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TABLE OF CONTENTS

Articles »

Protecting Privilege While Preserving Coverage

By John Buchanan and Wendy Feng

Liability insurance for a large, complex claim is often a love-hate relationship balancing the rights and interests of the policyholder and the insurer. Here are some tips for achieving equilibrium.

Insurance 101: Liability of Third-Party Administrators and Adjustors

By Kenneth Anspach

Insurance companies are increasingly handing off their claims-handling functions to third parties with no contractual relationship with the insured. The result: A slew of new case law.

Distinguishing Between Large or Matching Deductibles and Self-Insured Retentions

By Deborah M. Minkoff

Understanding the similarities and differences between different methods of apportioning risk between insurers and insured paves the way to efficient handling of claims.

Trigger of Insurance Coverage for Wrongful Arrest, Prosecution and Conviction Lawsuits

By Benjamin C. Eggert and Ashley Eiler

A rising tide of exonerations is producing a wave of lawsuits over when coverage should begin for such wrongful litigation.

FROM THE CHAIRS »

Welcome to the First All-Electronic Issue of Coverage

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EDITOR'S NOTES »

Welcome New Team Members

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Protecting Privilege While Preserving Coverage[1]

By John Buchanan and Wendy Feng – March 8, 2012[2]

Liability insurance for a large, complex claim is often a love-hate relationship. On the one hand, the policyholder and the insurer may stand on common ground in their adversity to the underlying claimant. On the other hand, the policyholder may find that the insurer—though the enemy of his enemy—is not necessarily his friend. The bigger and thornier the claim, the more likely that the insurer will reserve its rights to deny coverage. That reservation of rights often results in the policyholder defending the underlying litigation with independent counsel, while facing actual or potential coverage litigation with the insurer. This is hardly the “common interest” defense relationship found in a simple auto accident or slip-and-fall claim, where the insurer accepts its duty to defend without reservation and hires counsel to defend its policyholder in the underlying litigation.

During the course of this ambivalent, rights-reserved insurance claims relationship, the insurer is still likely to ask the policyholder or its defense counsel for work product or privileged information about the underlying case. The policyholder may want to provide that information, for a variety of good reasons: to get its defense costs paid; to elicit the insurer’s expertise in defending the claim; or to avoid the risk of motivating the insurer to assert a new coverage defense alleging breach of the so-called cooperation clause in its policy. The insurer’s motives in requesting the information may range from fulfilling its duty to pay reasonable defense costs, to offering useful input on settlement evaluation, to setting its own reserves, to discovering ammunition for its coverage defenses.

Meanwhile, given the actual or potential adversity between the policyholder and the insurer, the policyholder’s in-house and outside counsel confront a grave risk on another front: the underlying plaintiff might successfully claim that when the policyholder disclosed documents from defense counsel’s confidential files to a less-than-friendly insurer, it waived all attorney-client privilege and work product protection attaching to them.

In short, the policyholder and its counsel are caught between the risk of impairing coverage (for cooperating too little with the insurer) and the risk of waiving privilege (for cooperating too much). Tacking to compensate for the risk on one side may simply enhance the risk on the other. The classically inclined might describe this dilemma as “sailing ’twixt Scylla and Charybdis.”[3] We call it “caught between a rock and a hard place.”

That awkward position is the focus of this article. In Part I, we pose a simplified hypothetical to provide more context for the dilemma that policyholders and their counsel face. Part II then analyzes relevant case law and statutes that shed light on how the dilemma is currently addressed—or ignored—in various jurisdictions. Finally, again in

the context of the hypothetical, Part III concludes with a few practical tips for navigating the straits between cooperation clause violations and privilege waivers.

I. The Hypothetical and the Dilemma

Here is a common scenario in a disputed coverage claim: Assume that a policyholder—call it CleanChem, Inc.—produces chemicals through processes that involve heating and refining petroleum-based feedstock. Assume that the Wenopayah Insurance Co. is CleanChem’s general liability insurer. CleanChem’s policy with Wenopayah is written on a standard Commercial General Liability form.^[4] By the terms of this policy, the insurer promises to pay those sums that the insured becomes legally obligated to pay as damages because of covered bodily injury or property damage, and it has the right and duty to defend the policyholder against any suit seeking those damages. The policy excludes the release or escape of pollutants, but an exception to that exclusion permits coverage for bodily injury or property damage arising out of “smoke or fumes from a ‘hostile fire,’” which is defined as a fire that “becomes uncontrollable or breaks out from where it was intended to be.”^[5]

A stack fire one night at CleanChem’s plant causes the release of a toxic plume that peels the paint off buildings immediately adjacent to the plant. Soon thereafter, I. M. Green, a local plaintiff’s lawyer and environmental activist, files a class action against CleanChem on behalf of a class of area residents. Mr. Green alleges that the toxic particles in the smoke from the stack fire have contaminated homes, yards and groundwater throughout a 10-mile radius and that residents within that area suffer, or fear, various health problems as a result. In addition to standard negligence and strict liability counts in the complaint, a punitive damages count also alleges that for some time, CleanChem has been clandestinely burning off the toxic wastes from its production processes whenever its stack scrubbers malfunctioned and that this environmentally irresponsible practice inevitably resulted in the most recent stack fire and its accompanying toxic discharge.

CleanChem tenders the complaint to Wenopayah Insurance for defense and coverage of any liability arising from the underlying plaintiffs’ claims. Wenopayah responds with a tartly worded letter, reserving its right to deny coverage. It cites as grounds for potential denial not only the policy’s pollution exclusion—questioning whether the “hostile fire” exception to that exclusion would apply if the plaintiffs’ allegations prove true—but also its exclusion for harm “expected or intended from the standpoint of the insured.”^[6]

Under applicable law, this reservation of rights is deemed to create a conflict of interest, affording the policyholder a right to select independent defense counsel and Wenopayah Insurance’s letter offers to reimburse CleanChem for the “reasonable and necessary” costs of defense by independent counsel selected by CleanChem. Accordingly, CleanChem hires Bess D. Fence, Esq. to defend the class action. Ina House, Esq. of the CleanChem Law Department oversees the defense effort and communicates with Ms. Fence about the case regularly.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

At the outset, Wenopayah Insurance requests that Ms. Fence keep it informed about the progress of CleanChem's defense. She duly prepares short updates for the insurer once a quarter. After Ms. Fence's bills exceed the \$100,000 deductible under its policy, CleanChem requests reimbursement for the excess defense costs from Wenopayah Insurance. The insurer promptly requests copies of all Ms. Fence's daily time entries and all other backup for her invoices.

In the meantime, Ms. Fence and Ms. House have agreed that CleanChem should explore early settlement, not only to save rapidly increasing legal expenses on both sides, but also to end the unfavorable publicity that I. M. Green's periodic press conferences about the class action are generating for the company. CleanChem's management is eager to settle. Wenopayah Insurance, on the other hand, asserts that CleanChem appears willing to buy off Mr. Green's clients at virtually any price and that Ms. Fence appears unprepared to take the case to trial. As the underlying settlement talks progress, the insurer's demands for information from Ms. Fence become more frequent and more probing. It requests all confidential settlement evaluations that Ms. Fence has prepared for her client, any related correspondence between her and Ms. House regarding the company's prospects in the litigation, all their notes of witness interviews relating to the stack fire, and Ms. Fence's draft trial outline.

In sum, Wenopayah Insurance's information requests have escalated from a quarterly status report, which Ms. Fence could craft in objective terms without disclosing confidential or sensitive information; to her daily time descriptions, some of which may reflect confidential litigation strategy or planned initiatives; to communications between in-house and outside counsel and the most sensitive opinion work product in counsel's files. Ms. House's initial reaction is to agree to provide only the portions of her bills that do not show timekeepers' work descriptions and to withhold the rest of the requested material. She points out that Wenopayah Insurance has never committed to cover the claim, nor ever paid its first dollar of defense, and that I.M. Green would aggressively assert in the underlying litigation that the company waived any privileges or protections attaching to defense counsel's files by disclosing them to a potentially adverse entity.

Wenopayah Insurance will hear none of it. Repeatedly invoking both the cooperation clause and the consent-to-settlement clause in CleanChem's policy,^[7] it insists on access to all the information it has requested. It follows up with another tart letter warning that CleanChem's failure to cooperate, or to secure the insurer's written consent to any settlement, will result in new, independent grounds for denying coverage—not only for any settlement or judgment, but also for defense costs.

CleanChem and its counsel now face tough choices. CleanChem wants to provide whatever information about Ms. Fence's bills is necessary to start the defense reimbursement payments flowing from its insurer. It would also be willing to provide most of counsel's interview notes, because most witnesses have said the stack fire was truly accidental and would support the case for coverage under the policy. Two witnesses, however, were more equivocal on this subject, and Ms. Fence and Ms. House are not eager to release their interview notes. Ms. Fence's settlement evaluation,

similarly, is a two-edged sword. It persuasively demonstrates the potential for high compensatory damages and thus would objectively show the reasonableness of the settlement range currently under discussion, but it also contains candid comments about the evidence that could support punitive damages. Ms. Fence personally would like to produce her meticulous trial outline to disprove the insurer's unfair charge that she is unprepared. But at the end of the day, the prospect of *any* of this material from counsel's file ever getting into the hands of I.M. Green (and perhaps from him to his many friends in the press and in the plaintiffs' bar) is a daunting prospect to all on the CleanChem side.

This is the kind of problem that many policyholders and their defense counsel face under standard liability policies, when an insurer has asserted a potentially coverage-defeating reservation of rights. There is, unfortunately, no one-size-fits-all solution to the problem. The next part surveys relevant statutes and case law in order to identify some of the considerations that may affect CleanChem's and its counsel's response.

II. The Law of Cooperation and Waiver

Where an insurer has a duty to defend but acts under a reservation of rights that introduces an actual or a potential conflict between its interests and those of the policyholder, most states that have addressed the issue afford the policyholder some form of a right to independent defense counsel.^[8] Providing independent counsel prevents the risk that counsel hired and controlled by the insurer might provide a less than zealous defense for the policyholder against underlying claims that, if successful, would relieve the insurer of its coverage obligations; for example, in the CleanChem hypothetical, the underlying plaintiff's punitive damages claim alleging that CleanChem willfully or recklessly caused the harm at issue. Even where the issue is not regulated by statute, case law provides the policyholder with a right to independent counsel, and in some complex cases that inherently involve issues of knowledge or intent, the insurer may simply assume that the policyholder will retain its own defense counsel.

While the retention of independent counsel may protect a policyholder from conflicting loyalties in the conduct of its defense, it also presents the problematic questions faced by counsel in our hypothetical. In seeking guidance from the law for answers to these questions, counsel should analyze the matter from two different perspectives: first, that of potential coverage litigation between policyholder and insurer; and second, that of litigation with underlying claimants. That is, in our hypothetical case, would Wenopayah Insurance be able to compel CleanChem to produce otherwise protected confidential materials from its defense counsel's files through discovery in coverage litigation? Alternatively, if CleanChem voluntarily shared such materials with Wenopayah, would I.M. Green be able to compel their production in the underlying environmental litigation on the alleged ground that their privilege protection had been waived?

The Rock: Cooperation and Disclosure Obligations

Standard general liability policies provide that the policyholder must “[c]ooperate with [the insurer] in the investigation or settlement of the claim or defense against the [underlying lawsuit].”^[9] Such cooperation typically involves providing the insurer with regular updates on the underlying litigation. But as in our hypothetical, some insurers use

this cooperation language as a basis for requesting privileged materials from an independent defense counsel's files. In addition, in connection with settlements, a "voluntary payments" clause provides that "[n]o insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, *without our consent*."^[10] Insurers may be inclined to withhold such consent until they have reviewed defense counsel's settlement evaluations and perhaps considerably more information from counsel's files.

Where the insurer is acting under a reservation of rights, the policyholder may not wish to disclose such materials to the insurer, particularly if it appears that the insurer is fishing for evidence to support a defense in a future coverage case against the policyholder. In coverage litigation, an insurer will routinely argue that it has the right to discover defense counsel's privileged files. Such an argument is usually based on a) the above cooperation language in the policy, b) the "common interest" doctrine,^[11] and c) the "at issue" doctrine.^[12]

At least two states—Alaska and California—have passed so-called *Cumis* statutes,^[13] which regulate the right to independent counsel, but which also provide a statutory basis for limited discovery of defense counsel's files by an insurer. Alaska Statutes section 21.89.100(e) provides:

If the insured selects independent counsel at the insurer's expense, the independent counsel and the insured shall consult with the insurer on all matters relating to the civil action and shall disclose to the insurer in a timely manner all information relevant to the civil action, except information that is privileged and relevant to disputed coverage. A claim of privilege is subject to review in the appropriate court. Information disclosed by the independent counsel or the insured does not waive another party's right to assert privilege.

Similarly, California Civil Code section 2860(d) states:

When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action. Any claim of privilege asserted is subject to in camera review in the appropriate law and motion department of the superior court. Any information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.^[14]

While both statutes seek to encourage—even mandate—cooperation between policyholder and insurer where the policyholder is represented by independent counsel, they also recognize the tension created by their potentially conflicting interests. Both statutes attempt to strike a balance between cooperation and preservation of privilege. Ultimately, privilege prevails to this extent: Both statutes make clear that a policyholder is not required to disclose privileged, *coverage*-relevant information to the insurer.^[15]

Hence, in either Alaska or California, if Wenopayah Insurance seeks CleanChem's defense counsel's files in order to bolster its coverage defenses (rather than to assist in the underlying defense or evaluate settlement), then CleanChem and its counsel may assert this statutory language as a basis to withhold the files from discovery.[16]

In the absence of clear statutory language, the courts in several states have more broadly protected defense counsel's privileged files from disclosure at the behest of insurers. For example, the Connecticut Supreme Court in *Metropolitan Life Ins. Co. v. Aetna Cas. & Sur. Co.*, 249 Conn. 36, 60-63 (1999) rejected the cooperation clause, the "common interest" doctrine, and the "at issue" doctrine as grounds for compulsory disclosure, finding that if an insurer had reserved its rights or denied coverage, it was not entitled to receive privileged communications from the policyholder or its independent defense counsel.

Similarly, in *Eastern Air Lines, Inc. v. United States Aviation Underwriters, Inc.*, 716 So. 2d 340, 343-44 (Fla. App. 1998), a Florida court denied an insurer's motion to compel discovery of communications between its policyholder and independent counsel, rejecting the insurer's arguments based upon the cooperation clause and the "at issue" doctrine. The insurer had not agreed to coverage in the underlying litigation, which concerned environmental contamination.[17] When Eastern sued for a declaration of coverage, the insurer sought discovery of communications between Eastern and its counsel in the underlying action.[18] The court found that "[u]nder Florida law, the cooperation clause does not eviscerate the attorney-client privilege." [19] The court also held that a policyholder does not put communications with its independent counsel "at issue" merely by filing suit against its insurer for a declaration of coverage.[20] Hence, Eastern had not waived the attorney-client privilege as to its insurer, and the insurer was precluded from access to the policyholder's communications with its independent counsel. Other courts have adopted reasoning similar to that in *Metropolitan Life* and *Eastern Air Lines*. [21]

Yet this reasoning has not been universally followed. At least one state, Illinois, has reached a diametrically opposite conclusion on all three issues addressed in the cases discussed above: the cooperation clause, the common interest doctrine, and the "at issue" doctrine. In *Waste Management, Inc. v. International Surplus Lines Insurance Co.*, 144 Ill. 2d 178, 201 (1991), the Illinois Supreme Court held that the attorney-client privilege did not prevent the insurer from discovering the policyholder's counsel's files in the underlying litigation—even though the policyholder had independent defense counsel in that litigation, and even though the parties were actively at odds in a coverage action. In *Waste Management*, the court downplayed the attorney-client privilege, noting that "in Illinois, we adhere to a strong policy of encouraging disclosure, with an eye toward ascertaining that truth which is essential to the proper disposition of a lawsuit." [22] Given that defense counsel's actions in the underlying litigation formed "the basis of insurers' declaratory judgment action and its defense to insured's declaratory judgment action," the court found that the communications sought were discoverable because they were "at issue" in the litigation between the policyholder and the insurer. [23] Next, the court found that the relevant cooperation clause imposed an exceptionally broad duty of

cooperation on the policyholder, which in turn meant that the attorney-client privilege did not bar discovery of the communications in the underlying lawsuits.[24] Finally, the court found that the policyholder and insurers shared a common interest in defeating or settling the underlying claims.[25] This loosely defined community of interest was enough to defeat the policyholder's claims of attorney-client privilege and permit discovery by insurers.[26] Nor did the work product doctrine provide a shield: The court deemed that the materials sought were prepared for the benefit of the insurer and policyholder in the underlying action, not in anticipation of the coverage litigation.[27]

As the court observed in *Allianz Ins. Co. v. Guidant Corp.*, 373 Ill. App. 3d 652 (2007), “almost every foreign jurisdiction that has considered the holding of *Waste Management* has assailed the decision as unsound and improperly reasoned.”[28] Courts in most other states, as previously discussed, have held that the work product doctrine and attorney-client privilege protect communications between a policyholder and its defense counsel from discovery by an adversely situated insurer. Hence, in our hypothetical, CleanChem's contractual duty to cooperate would be construed as one of *reasonable* cooperation in most states. It does not require CleanChem or its counsel to jeopardize the protection attaching to confidential communications by disclosing them to Wenopayah Insurance.

Even where the broader reasoning of *Waste Management* has been rejected, courts may require disclosure of confidential defense-related documents to insurers on narrower grounds. For example, although the court in *Rockwell Int'l Corp. v. Superior Court*, 26 Cal. App. 4th 1255 (Cal. Ct. App. 1994) generally rejected the reasoning of *Waste Management*,[29] it did note that “if the insured places an otherwise privileged communication ‘in issue’ during the course of the coverage litigation (e.g., by a demand for reimbursement of money paid to settle a third party claim), the trial court can consider whether and to what extent the *in issue* doctrine applies to that particular issue.”[30]

Thus, even in jurisdictions that generally protect independent defense counsel's files from disclosure to insurers, policyholders should not expect absolute protection, particularly with respect to documents reflecting advice about an underlying settlement that the insurer will be asked to pay. If the parties or the litigation have some nexus to a state with explicit rules requiring disclosure—the arguably anomalous judge-made disclosure rule in Illinois and the limited statutory disclosure rules in California and other states with *Cumis* statutes—then underlying defense counsel must be even more mindful that her communications could be produced to a hostile insurer in future coverage litigation.

The Hard Place: Waiver of Privilege as to Third Parties

The previous section has focused on potential coverage litigation between our hypothetical policyholder CleanChem and Wenopayah Insurance, where CleanChem would presumptively resist discovery of its confidential defense files. In the real world of claims-handling—at least where the policyholder and its insurer have not reached an impasse over coverage—this often is not the case. CleanChem may wish to cooperate with Wenopayah Insurance in hopes that Wenopayah will agree to coverage, or to encourage Wenopayah to consent to a proposed settlement between CleanChem and the

underlying plaintiff class represented by I.M. Green. CleanChem's outside defense counsel, Ms. Fence, also needs to submit her bills, which may include privileged information or attorney work product, to Wenopayah for payment. In these situations, CleanChem and its counsel face a different question: How can they share confidential materials with Wenopayah Insurance without waiving privilege and opening the materials to discovery by I.M. Green in the underlying tort action?

On one hand, as already discussed, the very existence of independent counsel may provide protection against discovery of privileged materials by an insurer. That protection is based on the principle that where an insurer acts under a reservation of rights or denies coverage, the policyholder and insurer are potentially adverse. Yet, that same reasoning—and, indeed, the need for independent counsel that confirms the adversity of interest—may also allow the underlying plaintiff or another third party to allege that the policyholder has waived privilege protection, because it *voluntarily* shared the materials with its insurer. That is, because CleanChem and Wenopayah Insurance lack a common interest, CleanChem risks waiving the attorney-client and/or work product privileges attached to materials that it chooses to turn over to Wenopayah Insurance. This may allow Mr. Green to discover those materials and use them against CleanChem in the underlying tort action.

This is the true rock-and-a-hard-place situation. Unfortunately, case law addressing this situation is sparse. Policyholders and defense counsel are often muddling through uncharted territory when deciding whether to agree to disclose privileged communications or work product to an insurer.

