure consumers, then no manufacturer would ever be able to seek coverage from an insurer because every product has certain known dangers and risks”).

²⁵¹ See Section IV.D.1, *supra*.

²⁵² See Donald F. Farbstein & Francis J. Stillman, *Insurance for the Commission of Intentional Torts*, 20 Hastings L.J. 1219 (1969) (hereinafter “Farbstein & Stillman”).

²⁵³ See, e.g., *Atl. Mut. Ins. Co. v. J. Lamb, Inc.*, 100 Cal. App. 4th 1017, 1032 (2002); see also *Gen. Accident Ins. Co. v. W. Am. Ins. Co.*, 42 Cal. App. 4th 95, 103 (1996) (“‘[T]he term personal [in personal injury] is used in a highly specialized sense. It does not mean physical damage to a person; rather, it means injury arising out of one or more specified offenses.’”) (alterations in original) (citation omitted) *overruled on other grounds by Sterling Builders, Inc. v. United Nat’l Ins. Co.*, 79 Cal. App. 4th 105 (Cal. Ct. App. 2000); *Liebovich v. Minnesota Ins. Co.*, 751 N.W.2d 764, 771 (Wis. 2008) (personal injury coverage broader than CGL coverage).

²⁵⁴ *Atlantic Mutual*, 100 Cal. App. 4th at 1032; *Novell, Inc. v. Vigilant Ins. Co.*, 2010 WL 1734771, at *6 (D. Utah Apr 27, 2010) (“the focus must be on [the insured’s] alleged actions, not the harms allegedly suffered” by a third party).

²⁵⁵ *General Accident*, 42 Cal. App. 4th at 103. Subsequently, in the 1986 revision of the standard CGL policy form, this provision was modified to read “wrongful entry into, or eviction of a person from, a room, dwelling or premises that the person occupies.” *Id.* at 104.

²⁵⁶ See *Garvis v. Emp’rs Mut. Cas. Co.*, 497 N.W.2d 254, 259 (Minn. 1993) (Wrongful entry “is ordinarily understood as related to the invasion of an interest in real property, and it is in this sense we think it is used in ‘personal injury’ insurance coverage”); *Nichols v. Great Am. Ins. Cos.*, 169 Cal. App. 3d 766, 775-76 (1985) (“[T]he ‘personal injury’ contemplated by the business liability policies was the ‘wrongful entry, eviction or other invasion of the right to private occupancy’ relating to some interest in real property.”).

²⁵⁷ See, e.g., Mont. Code Ann. § 27-30-101 (defining “nuisance” in part as “an obstruction to the free use of property, so as to interfere with the comfortable enjoyment of life or property”); Cal. Civ. Code § 3479 (same).

²⁵⁸ See *Great Am. Ins. Co. of N.Y. v. Helwig*, 419 F. Supp. 2d 1017, 1026 (N.D. Ill. 2006); *Martin Marietta Corp. v. Ins. Co. of N. Am.*, 40 Cal. App. 4th 1113 (1995). In particular, the *Martin Marietta* court found that “[i]nvasion of the right of private occupancy” resembles the definition of nuisance, an “interference with the interest in the private use and enjoyment of the land.” *Id.* at 1134 (citations omitted). The court determined that the term is

susceptible to multiple interpretations and, therefore, must be interpreted against the insurer to include a broad array of potential liability. *Id.* at 1131-32. The court further applied this coverage to statutory claims for environmental contamination.

²⁵⁹ *Hirschberg v. Lumbermens Mut. Cas.*, 798 F. Supp. 600, 604 (N.D. Cal. 1992) (“invasion of the right of private occupancy” provides coverage for “interference with possession and enjoyment”).

²⁶⁰ See *Trammell Crow Residential Co. v. Virginia Sur. Co., Inc.*, 643 F. Supp. 2d 844, 854 (N.D. Tex. 2008); *State Bancorp, Inc. v. U.S. Fid. & Guar. Ins. Co.*, 483 S.E.2d 228, 237 (W.Va. 1997); *Am. Cyanamid Co. v. Am. Home Assurance Co.*, 30 Cal. App. 4th 969, 981-82 (1994).

²⁶¹ See *Mangini v. Aerojet-General Corp.*, 230 Cal. App. 3d 1125, 1147 (1991) (“We note plaintiffs’ land may be subject to a continuing nuisance even though defendant’s offensive conduct ended years ago. That is because the ‘continuing’ nature of the nuisance refers to the continuing damage caused by the offensive condition, not to the acts causing the offensive condition to occur.”).

²⁶² *Hydro Sys., Inc. v. Cont’l Ins. Co.*, 929 F.2d 472, 474 (9th Cir. 1991).

²⁶³ *Id.*

²⁶⁴ See Section IV.C.1., *supra*.

²⁶⁵ See, e.g., *Fibreboard*, 16 Cal. App. 4th at 503-05 (The term “arising out of the named insured’s products” does not regulate the theory of liability or the standard of causation, but instead “identifies a core factual nucleus, i.e., products manufactured, sold or distributed by the insured, and links that nucleus to the bodily injury or property damage covered under the policy.”).

²⁶⁶ See Section II.A., *supra*.

²⁶⁷ *Commercial Union Ins. Co. v. Walbrook Ins. Co.*, 7 F.3d 1047, 1053 (1st Cir. 1993).

²⁶⁸ 740 N.E.2d 220 (N.Y. 2000).

²⁶⁹ 37 Cal. 4th 377 (2005) (“*Powerine II*”).

²⁷⁰ *Ace Am. Ins. Co. v. RC2 Corp., Inc.*, 600 F.3d 763 (7th Cir. 2010).

²⁷¹ See Section IV.D(2), *supra*.

²⁷² 813 F. Supp. 576, 585 (N.D. Ohio 1993); see also *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 748, 15 Cal. Rptr. 2d 815, 836 (1993) (“The appropriate test for ‘expected’ damage is whether the insured knew or believed its conduct was substantially certain or highly likely to result in that kind of damage.”); accord *Armstrong World Indus. Inc. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 76, 52 Cal. Rptr. 2d 690, 723 (1996) (“[G]eneral knowledge of the hazards of asbestos is not equivalent to knowledge that asbestos bodily injuries [for which coverage is sought] were practically certain to occur.”).

²⁷³ See, e.g., *Golden Eagle Ins. Co. v. Ins. Co. of the West*, 99 Cal. App. 4th 837, 121 Cal. Rptr. 2d 682 (2002) (rejecting insurers' argument that coverage under insured contract provision did not include defense costs).

²⁷⁴ *Forest City Dillon, Inc. v. Aetna Cas. & Sur. Co.*, 852 F.2d 168 (6th Cir. 1988).

²⁷⁵ 228 F.3d 909 (8th Cir. 2000).

²⁷⁶ 457 F.2d 962 (8th Cir. 1972).

²⁷⁷ *Id.* at 966.

²⁷⁸ See *Prisco Serena Sturm Architects, Ltd. v. Liberty Mut. Ins. Co.*, 1995 WL 417531 at *5 (N.D. Ill. July 14, 1995) (impaired property exclusion "does not apply to the present case, because the underlying complaints definitively allege 'physical injury to tangible property'").

²⁷⁹ See *Centillum Commc'ns, Inc. v. Atl. Mut. Ins. Co.*, 528 F. Supp. 2d 940, 950 (N.D. Cal. 2007) ("

²⁸⁰ 528 F. Supp. 2d 940, 950 (N.D. Cal. 2007) (citations omitted).

²⁸¹ See Carolyn Aldred, *Dell and Cadbury Embarrassments Serve as Warning for Insurance Buyers*, Sept. 11, 2006 Business Ins. Europe. Some companies nonetheless face challenges in procuring coverage. See Michael Bradford, *Product Recall Insurance Scarce for Pharmaceutical Companies*, Business Insurance, Dec. 18, 2006.

²⁸² Meg Green, *Tainted Spinach Could Highlight Recall Insurance*, Best's Review, Nov. 1, 2006.

²⁸³ ISO Form No. CG 00 66 12 07 (2007).

²⁸⁴ ISO Form § V.9.

²⁸⁵ ISO Form § V.10.

²⁸⁶ *St. Paul Fire & Marine Insurance Co. v. Medical X-Ray Center, P.C.*, 146 F.3d 593, 594-95 (8th Cir. 1998); *Insurance Corp. of Ireland, Ltd. v. Board of Trustees of Southern Illinois University*, 937 F.2d 331, 338 (7th Cir. 1991); *Am. Contract Bridge League v. Nationwide Mutual Fire Ins. Co.*, 752 F.2d 71, 75 (3d Cir. 1985).

²⁸⁷ *Westchester Fire Insurance Co. v. G. Heileman Brewing Co.*, 747 N.E.2d 955 (Ill. App. Ct. 2001).

²⁸⁸ *Federal Insurance Co. v. Stroh Brewing Co.*, 127 F.3d 563, 568 (7th Cir. 1997).

²⁸⁹ *Travelers Prop. Cas. Co. of Am. v. Charlotte Russe Hldg., Inc.*, 144 Cal. Rptr. 3d 12 (Cal. Ct. App. 2012); *E.piphany, Inc. v. St. Paul Fire & Marine Ins. Co.*, 590 F.Supp.2d 1244, 1251-54 (N.D.Cal. 2008).

²⁹⁰ *Tire Kingdom, Inc. v. First Southern Insurance Co.*, 573 So. 2d 885 (Fla. Dist. Ct. App. 1990).

²⁹¹ *DISH Network Corp. v. Arch Specialty Insurance Co.*, 659 F.3d 1010, 1013-27 (10th Cir. 2011); *Hyundai Motor America v. National Union Fire Insurance Co. of Pittsburgh, PA*, 600 F.3d 1092, 1097-1104 (9th Cir. 2010).

²⁹² *Foundation for Blood Research v. St. Paul Marine & Fire Insurance Co.*, 1999 ME 87, ¶ 13, 730 A.2d 175, 180 (Me. 1999).

²⁹³ *Hudson Insurance Co. v. Colony Insurance Co.*, 624 F.3d 1264, 1268-70 (9th Cir. 2010); *Capitol Indemnity Corp. v. Elston Self Service Wholesale Groceries, Inc.*, 559 F.3d 616, 617-19 (7th Cir. 2009).

²⁹⁴ *Bridge Metal Industries, L.L.C. v. Travelers Indemnity Co.*, 812 F.Supp.2d 527 (S.D.N.Y. 2011).

²⁹⁵ *Australia Unlimited, Inc. v. Hartford Cas. Ins. Co.*, 198 P.3d 514, 518-22 (Wash. Ct. App. 2008).

²⁹⁶ *Travelers Prop. Cas. Co. of Am. v. Hillerich & Bradsby Co.*, 598 F.3d 257, 262-64, 272-73 (6th Cir. 2010).

²⁹⁷ *Align Technology, Inc. v. Federal Insurance Co.*, 673 F. Supp. 2d 957, 969-73 (N.D. Cal. 2009).

²⁹⁸ Commercial General Liability Insurance Policy Form CG 00 01 04 13, § I, Coverage B, ¶ 1.a Definitions ¶ 1 (Insurance Services Office, Inc. 2013).

²⁹⁹ *Id.*

³⁰⁰ *Id.*, § V, ¶ 14.

³⁰¹ *Federal Insurance Co. v. Stroh Brewing Co.*, 127 F.3d 563, 566-67 (7th Cir. 1997).

³⁰² *Union Ins. Co. v. Land & Sky, Inc.*, 529 N.W.2d 773, 777-78 (Neb. 1995).

³⁰³ *Id.*

³⁰⁴ Commercial General Liability Insurance Policy Form CG 00 01 04 13, *Id.*, § V, ¶ 1.

³⁰⁵ *Bridge Metal Industries, L.L.C. v. Travelers Indemnity Co.*, 559 F.App'x 15, 19 (2d Cir. 2014); *Hyman v. Nationwide Mut. Fire Ins. Co.*, 304 F.3d 1179, 1187-91 (11th Cir. 2002); *Capitol Indem. Corp. v. Elston Self Serv. Wholesale Groceries, Inc.*, 551 F. Supp. 2d 711, 724 (N.D. Ill. 2008), *aff'd* 559 F.3d 616, 617-19 (7th Cir. 2009); *State Auto Prop. & Cas. Ins. Co. v. Travelers Indem. Co. of Am.*, 343 F.3d 249, 258-59 (4th Cir. 2003); *NorFab Corp. v. Travelers Indem. Co.*, 555 F. Supp. 2d 505, 508-12 (E.D. Pa. 2008); *Union Ins. Co. v. Knife Co.*, 897 F. Supp. 1213, 1216 (W.D. Ark. 1995); *Gen. Cas. Co. of Wis. v. Wozniak Travel, Inc.*, 762 N.W.2d 572, 576-78 (Minn. 2009); *Super Duper Inc. v. Pa. Nat'l Mut. Cas. Ins. Co.*, 683 S.E.2d 792, 797 (S.C. 2009); *Acuity v. Bagadia*, 750 N.W.2d 817, 826 (Wis. 2008).

³⁰⁶ *Am. Employers' Ins. Co. v. DeLorme Pub. Co.*, 39 F. Supp. 2d 64, 74 (D. Me. 1999); *Dogloo, Inc. v. N. Ins. Co. of New York*, 907 F.Supp. 1383, 1391 (C.D. Cal. 1995); *cf. Sport*

Supply Group, Inc. v. Columbia Cas. Co., 335 F.3d 453 463 (5th Cir. 2003) (concluding that trademark identifies but does not advertise).

