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An Overview of Important Insurance Coverage Issues for the Non-Coverage Lawyer

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Conflicts of Interest and the Tripartite Relationship

Although defense counsel is often required to walk an "ethical tightrope" between the insurer and the policyholder in a third-party liability claim, it is also a dangerous minefield for insurers. *See, e.g.*, Douglas R. Richmond, *Walking a Tightrope: The Tripartite Relationship Between Insurer, Insured, and Insurance Defense Counsel*, 73 NEB. L. REV. 265 (1994); Karon O. Bowdre, *Enhanced Obligation of Good Faith: A Mine Field of Unanswered Questions After L&S Roofing Supply Co.*, 50 ALA. L. REV. 755 (1999) ("a mine field awaits even cautious insurance companies and prudent defense counsel").

The three parties to the tripartite relationship are insurer, insured, and defense counsel. As part of this relationship, "[t]he insured and the insurer have certain obligations to each other...arising from the insurance contract." *Am. Mut. Liab. Ins. Co. v. Superior Court for Sacramento County*, 38 Cal. App. 3d 579, 591-92 (1974). Defense counsel is engaged by the insurer to defend the policyholder in the underlying litigation, and

> [i]n such a situation, the attorney has two clients whose primary, overlapping and common interest is the speedy and successful resolution of the claim and litigation. . . . The three parties may be viewed as a loose partnership, coalition or alliance directed toward a common goal, sharing a common purpose which lasts during the pendency of the claim or litigation against the insured. . . . Insured, carrier, and attorney, together form an entity—the defense team—arising from the obligations to defend and to cooperate imposed by contract and professional duty.

Id. Certainly, the insurer and its coverage counsel must tread carefully through this minefield, and good claims-handling practice requires an insurer to consider its rights and responsibilities with regard to its duty to defend and indemnify its policyholder. However, the question often arises as to whether, merely because an insurer has a duty to indemnify, the insurer has an obligation to accept any settlement demand made within policy limits. Likewise, issues arise as to the extent of an insurer's right to control the defense of its policyholder. Even where there is an actual or potential conflict of interest, many jurisdictions still allow the insurer to select defense counsel, and other jurisdictions place limitations on the policyholder's selection of defense counsel. Finally, does an insurer have the right to recover damages against defense counsel for malpractice either in its own name or on behalf of the insured?

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I. Evaluating Settlement Offers Within Policy Limits

When a settlement offer within policy limits is received by defense counsel, the question becomes whether the insurer has any right to refuse such an offer. Absent a conflict of interest, courts have consistently upheld an insurer's right to control the settlement in the underlying litigation. This well-established rule is based on the language of the insurance policy that typically provides the insurer with the right to control the settlement of claims and suits against the policyholder. However, courts have tempered the insurer's right to settle cases by imposing a variety of obligations on insurers to consider the interests of their insureds before refusing such an offer.

Courts and legislatures have applied a variety of standards when evaluating an insurer's refusal to accept a settlement offer. Some jurisdictions apply a bad faith standard. Courts utilizing a bad faith test place the burden on the policyholder to prove that the insurer's behavior was unreasonable and arbitrary. Some of these jurisdictions include:

- California – *See, e.g., PPG Indus., Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999) (an implied covenant of good faith and fair dealing imposes an obligation upon an insurer to accept a reasonable offer of settlement).
- New Jersey – *See, e.g., Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 323 A.2d 495 (N.J. 1974) (insured may recover an amount in excess of the policy limit for a liability insurer's bad faith refusal to settle a third-party claim within the policy limits, when the refusal results in an adverse judgment exceeding those limits).
- Virginia – *See, e.g., State Farm Auto. Ins. Co. v. Floyd*, 366 S.E.2d 93 (Va. 1988) (to recover for an excess judgment, insured was required to show that insurer acted in furtherance of its own interest with intentional disregard of insured's financial interest by clear and convincing evidence).

Other jurisdictions impose a negligence standard. Under this standard, an insurer is merely required to exercise due care in making decisions about whether to accept an offer to settle a claim against its insured. The standard considers whether a reasonable insurer, exercising due care for the interests of its insured, would have settled the claim against the insured. Some of these jurisdictions include:

- Georgia – *See, e.g., Davis v. Cincinnati Ins. Co.*, 288 S.E.2d 233 (Ga. App. 1982) (jury determination that insurer did not exercise bad faith in refusing settlement did not preclude award of statutory damages for negligent failure to settle).
- New Hampshire – *See, e.g., Douglas v. United States Fid. & Guar. Co.*, 127 A. 708 (N.H. 1924) (defense of advice of counsel not available to an insurer charged with negligent failure to settle a claim within limits of policy where counsel had not been informed of all known relevant facts); Gelinas v. Metro. Prop. & Liab. Ins., 551 A.2d 962, 966 (N.H. 1988) (defining the negligence standard as how a reasonable man might act under the same circumstances.
- Texas – *See, e.g., G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544, 548 (Tex. Comm'n App. 1929) (insurer defending suit against insured must exercise ordinary care in considering offer of settlement).

Some courts apply a mixture of the negligence and bad faith standards to failure to the settlement of claims. Examples include:

- Arkansas – *See, e.g., Am. Underwriters Ins. Co. v. Shook*, 449 S.W.2d 402, 403 (Ark. 1970) ("a liability insurer may be liable to its insured for the amount of a judgment in excess of policy limits if the insurer, in refusing to settle a claim within the policy limits, was guilty of negligence or acted in bad faith").
- Illinois – *See, e.g., Cernocky v. Indem. Ins. Co.*, 216 N.E.2d 198, 204 (Ill. 1966) ("While the various jurisdictions differ as to the conduct which may subject an insurance carrier to liability for the excess of a judgment over its policy limits, in this jurisdiction conduct constituting fraud, negligence or bad faith may render the insurer so liable.").
- Washington – *See, e.g., Hamilton v. State Farm Ins. Co.*, 523 P.2d 193, 196 (Wash. 1974) ("the terms 'bad faith' and 'negligence' are actually interchangeable, but the terminology means little. It is the factual situation which is significant, in light of the duty which exists, and in the ordinary case the trier of fact must make the determination of liability and nonliability").

"Regardless of the standard adopted, courts tend to strike the same balance between the parties' interests and to identify the same factors as indicating culpable conduct by the insurer. For this reason, the distinction between the negligence standard and the bad faith standard is more rhetorical than real." Stephen S. Ashley, Bad Faith Actions Liability & Damages § 2:6 (2004) (on the "coalescence of negligence and bad faith standards").

In addition to common law obligations and remedies, some states have enacted statutory schemes that impose duties on insurers with regard to the evaluation of settlement offers within policy limits. For example, pursuant to Article 21.21 of the Texas Insurance Code and the Texas Deceptive Trade Practices Act, Texas recognizes statutory liability for an insurer to its insured for failing to settle a third-party claim. *See Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co.*, 77 S.W.3d 253, 260 (Tex. 2002). To establish liability under the Act, the insured must show that:

1. the policy covers the claim;
2. the insured's liability is reasonably clear;
3. the claimant has made a proper settlement demand within the policy limits; and
4. the demand's terms are such that an ordinarily prudent insurer would accept it.

Id. at 262. *See also, e.g.*, Fla. Stat. Ann. § 626.9541 (West 2004) (Unfair Insurance Trade Practices Act provisions relating to the settlement of claims); Fla. Stat. Ann. § 624.155 (West 2004) (providing policyholders with civil remedies for insurers' claims-handling practices). Nonetheless, insurers have successfully argued that claims-handling statutes such as Article 21.55 of the Texas Insurance Code related to the prompt payment of claims do not apply to third-party claims. *See TIG Ins. Co. v. Dallas Basketball, Ltd.*, 129 S.W.3d 232 (Tex. App. – Dallas 2004, pet. filed) (statutory penalties do not apply to defense costs). But *see, e.g., E & R Rubalcava Constr., Inc. v. Burlington Ins. Co.*, 148 F. Supp. 2d 746 (N.D. Tex. 2001) (applying Art. 21.55 to a third-party claim).

Certainly, because of the diversity of the applicable rules and standards, counsel to insurers must determine the common law and statutory standards applicable to the settlement of the claim. However, in general, absent bad faith or negligence, an insurer will not be held liable for refusing to settle within policy limits even where that refusal ultimately results in an excess judgment against the policyholder.

II. Selection of Defense Counsel

Absent a conflict of interest, an insurer has a contractual right to control the defense of its policyholder. Included within this right, the insurer may select defense counsel to defend the third-party liability claim. Nevertheless, an insurer's right to control the defense may be circumscribed where there is a conflict of interest between it and its insured. Conflict of interest questions most frequently arise in situations where, although the insurer has a duty to defend the policyholder, it disclaims a duty to indemnify based on one or more coverage defenses.

Courts and legislatures in some jurisdictions have determined that a policyholder is entitled to representation by independent counsel whenever the insurer issues a reservation of rights. *See, e.g.*, Fla. Stat. Ann. § 627.426(2)(b)(3) (West 2002) (absent non-waiver agreement, when insurer reserves rights, insured is entitled to "mutually acceptable" independent counsel); *State Farm Mut. Auto. Ins. v. Ballmer*, 899 S.W.2d 523, 525 (Mo. 1995) (en banc) (insured has the right to reject defense under reservation of rights); *Nat'l Union Fire Ins. Co. v. Circle, Inc.*, 915 F.2d 986, 991 (5th Cir. 1990) (insurer that reserves rights discharges contractual obligation to defend by engaging separate counsel to represent insured); *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 120 (5th Cir. 1983) (when insurer proposes to defend under reservation of rights, insured may refuse insurer's offer and pursue his own defense, and insurer remains liable for attorneys' fees); *Three Sons Inc. v. Phoenix Ins. Co.*, 257 N.E.2d 774, 776-77 (Mass. 1970) (insured did not breach duty to cooperate by refusing to accept insurer's defense under reservation of rights).

However, many other jurisdictions have declined to adopt such a *per se* rule and instead consider:

1. whether the insurer would be able to direct the insured's defense in a manner adverse to the insured on the disputed coverage issue; and/or
2. which party, insurer or insured, bears the greater financial stake in the underlying litigation.

See, e.g., Cal. Civ. Code § 2860(b) (West 2002) (policyholder has the right to independent counsel when "insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim" implying that reservation of rights may not always require independent counsel); *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 425 N.E.2d 810 (N.Y. 1981) (independent counsel is required only when the defense attorney's duty to the insured would require a defense on any grounds, but his duty to the insurer would require a defense only on those grounds that would defeat insurer liability); *Burd v. Sussex Mut. Ins. Co.*, 267 A.2d 7, 10 (N.J. 1970) (an insurer cannot defend its policyholder if (1) the trial will leave the issue of coverage unresolved so that the policyholder may later be called upon to pay; or (2) the case may be so defended by a carrier as to prejudice the policyholder thereafter on the issue of coverage).

Admittedly, there is one very common set of facts that is almost certain to give rise to an independent counsel requirement, even in jurisdictions that do not apply a per se rule—if the underlying complaint alleges mutually exclusive theories of recovery (such as negligence and intentional tort), some of which would be covered under the policy and some of which would not. Courts almost unanimously hold that the policyholder is entitled to separate representation if the litigation can be controlled in a manner that would result in a finding of liability only on non-covered claims. *See, e.g., Howard v. Russell Stover Candies, Inc.*, 649 F.2d 620 (8th Cir. 1981) (policyholder entitled to separate counsel where underlying complaint alleged covered non-willful statutory violation and non-covered willful statutory violation); *Steel Erection Co. v. Travelers Indem. Co.*, 392 S.W.2d 713, 716 (Tex. Civ. App.), *writ refused n.r.e.* (1965) (insured entitled to counsel of its own selection where insurer disputed coverage, and existence of coverage depended on findings in the underlying action).

