604 30 Developments in Insurance Coverage

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Mollie Cohn Lambert is a partner in the litigation section of Jackson Walker in Houston. She has represented clients in a variety of simple and complex commercial litigation matters, including insurance coverage, insurance defense and the defense of products liability cases, medical malpractice claims, defamation suits, construction claims, and trade secret litigation. She has trial experience in all areas of her practice.

Ms. Lambert is a member of the State Bar of Texas and its litigation section, the Houston Bar Association, and the ABA.

Ms. Lambert received her B.A. degree from Stephen F. Austin State University and her J.D. degree from Baylor University.

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Richard S. Mannella is senior counsel for Total American Services, Inc., in Philadelphia, the North American service company of Total S.A., the world's fourth largest publicly traded oil and gas company. Total American Services encompasses 21 operating entities involved in a variety of manufacturing businesses from adhesives and sealants, aeronautics and automotive components, consumer products, electronics, paints and coatings, petrochemicals and specialty chemicals, in addition to oil and gas exploration activities. Mr. Mannella handles a broad range of litigation and transactional work, and counsels the operating entities on compliance, insurance, and risk management issues.

Mr. Mannella is an experienced attorney with more than 15 years of comprehensive legal and managerial experience in diverse environments, including a Philadelphia law firm, a Fortune 500 pharmaceutical company, and an international provider of property, casualty, financial, risk-management, and accident and health products and services.

Mr. Mannella is currently a member of the executive committee of ACC's Litigation Committee. In addition, he serves on the board of a non-profit educational institution for children with learning differences. Mr. Mannella has also acted as pro bono counsel successfully representing exceptional children in due process proceedings under the Individuals with Disabilities in Education Act.

Mr. Mannella received a B.A. from Rutgers College and is a graduate of Rutgers University School of Law.

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Steve Shappell is managing director of the legal and claims practice at Aon Financial Services Group, Inc. in Denver. In this position, he is responsible for the management of client litigation and claims services. Mr. Shappell assists clients and the FSG network on litigation, claims, coverage, risk management, and brokerage issues. He provides legal support on directors and officers liability, errors and omissions, employment practices, and other FSG matters.

Mr. Shappell has over 16 years of experience in the insurance industry, most of which involved litigation of complex insurance issues. He previously served as counsel in the CIGNA house counsel operation. Prior to that, he was in private practice with a prominent Denver law firm, specializing in insurance-related matters.

Mr. Shappell is a frequent lecturer at UCLA Graduate School of Business, University of Wisconsin School of Business, PLUS, NVCA, and RIMS. He is a member of the Colorado and Wyoming Bar Associations.

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INSURANCE LAW UPDATE

I. REIMBURSEMENT FOR CLAIMS PAID BUT NOT COVERED

Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., WL 1252321 (Tex. May 27, 2005) is unquestionably the most important insurance law decision handed down by the Texas Supreme Court in several years because of its effect on an insurer's reimbursement rights. For that reason, *Frank's Casing* warrants extensive attention.

The majority opinion was authored by Former Justice Priscilla Owen, now a member of the Fifth Circuit Court of Appeals. The issue in *Frank's Casing*, as framed by the Court, was whether certain excess insurance carriers that disputed coverage but that settled third-party claims against their insured were entitled to recoup the settlement payments from their insured when it was later determined that the claims against the insured were not covered.

The trial court granted summary judgment for the insured, holding there was no right to reimbursement; and the court of appeals affirmed. 93 S.W.3d 178 (Tex.App.—Houston [1st Dist.] 2002) (Brister, J.). Both courts concluded that the Court's prior decision in *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000) was controlling. But on petition for review, the Court distinguished *Matagorda County* and held that "*a right of recoupment can arise even absent an insured's express agreement to reimburse settlement payments made by an insurer if there is no coverage*…." *Frank's Casing*, WL 1252321, at *1 (emphasis added). The Court accordingly reversed the court of appeals' judgment and remanded the case to the trial court to enter judgment in the excess underwriters' favor.

The Court found it significant in reaching its holding that the facts of *Matagorda County* were distinguishable. Accordingly, the facts of both cases must necessarily be described here in some detail.

Frank's Casing fabricated a drilling platform at its facility in Louisiana for ARCO/Vastar. The platform was installed in the Gulf of Mexico and collapsed several months later. ARCO later sued Frank's Casing, among others. Frank's Casing had a primary liability policy with a limit of $1 million, and Frank's Casing had obtained excess coverage of up to $10 million from Excess Underwriters at Lloyd's, London, among others (whom the Court referred to collectively as the "excess underwriters"). The excess underwriters issued reservation of rights letters in which they asserted that same of ARCO's claims against Frank's Casing were not covered.

The primary carrier retained defense counsel for Frank's Casing. ARCO made a pre-trial settlement offer of $9.9 million, which Frank's Casing rejected. Two weeks before trial, the excess underwriters contacted ARCO directly—without Frank's Casing's knowledge—and attempted to settle only the claims the underwriters were willing to concede were covered, but no agreement was reached. As trial approached, the excess underwriters retained counsel to associate with Frank's Casing and its primary carrier in the defense of ARCO's claims, as the underwriters were entitled to do under the excess liability policy. ARCO's suit against Frank's Casing proceeded to trial, and it readily became apparent that Frank's Casing was the target defendant. By the close of the second day of trial, Frank's Casing's in-house counsel had contacted ARCO and requested that it make a settlement demand within the excess policy's limits, suggesting $7 million. ARCO promptly responded with a demand of $7.5 million, which Frank's Casing communicated to the excess underwriters accompanied by a demand that the underwriters accept this offer, thus "*Stower*izing" the excess underwriters. The underwriters agreed that the case should be settled for $7.5 million and stated that they would fund the settlement up to $7.5 million, less any contribution from the primary carrier, if Frank's Casing would expressly agree that all coverage issues would be resolved at a later date. Frank's Casing refused and sent a second letter demanding that the underwriters accept ARCO's settlement offer. The excess underwriters then advised Frank's Casing that they would pay $7.5 million, less any contribution from the primary carrier, and seek reimbursement from Frank's Casing. That same day, the underwriters contacted ARCO and orally accepted the settlement offer. Significantly, the excess insurance policy required Frank's Casing's approval of any settlement, and it gave that approval.

A written settlement agreement among ARCO, Frank's Casing, and the excess underwriters preserved "any claims that exist presently" between Frank's Casing and the excess underwriters. Prior to the settlement agreement's execution, the excess underwriters filed the instant coverage suit against Frank's Casing for reimbursement, and Frank's Casing had answered. The trial court initially granted three separate motions for partial summary judgment for the excess underwriters, finding that none of ARCO's claims against Frank's Casing were covered, requiring Frank's Casing to reimburse the excess underwriters, and awarding the excess underwriters $7,013,612.00.

But then the Court handed down *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000). As a result, the trial court directed Frank's Casing to file a motion for new trial only on the reimbursement issue, and Frank's Casing did so. The trial court then withdrew its order granting partial summary judgment on the reimbursement issue and signed a take-nothing judgment against the excess underwriters. The court of appeals affirmed, but stated: "We recognize this case carries *Matagorda County* to a logical conclusion that is somewhat disquieting—Frank's was able to resolve the parties' coverage dispute in its own favor simply by sending a *Stowers* demand to the underwriters…But this is a matter that the underwriters must take up with the superior court." 93 S.W.3d at 180. Which of course is precisely what happened.

At this point, the facts and holdings of *Matagorda County* need to be discussed so that the Court's holding in *Frank's Casing* can properly be put into context. In *Matagorda County*, the County was sued after inmates armed with razor blades physically and sexually assaulted other inmates in the County's jail. The County's policy with the Texas Association of Counties' risk pool specifically excluded any claim arising out of the operation of the jail. The risk pool nevertheless agreed to defend the inmates' suit against the County with a reservation of rights and concurrently sought a declaratory

judgment that the inmates' claims were not covered. Before the declaratory judgment action was resolved, the inmate plaintiffs offered to settle their suit against the County for $300,000, which was within policy limits. The County advised the risk pool that this was a reasonable settlement offer, but it did not ask the risk pool to accept the offer and refused to fund the settlement itself, insisting that there was coverage. The risk pool then sent the County a letter, reasserting its position that there was no coverage, but advising the County that the risk pool would fund the settlement and then seek reimbursement from the County in the declaratory judgment action. The County did not respond, and the risk pool settled the inmates' claims. The County later stipulated in the declaratory judgment action that the settlement amount was reasonable. Notably, the risk pool had the unilateral right to settle the claims against the County without the County's consent.

On these facts, the Court in *Matagorda County* held that an implied-in-fact agreement that the risk pool could seek reimbursement could not be found from the County's silence in response to the risk pool's letter stating it would seek reimbursement after it funded the settlement. The Court also concluded that the doctrine of equitable subrogation did not apply. The Court further concluded that the quasi-contractual theories of quantum meruit and unjust enrichment should not be applied. Instead, the Court held that the risk pool was not entitled to reimbursement unless the insured "consent[ed] to the settlement and the insurer's right to seek reimbursement." 52 S.W.3d 135. That consent, moreover, had to be "clear and unequivocal." In reaching its holding, the Court expressed concern that when an insurer has the unilateral right to settle, an insurer could accept a settlement that the insured considered out of the insured's financial reach, and the insured could then be required to reimburse the insurer for that amount.

After a lengthy analysis of *Matagorda County*, the Court in *Frank's Casing* held that "in cases such as the one presently before us, an agreement to reimburse an insurer is implied in law. It is quasi-contractual." *Frank's Casing*, WL 1252321, at *5. The Court stated that in at least two circumstances the insurer has a right to be reimbursed if it has timely asserted its reservation of rights, notified the insured it intends to seek reimbursement, and paid to settle claims that were not covered. To this end, the Court said that the concerns it expressed in *Matagorda County* were "ameliorated if not eliminated" in at least two circumstances: (1) when an insured has demanded that its insurer accept a settlement offer that is within policy limits, or (2) when an insured expressly agrees that the settlement offer should be accepted. *Id.* at *3. The Court concluded by remarking that "[t]o the extent *Matagorda County* indicated that the *only* circumstance under which an insurer may obtain reimbursement from an insured for settlement payments when there is no coverage is when there is an express agreement that there is a right to seek reimbursement, we clarify that there are additional circumstances that will give rise to a right to reimbursement." *Id.* at *6 (emphasis original).

In reaching its holding, the Court reasoned that when Frank's Casing "*Stower*ized" the excess underwriters, it could not later take the inconsistent position that the settlement offer was reasonable if the insurer bore the cost of settling but unreasonable if it ultimately bore the cost. The Court stated that once an insured asserts that a settlement offer has triggered a *Stowers* duty, and the insurer then accepts the settlement offer or a lower one, the insured is then estopped from asserting that the settlement is too financially burdensome for the insured to bear if it turns out that the claims against the insured are not covered. The Court further said that when an insured demands that its insurer accept a settlement offer within policy limits, the insured is deemed to have viewed the settlement offer as a reasonable one. The Court reasoned that if a settlement offer is one that a reasonable insurer should accept, it is one that a reasonable insured should accept if there is no coverage. The Court further reasoned that the insured is in precisely the same position it would have been in absent any insurance policy, except that the insurer is now the insured's creditor rather than the injured third party. Finally, the Court reasoned that reimbursement rights encourage insurers to settle cases even when coverage is in doubt and that such a practice benefits injured third parties because the risk that the insured lacks the resources to fund a settlement is shifted to the insurer and is lifted from the injured party who sued the insured.

Notably, Justices Hecht, O'Neill, and Wainwright wrote significant concurring opinions that expressed divergent rationales in support of the result reached by the Court.

To summarize, *Frank's Casing* has dramatically changed the legal landscape regarding an insurer's right to recover funds expended to extinguish noncovered claims. Additionally, as discussed below, it will likely pave the way for insurers to also recover funds spent in defense of noncovered claims in Texas and possibly other jurisdictions.

II. REIMBURSEMENT OF DEFENSE COSTS

Cases examining the reimbursement of defense costs expended to defend noncovered claims have reached different results. Some of the most prominent and most recent cases on the issue are discussed below.