³⁰⁷ *Capitol Indem. Corp. v. Elston Self Serv. Wholesale Groceries, Inc.*, 551 F. Supp. 2d 711 (N.D. Ill. 2008), *aff'd*, 559 F.3d 616 (7th Cir. 2009); *NorFab Corp. v. Travelers Indem. Co.*, 555 F. Supp. 2d 505, 508-12 (E.D. Pa. 2008); *Auto Owners Ins. Co. v. La Oasis, Inc.*, 2005 U.S. Dist. LEXIS 43565, at *10 (N.D. Ind. May 26, 2005). *Gen. Cas. Co. of Wis. v. Wozniak Travel, Inc.*, 762 N.W.2d 572, 577-78 (Minn. 2009); *Acuity v. Bagadia*, 750 N.W.2d 817, 826 (Wis. 2008).

³⁰⁸ *Acuity v. Bagadia*, 750 N.W.2d 817, 824 (Wis. 2008) (citing *Random House Unabridged Dictionary* 1989 (2d ed. 1993) and *Black's Law Dictionary* 1485 (6th ed. 1990)). *But see* *CGS Indus., Inc. v. Charter Oak Fire Ins. Co.*, No. 11-2647, 2013 U.S. App. LEXIS 11700, at *10-11 (2nd Cir. June 11, 2013) (holding that the “prevailing federal definition” of intellectual property terms and concepts included in an insurance policy controls indemnity coverage).

³⁰⁹ *See A Touch of Class Imports, Ltd. v. Aetna Cas. & Sur. Co.*, 901 F. Supp. 175, 177 (S.D.N.Y. 1995); *Cincinnati Ins. Co. v. Zen Design Group, Ltd.*, 329 F.3d 546, 554-57 (6th Cir. 2003) (duty to defend).

³¹⁰ *Hyman v. Nationwide Mut. Fire Ins. Co.*, 304 F.3d 1179, 1188 (11th Cir. 2002); *Fid. & Guar. Ins. Co. v. Kocolene Mktg. Corp.*, 2002 U.S. Dist. LEXIS 8518, at *27-*28 (S.D. Ind. Mar. 26, 2002); *Flodine v. State Farm Ins. Co.*, 2001 U.S. Dist. LEXIS 2204 (N.D. Ill. Feb. 27, 2001); *Ryland Group, Inc. v. Travelers Indem. Co. of Ill.*, 2000 U.S. Dist. LEXIS 21412, at *18-*21 (W.D. Tex. Oct. 25, 2000); *Gen. Cas. Co. of Wis. v. Wozniak Travel, Inc.*, 762 N.W.2d 572 (Minn. 2009); *Super Duper, Inc. v. Pa. Nat'l Mut. Cas. Ins. Co.*, 683 S.E.2d 792, 796 (S.C. 2009).

³¹¹ *R.C. Bigelow, Inc. v. Liberty Mut. Ins. Co.*, 287 F.3d 242, 247-48 (2d Cir. 2002).

³¹² *Advance Watch Co. v. Kemper Nat'l Ins. Co.*, 99 F.3d 795, 802 (6th Cir. 1996) (applying Michigan law) (offense of “misappropriation of advertising ideas” is limited to the common law tort of misappropriation and “unauthorized taking or use of interests other than those which are eligible for protection under statutory or common-law trademark law.”); *Callas Enters., Inc. v. Travelers Indem. Co. of Am.*, 193 F.3d 952, 957 (8th Cir. 1999) (Minnesota law) (following *Advance Watch*); *but see Westfield Ins. Co. v. Factfinder Mktg. Research, Inc.*, 2006-Ohio-4380, ¶ 26, 168 Ohio App. 3d 391, 401, 860 N.E.2d 145, 152, cause dismissed, 2007-Ohio-709, ¶ 26, 112 Ohio St. 3d 1480, 861 N.E.2d 820 (rejecting *Advance Watch* and holding that “the common meaning of ‘misappropriation’ incorporates the idea of trade-dress and trademark infringement”).

³¹³ *Am.'s Recommended Mailers Inc. v. Md. Cas. Co.*, 339 F. App'x 467, 469 (5th Cir. 2009) (trademark); *EKCO Group, Inc. v. Travelers Indem. Co. of Ill.*, 273 F.3d 409, 410 (1st Cir. 2001) (trade dress); *Sport Supply Group, Inc. v. Columbia Cas. Co.*, 335 F.3d 453, 462-64 (5th Cir. 2003) (holding that although trademark infringement could be considered “misappropriation,” a trademark is only “a label that serves primarily to identify and distinguish” and does not by itself serve as a marketing device designed to induce the public to patronize a particular establishment. The court recognized that trademarks could be an advertisement from a theoretical standpoint, but limited the term “advertisement” under a CGL policy to “conventional” advertising such as billboards, newspapers, signs, or

commercials).

³¹⁴ *Palmer v. Truck Ins. Exch.*, 988 P.2d 568, 573 (Cal. 1999); *ShoLodge, Inc. v. Travelers Indem. Co. of Ill.*, 168 F.3d 256, 259 (6th Cir. 1999).

³¹⁵ *Street Surfing, LLC v. Great Am. E&S Ins. Co.*, 776 F.3d 603, 609-15 (9th Cir. 2014).

³¹⁶ Commercial General Liability Insurance Policy Form CG 00 01 04 13, § I, Coverage B, ¶ 2.i (Insurance Services Office, Inc. 2013).

³¹⁷ *Mid-Continent Cas. Co. v. Kipp Flores Architects, L.L.C.*, 602 Fed. App'x 985, 992-95 (5th Cir. Tex. 2015); *Zurich Ins. Co. v. Killer Music, Inc.*, 998 F.2d 674 (9th Cir. 1993); *Irons Home Builders, Inc. v. Auto-Owners Ins. Co.*, 839 F. Supp. 1260, 1264-67 (E.D. Mich. 1993); *Phoenix Control Sys., Inc. v. Ins. Co. of N. Am.*, 796 P.2d 463, 465-66 (Ariz. 1990) (finding coverage based on reading of policy language that separated "advertising" requirement from copyright coverage); *Acuity v. Bagadia*, 750 N.W.2d 817, 828-29 (Wis. 2008).

³¹⁸ *Amco Ins. Co. v. Lauren-Spencer, Inc.*, 500 F. Supp. 2d 721, 728-36 (S.D. Ohio 2007).

³¹⁹ *Axelrod v. Magna Carta Cos.*, 880 N.Y.S.2d 69 (N.Y. App. Div. 2009).

³²⁰ *Liberty Corp. Capital Ltd. v. Sec. Safe Outlet*, 577 F. App'x 399, 404-06 (6th Cir. 2014); *State Farm Fire & Cas. Co. v. Steinberg*, 393 F.3d 1226, 1234 (11th Cir. 2004).

³²¹ *Frog, Switch & Mfg. Co. v. Travelers Ins. Co.*, 193 F.3d 742, 748-50 (3d Cir. 1999); *Lemko Corp. v. Fed. Ins. Co.*, 70 F. Supp. 3d 905, 918-19 (N.D. Ill. 2014); *GAF Sales & Serv., Inc. v. Hasting Mut. Ins. Co.*, 568 N.W.2d 165, 167-68 (Mich. Ct. App. 1997).

³²² See, e.g., *South Fastening Sys. v. Grabber Constr. Prods.*, 2015 NCBC LEXIS 42, at *3-*5 (N.C. Super. Ct. Apr. 28, 2015) (employee's agreement provided for protection of confidential information, including trade secrets); *AZZ Inc. v. Morgan*, 2015 Tex. App. LEXIS 3471, at *1 (Tex. App. Fort Worth Apr. 9, 2015) ("In connection with his employment with AZZ, Morgan signed a 'Code of Ethics' and an 'Employee Invention, Trade Secret, and Non-Compete Agreement.'").

³²³ *Capitol Specialty Insurance v. Indus. Elecs., LLC*, 407 F. App'x 47, 51-52 (6th Cir. 2011).

³²⁴ See *Union Ins. Co. v. Land & Sky, Inc.*, 529 N.W.2d 773, 777-78 (Neb. 1995); *Rymal v. Woodcock*, 896 F. Supp. 637, 638-39 (W.D. La. 1995); but see *U.S. Fid. & Guar. Co. v. Star Techs., Inc.*, 935 F. Supp. 1110, 1116 (D. Or. 1996) (holding that the "piracy" of inducement to infringe a patent must occur during the course of advertising activities).

³²⁵ See, e.g., *Homedics, Inc. v. Valley Forge Ins. Co.*, 315 F.3d 1135, 1142 (9th Cir. 2003); *U.S. Test, Inc. v. NDE Envtl. Corp.*, 196 F.3d 1376, 1380-81 (Fed. Cir. 1999) (applying Louisiana law); *Kim v. Truck Ins. Exch.*, No. CV 14-4270 RSWL VBKX, 2015 U.S. Dist. LEXIS 82852, at *10-*15 (C.D. Cal. June 25, 2015); *U.S. Fire Ins. Co. v. Cyanotech Corp.*, No. CIV. 12-00537 JMS, 2013 U.S. Dist. LEXIS 152160, at *30-*35 (D. Haw. Oct. 23, 2013).

³²⁶ See, e.g., *Parkham Indus. Distribs., Inc. v. Cincinnati Ins. Co.*, No. 3:06CV-533-S, 2008 U.S. Dist. LEXIS 11642, at *5 (W.D. Ky. Feb. 14, 2008), *aff'd*, 318 F. App'x 391 (6th Cir. 2009); *Greenwich Ins. Co. v. RPS Prods., Inc.*, 882 N.E.2d 1202, 1206 (Ill. App. Ct. 2008); see also *Molecular Bioproducts, Inc. v. St. Paul Mercury Ins. Co.*, No. 03-0046-IEG, 2003 U.S. Dist. LEXIS 27903, at *4, *12, *18 (S.D. Cal. July 9, 2003) (holding that similar exclusionary language barred coverage for claims of patent infringement).

³²⁷ *A. Meyers & Sons Corp. v. Zurich Am. Ins. Group*, 545 N.E.2d 1206, 1208-09 (N.Y. 1989); see also *Elite Brands, Inc. v. Pennsylvania Gen. Ins. Co.*, 164 F. App'x 60, 62 (2d Cir. 2006); *EKCO Group, Inc. v. Travelers Indem. Co. of Ill.*, 273 F.3d 409, 413-15 (1st Cir. 2001).

³²⁸ *Amazon.com Int'l, Inc. v. Am. Dynasty Surplus Lines Ins. Co.*, 85 P.3d 974 (Wash. Ct. App. 2004); *Hyundai Motor Am. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 600 F.3d 1092 (9th Cir. 2010); *Dish Network Corp. v. Arrowwood Indem. Co.*, 772 F.3d 856, 873 (10th Cir. 2014) (finding that patent allegations fell within coverage but that "broadcasting" and "telecasting" exclusion applied); *Air Eng'g, Inc. v. Indus. Air Power, LLC*, 2013 WI App 18, ¶ 17 (Ct. App. Wis. 2013), review denied, 2013 WI 80, ¶ 17 (Wis. 2013);

³²⁹ *Dish Network Corp. v. Arrowwood Indem. Co.*, 772 F.3d 856, 873 (10th Cir. 2014).

³³⁰ See *Gateway Group Advantage, Inc. v. McCarthy*, 300 F. Supp. 2d 236, 241-43 (D. Mass. 2003); *PepsiCo, Inc. v. Cont'l Cas. Co.*, 640 F. Supp. 656, 659 (S.D.N.Y. 1986).

³³¹ The underlying complaint need not state explicitly that the individual sued is an officer or director in order for D&O coverage to apply. Rather, some courts will look to the allegations of the underlying complaint to determine if there is a "connection [between claimed policyholder and corporation] . . . implicit in the allegations" that would bring the underlying action within a policy's coverage. E.g., *U.S. Fid. & Guar. Co. v. Exec. Ins. Co.*, 893 F.2d 517, 519 (2d Cir. 1990).

³³² E.g., Del. Gen. Corp. Law § 145(a).

³³³ See, e.g., N.Y. Bus. Corp. Law § 726(b)(1) (precludes indemnification for final adjudication of deliberate dishonesty). State law also may allow for partial indemnification. For example, a provision of the Delaware General Corporation Law, adopted by many states, provides for mandatory indemnification where the director or officer has been "successful [in a criminal action] on the merits or otherwise," see Del. Gen. Corp. Law § 145(c) (emphasis added), while other states may allow indemnification only where the director or officer was "wholly successful on the merits or otherwise." The Delaware statute, therefore, can be read to allow indemnification where an insured is successful on some, but not all, counts in an underlying lawsuit.

³³⁴ Most, if not all, D&O policies also provide that, if notice of circumstances that could lead to a claim is given to an insurance company during the policy period, all related claims that are subsequently brought will fall within that policy's coverage.

³³⁵ Compare *Continental Ins. Co. v. Metro-Goldwyn-Mayer, Inc.*, 107 F.3d 1344, 1348 (9th Cir. 1997) with *Resolution Trust Corp. v. Artley*, 24 F.3d 1363 (11th Cir. 1994).

³³⁶ See, e.g., *Sch. Bd. of the City of Newport News v. Commonwealth*, 689 S.E.2d 731, 737 (Va. 2010); *Exec. Risk Indem., Inc. v. CIGNA Corp.*, 976 A.2d 1170, 1173 (Pa. Super. Ct. 2009); *MGIC Indem. Corp. v. Cent. Bank*, 838 F.2d 1382, 1388 (5th Cir. 1988); *Emp'rs Reinsurance Corp. v. Sarris*, 746 F. Supp. 560, 563 (E.D. Pa. 1990).

³³⁷ See, e.g., *KB Home v. Travelers Ins. Co.*, 339 F. App'x 910, 911 (11th Cir. 2009).

³³⁸ See, e.g., *Phoenix Ins. Co. v. Sukut Constr. Co.*, 136 Cal. App. 3d 673, 677, 186 Cal. Rptr. 513, 515 (Ct. App. 1982).