Voluntary disclosure may constitute a waiver of both the attorney-client privilege and work product protection. Each requires a separate analysis for waiver. For example, in *Go Medical Industries PTY, Ltd. v. C.R. Bard, Inc.*, No. 3:95MC522(DJS), 1998 WL 1632525, *1 (D. Conn. Aug. 14, 1998), *rev'd in part on other grounds*, 250 F.3d 763 (Fed. Cir. 2000), one party in patent infringement litigation (C.R. Bard) sought documents that the other party (Go) had shared with its insurer.^[31] The court found that Go's interests and its insurer's interests were "insufficiently compatible for the common interest rule to apply," and therefore that Go's disclosure to its insurer waived the attorney-client privilege.^[32] Work product shared with the insurer fared better, however: "unlike the attorney-client privilege, the work product privilege is not automatically waived by any disclosure to third persons." 1998 WL 1632525, *7 (internal quotations omitted). Because Go's disclosure to its insurer "did not substantially increase the opportunity for *C.R. Bard* to obtain its work product," it did not waive work product protection.^[33]

In *In re Pfizer, Inc. Securities Litigation*, No. 90 Civ. 1260(SS), U.S. Dist. LEXIS 18215 (S.D.N.Y. Dec. 22, 1993), similar reasoning resulted in a similar conclusion. The court found that disclosure of documents by Pfizer to its insurers waived the attorney-client privilege, noting a lack of evidence that Pfizer and its insurers "agreed to act as partners in a single unified litigation strategy."^[34] However, the court held that to the extent the

documents merited work product protection, “the disclosure of the documents to an insurance carrier will not operate as a waiver.”^[35]

Contrast those decisions with *In re Imperial Corp. of America*, 167 F.R.D. 447 (S.D. Cal. 1995). In *Imperial*, which involved an underlying derivative suit by shareholders, the insured directors retained their own defense counsel because the insurer had no affirmative duty to defend under the applicable directors and officers liability policy.^[36] Counsel for the policyholders sent letters to the insurer, addressing the likelihood of success in the underlying defense, as well as a settlement demand by plaintiffs in that action.^[37] After learning of these letters during a deposition in the underlying case, the shareholder plaintiffs demanded their production.^[38] In spite of a “joint defense agreement” signed by both the policyholders and their insurer (which was deemed ineffective because the parties were potentially adverse in coverage litigation), the court found no attorney-client protection for the letters.^[39] The court further held that the policyholders’ defense counsel had waived work product protection in disclosing the letters to an insurer that had not committed to coverage, because it knew “a future coverage action pitting the insured against the insurer [was] a distinct possibility.”^[40]

Nonetheless, the rulings are not uniform, even among courts in the same state. Another California federal court applied a more nuanced analysis to reject waiver, in *Lectrolarm Custom Systems, Inc. v. Pelco Sales, Inc.*, 212 F.R.D. 567 (E.D. Cal. 2002). There the underlying plaintiff (Lectrolarm) sought discovery of documents sent by Pelco to its insurer, Fireman’s Fund, which was partially paying at least some of Pelco’s independent defense counsel expenses under a reservation of rights. The court acknowledged that because of “inherent tension between the carrier’s interest and the interests of the insured,” and because of their separate counsel, “communications between Pelco and [its insurer] are not privileged per se,” and that “[g]enerally, disclosure of otherwise privileged communication to a third party waives the attorney client privilege and/or the attorney work product privilege.”^[41] Despite the parties’ potential adversity on coverage for the claim, however, the court held that the “common defense doctrine,” typically applied only to co-defendants in the same litigation, precluded a waiver.^[42] Looking at the particular communications at issue—those “relating to the claims and defenses in the underlying lawsuit”—the court found sufficient “commonality of interest” to preserve both attorney-client privilege and work product protection.^[43] In contrast to the *Imperial* court, therefore, the *Lectrolarm* court’s waiver analysis implicitly distinguished insurer-insured adversity on the coverage side of their relationship from their common interest with respect to the underlying defense. Accordingly, it barred the underlying plaintiff from discovering communications between the policyholder and its insurer that supported the latter interest.^[44] The ostensibly differing outcomes in *Imperial* and *Lectrolarm* underscore the need for policyholders and their counsel to tread cautiously when considering voluntary disclosure of privileged materials to an insurer that has reserved rights. As discussed previously, the California *Cumis* statute, Civil Code section 2860(d), expressly clarifies that “[a]ny information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.”^[45] In *First Pacific Networks, Inc. v. Atlantic Mutual Insurance Company*, 163 F.R.D. 574 (N.D. Cal. 1995), the court relied on this provision to hold that a policyholder did not waive the attorney-

client privilege for documents provided to its insurer.^[46] The court suggested, however, that absent the statute, waiver would have occurred, because no common interest existed between the policyholder and an insurer acting under a reservation of rights.^[47] Following the statute with seeming reluctance, the court characterized section 2860(d) as follows:

The extent of the insured's power to control disclosure of some privileged communications, without risking waiver, is most visible in the fact that California law seems to permit an insured to pick and choose which of the insured's otherwise privileged communications it will share with a carrier funding a defense under a reservation of rights—and to do such picking and choosing without waiving the right to prevent its carrier from having access to other privileged communications—even communications on the same subjects.^[48]

For somewhat different reasons, Illinois provides similarly strong protection against waiver of privilege as to third parties. As discussed above, under *Waste Management*, a policyholder and its insurer are deemed to share a common interest, even where the policyholder is represented by independent counsel. The flip side of that “common interest” coin is that communications between them fall within the protection of the attorney-client privilege with respect to underlying plaintiffs and other third parties. In its own anomalous way, therefore, Illinois law promotes (or mandates, depending upon one's point of view) policyholder-insurer cooperation, while allaying fears of opening privileged communications to discovery by third parties.^[49]

In summary, if California law or Illinois law is controlling in the dispute between CleanChem and I.M. Green's clients, then Ms. Fence and Ms. House (CleanChem's defense counsel and in-house counsel, respectively) may take reasonable comfort that voluntary disclosure of confidential defense-related materials to Wenopayah Insurance will not open their client to discovery and claims of waiver by Mr. Green on behalf of the claimants in the underlying case. Yet, outside such “more-or-less-safe haven” jurisdictions—given the potential damage that discovery of privileged materials could have on CleanChem's defense of the underlying litigation—CleanChem and its counsel must choose their voluntary disclosures to Wenopayah Insurance with extreme caution.

III. Strategies for Balancing Reasonable Cooperation and Protection of Privilege

As the discussion above demonstrates, the law in most states remains unrefined and uncertain on the question of whether a policyholder can disclose defense counsel's confidential materials to its insurer without waiver. Where the issue has not been regulated by statute, most courts to date have simply determined that the policyholder and the insurer did, or did not, have a common interest—without considering that in this love-hate relationship, it is usually a bit of both. Rulings such as that in *Lectrolarm*, 212 F.R.D. at 572, suggest that some courts are willing to distinguish the friendly side of this relationship from its unfriendly side, and to protect the confidential communications that support the former. Until this more nuanced approach becomes the norm, however, uncertainty about the risk of waiver will continue to inhibit cooperation and communication between policyholders and insurers that have reserved their rights,



particularly in jurisdictions where that reservation of rights is recognized to preclude a common interest.

Conversely, there may be less risk of waiver in jurisdictions such as California and Illinois, as discussed above, but only because such jurisdictions require the policyholder and its defense counsel to communicate some types of information more freely to insurers. The insurer may ultimately have a right to review counsel's confidential claim files. If counsel has not been careful, those files may carry the potential for embarrassment or worse. Otherwise stated, the reduced risk of privilege waiver may carry an enhanced risk of prejudice with regard to insurance coverage.

The disclosure questions that arise whenever an insurer has reserved its rights against its insured have neither simple nor universal answers. Nonetheless, we offer here a few pointers—once again, in the context of our hypothetical—that may provide some practical guidance to policyholders' in-house counsel and independent defense counsel, as they navigate the treacherous straits between coverage preservation and privilege protection in this ambivalent relationship.

Learn the traps, or bring in help.

The first step that the policyholder company's supervising counsel (Ms. Ina House in our hypothetical) and its underlying defense counsel (Ms. Bess D. Fence) must take is to inform themselves as best they can about the rules governing cooperation and waiver under the law or laws governing the case. Even better, if CleanChem has retained outside coverage counsel to pursue its insurance claim—call her Ida Sue Carrier, Esq.—this is a good time for Ms. House to make sure that Ms. Fence and Ms. Carrier get well acquainted. They should feel comfortable consulting each other whenever tough questions about disclosure and privilege arise. Almost certainly, such questions *will* arise, both in the pursuit of the coverage claim and in the defense of the underlying claim. Any documentation of these consultations between defense counsel and coverage counsel on issues of coverage preservation should be carefully segregated from defense counsel's litigation files, to protect them against discovery in coverage litigation. Finally, defense counsel should normally bill this coverage-related work under a separate matter number that will not be submitted to (and reviewed by) the insurer.

Remind timekeepers that third parties may review their time entries.

It is well recognized that “[b]illing records and underlying documentation may . . . reveal the motive of the client in seeking representation, litigation strategy, or the specific nature of the services provided to the insured. This information generally is protected by the confidentiality rule or the attorney-client privilege or both.” ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 01-421 (2001). Nonetheless, Ms. Fence should understand that at least Wenopayah Insurance will likely see her defense bills if CleanChem is to get the benefit of the defense coverage it bought from its insurer. And as discussed above, there is the outside risk in some jurisdictions that I.M. Green on behalf of the underlying claimants will ultimately discover her bills. Thus, timekeepers should practice the fine art of recording their time accurately, informatively, and with sufficient lawyerly generality that they will not reveal the specifics of strategy or sensitive matters

to unfriendly eyes. Otherwise, Ms. Carrier, as the policyholder's coverage counsel, is likely to spend many hours trying to protect the privilege by redacting the bills before disclosing them to Wenopayah Insurance, and then many more hours haggling with Wenopayah Insurance over her redactions.

Remember that third parties may see settlement evaluations and sensitive client reports.

Ms. Fence may have concluded in her own mind that proceeding to trial against I.M. Green's clients would be a financial and public relations disaster for CleanChem. Her written settlement evaluation, however, should not turn into an advocacy piece for capitulation. It should stick to the objective facts, particularly those that relate to causation and the plaintiffs' quantifiable damages. To the extent that CleanChem's conduct or intent is unavoidably the focus of the case, Ms. Fence must remember that an insurer reviewing her settlement evaluation may actually be seeking support for a coverage defense based on its exclusion for damage "expected or intended from the standpoint of the insured"^[50] or some other knowledge-based defense. Worse, I.M. Green might demand these or similar documents in discovery, once it emerges that CleanChem shared them with an unfriendly insurer. Ms. Fence should draft her written evaluations for the eyes of the most hostile reader, and elaborate as necessary by phone or in person with Ms. House or other CleanChem managers. In general, Ms. Fence and Ms. House should keep in mind that where sensitive or highly nuanced issues need to be communicated, an old-fashioned conversation will usually be preferable to an exchange of emails.

Mediation may help protect privileged information against third parties.

Many states recognize some form of statutory "mediation privilege," whereby communications in the course of mediation enjoy enhanced protection from disclosure to third parties.^[51] If the parties are otherwise disposed to seek a coverage resolution, initiating a formal mediation procedure within which the policyholder can more readily comply with requests for defense invoices or other sensitive information will ease the tension between cooperation and privilege protection. Of course, the mediation process cannot be a mere charade. The parties should pursue a mediated resolution in good faith and with all deliberate speed, to justify the cloak of confidentiality that the mediation statute may throw over their sensitive exchange of information. If the mediation is successful, then they will have benefited doubly from the process. In our hypothetical, CleanChem and Wenopayah Insurance will no longer be adverse, thus reducing the risk of privilege waiver against I.M. Green's clients and other underlying claimants going forward.

Eliminate, or minimize, the adversity in the policyholder-insurer relationship.

Even without a mediated or negotiated resolution, the adversity of interest between policyholder and insurer may become moot in some circumstances, while in others it may not yet be ripe. All counsel, including the insurer's, should be alert for ways to eliminate or minimize the differences between CleanChem and Wenopayah Insurance, and to memorialize that circumstance before exchanging confidential information. The most favorable situation arises when the basis for the Insurer's reserved coverage defense has simply vanished. In our hypothetical, this might happen if Ms. Fence succeeded in

dismissing I.M. Green's punitive damages count on summary judgment. A Confidentiality/Non-Waiver of Privilege Agreement between CleanChem and an excess insurer, for example, could acknowledge that the underlying claim does not currently reach the layer of the excess insurer's coverage, and further state that there is no need for the insurer to raise—and that the insurer does not presently raise—any preliminary coverage defenses.

Craft an insurance communication protocol.

To improve their chances of avoiding a mutually detrimental waiver with respect to the underlying claimants, CleanChem and Wenopayah Insurance should consider entering into an agreement governing their exchange of information about the underlying litigation. Of course, as the *Imperial* case demonstrates, a one-size-fits-all "joint defense agreement" between policyholder and insurer may prove ineffective against third parties.^[52] But by clarifying and documenting the parties' interests and intentions, an information agreement could help a court to distinguish the friendly side of the policyholder-insurer relationship from its unfriendly side, it protects confidential communications supporting the former as the *Lectrolarm* court did.^[53]

Such agreements must be tailored to the specific circumstances, but should include the following features:

- *Define common interests, and confine disclosures to their support.* The agreement should memorialize how the parties' interests are aligned; for example, in preventing or minimizing the underlying liability. It should further clarify that confidential information is provided solely to further common interests.
- *Conversely, clarify that no disclosures relating to issues of adverse interest will be made.* Since the insurer's reservation or denial of coverage may be limited to particular issues, for example, a punitive damages claim in the underlying complaint, the agreement should identify the boundaries of the parties' adversity and state that no disclosures relating to those issues are expected. It also should identify where possible the circumstances under which the parties' adversity may disappear, such as after dismissal of an underlying claim implicating the policyholder's knowledge or intent.
- *Limit disclosure of protected material.* Summaries or other information alternatives will often suffice instead of actual protected documents. It is in both parties' interest to minimize the waiver risk by limiting sensitive disclosures in the first instance; such disclosures should not be made or requested without good cause.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

- *Document the expectation of privacy.* The agreement should provide for confidential treatment of privileged or protected information, confine its use to common interests, and memorialize the parties' intent to preserve applicable privileges without waiver.

Conclusion

None of the solutions proposed above is fail-safe. Nevertheless, CleanChem needs to get its defense bills paid; Wenopayah Insurance needs to set its reserves; and both want to resolve the underlying litigation on the most favorable terms feasible. Some information must be exchanged to make all that happen. In the real world of ambivalence and uncertainty that accompanies a complex, rights-reserved insurance claim, imperfect solutions for policyholder-insurer communications are better than none.

Keywords: litigation, insurance coverage, privilege, profilege waiver, rights-reserved claims, work product protection, third parties, settlement evaluations, conflict of interest.

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[3] See George Chapman, trans., *The Twelfth Book Of Homer's Odysseys*, lines 346-48 (1857) ("I then took a strait/ That gave myself, and some few more, receipt/ "Twixt Scylla and Charybdis").

[4] See, e.g., Insurance Services Office, Commercial General Liability Policy Form CG 00 01 12 07, an example of which can be found reproduced at www.sloanmason.com/files/pdf/ISO%20PDF%20CG%2000%2001%2012%2007.pdf (CGL Policy). All policy language quoted in this paper is taken from this form.



[5] See CGL Policy, Sections I.2.f.(1)(a)(iii), V.7.

[6] See CGL Policy, Section I.2.a. (“expected/intended” exclusion).

[7] See CGL Policy, Sections IV.2.c.(3) and 2.d.

[8] 3-16 Appelman on Insurance § 16.04[4][c][5] (Paul E.B. Glad, William T. Barker, Michael Barnes, authors) (2010); *see, e.g.*, Hartford Underwriters Ins. Co. v. Found. Health Servs., 524 F.3d 588, 592–93 (5th Cir. 2008) (“Mississippi law requires an insurer defending an insured under a reservation of rights to provide the insured with independent counsel because of the ‘built-in’ conflict that is created.”); Am. Family Mut. Ins. Co. v. C.M.A. Mortg., Inc., 682 F. Supp. 2d 879, 890–91 (S.D. Ind. 2010) (under Indiana law, where insurer reserves its rights to deny coverage and identifies a reason for denial that creates a conflict, insurer must reimburse the insured’s independent counsel); Northern County Mut. Ins. Co. v. Davalos, 140 S.W. 3d. 685, 689 (Tex. 2004); Hartford Cas. Ins. Co. v. A&M Assocs., 200 F. Supp. 2d 84, 89–90 (D.R.I. 2002) (under Massachusetts law, insured was entitled to independent counsel at insurer’s expense due to reservation of rights); Nowacki v. Federated Realty Group, Inc., 36 F. Supp. 2d 1099, 1109 (E.D. Wis. 1999) (under Wisconsin law, insured was free to select its counsel at insurer’s expense after insurer reserved its rights); Moeller v. American Guarantee and Liab. Ins. Co., 707 So.2d 1062, 1070 (Miss. 1996); Great Divide Ins. Co. v. Carpenter, 79 P.3d 599, 610 (Alaska 2003); Patrons Mut. Ins. Assoc. v. Harmon, 732 P.2d 741, 745 (Kan. 1987).

The case law varies as to what circumstance can trigger a right to independent counsel. Some courts have held that a mere reservation of rights is not by itself sufficient to warrant independent counsel. *See, e.g.*, Travelers Prop. v. Centex Homes, No. C 10–02757, 2011 U.S. District LEXIS 36128, *24 (N.D. Cal. Apr. 1, 2011) (“A reservation of rights alone does not automatically create a conflict” that requires independent counsel); Exec. Risk Indem. Inc. v. Icon Title Agency, LLC, 739 F. Supp. 2d 446, 450 (S.D.N.Y. 2010) (under New York law, insurer’s reservation of rights does not automatically entitle insured to representation of its choice at insurer’s expense); Nat’l Cas. Co. v. Forge Indus. Staffing Inc., 567 F.3d 871, 874–75 (7th Cir. 2009) (Illinois law requires an actual conflict of interest to justify an insured’s right to independent counsel at insurer’s expense); Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., LP, 336 F. Supp. 2d 610, 621 (D.S.C. 2004) (South Carolina law has no per se disqualification rule giving an insured the right to retain independent counsel of its own choosing at insurer’s expense, where only a potential for a conflict of interest exists because of a reservation of rights); Driggs Corp. v. Pennsylvania Mfrs’ Ass’n Ins. Co., 3 F. Supp. 2d 657, 658–59 (D. Md. 1998) (under Maryland law, mere reservation of rights does not create an actual conflict that requires insurer to furnish independent counsel to insured); L & S Roofing Supply Co., Inc. v. St. Paul Fire & Marine Ins. Co., 521 So. 2d 1298, 1304 (Ala. 1987) (reservation of rights does not *ipso facto* constitute a conflict entitling insured to engage independent counsel at insurer’s expense); Finley v. Home Ins. Co., 90 Haw. 25, 31–32 (1998) (insured does not have a right to select counsel at insurer’s expense solely due to insurer’s reservation of interests); Red Head Brass, Inc. v. Buckeye

Union Ins. Co., 135 Ohio App. 3d 616, 626 (1999) (reservation of rights by itself did not obligate insurer to pay for insured's private counsel).

Particularly on the West Coast, the independent counsel required because an insurer has asserted a sufficient conflict is often called "*Cumis* counsel," after the California Court of Appeal's landmark decision in *San Diego Navy Fed. Credit Union v. Cumis Insurance Society, Inc.*, 162 Cal. App. 3d 358 (1984)—even though the *Cumis* decision has been largely superseded by statute, Cal. Civ. Code § 2860(d) (discussed below). For a discussion of privilege issues related to *Cumis* counsel, see Wendy L. Feng and Geoffrey Painter, *Cumis Privilege and the Risk of Waiver: A Policyholder's Perspective*, 19 The Prac. Litigator 21 (July 2008).

[9] CGL Policy, Section IV.2.c.(3).

[10] CGL Policy, Section IV.2.d. (emphasis added).