A. Selected Cases Denying Reimbursement

Terra Nova Insurance Co. v. 900 Bar, Inc., 887 F.2d 1213 (3rd Cir. 1989) was one of the first cases to consider the insurer's right to reimbursement for costs incurred in defending noncovered claims. There, a liability insurer sought a declaratory judgment on the question of its duties to defend and indemnify the insured with respect to negligence and intentional infliction of serious bodily harm claims brought by the insured's customers, who claimed they had been shot in the insured's tavern by one of the insured's employees. The insurer argued that the policy's assault and battery exclusion eliminated coverage and that, as a result, the insurer had no duty to defend. In reaching its result, the Third Circuit Court of Appeals found it necessary to analyze whether Pennsylvania law would allow an insurer to obtain reimbursement of costs incurred in defending noncovered claims. The Third Circuit concluded that Pennsylvania law would not allow and insurer to obtain reimbursement for uncovered claims. The Court stated:

> A rule permitting such recovery would be inconsistent with the legal principles that induce an insurer's offer to defend under reservation of rights. Faced with uncertainty as to its duty to indemnify, an insurer offers a defense under reservation of rights to avoid the risks that an inept or

> lackadaisical defense of the underlying action may expose it to if it turns out there is a duty to indemnify. At the same time, the insurer wishes to preserve its right to contest the duty to indemnify if the defense is unsuccessful. Thus, such an offer is made at least as much for the insurer's own benefit as for the insured's. If the insurer could recover defense costs, the insured would be required to pay for the insurer's action in protecting itself against the estoppel to deny coverage that would be implied if it undertook the defense without reservation.

To sum up, *Terra Nova* has been widely cited as precedent for denying the recover of defense costs.

The Illinois Supreme Court has just recently addressed the reimbursement of defense costs. In ***General Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co.,*** 828 N.E.2d 1092 (Ill. 2005), the Illinois Supreme Court held that the insurer was not permitted to recover defense costs pursuant to a reservation of rights absent an express provision to that effect in the parties' insurance contract; since there was not such a provision in the policy at issue, the Court concluded that the insurer was not entitled to reimbursement.

In the underlying action, Chicago and Cook County sued the insured, Midwest Sporting Goods ("Midwest"), for creating a public nuisance by selling guns to inappropriate purchasers. The Midwest tendered defense of the suit to Gainsco, its liability carrier; Gainsco denied coverage. Nevertheless, Gainsco elected to provide a defense to the Midwest while seeking a determination through a declaratory judgment about whether it was obligated to provide coverage. Then Gainsco informed Midwest that the defense was being provided pursuant to a reservation of rights clause in the applicable policy. The reservation of rights letter stated that Gainsco was not waiving any of its rights and defenses, "including the right to recoup any defense costs paid in the event that it is determined that the company does not owe the insured a defense in this matter." Midwest never responded to Gainsco's reservation of rights letter, and Midwest thereafter accepted Gainsco's payment of defense costs. In the coverage action, the trial court declared that Gainsco was not obligated to defend the insured and ruled that the insured owed $40,517 to Gainsco for Gainsco's defense because the claims were not covered and the appellate court affirmed.

On further review, the Illinois Supreme Court, after cataloguing several cases permitting or denying reimbursement, chose to adopt the minority view and refused to permit Gainsco to recover defense costs under its reservation of rights absent, as Justice Thomas put it, "an express provision to that effect in the insurance contract between the parties." The Court cited several cases noting that the majority rule pointed out that the majority of decisions finding that an insurer is entitled to reimbursement of defense are based on a finding that that there was a contract implied in fact or law, or a finding that the insured was unjustly enriched when the insurer paid defense costs for uncovered claims.

B. Selected Cases Allowing Reimbursement

Buss v. Superior Court, 939 P.2d 766 (Cal. 1997) is the most prominent case allowing for reimbursement. In the underlying litigation, plaintiff H&H Sports ("H&H") filed a complaint containing twenty-seven causes of action against Jerry Buss & California Sports, Inc. ("Buss"). Buss tendered all of the actions to his insurers for a defense, but each insurer—with the exception of Transamerica Insurance Company ("Transamerica"), which had issued two comprehensive general liability ("CGL") policies to Buss—denied coverage and refused to defend. Transamerica accepted the defense of the H&H actions because one of the twenty-seven causes of action (defamation) was, in Transamerica's judgment, at least potentially covered, even though the other twenty-six causes of action were not. Because of the prevalence of noncovered claims, Transamerica reserved all its rights, including the right to deny coverage and to seek reimbursement of defense costs. Transamerica also agreed to provide independent counsel for Buss. Buss and H&H ultimately settled the underlying litigation for $8.5 million, and Transamerica paid Buss' independent counsel a sum just over $1 million for the defense. An expert for Transamerica testified that a figure somewhere between two and five percent of the total amount paid to Buss' independent counsel was the cost of defending the defamation claim and that approximately $950,000 was therefore spent by Transamerica in defending Buss' noncovered claims. Transamerica filed suit to recover this sum from Buss and ultimately prevailed in the court of appeals on the reimbursement issue.

On appeal to the California Supreme Court, the Court explained that under California law the insurer has a duty to defend potentially covered claims as soon as the defense of the underlying claims is tendered and until the underlying litigation is concluded. Thus, in an action where all claims are potentially covered, the insurer has a duty to defend; but if no claims are potentially covered, the insurer has no duty to defend. If potentially covered claims and noncovered claims are combined in the same complaint (thereby giving rise to a so-called "mixed action"), the insurer's contractual duty to defend extends to the potentially covered claims only. Even so, as the Court explained, the insurer has a duty implied by law to defend the mixed action in its entirety. Thus, when the insurer performs the noncontractual implied duty and defends a mixed action in its entirety, the insured may receive extra-contractual benefits from the insurer.

The Court next considered whether in a mixed action...the insurer may seek reimbursement from the insured for defense costs. The Court's answer was "no" regarding potentially covered claims; but "yes" regarding noncovered claims. In explaining why the insurer has no right to reimbursement for potentially covered claims, the Court observed that the insurance contract does not implicitly create a right to reimbursement, given that the insurer agreed to bear the costs of defense. Further, no right to reimbursement can be implied in law; because the insurer bargained to bear defense costs, any resulting enrichment of the insured is "just," and, therefore, no right to restitution exists. But regarding claims that are not even potentially covered, the insurer did not bargain to bear the costs of defense, and the insurer's attempt to recoup these costs does not "upset the arrangement" in the liability insurance contract. The insurer's right is "implied in law as quasi-contractual"; that is, the insurer can recoup its costs

because the expenditure of the same unjustly enriches the insured under the law of restitution. The Court observed:

> The "enrichment" of the insured by the insurer through the insurer's bearing of unbargained-for defense costs is inconsistent with the insurer's freedom under the policy and therefore must be deemed "unjust." It is like the case of A and B. A has a contractual duty to pay B $50. He has only a $100 bill. He may be held to have a prophylactic duty to tender the note. But he surely has a right, implied in law if not in fact, to get back $50.

Finally, the Court asserted that recognizing the right of reimbursement makes "good sense" and reasoned that the availability of the right reduces the temptation the insurer might otherwise have to deny the insured a defense in mixed actions where noncovered claims predominate, given that the insurer escapes the possibility of not recouping any of its expenses for defending noncovered claims if the insurer does not defend at all.

Just this year, in ***Travelers Casualty & Surety Co. v. Ribi Immunochem Research,*** 108 P.3d 469 (Mont. 2005), the Montana Supreme Court considered whether Travelers could recoup its defense costs that it expended on Ribi's behalf for the claims that the district court ultimately determined were barred by the CGL policy's pollution exclusion. The Court held that the district court properly determined that Travelers could recoup its defense costs expended on Ribi's behalf for the claims outside the CGL policy's pollution exclusion provision. The Court observed that Travelers timely and explicitly reserved its right to recoup defense costs when it notified Ribi of the reservation prior to the payment of the defense costs. The Court further observed that Travelers expressly reserved its right to recoup defense costs if a court determined that it had no duty to provide such costs. Moreover, the Court stated that Travelers had provided specific and adequate notice of the possibility of reimbursement and that Ribi implicitly accepted Traveler's defense under a reservation of rights when it posed no objections. The Court concluded that under these circumstances, the district court correctly concluded that Travelers could recoup its defense costs.

The United States District Court for the District of Minnesota, citing *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc*., WL 1252321 (Tex. May 27, 2005), recently held that Texas law would permit an insurer to recover defense costs for uncovered claims. ***See St. Paul Fire and Marine Insurance Co. v. Compaq Computer Corporation,*** Civ. No. 03-6485 (D. Minn. July 13, 2005). The Texas Supreme Court has not yet addressed the issue of the reimbursement of defense costs for noncovered claims. *But see Texas Association of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000) (Owen, J.) (dissenting) (recovery of defense costs does not offend Texas public policy).

III. INSURABILITY OF PUNITIVE DAMAGES

The cases examining the insurability of punitive damages have reached different conclusions. Selected cases and the policy considerations underlying them are discussed below.

A. Texas law

The issue of whether punitive damages are insurable under Texas Law has undergone a heated debate since the Texas Supreme Court's decision in *Transportation Insurance Co. v. Moriel*, 879 S.W.2d 10 (Tex. 1994). Prior to 1994, punitive damages for grossly negligent conduct were generally insurable under Texas law. *See, e.g., Dairyland County Mut. Ins. Co. v. Wallgren*, 477 S.W.2d 341 (Tex. Civ. App.—Fort Worth 1972 writ ref'd n.r.e.); *Ridgway v. Gulf Life Ins. Co.*, 578 F.2d 1026 (5th Cir. 1978). The Court's emphasis in *Moriel* on punishment and deterrence as the legal justifications for the imposition of punitive damages, however, led to intermediate appellate court and federal district court confusion over whether or not punitive damages were still insurable under Texas law. *See, e.g.*, *Milligan v. State Farm Mut. Auto Ins. Co.*, 940 S.W.2d 228 (Tex. App.—Houston [14th Dist.] 1997, writ denied) (holding that the uninsured motorist clause in the auto policy at issue did not cover exemplary damages); *Hartford Cas. Ins. v. Powell*, 19 F. Supp. 2d 678 (N.D. Texas) (Texas public policy now prohibits insurance coverage for punitive damages); *cf. Westchester Fire Ins. Co. v. Admiral Ins. Co.*, 2003 WL 21475423 (Tex. App.—Fort Worth 2003) (holding that the insurance policy at issue covered the policyholder's liability for punitive damages arising from his gross negligence); *Philadelphia Indem. Ins. Co. v. Stebbins Five Companies*, 2004 WL 210636 (N.D. Tex. Jan. 27, 2004) (insurance coverage for punitive damages does not offend Texas public policy).

The recent case responsible for refocusing the spotlight back on this issue in Texas is ***Fairfield Ins. Co. v. Stephens Martin Paving, L.P. et al.,*** 2003 WL 22005877 (N.D. Tex. 1998). In *Fairfield*, the insurer, Fairfield Insurance Company, filed an action in Texas federal court seeking a declaratory judgment that it did not owe the insured a duty to defend or indemnify it in the underlying suit because the plaintiff was only seeking punitive damages. The district court found for the insured, holding that the insurer owed him both a duty to defend and a duty to indemnify under its policy. Fairfield appealed the district court's opinion to the Fifth Circuit, and it is this appeal that has paved the way for a decision from the Texas Supreme Court.

The Fifth Circuit heard oral arguments in *Fairfield Insurance Co. v. Stephens Martin Paving, L.P. et al.*, 381 F.3d 435 (5th Cir. 2004) in early 2004. Fairfield Insurance Company argued that the Texas Supreme Court's decision in *Moriel* changed Texas law. On August 27, 2004, the Texas Supreme Court accepted the following certified question for the Fifth Circuit: "Does Texas public policy prohibit a liability insurer provider from indemnifying an award of punitive damages imposed on an insured because of gross negligence? The Texas Supreme Court heard oral argument on November 9, 2004, but has not issued an opinion as of the date of this writing. The result

is clearly much anticipated. Whatever the result, it appears that Texas law on the insurability of punitive damages will soon receive some clarity.