If a conflict of interest exists, the majority of jurisdictions allow the insured the right to choose independent counsel, whose reasonable fee must be reimbursed by the insurer. *See Union Ins. Co. v. Knife Co., Inc.*, 902 F. Supp. 877, 881 (W.D. Ark. 1995) (the majority rule "supports giving the choice of counsel to the insured"). The majority rule has been adopted by – among others – courts in:

- Illinois – *See, e.g., Maryland Cas. Co. v. Peppers*, 355 N.E.2d 24, 31 (Ill. 1976) ("[insured] has a right to be defended in the personal injury case by an attorney of his own choice who shall have the right to control the conduct of the case").
- Mississippi – *See, e.g., Am. Guarantee & Liab. Ins. v. 1906 Co.*, 273 F.3d 605, 621 (5th Cir. 2001) (applying Mississippi law) (finding that insureds were entitled to reimbursement where "[t]he insureds hired separate counsel because [the insurer] only agreed to defend [the insureds] under a reservation of rights and because the insureds were potentially exposed to liability in excess of the CGL policy limits.").
- New York – *See, e.g., Utica Mut. Ins. Co. v. Cherry*, 358 N.Y.S.2d 519, 524 (App. Div. 1974) ("[i]n this State, at least, the relative interests of the insured and insurer [where a conflict arises] are accommodated . . . by permitting the insured to choose his counsel and requiring the reasonable value of counsel's services to be reimbursed by the insurer").
- Ohio – *See, e.g., State Farm Fire & Cas. Co. v. Pildner*, 321 N.E.2d 600, 603 (Ohio 1974) (in conflict situations, local ethical rules "dictate that the insurance company not be allowed to select counsel to defend the insured...The insurance company . . . should invite the insured to select his own counsel").
- Pennsylvania – *See, e.g., Krueger Assocs., Inc. v. ADT Sec. Sys., Inc.*, No. 93-1040, 1994 U.S. Dist. LEXIS 18168, at *17 (E.D. Pa. Dec. 20, 1994) ("[i]t is settled law that where conflict of interest between an insurer and its insured arises...the insured is entitled to select its counsel"). *But see, e.g., Consol. Rail Corp. v. Hartford Accident & Indem. Co.*, 676 F. Supp. 82, 86 (E.D. Pa. 1987) (when a conflict arises, "one appropriate resolution is for the insurer to obtain separate, independent counsel for each of its insureds or to pay the costs incurred by an insured in hiring counsel").
- Texas – *See, e.g., Steel*, 392 S.W.2d at 716 (the insurer "chose not to admit full coverage, and thus [the insured] had a right to be defended by . . . an attorney of their own selection").

Not all jurisdictions give the policyholder the right to select defense counsel when a conflict of interest arises. Some jurisdictions require the selection of mutually agreeable defense counsel and allow the insurer to participate in the selection. The states adopting this approach include:

- Alaska – *See, e.g.*, Alaska Stat. § 21.89.100 (West 2004) (the insurer may require minimum qualifications from the independent counsel).
- California – *See, e.g.*, Cal. Civ. Code § 2860 (West 2004) (also providing that the insurer may require minimum qualifications from the independent counsel).
- Florida – *See, e.g.*, Fla. Stat. Ann. § 627.426 (West 2004) (independent counsel must be "mutually agreeable" to both parties).
- Rhode Island – *See, e.g., Employers Fire Ins. Co. v. Beals*, 240 A.2d 397 (R.I. 1968), overruled on other grounds, 667 A.2d 785 (R.I. 1995) (granting the insurer the right to approve independent counsel, but "[s]uch approval…should not be unreasonably withheld").

In yet another approach, some courts continue to allow the insurer to select defense counsel in conflict situations but have tempered this selection by imposing an enhanced duty of good faith on the insurer and defense counsel. These jurisdictions include:

- Alabama – *See, e.g., Shelby Steel Fabricators, Inc. v. U.S. Fid. & Guar. Ins. Co.*, 569 So. 2d 309 (Ala. 1990) (setting out relevant criteria for insurer to meet its obligations under the "enhanced good faith" standard).
- Washington – *See, e.g., Tank v. State Farm Fire & Cas. Co.*, 715 P.2d 1133, 1141 (Wash. 1986) (where a conflict arises, Washington law imposes an "enhanced duty of good faith" on the insurer in carrying out its duties to investigate the claim and in selecting independent counsel).

Some courts grant the insurer the responsibility of deciding whether to select independent counsel or to simply reimburse the insured's choice for independent counsel. Courts applying the following states' laws have adopted this approach:

- Indiana – *See, e.g., All-Star Ins. Corp. v. Steel Bar, Inc.*, 324 F. Supp. 160, 165 (N.D. Ind. 1971) ("[t]he insurer must either provide an independent attorney to represent the insured, or pay for the cost of defense incurred by the insured hiring an attorney of his choice").
- North Dakota – *See, e.g., Fetch v. Quam*, 530 N.W.2d 337, 341 (N.D. 1995) (finding insurer has "duty to furnish independent counsel to [insured] or to reimburse [insured's] attorney's fees").
- Wisconsin – *See, e.g., American Motorists Ins. Co. v. Trane Co.*, 544 F. Supp. 669, 686 (W.D. Wis. 1982) ("[w]here there is a conflict, the insurer must either provide an independent attorney to represent the insured or pay the costs incurred by the insured in hiring counsel of the insured's own choice"), *aff'd*, 718 F.2d 842 (7th Cir. 1983).

Finally, several jurisdictions still allow the insurer to select independent counsel to represent the insured even where there is a reservation of rights. These jurisdictions include:

- Hawaii – *See, e.g., Finley v. Home Ins. Co.*, 975 P.2d 1145, 1151 (Haw. 1998) ("The insured does not have the right to select counsel to represent its interests solely due to an insurer's reservations of rights."); *First Ins. Co. of Hawaii, Inc. v. State, by Minami*, 665 P.2d 648, 654 (Haw. 1983) (holding that an insurer is required to provide separate counsel by selecting independent outside counsel for each insured) (citation omitted).
- Kansas – *See, e.g., Patrons Mut. Ins. Assoc. v. Harmon*, 732 P.2d 741, 745 (Kan. 1987) (stating that the proper procedure to protect the rights of both parties under the insurance contract is for the insurer to hire "independent counsel to defend the insured in the civil action and notif[y] the insured that it [is] reserving all rights under the policy").
- Michigan – *See, e.g., Federal Ins. Co. v. X-Rite, Inc.*, 748 F.Supp. 1223 (W.D. Mich. 1990) (although an insurer must surrender control of the litigation due to the conflict of interest, it retains the right to select independent counsel to represent the insured).
- Virginia – *See, e.g., Norman v. Insurance Co. of N. Am.*, 218 Va. 718, 239 S.E.2d 902, 907 (Va. 1978) (approving right to insurer to select independent counsel under a reservation of rights provided that it discloses its reservation of rights to the insured and gives timely notice).

These jurisdictions generally reject the more prevalent notion that defense counsel will necessarily—even if only subconsciously—favor the interests of the insurer over that of the insured. Moreover, this view generally rejects the proposition that defense counsel provides dual representation to both the insured and the insurer. Rather, the attorney's sole client is the insured.

With so little consistency in these various approaches, it is clear that insurers should be careful in the selection of independent counsel and should review the rules of the given jurisdiction before the selection is made. *See Cent. Mich. Bd. of Trustees v. Employers Reinsurance Group*, 117 F. Supp. 2d 627, 635 (E.D. Mich. 2000) noting that "there are divergent views on this issue which appear to be 'jurisdiction specific'").

Insurers also must continue to be wary of actual or potential conflicts of interest after the initial selection of counsel. If a conflict of interest arises during the course of the litigation, disqualification is necessary where the attorney represents both the insurer and the insured. *See, e.g., State Farm Mut. Auto. Ins. Co. v. Fed. Ins. Co.*, 86 Cal. Rptr. 2d 20, 22 (Ct. App. 1999) (counsel disqualified because "the obligations and duties an attorney owes to an insurance company in this situation support finding an attorney-client relationship for purposes of a disqualification motion"); *State Farm Mut. Auto. Ins., Co. v. Armstrong Extinguisher Serv., Inc.*, 791 F. Supp. 799, 802 (D. S.D. 1992) (disqualifying attorney from representing insurer in coverage action when attorney had previously represented insured in underlying action). If a conflict arises, the attorney may not continue to represent either insurer or insured.

Yet, even when the insured has the right to select counsel, the insured's selection of defense counsel should be reasonable, based on counsel's qualifications and experience, as well as fees. *See, e.g.*, Alaska Stat. §21.89.100(d) (West 2002) ("[i]f the insured selects independent counsel at the insurer's expense, the insurer may require that the independent counsel have at least four years of experience in civil litigation, including defense experience in the general area at issue in the civil action, and malpractice insurance"); Cal. Civ. Code §2860(c) (West 2002) (insurer may "require that the counsel selected by the insured possess

certain minimum qualifications which may include that the selected counsel have (1) at least five years of civil litigation practice which includes substantial defense experience in the subject at issue in the litigation, and (2) errors and omissions coverage").

Finally, an insurer is not without a course of redress should the fees and expenses of the policyholder's counsel prove to be excessive. The near unanimous rule is that the insurer is only obligated to reimburse "reasonable" fees and expenses (*see, e.g., San Diego Navy Fed. Credit Union v. Cumis Ins. Society, Inc.*, 208 Cal. Rptr. 494, 506 (Ct. App. 1984) ("the insurer must pay the reasonable cost for hiring independent counsel by the insured")), but there is little case law as to what constitutes "reasonable" fees in this context. However, in *Ctr. Found. v. Chicago Ins. Co.*, 278 Cal. Rptr. 2d 13 (Cal. Ct. App. 1991), the court offered some general guidance. The court stated,

> [i]n our view, the duty of good faith imposed upon an insured includes the obligation to act reasonably in selecting as independent counsel an experienced attorney qualified to present a meaningful defense and willing to engage in ethical billing practices susceptible to review at a stricter standard than that of the marketplace.

Id. at 21. In a recent case, the federal district for Rhode Island held that it was "patently unreasonable" for the policyholder to demand that an insurer pay two counsel to do the job of one. *See Hartford Cas. Ins. Co. v. A & M Assocs., Ltd.*, 200 F. Supp. 2d 84, 93 (D. R.I. 2002) (applying Massachusetts law and citing *Magoun v. Liberty Mut. Ins. Co.*, 195 N.E.2d 514, 519 (Mass. 1964)). Moreover, by statute, some jurisdictions limit fees to "the rate that is actually paid by the insurer to an attorney in the ordinary course of business in the defense of similar civil action in the community in which the claim arose or is being defended." Alaska Stat. § 21.89.100(d) (West 2002). *See also* Cal. Civ. Code § 2860(c) (West 2002).

III. Legal Malpractice

Can an insurer sue defense counsel for legal malpractice? Issues related to the tripartite relationship are often examined in terms of the ethical and legal responsibilities that both the insurer and defense counsel owe to the insured. What responsibilities does defense counsel owe to the insurer and what remedies are available to insurers in relation to negligent attorneys?

Jurisdictions across the country have reached competing conclusions regarding these questions. A minority of courts have concluded that an attorney-client relationship exists between the insurer and defense counsel, at least to the extent that no conflict of interest exists between the insurer and its insured. Although many courts have held that defense counsel owe an undivided duty of loyalty to their sole client, the insured, a growing number of jurisdictions allow primary and excess insurers to bring legal malpractice claims under the doctrine of equitable subrogation.

A recent decision from the United States District Court for the District of Colorado, *Essex Ins. Co. v. Tyler*, 309 F. Supp. 2d 1270 (D. Colo. 2004), examined many of the competing legal theories and policy considerations regarding the issue on an insurer's right to bring a malpractice claim against defense counsel. In Essex, an excess insurer claimed that it was equitably subrogated to the rights of its insureds. The excess insurer brought claims

for malpractice and breach of fiduciary duty against the attorney and the law firm that represented its insureds in the underlying action. Unlike the many recent courts that have applied principles of equity to such claims, the district court concluded that the excess insurer could not pursue professional malpractice-based claims against the insured's attorney under a theory of equitable subrogation.

