

All About Captives

By Bruce Molnar

In recent months, captives have come to the forefront of the insurance industry. And, as a result, there has been increased interest in what they are, the benefits they provide and if they are a viable option for companies.

A captive is a privately held insurance company, and it can be a subsidiary of the insured business. It issues policies, collects premiums and pays claims, just like a commercial insurer; however, it does not offer insurance to the public.

While a captive can be a great financial tool, it will not work for every business. In order to create and operate a successful captive insurance program, the operating company must generally have a substantial amount of risk. That risk can be insured commercially, or it can be self-insured by the business. If a particular area of risk is already insured, then the business may elect to cancel its current commercial policies and insure those risks with a captive. If the risk is already being self-insured, there may be certain benefits of financing that risk via a captive. Other qualifying characteristics include:

- Profitable operations, with taxable income ranging from \$1.5 to \$100 million;
- \$250,000 or more of self-insured or uninsured business risk;
- 100 or more employees; and
- \$500,000 or more of commercial insurance expenses.

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The Discoverability and Admissibility of Reserve Information

By Kirk A. Pasich

Insureds and insurance carriers typically dispute the discoverability and admissibility of evidence of a carrier's reserves. In *Lipton v. Superior Court*, 48 Cal. App. 4th 1599, 56 Cal. Rptr. 2d 341 (1996), the California Court of Appeal defined reserves, stating that they represent the amount anticipated to be sufficient to pay all obligations for which the insurance company may be responsible under the policy with respect to a particular claim. That amount necessarily includes expenses that are likely to be incurred in connection with the settlement or adjustment of the claim, as well as the legal fees and other costs required to defend the insured. *Id.* at 1613.

The *Lipton* court also stated that "[t]he main purpose of a loss reserve is to comply with statutory requirements and to reflect, as accurately as possible, the insured's potential liability." *Id.* See also Cal. Ins. Code §923.5 ("reserves" are the amounts "estimated in the aggregate to provide for the payment of all losses and claims for which the insurer may be liable and to provide for the expense of adjustment or settlement of losses and claims"); Treas. Reg. §1.832-4(b) (for federal tax purposes, insurance carrier reserves "must be stated in amounts which, based upon the facts in each case and the company's experience with similar cases, represents a fair and reasonable estimate of the amount the company would be required to pay"); *MacGregor Yacht Corp. v. State Comp. Ins. Fund*, 63 Cal. App. 4th 448, 457, 74 Cal. Rptr. 2d 473 (1998) (an insurance carrier's standard for reserves that was based on a "realistic evaluation of all information in the file which reflects the reasonably anticipated final costs" satisfies the carrier's duties under Insurance Code).

Insureds contend that information regarding reserves is relevant to a wide range of issues, including a carrier's ability to pay, when a carrier received notice of or learned about claims, and whether a carrier acted in bad faith. Carriers typically disagree, contending that reserve information is confidential and is irrelevant to disputes with their insureds.

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Reserve Information

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THE DISCOVERABILITY OF RESERVES INFORMATION

The law is clear in many jurisdictions that insureds typically are entitled to discover information about reserves. *Lipton* is one of the leading cases. In *Lipton*, an insured had sued his insurance carrier for bad faith. He sought production of records regarding liability reserves that the carrier may have established regarding a malpractice action against him. The carrier refused to produce the documents, so the insured brought a motion to compel. The trial court denied the motion, concluding that the disclosure of setting reserves was not likely to lead to the discovery of admissible evidence and that "the percentage of its risk that [the carrier] assigns to other carriers is of no moment." *Id.* at 1605. The insured then filed a petition for writ of mandate, which the court of appeal issued.

The appellate court held that for discovery purposes, "information is relevant if it "might reasonably assist a party in evaluating the case, preparing for trial, or facilitating settlement." *Id.* at 1611. It stated, "Admissibility is not the test and information, unless privileged, is discoverable if it might reasonably lead to admissible evidence." *Id.* at 1611-12.

The court then explained why reserve information could be relevant:

[I]n a case where the insurer has denied coverage and refused a defense, the fact that a reserve had been set by the insurer might well be relevant to show that the insurer must have had some knowledge that a potential for coverage existed. In addition, an argument can be made for the proposition that loss reserve

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information might have some relevance to the question of whether a reasonable likelihood of an excess verdict existed or the insurer had conducted a proper investigation or given reasonable consideration to all of the factors involved in a specific case which might expose its insured to an excess verdict.

Id. at 1614.

The court's rationale is consistent with other California decisions. For example, in *Samson v. Transamerica Insurance Co.*, 30 Cal. 3d 220, 240, 178 Cal. Rptr. 343 (1981), the court noted that the establishment of a reserve fund was an indication that the insurance carrier knew of a duty to defend its insured. *Id.* See also *Miller v. Elite Ins. Co.*, 100 Cal. App. 3d 739, 753, 161 Cal. Rptr. 322 (1980) (in a bad faith case, carrier's establishment of a reserve fund for defense of insured's claim indicated that it perceived a possible duty to defend).

Evidence of a carrier's reserves is highly relevant in bad faith cases. The initial reserve that a carrier sets and the carrier's adjustments to the reserve may belie any claim by the carrier that it thought in good faith that there was no possibility of the claim's falling within coverage. In addition, communications regarding reserves may show that a carrier's own internal evaluation of the claim greatly differed from what it communicated to its insured.

Reserves also may show that a carrier acted in bad faith by seeking to avoid paying for claims for which it has clear exposure. For example, upon receiving notice of the underlying claims, the carrier has a duty to conduct an investigation to understand the claims and search for coverage. See *Egan v. Mut. of Omaha Ins. Co.*, 24 Cal.3d 809, 819, 157 Cal. Rptr. 482 (1979) ("it is essential that an insurer fully inquire into possible bases that might support the insured's claim"). Its failure to conduct the requisite investigation may subject it to liability for bad faith. See, e.g., *Id.* at 817 ("an insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured's claim");

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A Look at a Key Illinois Decision

By Bruce Lichtcsien

An Illinois appellate court recently held that a subcontractor's insurer wrongfully rejected a general contractor's tender of defense for a suit filed by the subcontractor's employee. *State Automobile Mut. Ins. Co. v. Habitat Constr. Co.*, ___Ill.App.3d___, 875 N.E.2d 1159 (1st Dist. 2007).

INTRODUCTION

Construction accidents have historically provided fertile ground for civil litigation. An inherently hazardous and sometimes dangerous work environment makes injuries at construction sites all too common. Illinois law has generally provided injured construction workers with numerous remedies to seek compensation for their injuries. Because Illinois prohibits employees from filing suits directly against their employers, injured workers, as a first avenue of recovery, often exercise their rights under the Illinois Workers' Compensation Act. The Structural Work Act, repealed in 1995, formerly provided injured workers with another statutory basis of recovery in the construction setting.