B. Additional Jurisdictions

1. Jurisdictions Not Permitting Insurability of Punitive Damages

Courts in Colorado, California, Florida, Illinois, New Jersey, New York, and Pennsylvania, for example, have decided that it is against their states' public policy to insure for punitive damages. *See Lira v. Shelter Ins. Co.*, 913 P.2d 514 (Colo. 1996); *City Products Corp. v. Globe Indemnity Co.*, 88 Cal. App. 3d 31 (Cal. Ct. App. 1979); *Northwestern Nat'l Cas. Co. v. McNulty*, 307 F.2d 432 (5th Cir. 1962) (applying Florida law); *Beaver v. Country Mut. Ins. Co.*, 420 N.E.2d 1058 (Ill. App. Ct. 1981); *Johnson & Johnson v. Aetna Cas. & Sur. Co.*, 667 A.2d 1087 (N.J. Super. Ct. App. Div. 1995); *Home Ins. Co. v. American Home Products Corp.*, 550 N.E.2d 930 (N.Y. 1990); *Butterfield v. Giuntoli*, 670 A.2d 646 (Pa. Super. Ct. 1996).

a. Intentional Misconduct Exception

Some states that do not permit the insurability of punitive damages make an exception for punitive damages assessed for intentional misconduct. *See, e.g., Ranger Ins. Co. v. Bal Harbour Club, Inc.*, 549 So. 2d 1005, 1007 (Fla. 1989) (stating that "it is axiomatic in the insurance industry that one should not be able to insure against one's own intentional misconduct"); *Hensley v. Erie Ins. Co.*, 283 S.E.2d 227, 232 (W. Va. 1981) (insurance coverage for punitive damages arising from gross, reckless, or wanton negligence is insurable, but not for punitive damages arising from intentional misconduct).

b. Vicarious Liability Exception

Some states that do not permit the insurability of punitive damages make an exception for punitive damages assessed against a principal as a result of vicarious liability. *See, e.g., Scott v. Instant Parking, Inc.*, 245 N.E.2d 124 (Ill. App. Ct. 1969); *U.S. Concrete Pipe Co. v. Bould*, 437 So. 2d 1061 (Fla. 1983); *Butterfield v. Giuntoli*, 670 A.2d 646, 655 (Pa. Super. Ct. 1996). *But see Johnson & Johnson v. Aetna Cas. & Sur. Co.*, 667 A.2d 1087, 1091-92 (N.J. Super. Ct. App. Div. 1995) (finding no reason to carve out a vicarious liability exception).

2. Jurisdictions Permitting Insurability of Punitive Damages

Iowa, South Carolina, Wisconsin, Washington, for example, have ruled that it is not against their states' public policy to insure against punitive damages. *See Skyline Harvestore Sys., Inc. v. Centennial Ins. Co.*, 331 N.W.2d 106, 107-108 (Iowa 1983) (punitive damages are covered unless specifically excluded from policy); *South Carolina Budget Control Bd. v. Prince*, 403 S.E.2d 643, 648 (S.C. 1991) (punitive damages insurable unless expressly exclude from the policy); *Fluke Corp. v. Hartford Accident & Indem. Co.*, 34 P.3d 809 (Wash. 2001); *Brown v. Maxey*, 369 N.W.2d 677 (Wis. 1985).

C. Policy Considerations

Good discussions of the policy considerations of why punitive damages should or should not be insurable are found in ***Hartford Cas. Ins. v. Powell,*** 19 F. Supp. 2d 678, 685 (N.D. Texas) and ***Lazenby v. Universal Underwriters Ins. Co.,*** 383 S.W.2d 1 (Tenn. 1964). In *Powell*, the United States District Court for the Northern District of Texas, quoting from ***Northwestern National Casualty Co. v. McNulty,*** 307 F.2d 432, 440-42 (5th Cir. 1962), stated:

> Where a person is able to insure himself against punishment he gains a freedom of misconduct inconsistent with the establishment of sanctions against such misconduct. It is not disputed that insurance against criminal fines or penalties would be void as violative of public policy. The same public policy should invalidate any contract of insurance against the civil punishment that punitive damages represent.
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> The policy considerations in a state where, as in Florida and Virginia, punitive damages are awarded for punishment and deterrence, would seem to require that the damages rest ultimately as well [as] nominally on the party actually responsible for the wrong. If that person were permitted to shift the burden to an insurance company, punitive damages would serve no useful purpose. Such damages do not compensate the plaintiff for his injury, since compensatory damages already have made the plaintiff whole. And there is no point in punishing the insurance company; it has done no wrong. In actual fact, of course, and considering the extent to which the public is insured, the burden would ultimately come to rest not on the insurance companies but on the public, since the added liability to the insurance companies would be passed along to the premium payers. Society would then be punishing itself for the wrong committed by the insured.
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> Considering the theory of punitive damages as punitory and as a deterrent and accepting as common knowledge the fact that death and injury by automobile is a problem far from solved by traffic regulations and criminal prosecutions, it appears to us that there are especially strong public policy reasons for not allowing socially irresponsible automobile drivers to escape the element of personal punishment in punitive damages when they are guilty of reckless slaughter or maiming on the highway. It is no answer to say, society imposes criminal sanctions to deter wrongdoers; that it is enough when a civil offender, through insurance, pays what

> he is adjudged to owe. A criminal conviction and payment of a fine to the state may be atonement to society for the offender. But it may not have a sufficient effect on the conduct of others to make the public policy in favor of punitive damages useful and effective. So, at least, seems to be the policy of Florida and Virginia. To make that policy useful and effective the delinquent driver must not be allowed to receive a windfall at the expense of the purchasers of insurance, transferring his responsibility for punitive damages to the very people--the driving public--to whom he is a menace. We are sympathetic with the innocent victim here; perhaps there is no such thing as money damages making him whole. But his interest in receiving non-compensatory damages is small compared with the public interest in lessening the toll of injury and death on the highways; and there is such a thing as a state policy to punish and deter by making the wrongdoer pay.

The Tennessee Supreme Court issued one of the earliest and most prominent opinions holding that public policy does not preclude the insurability of punitive damages in ***Lazenby v. Universal Underwriters Ins. Co.,*** 383 S.W.2d 1 (Tenn. 1964). In *Lazenby*, the Court offered the following rationales in support of the insurability of punitive damages:

> First. We accept, as common knowledge, the fact death and injuries on our highways and streets is a very serious problem and such is a matter of great public concern. We further accept, as common knowledge, socially irresponsible drivers, who by their actions in operation of motor vehicles, could be liable for punitive damages are a great part of this problem. We, however, are not able to agree the closing of the insurance market, on the payment of punitive damages, to such drivers would necessarily accomplish the result of deterring them in their wrongful conduct. This State, in regard to the proper operation of motor vehicles, has a great many detailed criminal sanctions, which apparently have not deterred this slaughter on our highways and streets. Then to say the closing of the insurance market, in the payment of punitive damages, would act to deter guilty drivers would in our opinion contain some element of speculation.
>
> Second. The language in the insurance policy in the case at bar, which is similar to many types of liability polices, has been construed by most courts, as a matter of interpretation of the language of a policy, to cover both compensatory and punitive damages. Since most courts have so construed this language in the policy, we think the average policy holder reading this language would expect to be protected against all claims, not intentionally inflicted.
>
> Third. There is often a fine line between simple negligence and negligence upon which an award for punitive damages can be made.
>
> Public policy is the present concept of public welfare or general good. *State ex rel. Loser v. National Optical Stores*, 189 Tenn. 433, 225 S.W.2d 263 (1949), *Ford Motor Company v. Pace*, 206 Tenn. 559, 335 S.W.2d 360 (1960). Public policy is practically synonymous with public good and unless the private contact is in terms of such a character as to tend to harm or injury the public good, public interest on public welfare or to violate the Constitution, laws, common or statutory, or judicial decisions of the State, it is not violative or public policy nor void on that account. *Home Beneficial Association v. White*, 180 Tenn. 585, 177 S.W.2d 545 (1944).
>
> The insurance contract in the case at bar is a private contract between defendant and their assured, Norman Frank Crutchfield, which when construed as written would be held to protect him against claims for both compensatory and punitive damages. Then to hold assured, as a matter of public policy, is not protected by the policy on a claim for punitive damages would have the effect to partially void the contract. We do not think such should be done except in a clear case, and the reasons advanced do not make such a clear case.

Id. at 5.

Subsequent cases have expanded upon the rationale set forth in *Lazenby*. *See, e.g., LeDoux v. Continental Ins. Co.*, 666 F. Supp. 178, 180 (D. Alaska 1987); *Brown v. Maxey*, 369 N.W.2d 677 (Wis. 1985). In *LeDoux*, the Court focused on the consequences of a punitive damages award and determined that awarding punitive damages punishes and deters, notwithstanding the availability of insurance coverage. 666 F. Supp. at 178. The *LeDoux* Court stated that the punitive damages award harms the wrongdoer's reputation in the community. *Id.* The Wisconsin Supreme Court similarly recognized this effect in *Brown v. Maxey*, 369 N.W.2d 677, 688 (Wis. 1985). Further, the *LeDoux* Court also stated that the wrongdoer's insurance premiums will likely increase and that further purchases of insurance may be difficult. 666 F. Supp. at 178.

IV. SELECTION OF DEFENSE COUNSEL

A. Texas Law

In ***Northern County Mutual Insurance Co. v. Davalos,*** 140 S.W.3d 685 (Tex. 2004), the Texas Supreme Court recently held in a matter of first impression that, in certain situations, the insured has the right to reject the insurer's tender of defense and select counsel of its own choosing paid for by the insurer.

The liability policy in *Davalos* contractually obligated the insurer to provide a defense for covered claims and granted the insurer the right to conduct that defense. The insured, however, refused the insurer's tendered defense because of a disagreement over the venue where the case should be defended.

Davalos, the insured, a resident of Matagorda County, was injured in an automobile accident in Dallas County. Davalos sued the driver of the other car in Matagorda County. The driver of the other car then sued Davalos in Dallas County. Although Davalos was insured, he turned the Dallas litigation over to the attorneys representing him in the Matagorda County suit. These attorneys answered the suit filed against Davalos in Dallas County and moved to transfer venue to Matagorda County. Davalos' counsel then notified his insurer of the Dallas County suit. In response to being notified of the Dallas County suit, the insurer stated that it did not wish to hire the counsel that Davalos had selected, that it opposed his motion to transfer venue to Matagorda County, and that it had chosen other counsel to defend Davalos in Dallas County.

On these facts, the issue presented to the Court was whether a disagreement over venue between the insurer and the insured was a sufficient reason for the insurer to lose its right to conduct the defense while remaining obligated to pay for it. The Court had previously acknowledged, without explanation, that an insurer's right to control the defense generally includes the authority to make defense decisions "where no conflict of interest exists." Relying on that precedent, the lower appellate court held that Davalos' disagreement with the insurer created a conflict of interest and, as a result, the insurer breached the duty to defend by insisting on the right to control the defense in the face of that conflict. The Court disagreed, holding that a disagreement about venue between the insurer and the insured did not amount to a conflict of interest.

The Court next discussed what amounts to a conflict of interest. The Court stated that the existence or scope of coverage is ordinarily a basis for a disqualifying conflict. Accordingly, a conflict of interest may arise between the insurer and the insured when the insurer issues a reservation of rights based on the same facts that will be needed to determine liability. Moreover, adopting the analysis of a well-known insurance treatise,[1] the Court concluded that the following types of conflicts may also justify an insured's refusal of an offered defense: (1) when the defense tendered "is not a complete defense under circumstances in which it should have been," (2) when "the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interests at the expense of the insured's," (3) when "the defense would not, under the governing law, satisfy the insurer's duty to defend," and (4) when, though the defense is otherwise proper, "the insurer attempts to obtain some type of concession from the insured before it will defend."

In ***The Housing Authority of the City of Dallas, Texas v. Northland Ins. Co.,*** 333 F. Supp.2d 595 (N.D. Tex. 2004), the United States District Court for the Northern District of Texas provided the first application of *Davalos*, holding that the insured was entitled to the selection of its counsel because coverage depended upon the facts that would have been adjudicated at trial.