[11] The "common interest" doctrine applies in its purest form where two parties "engage the same attorney to represent their respective interests, and each communicates separately with the attorney about some phase of common transaction." *Remington Arms Co. v. Liberty Mut. Ins. Co.*, 142 F.R.D. 408, 417 (D. Del. 1992) (quoting McCormick on Evidence § 91 (1984)). But the doctrine "preempts the attorney-client privilege only when it is evident from the nature of the representation that the client and attorney did not intend and could not expect that information imparted between them would remain confidential." *Dedham-Westwood Water Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, No. Civ. A. 96-00044, 2000 Mass. Super. LEXIS 29 (Feb. 4, 2000).

The "common interest" doctrine has also been extended to apply "where the attorney, though neither retained by nor in direct communication with the insurer, acts for the mutual benefit of both the insured and the insurer." *Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 194 (1991). For a general discussion of the "common interest" doctrine and other authorities in the insurance context, see Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 2.07(b) (15th ed. 2010) ("Ostrager Treatise").

[12] The "at issue" doctrine, which is related to general principles of waiver of the attorney-client privilege, "creates an implied waiver of the privilege only when the client tenders an issue involving the substance or content of a protected communication, not where the privileged communication simply represents one of several forms of indirect evidence in a particular case." *Rockwell Int'l Corp. v. Superior Court*, 26 Cal. App. 4th 1255, 1268 (1994). Essentially, "[b]y taking an action that places privileged information 'at issue' the party may forfeit the privilege." *Remington Arms*, 142 F.R.D. at 412. The Ostrager Treatise also discusses the "at issue" doctrine at § 2.07(b).

[13] See n. 7, above.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[14] The territory of Guam has also recently adopted legislation governing the right to independent counsel, which closely follows the pattern of the California statute including the provision quoted above. *See* 22 Guam Code Ann. § 12111 (2009).

[15] *See also* Rockwell Int'l Corp. v. Superior Court, 26 Cal. App. 4th 1255, 1264 (1994).

[16] Further support for policyholder counsel's withholding of privileged information may also be found in a provision governing cooperation between insurer-provided counsel and policyholder-selected independent counsel: "[c]ounsel shall cooperate fully in the exchange of information that is *consistent with each counsel's ethical and legal obligation to the insured.*" Cal. Civ. Code § 2860(d) (emphasis added); *accord*, Alaska Stat. §21.89.100(g); Guam Code Ann. § 12111(f). Arguably the exchange of privileged or sensitive information would be inconsistent with "counsel's ethical and legal obligation to the insured."

[17] *Eastern Airlines*, 716 So.2d.at 341.

[18] *Eastern Airlines*, 716 So.2d at 341.

[19] *Eastern Airlines*, 716 So.2d. at 343.

[20] *Eastern Airlines*, 716 So.2d. at 343.

[21] *See, e.g.*, RML Corp. v. Assurance Co. of Am., No. CH02-127, 2002 Va. Cir. LEXIS 392, *18 (Oct. 25, 2002) (rejecting insurer's common interest and "at issue" arguments); Dedham-Westwood Water Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh, No. Civ. A. 96-00044, 2000 Mass. Super. LEXIS 29, *15 (rejecting an insurer's argument that the cooperation clause, common interest doctrine, and "at issue" doctrine entitled the insurer to discover communications between the policyholder and its independent counsel during the underlying litigation); State v. Hydrite Chem. Co., 220 Wis. 2d 51, 78-79 (1998) (finding no merit in an insurer's arguments on "at issue," cooperation clause, and common interest grounds in coverage action brought by insurer who did not participate in defense of underlying action); First Pac. Networks, Inc. v. Atl. Mut. Ins. Co., 163 F.R.D. 574 (N.D. Cal. 1995) (insurer's reservation of rights eliminates common interest); North River Ins. Co. v. Columbia Cas. Co., No. 90 Civ. 2518, U.S. Dist. LEXIS 53 (S.D.N.Y. Jan. 5, 1995) (no common interest); Rockwell Int'l Corp. v. Superior Court, 26 Cal. App. 4th 1255, 1259 (1994) (finding the cooperation clause, the "at issue" doctrine, and the common interest doctrine inadequate bases to overcome the attorney-client privilege and permit discovery of documents related to the underlying litigation by the insurer); Owens-Corning Fiberglass Corp. v. Allstate Ins. Co., 660 N.E.2d 765, 769 (Ohio Ct. Com. Pl. 1993) (holding that there was no "common interest" between an insurer and policyholder where the insurer had neither defended nor indemnified the policyholder); NL Indus., Inc. v. Commercial Union Ins. Co., 144 F.R.D. 225, 231 (D.N.J. 1992) ("To permit insurers, however, unrestrained access to attorney-client communications and work product where those insurers refused to take part in

litigation despite notice and opportunity to participate would distort the ‘common interest’ doctrine.”); *In re Env'tl. Ins. Declaratory Judgment Actions*, 612 A.2d 1338, 1343 (N.J. Super. A.D. 1992) (holding that material created in underlying action at direction of defense counsel must be produced over work product objections subject to in-camera review, but attorney-client communications or work product containing mental impressions of attorney were privileged from discovery); *Int'l Ins. Co. v. Newmont Mining Corp.*, 800 F. Supp. 1195 (S.D.N.Y. 1992) (insurer's common desire for successful underlying defense is insufficient basis to establish common interest for privilege purposes); *Eureka Inv. Corp. v. Chicago Title Ins. Co.*, 743 F.2d 932, 937 (D.C. Cir. 1984) (finding that attorney-client communications made after an insurer's and policyholder's interests had diverged were privileged, but not addressing the discoverability of communications made beforehand).

[22] *Waste Management*, 144 Ill.2d at 190.

[23] *Waste Management*, 144 Ill.2d at 190–91.

[24] *Waste Management*, 144 Ill.2d at 193.

[25] *Waste Management*, 144 Ill.2d at 194. It is difficult to square the Illinois Supreme Court's determination that the policyholder and its insurer share a “common interest” in *Waste Management* with its recognition in other decisions that the insurer may have an actual conflict of interest that requires it to hire independent counsel for the policyholder. *See, e.g., Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24, 30–31 (Ill. 1976).

[26] *Waste Management*, 144 Ill.2d at 195.

[27] *Waste Management*, 144 Ill.2d at 199–200.

[28] *Allianz Ins. Co. v. Guidant Corp.*, 373 Ill. App. 3d at 664 (though applying *Waste Management* under Illinois law); *accord, e.g., Dedham-Westwood Water Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, No. Civ. A. 96-00044, 2000 Mass. Super. LEXIS 29 (Feb. 4, 2000) (“*Waste Management* has been rejected or criticized on numerous occasions.”); *Kimberly-Clark Corp. v. Cont'l Cas. Co.*, No. 3-05-CV-0475-D, 2006 U.S. Dist. LEXIS 63576, *3–*5 (N.D. Tex. Aug. 18, 2006) (declining to follow *Waste Management's* approach to cooperation clauses); *Bituminous Cas. Corp. v. Tonka Corp.*, 140 F.R.D. 381, 386–87 (D. Minn. 1992) (finding the reasoning of *Waste Management* “fundamentally unsound”); *Pittston Co. v. Allianz Ins. Co.*, 143 F.R.D. 66, 70, 72 (D.N.J. 1992) (rejecting *Waste Management's* view on common interest and cooperation clauses); *Owens-Corning Fiberglas Corp. v. Allstate Ins. Co.*, 66 N.E.2d 765, 769 (Ohio C.P. 1993) (rejecting *Waste Management's* common interest theory where the attorney did not represent both the insurer and the insured in the underlying action).

[29] *Rockwell*, 26 Cal. App. 4th at 1264.

[30] *Rockwell*, 26 Cal. App. 4th at 1268, n. 6.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[31] *Go Medical*, 1998 WL 1632525, *1.

[32] *Go Medical*, 1998 WL 1632525, *3–*4; *see also* *Linde Thomson Langworthy Kohn & Van Duke, P.C. v. Resolution Trust Corp.*, 5 F.3d 1508, 1514–15 (D.C. Cir. 2003) (“[I]f what is sought is not legal advice but insurance, no privilege can or should exist.”).

[33] *Go Medical*, 1998 WL 1632525, *1.

[34] *In re Pfizer*, 1993 U.S. Dist. LEXIS 18215, *26.

[35] 1993 U.S. Dist. LEXIS 18215, *26.

[36] *In re Imperial Corp.*, 167 F.R.D. at 449–50. D&O policies typically provide only for insurer reimbursement of the insured’s defense costs, in contrast to the affirmative duty to defend under standard CGL policies. Presumably for this reason, the court did not rely on California Civil Code section 2860(d), discussed above, text at n. 13, in deciding the issue.

[37] *In re Imperial Corp.*, 167 F.R.D. at 450.

[38] *In re Imperial Corp.*, 167 F.R.D. at 450.

[39] *In re Imperial Corp.*, 167 F.R.D. at 452–53.

[40] *In re Imperial Corp.*, 167 F.R.D. at 454–55; *see also, e.g., Continental Cas. Co. v. St. Paul Surplus Lines Ins. Co.*, 265 F.R.D. 510, 523, 528 (E.D. Cal. 2010) (in contribution action by defending insurer against non-defending insurer, the latter was required to produce its communications with policyholder and underlying defense counsel; both attorney-client privilege and work product protection were waived due to lack of common interest).

[41] *Lectrolarm*, 212 F.R.D. at 571–72.

[42] *In re Imperial Corp.*, 167 F.R.D. at 572. The court further explained:

This “common defense doctrine” also referred to as the “joint defense privilege” serves to “protect the confidentiality of communications passing from one party to the attorney for another party where a joint defense effort or strategy has been decided upon and undertaken by the parties and their respective counsel.” *United States v. Schwimmer* 892 F.2d 237, 243 (2d Cir. 1989). The doctrine only protects communications when they are part of an ongoing and joint effort to set up a common defense strategy. *Eisenberg v. Gagnon*, 766 F.2d 770, 787 (3rd Cir. 1985), *cert. denied, sub nom., Weinstein v. Eisenberg*, 474 U.S. 946, 106 S. Ct. 342, 88 L.Ed.2d 290 (1985); *see Schwimmer*, 892 F.2d at 243 (explaining that “[o]nly those communications made in the course of an ongoing common enterprise and intended to further the enterprise are protected.”); *Matter of Beville, Bresler & Schulman*, 805 F.2d 120, 125 (3rd Cir. 1986) (holding that the party



seeking the benefit of the joint defense doctrine must show that (1) the communications were made in the course of a joint defense effort, (2) the statements were designed to further that effort, and (3) the privilege has not been waived). Where a “joint defense effort or strategy has been decided upon and undertaken by the parties and their respective counsel,” communications may be deemed privileged whether litigation has been commenced against both parties or not. *Schwimmer*, 892 F.2d at 244.

Id.

[43] *Lectrolarm*, 212 F.R.D. at 572.

[44] *Lectrolarm*, 212 F.R.D. at 573.

[45] Alaska’s statutory counterpart is less clear: “Information disclosed by the independent counsel or the insured does not waive another party’s right to assert privilege.” Alaska Stat. § 21.89.100(e).

[46] *First Pacific Networks, Inc.* 163 F.R.D. at 584.

[47] *First Pacific Networks, Inc.* 163 F.R.D. at 579–80.

[48] *First Pacific Networks, Inc.* 163 F.R.D. at 584. The protection afforded by Cal. Civ. Code § 2860(d) was recently underscored by negative implication, in *Continental Casualty Co. v. St. Paul Surplus Lines Insurance Co.*, 265 F.R.D. 510 (E.D. Cal. 2010). There another California federal court found a waiver where the policyholder sent privileged communications to an insurer that had no duty to provide a defense—and therefore did not fall within the scope of § 2860(d). *See id.* at 526–27 (E.D. Cal. 2010).

[49] *See, e.g.*, *United Nat’l Ins. Co. v. City of Paris*, No. 09-2300, 2011 U.S. Dist. LEXIS 46198, *2–*3 (C.D. Ill. Apr. 29, 2011) (noting that although *Waste Management* did not allow an insured to withhold materials from its insurer, the insured still retained attorney-client privilege and work-product protection as to other parties); *In re Quantum Chemical/Lummus Crest*, No. 90 C778, 1992 U.S. Dist. LEXIS 5448, *10–*12 (N.D. Ill. Mar. 27, 1992) (recognizing that an insured’s documents were attorney-client privileged as to third parties, even though the insured’s disclosure of documents to an insurer would not waive such privilege under the common interest doctrine); *Allianz Ins. Co. v. Guidant Corp.*, 373 Ill. App. 3d 652, 674–75 (2007) (recognizing a common interest between an insured and its insurer, and commenting that the insured’s documents would enjoy privileged status as to underlying plaintiffs even after the insured shared those documents with its insurer).

[50] *See* CGL Policy, Section I.2.a.

[51] *See, e.g.*, Cal. Evid. Code § 1119; D.C. Code §§ 16-4203 to 4205; Utah Code Ann. §§ 78B-10-104 to 106.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[52] *See* *In re Imperial Corp.*, 167 F.R.D. at 455–56.

[53] *See* *Lectrolarm*, 212 F.R.D. at 573.

Insurance 101: Liability of Third-Party Administrators and Adjustors

By Kenneth Anspach– March 8, 2012[1]

Insurance companies are increasingly handing off their claims-handling functions to third parties. Those third parties, known as adjusters or third-party administrators (TPAs), have no contractual relationship with the insured. Adjusters and TPAs use that lack of privity as a shield against liability for negligent and reckless conduct. Yet, any rule immunizing adjusters and TPAs against such liability is unfair to the insured and merely serves to encourage wrongful future conduct. While not exhaustive, this article examines case law both in certain jurisdictions that hold adjusters and TPAs to account for wrongful conduct and certain of those that do not, as well as applicable law in certain jurisdictions that have not decided the issue. It concludes that the current trend in this area is to hold these entities accountable for their wrongful conduct.

In many instances, adjusters and TPAs have been vested with many of the duties of insurers, such that the actions of the adjusters and TPAs are, for all practical purposes, the actions of the insurer. Yet, attempts to hold adjusters and TPAs accountable as insurers are routinely barred by the rule of privity. A typical iteration of this rule was stated in *Brand v. AXA Equitable Life Ins. Co.*,[2] as follows:

[I]t is the general rule that an insured may bring claims for breach of contract and bad faith against the insurer who issued the policy but not against related parties, such as reinsurers and third-party administrators, who are not in privity with the insured.

Said another way in *Meineke v. GAB Business Services, Inc.*: [3]

[T]he relationship between adjuster and insured is sufficiently attenuated by the insurer's control over the adjuster to be an important factor that militates against imposing a further duty on the adjuster to the insured.

Based upon these judicial statements, one might believe that the rule of privity is universally accepted in claims against these third-party entities. Indeed, it seems obvious that where there is a contract of insurance between the insurer and the insured, the insurer is the party responsible for fulfilling upon the contractual obligations owed to the insured. Under such circumstances, the assertion that a TPA is “a stranger to the policy” certainly seems plausible.[4]

While the rule of privity appears ironclad, its blanket application was seriously eroded a century and a half ago in the seminal case of *Lawrence v. Fox*. [5] There, the New York Court of Appeals declared the principle “that a promise made to one for the benefit of another, he for whose benefit the promise it is made may bring an action for its breach.” [6] This principle is known as the third-party beneficiary rule. [7] Where an insurer enters into a contract for claims handling with a TPA, the beneficiaries of that

contract are the policyholders who submit claims under their contracts of insurance. The insureds are third-party beneficiaries of the claims-handling contract. Given that relationship, the continuing legal basis for a rule of privity protecting adjusters and TPAs from direct bad faith claims by policyholders seems doubtful, at best. One noted commentator, Jeffrey W. Stempel, agrees:

Under these circumstances, the traditional citadel of contract privity now seems as outmoded in this situation as it does in the context of product liability. In addition, these intermediaries [(adjusters and TPAs)] have morphed from mere agents into the alter ego replacements of insurers, at least as respects their dealings with policyholders and the public. Consequently, a rule of law immunizing them from the consequences of their conduct towards these groups appears increasingly outdated, unfair, and insufficiently deterrent of negligent or wrongful behavior by these intermediaries.[8]

Thus, in a world where adjusters and TPAs have become the “alter ego replacements of insurers,” the rationale for a rule of law immunizing them from the consequences of their wrongful conduct is increasingly difficult to justify.

I. Jurisdictions Holding that TPAs and Adjusters May Be Held Liable

The current jurisprudential trend is to hold adjusters and TPAs liable for their acts of negligence and bad faith. Courts adopting this approach sidestep the rule of privity by finding that adjusters and TPAs owe insureds a duty of due care in the administration and investigation of their claims for which the adjusters and TPAs may be held liable upon breach. The most prominent of the cases holding that adjusters and TPAs may be held liable in tort is *Continental Insurance Company v. Bayless and Roberts, Inc.*,^[9] a decision of the Supreme Court of Alaska. There, Continental refused a settlement demand recommended by independent counsel defending the insured. Continental and Stanford, the branch manager of Underwriters Adjusting Company, an outside adjuster functioning as Continental’s claims department, were sued for breach of fiduciary duty. Stanford allegedly failed to adequately investigate the claim and to inform previous panel counsel when the insured’s principal testified differently at deposition than in a prior affidavit. The court held Stanford could not be held liable for breach of fiduciary duty arising out of insurance contract, but could be held liable for negligence arising out of a breach of the general tort duty of ordinary care.

Similarly, in *Morvay v. Hanover Insurance Companies*,^[10] the insureds owned property that was damaged by fire, for which they were insured by Hanover. Hanover hired Verity Research Limited to investigate the fire. Verity concluded that the fire was of an incendiary nature. On that basis, Hanover denied the claim. The insureds sued Hanover and Verity and its investigator under the policy. The insured alleged that Verity negligently conducted the investigation. The trial court dismissed the claim against Verity. The Supreme Court of New Hampshire reversed, finding that while Verity and the investigator were not in privity with the insureds, they owed the insureds a duty to conduct a fair and reasonable investigation of the claim.

In *Brown v. State Farm Fire & Cas. Co.*,^[11] the insured's home was damaged by fire. The insurer, State Farm, hired investigating firm, JJMA, and investigator, Cooper, to conduct an investigation. JJMA and Cooper determined that the fire was the result of a deliberate act, and State Farm denied the claim. After settling with State Farm, the insured sued JJMA and Cooper for, *inter alia*, negligent investigation. The Court of Appeals of Oklahoma held that, since JJMA and Cooper owed the insured as well as State Farm the duty to conduct a fair and reasonable investigation of the claim, it was error to grant summary judgment to the investigators on the negligence claim.

The holdings in both *Morvay v. Hanover Insurance Companies* ^[12] and *Brown v. State Farm Fire & Cas. Co.*^[13] were cited as supporting authority in *Shepard v. Allstate Ins. Co.*^[14] There, the United States District Court for the Southern District of Ohio, finding no Ohio state law directly on point, found that colorable claims for both negligence and tortious interference with contract were stated by insureds against the insurer's investigative firm who investigated a fire and found that it was of an incendiary nature and caused by one or more of the insureds.

Further, in *Pohto v. Allstate Ins. Co.*^[15] the insured was injured in a motorcycle accident and made an uninsured motorist's claim with his insurer, Allstate, who assigned it to Boggs to adjust. Allstate denied the claim, presumably based on Boggs's findings. The insured sued Allstate and Boggs, alleging they acted in bad faith and/or negligently in the handling of his claim. The U.S. District Court for the District of South Carolina, noting that "no South Carolina court has addressed whether an insurance adjuster may be held personally liable for the bad faith or similar torts committed within the scope of the adjuster's employment,"^[16] held that Boggs's status as a non-party to the insurance contract did not foreclose the possibility that Boggs could be held liable for adjusting the insured's claims in bad faith.^[17]

Similarly, in *O'Fallon v. Farmers Ins. Exchange*^[18] the court found that an adjuster may be found liable for bad faith. In that case, the Supreme Court of Montana held that a claims adjuster employed by the insurer who filed a third-party complaint against the insureds in the underlying personal injury action was liable under state statute to claimants for the bad faith adjustment of their claim.^[19]

Cary v. United of Omaha Life Ins. Co.^[20] is a case very much indicative of the modern trend toward finding of a legal basis for the imposition of adjuster liability. There, a municipality hired the defendant TPA to administer its health insurance plan and provide reinsurance for certain claims paid by the municipality. The trial court upheld the TPA's denial of a plan beneficiary's claim for health insurance benefits arising out of the beneficiary's unsuccessful suicide attempt. The Supreme Court of Colorado held that when a TPA performs many of the tasks of an insurance company and bears some of the financial risk of loss for the claim, the administrator has a duty of good faith and fair dealing to the insured in the investigation and servicing of the insurance claim.^[21]

In *Farr v. Transamerica Occidental Life Ins. Co.*,^[22] the Court of Appeals of Arizona found that where a third-party insurance administrator collected premiums, handled

claims according to guidelines provided by the insurer, received a commission on premiums collected as well as a percentage of renewal commissions, and where the insurer did not become involved in the management of claims unless unusual circumstances were involved, the insurer and administrator were engaged in a joint venture. Further, the court found that where the insurer and its administrator are engaged in a joint venture, each is jointly and severally liable for a bad faith refusal to pay a claim.