³³⁹ See, e.g., *Nat'l Union Fire Ins. Co. v. Baker & McKenzie*, 997 F.2d 305, 307 (7th Cir. 1993).

³⁴⁰ See, e.g., *Mt. Hawley Ins. Co. v. FSLIC*, 695 F. Supp. 469, 479 (C.D. Cal. 1987).

³⁴¹ See, e.g., *Burns v. Int'l Ins. Co.*, 709 F. Supp. 187, 189 (N.D. Cal. 1989), *aff'd*, 929 F.2d 1422 (9th Cir. 1991).

³⁴² See, e.g., *Cent. Ill. Pub. Serv. Co. v. Am. Empire Surplus Lines Ins. Co.*, 642 N.E.2d 723, 725 (Ill. 1994).

³⁴³ See, e.g., *Katz Drug Co. v. Commercial Standard Ins. Co.*, 647 S.W.2d 831, 836 (Mo. Ct. App. 1983).

³⁴⁴ See, e.g., *Bendis v. Fed. Ins. Co.*, 958 F.2d 960, 962 (10th Cir. 1991).

³⁴⁵ See, e.g., *Specialty Food Sys., Inc. v. Reliance Ins. Co.*, 45 F. Supp. 2d 541 (E.D. La. 1999) (employment practices liability policy), *aff'd*, 200 F.3d 816 (5th Cir. 1999); *see also Charles Dunn Co. v. Tudor Ins. Co.*, 308 F. App'x 149, 150 (9th Cir. 2009) (a claim "is a demand for something as a right, or as due"); *Richardson Elecs., Ltd. v. Fed. Ins. Co.*, 120 F. Supp. 2d 698, 700-01 (N.D. Ill. 2000) ("A claim is a demand for *something* due. A demand for money is not required for a claim."). At least one court has held, in a criminal case, that the return of the indictment by the grand jury which "gives the government the right to seek a judicial remedy" constitutes a claim. *Polychron v. Crum & Forster Ins. Cos.*, 718 F. Supp. 33, 35

(W.D. Ark. 1989), *rev'd on other grounds*, 916 F.2d 461 (8th Cir. 1990). Where the criminal case has been settled, however, one court has found that no claim existed. *See MGIC Indem. Corp. v. Home State Sav. Ass'n*, 797 F.2d 285 (6th Cir. 1986). *But see Hyde v. Fid. & Deposit Co.*, 23 F. Supp. 2d 630, 633 (D. Md. 1998) (“A claim is something demanded as of right in a court.”); *Bensalem Twp. v. W. World Ins. Co.*, 609 F. Supp. 1343, 1348-49 (E.D. Pa. 1985) (letter from EEOC notifying township that a discrimination charge had been filed against it, and the discrimination charge itself, was not a “claim”).

³⁴⁶ *E.g.*, *Wintermute v. Kan. Bankers Sur. Co.*, 2009 WL 1939971, at *7-*9 (W.D. Mo. July 2, 2009) (criminal indictment did not constitute claim where there was no “loss” or “something due or believed to be due”); *Nat'l Union Fire Ins. Co. v. Ambassador Group, Inc. (In re Ambassador Group, Inc. Litig.)*, 830 F. Supp. 147, 155 (E.D.N.Y. 1993) (letters from Vermont Commission of Banking regarding possible wrongful acts by directors and officers was merely notice of an occurrence, not of a claim, because they did not demand specific or full relief from the directors and officers for some particular wrongful act).

³⁴⁷ 11 N.Y.C.R.R. § 73.0(a), (c).

³⁴⁸ *Id.* § 73.0(c).

³⁴⁹ 95 F. Supp. 2d 180 (S.D.N.Y. 2000),

³⁵⁰ *Id.* at 193 (citations omitted).

³⁵¹ *See, e.g.*, *Axis Reinsurance Co. v. Bennett*, 07 CIV. 7924 (GEL), 2008 WL 2600034 (S.D.N.Y. June 27, 2008); *National Union Fire Ins. Co. of Pittsburgh, Pa. v. Willis*, 139 F. Supp. 2d 827 (S.D. Tex. 2001); *Aspen Ins. UK, Ltd. v. Fiserv, Inc.*, No. 09-CV-02770-CMA-CBS, 2010 WL 5129529 (D. Colo. Dec. 9, 2010).

³⁵² *In re WorldCom, Inc. Sec. Litig.*, 354 F. Supp. 2d 455, 465 (S.D.N.Y. 2005); *Fed. Ins. Co. v. Kozlowski*, 792 N.Y.S.2d 397 (App. Div. 2005); *In re HealthSouth Corp. Ins. Litig.*, 308 F. Supp. 2d 1253 (N.D. Ala. 2004); *see also Great Am. Ins. Co. v. Geostar Corp.*, 2010 WL 845953, at *15-*17 (E.D. Mich. Mar. 5, 2010); *Axis Reinsurance Co. v. Bennett*, 2008 WL 2600034 (S.D.N.Y. June 27, 2008).

³⁵³ 272 F.3d 908, 911 (7th Cir. 2001).

³⁵⁴ *Id.* at 911; *accord Conseco, Inc. v. Nat'l Union Fire Ins. Co.*, 2002 WL 31961447, at *11 (Ind. Cir. Ct. Dec. 31, 2002) (unpublished); *Bank of the West v. Superior Court*, 833 P.2d 545, 553-54 (Cal. 1992). *But see Limelight Prods., Inc. v. Limelite Studios, Inc.*, 60 F.3d 767,769 (4th Cir. 1995) (allegedly ill-gotten profits sought by claimant constitute covered “damages”).

³⁵⁵ *Id.* at 554 (citation omitted).

³⁵⁶ 2006 WL 3409156 (N.D. Ill. Nov. 22, 2006), *aff'd on other grounds*, 260 F. App'x 914 (7th Cir. 2008),

³⁵⁷ *Id.* at *7.

³⁵⁸ 457 F.3d 1106, 1115 (9th Cir. 2006).

³⁵⁹ See *id.* at 1115-16.

³⁶⁰ See also *McCost's v. Home Ins. Co. of Indiana*, 31 F.3d 110 (2d Cir. 1994) (an exclusion for "restitution" did not bar all coverage when underlying claimant sought recovery of more than the amount of fees received by the policyholder itself); *Virginia Mason Medical Center v. Executive Risk Indem. Inc.*, 2007 WL 3473683, at *1 (W.D. Wash. Nov. 14, 2007), *aff'd*, 331 Fed. App'x. 473 (9th Cir. May 26, 2009).

³⁶¹ 2014 WL 3012969, at *3 (D. Minn. July 3, 2014); see also *Gallup, Inc. v. Greenwich Ins. Co.*, 2015 WL 1201518, at *10 (Del. Super. Ct. Feb. 25, 2015).

³⁶² 992 N.E.2d 1076 (N.Y. 2013).

³⁶³ *Id.* at 1083.

³⁶⁴ *Id.* at 1082; see also *Nutmeg*, 2006 WL 3409156, at *8; *Liss v. Fed. Ins. Co.*, 2006 WL 2844468, at *5 (N.J. Super. Ct. App. Div. Oct. 6, 2006).

³⁶⁵ *J.P. Morgan Sec., Inc. v. Vigilant Ins. Co.*, 2018 WL 4494692, at *3 (N.Y. App. Div. Sept. 20, 2018).

³⁶⁶ 137 S. Ct. 1635, 1639, 198 L. Ed. 2d 86 (2017).

³⁶⁷ 489 A.2d 536, 545 (Md. 1985) ("So long as an item of service or expense is reasonably related to defense of a covered claim, it may be apportioned wholly to the covered claim.").

³⁶⁸ 186 P.3d 1188, 1193 (Wash. Ct. App. 2008) ("No right of allocation exists for the defense of non-covered claims that are 'reasonably related' to the defense of covered claims."), *review denied*, 203 P.3d 380 (Wash. 2009).

³⁶⁹ 2008 WL 3413327, at *14 (Del. Super. Ct. July 31, 2008) (allocation analysis not required prior to advancement of defense costs).

³⁷⁰ 64 F.3d 1282, 1289 (9th Cir. 1995); *Raychem Corp. v. Fed. Ins. Co.*, 853 F. Supp. 1170, 1182 (N.D. Cal. 1994) (insurance company obligated to pay all costs "reasonably related" to a covered claim).

³⁷¹ 820 F. Supp. 530, 536 (W.D. Wash. 1992), *aff'd*, 54 F.3d 1424 (9th Cir. 1995).

³⁷² 760 F. Supp. 533, 536-37 (D. Md. 1991) (insurance company is not entitled to allocation of defense costs when legal services benefited the defense of both covered and non-covered claims).

³⁷³ 715 F. Supp. 1458, 1465 (W.D. Mo. 1989), *aff'd*, 916 F.2d 1362 (8th Cir. 1990).

³⁷⁴ 1988 WL 123149, at *12-*13 (M.D. Pa. Nov. 15, 1988) (costs and expenses for items that were of use in defense of an insured director are recoverable from the insurance company).

even though they also may have been useful in the defense of an uninsured corporation).

³⁷⁵ 751 A.2d 284, 293 (Vt. 2000) (insured “entitled to the \$359,413 in fees because it would have incurred those fees even if the noncovered claims had not existed”).

³⁷⁶ *Smoral v. Hanover Ins. Co.*, 322 N.Y.S.2d 12, 14 (App. Div. 1971); *see also Kauffman v. Cal. State Auto. Ass’n Interinsurance Bureau*, 2009 WL 4049153, at *1 (Cal. Ct. App. Nov. 24, 2009) (an insurer “has no ‘good faith’ duty to accept a policy limits settlement offer for the release of only one of multiple defendants insured under the same policy”); *Great Lakes Dredge & Dock Co. v. Commercial Union Assurance Co.*, 1999 WL 705599, at *7 (N.D. Ill. Aug. 27, 1999), *aff’d in part, vacated in part on other grounds sub nom., Great Lakes Dredge & Dock Co. v. City of Chicago*, 260 F.3d 789 (7th Cir. 2001); *Lehto v. Allstate Ins. Co.*, 36 Cal. Rptr. 2d 814, 822 (Cal. Ct. App. 1994); *Schwartz v. State Farm Fire & Cas. Co.*, 106 Cal. Rptr. 2d 523, 526 (Cal. Ct. App. 2001).

³⁷⁷ *Allstate Ins Co. v. Russell*, 788 N.Y.S.2d 401 (N.Y. App. Div. 2004); *Travelers Indem. Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 764 (5th Cir. 1999); *Sampson v. Cape Industries*, 185 Ill.App.3d 83, 540 N.E.2d 1143 (1989).

³⁷⁸ 2002 WL 1008240 (Bankr. S.D.N.Y. May 17, 2002).

³⁷⁹ *Id.* at 607-08.

³⁸⁰ *See, e.g., Pendergest-Holt v. Certain Underwriters at Lloyd’s of London*, 600 F.3d 562, 567 (5th Cir. 2010) (“fraud” exclusion does not apply until there is a “final adjudication” that the insured engaged in fraudulent conduct); *Nat’l Union Fire Ins. Co. v. Brown*, 787 F. Supp. 1424, 1429 (S.D. Fla. 1991), *aff’d*, 963 F.2d 385 (11th Cir. 1992); *cf. PepsiCo, Inc. v. Cont’l Cas. Co.*, 640 F. Supp. 656, 660 (S.D.N.Y. 1986) (noting that dishonesty exclusion “attaches only after a ‘final judgment or other final adjudication’ implicates the directors”).

³⁸¹ 2008 WL 2583007 (Del. Super. Ct. Feb. 11, 2008).

³⁸² *Id.*, 2008 WL 2583007, at *7 (emphasis in original).

³⁸³ *See, e.g., Atl. Permanent Fed. Sav. & Loan Ass’n v. Am. Cas. Co.*, 839 F.2d 212, 216-17 (4th Cir. 1988); *Nat’l Union Fire Ins. Co. v. Cont’l Ill. Corp.*, 666 F. Supp. 1180, 1199-2000 (N.D. Ill. 1987); *see also Golf Course Superintendents Ass’n of Am. v. Underwriters at Lloyd’s, London*, 761 F. Supp. 1485, 1491 (D. Kan. 1991) (where dishonesty was undefined in the policy, court denied summary judgment to the insurance company: “We believe this is an instance in which the provisions of the insurance contract must be construed against the insurance company. It is not clear that retaliation or discrimination are acts of dishonesty as that term is used in the insurance policy.”).

³⁸⁴ CIV.A. 06C-11108RRC, 2007 WL 1811265 (Del. Super. June 20, 2007).

³⁸⁵ *See, e.g., Official Comm. of Unsecured Creditors v. Berry*, 2009 WL 5175215, at *7 (E.D. La. Dec. 18, 2009); *Cohen v. Nat’l Union Fire Ins. Co. (In re Cnty. Seat Stores, Inc.)*, 280 B.R. 319, 326-28 (Bankr. S.D.N.Y. 2002); *Rieser v. Baudendistel (In re Buckeye Countrymark, Inc.)*, 251 B.R.

835 (Bankr. S.D. Ohio 2000); *Reliance Ins. Co. v. Weis*, 148 B.R. 575, 583 (E.D. Mo. 1992), *aff'd in relevant part*, 5 F.3d 532 (8th Cir. 1993).

