COMMITTEE ON INSURANCE COVERAGE LITIGATION

Coverage

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Articles

Mandatory Arbitration Provisions—not in my State—Mccarran-Ferguson, the FAA, and Reverse Preemption

by John E. James and Michael B. Rush

There is a well-established public policy recognized in both the federal and state court systems that arbitration, rather than litigation, is a procedure that, in many cases, is the most economical, efficient, and fair method for the resolution of disputes. However, in the world of insurance coverage litigation, from complex commercial to personal lines disputes, there is a view, especially among policyholders, that mandatory arbitration is not necessarily the most effective or fair way to resolve such disputes. Indeed, there are instances, such as reinsurance disputes, in which insurers themselves have embraced that position. The ambivalence concerning the merits of arbitration as an insurance coverage dispute resolution mechanism has led some states to enact laws that preclude the enforcement of arbitration clauses that are included in insurance policies.

The focus of this article is how the courts have handled litigation concerning the enforceability of such statutes in a number of different contexts. In many instances, the

(Continued on page 14)

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From the Chairs

Dear ICLC members:

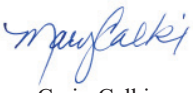
We continue to bask in the glow of a very successful 2011 Annual Meeting. Thanks to all who attended-a whopping 333 registrations, which for the second year in a row topped all other Section of Litigation Committee meetings. Our great appreciation and thanks to 2011 Meeting Chairs **Ted Howard** and **Tracy Alan Saxe** for a job well done. But with no rest for the weary, last year's Vice Chairs and 2012 Meeting Chairs **Linda Klamm** and **John Mumford** and Meeting Vice Chairs **Suzan Charlton** and **Rahul Karnani** are already starting work on the ICLC's 2012 Annual Meeting. Mark your calendars for our traditional first weekend in March, **March 1-3, 2012** (Early Bird Reception on **February 28th** with a Saturday farewell cocktail hour and dinner), at our new venue the **Loews Ventana Canyon Resort**, and save the date for our quality programming and networking events.

The ICLC was present with flags (or umbrellas) flying at the Section of Litigation's Section Annual Conference, held on April 13-15, 2011, at the Fontainebleau Hotel in Miami. Vice Chair **Sheri Pastor** created our booth for the Conference's Committee Expo, which featured movie themes. After selecting *Rainmaker* (of course), we pushed the theme "*Are You Covered*?" by handing out umbrellas and recyclable tote bags (thanks to McCarter & English for the umbrellas and **Angela Elbert**'s swag stash) to new ICLC members. Kudos also to **Laura Hanson**, who led a dynamite discussion on new Punitive Wrap Policies at the Insurance Coverage Practice Area Discussion and Networking luncheon. **Lane Finch** was honored as our Outstanding Subcommittee Cochair Award Winner for his work on the Programming Subcommittee, including the submission of webinars and panels for various ABA meetings. And a special thanks to **Zesara Chan**, **Lee Shidlofsky**, **Cara Tseng Duffield** and **Marnie Hamel** of Marsh, who led our panel "*But Who Pays The Bills - Spotting and Handling the Complex Insurance Issue in Play for the Defense of Investigations, Criminal Prosecutions and Ponzi Scheme Litigation*." Finally, thanks to those of you who attended our Insurance Coverage Litigation Committee dinner hosted by Cochair **Ron Kammer**.

Speaking of new members, our Membership Subcommittee will be circulating materials and asking you to help us with our Summer 2011 Membership Drive. The Section of Litigation asked us to increase our ranks by ten percent-a daunting task considering that we have 2,400 members but doable with your help. Please work with the **Membership Subcommittee** by forwarding the materials to members of your firm and other colleagues, with a special focus on our Young Lawyers.

In closing, we always need journal-quality articles for *Coverage* magazine and smaller articles and case notes for our Website. Contact *Coverage* Editor-in-Chief **Erik Christiansen** (echristiansen@parsonsbehle.com) or Website Editors-in-Chief **Rina Carmel** (rcarmel@ccplaw.com), **Jim Davis** (jdavis@reedsmith.com), **John Buchanan** (jbuchanan@cov.com) and **Jayson Sowers** (jsowers@riddellwilliams.com). Check out our new *Coverage* Index, now posted on our Website. Kudos to Jayson Sowers, **Lorie Masters** and others who worked diligently over many years to prepare the Index! Finally, if you have any ideas for webinars, activities for our Annual Meetings, or general suggestions for improving our outreach efforts, please contact ICLC cochairs Ron Kammer (rkammer@hinshawlaw.com) or me (mcalkins@jenner.com). Best to all,

Mary and Ron



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Coverage for Cyber Risks

by Louis Chiafullo and Brett Kahn

Louis A. Chiafullo, Esq., is a partner in McCarter & English, LLP's Insurance Coverage Litigation practice group. His primary practice focuses on the representation of policyholders in many types of insurance coverage disputes, and he has counseled clients on and litigated matters involving insurance coverage for environmental impairment, products liability, business interruption, directors' and officers' liability, errors and omissions, and computer crime and fraud issues. In addition, he provides advice to clients by assessing their potential risks, analyzing new insurance products, and considering the adequacy of their existing insurance programs.

Brett Kahn, Esq. is an associate in McCarter & English, LLP's Insurance Coverage Litigation practice group. He primarily represents corporate policyholders in coverage disputes arising in state and federal court, as well as in domestic and international arbitrations. Mr. Kahn also works on a broad range of general litigation and pro bono matters.

BACKGROUND

Since 2005, hackers have illegally accessed hundreds of millions of data records through thousands of breaches.[1] The problem is only getting worse—incidents of breaches, and the costs associated with them, are escalating exponentially. According to a recent study by the Ponemon Institute, for the fifth year in a row, data breach costs have continued to rise.[2] The average cost of a data breach in 2010 increased to $7.2 million, up 7 percent from $6.8 million in 2009.[3] The study also found that, for the first time, malicious or criminal attacks are among the most expensive cause of data breaches and not the least common cause, which signals a troubling trend for both companies and individuals.[4]

Add to that the fact that the business world has become a gadget wonderland—laptop computers, tablet notebooks, USB thumbdrives, and the like—and it becomes quite clear that there are multiple ways in which sensitive information can make its way into a third-party's hands. The issue is pervasive across industries and geographical boundaries. Social security numbers, bank account information, credit card numbers and intellectual property are just a sampling of the types of data targeted by cyber criminals. Equally problematic is the risk of impaired services or denial of access to data.

> ***The average cost of a data breach in 2010 increased to $7.2 million, up 7 percent from $6.8 million in 2009***

For corporations, the problem can be especially damaging as individuals (sometimes in class actions), shareholders (in securities suits) and other entities affected by a data breach commonly initiate expensive and very public litigation. This litigation represents third-party costs to the corporation affected by the breach. But costs arising from data losses may also come in the form of first-party losses. First-party losses include the costs to comply with state and federal regulations, contractual fines imposed by credit card companies, credit monitoring services, and the retention of vendors like outside counsel, computer forensics experts and public relations consultants.

Faced with such situations, corporate policyholders may turn to their insurers to alleviate some of the costs associated with these losses. Internet and cyber crime insurance (together "cyber coverage") is a fairly recent product that began to emerge in the late 1990s. Because of the relative nascency of the product, insurers have been unable to quantify cyber risks, which generally make cyber insurance policies expensive for policyholders, with coverage that may not meet the needs of certain businesses. More often than not, corporate policyholders affected by a breach that become targets of litigation seek coverage under commercial general liability (CGL), directors and officers (D&O) or errors and omissions (E&O) policies that they previously purchased without data loss in mind.

This article will examine what coverage, if any, may be available under these more "mainstream" insurance policies that comprise the insurance portfolio of many companies. It will also briefly examine the type of coverage afforded under a specialty "Cyber Coverage" policy available to corporate

policyholders through many reputable insurance brokers. The authors conclude by offering practical tips for policyholders when faced with a claim that may implicate some of the issues discussed in this article.

DEFENSE AND INDEMNITY OF A CLAIM

In jurisdictions across the country, case law on coverage for cyber crimes and data losses is scant, which makes it difficult to predict the nature and outcome of disputes likely to arise from first- and third-party losses relating to viruses, cyber hacking, unintended disclosure of personal or confidential information, card fraud and physical losses or theft (such as theft of a USB ''thumbdrive'' or laptop). Basic principles of insurance coverage, however, still apply.

When a covered claim is presented under a policy, the insurer has a duty to defend and indemnify its policyholder. The duty to defend generally is broader than the duty to indemnify. In most jurisdictions, the duty to defend is determined by comparing the underlying plaintiff's pleadings, regardless of the actual facts, with the policy. If the alleged claims are arguably covered, the insurer must provide a defense even if the claims are false, fraudulent or frivolous.

The duty to indemnify requires an insurer to pay a judgment or settlement. This duty generally is based on the facts revealed in litigation, not upon the allegations contained in the pleadings.

COMMERCIAL GENERAL LIABILITY POLICIES

A corporate policyholder that has not purchased a specialized cyber policy most likely would tender a claim under its CGL policy. CGL policies broadly provide coverage for bodily injury, as well as for property damage and personal or advertising injury.

Property Damage

Standard CGL policies provide that the insurer ''will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies.''[5] ''Property damage'' typically means ''physical injury to tangible property, including all resulting loss of use of that property'' and ''loss of use of tangible property that is not physically injured.''[6]

Courts generally find that this data does not amount to ''tangible property'' because computer information lacks physical substance

The ''property damage'' requirement coupled with the ''tangible property'' language commonly precludes recovery of losses arising from data breaches, even though the computer storing the data clearly is ''tangible.'' Courts generally find that this data does not amount to ''tangible property'' because computer information lacks physical substance.[7] Other cases have come out differently where the data is actually lost to the owner (''loss of use'') and not simply stolen,[8] though not all courts have found ''property damage'' to ''tangible property'' from this loss of use of data.[9]

For instance, in *State Auto Property & Casualty. Insurance Co. v. Midwest Computers & More*, a third-party sued a policyholder that sold, repaired and serviced computers, alleging that faulty service work by the insured caused both data loss and loss of use of the computer the third-party had taken to the insured for servicing.[10] The policyholder sought coverage under its general liability policy while the insurer denied that any property damage to tangible property had occurred.[11]

The federal court in Oklahoma reasoned that ''computer data cannot be touched, held, or sensed by the human mind [and thus] it has no physical substance'' and is, therefore, not tangible property.[12] On the other hand, the court recognized that ''[b]ecause a computer is tangible property, an alleged loss of use of computers constitutes 'property damage' within the meaning of the [insured's] policy.''[13] Nevertheless, the *Midwest Computers* court held that the policyholder was not entitled to coverage due to an exclusion in the policy for property damage to ''that particular part of any property that must be restored, repaired or replaced because '[the insured's] work' was incorrectly performed on it'' because the third-party alleged that the policyholder's ''negligent performance of service work caused them to lose the use of their computers.''[14]

For policyholders, Judge Widener's concurring opinion in *NMS Services, Inc. v. The Hartford* perhaps best articulates the proposition that data constitutes tangible property. In *NMS Services*, the policyholder was a software company that sold telemarketing software. One of the company's former employees hacked into the company's computer system and erased vital data needed to run the company's manufacturing, sales and administrative systems. The company sought coverage under a first-party Special Property Form policy, which required ''direct physical loss of or damage to property.''[15] The majority held that the Special Property Form covered the data-breach-related losses because it considered the damaged computers to be ''property'' under multiple areas of the policy.[16] In his concurrence, Judge Widener found that loss of data

amounted to a ''physical'' loss because ''a computer stores information by the rearrangement of the atoms or molecules of a disc or tape to effect the formation of a particular order of magnetic impulses, and a 'meaningful sequence of magnetic impulses cannot float in space.' ''[17]

Unfortunately, for policyholders, the most recent standard definition of ''property damage'' contains the following specification:

> For the purposes of this insurance, electronic data is not tangible property. As used in this definition, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or from computer software, including systems and applications software, hard or floppy disks, CD-ROMS, tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.[18]

Further, the most recent standard policies contain an exclusion for ''electronic data,'' which states:

> Damages arising out of the loss of, loss of use of, damage to, corruption of, inability to access, or inability to manipulate electronic data. As used in this exclusion, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or from computer software, including systems and applications software, hard or floppy disks, CD-ROMS, tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.[19]

CGL policies, therefore, generally do not provide coverage for ''property damage'' unless there is physical loss or damage and there are no applicable exclusions. In at least one recent instance, however, a court has accepted a policyholder's argument that the second half of the ''property damage'' definition obligated the insurer to provide coverage if the policyholder allegedly caused ''the loss of use of tangible property that is not physically injured.''[20]

Personal or Advertising Injury

Many policyholders seeking coverage for data-breach losses under a CGL policy have obtained favorable rulings, at least with respect to coverage for defense costs, when arguing under Coverage B of a CGL policy. Advertising injury coverage broadly refers to liability coverage for certain enumerated competitive ''offenses'' that a policyholder may commit in the course of its advertising.[21] This coverage obligates an insurer to pay ''those sums that the insured becomes legally obligated to pay as damages because of 'personal and advertising injury' to which this insurance applies.''[22]

Unlike other forms of liability coverage, advertising injury coverage is triggered by certain offenses listed in the policy, many of which are intentional torts; thus, this coverage differs from traditional liability coverage in that the injury need not be triggered by an accidental or fortuitous event subject to the ''occurrence'' provision in most general liability policies.[23]

The advertising injury must generally arise out of at least one of the following offenses:

- ''Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services'';
- ''Oral or written publication, in any manner, of material that violates a person's right of privacy'';
- ''The use of another's advertising idea in [the insured's] 'advertisement' ''; or
- Infringing upon another's copyright, trade dress or slogan in [the insured's] ''advertisement.''[24]

The standard ISO CGL policy defines ''advertisement'' as ''a notice that is broadcast or published to the general public or specific market segments about [the insured's] goods, products or services for the purpose of attracting customers or supporters.''[25] The definition includes ''material placed on the Internet''; but, with respect to websites, ''advertisement'' refers only to that part of a site ''that is about

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[the insured's] goods, products or services for the purposes of attracting customers."[26]

Advertising injury can occur through publication "in any manner," including publication via the Internet and a wide range of other media outlets.[27] The standard insurance policy's "coverage territory" also extends to advertising injury offenses that occur through the Internet or via other means of communication.[28]

To obtain coverage under the advertising injury section of a CGL policy, the insured must demonstrate: first, that it engaged in advertising injury; second, that the underlying claim against it (for inadvertent disclosure of data or failed security) constituted a "publication" that violated the third party's "right of privacy" (terms not defined in the standard ISO policy); and, third, a causal nexus between the injury arising from the alleged offense and the advertising activity.[29]

Most coverage disputes under CGL Part B focus on whether the data breach involved an "oral or written publication" and/or on whether the breach violated a third person's "right of privacy." Most courts broadly construe the first requirement, for "publication," finding that the protected information need only be disclosed to one person or entity.[30] Many courts have determined that the term "publication" is ambiguous and, therefore, should be construed in favor of the policyholder.[31]

For example, in *Netscape Communications Corp. v. Federal Insurance Co.*, third-party plaintiffs alleged that the policyholder's software products "violated the claimants' privacy by, among other things, collecting, storing, and disclosing to [personnel within the policyholder's company] and their engineers [third-party] claimants' Internet usage."[32] The Ninth Circuit agreed with a decision by the Northern District of California and found "language covering disclosure of [information] to 'any' person or organization" to be dispositive that the internal dissemination of private information—namely, private online communications—within the company amounted to a "publication".[33]

The second requirement under personal or advertising injury coverage—that an offense violated a person's "right of privacy"—often turns on two issues. First, whether the underlying suit against the policyholder must specifically allege a right of privacy violation. Most courts find that the focus should be on the manner in which an ordinary person would perceive the alleged injuries, not on how a plaintiff or court would label a claim.[34] Other courts, somewhat surprisingly, require that the underlying allegations include violations of invasion of privacy law(s) analogous to the "offenses" set out in the CGL policy.[35]

Second, courts must consider what constitutes data to which an individual has a privacy right.[36] An issue often and more recently disputed, and usually resolved in the insureds' favor, is whether improper access and use of credit reports violates a right of privacy.[37] As with the term "publication," courts have found that the ambiguity inherent in "right of privacy" is cause to construe the term in favor of the policyholder.[38]

In connection with cyber offenses, however, the nexus should be easily satisfied since virtually everything posted on a website respecting a policyholder's goods and services can reasonably be construed as advertising

As to the final requirement–that there be a nexus–several courts have concluded that the enumerated offense generally must occur in advertising, not just be exposed by it. Consequently, parties frequently dispute whether an alleged injury or offense is connected to a policyholder's advertising activities.[39] In connection with cyber offenses, however, the nexus should be easily satisfied since virtually everything posted on a website respecting a policyholder's goods and services can reasonably be construed as advertising.

DIRECTORS' AND OFFICERS' POLICIES

D&O policies vary in form and substance. Generally, this insurance comes in the form of claims-made policies and cover losses arising from the wrongful acts of "directors and officers" of the policyholder who are sued in connection with their corporate responsibilities. The terms "directors and officers" are intricately defined in virtually all D&O policies. The wrongful acts by the covered individuals commonly must amount to no more than negligence or errors in judgment. Intentional wrongs are usually excluded.[40]

Like CGL insurance, D&O policies provide coverage for: (1) for defense costs (usually within limits, though sometimes on a duty-to-defend basis by which defense costs will not exhaust limits); and (2) indemnification of covered "directors and officers" for claims brought by third-parties.

Most D&O policies contain exclusions for claims alleging violations of privacy rights; therefore, it is often difficult for an insured to procure coverage for data losses under a D&O policy. In theory, however, D&O policies could provide coverage for losses incurred in defending a derivative action based on an alleged breach of a director's or officer's fiduciary duty to maintain administrative security measures

designed to thwart cyber attacks and data loss,[41] or for not taking preventative measures against risks from phishing or improper data manipulation.

ERRORS AND OMISSIONS POLICIES

E&O insurance is intended to cover losses and liabilities related to wrongful acts committed in the course of a policyholder's professional services. These policies typically are sold on a claims-made basis with defense costs within limits and requires the insurer "to pay on behalf of the insured those sums which the insured becomes legally obligated to pay as damages because of a negligent act, error or omission in the performance of the insured's professional services."[42] E&O policies often require that the error or wrongful act be no more than "negligence," though that is not a blanket rule.

It is possible that E&O policies may only respond to losses arising from data breaches where the policyholder provides professional services that are technical in nature, such as a software or data security consulting firm, software and hardware providers, or similar technology experts

E&O policies can also apply to "non-professionals" (*i.e.*, insureds other than doctors, lawyers and accountants) who seek coverage for their errors that allegedly cause harm to others if those insureds provide some type of service.

It is possible that E&O policies may only respond to losses arising from data breaches where the policyholder provides professional services that are technical in nature, such as a software or data security consulting firm, software and hardware providers, or similar technology experts.[43] Increasingly, E&O policies have been trending towards coverage for such insured's products and services and have focused on four main areas: (1) security; (2) advertising and personal injury; (3) electronic activity liability; and (4) infringement on intellectual property.[44]

A court's resolution of whether or not the insured's error causing the alleged damages falls under the policy's definition of "wrongful act" likely will determine the outcome of an E&O policy dispute. The Eighth Circuit has twice, recently, found that E&O policies cover claims alleging damages caused by intentional acts that lead to unintended consequences. The distinction is a fine, but important, one (that is similarly encountered in claims for coverage under CGL policies in environmental matters).

In the more recent of the two cases, *Eyeblaster, Inc. v. Federal Insurance Co.*, the policyholder's website uploaded spyware onto a third party's computer, which allegedly resulted in changed settings, freezing of the computer and, ultimately, lost tax data.[45] The policyholder did not know the spyware would be harmful.[46] The insured's E&O policy obligated the insurer to cover losses for financial injury caused by a "wrongful act" that resulted in a failure of the insured's product to perform its intended function or serve its intended purpose.[47] The policy defined "wrongful act" as "an error, unintentional omission, or negligent act".[48] The Eighth Circuit overturned a decision by the District Court of Minnesota and found that the insurer could not meet its burden of proving that the act in question (the installation of the software), while intended, amounted to an intentionally wrongful act such that coverage would be excluded.[49]

CYBER POLICIES

The simplest and surest, though by no means bullet-proof or inexpensive, way for a corporate policyholder to insulate its company from liability associated with cyber-related losses is to purchase a special cyber policy. As noted above, cyber coverage for corporate policyholders emerged as an insurance product in the late 1990s and is relatively expensive, largely due to the unavailability of actuarial information. If a policyholder does purchase such specialized insurance, it likely will have some of its first-party costs covered and its third-party claims defended.