Relying on *Farr*, the Supreme Court of Nevada, in *Albert H. Wohlers & Co. v. Bartgis*,^[23] also based a finding of adjuster liability on a joint venture theory. There, the court stated:

Here, the evidence proffered at trial indicated that Wohlers developed promotional material, issued policies, billed and collected premiums, paid and adjudicated claims, and assisted Allianz in the development of the ancillary charges limitation provision. Further because Wohlers shared in Allianz's profits, it had a direct pecuniary interest in optimizing Allianz's financial condition by keeping claims costs down. Indeed, Wohlers's administrative responsibilities and its special relationship with Allianz are more indicative of the existence of a joint venture than the situation presented in *Farr*.^[24]

Accordingly, the court held that Wohlers, the administrator, and Allianz, the insurer, were involved in a joint venture to an extent sufficient to expose Wohlers to liability on all contract and bad faith claims.^[25]

In California, where in 1973 in *Gruenberg v. Aetna Ins. Co.*,^[26] discussed in further detail *infra*, the California Supreme Court held that adjusters are not liable, the current trend appears to be toward finding of intermediary liability. Thus, in *Forest v. Equitable Life Assurance Society*,^[27] Equitable and Paul Revere, the claims administrator, had an agreement providing for incentive fees to be paid by Equitable to Paul Revere on the basis of a profitable claims experience and for payments to be paid by Paul Revere to Equitable when the annual claims experience resulted in a loss. Paul Revere discontinued the insured's disability benefits. The court found that the insured raised triable issues concerning proving the elements of a claim arising out of an alleged joint venture between Paul Revere and Equitable. The court, accordingly, ruled that Paul Revere was not entitled to summary judgment as to the insured's claims for breach of contract and breach of implied covenant of good faith and fair dealing. Continuing this California trend, in *Mintz v. Blue Cross of California*^[28] the claims administrator of a health care plan was found to have owed a duty of care to its members to protect plan members from physical injury resulting from its administration of benefits. Finally, in *McNeill v. State Farm Life Ins. Co.*,^[29] the California Court of Appeal found that insurance agents may be held liable for intentional misrepresentation or fraud.

II. Jurisdictions Holding That TPAs and Adjusters May Not Be Held Liable

Hudock v. Donegal Mutual Insurance Company^[30] and *Gruenberg v. Aetna Ins. Co.*^[31]

In *Hudock*, several adjusters hired to adjust claims for fire loss to an apartment building were sued for breach of contract. The insured argued that the adjusters, by means of unreasonable or fraudulent acts and delays, breached the insurance contracts between the adjusters and the insurance companies and rendered the adjusters personally liable to the insured.[32] The Supreme Court of Pennsylvania disagreed, finding that the insured, as a third party, was “in no way privy” to the contractual arrangement between the adjusters and the insurers.[33]

In *Gruenberg*,[34] the insured was denied coverage for fire loss after refusing to appear for an examination under oath while criminal arson charges were pending against him. The insured sued his carriers as well as an adjusting firm and its employee who performed the fire investigation for breach of the duty of good faith under the pertinent policies. The Supreme Court of California held that the adjusting firm and its employee were not parties to the insurance contract and could not be held liable for breach of the duty of good faith and fair dealing. The court left open the possibility that such entities could be found liable in tort.[35]

Sanchez v. Lindsey Morden Claims Services, Inc.,[36] explored the possibility left open by the *Gruenberg* court that adjusters could be found liable in tort. In *Sanchez*, a three-month delay in the handling of a cargo claim filed by the insured moving company for repair of a commercial dryer damaged in transit resulted in a judgment against the mover in the amount of \$1,325,000. The mover sued the adjuster under a negligence theory. The Court of Appeal of California found that the insurer, not the adjuster, has the ultimate power to grant or deny coverage, and the insurer would be ultimately liable for negligent claims handling. The court further found that, since the adjuster is the agent for the insurer, the only duty owed by the adjuster was to the insurer who engaged him, not to the insured. Thus, the court held that insurer-retained adjusters owe no duty of care to the insured under California law.[37]

Similarly, in *Hamill v. Pawtucket Mutual Insurance Co.*,[38] a homeowner made a claim for water damage and mold that arose out of burst pipes. The homeowner claimed that the adjusters engaged by his insurer negligently investigated his claim, thereby causing him to incur costs he would not have otherwise incurred. The Supreme Court of Vermont found on the basis of the law of agency that the conduct of an adjuster acting within the scope of his authority is imputed to the insurer, thus making the insurer liable for the adjuster’s mishandling of claims in actions alleging breach of contract or bad faith.[39] The homeowner argued that state law created protections for insureds against unfair insurance trade practices on the part of adjusters, but the court found that such statutory protections did not afford the insured a private right of action.[40]

III. Jurisdictions That Have Not Decided the Issue of Adjuster and TPA Liability

While a number of jurisdictions may not have decided this issue, it may be helpful to look at how their courts view the duty of good faith and fair dealing generally, and specifically the potential liability of other insurance intermediaries such as insurance agents. Doing so may provide insight on how courts will treat adjusters and TPAs.[41] For example, the State of Illinois has yet to opine on the liability of adjusters and TPAs.

In *Cramer v. Ins. Exchange Agency*,^[42] the Supreme Court of Illinois refused to recognize an independent action in tort for breach of an implied covenant of good faith and fair dealing except in the narrow context of cases involving an insurer's obligation to settle with a third party who has sued the policyholder. However, the *Cramer* court also held that an insurer's conduct may give rise to both a breach of contract action and a separate and independent tort action for example, common law fraud.^[43] Further, in *Talbot v. Country Life Ins. Co.*,^[44] the Illinois Appellate Court held that an insurance agent who delays in acting upon an application for life insurance may be found liable for breach of a duty of due care.^[45]

Since at least 1873, the Maryland courts have recognized that the insurer owes its insured a duty of good faith and fair dealing.^[46] Further, in *Popham v. State Farm Mut. Ins. Co.*,^[47] the Court of Appeals of Maryland found that an insurance *agent* must exercise reasonable care and skill in performing his duties. If such a representative fails to do so, he may become liable to those who are caused a loss by his failure to abide by such a standard of care.^[48] Since these states find intermediary liability for agents, they may also be inclined in appropriate future cases to extend such a finding to adjusters and TPAs.

IV. Conclusion

Upon examining case law of those jurisdictions that hold adjusters and TPAs to account for wrongful conduct and those jurisdictions that do not, as well as examining applicable law in jurisdictions that have not decided the issue, one finds that the current trend is in the direction of holding these intermediaries accountable for their wrongful conduct. The courts have applied various legal theories in arriving at this result, that is, the duty to conduct a fair and reasonable investigation of the claim, duty of good faith and fair dealing, bad faith, breach of contract, negligence, fraud and joint venture including joint and several liability. These courts recognize that a rule immunizing intermediaries that have become stand-ins for insurers fails to adequately deter negligent and wrongful behavior. Accordingly, under such circumstances, adjusters and TPAs are increasingly being held accountable.

Keywords: third-party administrators, adjusters, TPA, wrongful conduct, contract privity, broker, agent

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Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

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[2] *Brand v. AXA Equitable Life Ins. Co.*, 2008 U.S. Dist. LEXIS 69661 (E.D. Penn. 2008).

[3] *Meineke v. GAB Business Services, Inc.*, 195 Ariz. 564, 567 (Ariz. App. 1999).

[4] *Eves v. AIG, Inc.*, 2010 U.S. Dist. LEXIS 25403. (In a case where the insured sought to hold an insurer's management company liable on the grounds of bad faith in the handling of a claim, the company contended "that it is a stranger to the policy." The court, despite agreeing that privity of contract did not exist, concluded otherwise.)

[5] *Lawrence v. Fox*, 20 N.Y. 268 (1859).

[6] *Lawrence v. Fox*, 20 N.Y. at 274.

[7] Restatement of the Law, Second, Contracts, Section 302, Intended and Incidental Beneficiaries.

[8] Stempel, The "Other" Intermediaries: The Increasingly Anachronistic Immunity of Managing General Agents and Independent Claims Adjusters, 15 Conn. Ins. L.J. 599, 629.

[9] *Continental Insurance Company v. Bayless and Roberts, Inc.*, 608 P.2d 281 (Alas. 1980).

[10] *Morvay v. Hanover Insurance Companies*, 127 N.H. 723 (N.H. 1986).

[11] *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217 (Okla. Civ. App. 2002).

[12] *Morvay v. Hanover Insurance Companies*, 127 N.H. 723 (N.H. 1986).

[13] *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217 (Okla. Civ. App. 2002).

[14] *Shephard v. Allstate Ins. Co.*, 2006 U.S. Dist. LEXIS 563 (S.D. Ohio 2006).

[15] *Pohto v. Allstate Ins. Co.*, 2011 U.S. Dist. LEXIS 73460 (D.S.C. 2011).

[16] *Pohto v. Allstate Ins. Co.*, 2011 U.S. Dist. LEXIS at 73460.



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[17] The *Pohto* holding appears to contradict a prior holding of the Supreme Court of South Carolina in *Charleston Dry Cleaners & Laundry Inc. v. Zurich American Ins. Co.*, 355 S.C. 614 (2003).

There that court held that “no bad faith claim can be brought against an independent adjuster or independent adjusting company.” *Charleston Dry Cleaners & Laundry Inc. v. Zurich American Ins. Co.*, 355 S.C. at 618. It further held that “[w]e decline to recognize a general duty of due care from an independent insurance adjuster or insurance adjusting company to the insured . . .” *Charleston Dry Cleaners & Laundry Inc. v. Zurich American Ins. Co.*, 586 S.E.2d at 619.

[18] *O’Fallon v. Farmers Ins. Exchange*, 260 Mont. 233, 859 P.2d 1008 (1993).

[19] *O’Fallon v. Farmers Ins. Exchange*, 260 Mont. at 242–245, citing Section 33-18-201, MCA.

[20] *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d 462 (Colo. 2003).

[21] *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d at 469.

[22] *Farr v. Transamerica Occidental Life Ins. Co.*, 145 Ariz. 1, 12 (Ariz. App. 1984).

[23] *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249 (1998).

[24] *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. at 1263.

[25] *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. at 1263.

[26] *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).

[27] *Forest v. Equitable Life Assurance Society*, 2001 U.S. Dist LEXIS 22694 (N.D. Cal. 2001).

[28] *Mintz v. Blue Cross of California*, 92 Cal. Rptr. 3d 422 (Cal. App. 2009).

[29] *McNeill v. State Farm Life Ins. Co.*, 116 Cal. App. 4th 597 (Cal. App. 2004).

[30] *Hudock v. Donegal Mutual Insurance Company*, 438 Pa. 272 (Pa. 1970).

[31] *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).

[32] *Hudock v. Donegal Mutual Insurance Company*, 264 A.2d at 278.

[33] *Hudock v. Donegal Mutual Insurance Company*, 264 A.2d at 279.

[34] *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

- [35] *Gruenberg v. Aetna Ins. Co.*, 510 P.2d at 1038–1039.
- [36] *Sanchez v. Lindsey Morden Claims Services, Inc.*, 84 Cal. Rptr. 2d 799 (Cal. App. 1999).
- [37] *Sanchez v. Lindsey Morden Claims Services, Inc.*, 84 Cal. Rptr. 2d at 803.
- [38] *Hamill v. Pawtucket Mutual Insurance Co.*, 179 Vt. 250 (Vt. 2005).
- [39] *Hamill v. Pawtucket Mutual Insurance Co.*, 179 Vt. at 256–257.
- [40] *Hamill v. Pawtucket Mutual Insurance Co.*, 179 Vt. at 258–259 citing 8 V.S.A. Sections 4721–4726.
- [41] On the other hand, it may not. For example, in California, which under *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973), does not recognize adjuster liability, the courts nevertheless do find that insurance agents may be held liable for a failure to exercise reasonable care in the obtaining or maintenance of insurance coverage. *Hydro-Mill Co., Inc. v. Hayward, Tilton & Rolapp Ins. Assoc., Inc.*, 115 Cal. App. 4th 1145, 1153 (Cal. App. 2004). Further, in *McNeill v. State Farm Life Ins. Co.*, *supra*, 116 Cal. App. 4th 597 (Cal. App. 2004), the California Court of Appeal found that insurance agents may be held liable for intentional misrepresentation or fraud. Thus, a finding of intermediary liability for agents does not necessarily indicate that the jurisdiction will also find such liability for adjusters and TPAs.
- [42] *Cramer v. Ins. Exchange Agency*, 174 Ill. 2d 513 (1996).
- [43] *Cramer v. Ins. Exchange Agency*, 174 Ill. 2d at 528–529.
- [44] *Talbot v. Country Life Ins. Co.*, 8 Ill. App. 3d 1062 (3rd Dist. 1973).
- [45] *Talbot v. Country Life Ins. Co.*, 8 Ill. App. 3d at 1065–1066.
- [46] *Planters' Mut. Ins. Co. v. Deford*, 38 Md. 382, 398 (1873).
- [47] *Popham v. State Farm Mut. Ins. Co.*, 333 Md. 136, 153 (1993).
- [48] *Popham v. State Farm Mut. Ins. Co.*, 333 Md. at 153.

Distinguishing Between Large or Matching Deductibles and Self-Insured Retentions

By Deborah M. Minkoff— March 8, 2012^[1]

Many liability insurance policies incorporate a provision under which the insured retains a portion of the risk and provisions that establish the precise point at which the insurer's defense and indemnity obligations arise. Common forms of significant risk retention are large deductibles, matching deductibles, and self-insured retentions (SIRs). These terms are often used interchangeably. While they share certain similarities, key differences exist. The distinctions between large deductibles and SIRs present themselves in connection with a variety of issues: the duty to defend, erosion of the insured's retention by defense costs, "other insurance," and allocation.

Understanding the differences and similarities paves the way toward the efficient handling of claims under policies subject to these provisions and defines the insurer-insured relationship under policies subject to these risk management and retention mechanisms.

I. The Economy's Effect on Risk Retention and Risk Transfer

In the 1980s, in response to declining interest rates and greater commercial and municipal liability exposure, liability insurers re-evaluated premiums, re-examined policy exclusions and withdrew certain types of insurance from the market, such as insurance for pollution liability. In light of the increased costs associated with certain types of insurance, a growing number of insured entities began to explore methods of self-insurance.

The adverse factors that surfaced in the 2000's economy led many business entities to again consider methods of risk retention and cost-shifting. The most common arrangements to produce increased risk retention are large deductibles, matching deductible policies, and SIRs.

II. Common Forms of Risk Retention

Large Deductibles

A deductible, of whatever magnitude, is the most common type of risk retention mechanism. Deductibles traditionally apply to indemnity only. *Black's Law Dictionary* defines a deductible as "the portion of the loss to be borne by the insured before the insurer becomes liable for payment."^[2] A deductible traditionally does not preclude or defer the insurer's duty to defend.^[3] As a general rule, under a primary policy including a duty to defend, the insurer must defend a claim potentially within coverage from "dollar one."

However, depending on the policy language, an insured's defense expenses can satisfy its deductible. Consider the following language:

Subject to the limits of liability under this policy, the Company shall pay only that part of the damages and claims expenses which exceeds the deductible as stated in Item V. of the Declarations. The insured shall bear at its own risk and uninsured the sum stated in Item V. of the Declarations for each and every claim made against the insured during the policy period or during the extended reporting period. The deductible shall apply to all damages and claims expenses. The Company shall not have any obligation to make any payments under this policy for damages or claims expenses until the deductible has been paid.[4]

Concerning indemnity, the deductible amount is typically within the policy's limit of liability. For example, if the policy's limit of liability is \$1,000,000 subject to a \$250,000 deductible, the insurer's indemnity exposure is the \$750,000 difference between the deductible and the policy limit. The deductible does not increase the primary layer of coverage. In this example, excess coverage would attach at \$1,000,000, not at \$1,250,000.

Advantages and Disadvantages of Deductibles (to Insured and Insurer).

- Unless the policy language provides to the contrary, a large deductible does not alter an insurer's standard responsibility to defend. In particular, the insurer does not need to obtain insured's consent to settle within policy limits, and the insurer is usually required to investigate and assume the defense of potentially covered claims upon proper notice without regard to the existence of an indemnity deductible.
- The insurer must assume defense even if insured is insolvent and is not able to satisfy deductible obligation.
- The insurer is obligated to defend additional insureds from inception, regardless of the deductible that the insured is obligated to pay.

Matching Deductible Policies or "Fronting" Policies

A deductible that matches the policy's limit of liability is typically referred to as either a "matching deductible" policy or a "fronting policy." For example, in *Dorsey v. Federal Insurance Co.*,^[5] the court explained "[i]n a fronting policy, the insured essentially rents

an insurance company’s licensing and filing capabilities, but the insurance company does not actually pay any claims.”

Fronting policies allow an insured to purchase excess coverage, with the assurance for the excess insurers that the claims will be handled in a consistent and reliable fashion.^[6] Fronting policies permit insureds to conduct business without meeting the formal requirements for qualifying as a self-insurer.^[7] Fronting policies often are issued to satisfy financial responsibility laws by guaranteeing payment for third-party liabilities. The premium will be lower for the insured in a fronting policy arrangement than in traditional coverage. The insured generally will be responsible for the claims adjustment costs, but the insurer may reserve this authority.

One court tied these principles together and stated:

[A] “fronting policy” program is a legal risk management device commonly used by large corporations, operating in multiple states, in which the corporation pays a discounted premium to an insurer, which maintains insurance licensing and filing capabilities in a particular state or states, to issue and maintain an “insurance policy” covering the corporation in order to comply with the insurance laws and regulations of each state in which the corporation is required to maintain proof of insurance. However, through the use of self-insurance mechanisms, the corporation retains all of the risk covered under the “fronting policy.” In effect, the corporation “rents” the insurer’s licensing and filing capabilities in a particular state or states, and thereby becomes a self-insurer and is not subject to the requirements of [the statute].^[8]

Fronting policies are generally interpreted as any other policy of insurance. For example, in discussing the obligations of the issuer of a “fronting” policy, the court in *Fireman’s Fund Insurance Co. v. TIG Insurance Co.*^[9] noted that the insurer owed payment obligations to its insured for claims potentially covered under the policy, notwithstanding the insurer’s right to immediate reimbursement from its insured of the amounts paid.

While the insurer may be required to pay claims in the event of insolvency, the insurer typically requires collateral in exchange for issuing the policy. Because the insured agrees by virtue of a side agreement that the insurer can use the collateral for such payments, some courts have found that this type of arrangement does not constitute a transfer of risk to the insurer.^[10]

Many courts observe that fronting policies are not risk-shifting mechanisms. In *Pyramid Insurance Co.*,^[11] Judge (now Supreme Court Justice) Sotomayor observed that “insurance policies which do not actually transfer risk to the insurer but that serve other purposes are very much a custom of the industry.”^[12]

If a court finds that a fronting policy does not transfer risk, it will also likely conclude that a “true” insurer may not seek equitable contribution against an insured with a fronting policy. In *Weyerhaeuser Co. v. Firemen’s Fund Insurance Co.*,^[13] the court

explained that in cases involving continuous loss under Washington law, liability cannot be apportioned between an insurer and an insured that cannot collect for uninsured periods. The court extended this analysis to fronting policies and held that other insurers cannot seek equitable contribution from a fronting policy insured, because this would actually be an attempt to collect from the insured.[14]

On the other hand, some courts conclude that fronting policies qualify as “insurance.” For example, in 2005, the South Carolina Supreme Court ruled that fronting policies do involve a transfer of risk.[15] Other courts find that “fronting policies” qualify as “insurance” for purposes of traditional policies issued by other insurers. In *Chicago Insurance Co. v. Travelers Insurance Co.*,[16] the court held that a fronting policy qualified as insurance for purposes of an “other insurance” clause that stated that the policy was excess over all other insurance or self-insurance.