In *Essex*, Essex Insurance Company ("Essex") filed a diversity action against an attorney and his law firm, Cameron W. Tyler and Cameron W. Tyler & Associates P.C. (collectively, "Tyler"). Tyler represented Fleet Car, L.L.C., and its driver Glen Taylor (collectively, "Fleet"), in an underlying lawsuit related to a 1996 automobile accident. After a trial in 2000, Essex as the excess insurer paid $237,813.66. Essex then brought suit against Tyler on the theory that it was equitably subrogated to the rights of its insureds, Fleet, for Tyler's alleged professional negligence and breach of fiduciary duty. Essex alleged that Tyler acted below the standard of care by failing to file vital pleadings and failing to adequately protect against surprise testimony. Essex further alleged that as a result of this negligence, it incurred monetary losses, including payment of the judgment, as a subrogee for Fleet. Tyler moved to dismiss the complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure for failure to state a claim. For the reasons discussed below, the district court concluded that, under Colorado law, an excess insurer could not bring a malpractice claim against defense counsel on a theory of equitable subrogation. The district court granted the motion to dismiss, and the matter is currently on appeal to the United States Court of Appeals for the Tenth Circuit.

A. The Attorney-Client Relationship

It is axiomatic that a necessary element of professional negligence claims such as legal malpractice and breach of fiduciary duty is an attorney-client relationship.[1] In *Essex*, the excess insurer did not claim any right to recovery based on an attorney-client relationship between itself and defense counsel.

> In Colorado, an attorney retained by the insurance carrier owes a duty to the insured only; there is no attorney-client relationship between an insurance carrier and the attorney it hires to represent the insured.

Essex, 309 F. Supp. 2d at 1272 (citing generally *CBA Ethics Committee, Formal Op. 91* (1993)).

The *Essex* court noted that, under Colorado law, "an attorney's liability to third parties is strictly limited." *Id*. This rule is based on three public policy considerations:

> the protection of the attorney's duty of loyalty to and effective advocacy for his or her client; the nature of the potential for adversarial relationships between the attorney and third parties; and the attorney's potential for unlimited liability if his duty of care is extended to third parties.

Id. (quoting *Glover v. Southard*, 894 P.2d 21, 23 (Colo. Ct. App. 1994)).

Like Colorado, many jurisdictions hold that the attorney's sole client is the insured and, therefore, counsel cannot form an attorney-client relationship with the insurer. *See Higgins v. Karp*, 687 A.2d 539, 543 (Conn. 1997) ("even when an attorney is compensated or expects to be compensated by a liability insurer, his or her duty of loyalty and representation nonetheless remains exclusively with the insured"). In fact, a majority of jurisdictions have concluded that, in the context of the tripartite relationship, an attorney's sole duty of loyalty lies with the insured and not the insurer.

- Arkansas – *See, e.g., First Am. Carriers, Inc. v. Kroger Co.*, 787 S.W.2d 669, 671 (Ark. 1990) ("when a liability insurer retains a lawyer to defend an insured, the insured is the lawyer's client");
- Connecticut – *See, e.g., Continental Cas. Co. v. Pullman, Comley, Bradley & Reeves*, 929 F.2d 103, 108 (2d Cir. 1991) (attorney owes duties and allegiance to insured, not to the insurer);
- Kansas – *See, e.g., United States v. Daniels*, 163 F. Supp. 2d 1288, 1290 (D. Kan. 2001) ("[I]nsurance companies often hire independent counsel to represent an insured while reserving the right to later contest coverage… In such circumstances, retained counsel owe their duty of loyalty to the insured, not the insurance carrier.");
- Hawaii – *See, e.g., Finley v. Home Ins. Co.*, 975 P.2d 1145, 1152 (Haw. 1998) (applying Hawaii law, the district court held that an attorney retained by the insurer to represent the insured owes its sole duty to insured, not to insurer);
- Michigan – *See, e.g., Atl. Int'l Ins. Co. v. Bell*, 475 N.W.2d 294, 295-96 (Mich. 1991) (attorney-client relationship does not exist between insurer and attorney which insurer hired to defend its insured);
- Montana – *See, e.g., In re Rules of Prof'l Conduct*, 2 P.3d 806, 814 (Mont. 2000) (an insured is the sole client of defense counsel appointed by the insurer, and thus, the insurer is not a coclient of defense counsel);
- New Jersey – *See, e.g., Lieberman v. Employers Ins. of Wausau*, 419 A.2d 417, 424 (N.J. 1980) (defense counsel retained to represent the insured owed his sole duty to the insured);
- Pennsylvania – *See, e.g., Point Pleasant Canoe Rental, Inc. v. Tinicum Township*, 110 F.R.D. 166, 170 (E.D. Pa. 1986) (the insured is attorney's client when the insurer retains an attorney to defend insured); *Gov't Employees Ins. Co. v. Forbes*, No. CIV. A. 99-891, 1999 WL 371625, at *1 (E.D. Pa. June 2, 1999) (relying upon *Allstate Ins. Co. v. LaBrum and Doak*, C.A. No. 88-8448, 1989 WL 51553 (E.D. Pa. May 12, 1989) to conclude that an "insurance company is also a client of the law firm it hires to represent its insured, and so has a separate malpractice claim"); and
- Tennessee – *See, e.g., Givens v. Millikin ex rel. Estate of McElwaney*, 75 S.W.3d 383, 396 (Tenn. 2002) ("no doubt can exist that the insured is the sole client of an attorney hired by an insurer pursuant to its contractual duty to defend").

Absent an attorney-client relationship with defense counsel, the insurer cannot bring a claim for malpractice.

In contrast, some jurisdictions have allowed insurers to form an attorney-client relationship with defense counsel and assert claim for malpractice on their own behalf. For example, in *Pine Island Farmers Coop v. Erstad & Riemer P.A.*, 649 N.W.2d 444, 452 (Minn. 2002), the Supreme Court of Minnesota held that the insurer and insured can be "co-clients" of defense counsel. In that case, the insurer hired defense counsel to represent the policyholder in the underlying action. *See id.* at 446. There was no conflict of interest, but the jury returned a substantial verdict against the policyholder. *See id.* After the case was settled on appeal, the insurer and the insured both brought legal malpractice claims against defense counsel, contending that they both had an attorney-client relationship with the attorneys retained to represent the insured. *See id.*

The court held that "in the absence of a conflict of interest between the insured and the insurer, the insurer can become a co-client of defense counsel. . .if two conditions are satisfied. First, defense counsel or another attorney must consult with the insured, explaining the implications of dual representation and the advantages and risks involved. Second, after consultation, the insured must give its express consent to the dual representation." *Id.* at 452. The court then affirmed summary judgment for defense counsel on the ground that there was no evidence that, after consultation, the insured consented to dual representation. *See id.*

Similarly, in *Unigard Ins. Group v. O'Flaherty & Belgum*, 45 Cal. Rptr. 2d 565, 568 (Ct. App. 1995), a California intermediate appellate court held that a lawyer "owes a duty of care to the insurer[,] which will support its independent right to bring a legal malpractice action against the attorney for negligent acts committed in the representation of the insured."

There, Unigard Insurance Group ("Unigard") agreed to defend and indemnify its insured, The Wilkinson Company ("Wilkinson") for a personal injury lawsuit. *See id.* at 566. Unigard hired O'Flaherty, Prestholt & Bennington ("O'Flaherty") to represent Wilkinson. *See id.* In the answer to the personal injury suit, O'Flaherty failed to assert the exclusivity provisions of workers' compensation as an affirmative defense. *See id.* O'Flaherty's representation was ultimately terminated, and the new law firm sought leave to amend Wilkinson's answer, but this motion was denied. *See id.* at 567. Unigard settled the underlying case by agreeing to pay $500,000, the limits of policy coverage. *See id.* Thereafter, Unigard filed a complaint for damages for the negligence of O'Flaherty in failing to properly raise all affirmative defenses. *See id.*

Although the Unigard court recognized that California law had previously rejected equitable subrogation as the basis for an insurer's legal malpractice claim, the court concluded:

> when, pursuant to insurance policy obligations, an insurer hires and compensates counsel to defend an insured, *provided that the interests of the insurer and insured are not in conflict*, the retained attorney owes a duty of care to the insurer which will support its independent right to bring a legal malpractice action against the attorney for negligent acts committed in the representation of the insured.

Id. at 568 (emphasis in the original). The court found that any potential harm to the attorney-client relationship between defense counsel and the insured was outweighed by the fact that to rule otherwise would "'completely absolve a negligent defense counsel'" and "'would place the loss for the attorney's misconduct on the insurer.'" *Id.* at 568 (quoting *Atlanta Intern. Ins. Co. v. Bell*, 475 N.W.2d 294, 298 (Mich. 1991)). *But see American Cas. Co. of Reading, Pa. v. O'Flaherty*, 67 Cal. Rptr. 2d 539 (Cal. App. 1997) (refusing to apply *Unigard's* rationale where the insurer did not retain defense counsel and where there was a conflict of interest).

B. Equitable Subrogation

Although insurers may not be able to assert a legal malpractice claim directly, an insurer may be equitably subrogated to its insured's rights to bring a malpractice action. "Subrogation, simply defined, involves 'the substitution of one person in the place of another with reference to a lawful claim of right.'" *Bell*, 475 N.W.2d at 298 (quoting 73 Am. Jur. 2d, Subrogation, § 1, p. 598). More specifically, equitable subrogation is a "legal fiction" that allows one to assert the rights of another and is often "'viewed as an important technique for serving the ends of

justice by placing the economic responsibility for injuries on the party whose fault caused the loss.'" *See id*. at 298 n.13 (citations omitted).

Many jurisdictions have allowed insurers to assert legal malpractice claims under a theory of equitable subrogation:

- Illinois – *See, e.g., Nat'l Union Ins. Co. v. Dowd & Dowd*, P.C., 2 F. Supp. 2d 1013 (N.D. Ill. 1998) (dismissing excess insurer's legal malpractice claim, but allowing claim for equitable subrogation);
- New Jersey – *See, e.g., Charter Oak Fire Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 782 A.2d 452, 456 (N.J. Super. Ct. App. Div. 2001) (permitting a claim for equitable subrogation even where the facts did not support excess carriers' legal malpractice claims);
- New York – *See, e.g., Allstate Ins. Co. v. Am. Transit Ins. Co.*, 977 F. Supp. 197 (E.D. N.Y. 1997) (holding that excess insurers stated malpractice claim against law firm under principles of equitable subrogation);
- Pennsylvania – *See, e.g., Ohio Cas. Ins. Co. v. Southland Corp.*, No. CIV. A. 98-CV-6187, 1999 WL 236733 (E.D. Pa. Apr. 22, 1999) (predicting that the Pennsylvania Supreme Court would apply the doctrine of equitable subrogation to a legal malpractice claim); and
- Texas – *See, e.g., Am. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480 (Tex. 1992) (excess insurers could bring equitable subrogation action against primary insurer and defense counsel for mishandling claim).

Under the principles of equitable subrogation, if the insured has an action for legal malpractice, the insurer may also be able to state a claim. *See Bell*, 475 N.W.2d at 296-97. *But see Pine Island*, 649 N.W.2d at 452-53 (rejecting equitable subrogation claim for the insurer where the insured had brought a malpractice claim against defense counsel).

In *Bell*, 475 N.W.2d at 299, for example, the Michigan Supreme Court held that an insurer could maintain a legal malpractice action under the doctrine of equitable subrogation even though an attorney-client relationship did not exist between the insurer and the attorneys. There, Atlanta International Insurance Company ("Atlanta") retained defense counsel to represent Security Services, Inc. ("Security Services") in a wrongful death action. *See id*. at 296. The attorneys failed to raise comparative negligence as a defense. *See id*. After judgment was entered against Security Services, Atlanta filed suit, alleging that defense counsel committed legal malpractice. *See id*.

Because "the tripartite relationship between insured, insurer, and defense counsel contains rife possibility of conflict," the Court recognized that it has been "consistently held that the defense attorney's primary duty of loyalty lies with the insured, and not the insurer." *Id*. at 297. However,

> [t]o hold that an attorney-client relationship exists between insurer and defense counsel could indeed work mischief, yet to hold that a mere commercial relationship exists would work obfuscation and injustice. The gap is best bridged by resort to the doctrine of equitable subrogation to allow recovery by the insurer. Equitable subrogation best vindicates the attorney-client relationship and the interests of the insured, properly imposing the social costs of malpractice where they belong. Allowing the insurer to stand

> in the shoes of the insured under the doctrine of equitable subrogation best serves the public policy underlying the attorney-client relationship.