³⁸⁶ See, e.g., *Feldman v. Illinois Union Ins. Co.*, 198 Cal. App. 4th 1495, 1503, 130 Cal. Rptr. 3d 770, 776 (2011); *Reeves Cnty. v. Houston Cas. Co.*, 356 S.W.3d 664, 675 (Tex. App. 2011); *Cont'l Cas. Co. v. Wendt*, 205 F.3d 1258, 1264 (11th Cir. 2000); *Anglo-American Ins. Co. v. Molin*, 691 A.2d 929 (Pa. 1997). At times, however, “relatedness” provisions may favor the policyholder and bring claims within coverage even though the claim was first made after the policy period. See, e.g., *Federal Insurance Co. v. DBSI, Inc. (In re DBSI, Inc.)*, No. 09-52031(PJW), 2011 WL 3022177 (Bankr. D. Del. July 22, 2011).

³⁸⁷ Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. § 1001 et seq. (1974).

³⁸⁸ Some states have statutes that detail when an insurance company may rescind because of misrepresentation. See Fla. Stat. Ann. § 627.409; 18 Del. Code Ann. § 2711.

³⁸⁹ E.g., *Great Am. Ins. Co. v. Gross*, 2008 WL 376263, at *13-*14 (E.D. Va. Feb. 11, 2008); *Shapiro v. Am. Home Assurance Co.*, 584 F. Supp. 1245, 1251-52 (D. Mass. 1984); *Bird v. Penn Cent. Co.*, 334 F. Supp. 255, 260-62 (E.D. Pa. 1971). But see *Atl. Permanent*, 839 F.2d at 215.

³⁹⁰ See, e.g., *Mitchell v. United Nat'l Ins. Co.*, 25 Cal. Rptr. 3d 627, 638-39 (Cal. Ct. App. 2005); see also *Gulf Ins. Co. v. Transatlantic Reinsurance Co.*, 886 N.Y.S.2d 133, 151 (App. Div. 2009) (“Material facts are those likely to influence the decisions of underwriters; facts which, had they been revealed by the [insured], would have either prevented [an insurer] from issuing a policy or prompted [an insurer] to issue it at a higher premium.” (citation omitted)).

³⁹¹ See, e.g., *Admiral Ins. Co. v. SONICblue, Inc.*, 2009 WL 2512197 (N.D. Cal. Aug. 14, 2009) (where application requested information related to any “written demands for money or services,” court had to determine that letters from noteholders constituted such “demands” to permit rescission based on non-disclosure); *St. Paul Fire & Marine Ins. Co. v. Jacobson*, 48 F.3d 778, 780-81 (4th Cir. 1995); *Vella v. Equitable Life Assurance Soc’y of the United States*, 887 F.2d 388, 393 (2d Cir. 1989); *Cora Pub, Inc. v. Cont’l Cas. Co.*, 619 F.2d 482, 487 (5th Cir. 1980).

³⁹² See, e.g., *William Penn Life Ins. Co. v. Sands*, 912 F.2d 1359, 1362-64 (11th Cir. 1990); *N.H. Ins. Co. v. Diller*, 678 F. Supp. 2d 288, 300-01 (D.N.J. 2009); *Skinner v. Aetna Life & Cas.*, 804 F.2d 148, 150 (D.C. Cir. 1986); *Espinosa v. Guardian Life Ins.*, 856 F. Supp. 711, 717 (D. Mass. 1994); *Winterthur Int’l Am. Ins. Co. v. Bridgestone/Firestone, Inc.*, No. 3:01-CV-0059-P, Order at 5-6 (N.D. Tex. Nov. 14, 2001); *Green v. Life & Health of Am.*, 704 So. 2d 1386, 1391 (Fla. 1998).

³⁹³ *Exec. Risk Indem., Inc. v. AFC Enters., Inc.*, 510 F. Supp. 2d 1308, 1325 (N.D. Ga. 2007), *aff’d*, 279 F. App’x 793 (11th Cir. 2008); *Wedtech Corp. v. Fed. Ins. Co.*, 740 F. Supp. 214, 216, 218-19 (S.D.N.Y. 1990); *Shapiro v. Am. Home Assurance Co.*, 616 F. Supp. 900, 903-05 (D. Mass. 1984).

³⁹⁴ See, e.g., *Prudential Ins. Co. of Am. v. Barden*, 424 F.2d 1006, 1010 (4th Cir. 1970); *N. Nat’l Life Ins. Co. v. Lacy J. Miller Mach. Co.*, 305 S.E.2d 568, 572 (N.C. Ct. App. 1983), *aff’d*, 316 S.E.2d 256 (N.C. 1984); *Gov’t Emps. Ins. Co. v. Govan*, 451 A.2d 884, 885-86 (D.C. 1982); *DiPasqua v. Cal. W. States Life Ins. Co.*, 235 P.2d 64 (Cal. Dist. Ct. App. 1951).

³⁹⁵ See, e.g., *GuideOne Specialty Mut. Ins. Co. v. Congregation Adas Yereim*, 593 F. Supp. 2d 471, 485 (E.D.N.Y. 2009) (insurer waived right to rescind by continued acceptance of premiums and by sending notice that policy would remain in effect until scheduled expiration after learning of facts that allegedly supported rescission of policy); *Prudential Ins. Co. of Am. v. Saxe*, 134 F.2d 16, 29 (D.C. Cir. 1943); *SEC v. Credit Bancorp, Ltd.*, 147 F. Supp. 2d 238, 256 (S.D.N.Y. 2001); *Fla. Int'l Indem. Co. v. Osgood*, 503 S.E.2d 371, 374 (Ga. Ct. App. 1998); *Scalia v. Equitable Life Assurance Soc'y of the United States*, 673 N.Y.S.2d 730 (App. Div. 1998); *Gouldin v. Inter-Ocean Ins. Co.*, 102 S.E.2d 846, 848-49 (N.C. 1958); *Archstone-Smith Operating Trust v. Travelers Indem. Co. of Ill.*, No. CL-2004-220831, Letter Opinion (Va. Cir. Ct. July 8, 2005), *reh'g denied*, Letter Opinion (Va. Cir. Ct. Aug. 26, 2005).

³⁹⁶ See, e.g., *S.E.C. v. Credit Bancorp, Ltd.*, 147 F. Supp. 2d 238, 257 (S.D.N.Y. 2001); *Thompson v. Permanent Gen. Assur. Corp.*, 519 S.E.2d 249, 251 (Ga. Ct. App. 1999); *Burton v. Wolverine Mut. Ins. Co.*, 540 N.W.2d 480, 483 (Mich. Ct. App. 1995).

³⁹⁷ See, e.g., *Fed. Ins. Co. v. Kozlowski*, 18 A.D.3d 33, 39, 792 N.Y.S.2d 397, 401 (2005); *Gon v. First State Ins. Co.*, 871 F.2d 863, 864-65 (9th Cir. 1989); *In re WorldCom*, 354 F. Supp. 2d at 465-68; *Nat'l Union Fire Ins. Co. v. Brown*, 787 F. Supp. 1424, 1427 n.8 (S.D. Fla. 1991), *aff'd*, 963 F.2d 385 (11th Cir. 1992); *Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 654 F. Supp. 1334, 1345-46 (D.D.C. 1986), *aff'd in part and rev'd in part*, 944 F.2d 940 (D.C. Cir. 1991). *But see Those Certain Underwriters at Lloyd's v. Prof'l Underwriters Agency, Inc.*, 848 N.E.2d 597 (Ill. App. Ct. 2006) (holding no present obligation to defend while rescission claim is pending).

³⁹⁸ E.g., *Wedtech Corp. v. Fed. Ins. Co.*, 740 F. Supp. 214, 216, 218-19 (S.D.N.Y. 1990); *Geostar*, 2010 WL 845953, at *7; *Shapiro v. Am. Home Assurance Co.*, 616 F. Supp. 900, 904-05 (D. Mass. 1984) ("*Shapiro II*"). *But see Mazur v. Gaudet*, 826 F. Supp. 188, 195 (E.D. La. 1992) (absent specific language regarding applicability to policy application, severability clause is not applied).

³⁹⁹ It is well settled that a corporation will be bound by a statement or declaration made by an employee, but only when the statement or declaration is made *within the scope of employment and with the authority of the employer*. *Wight v. BankAmerica Corp.*, 219 F.3d 79, 87 (2d Cir. 2000). Conversely, under the so-called "adverse interest" exception, where the corporate officer acts in his own interests and not in the interests of the company, his misconduct should *not* be imputed to the corporation. *See id.*

⁴⁰⁰ 147 F. Supp. 2d 238, 265-66 (S.D.N.Y. 2001).

⁴⁰¹ 179 F. Supp. 2d 376, 378 (D. Del. 2002).

⁴⁰² *Id.* at 398.

⁴⁰³ 616 F. Supp. 900, 903 (D. Mass. 1984).

⁴⁰⁴ *Id.* at 904 (emphasis added).

⁴⁰⁵ 2010 WL 1338380 (D. Idaho Mar. 31, 2010).

⁴⁰⁶ *Id.*, 2010 WL 1338380, at *7.

⁴⁰⁷ 2010 WL 1931239 (D.N.J. May 12, 2010).

⁴⁰⁸ *Id.*, 2010 WL 1931239, at *10.

⁴⁰⁹ *Id.*

⁴¹⁰ Sometimes EPL insurance is included in or added onto Directors and Officers (“D&O”) policies. For privately held companies it is not unusual to have entity coverage for EPL claims.

⁴¹¹ Employment-Related Practices Liability Coverage, Form EP 00 01 09 07, §VII Definitions (ISO Properties, Inc. 2007).

⁴¹² *See, e.g.*, Employment Practices Liability Coverage, Form EPL-3001, § II Definitions (The Travelers Companies, Inc. 2009); *Payless Shoesource Inc. v. Travelers Cos.*, 569 F. Supp. 2d 1189, 1192-93 (D. Kan. 2008), *aff’d*, 585 F.2d 1366 (10th Cir. 2009); *Rider v. Ambeau*, 2011-0532 (La. App. 1 Cir. 2/1/12), 100 So. 3d 849, 861 (EPL policy exclusion restricting coverage for “back wages, future wages, overtime or similar claims” did not clearly and unambiguously exclude coverage for loss of future earning capacity).

⁴¹³ *See, e.g.*, *Tim Campbell v. Best Buy Stores LP et al.*, case number 2:12-cv-07794, (C.D. Cal.); *Brian Kim v. Benihana National Corp.*, case number 0:13-cv-62061, (S.D.Fla.); *Glatt v. Fox Searchlight Pictures Inc.*, case number 13-2467, (S.D.N.Y.), petition to 2nd Cir. for review of order *Espanol et al. v. Avis Budget Rental LLC et al.*, case number 8:10-cv-00944 (M.D.Fla.); *Cardoza et al. v. Bloomin' Brands Inc. et al.*, case number 2:13-cv-01820 (D.Nev.); *Christopher Boyle v. Swann Inc. et al*, case number 2:13-cv-00645 (W.D.Pa. 2013); *Patrick Cotter et al. v. Lyft Inc. et al.*, case number 3:13-cv-04065 (N.D.Cal.); *Valentino Smith v. Donna Karan International Inc. and Donna Karan Studio LLC*, Case Number 157912-2013 (Sup. Ct. NY); *Stanley v Toys R Us-Delaware Inc.*, case No. BC519171 (Los Angeles Superior Ct.).

⁴¹⁴ Travelers Employment Practice Liability Policy, Policy No. 105622142, Definition Z “Wage and Hour Law”; Travelers Policy, Exclusion A(13) “Exclusions Applicable to All Loss.”

⁴¹⁵ Travelers Employment Practice Liability Policy, Form No. EPL-3001 (07-05), Exclusion B(3).

⁴¹⁶ 695 N.W.2d 298, 304 (Wis. 2005) (defining misrepresentation “as an act of making a false or misleading statement about something” (citation omitted)).

⁴¹⁷ 763 N.Y.S.2d 427, 433 (Civ. Ct. 2003); Webster’s New Collegiate Dictionary 724 (1980) (“misrepresent” defined as “to give a false or misleading representation of [usually] with an intent to deceive or be unfair”).

⁴¹⁸ 200 F. 593, 597 (W.D.N.Y. 1912).

⁴¹⁹ 610 N.E.2d 799, 803 (Ill. App. Ct. 1993) (same).

⁴²⁰ Black's Law Dictionary 1091 (9th ed. 2009), quoting Restatement (Second) of Contracts § 159 cmt. a (1979).

⁴²¹ 171 P.2d 21-25 (Cal. 1946).

⁴²² No. 07-cv-1119, 2010 WL 749368, at *6 (W.D. Ark. Mar. 2, 2010).

⁴²³ See Nicole Perlroth, *Ashley Madison Chief is Latest Executive to Depart After a Data Breach*, N.Y. Times, Aug. 29, 2015 at B5.

⁴²⁴ *Id.*

⁴²⁵ Divonne Smoyer and Aaron Lancaster, *AGs Encouraged to Take More Action on Data Privacy at NAAG Presidential Initiative Summit*, State AG Monitor (April 19, 2013) available at: <http://www.stateagmonitor.com/2013/04/19/ags-encouraged-to-take-more-action-on-data-privacy-at-naag-presidential-initiative-summit/>.

⁴²⁶ See Nicole Perlroth, *Cyberattack On Saudi Firm Disquiets U.S.*, N.Y. Times, Oct. 23, 2012 at A1.

⁴²⁷ *Security experts hack into moving car and seize control* (Jul. 22, 2015, 7:27 AM), <http://www.cnn.com/2015/07/22/>.

⁴²⁸ <http://www.sec.gov/divisions/corpfin/guidance/cfguidance-topic2.htm>.

⁴²⁹ See *P.F. Chang's v. Federal Ins. Co.*, 2016 WL 3055111 (D. Ariz 2016) (contractual liability exclusion precluded coverage for obligation to reimburse credit card processor for costs arising out of credit card data breach).

⁴³⁰ 2013 ISO CG 00 01 04 13.

⁴³¹ 2013 ISO CG 00 01 04 13.