However, injured workers have not been left without a civil remedy since the repeal of the Structural Work Act. Illinois courts still permit suits against third parties under general principles of negligence. The Restatement (Second) of Torts ("Restatement") codifies many of these principles of negligence, which Illinois courts have recognized as valid authority in many cases. See, e.g., *Rangel v. Brookhaven Constructors, Inc.*, 307 Ill.App.3d 835, 719 N.E.2d 174 (1st Dist. 1999) (applying Section §414 of the Restatement). Under the Restatement, injured construction workers can seek to hold third parties civilly liable if a third party's conduct caused or contributed to the injury.

Construction litigation lends itself to a predictable pattern. In a large

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commercial project, a property owner will typically hire a general contractor to perform the construction work. The contract between the owner and a single general contractor simplifies the process for the owner who, in theory, only has to deal with the general contractor. The general contractor, however, does not usually perform all of the construction. The general contractor will, in turn, enter into subcontracts with various subcontractors to perform specialized work such as electrical, glazing, plumbing and general labor.

The usual scenario involving a personal injury lawsuit in the construction context arises when an employee of one of the subcontractors suffers an injury on the job. Because Illinois law does not permit him to sue his employer, an injured worker will seek to hold the general contractor liable for causing the worker's injuries. Theories against general contractors usually allege that the general contractor controlled the site but failed to provide a safe place for the injured worker to perform his job.

When an injured worker files suit against the general contractor, the latter usually has a couple of options regarding who will pay for its defense of the lawsuit. A general contractor can first turn to its own commercial general liability ("CGL") insurer. A second option is the possibility of a tender of the defense to the CGL insurer for the subcontractor whose employee was injured. As consideration to win the bid for the subcontract, the subcontractor will often agree to obtain insurance for the general contractor that names the general contractor as an additional insured on the subcontractor's CGL policy. In that case, the general contractor can request the subcontractor's insurer to defend the lawsuit and "deselect" or avoid triggering the general contractor's own insurance. This scenario is referred to as a "targeted tender." See *John Burns Constr. Co. v. Indiana Ins. Co.*, 189 Ill.2d 570, 727 N.E.2d 211 (2000).

FACTS OF THE CASE

In *Habitat*, the First District Appellate Court clarified the propriety of tendering the defense of a per-

sonal injury lawsuit in construction cases. *Habitat* arose in the typical fashion. Habitat Construction Company ("Habitat"), the general contractor for a construction project, hired Central Building & Preservation ("Central") as a subcontractor for the job. The written subcontract between Habitat and Central required Central to add Habitat as an additional insured to Central's CGL policy (the "State Auto Policy") with State Automobile Mutual Insurance Company ("State Auto"). Habitat also had its own CGL policy with Pennsylvania General Insurance Company ("Pennsylvania General").

The State Auto Policy contained a blanket additional insured endorsement, which defined an Insured as "any person or organization whom you are required to name as an additional insured on this policy under a written contract or agreement." The State Auto Policy limited the insurance for all additional insureds to "liability arising out of: (b) 'Your work' for that additional insured for or by you." The State Auto Policy further defined "Your work" as "Work or operations performed by you or on your behalf; and ... [m]aterials, parts or equipment furnished in connection with such work or operations."

Larry Medolan, an employee of Central, allegedly sustained an injury while working at the construction site. Medolan filed a complaint against Habitat alleging that Habitat was in charge of the construction project and that he suffered his injury in furtherance of the work. Medolan also alleged that Habitat was present during construction, coordinated the work, designed work methods and had the authority to stop the work if it was dangerous. Medolan's complaint claimed that his injury occurred when Habitat erected a concrete wall that fell on a scaffold on which Medolan was working. Medolan accused Habitat of negligence in failing to inspect the site, failing to supervise the site, failing to warn him of the dangerous condition, and directing workers to cut excessive amounts of concrete. Habitat filed a third-party complaint

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against Central in which it alleged that Central's negligence proximately caused Medolan's injuries.

Pursuant to the terms of its sub-contract with Central, Habitat tendered Medolan's complaint to Central for defense and indemnification. Central forwarded the matter to State Auto, which rejected Habitat's tender and filed a declaratory judgment action seeking a declaration that the State Auto Policy did not provide any defense or indemnity coverage to Habitat for the Medolan complaint.

ANALYSIS

The trial court entered summary judgment on behalf of State Auto. In reversing the trial court, the First District Appellate Court conducted a two-part analysis. First, the First District examined whether the State Auto Policy contained any exclusions specifically for the additional insured's own negligence. Next, the court considered whether the allegations in the complaint triggered coverage under the "additional insured" coverage based on liability "arising out of" Central's work.

The State Auto Policy Did Not Contain an Exclusion For Habitat's Own Negligence

The First District did not find any exclusions in the State Auto Policy for the additional insured's own negligence. Relying on several other Illinois decisions, the Court concluded that if the insurance policy contains an express exclusion directly applicable to the facts alleged in the complaint against the additional insured, the insurer has no duty to defend or indemnify. For example, in *National Union Fire Insurance Co. v. R. Olson Construction Contractors, Inc.*, 329 Ill.App.3d 228, 769 N.E.2d 977 (2d Dist. 2002), the Second District Appellate Court held that an exclusion for "Liability Resulting From [The Additional Insured's] Own Negligence Or The Negligence Of Its Servants, Agents Or Employees" operated to bar coverage to the general contractor on the subcontractor's insurance policy. See also *Am. Country Ins. Co. v. James McHugh*

Constr. Co., 344 Ill.App.3d 960, 801 N.E.2d 1031 (1st Dist. 2003) (barring coverage where policy excluded coverage for liability "arising out of any act or omission of the additional insured or any of their employees").

In contrast to policies that contain an express exclusion, the court concluded that a policy containing a provision that simply limits the insurer's coverage to liability "arising from your [subcontractor's] work" is insufficient to remove the complaint from the terms of coverage. Here again, the First District relied on what it considered controlling precedent in *State Automobile Mutual Insurance Co. v. Kingsport Development, LLC*, 364 Ill.App.3d 946, 846 N.E.2d 974 (2d Dist. 2006). Importantly, the policy at issue in *Kingsport* was identical to the policy at issue in *Habitat*. The First District adopted the reasoning of *Kingsport* in a wholesale fashion. Construing the same policy terms, *Kingsport* distinguished those cases involving an express exclusion on the grounds that the State Auto Policy required "only that the liability arise out of [subcontractor's] work and [did] not require a more detailed examination of whose acts and omissions are alleged to have caused the injury." *Id.* at 1166.

