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September 12, 2005

Passing Thoughts on the Vanishing Trial

by Julia A. Molander, Vice-Chair, DRI Insurance Law Committee

During that same time period, the federal limit for diversity jurisdiction has risen several times, to its present requirement of \$75,000 in controversy. The increase in the amount required for federal court could be a possible explanation for a decrease in federal trials, if it were true that state court trials were increasing. However, state court trials are dropping at a similar rate. This means that the cases not tried in federal court are not being tried in state court either.

Why are trials rapidly becoming an artifact of the past? An increase of criminal prosecutions is thought to be a factor, but the statistical evidence shows that criminal trials have decreased too. The rising cost of going to trial is often proffered as an explanation. This certainly is a strong reason for avoiding trial; however, the cost of arbitration ultimately can exceed that of trial. A corollary argument is that trials involve discovery and discovery is expensive. However, even cases that go to ADR typically involve some level of discovery.

Another reason cited for fewer civil trials is the runaway jury verdict and the adverse publicity associated with it. The Vioxx verdict, though, is anomalous. The Department of Justice reports that the median jury verdict decreased from 1992 to 2001, from \$65,000 to \$37,000. That same study also shows that the percentage of trials resulting in a punitive award has similarly declined.

The most likely explanation for the decline in tort trials is the corresponding rise in the use of alternative dispute resolution. Non-judicial ADR was virtually unknown in 1970, with the notable exception of traditional labor mediations. Twenty-five years later it has overtaken judicial resolution as the method of disposition of the majority of cases. Today, courts expect cases to settle extra-judicially, and may impose hefty sanctions if they do not.

Why should we care about the vanishing trial? Three reasons. First, we are rapidly losing trial experience, with a full generation of attorneys having practiced in the ADR era. If our lawyers and our judges no longer try cases, they will not perform well on those rare occasions when a case goes to trial. Second, if we do not have trials, we no longer have a way to gauge the jury verdict potential for purposes of settlement or trial. Third, and perhaps most important, we are limiting the development of our system of law. If significant cases are siphoned out of our judicial system, we will lack the cases upon which to build the common law.

What can we do to keep the trial from vanishing? We can support efforts, such as that of DRI, to provide lawyers with hands-on training in trial-like settings. We can choose to try the hard cases, knowing that some of the verdicts may not be ones we like but that the overall average will be positive. We can resist efforts by individual courts to treat every lawsuit as if it must settle. Above all, we can continue to advocate for the value of our judicial system and the rule of law.

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The views expressed herein are solely those of the author, and do not represent the opinions of DRI nor of the law firm of Sedgwick, Detert, Moran & Arnold.

September 12, 2005

Interpretation and Enforcement of the Policy Exclusion for Mold Claims

Nationally, the number of mold claims made on homeowner and commercial insurance policies has increased dramatically over the last few years. Insurance companies in most states are now permitted to exclude mold coverage from new policies as well as existing policies. There are hundreds of pending cases against homeowner's insurance carriers seeking coverage for losses incurred as a result of mold contamination. In many of these homeowner's policies, damage "caused by" mold contamination is expressly excluded from coverage. In the face of this exclusion, homeowners often take the position that their claimed damages were not "caused by" mold, but rather that the damage was caused by some form of water intrusion which resulted in mold contamination, or some

other covered peril, and therefore the loss is covered. Carriers, on the other hand, often assert that the exclusion does apply to any claimed damages concerning mold, arguing either that the damage itself was caused by mold or some other excluded cause or event.

There is currently a split of authority among the state courts that have faced this issue. Some courts have held that the “caused by” exclusion does apply to all mold damage, while other courts have found an ambiguity in the exclusion and therefore a material issue of fact regarding coverage, thus precluding summary judgment for the insurance carrier. To date, no state supreme court has ruled on this issue. However, in December of last year, the Fifth Circuit Court of Appeals, in a case entitled *Fiess v. State Farm Lloyds*, certified a question to the Texas State Supreme Court related to this issue. The Texas Supreme Court recently agreed to consider the issue. This article will examine the current state of the law on this issue, with an initial focus on the *Fiess* case.