Specialty policies providing coverage for cyber-related risks typically offer third party liability coverage for certain losses on a claims-made basis with no duty to defend and defense costs within limits

The authors have found no cases arising from a dispute related to a cyber insurance policy, or any cases construing language in such a policy. Basic contract and coverage principles, of course, would apply.

Specialty policies providing coverage for cyber-related risks typically offer third party liability coverage for certain losses on a claims-made basis with no duty to defend and defense costs within limits. Some policies also provide broad form first-party liability coverage for "cyber crime" losses—including the costs of investigating and responding to a breach. Most cyber policies generally have a sixty (60) day reporting requirement to insurers in order to trigger coverage. These policies commonly exclude

losses arising from computer malfunctions due to programming errors, ordinary wear and tear, failure to back up computer systems, and failure of telecommunication facilities.

First-Party Coverage for Cyber Liability

Insurers that offer first-party coverage sometimes split their coverage into two policies—one covering "cyber crimes" and the other for third-party liability. First-party cyber crime policies may contain insuring clauses covering loss "resulting directly from":

- fraudulent input, preparation or modification of data in a policyholder's computer system; cyber-attacks and fraudulent communications causing loss ("e-theft");
- lost business income or extra expenses incurred by the policyholder due to denial or impairment of services ("denial or impairment of e-service");
- fraudulent communications from an unauthorized party to a customer of the policyholder relating to the transfer, payment, delivery or receipt of funds or property ("e-communication");
- malicious acts by a person who alters, damages, deletes or destroys any data, instructions or communication that are part of the policyholder's computer system ("e-vandalism");
- extortion or an unauthorized person gaining access to the policyholder's computer system and making certain threats, typically only if the policyholder responds reasonably ("e-threat");
- fraudulent electronic signatures of any maker, drawer, issuer, endorser, assignor or similar party on an electronic record for which the policyholder in good faith acquired, gave value, extended credit or assumed liability ("e-signature");
- misappropriation of a record during the policy period due to cyber-attack or unauthorized access ("privacy notification expenses"); and
- generally incurred from audits or examinations by either a supervisory authority (for losses arising from e-theft) or by an independent party (for any losses) if the loss exceeds the deductible amounts ("audit and claim expenses").

Most courts narrowly construe the "resulting directly from" language so that it would not cover liability to third parties as a result of an employee's dishonesty.[50] These jurisdictions include, for example, New York, Connecticut, Massachusetts, Minnesota and the Fifth and Ninth Circuits.[51] A minority of courts, however, expand the "directly resulting from" language to hold that the employee's dishonesty need only have proximately caused the loss. New Jersey and the Third Circuit, for example, adopt this minority approach.[52]

One noteworthy potential exclusion relates to non-coverage for employee acts with respect to losses "resulting directly from" an e-communication or e-signature. This exclusion, however, may or may not apply to coverage for losses resulting directly from e-theft, denial or impairment of service, e-vandalism and e-threats.

Third-Party Coverage for Cyber Liability

Cyber policies generally cover losses resulting from third-party claims against the policyholder for which it becomes legally obligated to pay for wrongful acts arising from the policyholder's provision of services and relating to:

- damage to a third party's computer system or content in that system;
- invasion of privacy;
- libel, slander and defamation;
- loss or damage to the electronic data of a policyholder customer;
- denial, impairment or interruption of service or access to a customer's account;
- loss of business opportunity;
- unauthorized access to or display of a customer's account maintained by the policyholder; and
- intellectual property infringement (though, often not patent infringement).

Policy language covering third-party liability sometimes does not clearly define the above categories. Such ambiguity may inure to the policyholder's benefit because courts are supposed to construe ambiguities in favor of coverage; but, it also leaves open questions as to the scope of coverage. For instance, if a policyholder allows a payroll service provider access to its system and a hacker, who gains access to the policyholder's computer network through the payroll service, causes damages otherwise covered by the policy, the insurer may try to disclaim coverage for such damage. Without a more explicitly defined category of loss, it is debatable whether the policy would cover that wrongful act.

Even if a policyholder decides to purchase a specialized cyber insurance policy, the company should be aware that not all cyber insurance is identical

PRACTICAL TIPS AND CONCLUSION

Whether a particular loss is covered will depend on the factual circumstances presented, the controlling policy terms (including specific definitional and exclusionary language), and the law of the controlling jurisdiction. Analyzing cyber coverage, therefore, can be particularly challenging for policyholders who are unfamiliar with insurance jargon. The following tips may help:

- When faced with a claim, compare the complaint's allegations to the policy's insuring agreement, definitions and exclusions.
- If the claim is arguably covered, consider the policy's notice requirements and provide timely notice to the insurer(s) whose coverage may be triggered.
- If the underlying complaint is ambiguous, consider providing the insurer with "extrinsic evidence" (outside of the complaint) to support coverage.
- Determine what law may govern the insurance issues, as jurisdictions are divided over the scope and application of cyber coverage provisions.
- If your insurer refuses promptly to accept its coverage obligations, determine whether the policy provides for arbitration, mediation or a further claim review process. Consider commencing a declaratory action seeking a judicial determination of your rights under a policy, including a declaration of the appropriate forum to resolve a coverage dispute.
- Before a claim develops, speak with your broker and consider whether there are any gaps in existing coverage. Also discuss whether your company would benefit by purchasing supplemental coverage.

Even if a policyholder decides to purchase a specialized cyber insurance policy, the company should be aware that not all cyber insurance is identical. For instance, with respect to intentional acts of a corporate employee, some policies exclude losses arising from such acts but provide coverage for defense costs until final adjudication; others exclude only directors or senior managers; and other policies do not apply the exclusion to a named insured who did not participate or acquiesce in the act after having knowledge of the actions that gave rise to the claim. As technology advances, potential exposures advance just as quickly. It, therefore, is critical for companies to ensure that they have an insurance portfolio that will provide adequate coverage for these risks.

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[1] *See* Privacy Rights Clearinghouse website, *available at* <www.privacyrights.org/data-breach#CP> (last visited on March 11, 2011).

[2] 2010 Annual Study: U.S. Cost of a Data Breach 13 (March 2011), *available at* <http://www.symantec.com/content/en/us/about/media/pdfs/symantec_ponemon_data_breach_costs_report.pdf> (last visited on March 16, 2011).

[3] 2010 Annual Study: U.S. Cost of a Data Breach 13 (March 2011), *available at* <http://www.symantec.com/content/en/us/about/media/pdfs/symantec_ponemon_data_breach_costs_report.pdf> (last visited on March 16, 2011).

[4] 2010 Annual Study: U.S. Cost of a Data Breach 16–17 (March 2011), *available at* <http://www.symantec.com/content/en/us/about/media/pdfs/symantec_ponemon_data_breach_costs_report.pdf> (last visited on March 16, 2011).

[5] Insurance Services Office, Inc. ("ISO") Form CG 00 01 12 07. Similarly, many first-party property policies offer coverage comparable to that found in CGL policies, but for losses incurred by the policyholder, not by a third-party that sues the policyholder. Data loss issues arising under these first-party property policies implicate the central concern at issue here—that is, whether "data" falls under the definition of "property" in a CGL policy. Some of the cases below, where noted, involve first-party property policies instead of CGL policies.

[6] ISO Form CG 00 01 12 07.

[7] Ward General Servs., Inc. v. Employers Fire Ins. Co., 114 Cal. App. 4th 548. 556–57 (Cal. App. 4 Dist. 2003) (where a computer crash, due at least in large part to human (operator) error, resulted in data loss, the court held that there was no physical loss or damage, as, the court found, the data loss was simply a "loss of organized information . . . [such as client names and addresses]. . . ."; concluding that such information "can[not] be said to have a material existence, be formed of tangible matter, or be perceptible to the sense of touch"); America Online, Inc. v. St. Paul Mercury Ins. Co., 347 F.3d 89, 93–98 (4th Cir. 2003) (finding no physical damage to tangible property where software was damaged because, though the software itself was rendered unusable, the hardware housing it remained available and intact; the court analogized software to a lock combination and the hardware to a lock— even if the combination is forgotten or changed and the lock becomes useless, the lock is not physically damaged); AFLAC, Inc. v. Chubb & Sons, Inc., 581 S.E.2d 317, 319 (Ga. Ct. App. 2003) (finding no coverage for Y2K remediation costs under a variation of a CGL policy (that contained much of the same relevant language) because insured could not allege "direct physical loss of or damage to" its computer systems).

[8] *See, e.g.*, Southeast Mental Health Center, Inc. v. Pacific Ins. Co,, 439 F. Supp. 2d 831, 837–39 (W.D. Tenn. 2006) (policyholder suffered data loss from corruption of its pharmacy computer caused by a power outage; holding, under first-party property policy, that computer suffered physical damage due to its inability to function when it lost stored programming information and configurations; finding that "property damage" includes not only "physical destruction or harm of computer circuitry, but also loss of access, loss of use, and loss of functionality"); Lambrecht & Associates, Inc. v. State Farm Lloyds, 119 S.W.3d 16, 25 (Tex. App. 2003) (finding that where virus destroyed insured's server and data stored in server and software, first-party policy covering property damage covered virus-related

data losses because "the server falls within the definition of 'electronic media and records' because it contains a hard drive or 'disc' which could no longer be used for 'electronic data processing, record, or storage' "); Computer Corner, Inc. v. Fireman's Fund Ins. Co., 46 P.3d 1264, 1266, 1268–70 (N.M. 2002) (adopting lower court's ruling, which was not challenged, that data lost on a computer "was physical, had an actual physical location, occupied space and was capable of being physically damaged and destroyed" and was, therefore, tangible property; concluding that the impaired property exclusion was too vague and ambiguous to be enforceable); American Guar. & Liab. Ins. Co. v. Ingram Micro, Inc., 2000 U.S. Dist. LEXIS 7299 (D. Ariz. Apr. 18, 2000) (finding damage to a computer system from a power outage resulting in lost data constituted physical damage and that the computer that once housed the data was still able to perform its usual function was not determinative of coverage).

[9] *See, e.g.*, Sony Computer Entm't Am., Inc. v. American Home Ass. Co., 532 F.3d 1007, 1020 (9th Cir. 2008) (finding alleged defects in Sony's PlayStation 2 did not amount to a "classic 'loss of use' claim" since the discs at issue were not defective or damaged, they were simply incompatible with the gaming console; noting that impaired property exclusion would preclude coverage even if policyholder could establish property damage to tangible property); Cincinnati Ins. Co. v. Professional Data Servs., Inc., No. 01-2610-CM, 2003 U.S. Dist. LEXIS 15859, *21 (D. Kan. July 18, 2003) (holding that, where policyholder's business was providing software and customer support for computer systems used to manage medical information, allegations that policyholder failed to properly maintain software were insufficient to trigger coverage for property damage under CGL policy because hardware itself was not damaged; finding computer hardware "may quite possibly still function" even if there are defects in the software; noting loss of use of software and data did not constitute loss of use of tangible property because "neither has any physical substance and neither is perceptible to the senses").

[10] 147 F. Supp. 2d 1113, 1114–15 (W.D. Okla. 2001).

[11] 147 F. Supp. 2d at 1115.

[12] 147 F. Supp. 2d at 1116.

[13] 147 F. Supp. 2d at 1116.

[14] 147 F. Supp. 2d at 1116.

[15] NMS Servs., Inc. v. The Hartford, 62 Fed. Appx. 511, 514 (4th Cir. 2003).

[16] *Id.* at 514–15.

[17] *Id.* at 515 (Widener, J., concurring) (quoting Comptroller of the Treasury v. Equit. Trust Co., 464 A.2d 248 (Md. Ct. App. 1983)).

[18] ISO Form CG 00 01 12 07.

[19] ISO Form CG 00 01 12 07.

[20] Eyeblaster, Inc. v. Federal Ins. Co., 613 F.3d 797, 801–02 (10th Cir. 2010) (holding that since the insurer did not include a definition of "tangible property," the court could apply a plain meaning of that term to include computers; where the underlying complaint alleged the "loss of use" of the third party's computer, the complaint falls within the scope of the CGL policy and the insurer must defend).

[21] ISO Form CG 00 01 12 07.

[22] ISO Form CG 00 01 12 07.

[23] Zelda, Inc. v. Northland Ins. Co., 56 Cal. App. 4th 1252, 1263 (1997).

[24] ISO Form CG 00 01 12 07.

[25] ISO Form CG 00 01 12 07.

[26] ISO Form CG 00 01 12 07.

[27] The phrase "in any manner" is included in earlier standard policy forms, as well. *See* ISO Form CG 00 01 10 01 (ed. 2000).

[28] ISO Form CG 00 01 12 07.

[29] *See, e.g.*, Zurich Ins. Co. v. Sunclipse, Inc., 85 F. Supp. 2d 842, 852 (N.D. Ill. 2000), *aff'd*, Zurich Ins. Co. v. Amcor Sunclipse N. Am., 21 F.3d 605 (7th Cir. 2001); Bay Elec. Supply, Inc. v. Travelers Lloyds Ins. Co., 61 F. Supp. 2d 611, 615 (S.D. Tex. 1999).

[30] *See, e.g.*, Zurich American Ins. Co. v. Fieldstone Mortgage Co., No. CCB-06-2055, 2007 U.S. Dist. LEXIS 81570, *14 (Md. Dist. Ct. Oct. 26, 2007) ("Of the circuits to examine 'publication' in the context of an 'advertising injury' provision, the majority have found that the publication need not be to a third party."); Park University Enterprises, Inc. v. American Cas. Co. of Reading, 442 F.3d 1239, 1248–50 (10th Cir. 2006) (relying on dictionary definition to find that it is reasonable for "publication" to mean "making something generally known"); Bowyer v. Hi-Lad, Inc., 609 S.E.2d 895, 912 (W.Va. 2004) (holding that "nothing in the policy indicat[ed] that the word publication necessarily means transmitting the intercepted communications to a third party. . . ."; therefore, an employer subjecting his employee to audio surveillance without the employee's knowledge constituted a "publication" under the policy); Tamm v. Hartford Ins. Co., No. 02054BLS2, 2003 Mass. Super. LEXIS 214, *10–14 (Mass. Super. Ct. July 10, 2003) (finding a "publication" of private information where an employee-policyholder obtained emails between his co-workers and the employer's outside counsel and then communicated with outside counsel regarding the contents of the emails; holding that "intra-corporate disclosures among employees of the same company constitutes publication for purposes of an invasion of privacy"). *But see* Whole Enchilada, Inc. v. Travelers, 581 F. Supp. 2d 677, 698 (W. Dist. Pa. 2008) (finding no "publication" where insured printed in full a third party's credit card information on a sales receipt because the data was given only to the third-party cardholder and not "in any way made generally known, announced publicly, or released for distribution").

[31] *See, e.g.*, LensCrafters, Inc. v. Liberty Mut. Fire Ins. Co., No. C 04-1001-SBA, 2005 U.S. Dist. LEXIS 47185, *31–32, 36 (N.D. Cal. Jan. 20, 2005) (finding that the term is ambiguous and that "publication of material that violates a person's right of privacy does not require widespread disclosure"); Moore v. Hudson Ins. Co., No. B189810, 2007 Cal. App. Unpub. LEXIS 574, *17–19 (Cal. Ct. App. Jan. 24, 2007) (disclosing credit history and workers' compensation information uncovered in background check without employment

applicant's permission to Subway constituted a "publication" under policy; "publication" may be reasonably interpreted as meaning "disclosure to one person or entity").

[32] Netscape Comms. Corp. v. Federal Ins. Co., No. C 06-00198, 2007 U.S. Dist. LEXIS 35951, *2–3 (N.D. Cal. 2006). The private information allegedly was also disclosed to a third-party advertising company. 2007 U.S. Dist. LEXIS 35951, at *7–8.

[33] Netscape Comms. Corp. v. Federal Ins. Co., 343 Fed. Appx. 271, 272 (9th Cir. 2009). The Ninth Circuit disagreed with the lower court's broad interpretation of an exclusion for losses arising from the policyholder "providing Internet access to 3rd parties" because AOL's allegedly wrongful act in dissemination the private information through its software product actually relied upon an Internet connection to be possible and did not fall within the exclusion. 343 Fed. Appx. at 272.

[34] *See, e.g.*, American Family Mutual Ins. Co. v. C.M.A. Mortgage, Inc., No. 1:06-cv-1044-SEB-JMS, 2008 U.S. Dist. LEXIS 30233, *15–16 (S.D. Ind. Mar. 31, 2008) (finding that "a reasonable person who reads the advertising injury provisions of these policies would conclude that coverage exists for a claim arising out of the mailing of a solicitation letter that was triggered by a violation of the privacy protection rights established" by federal law); *Boston Symphony Orchestra, Inc. v. Commercial Union Ins. Co*., 545 N.E.2d 1156, 1159 (Mass. 1989) (finding that defamation coverage provided under CGL Coverage B does not only apply where the underlying plaintiffs allege a similarly-labeled tort).

[35] *See, e.g.*, Microsoft Corp. v. Am. Nat'l Fire Ins. Co., 59 Fed. Appx. 971, 971 (9th Cir. 2003) (finding that complaint in underlying suit did not allege facts that were "analogous or equivalent to the offenses set forth in the policy"; "the context of the term 'offenses' reveals that it refers to legally cognizable wrongs, not merely bad deeds that may be part of a legally cognizable wrong"); Allstate Ins. Co. v. Ginsberg, 863 So. 2d 156, 160–62 (Fla. 2003) (because the underlying claims did not allege violation of common law invasion of privacy, the insured was not entitled to coverage for personal or advertising injury under a CGL policy).

[36] *Compare* Park University Enterprises, Inc. v. American Cas. Co. of Reading, 442 F.3d 1239, 1248–50 (10th Cir. 2006) (finding that violation of a Kansas law prohibiting unsolicited fax advertisements violated "a species of privacy interest") *with* Resource Bankshares Corp. v. St. Paul Mercury Ins. Co., 407 F.3d 631 (4th Cir. 2005) (finding that the Telephone Consumer Protection Act was intended to protect consumers from receiving intrusive "junk" faxes, not from being exposed to the content of those faxes).

[37] *See, e.g.*, American Family Mutual Ins. Co. v. C.M.A. Mortgage, Inc., No. 1:06-cv-1044-SEB-JMS, 2008 U.S. Dist. LEXIS 30233, *14–16 (S.D. Ind. Mar. 31, 2008) (holding solicitation letter based on unauthorized use of third party's credit report triggered policy Coverage B because it violated the individual's right of privacy under the Fair Credit Reporting Act, which addressed concerns regarding, among other things, a consumer's right to privacy); *accord* Zurich American Ins. Co. v. Fieldstone Mortgage Co., No. CCB-06-2055, 2007 U.S. Dist. LEXIS 81570, *14 (Md. Dist. Ct. Oct. 26, 2007).

[38] *See, e.g.*, New Castle County v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 243 F.3d 744, 756 (3d Cir. 2001) ("A single phrase, which insurance companies have consistently refused to define, and that has generated literally hundreds of lawsuits, with widely varying results, cannot, under our application of commonsense, be termed unambiguous.").

[39] *See, e.g.*, Perdue Farms, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, *PA*, 197 F. Supp. 2d 370, 379 (D. Md. 2002); Information Spectrum, Inc. v. The Hartford, 364 N.J. Super. 54, 63 (App. Div. 2003).

[40] *See, e.g.*, Greenwich Insurance Co., v. Media Breakaway LLC, No. 09-56347 (9th Cir. Mar. 1, 2011), *available through* Mealey's Litigation Report, California Insurance, Vol. 10, Issue 9, (finding no coverage for online marketer that allegedly sent spam mail to MySpace users' accounts without their knowledge or permission by "phishing" or by acquiring "phished" names and passwords from other parties because the policy excluded coverage for intentional conduct resulting in wrongful profits; finding no coverage under E&O policy for similar reason).