⁴³² *Eyeblaster, Inc. v. Fed. Ins. Co.*, 613 F.3d 797 (8th Cir. 2010).

⁴³³ See, e.g., *Se. Mental Health Ctr., Inc. v. Pac. Ins. Co.*, 439 F. Supp. 2d 831, 838-39 (W.D. Tenn. 2006); *Lambrech & Assocs., Inc. v. State Farm Lloyds*, 119 S.W.3d 16, 25 (Tex. App. 2003); see also *Midwest Computers & More*, 147 F. Supp. 2d at 1115-16 (allegations of loss of use of a computer system because of loss of business information qualified as loss of use of tangible property under the terms of the policy).

⁴³⁴ *Ward Gen. Ins. Servs., Inc. v. Emp'rs Fire Ins. Co.*, 7 Cal. Rptr. 3d 844, 850-51 (Cal. Ct. App. 2003) (holding that the loss of data without corresponding loss to tangible property is not a "direct physical loss of or damage" to covered property under the terms of the subject insurance policy, and, therefore, the loss is not covered"); *Midwest Computers & More*, 147 F. Supp. 2d at 1116 (holding that "[a]lthough the medium that holds the information can be perceived, identified or valued, the information itself cannot be" and thus computer data alone is not tangible property).

⁴³⁵ See, e.g., *Pa. State Emps. Credit Union v. Fifth Third Bank & BJ's Wholesale Club, Inc.*, 2005 U.S. Dist. LEXIS 42334, at *37 (M.D. Pa. May 3, 2005), *rev'd on other grounds sub nom., Sovereign Bank v. BJ's Wholesale Club, Inc.*, 533 F.3d 162 (3d Cir. 2008) (noting in dicta that reasonable courts could and have disagreed about the tangibility of data, but ultimately holding that the claim for coverage failed because no claim of damage to data had been asserted).

⁴³⁶ See, e.g., 2013 ISO CG 00 01 04 13, Section V(17).

⁴³⁷ The amendment of policies relating to electronic data has not been universal. For example, the Mutual Service Office ("MSO"), a multi-state bureau for policy language since 1944, has elected not to put a standard exclusion for loss of electronic data into its general liability form. See, e.g., Doug Clark, *Comparing Bureau Forms – How Does MSO Fit into the Picture?*, GenRe Research Policy Wording Matters at 3 (Dec. 2008), available at http://www.msonet.com/GenRe_PolicyWordingMatters2008.pdf. Additionally, some boilerplate endorsements can change the property damage coverage for data. For example, the Electronic Data Liability endorsement writes certain coverage for electronic data back into the policy, if the policyholder purchases that endorsement and coverage. 2013 ISO (CG 04 37 04 13). There are other "claims-made" endorsements available as well that provide some coverage. See generally Mary E. Borja, *Catastrophic Computer Events – Data Losses and Systems Failures*, 2 Mealey's Litigation Report: Catastrophic Loss 7 at 1 (Apr. 2007).

⁴³⁸ See, e.g., *Advanced Computer Servs. of Mich., Inc. v. MAI Sys. Corp.*, 845 F. Supp. 356, 363 (E.D. Va. 1994) ("[E]lectrical impulses of a [software] program in RAM are material objects, which, although themselves imperceptible to the ordinary observer, can be perceived by persons with the aid of a computer."); *Am. Guar. & Liab. Ins. Co. v. Ingram Micro, Inc.*, 2000 U.S. Dist. LEXIS 7299, at *6-*7 (D. Ariz. Apr. 18, 2000) (there was "physical damage," as required by the applicable all risk, first-party policy, when information stored in random access memory ("RAM") was destroyed and reduced the computer's functionality); *NMS Servs. Inc. v. Hartford*, 62 F. App'x 511, 514-15 (4th Cir. 2003) (policyholder's lost data, due to a hacking, was within the coverage provided for lost valuable papers and records); *id.* at 515 (Widener, J., concurring) (concurring stating that the loss of data alleged was a "direct physical loss" because "a computer stores information by the rearrangement of the atoms or molecules of a disc or tape to effect the formation of a particular order of magnetic impulses, and a 'meaningful sequence of magnetic impulses cannot float in space.'"); *Computer Corner, Inc. v. Fireman's Fund Ins. Co.*, 46 P.3d 1264, 1266 (N.M. Ct. App. 2002) (construing CGL policy, trial court "found that the computer data in question 'was physical, had an actual physical location, occupied space and was capable of being physically damaged and destroyed[,] [i.e.,] 'computer data is tangible property;' issue not challenged on appeal).

⁴³⁹ See, e.g., *United States v. Thomson Corp.*, No. Civ. A. 01-1419 (D.D.C. Oct. 30, 2001); see also *Seagate Tech., Inc. v. St. Paul Fire & Marine Ins. Co.*, 11 F. Supp. 2d 1150 (N.D. Cal. 1998).

⁴⁴⁰ *State Auto Prop. & Cas. Ins. Co. v. Midwest Computers & More*, 147 F. Supp. 2d 1113, 1116 (W.D. Okla. 2001).

⁴⁴¹ See, e.g., *Retail Sys., Inc. v. CNA Ins. Cos.*, 469 N.W.2d 735 (Minn. Ct. App. 1991). But see

Dist. of Columbia v. Universal Computer Assocs., Inc., 465 F.2d 615, 618 (D.C. Cir. 1972) (concluding that software embodied in punch cards is not tangible property for purposes of personal property tax); *Xereas v. Heiss*, No. 12-456 (RWR), 2013 U.S. Dist. LEXIS 43262, at *8 n.4 (D.D.C. Mar. 27, 2013) (holding that domain names are not tangible property for purposes of the tort of conversion, recognizing conflicting authorities but following *Retail Systems*).

⁴⁴² *But see, e.g., Landmark Am. Ins. Co. v. Gulf Coast Analytical Labs., Inc.*, No. 10-809, 2012 U.S. Dist. LEXIS 45184 (M.D. La. Mar. 30, 2012) (holding that under Louisiana law “tangibility is not a defining quality of physicality,” that data is “corporeal movable or physical in nature,” and that “electronic data is susceptible to ‘direct, physical loss or damage’ within the meaning of an Information Systems Coverage Form).

⁴⁴³ *See, e.g., Midwest Computers & More*, 147 F. Supp. 2d at 1116-17.

⁴⁴⁴ *Recall Total Information Mgmt., Inc. v. Federal Ins. Co.*, 317 Conn. 46 (Conn. 2015).

⁴⁴⁵ *See Netscape Commc'ns Corp. v. Fed. Ins. Co.*, 343 F. App'x 271 (9th Cir. 2009).

⁴⁴⁶ *See, e.g., Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570, at *14 (D. Md. Oct. 26, 2007) (rejecting insurance company's argument “that in order to constitute a publication, the information that violates the right to privacy must be divulged to a third party” and explaining that “the majority [of courts] have found that the publication need not be to a third party.” (emphasis added)); *Am. Family Mut. Ins. Co. v. C.M.A. Mortg., Inc.*, 682 F. Supp. 2d 879, 885 (S.D. Ind. 2010) (same result).

⁴⁴⁷ *Zurich Am. Ins. Co., et al. v. Sony Corp. of Am., et al.*, Index No. 651982/2011 (N.Y. Sup. Ct. February 21, 2014) (*trial court decision determining that there was no coverage for a data breach because the insured did not itself cause the data breach*).

⁴⁴⁸ ISO Form Nos. CG 21 08 05 14 (2014); CG 21 07 05 14, CG 21 06 05 14 (2014).

⁴⁴⁹ *See* ISO CG 00 01 04 13 (2013).

⁴⁵⁰ *See WMS Indus., Inc. v. Fed. Ins. Co.*, 384 F. App'x 372 (5th Cir. 2010) (business interruption and contingent business interruption coverage for post-Katrina interruptions of network of slot machines and electronic gambling machines; *WMS Indus., Inc. v. Fed. Ins. Co.*, 588 F. Supp. 2d 730, 734-35 (S.D. Miss. 2008) (possible coverage for post-hurricane business interruption and extra expense losses due to failure of wide area network).

⁴⁵¹ *NMS Servs. Inc. v. Hartford*, 62 F. App'x 511, 514-15 (4th Cir. 2003) (policyholder's lost data, due to a hacking, was within the coverage provided for lost valuable papers and records).

⁴⁵² *See Retail Ventures, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 691 F.3d 821 (6th Cir. 2012) (upholding district court decision that computer fraud rider in policyholder's crime insurance policy provided both first-party and liability coverage for loss resulting from hackers' theft of customer credit card data).

⁴⁵³ See Section VI.A, *infra*, for a more detailed discussion of E&O Insurance.

⁴⁵⁴ *Eyeblaster, Inc. v. Fed. Ins. Co.*, 613 F.3d 797 (8th Cir. 2010) (insurer had duty to defend allegations that insured wrongfully installed cookies, Flash, and JavaScript, intentional acts that resulted in computer slowdowns); *St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 539 F.3d 809, 820 (8th Cir. 2008) (insurer had duty to defend, under Technology E&O policy, class action alleging manufacture of computer with allegedly faulty controllers for disc drives and defective software used to correct drives).

⁴⁵⁵ See Section V, *infra*, for a more detailed discussion of D&O Insurance.

⁴⁵⁶ See, e.g., *Spec's Family Partners, Ltd. v. Hanover Insurance Co.*, No. 17-20263, 2018 U.S. App. LEXIS 17246 (5th Cir. June 25, 2018) (court of appeals found that a contractual liability exclusion in a management liability policy did not excuse the insurer of its duty to defend its policyholder, a private company, against a claim arising out of a payment card data breach).

⁴⁵⁷ *Medidata Sols., Inc. v. Fed. Ins. Co.*, 268 F. Supp. 3d 471, 479 (S.D.N.Y. 2017) (computer fraud coverage in crime policy covered losses arising out of losses due to receipt of fraudulent email) *aff'd* 729 F. App'x 117, 118 (2d Cir. 2018); *Am. Tooling Ctr. v. Travelers Cas. & Sur. Co. of Am.*, 2018 U.S. App. LEXIS 19208 (6th Cir. July 13, 2018) (reversing district court decision and holding that computer fraud coverage applied to losses from business email compromise scheme).

⁴⁵⁸ See, e.g., <http://www.infosecurity-magazine.com/view/33946/two-men-arrested-in-london-over-ddos-extortion-threats/>; http://www.computerworld.com/s/article/9223971/Hungarian_hacker_gets_30_months_for_extortion_plot_on_Marriott

⁴⁵⁹ See *Dalton v. Harleysville Worcester Mut. Ins. Co.*, 557 F.3d 88, 90 (2d Cir. 2009); *Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marine Ins. Co.*, 472 F.3d 33, 41 (2d Cir. 2006) ("Under an all-risk policy, 'losses caused by any fortuitous peril not specifically excluded under the policy will be covered.'" (citation omitted)); *Chernuchin v. Associated Indem. Corp.*, 2006 Cal. App. Unpub. LEXIS 11699, at *8 (Cal. Ct. App. Dec. 29, 2006) (all risk policy "'covers risks of physical loss except those excluded under the terms of the insuring contract'" (citation omitted)).

⁴⁶⁰ See *Nw. Airlines, Inc. v. Globe Indem. Co.*, 225 N.W.2d 831 (Minn. 1975) (holding that a reasonable insured would interpret the policy as a whole to be an all-risk policy and, therefore, the theft of money by a hijacker would be covered, unless that specific risk was expressly excluded); *Miller v. Boston Ins. Co.*, 218 A.2d 275, 278 (Pa. 1966) ("[T]he very nature of the term 'all risks' must be given a broad and comprehensive meaning as to covering any loss other than a willful or fraudulent act of the insured."); *Phoenix Ins. Co. v. Branch*, 234 So. 2d 396 (Fla. Dist. Ct. App. 1970).

⁴⁶¹ *Great N. Ins. Co. v. Benjamin Franklin Fed. Sav. & Loan Ass'n*, 793 F. Supp. 259 (D. Or. 1990), *aff'd*, 953 F.2d 1387 (9th Cir. 1992).

⁴⁶² 397 F.3d 158 (2d Cir. 2005).

⁴⁶³ 397 F.3d at 165-67.

⁴⁶⁴ *Id.* at 169-70.

⁴⁶⁵ 486 S.E.2d 249 (N.C. Ct. App. 1997).

⁴⁶⁶ If the *Harry's Cadillac* policy had contained ingress/egress coverage, the loss might have been covered.

⁴⁶⁷ 893 F. Supp. 987, 991 (D. Kan. 1995), *aff'd*, 89 F.3d 850 (10th Cir. 1996).

⁴⁶⁸ See, e.g., *Azta Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960,965-71 (Ariz. Ct. App. 2010 (decreased patronage at casino and hotel could be sufficient to trigger BI coverage); *Vinyl-Tech Corp. v. Continental Cas. Co.*, 2000 WL 1744939, at *6 (D. Kan. Nov. 15, 2000) (policy may be “reasonably read to cover any actual loss resulting from a total or partial interruption of business”); *Am. Med. Imaging Corp. v. St. Paul Fire & Marine Ins. Co.*, 949 F.2d 690, 692 (3d Cir. 1991) (policyholder experienced “necessary suspension” of its business operations briefly and faced a “potential suspension” of a much longer duration). *But see Brand Mgmt., Inc. v. Md. Cas. Co.*, 2007 WL 1772063, at *3 (D. Colo. Jun. 18, 2007) (“The phrase ‘necessary suspension of operations,’ although not defined in the policy, is generally understood to connote a total cessation of business activity. Thus, once the insured is able to resume operations, the business interruption clause does not provide coverage for the subsequent market consequences of the temporary cessation of business.”) (internal citations omitted); *Madison Maidens, Inc. v. Am. Mfrs. Mut. Ins. Co.*, 2006 WL 1650689, at *4 (S.D.N.Y. Jun. 15, 2006) (“a complete cessation of activity, even a temporary one, was required”) (emphasis in original).