The ISO Form and Interpreting Insurance Policies

The most recent Insurance Services Office, Inc. (“ISO”) standardized coverage forms, which are used by many insurers in their homeowner policies, contain the following form exclusion regarding mold: “We will not pay for loss or damage caused directly or indirectly by [mold]. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss. But if [mold] results in a Covered Cause of Loss, we will pay for the loss or damage caused by that Covered Cause of Loss.” Many homeowner policies use this or very similar language in their mold exclusions, and courts across the country have reached different conclusions regarding its meaning and applicability.

Before beginning a discussion of the cases interpreting this type of mold exclusion, a few words should be said about the interpretation of insurance policies generally. When interpreting an insurance policy, the basic rule is to determine the intention of the parties from the language of the policy, giving effect to all parts so as to give a reasonable meaning to the terms. When the terms of the policy are clear and unambiguous, the court will often enforce the policy as it is written. However, where an ambiguity exists, it is usually resolved against the insurer. If the controlling language of the policy will support two meanings, one favorable to the insurer and one favorable to the insured, the interpretation supporting coverage will be applied. In this regard, coverage clauses are often interpreted liberally, whereas those of exclusion are strictly construed.

The *Fiess* Case

Fiess v. State Farm Lloyds, 2004 WL 2801796 (5th Cir. Dec. 7, 2004), is an important case because it will be the first time that a state supreme court has ruled on an issue related to the meaning and applicability of the standard ISO mold exclusion contained in many homeowner’s policies.

In *Fiess*, plaintiffs sustained flooding and related damage to their home and filed a claim with their insurer under their flood insurance policy. *Id.* at *1. The insurer paid them \$48,626 under the policy for home repairs and replacement of flood-damaged personal property. *Id.* One week after the flood, plaintiffs discovered black mold growing throughout the residence and were advised to leave their residence. *Id.* After discovering the mold, plaintiffs filed a claim for mold contamination. *Id.* at *2. Their insurer paid plaintiffs \$34,425 for non-covered mold remediation in those areas of the home where there was evidence of pre-flood water leaks, but, according to the complaint, did not compensate plaintiffs for damage “caused by” the mold. *Id.*

The insurance policy stated: “We do not cover loss *caused by*: ... rust, rot, mold or other fungi.... We do cover ensuing loss caused by collapse of building or any part of the building, water damage ... if the loss would otherwise be covered under this policy.” *Id.* (emphasis added)

The Federal District Court held that summary judgment was warranted on all of plaintiffs’ claims, finding that the

plain language of the policy excluded from coverage any loss resulting from mold. *Id.* The District Court rejected plaintiffs' argument that the mold was caused by water damage stemming from the leaks in the home and, therefore, covered by the ensuing loss clause. *Id.* The District Court noted that the leaking water could have contributed to the mold growth and caused damage to the property, but the mold did not cause the intrusion of water into the home and the ensuing loss. *Id.* The District Court also held that plaintiffs could not satisfy the doctrine of concurrent causation where they were unable to provide sufficient evidence to distinguish between mold caused by the flood and mold caused by non-flood-related events. *Id.*

The Fifth Circuit held that plaintiffs failed to appeal the District Court's ruling rejecting their contention that coverage should be extended to all mold contamination in their house caused by water intrusion, and therefore the Fifth Circuit lacked jurisdiction to address that issue. *Id.* at *3. The Fifth Circuit reversed the District Court's ruling with respect to the doctrine of concurrent causation, finding that plaintiffs presented some evidence that would allow a finder of fact to segregate those losses potentially covered under the policy (e.g., leaking pipes) from those that are excluded (e.g., water from a flood). *Id.* at *4.