[41] *See* David R. Cohen & Roberta D. Anderson, Insurance Coverage for "Cyber-Losses," 35 Torts & Ins. L.J. 891, 926 (2000); *see also* Joseph G. Manta and Christine N. Shultz, Y2K: Liability and Coverage Issues, 18 Temp. Envtl. L. & Tech. J. 27, 52 (describing situations in which directors or officers could be held liable for breach of a fiduciary duty by failing to implement compliance procedures to minimize the risk of Y2K-related losses).

[42] Note that CGL policies typically contain an exclusion barring coverage for property damage, personal injury or advertising injury related to professional services. This is precisely the type of coverage that E&O policies provide. *See* Search EDP, Inc. v. American Home Assur. Co., 632 A.2d 286, 288–89 (N.J. Super. Ct. App. 1993).

[43] *See* Bruce Telles, Insurance Coverage for Intellectual Property Torts, 602 PLI/Lit 629, 657–58 (1999).

[44] *See* Robert W. Hammesfahr & Zac Chacon, Insurers Develop New Products to Cover Web Perils, Nat'l L.J., Aug. 20, 2001, at C8 (describing the details of emerging E&O policies).

[45] 613 F.3d 797, 799–800 (8th Cir. 2010).

[46] *See* 613 F.3d at 799–800.

[47] 613 F.3d at 803–04.

[48] 613 F.3d at 803–04.

[49] 613 F.3d at 804. Accord St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp. 539 F.3d 809, 815 (8th Cir. 2008) (defining "error" in a technology E&O policy to include intentional, non-negligent acts and exclude intentionally wrongful acts; finding coverage under such an E&O policy for insured that intentionally sold computers that the policyholder did not know contained defective controllers). The Eighth Circuit in *Eyeblaster* also found coverage for the policyholder under its CGL policy, holding that "[t]he plain meaning of tangible property includes computers, and the [third-party] complaint alleges repeatedly the 'loss of use' of his computer." 613 F.3d at 802.

[50] Other cyber policies use "arising directly out of" instead of "resulting directly from" language to trigger coverage. The difference appears to be trivial.

[51] *See, e.g.*, Drexel Burnham Lambert Group, Inc. v. Vigilant Ins. Co., 595 N.Y.S.2d 999, 1007 (N.Y. App. Div. 1993); ITT Hartford Life Ins. Co v. Pawson, No. CV940361910S, 1997 Conn. Super. LEXIS 1646, *6–8 (Conn. Super. Ct. June 16, 1997); Kriegler v. Aetna Cas. & Sur. Co., 485 N.Y.S.2d 1017 (N.Y. App. Div. 1985); Lynch Props., Inc. v. Potomac Ins. Co. of Ill., 140 F.3d 622 (5th Cir. 1998); The Vons Cos., Inc v. Federal Ins. Co., 212 F.3d 489 (9th Cir. 2000); Atlas Metals Products Co., Inc. v. Lumbermans Mut. Cas. Co., 63 Mass. App. Ct. 738 (2005); Cargill, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 2004 Minn. App. Lexis 33 (Jan. 13, 2004); Finkel v. St. Paul Fire and Marine Ins. Co., 2002 U.S. Dist. Lexis 11581 (D. Conn. June 6, 2002).

[52] *See, e.g.*, Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc., 181 N.J. 245, 257–59 (2004); Scirex Corp. v. Federal Insurance Co., 313 F.3d 841, 849–50 (3d Cir. 2002); Resolution Trust Corp. v. Fidelity and Deposit Co., 205 F.3d 615, 655–6 (3d Cir. 2000); Jefferson Bank v. Progressive Cas. Ins. Co., 965 F.2d 1274, 1282 (3d Cir. 1992); *see also* John A. Appleman & Jean Appleman, INSURANCE LAW AND PRACTICE § 5666 (2008).

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SECTION of LITIGATION
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Editor's Notes

There is good news to report. From ongoing discussions with the ABA, it appears that while the look of *Coverage* will change as we convert to an all electronic publication, the positive development is that the high quality content of *Coverage* will not change. Given the unique and valued relationship between the ABA and LexisNexis, it appears that *Coverage* will not have to alter its content to become an electronic publication. I am optimistic that *Coverage* will continue to present high quality scholarly articles in much the same way as it has done since its inception, and that the high quality content will continue unabated as we transition into the digital age. Like many readers of *Coverage*, I appreciate the credentialed authors who appear in *Coverage*, and the in-depth analysis that epitomizes the articles we publish. I know that *Coverage* is a valued member benefit, and one of predominant reasons people join the ICLC. I am optimistic about our ability to maintain the quality of the articles we publish, while curious about how the publication will look as the ABA transitions *Coverage* into an all electronic email format. I encourage you to submit articles for our consideration, with the knowledge that *Coverage* will continue to be an important platform for the interaction and sharing of ideas among the insurance coverage bar.

—Erik A. Christiansen
Editor-in-Chief

Managing Editor's Profile

The Managing Editor of this issue is Céleste D. Elliott who is a shareholder at Lugenbuhl, Wheaton, Peck, Rankin & Hubbard in New Orleans, Louisiana. She has served in the past as a Co Vice Chair of the committee and as a Cochair of the membership subcommittee. She has spoken on insurance coverage issues at the Litigation Section's annual meeting and teleconferences, and at the committee's annual meeting. Ms. Elliott counsels insurer clients, manages disputes and litigates cases involving a wide variety of insurance coverage issues, including matters arising from environmental claims, toxic tort claims, construction defects, multiple-year trigger and allocation issues, marine liability claims, and Louisiana direct action claims.

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Mandatory Arbitration Provisions—not in my State—Mccarran-Ferguson, the FAA, and Reverse Preemption

(continued from page 1)

enforceability of such statutes depends upon the resolution of the clash between two federal statutes—the McCarran-Ferguson Act,[1] enacted in 1945 and the Federal Arbitration Act,[2] a part of federal law since 1925.

STATES WITH LIMITED RESTRICTIONS ON ARBITRATION IN INSURANCE COVERAGE DISPUTES

Remarkably, almost half of the 50 states and the District of Columbia have either general or more limited restrictions on the use of mandatory arbitration in insurance policies. At present, 24 states and the District of Columbia have such restrictions.[3] A significant number of these states have enacted legislation restricting the use of arbitration in insurance disputes only with respect to certain types of coverage. The most common restrictions on the use of arbitration in insurance disputes relate to certain types of ''consumer'' or personal lines insurance contracts, such as health, life, homeowners, and automobile insurance policies. Maryland is a good example of a state that restricts the use of mandatory arbitration provisions in any type of ''consumer'' insurance policy. The relevant Maryland statute provides:

§ 3-206.1. Arbitration provisions in insurance contracts with consumers

(a) In this section, ''consumer'' means a party to an arbitration agreement who, in the context of the arbitration agreement, is an individual, not a business, who seeks or acquires, including by lease, any goods or services primarily for personal, family, or household purposes including financial services, health care services, or real property.

(b)(1) Except as provided in paragraph (2) of this subsection, any provision in an insurance contract with a consumer that requires arbitration is void and unenforceable.

(2) This subsection does not apply to a provision that establishes an appraisal process to determine the value of property.[4]

Subsection (b)(1) of the Maryland statute encompasses the whole spectrum of personal lines coverage, such as homeowners' policies and automobile insurance, in which case mandatory arbitration provisions are proscribed.

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Some states have added flexibility to their statutory schemes on restricting arbitration in the context of consumer, personal lines oriented coverage by permitting the inclusion of an arbitration provision in such insurance policies but giving the option to use arbitration to the policyholder alone. For example, in Louisiana, the pertinent subsection dealing with uninsured motorists' coverage in its insurance code states:

> The coverage required under this Section may include provisions for the submission of claims by the assured to arbitration; however, the submission to arbitration shall be optional with the insured, shall not deprive the insured of his right to bring action against the insurer to recover any sums due under the terms of the policy and shall not purport to deprive the courts of this state jurisdiction of actions against the insurer.[5]

STATES WITH BROAD PROHIBITIONS ON THE USE OF ARBITRATION IN INSURANCE COVERAGE DISPUTES

In contrast to the states with more limited restrictions on the use of arbitration, a significant number of states have taken a more comprehensive approach and prohibited the use of mandatory binding arbitration in most if not all types of insurance coverage disputes. For example, South Carolina's Uniform Arbitration Act, states:

(a) A written agreement to submit any existing controversy to arbitration or a provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract. . . .

(b) This chapter however shall not apply to:

* * *

(4) Any claim arising out of personal injury, based on contract or tort, ***or to any insured or beneficiary under any insurance policy or annuity contract.***[6]

Some states with broad prohibitions on the use of arbitration in insurance disputes, such as Montana,

provide, however, an exception for disputes among insurers.[7]

THE FEDERAL STATUTORY FRAMEWORK AND STATE RESTRICTIONS ON ARBITRATION IN INSURANCE COVERAGE DISPUTES

The area in which policyholders, insurers, and reinsurers litigate the applicability of mandatory arbitration provisions is bisected by the fault line created by the broad mandate of the Federal Arbitration Act on one side and state statutes enacted under the aegis of the McCarran-Ferguson Act on the other.

The relevant statutory language of both the FAA and McCarran-Ferguson are straightforward in the present context. The FAA provides:

> A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.[8]

McCarran-Ferguson states in relevant part:

> (a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. . . .[9]

As discussed in more detail below, the tension between state statutes that restrict the use of arbitration in insurance disputes and the broad reach of the FAA arises out of the language in McCarran-Ferguson providing that, "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state ***for the purpose of regulating the business of insurance*** . . . unless such Act specifically relates to the business of insurance. . . ."[10]

The area in which policyholders, insurers, and reinsurers litigate the applicability of mandatory arbitration provisions is bisected by the fault line created by the broad mandate of the Federal Arbitration Act on one side and state statutes enacted under the aegis of the McCarran-Ferguson Act on the other

The question of whether a state enactment is "for the purpose of regulating the business of insurance" has been the subject of Supreme Court decisions that have figured in the state and federal courts' analysis of specific situations where states have attempted to circumscribe the FAA's reach into areas of insurance regulation. The earliest of these Supreme Court cases is *Securities & Exchange Commission v. National Securities, Inc.*[11] In that decision, the Supreme Court considered the relationship between the policyholder and the insurer to be the most significant factor in determining whether a state statute or regulation constitutes the business of insurance:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." . . . But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly are laws governing the "business of insurance."[12]

The Supreme Court in 1982 in *Union Labor Life Insurance Company v. Pireno*[13] articulated three criteria relevant to deciding whether a practice is part of the "business of insurance:"

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. None of these criteria is necessarily determinative in itself. . . .[14]

While the guidance from the Supreme Court on what constitutes the "business of insurance" seems relatively clear, that guidance has not diminished the number of cases in which that issue and others have figured in debates as to whether state restrictions on arbitration in insurance coverage disputes are protected because McCarran-Ferguson acts to reverse preempt the FAA.

SOME COURTS HAVE HELD THAT MCCARRAN-FERGUSON REVERSE PREEMPTS THE FAA WHEN APPLIED TO STATE ANTI-ARBITRATION PROVISIONS

Whether a state's anti-arbitration statute precludes the enforcement of a policy's mandatory arbitration provision has been widely litigated in various factual contexts involving different types of insurance coverage, different statutory language, and different underlying facts. The discussion of a few representative cases, below, reflects the analysis applied by courts that have found the McCarran-Ferguson Act to reverse preempt the FAA when an insurer seeks to enforce an arbitration clause against a policyholder.

The decision by the Court of Appeals of Georgia in *Continental Insurance Company v. Equity Residential Properties Trust*[15] is representative. The policyholder, Equity Residential Properties Trust ("Equity"), filed suit against its insurer, Continental Insurance Company ("Continental"), claiming that Continental breached its insurance contract with Equity by failing to pay amounts due under the policy. Continental moved to stay the action because of a mandatory arbitration provision in the policy.[16] Applying Georgia law,[17] the court looked to the Georgia Arbitration Code[18] to determine whether the arbitration provision was enforceable under Georgia law. The relevant section of the Georgia Arbitration Code specifically excluded contracts of insurance from mandatory arbitration.[19] The court recognized, however, that the insurance policy involved interstate commerce and, absent an exception, would be subject to federal preemption under the FAA.

Whether a state's anti-arbitration statute precludes the enforcement of a policy's mandatory arbitration provision has been widely litigated in various factual contexts involving different types of insurance coverage, different statutory language, and different underlying facts

Because the Georgia Arbitration Code was specifically directed to arbitration matters, the arbitration agreement in the Continental policy would ordinarily have been protected by the FAA.[20] The policyholder argued, however, that the McCarran-Ferguson Act applied in this situation because the language in the arbitration provision, when applied to insurance policies, affected an integral part of the business of insurance as regulated by Georgia, even though the provision in question was part of Georgia's arbitration statutory scheme, rather than its insurance code.

The court held that the dispositive issue was whether the provision in question was indeed for the purpose of regulating the business of insurance and found that it was. Relying principally on the Supreme Court decisions in *National Securities* and *Pireno*, the court held that the language in the Georgia Arbitration Act, if not directly, at least indirectly regulated the relationship between an insured and the insurer with respect to a disputed insurance claim. Further, applying the *Pireno* standards discussed above, the Georgia court found that the prohibition was integral to the policy relationship between the insured and the insurer and had the effect of transferring or spreading risk by confirming the right to a decision on coverage by a jury, rather than a decision by a single arbitrator. In sum, the Georgia court held that the McCarran-Ferguson Act reverse preempted the FAA and permitted the policyholder to litigate its coverage dispute in court, rather than through an arbitration process.[21]

The decision by the court in *National Home Insurance Company v. King*[22] provides another interesting perspective on whether an arbitration provision in a contract is preempted by the state's anti-arbitration provision relating to insurance. The background to the decision in *King* arises from the purchase by the policyholders of a homeowners' construction warranty plan from the builder of their home, a warranty that was backed by insurance coverage issued by National Home Insurance Company ("National Home"). After failing to obtain the necessary repairs to structural defects to their home from the builder, the Kings demanded that National Home pay for the correction of the defects in accordance with the warranty agreement. When the insurer advised the Kings that they were required under the warranty agreement to submit the dispute to arbitration, the Kings filed suit in state court against National Home for breach of contract and bad faith. Shortly thereafter, National Home filed the instant action in federal court to compel arbitration of the coverage dispute in question.[23]

The Kentucky anti-arbitration statute in question provides:

> A written agreement to submit any existing controversy to arbitration or a provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law for the revocation of any contract. This chapter does not apply to:
>
> * * *

(2) Insurance Contracts. Nothing in this subsection shall be deemed to include or render unenforceable contractual arbitration provisions between two (2) or more insurers, including reinsurers.[24]

In deciding the preemption issue, the court relied upon the Supreme Court's decision in *United States Department of Treasury v. Fabe*.[25] The Supreme Court stated, in determining whether the McCarran-Ferguson Act prevented the preemption of a state law dealing with arbitration in an insurance coverage dispute by the FAA, that a three-part test should apply. The three factors are:

(1) Whether the federal statute specifically relates to the business of insurance;

(2) Whether the state law at issue was enacted for the purpose of regulating the business of insurance; and

(3) Whether the application of the federal law invalidates, supersedes or impairs the state law.[26]

In applying those factors, the *King* court held that the McCarran-Ferguson Act's language, ''for the purpose of regulating the business of insurance,'' was to be given a broad reading and that any law with an ''end, intention, or aim of adjusting, managing, or controlling the business of insurance'' is a law ''enacted for the purpose of regulating the business of insurance'' for purposes of the McCarran-Ferguson Act.[27] Thus, the court concluded that National Home could not invoke the arbitration provision to forestall the state litigation initiated by the policyholder homeowners.

OTHER COURTS HAVE HELD THAT THE FAA PREEMPTS STATE ANTI-ARBITRATION PROVISIONS IN INSURANCE COVERAGE DISPUTES

One interesting example of the limitations of the McCarran-Ferguson reverse preemption argument is reflected in *IGF Insurance Co. v. Hatcreek Partnership*.[28] The insurance coverage dispute in *Hatcreek* involved a crop insurance policy issued to Hatcreek by IGF under which Hatcreek sought coverage damage to its wheat crop.[29] The wheat crop was a total loss, and when a claim was submitted to the insurer by Hatcreek, the IGF claims representative informed Hatcreek, for the first time, that more than 1,100 acres of the wheat crop was not insured.[30] Hatcreek subsequently filed an action against IGF, alleging that IGF had breached the insurance contract and that the claims representative was separately liable for negligent misrepresentation as to the portion of the Hatcreek property that Hatcreek thought had been insured.[31]

IGF sought to stay the action in favor of arbitration under the FAA based upon an arbitration provision in the crop insurance policy issued by IGF to Hatcreek.[32] Hatcreek responded by contending that the anti-arbitration provision as to insurance matters in the Arkansas Uniform Arbitration Act reverse preempted the FAA.[33] In analyzing the parties' contentions, the Arkansas Supreme Court recognized that the McCarran-Ferguson Act precluded the regulation of insurance by the federal government, so long as there was no federal statute in question that ''specifically relate[d] to the business of insurance. . . .''[34]

The direct insurance policy at issue in the dispute between Hatcreek and IGF was issued without reference to any type of federal policy regarding insurance coverage. However, the IGF policy provided that it was ''reinsured by the Federal Crop Insurance Corporation (FCIC) under the provisions of the Federal Crop Insurance Act. . . . All provisions of the policy and rights and responsibilities of the parties are specifically subject to the Act.''[35] Because of this nexus to federal law relating to the business of insurance, the *Hatcreek* court held that the McCarran-Ferguson Act was inapplicable; and, the FAA supported the procedural limitation of arbitration that was contained in the IGF policy.[36] The fact that the Federal Crop Insurance Act's relationship to the coverage dispute at issue involved reinsurance, rather than direct insurance, did not affect the Arkansas Supreme Court's view that the Federal Crop Insurance Act was designed to preempt state statutes that might otherwise be permissible under McCarran-Ferguson:

> Thus, it is clear that Congress contemplated that the FCIC's reinsurance contracts should be able to provide that state law would be inapplicable to an insurance contract reinsured by the FCIC. The Arkansas statute purporting to prevent the enforceability of arbitration clauses in insurance contracts ''directly or indirectly affect[s] or govern[s]'' the crop insurance contract authorized by the FCIC, and it is therefore inconsistent with, and preempted by, the federal statute.[37]

McCarran-Ferguson reverse preemption was also held by the Alabama Supreme Court not to preclude the enforcement of an arbitration provision in an insurance policy that was the source of a coverage dispute in *American Bankers Insurance Company of Florida v. Crawford*.[38] The key to the Alabama Supreme Court's rejection of a McCarran-Ferguson reverse preemption argument as to the arbitration provision in question was the location of the restriction on arbitration in Alabama's statutory scheme.

The trial court had held that the arbitration provision that was in a mortgage insurance policy was not enforceable because it was reverse preempted under McCarran-Ferguson by a section of Title 8 of the Alabama Code that dealt generally with contracts and precluded the specific enforcement of an agreement to submit a controversy to arbitration.[39] Significantly, though, the Alabama Supreme Court held that there was no similar provision in the Alabama Insurance Code respecting arbitration provisions and their enforceability.

What happens when a policyholder seeks to compel arbitration, and an insurer resists on the basis of a state provision precluding the arbitration of future controversies arising between parties to the insurance policy?