To sum up, after *Davalos*, insurers may now face a variety of circumstances where they will be obligated to pay for the defense of an insured that they do not have the right to control.

B. California Law

In contrast to Texas, California has for some time had established jurisprudence on the issue of what constitutes a sufficient conflict of interest to entitle an insured to retain its own independent counsel at the insurer's expense. In a landmark opinion, *San Diego Federal Credit Union v. Cumis Insurance Society, Inc.*, 162 Cal. App. 3d 358 (1984), the California court of appeals held that if a conflict of interest exists between an insurer and its insured, based on possible noncoverage under the insurance policy, the insured is entitled to retain its own independent counsel at the insurer's expense. The court of appeals' opinion in *Cumis* was later codified in 1987 by the enactment of California Civil Code section 2860, which "clarifies and limits" the rights and responsibilities of an insurer and insured as set forth in *Cumis*. *See Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997).

James 3 Corp. v. Truck Insurance Exchange, 91 Cal. App. 4th 1093 (Cal. Ct. App. 2001) is a recent notable opinion dealing with conflict of interest issues. There, James 3 Corporation ("James 3"), the insured, filed a declaratory judgment action requesting a determination of whether defendant Truck Insurance Exchange ("Truck") was obligated to pay for "*Cumis*" counsel in accordance with California Civil Code section 2860. In the underlying action, James 3, a manufacturer and seller of beverage syrups used in "Slurpees," was sued by Coca-Cola in federal district court. Coca-Cola alleged that James 3 was dispensing generic syrups through Coca-Cola dispensers and thereby misleading the public into believing that they were receiving Coca-Cola products. James 3 retained an attorney who filed an answer to Coca-Cola's complaint and then tendered defense of the action to Truck. Truck accepted the tender but reserved the right to deny coverage if Coca-Cola did not recover damages sustained as a result of James 3's advertising activities, which were covered under James 3's insurance policy. Truck also denied coverage for any breach of contract or punitive damages and reserved its right to seek reimbursement of any attorneys' fees and costs paid to defend claims not covered by James 3's insurance policy.

[1] 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 4.20 at 369, 370-71 (4th ed. 2001).

The attorney retained by Truck performed an initial evaluation of the case and identified affirmative defenses and counterclaims available to James 3, but these counterclaims and defenses were not pursed. James 3 then retained independent counsel to pursue the affirmative defenses and counterclaims against Coca-Cola identified by Truck's counsel in the initial evaluation.

Because of Truck's refusal to assert the affirmative defenses and prosecute the counterclaims, James 3 asserted that it had a right to *Cumis* counsel. The court of appeals, however, disagreed. It concluded that Truck's refusal to pursue the affirmative defenses would not adversely affect James 3 and that the failure to purse the counterclaims therefore did not warrant *Cumis* counsel because Truck's contractual obligation to defend James 3 did not extend to paying for the prosecution of counterclaims.

James 3 also argued that Truck's reservation of the right to seek reimbursement of costs for the defense of noncovered claims automatically triggered Truck's obligation to provide *Cumis* counsel. The court of appeals determined that insurers have an obligation to defend an entire action even if certain claims are potentially not covered under the policy. However, the court of appeals made clear that insurers have an "implied-in-law" right to be reimbursed for defense costs of noncovered claims because the insurer did not receive premiums for such claims and defending both covered and noncovered claims would unjustly enrich the insured. As a result, the court of appeals found that Truck's reservation of the right to seek reimbursement did not automatically require the appointment of *Cumis* counsel.

James 3 further argued that, pursuant to section California Civil Code section 2860, Truck's counsel could control the outcome of a "coverage issue" in the defense of the claim because Truck's retained attorney decided how to defend the action, how to allocate his time, and how to bill for his services, which directly determined Truck's reimbursement request, thereby triggering the *Cumis* counsel requirement. The court of appeals, however, found that reimbursement was not a coverage issue as stated in the Civil Code, concluding that a coverage dispute "must be one that will be litigated in the underlying action."

For these reasons, the court of appeals concluded that James 3 had not rebutted Truck's showing that there was no actual conflict of interest and therefore that James 3 was not entitled to *Cumis* counsel.

V. EXTRINSIC EVIDENCE AND THE DUTY TO DEFEND

In ***Northfield Ins. Co. v. Loving Home Care, Inc.***, 363 F.3d 523 (5th Cir. 2004), the Fifth Circuit recently addressed whether Texas would allow the use of extrinsic evidence to determine an insurer's duty to defend. Loving Homes operated an in-home childcare service, and one of its employees fatally injured a child for whom she was caring. The parents sued Loving Homes, and its insurer attempted to introduce evidence of the caretakers criminal conviction and the child's autopsy report to invoke exclusions to its duty to defend the insured. The Fifth Circuit predicted that the Texas Supreme Court would not deviate from the traditional "eight corners" rule, which dictates that an insurer's duty to defend is determined solely by the facts alleged in the complaint and the terms of the policy. The Fifth Circuit believed that "the current Texas Supreme Court would not recognize any exception to the strict eight corners rule." The Fifth Circuit did offer the caveat that if the Texas Supreme Court were to recognize an exception to the rule, that exception would be limited to situations where the allegations do not remotely allege sufficient facts to determine coverage and when the evidence goes solely to the issue of coverage, but does not overlap with the veracity of the claims alleged.

VI. DEVELOPING CASE LAW INTERPRETING CLAIM–MADE POLICIES

A. What is a Claim? Or a Related Claim?

1. ***LensCrafters, Inc. v. Liberty Mutual Fire Ins. Co.,*** 2005 WL 146896 (N.D. Cal. 2005) (E & O insurer disclaimed coverage for a lawsuit filed against company alleging company violated their privacy rights by placing representatives in examination room while licensed optometrists associated with the company performed eye exams. The insurer argued that notice of the lawsuit was untimely because a letter from several optometrists to their state governing board sent eight months earlier constituted a "related claim" under the policy. In rejecting the insurer's argument, the court held, under California law, that the optometrists' letter seeking ethical guidance on the disclosure of patient information by the company insured under the E & O policy did not constitute a "claim" because it did not make a demand of the company. The court further opined that the ordinary meaning of "claim" is "the assertion of a right or demand for money.")

2. ***WFS Financial Inc. v. Progressive Ins. Co.,*** No. EDCV 04-976 (C.D. Cal. 2005) (California federal court ruled that language of claims-made casualty policy precluded coverage of a second class action against an automobile finance lender, because claim was based on facts similar to a claim made during a prior policy period. Specifically, during the first policy period, a class action alleged that the lender discriminated against African-Americans by allowing dealers to add "a subjective markup" to interest rates in violation of the Equal Credit Opportunity Act. During the second policy period, another class action was filed against the lender alleging that the markups discriminated against minorities in violation of California law. Rejecting the lender's contention that, as a matter of law, claims made after the expiration of a claims-made policy can never relate back to a prior policy period, the district court focused on the "unambiguous language" of the second policy which provided the "claims based upon or arising out of the same Wrongful Act or Interrelated Wrongful Acts

committed by one or more of the Insured Persons shall be considered a single claim….” The policy further stated that each such single claim shall be deemed to be first made on the date the earliest of such claims was first made, regardless of whether the date is before or during the policy Period.”)

3. ***BCS Ins. Co. v. Wellmark Inc.,*** 410 F.3d 349 (7th Cir. 2005) (in a dispute over whether an insurance coverage dispute was subject to arbitration, an E & O insurer contended that because all of the claims related to a single wrongful act, they “related back” to earlier claims-made E & O policies that included mandatory arbitration provisions. The Court of Appeals, applying Illinois law, rejected the insurer’s “relation back” argument, opining that the “relation back” provision had no bearing on whether to compel arbitration under the policy at issue which gave the insured the option of settling disputes by arbitration.)

4. ***Westport Ins. Corp. v. Law Offices of Marvin Lundy,*** 2004 WL 555415 (E.D. Pa. 2004) (a claims-made legal malpractice policy did not provide coverage for a lawsuit filed during policy period because the claim was first made prior to the inception of the policy. The firm had argued that the letter, threatening a malpractice suit for $1 million in damages, was “unreasonable” and, therefore, could not be considered a “claim” as defined by the malpractice insurance policy. The court reasoned that a letter from the underlying plaintiff to the law firm threatening to file suit qualified as a “claim” which the policy defined as “a demand made upon any insured for loss.” The court further noted that the policy made no reference to “reasonableness” and was concerned only with whether something fits the definition of a “claim.” It made no difference that the law firm believed it was not really a “claim”.)

B. When is a Claim “First Made”?

1. ***Cade & Saunders, P.C. v Chicago Ins. Co.***, 307 F. Supp. 2d 442 (N.D. N.Y. 2004) (applying New York law, a federal court ruled that a factual question existed, precluding summary judgment, on the issue of whether an attorney insured under a claims-made legal malpractice policy had knowledge of a potential claim at the time a trial court in the underlying personal injury action precluded him from using an expert because he failed to serve the expert report in a timely manner. Three years after the underlying case was over, the attorney’s former client wrote a letter advising that he was contemplating a malpractice lawsuit against the attorney. Although the attorney prompted sent the former client’s letter to the insurer, the insurer argued that notice was untimely under the policy’s notice provision. The policy’s notice provision provided that written notice be given to the insurer as soon a s practicable “upon the insured becoming aware of any negligent act, error, omission or personal injury in the rendering of, or failure to render Professional Services which could reasonably be expected to be the basis of a Claim ….” The attorney argued that he did not give notice of the claim at the time of the trial court’s expert preclusion order because the preclusion order resulted from a “strategic choice” and because of his “good faith” belief that the former client, with whom he had a close relationship, would not file a malpractice claim. While acknowledging that it is “well settled” that an insured must provide notice upon learning of facts and circumstances that would “lead an objectively reasonable person to believe in the possibility of a claim”, the federal court ultimately concluded that the determination of reasonableness is a factual issue.) [NOTE: following a trial on the matter, the court ruled that the attorney’s good faith belief that trial court’s denial of their motion to provide disclosure of expert witness in personal injury action would not give rise to legal malpractice claim, and thus attorneys’ failure to give their legal malpractice insurer notice of potential claim at that time did not bar coverage under malpractice policy, even though verdict was adverse to attorneys’ client. Cade & Saunders. P.C., 332 F.Supp 2d 490 (N.D. N.Y. 2004)]

2. ***Preston v. Wisconsin Health Fund*** (E.D. Wis. 2004) (in an unreported decision, a federal magistrate, applying Wisconsin law, held that under an EPL claims-made policy, an amended complaint that added a new defendant and asserted a new count was a claim “first made” when the original complaint was filed prior to the policy’s inception. In the original complaint, the underlying plaintiff sued the health fund and one of its directors alleging age and gender discrimination and tortious interference with an employment contract. During the EPL policy period, the plaintiff amended her complaint adding another director of the health fund as a defendant and asserting a new conspiracy claim against all defendants. In ruling that coverage for the amended complaint was precluded, the magistrate judge emphasized that the policy provided that a claim is first made when “any” insured becomes aware of the filing of a complaint against an insured.)

3. ***Bancinsure, Inc. v. The Park Bank,*** 318 F.Supp.2d 746 (W.D. Wis. 2004) (in another unreported decision, a Wisconsin federal court held that the prior notice exclusion in a bank’s D & O policy precluded coverage for a claim asserted solely against the bank even though the D & O policy in effect when the bank provided precautionary notice did not provide entity coverage. Specifically, the policyholder bank received notice of a possible check kite fraud and advised its D & O insurer. At the time, the policy named

as "Insured Persons … all persons who were, now are or shall be the directors and officers of the Company." A renewal D & O policy amended the Insured Person language to define Insured to include the bank, its parent company and their employees. During the period of the renewal D & O policy, the policyholder bank, but not its directors or officers, was sued by another bank for conversion of funds and breach of contract based on the check kite fraud scheme which was the subject of the bank's prior notice under the old D & O policy. In rejecting the policyholder bank's coverage claim under the renewal D & O policy, the court stated that it was undisputed that the bank was an insured under the policy and that the policy "excludes claims made against insureds if notice [of the facts or circumstances leading to a claim] has previously been given under any prior policy.")