Self-Insured Retentions

A SIR represents the amount of risk (defense and indemnity) that the insured retains before actual coverage applies. In 2009, the Massachusetts Supreme Judicial court observed,

[A] “self insured retention” is “the amount that is not covered by an insurance policy and that usually must be paid before the insurer will pay benefits. . . .” The difference between a self-insured retention and a deductible is usually that, under policies containing a self-insured retention, the insured assumes the obligation of providing itself a defense until the retention is exhausted.[17]

Therefore, the insured must satisfy its SIR before the insurer is obligated to respond to the loss.

Courts often analogize SIRs to primary insurance in discussing the insured’s own obligation to defend claims until the SIR amount is satisfied. As stated by one court recently, SIRs “are the equivalent to primary insurance, and . . . policies which are subject to self insured retentions are ‘excess policies’ which have no duty to indemnify until the self-insured retention is exhausted.”[18] However, this general rule does not control over precise policy language that provides otherwise. For example, in *Legacy Vulcan Corp. v. Superior Court*,[19] the court observed that a “retained limit” provision relieves an insurer of the duty to defend from “dollar one” only if the policy language so provides. The court stated that “the impact of a policy reference to a ‘self insured retention’ or ‘retained limit’ on the duty to defend will depend on the language of a particular policy.”[20]

A commonly litigated issue involving SIRs is whether the insured’s defense costs exhaust the SIR. The answer depends on the particular policy language. However, as a general rule, an insured is obligated to exhaust the retained amount by payment of judgments or settlements.[21]

A SIR sits underneath a policy's limit of liability and, for this reason as well, the analogy to primary insurance is appropriate. For example, if a policy's limit of liability is \$1,000,000 subject to a \$500,00 self-insured retention, the first layer of insurance excess of the retention attaches at \$500,000, and the layer excess of the first layer of true coverage attaches at \$1,500,000.

However, as the *Forecast* court noted, the analogy to primary insurance cannot be taken too far. A SIR does not qualify as primary insurance for all purposes. For example, under California law, an excess insurer that does not sit directly above a SIR cannot insist on satisfaction of the SIR for purposes of horizontal exhaustion.^[22] Other courts also find that self-insured retentions are not "insurance."^[23]

Satisfaction of a SIR, in order to access "true" coverage excess of the SIR, raises its own issues. Courts are willing to support an insurer's position that only the insured can satisfy the SIR, and not payment by additional insureds, if the policy language effectuates that intent.^[24] On the other hand, where the policy language is not precise on this issue, payment from other sources can trigger the obligations of the insurer whose policy is subject to the SIR.^[25]

Advantages and Disadvantages of SIRs (to Insured and Insurer).

- For claims that can be settled or result in damages within the amount of the retention, the insured bears responsibility for the claims-managing process and defense of any suit.
- Because claims administration can be costly and time-consuming, insureds usually retain a third-party administrator. The insurer excess of the SIR has no control, and often little knowledge, of claims handled within the SIR.
- The insurer has no claims handling responsibility and no risk exposure for claims within a SIR. If an insured fails to satisfy its SIR in accordance to the policy terms, the insurer's obligations will not arise except in the event of the insured's insolvency, and only then in excess of the SIR.
- Until the retained limit is reached, additional insureds cannot look to the insurer for defense or indemnity.

III. Comparison of Deductibles and SIRs

The similarities between policies including large deductibles, fronting policies, and policies incorporating a SIR can cause confusion at many levels: at the risk manager level within the insured account; at the claims administration level (third-party administrator); at the level of “true insurance”; and for courts, arbitrators, or mediators. All three mechanisms represent an intent to define the extent of risk that is retained by the insured. In all mechanisms of retaining risk, the insurer’s payment obligations come into effect at the point at which the insured’s own obligations have been met.

In light of the similarities, some courts use language that does not reflect an appreciation of the distinctions between large deductibles and retained limits. These courts, perhaps, focus on the title and not on the language chosen to effectuate the intended risk retention and transfer.^[26] Most courts, however, recognize that deductibles and SIRs differ significantly. As Judge Hellerstein of the Southern District of New York noted:

[A] self-insured retention (“SIR”) "differs from a deductible in that a SIR is an amount that an insured retains and covers before insurance coverage begins to apply. Once a SIR is satisfied, the insurer is then liable for amounts exceeding the retention less any agreed deductible. . . . Policyholders frequently employ SIRs to forego increased premiums where they face high frequency, low severity, losses. . . . In contrast, a deductible is an amount that an insurer subtracts from a policy amount, reducing the amount of insurance. With a deductible, the insurer has the liability and defense risk from the beginning and then deducts the deductible amount from the insured coverage.^[27]

Summary of Key Differences Between Deductibles and SIRs

	Self-Insured Retention	Deductible
Duty to Defend	Insured generally responsible for its defense until exhaustion of retained amount	Insurer’s duty to defend arises at dollar one (assuming prompt notice of a potentially covered claim)
Indemnity	No obligation to pay until SIR is satisfied	Obligation to pay deductible amounts and seek reimbursement (“pay and chase”)
Policy Limits	Policy limits apply in excess of SIR	Deductible typically is encompassed within the policy limits.
Additional Insureds	Additional insureds cannot seek coverage from insurer for claims within the SIR.	Additional insureds can seek coverage under policy (defense) before deductible is satisfied.
Insurance	May be considered insurance for certain purposes	Generally will not be considered insurance for any purpose

IV. Common Issues Presented by Large Deductibles and SIRs

Timing of Obligations and Cost and Control of Defense

When a policy is subject to a deductible, the insurer has a duty to defend the insured from the time the claim is presented (assuming potential coverage and compliance with notice provisions). The insurer generally cannot wait until the insured pays its deductible.

With a SIR, the insurer generally does not have a duty to defend until the insured's SIR is exhausted by payments of judgments or settlements.[28] For this reason, courts refer to a SIR as akin to primary insurance, and the insurance over the SIR as excess insurance.

The discussion in *Axis Specialty Insurance Co. v. The Brickman Group*[29] illustrates this general rule. As background to that case, the true excess insurer negotiated a settlement of the underlying claim that required payment of the SIR, the limits in excess of the SIR, and a portion of the true excess coverage. The insured argued, in order to reduce its exposure for the claim, that its defense costs satisfied the SIR. The court explained that the policy language controlled and, under the operative policy language, the underlying insurance, which included the SIR, could be exhausted only by payment of judgments or settlements.[30]

The Claims Adjustment Process and Settlement of Claims

The insurer controls claims adjustment when its coverage is subject to a deductible, even a large deductible. In *Orion Insurance Co. v. General Electric Co.*,[31] the insured airplane-engine manufacturer maintained three liability policies providing coverage up to \$25 million, subject to a \$5 million deductible. The policies gave each insurer the right to settle any claim that it "deems expedient." The insurers settled a lawsuit against the insured for \$13.5 million, over the insured's objections. The insurers sued the insured after it refused to pay the deductible. The insured argued that the insurers' right to control the settlement did not extend to amounts within the deductible. The court rejected this argument and held that the policy provided the insurers with the right to settle the case, with or without the insured's consent. The court stated:

Under the terms of this contract, it is perfectly proper for the insurers to settle an action for a figure where G.E.'s contribution in the form of the deductible is considerably larger than the insurer's contribution. That is in fact what happened here. It would even be proper for the insurers to settle for a figure within the deductible, thus spending G.E.'s money without its consent and at no cost to themselves. While either of these results might seem to be burdensome to G.E., particularly the latter, that is the contract which G.E. made with its insurers[.][32]

More recent case law reaffirms this principle. For example, in *American Protective Insurance Co. v. Airborne, Inc.*,[33] the court explained that even if the insured defends

under a large deductible, the insurer controls the settlement, and the insured is obligated to contribute its deductible to the settlement reached by the insurer.

In contrast, when a policy is subject to a SIR, the insured is responsible for claims handling, settlement, and payment of claims within the retained amount. While the insured must act in good faith, it owes no obligation to settle within the SIR to avoid exposure to the insurer. In *Commercial Union Assurance Companies v. Safeway Stores*,^[34] the court held that an insured with a SIR has no duty to accept a settlement offer that would avoid exposing the excess insurer to liability. Courts have adopted the holding of *Safeway*.^[35] However, *Safeway* and its progeny acknowledge that “equity requires fair dealing between the parties to an insurance contract” and an insured cannot make unconscionable decisions in regard to the excess insurer’s liability.”^[36]

For claims that have a reasonable potential to exceed the retained amount, the general rule is that if the policy language gives the insurer the exclusive right to settle claims, the insurer controls the settlement despite the insured’s financial stake in the settlement. In *N.Y. City Housing Authority v. Housing Authority Risk Retention Group, Inc.*,^[37] the court enforced an insurance provision that allowed the insurer to settle if there was a reasonable chance the loss would exceed the SIR.^[38]

Under a minority view represented by less recent opinions, where the insured has a financial stake in the settlement, the insurer must obtain insured’s consent before settling.^[39]

Payment and Satisfaction Issues

Two issues have emerged that relate to satisfaction of deductibles and SIRs. These issues are whether defense costs exhaust the insured’s obligation under a deductible or a retention, and who can satisfy the retained limit obligation in order to implicate true coverage.

i. Do Defense Costs Satisfy an Insured’s Deductible or Retained Limit Obligation?

Typically, an *insurer* bears the responsibility to defend under a policy that is subject to a deductible, but the *insured* is responsible for its own defense of claims within a self-insured retention until the retained amount is satisfied by payment of settlements or judgments.^[40] In neither case would defense costs satisfy the insured’s policy obligations. However, both of these general rules can be altered by policy language.

Sample Language—Defense Costs Satisfy SIR

You are responsible for the payment of the “Self-Insured Retention.” Under this option, any amount paid in “Allocated Loss Adjustment Expense” will be included toward the satisfaction of the “Self-Insured Adjustment Expense” you incur with our prior written approval, in excess of the “Self-Insured Retention.” We have the right but not the duty to defend any “suit.” If we do not assume defense or control of the claim or “suit,” we will



reimburse to you all reasonable and necessary “Allocated Loss Adjustment Expense” you incur with our prior written approval, in excess of the “Self Insured Retention.”

Sample Language—Defense Costs Satisfy Deductible

Subject to the limits of liability under this policy, the Company shall pay only that part of the damages and claims expenses which exceeds the deductible as stated in Item V of the Declarations. The insured shall bear at its own risk and uninsured the sum stated in Item V of the Declarations for each and every claim made against the insured during the policy period or during the extended reporting period. The deductible shall apply to all damages and claims expenses. The Company shall not have any obligation to make any payments under this policy for damages or claims expenses until the deductible has been paid.

Defense costs within a SIR or a deductible can benefit both the insured and the insurer, but can also present concerns. In terms of benefits, defense within the retained limit decreases the insured’s exposure, and removes the insurer’s obligation to defend from dollar one. If the insurer has concerns regarding the insured’s own ability to manage its claims, an accelerated obligation to defend can reduce the insurer’s ultimate indemnity exposure. On the other hand, an insured may determine that the time required to defend itself against suits argues in favor of permitting the insurer to control the defense. Likewise, an insurer may desire a decreased risk transfer based on the insured’s past loss history. In that event, defense costs outside the SIR decelerates the SIR’s exhaustion and the point at which the insurer’s obligations would arise.

ii. Can a Party Other than the Named Insured Satisfy the Insured’s Deductible or SIR Obligation?

The cases that address whether a person or party other than the named insured can satisfy the retained limit obligation underscore the importance of the precise policy language. Where the policy specifies that the insured must meet the obligation, the insurer has no obligations until the insured itself makes the payment. This same rule applies to both an insured’s deductible obligation and an insured’s SIR obligation.

The following cases illustrate this rule in the context of deductibles: *Hartford Accident & Indemnity Co. v. U.S. Natural Resources Inc.* (held only named insured, not employee who was an additional insured, was required to pay deductible to insurer because policy referred to “named insured’s” obligation to pay); *Northbrook Insurance Co. v. Kuljian Corp.* (applying Pennsylvania law and affirming lower court’s ruling that policy’s plain terms required both named insureds to pay deductible, including “innocent” named insured); *Tidewater Equipment Co. v. Reliance Insurance Co.* (holding that named insured must pay deductible because additional insured has rights under policy by virtue of contract between insurer and named insured).[41]

Forecast Homes illustrates this rule in the context of self-insured retentions. In that case, the court held that additional insureds were not entitled to coverage unless and until the named insured satisfied the SIR. In reaching this result, the court relied on the language of the SIR endorsement and the policy explanation under which “you” referred solely to

the named insured. Accordingly, in that context, an additional insured cannot pay the SIR to access true coverage.

Where the policy language does not expressly require the insured itself to pay the retained amount, the excess insurer's obligations can be implicated by another person's or business's payment in satisfaction of the retained amount.[42]

Issues Involving Insolvent Insureds

Insolvency of an insured that chose (pre-insolvency) to retain a significant amount of risk presents the issue of whether payment of the SIR or deductible is a condition precedent to coverage.

The obligations of an insurer under a policy subject to a deductible are not excused by virtue of the insured's inability to pay its deductible. For this reason, insurers issuing coverage subject to a large deductible often enter into side agreements with insureds, under which the insured provides collateral to be drawn upon in the event that the insured is unable to reimburse the insurer for the deductible amount of a settled claim.

A few courts relieve the insurer of its obligations if the insured does not satisfy its payment obligations under a SIR.[43] Other courts hold that an insurer providing coverage in excess of a SIR is obligated to defend and indemnify to the extent claims exceed the SIR, even if the SIR has not been paid. Many of these decisions are based on states' statutory bankruptcy laws that provide "the insolvency or bankruptcy of the insured shall not release the company from the payment of damages for injuries sustained." [44] For example, in *In re OES Environmental, Inc.*, [45] the court held that the insurer was responsible for amounts in excess of the SIR even if the SIR was not paid. The court distinguished *Apache* because the policy at issue stated that the retained limit was to be "borne by" the insured and did not explicitly require exhaustion.[46]

In *Pak-Mor Manufacturing Co. v. Royal Surplus Lines Insurance Co.*, [47] the SIR endorsement provided that actual payment of the SIR was a condition precedent to coverage. While the court held that the insurer had no obligation to pay until the SIR was satisfied, it explained that the insured "may satisfy the self-insured retention by making its payment in whatever form it wants [i.e., a promissory note issued to the creditors]. . . . so long as the Bankruptcy Court confirms that the payment is performed in a credible and reliable manner." [48]

"Other Insurance" and Allocation Issues

The nature of deductibles and SIRs provides an extra layer of complexity to cases addressing how insurers are to allocate responsibility for losses that implicate multiple insurance policies. The "other insurance" issue arises where both the insured's own risk retention mechanism and one or more policies providing for true risk transfer provide concurrent coverage, or would apply to the same occurrence or claim. In this context, a court will consider whether the insured's retention mechanism qualifies as "other insurance." In contrast, when a loss continues across multiple successive policy periods,

courts must consider whether and how the loss should be allocated across multiple carriers, one or more of which may be subject to SIRs or large deductibles.

1. Whether the Insured's Retained Amount Qualifies as "Other Insurance"

The majority of courts hold that a self-insured retention does not qualify as "other insurance" for a particular claim or occurrence. In *Wake County Hospital System, Inc. v. National Casualty Co.*,^[49] a bodily injury claim was asserted against a hospital and the treating nurse. The hospital's coverage (through St. Paul Fire & Marine) was subject to a \$750,000 SIR; the nurse maintained a liability policy with National Casualty that was not subject to a deductible. The claim settled for an amount within the SIR. National Casualty argued that it had no duty to defend or indemnify because, under its "other insurance" clause, the National Casualty coverage was excess to the hospital's SIR.

The court agreed with the hospital that National Casualty was obligated to pay the claim. The court stated:

Because Wake [the hospital] had a self-insured retention of \$750,000, it was essentially uninsured for that amount. As a result, Wake cannot be viewed as having "insurance" as that term is plainly and ordinarily used, since it had no insurance for valid claims made which were under \$750,000.^[50]

Contrary to the majority, a number of decisions hold that a SIR qualifies as other insurance. These cases fall into two categories. The first category consists of cases in the auto liability context.^[51] In this context, states' financial responsibility laws regard internal insurance programs as the functional equivalent of true coverage.^[52]

The second category involves cases in which courts addressed and enforced policy language specifying that the coverage is excess over insurance, including a deductible portion or SIR. In *Warren Hospital v. American Casualty Co. of Reading, PA.*,^[53] the facts and issues paralleled those presented in *Wake County Hospital*. In the context of a bodily injury action against a hospital and a nurse, the nurse's liability insurer asserted that it was excess over the hospital's SIR. The court agreed with the nurse's insurer based on the language of its "other insurance" clause. That clause stated in relevant part, "[i]f there is any other insurance policy or risk transfer instrument, including but not limited to self-insured retentions, deductibles, or other alternative arrangements ('other insurance'), that applies to any amount payable under this policy, such other insurance must pay first."^[54] The court enforced the policy language as written.^[55]

2. Allocation Issues

Few courts address the issue of how deductibles apply where a loss is prorated among multiple policies. The majority approach holds that the full amount of the deductible established by each policy must be satisfied.^[56] These courts reason that to prorate a deductible in the context of a continuous loss would upset the balance of risk to which insureds and insurers previously agreed. Specifically, "[d]eductibles constitute a bargained-for aspect of the insurance contract that affects the premiums the insured pays.



. . . Insureds purchase policies with deductibles that are directly related to their premiums, risking the possibility that the loss will be low and that the deductible will equal or exceed it. When that occurs, the insured gets exactly what it has bargained for.”[57]

A minority of courts hold that only prorated deductibles or self-insured retentions must be satisfied for each policy in a situation involving pro-rate allocation.[58] These courts have declined to set forth a thorough analysis, and instead reason that prorating the deductible is “equitable” where the policies are “at best ambiguous as to what happens when the insurer is held liable for only part of a continuous occurrence.”[59]

With respect to SIRs, several cases hold that an insured is required to exhaust each SIR applicable to a loss before it can access its excess coverage.[60]

Other courts reject the premise that an insured must exhaust multiple SIRs over multiple triggered policy years.[61] According to these courts, the principles of horizontal exhaustion are not applicable because a SIR does not qualify as primary insurance, and thus each SIR did not need to be exhausted before the insurers had any duty to indemnify.[62] In *Bordeaux*, the court emphasized the importance of particular policy language, noting that the policy said “nothing about whether or not *Bordeaux*’s obligation to pay the American Safety SIR is satisfied when it fulfills a similar obligation under another policy.”[63] These courts focus on the policy language, noting that the subject policy did not contain any language regarding whether the insured’s SIR obligation is satisfied.

IV. Conclusion

To determine the precise point at which an insurer’s rights and duties arise, claims professionals and their counsel should focus on the specific language used to describe the retention and the events that implicate the insurer’s obligations. Courts consider the language defining the retention, rather than its title, in determining whether it should be treated as a deductible or SIR.[64] If questions arise, claims professionals and their counsel can involve the underwriter to confirm that the policy language captures intended risk retention and risk transfer, and to implement the proper risk-management protocol. Risk-transfer mechanisms can be complex but can benefit the insured and the insurer, and foster successful insured/insurer relationships.

Keywords: deductibles, matching deductibles self-insured retentions, SIRs, indemnity, fronting policy.

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Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[1] The author would like to thank Abby Sher of Cozen O'Connor's Global Insurance Group for her assistance and insight in preparing this article.

[2] Black's Law Dictionary at 1391 (8th ed. 2004) (emphasis added).

[3] 2 A.D. Windt, *Insurance Claims and Disputes* § 11:31, 11-495 (5th ed. 2007).