Relying on Supreme Court precedent discussed above, the Alabama Supreme Court stated that the McCarran-Ferguson Act's reverse preemption provision applied in three instances: (1) the federal statute that is the subject of preemption does not relate to the business of insurance; (2) the state statute in question was enacted for the purpose of regulating the business of insurance; and (3) the application of the federal statute would invalidate or otherwise impair the state's statute.[40] For the *Crawford* court, the nub of the dispute related to the second factor, above, and specifically whether the restriction on arbitration that appeared in a portion of the Alabama Code dealing with contracts dealt with the regulation of the business of insurance.[41] The court found that the Alabama anti-arbitration provision at issue had no bearing on the more essential aspects of the insurer-insured relationship, including, *inter alia*, the scope of the insurance coverage, the term of the policy, or the price of the coverage. In short, the general anti-arbitration provision in the contract section of the Alabama Code, as opposed to the insurance portion of the Alabama Code, was not integral to the insurer-insured relationship, and the arbitration provision was not subject to reverse preemption.[42]

OTHER TYPES OF DISPUTES ON THE APPLICATION OF STATE ANTI-ARBITRATION PROVISIONS

Insurers' Reliance on Anti-Arbitration Provisions

What happens when a policyholder seeks to compel arbitration, and an insurer resists on the basis of a state provision precluding the arbitration of future controversies arising between parties to the insurance policy? This issue was addressed by the Iowa Supreme Court in *Mutual Service Casualty Insurance Company v. Iowa District Court for Woodbury County*.[43] In that case, there was an odd role reversal between policyholder and insurer with respect to the application of an arbitration provision in an insurance policy in Iowa, a state with an anti-arbitration provision as to ''contracts of adhesion'' which the court in this case construed to include automobile insurance policies.

The plaintiff policyholders filed suit based on a dispute with their automobile insurer with respect to uninsured motorist coverage.[44] The insurance policy contained a mandatory arbitration requirement.[45] The Iowa Code had two provisions relating to contract provisions requiring the arbitration of contract disputes. One provision precluded the mandatory arbitration of ''contracts of adhesion'' as to a future controversy arising between the contracting parties.[46] However, parties to a contract, including insurance policies, could agree to arbitrate an existing controversy, regardless of the nature of the contract at issue.[47] Interestingly, the insurer argued that its policy contained an unenforceable arbitration provision because the provision was contained in what it admitted to be a contract of adhesion, an automobile insurance policy, and related to a future controversy arising between that insurer and the plaintiffs.[48]

The key question was whether the dispute between the parties, or in the words of the Iowa Code the ''controversy,'' was an existing or future one and how it was determined whether a controversy was an existing or future one. The plaintiffs argued that the answer to this question depended on when arbitration was demanded. Because the plaintiffs sought to enforce the terms of the mandatory arbitration provision in their insurance policy when the dispute with their insurer had ripened to the point of litigation, they argued that their claim to arbitration was not proscribed because they were agreeing to arbitrate an existing controversy.

The court found the insurer's argument to be more compelling. It ruled that the time for determining when the controversy would be considered a future or existing one was at the time the policyholder purchased the policy.[49] In the court's view, looking at the date that arbitration was demanded, rather than the date of the inception of the contract, would vitiate that part of the Iowa Code that barred mandatory arbitration as to future contracts arising between parties concerning contracts of adhesion, like insurance policies.[50]

The Iowa Supreme Court also rejected the secondary basis for the lower court's decision to enforce arbitration at the policyholder's request. The lower court ruled that regardless of the proper interpretation of when a future or existing controversy

arises, the statute precluding mandatory arbitration with respect to insurance policies was intended to protect the policyholder (or other party to a contract of adhesion) from unwanted arbitration, but should not be read to preclude the policyholder from electing to choose arbitration, notwithstanding the fact that to do so would be in direct derogation of the Iowa statute precluding such enforcement of arbitration provisions.[51] The Iowa Supreme Court held that the statute should be read literally and that if the General Assembly had intended to give policyholders the option to choose arbitration or not, it would have done so explicitly.[52] Thus, the Iowa Supreme Court held that the coverage dispute could not be arbitrated even though that is what the policyholder preferred.

Surety and Performance Bonds

Another interesting twist on the application of anti-arbitration provisions in certain states relates to whether a statute precluding arbitration with respect to insurance coverage disputes extends to surety or performance bonds. This issue was addressed by the Kentucky Supreme Court in *Buck Run Baptist Church, Inc. v. Cumberland Surety Insurance Co., Inc*.[53] The plaintiff church purchased a performance bond from the defendant insurer, which guaranteed the performance of the general contractor on the church's construction work. The church and the contractor entered into an agreement that included a mandatory binding arbitration provision, and the defendant insurer, in its performance bond sold to the church, incorporated the terms of the contract between the church and the contractor into its bond.[54]

The church sought damages from the contractor and requested coverage under the performance bond. The surety, Cumberland, disputed the church's right to coverage and filed a declaratory judgment action seeking to compel the church to arbitrate the claim. The church argued that it was not required to arbitrate the dispute because of a Kentucky anti-arbitration statute applicable to insurance contracts.[55]

The Kentucky Supreme Court determined that Kentucky's anti-arbitration statute did not apply. It reasoned that because the contract between the church and the contractor was the contract that incorporated the arbitration provision, which in turn was incorporated by reference into the performance bond, the ''dispute involve[d] a construction contract, and not the applicability of an insurance exemption to the [anti-arbitration] statute.''[56] The court further held that the performance bond was not a typical contract of adhesion as with most insurance policies. It determined that because the facts of the case involved a commercial construction project and a negotiated voluntary agreement between sophisticated commercial entities, such factors placed the performance bond outside of the realm of insurance policies.[57]

Another area in which the courts have addressed the interaction of statutes with anti-arbitration provisions regarding insurance matters, the FAA, and McCarran-Ferguson reverse preemption relates to state insurance receivership proceedings

The Kentucky court's reasoning was made in the face of a compelling argument by the plaintiff church. It pointed out that the word ''insurance'' was defined by the Kentucky Code as including ''a contract to act as a surety.''[58] The court was forced to recognize that Kentucky surety companies were regulated by the Kentucky Insurance Department. However, it distinguished a performance bond from an insurance contract by explaining that an insurance policy was based on an underwriting process that took into account risks over a large market. In contrast, the court held that a surety bond was underwritten based on an evaluation of only a specific contractor and that contractor's capability to perform a construction contract, a debatable conclusion.[59]

Insurance Company Receivership Provisions

Another area in which the courts have addressed the interaction of statutes with anti-arbitration provisions regarding insurance matters, the FAA, and McCarran-Ferguson reverse preemption relates to state insurance receivership proceedings. *Munich American Reinsurance Company v. Crawford*[60] addressed the anti-arbitration provisions and receivership proceedings under Oklahoma law in this context. The *Crawford* case involved a claim by a reinsurer, Munich American Reinsurance Company (''Munich''), and its claim against an insurer, Employers National Insurance Corporation (ENIC), that was placed in receivership by an Oklahoma state court subject to the decisions of the receiver, the Insurance Commissioner of Oklahoma, John Crawford. Munich sought the return of monies to which it would otherwise have been entitled pursuant to its reinsurance of ENIC that Crawford now considered part of the receivership estate.[61]

Munich filed a petition in federal court to compel arbitration under the FAA.[62] Crawford sought the dismissal of the federal action to compel arbitration because of the prior injunction entered in Oklahoma state court precluding all actions involving the receivership estate. The principal issue before the court was, notwithstanding the injunction by the Oklahoma

state court, whether Munich could still require arbitration because of the FAA's preemption of state law as it relates to arbitration. Further, the court was required to address the argument of Crawford that the FAA was reverse preempted by the McCarran-Ferguson Act.[63]

The court's analysis focused first on whether the Oklahoma legislation dealing with receivership actions qualified under McCarran-Ferguson's requirement that the laws promulgated by the state were for the purpose of regulating the business of insurance. In that regard, the *Crawford* court decided that the Oklahoma receivership legislation was crucial to the relationship between insurers and policyholders because it provided assurance to insurers and policyholders that an insurance company's liquidation would be done in an organized fashion. Secondly, the law was limited to the insurance industry—not companies in general.[64] Lastly, Munich and another reinsurer argued that under the Oklahoma Arbitration Act, arbitration clauses in contracts between insurance companies were permitted. Thus, in their view, when the dispute did not involve a policyholder but rather the insolvent insurer and its reinsurers, the FAA, rather than McCarran-Ferguson, should dictate the outcome. The court rejected that argument as well, finding that the Oklahoma receivership statutory scheme was broad enough to encompass the receiver's control of the property of the insolvent insurer and therefore was for the purpose of regulating the business of insurance.[65]

Anti-Arbitration Statutes and Mandatory "Appraisal" or "Adjustment" of Claims

Finally, another area in which there has been litigation regarding the application of states' anti-arbitration provisions relating to insurance coverage disputes concerns whether those statutes apply to "appraisal" or "adjustment" provisions in first-party policies. Many types of first-party policies require that disputes as to the amount of coverage available for a first-party loss should be determined through a process of mandatory arbitration concerning the extent of the policyholder's loss. The courts in those states which have statutory anti-arbitration provisions have decided the issue differently.

In *J. C. Rawlings v. AMCO Insurance Co.*,[66] the Nebraska Supreme Court held that a mandatory arbitration process as to the appraisal of the value of the loss was unenforceable under the state's anti-arbitration provision. Nebraska, like some of the other states with anti-arbitration provisions, precluded the inclusion of a mandatory arbitration provision regarding an insurance dispute that related to a future coverage dispute. The insurer in *Rawlings* recognized that such an aspect of Nebraska's anti-arbitration statute as construed by the Nebraska courts would normally apply to the insurance policy at issue.[67] However, the insurer argued that an "appraisal clause" was qualitatively different from an arbitration provision because the appraisal clause was limited simply to the amount of coverage as opposed to whether the insurer had a duty to provide coverage, which, on the facts of this case, the insurer admitted it did.[68] In finding the appraisal provision to be unenforceable, the *Rawlings* court held that the extent of a policyholder's level of recovery is no less a function of the insurance contract than the existence of the right to coverage in the first instance. Accordingly, the plaintiff homeowner was not precluded from litigating in a court the extent of the coverage that it was owed under the insurance contract at issue.[69]

The Supreme Court of Montana reached a different result in *Garretson v. Mountain West Farm Bureau Mutual Insurance Co.*[70] The *Garretson* court's decision concerned a dispute between the owners of an automobile and the insurer with respect to a first-party loss and the value of the damage to the vehicle. The insurance policy contained a provision applicable to first-party coverage that required an appraisal process when a dispute arose as to the amount of the loss. The automobile owners filed a complaint, and the insurer filed a motion for summary judgment, contending that even though Montana has an anti-arbitration provision relating to insurance disputes, it did not apply to the mandatory appraisal process contained in its insurance policy.[71] The court recognized that the Montana anti-arbitration statute[72] precludes mandatory arbitration provisions in contracts relating to insurance policies, except for contracts between insurance companies.[73] The court even noted the fact that the statute was the product of a long history in common law that reflected a public policy against depriving courts of jurisdiction by contract over disputes.[74] However, with virtually no analysis, the court found that a mandatory appraisal process as to value did not fall within the intent of the statute, stating: "Therefore a provision in a contract like the one under consideration in the case at bar, requiring that the value of the assured property, under certain conditions, shall be ascertained by appraisal, is not disregarded as against public policy, but is upheld as valid."[75]

The court seemed to ignore the fact that with first-party coverage, when there are disputes between a policyholder and the insurer, in a substantial number of those cases, the primary dispute is as to the amount of the loss, the very reason that policyholders prefer to have such a claim resolved in the courts.

CONCLUSION

The above discussion shows that anti-arbitration statutes come in many shapes and sizes, and the courts' treatment of them is equally varied even within the same state. Thus, neither a policyholder nor an insurer should assume, automatically, that a mandatory arbitration provision is enforceable.

Finally, a key threshold issue for the insurance coverage litigator, that is beyond the scope of this article, will be what law applies to a dispute that involves the enforcement of an anti-arbitration provision. The resolution of choice of law will be straightforward in those cases in which the insurance coverage dispute arises among parties all of whom are domiciled in a state with a statutory anti-arbitration scheme. However, that situation will more likely be the exception than the rule, particularly in more complex commercial coverage cases. The forum court will need to address two critical issues. One is whether the decision on the application of an anti-arbitration statute is substantive or procedural. The second, and related issue, is whether the law of the insurer's domicile, the forum state, or some other state's law should govern the decision as to whether the anti-arbitration statute should apply. As experienced coverage practitioners know, choice of law issues can often be case dispositive and should figure in a choice of forum decision.[76]

[1] 15 U.S.C. § 1012 (b).

[2] 9 U.S.C. §§ 1–14.

[3] The states and the relevant statutes restricting the use of arbitration in insurance coverage matters to one degree or another are as follows:

- Arkansas—Ark. Code Ann. § 16-108-201.
- California—Cal. Ins. Code § 10123.19 and Cal. Health & Safety Code § 1363.1.
- District of Columbia—D.C. Code § 16-4403.
- Georgia—Ga. Code Ann. § 9-9-2.
- Hawaii—Haw. Rev. Stat. § 431:10-221.
- Iowa—Iowa Code Ann. § 679A.1.
- Kansas—Kan. Stat. Ann. § 5-401.
- Kentucky—Ky. Rev. Stat. Ann. § 417.050 and Ky. Rev. Stat. Ann. § 304.20-050.
- Louisiana—La. Rev. Stat. Ann. § 22:1295 (5) and La. Rev. Stat. Ann. § 22:868.
- Maine—Me. Rev. Stat. Ann. Tit. 14 § 5948 and 24-A § 2747.
- Maryland—Md. Code Ann., Cts. & Jud. Proc. § 3-206.1 and Md. Code Ann. Ins. § 19-509 and Md. Ins. Admin. 31.11.10.07.
- Mississippi—Miss. Code Ann. § 83-11-109.
- Missouri—Mo. Ann. Stat. § 435.350.
- Montana—Mont. Code Ann. § 27-5-114.
- Nebraska—Neb. Rev. Stat. § 25-2602.01.
- Nevada—Nev. Rev. Stat. § 690 B.017 and Nev. Rev. Stat. § 689 B.067.
- Oklahoma—Okla. Stat. Tit. 12 § 1855.
- Rhode Island—R.I. Gen. Laws § 10-3-2 and R.I. Gen. Laws § 27-10.3-1.
- South Carolina—S.C. Code Ann. § 15-48-10 and S.C. Code Ann. § 38-77-200.
- South Dakota—S.D. Codified Laws § 21-25 A-3.
- Utah—Utah Code Ann. § 31A-21-313 and Utah Admin. Code R. 590-122.
- Virginia—Va. Code Ann. § 38.2-312 and Administrative Letter 1998-12.
- West Virginia—W.Va. Code § 33-6-31.
- Wyoming—Wyo. ADC Ins. Gen. Ch. 23 § 9.

[4] Md. Code Ann., Cts. & Jud. Proc. § 3-206.1.

[5] La. Rev. Stat. Ann. § 22:1295(5).

[6] S.C. Code Ann. § 15-48-10(b)(4) (emphasis added). *See also* Mo. Ann. Stat. § 435.350; Mont. Code Ann. § 27-5-114.

[7] Mont. Code Ann. § 27-5-114.

[8] 9 U.S.C. § 2.

[9] 15 U.S.C. § 1012 (a)-(b).

[10] 15 U.S.C. § 1012(b) (emphasis added).

[11] 393 U.S. 453 (1969).

[12] *Securities & Exchange Comm'n*, 393 U.S. 453, 460. This position was reiterated a decade later in Group Life and Health Insurance Co. v. Royal Drug, 440 U.S. 205 (1979).

[13] 458 U.S. 119 (1982). *See also* United States Department of Treasury v. Fabe, 508 U.S. 491 (1993).

[14] *Pireno*, 458 U.S. 119, 129.

[15] 565 S.E. 2d 603 (Ga. Ct. App. 2002).

[16] *Equity Residential*, 565 S.E. 2d 603.

[17] The insurance policy contained an Illinois choice of law provision. However, the court held that the choice of law provision did not control the procedural law applicable to the forum state. "Lex Fori" required the application of Georgia law in the context of procedural matters. *See Equity Residential*, 565 S.E. 2d 603, 604.

[18] Ga. Code Ann. § 9-9-2 (c)(3).

[19] *Equity Residential*, 565 S.E. 2d 603, 604, *citing* Ga. Code Ann. § 9-9-2 (c)(3).

[20] *Equity Residential*, 565 S.E. 2d 603, 605.

[21] *Equity Residential*, 565 S.E. 2d 603, 605. The court did not attempt to explain how risk would be spread by reliance upon the collective wisdom of a jury as opposed to an individual or multiple arbitrators. Presumably, an argument could be made that there is greater risk to both the policyholder and the insurer in relying upon a judge and jury to decide a coverage dispute, as opposed to a single or multiple arbitrators.

[22] National Home Insurance Co. v. King, 291 F. Supp. 2d 518 (E.D. Ky. 2003).

[23] *National Home*, 291 F. Supp. 2d 518, 521–24.

[24] Ky. Rev. Stat. Ann. § 417.050.

[25] *Fabe*, 508 U.S. 491 (1993).

[26] *National Home*, 291 F. Supp. 2d 518, 528 (*citing Fabe*, 508 U.S. at 501).

[27] *National Home*, 291 F. Supp. 2d 518, 529. Other courts have ruled that broad state statutes barring mandatory arbitration in insurance coverage disputes are enforceable based on reverse preemption. *See, e.g.*, Standard Security Life Insurance Co. of New York v. West, 267 F. 3d 821 (8th Cir. 2001) (applying Missouri law); Stephens v. American International Insurance Co., 66 F. 3d 41 (2d Cir. 1995); Mutual Reinsurance Bureau v. Great Plains Mutual Insurance Co., Inc., 969 F.2d 931 (10th Cir. 1992) (applying Kansas law); Riceland Foods, Inc. v. Liberty Mutual Insurance Co., No. 10CV00091, SWW, 2010 U.S. Dist. LEXIS 800100 (E.D. Ark. Aug. 6, 2010) (applying Arkansas law); American Health and Life Insurance Co. v. Heyward, 272 F.Supp. 2d 578 (D.S.C. 2003) (applying South Carolina law); Ernst & Young LLP v. David S. Meyer, 323 S.W. 3d 682 (Ky. 2010); Cox v. Woodmen of the World Insurance Co., 556 S.E. 2d 397 (S.C. Ct. App. 2001).

[28] 76 S.W. 3d 859 (Ark. 2002).

[29] *Hatcreek*, S.W. 3d 859, 861.

[30] *Hatcreek*, 76 S.W. 3d 859, 861.

[31] *Hatcreek*, 76 S.W. 3d 859, 861.

[32] *Hatcreek*, 76 S.W. 3d 859, 862.

[33] *Hatcreek*, 76 S.W. 3d 859, 862.

[34] *Hatcreek*, 76 S.W. 3d 859, 863.

[35] *Hatcreek*, 76 S.W. 3d 859, 864.

[36] *Hatcreek*, 76 S.W. 3d 859, 864.

[37] *Hatcreek*, 76 S.W. 3d 859, 865.

[38] 757 So.2d 1125 (Ala. 1999).

[39] *American Bankers*, 757 So.2d 1125, 1131.

[40] *American Bankers*, 757 So.2d 1125, 1131 (*citing Fabe*, 508 U.S. 491, 500–01).

[41] *American Bankers*, 757 So.2d 1125, 1132.

[42] *American Bankers*, 757 So.2d 1125, 1133. Other courts have ruled that broad state statutes barring mandatory arbitration in insurance coverage disputes are not enforceable because of FAA preemption. *See, e.g.*, Mid-Continent Casualty Co. v. General Reinsurance Corp., 2009 U.S. App. LEXIS 11057 (10th Cir. May 22, 2009) (applying Oklahoma law); Northwestern Corp. v. National Union Fire Insurance Co. of Pittsburgh, Pa., 321 B.R. 120 (Bankr. D. Del. 2005) (applying Montana law); Heaberlin Farms, Inc. v. IGF Insurance Co., 641 N.W.2d 816 (Iowa 2002); Little v. Allstate Insurance Co., 705 A.2d 538 (Vt. 1997); Doucet v. Dental Health Plans Management Corp., 412 So.2d 1383 (La. 1982).

[43] 372 N.W. 2d 261 (Iowa 1985).

[44] *Iowa District Court*, 372 N.W. 2d 261, 262.

[45] *Iowa District Court*, 372 N.W. 2d 261, 262.

[46] *Iowa District Court*, 372 N.W. 2d 261, 263.

[47] *Iowa District Court*, 372 N.W. 2d 261, 263.

[48] *Iowa District Court*, 372 N.W. 261, 263.

[49] *Iowa District Court*, 372 N.W. 261, 263.

[50] *Iowa District Court*, 372 N.W. 261, 263.

[51] *Iowa District Court*, 372 N.W. 261, 264.

[52] *Iowa District Court*, 372 N.W. 261, 264.