C. Extended Reporting Period Decisions

1. ***Liberty Surplus Ins. Corp. v. Segal Co.,*** 2004 WL 2102090 (S.D. N.Y. 2004) (federal district court held that an extended reporting period (ERP) endorsement to a claims-made excess policy extended the time period during which a claim could be made against the insured and still be subject to coverage. The ERP endorsement at issue stated that reporting period was "extended to apply to claims first made against the insured during 36 calendar months immediately following … the effective date of nonrenewal of this policy." The ERP endorsement also stated it applied "only to claims which arise out of any act, error or omission of the Insured prior to [the effective date of nonrenewal] and which would otherwise be covered hereunder." During the extended reporting period, the policyholder was sued based on actions which occurred prior to the policy nonrenewal date and sought coverage. The court rejected the insurer's argument that because the ERP endorsement applied only to claims "which would otherwise be covered hereunder", only claims first made against the insured company during the original policy period were covered. In so ruling, the court found that the plain meaning of the phrase "which would otherwise be covered hereunder" simply limited coverage to those claims that exhausted the company's underlying insurance.)

2. ***Segal Company v. Certain Underwriters at Lloyd's, London,*** 2005 WL 1530233 (N.Y. A. D. 2005) (reversing an interesting trial court decision, the New York Appellate Division held that public policy did not require the offer of ERP, since the policy was outside state regulatory scheme for claims-made policies, and even assuming that policy was within regulatory scheme, it was within exception for "large commercial insureds." The trial court, relying on New York Insurance Department regulation (11 NYCRR § 73.3 (c) (1)), opined that all claims-made policies must allow the policyholder to purchase ERP coverage upon termination or non-renewal, even if caused by the policyholder. In so ruling, the trial court also rejected Lloyds contention that the regulation did not apply to a foreign insurer not doing business in New York, stating "not being authorized to do business in New York has nothing whatsoever to do with the right of New York to regulate industries affecting its residents." The Extended Reporting Period at issue was defined in the policies as "the selected period of time purchased in accordance with Clause X after the end of the Period of Insurance for reporting Claims, suits or proceedings arising out of acts, errors or omissions which take place prior to the end of the Period of Insurance and otherwise covered by this insurance." Clause X provides that "[i]n the event of cancellation or non-renewal of this insurance by Underwriters, the Named Insured shall then have the right, in consideration of the appropriate additional premium, to an extension of the cover granted by this policy to apply ... in respect of any Claim made against any Insured during the period selected below after the expiration date of this policy but only when such Claim arises out of acts, errors or omissions committed prior to the expiration date of this policy. Clause X further provided that: "[t]he quotation by Underwriters of a different premium or deductible or limits of liability or changes in policy language for the purpose of renewal shall not constitute a refusal to renew by the Underwriters.")

D. Application of Retroactive Dates

1. ***Evans v. Medical-Inter-Insurance Exchange,*** 856 A. 2d 609 (D.C. App. Ct. 2004) (appeals court held that coverage of claims-made professional liability policy for injury arising out of the rendering of or failure to render, on or after the retroactive date, professional services by the insured did not apply if the services or failure to render services occurred before the retroactive date, even if injuries fully developed or were still being experienced after the retroactive date; the rule of the last antecedent pointed toward the conclusion that the phrase "on or after the retroactive date" modified the immediately preceding words "rendering or failure to render," rather than "injury," and the policy contained a notice that it did not provide coverage for medical incidents that took place before the retroactive date. Specifically, the policy sets forth that the "Policy Period" is "Effective from May 1, 1997 to January 1, 1998...." and that its "Retroactive Date" is "01/01/95." It sets forth the following in large type, all capitalized, across its front page near the top: "NOTICE: THIS POLICY DOES NOT PROVIDE COVERAGE FOR MEDICAL INCIDENTS THAT TAKE

PLACE BEFORE THE RETROACTIVE DATE SHOWN ON THE DECLARATIONS PAGE."

That notice is followed directly by:

I. COVERAGE AGREEMENTS

The Exchange will pay on behalf of the insured all sums that the insured shall become legally obligated to pay as damages because of:

Coverage A--Individual Professional Liability

Injury arising out of the rendering of or failure to render, on or after the retroactive date, professional services by the individual insured, or by any person for whose acts or omissions such insured is legally responsible, except as a member of a partnership ....")

2. State of Washington v. Zurich Specialties London Ltd., 116 Wash App. 1033, 2003 WL 1824966 (Wash App. 203), review denied by, 150 Wash. 1022, 81 P. 3d 1120 (Wash 2003) (The State paid Linda David $8.8 million to settle a claim for injuries her husband inflicted on her while acting as her State-appointed caregiver. The State sued its insurer, Zurich Specialties, for coverage. The trial court granted summary judgment to the State and the Court of Appeals affirmed.

On appeal, Zurich argues that the policy did not cover David's claim because all her injuries flowed from the appointment of her husband as her caregiver, an act that occurred before the policy's coverage began. In the alternative, Zurich argued that if the policy covered any of David's injuries, the trial court should have allocated liability for the settlement between the parties based on the number of negligent acts occurring before and after the retroactive date. In rejecting Zurich's arguments, the Appeals Court observed that the State's appointment of David's husband as her caregiver was only the first in a series of negligent acts by the State, a number of which took place after the policy's effective date. The policy therefore covered David's claim. Further, the trial court properly ruled that the policy covered the entire settlement because there was no rational basis for allocating it between events or injuries occurring before and after the effective date of the policy.)

VII. APPLICATION OF THE TOTAL OR ABSOLUTE POLLUTION EXCLUSION

A. Read literally, the exclusion requires its application to all instances of injury or damage to persons or property caused by "any pollutants arising out of the discharge, dispersal, seepage, migration, release or escape of ... any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste."

B. Is there a trend toward limiting pollution exclusion to those hazards traditionally associated with environmentally related claims (i.e., any loss or expense arising out of a demand, order, regulatory requirement or suit to assess the effects of, monitor, clean up, remove or neutralize hazardous waste)? Or does the clause apply equally to negligence involving toxic substances and traditional environmental pollution, and thus is as unambiguous in excluding the former as the latter? *See, e.g.*, ***Bituminous Casualty Corporation v. Sand Livestock Systems, Inc.,*** 2005 WL 1476441 (N.D. Iowa June 22, 2005) (certifying question to Iowa Supreme Court regarding application of total pollution exclusion, collecting cases, and noting lack of unanimity as to how the clause should be interpreted).

C. The majority of reported cases construe "absolute" pollution exclusions, which began to be used by the insurance industry in 1985. Some cases, however, construe the "total" pollution exclusion, introduced in 1988. Further, note that, in contrast to the "sudden and accidental" pollution exclusion, there is great variety in draftsmanship of "absolute" and "total" pollution exclusions.

D. Pro-Policyholder Decisions (i.e., limiting the exclusion in favor of coverage).

1. ***Nav-Its, Inc. v. Selective Insurance Co.,*** 869 A.2d 929 (NJ 2005) (CGL insurer had duty to defend and indemnify construction contractor for lawsuit alleging personal injuries by tenant exposed to fumes released from flooring coating and sealant).

2. ***Auto-Owners Ins. Co. v. Potter,*** 105 Fed. Appx. 484, 2004 WL 1662454 (4th Cir.2004) (applying North Carolina law to hold the exclusion applies only to discharges into the environment and finding duty to defend where homeowners' complaint alleged that housing developer provided water containing excessive concentrations of manganese, iron, calcium, arsenic, barium, chloride, hard water constituents, and total dissolved solids from its four wells, and that such contaminants caused skin problems, adverse health effects, damage to household goods, and diminution of property values.)

3. ***Belt Painting Corp. v. TIG Ins. Co.,*** 100 N.Y.2d 377, 763 N.Y.S.2d 790, 795 N.E.2d 15, 18 (N.Y.2003) (under New York law, CGL policy's pollution exclusion did not absolve insurer of its duty to defend insured painting subcontractor in negligence action brought by building owner's employee, seeking to recover for inhalation injuries resulting from released paint or paint solvent fumes, where exclusion did not clearly and unequivocally exclude a bodily injury claim arising from indoor exposure to insured's tools of its trade.)

4. ***MacKinnon v. Truck Insurance Exchange,*** 31 Cal.4th 635, 3 Cal.Rptr.3d 228, 73 P.3d 1205 (Cal.2003)(pollution exclusion given a narrow meaning, under California law. Noting that the policy definition of a "pollutant" as including "any irritant or contaminant," read literally, leads to "absurd results and ignores the familiar connotations of the words used in the exclusion," the court felt it " 'far more reasonable that a policyholder would understand [a pollutant] as being limited to irritants and contaminants commonly thought of as pollution and not as applying to every possible irritant or contaminant imaginable.' " Applying this standard, the court held that a landlord's allegedly negligent use of a pesticide by spraying to eradicate yellow jackets around its apartment building did not come within the scope of the pollution exclusion. The court found it "far from clear MacKinnon's claim ... for injuries arising from the normal, though negligent, residential application of pesticides, would be commonly thought of as pollution.")

5. ***Gainsco Ins. Co. v. Amoco Prod. Co.,*** 53 P.3d 1051, 1066 (Wyo.2002) (in action seeking coverage for the death of a subcontactor's employee who was fatally exposed to hydrogen sulfide gas while emptying a vacuum tank, the court stated, "We do not know if it is the majority position, but we will join with those courts that have held the total pollution exclusion to be limited to the concept of environmental pollution").

E. Pro-Insurer Decisions (i.e., applying exclusion and denying coverage)

1. ***United States Fidelity & Guaranty Co. v. Lehigh Valley Ice Arena, Inc.,*** 121 Fed. Appx. 979, 2005 WL 388659 (3rd Cir.2005) (applying Pennsylvania law to exclude claims based on inhalation of carbon monoxide from a malfunctioning Zamboni machine);

2. ***Quadrant Corp. v. American States Ins. Co.,*** 110 P. 3d 733 (Wash. 2005) (apartment tenant's injury claim from exposure to sealant applied to nearby deck excluded from coverage by "the plain language" of the absolute pollution exclusion. In so ruling the Washington Supreme Court distinguished its prior decision in *Kent Farms, Inc. v. Zurich Insurance Co.*, 140 Wash.2d 396, 402, 998 P.2d 292 (Wash. 2000), notwithstanding its observation that the policy language at issue in both *Kent Farms* and *Quadrant* was identical in all relevant respects. In *Kent Farms*, the Washington Supreme Court held that: (1) absolute pollution exclusion was intended to apply to environmental damage; (2) exclusion did not apply to a negligence claim by fuel deliveryman who was injured when diesel fuel back-flowed over him because of a faulty intake value, and (3) diesel fuel was not acting as "pollutant" within absolute pollution exclusion when it struck deliveryman.)

3. ***City of Grosse Pointe Park v. Michigan Municipal Liability and Property Pool,*** 2005 WL 1684958 (July 19, 2005) (Although term "waste' in pollution exclusion was not defined, the Michigan Supreme Court ruled sewage is a "pollutant" within the meaning of the pollution exclusion with respect to municipal discharges into a creek. Thus, coverage excluded for lawsuits by city residents seeking damages arising from the city's practice of discharging sewage into a nearby creek when its sewer system became overtaxed during, for example, heavy periods of rain.)

4. *Mark I Restoration SVC v. Assurance Co. of America*, 112 Fed. Appx. 153 (3rd. Cir 2004) affirming 248 F. Supp. 397 (E.D. Pa 2003) (coverage denied to subcontractor of restoration company sued by homeowner for bodily injury allegedly caused by misuse of deodorizers, odor eliminators and chemicals to remediate home from skunk infestation. Court of Appeals observed that, as used in restoration contractor's third-party complaint against subcontractor-insured, which alleged that insured introduced chemicals, deodorizers, odor eliminators, and/or other foreign substances at homeowner's residence, terms "chemicals, deodorizers, odor eliminators, and/or other foreign substances" unambiguously qualified as "irritants or contaminants" included in definition of "pollutant" in pollution exclusion clause in insured's liability policy, and therefore allegations triggered exclusion under Pennsylvania law, even though complaint did not identify substances involved with additional particularity.)