'But for' Central's Work, Medolan Would Not Have Been Injured

After concluding that the State Auto Policy did not bar coverage based on an exclusion for the additional insured's own negligence, the court next addressed whether a "but for" analysis should be the test employed to determine coverage under the "arising out of" language. Once again, the court found *Kingsport* authoritative. *Kingsport* determined the "but for" analysis to be the appropriate standard and "held that the allegations in the injured employee's complaint established that but for his work for [subcontractor] and [subcontractor's] presence on the construction site, he would not have been injured." *Id.* at 1167. Likewise, the First District determined that because the policy in *Kingsport* contained the identical "arising out of" language as found in the State Auto Policy, it was compelled to reach the same result. The court reasoned:

When the allegations of Medolan's complaint, which establish Medolan was injured in furtherance of his work for Central Building, are liberally construed, and are compared to the relevant provisions of the State Auto policy, it is clear that Medolan's alleged injuries at least potentially arose out of Central Building's work. *Id.* at 1167-68.

Thus, State Auto owed a duty to defend Habitat under the State Auto Policy.

A Final, Critical Wrinkle

In theory, Habitat seemingly emerged with a complete victory from the litigation based on the Court's holding that State Auto owed a duty, as a matter of law, to defend Habitat against the Medolan complaint. As a practical matter, however, the decision did not leave Habitat without a few remaining problems. In fact, based on the final section of the court's decision, Habitat may have notched only a pyrrhic victory.

Among the terms of the State Auto Policy was an "other insurance" clause, which provided:

Any coverage provided hereunder shall be excess over any other valid and collectible insurance available to the additional insured whether primary, excess, contingent, or on any other basis unless a contract specifically requires that this insurance be non-contributory and or primary or you [Central Building] request that it apply on a non-contributory and or primary basis. *Id.* at 1168-69.

State Auto contended that because the "other insurance" clause made the State Auto Policy excess, State Auto did not owe a duty to defend or indemnify Habitat until Habitat exhausted all of its primary insurance. Recognizing Habitat's right under *John Burns Construction Co. v. Indiana Insurance Co.*, 189 Ill.2d 570, 727 N.E.2d 211 (2000) and its progeny to make a "targeted tender" to State Auto, the First District tempered Habitat's apparent victory with a reference to the Court's decision in

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New Approach to Policy Interpretation

By Sheila R. Caudle and Tyler Henkel

Once upon a time, the relationship between insurer and insured was one of contract and was governed by the terms and conditions of the policy. Even after common law modifications of this common law relationship and legislative regulation of the parties' consensual relationship, it still is fundamentally based on agreement of the parties.

Justice J. Dale Wainwright, concurring, in the 2005 decision of the Texas Supreme Court in *Excess Underwriters at Lloyds v. Frank's Casing Crew & Rental Tools, Inc.*, 2005 WL 1252321 (decided May 27, 2005) (citations omitted).

Justice Wainwright's concurrence appears prophetic, for in a series of recent decisions, the Texas Supreme Court has refused to imply terms or conditions in an insurance contract, even if it had strong equitable or public policy reasons to do so. The Texas court is an influential one, so its "show me the language" approach could be coming to a court near you.

Three decisions — *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007); *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*, 236 S.W.3d 765 (Tex. 2007); and *Excess Underwriters at Lloyd's v. Frank's Crew & Rental Tools, Inc.*, 2008 WL 274878 (decided Feb. 1, 2008) — appear to reflect the Texas Supreme Court's view that courts applying Texas law should not read more into policies than what is expressly included. And, if there is an agreement apart from the insurance contract, the Texas Supreme Court will look for it to be in writing.

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THE CANTU DECISION

In *Cantu*, an insured sued multiple parties for severe injuries sustained in an auto accident. Her medical insurer intervened, claiming a subrogation right under the policy. The insurer looked only to the insured for its recovery after she settled with various defendants. Her medical expenses exceeded the settlement amount plus the benefits the medical insurer had paid. Under the equitable "make whole" doctrine applied at the time, an insurer was not entitled to subrogation of medical benefits paid to an insured.

However, the Texas Supreme Court rejected nearly three decades of common law to hold that the doctrine must yield to an insurer's right to contractual subrogation under the "plain terms of the insurance policy." 234 S.W.3d at 644. In holding that the equitable doctrine could not supplant contract language, the court observed:

We do not disagree that equitable and contractual subrogation rest upon common principles, but contract rights generally arise from contract language; they do not derive their validity from principles of equity but directly from the parties' agreement. The policy declares the parties' rights and obligations, which are not generally supplanted by court-fashioned equitable rules that might apply, as a default gap-filler, in the absence of a valid contract. If subrogation arises independent of any contract, then an express subrogation agreement would be superfluous and serve only to acknowledge this pre-existing right, a position we reject. Contractual subrogation clauses express the parties' intent that reimbursement should be controlled by agreed contract terms rather than external rules imposed by the courts. *Id.* at 647-648.

Signaling the rationale for subsequent decisions, the *Cantu* court added that "[w]here a valid contract prescribes particular remedies or imposes particular obligations, equity generally must yield unless the contract violates positive law or offends public policy." *Id.* at 648-649. It went on to reaffirm its view that insurers

are equipped to evaluate and reduce risk through the way they draft policies, such as replacing implied equitable rights with specific contractual rights. "We agree with those courts holding that contract-based subrogation rights should be governed by the parties' express agreement and not invalidated by equitable considerations that might control by default in the absence of an agreement." *Id.* at 650.

THE MID-CONTINENT DECISION

A few months after its June 2007 *Cantu* decision, the Texas Supreme Court decided "what happens when two insurance companies do battle in that court?" (Texas Supreme Court Chief Justice Wallace B. Jefferson, writing in *The Jefferson Court Blog*, <http://texas-opinions.blogspot.com/2007/10/supreme-court-answers-certified.html>, Sunday Oct. 14, 2007.) On Oct. 12, 2007, the court ruled in *Mid-Continent* that a primary insurer that pays more than what it considers to be its fair share toward the settlement of a tort claim has no remedy against another primary insurer who paid the smaller portion. As in *Cantu*, the decision turned on the language of the agreements.

In *Mid-Continent*, a car crashed in a construction zone where lanes narrowed for a highway project. Among others, the injured parties sued the general contractor, Kinsel Industries, and Crabtree Barricades, a subcontractor responsible for the signs and dividers. Kinsel had a \$1 million primary liability policy with Liberty Mutual and a \$10 million excess policy, also with Liberty Mutual. Crabtree had a \$1 million policy with Mid-Continent, which identified Kinsel as an additional insured for liability arising from Crabtree's work.