[53] 983 S.W. 2d 501 (Ky. 1998).

[54] *Buck Run*, 983 S.W. 2d at 503.

[55] *Buck Run*, 983 S.W. 2d at 502–03.

[56] *Buck Run*, 983 S.W. 2d at 503.

[57] *Buck Run*, 983 S.W. 2d at 504.

[58] *Buck Run*, 983 S.W. 2d at 504.

[59] *Buck Run*, 983 S.W. 2d at 504–05. *But see* National Home Insurance Co. v. King, 291 F. Supp. 2d 518 (E.D. Ky. 2003) (applying Kentucky law).

[60] 141 F.3d 585 (5th Cir. 1998).

[61] *Crawford*, 141 F.3d 585, 587.

[62] *Crawford* 141 F.3d 585, 587.

[63] *Crawford* 141 F.3d 585, 590.

[64] *Crawford* 141 F.3d 585, 591–92.

[65] *Crawford* 141 F.3d 585, 594. *See also* Transit Casualty Company in Receivership v. Certain Underwriters at Lloyd's of London, C.A. No. 96-4173-CV-C-2, 1996 U.S. Dist LEXIS 22710 (W.D. Mo. June 10, 1996) (in an action involving reinsurance contracts between Lloyd's and Transit Casualty, which was in a Missouri receivership, and Missouri statutory law precluded arbitration in insurance matters, the court held that both the FAA and the Convention on Recognition and Enforcement of Foreign Arbitral Awards were reverse preempted by the McCarran-Ferguson Act).

[66] 438 N.W.2d 769 (Neb. 1989).

[67] *Rawlings*, 438 N.W.2d 769, 770.

[68] *Rawlings*, 438 N.W.2d 769, 770.

[69] *Rawlings*, 438 N.W.2d 769, 771. *See also* Friday v. Trinity Universal of Kansas, 939 P.2d 869, 871 (Kan. 1997) ("the issue is what the legislature intended when it prohibited a contract of insurance from providing for mandatory arbitration of future controversies. We do not see a meaningful distinction between appraisal and arbitration").

[70] 761 P.2d 1288 (Mont. 1988).

[71] *Garretson*, 761 P.2d 1288, 1289.

[72] Mont. Code Ann. § 28-2-708.

[73] *Garretson*, 761 P.2d 1288, 1290.

[74] *Garretson*, 761 P.2d 1288, 1290.

[75] *Garretson*, 761 P.2d 1288, 1290.

[76] *See, e.g.*, Safety Nat'l Casualty Co. v. Cinergy Corp., 829 N.E.2d 986 (Ind. Ct. App. 2005).

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Revisiting the Three Rs: Risks, Rewards, and Rescission

by Mary McCutcheon and Amanda Hairston

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INTRODUCTION

After the tender of a claim, coverage counsel on both sides typically pore over the policy at issue, looking at every provision, exclusion, and endorsement to evaluate the strengths and weaknesses of their position. While lawyers have their noses buried in the policy itself, a key coverage issue may be lurking outside of the policy: whether the carrier has a claim for rescission. Rescission voids the insurance coverage *ab initio*, as if the coverage had never existed.

Rescission typically arises in the context of claims-made policies, which cover Wrongful Acts, such as breaches of duty, neglect, error, misstatement, misleading statement, omission or act of the Insureds in their official capacities as such, that may have occurred during prior policy years. From a carrier's point of view, rescission helps insurers guard against covering a risk that the insured was already aware of at the time it purchased the coverage. In almost every state, a carrier must prove the following elements to succeed on a claim for rescission: 1) the insured made a representation; 2) the falsity of that representation; 3) the materiality of the misrepresentation; and 4) the insurer's reliance on the misrepresentation.

Rescission typically arises in the context of claims-made policies, which cover Wrongful Acts that may have occurred during prior policy years

Some states also require the carrier to prove a fifth element—some form of intent to deceive by the insured. Notably, California and New York do not require that the carrier prove either scienter or intent and follow the so-called "innocent misrepresentation" rule. In states that do require the carrier to show scienter or intent, the requirements vary. Some states require that the carrier prove that the insured specifically intended to deceive the insurer in connection with the underwriting and issuance of the policy. Others merely require the carrier to show that the insured knew the information was false when published or acted in bad faith by, for example, making a false statement without any knowledge as to its truth or signing the application without reviewing it to ensure it was correct.

As this article discusses, there are several responses to a rescission claim. First, insureds can challenge whether or not they were under a duty to disclose in the first instance. This almost always turns on what the insurer asked in the application and the exact wording of its questions. Second, insureds may rely on a severability of the application provision to prevent the policy from being rescinded as to all insureds. Third, insureds can try to insist that the carrier keep advancing defense costs while the claim is pending. For each of the responses, both carriers and policyholder can find their own comfort in the case law.

WORDING OF APPLICATION QUESTIONS IS CRITICAL

Generally, in the absence of a question and where the application is either silent or only imposes a subjective standard, an insured only has an affirmative obligation to disclose information which the insured believes to be material.[1] Given the uphill battle to prove what an insured believed or did not believe to be material at the time, carriers often rely on application questions to determine what the insured knows

about potential claims before the policy incepts. However, policyholders and carriers should carefully review the application whenever the issue of rescission is raised because the scope of the insured's duty to disclose will often turn on what the insurer asked in the application and how the insurer asked it.

Policyholders and carriers should carefully review the application whenever the issue of rescission is raised because the scope of the insured's duty to disclose will often turn on what the insurer asked in the application and how the insured asked it

In *Home Ins. Co. v. Spectrum Information Technologies, Inc*.,[2] the insured (Spectrum) received a letter from the U.S. Securities and Exchange Commission (SEC) stating "that it had initiated an 'informal inquiry into recent trading and disclosures involving Spectrum' " and requesting that Spectrum voluntarily produce documents.[3] The letter also stated that the informal inquiry was " 'confidential and should not be construed as an indication by the Commission . . . that any violation of law . . . [had] occurred, nor should it be considered an adverse reflection upon any persons, entities or securities.' "[4] The SEC's inquiry was related to several class action securities lawsuits filed against Spectrum arising out an agreement between Spectrum and AT&T (the AT&T suits).

Six days later, Spectrum applied to renew its primary Directors and Officers (D&O) policy with Home and twelve days later, Spectrum applied to renew its excess D&O policy with Aetna. Section 7 of the Home application contained the following question:

> Has the Applicant Corporation (or any subsidiary thereof) and/or any of its directors or officers been involved in the following within the past eighteen (18) months: . . . (a) any representative action, class action or derivative suit [?] (b) any civil or criminal action or proceeding investigating or charging a violation of any federal or state security law or regulation?"

In response to 7(a), Spectrum answered "yes" and referred to the AT&T suits. In response to 7(b), Spectrum answered "no." Spectrum did not disclose the existence of the SEC letter or inquiry anywhere in the Home application.[5]

Section 11(a)(2) of the Aetna application stated: Has any person or entity proposed for this insurance been a party to any of the following: . . . Any civil, criminal or administrative proceeding alleging or investigating a violation of any security law or regulation? Again, Spectrum answered "yes" and referred to the AT&T suits but did not disclose the existence of the SEC letter or inquiry anywhere in the Aetna application.[6]

The Spectrum court found that sections 7(b) and 11(a)(2) of the respective applications did not require the disclosure of the SEC letter or inquiry because: 1) the SEC had only initiated an "informal inquiry"; 2) the SEC had only requested that Spectrum voluntarily produce copies of certain documents; and 3) the SEC letter specifically stated that it "should not be construed as an indication by the Commission . . . that any violations of law . . . [had] occurred, nor should it be considered an adverse reflection upon any persons, entities or securities." As a result, the Spectrum court found that the word "proceeding" as used in the context of sections 7(b) and 11(a)(2) "suggests something more formal than an 'informal inquiry.' "[7] The court continued, holding that "[i]n any event, the term 'proceeding' is, at best, here ambiguous because it is not so plain and intelligible that the applicant could comprehend its meaning to include this informal inquiry."[8] The court also noted that "Home and Aetna, as the drafters could easily have fashioned more specific questions related to potential SEC involvement."[9]

With the expanding definition of "Claim" to encompass investigations or other notices short of a lawsuit, both policyholders and carriers should be conscious of how the policy's definition of claim may impact the policyholder's duty to disclose such a notice in the policy application. Additional issues may arise where the company is the subject of a confidential investigation that could fall within the coverage grant but may not be disclosed in the application.

POLICIES MAY BE RESCINDED WHERE THE CARRIER ASKS FOR A CATEGORY OF INFORMATION

Although the carriers in Spectrum failed to ask a question that would trigger disclosure of the SEC letter there, insureds may be obligated to disclose a letter alleging breach of fiduciary duties where the carrier asks for the disclosure of all written demands for money or services.

In *Admiral*, the coverage case arose from a dispute between Sonicblue's directors and officers and its bondholders.[10] In 1996, Sonicblue placed $103 million in long-term debt with one set of investors. In April 2002, the company placed an additional $75 million in long-term debt with a different set of investors.[11] Unfortunately the 2002 debt placement did not relieve Sonicblue's financial problems and

the company was forced to file bankruptcy in March 2003.[12]

In April 2005, the bondholders on both debts brought an action for breach of fiduciary duty and constructive fraud against Sonicblue's directors and officers.[13] The claim was tendered to the company's D&O carrier who denied coverage.[14] The carrier claimed it was entitled to rescind the policy because the company had failed to disclose a series of letters sent by the bondholders as early as November 2002 regarding the company's ''impending insolvency and the attendant fiduciary duties of the directors and officers.''[15] The insurer cited the requirement in the policy's application that the insured disclose all written demands for money or services against Sonicblue and its directors and officers.[16] The carrier also alleged that it ''reasonably relied on the misrepresentations and/or omissions'' in the application process when it issued the policy and that such ''non-disclosures'' were material to the insurer.[17] In addition, the carrier claimed it would either not have issued the policy or would have done so on different terms if it had known about the demand letters.[18]

While the court noted that the application did not request information with respect to an event that may give rise to a claim, it did request information related to ''any demands'' involving allegations of federal or state securities law violations.[19] The court noted the term ''demand'' in the application appeared to contemplate a formal proceeding as well as any demands related to alleged violations of federal or state law or written communications demanding a course of action based on the rights of the author.[20] Thus, the court concluded the letters constituted a ''demand'' as contemplated by the Policy application as it was not a mere ''expression of dissatisfaction'' but rather alleged a right had been violated and notified defendants litigation might ensue absent rectifying action.[21]

FULL SEVERABILITY OF THE APPLICATION WILL PROTECT INNOCENT INSUREDS

Even where there has been a material misrepresentation, one response from policyholders may be that the policy not be rescinded as to all insureds because of a severability of the application provision. Such a provision may be full or partial. A full severability provision means that the application is deemed to be a separate application made by each insured and the knowledge of one insured will not be imputed to another. In that case, the insurer cannot rescind the entire policy. However, a partial severability provision may provide that the knowledge of certain individuals may be imputed to other insureds, usually the person signing the application and/or specific executives. Under that language, the policy may be rescindable as to all insureds.

Even where there has been a material misrepresentation, one response from policyholders may be that the policy not be rescinded as to all insureds because of a severability of the application provision

The *HealthSouth* case involved ten carriers seeking to rescind coverage for the company and various individual insureds.[22] The carriers claimed that HealthSouth provided materially false and misleading financial information in connection with its application for insurance and that the carriers were entitled to rescind the policies as to all insureds.[23]

The insureds countered by relying on the severability provisions in the primary policy.[24] The primary policy contained a full severability provision, which provided that: ''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.''[25] With respect to the company, the severability provision was partial and provided that: ''knowledge possessed by any past, present or future chief financial officer, President or Chairman of any Insured Organization shall be imputed to any Insured Organization.''[26] Since none of the excess policies contained severability provisions and most ''followed form,'' the insureds argued that none of the carriers were entitled to rescind.[27]

The court agreed with respect to the individual insureds but found that the severability clause applied a different standard to the company under its Side B coverage.[28] The court found that if any specifically referenced applications or referenced documents contained knowing representations, then those statements by and knowledge of any insured person could be imputed to HealthSouth and result in rescission.[29] The court also found that the policy's Side B coverage was subject to the more favorable severability language and that the company's right to coverage was derivative of the individual insured person's right to coverage.[30] As a result, the carriers could not deny coverage to HealthSouth, or rescind coverage under Side B unless they could prove that each insured person whom HealthSouth was obligated to indemnify made knowing misstatements in the application or specific documents referenced in the policies sought to be rescinded.[31]

PARTIAL SEVERABILITY PROVISION MAY ALLOW RESCISSION OF ENTIRE POLICY

Policies without such favorable severability provisions may be rescindable depending on who had knowledge of the false statements and whether that knowledge can be imputed to other insureds.

For example, in *TIG Insurance Company of Michigan v. Homestore Inc*., Homestore was sued by its shareholders in securities class actions and derivative liability actions on the grounds that the company materially overstated its revenues and that its financial statements were inaccurate.[32] After a criminal investigation, Homestore's CFO pled guilty to one count of conspiracy to commit securities fraud and admitted to conspiring to overstate Homestore's revenue and filing false Form 10-Qs with the SEC.[33]

Shortly before the shareholder suits were filed, the CFO had submitted and signed a renewal application for the company's primary D&O policy and an excess D&O policy with TIG.[34] Along with its application, Homestore had provided its most recent 10-Q.[35] After the shareholder suits were tendered, TIG filed a complaint against Homestore for rescission alleging it was entitled to rescind the entire policy because the CFO knew that the Form 10-Q submitted with the application, contained material misrepresentations regarding Homestore's financial condition.[36] The company claimed that the policy was ambiguous with respect to whether the carrier could rescind the policy as to individual insureds who did not sign the application and who were unaware of the misrepresentations.[37]

Policies without favorable severability provisions may be rescindable depending on who had knowledge of the false statements and whether that knowledge can be imputed to other insureds

The policy's general provisions provided that in the event that misrepresentations were made in connection with the policy,

> no coverage shall be afforded under this Policy ... for any Director or Officer who did not sign the application but knew on the inception date of this Policy the facts that were so misrepresented, and this Policy in its entirety shall be void and of no effect whatsoever if such misrepresentations were known to be untrue ... by one or more individuals who signed the application.[38]

The court found this provision was unambiguous and found that it allowed the carrier to rescind as to the company and all individual insureds.[39] Although it allowed for rescission where the individual did not sign but knew of the misrepresentations, that did not restrict the carrier's broader right to rescind the policy as to all insureds in the case of an application actually signed by an officer who had knowledge of the false statements.[40] Although the company and individual insureds argued that this result was against public policy, the court noted that some policies have unambiguous severability provisions designed to protect against exactly what happened in Homestore and that the company could have purchased a policy with such a provision.[41]

CASE LAW IS UNCLEAR ON WHETHER CARRIER HAS A CONTINUING DUTY TO ADVANCE DEFENSE FEES

As a stopgap measure, policyholders may respond to a claim for rescission by arguing that the insurer is still obligated to advance defense fees. However, courts have gone both ways on this issue.

Two federal courts in New York have found that the insurer is not relieved of its duty to defend just because it has filed a rescission action.

In *Tyco*, Federal Insurance filed an action against Tyco and its directors and officers, seeking a declaration confirming that Federal Insurance had unilaterally rescinded the D&O policy it sold to Tyco.[42] In response, individual insureds sought a ruling that Federal Insurance was obligated to continue advancing defense costs despite its attempt to rescind the policy.[43] The trial court granted the insureds' motion for partial summary judgment on the duty to defend, reasoning that, "until Federal's rescission claims are litigated in its favor and the Policies are declared void ab initio, they remain in effect and bind the parties."[44] The court also found that "Federal's unproven rescission claim does not affect its present obligation to defend" its insureds.[45]

On the heels of *Tyco*, a New York District Court came to a similar conclusion.[46] In *WorldCom*, the court also held under New York law that a D&O carrier seeking to rescind an insurance contract must advance defense costs until the issue of rescission is adjudicated in its favor.[47]

In contrast, the Illinois Appellate Court affirmed a trial court's grant of summary judgment in favor of an insurer, holding the insurer had no duty to defend an insured pending an action for rescission of the insurance contract.[48] There, the court held that an insurer's duty to defend is suspended pending an action for rescission of the contract.[49] The court reasoned that if the insurer eventually loses in the rescission action, it would be ultimately liable for all of the costs of defense.[50]

A district court in Texas recently had a more difficult time grappling with this issue. After initially ruling that the carriers had a duty to advance fees, the court reversed course and held that D&O carriers for the Stanford Financial Group were no longer required to advance defense costs relating to criminal charges and civil litigation filed against several individuals including R. Allen Stanford arising out of an alleged widespread investment fraud run by the three.[51] After the court granted the individual insureds' motion for preliminary injunction and forced the carrier to continue advancing defense costs, the insurers appealed to the Fifth Circuit.[52] The case was remanded for a determination of whether the Money Laundering exclusion applied.[53]

After hearing expert testimony, the court found that the explanation given by two of the individuals was not credible and that coverage was barred based on the exclusion because the individuals ''knew, suspected, or reasonably should have known or suspected'' that the investment figures were not accurate.[54] As to Stanford himself, the court found that he was personally aware of the misrepresentations related to the investments and that the exclusion applied to him as well.[55] Since the carriers' were able to show a substantial likelihood that the evidence would show that the exclusion would apply, the court vacated the preliminary injunction and relieved the carriers' of their obligation to advance defense costs.[56]

CONCLUSION

As the scope of coverage continues to evolve and rescission claims becomes more common, insurers looking at claims and policyholders applying for coverage must be mindful of exactly what the insured was under a duty to disclose. Once a rescission claim is made, both sides will find themselves relying on that application language along with the severability provisions to determine what extent the carrier still has a duty to defend or indemnify its insureds.

[1] Cal. Ins. Code § 332.
[2] Home Ins. Co. v. Spectrum Information Technologies, Inc., 930 F. Supp. 825 (E.D.N.Y. 1996).
[3] *Home*, 930 F.Supp. at 830.
[4] *Home*, 930 F.Supp. at 830.
[5] *Home*, 930 F.Supp. at 830.
[6] *Home*, 930 F.Supp. at 831.
[7] *Home*, 930 F.Supp. at 838.
[8] *Home*, 930 F.Supp. at 838.
[9] *Home*, 930 F.Supp. at 838.
[10] Admiral Ins. Co. v. Sonicblue, Inc., 2009 U.S. Dist. LEXIS 71935 (N.D. Cal. Aug. 14, 2009).
[11] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[12] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[13] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[14] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[15] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[16] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *2.
[17] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *5.
[18] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *5.
[19] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *5.
[20] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *5.
[21] *Admiral*, 2009 U.S. Dist. LEXIS 71935 at *6.
[22] *In re HealthSouth Corp.*, 308 F.Supp. 2d 1253, 1257 (2004).
[23] *HealthSouth*, 308 F.Supp. 2d at 1257.
[24] *HealthSouth*, 308 F.Supp. 2d at 1258.
[25] *HealthSouth*, 308 F.Supp. 2d at 1261.
[26] *HealthSouth*, 308 F.Supp. 2d at 1261.
[27] *HealthSouth*, 308 F.Supp. 2d at 1262–3.
[28] *HealthSouth*, 308 F.Supp. 2d at 1284–5.
[29] *HealthSouth*, 308 F.Supp. 2d at 1284–5.
[30] *HealthSouth*, 308 F.Supp. 2d at 1284–5.
[31] *HealthSouth*, 308 F.Supp. 2d at 1284–5.
[32] TIG Ins. Co. Of Mich. v. Homestore, Inc., 137 Cal. App. 4th 749, 752 (2006).
[33] *TIG*, 137 Cal. App. 4th at 752.