Id. Indeed, it is in the best interests of both insurer and insured to encourage "competent representation." *Id*. at 298. For those reasons, the Court concluded that equitable subrogation was "a more flexible, more equitable solution" than either defense counsel's absolution from liability or the creation of a rigid attorney-client relationship between insurer and defense counsel. *See id*. at 299.

Similarly, in *Dowd*, 2 F. Supp. 2d at 1024, a federal district court predicted that the Illinois Supreme Court would "recognize that it would be inequitable to place the burden of legal malpractice upon the excess insurer, allowing a negligent attorney to escape the consequences of his misconduct, merely because the insured lacks the economic incentive to sue." Rather, like the *Bell* court, *Dowd* applied the principles of equitable subrogation to allow an insurer to assert a legal malpractice claim against the defense attorney. *See id*. at 1027.

The *Essex* court, however, rejected the rationale of *Bell* and *Dowd*. *See Essex*, 309 F. Supp. 2d at 1274. Because Colorado law prohibits the assignment of legal malpractice claims to third parties, the district court predicted that the Colorado Supreme Court

> would follow the policy concerns related to the limitation of non-client third-party claims of legal malpractice and the prohibition of the assignment of such claims under Colorado law, and would proscribe professional malpractice-based claims by excess insurers based on a theory of equitable subrogation.

Id. (citing *Roberts v. Holland & Hart*, 857 P.2d 492, 495 (Colo. Ct. App. 1993) (*cert. denied* Aug. 30, 1993)). *See also Capitol Indem. Corp. v. Fleming*, 58 P.3d 965, 969 (Ariz. Ct. App. 2002) (refusing to apply subrogation to legal malpractice claims because such claims are not assignable under Arizona law). In refusing to adopt the principles of *Bell* and *Dowd*, the district court expressed no concern that its decision would result in a windfall for the negligent defense counsel and would fail to encourage the competent representation of the insured's interests.

In sum, although many jurisdictions continue to restrict an insurer's right to assert professional malpractice claims against defense counsel, an increasing number of jurisdictions are expanding the legal avenues available to insurers to assert such claims. Based on public policy considerations and principles of equity, insurers can assert malpractice claims against defense counsel either directly on their own behalf as a client of the attorney or, more likely, on behalf of their insured under a theory of equitable subrogation.

Number of Occurrences

In addition to aggregate limits, many insurance contracts often contain "per occurrence" policy limits. Insurance contracts may also contain either self-insured retentions or deductibles "per occurrence." Consequently, in cases involving multiple claims and/or plaintiffs, the issue of the number of applicable "occurrences" often arises.

Courts take various approaches in resolving these number of "occurrence" disputes. A majority of courts apply what has been called a "cause" approach, identifying the number of

"occurrences" based on the number of causes for the injury, by the insured in some cases or by the tort-feasor in others. *See Mason v. Home Ins. Co. of Ill.*, 177 Ill. App. Ct. 3d 454, 459, 532 N.E.2d 526, 529 (1988) (stating that the vast majority of courts have "concluded that the number of occurrences is determined by referring to the cause or causes of the damage, rather than to the number of individual claims or injuries"). A minority of courts apply an "effects" approach, looking to how many injurious effects have resulted. *See Folz v. State of New Mexico*, 110 N.M. 457, 462, 797 P.2d 246, 251 (1990) (rejecting the "effects" test).

I. The "Effects" Approach

Few courts apply an "effects" approach to resolving number of "occurrence" disputes. One Tennessee case is often cited as having applied an "effects" approach. In *Kuhn's of Brownsville, Inc. v. Bituminous Cas. Co.*, 197 Tenn. 60, 270 S.W.2d 358 (1954), Tennessee's highest court held that a collapse of one building, and then a second building two days later, as a result of the same excavation, constituted two separate "accidents" under a pre-"occurrence" policy. In *Kuhn's*, a retail store had undertaken to remodel its premises, including excavation work. *See id.* at 60, 270 S.W.2d at 358. On May 27, 1952, the excavation work caused a building to the east of the premises to collapse, and two days later a building immediately west of the premises also collapsed as a result of the same work. *Id.* at 60, 270 S.W.2d at 359. The policy had a $10,000 limit of liability for property damage from "one accident," and provided coverage for "for damages because of injury to or destruction of property . . . caused by accident and arising out hazards hereinafter defined" including the "use of the premises, and all operations which are necessary or incidental thereto." *Id.* at 63, 270 S.W.2d at 359.

The Tennessee Supreme Court concluded that the damage to the two buildings resulted in two "accidents" based on this language. *See id.* at 65, 270 S.W.2d at 360. Without further analysis or explanation, the court issued a holding that started with a conclusion that coverage would be maximized.

> If the losses complained of by the complainant[s] were for one accident, the liability would be $10,000, but if there were two separate accidents, then complainants would be entitled to recover twice the amount. The second collapse did not happen until two days after the first, and we think it clear that there were two accidents involved herein. If the excavation was a single act, and constitutes a single accident, then the question comes as to when the accident occurred. The owners on the west suffered no loss and experienced no unforeseen event until the 29th.

Id. at 65-66, 270 S.W.2d at 360; *cf. Brooks v. Memphis & Shelby County Hosp. Auth.*, 717 S.W.2d 292, 297 (Tenn. Ct. App. 1986) (failure to prevent patient from falling and fracturing hip was one accident and overdose of Lidocaine after surgery on the hip was a second accident because there were "two separate and distinct acts of negligence by two different individuals that occurred on two different dates, albeit that [negligence was caused by two employees of] the same defendant hospital").

The holding in *Kuhn's* is generally inapplicable to the policy language in modern insurance contracts. *Kuhn's* construed the meaning of "accident" under a pre-"occurrence" policy. The switch by most insurance contracts in 1966 to the "definition [of occurrence, including continuous or repeated exposure] was designed to 'make it clear that occurrence embraces

not only the usual accident, but also exposure to conditions which may continue for an unmeasured period of time.'" *Reliance Ins. Co. v. Armstrong World Indus., Inc.*, 614 A.2d 642, 649 (N.J. Super. Ct. Law Div. 1992) (citing *Broadwell Realty v. Fid. & Cas.*, 528 A.2d 76 (N.J. Super. Ct. App. Div. 1987)). Applying the *Kuhn's* "effects" approach would fail to give any consequence to the distinct language in most modern insurance contracts.

II. The "Cause" Approach

For those courts that apply a "cause" approach, some look to the cause of the insured's liability, and others look to the immediate cause of the injury. *See, e.g., Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, 61 (3d Cir. 1982) (finding that the adoption of a discriminatory employment policy constituted the single "occurrence" for purposes of coverage); *Champion Int'l Corp. v. Cont'l Cas. Co.*, 546 F.2d 502, 506 (2d Cir. 1976) (finding that 1400 claims arising out of the insured's sale of defective paneling to many manufacturers resulted from a single "occurrence"); *Travelers Indem. Co. v. Olive's Sporting Goods, Inc.*, 297 Ark. 516, 764 S.W.2d 596 (1989) (the Arkansas Supreme Court concluded that insured's negligent sale of guns constituted a single "occurrence"). *Compare, e.g., Mason*, 177 Ill. App. Ct. 3d at 460, 532 N.E.2d at 529 (holding that "[e]ach instance in which a customer was presented with tainted food over a three day period created additional exposure to liability and constituted a separate occurrence"); *Mich. Chem. Corp. v. Am. Home Assurance Co.*, 728 F.2d 374, 383 (6th Cir. 1984) (concluding that each shipment of contaminated livestock feed would "create[] additional exposure to liability," and therefore, would constitute a separate occurrence).

As between the competing "cause" approaches outlined above, the cases looking to the "cause" of the insured's liability appear to be better decided because they give effect to the policy language. One such case is *Washoe County v. Transcontinental Ins. Co.*, 110 Nev. 798, 878 P.2d 306 (1994). In *Washoe*, the Supreme Court of Nevada held that a county's alleged negligence in licensing and monitoring a day-care center, resulting in multiple acts of child molestation by a day-care center employee, was a single "occurrence" for purposes of liability limits of the county's liability insurance policy. In that case, the employee of the day-care center, Papoose Palace Day Care Center ("Papoose"), admitted that he had sexually abused numerous children over a three-year period. *See Washoe County*, 110 Nev. at 799, 878 P.2d at 307.

Over forty children and their parents sued Washoe County for negligently licensing Papoose. *See id*. "The plaintiffs alleged that the County breached its duty to investigate Papoose's employees and its duty to monitor Papoose's activities." *Id*. Washoe County settled the claims with each claimant for amounts ranging from $2,000 to $25,000. *See id*. The settlements totaled $406,000. *See id*. Washoe County sought indemnification from its insurers, but the insurers denied any obligation to pay the settlements because the County never met the $50,000 per "occurrence" retained limit in the insurance policies. *See id*. at 800, 878 P.2d at 307. The trial court granted summary judgment in favor of the insurers, and the Supreme Court reversed. *See id*. at 805, 878 P.2d at 311.

The *Washoe County* court concluded that a single $50,000 retained limit applied to all claims because all claims arose out of one "occurrence." To reach its decision, the court applied the "cause" approach. *See id*. at 801, 878 P.2d at 308 (citing *Bish v. Guaranty Nat'l Ins. Co.*, 109 Nev. 133, 135, 848 P.2d 1057, 1058 (1993)).

> In interpreting coverage for such entities under the "caus[e]" approach, "occurrence" should be defined in such a way as to give meaning to the entity's connection to liability. In the case at bar, the County "caused" the children's injuries through its failure to act with the requisite care in the process of licensing Papoose. Therefore, such failure must be considered the "occurrence" for purposes of insurance liability.

Washoe, 110 Nev. at 805, 878 P.2d at 310. The court noted that this interpretation was consistent with the language in the policy that provided that "all damages arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence." *Id.* The court also looked not at the actions of the individual wrongdoers, but at the actions of the entities whose negligence in performing a duty permitted the intervening conduct of those of actively caused the victims' harm. *See id.* at 804, 878 P.2d at 310 (*citing Mead Reinsurance v. Granite State Ins. Co.*, 873 F.2d 1185 (9th Cir. 1989)). Several courts have also agreed with *Washoe County*:

- Kansas – *See, e.g., Atchison, Topeka and Santa Fe Ry. Co.*, No. 94 CV 1464, 2000 WL 33996655 (Kan. Dist. Ct. July 24, 2000) (citing *Washoe County* in deciding that insured's "corporate failure to act" by failing to timely implement a hearing conservation program was a single "occurrence");

- Massachusetts – *See, e.g., RLI Ins. Co. v. Simon's Rock Early Coll.*, 54 Mass. App. Ct. 286, 293-94, 765 N.E.2d 247, 253-54 (2002) (citing *Washoe County* when deciding that negligent acts or omissions of an insured college in failing to prevent one student from shooting several individuals was a single "occurrence"); and

- Pennsylvania – *See, e.g., General Accident Ins. Co. of Am. v. Allen*, 708 A.2d 828 (Pa. Super. Ct. 1998) (injury to children was caused by negligent failure to prevent abuse, and thus, resulted from one "occurrence").

Some courts have disagreed with this sort of "cause" approach and look not to the "cause" of the insured's liability, but rather to the cause of the immediate injury-producing act. In one such seminal case, *Murice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co.*, 447 F.2d 204, 207 (5th Cir. 1971), the court concluded that eight sales of bird seed contaminated by the insured's supplier "were eight separate occurrences." The court explained that it "was the sale that created the exposure to 'a condition which resulted'" in injury and "for each of the eight sales . . . there was a new exposure and another occurrence." *Id.* at 206. However, the court distinguished this from a situation where the "liability of the insured could be traced to a single act for which the policyholder was legally responsible for the multiple damage claims," such as a situation where "a water faucet had been left running" and had damaged the property of multiple parties. *Id.* at 207.

In the more recent case of *Koikos v. Travelers Ins. Co.*, 849 So.2d 263, 271 (Fla. 2003), the Supreme Court of Florida held that two shootings by the same third-party just seconds apart would constitute multiple "occurrences." The court "conclude[d] consistent with the 'cause' theory, that in the absence of clear language to the contrary, when the insured is being sued for negligent failure to provide security, 'occurrence' is defined by the immediate injury-producing act and not by the underlying tortuous omission," in that case "the intervening intentional acts of the third-party – the intruder's gunshots." *Id.* at 271-72.