Liberty Mutual and Mid-Continent agreed that each owed some portion of Kinsel's defense and indemnification, but disagreed on the settlement value of the case against Kinsel. Mid-Continent valued the case at \$300,000, while Liberty Mutual was prepared to pay its share of \$1.5 million. After Mid-Continent's repeated refusal to increase its contribution, Liberty Mutual agreed at a mediation to settle on Kinsel's behalf for \$1.5

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million. Liberty Mutual demanded that Mid-Continent pay half, but Mid-Continent would agree to pay no more than \$150,000 on Kinsel's behalf. Ultimately, Liberty Mutual paid \$1.35 million, or \$350,000 more than its \$1 million primary limit.

Liberty Mutual sued Mid-Continent, seeking to recover the latter's *pro rata* share of the settlement. After a bench trial, the United States District Court for the Northern District of Texas held that Liberty Mutual was entitled to recover \$550,000 from Mid-Continent through subrogation, concluding that Mid-Continent unreasonably assessed its insured's exposure.

Upon appeal, the United States Court of Appeals for the Fifth Circuit certified questions to the Texas Supreme Court. In response, the Texas high court held that: 1) *pro rata* "other insurance" clauses precluded any equitable contribution claim; 2) Liberty Mutual had no subrogation claim against its co-insurer after fully indemnifying the insured; and 3) Liberty Mutual had no subrogation claim based on the insured's alleged right to reasonable negotiation and participation by the co-insurer in settlement.

In reaching these holdings, the court explained that a *pro rata* "other insurance" clause precludes a direct claim for contribution among insurers because the clause makes the contracts several and independent of each other. With independent contractual obligations, co-insurers do not meet the common obligation requirement of a contribution claim. In effect, each co-insurer contractually agreed with the insured to pay only its *pro rata* share of a covered loss. In the Texas court's view, a co-insurer paying more than its contractually agreed-upon proportionate share does so voluntarily, that is, without a legal obligation to do so, and cannot recover the excess from the other co-insurers.

Liberty Mutual also could not pursue subrogation, the court concluded, because in a case of contractual or equitable subrogation, the insurer stands in the shoes of the insured, obtaining only those rights held by

the insured against a third party, subject to any defenses held by the third party against the insured. The court decided that because "[a]n insured's right of indemnity under an insurance policy is limited to the actual amount of loss" and the insured had been made whole, the insured had no rights against Mid-Continent. 236 S.W.3d at 775. Because Liberty Mutual's insured had no right of recovery against Mid-Continent, Liberty Mutual did not have a right of recovery against Mid-Continent.

In addition, the Texas Supreme Court determined that Liberty Mutual had no claim against Mid-Continent based on subrogation to the insured's alleged right to reasonable negotiation and participation by Mid-Continent in the settlement of the tort claim. The majority reasoned that the accident victims did not make a settlement offer within policy limits, so Mid-Continent breached no duty to the insured. In this regard, the court re-affirmed that the only common law duty owed by a liability insurer to an insured is the *Stowers* duty to accept reasonable settlement offers within policy limits. (In *Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved), it was held that an action for improperly failing to settle a claim could be brought when certain requirements were met.)

THE FRANK'S CASING DECISION

Just a short time ago, the Texas Supreme Court withdrew its prior opinion and reversed itself to hold that reimbursement of amounts paid for portions of claims that are not covered will not be had unless an insurer includes a right to seek such reimbursement in the policy itself or obtains an insured's consent to seek reimbursement.

Frank's Casing examined whether the court should recognize an exception to the rule established in a prior case, *Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128, 135 (Tex. 2000), and "imply a reimbursement obligation when the policy involves excess coverage, the insurer has no duty to defend under the policy, and the insured acknowledges that the claimant's settlement offer is reason-

able and demands that the insurer accept it." 2008 WL 274878 at *2. Once again, focusing on the *writing* it had before it, the Texas Supreme Court answered in the negative.

In the case, the insured, Frank's Casing Crew & Rental Tools, Inc. was sued when the drilling platform it fabricated collapsed. Frank's Casing had a \$1 million primary liability policy and excess coverage up to \$10 million with Excess Underwriters at Lloyd's ("Underwriters"). The excess policy did not require Underwriters to assume control of the defense or the settlement of any claims, but gave it the right to associate with defense counsel retained by Frank's Casing or the primary insurer if it was reasonably likely that the excess coverage layer would be reached.

Identifying coverage issues when notified of the drilling platform claim, Underwriters reserved its rights under the excess policy. Before trial, Frank's Casing forwarded a \$7.5 million settlement demand to Underwriters, stating that the demand was reasonable and should be accepted. Frank's Casing reiterated its disagreement with Underwriters' coverage position, stating that it was looking to Underwriters to fund the settlement. Underwriters responded that it would pay \$7.5 million to settle the claim, less any contribution from the primary carrier, and then seek reimbursement from Frank's Casing. Within hours, Underwriters contacted the claimant and settled the claim. Frank's Casing did not consent to Underwriters' terms.

Initially, the trial court granted Underwriters' motion for summary judgment on the right to reimbursement. Before a final judgment was entered, however, the *Matagorda County* decision was issued, declining to recognize an implied-in-fact, implied-in-law or equitable reimbursement right outside of the insurance policy's provisions. Ultimately, the Texas Supreme Court took the case to decide the reimbursement issue.

In refusing to imply a reimbursement right, the *Frank's Casing* court, in large degree, focused on the agreement between the insured and the insurer — and its documentation. In

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particular, the court reiterated its view that an insurer could impose a reimbursement obligation on its insured by either drafting policies to specifically include such a right, or by obtaining the insured's clear and unequivocal consent to the settlement and the insurer's reimbursement right.

Underwriters argued that Frank's Casing impliedly consented to reimbursement by soliciting the settlement. However, this argument did not convince the Texas Supreme Court. It reasoned that Frank's Casing's role in procuring the settlement demonstrated its belief that the claim should be settled, but did not establish an agreement to reimbursement, particularly when Frank's Casing continued to express disagreement with Underwriters' coverage position and looked to the insurer to fund the settlement.

The court also rejected Underwriters' argument that it was entitled to equitable reimbursement under the doctrines of *quantum meruit* and *assumpsit*. In the court's view, the insurance policy addressed the matter: recovery under equitable theories would be inconsistent with the express agreement because allowing reimbursement would require the court to rewrite or add language to the policy.

THE CASES REFLECT A TREND

These three cases sound a common theme — the Texas Supreme Court is likely to place its energy into focusing

on policy language and will be relatively unimpressed by arguments rooted in equity and public policy. "Show me the language" appears to be the court's mantra. In *Mid-Continent*, the court looked to the language of the "other insurance" clauses and gave them effect. The court placed *Mid-Continent* and *Liberty* in the position of independent obligors with no rights against each other, and refused to read equity into the contract language or to create an extra-contractual right. Similar reasoning is reflected in the *Cantu* and *Frank's Casings* decisions.