[34] *TIG*, 137 Cal. App. 4th at 753.
[35] *TIG*, 137 Cal. App. 4th at 753.
[36] *TIG*, 137 Cal. App. 4th at 753–754.
[37] *TIG*, 137 Cal. App. 4th at 754.
[38] *TIG*, 137 Cal. App. 4th at 753.
[39] *TIG*, 137 Cal. App. 4th at 755.
[40] *TIG*, 137 Cal. App. 4th at 757.
[41] *TIG*, 137 Cal. App. 4th at 758–759.
[42] Federal Ins. Co. v. Tyco Int'l Ltd., 2004 N.Y. Misc. LEXIS 228 (N.Y.S. 2d Mar. 5, 2004).
[43] *Tyco*, 2004 N.Y. Misc. LEXIS 228 at *1.
[44] *Tyco*, 2004 N.Y. Misc. LEXIS 228 at *6.
[45] *Tyco*, 2004 N.Y. Misc. LEXIS 228 at *6.
[46] *In re WorldCom, Inc. Sec. Litig.*, 354 F.Supp.2d 455 (S.D.N.Y. 2005).
[47] *In re WorldCom, Inc. Sec. Litig.*, 354 F.Supp.2d 455 (S.D.N.Y. 2005).
[48] *In* Certain Underwriters at Lloyd's v. Prof'l Underwriters Agency, Inc., 848 N.E.2d 597 (2006).
[49] *Lloyd's*, 848 N.E.2d at 598.
[50] *Lloyd's* 848 N.E.2d at 598.
[51] Pendergest-Holt v. Certain Underwriters at Lloyd's of London, 2010 U.S. Dist. LEXIS 108920 at *18 (S.D. Tex. Oct. 13, 2010).
[52] *Pendergest-Holt*, 2010 U.S. Dist. LEXIS 108920 at *14.
[53] *Pendergest-Holt*, 2010 U.S. Dist. LEXIS 108920 at *14.
[54] *Pendergest-Holt*, 2010 U.S. Dist. LEXIS 108920 at *53.
[55] *Pendergest-Holt*, 2010 U.S. Dist. LEXIS 108920 at *64.
[56] *Pendergest-Holt*, 2010 U.S. Dist. LEXIS 108920 at *72.

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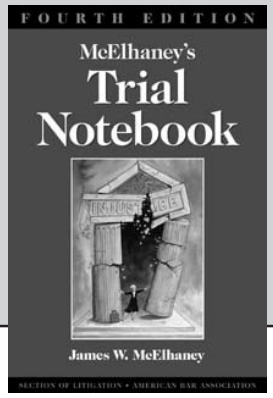

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Insurance 101-Insights for Young Lawyers: When, What and Why?: Notifying Insurer of a ''Claim'' or a Potential Claim under an EPLI Policy

by Erica J. Dominitz and Amy J. Woodworth

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OVERVIEW

Employment litigation involves a wide range of claims including wrongful termination, discrimination, harassment, defamation and privacy type claims. Employment claims typically involve fact issues, which, in turn, can result in high defense costs. Thus, many insureds purchase specific employment-related practices liability insurance policies (EPLI policies) to obtain coverage for various employment-related claims. EPLI policies came into existence in the early 1980s as a response to the growth of employers' liability claims.[1] Today, most EPLI policies are specifically written to insure employers against claims for wrongful termination, discrimination, harassment, defamation, negligent hiring, and privacy type claims. EPLI policies also sometimes provide coverage for discrimination and harassment claims that are made against employers by third parties, such as the employer's vendors or customers. EPLI policies are particularly valuable assets where, as has been the case over the past few years, the weak economy has resulted in high unemployment rates and an uptick in employment litigation.

[A]n issue that frequently arises with respect to determining coverage under an EPLI policy is one of timing-i.e., when was a claim made (or, in certain contexts, when did the insured know of facts that could give rise to a claim under the policy)?

EPLI policies typically are written on a claims-made basis (unlike, for example, commercial general liability policies, which usually are written on an ''occurrence'' basis). EPLI policies thus typically cover claims that were made against the employer/insured during the applicable coverage period, which generally is the policy period as well as any extended reporting period. Accordingly, an issue that frequently arises with respect to determining coverage under an EPLI policy is one of timing—*i.e.*, when was a claim made (or, in certain contexts, when did the insured know of facts that could give rise to a claim under the policy)? The answer, of course, turns on what constitutes a "claim" under an EPLI policy, and impacts numerous EPLI coverage issues, including, but not limited to, when notice of a claim is due, the scope of coverage afforded by an EPLI policy, and the applicability of the ''prior or pending'' exclusion.

WHAT IS A "CLAIM"?

The determination of what constitutes a ''claim'' generally turns on the specific definition of "claim" in the EPLI policy at issue. It is important to note that EPLI policies are not standardized—policy language therefore tends to vary from policy to policy. It therefore is extremely important to carefully

review your policy language—cases from controlling jurisdictions holding that an EPLI policy does or not cover a particular type of employment claim may be factually distinguishable and inapt based on policy language differences. For example, some EPLI policies define "claim" as "any judicial, administrative or other proceeding against any Insured for any Employment Practices Wrongful Act."[2] Other EPLI policies, by contrast, define "claim" as including, among other things, "a formal administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order or similar document."[3] Some EPLI policies do not define the term "claim."

The determination of what constitutes a "claim" generally turns on the specific definition of "claim" in the EPLI policy at issue

Disputes over what types of regulatory or agency proceedings or complaints qualify as "administrative proceedings" or "formal administrative proceedings," and thus constitute claims that may need to be reported to an insurer in order to satisfy the claims-made requirements, often arise in the context of an employee filing an employment-related complaint regarding its employer/the insured with a federal, state or local agency. The nature of the complaint and the relief sought, as well as the nature of the administrative body to which it was directed, are factors generally considered when determining whether the complaint constitutes a "claim" within the meaning of an EPLI policy.

If the regulatory or agency proceeding is deemed to be a "claim," the failure of an insured to report it to its insurer could bar coverage for any subsequent litigation filed against the insured arising out of the same basic facts or events even if the litigation raises issues that were not included in the initial complaint.

For example, in *Pantropic Power Products, Inc. v. Fireman's Fund Ins. Co.*, the insured purchased an EPLI policy from Fireman's Fund, which limited coverage to claims first made against the insured during the policy period and reported to the insured "as soon as practicable after the claim is made (but in no event more than 60 days following the end of the policy period)."[4] The policy stated that a claim was first made when "the insured receives written notice from the claimant . . . alleging that the insured has committed a wrongful employment practice."[5] The policy also stated that claims arising from "the same wrongful employment practice or series of similar or related wrongful employment practices" are deemed to be a single claim for purposes of the notice provision.[6] The first policy at issue had an inception date of July 1, 1998 and the second policy had an inception date of July 1, 1999.[7]

On November 12, 1998, an employee of the insured filed an administrative charge of sexual harassment against the insured. Following the investigation by the Florida Commission on Human Rights, the employee filed a civil complaint against the insured on September 3, 1999.[8] The civil complaint contained charges of retaliation and negligent retention in addition to the prior allegations of sexual harassment. The insured reported the suit to Fireman's Fund on September 17, 1999. Fireman's Fund denied coverage because the claim was not reported within sixty days of the expiration of the policy under which the claim was first made—i.e., the policy which incepted on July 1, 1998.[9]

The insured argued that, at a minimum, Fireman's Fund owed it a defense in the civil suit because the civil suit contained allegations that were not at issue in the administrative charge. The insured argued that the additional claims at issue in the civil suit could not have come into existence until after the filing of the administrative charge.[10] Fireman's Fund argued that the claims in the civil suit arose from the same wrongful practice or related wrongful practice and thus, under the terms of the policy, were deemed a single claim.[11] The court agreed with Fireman's Fund and noted that the policy language placed importance on the prompt notice of claims—allowing the insured to anticipate the extent of its exposure and plan for the defense. The court further noted that the new claims in the civil suit—retaliation and negligence—"occurred not in a vacuum but as a consequence of the prior acts of harassment."[12]

A number of courts[13] have likewise held that the filing of a charge with the U.S. Equal Employment Opportunity Commission (EEOC) or with the state equivalent constitutes a "claim" in the context of an EPLI policy, and thus obligates an insured to provide notice to its insurer within the specified notice period in order to preserve any claim for coverage.[14]

The court in *City of Santa Rosa v. Twin City Fire Insurance Co.*, however, reached the opposite conclusion based on the narrow definition of "claim" in the Errors and Omissions (E&O) policy at issue.[15] In that case, the court held that a discrimination charge that a former employee filed with the EEOC and the state Human Rights Division did not constitute a "claim" within the meaning of the employer's/insured's E&O policy, which defined "claim" as "a demand received by any insured for damages alleging injury or damage to persons or property, including the institution of a **suit** for such damages against any insured."[16] The policy defined damages as a "monetary judgment, award or settlement but does not include fines or

penalties or damages for which insurance is prohibited by law applicable to the construction of the policy.''[17] The court thus concluded that the administrative grievance'' at issue was not a ''demand for damages'' as defined by the policy.[18] In so ruling, the court distinguished numerous cases holding that an EEOC proceeding is a ''claim,'' explaining that those cases involved policies that either did not define the term ''claim'' or that expressly defined ''claim'' as including ''administrative proceedings.''[19] The court further emphasized that it based its holding on the policy language at issue and ''express[ed] no opinion about whether an EEOC or NMHRD [New Mexico Human Rights Division] charge of discrimination would constitute a claim where that term is left undefined in a policy or is defined differently.''[20]

A number of courts have likewise held that the filing of an EEOC or state equivalent charge constitutes a "claim" in the context of an EPLI policy, and thus obligates an insured to provide notice to its insurer within the specified notice period in order to preserve any claim for coverage

And, as with any coverage issue and as noted above, the policy's precise definitions must be considered to determine whether the particular type of proceeding at issue meets the definition of ''claim.'' For example, as noted above, some EPLI policies' ''claim'' definition includes ''administrative proceedings;'' others contain more restrictive definitions of ''claim'' in that they preface the term ''administrative'' with ''formal.'' Therefore, if an administrative proceeding does not qualify as a ''formal administrative'' proceeding, the insured may not be obligated to report it to its insurer. Indeed, this was the precise issue considered in *The American Center for International Labor Solidarity v. Federal Ins. Co.*, (*ACILS*),[21] and in *Capella University, Inc. v. Executive Risk Specialty Insurance Co.*, (''*Capella University*'').[22]

In *ACILS*, the plaintiff-insured American Center for International Labor Solidarity requested insurance coverage for an employment discrimination lawsuit.[23] ACILS had previously received notice of charges from the EEOC that a former employee had filed a charge of discrimination.[24] After the investigation, the EEOC dismissed the charge because it found no violation of federal statutes.[25] The former employee, though, then filed a civil lawsuit against ACILS containing similar allegations of discrimination. While the insured notified its insurer, Federal Insurance Company, of the civil lawsuit it never notified the company of the EEOC claim. Federal therefore denied coverage for the civil lawsuit because ACILS failed to notify it of the EEOC claim—an interrelated wrongful act under its policy—''as soon as it is practicable'' as required by the policy.[26] ACILS argued that it was not required to report the prior proceedings because the EEOC proceedings were not ''formal administrative proceedings'' and, thus, no claim existed to trigger the notice to Federal.

The *ACILS* district court rejected the argument that an EEOC administrative proceeding was not ''formal,'' noting that ''nearly all aspects of the EEOC's proceedings were prescribed by statute or regulation.''[27] The court noted that the EEOC can receive evidence, gather witness testimony, subpoena documents, and compel enforcement.[28] Therefore, the court found the EEOC proceeding was a ''formal administrative'' proceeding. On appeal, the D.C. Circuit similarly held that, because ''extensive regulations'' govern almost every facet of the EEOC's work, the EEOC charge constituted a ''claim'' as that term was defined in the policy.[29]

On the other hand, in *Capella University v. Executive Risk Specialty Insurance Co.*, which construed a ''claim'' definition under a professional liability policy, the Eight Circuit held that complaints filed with the United States Department of Education, Office of Civil Rights (OCR) did not constitute a ''formal administrative proceeding,'' and therefore did not constitute a ''claim,'' within the meaning of the EPLI policy at issue.[30] In *Capella*, the insured university suspended a student, and the student filed three OCR complaints against Capella prior to the inception of the EPLI policy at issue, which had a policy period of May 9, 2005 through May 9, 2006.[31] The student subsequently filed a federal civil lawsuit against Capella in July 2005 (the ''La Marca Lawsuit''), which ''was based on the same historical facts as the OCR complaints.''[32] The insurer denied coverage, contending that the La Marca Lawsuit was not a claim first made during the policy period, and further that the La Marca Lawsuit also was excluded under the ''prior or pending'' exclusion.[33] Capella did not dispute that OCR was an administrative body; nor did it dispute that the student's OCR complaint initiated an administrative proceeding.[34] Rather, Capella argued that ''the OCR proceedings were not formal,'' and the court agreed.[35]

In so ruling, the court contrasted OCR proceedings with EEOC proceedings.[36] It conducted a detailed examination of the ACILS court's reasons for concluding that EEOC proceedings do qualify as ''formal administrative proceedings,'' and then distinguished *ACILS* by explaining various ways in which OCR proceedings are less formal.[37] For example, while EEOC proceedings are ''governed

by extensive regulation," OCR proceedings "were subject to much less regulation."[38] Second, unlike EEOC proceedings, "the OCR proceedings that actually occurred in this case implicated relatively fewer consequences for Capella"—*e.g.*, the preliminary investigation "lacked teeth to require production of documents," and, because it did not require Capella to make "written admissions" or the OCR to issue a written decision, it was "unlikely that such writings would be later used against Capella."[39] Third, "because the informal OCR investigation did not reveal a failure to comply with programming regulations, the enforcement and remedy regulations did not even call for attempts at informal resolution."[40] (emphasis in original). Fourth, "the OCR proceedings were not a necessary predicate to the lawsuit against Capella."[41] Although the court recognized that possibility that the OCR could have taken further steps that may have "implicated" the concerns referenced in *ACILS*, the court concluded that "the administrative proceedings undertaken by the OCR in this case were not yet formal."[42]

A related issue to the timeliness of reporting a "claim" also arises in the context of EPLI exclusions that bar coverage for "known losses" or for claims arising out of any civil, criminal, administrative, or regulatory proceeding pending before the policy incepted

The above cases provide thorough and elucidating discussions of factors courts generally consider when determining whether a regulatory proceeding qualifies as a "formal administrative proceeding" within the meaning of an EPLI policy's "claim" definition.

COVERAGE EXCLUSIONS FOR KNOWN LOSS AND "PRIOR OR PENDING" PROCEEDINGS.

A related issue to the timeliness of reporting a "claim" also arises in the context of EPLI exclusions that bar coverage for "known losses" or for claims arising out of any civil, criminal, administrative, or regulatory proceeding pending before the policy incepted. With respect to "known losses," EPLI policies often exclude coverage for an employment claim if prior to the policy period the insured had knowledge of circumstances which could reasonably be expected to give rise to a claim.

In *Service Cas. Ins. Co. v. Travelers Ins. Co.*, the employee was terminated by the insured on March 31, 2001.[43] The employee filed a civil action alleging she was discriminated or retaliated against for filing a workers compensation claim. The employee suffered an occupational injury in December 2000 and alleged her employer, Gillespie Motors, delayed the filing of her workers compensation claim for two weeks.[44] Thereafter, she alleged that from December 2000 to March 2001 she made repeated requests for accommodations which were denied and she alleged that she was retaliated against by having her workload increased and she was insulted on the job.[45] The insured/employer, Gillespie Motors, was insured under a commercial general liability policy issued by Service Casualty.[46] In addition, Travelers insured Gillespie under an EPLI policy effective March 15, 2001 through March 15, 2002.[47] The Travelers' policy contained the following exclusion to coverage:

> This insurance shall not apply to, and the Company shall have no duty to defend or pay Defense Expenses for any Claim:
>
> ***
>
> For or arising out of facts, transactions or events which are or reasonably should be regarded as Wrongful Employment Practices, about which any Responsible Person had knowledge prior to the inception of coverage under the Policy . . .[48]

Travelers denied coverage for the EPLI claim because Gillespie had been aware of discriminatory and retaliatory conduct that had occurred before Travelers' policy incepted.[49] In response, the insured argued that it was not aware of a litigation threat by the employee until just before she resigned.[50] Travelers argued that the exclusion did not require the insured knew of a claim or lawsuit—rather, the exclusion precluded coverage as long as the insured was aware of facts or events that could be regarded as a Wrongful Employment Practice.[51] The court held the exclusion did bar coverage because a review of the allegations in the employee's complaint specifically outlined facts that established the insured had knowledge of a Wrongful Employment Practice before the policy incepted.[52]

In a more recent case, the court determined that a similar argument relied on by an insurer to defeat a claim for coverage under an EPLI policy raised an issue of fact. In *Manganella v. Evanston Ins. Co.*, the insurer denied coverage under an EPLI policy on grounds that some of the conduct occurred prior to the inception of the first EPLI policy issued to the insured.[53] The EPLI policy provided coverage for wrongful employment practice provided that the entirety of the wrongful conduct occurred during the policy period as amended by the Retroactive Date. The Retroactive Date was the date the first EPLI policy incepted—April 28, 1999.[54] In *Manganella*, the insured employer (Jasmine) applied for EPLI

coverage after being sued for sexual harassment by a former employee (the *Bawa* complaint). When applying for the coverage in 1998, the insured's president (Manganella) and human resource director (Burgess) both stated that the pending sexual harassment suit was the only instance they were aware of regarding a wrongful employment practice.[55] The application was signed on November 10, 1998. In addition, as part of the *Bawa* litigation, on November 13, 1998, Burgess submitted an affidavit saying that she was not aware of Manganella committing any acts of sexual harassment towards Ms. Bawa or others.[56] But, in May of 2006, Burgess complained that she has been sexually harassed by Mr. Manganella since she began working at the company in 1997.[57] Because Ms. Burgess' complaint contained allegations dating back to 1997, Evanston denied coverage because the wrongful acts did not occur entirely within the policy period.[58] Based on the conflicting evidence, the court found that, at a minimum, Evanston was required to investigate the inconsistencies ''before choosing the version of the facts that justified a denial of coverage, while ignoring another under which coverage attached.''[59]

Insureds also should be aware that a prior proceeding—that falls outside an EPLI policy's coverage grant but relates to a claimant's employment—may still be deemed to trigger a ''prior or pending proceeding'' exclusion. In *National Waste Associates, LLC v. Travelers Casualty and Surety Company of America*, for example, the Connecticut Supreme Court affirmed the trial court's judgment that a ''prior or pending'' exclusion in an EPLI policy barred coverage for a wrongful discharge lawsuit because, prior to the inception of the policy, the former employee/plaintiff had filed a claim for unemployment benefits.[60] ''The documents [evidencing the unemployment proceedings] and the complaint indicated that the plaintiff's former employee had claimed, both when pursuing unemployment benefits and in the action against the plaintiff, that she wrongfully had been discharged from employment with the plaintiff after resisting the plaintiff's attempt to invade her privacy.''[61] An unemployment claim is not a claim against an employer, but rather is a state-provided benefit available (under certain circumstances), that would not trigger coverage under an EPLI policy. Indeed, in *National Waste*, the insured argued that the ''prior or pending'' exclusion should not apply in this context because EPLI policies do not cover unemployment compensation proceedings and '' 'it makes no sense that the [p]olicy's prior litigation exclusion would be triggered by the occurrence of prior uncovered events.' ''[62] The Connecticut Superior Court, disagreed, finding that the purpose of the exclusion was to apprise the insurer of ''events that might blossom into a covered event during the policy period.[63] The trial court's decision was adopted by the Connecticut Supreme Court.[64]

PRIOR KNOWLEDGE AND RESCISSION

While knowledge of circumstances known to the insured before the policy incepted and not reported to the insurer on an application of insurance may trigger an exclusion, the issue quickly may become more problematic for an insured if the failure to report the information is determined to be a material misrepresentation and allows for rescission of the policy. In *Admiral Ins. Co. v. Debber*, the insurer, Admiral, sought to rescind a policy issued to Data Control Corporation (DCC) because DCC failed to disclose on its application for EPLI coverage two prior lawsuits involving DCC employees and containing claims for sexual harassment and retaliation against DCC.[65] DCC argued that it did not fail to disclose material information on its application for insurance.[66]

The applications for insurance were completed in 2002 and 2003.[67] The prior lawsuits were initiated in 1998 and concluded in 1999 and 2001.[68] The applications asked DCC whether ''in the last 5 years has any current or former employee or third-party made any claim or otherwise alleged discrimination, harassment, wrongful discharge and/or Wrongful Employment Act(s) against the Insured Entity or its directors, officers, or Employees.'' It also asked if ''during the last 5 year, has the Insured Entity or any of its directors, officers or Employees thereof known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances, or other administrative hearings or proceedings before any of the following agencies and/or under any of the following forums[:]''—the National Labor Relations Board, Equal Employment Opportunity Commission, Office of Federal Contract Compliance Programs, U.S. Department of Labor, any state or local government agency such as the Labor Department or fair employment agency or ''U.S. District of state court.''[69] The insured answer no to both questions and claimed she was instructed by her agent/broker to use a previous renewal application for an EPLI policy for another carrier as a template to complete the Admiral application.[70] The renewal application for the other carrier did not require DCC to list prior claims because DCC had previously described such claims in the original application and the renewal only requested information about *additional* claims.[71] In essence, the insured argued it was excusable neglect that lead to the wrong answers on the application.