A close analysis of *Koikos* shows that the "relevant inquiry in determining the number of occurrences in [that case regarded] the meaning of 'occurrence' as '[a]n accident' . . . .

[because the latter term] is susceptible to varying interpretations including not only an 'accidental event' but also 'injuries or damage' that are 'neither expected nor intended from the standpoint of the insured.'" *Koikos*, 849 So.2d 263-269 (citations omitted). The court explained that few "terms have 'provoked more controversy in litigation than the word 'accident'. . . . the courts of this state have given varying interpretations . . . when not otherwise explicitly defined or clarified" and when "subject to differing interpretations, the term should be construed liberally in favor of the insured and strictly against the insurer." *Id*. at 266-67 (citations omitted). Given the lack of clarity on the meaning of "accident," the court in *Koikos* was free to conclude that the shooting "victims were not 'exposed' to the negligent failure to provide security" but rather "if . . . anything it was the bullets fired from the intruder's gun." *Id*. at 268. *Cf. H.E. Butt Grocery Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 150 F.3d 526, 531 (5th Cir. 1998) (in a case later relied upon by *Koikos*, the Fifth Circuit held, based on *Pincoffs*, that "independent acts of sexual abuse 'caused'" injury to two children and thus two "occurrences," rather than one "occurrence" as a result of the insured's failure "in overseeing its pedophilic" employee).

In reaching its conclusion, *Koikos* and many similar cases have identified an ambiguity in the insurance contract based on the term "accident," when it is not defined or otherwise clarified. These courts include:

- Connecticut – *See, e.g., Metro. Life Ins. Co. v. Aetna Cas. & Sur. Co.*, 255 Conn. 295, 305, 765 A.2d 891, 896 (2001) ("based on the wording of the policies," which included only a standard "occurrence" definition, the court concluded that "a course of conduct spanning many decades [was] not a single occurrence as that term is used in the subject policies");

- District of Columbia – *See, e.g., Am. Red Cross v. Travelers Indem. Co. of Rhode Island*, 816 F. Supp. 755, 761 (D.D.C. 1993) (finding that each act of distribution of contaminated blood constituted a separate "occurrence" because the "facts do not support the suggestion that plaintiff engaged in a single, negligent practice"); and

- Virginia – *See, e.g., S.F. v. W. Am. Ins. Co.*, 250 Va. 461, 465, 463 S.E.2d 450, 452 (1995) (policy's traditional definition of "occurrence" was ambiguous and thus, where each claimant was subjected to acts of molestation, these acts constitute one "occurrence" per claimant).

Many of these cases are arguably fatally flawed because they fail to take into account additional language within many insurance contracts that has been referred to in some cases as "batching" language or a "unifying directive."

Specifically, many insurance contracts expressly provide that a single "occurrence" limit of liability is the most that the insurer is required to pay "regardless of the number of . . . [c]laims made or 'suits' brought; or . . . [p]ersons or organizations" involved and that one "occurrence" includes all "continuous or repeated exposure to substantially the same general harmful conditions." Courts have enforced such language. For example, in *Sunnyside Seed Farms, Inc. v. Refuse Hideaway, Inc.*, No. 91-CV-4264 (Wis. Cir. Ct., Dane County Apr. 6, 1993), a Wisconsin court, relying on similar language, though located in different portions of the policy, held that claims asserted by adjoining landowners caused by contamination migrating from a landfill arose from a single "occurrence" under a single policy. Any other result would nullify the "unifying" language:

> [The insured's] argument for multiple occurrences based on the "sequence of events that occurred over a period of years, involving multiple negligent

> acts that created more and potentially different pollution problems" would [] nullify the policy language. Whether the cause of the property damage was the plume or the continuing negligence of the landfill's management, under the [unifying language there is] a single, continuous exposure that can only be classified as one occurrence.

Id., slip op. at 14-15. Similarly, in *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994), the Texas Supreme Court held that, regardless of the number of negligent acts or omissions within a single policy period, the resulting injuries could constitute only one "occurrence" within the meaning of the policy given the meaning of such "unifying" language. *Id.* at 853-54.

Allocation

I. Allocation of indemnification obligations among multiple insurers – analysis of time-on-the-risk versus "coverage provided"

When an occurrence implicates multiple policies, courts often use one of the following methods to allocate indemnity obligations among multiple insurers: (1) joint and several liability or "all sums"; (2) time-on-the-risk; (3) coverage provided; or (4) proration by exposure. Application of any one of these methods will have a significant effect on an insurer's loss allocation. However, as agreed by both courts and commentators, the two predominant allocation methods are the "time-on-the-risk" method by which a court apportions the total loss among all triggered policies in proportion to the number of years each triggered policy was on the risk and the "coverage provided" method by which a court apportions liability based not only on the time-on-the-risk factor but also considers the amount of policy limits provided by each insurer. Therefore, the two predominant methods of allocation are examined below.

A. Time-on-the-Risk Method of Allocation

Time-on-the-risk, otherwise referred to as "proration by years," is a method of allocation by which a court only looks to the period of time any given policy was on the risk without regard to total policy limits. The more years on the risk, the higher the assigned portion to that insurer, subject to policy limits. For example, if Insurer X issued policies for three years on a ten-year loss with a $20 million liability, then Insurer X is responsible for three-tenths of that $20 million claim, or $6 million. If Insurer Y issued the policyholder one policy during the ten-year period, and Insurer Z six policies, then Insurer Y would bear the responsibility for one-tenth of the loss, or $2 million, and Insurer Z would owe $12 million – or six-tenths of the $20 million loss. However, under the time-on-the-risk method of allocation, no insurer pays more than its policy limits in relation to its share of the loss.

The seminal case adopting time-on-the-risk is *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980). In *Forty-Eight Insulations*, the Sixth Circuit held that indemnification and defense costs should be "prorated…among all of the insurance companies which were on the risk while the injured victim was breathing in asbestos." *Id.* at 1224, 1226. The Court explained that the obligation of each insurer was to be determined by looking at the ratio of each policy period to the total number of years a claimant was exposed

to asbestos. *Id*. Furthermore, the court concluded that the insured itself was to be treated as an insurer for those periods of time during which it had no insurance coverage. "Thus, if insurer A provided 3 years of coverage, insurer B an additional 3 years, and the manufacturer was uninsured for the remaining 3 years, liability would be allocated at 1/3 for each of the three concerns. *Id*. The Sixth Circuit further explained its holding, by stating that "given the impossibility in most cases of ascertaining which company provided asbestos in different years, we think that this is the fairest way to apportion liability." *Id*. at 1225.

According to the time-on-the-risk method, more liability will be assigned to those insurers that provided more coverage or have been on the risk for longer periods of time. Thus, the intent of this method is to correlate the extent of liability borne by each insurer to the amount of premium received. However, it is for this same reason that some courts have rejected this method, stating that this method fails to take into account that some insurers offered higher policy limits and, therefore, would have received higher premiums. Despite this apparent inequity, time-on-the-risk has proven to be the majority position among courts which address the allocation issue. *See* William P. Shelley, Richard C. Mason, and Nancy C. Thome, *Introduction to Insurance Allocation*, 14-9 Mealey's Litig. Rep. Ins. 13 (January 5, 2000) (*citing USF&G v. Treadwell Corp.*, 1999 WL 436498 at *25 (S.D.N.Y. June 21, 1999).

B. Coverage Provided Method of Allocation

Unlike the time-on-the-risk method, which focuses on the length of time an insurer was on the risk, the coverage provided method takes into account both policy limits and years on the risk. *See Owens-Illinois, Inc. v. United Ins. Co., et al.*, 650 A.2d 974 (N.J. 1994). Specifically, an insurer's proportionate share is established by dividing its aggregate policy limits for all the years it was on the risk for the single, continuing occurrence by the aggregate policy limits of all the available policies and then multiplying that percentage by the amount of indemnity costs. Thus, policies with higher limits face greater liability.

For example: suppose Insurer X issued three successive policies each for $500,000; Insurer Y issued one policy with policy limits of $2 million; and Insurer Z issued six successive policies, each with $1 million limits. The total limits of all the triggered policies is $9.5 million. This number is used as the denominator. Suppose further that the policyholder has incurred $5 million in response costs under CERCLA. Consequently, Insurer X, whose total policy limits add up to $1.5 million, would be prorated approximately $800,000 of the $5 million liability ($1.5 million divided by $9.5 million, multiplied by the $5 million liability); Insurer Y is prorated $1.05 million; and Insurer Z would have to pay $3.15 million.

The seminal case adopting the coverage provided method of allocation is the New Jersey Supreme Court's decision in *Owens-Illinois*. In *Owens-Illinois*, the insured manufactured asbestos-containing products from 1948 to 1958 and was eventually named in thousands of lawsuits. The insured sought indemnification under both primary and excess policies that were issued from 1963 to the 1980's. Prior to 1963, Owens-Illinois had no insurance. After concluding that a continuous trigger was applicable, the court then addressed the allocation issue. The court rejected the joint and several liability method of allocation, stating that a better method "appears to be one that is related to both time-on-the-risk and the degree of risk assumed." *Id*. at 995. The court then proposed "proration on the basis of policy limits, multiplied by years of coverage." *Id*. at 993. The court provided the following example to illustrate what it meant by an allocation scheme that was related both to the years of coverage and the degree of risk assumed:

> During a nine year period, our model assumed that in years one through three coverage for the owners of an office building was provided in the amount of two million dollars per year; in years four through six the applicable coverage had a limit of three million dollars a year; and in years seven through nine, during which time no insurance was purchased, the self-insured risk was four million dollars per year. Carriers during the first three years would bear roughly twenty-two percent (6/27ths); carriers covering the middle three years would bear thirty-three percent (9/27ths); and the building owners would bear forty-four percent of the risk (12/27ths).

Id. at 994. However, the court noted the complexity of applying the method of allocation that it adopted by stating: "We recognize that such even mathematical proportions will not occur, and so we must repose a substantial measure of discretion in a master who must develop the formula that fairly reflects the risks assumed or transferred." *Id.*

While the *Owens-Illinois* decision did craft a concrete method of allocation, the Court expressly declined to address how that method would affect excess insurers:

> We realize that many complexities encumber the solution that we suggest involving, as it does, proration by time and degree of risk assumed -- for example, determining how primary and excess coverage is to be taken into account or the order in which the policies are triggered. The parties did not focus on those issues.

Id. As discussed in the next section, the New Jersey Supreme Court decision in *Carter-Wallace, Inc.*, picked up where the *Owens-Illinois* decision left off with respect to allocation of excess coverage.

The major flaw with the coverage provided method is that insurers with higher limits may be liable for a disproportionate share of damages based solely on their limits. The coverage provided method assumes that policy limits are a reliable indication of the risks underwritten by each insurer and the premiums each earned. However, the reality of the insurance industry is that premiums paid for liability insurance do not necessarily increase proportionately with the policy limits.

II. Exhaustion of layers of coverage over multiple policy periods

After determining how to allocate multi-year losses among successive primary insurance policies, courts often must determine the manner in which excess layers of coverage should respond to the loss. There is little case law on this issue, and the case law that does exist is often confusing. Therefore, based primarily on leading commentators and the few court decisions, the commonly accepted methods of allocation with respect to excess layers of coverage are discussed. The three primary methods of exhaustion are: exhaustion by years or "vertical exhaustion"; exhaustion by layers or "horizontal exhaustion"; and a modified method of exhaustion known as the *Carter-Wallace* method, named after the New Jersey Supreme Court decision which adopted the method.