[4] FICC Endorsement No. LP 00 R007 02 0993.

[5] *Dorsey v. Fed. Ins. Co.*, 798 N.E.2d 47 (Ohio Ct. App. 2003); *see also Shakir v. U.S. Leasing Int'l, Inc.*, 831 N.Y.S.2d 362 (N.Y. Sup. 2006); *Delphi Auto. Sys., LLC v. Slaughter*, 261 F.Supp.2d 950 (S.D. Ohio 2003); *Carns v. Smith*, No. 01-972H, 2003 Ohio Misc. LEXIS 38 (Ohio Comm. Pleas 2003); *Tribune Co. v. Allstate Ins. Co.*, 715 N.E.2d 263 (Ill. Ct. App. 1999); *Columbia Cas. Co. v. Northwestern Nat. Ins. Co.*, 231 Cal.App.3d 457 (Cal. Ct. App. 1991) (explaining a fronting policy is basically a surety arrangement).

[6] *Ins. Co. of N. Am. v. Pyramid Ins. Co.*, 1994 U. S. Dist LEXIS 3001 (S.D.N.Y. 1994).

[7] *Forest Ins. Ltd. v. Am. Motorists Ins. Co.*, 1994 U. S. Dist. LEXIS 3334, at * 5 (S.D.N.Y. 1994).

[8] *Tharp v. Berdanier*, No. 21473; 2003 Ohio App. LEXIS 5864 (Ohio Ct. App. 2003).

[9] *Fireman's Fund Ins. Co. v. TIG Ins. Co.*, 14 S.W.3d 203, 233-34 (Mo. Ct. App. 2000) ("It may have been a 'fronting' policy, but it was still a policy of insurance, placing contractual obligations on Reliance."); *see also Scott v. Dauterive Hosp. Corp.*, 851 So.2d 1152, 1159 (La. Ct. App. 2003) (a "fronting" policy "requires performance to a claimant just as it would if the 'fronting' provisions contained in the indemnity agreement were not attached."); *Gilchrest v. Gonsor*, 821 N.E.2d 154 (Ohio 2004) (stating that a "matching deductible" policy should be interpreted as any other policy of insurance).

[10] *Carns*, 2003 Ohio Misc. LEXIS 38.

[11] *Pyramid Ins. Co.*, 1994 U.S. Dist. LEXIS 3001

[12] *Pyramid Ins. Co.*, 1994 U.S. Dist. LEXIS 3001 at *12; *Shakir*, 831 N.Y.S.2d 362 (noting that in a fronting policy, the insured bears the entire risk of loss and pursuing a suit against the insurer would be "somewhat illusory"); *Playtex FP, Inc. v. Columbia Cas. Co.*, 609 A.2d 1087 (Del. Super. 1991) (describing fronting policy as non-risk transfer policy though acknowledging that insurer may assume risk if insured becomes insolvent).

[13] *Weyerhaeuser Co. v. Firemen's Fund Ins. Co.*, No. C06-1189, 2007 U.S. Dist. LEXIS 92521 (W.D. Wash. Dec. 17, 2007).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[14] *See also Aerojet Gen. Corp. v. Transport Indem. Co.*, 948 P.2d 909 (Cal. 1997).

[15] *Croft v. Old Republic Ins. Co.*, 618 S.E.2d 909 (S.C. 2005) (explaining that the insurer assumes the risk that it will have to pay certain claims if the insured becomes insolvent).

[16] *Chicago Ins. Co. v. Travelers Ins. Co.*, 967 S.W.2d 35 (Ky. Ct. App. 1997).

[17] *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290 (Mass. 2009) (quoting Black's Law Dictionary, *supra*, and Windt, *supra*).

[18] *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 105 Cal. Rptr. 3d 200, 207 (Cal. Ct. App. 4th Dist. 2010).

[19] *Legacy Vulcan Corp. v. Superior Court*, 110 Cal. Rptr. 3d 795 (Cal. Ct. App. 2010).

[20] *Legacy Vulcan*, 110 Cal. Rptr. 3d at 808.

[21] *Virginia Surety Co. v. Lexington Ins. Co.*, 2011 U. S. Dist. LEXIS 72336 (N.D. Cal. 2011); *General Star Indem. Co. v. Superior Court*, 55 Cal. Rptr. 2d 322 (Cal. Ct. App. 1996).

[22] *Montgomery Ward & Co. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356, 370, 97 Cal. Rptr. 2d 44 (Cal. Ct. App. 2000) (rejecting stacking of SIRs in other triggered policies).

[23] *Bordeaux v. Am. Safety Ins. Co.*, 186 P. 3d 1188 (Wash. App. 2008).

[24] In *Forecast Homes*, the SIR endorsement stated:

The 'Self Insured Retention' under this policy must be satisfied by actual payment by you[.] The 'Self Insured Retention' shall not be satisfied by payment by the insured of any deductible of any other policy or payments made on behalf of the insured by any other insurer, person or entity. The 'Self Insured Retention' under this policy shall not be satisfied by any insurance coverage whatsoever. In the event that 'bodily injury,' 'property damage' and/or 'personal and advertising injury' covered by this policy is also covered by any other insurance, even if such insurance is provided by us, the insured must make actual payment of the 'Self Insured Retention' under this policy without regard to whether the insured must pay other 'Self Insured Retentions' under any other policy even if such other policy is issued by us and even if the damages claimed are deemed to have been caused by one 'occurrence.'

[25] *Vons Cos. v. U.S. Fire Ins. Co.*, 92 Cal. Rptr. 2d 597 (Cal. Ct. App. 2000).

[26] *See, e.g., Gen. Star Nat. Ins. Corp. v. World Oil Co.*, 973 F. Supp. 943 (C.D. Cal. 1997) (holding SIR in policy was actually a deductible and noting "[t]here is no



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

dispositive case law differentiating deductibles from SIRs”); *Stamp v. Dep’t of Labor & Indus.*, 859 P. 2d 597 (Wis. 1999) (stating that self-insurance is “in simplest terms, to make the insured ‘self-insured’ up to the amount of the deductible”).

[27] *In re September 11th Liab. Ins. Coverage Cases*, 458 F. Supp. 2d 104, 113 n. 10 (S.D.N.Y. 2006) (internal citations omitted).

[28] *City of Oxnard v. Twin City Fire Ins. Co.*, 44 Cal. Rptr. 2d 177 (Cal. Ct. App. 1995) (“As a self-insurer, an insured is solely liable for its defense costs attributable to the extent of its SIR, just as a primary insurer is responsible for defense expenses attributable to the extent of its coverage”).

[29] *Axis Specialty Ins. Co. v. The Brickman Group*, 756 F. Supp. 2d 644 (E.D. Pa. 2010).

[30] *Compare Cooper Labs., Inc. v. Int’l Surplus Lines Ins. Co.*, 802 F.2d 667 (3d Cir. 1986) (insurer had duty to defend under policy language where demand exceeded SIR).

[31] *Orion Ins. Co. v. Gen. Electric Co.*, 493 N.Y.S.2d 397 (N.Y. Sup. 1985).

[32] *Orion*, 493 N.Y.S.2d at 401.

[33] *Am. Protective Ins. Co. v. Airborne, Inc.*, 476 F. Supp. 2d 985 (N.D. Ill. 2007).

[34] *Comm. Union Assurance Group v. Safeway Stores*, 610 P.2d 1038 (Cal. 1980).

[35] *Int’l Ins. Co. v. Dresser Indus., Inc.*, 841 S.W.2d 437 (Tex. App.—Dallas 1992); *Twin City Fire Ins. Co. v. Superior Court*, 792 P.2d 758 (Ariz. 1990).

[36] *Safeway*, 610 P.2d at 1043.

[37] *N.Y. City Housing Auth. v. Housing Auth. Risk Retention Group, Inc.*, 203 F.3d 145 (2d Cir. 2000).

[38] *See also Nat’l Cas. v. Green*, 711 So.2d 609 (Fla. App. 1998) (upholding policy provision that excused insurer from any obligation where insured refused to accept reasonable offer within SIR); *Methodist Hosp. v. Zurich Am. Ins. Co.*, 329 S.W.3d 510 (Tex. App. – Houston [14th Dist.] 2009); *Stan Koch & Sons Trucking, Inc. v. Great West Cas. Co.*, 517 F.3d 1032 (8th Cir. 2008) (allowing insurer to settle claim over insured’s objection where policy contained provision that insurer had the right to “settle or defend, as we consider appropriate”).

[39] *St. Paul Fire & Marine Ins. Co. v. Edge Memorial Hosp.*, 584 So.2d 1316 (Ala. 1991); *Nat’l Serv. Indus., Inc. v. Hartford Acc. & Indem. Co.*, 661 F.2d 458, 462 (5th Cir. 1981) (applying Georgia law and noting that policy did not explicitly provide that insurer can elevate its interests over those of the insured).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[40] *See, e.g., In re September 11th Liability Insurance Coverage Cases*, 458 F. Supp 2d at 113 n. 10.

[41] *Hartford Acc. & Indem. Co. v. U.S. Natural Resources Inc.*, 897 F. Supp. 466, 473 (D. Or. 1995) (held only named insured, not employee who was an additional insured, was required to pay deductible to insurer because policy referred to “named insured’s” obligation to pay); *Northbrook Ins. Co. v. Kuljian Corp.*, 690 F.2d 368, 373 (3d Cir. 1982) (applying Pennsylvania law and affirming lower court’s ruling that policy’s plain terms required both named insureds to pay deductible, including “innocent” named insured); *Tidewater Equip. Co. v. Reliance Ins. Co.*, 650 F.2d 503 (4th Cir. 1981) (holding named insured must pay deductible because additional insured has rights under policy by virtue of contract between insurer and named insured).

[42] *See, e.g., Vons Cos., Inc.*, 92 Cal. Rptr. 2d at 605 (“[n]owhere does the SIR expressly state that [the insured] itself, not other insurers, must pay the SIR amount”); *Coffeyville Resources Refining & Mktg., LLC v. Liberty Surplus Ins. Corp.*, No. 08-1204, 2010 U.S. Dist. LEXIS 113457 (D. Kan. Oct. 25, 2010) (payments made by another insurer could serve to reduce the SIR of the subject policy). Certain policies specifically state that another insurer cannot satisfy the SIR.

[43] *See, e.g., In re Apache Prods. Co.*, 311 B.R. 288 (Bankr. M.D. Fla. 2004) (holding insurer was relieved of obligation to pay where insured is incapable of satisfying SIR where policy language required exhaustion of SIR); *In re Kismet Prods., Inc.*, 2007 WL 6872750 (N.D. Ohio Aug. 28, 2007) (holding insurer was relieved of obligation to pay where debtor was unable to pay one month’s premium as required by the policy).

[44] *See, e.g., Home Ins. Co. v. Hooper*, 691 N.E.2d 65, 69 (Ill. Ct. App. 1998).

[45] *In re OES Environmental, Inc.*, 319 B.R. 266 (M.D. Fla. 2004).

[46] *See also Hooper*, 691 N.E.2d 65 (not requiring insurer to drop down, but holding that requiring actual payment of SIR as condition precedent to trigger of coverage violated public policy and policy language where insured was bankrupt); *Admiral Ins. Co. v. Grace Indus., Inc.*, 409 B.R. 275 (E.D.N.Y. 2009) (holding insurer was obligated to pay claims in excess of SIR even where SIR was not paid); *Travelers Cas. & Sur. Co. v. AISLIC*, 465 F.Supp.2d 1005 (S.D. Cal. 2006) (holding insurer’s credit to itself of amount of SIR in underlying action satisfied SIR as to additional insured in spite of insured’s bankruptcy).

[47] *Pak-Mor Mfg. Co. v. Royal Surplus Lines Ins. Co.*, No. SA-05-CA-135-RF, 2005 U.S. Dist. LEXIS 34683 (W.D. Tex. Nov. 3, 2005).

[48] *Pak-Mor Mfg. Co.*, 2005 U.S. Dist. LEXIS 34683 at 6-7.

[49] *Wake Cty. Hosp. Sys., Inc. v. Nat’l Cas. Co.*, 804 F. Supp. 768 (E.D.N.C. 1992), *aff’d* 996 F.2d 1213 (4th Cir. 1993).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

[50] *Wake Cty.*, 804 F. Supp. at 778. For other cases also holding that an insured's "SIR" does not constitute "other insurance," see *Bordeaux, Inc.*, 186 P.3d 1188 (holding that rights of insured with SIR was superior to rights of insurers that sit above SIR for purposes of subrogation claim); *Am. Nurses Assoc. v. Passaic Gen. Hosp.*, 471 A.2d 66 (N.J. Super. 1984), rev'd in part on other grounds, 484 A.2d 670 (N.J. 1984) (holding that SIR is not considered "other insurance" so as not to allocate loss to insured hospital).

[51] See, e.g., *Atchison, Topeka & Sante Fe Ry. Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003); *Hillegass v. Landwehr*, 499 N.W.2d 652 (Wis. 1993) (holding self-insurance qualifies as "other insurance" in automobile liability context); *White v. Howard*, 573 A.2d 513, 515 (N.J. Super. Ct. App. Div. 1990) (stating that car rental agency's decision to act as self-insurer and secure applicable New Jersey certificate was functional equivalent of it writing separate insurance policy covering itself).

[52] See Richmond, D. R., Issues and Problems in "Other Insurance," Multiple Insurance, and Self Insurance, 22 *Pepperdine L. Rev.* 1373, 1453 (February 1995).

[53] *Warren Hosp. v. Am. Cas. Co. of Reading, PA*, 2009 U.S. Dist. LEXIS 87975 (D.N.J. 2006),

[54] *Warren Hosp.*, 2009 U.S. Dist. LEXIS 87975 at * 9–10.

[55] See also *Redeemer Covenant Church of Brooklyn Park v. Church Mut. Ins. Co.*, 567 N.W.2d 71, 79 (Minn. Ct. App. 1997) (interpreting policy with language that insurance was "excess over and above any other valid and collectible insurance (including any deductible portion) or agreement of indemnity available to the insured"); *Nabisco, Inc. v. Transp. Indem. Co.*, 143 Cal.App.3d 831, 192 Cal.Rptr. 207, 208 09 (1983) (holding self-insurance was "other insurance" where policy stated that coverage was excess if there was "other insurance or self insurance").

[56] See *Liberty Mut. Fire Ins. Co. v. J.T. Walker Indus. Inc.*, No. 2:08-cv-02043 (D.S.C. Sept. 22, 2011); *Benjamin Moore & Co. v. Aetna Cas. & Sur. Co.*, 843 A.2d 1094 (N.J. 2004); *Olin Corp. v. Ins. Co. of N. Am.*, 221 F.3d 307, 327–28 (2d Cir. 2000); *In re Prudential Lines Inc.*, 158 F.3d 65 (2d Cir. 1998).

[57] *Benjamin Moore*, 843 A.2d at 1106.

[58] See *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, 315-16 (Mass. 2009); *Nationwide Mut. Ins. Co. v. Lafarge Corp.*, 910 F.Supp. 1104 (D. Md. 1996), *aff'd* 121 F.3d 699 (4th Cir. 1997) (applying Texas law); *Lafarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389 (5th Cir. 1995) (holding proration of deductible or retention is "equitable").

[59] *Boston Gas*, 910 N.E.2d at 316 (citing *Lafarge*, 61 F.3d at 401).

[60] See, e.g., *Atchison*, 71 P.3d 1097 (holding insured was required to exhaust SIR for each triggered policy period before seeking recovery from insurers under policy); *Sec.*



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

Ins. Co. v. Lumbermens Mut. Cas. Co., 826 A.2d 107 (Conn. 2003) (applying the pro-rata approach and allocating defense and liability to periods in which the insured was self-insured or lost its policies); *Norfolk Southern Corp. v. Cal. Union Ins. Co.*, 859 So.2d 201 (La. App. 2003); *U.S. Gypsum Co. v. Admiral Ins. Co.*, 286 Ill. App. 3d 598 (Ill. Ct. App. 1994).

[61] *Montgomery Ward & Co. Inc. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356 (Cal. Ct. App. 2000) (holding principles of horizontal exhaustion did not apply to SIR requiring insured to satisfy amount of largest SIR); *Cal. Pacific Homes, Inc. v. Scottsdale Ins. Co.*, 83 Cal. Rptr. 329 (Cal. Ct. App. 1999).

[62] *See also Bordeaux, Inc.*, 186 P.3d 1188 (holding insured only required to satisfy one SIR even where two policies, both of which are subject to SIRs, respond to a loss).

[63] *Bordeaux*, 186 P.3d at 1190.

[64] *See, e.g., Legacy Vulcan Corp.*, 110 Cal. Rptr. 3d at 808.

Trigger of Insurance Coverage for Wrongful Arrest, Prosecution and Conviction Lawsuits

By Benjamin C. Eggert and Ashley Eiler— March 8, 2012^[1]

As Chief Justice John Roberts noted in a recent opinion, “DNA testing has an unparalleled ability both to exonerate the wrongfully convicted and to identify the guilty.”^[2] Justice Roberts’s observation is clearly correct given that, in the last two decades, DNA testing has led courts to set aside nearly 300 criminal convictions of persons who later were found to be innocent. Hundreds of other individuals also have been exonerated through other means without DNA evidence. By some estimates, the rate of exonerations has been rapidly increasing, and as many as 50 wrongfully convicted persons are exonerated annually in states nationwide.^[3]

Federal and state courts are wrestling with a range of complex issues presented by such exonerations, and in 2011, the United States Supreme Court ruled on or heard argument as to at least three cases bearing on wrongful convictions.^[4] Meanwhile, exonerations have given rise to a surge in the filing of federal and state civil rights lawsuits seeking compensation from governmental entities and public officials for wrongful arrests, prosecutions, and convictions (“wrongful APC litigation”).^[5] Recent studies conclude that wrongful APC litigation can lead to millions of dollars of exposure for governments and their officials for payment of defense costs, settlements, and judgments.^[6]

Such lawsuits, in turn, have led to disputes between insurers and their insureds concerning insurance coverage for wrongful APC litigation, with specific focus on the applicable trigger of coverage under public entity and officials liability policies or similar coverage. In the two years since the article *Trigger of Insurance Coverage for Wrongful Conviction Lawsuits* was published in the January/February 2010 issue of this journal,^[7] courts have issued at least seven opinions concerning the appropriate trigger of coverage for wrongful APC litigation.^[8] These decisions are generally consistent with the established judicial consensus that the trigger of coverage typically is when the wrongfully accused first experiences injury, which, at the latest, is the date of conviction.

National Casualty Co. v. McFatridge, 604 F.3d 335 (7th Cir. 2010), however, is a notable exception to this general rule. In *McFatridge*, the United States Court of Appeals for the Seventh Circuit predicted that the Illinois Supreme Court would hold that two different triggers of coverage may apply in the context of wrongful APC litigation. A claim challenging an accused’s *arrest* could trigger potential insurance coverage under a policy in effect at the time of arrest. A challenge to an accused’s *conviction*, on the other hand, could trigger coverage under a policy in effect at the time the victim is exonerated, which might be decades after conviction.