The *Mid-Continent* case is likely to be the most far-reaching. Commentators have lamented that by precluding a contribution or subrogation action in the circumstances of *Mid-Continent*, the Texas Supreme Court has discouraged settlement by insurers, particularly where insurers disagree about a claim's value. In the past, insurers that disagreed about a claim's value might nevertheless agree to settle the case and deal with allocation later. *Mid-Continent* presents a serious obstacle to that approach, with some predicting that many more cases will be tried to verdict.

The court's pronouncements about *Liberty Mutual's* right to subrogate facially run contrary to the logic of subrogation. It is by payment through the insured that insurers become subrogated to the insured's rights against third parties. The court instead found the payment to the insured, the very

act that creates a right of subrogation, defeated *Liberty Mutual's* ability to proceed against *Mid-Continent* under a subrogation theory because "[a]n insured's right of indemnity under an insurance policy is limited to the actual amount of loss."

However, the court simply understood the policy to say that an insurer could subrogate to an insured's loss. In a literal sense, the insured no longer had a loss. The insurer covered the insured's loss. The court likely understood that its literal reading of the policy and its literal understanding of "loss" were inconsistent with common assumptions about insurance policies and principles of subrogation. However, in its view, such an interpretation is consistent with a literal reading of the policy.

CONCLUSION

The message in *Cantu*, *Mid-Continent*, and *Frank's Casing* is: *Put it in writing*. Reliance on arguments rooted in public policy and equity are not likely to get a party very far, but reliance on policy language probably will. Insurers that carefully draft their policies are likely to see them enforced by a court applying a strict constructionist approach.



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Key Illinois Decision

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Kajima Construction Services, Inc. v. St. Paul Fire & Marine Insurance Co., 368 Ill.App.3d 665, 856 N.E.2d 453 (1st Dist. 2006), in which the First District held that an insured cannot make a targeted tender to an excess insurer until the insured's primary coverage is exhausted. In other words, under *Kajima*, horizontal exhaustion trumps a targeted tender. The Supreme Court of Illinois recently affirmed the First District's decision in *Kajima*, reinforcing the principle that *Habitat* must exhaust its primary limits of insurance before

the State Auto Policy is triggered. See *Kajima Constr. Servs., Inc. v. St. Paul Fire and Marine Ins. Co.*, No. 103588, 2007 WL 4200949 (Ill. Nov. 29, 2007).

Habitat carried a CGL policy with Pennsylvania General. However, the court did not have any information about the terms of the Pennsylvania General policy to determine whether the primary limits of the policy were exhausted such that the Medolan complaint would trigger the State Auto Policy. Consequently, the court remanded the case to the trial court to decide whether *Habitat* had any other primary insurance and, if so, whether *Habitat's* primary policy(ies) would be exhausted to the extent

that State Auto would be obligated to provide a defense or indemnity under the State Auto Policy.

CONCLUSION

Habitat teaches an important and cautionary lesson. In the current landscape of targeted tenders in construction cases, insurers for subcontractors often provide "additional insured" coverage to general contractors pursuant to the subcontractor's contractual obligation to furnish insurance naming the general contractor as an additional insured on the subcontractor's CGL policy. Under *Habitat* and *Kingsport*, in the absence of a specific exclusion

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barring coverage for liability resulting from the additional insured's own negligence, the general contractor may make a valid tender of defense to the subcontractor's insurer. Terms in the subcontractor's policy which

merely limit the coverage to liability "arising out of" the subcontractor's work are not enough to avoid coverage. The policy must contain a specific exclusion.

Whether the expansion of the targeted tender rule in *Habitat* and *Kingsport* amounts to an increase in insurance coverage remains in doubt.

In light of *Kajima*, many targeted tenders may be short-circuited if the subcontractor's policy contains an "other insurance" clause and the general contractor has other primary insurance which it has yet to exhaust.



Reserve Information

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Hughes v. Blue Cross of N. Cal., 215 Cal. App. 3d 832, 845, 263 Cal. Rptr. 850 (1989) (carrier's practice of denying claims without investigation into facts that support coverage may constitute bad faith). Thus, evidence of reserves that a carrier initially set may show that a carrier did just the opposite of looking for facts supporting coverage — it instead looked for ways to avoid coverage.

Indeed, it long has been understood that what a carrier does internally when it sets and changes reserves with respect to underlying claims is helpful to a determination of whether the carrier has acted in bad faith. See Lee R. Russ, COUCH ON INSURANCE, §251:29 (3d ed. 2007) ("The general relevance of loss reserves is highest in cases involving alleged bad faith on the part of the insurer in denying coverage, especially when the insurer also disclaims any duty to defend its insured against a third-party claim, in which the amount of the reserve and the date the reserve was set or adjusted could well belie a later claim that the insurer thought in good faith that there was no possibility of the claim falling within coverage."); Robert Marc Chemers, *Bad Faith Litigation*, National Business Institute Insurance Coverage Litigation, at 68, §(E)(1)(d) (2006) ("In considering a bad faith claim in third-party insurance, the fact that the [insurance carrier] established a reserve may offer proof of potential liability, and is, therefore, relevant to the issue of bad faith").

Therefore, information regarding reserves should be discoverable in many situations. For example, if an insured has a policy with "retrospective" premiums, reserve information should be discoverable. With such

policies, the reserve set by a carrier and the carrier's loss experience often impact the amount that the insured has to pay as premiums and/or the dividends that the insured otherwise might be entitled to receive. "In such a case, the setting of reserves can be directly related to the insured[']s damages." *Lipton*, 48 Cal. App. 4th at n.16.

LATE NOTICE OF A SUIT

Reserve information also may be discoverable if an insurance carrier claims that the insured's notice of a suit was late. In that situation, when the carrier established a reserve could be directly relevant to the question of when it first learned of the claim against the insured.

Additionally, as the *Lipton* court observed, a carrier's valuation of a claim against its insured, "whether compelled by law or business prudence, is information which might well lead to discovery of evidence admissible on any number of issues which commonly are presented in bad faith actions." *Id.* This includes, as the *Lipton* court noted, whether a carrier conducted a proper investigation, whether the carrier was aware of a reasonable likelihood of an excess verdict, whether the carrier gave proper consideration to factors regarding its duties, and, in many instances, whether the carrier actually interpreted the policy in manner inconsistent from what it was telling its insured. As another court aptly explained:

[E]xamination with respect to the reserve may develop evidence on the issue of defendant's bad faith. Bad faith is a state of mind which must be established by circumstantial evidence. The actions of defendant in respect to the reserve are relevant. Negligent investigation and uninformed evaluation of the worth of the ...

claims [against the insured] go to the heart of the case since serious and recurring negligence can be indicative of bad faith.

Groben v. Travelers Indem. Co., 49 Misc. 2d 14; 266 N.Y.S.2d 616, 619 (N.Y. Sup. Ct. 1965).