A. Exhaustion By Years

Exhaustion by years, or so-called "vertical exhaustion," allows an insured to select policy periods triggered by a continuous loss. *See* Douglas R. Richmond, R*ights and*

Responsibilities of Excess Insurers, 78 DENV. U. L. REV. 29, 79 (2000). Under exhaustion by years, "the first-in-time primary and excess policies will be exhausted before the next-in-time primary and excess policies will be tapped." *See* Mary K. Gogoel and Mitchell A. Orpett, *Allocation and Excess Insurance*, UNDERSTANDING ALLOCATION 135, 138 (Def. Research Inst.1999). Exhaustion by years benefits the insured because it allows the insured to select the policy periods in which it has the most available coverage to respond to a loss, thereby maximizing indemnity dollars. *See, e.g.*, William P. Shelley, Richard C. Mason, and Nancy C. Thome, *Introduction to Insurance Allocation*, 14-9 Mealey's Litig. Rep. Ins. 13 (January 5, 2000); Richmond, 78 DENV. U. L. REV. at 79, *citing* Gogoel and Orpett, UNDERSTANDING ALLOCATION at 138. It also benefits the insured because it preserves coverage under successive primary policies, thereby ensuring the insured of a continued defense. *See* Richmond, 78 DENV. U. L. REV. at 79, *citing* Gogoel and Orpett, UNDERSTANDING ALLOCATION at 138. Additionally, because primary policies usually provide defense costs in addition to liability limits, exhaustion by years frequently provides greater overall coverage. *See* Shelley, Mason, and Thome, *Introduction to Insurance Allocation*, 14-9 Mealey's Litig. Rep. Ins. 13.

Dayton Indep. Sch. Dist. v. Nat'l Gypsum Co., 682 F. Supp. 1403 (E.D. Tex. 1988), *rev'd on other grounds sub nom., W.R. Grace & Co. v. Cont'l Cas. Co.*, 896 F.2d 865 (5th Cir. 1990), is a representative case. In *National Gypsum*, the U.S. District Court for the Eastern District of Texas, where the insured sought coverage for asbestos-in-buildings property damage claims, adopted the exhaustion by years theory in holding that "once the limits immediately underlying a given excess policy are exhausted, Grace [the insured] may call upon that excess policy to provide coverage." *Id.* at 1411 n.23.

The *National Gypsum* court noted that the policies provided that the carriers would indemnify the policyholder for "all sums" which the policyholder was obligated to pay and because each triggered policy was required to indemnify the policyholder for its entire liability, up to its coverage limits, the policyholder could select which triggered policy it wished to provide coverage. *Id.* at 1410-11. Consequently, exhaustion by years allowed the policyholder to designate the policy year that would cover the loss and receive indemnification from excess insurers for that period as the underlying policies were exhausted. *Id.*

Few courts have adopted the exhaustion by years methodology. *See, e.g., Associated Int'l Ins. Co. v. St. Paul Fire and Marine Ins. Co.*, 220 Cal. App. 3d 692 (6th Dist. 1990), *review denied and opinion ordered not published* (Cal. Aug. 30, 1990); *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305 (Minn. 1995); *Port of Seattle v. Am. Nat'l Fire Ins. Co.*, No. C96-434D (W.D. Wash. Jan. 27, 1998), reported in Mealey's Litig. Reports: Insurance, Vol. 12, No. 14 (Feb. 10, 1998).

B. Exhaustion by Layers

Exhaustion by layers, or "horizontal exhaustion," requires "that the primary insurance must be exhausted across all of the triggered policy periods before the next layer of coverage, whether excess or umbrella, will respond to a continuous loss. See Thomas M. Jones and John D. Hurwitz, *An Introduction to Insurance Allocation Issues in Multiple-Trigger Cases*, 10 VILL. ENVTL. L.J. 25, 33 (1999). In other words, every primary policy triggered by a continuous loss must be exhausted before any excess insurer can be required to pay. *See* BARRY R. OSTRAGER AND THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES §13.14 at 870 (11th ed. 2002). Exhaustion by layers comports with the continuous trigger theories favored in many jurisdictions.

> [I]f "occurrences" are continuously occurring throughout a period of time, all of the primary policies in force during that period of time cover these occurrences, and all of them are primary to each of the excess policies; and if the limits of liability of each of these primary policies is adequate in the aggregate to cover the liability of the insured, there is no "excess" loss for the excess policies to cover.

See Richmond, 78 DENV. U. L. REV. at 80, *citing Stonewall Ins. Co. v. City of Palos Verdes Estates*, 54 Cal. Rptr. 2d 176, 199 (Dist. Ct. App. 1996). Exhaustion by layers benefits excess insurers by increasing the insulation from loss that underlying insurance provides.

A majority of courts appear to favor the exhaustion by layers approach. *See* BARRY R. OSTRAGER AND THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 13.14 at 870 (11th ed. 2002). These include:

- *In re Asbestos Insurance Coverage Cases*, Judicial Council Coordination Proceeding No. 1072, Judgment, slip op. at 22 (Cal. Super. Ct. San Francisco County Jan. 24, 1990), aff'd in part, remanded in part sub nom.;
- *Armstrong World Indus. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 52 Cal. Rptr.2d 690 (1st Dist. 1996), review denied (Cal. Aug. 21, 1996);
- *Cont'l Cas. Co. v. Armstrong World Indus., Inc.*, 776 F. Supp. 1296, 1301 (N.D. Ill. 1991) (Pennsylvania law);
- *Schering Corp. v. Evanston Ins. Co.*, No. UNN L-97311-88 (N.J. Super. Ct. Law Div. Union County Jan. 24, 1995), *appeal denied* (N.J. Super. Ct. App. Div. May 1995), appeal denied, No. 40,481 (N.J. July 13, 1995);
- *United States Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994), *appeal denied*, 161 Ill. 2d 542, 649 N.E.2d 426 (1995);
- *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, No. 86 MR 308, slip op. at 24 (Ill. Cir. Ct. Lake County Mar. 20, 1995), *aff'd in relevant part, rev'd in part*, 283 Ill. App. 3d 630, 670 N.E. 2d 740 (2d Dist.), *appeal denied*, 169 Ill. 2d 570, 675 N.E.2d 634 (1996).

A representative case is *Cont'l Cas. Co. v. Armstrong World Industries, Inc.*, 776 F. Supp. 1296 (N.D. Ill. 1991). In *Continental Casualty*, a case involving thousands of asbestos-related personal injury claims spanning twenty-two years of coverage, the court held that the policyholder was required to exhaust all of its triggered primary liability insurance policies before it called upon Continental's excess umbrella policies for payment. *Id*. at 1298-99, 1301. The court concluded that the Continental policies' "other insurance" clauses stated with clarity that coverage would begin only after the exhaustion of any applicable primary insurance. *Id*. at 1301. As a result, the Continental policies' plain meaning contradicted the policyholder's argument that only the underlying primary policies issued during the same policy period need be exhausted before Continental's excess liability would begin. *Id*. By ruling in favor of the excess insurer, the court ordered that policies were to be exhausted by layers. *Id*.

In *Hoerner v. ANCO Insulations, Inc*., 812 So.2d 45 (La. Ct. App. 2002), a Louisiana court adopted the exhaustion by layers theory. In *Hoerner*, a plaintiff was seeking damages for injuries caused by occupational exposure to asbestos-containing products. *Id*. at 52. An excess insurer had issued an excess policy to a defendant for a three-year period. *Id*. at 69.

Another insurer had issued a primary CGL policy to that defendant during each of the one-year periods that the excess insurer had issued the policy. *Id*. The court concluded that an "insurer that issued primary policies to a defendant in an asbestos case in consecutive years is liable for an amount up to the limits of all of the policies issued for relevant years added together." *Id*. Further, "excess insurers are not required to make indemnity payments until all applicable primary limits are exhausted." *Id*. Therefore, because the damage award to the plaintiff was less than the total limits of the underlying primary CGL policies, the excess insurer could have no liability for the damages. *Id*.

The United States District Court for the Eastern District of Pennsylvania relied on *Continental Casualty* in applying exhaustion by layers when a similar dispute arose in *Gen. Refractories Co. v. Allstate Ins. Co.*, 1994 WL 246375 (E.D. Pa. 1994). In *General Refractories*, Commercial Union provided umbrella coverage to General Refractories for two separate three-year periods. *Id*. at *1. General Refractories faced various lawsuits related to its manufacture of products containing asbestos and silica. *Id*. General Refractories brought a declaratory judgment action, seeking a determination as to its rights under the excess liability insurance policies issued by Commercial Union. *Id.*

Commercial Union argued that General Refractories must exhaust all primary coverage prior to seeking indemnification from its excess insurers. *Id.* at *2. The court noted that each Commercial Union policy contained an "other insurance" clause which stated clearly that Commercial Union shall not be liable for any "ultimate net loss" so long as "other valid and collectible insurance" existed. *Id.* *5. The court stated that these provisions "unambiguously provide that even if stated policy limits are exhausted, an excess insurer's liability will not arise if other insurance is available." *Id.* at *8. Thus, the court held General Refractories must exhaust all primary coverage before it could seek indemnification from Commercial Union. *Id.*

The *General Refractories* court advanced an additional factor in support of its application of exhaustion by layers – the underlying purpose of excess insurance policies. *Id.* The court stated that "unlike primary insurance policies, umbrella policies' raison d'etre is to provide affordable protection against excess judgments of third parties…[which] is underscored by the difference in premiums…insurance companies charge for the two types of policies." *Id.* The court stated that premiums for umbrella policies are substantially less than premiums for primary insurance because the related risks for umbrella policies are substantially less than those for primary policies. *Id.* Further, the court concluded that exhaustion by layers was appropriate because to permit a policyholder to seek payment from excess carriers before exhausting all of its primary insurance would be to subvert the purpose of excess insurance. *Id.*

III. The *Mayor and City Council of Baltimore v. Utica Mut. Ins. Co.* Case – A Representative Case of How Courts Often Confuse the Exhaustion by Layers Methodology.

As noted previously, many courts confuse the distinction between exhaustion by years and exhaustion by layers. For example, in *Mayor and City Council of Baltimore v. Utica Mut. Ins. Co.*, 802 A.2d 1070 (Md. Ct. Spec. App. 2002), the Court of Special Appeals of Maryland considered how to allocate losses among primary and excess insurers for a long-tail asbestos claim. The court began by determining how to allocate liability among all of the triggered policies. The court rejected the "all sums" or "joint and several" approach which would allow a policyholder to choose which policy would be required to respond to the entire loss. *Id.*

at 1102. Instead, the court concluded that pro-rata allocation by time-on-the-risk would be the proper allocation method. *Id.* at 1104. The court noted that while the time-on-the-risk method does not address any variations in policy limits, no policy would be required to exceed its indemnification limits in any event. *Id.* The court expressly declined to apply the coverage provided method adopted in *Owens-Illinois*. *Id.* at n.55.

The court then addressed the issue of the proper method of exhaustion with respect to the excess layers of coverage. The court concluded that exhaustion by layers or "horizontal exhaustion" was the most appropriate method to apply in cases like the one at issue which involved a continuing loss.

> The exhaustion of all primary policies on the risk should occur prior to the requirement that any excess policy respond to the loss, unless the language of the excess policies states that (1) it is excess insurance over a particular, specific, primary policy, and (2) will be triggered when that discrete policy is exhausted.

Id. at 1105. The court noted that exhaustion by layers is consistent with the application of continuous trigger and pro rata allocation. *Id.* However, it is in this discussion that the *City of Baltimore* opinion becomes confusing. The court states, in dicta, that:

> [b]ecause the allocation will be based on the time on the risk, some primary policies that provide less coverage will be exhausted sooner than others, and their excess insurers, if any, would accordingly have to respond at an earlier point. This is consistent with the expectation of the parties that a higher tier of coverage would be reached only when the limits of the primary policy had been exhausted.

Id. This language suggests that excess policies with lower limit underlying policies would be implicated before the exhaustion of all primary policies. Such an exhaustion scheme is inconsistent with true exhaustion by layers. Furthermore, the exhaustion method suggested by the *City of Baltimore* opinion has not been adopted by any other court. However, the actual holding of the *City of Baltimore* case was to apply a pure exhaustion by layers method. Therefore, it is not clear which method of exhaustion the court intended to apply and the decision is a prime example of how courts often confuse the method of exhaustion that they intend to apply.

IV. Modified Method of Exhaustion Pursuant to Carter-Wallace

In *Carter-Wallace*, the New Jersey Supreme Court expanded on the coverage provided method of allocation that it adopted previously in *Owens-Illinois* by creating a method of allocation which takes into account excess layers of coverage.