McFatridge's approach to trigger is flawed and thus should not be adopted by other courts confronting insurance coverage disputes concerning wrongful APC litigation. The reasoning in *McFatridge* is contrary to the terms of liability policies typically at issue in such suits and improperly relies on authority relating to the accrual of a claim for statute of limitations purposes. In addition, the trigger analysis in *McFatridge* is at odds with nearly two dozen other decisions that have addressed trigger of coverage in analogous situations. Moreover, courts attempting to apply its novel and dubious holding have reached anomalous results. Consequently, a court confronting trigger issues in connection with wrongful APC litigation should not follow the approach taken by the court in *McFatridge*. Moreover, the Seventh Circuit soon will have two opportunities to revisit the trigger analysis set forth in *McFatridge*, as two Illinois federal court decisions involving the application of that decision recently have been appealed to the court.[9]

I. Framework for Assessing Trigger of Coverage in Wrongful APC Litigation

Wrongful APC litigation typically is brought by individuals whose criminal convictions have been set aside, generally through a judicial declaration of “actual innocence” or a ruling to vacate the conviction on some other grounds. Such individuals often assert both common law tort and constitutional causes of action under 42 U.S.C. § 1983, a federal statute that provides relief for civil rights violations committed by officials acting “under color of law.”[10] Section 1983 lawsuits allow an exonerated individual to bring an action to seek damages from governmental entities and their officials, such as police officers, investigators, forensic lab workers and prosecutors. In addition to asserting causes of action under Section 1983 for false arrest and imprisonment and malicious prosecution, these lawsuits often also feature causes of action that focus on specific official misconduct. Most commonly, plaintiffs contend that police officials suppressed or failed to disclose exculpatory evidence to prosecutors, fabricated evidence, engaged in suggestive identification procedures, or conducted coercive interrogations.[11]

Courts are in widespread agreement that insurance coverage for wrongful APC litigation is triggered, at the latest, when the exonerated person was convicted of the crime. Many courts have held that coverage is triggered at the time that prosecution is initiated—either at the time of arrest, indictment, or detention in jail pending a criminal trial—because that date represents the point in time when the claimant’s rights were first violated.[12] As observed recently by the court in *Northfield Insurance Co. v. City of Waukegan*, “[u]nder the majority rule, civil rights claims such as malicious prosecution, false imprisonment, and wrongful conviction trigger insurance policies in effect when the injury first occurs, i.e., when the underlying charges are filed, or when the plaintiff is wrongfully arrested or first incarcerated.”[13] The use of such a trigger date in part reflects courts’ well-established approach to trigger of coverage for similar lawsuits. Most causes of action typically asserted in wrongful APC litigation approximate the common law tort of malicious prosecution, and courts historically have held that the trigger date for malicious prosecution actions is when the prosecution first commences.[14]

Alternatively, some courts have determined that the date of conviction may be the appropriate trigger, reasoning that any injuries alleged by a claimant would become manifest no later than the time of conviction. *Gulf Underwriters Insurance Co. v. City of*

Council Bluffs is illustrative of this analysis. In that case, the court noted that because the claimants' alleged injuries "became apparent no later than 1978, the year in which [c]laimants were convicted of murder and given life sentences[,] . . . these injuries should be deemed to have occurred, for insurance purposes, no later than 1978."^[15] Tying trigger of coverage to the date of conviction may be appropriate because the analysis focuses on the last possible point during the underlying criminal proceeding at which point the injuries or offenses giving rise to wrongful APC litigation actually took place.^[16]

By contrast, courts repeatedly have rejected attempts to trigger coverage under policies in effect after the date of conviction. For example, the United States Court of Appeals for the First Circuit in *Sarsfield v. Great American Insurance Co.* made clear that an allegation of continuing misconduct by a government official will not trigger coverage under any policy issued after the accused was convicted.^[17] As noted by the First Circuit, the allegation in the complaint that "the defendants 'continued to cover up their misconduct' . . . is not enough to allege a 'wrongful act' occurring during the coverage period [which incepted four years after conviction]."^[18] In *Idaho Counties Risk Management Program Underwriters v. Northland Insurance Cos.*, the Idaho Supreme Court rejected the argument that an official's ongoing failure to disclose wrongfully withheld evidence affected the trigger of coverage, noting that "the initial failure led to the continued withholding of exculpatory evidence and thus continued injury; however, such continued action and ongoing injury arose out of a single occurrence . . . that took place prior to the policy period, and [the insurer] is not liable for it."^[19]

Similarly, courts have held that a plaintiff's ongoing injury from civil rights violations (including those suffered during long-term incarcerations) cannot activate coverage under policies in effect after the conviction.^[20] For example, the district court held in *Sarsfield* that once a claimant suffers a specific injury from a civil rights violation, all other injury will be viewed as part of the initial injury unless it is "distinct"—that is, wholly unrelated.^[21] Most courts agree with this view that all potential violations of an exonerated individual's rights stem from the single event of the initial injury.

Courts also repeatedly have held that a "continuous" trigger of coverage is inapplicable in wrongful APC litigation in response to insureds that urge reliance on authority addressing trigger in the latent bodily injury context. The rationales that lead to the adoption of a continuous trigger in cases involving asbestosis and other gradually developing long-term diseases simply are not present in the context of wrongful arrest, prosecution, and conviction. Unlike a situation in which a latent injury caused by exposure to a hazardous substance or defective product is difficult to detect in its early stages or as of its date of origin, identifying the relevant injury or offense in wrongful APC litigation is straightforward and must be evident to the victim from at least the time of conviction if not earlier. As one court noted, "the 'continuous trigger' theory . . . is not well-suited to a situation where, as here, any injury was evident from the outset and first occurred prior to the inception of insurance coverage."^[22] Moreover, as the United States Court of Appeals for the Third Circuit observed in *City of Erie*, unlike asbestosis cases, "in malicious prosecution cases, there is no interval between arrest and injury that would

allow an insurance company to terminate coverage.”^[23] Rather, a claimant’s injuries all stem from the initial violation of his or her rights that accrues “as soon as charges are filed,” which has led numerous courts to conclude that a continuous trigger is inapplicable in the context of wrongful APC litigation.^[24]

II. The *McFatrige* Decision

Against this legal backdrop, in *National Casualty Co. v. McFatrige*, the Seventh Circuit considered the coverage implications raised by wrongful APC litigation filed by Gordon “Randy” Steidl, who was convicted of murder in 1987 in Edgar County, Illinois.^[25] In 2003, a federal district court granted Steidl’s writ of habeas corpus based on his claims of ineffective assistance of counsel and sentencing errors. Steidl subsequently brought a civil suit under state and federal law against various law enforcement officials and entities, including Edgar County and Michael McFatrige, the Edgar County State’s Attorney who prosecuted the murder case. Steidl alleged that McFatrige led a conspiracy to frame him for murder and sought damages based on numerous tort claims, including false arrest, false imprisonment, malicious prosecution, conspiracy, and intentional infliction of emotional distress. National Casualty Company and Scottsdale Indemnity Company sought a declaratory judgment that they had no duty to defend or indemnify under any of the policies issued by the companies.^[26]

After first determining that McFatrige was not an “insured” under either the Scottsdale-issued law-enforcement policy in effect while he was in office,^[27] or the three CGL policies that took effect after he left the state’s attorney office,^[28] the court nevertheless went on to address the county’s argument that McFatrige’s alleged continued suppression of exculpatory evidence constituted an ongoing tort that began with Steidl’s arrest in 1987 and continued until his release in 2003 and therefore triggered all policies in effect during that interval.^[29] The court rejected this argument, holding that “[n]one of the tort offenses Steidl claims McFatrige committed . . . occurred during any of the policy periods.”^[30]

In support of the conclusion that McFatrige had not committed an offense during any of the policy periods at issue, the Seventh Circuit went on further to analyze trigger of coverage for Steidl’s claims in two ways. First, concerning Steidl’s claim for false imprisonment, the court held that the trigger of coverage coincided with the accrual of the claim for statute of limitations purposes, which, under Illinois law, occurred when Steidl first was held pursuant to a warrant or other judicially issued process.^[31] Notably, however, the insurer on the risk at the time of arrest was not a party to the coverage litigation.

The Seventh Circuit also held that Steidl’s claims relating to his conviction^[32] did not accrue until the date of exoneration and thus could trigger coverage in 2003, when he was exonerated more than a decade after his arrest in 1987. As with the time of arrest, the insurer on the risk at the time of exoneration was not a party to the coverage litigation. To support its prediction that exoneration could trigger coverage under Illinois law, the court cited United States Supreme Court precedent establishing that, to prove a claim for malicious prosecution or similar offenses, Steidl was required to show “that his

conviction . . . has been reversed on direct appeal, . . . or called into question by a federal court’s issuance of a writ of habeas corpus.”^[33] Because Steidl “did not have a complete cause of action” until the court granted his writ of habeas corpus, the Seventh Circuit reasoned that coverage was not triggered until exoneration, long after the policies at issue had lapsed. Thus, the court held that Steidl’s suit potentially could trigger more than one policy (i.e., the policies in effect at the time of arrest and exoneration, respectively), although no such policy was issued by the insurers who were parties to the case.

In arriving at its conclusion that the subject insurers had no duty to defend, *McFatridge* undertook an especially unusual approach to the issue of trigger not suggested by the array of parties actually litigating before the court. The court conducted its bifurcated trigger analysis to refute the insured’s argument in favor of continuous trigger and made rulings with respect to ostensibly triggered policies that were not even at issue in the litigation. The court thus reached its conclusion without full consideration of the implications of coverage and without any input by insurers affected by the result. The decision also registered no awareness of authority in other cases holding that ongoing injuries from civil rights violations do not trigger coverage under policies issued subsequent to the initial injury.^[34] Instead, the *McFatridge* court conducted an unnecessary trigger-of-coverage analysis largely devoid of reason or support to reach conclusions about policies that were not at issue.^[35]

III. *McFatridge* Is Flawed and Should Not Be Followed

The Seventh Circuit’s decision in *McFatridge* to use the date of exoneration as one of two possible trigger dates for insurance coverage in wrongful APC litigation is problematic in several respects. It is inconsistent with the terms of the policies at issue in the case (and those typically found in policies procured by public entities and officials), departs from the reasoning adopted by the vast majority of other courts, and is doctrinally unsound on its own merits. Moreover, *McFatridge* stands to lead to inconsistent results for insureds and insurers, as subsequent authority demonstrates.

As an initial matter, the *McFatridge* decision is contrary to the terms of the liability policies at issue in the case and in wrongful APC litigation generally. The operative provisions of public entity or officials liability policies generally provide coverage based on whether specified injuries or offenses took place during the policy period.^[36] Therefore, a court considering trigger necessarily must focus on when the alleged injury or offense first took place. Critically, no injury or offense takes place when an individual is cleared of a crime. Rather, exoneration is remedial.

As noted by one court, an accused is “not in any sense legally injured by the [municipality] when the criminal prosecution against him was dismissed on his motion, and the [municipality] at that juncture ‘committed’ no ‘offense’ against [the accused].”^[37] Indeed, in many instances, an insured public official defending the wrongful APC litigation long ago lost all control over the underlying criminal action to prosecutors, meaning that termination of the criminal proceeding and exoneration are both outside of the control of the insured.^[38] In other words, exoneration constitutes a

remedy provided by a court rather than an insured's act or omission or an accused's injury. Using the date of exoneration to trigger coverage thus directly contradicts the plain language of occurrence-based coverage provisions typically found in public officials and entity liability policies and other similar types of policies.

Furthermore, *McFatridge*'s adoption of a trigger rule that focuses on the date of exoneration improperly relies on the accrual of a claim for statute of limitations purposes. As noted by the Third Circuit, a confluence of trigger and accrual is illogical.

[T]hese dates need not necessarily correspond. Reliance on the commencement of the statute of limitation is not dispositive in determining when a tort occurs for insurance purposes. Statutes of limitation and triggering dates for insurance purposes serve distinct functions and reflect different policy concerns. . . . Because of this fundamental difference in purpose, courts have consistently rejected the idea they are bound by the statutes of limitation when seeking to determine when a tort occurs for insurance purposes. For this reason, we do not believe the date on which the statute of limitation begins to run on malicious prosecution claims should determine when the tort occurs for insurance coverage purposes.[39]

Consistent with this approach, courts typically have rejected arguments that a tort claim's accrual for statute of limitations purposes can control the question of when a tort "occurs" for purposes of trigger of insurance coverage.[40]

The *McFatridge* decision also contravenes the widely held principle in the majority of wrongful APC litigation that there is only a single trigger of coverage that takes place, at the latest, at the time of conviction.[41] By suggesting that more than one trigger of coverage date is possible (i.e., the date of arrest for some claims and the date of exoneration for malicious prosecution claims), *McFatridge* diverges from more than a decade of precedent from other jurisdictions that has made clear that an exonerated individual's damages are apparent from the date of the initial violation of rights, which is, at the latest, the date of his or her conviction.[42]

In addition to departing from the analysis employed by a majority of courts addressing trigger of coverage, *McFatridge* is doctrinally unsound because it relies on inapposite precedent that does not address the interpretation of insurance contracts. The Seventh Circuit's trigger analysis principally relies on *Heck v. Humphrey*, a U.S. Supreme Court decision that involved a civil rights claim and had nothing to do with contract law, insurance policies, or trigger of coverage. *Heck* involved a prisoner who had not exhausted his state and federal remedies to contest his criminal conviction. The prisoner instead filed a Section 1983 suit seeking damages against government officials for alleged violations of his civil rights. The Supreme Court's ruling in *Heck* thus "lies at the intersection of the two most fertile sources of federal-court prisoner litigation," Section 1983 claims and habeas corpus proceedings.[43] In an attempt to resolve some of the overlap between the two statutes, the court held that a claimant must prove his "conviction . . . has been reversed on direct appeal, . . . or called into question by a

federal court's issuance of a writ of habeas corpus" in order to recover damages on unconstitutional conviction claim brought under Section 1983.[44]

The *Heck* Court's "favorable termination rule," as it is often referred to, primarily was designed to avoid the anomalous situation where Section 1983 claims and habeas corpus actions could produce inconsistent results, recognizing that "to permit a convicted criminal defendant to proceed with a malicious prosecution claim [absent a reversal of the criminal conviction] would permit a collateral attack on the conviction through the vehicle of a civil suit." [45] The policy concerns underpinning the *Heck* decision may be sound, but they are completely unrelated to the trigger-of-coverage analysis that is a fundamental aspect of insurance law. Trigger of coverage involves the application of the terms of an insurance contract relating to the determination of which insurance policy or policies is conceivably implicated by injuries or damages alleged by a third party to have resulted from an act or omission of the insured. The rules regarding the interpretation and application of such contract terms had no consideration in or impact on the *Heck* Court's holding, making the decision conceptually irrelevant to the determination of insurance coverage for a wrongful conviction claim or suit.

The shortcomings of the *McFatrige* trigger analysis, due in significant part to its misplaced reliance upon wholly inapposite civil rights authority, are well illustrated by *Northfield*, which was recently decided by a federal district court within the Seventh Circuit. In *Northfield*, the court struggled to apply *McFatrige* where the accused obtained relief as to one criminal conviction, but was being retried for that crime, and remained convicted as to yet another crime.[46] The court concluded that—because the accused had not yet achieved a "favorable termination" under *Heck* and "it is quite unclear whether [the accused] has been exonerated"—a strict application of *McFatrige* precluded any insurance coverage for the insured as to the wrongful APC litigation at issue.[47] As the court noted, *McFatrige* offers "imperfect guidance," and the Seventh Circuit court surely did not anticipate the "murky situation[s]" created by its ruling where exoneration is unclear yet wrongful APC litigation has been brought. Given that an exoneration date itself is not nearly as certain as the *McFatrige* decision presumes, it makes little sense to depart from the contract language and the numerous other well-reasoned decisions and instead impose the exoneration date as an anchor for a trigger determination. As *Northfield* intimates, the Seventh Circuit likely did not anticipate that a court applying its holding could fail to trigger potential coverage under *any* insurance policy even where the insured municipality maintained coverage during all times relevant to the dispute.[48]

The result in *Northfield* suggests that application of *McFatrige*'s trigger-of-coverage rules will result in vastly different outcomes from case to case, creating uncertainty for the parties to an insurance contract. It is critical for insurers and insureds to be able to rely on courts to interpret a contract according to its terms; otherwise, it is difficult to assess the risk that is assumed under the insurance contract. With the Seventh Circuit's decision in *McFatrige*, however, insurers and insureds face inconsistent results in wrongful APC litigation depending on the jurisdiction. In Illinois, at least,[49] insurers potentially are now exposed to much greater risk because wrongful conduct that occurred

decades ago can lead to civil rights suits that trigger coverage under policies that are meant to cover only wrongful conduct taking place in the present policy period.^[50] In short, courts that adopt the analysis employed in *McFatridge* would contradict the terms of public entity and officials liability policies and the vast majority of courts considering trigger of coverage in this context, and would introduce an array of other difficulties for insurers and insureds alike in analyzing trigger in wrongful APC litigation going forward.

IV. Conclusion

As noted in the introduction, the Seventh Circuit will have two opportunities to provide authoritative attention to the question of the trigger of coverage in wrongful APC litigation in *American Safety Casualty Insurance Co., et al. v. City of Waukegan* and *Northfield Insurance Co., et al. v. City of Waukegan*.^[51] Both cases involve the application of *McFatridge* in wrongful APC litigation and provide the Seventh Circuit a chance to reconsider its earlier opinion and prediction about trigger of coverage under Illinois law. Because *McFatridge* is contrary to numerous decisions in other jurisdictions, the Seventh Circuit properly should revisit its earlier outlier decision and bring its jurisprudence in line with the nearly two dozen other decisions addressing policy trigger in a similar context.

The majority of courts have, until recently, maintained a clear consensus that wrongful APC litigation triggers insurance coverage, at the latest, at the time of the accused's conviction. The Seventh Circuit's decision in *McFatridge* not only departs from well-established precedent but also contravenes traditional principles of contract interpretation. The decision is also doctrinally unsound because of its misguided reliance on precedent that is irrelevant and outdated. Moreover, the decision stands to have undesirable policy consequences by introducing uncertainty into the trigger analysis in the context of wrongful APC litigation. For these reasons, regardless of the outcome of the two recent appeals to the Seventh Circuit regarding the application of *McFatridge*, subsequent courts considering arguments that exoneration should trigger cover should ignore *McFatridge*'s holding and analysis because it is simply out of step with the approach taken by the majority of courts in wrongful APC litigation.

Keywords: trigger of coverage, wrongful conviction, malicious prosecution, exoneration, DNA evidence, *McFatridge*

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[2] *District Attorney's Office v. Osborne*, 557 U.S. 52 (2009).

[3] Kevin Davis, *After Years, Even Decades, The Exonerated Leave Prison Wall Behind—Only To Find New Barriers*, ABA Journal (Jan. 1, 2011) (“Director Rob Warden [of Northwestern University’s Center on Wrongful Convictions] estimates there are about 50 exonerations each year from both DNA and non-DNA cases.”); Samuel R. Gross, et al., *Exonerations in the United States: 1989 through 2003*, 95 J. Crim. L. & Criminology 523, 527 (2005) (“The rate of exonerations has increased sharply over the fifteen year period of this study, from an average for twelve a year from 1989 through 1994, to an average of forty-two a year since 2000.”). The increase in exonerations has exposed what some view as substantial weaknesses in the criminal justice system, which are being studied closely by policymakers and academics in an effort to better understand the factors that lead to wrongful convictions. See, e.g., Brandon Garrett, *Convicting the Innocent* (2011).

[4] *Skinner v. Switzer*,—U.S. —, 131 S. Ct. 1289 (2011) (federal courts have subject matter jurisdiction under 28 U.S.C. § 1983 to entertain claims of post-conviction prisoners seeking access to DNA evidence); *Connick v. Thompson*,—U.S. —, 131 S. Ct. 1350 (2011) (prosecutor’s office cannot be liable for wrongful conviction under 42 U.S.C. § 1983 for failure to train its prosecutors based on a single *Brady* violation); *Smith v. Cain*, U.S. Sup. Ct. Case No. 10-8194 (Nov. 8, 2011 oral argument regarding whether repeated failures to disclose exculpatory evidence constituted prosecutorial misconduct and resulted in constitutional violations under *Brady*). The U.S. Supreme Court’s focus on issues relating to wrongful convictions is not new. Prior to 2011, the U.S. Supreme Court recently decided several cases relating to wrongful convictions. See, e.g., *In re Davis*, 130 S. Ct. 1 (2009) (granting writ of *habeas corpus* filed directly with the Supreme Court—for the first time in over 50 years—and ordering district court to hear testimony and argument concerning evidence of actual innocence not available at criminal trial); *Osborne*, 557 U.S. 52 (holding that there is no constitutional right to DNA testing following guilty verdict); *Pottawattamie Cnty. v. McGhee*, 129 S. Ct. 2002 (2009) (granting petition for *certiorari* regarding whether prosecutors are absolutely immune for procuring false testimony during criminal investigation); *Van De Kamp v. Goldstein*, 555 U.S. 335 (2009) (ruling that prosecutors have absolute immunity from supervisory liability concerning failure to disclose potentially exculpatory evidence related to jailhouse informant). In addition, reflecting that eyewitness misidentification is a chief cause of wrongful convictions (Garrett, *Convicting the Innocent* at 9), state supreme courts recently have implemented sweeping new procedures whenever a criminal defendant challenges a witness’s identification. *New Jersey v. Henderson*, 27 A.3d 872



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

(N.J. 2011); *Minnesota v. Ferguson*, 804 N.W.2d 586 (Minn. 2011). See also *Perry v. New Hampshire*, U.S. S. Ct. Case No. 10-8974 (Nov. 2, 2011 oral argument before U.S. Supreme Court regarding procedural safeguards for and reliability of eyewitness identification).