THE ADMISSIBILITY OF RESERVES INFORMATION

The fact that information about reserves may be discoverable does not mean that the information is admissible into evidence during trial. However, many courts have admitted evidence regarding reserves during trial. For example, in *Kirchoff v. American Casualty Co.*, 997 F.2d 401, 405 (8th Cir. 1993), the insured argued at trial that the fact that the carrier set a \$300,000 reserve, but offered only an amount substantially below that reserve to settle the underlying action, as evidence that the carrier acted in bad faith in considering settlement offers. On appeal, the carrier argued for a new trial because it claimed that the trial court erred by admitting the reserves evidence, which the carrier argued prejudiced its position at trial. In upholding the trial court's decision to admit reserve evidence, the court found:

Clearly, if [the carrier's claims handler] valued [the insured's] claim at \$300,000 (and [the carrier] concedes for purposes of this appeal that she did) but offered only \$8,000 to settle [the insured's] claim, evidence of that valuation was relevant to the issue of whether [the carrier's] settlement offers were made in good faith. The District Court did not abuse its discretion in receiving such evidence.

Id.

In *Kabatoff v. Safeco Insurance Co. of America*, 627 F.2d 207, 210 (9th

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Reserve Information

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Cir. 1980), the court upheld a jury verdict finding that the carrier acted in bad faith because it refused to settle the policyholder's claim within the policy limit. In upholding the verdict, the Ninth Circuit discussed the evidence presented to the jury, including the fact that the insurance company set a \$22,500 reserve for the underlying claims, but never offered to settle them for more than \$6,500. *Id.* at 208.

In *First National Bank of Louisville v. Lustig*, 1993 U.S. Dist. LEXIS 14128, at *2 (E.D. La. Oct. 4, 1993), the court also addressed similar facts. At trial in that action, the insured argued that evidence of the reserve set by the carrier supported the insured's claim that the carrier refused to settle the underlying action in bad faith. The court admitted the reserves evidence because it concluded that "[r]eserve information is relevant to show the insurer's state of mind in relation to its claims settlement practices." *Id.* According to the court, reserve information was relevant because "[e]xamination with respect to the reserve may develop evidence on the issue of the defendant's bad faith." Thus, the court concluded, "reserve information is relevant and has probative value regarding the bad faith claim because it tends to elucidate the [carrier's] state of mind." *Id.* The court also rejected the carrier's claimed issue of prejudice: "[F]urther, the court finds that reserve information will not unfairly prejudice the [carrier], confuse the issues, or mislead the jury." *Id.* at *3. See also *MacGregor Yacht Corp. v. State Comp. Ins. Fund*, 63 Cal. App. 4th 448, 460, 74 Cal. Rptr. 2d 473 (1998) (covenant of good faith

and fair dealing required the carrier to conduct its claims resolution and reserve allocation processes with good faith concerning the insured's interests, and setting an unreasonably high reserve was in bad faith).

California courts have reached similar conclusions. For example, in *Greene v. Century National Insurance Co.*, 2004 WL 1682129 (Cal. Ct. App. July 28, 2004), the insured claimed that the carrier acted in bad faith with respect to handling its claim for coverage. As evidence of the carrier's unreasonable conduct, the insured sought to rely at trial upon evidence regarding the reserves set by the carrier in that action. The carrier filed a motion *in limine* seeking to exclude any evidence regarding its reserves. In affirming the trial court's admission of reserves evidence, over the carrier's objection, the appellate court found:

Respondents submitted a motion *in limine* to exclude testimony about the amount of reserves [the insurance carrier] set during the handling of the claim. The trial court ruled that evidence regarding reserves was admissible to judge [the insurance carrier's] state of mind with respect to the bad faith claim.

While the setting of reserves is statutorily mandated, the existence of reserves may be relevant to the issue of whether an insurer acts in bad faith by not investigating a claim reasonably and in good faith. ... Here, the setting of the several hundred thousand dollars in reserves did bear on the issue of whether [the carrier] acted reasonably when it initially closed its file and later when negotiating with appellant's representatives. We find no abuse of discretion in the denial

of respondent's motion. *Id.* at *20.

In *Shade Foods v. Innovative Products Sales & Mktg.*, 78 Cal. App. 4th 847, 93 Cal. Rptr. 2d 364 (2000), the appellate court reviewed a trial court decision finding that the carrier acted in bad faith. In upholding the decision, the court reviewed the evidence presented at trial in support of the carrier's bad faith conduct. In that context, the court acknowledged that the carrier set an \$800,000 reserve, and in light of that fact, the carrier "could not reasonably maintain that there was no potential for coverage under the policy." *Id.* at 883.

In *Miller v. Elite Insurance Co.*, 100 Cal. App. 3d 739, 161 Cal. Rptr. 322 (1980), the appellate court upheld the trial court's directed verdict for the insured, finding that the carrier committed bad faith. In deciding whether the carrier acted in bad faith, the trial court considered, among other evidence, the carrier's reserves information. *Id.* at 757. Specifically, the appellate court identified evidence considered by the trial court that the carrier initially set a \$5,000 policy limit reserve, but then reduced it to \$2,000 because it believed that a policy exclusion applied to limit coverage. *Id.* at 749. The court affirmed the trial court's directed verdict, finding that the carrier acted in bad faith by rejecting a policy limit settlement demand of \$5,000, instead relying upon the potential application of an exclusion to deny coverage. *Id.* at 757.

Thus, evidence of reserves should be both discoverable and admissible into evidence in many bad faith cases and in other cases in which reserves relate to a disputed issue.



Captives

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The Internal Revenue Code, related IRS rulings, and case law all support the use of captive insurance companies to manage risk. When properly employed, the use of a captive insurance strategy can help a

business owner to better manage his or her insurance costs, control claims, accumulate surplus in anticipation of unforeseen risk, and allow for the accumulation of wealth on a tax-deductible basis. And while the company may exhibit the above stated characteristics, how does a business owner know if his or her business truly qualifies for a captive?

QUALIFYING FOR A CAPTIVE

For large builders, manufacturers, distributors and trucking companies, captives are becoming more and more widespread thanks to increased industry awareness.

As a business owner, regardless of industry, the first step is to take a closer look at the overall risk that

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CASE BRIEFS

MASSACHUSETTS HIGH COURT UPHOLDS USE OF CATASTROPHE MODELS

The Massachusetts Supreme Judicial Court issued the first judicial decision to address the use of computer catastrophe models as evidence in January. The court found “substantial evidence” to support using hurricane models to develop homeowners insurance rates for the Massachusetts Property Insurance Underwriting Association (or FAIR Plan). This evidentiary ruling was one of several grounds on which the court upheld a decision by the Massachusetts Commissioner of Insurance that approved a 12.7% increase in Mass FAIR Plan rates.