5. ***National Union Fire Insurance Company v. U.S. Liquids, Inc.,*** 88 Fed. Appx. 725 (5th Cir. 2004), affirming 271 F. Supp. 2d 926 (S.D. Tex. 2003) (Under Texas law, securities fraud suit and related derivative action against insured waste management company and its executives alleging losses from nondisclosure of improper waste disposal practices fell within broad pollution exclusion in directors, officers, and corporate liability insurance policy applicable to any loss "arising out of" actual discharge of

pollutants "including ... damage to the [insured] or its [shareholders]."

6. ***Ferrell v. State Farm Insurance Co.,*** 2003 WL 21058165 (Neb.Ct.App., May 13, 2003) (court denied coverage to building owner for lawsuits filed by former tenants based on injuries the tenants received due to the presence of mercury in the apartment they had rented. Court opined that "given the plain and ordinary meaning of the pollution exclusion in State Farm's insurance policy, mercury is well within the definition of "pollutant" as a reasonable person might read the exclusion.")

VIII. RESCISSION CASE SURVEY

A. Chronological history of the cases that have focused upon the issue of rescission and the effect upon the insurance coverage of "innocent" directors.

1. ***In Bird v. Penn Central Co.,*** 334 F.Supp. 255 (E.D.Pa.1971), motion for reargument granted and decision adhered to, 341 F.Supp. 291 (E.D.Pa.1972), Lloyd's sought to rescind a $10 million policy obtained by Penn Central two years before the corporation's collapse. Lloyd's contended that the chairman of the corporation's finance committee had falsely represented in the company's application that none of the directors and officers seeking coverage knew of any acts or omissions that "might afford valid grounds for any future claims." 334 F.Supp. at 257; 341 F.Supp. at 292. The court, denying a motion for summary judgment made by outside directors who had no knowledge of any probable claims at the time the policy was obtained, held that Lloyd's would be entitled to rescind the policy if it established at trial the materiality of the misrepresentations and that it had relied upon the misrepresentations. 334 F.Supp. at 262; 341 F.Supp. at 295-96. The court based its decision upon the status of the innocent directors as third party beneficiaries, whose rights could be no greater than those of the corporation: if the finance chairman's application responses were fraudulent, the court reasoned, this fraud would be imputed to his principal--the corporation--regardless of the innocence of third party beneficiaries. 334 F.Supp. at 261; 341 F.Supp. at 292, 294-95. Alternatively, the court viewed the innocent directors as individually contracting parties. Under this view, "each insured would have to be considered a separate principal for the purposes of agency law," thus in each instance raising the factual question whether the finance committee chairman was authorized within the meaning of agency law to act when he completed the application, a sufficient ground upon which summary judgment could be denied. 334 F.Supp. at 261-62. The *Bird* court--in a passage quoted in several of the decisions discussed below--observed that "[w]hile we sympathize with movants' position, and recognize that innocent officers and directors are likely to suffer if the entire policy is voidable because of one man's fraudulent response, it must be recognized that plaintiff insurers are likewise innocent parties." 341 F.Supp. at 294.

2. The court in ***Shapiro v. American Home Assurance Co.,*** 584 F. Supp. 1245 (D. Mass. 1984) similarly held that material misrepresentations by the former president of an insured corporation--including overstatements of the corporation's earnings and false statements that he knew of no acts or omissions by officers or directors that might give rise to a claim under the policy--defeated coverage under the policy to all insureds, including those officers and directors who had no knowledge of the misrepresentations. *Id.* at 1249, 1252. The court rejected the agency analysis relied upon by the Bird court, however, on the ground that "an innocent director or officer, particularly an 'outsider,' may have no control over the individual who applies for insurance coverage. Thus, binding the directors as principals is somewhat fictional." *Id.* at 1251-52. Instead, the court relied upon the material misrepresentation made in the application by the corporation's president: The language in the application form, which was part of the insurance contract, is straightforward. The form, in Question No. 14, inquires about knowledge of any officer or director concerning facts, which might give rise to claims under the policy. Because of the likelihood of joint and several liability being imposed on all directors for the wrongdoing of one, the facts known by [the corporation's president] were highly material not only to his potential liability, but to that of all other directors. Since [the president's] answer misrepresented the risk incurred in insuring all those covered by the policy, it follows that [the insurer] can avoid responsibility to all the insureds on the basis of that misrepresentation. *Id.* at 1252; *see also INA Underwriters Ins. Co. v. D.H. Forde & Co.*, 630 F. Supp. 76, 77 (W.D.N.Y.1985) (same result as in *Bird* and *Shapiro*). The Shapiro court suggested, however, that policies could be negotiated that would protect innocent directors under these circumstances, in return for higher premiums for such coverage. 584 F. Supp.at252.

Shapiro II. In a subsequent decision in the same case (involving Securities Act liability policies rather than D&O policies), the court held that two innocent directors and officers were protected by severability provisions stating that the policies were to be construed as "separate contract[s] with each Insured," and that references "to the Insured shall be construed as referring only to

that particular Insured, and the liability of the Insurer to such Insured shall be independent of its liability to any other Insured." *Shapiro v. American Home Assurance Co.*, 616 F.Supp. 900, 902, 903-05 (D. Mass.1984).

3. In ***Jaunich v. National Union Fire Ins. Co.,*** 647 F. Supp. 209 (N.D. Cal., 1986), the court held that the D&O insurer was entitled to rescind the policy because the insured failed to disclose material information regarding potential claims. The court based its ruling on a letter written by the insured's secretary and general counsel to the insured's accounting firm five days prior to the amendment of the insurance application. The letter described a number of potential lawsuits against the insured, only some of which were disclosed to the insurer.

(a) The court noted that under California law the insurer may waive its right to additional information beyond that disclosed in the application if the disclosed information "distinctly implies" other facts are not disclosed and the insurer makes no additional inquiry.

(b) The court further ruled that the insurer was not estopped from raising the rescission issue sometime after the litigation was filed, as long as the insureds were not prejudiced by the delay.

4. In ***National Union Fire Ins. Co. v. Seafirst Corp.,*** 662 F.Supp. 36 (W.D. Wash. 1986), the court refused to rescind a D&O policy based upon alleged fraud in the application. In response to the application question inquiring whether any director or officer had knowledge or information of any act, error or omission which might give rise to a claim under the policy, the insureds answered, "No, except as respects any involvement with Penn Square. See Addendum." The addendum explained that Seafirst's involvement in Penn Square loans might give rise to types of claims that would involve the policy but that, as of the date coverage was applied for, no director or officer was aware of any claim.

(a) The insurer contended that the policy should be rescinded because internal bank reports existing at the time of the application indicated that the insured's personnel were aware of the potential for litigation. The court held that "claim", as used by the insured in the application answers, referred to a lawsuit or adversarial proceeding, not merely to the existence of facts giving rise to a right enforceable in court. The court found the application to be true, since no director or officer was aware of any threatened or filed lawsuit challenging the bank's participation in Penn Square loans as of the date of the application.

(b) The court subsequently ruled in the same case on December 28, 1987, that the insurer does not lose its right to rescind the policy simply because it fails to investigate within a reasonable time after grounds for rescission first come to its attention. Rather, an insurer's relinquishment of its right to rescind must be intentional. (c) Ultimately, a jury decided on March 25, 1988, that officers of the insured corporation did not cover up the bank's financial difficulties when they applied for the D&O policy. The insureds argued that the insurer leaped at the chance to write the policy for nine times the going rate for such insurance.

5. In ***Federal Insurance Co. v. Oak Industries. Inc.,*** CCH Fed. Sec. L. Rep. ¶92,519 (S.D. Cal., 1986), the court refused to rescind a D&O policy which was issued based upon a short form application with continuity of coverage. Because the application did not specifically require the insureds to reveal knowledge of facts which could give rise to potential claims, the court ruled that the insureds were under no duty to disclose such information.

The court further stated that even if there existed misrepresentations sufficient for rescission of the policy, the insurer was estopped from seeking rescission because it did not notify the insured of its intention to rescind the policy for a period of twelve to eighteen months following notice of the possible misrepresentations. The court did not require the insureds to show any prejudice by that delay.

This holding was restated in a subsequent opinion in the same case. *Federal Insurance Company v. Oak Industries. Inc.*, Case No. 85-985 (S.D. Cal., Feb. 6, 1988). In National Union Fire Ins. Co. v. Continental Illinois Corp., 658 F.Supp. 775 (N.D.Ill., 1987), the court refused to rescind a D&O policy for fraud on the ground that financial statements attached to the insurance application were false and misleading. The insurance application in that case did not contain language which specifically incorporated the attached financial statements as part of the application. In addition, the D&O policy did not incorporate the application as an attachment, although the policy stated that any misrepresentation in the written application physically attached to the policy would void the policy. In holding that the insured did not represent or warrant the truthfulness of the attached financial statements, the court stated:

By the terms of their own forms, neither Harbor nor National Union asked CIC to represent or warrant the truth of the financial statements. They merely asked that the statements be attached. CIC did that.

(b) In a related opinion, the court in the same case held that under Illinois law, a D&O insurer may not rescind the policy based on negligent misrepresentations if the insured is not in the business of providing information such as that sought in the application. *National Union Fire Ins. Co. v. Continental Illinois*, 654 F.Supp. 316 (N.D.Ill. 1987).

(c) The requirement in some states that the application be attached to the policy when the policy is issued may prove critical in the insurer's efforts to avoid coverage on the basis of misrepresentations in the policy application. *See, e.g., Gibralter Cas. Co. v. A. Epstein & Sons Int'l., Inc.*, 562 N.E.2d (Ill. App. 1st Dist. 1990) (failure of an insurer to attach application to issued policy precludes insurer from asserting misrepresentation as a policy defense).

6. In ***Mt. Hawley Insurance Co. v. FSLIC,*** 695 F.Supp. 469 (C.D. Cal. 1987), the court refused to rescind a D&O policy. Applicable California insurance statutes require the insurer to give prompt notice of its intention to rescind the policy before any suit is filed on the policy. Because no notice was given prior to the insurer filing an interpleader suit, the court ruled the insurer was not permitted to rescind the policy.

7. In ***Atlantic Permanent Federal Savings and Loan v. American Casualty Company***, Case No. 86-172-N (E.D. Va., Mar. 12, 1987) aff'd. on other grounds, 839 F.2d 212, cert. denied, 108 S.Ct. 2824 (1988), the Fourth Circuit Court of Appeals upheld the trial court's jury instructions that the D&O insurance policy, which contained a warranty severability clause, could be rescinded as to certain insured D&O's based upon misrepresentations in the application only if the insurer proves that those insured D&O's had knowledge of the misrepresentations.

The court in *Atlantic Permanent Federal Sav. & Loan Ass'n v. American Casualty Co.*, 839 F.2d 212 (4th Cir.), cert. denied, 486 U.S. 1056 (1988), construed a similar provision, which stated that "this policy shall not be voided or rescinded and coverage shall not be excluded as a result of any untrue statement in the [application] form, except as to those persons making such statement or having knowledge of its untruth." Id. at 215. The court emphasized that this provision "was plainly designed to prevent misrepresentations made by the particular officers responsible for preparing an application from depriving their innocent colleagues of coverage." Id.

8. In ***Home Insurance Company v. Cooper & Cooper, Ltd.,*** Case No. 88 C 5276 (N.D.Ill. Nov. 7, 1988), the court refused to rescind the entire professional liability policy based on the misrepresentation in the application by only one insured, even in the absence of a severability provision. The court stated that between an innocent insured and an innocent insurer, the dispute should be resolved in favor of the insured unless clear language to the contrary exists. 15. In Continental Casualty Co. v. Allen, 710 F.Supp. 1088 (N.D. Tex., 1989), the court refused to rescind a D&O policy based on misrepresentation in the application because the jury found no intent to deceive the insurer.