[5] Brandon L. Garret, *Innocence, Harmless Error, and Federal Wrongful Conviction Law*, 2005 *Wis. L. Rev.* 35, 36, 42–45 (2005).

[6] See, e.g., John Conroy & Rob Warden, *The High Costs of Wrongful Convictions: Illinois Taxpayers Forced to Pick Up Big “Injustice Tab,”* Better Government Association, available at http://www.bettergov.org/investigations/wrongful_convictions_financial_costs.aspx (last visited Dec. 1, 2011) (noting that over the last 20 years, Illinois taxpayers had spent more than \$200 million on wrongful prosecution suits, including over \$30 million in attorney fees); Ryan Murphy, *Interactive: Payouts to Exonerated Prisoners*, *Texas Tribune*, Sept. 16, 2011, available at <http://www.texastribune.org/library/data/texas-exoneree-payouts> (last visited Dec. 1, 2011) (noting that Texas has spent more than \$33 million in payouts in 2010 and 2011).

[7] Benjamin C. Eggert & Amanda Schwoerke, *Trigger of Insurance Coverage for Wrongful Conviction Lawsuits*, *Coverage*, Vol. 20, No. 1, January/February 2010 at 21–27.

[8] See *Nat’l Cas. Co. v. McFatridge*, 604 F.3d 335 (7th Cir. 2010); *Selective Ins. Co. v. City of Paris*, 681 F. Supp. 2d 975 (C.D. Ill. 2010); *Gulf Underwriters Ins. Co. v. City of Counsel Bluffs*, 755 F. Supp. 2d 988 (S.D. Iowa 2010); *Northfield v. City of Waukegan*, 761 F. Supp. 2d 766 (N.D. Ill. 2010); *Am. Safety Cas. Ins. Co. v. City of Waukegan*, 776 F. Supp. 2d 670 (N.D. Ill. 2011); *Billings v. Commerce Ins. Co.*, 936 N.E.2d 408 (Mass. 2010); *Waters v. W. World Ins. Co.*, No. MICV200800089, 2011 Mass. Super. LEXIS 229 (Mass. Super. Ct. Sept. 12, 2011).

[9] *Am. Safety Cas. Ins. Co. v. City of Waukegan*, Nos. 11-2775, 11-2789 and 11-2961 (7th Cir.) and *Northfield Ins. Co. v. City of Waukegan*, No. 11-1215 (7th Cir.).

[10] 42 U.S.C. § 1983 (“Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .”).

[11] See Michael Avery, *Obstacles to Litigating Civil Claims for Wrongful Conviction: An Overview*, 18 *B.U. Pub. Int’l L. J.* 439 (2008–09).

[12] See *City of Erie v. Guar. Nat’l Ins. Co.*, 109 F.3d 156, 159 (3d Cir. 1997) (trigger for malicious prosecution is “when the underlying charges are filed”); *Selective*

Ins. Co. of S.C., 681 F. Supp. 2d at 980 (“[T]he majority of courts have held the tort occurs when the underlying criminal charges are filed.”); *N. River Ins. Co. v. Broward Cnty. Sheriff’s Office*, 428 F. Supp. 2d 1284, 1290 (S.D. Fla. 2006) (“The better rule . . . is to consider the time of the arrest and incarceration the ‘trigger’ in both malicious prosecution and false imprisonment cases.”); *Coregis Ins. Co. v. City of Harrisburg*, No. 1:03-CV-920, 2006 U.S. Dist. LEXIS 20340, at *32–38 (trigger related to time when claimant was arrested and incarcerated); *Town of Newfane v. Gen. Star Nat’l Ins. Co.*, 14 A.D.3d 72, 77 (N.Y. App. Div. 2004) (trigger for malicious prosecution is “date of the commencement of the underlying criminal prosecution”).

[13] *Northfield Ins. Co.*, 761 F. Supp. 2d at 773.

[14] See, e.g., *Zurich Ins. Co. v. Peterson*, 232 Cal. Rptr. 807, 813 (Cal. Ct. App. 1986) (California law) (“[A]n individual is first injured upon the filing of a complaint with malice and without probable cause.”); *Harbor Ins. Co. v. Cent. Nat’l Ins. Co.*, 211 Cal. Rptr. 902, 907 (Cal. Ct. App. 1985) (California law) (“[T]he gist of the tort is committed when the malicious action is commenced and the defendant is subjected to process or other injurious impact by the action.”); *N. River Ins. Co.*, 428 F. Supp. 2d at 1291 (Florida law) (holding that a municipality cannot invoke “personal injury” provisions of a policy “to cover allegations of malicious prosecution, false imprisonment and numerous allegations of negligence and civil rights violations” that took place prior to policy inception); *S. Md. Agric. Ass’n, Inc. v. Bituminous Cas. Corp.*, 539 F. Supp. 1295, 1302 (D. Md. 1982) (Maryland law) (holding that trigger is when “the alleged tortfeasor takes action resulting in the application of the state’s criminal process to the claimant”); *Billings*, 936 N.E.2d at 412 (Massachusetts law) (“The majority of jurisdictions that have considered the issue have concluded that the ‘occurrence’ causing personal injury under an insurance policy is the filing of the underlying malicious suit.”); *Royal Indem. Co., v. Werner*, 979 F.2d 1299, 1300 (8th Cir. 1992) (Missouri law) (“‘personal injury’ . . . is more likely intended to describe the time when harm begins to ensue, when injury occurs to the person, that is, in this case, when the relevant lawsuit is filed”); *Am. Family Mut. Ins. Co. v. McMullin*, 869 S.W.2d 862, 864 (Mo. Ct. App. 1994) (Missouri law) (“[T]he filing date of the underlying [malicious] lawsuit controls whether an insurance policy provides coverage.”); *Newfane*, 14 A.D.3d at 77 (New York law) (holding that trigger of coverage is when the prosecution is initiated, and “not[ing] that our determination of the issue accords with the great weight of authority from other jurisdictions”); *Ethicon, Inc. v. Aetna Cas. & Sur. Co.*, 688 F. Supp. 119, 127 (S.D.N.Y. 1988) (New York law) (“in a criminal or civil prosecution that is malicious . . . injury begins to flow from the time when the [malicious] complaint is filed”); *Paterson Tallow Co. v. Royal Globe Ins. Cos.*, 444 A.2d 579, 586 (N.J. 1982) (New Jersey law) (“We hold that for the purpose of determining the existence of coverage under this type of policy, in the absence of any qualifying exclusion or exception the offense of malicious prosecution occurs on the date when the underlying [malicious] complaint is filed.”); *Consulting Eng’rs, Inc. v. Ins. Co. of N. Am.*, 710 A.2d 82, 86–88 (Pa. Super. Ct. 1998), *aff’d*, 743 A.2d 911 (Pa. 2000) (Pennsylvania law) (holding that trigger occurs when the allegedly wrongful suit is filed).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

- [15] *Gulf Underwriters Ins. Co.*, 755 F. Supp. 2d at 1007.
- [16] See also *Sarsfield v. Great Am. Ins. Co. of N.Y.*, Civ. A. No. 07-11026-RWAZ, 2008 U.S. Dist. LEXIS 121421, at *11 (June 3, 2008 D. Mass. 2008), *aff'd*, 335 F. App'x. 63, 66–67 (1st Cir. 2009); *TIG Indem. Co. v. McFatridge*, No. 06-2008, 2007 U.S. Dist. LEXIS 23788, at *10 (C.D. Ill. Mar. 30, 2007); *Coregis Ins. Co.*, 2006 U.S. Dist. LEXIS 20340, at *34.
- [17] *Sarsfield*, 335 F. App'x at 67–68.
- [18] *Sarsfield*, 335 F. App'x at 68.
- [19] *Idaho Cntys. Risk Mgmt. Program Underwriters v. Northland Ins. Cos.*, 205 P.3d 1220, 1226 (Idaho 2009).
- [20] See, e.g., *Sarsfield*, 2008 U.S. Dist. LEXIS 121421, at *15–19; *Coregis Ins. Co.*, 2006 U.S. Dist. LEXIS 20340, at *35 (“That the effects of [the claimant’s] alleged injuries . . . may have extended into the respective policy periods does not change the Court’s analysis”); *Gulf Underwriters Ins. Co.*, 755 F. Supp. 2d at 1000 n.15.
- [21] *Sarsfield*, 2008 U.S. Dist. LEXIS 121421, at *12–13. See also *Coregis Ins. Co.*, 2006 U.S. Dist. LEXIS 20340, at *38 (“[N]or does [the accused] suggest that he has incurred injuries distinct from those he suffered as a result of his arrest, prosecution and ultimate conviction.”).
- [22] *City of Erie*, 109 F.3d at 165.
- [23] *City of Erie*, 109 F.3d at 165.
- [24] See *City of Erie*, 109 F.3d at 165; *Am. Safety*, 776 F. Supp. 2d at 712–13 (“[A]lthough the ‘multiple’ trigger theory has been applied in cases involving latent injury, such as asbestosis, or progressively worsening injuries, such as sexual abuse and environmental contamination, courts have consistently rejected this approach in cases involving civil rights claims like those at issue here.”); *Northfield Ins. Co.*, 761 F. Supp. 2d at 766 (rejecting continuous theory of trigger); *Billings*, 936 N.E.2d at 413 (“We also reject [the insured’s] suggestion that malicious prosecution be treated as a continuing tort for the duration of the underlying litigation, and that an ‘occurrence’ under the policy continues from the date the underlying malicious complaint was filed until the termination of that underlying litigation.”); *Coregis Ins. Co.*, 2006 U.S. Dist. LEXIS 20340, at *32–38 (rejecting continuous theory of trigger).
- [25] *McFatridge*, 604 F.3d 335.
- [26] Four different occurrence-based policies were at issue in the declaratory judgment action. Scottsdale issued a law enforcement policy naming the “County of Edgar S.D.” as the insured that was in effect from May 25, 1989, until May 25, 1990.

Scottsdale also issued two CGL policies to Edgar County for one-year periods between July 1, 1997, and July 1, 1999; National Casualty issued a CGL policy for the period covering July 1, 1999, to July 1, 2000. *McFatridge*, 604 F.3d at 337–38.

[27] In the first part of the opinion, the Seventh Circuit addressed whether coverage under the law enforcement policy issued by Scottsdale was triggered, given that the policy period (May 25, 1989 through May 25, 1990) included McFatridge’s tenure as a state’s attorney. The court ultimately held that McFatridge did not qualify as an insured under the terms of the policy because, *inter alia*, he was an employee of the state, not the Edgar County Sheriff’s Department, the named policyholder. *McFatridge*, 609 F.3d at 339–43.

[28] In the second part of its opinion, the court addressed whether coverage was triggered under any of the three CGL policies at issue, all of which took effect after McFatridge left the state’s attorney’s office (from July 1, 1997 to July 1, 2000). At the outset of its discussion, the court held that McFatridge was not an insured under any of these three policies that covered only offenses committed by “employees,” “elective officers,” and “duly elected officials”—categories that did not include McFatridge during the policy period of 1997–2000, given that he left office in 1991. *McFatridge*, 604 F.3d at 343–44. The court did acknowledge the county’s argument that the language of the third CGL policy referenced “all persons who *were* . . . your lawfully elected . . . officials” as insureds, but the court concluded that the allegations in the complaint did not allege any misconduct by McFatridge during the third policy period of 1999–2000. *McFatridge*, 604 F.3d at 343–44.

[29] *McFatridge*, 604 F.3d at 344.

[30] *McFatridge*, 604 F.3d at 344.

[31] *McFatridge*, 604 F.3d at 344.

[32] Steidl’s suit included a state law malicious prosecution claim and federal claims for denial of due process, unconstitutional conviction, and unconstitutional imprisonment. *McFatridge*, 604 F.3d at 344.

[33] *McFatridge*, 604 F.3d at 344 (citing *Heck v. Humphrey*, 512 U.S. 477, 486–87 (1994)).

[34] See cases cited *supra* note 16–23.

[35] Indeed, the *McFatridge* court’s statements about trigger arguably may be construed as dicta.

[36] See, e.g., *McFatridge*, 604 F.3d at 339 (quoting insuring agreement and definition of “occurrence” in policies at issue).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

- [37] *Newfane*, 784 N.Y.S.2d at 792. See also *Billings*, 936 N.E.2d at 413 (exoneration “is not an event that causes harm to the plaintiff and therefore [is] not an ‘occurrence’ within the meaning of the policy”).
- [38] See *Newfane*, 784 N.Y.S.2d. at 793.
- [39] *City of Erie*, 109 F.3d at 161.
- [40] See, e.g., *AC & S, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 972 (3d Cir. 1985) (statute of limitation cases “are not particularly relevant” to determining what event triggers insurance coverage); *Keene Corp. v. Ins. Co. of N.A.*, 667 F.2d 1034, 1044 (D.C. Cir. 1981) (statute of limitation cases “have no bearing” on a determination of when tort occurred for insurance purposes); *Ins. Co. of N.A. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1220 (6th Cir. 1980) (because of differences in underlying policies, statute of limitations cases are irrelevant to determining when asbestos-related tort occurs for insurance purposes); *Commercial Union Assurance Co. v. Zurich Am. Ins. Co.*, 471 F. Supp. 1011, 1015 (S.D. Ala. 1979) (“[C]ases dealing with the determination of the date or occurrence of a continuing injury or disease for the purpose of applying appropriate statute of limitations are not controlling for purposes of determining insurance coverage.”); *S. Md. Agric. Ass’n*, 539 F. Supp. at 1302–03 (date of accrual for statute of limitations is not determinative of date when tort of malicious prosecution occurs for insurance purposes); *S. Freedman & Sons v. Hartford Fire Ins. Co.*, 396 A.2d 195, 198–99 (D.C. 1978) (statute of limitations “provides little assistance” and “need not determine” when tort of malicious prosecution occurs).
- [41] See *supra* notes 12–16 and accompanying text.
- [42] *McFtridge* also improperly relied on a 30-year-old Illinois state intermediate appellate court decision, *Security Mutual Casualty Co. v. Harbor Insurance Co.*, for the proposition that, in Illinois, the offense of malicious prosecution “d[oes] not occur for insurance purposes, until [the date of exoneration].” See *Sec. Mut. Cas. Ins. Co. v. Harbor Ins.*, 382 N.E.2d 1, 5–6 (Ill. Ct. App. 1978) (citing *Roess v. St. Paul Fire & Marin Ins. Co.*, 383 F. Supp. 1231 (M.D. Fla. 1974)). Notably, *Security Mutual* decision was later overturned by the Illinois Supreme Court, though on grounds not relevant to *McFtridge*. See *Sec. Mut. Cas. Co. v. Harbor Ins. Co.*, 397 N.E.2d 839 (Ill. 1979). In addition, *Security Mutual* principally relied on a Florida district court decision addressing trigger of coverage for a malicious prosecution claim, a holding that had been abrogated by more recent Florida case law and has been “consistently criticized” by other courts declining to adopt its reasoning. See *N. River Ins. Co.*, 428 F. Supp. 2d at 1291 (noting that the *Roess* decision has been “consistently criticized” and declining to adhere to its holding); *Zurich*, 232 Cal. Rptr. at 813 (same); *Billings*, 936 N.E.2d at 413 (rejecting *Roess*). Finally, no other court addressing trigger of coverage in wrongful conviction cases has relied on *Security Mutual*’s holding; indeed, most courts have found that the Illinois Appellate Court’s reasoning is lacking in logic. See, e.g., *City of Erie*, 109 F.3d at 160 (acknowledging *Security Mutual* but declining to adopt its holding); *Selective Ins. Co. of S.C.*, 681 F. Supp. 2d at 980 (same).



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

- [43] *Heck*, 512 U.S. at 484.
- [44] *Heck*, 512 U.S. at 486–87.
- [45] *Heck*, 512 U.S. at 484 (internal quotation marks omitted).
- [46] *See Northfield Ins. Co.*, 761 F. Supp. 2d at 774–76.
- [47] *Northfield Ins. Co.*, 761 F. Supp. 2d at 776.
- [48] *Northfield Ins. Co.*, 761 F. Supp. 2d at 776. The anomalous result in *Northfield* is not unexpected given that “favorable termination” may not always exist. Indeed, the “favorable termination” requirement may be relaxed in Section 1983 suits in certain situations. *See, e.g., Spencer v. Kemna*, 523 U.S. 1, 20–21 (1998); *Wilson v. Johnson*, 535 F.3d 262, 267 (4th Cir. 2008). The variable application of *Heck*’s “favorable termination” requirement in some Section 1983 suits makes the Seventh Circuit’s choice in *McFatridge* to anchor its trigger determination upon civil rights jurisprudence regarding accrual of Section 1983 claims impractical in the insurance context, which is premised on consistency of contractual meaning.
- [49] The *McFatridge* decision applied Illinois law and thus is not necessarily binding authority for district courts within the Seventh Circuit applying the law of other states.
- [50] Indeed, as a matter of public policy, using the date of exoneration to trigger liability potentially creates perverse incentives for Illinois insureds. As the Third Circuit observed in *City of Erie*, reliance on the time of favorable termination can potentially allow “tortfeasors with information about their own potential liability to shift the burden to unwary insurance companies.” *City of Erie*, 109 F.3d at 160. A government with information regarding past prosecutorial misconduct potentially could secure prospective liability coverage from an unsuspecting insurer.
- [51] The authors’ firm, Wiley Rein LLP, has filed an amicus curiae brief on behalf of the American Insurance Association in *American Safety Casualty Insurance Co. v. City of Waukegan*.



Message from the Chairs

Welcome to the First All-Electronic Issue of Coverage

Coverage truly is a cutting-edge publication, and it is one of many benefits enjoyed by our Insurance Coverage Litigation Committee membership. The Section of Litigation has made the transition to an all-electronic format for a variety of “green” reasons. In addition, we now have the added benefit of reaching more than 58,000 Section of Litigation members with our new format. Some die-hards might bemoan the loss of glossy pages and purple banner of publications past. However, the new format will enable ICLC members to archive important articles, share in-depth analyses with others, and even print obligatory hard copies from each of our six annual editions. Many thanks to Erik Christiansen, our editor-in-chief, managing editors Ted Howard, Georgia Kazakis, Mike Levine, Ellis Medoway, Tonya Newman, and Amy Woodworth, and our many ICLC authors for their fabulous efforts.

Visit our [ICLC Website](#) for additional updates that will assist your practice. Kudos to our Website editors-in-chief John Buchanan, Rina Carmel, Jim Davis and Jayson Sowers, who work with Website Managing Editors Tred Eyerly, Marla Kanemitsu, Katherine Mast, Helen Michael, Greg Miller, and John Mumford and our almost 200 subcommittee cochairs.

Ron Kammer and Mary Calkins
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Editor's Notes

Welcome New Team Members

I would like to welcome to the *Coverage* team two new members. First, we have a new managing editor, as Amy J. Woodworth has replaced Celeste Elliott. Ms. Woodworth represents insurers, and she will help maintain the balance that traditionally has existed on *Coverage's* editorial board, as well as within the leadership of the Insurance Coverage Litigation Committee (ICLC). I look forward to working with Ms. Woodworth in 2012.

We also welcome Scott Lewis from the ABA to the team. As *Coverage* has transitioned to an electronic publication, the technological requirements of electronic distribution require the special expertise and knowledge of the ABA's excellent staff. We look forward to working with Mr. Lewis, and look forward to his assistance in bringing *Coverage* into the digital age.

Finally, we once again encourage anyone who attended the ICLC's Annual Meeting in Tucson, AZ, on March 1-3, 2012, to take the opportunity to convert your presentation



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

into an article for *Coverage*. Some of the best articles that *Coverage* has published have come out of the Tucson meeting.

[Erik A. Christiansen](#)

Editor in Chief—*Coverage*



Insurance Coverage Litigation

FROM THE SECTION OF LITIGATION INSURANCE COVERAGE LITIGATION COMMITTEE

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