The court found that the reason offered by the insured did not alter the analysis of whether or not rescission was warranted. The court found that even an unintentional nondisclosure was sufficient to support rescission of the policy.[72] In addition, the court found the requested information which pertained to the insured's loss history was clearly material.[73]

CONCLUSION

The above cases illustrate the importance of understanding what types of events are likely to be deemed to constitute "claims" under EPLI policies. An insured's failure to fully comprehend the scope of an EPLI policy's "claim" definition can result in the forfeiture of coverage in a number of different, but related, ways—either because (1) the insured may be deemed to have failed to provide timely notice of a claim, (2) a claim for which the insured seeks coverage may be deemed not to have been first made during the policy period, (3) a claim for which the insured seeks coverage may be deemed barred by the "prior or pending" exclusion, and/or (4) the insured's failure to report an event qualifying as a "claim" during the underwriting process could result in application of the "known loss" exclusion or in rescission of the policy.

[1] Krueger International, Inc. v. Royal Indemnity Co., 481 F.3d 993, 994 (7th Cir. 2007).

[2] *See, e.g.*, Munsch Hardt Kopf & Harr v. Executive Risk Specialty Ins., 2007 U.S. Dist. LEXIS 16647, at *1 (N.D. Tex. 2007).

[3] American Center for International Labor Solidarity v. Federal Insurance Co., 548 F.3d 1103, 1104 (D.C. Cir. 2008).

[4] Pantropic Power Products, Inc., v. Fireman's Fund Ins. Co., 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[5] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[6] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[7] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[8] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[9] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1368 (S.D. Fla. 2001).

[10] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1371 (S.D. Fla. 2001).

[11] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1371 (S.D. Fla. 2001).

[12] *Pantropic Power Products, Inc.*, 141 F.Supp.2d 1366, 1371–72 (S.D. Fla. 2001).

[13] *Munsch Hardt Kopf & Harr, P.C.*, 2007 U.S. Dist. LEXIS 16647, at *4 (N.D. Tex. 2007); Specialty Food Systems, Inc. v. Reliance Ins. Co. of Illinois, 45 F.Supp.2d 541, 544 (E.D. La.), *aff'd mem.*, 200 F.3d 816 (5th Cir. 1999).

[14] Nevertheless, both insurers and insureds should be aware that while there has been some uniformity in courts finding that an EEOC or similar charge made to a state agency constitutes a "claim," there are at least two states which may require an insurer to establish prejudice before it can disclaim coverage even under a claims-made policy. Thus, the fact that an EEOC charge was made but not reported to the insurer during the policy period may not be an absolute bar to coverage depending on the jurisdiction. For example, Wisconsin has statutes requiring that an insurer must show prejudice to deny coverage if notice is given within one year after the time required by the policy. Wis. Stat. §§ 631.81, 632.26. In Lexington Ins. Co. v. Rugg & Knopp, Inc., 1 F.Supp.2d 937 (E.D. Wis. 1998), aff'd, 165 F.3d 1087 (7th Cir. 1999), the court rejected the insurer's argument that the Wisconsin notice prejudice statutes do not apply to claims-made policies. The court found the statutes to be unambiguous in their intent and, therefore, held the insurer must show prejudice to defeat the insured's claims for coverage under a late notice defense. *See also* Hardwick Recycling & Salvage, Inc. v. Acadia Ins. Co., 869 A.2d 82 (Ct. 2004) (noting an insurer must show prejudice to deny coverage as a result of the insured's late notice).

[15] City of Santa Rosa v. Twin City Fire Insurance Co., 143 P.3d 196, 197 (N.M. Ct. App. 2006).

[16] *City of Santa Rosa*, 143 P.3d 196 at 199 (N.M. Ct. App. 2006).

[17] *City of Santa Rosa*, 143 P.3d 196, 199 (N.M. Ct. App. 2006).

[18] *City of Santa Rosa*, 143 P.3d 196, 197 (N.M. Ct. App. 2006).

[19] *City of Santa Rosa*, 143 P.3d 196, 201 (N.M. Ct. App. 2006).

[20] *City of Santa Rosa*, 143 P.3d 196, 197 (N.M. Ct. App. 2006).

[21] *The* American Center for International Labor Solidarity v. Federal Ins. Co., 518 F.Supp.2d 163 (D.C. D. 2007) aff'd 548 F.3d 1103 (D.C. Circuit 2008).

[22] Capella University, Inc. v. Executive Risk Specialty Insurance Co., 617 F.3d 1040 (8th Cir. 2010).

[23] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 165 (D.C. D. 2007).

[24] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 165 (D.C. D. 2007).

[25] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 166 (D.C. D. 2007).

[26] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 166–167 (D.C. D. 2007).

[27] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 169 (D.C. D. 2007).

[28] *The American Center for International Labor Solidarity*, 518 F.Supp.2d 163, 170 (D.C. D. 2007).

[29] American Center for International Labor Solidarity v. Federal Insurance Co., 548 F.3d 1103, 1105–1106 (D.C. Cir. 2008).

[30] *Capella University, Inc.*, 617 F.3d 1040 at 1045 (8th Cir. 2010).

[31] *Capella University, Inc.*, 617 F.3d 1040 at 1042–44 (8th Cir. 2010).
[32] *Capella University, Inc.*, 617 F.3d 1040 at 1043 (8th Cir. 2010).
[33] *Capella University, Inc.*, 617 F.3d 1040 at 1043–44 (8th Cir. 2010).
[34] *Capella University, Inc.*, 617 F.3d 1040 at 1045 (8th Cir. 2010).
[35] *Capella University, Inc.*, 617 F.3d 1040 at 1046–49 (8th Cir. 2010).
[36] *Capella University, Inc.*, 617 F.3d 1040 at 1046–49 (8th Cir. 2010).
[37] *Capella University, Inc.*, 617 F.3d 1040 at 1046–49 (8th Cir. 2010).
[38] *Capella University, Inc.*, 617 F.3d 1040 at 1048 (8th Cir. 2010).
[39] *Capella University, Inc.*, 617 F.3d 1040 at 1049 (8th Cir. 2010).
[40] *Capella University, Inc.*, 617 F.3d 1040 at 1049 (8th Cir. 2010).
[41] *Capella University, Inc.*, 617 F.3d 1040 at 1049 (8th Cir. 2010).
[42] *Capella University, Inc.*, 617 F.3d 1040 at 1049 (8th Cir. 2010).
[43] Service Cas. Ins. Co. v. Travelers Ins. Co., 2004 U.S. Dist. LEXIS 19797 (W.D. Tex. 2004).
[44] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *2.
[45] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *13.
[46] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *2.
[47] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *2.
[48] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *13–14.
[49] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *14.
[50] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *15.
[51] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *15.
[52] *Service Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 19797 *18.
[53] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 (D. Mass. 2010).
[54] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *6 (D. Mass. 2010).
[55] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *2–3 (D. Mass. 2010).
[56] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *2–3 (D. Mass. 2010).
[57] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *12 (D. Mass. 2010).
[58] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *13 (D. Mass. 2010).
[59] Manganella v. Evanston Ins. Co., — F.Supp.2d —, 2010 U.S. Dist. LEXIS 113608 *17–18 (D. Mass. 2010).
[60] National Waste Associates, LLC v. Travelers Casualty and Surety Company of America, 988 A.2d 186, 186–88 (Ct. 2010).
[61] *National Waste Associates, LLC*, 988 A.2d 186 at 187 (Ct. 2010).
[62] *National Waste Associates, LLC*, 988 A.2d 186 at 186–88 (Ct. 2010).
[63] *National Waste Associates, LLC*, 988 A.2d 186 at 186–88 (Ct. 2010).
[64] *National Waste Associates, LLC*, 988 A.2d 186 at 188 (Ct. 2010).
[65] Admiral Ins. Co. v. Debber, 442 F.Supp.2d 958 (E.D. Ca. 2006) aff'd by 295 Fed.Appx. 171 (9th Cir. 2008).
[66] *Admiral Ins. Co*, 442 F.Supp.2d 958, 960 (E.D. Ca. 2006).
[67] *Admiral Ins. Co*, 442 F.Supp.2d 958, 961–62 (E.D. Ca. 2006).
[68] *Admiral Ins. Co*, 442 F.Supp.2d 958, 963–64 (E.D. Ca. 2006).
[69] *Admiral Ins. Co*, 442 F.Supp.2d 958, 961–62 (E.D. Ca. 2006).
[70] *Admiral Ins. Co*, 442 F.Supp.2d 958, 962 (E.D. Ca. 2006).
[71] *Admiral Ins. Co*, 442 F.Supp.2d 958, 962 (E.D. Ca. 2006).
[72] *Admiral Ins. Co*, 442 F.Supp.2d 958, 968–69 (E.D. Ca. 2006).
[73] *Admiral Ins. Co*, 442 F.Supp.2d 958, 968–69 (E.D. Ca. 2006).

Policy Language Should Control in Issues of Allocation and Reimbursement of Defense Costs

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Under a duty to defend or a "pay on behalf of" policy, the insurer owes the insured an indivisible duty to defend. As such, allocation is an issue for the insurers, not the insured

INTRODUCTION

Insurance coverage disputes have grown increasingly complex. Policyholders today often procure multiple types and layers of insurance coverage to protect against varied and complex claims. As the cost of defending underlying litigation has grown, insurers have developed more complex arguments in order to shift their defense burden to others. Discussed below are various methods that insurers often seek to employ in order to limit their obligations and push defense costs to other insurers or the insured.

When a suit against an insured triggers the defense obligations of multiple policies, the insurers may seek to limit their duties by allocating defense costs between the policies. For example, if an insured has a loss that triggers policies in several consecutive years, the issue arises as to which policy or policies are obligated to pay defense costs and in what amount. The fact scenarios may be complicated by the presence of multiple types of policies, policies spanning multiple years, or gaps in insurance coverage. Determining who has to pay and in what proportion is not an easy task. Once defense costs have been paid by the insurer(s), related issues may arise as to whether the paying insurer can recoup any of the amounts paid, and if so from whom. This article identifies the different approaches courts have taken to these issues, and urges that—as with all insurance policy interpretation issues—the analysis begin by examining the terms of the policies.

ALLOCATION

As with all insurance policy interpretation issues, the first step in determining how to allocate defense costs between or among policies is to look at the policies themselves. The most important policy provision is the provision describing the insurer's obligation to provide for the insured's defense. The policy may impose on the insurer a duty to defend or "to pay [defense costs] on behalf of" the insured. Alternatively, the policy might require the insurer to advance defense costs as they are incurred, or to reimburse or provide indemnification for defense costs that already have been paid by the insured.

Under a duty to defend or a "pay on behalf of" policy, the insurer owes the insured an indivisible duty to defend. As such, allocation is an issue for the insurers, not the insured.[1] Accordingly, the "other insurance" clause is relevant to the determination of allocation. The "other insurance" clause may state, for example, that the policy is primary to other insurance or that the policy is excess of other available coverage. The "other insurance" clause may even state how indemnity coverage provided by that policy is to be apportioned.[2] However, because there are multiple policies that may be responsible for defense costs, the various policies' "other insurance" clauses must be read together. Because an insurer does not have a contractual relationship with the other insurers on the risk, an insurer cannot by its insurance policy language alone control how defense costs will be apportioned between and among itself and the other insurers.[3]

In practice, "other insurance" provisions from multiple policies typically will cancel one another out. For example, if two policies both provide a duty to defend the insured for the suit at issue, and

both policies state that they are excess to other available insurance, there is a problem.[4] Both policies cannot be excess to each another. One, or both, must be primary.

In addition, because ''other insurance'' clauses usually are silent as to the apportionment of *defense* costs, even where the ''other insurance'' clauses appear harmonious as to the apportionment of *indemnity* costs, the insurers may disagree on the apportionment of defense costs. For example, in *Federal Insurance Company v. Cablevision Systems Development Company*, 836 F.2d 54 (2d Cir. 1987), the three policies responsive to the loss all contained ''other insurance'' clauses that provided for ''contribution by equal shares.''[5] Yet one insurer refused to contribute equally to the defense.[6] Thus, court intervention was required to determine how to apportion defense costs.[7]

Courts have handled defense costs allocation issues in a variety of different ways. Some courts allocate defense costs across multiple years of coverage on a pro rata basis in proportion to policy limits. Other courts allocate defense costs among insurers in equal shares. Yet other courts allow the insured to choose which policy will respond by allowing ''targeted tender.''[8] Some courts allocate defense costs in the same way that the indemnity costs are apportioned in the same case, while others apply different apportionment schemes for defense and indemnity in the same case.[9] The allocation method used often depends on the facts and policy language at issue.[10]

PRO RATA IN PROPORTION TO POLICY LIMITS

The pro rata apportionment attempts to divide the defense responsibilities in accordance with the indemnity risk each insurer assumed. For example, where there are four insurers that are required to defend an insured and three insurers have policy limits of $300,000 and one insurer has policy limits of $100,000, a pro rata policy limits allocation would require each of the three insurers with $300,000 policy limits to contribute 30 percent of the defense costs and the fourth insurer to contribute 10 percent of the defense costs.[11] This is the majority rule and has been implemented by many state and federal courts.[12] At least one court, however, has noted that the indemnity risk assumed is not always proportional to the costs of insurance:

> When pro-rating liability between insurers, courts must consider that each additional increment of coverage costs less to provide than the previous increment. In other words, the cost of insuring the first million dollars of risk may be substantially greater than the cost of insuring the second million dollars. . . . Because cost does not increase in direct proportion to the amount of coverage, neither apportioning liability according to policy limits-the ''majority'' rule-nor apportioning liability equally-the ''minority'' rule-accurately allocates liability according to the cost of the burden each insurer contracts to carry.[13]

EQUAL SHARES

The equal shares method is simple to implement. All insurers with a defense obligation are required to share equally in the defense costs on a per capita basis. The logic supporting this approach is that the duty to defend is indivisible, and as such it is unnecessary to prorate the defense costs. For example, in *Federal Insurance Company v. Cablevision Systems Development Company*, 836 F.2d 54 (2d Cir. 1987), the court stated:

> Under New York law, the duty of each of the three insurers to defend Cablevision is separate and equal. Since the insurers cannot defend ''part'' of the antitrust claims against Cablevision in the underlying *Nishimura* action, it is logical that the insurers bear the costs of defense equally.[14]

Courts apportioning defense costs by equal shares often cite public policy reasons for doing so. In *Wooddale Builders, Inc. v. Maryland Cas. Co.*, 722 N.W.2d 283 (Minn. 2006), the Minnesota Supreme Court explained:

> [A]llowing an insured to seek recovery of defense costs from any insurer, but making insurers equally liable among themselves, ''will encourage [the] insurers, when tendered a defense, to resolve promptly the duty to defend issue either by some cooperative arrangement between them, or by a declaratory judgment action, or by some other means.''[15]

TARGETED TENDER

Some courts have found that the duty to defend is not triggered until the defense has been tendered to the insurer. In a jurisdiction that so limits the trigger of the duty to defend, an insured can tender the defense to a specific insurer—a ''targeted tender'' or ''selective tender.'' That insurer then is responsible for all the defense costs.[16] A targeted tender approach ''preserves the insured's right to invoke or not to invoke the terms of its insurance contracts.''[17] By selecting one insurer, the insured may effectively ''deselect'' another insurer, which prevents the targeted insurer from seeking contribution from other insurers.[18] However, at least one court has

determined that under the doctrine of horizontal exhaustion, an insurer cannot "target" or "select" an excess carrier to provide coverage until the limits of all primary insurance are exhausted.[19]

PRIMARY v. EXCESS

In general, where an insured has primary and excess insurance, the excess insurer need not participate in the defense until the primary policy is exhausted.[20] The rationale for this rule is that it accords with the reasonable expectations of the parties:

> Excess insurers are able to provide relatively inexpensive insurance with high policy limits because they require the insured to contract for underlying primary insurance with another carrier. The primary carrier generally provides a much lower amount of coverage, but must insure against what is likely to be a greater number of claims and must provide a defense. *See Harville v. Twin City Fire Ins. Co.*, 885 F.2d 276, 279 (5th Cir.1989); *Hartford Accident & Indem. Co. v. Continental Nat'l Am. Ins. Cos.*, 861 F.2d 1184, 1187 (9th Cir.1989). The premiums charged are thus a reflection of the risks undertaken. Because the primary insurer's duty to defend extends to covered claims without regard to their amount, an excess insurer's duty to defend is not typically invoked merely because a claim has been asserted against the insured in excess of primary limits. *See* 1 WINDT, INSURANCE CLAIMS & DISPUTES § 4.11 (3 rd ed.1995).[21]

As a practical matter, where the primary policy cannot be exhausted until the insurer has made payment of indemnity costs equal to policy limits, often that primary policy will not be exhausted until the case is resolved. In that situation, the primary insurer is liable for the full costs of defense.[22] However, if both the primary and excess insurers fail to defend the insured and the matter is resolved for an amount that penetrates the excess insurer's policy, the excess insurer may be required to pay a portion of the defense costs.[23]

AMONG INSURERS AND INSURED

When a policyholder has uninsured periods (for example, due to insurer insolvency) or has periods with self-insured retentions, the issue arises as to whether defense costs can be allocated to the insured for that time period. The short answer—grounded in policy terms and basic principles of insurance—is that defense costs should ***not*** be allocated to the insured. The allocation analyses above are based on the basic premise that an insurance policy containing a duty to defend provision (or a duty to "pay on behalf of") creates a contractual—and indivisible—duty as between the insured and insurer. Faced with an indivisible duty (or in the case of multiple insurers with defense obligations—multiple indivisible duties) to the insured, it makes no sense to force the insured to give up part of that to which it is entitled by contract. As the California Supreme Court explained:

> Although insurers may be required to make an equitable contribution to defense costs *among themselves*, that is all: An insured is not required to make such a contribution *together with insurers*. Equitable contribution applies *only* between insurers, and *only* in the absence of contract. It therefore has no place between insurer and insured, which have contracted the one with the other. Neither does it have any place between an insurer and an uninsured or "self-insured" party.[24]

In *Insurance Company of North America v. Forty-Eight Insulations, Inc.*, the Sixth Circuit allowed defense costs to be prorated to an insured on the basis that "it is reasonable to treat [the insured] as an insurer for those periods of time that it had no insurance coverage."[25] This assertion, however, contradicted the language and intent of the insurance policies at issue, and has been flatly rejected by many later courts, with good reason.[26]

> ***A court that seeks to impose amorphous concepts of "fairness" and "justice" in order to apply a non-existent contract, while disregarding the terms of the actual insurance policies, destroys the meaning of the explicit terms of the policies and the reasonable expectations of the parties***

The entire purpose of judicial intervention in defense cost allocation is to determine the rights of the parties where there are multiple, conflicting policies of insurance. The first step in balancing the rights and duties of the parties is to look at the insurance policies: what do the defense provisions say about the duty to defend or to pay defense costs; and what do the policies say about the relationship between the policies—about "other insurance." It does not make sense to interject into the mix a non-existent contract between the insured and itself (as an insurer on the one hand and an insured on the other). On the contrary, the insured did not contract with itself to provide insurance, and there are no written defense obligations or "other insurance" clauses for the period of time when an insured was uninsured. The United States Court of Appeals for the District of Columbia Circuit pointed out some of the problems

associated with crafting judicial opinions based on make-believe self-insurance policies:

> We have no authority upon which to pretend that [the insured] also has a 'self-insurance' policy that is triggered for periods in which no other policy was purchased. Even if we had the authority, what would we pretend that the policy provides? What would its limits be? There are no self-insurance policies, and we respectfully submit that the contracts before us do not support judicial creation of such additional insurance policies.[27]

A court that seeks to impose amorphous concepts of ''fairness'' and ''justice'' in order to apply a nonexistent contract, while disregarding the terms of the actual insurance policies, destroys the meaning of the explicit terms of the policies and the reasonable expectations of the parties.[28]

Moreover, when the analysis moves from contract interpretation to post hoc determinations about fairness, the inquiry into the facts necessarily becomes more convoluted. Even those courts that allow a portion of the indemnity costs to be allocated to the insured recognize that allocation to the insured is inappropriate where the insured did not purposely act to assume a risk.[29] It does not make sense, however, that an insured's later (or earlier) determination about whether (or with whom) to enter into an insurance contract should affect the indivisible duty to defend that was negotiated and put in writing with its actual insurer. As the California Supreme Court explained, it is not the role of the court to re-write the policy terms:

> Beneath the Court of Appeal's concern about ''fairness'' and ''justice'' is, apparently, a belief that, without an approach like the one it adopted, Aerojet might get a windfall from the insurers. That is not the case.... the pertinent policies provide what they provide. Aerojet and the insurers were generally free to contract as they pleased. They evidently did so. They thereby established what was ''fair'' and ''just'' inter se. We may not rewrite what they themselves wrote. We must certainly resist the temptation to do so here simply in order to adjust for chance-for the benefits it has bestowed on one party without merit and for the burdens it has laid on others without desert. As a general matter at least, we do not add to, take away from, or otherwise modify a contract for ''public policy considerations.'' We would certainly not do so here, where such considerations depend in large part on the amassing and analyzing of complex and extensive empirical data, which belong more appropriately to the executive and legislative branches than to the judicial. We shall therefore allow whatever ''gains'' and ''losses'' there may be to lie where they have fallen.[30]

RECOUPMENT

An insurer that provides a defense for its insured often seeks a way to recover the costs of defense. In many jurisdictions, the insurer will be able to seek contribution from other insurers that also have defense obligations. Where the claim or suit ultimately is determined not to be covered, an insurer may seek to recoup its costs from the insured. The analysis of whether an insurer can recoup defense costs should be based on the terms of the insurance policies. Again, the relevant provisions include the description of the insurer's obligations with respect to the insured's defense and the other insurance clause.