⁴⁶⁹ 949 F.2d 690 (3d Cir. 1991).

⁴⁷⁰ 949 F.2d at 692-93.

⁴⁷¹ As already mentioned, there are two general types of first-party policies: (1) an “All Risk” policy, and (2) a “Named Peril” policy.

⁴⁷² See, e.g., *Fountain Powerboat Indus., Inc. v. Reliance Ins. Co.*, 119 F. Supp. 2d 552, 556-57 (E.D.N.C. 2000).

⁴⁷³ See *Datatab, Inc. v. St. Paul Fire & Marine Ins. Co.*, 347 F. Supp. 36, 37 (S.D.N.Y. 1972) (water that entered the building’s basement damaged pumps and impacted the air conditioning system, and therefore forced computer equipment on fifth and sixth floor to shut down. The court held that the shutdown still constituted actual loss, even though water did not make contact with fifth or sixth floor and there was no physical damage to the computer equipment; the premises were impeded by the air conditioning system’s failure).

⁴⁷⁴ *Archer-Daniels-Midland Co. v. Phoenix Assurance Co.*, 936 F. Supp. 534, 540 (S.D. Ill. 1996)

(quoting policies).

⁴⁷⁵ 936 F. Supp. 534 (S.D. Ill. 1996).

⁴⁷⁶ See *Dictiomatic, Inc. v. U.S. Fid. & Guar. Co.*, 958 F. Supp. 594, 603-05 (S.D. Fla. 1997).

⁴⁷⁷ Compare *Vinyl-Tech Corp. v. Cont'l Cas. Co.*, 2000 WL 1744939 (D. Kan. Nov. 15, 2000), and *Lexington Ins. Co. v. Island Recreational Dev. Corp.*, 706 S.W.2d 754 (Tex. App. 1986), with *Pennbarr Corp. v. Ins. Co. of N. Am.*, 976 F.2d 145 (3d Cir. 1992).

⁴⁷⁸ See, e.g., *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 411 F.3d 384, at 393 (“[t]he purpose of the Extended Recovery Period is to provide additional coverage for the likely event that Duane Reade will continue to suffer losses due to its business interruption after it reopens[]”).

⁴⁷⁹ See *Fountain Powerboat*, 119 F. Supp. 2d at 557-58.

⁴⁸⁰ See, e.g., *Gillis v. Sun Ins. Office, Ltd.*, 238 Cal. App. 2d 408 at 419 (Cal. Dist. Ct. App. 1965) (“the peril proximately causing the loss was the windstorm which directly caused the original damage to the docking facility. The fact that the immediate cause of loss was . . . water . . . should not defeat recovery.”)

⁴⁸¹ See, e.g., *Simonetti v. Selective Ins. Co.*, 859 A.2d 694 at 700 (N.J. Super. Ct. App. Div. 2004) (“The fact that two or more identifiable causes—one a covered event and one excluded—may contribute to a single property loss does not necessarily bar coverage [W]here included and excluded causes occur *concurrently*, it is for the factfinder to determine which part of the damage was due to the included cause of loss and for which the insured can recover”)(emphasis in original).

⁴⁸² See, e.g., *Urrate v. Argonaut Great Cent. Ins. Co.*, 881 So. 2d 787 (La. Ct. App. 2004) (court rejected property insurer’s contention that most of the damage was caused by flooding and wave action, which were not covered by its policy, finding instead that glass breakage and business losses due to wind would be covered by the property policy).

⁴⁸³ See, e.g., *Hardware Dealers Mut. Ins. Co. v. Berglund*, 393 S.W.2d 309, 312-14 (Tex. 1965) (holding flood damage not covered under all risk policy, emphasizing the significance of the words “whether driven by wind or not,” which appeared in the applicable flood exclusions)].

⁴⁸⁴ See, e.g., *Park Country Club of Buffalo, Inc. v. Tower Ins. Co. of N.Y.*, 893 N.Y.S.2d 408 (App. Div. 2009) (insurer required to pay for flood damage to sand traps at golf course because insured had added coverage for flood by way of endorsement).

⁴⁸⁵ See FEMA, National Flood Insurance Program Claims Manual at Rate 1 (Jan. 2013).

⁴⁸⁶ 8 F.3d 587, 589-90 (7th Cir. 1993).

⁴⁸⁷ See *id.*; see also *Royal Ins. Co. v. Bithell*, 868 F. Supp. 878, 881 (E.D. Mich. 1993) (holding that land exclusion precluded coverage for the costs of removing and replacing soil underneath and around policyholder's home after it was contaminated by raw sewage).

⁴⁸⁸ 1999 WL 33911358, at *6-*7 (D. Minn. Dec. 23, 1999).

⁴⁸⁹ 780 F. Supp. 148, 158 (S.D.N.Y. 1991).

⁴⁹⁰ 289 Fed. App'x 161, 164-65 (9th Cir. 2008) (unpublished).

⁴⁹¹ *Id.* at 164.

⁴⁹² *Id.*

⁴⁹³ *Id.*

⁴⁹⁴ *Id.* at 165.

⁴⁹⁵ 185 F. Supp. 605 (N.D. Cal. 1960).

⁴⁹⁶ See Section VII.E.2, *infra*.

⁴⁹⁷ 989 F. Supp. 159, 163 (D. Conn. 1997).

⁴⁹⁸ The word "sue" in this clause does not refer to a lawsuit. Rather, it has the now obsolete meaning of "to go in pursuit of." See *Webster's Third New International Dictionary of the English Language Unabridged* (1993); Jean Lucey, "Sue and Labor: Past Gives Context to Present," *The John Liner Rev.*, Fall 1999, at 90.

⁴⁹⁹ 48 F. Supp. 808, 812-13 (E.D. Mich. 1943).

⁵⁰⁰ 550 N.W.2d 1 (Minn. Ct. App. 1996).

⁵⁰¹ *Id.* at 7. See also *Am. Home Assurance Co. v. J.F. Shea Co.*, 445 F. Supp. 365 (D.D.C. 1978) (noting that a sue and labor clause provides separate coverage for the underwriter's benefit, to which the policy's deductible does not apply).

⁵⁰² 989 F. Supp. 159, 162-63 (D. Conn. 1997) (finding coverage under a debris removal provision in a homeowner's policy for the removal of oil-contaminated soil).

⁵⁰³ See, e.g., ISO Business Owners Coverage Form, BP 00 03 07 13, § A(5)(i) (2013).

⁵⁰⁴ 65 Va. 238, at 244-45 (Va. Cir. Ct. July 23, 2004).

⁵⁰⁵ *Id.* at 244.

⁵⁰⁶ 949 F.2d 690 (3d Cir. 1991),

⁵⁰⁷ *Id.* at 692, 695.

⁵⁰⁸ No. 88 Civ. 2613(JSM), 1996 U.S. Dist. LEXIS 4500 (S.D.N.Y. Apr. 11, 1996).

⁵⁰⁹ *Id.* at *10-*13.

⁵¹⁰ *Id.* at *13-*15.

⁵¹¹ No. 96-1790, 1997 U.S. Dist. LEXIS 5883 at *8 (E.D. La. Apr. 28, 1997).

⁵¹² *Id.*

⁵¹³ See, e.g., *Security Mut. Ins. Co. v. Acker-Fitzsimons Corp.*, 31 N.Y.2d 436 (1972); *L'Italia Provisions Corp. v. Interboro Mut. Indem. Ins. Co.*, 86 A.D.2d 888 (2d Dep't 1982); *Christiana Gen. Ins. Corp. v. Gr. Am. Ins. Co.*, 979 F.2d 268 (2d Cir. 1992).

⁵¹⁴ See, e.g., *Transportes Ferreos de Venezuela II CA v. NKK Corp.*, 239 F.3d 555, 561 (3d. Cir. 2001) (applying New Jersey law); *Sherwood Brands, Inc. v. Harford Accident & Indem. Co.*, 698 A.2d 1078, 1082 (Md. 1997); *Struna v. Concord Ins. Servs., Inc.*, 11 S.W.3d 355, 359-60 (Tex. App. 2000).

⁵¹⁵ See, e.g., *Shell Oil co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 760-61 (1993) ("California law is settled that a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice.") (citations omitted).

⁵¹⁶ Patrick F. Fitzgerald, *Private Sector Political Risk Insurance Coverages*, 803 PLI/Comm 427, 469 (2000).

⁵¹⁷ See Mark Kantor, *Are You In Good Hands With Your Insurance Company? Regulatory Expropriation And Political Risk Insurance Policies*, 12-17 Mealey's Emerg. Ins. Disps. 16, at *16 (LexisNexis 2007). In the event that the insurer successfully voids the policy, the insured may be entitled to a refund of the premium paid for the policy.

⁵¹⁸ *Id.* at *16-17. The information collected by the insured in the course of its determination of whether to do business in the foreign nation will provide an assessment of the specific risks that the insured might face in that country. For example, there may be speculation that the government could change laws regarding foreign contracts, reflected in memoranda, e-mails, reports of conversations with advisors or government officials, or other documents. There also could be rumors, gossip, or other "noise" indicating that the foreign government might expropriate certain assets (e.g., oil, gas, or coal) due to concerns over the country's economy.

⁵¹⁹ *Id.* at *17.

⁵²⁰ *Id.*

⁵²¹ This concept of "due diligence" in a political risk insurance policy should not be confused with the distinct concept of "due diligence" in the commercial or financial context relating to pre-closing investigations. See *id.* at *20 n.38.

⁵²² Fitzgerald, 803 PLI/Comm at 442 (emphasis added).

⁵²³ Insureds may also have other mitigation options available. For example, if operating under an investment treaty, an insured may be able “to take their host State directly to international arbitration for breaches of the substantive protections offered by such treaties.” 1 Int’l Cont. Manual § 31:73 (2012).

⁵²⁴ See *Valencia v. Shell Oil Co.*, 23 Cal. 2d 840, 846 (1944).

⁵²⁵ See, e.g., *Kleinclaus v. Marin Realty Co.*, 94 Cal. 2d 733, 739 (1949); *Slay Warehousing Co. v. Reliance Ins. Co.*, 471 F.2d 1364, 1367-68 (8th Cir. 1973); *Winkler v. Gr. Am. Ins. Co.*, 447 F. Supp. 135, 142 (1978).

⁵²⁶ See *G & C Constr. Corp. v. St. Paul Fire & Marine Ins. Co.*, 731 F.2d 183 (4th Cir. 1984); *Check Cashing Corp. v. Chubb Pac. Indem. Group*, 464 N.Y.S.2d 118 (App. Div. 1983).

⁵²⁷ See, e.g., *RBC Mortgage Co. v. Nat’l Union Fire Ins. Co.*, 812 N.E.2d 728 (Ill. App. Ct. 2004); *Tri City Nat’l Bank v. Fed. Ins. Co.*, 674 N.W.2d 617, 624-25 (Wis. Ct. App. 2003).

⁵²⁸ See, e.g., *First Defiance Fin.l Corp. v. Progressive Cas. Ins. Co.*, 688 F.Supp.2d 703, 708 (N.D. Ohio 2010); *Frontline Processing Corp. v. American Economy Ins. Co.*, 149 P.3d 906 (Mont. 2006); *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*, 854 A.2d 378 (N.J. 2004).

⁵²⁹ *Frommoethelydo v. Fire Ins. Exch.*, 721 P.2d 41, 44 (Cal. 1986); *Brase by Brase v. Loempker*, 642 N.E.2d 202, 206 (Ill. App. Ct. 1994) (“[I]n Illinois every insurer has an implied duty of good faith and fair dealing with respect to an insured”); *Clients’ Sec. Fund of the Bar of N.J. v. Sec. Title & Guar. Co.*, 634 A.2d 90, 96 (N.J. 1993) (“[A] duty of good faith and fair dealing is implicit in an insurance contract, and . . . the insurer has an even greater duty than the insured to act fairly and in good faith”); *Hartford Accident & Indem. Co. v. Mich. Mut. Ins. Co.*, 462 N.Y.S.2d 175, 178 (App. Div. 1983) (“It is well established that, as between an insurer and its assured, a fiduciary relationship does exist, requiring utmost good faith by the carrier in its dealings with its insured”), *aff’d*, 463 N.E.2d 608 (N.Y. 1984).

⁵³⁰ *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200 (Cal. 1958).

⁵³¹ See, e.g., *Stark v. Pioneer Cas. Co.*, 34 P.2d 731, 732 (Cal. Ct. App. 1934).

⁵³² See *Karl v. New York Life Ins. Co.*, 381 A.2d 62, 64 (N.J. Super. Ct. App. Div. 1977); *Eagle Star Ins. Co. v. Int’l Proteins Corp.*, 360 N.Y.S.2d 648, 650 (App. Div. 1974), *aff’d*, 346 N.E.2d 249 (N.Y. 1976).

⁵³³ See *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 146 (Cal. 1979); see generally 46 Shernoff, Gage, and Levine, *Insurance Bad Faith Litigation* § 1.04 (2009).

⁵³⁴ See *Egan*, 620 P.2d at 146; see also 3 Couch, *Cyclopedia of Insurance Law* § 23.11 at 11 (2d ed. 1960) (citing *Bowler v. Fid. & Cas. Co.*, 250 A.2d 580, 587-588 (N.J. 1969); 46 Shernoff, Gage, and Levine, *Insurance Bad Faith Litigation* § 1.05 (2009).

⁵³⁵ *Neal*, 582 P.2d at 986 n.5.

⁵³⁶ 472 F.3d 99 (4th Cir. 2006)

⁵³⁷ *Id.* at 125.