Carter-Wallace, a pharmaceuticals manufacturer, sent industrial waste to the Lone Pine Landfill from the 1960s to 1979. The EPA subsequently ordered Carter-Wallace to remediate the site, which it did at a total cost of $9.2 million. Carter-Wallace then sought indemnification from its insurance liability carriers for the cost of the clean-up. Carter-Wallace settled with all of its carriers but one, Commercial Union, who had issued a second-layer excess policy with a policy period of 1969 through 1972. Commercial Union argued for exhaustion by layers, whereby the second-layer excess policy could not be tapped until all triggered primary and first-layer excess policies had been exhausted. In contrast, Carter-Wallace argued for an exhaustion by years approach, whereby it could choose the policy year

with all of the corresponding layers which would respond to the loss.

The New Jersey Supreme Court rejected both approaches as "untenable and inconsistent" with the principles of *Owens-Illinois. Carter-Wallace*, 712 A.2d at 1123. Using the same example it employed in *Owens-Illinois* to explain the coverage provided method, the *Carter-Wallace* Court added a vertical exhaustion component to the coverage provided method. That is, after using the coverage provided method of allocation to reach a figure for each year, the *Carter-Wallace* Court adopted the idea of vertically allocating each policy in effect for a given year, beginning with the primary policy and proceeding upward through each succeeding excess layer. The New Jersey Supreme Court explained its holding with the following example:

> Assume that primary coverage for one year was $100,000, first-level excess insurance totaled $200,000 and assume that second-level excess coverage was $450,000. If the loss allocated to that specific year was $325,000, the primary insurer would pay $100,000, the first-level excess policy would be responsible for $200,000, and the second-level excess policy would pay $25,000.

Id. at 1124. The *Carter-Wallace* decision did not go so far as to actually calculate Commercial Union's portion of the loss under this method, but rather remanded the matter to the trial court for proceedings consistent with its opinion.

The court stated that its modified approach to allocation involving excess insurance was appropriate for several reasons. First, the method efficiently used available resources because it neither minimized nor maximized the liability of either primary or excess insurance, thereby promoting cost efficiency by spreading costs. *Id.* Second, it promoted "simple justice" by differentiating between primary and excess insurance while not permitting excess insurers to avoid their obligations in continuous losses. *Id.* Third, it introduced "a degree of certainty and predictability into the complex world" of continuous trigger cases. *Id.*

D&O Coverage

This is an overview of the essential features of directors' and officers' coverage, as well as the issues that are currently at the forefront of litigation between corporate policyholders and D&O insurers with respect to insurance coverage for underlying actions in which the typical litigator may be involved. Disputes as to D&O coverage are not limited to large, publicly held corporations. To the contrary, businesses of all sizes, public and private, have purchased D&O coverage and a knowledge of how these policies operate is, therefore, not limited to the securities and corporate litigation bar, but a large part of the spectrum of lawyers who practice in all areas of civil litigation.

In most cases, the insurance coverage counsel hired by a corporation with respect to an insurance coverage dispute with its insurer inherits an underlying action that has usually progressed to a point where key issues affecting coverage, including strategic decisions made by the corporation's underlying counsel, will have had a significant impact on the success or failure of insurance coverage counsel to obtain D&O coverage for the policyholder. Thus, it is useful for counsel who do not routinely handle insurance coverage cases to be familiar with some of the facets of D&O coverage that could affect their clients' right to insurance coverage whether the underlying action is still pending or has been resolved by settlement or judgment. This fact of life is one reason why it is important for counsel involved in underlying

securities or corporate litigation, or other types of litigation for which there may be coverage under a D&O policy, to encourage their corporate clients to retain insurance coverage counsel as early as possible so that their expertise and experience in insurance coverage litigation can be employed to ensure maximum insurance coverage under the applicable D&O policies.

This article will first provide an overview of the structure of D&O policies, followed by an analysis of those portions of the D&O policies that traditionally and currently have been a frequent source of litigation between policyholders and insurance companies.

I. Structure Of The D&O Policy

The insuring agreement of the D&O policy reflects, of course, the unique nature of the coverage provided by a D&O policy. Policy language differs somewhat from insurer to insurer and policyholder to policyholder. However, as a general rule, in every D&O policy, there is coverage provided to the directors and officers and also to the corporation to the extent that it sustains a loss by having to indemnify its directors and officers. Also, in some policies, there will be separate coverage for the corporation arising from securities claims made against the corporate policyholder separate and apart from its directors and officers, i.e., so-called "entity" coverage. A typical example of policy language containing these three basic components of insurance coverage is set forth below:

> INSURING AGREEMENTS [2]
>
> With respect to Coverage A, B, and C, solely with respect to Claims first made against an Insured during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy, and subject to the other terms, conditions and limitations of this policy, this policy affords the following coverage:
>
> COVERAGE A: EXECUTIVE LIABILITY INSURANCE
>
> This policy shall pay the Loss of any Insured Person arising from a Claim made against such Insured Person for any Wrongful Act of such Insured Person, except when and to the extent that an Organization has indemnified such Insured Person. Coverage A shall not apply to Loss arising from a Claim made against an Outside Entity Executive.
>
> COVERAGE B: ORGANIZATION INSURANCE
>
> (i) *Organization Liability*. This policy shall pay the Loss of any Organization arising from a Securities Claim made against such Organization for any Wrongful Act of such Organization.
>
> (ii) *Indemnification of an Insured Person*. This policy shall pay the Loss of an Organization arising from a Claim made against an Insured Person (including an Outside Entity Executive) for any Wrongful Act of such Insured Person, but only to the extent that such Organization has indemnified such Insured Person.

Standard exclusions in D&O policies apply to, *inter alia*, claims against the policyholder that arise from any deliberate criminal or deliberate fraudulent act by the insured, claims arising out of any profit or advantage to which the insured was not legally entitled (unjust enrichment, for example), claims that arise out of circumstances relating to a claim or litigation in an

earlier policy period, and, finally, any claim brought by any insured party under the policy against another insured party. Representative examples of these and other exclusions are included in the Appendix to this article.

D&O polices are, of course, claims-made policies. Under this type of policy, the policyholder is obligated to provide notice of a "claim," as opposed to a notice of an "occurrence," upon learning of the existence of the claim. A "claim" may be as complex as a lawsuit or as simple as a letter demanding payment for some alleged wrongful act. Most D&O policies also provide that to the extent the policyholder becomes aware of any circumstances which might be reasonably expected to lead to a claim, then the policyholder shall give written notice to the insurer of such circumstances and the nature of the claim that is likely to emerge from such circumstances. In determining which policy is triggered by an action or actions that may have multi-year time dimensions, D&O policies provide that the date at which a notice of circumstance is given is the date the policy is triggered, even though the "claim" against the policyholder may arise in a subsequent policy period. Of course, if the claim arises with little or no notice, or the circumstances relating to the claim may not be such as to lead a reasonable person to conclude that a claim will eventuate, then the trigger of coverage and notice obligations as to "claims" versus "circumstances" preceding a claim are of lesser or little significance.

In briefest outline, the above features are the fundamental elements of the D&O policy. Despite their straightforward appearance, D&O policies have become a source in recent years of a plethora of case law. Within the last several years, there have been an abundance of decisions from the courts with respect to all of the principal areas of dispute between policyholders and insurers involving D&O insurance policies. The reasons for the breadth of disputes are many. Notwithstanding the passage of the Private Securities Litigation Reform Act of 1995, there has continued to be substantial securities and other corporate litigation. In part, this is due to the high profile corporate fraud scandals such as Enron, WorldCom, Tyco, HealthSouth, and Adelphia. It also flows from less scandalous but equally significant situations involving corporations that have had major financial restatements, if not outright accounting fraud. Furthermore, both state and federal governments have become more active in prosecuting corporate malfeasance. The actions of Elliott Spitzer, the Attorney General of New York, are well known, but the United States Securities and Exchange Commission has been even more active in filing actions against corporations and their directors and officers. There are any number of additional bases for the increase in the number of cases as reflected in the summary of decisions below.

II. The Related Acts Exclusion And Whether And When A Claim Is Made

One of the most frequent sources of litigation in the D&O arena relates to the fundamental structure of the claims-made D&O policy, in contrast to "occurrence" based policies. As explained briefly above, a D&O insurer will only provide coverage with respect to a policy that is triggered when a claim is made during the period of that policy, for the first time. Alternatively, in the event that the policyholder provides a notice of circumstances under that policy and then a claim is made subsequently with respect to a later policy period, the insurer's policy is triggered when the notice of circumstances is given. These policy provisions quite frequently raise a host of disputes between the policyholder and its insurers as to whether and when a claim has been made, whether notice has been provided under the appropriate policy, and whether there is coverage under a prior policy but not the policy from which the policyholder seeks coverage.

A typical example of this mare's-nest of complications for the policyholder and the insurer is one in which multiple lawsuits are filed against a policyholder that arguably relate to the same or related subject matters. For instance, a policyholder could be sued in one year in a derivative action in the Delaware Court of Chancery for certain improper accounting procedures which injured the corporation. In the next policy year, a federal securities action, filed either by stockholders or by the Federal government, could then be filed against the policyholder for certain of its actions in connection with accounting practices that may have some nexus to the same facts raised in the derivative action of the prior policy year. The policyholder is faced with the conundrum of arguing that the derivative claim is separate and apart or different from the securities claim that was made against it in the subsequent policy year. The policyholder wants to do this because whether it has the same insurer in those two different policy years or not, it will want to have the ability to obtain the full coverage limits for those two different policies in subsequent years.

From the insurer's perspective, the whole point of having language in the policy that limits its liability to claims that are original to the policy period in question is to reduce its exposure and to make the underwriting process more reliable and predictable. Thus, in the hypothesis involving the derivative action and the securities action, if there are two separate insurers in the two separate policy years, there inevitably will be finger-pointing and perhaps litigation among those two insurers as to which insurer is responsible for which of the claims that have been brought against the policyholder.

Specifically, the insurer for the policy year in which the derivative action is filed will contend that it is only liable for coverage with respect to the derivative action, and that the securities action has no relationship to the derivative action and is a separate claim that is subject to the subsequent policy year's coverage. The second insurer, on the other hand, will contend that the insurer in the earlier year should be liable for all of the coverage because while the securities action may technically be a separate claim, the second insurer is not obligated to pay that claim because of the exclusion that permits it to deny coverage when a claim made in its policy periods is related to a prior claim in a prior policy period. See Appendix, ¶ D. If the insurer is the same in both the first and second years of coverage in our hypothetical, then it will make the same argument that only the first year is triggered with respect to both of the cases because an insurer always seeks to restrict its liability to the limits of the first policy year.

While the decisions in this area are affected to some degree by the policy language, for the most part the courts are confronted with efforts of the policyholder and the insurers to creatively demonstrate that the facts related to the first claim are or are not related to the facts with respect to the second claim. Accordingly, it is difficult to draw broad conclusions as to the law on this aspect of D&O coverage because virtually every one of these disputes is very fact specific. There are a host of court decisions that can be studied to understand how these issues are presented and resolved. *See, e.g., Banc Insurer, Inc. v. The Park Bank*, 318 F.Supp. 2d 746 (W.D. Wis. 2004); *Brown v. Am.Int'l Group, Inc.*, 339 F.Supp. 2d 336 (D. Mass. 2004); *Lehigh Valley Health Network v. Executive Risk Indem., Inc.*, C.A. No. 1999-CV-5916, 2001 U.S. Dist. LEXIS 73 (E.D. Pa. Jan. 5, 2001); *ML Direct, Inc. v. TIG Specialty Ins. Co.*, 93 Cal. Rptr. 2d 846 (Cal. Ct. App. 2000).