The opinion took into account the widespread use of hurricane catastrophe models throughout the insurance industry. Because the use of the models was extensively litigated and was upheld based on standards for scientific evidence applied in many courts, the Massachusetts decision sets a significant precedent for the use of catastrophe models.

In recent years, as a result of the growth in its business in coastal areas exposed to hurricanes, the MPIUA has become the largest homeowners insurer in Massachusetts and the second largest residual market homeowners insurer in the nation (after Citizens in Florida). For more than a decade, Mass FAIR Plan rates were capped as a function of statewide voluntary market rates, which lead to a widening gap between FAIR Plan rates and actuarially indicated rates in coastal areas. Legislation enacted in 2004 addressed this gap by directing the Commissioner of Insurance to consider predicted hurricane losses and costs of reinsurance “notwithstanding” the rate caps.

In its ensuing rate case, the MPIUA included a hurricane loss load developed using hurricane catastrophe models from AIR Worldwide Corporation and Risk Management Solutions, Inc. (RMS). The Massachusetts Attorney General challenged the use of these widely accepted models in place of the MPIUA’s historical losses (which

were negligible because of the interval since a hurricane has struck Massachusetts and the changes in the MPIUA portfolio since then). Even so, the Attorney General’s proposed rates also blended historical data with loss projections from the AIR model. The Massachusetts State Rating Bureau, too, challenged use of the RMS model, which produced higher projected losses for the MPIUA’s portfolio than did AIR’s.

The result was an extensive hearing before the Massachusetts Commissioner of Insurance, with over 100 exhibits and several days of testimony in support of and opposed to the MPIUA’s use of models. In the end, the Commissioner rejected the Attorney General’s position that hurricane loads should incorporate historical experience and was “persuaded that it is appropriate to use mathematical models to develop rates, but that there is no single preferred approach for doing so.” In turn, she determined that, although the AIR and RMS models “may not be perfectly calibrated to the characteristics of Massachusetts ... they are evidence of the range of predicted hurricane losses.” Accordingly, she concluded “it is reasonable to use the AIR and RMS models as predictors of hurricane losses and to average the two models to develop a range of predicted hurricane losses.”

The Supreme Judicial Court upheld this ruling and several other aspects of the rate decision in *Attorney General v. Commissioner of Insurance & Massachusetts Property Insurance Underwriting Association* (SJC-09966, Jan. 3, 2008). The court gave deference to the Commissioner’s experience, technical competence, and specialized knowledge, which it found particularly appropriate when reviewing her choice of methodology.

As “substantial evidence” in support of her decision, the court cited “expert testimony that *the use of models to estimate potential hurricane losses had become the standard in insurance markets for actuaries, insurers and reinsurers, rating agencies and regulators, and that the AIR*

and RMS models are the most reliable and widely used in the field.” This widespread acceptance was an indicator that the models are reliable and, as the Insurance Commissioner had found, market forces exert pressure on hurricane modelers to be accurate. The averaging of two models was supported by expert testimony that a “blended result is thought to offer a more balanced estimate of probable catastrophic losses.”

Because of their impact on rates and costs of reinsurance, coupled with their use of proprietary intellectual property, hurricane catastrophe models have been the focus of criticism from advocates who charge that they are “black boxes” used to inflate insurer and reinsurer profits. The AIR and RMS models, along with other catastrophe models, do undergo thorough annual review by the Florida Commission on Hurricane Loss Projection Methodology, as well as review by insurance regulators in Florida, South Carolina, and other states. But this is the first time any court has considered the use of the models as evidence.

In its review of the MPIUA rate decision, the Massachusetts court applied widely-used standards for use of scientific evidence. Massachusetts has adopted “*Lanigan*” standards for such evidence based on federal court standards adopted following the 1993 U.S. Supreme Court decision in *Daubert v. Merrell Dow Pharmaceuticals*. In argument before the court, the Insurance Commissioner argued — and the Attorney General agreed — that the *Lanigan* issues had been thoroughly vetted in the agency proceeding. An expert witness who also has been involved in the Florida Commission review testified that the review before the Massachusetts Insurance Commissioner was the most thorough he had seen outside of the Florida Commission.

Because the use of the models was so extensively vetted and their use was upheld based on standards of evidence widely-followed in many courts, the Massachusetts decision establishes a significant beachhead for use of catastrophe models in most jurisdictions. How high the bar is will

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vary according to the jurisdiction, but establishing a foundation for use of such models may remain a complex and expert-intensive process.

Cameron F. Kerry, a partner in the Boston office of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., and **Steven J. Torres**, an associate in the same office, contributed the above case brief.

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Pfizer v. Employers Ins. of Wausau: Not Just for Environmental Clean-Up Cases

The choice-of-law analysis in two seminal environmental clean-up cases, *Gilbert Spruance v. Pennsylvania Mfrs. Assn. Ins. Co.*, 134 N.J. 96 (1993) and *Pfizer v. Employers Ins. of Wausau*, 154 N.J. 187 (1998), has been held applicable to insurance coverage for product liability lawsuits. In a recent unreported decision in *IMO Industries Inc. v. Transamerica Corp et al.*, No. MER-L-2140-03 (Aug. 3, 2007), the court was clear as to this point.

The choice-of-law question in *IMO Industries* was which state's law applies — New Jersey or California's — to the allocation of IMO's asbestos liabilities among multiple insurance policies issued over several decades. The excess insurer defendants argued that the insurance policies at issue were negotiated in California by IMO's parent company's California-based risk management department, and therefore, California law applied. IMO, its former parent Transamerica Corporation, and its primary insurer TIG Insurance Company argued that the claims arose out of the manufacturing activities of New Jersey-based IMO, who managed its asbestos claims from its New Jersey headquarters, and therefore, New Jersey law applied.

The court in *IMO Industries* rejected the insurers' argument that a footnote in *Pfizer* precluded the choice-of-law framework in *Pfizer* and *Spruance* from applying to products liability cases. See *IMO Industries*, Transcript of Decision at Tr. 17:6-18.

That footnote read, "(T)he Spruance principles may not be readily transferable from environmental coverage cases to products liability cases," *Pfizer*, 154 N.J. at 195, n. 3 (concurring with the Third Circuit's analysis in *NL Industries, Inc v. Commercial Union Ins. Co.*, 65 F.3d 314 (3d Cir. 1995)). The excess-insurer defendants also based their reasoning on the Third Circuit's dicta in *NL Industries* that "the state's interest in determining coverage for product liability actions is more amorphous and therefore less compelling than its interest in environmental cleanup." *NL Industries*, 65 F.3d at 322.