With respect to the ensuing loss provision of the policy, the Fifth Circuit found that some courts in Texas have interpreted an ensuing loss provision as an exception to the exclusion for mold. *Id.* at *6. Under this interpretation, mold contamination that results or ensues from a covered water damage event is covered under the policy notwithstanding the exclusionary language specifically denying coverage for mold. *Id.* However, if mold contamination results from a water event that is not covered under the policy, coverage must be denied under the general mold exclusion. *Id.* Other courts in Texas have reached a different conclusion regarding the interpretation of the ensuing loss provision. *Id.* Those cases do not interpret the ensuing loss provision as an exception to the mold exclusion. *Id.* Rather, they interpret the provision as a type of "savings clause" intended to safeguard otherwise covered losses from an overly expansive construction of the policy exclusions. *Id.* These cases read the "ensuing loss" provision as requiring a preceding cause, a proximate cause, and an ensuing loss. *Id.* For purposes of the issue addressed in this article, the preceding cause must be mold, while the proximate cause must be a covered damage listed in the ensuing loss provision, and the loss must occur as a result of the proximate cause. *Id.*

Noting that courts have offered conflicting opinions regarding application of the ensuing loss provision to the mold exclusion contained in Texas homeowners insurance policies, the Court of Appeals certified the coverage question pertaining to the ensuing loss provision to the Texas Supreme Court. *Id.* at *5-6. The Texas Supreme Court is expected to rule in that case within the next few months.

Split of Authority among Some State Courts

While the *Feiss* case will be an important decision from the Texas Supreme Court with respect to the interpretation of an ensuing loss provision concerning mold damage, other courts across the country continue to wrestle with the meaning and interpretation of the causation exclusion in homeowner's policies as it relate to mold damage.

For instance, in *Liristis v. American Family Mutual Insurance Co.*, 61 P.3d 22 (Ariz. Ct. App. 2002), plaintiffs had a fire in their home resulting in fire damage and also water damage, because of the water used to suppress the fire. A contractor performed repairs, and plaintiff's insurer paid plaintiffs for claims related to that fire. *Id.* at 23. Plaintiffs claimed they noticed mold growth in the home within a month or two after the fire. *Id.* Upon moving back into the home, plaintiffs claimed they suffered from allergic reactions and respiratory and other unexplained illnesses. *Id.* Plaintiffs retained an expert to perform an environmental assessment of their home and their expert confirmed the presence of mold growth in the home and recommended immediate biological remediation to the home. *Id.* at 24. Plaintiffs made a claim for contamination caused by the mold. *Id.* Their insurer denied the claim based on a policy exclusion for mold. *Id.* Plaintiffs filed a complaint alleging breach of contract, bad faith and unfair insurance trade practices. *Id.* Both parties moved for summary judgment on the issue of coverage. *Id.* The trial court concluded that there was no coverage for the mold damage, denied plaintiffs' motion, and granted summary judgment in favor of the insurer. *Id.*

The policy at issue stated: "We cover risks of accidental direct physical loss to property ... unless the loss is excluded in this policy. We do not cover loss to the property ... resulting directly or indirectly from or caused by one or more of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss. Other Causes of Loss ... mold" *Id.*

The insurer contended that mold damage was excluded under the losses-not-covered provisions because the policy did “not cover loss to the property ... resulting directly or indirectly from or caused by [mold].” *Id.* In response, plaintiffs argued that the loss to the property was not caused by mold; rather, the loss was mold, and thus the losses-not-covered provisions did not apply. *Id.* The court stated that when a covered event, like water or fire damages, causes mold, the resulting mold damage is covered, including the cost of removal. *Id.* The court further held that if the insurer intended to exclude not only losses caused by mold but also mold itself, it could have expressed that intention by adding the words “either consisting of, or ...” to its exclusionary language, then loss “consisting of” mold as well as loss caused by mold would have been excluded. *Id.* Thus, the appellate court reversed the dismissal of plaintiffs’ claims, finding a material issue of fact that precluded summary judgment for the insurer. *Id.* at 26.