Frequently, an adjunct to the related acts or prior litigation exclusions in D&O policies is whether a claim is, in fact, a claim. For example, not infrequently, an insurer will take the position that an "investigation," as opposed to a lawsuit, by an administrative agency, even one that can result in criminal sanctions against the corporation or its directors and officers,

is not a claim. For example, in *Treasure Valley Transit v. Philadelphia Indem. Ins. Co.*, 88 P.3d 744 (need court name 2004), the court held that an administrative investigation into the policyholder's billing practices with respect to Medicaid did not constitute a claim. The court's decision was based on the policy language that defined "claim" so as not to include the investigation phase of an administrative agency's action, as opposed to any lawsuit filed by the agency against the policyholder. Similarly, *Minute Man Int'l Inc. v. Great Am. Ins. Co.*, C.A. No. 03-0-6067, 2004 U.S. Dist. LEXIS 4660 (N.D. Ill. Mar. 18, 2004), a demand for relief pursuant to an SEC investigation was considered by the court to be broad enough to constitute a claim. However, the court then determined that there was no coverage because the expenses that the policyholder was incurring in complying with the SEC's orders did not constitute a "loss" as defined in the policy.

III. The Insured Versus Insured Exclusion

The "insured versus insured" exclusion (the "IVI Exclusion") has been an integral part of D&O coverage for many years. The purpose of the IVI Exclusion is to prevent collusive lawsuits by separate policyholders under D&O coverage for recouping losses resulting from business decisions. Interestingly, because the policy wording of the IVI Exclusion has been relatively clear with respect to intra-corporate insureds, the most frequent litigation in recent years with respect to this exclusion has involved third parties which have filed actions against the directors and officers. In these circumstances, principally in a bankruptcy or insolvency context, insurers have attempted to argue that the third party really stands in the shoes of the policyholder, the corporate purchaser of the insurance, and any coverage related to that claim is therefore barred.

Insurers, despite their persistence in denying coverage, have not succeeded in these cases, in large part because their policies either permit coverage with respect to third-party actions brought by, for example, a bankruptcy trustee, or, to the extent that insurers have attempted to limit the standing of certain third parties, particularly in bankruptcy, the language has been sufficiently ambiguous that the courts have rejected the insurers' attempts to limit coverage.

A typical example of this phenomenon is the case of *Cirka v. Nat'l Union Fire Ins. Co.*, C.A. No. 20250-NC, 2004 Del. Ch. LEXIS 118, at *___ (Del. Ch. Aug. 6, 2004). In that action, a committee of unsecured creditors, over the opposition of the debtor-in-possession, was permitted by the Bankruptcy Court to bring an action against the directors of the debtor corporation. The court rejected the argument of the insurer that IVI Exclusion applied because the plaintiff committee of unsecured creditors was somehow the alter ego for the former corporate policyholder, then the debtor-in-possession, and subsequently the trustee in liquidation, when the facts demonstrated to the contrary that the interests of the committee were clearly adverse to those of the debtor and certainly the director defendants. Additionally, the policy made no provision for excluding coverage when a committee of unsecured creditors sued the policyholder.

Similarly, in *Ha 2003, Inc. v. Fed. Ins. Co.*, 310 B.R. 710 (Bankr. N.D. Ill. 2004), the D&O insurer denied coverage in the bankruptcy context with respect to coverage sought by a former director who had been sued by the debtor-in-possession ("DIP") in an adversary action. The insurer contended that an exception to the IVI Exclusion (similar to the one in the Appendix hereto at ¶ E), did not apply. The exception stated that the IVI Exclusion did not apply to a "claim . . . brought by or on behalf of a bankruptcy trustee, magistrate, or any other person appointed by a bankruptcy court or judge, or authorized under applicable law to act on behalf of a debtor . . . ." The crux of the insurer's argument was that a DIP was not specifically

listed in the exception to the exclusion and that being an organization, the DIP could not be a “person” as set forth in the exception. The court rejected the insurer’s argument, holding that in the context of the IVI Exclusion, the definition of “person” was ambiguous, and that under bankruptcy law, “person” could include organizations or similar entities. *See also Powersports, Inc. v. Royal & SunAlliance Ins. Co.*, 307 F.Supp. 2d 1355 (S.D. Fla. 2004); *Walz v. Fed. Ins. Co.*, 2004 U.S. Dist. LEXIS 21882, C.A. No. 04-C-2286, (N.D. Ill. Oct. 27, 2004); *Hebla v. Healthcare Ins. Co.*, 851 A.2d 95 (N.J. Super Ct. App. Div. 2004); *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F.Supp. 2d 376 (D. Del. 2002).

IV. Severability And Allocation

For a number of years, D&O policies only provided coverage to directors and officers and, in some instances, to the corporation, *i.e.*, the principal policyholder, to the extent that the insured corporation indemnified the directors and officers pursuant to its obligations under law or in accordance with contractual agreements among the corporation and its directors and officers. Over time, the breadth of D&O coverage has expanded to include “entity” coverage, in which with respect to certain types of claims, securities actions being the most typical example, the policyholder corporation itself is entitled to coverage with respect to any damages awards made against the corporation, as opposed to the directors and officers.

The advent of entity coverage has created conflicts among outside directors, inside directors and officers and the corporation. D&O policies provide only a finite set of limits with respect to covered claims that are made against all classes of D&O insureds. In the context of these policies, directors and officers, who of course have fewer resources to pay awards than their corporation, could face situations in which they are not fully covered. This occurs when the corporation obtains indemnity under the entity coverage in the D&O policy before any decision in the same or different action that would have triggered the insurance company’s obligation to indemnify the directors and officers.

Not surprisingly, this situation has contributed to efforts by directors and officers, who ultimately make the decisions as to the shape of their D&O coverage, to include allocation or severability provisions with respect to the separate interests of inside directors and officers, outside directors, and the corporation. These efforts are reflected in the insurance policies themselves or in documents of corporate governance, *e.g.*, the by-laws of the corporation.

The typical feature that is being widely adopted in D&O insurance policies to address the conflicts referenced above is some form of “severability” provision. For example, some policies are written so that there is the right of full indemnification and payment of defense costs with respect to those directors and officers who were found not to be culpable with respect to the wrongful actions that are the subject of the underlying lawsuit, even though other directors or officers may be held liable. This provision works reasonably well when there is an actual judgment that exonerates certain directors and officers while inculpating others. However, in the more likely situation of a settlement of an action that implicates D&O coverage, there may be no clear delineation as to who the culpable directors and officers are versus those who clearly had no involvement in the alleged wrongful activities. This situation lends itself, of course, to insurance coverage litigation upon the settlement of the underlying action. One way in which insurers have attempted to deal with this problem is to extend severability coverage provisions only to directors and officers – not the to the corporation itself.

Another facet of the D&O policy language regarding severability that is helpful to outside directors or officers who may be innocent vis-à-vis the insiders relates to insurers' claims for rescission because of fraudulent misrepresentations made in the underwriting process. This dispute raises the issue of whether all directors and officers should suffer from the actions of a few, almost always inside directors and officers. To respond to this situation, policyholders and insurers have attempted to craft coverage provisions which limit insurers' ability to rescind coverage to those situations in which either no actions of any director or officers can be imputed to another or only certain officers' actions can be imputed to other officers and directors. Again, this provision works well when there is actually a final determination as to who the wrongdoers are, but becomes more problematic when, as happens in most circumstances, cases settle rather than proceed to trial.

There are a number of recent decisions that reflect the mixed results in the rescission context based on insurers' allegations of misrepresentations in the policy underwriting and application process. *See, e.g., In re HealthSouth Corp. Ins. Litig.*, 308 F.Supp. 2d 1253 (N.D. Ala. 2004); *Nat'l Union Fire Ins. Co. v. Xerox Corp.*, C.A. No. 603360/03, 2004 N.Y. Misc. LEXIS 2347 (N.Y. Sup. Ct. Nov. 10, 2004); *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F.Supp. 2d 988 (W.D. Wash. 2004).

V. Defense Costs And Duty To Defend

An insurer's defense obligation in the D&O coverage context, like any number of other insurance contexts, is an often-disputed one. For example, is an insurance company obligated to pay defense costs or does it have a duty to defend when some of the claims are covered and some or all are not? This issue is addressed in the high profile Tyco litigation in which former CEO Dennis Kozlowski faces criminal and civil suits alleging a host of wrongful conduct. His ability to obtain defense costs from Tyco's D&O insurer is addressed in *Fed. Ins. Co. v. Kozlowski*, C.A. No. 5109, 2005 N.Y. App. Div. LEXIS 3029 (N.Y. Sup. Ct. App. Div. Mar. 22, 2005). Federal not only sought to avoid the payment of any defense costs to Kozlowski because some of the claims against him were for illegal personal gain (*i.e.*, unjust enrichment excluded from coverage), but it moved to rescind the policy because of misrepresentations made by Tyco personnel. The court affirmed the trial court's rejection of Federal's arguments with one important exception. On appeal, the court held that while Federal had to pay all of Kozlowski's defense costs, that obligation was subject to a right of reimbursement to the extent some defense costs were incurred to defend Kozlowski on claims that are not covered by the policy, such as unjust enrichment. This part of the decision modified the trial court's ruling which had held that Federal had to pay all of Kozlowski's defense costs regardless of whether claims were covered or not, unless Federal prevailed on its rescission defense.

Along the same lines, some courts have held that even though a D&O policy may specifically provide for the advancement of defense costs, an insurer is obligated to advance such costs pursuant to that provision only if the claim suggests a reasonable potential for coverage. *See Brown v. Am. Int'l Group, Inc.*, 339 F.Supp. 2d 336 (D. Mass. 2004). The *Brown* court determined that the policies at issue like most D&O policies did not have a duty to defend but simply a duty to pay defense costs. The insurer's obligation to pay depended on whether the underlying claims are covered or not. In contrast to the Tyco case, the *Brown* court ruled that the insurer's obligation to pay defense costs only for covered claims should be addressed at the outset, rather than giving the insurer an after-the-fact right to seek reimbursement. Thus, the court addressed the insurer's argument that the interrelated acts barred coverage and rejected it. In the end, the policyholders obtained the payment of defense costs. *See also Habela v. Healthcare Ins. Co.*, 851 A.2d 75 (N.J. Super. Ct. App. Div. 2004)

Appendix

Coverage in a D&O policy is typically excluded with respect to any claim brought against the policyholder:

A. Unjust Enrichment

arising out of, based upon or attributable to the gaining in fact of any profit or advantage to which the Insured was not legally entitled;

B. Intentional Fraudulent Act

arising out of, based upon or attributable to the committing in fact of any deliberate criminal or deliberate fraudulent act by the Insured;

C. Related Acts

alleging, arising out of, based upon or attributable to the facts alleged, or to the same or related Wrongful Acts alleged or contained in any Claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this policy is a renewal or replacement or which it may succeed in time;

D. Prior Litigation

alleging, arising out of, based upon or attributable to, as of the Continuity Date, any pending or prior: (1) litigation; or (2) administrative or regulatory proceeding or investigation of which an Insured had notice, or alleging or derived from the same or essentially the same facts as alleged in such pending or prior litigation or administrative or regulatory proceeding or investigation;

E. Insured Versus Insured

which is brought by or on behalf of an Organization or any Insured Person, other than an Employee of an Organization; or which is brought by any security holder or member of an Organization, whether directly or derivatively, unless such security holder's or member's Claim is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any Executive of an Organization or any Organization; [with certain exceptions such as:]

> any Employment Practices Claim brought by an Insured Person, other than an Insured Person who is or was a member of the Board of Directors (or equivalent governing body) of an Organization;

-or-

> in any bankruptcy proceeding by or against an Organization, any Claim brought by the examiner, trustee, receiver, liquidator or rehabilitator (or any assignee thereof) of such Organization, if any;

F. Pollution Exclusion

alleging, arising out of, based upon or attributable to, directly or indirectly: (i) the actual, alleged or threatened discharge, dispersal, release or escape of Pollutants; or (ii) any direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize

Pollutants, (including but not limited to a Claim alleging damage to an Organization or its securities holders); provided, however, that this exclusion shall not apply to Non-Indemnifiable Loss, other than Non-Indemnifiable Loss constituting Cleanup Costs.

Notes:

1 In rare instances, courts have concluded that defense counsel can owe a duty of care to the insurer, even if the insurer is not a client. *See, e.g., Paradigm Ins. Co. v. Langerman Law Offices, P.A.*, 24 P.3d 593, 601-02 (Ariz. 2001) (holding that an attorney-client relationship was not a prerequisite to a liability insurer's tort action against the insured's attorney for its alleged negligence in handling the case against the insured).

2 Words or phrases that are in bold type are defined terms in the policy.