The *IMO Industries* court reasoned that the *Restatement (Second) of Conflict of Laws*, §193, on which *Pfizer's* choice-of-law analysis is partially based, is flexible and provides that the principal location of the insured risk as understood by the parties governs, unless some other state has a more significant relationship under the principles articulated in *Restatement* §6. See *Id.*, Transcript of Decision at Tr. 17:13-18.

Pfizer's choice-of-law analysis asks a court to first consult *Restatement* § 193, which says that wherever "the parties understood ... to be the principal location of the insured risk governs unless some other state has a more significant relationship under the principles stated in [section] 6 to the transaction and the parties." *Pfizer*, 154 N.J. at 194-95 (quoting *Spruance*, 134 N.J. at 112). The *Pfizer* Court recognized that the location of the insured risk is less significant when "an insured operation or activity is predictably multi-state." *Id.* at 195. In such cases, the court looks to the factors set forth in *Restatement* §6: 1) the needs of the interstate and international system; 2) the relevant policies of the forum; 3) the relevant policies of other affected states and the relevant interests of those states in the determination of the particular issue; 4) the protection of justified expectations; 5) the basic policies underlying the particular field of law; 6) certainty, predictability, and uniformity of result; and 7) ease in the determination and application of the law to be applied. *Id.*, n. 2.

The *Pfizer* court collapsed the *Restatement* §6 factors into four factors: 1) the competing interests of the

states (which require a court "to consider whether application of a competing state's law will advance the policies that the law was intended to promote"); 2) the interests of commerce (which require a court "to consider whether application of a competing state's law would frustrate the policies of other states"); 3) the interests of parties (which require a court "to focus on their justified expectations and their needs for predictability of result"); and 4) the interest of judicial administration (which require a court to consider whether the fair, just and timely disposition of controversies with the available resources of courts will be fostered by the competing law chosen). See *Id.* at 198-99.

The *Restatement* factors are neutral in their application and not limited to any one type of case, which is why the court in *IMO Industries* rightly decided that *Pfizer's* choice-of-law analysis applied to more than just environmental contamination lawsuits. As the court noted, "the overarching goal [of *Pfizer*] is to apply the law of the state with the greatest interest in resolving the particular issue that's raised." *IMO Industries*, Transcript of Decision at Tr. 7:19-21.

In applying *Pfizer*, the court in *IMO Industries* specifically rejected "an automatic default to the place of contracting." *Id.* at Tr. 9:11-13. The court applied the first *Pfizer* factor — the competing interests of the states — reasoning that the public policy imperative of New Jersey allocation law, as set forth in *Owens-Illinois v. United Ins. Co.*, 138 N.J. 437 (1994) and *Carter-Wallace v. Admiral Ins. Co.*, 154 N.J. 312 (1998) dictated that New Jersey allocation law apply to allocation-related issues in *IMO Industries*. *Id.* at Tr. 11:10-23.

The court then examined the second *Pfizer* factor — whether the application of New Jersey law would frustrate California's policy — and "was not persuaded that application of New Jersey law would frustrate any of California's interests in this case." *Id.* at Tr. 14:5-10. Rather, the court found that the application of California allocation law would frustrate New Jersey's allocation policy for New Jersey-based

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policyholders because *Owens-Illinois* clearly rejected California's allocation scheme. *Id.* at Tr. 14:6-15:2.

In examining the third *Pfizer* factor — the interests/expectations of the parties — the court found it noteworthy that the insurance contracts, although made in California, had no choice-of-law provision, because the parties "could have included a choice-of-law provision if they wanted to." *Id.* at Tr. 15:9-23. The court further reasoned that because the products

liability exposure emanated from manufacturing operations in New Jersey, the application of New Jersey law to IMO's asbestos liabilities would not frustrate the expectations of the parties. *Id.* at Tr. 15:23-16:5.

Finally, with respect to the fourth *Pfizer* factor, the court decided that the application of New Jersey law would be consistent with the interest in judicial administration because New Jersey's allocation law "has laid out clear principles...that are based on public policy concerns," while California's allocation law "is not well defined." *Id.* at Tr.18:17-19:2.

As illustrated by the court's decision in *IMO Industries*, *Pfizer's* choice-of-law analysis can be applied to choice-of-law questions arising in the products liability context. Despite the *dicta* of the *Pfizer* footnote, the policy-based choice-of-law framework of the *Restatement* is readily applicable to cases not involving environmental clean-up.



Stephanie Platzman-Diamant, an associate at McCarter & English, LLP, Newark, NJ, contributed the above case brief.

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your business faces. You should examine risks that are typically insured by commercial property and casualty insurance and consider risks that are already self-insured. A good place to start is by carefully reading your property and casualty insurance policies. This will allow you to see what is covered, and what is not. In fact, most policies exclude the most severe types of risk — those that are potentially catastrophic, such as a product recall or construction defect.

Once you have taken inventory of the various risks, you must assess each risk and determine a strategy to address that risk. For example, there are certain risks that cannot be insured in the commercial marketplace and others that must be insured such as Workers' Compensation insurance, which is a requirement in many states.

In determining a strategy to address each risk, a cost benefit analysis must be undertaken. Can insurance be purchased? Is it economically beneficial to purchase insurance? Is that risk better financed with a captive? These

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are just a few of the questions that need to be answered in order to gain a complete understanding of whether or not a captive is beneficial for your company.

If the risk is already being self-insured by the business, then structuring a captive enables that business to transfer that risk off its balance sheet in a tax favorable manner. For example, a manufacturer that does not have coverage for a product recall can now transfer that risk to a captive via an insurance premium. Thanks to unique insurance company taxation rules, captives rarely pay tax on income in the year in which it is received. What this means for the manufacturer is that a product recall can now be financed on a pre-tax basis.

Once you have completed a self-analysis, it is critical to engage a qualified captive management company to conduct a feasibility study. But how do you determine if the management company you have selected is qualified?

FINDING A QUALIFIED PROVIDER

Some captive management companies have little experience; others have much. Some have little understanding of taxation; others are experts. It can be confusing and even overwhelming when choosing a firm with which to work. Too, ill-advised captive transactions can expose own-

ers to significant tax liabilities, penalties and interest. Additionally, guidance by qualified experts can be costly. A business considering a captive should expect to invest time, resources, and money when evaluating the feasibility of such a program.

When determining if a captive is appropriate, it is important to qualify your service provider by examining the following aspects:

- Client References — Checking client references is key to learning, direct from a provider's clients, their satisfaction;
- Experience and Track Record;
- Multiple Domiciles;
- Ingenuity and Creativity;
- Actuarial Services; and
- Cost — Fees should reflect the value of the services provided. If you want a basic bookkeeping service, the price should be low. Fuller services will cost more.

CONCLUSION

Developing and initiating a captive program may not be suitable for all companies, but by employing the tactics outlined in this article, you can make the decision that best suits your company's needs.



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