Similarly, in *Vvalther v. American Family Insurance Co.*, 673 N.W.2d 412 (Wis. Ct. App. 2004) (unpublished disposition), the trial court granted the insurer’s motion for summary judgment and dismissed plaintiff’s claim for insurance coverage for mold remediation and living expenses during the repair of her home.

The policy at issue stated: “We do not cover loss to the property described in Coverage A - Dwelling and Dwelling Extension resulting directly or indirectly from or caused by one or more of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss ... Other Causes of Loss ... mold.” *Id.*

Plaintiff contended that this language excluded losses caused by mold, but not mold itself. *Id.* Citing the *Liristis* case, which involved the same insurer and similar policy language, the court in *Vvalther* concluded that the construction of that language was “fairly debatable” and therefore there was an issue of fact regarding whether the policy covered only mold damage, but not loss caused by mold. *Id.*

In *Kemmerer v. State Farm Insurance Co.*, 2004 WL 87017 (E.D. Pa. Jan. 19, 2004), the court dismissed plaintiff’s claims because she failed to provide adequate expert evidence regarding the cause of the claimed mold damage. Plaintiff sought damages for destruction to personal property from a mold infestation caused by a leaking toilet. *Id.* at *2. Plaintiff’s homeowner’s policy provided coverage for “physical loss to personal property by certain specified perils, including sudden and accidental discharge or overflow of water or steam from within a plumbing, heating, air conditioning or automatic fire protective sprinkler system, or from within a household appliance.” *Id.*

The insurer moved for summary judgment, arguing that without an expert report to establish the cause of the infestation, plaintiff had not satisfactorily established a genuine issue of material fact for trial. *Id.* at *2. The *Kemmerer* court found that the case presented an element of complex causation requiring expert evidence. *Id.* Plaintiff’s failure to provide such expert evidence required dismissal of her claim, because plaintiff did not adequately establish that a numerated specified peril under the policy caused the mold infestation and resulting property damage. *Id.* at *3.

In *Simonetti v. Selective Insurance Co.*, 859 A.2d 694 (N.J. Super. Ct. App. Div. 2004), the court addressed two issues: 1) whether mold was a “loss” and therefore covered, or was a “cause of loss” and therefore excluded by the express terms of the homeowner’s insurance policy; and 2) whether the mold and other damage to the insured’s home was caused by a covered peril, *i.e.*, a torrential rainstorm, or by one or more excluded causes, *i.e.*, faulty design, workmanship or maintenance.

The lower court granted summary judgment in favor of the insurer, finding no coverage under the policy for the mold contamination and other damage to the insured’s home allegedly caused by water damage. *Id.* at 697. The appellate court reversed, holding that while the policy is read to cover mold caused by a covered peril, there was a question of fact regarding causation, and ultimately coverage, under the policy that must be decided by the fact finder. *Id.* at 698–99. The court stated that mold can be both a “loss” and a “cause of loss,” and that if the insured proves the mold resulted from a covered event, *i.e.*, water damage, then the cost of removing the mold is within the policy’s coverage. *Id.* at 699. The court further held that, in the absence of an express anticoncurrent or antisequential clause in the exclusions section of the policy, where both included and excluded causes contribute to a single property loss, coverage is not necessarily barred and it is for the fact finder to determine which part of the damage was due to the included cause of loss and for which the insured can recover. *Id.* at 699–700.

In reaching its conclusion that mold can be both a loss and a cause of loss, the court relied on the language of the policy, which stated: “[w]e do not insure, however, for loss caused by ... mold....” *Id.* at 699. This language, which is very similar to the language to the policy language in the *Liristis* and *Vvalther* cases, clearly focuses on “cause” of the loss, conveying an intent to exclude mold as a cause of loss. But mold that is the loss is not mentioned. *Id.* The *Simonetti* court held that if the insurer had intended to exclude not only losses caused by mold, but also mold itself, it could have easily expressed that intention. *Id.*