⁵³⁸ *Id.* at 124-25.

⁵³⁹ *Id.* at 126.

⁵⁴⁰ *Meat Market, Inc. v. Am. Ins. Co.*, No. 1:11-cv-00983-AWI-SAB, slip op. at 12 (E.D. Cal. Mar. 19, 2013) (rejecting the insurer's motion for summary adjudication and finding that a reasonable trier of fact could conclude that the insurer conducted a biased investigation based on the insurer's error-ridden investigatory report).

⁵⁴¹ *Cher-D, Inc. v. Great Am. Alliance Ins. Co.*, 2009 U.S. Dist. LEXIS 30206, at *33 (E.D. Pa. Apr. 7, 2009).

⁵⁴² *Id.* at *8.

⁵⁴³ *Id.*

⁵⁴⁴ Fl. Stat. § 627.70131 (2011).

⁵⁴⁵ *Hat v. Depositors Ins. Co.*, 339 F. App'x 764 (9th Cir. 2009).

⁵⁴⁶ *Id.* at 765.

⁵⁴⁷ *Id.* (quoting *Waller v. Truck Ins. Exch., Inc.*, 900 P.2d 619 (Cal. 1995)).

⁵⁴⁸ *Mega Constr. Corp. v. Quincy Mut. Fire Ins. Co.*, No. 09-01728, slip op. at 23-24 (E.D. Pa. Sept. 12, 2012) (holding that a reasonable trier of fact could find that the insurer acted in bad faith by failing to respond to communications and to investigate the claim for more than two years).

⁵⁴⁹ *Samson v. Transamerica Ins. Co.*, 636 P.2d 32, 42 (Cal. 1981) ("[A]n insurer who fails to accept a reasonable settlement offer within policy limits because it believes the policy does not provide coverage assumes the risk that it will be held liable for all damages resulting from such refusal, including damages in excess of applicable policy limits"); *Campbell v. Gov't Emp. Ins. Co.*, 306 So. 2d 525, 530-31 (Fla. 1974) (citing *Auto Mut. Indem. Co. v. Shaw*, 184 So. 852 (Fla. 1938)) (finding the insurer liable for bad faith due, in part, to its failure to settle); *Cotton States Mut. Ins. Co. v. Brightman*, 580 S.E.2d 519, 521 (Ga. 2003) ("An insurance company may be liable for the excess judgment entered against its insured based on the insurer's bad faith or negligent refusal to settle a personal claim within the policy limits"); *Haddick v. Valor Ins.*, 763 N.E.2d 299, 303 (Ill. 2001) (citing *Cramer v. Ins. Exch. Agency*, 675 N.E.2d 897 (Ill. 1997)) ("[T]he law imposes upon the insurer the duty to settle in good faith"); *Hudson Ins. Co. v. Primary Health, Inc.*, No. CVOC 2011-24842 (Idaho Dist. Ct. 4th Jud. Dist. Mar. 25, 2013) (Judgment and Decree) (finding that the insurer acted in bad faith by failing to communicate settlement offers to the insured and was liable for the excess jury

verdict); *Phelps v. State Farm Mut. Auto Ins. Co.*, 680 F.3d 725, 734 (6th Cir. 2012)(italics omitted) (under Kentucky unfair claim settlement practices act, insurer may be liable for bad faith if it fails “to promptly offer its limits as soon as it knows or should have known that a reasonable evaluation of the claim is in excess of the limit . . .”).

⁵⁵⁰ 701 P.2d 795 (Utah 1985).

⁵⁵¹ *Id.* at 801.

⁵⁵² *Id.*

⁵⁵³ *Id.* at 802.

⁵⁵⁴ See *Diamond Heights Homeowners Ass’n. v. Nat’l Am. Ins. Co.*, 277 Cal. Rptr. 906, 917-18 (Cal. Ct. App. 1991) (excess insurer was not entitled to summary judgment on grounds that primary insurers did not tender defense before settling or that settlement did not comply with condition of excess policy). “Even when it has not assumed the defense or control of settlement negotiations, an excess insurer has the right under the policy to consent to any settlement reaching its coverage level. The excess insurer has an implied obligation to exercise that right in good faith.” *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 934 P.2d 65, 81 (Kan. 1997). See 1 Windt, *Insurance Claims & Disputes* § 5.26, p. 350 (3d ed. 1995) (“The duty [of an excess insurer] to settle exists independently of the duty to defend”). See also Ashley, *Bad Faith Actions: Liability and Damages* § 6.21 (1992) (“When an insured has both primary and excess liability insurance coverage, he can expect the excess carrier to respond to settlement offers with the same good faith required of primary carriers”).

⁵⁵⁵ *Kelley v. British Commercial Ins. Co.*, 34 Cal. Rptr. 564, 569 (Cal. Ct. App. 1963).

⁵⁵⁶ *Id.*

⁵⁵⁷ *Id.* at 569.

⁵⁵⁸ A number of courts have admitted evidence of an insurer’s post-filing conduct as proof of bad faith. These decisions, however, do not always make clear exactly what post-filing conduct is being admitted. See *T.D.S. Inc. v. Shelby Mut. Ins. Co.*, 760 F.2d 1520, 1527 (11th Cir.) (Florida law) (upholding admission of undefined “litigation conduct”), *modified in part*, 769 F.2d 1485 (11th Cir.1985); *Othman v. Globe Indem. Co.*, 759 F.2d 1458, 1467 & n.11 (9th Cir.1985) (California law) (upholding admission of insurer’s refusal to consider relevant evidence presented to insurer during litigation), *overruled on other grounds by Bryant v. Ford Motor Co.*, 832 F.2d 1080 (9th Cir.1987); *Journal Pub’g Co. v. Am. Home Assurance Co.*, 771 F. Supp. 632, 635, 637 (S.D.N.Y. 1991) (New Mexico law) (permitting policyholder to amend complaint to include statutory and bad faith tort claims based on the insurer’s failure to meet certain discovery obligations); *Southerland v. Argonaut Ins. Co.*, 794 P.2d 1102, 1106 (Colo. App. 1990) (refusing to find an abuse of discretion in admission of evidence of post-filing conduct on the ground that the evidence helped establish a habitual pattern of dealing with the plaintiff); *Home Ins. Co. v. Owens*, 573 So. 2d 343, 344 (Fla. Dist. Ct. App.1990) (upholding admission of evidence of an insurer’s pleadings as well as the insurer’s failure to answer a request for admissions); *Harris v. Fontenot*, 606 So.2d 72, 74 (La.

Ct. App. 1991) (holding that the Louisiana bad faith statute applies to post-litigation conduct by an insurance company); *Gregory v. Cont'l Ins. Co.*, 575 So. 2d 534, 542 (Miss. 1990) (remanding case for determination whether insurer's post-filing conduct constituted bad faith); *Safeco Ins. Co. v. Ellinghouse*, 725 P.2d 217, 223-25 (Mont. 1986) (upholding admission of post-filing correspondence which included references to settlement offers); *Smith v. Am. Family Mut. Ins. Co.*, 294 N.W.2d 751, 764 (N.D. 1980) (upholding admission of a letter written by an insurer to its counsel after policyholder filed suit proposing that counsel counterclaim against the policyholder's attorney for abuse of process); *Spadafore v. Blue Shield*, 486 N.E.2d 1201, 1204 (Ohio Ct. App. 1985) (noting that post-filing evidence is relevant if the conduct relates to bad faith in handling or refusing to pay a claim).

⁵⁵⁹ *Estee Lauder Inc. v. OneBeacon Ins. Group, LLC*, 2013 N.Y. Misc. LEXIS 1550, *29 (Sup. Ct. N.Y. Cnty. Apr. 15, 2013).

⁵⁶⁰ *Id.* at *25.

⁵⁶¹ *Dufrene v. Gauthreau Family LLC*, 28 So. 3d 465, 469 (La. Ct. App. 2009).

⁵⁶² *Id.*

⁵⁶³ *Mullen v. Nationwide Mut. Ins. Co.*, Index No. 1:11 cv 351, 2013 WL 228074, at *4 (W.D. Wash. Jan. 18, 2013).

⁵⁶⁴ *See, e.g., Bryant v. Country Life Ins. Co.*, 414 F. Supp. 2d 981 (W.D. Wash. 2006) (holding that a third-party beneficiary could assert a claim for **bad faith** claims handling and failure to investigate even if it is ultimately determined that there is no insurance coverage).

⁵⁶⁵ *Enoka v. AIG Hawaii Ins. Co.*, 128 P.3d 850 (Haw. 2006).

⁵⁶⁶ *Enoka*, 128 P.3d at 865

⁵⁶⁷ *Bi-Economy Mkt. Inc. v. Harleysville Ins. Co. of N.Y.*, 886 N.E.2d 127 (N.Y. 2008); *Panasia Estates Inc. v. Hudson Ins. Co.*, 886 N.E.2d 135 (N.Y. 2008).

⁵⁶⁸ *See Bi-Economy*, 886 N.E.2d at 131-32.

⁵⁶⁹ *Id.* at 131.

⁵⁷⁰ *Id.* at 132.

⁵⁷¹ 42 Pa. Cons. Stat. § 8371; *see also Meat Market, Inc. v. Am. Ins. Co.*, No. 1:11-cv-00983-AWI-SAB, slip op. at 13-14 (E.D. Cal. Mar. 19, 2013) (finding that a reasonable trier of fact could find that the insurer "was guilty of oppression" and, thus, liable for punitive damages).

⁵⁷² *See, e.g., Cal. Civ. Code* § 3294(a) (standard for punitive damages); *Miglicio v. HCM Claim Mgmt. Corp.*, 672 A.2d 266, 274 (N.J. Super. Ct. 1995) (punitive damages appropriate if insurer's act is wantonly reckless or malicious).

⁵⁷³ *Fletcher v. W. Nat'l Life Ins. Co.*, 89 Cal. Rptr. 78, 93 (Cal. Ct. App. 1970).

⁵⁷⁴ *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 418 (2003); *Johnson v. Ford Motor Co.*, 113 P.3d 82, 88 (Cal. 2005).

⁵⁷⁵ See, e.g., *Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 15 (1991) (“Under the traditional common-law approach, the amount of the punitive award is initially determined by a jury instructed to consider the gravity of the wrong and the need to deter similar wrongful conduct”); *Nakamura v. Superior Court*, 100 Cal. Rptr. 2d 97, 102 (Cal. Ct. App. 2000) (purpose of punitive damages “is to punish and deter”); *Hammond v. City of Gadsden*, 493 So. 2d 1374, 1379 (Ala. 1986) (The factors to be considered in awarding punitive damages are the “culpability of the defendant’s conduct,” the “desirability of discouraging others from similar conduct,” and the “impact upon the parties”); *Hawkins v. Allstate Ins. Co.*, 733 P.2d 1073, 1080 (Ariz. 1987) (factors to be considered in awarding punitive damages include “defendant’s financial position,” “nature of defendant’s conduct, including the reprehensibility of the conduct and the severity of the harm,” and “the profitability of the defendant’s conduct”).

⁵⁷⁶ See, e.g., *Adams v. Murakami*, 284 Cal. Rptr. 318, 321 (Cal. Ct. App. 1991) (“[T]he most important question is whether the amount of the punitive damages award will have [a] deterrent effect — without being excessive. . . . [An] award can be so disproportionate to the defendant’s ability to pay that the award is excessive *for that reason alone*”).

⁵⁷⁷ 140 Cal. App. 4th 327, 344 (2006). An insurance agent also may be personally liable for his/her own tortious conduct. See *Blouin v. Sanborn*, 155 N.H. 704 (2007).

⁵⁷⁸ 30 S.W.3d 128, 132-33 (Ky. 2000).

⁵⁷⁹ 984 P.2d 675, 680 (Colo. Ct. App. 1999).

⁵⁸⁰ See Kirk A. Pasich & Sandra Smith Thayer, *Insurance Broker Responsibility Extends Beyond Procuring Coverage*, Advocate, June 2010.

⁵⁸¹ 83 Cal. App. 4th 1116, 1123 (2000).

⁵⁸² 57 Cal. App. 4th 916, 927 (1997).

⁵⁸³ 96 N.Y.2d 20, 25 (2001).

⁵⁸⁴ 224 Cal. App. 3d 905, 908-09 (1990).

⁵⁸⁵ *Butcher v. Truck Ins. Exch.*, 77 Cal. App. 4th 1442, 1461 (2000). See also, *Hydro-Mill Co. c. Hayward, Tilton & Rolapp Ins. Assocs., Inc.*, 115 Cal. App. 4th 1145, 1153 (2004) (“[T]he general rule [is] that an agent or broker who fails to procure insurance as requested will be liable for any resulting damage . . .”).

⁵⁸⁶ See *Third Eye Blind, Inc. v. Near North Entertainment Insurance Services, LLC*, 127 Cal. App. 4th 1311 (2005).

⁵⁸⁷ *Id.* at 1318.

⁵⁸⁸ See e.g., *Clement v. Smith*, 16 Cal. App. 4th 39, 45 (1993); *Williams v. Hilb, Rogal & Hobbs Ins. Servs. of Cal., Inc.*, 177 Cal. App. 4th 624, 639 (2009) (“an insured’s failure to read his policy of insurance does not ... render the insured’s reliance on the agent’s advice unjustifiable as a matter of law”); *Paper Savers, Inc. v. Nacsa*, 51 Cal. App. 4th 1090, 1102-04 (1996) (court rejected insurance broker’s argument that insured’s reliance on broker’s alleged representations was unjustifiable as matter of law because insured did not read policy); *Am. Bldg. Supply Corp. v. Petrocelli Group, Inc.*, 19 N.Y.3d 730 (N.Y. 2012).