ABILITY TO SEEK CONTRIBUTION FROM OTHER INSURERS

A majority of courts allow a defending insurer to seek contribution from other insurers.[31] Those courts recognize that the basis for a claim by one insurer against another is not subrogation, but equitable contribution:

> Equitable contribution permits reimbursement to the insurer that paid on the loss for the excess it paid over its proportionate share of the obligation, on the theory that the debt it paid was *equally* and *concurrently* owed by the other insurers and should be shared by them pro rata in proportion to their respective coverage of the risk. The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others.[32]

Courts have noted that a rule allowing contribution encourages insurers to promptly defend an insured.[33] A minority of courts, however, have held that because the duty to defend is personal and indivisible as to each insurer, the insurers have no rights as against one another.[34]

REIMBURSEMENT OR "CLAW BACK" FROM INSURED

Sometimes an insurer that has provided for defense later seeks to ''claw back'' or be reimbursed for defense costs it has paid when the claim or suit ultimately is determined *not* to be covered based on its final resolution. In this situation, insurers have argued that they are entitled to reimbursement based on theories of restitution and unjust enrichment,[35]

quantum meruit,[36] quasi-contract and implied-in-fact contract.[37] In *Buss v. Superior Court*, 16 Cal. 4th 35 (Cal. 1997), the seminal case providing an avenue for recoupment, the insurer argued and the California Supreme Court agreed that because 26 of the 27 causes of action against the insured were not even potentially covered, and only two to five percent of the defense costs were allocable to the one potentially covered claim, the parties' rights were not governed by the insurance contract, but rather by implied contract or another equitable theory:

> Under the policy, the insurer does not have a duty to defend the insured as to the claims that are not even potentially covered. With regard to defense costs for these claims, the insurer has not been paid premiums by the insured. It did not bargain to bear these costs ... The insurer therefore has a right of reimbursement that is implied in law as quasi-contractual, whether or not it has one that is implied in fact in the policy as contractual. As stated, under the law of restitution such a right runs against the person who benefits from "unjust enrichment" and in favor of the person who suffers loss thereby. 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."[38]

Many courts since have relied on *Buss* to allow recoupment from the insured where the insurer "(1) specifically reserve[d] the right to seek reimbursement from the insured; and (2) provide[d] the insured with adequate notice of this potential reimbursement."[39]

Where a policy provides a broad duty to defend, "a partial right of reimbursement would thus serve only as a backdoor narrowing of the duty to defend, and would appreciably erode [the] long-held view that the duty to defend is broader than the duty to indemnify"

Insureds, on the other hand, have opposed insurer "claw back" of defense costs based on the terms of the insurance contract, specifically the terms relating to the defense obligation and the absence of a policy provision allowing reimbursement.[40] Where a policy provides a broad duty to defend, "a partial right of reimbursement would thus serve only as a backdoor narrowing of the duty to defend, and would appreciably erode [the] long-held view that the duty to defend is broader than the duty to indemnify."[41] As the Illinois Supreme Court explained, the existence of a potentially non-covered claim or suit should not give an insurer the right to unilaterally alter the negotiated terms of the contract:

> "[I]f an insurance carrier believes that no coverage exists, then it should deny its insured a defense at the beginning instead of defending and later attempting to recoup from its insured the costs of defending the underlying action. ... Furthermore, endorsing such conduct is tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract."[42]

It does not make sense that an insurer's reservation of rights letter could reserve a right not present in the insurance policy.[43] Although the contract-based approach to analyzing the recoupment issue has oft been referred to as the "minority view", in recent years, more courts have agreed with this approach.[44]

The analysis regarding recoupment is different under "defense cost advancement" policies (as opposed to policies that provide a duty to defend or "pay on behalf of") because these types of policies typically expressly provide for "claw back" of defense costs if the claim ultimately is determined not to be covered. Even under these policies, however, issues can arise as to from whom the insurer can "claw back" the defense costs. Under "defense cost reimbursement" or indemnification policies, "claw back" issues do not arise. In such policies, defense costs are subsumed within definitions of covered "loss" or "damages." If the claim is not covered, there is no obligation to pay "loss" or "damages" consisting of defense costs.

For many years insurers have written D&O and other policies that contain these provisions for "defense cost advancement" and "defense cost reimbursement" or indemnification. In other words, insurers know how to write provisions into their policies that will allow for recoupment of defense costs. In recent years, however, general liability insurers have sought to recoup defense costs under duty to defend and "pay on behalf of" policies—policies that by their terms provide the separate and distinct benefit of the duty to defend claims that are merely *potentially* covered, a duty much broader than the duty to indemnify. These insurers are seeking court approval to re-write the previously negotiated policy terms. Courts should put a stop to this disturbing trend and require insurers to comply with the terms of the policies they sold.

CONCLUSION

Policy interpretation should begin with the terms of the policies at issue. Insurers chose the words of their policies and should abide by them. Insurers that have a duty to defend or "pay on behalf of" should own

their indivisible duties; they should not be able to push defense costs back to the insured either through allocation or "claw back." Issues of allocation and reimbursement should be between the insurers. The insured should not be punished for procuring ample insurance.

[1] Aerojet—Gen'l Corp. v. Transport Indem. *Co.*, 17 Cal. 4th 38, 72 (Cal. 1997).

[2] Owens-Illinois, Inc. v. United Ins. Co., 138 N.J. 437, 470, (N.J. 1994) ("[T]here are three general types of other insurance clauses-excess, pro rata and escape. Excess insurance kicks in to provide additional coverage once the policy limits of other available insurance are exhausted. Pro rata provisions allocate financial responsibility between concurrent policies based upon the percentage of coverage each policy bears to the net amount of coverage under all applicable policies. An escape clause attempts to release the insurer from all liability to the insured if other coverage is available.") (quotations and citations omitted).

[3] *See* Amer. Auto. Ins. co. v. Seaboard Surety Co., 381 P.2d 84, 86 (Cal. App. 1957) ("The reciprocal rights and duties of several insurers who have covered the same event do not arise out of contract, for their agreements are not with each other. . . . Their respective obligations flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. As these principles do not stem from agreement between the insurers their application is not controlled by the language of their contracts with the respective policy holders."); *CNA* Casualty of California v. Seaboard Surety Co., 176 Cal.App.3d 598, 619 (1986) ("The costs of defense must be apportioned on the basis of equitable considerations not found in the insurers' own contracts, since the insurance companies who must share the burden do not have any agreements among themselves.").

[4] Continental Casualty Co. v. Aetna Casualty & Surety Co., 823 F.2d 708 (2d Cir. 1987) ("[W]e hold that the excess clauses of Aetna and Continental are mutually repugnant.").

[5] Federal Ins. Co. v. Cablevision Systems Devel. Co., 836 F.2d 54, 58 (2d Cir. 1987).

[6] Federal Ins. Co. v. Cablevision Systems Devel. Co., 836 F.2d 54, 57 (2d Cir. 1987).

[7] Federal Ins. Co. v. Cablevision Systems Devel. Co., 836 F.2d 54, 58 (2d Cir. 1987) (applying New York law; "[W]e hold that the 'other insurance' clauses in the instant case indicate an intent that the contributions by the co-insurers to defense costs should be in equal amounts.").

[8] Institute of London Underwriters v. Hartford Fire Ins. Co., 599 N.E.2d 1311 (Ill. App. Ct. 1992) (targeted tender).

[9] *See* Wooddale Builders, Inc. v. Maryland Cas. Co., 722 N.W.2d 283, 302 (Minn. 2006) (applying pro-rata-by-time-on-the risk apportionment to indemnity costs while requiring defense costs be apportioned by equal shares).

[10] *See* Signal Cos. v. Harbor Ins. Co., 612 P.2d 889, 895 (Cal. 1980) ("We expressly decline to formulate a definitive rule applicable in every case in light of varying equitable considerations which may arise, and which affect the insured and the primary and excess carriers, and which depend upon the particular policies of insurance, the nature of the claim made, and the relation of the insured to the insurers."); Wooddale Builders, Inc. v. Maryland Cas. Co., 722 N.W.2d 283, 302 (Minn. 2006) (noting that allocation of defense costs may differ as between concurrent insurers and consecutive insurers).

[11] *See* CNA Casualty of California v. Seaboard Surety Co., 176 Cal.App.3d 598, 619–20 (1986) (apportioning costs-30-30-30-10 on these facts).

[12] *See, e.g.*, Sacharko v. Center Equities Ltd. Partnership, 479 A.2d 1219, 1224 (Conn. App. 1984); American Simmental Ass'n v. Coregis Ins. Co., 107 F. Supp. 2d 1064, 1079 (D. Neb. 2000); Nat'l Grange Mut. Ins. Co. v. Continental Cas. Ins., 650 F. Supp. 1404, 1413 Shepardize (S.D. N.Y. 1986).

[13] Continental Casualty Co. v. Aetna Casualty & Surety Co., 823 F.2d 708, 711–12 (2d Cir. 1987).

[14] Federal Insurance Company v. Cablevision Systems Development Company, 836 F.2d 54, 58 (2d Cir. 1987); ABT Bldg. Prods. Corp. v. Nat'l Union Fire Ins. Co., 472 F.3d 135 (4th Cir. 2006) (after underlying limit was exhausted by settlement payments, excess carrier had duty to defend).

[15] Wooddale Builders, Inc. v. Maryland Cas. Co., 722 N.W.2d 283, 303 (Minn. 2006) (quoting at *Jostens, Inc. v. Mission Ins. co.*, 387 N.W.2d 161, 167 (Minn. 1986).

[16] *See, e.g.*, Mutual of Enumclaw Ins. Co. v. USF Ins. Co., 191 P.3d 866 (Wash. 2008); Kajima Const. Services, Inc. v. St. Paul Fire and Marine Ins. Co., 879 N.E.2d 305 (Ill. 2007); John Burns Const. Co. v. Indiana Ins. Co., 727 N.E.2d 211 (Ill. 2000); Cas. Indem. Exch. Ins. Co. v. Liberty Nat'l Fire Ins. Co., 902 F.Supp. 1235 (D. Mont. 1995).

[17] Mutual of Enumclaw Ins. Co. v. USF Ins. Co., 191 P.3d 866, 873 (Wash. 2008).

[18] Cas. Indem. Exch. Ins. Co. v. Liberty Nat'l Fire Ins. Co., 902 F.Supp. 1235, 1239 (D. Mont. 1995) ("The right of an insurer to contribution from a coinsurer exists when both insurers are liable for the loss; a situation which can only arise when the obligations of both insurers under their respective policies are 'triggered'. Otherwise, if the doctrine of equitable contribution were applied to a coinsurer for a claim never tendered by the insured to that coinsurer, the insurance policy becomes, in effect, a third-party beneficiary contract entered into by the insured for the direct benefit of other carriers.").

[19] Kajima Const. Services, Inc. v. St. Paul Fire and Marine Ins. Co., 879 N.E.2d 305, 313 (Ill. 2007).

[20] Texas Employers Ins. Ass'n v. Underwriting Members of Lloyds, 836 F.Supp. 398, 404 (S.D. Tex. 1993) (quoting 14 COUCH ON INSURANCE 2 ND § 51:36, at 446 and citing numerous cases).

[21] Keck, Mahin and Cate v. Nat'l Union Fire Ins. Co., 20 S.W.3d 692, 700–01 (Tex. 2000).

[22] *But see* Am. Fidelity Ins. Co. v. Emp. Mut. Cas. Co., 593 F.2d 14, 25–26 (Kan. 1979) ("Where the claim is over the limits of the primary policy and only one insurer undertakes the defense, the primary insurer and the excess insurer will each be liable for a pro rata share of the costs of defense in proportion to the amount of the claim each is required to pay.").

[23] Coastal Iron Works, Inc. v. Petty Ray Geophysical, 783 F.2d 577 (5th Cir. 1986)(Texas law) (primary and excess both had defense obligations, which neither performed, and after resolution of underlying case court ordered that primary and excess were required to share in both defense and indemnity costs).

[24] Aerojet—Gen'l Corp. v. Transport Indem. Co., 17 Cal. 4th 38, 72 (Cal. 1997) (citations and footnote omitted).

[25] Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1225 (6th Cir. 1980).

[26] *See, e.g.*, USF&G v. SocoWest, Inc., 2010 US Dist. LEXIS 110680 (D. Mont.); Continental Cas. Co. v. Rapid-American Co., 581 N.Y.S. 2d 669 (App. Div. 1992), *aff'd*, 609 N.E. 2d 506 (NY 1993); Puget Sound Power & Light Co. v. Great Am. Ins. Co., 51 F.3d 282 (9th Cir. 1995), *reported in full*, 1995 U.S. App. LEXIS 7787; Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981).

[27] Keene Corp. v. Ins. Co. of North America, 667 F.2d 1034, 1048–49 (D.C.Cir.1981), cert. denied, 455 U.S. 1007, 102 S.Ct. 1644, 71 L.Ed.2d 875 (1982).

[28] Aerojet—Gen'l Corp. v. Transport Indem. *Co.*, 17 Cal. 4th 38, 73 n. 22 (Cal. 1997).

[29] Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1203–04 (2d Cir. 1995) (noting that "judges who have endorsed proration-to-the-insured have done so only to oblige a manufacturer to accept a proportionate share of a risk that it elected to assume, either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount of insurance" and declining to prorate to the insured years during which pollution insurance was unavailable due to the absolute pollution exclusion).

[30] Aerojet—Gen'l Corp. v. Transport Indem. Co., 17 Cal. 4th 38, 75–76 (Cal. 1997).

[31] *See, e.g.*, Employers Ins. Co. of Wausau v. Travelers Indem. Co., 141 Cal. App. 4th 398 (Cal. App. 1st Dist. 2006); Sharon Steel Corp. v. Aetna Cas. & Sur. Co., 931 P. 2d 127 (Utah 1997).

[32] Employers Ins. Co. of Wausau v. Travelers Indem. Co., 141 Cal. App. 4th 398, 403–04 (Cal. App. 1st Dist. 2006) (quoting Fireman's Fund Ins. Co. v. Maryland Casualty Co. 65 Cal. App. 4th 1279, 1293 (1998)).

[33] Sharon Steel Corp. v. Aetna Cas. & Sur. Co., 931 P. 2d 127, 138 (Utah 1997) ("We agree with those jurisdictions that have allowed contribution where one insurer has paid more than its fair share of defense costs. . . . Holding otherwise would not only lead to an inequitable result but may also conflict with our stated policy of encouraging prompt payments to the insured, leaving disputes concerning coverage to be determined later").

[34] *See, e.g.*, Sloan Constr. Co. v. Central Nat'l Ins. Co., 236 S.E. 2d 818, 186–87 (S.C. 1977).

[35] *See* Am. & Foreign Ins. Co. v. Jerry's Sport Center, Inc., 2 A. 3d 526 (Pa. 2010) ("[Insurer] invokes the remedy of restitution based on the equitable theory of unjust enrichment to claim a right to be reimbursed.").

[36] St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 337 F. Supp 2d 719, 723 (D. Minn. 2005, *aff'd*, 457 F.3d 766 (8th Cir. 2006).

[37] United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914, 920 (6th Cir. 2002).

[38] Buss v. Superior Court, 16 Cal. 4th 35, 50–51 (Cal. 1997).

[39] *See, e.g.*, Travelers Cas & Sur. Co. v. Ribi Immunochem Research, Inc., 108 P.3d 469, 479–80 (Mont. 2005).

[40] Am. & Foreign Ins. Co. v. Jerry's Sport Center, Inc., 2 A. 3d 526, 542 n14 (Pa. 2010) ("Under the plain language of the contract, therefore, it was obligated to pay for the expenses it incurred in connection with the defense, an obligation that would be eviscerated if Insured had to reimburse Royal. *See* Elbert & Nardoni, *Buss Stop*, 13 Conn. Ins. L.J. 61, 95–96 (2006), ("[C]ontrary to what a reader may conclude from reviewing cases on both sides of the question, standard liability policies are not silent about allocation or recoupment. They expressly disclaim it.")".).

[41] Perdue Farms, Inc. v. Travelers Casualty & Surety Co. of America, 448 F.3d 252, 258 (4th Cir. 2006) (Maryland law).

[42] General Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co., 828 N.E. 2d 1092, 1102 (Ill. 2005).

[43] General Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co., 828 N.E. 2d 1092, 1103 (Ill. 2005).

[44] Am. & Foreign Ins. Co. v. Jerry's Sport Center, Inc., 2 A. 3d 526, 538 (Pa. 2010) (noting that "a growing number of courts [ ] have refused to follow the reasoning in *Buss*, and have not permitted an insurer to obtain reimbursement of defense costs fro non-covered claims"). *See also, e.g.*, Excess Underwriters at Lloyd's v. Frank's Casing Crew and Rental Tools, 246 S.W.3d 42 (Tex. 2008); Medical Liability Mutual Ins. Co. v. Alan Curtis Enterprises, Inc., 373 Ark. 525 (2008); Blue Cross of Idaho Health Service, Inc. v. Atlantic Mut. Ins. Co., 734 F.Supp.2d 1107, (D.Id. 2010); Elbert & Nardoni, *Buss Stop*, 13 Conn. Ins. L.J. 61 (2006).

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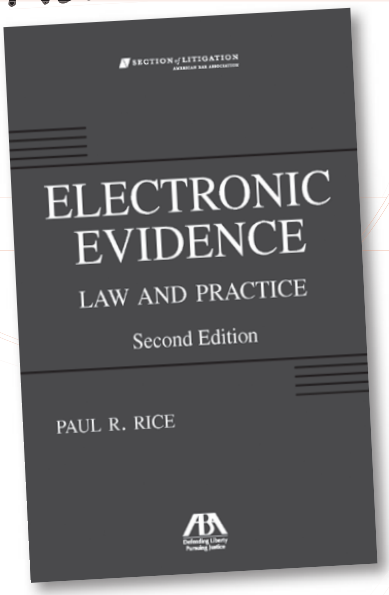

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