9. In ***McCuen v. International Insurance Co.,*** Case No. 87-54-D-1 (S.D. La., Sept. 29, 1988), the court held the D&O insurer was entitled to rescind the policy because the defendant D&O's failed to disclose in the application, in response to the insurer's inquiry concerning acts or omissions which they had reason to suppose might afford grounds for a future covered claim, that regulatory authorities were highly critical of their management policies and loans to certain persons. The court held that the defendant D&O's intended to and did induce the insurer to issue the policy based on these knowing misrepresentations.

10. In ***Harristown Development Corp. v. International Ins. Co.,*** Case No. 87-1380, 1988 U.S. Dist. LEXIS 12791 (M.D. Pa., Nov. 15, 1988), the court ruled that the insurer may not rescind the D&O policy based upon alleged misrepresentations to the question in the application inquiring into negligent acts, errors or omissions that could reasonably lead to litigation. Although facts existed which could have given rise to anti-trust litigation, the court ruled there were no negligent acts and therefore no misrepresentation. The court noted that "there is no duty to provide information which goes beyond the questions asked". The court also ruled that because the D&O policy is an indemnity, not a duty to defend/liability policy, the insurer did not waive its right to assert rescission of the policy by failing to disclaim coverage until the coverage litigation was filed.

11. In ***Chomat v. Spreckley***, Case No. 86-2215 (S.D. Fla. 1989), the court held the D&O insurer was entitled to rescind the policy based on the directors failing to disclose in the application as requested management wrongdoing which would have caused the D&O insurer to withhold issuance of the policy.

12. In ***National Union Fire Ins. Co. v. Walker,*** Case No. 84-1093 (W.D. Mo. May 24, 1989), the court denied the insurer's summary judgment motion where a corporate representative correctly

represented that he had no knowledge or information regarding potential claims, since this "greatly limited representation" was not a "corporate warranty as to the knowledge of all officers and directors".

13. In ***Citizens Bank of Jonesboro v. Western Employers Ins. Co.,*** 865 F.2d 964 (8th Cir., Jan. 20, 1989), the court refused to rescind a claims-made bankers trust errors and omission insurance policy based upon alleged incorrect statements in the application. The insureds answered "no" to the application question whether they were "aware of any fact, circumstance or situation involving the Trust Department...which he has reason to believe might result in any future claim which would fall within the scope of the proposed insurance". The insurer subsequently learned that the bank served as trustee for a bond issue that defaulted three months before the application was filed.

(a) The court, applying Arkansas law, ruled that when a question calls for an answer based on an interpretation of known facts and circumstances, as opposed to a simple disclosure of historical facts, the adequacy of the response is evaluated by whether the individual answering the question was justified in the belief expressed.

14. In ***Maryland Deposit Insurance Fund v. American Casualty Co.,*** Case No. 88-095087/CL 79669 (Cir. Ct. Balt. City, April 13, 1989), the court granted summary judgment to the insureds without an opinion, effectively ruling that as a result of the following severability clause the D&O insurer could not rescind the policy as to insureds who knew of facts requested by but not disclosed in the application unless those insureds also knew that the facts were misrepresented in or omitted from the application:

…[T]his policy shall not be voided or rescinded and coverage shall not be excluded as a result of any untrue statement in the application, except as to those persons making such statement or having knowledge of its untruth.

15. In ***Hefland v. National Union Fire Ins. Co.,*** Case No. 615589 (Col. Supr. Ct., Santa Clara Co., Aug. 21, 1989), the court refused to rescind a D&O policy based on allegedly false financial statements attached to the application because the insurer did not rely on those financial statements and because the court interpreted the "non-imputation" clause applicable to the exclusions and the dishonesty exclusion as creating severability of the warranties.

16. In ***Ratcliff v. International Surplus Lines Ins. Co.,*** 194 Ill. App. 3d 18, 550 N.E.2d 1052 (Ill. App. Ct., Jan. 16, 1990), the court upheld the trial court's finding that there was a material misrepresentation in the application for a trustee errors and omissions insurance policy. The court stated it is immaterial whether the insureds believed the undisclosed problems would lead to litigation since the trial court is not required to consider the trustees' subjective beliefs in determining if a misrepresentation occurred.

17. In ***Wedtech Corp. v. Federal Ins. Co.,*** 740 F.Supp. 214 (S.D.N.Y.1990) the court held that a D&O policy with a severability provision is not void ab initio based upon material misrepresentations by some but not all insured directors and officers. Rather, the intent of the parties to the insurance policy was to bar coverage only for those insureds who participated in the fraudulent inducement. The court in *Wedtech Corp. v. Federal Ins. Co.,* 740 F.Supp. 214 (S.D.N.Y.1990), likewise held that a D&O policy was not "void ab initio with respect to each and every director regardless of whether he participated in the alleged fraudulent inducement." Id. at 219. The court emphasized that the policy application "indicate[d] that no statement in the application or knowledge on the part of one insured is to be imputed to another insured in determining the availability of coverage," and further provided that "the written application for coverage is to be construed as a separate application by each insured." Id. See also *National Union Fire Ins. Co. v. Sahlen*, 807 F.Supp. 743, 746- 47 (S.D.Fla.1992) (following Bird and first Shapiro decision, with the court noting the absence of a clear severability provision, as in the second Shapiro decision); *Mazur v. Gaudet*, 1992 U.S.Dist. LEXIS 1684, at 16-36, 1992 WL 44397, at *4-7 (E.D.La. Feb. 7, 1992) (same); *International Ins. Co. v. McMullan*, 1990 U.S.Dist. LEWIS 19970, at 14-25, 1990 WL 483731, at *6-9 (S.D.Miss. Mar. 7, 1990) (distinguishing first *Shapiro* decision due to specific policy language and Mississippi case law protecting innocent insureds absent a policy provision specifically excluding coverage); *Federal Sav. & Loan Ins. Cow. v. Burdette*, 718 F.Supp. 649, 657 (E.D.Tenn.1989) (following Atlantic Permanent).

18. In ***Haley v. Continental Casualty Co.,*** 749 F.Supp. 560 (D.Vt. 1990), the court denied the insurer's summary judgment motion where the insurer delayed three and a half years before it advised the insureds that it deemed the policy to be void ab initio. During that time period, although the insurer was in possession of the facts it would later use to rescind the policy, the insurer had reserved its rights on various potential exclusions, but never raised the issue of rescission as a defense to coverage. But see Monumental Life

Insurance Co. v. U.S. Fidelity & Guaranty Co., 617 A.2d 1163 (Md. Ct. Spec. Appeals, Jan. 8, 1993), where the court held that the appropriate time for rescission is not when the insurer learns of facts which raise the mere potential of decision, but rather when the insurer learns the facts which would justify rescission.

19. In ***Harbor Insurance Co. v. Essman***, No. 89-2647 (4th Cir. November 5, 1990), the court ruled that the insurer could not claim that false and misleading financial statements caused it to issue a policy to the insured where it failed to allege that the statements were prepared for the specific purpose of enabling the insurer to determine the risks involved in issuing the policy.

20. In ***Home Savings Bank v. Gillam***, 952 F.2d 1152 (9th Cir. 1991), the Ninth Circuit held that under Oklahoma law, the D&O insurer's return of premium to the insured was a condition precedent to the insurer's rescission of a D&O policy.

21. In ***FDIC v. Bryan***, 1991 U.S. App. LEXIS 29485 (10th Cir., Dec. 10, 1991), the court ruled that if the D&O policy is rescinded only as to some insureds, the insurer need only return an allocable portion of the premium to the corporation, not to the D&O's.

22. In ***National Union Fire Insurance Co. v. FDIC***, 837 S.W.2d 373 (Tenn. 1992) the Tennessee Supreme Court ruled that neither 12 U.S.C. § 1823 (which protects FDIC against defenses to claims which it may acquire from a bank if such defenses are not explicitly contained within official bank records) nor the D'Oench, Duhme doctrine prevents a D&O insurer from asserting policy rescission and application exclusion coverage defenses based on misrepresentation by the insureds.

23. In ***Mazur v. Gaudet***, 826 F.Supp. 188 (E.D. La 1992), a policy will not be rescinded as to all insureds if it contains severability language.

24. In ***National Union Fire Ins. Co. v. Sahlen,*** 1993 U.S. App. LEXIS 22405 (11th Cir., Sept. 3, 1993), the court held that in the absence of an express severability provision, a material misrepresentation by the individual who signed the application voids the entire policy. (a) The court held that material misrepresentations contained in financial statements attached to the application can be the basis for a rescission of the policy.

(b) The court also held that materiality can be established by showing that the insurer would have charged a higher premium and/or offered a lower limit of liability had it been apprised of the true facts. (c) Finally, the court ruled that in the absence of a showing of prejudice to the insureds, the insurer would not be estopped from pursuing rescission based on late notice of the rescission to the insureds.

25. In ***Jackson v. Capital Bank & Trust Company***, 1993 U.S. Dist. LEXIS 7553 (E.D. La., June 3, 1993), the court held that the attorney/client privilege barred discovery by the insurer of questionnaires sent to the D&Os by in-house counsel asking about circumstances which could give rise to a claim. The FDIC, which had taken over the bank, claimed the privilege and was upheld.

26. In ***FDIC v. Duffy***, 1993 U.S. Dist. LEXIS 15274 (E.D.La., Oct. 27, 1993), the court found that a material misrepresentation in the application made with intent to deceive rendered the policy void ab initio under Louisiana law. The court found the policy was not severable even though there were some innocent insureds, and applied an exclusion for known prior wrongful acts. In this case the material misrepresentation in the application was not found until after the policy had expired, but there was no waiver by the insurer of any coverage defenses because there was no intentional relinquishment of known rights.

27. In ***Bankers Trust Co. v. The Old Republic Insurance Co.,*** 1993 U.S. Dist. LEXIS 11065 (N.D.Ill., Aug. 9, 1993), the court construed the question in the application which asked if each person proposed for coverage was aware of any fact or circumstance which might reasonably result in a claim. The insured answer "no" to this question. The court upheld a denial of coverage because a reasonable person would have foreseen the possibility of a claim. The court stated that the subjective belief of the insured in answering this question was irrelevant, and the materiality of the misrepresentation should be measured by an objectively reasonable test.

28. In ***Desman, Inc. v. North River Ins. Co.,*** WL 87392 N.D. Ill.,1994, the court held that in evaluating the accuracy of a warranty question answer in an insurance application, an objective--not subjective--test should be used. In this case the insureds should have known about the possibility of future claims and there was therefore no coverage because this was not disclosed.

29. In ***National Union Fire Ins. Co. v. FDIC***, 1995 Tenn. App. LEXIS 69 (Tenn. App. Feb. 8, 1995), the court permitted the D&O insurer to base its misrepresentation defense on financial statements attached to the application. Also, in this case the application warranty questions asked if "any D or O have

knowledge or information of any action, error or omission which gives rise to a claim under the proposed policy?" The court construed this question as soliciting the knowledge of all not just the signatory officer. The court stated that "it is the bank that is charged with a misrepresentation."

30. The United States District Court in ***American International Specialty Lines Ins. Co. v. Towers Financial Corp.,*** 1997 WL 906427 (S.D.N.Y. 1997) states that the one of the defendants, a sophisticated businessman could have protected himself from rescission of the policy had he required that there be a severability clause in the policy so that misrepresentation by another director only result in rescission against that director.

31. The U.S. District Court for the District of Alabama in ***In Re HealthSouth***, (March 2004) recently addressed these issues and issued a very strong opinion in favor of the insureds. This case actually involved the 10 excess carriers trying to rescind. Chubb, the primary had filed its action in the state courts. The carriers in both the state and federal court litigation essentially allege that HealthSouth used materially false and misleading financial information to procure insurance coverage, and that the policies are therefore void *ab initio* (*from inception*). The insureds sought a determination that the severability clauses in the various primary policies preclude rescission of coverage as to all insureds under the primary policies and the excess policies that they characterize as "following form" of the primary policies.

The Chubb policy provided the following severability language:

Representations and Severability

In granting coverage to any one of the Insureds, the Company has relied upon the *declarations and statements in the written application for this coverage section* and upon any declarations and statements in the original written application submitted to another insurer in respect of the prior coverage incepting as of the Continuity Date set forth in Item 9 of the Declarations for this coverage section. All such declarations and statements are the basis of such coverage and shall be considered as incorporated in and constituting part of this coverage section.