⁵⁸⁹ 115 Cal. App. 4th 1145 (2004).

⁵⁹⁰ 303 A.D.2d 468 (N.Y. App. Div. 2003).

⁵⁹¹ 89 Cal. App. 4th 638, 650-51 (2001).

⁵⁹² 879 N.E.2d 1076, 1083 (Ind. 2008).

⁵⁹³ 177 Cal. App. 4th 624 (2009).

⁵⁹⁴ *Id.* at 628.

⁵⁹⁵ *Id.* at 640.

⁵⁹⁶ *Id.* at 641-42.

⁵⁹⁷ *Id.* at 624.

⁵⁹⁸ *Id.*

⁵⁹⁹ See, e.g., *Atl. Balloon & Novelty Corp. v. Am. Motorists Ins. Co.*, 62 A.D.3d 920, 922 (N.Y. App. Div. 2009) (“[T]he [insureds] sustained an injury in the form of losing a property right to the proper insurance protection when [the broker] purportedly procured an inadequate policy”); but see *Bond v. Progressive Ins. Co.*, 82 A.D.3d 1318, 1320 (N.Y. App. Div. 2011) (claim against broker for failing to give proper notice to an insurer of a claim against the insured did not accrue until judgment against insured was entered); *Lewiarz v. Travelers Ins.*, 82 A.D.3d 1464, 1466 N.Y. App. Div. (2011) (action accrued against broker on date insurer denied coverage rather than date policy was issued).

⁶⁰⁰ 434 F. Supp. 2d 483, 492 (N.D. Ohio 2006) (“state corporation laws dictate that all of the assets and liabilities of a corporation transfer to the merged entity. Accordingly, insurance coverage for premerger occurrences transfers to the merged entity under those statutes.”).

⁶⁰¹ 70 Misc. 2d 1028, 334 N.Y.S.2d 959, 961 (1972).

⁶⁰² 2004 WL 1737489 (Ind. Cir. 2004).

⁶⁰³ 947 F. Supp. 1476, 1481 (W.D. Wash. 1996) (coverage passes to successor entity by operation of law, because “insurers’ risks have not increased when their duty to indemnify and defend relates to events occurring prior to transfer”).

⁶⁰⁴ 857 F. Supp. 140, 151 (D.N.H. 1994) (“[l]ike a corporation succeeding to the rights of the merged corporation, a potential successor corporation by definition should also be entitled to those same rights”).

⁶⁰⁵ 112 Ohio St. 3d 482, 483, 861 N.E.2d 121 (2006) (“[W]hen a covered occurrence under an insurance policy occurs before liability is transferred to a successor corporation, coverage does not arise by operation of law when the liability was assumed by contract.”).

⁶⁰⁶ 112 Ohio St. 3d 470, 474, 861 N.E.2d 109 (2006) (“Glidden III has assumed the liabilities in question by contract, so if Ohio law applies, insurance coverage does not arise by operation of law.”).

⁶⁰⁷ See *Ocean Accident & Guarantee Corp. v. Sw. Bell Telephone Co.*, 100 F.2d 441, 446 (8th Cir.), cert. denied, 306 U.S. 658 (1939) (The principle on which the courts hold that an assignment of a right under a policy prohibiting assignment may be made is that such an assignment is not the assignment of the policy itself (because the parties have contracted otherwise), but it is the assignment of a claim, or debt, or chose in action. The rule is stated on 2 May on Insurance, § 386, as follows: “An assignment after loss is not the assignment of the policy, but the assignment of a claim or debt — a chose in action”); *Citicorp Indus. Credit, Inc. v. Fed. Ins. Co.*, 672 F. Supp. 1105 (N.D. Ill. 1987) (“[T]his Court is persuaded that enforcement of [a “No Assignment”] provision after the loss had occurred and liability had already become fixed would wreak an unconscionable result, for insurance companies reluctant to pay a claim could unfairly rely on such a provision to escape liability on a risk which had legitimately been assumed when the contract was executed”). See also *Oklahoma Morris Plan Co. v. Sec. Mut. Cas. Co.*, 455 F.2d 1209, 1212 (8th Cir. 1972) (when insured transferred all assets to another company, asset transfer was effective to assign right to recover under banker’s bond policy for embezzlement losses occurring prior to assignment but discovered thereafter); *Int’l Rediscount Corp. v. Hartford Accident & Indem. Co.*, 425 F. Supp. 669, 673 (D. Del. 1977) (insured’s assignment of right to recover under “Comprehensive Dishonesty, Disappearance and Destruction” policy, after the insured-against acts had occurred, was valid); *Gopher Oil Co. v. Am. Hardware Mut. Ins. Co.*, 588 N.W.2d 756 (Minn. Ct. App. 1999); *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 112 Ohio St. 3d 482, 861 N.E.2d 121 (2006).

⁶⁰⁸ See, e.g., *Md. Cas. Co. v. W.R. Grace & Co.*, 794 F. Supp. 1206, 1233 (S.D.N.Y. 1991), rev’d on other grounds, 1993 U.S. App. LEXIS 22383 (2d Cir. 1993); *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483 (N.D. Ohio 2006) (“the insurer is not harmed by the assignment of rights to claims for preassignment occurrences since the assigned risk is the same risk it initially agreed to insure”); *Brunswick Corp. v. St. Paul Fire & Marine Ins. Co.*, 509 F. Supp. 750, 753 (E.D. Pa. 1981) (because the transfer of assets and liabilities by merger did not entail any increase in the risk or hazard assumed by the insurer, the “no assignment” clause should not be applied “ritualistically or mechanically so as to forfeit coverage”).

⁶⁰⁹ See note 607.

⁶¹⁰ 354 P.3d 302 (2015).

⁶¹¹ 62 P.3d 69 (2003). In *Henkel*, the court ruled that an insurer could enforce its “no-assignment” clause, even though the alleged injuries to third party claimants had already

taken place. 62 P.3d at 75-76. Because the third party liability claims against the policyholder had yet to be “reduced to sum of money due or to become due under the policy,” the court held that the insurance company could be faced with the need to defend two companies, rather than one. Furthermore, the insurers might face the additional undue burden relating to “disputes over the existence and scope of the assignment” of insurance rights. *Id.* at 75.

⁶¹² *Fluor*, 354 P.3d at 303-04.

⁶¹³ *Id.* at 304.

⁶¹⁴ *Id.* at 304 (quoting *Henkel*).

⁶¹⁵ *Id.* at 304; see also *Hartford Cas. Ins. Co. v. Fireman's Fund Ins. Co.*, No. 15-cv-002592, 2015 WL 5168643, at *4 (N.D. Cal. Sept. 3, 2015) (assignee had claim for reformation under policy because assignment had occurred after bodily injury giving rise to liability claim (citing *Fluor*)).

⁶¹⁶ *Fluor*, 354 P.3d at 316.

⁶¹⁷ *Id.* at 304.

⁶¹⁸ *Id.* at 322.

⁶¹⁹ *Id.* at 325 (“the liability of the insurer, and therefore the right of the assured to assign, arises immediately upon the happening of the accident or other occurrence for which the assured is, or is claimed to be, liable.” (quoting *Ocean Accident*) (emphasis removed)).

⁶²⁰ See, e.g., *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 861 N.E.2d 121, 125-26 (Ohio 2006); *In re Ambassador Ins. Co.*, 965 A.2d 486, 490-92 (Vt. 2008); *Viking Pump, Inc. v. Century Indem. Co.*, 2006 WL 3297559, at *19-*20 (Del. Ch. Oct. 14, 2009).

⁶²¹ *Fluor*, 354 P.3d at 325.

⁶²² *Id.* at 327 n.46 (citing *Travelers Cas. & Surety Co. v. United States Filter Corp.*, 895 N.E.2d 1172, 1179, 1180 (Ind. 2008)).

⁶²³ *Fluor*, 354 P.3d at 330.

⁶²⁴ 1991 U.S. Dist. LEXIS 11350 (N.D. Cal. 1991), *vacated by settlement*.

⁶²⁵ 1991 U.S. Dist. LEXIS at *1-2.

⁶²⁶ *Id.* at *5-7 (emphasis added, citations omitted).

⁶²⁷ 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996).

⁶²⁸ *Id.* at 78 n.31.

⁶²⁹ *Id.* at 80.

⁶³⁰ *Id.* at 81. *See also id.* at 80 (“Indeed, in all of the California cases we have located on this issue, the party who qualified as a named insured did so during the policy period.”).

⁶³¹ 365 F.3d 263, 270-73 (4th Cir. 2004).

⁶³² 113 Fed. App’x 700, 703-06 (6th Cir. 2004).

⁶³³ *See supra* § IV.D.5.

⁶³⁴ *See, e.g., UMG Recordings, Inc. v. Am. Home Assur. Co.*, 378 Fed.Appx. 766 (9th Cir. May 13, 2010) (holding that insured’s bad faith claims were not subject to arbitration; even though separate “payment agreements” with the insurer contained arbitration provisions, the insurance issues did not “arise out of” the payment agreements).

⁶³⁵ 714 F.Supp.2d 1098 (D. Or. May 18, 2010) (“Carson”).

⁶³⁶ *Id.* at *12.

⁶³⁷ *Id.* at *13–14.

⁶³⁸ 63 Cal. Rptr. 3d 816 (Cal. Ct. App. 2007).

⁶³⁹ *Id.* at 837-38.

⁶⁴⁰ *See HLTH Corp. v. Agricultural Excess & Surplus Ins. Co.*, 2008 WL 3413327, at *14 (Del. Super. Ct. July 31, 2008); *Grace v. Ins. Co. of N. Am.*, 944 P.2d 460 (Alaska 1997); *Rummel v. St. Paul Surplus Lines Ins. Co.*, 945 P.2d 985 (N.M. 1997); *Weaver v. Kitchens*, 570 So. 2d 508 (La. Ct. App. 1991); *Fed. Ins. Co. v. Srivastava*, 2 F.3d 98 (5th Cir. 1993); *Garmany v. Mission Ins. Co.*, 785 F.2d 941 (11th Cir. 1986); *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928); *Columbia Cas. Co. v. Appleton Papers, Inc.*, No. 05-CV-36, Order on Exhaustion, at 1 (Wis. Cir. Ct. Dec. 11, 2008).

⁶⁴¹ 73 Cal. Rptr. 3d 770 (Cal. Ct. App. 2008); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007).

⁶⁴² 458 F. Supp. 297 (D. Minn. 1978), *aff’d*, 586 F.2d 1291 (8th Cir. 1978).

⁶⁴³ 98 F.3d 1440 (3d Cir. 1996).

⁶⁴⁴ 221 F.3d 307 (2d Cir. 2000).

⁶⁴⁵ 667 F.2d 1034 (D.D.C. 1981).

⁶⁴⁶ In pro rata jurisdictions, each insurance company is liable only for its pro rata share of liability. Thus, settlement by one insurance company should not affect other insurance companies’ responsibility.

⁶⁴⁷ See generally, e.g., *Teigen v. Jelco of Wis.*, 367 N.W.2d 806, 810 (Wis. 1985), in which the court dismissed a settling primary insurance company over an excess insurance company's objection. The court observed that "[p]artial settlements not only benefit the parties involved, but the justice system as a whole," and reemphasized its prior statement that "'public interest requires that a plaintiff be permitted to settle claims against some of the exposed parties without releasing others.'" *Id.* (quoting *Loy v. Bunderson*, 320 N.W.2d 175, 189 (Wis. 1982)).

In the leading California case adopting the "all sums" result, the court rejected the notion of contribution claims by non-settling insurance companies against settled insurance companies in other policy periods:

The Court finds it . . . unacceptable to hold that a non-settling insurance company may seek contribution from a settling insurance company on the basis that the settling insurance company would have paid more absent the settlement. Strong public policy favors the settlement of litigation. Settlements promote peace and reduce the expense of litigation. It would greatly discourage settlements to hold that an insurance company who enters into a reasonable, good-faith settlement with its insured must thereafter pay more or differently from that agreed to in the settlement.

In re Asbestos Ins. Coverage Cases, No. 1072, Statement of Decision Concerning Phase IV Issues at 55 (Cal. Super. Ct. Jan. 24, 1990) (citations omitted), *aff'd in part and rev'd in part on other grounds sub nom. Armstrong World Indus. v. Aetna Cas. & Sur. Co.*, 26 Cal. Rptr 2d 35 (Cal. Ct. App. 1993), *vacated on other grounds*, 904 P.2d 370 (Cal. 1995).

⁶⁴⁸ No. 49D12 0102 CP 000243 (Ind. Super. Ct. Marion County July 15, 2002).

⁶⁴⁹ *Id.* slip op. at 3.

⁶⁵⁰ *Id.*

⁶⁵¹ *Id.* at 3.

⁶⁵² *Id.* at 4.

⁶⁵³ *Id.* Ultimately, however, the court allowed a set-off equal to "the amount actually paid in the settlement," but no more. *Id.* at 5.

⁶⁵⁴ 327 Wis.2d 120, 787 N.W.2d 894 (Wis. App. 2010).

⁶⁵⁵ 15 P.3d 115, 126 (Wash. 2001).

⁶⁵⁶ *Id.* at 125-27.

⁶⁵⁷ *Id.* at 125.

⁶⁵⁸ *Id.* at 126.

⁶⁵⁹ *Id.* at 127.

⁶⁶⁰ 770 A.2d 403, 413-14 (R.I. 2001).

⁶⁶¹ *Id.* at 413.

⁶⁶² *Id.* (quoting trial court decision).

⁶⁶³ *Id.*

⁶⁶⁴ *Id.* at 414.

⁶⁶⁵ 922 P.2d 126 (Wash. Ct. App. 1996).

⁶⁶⁶ *Id.* at 139.

⁶⁶⁷ *Id.*