Such written application(s) for coverage shall be construed as a separate application for coverage by each of the Insured Persons. With respect to the declarations and statements contained in such written application(s) for coverage, *no statement in the application or knowledge possessed by any Insured Person shall be imputed to any other Insured Person for the purpose of determining if coverage is available.* (Emphasis added.)

Alabama, like the majority of jurisdictions permits the rescission of a policy if there is fraudulent intent to deceive in the procurement or if the misrepresentation is "material".

The court quickly determined that the parties to an insurance policy could indeed contractually agree to create severability regarding representations and knowledge. Citing *Wedtech Corp v. Federal Insurance*, the court noted " a D & O policy can be found void *ab initio* and rescission deemed appropriate if the policy was obtained through a material misrepresentation, even when there are officers and directors who had no knowledge of the fraud.... *Where the insurance policy contains a severability provision, however, some of the officers and directors might still be entitled to coverage."*

The court also concluded,

"Federal policy language waived innocent misrepresentations as a basis for rescission. The severability clause, contained in the same provision as the representations clause, unambiguously provides that the rights of each insured as to coverage will be separately determined. No representations or *knowledge* of any insured person shall be imputed to any other insured person. The Federal severability clause by referencing knowledge of an insured person in the only provision relating to representations effectively negates innocent misrepresentations as a basis for rescission. Only statements made with personal knowledge of their falsity can be used by the carrier for the purpose of denying coverage. Thus, the severability clause read together with the representations clause provides that Federal can only rescind as to an insured person who personally made a knowing misrepresentation in the written application on which Federal relied to issue the policy."

The court then addressed the argument that carriers frequently make that the Representations and Severability clause, does not preclude it from rescinding the policy based on misrepresentations made outside and apart from the written application without being bound by the severability provision. In other words the severability clause only precludes it from imputing to an insured statements and knowledge about information provided in the written application by another insured, but has no effect on its right to rescind coverage based on misrepresentations contained in something other than the "written application" referenced in that paragraph. The court in rejecting this argument held,

> Not only would this argument produce a contorted reading of clear and plain policy language, it is the precise argument Federal made and lost in *Oak Industries*. Federal cannot negate the effect of paragraph 17 by claiming reliance upon some other information not mentioned in the policy and seeking to use any alleged misrepresentations outside of the written application to rescind the policy. An insurance company must live with the insurance policy it wrote and the court will not construe the policy to defy a common sense reading of the precise language chosen by the insurer that would bring about an absurd result.

The carriers argued that because the financial statements were made by HealthSouth, the "insured organization" and not an "insured person," the Federal severability clause does not apply to protect insured persons from rescission based on HealthSouth statements. The carriers pointed to the definition section that includes a separate definition for "Insured Organization," who in this case is HealthSouth and its subsidiaries. Because the severability clause does not preclude imputation of statements or knowledge by the "Insured Organization" to an "Insured Person," the carriers argued that HealthSouth's false financial statements could be imputed to all the "Insured Persons" to justify rescinding. The court rejected this argument concluding that this argument totally misreads the severability clause and rendered an absurd result.

The Federal severability clause reads: "No *statement* in the application or *knowledge* possessed by any Insured Person shall be imputed to any other Insured Person for the purpose of determining if coverage is available." (Bold in original; emphasis added.) The application referred to in this provision logically is the application submitted by HealthSouth. The severability clause also provides that HealthSouth's written application for coverage "shall be construed as a separate application for coverage by each of the Insured Persons." The severability clause applies both to the statements in the HealthSouth application and to *knowledge* possessed by any insured person. The severability clause makes knowledge of each individual insured relevant for rescission purposes as to each insured. Without proof that an individual insured had knowledge of any false statements by HealthSouth, the severability clause precludes rescission as to that insured.

Finally, the court stated that if the companies can rescind coverage because of misstatements or misleading statements in HealthSouth SEC filings, without showing that the individual insured *knew* of the misstatement, then coverage under the D & O policies would be totally illusory. Under the interpretation urged by the excess carriers, officers and directors who have no specific control over or intimate knowledge about statements contained in SEC filings and other financial reports would not have insurance protection in cases of misstatements by the corporation or other insureds. The insurers' argument would apply even if an individual director could not possibly determine the existence of any intentional deception, particularly in financial reports that were certified as correct by an outside accounting firm. The court felt that such an interpretation would violate the manifest intent of the policy, and would ignore the motivation for obtaining officers and directors coverage in the first place--to protect officers and directors from liability for actions of the corporation. It was ruled that the argument presented by some excess insurers that they can rescind as to all insureds merely because of false statements in publicly available financial reports must fail because the policy language did not support it and because such an argument would lead to an absurd result.

32. In ***Cutter & Buck***, (Feb. 2004) the corporation and directors and officers were named in multiple shareholder class action lawsuits in connection with financial statements that the company restated primarily as a result of revenue recognition. The insurance carrier Genesis, notified the company that it was rescinding the D&O policy. Litigation followed.

The court held "The language in the severability of application provision allows for only one reasonable interpretation. Under this interpretation, Steve Lowber's knowledge of the material misrepresentations in the renewal application is imputed to otherwise innocent directors and officers because Lowber signed the renewal application." The court concluded that the rescission was proper and ruled that the rescission applied to *all* insureds under the policy, regardless of any involvement in, or any knowledge of, the misrepresentations. The policy had a limited severability clause that unfortunately allowed the knowledge of the person who signed the Application to be imputed to all insureds. The signer Lowber plead guilty to fraud. It is important to note that this action was decided in Washington under Washington law which requires proof of intent to deceive to rescind an insurance policy.

33. ***Federal Insurance v. Tyco and Adelphia v. AEGIS*** (March 2004) both held that the D&O insurance carriers are required to continue to advance defense cost to the insureds until such time as

a court may determine that the carrier is entitled to rescind such coverage. The courts both stated that the carriers are not entitled to unilaterally rescind coverage under a D&O policy of insurance unless the policy expressly allows such unilateral action.

34. ***Federal Insurance v. Tyco***. In a subsequent ruling, the New York Supreme Court ruled on June 22, 2004, that the Insurer was obligated to defend Tyco's CEO in both the civil actions and the criminal proceeding. On appeal the issue presented was "whether the insurer may avoid its obligations by electing to rescind by notice on the grounds of material misrepresentations and omissions in the information provided for issuance of the policies." In examining the question, the court reviewed the severability provision in the application of insurance. The severability provision required the insurer to "show that Kozlowski participated, directly or indirectly, in misrepresenting facts to induce [the insurer] to issue the policy." The severability provision also precluded the insurer from imputing statements or knowledge of other insureds to Kozlowski. Because Kozlowski had never signed an application or furnished any answers or information as part of the application process, (and Federal never alleged that Tyco's public financial statements were part of the application), the appellate court held that the insurer had not yet met that burden. Federal also argued that case law supported its position that because it was fraudulently induced into entering into the contract of insurance, it should have been permitted to rescind the policies without judicial determination as to whether it met the referenced burden of proof. The appellate court disagreed. It stated that because the insurer elected to rescind the policy some two years after the policy had gone into effect and claims had already been asserted under the policy, notice of rescission could not retroactively suspend its obligations under a policy. Because the insurer had not met its burden, it was required to provide Kozlowski a defense in the ERISA action. With respect to the securities action and criminal prosecution, it determined that Federal only had a duty to pay those costs relating to liabilities that fall under the coverage provided (i.e., defense costs for covered claims). ***Federal Insurance Company v. Kozlowski***, 2005 WL646497, (N.Y.A.D., March 22, 2005).

35. ***Xerox v. AIG*** A New York state trial court dismissed the excess insurer's attempt to rescind a D&O policy based on alleged material misstatements contained in the insured company's financial statements issued prior to the policy's inception, ruling that the insurer could not rely on the financial statements, as they were not specifically incorporated in the policy. The coverage dispute arose from securities fraud lawsuits, derivative actions and SEC enforcement proceedings based on the allegedly fraudulent financial reporting. The insured company and a number of its directors and officers settled with the SEC in separate enforcement actions. The insurer denied coverage and brought a declaratory judgment action seeking to rescind the policy. The insurer argued that it was entitled to rescission based on a condition precedent contained in the policy's binder, but not in the policy itself. The binder contained the condition that no material change in risk occur between the issuance of the binder and the issuance of the policy. The carrier maintained that this provision was breached because of the inaccuracies contained in the financial statements. The policy did not contain the condition, and the alleged fraud was not discovered until after the issuance of the policy. Despite the insurer's contention that the condition precedent in the binder was meant to be incorporated into the policy, or, alternatively, that the binder and policy should be read together, the court held the condition did not apply to the policy. In reaching its decision, the court concluded that there was no evidence that the parties intended to incorporate the condition into the policy. The court also rejected the insurer's contention that a binder and policy are to be read together, noting that, "[a] binder provides interim insurance, usually effective as of the date of the application, which terminates when a policy is issued or refused." Further, the court rejected the insurer's rescission claim based on the alleged breach of the covenant of good faith and fair dealing, indicating that the insurer could not "transform this non-viable contract claim into a valid [breach of covenant claim]" because the covenant of good faith and fair dealing could not "nullify other express terms of a contract, or…create independent contractual rights." The court dismissed the insurer's claim for rescission based on fraudulent inducement, concluding that the insurer could not establish the requisite reliance. In doing so, the court first indicated that the policyholder's alleged reliance on false financial statements was contradicted by the express terms of the policy because the policy "provides coverage for claims arising from conduct . . . such as the filing of false financial statements, occurring prior to the Policy Period." Thus, the court concluded that any alleged reliance on financial statements was unreasonable as a matter of law. Further, the court noted that the terms of the policy provided that the "representations contained in the application for insurance are the basis for the coverage provided." Thus, according to the court, the insurer was "precluded from claiming reliance on financial statements" because they were not incorporated in any application. In that regard, the court noted that no application had ever been submitted by the policyholder. ***Nat'l Union Fire Ins. Co. of Pittsburgh v. Xerox Corp.,*** 2004 WL 2715603 (NY 2004).

36. ***In re WorldCom, Inc., Sec. Litig.***, 2005 WL 254684 (S.D.N.Y. Feb. 3, 2005).The district court held that the insurer was required to advance defense costs while the rescission action was pending. The court determined that the insurer could not refuse to advance defense costs based on its unilateral rescission of the policies because "[t]he [primary] policy imposes the obligation upon [the primary insurer], and through its follow form policy upon [the excess insurer], to pay [the director] the costs of his defense as those costs are incurred." The court held that "[u]ntil the issue of rescission is adjudicated, a contract of insurance remains in effect and the duty to pay defense costs is enforceable." In so holding, the court distinguished the precedents relied upon by the excess insurer on the basis of the specific policy language at issue in those cases. The court also rejected the excess insurer's argument that the director had failed to show a sufficient likelihood of success on the merits (i.e., of defeating the excess insurer's rescission claim). The court reasoned that the director needed only to show that "under the terms of the policies, he is entitled to payment of defense costs as they are incurred, and that as a matter of law, that obligation exists until the rescission issues have been litigated and resolved." The court found that the director had met his burden.

37. The former chief executive officer and chief financial officer of a bankrupt corporation sought coverage for two securities lawsuits under a D&O insurance policy. The policy contained a representation and severability provision, which provides that, if "the particulars and statements contained in the Proposal are untrue," there is no coverage for "any Director or Officer who knew as of the Inception Date of this Policy the facts that were not truthfully disclosed in the Proposal" whether or not such director or officer "knew of such untruthful disclosure in the Proposal." The insurer denied coverage based on the representation and severability provision because the two former officers had knowledge of a misrepresentation of fact in the application for the policy. The court found that the evidence produced by the insurer strongly suggested that both officers had knowledge of the truth of the fact misrepresented in the application. The court opined that if the officers could not afford the defense costs now, then they likely could not repay the insurer at a later time. ***Gaon v. Twin City Fire Ins. Co. (Hartford),*** 1:05-CV-04477-KMW (S.D.N.Y Jun. 3, 2005).