Consequently, the next issue the *Simonetti* court addressed was whether the mold and other damage claimed by plaintiffs were caused by a covered peril or a covered cause of loss. *Id.* Plaintiffs claimed the damage was a direct physical loss from a rainstorm and consequent water intrusion. *Id.* The insurer countered that the damage resulted from one or more excluded causes, or was actually previous damage from prior leaks. *Id.* Because a question of fact was presented as to whether some or all of the damage, including mold, was caused by the rainstorm, the appellate held that summary judgment for the insurer was inappropriate. *Id.*

The *Simonetti* court stated that the fact that two or more identifiable causes -- one a covered event and one excluded—may contribute to a single property loss does not necessarily bar coverage. *Id.* at 699–700. The insurer’s policy did not contain an anticoncurrent or antisequential clause in the exclusion dealing with faulty design, workmanship and maintenance, which would exclude coverage when a prescribed excluded peril, alongside a covered peril, either simultaneously or sequentially, causes damage to the insured. *Id.* at 700. Significantly, however, the policy did include such a clause in the exclusion for earth movement, evidencing a clear intent to bar coverage in the latter, but not the former. *Id.*

Moreover, the *Simonetti* court held that even where included and excluded causes occur concurrently, “it is for the fact finder to determine which part of the damage was due to the included cause of loss and for which the insured can recover.” *Id.* With regard to sequential causes of loss, the courts in New Jersey have determined that an insured deserves coverage where the included cause of loss is either the first or last step in the chain of causation that leads to the loss. *Id.* Ultimately, the *Simonetti* court found that there was a factual question as to the actual cause of the damage to plaintiffs’ home, namely whether they sustained a direct physical loss proximately caused by the unusual severity of a rainstorm, and stated that “issues of causation are for the jury to resolve.” *Id.*

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Broader Exclusionary Language

When insurers use broader language in the mold exclusion in their homeowner policies, to exclude more than just damage “caused directly or indirectly by” mold, courts are more willing to grant them summary judgment regarding coverage for any claims of mold damage.

For instance in *Hayley v. Allstate Insurance Company*, 686 N.W.2d 273 (Mich. Ct. App. 2004), plaintiffs brought an action against their insurer to recover for loss from mold caused by water backup from ice dam. The trial court denied the insurer’s motion for summary judgment, and the appellate court reversed and dismissed plaintiff’s case. The difference between *Haley* and cases like *Simonetti* and *Liristis*, turns on the breadth of the language of the mold exclusion. In *Haley*, the exclusion stated: “we do not cover loss *consisting of or caused by* ... mold ... [and] we do not cover loss to covered property ... when: a) there are two or more causes of loss to the covered property; and b) the predominant cause(s) of loss is (are) excluded” *Id.* at 276. (emphasis added) Based on the language of the exclusion, the *Haley* court found that the policy excluded both losses caused by mold and losses consisting of mold damage. *Id.*

Similarly in *Alea London Limited v. Rudley*, 2004 WL 1563002 (E.D. Pa. July 13, 2004), defendant insured alleged that a water leak caused mold contamination to an individual who subsequently started living with the insured and contaminated the insured’s home with mold. The policy at issue stated that it did not apply “any loss or damage involving in any way the actual or potential presence of mold ... whether or not directly or indirectly caused by or resulting from any peril insured under this Policy.” *Id.* at *2. The court, applying Pennsylvania law, concluded that based on the breadth of the language in the exclusion the insurer had no duty under the policy to defend or indemnify the insured in connection with the mold claims. *Id.*

Conclusion

The cases discussed in this article reveal that there is uncertainty for insurance companies with respect to the interpretation by courts of the mold exclusions contained in their policies. Policies with exclusion language based on the standard ISO form may have a difficult time obtaining summary judgment with respect to a claim of mold damage if the plaintiff can raise an issue of fact regarding the cause of the alleged damage. To ensure more predictability regarding the interpretation of such an exclusion, insurance companies may wish to consider using language in their mold exclusions similar to the language used in the *Hayley* and *Rudley* cases.

This issue of certainty in the interpretation of mold exclusions is of particular importance to defense counsel for insurance companies because in response to the huge rise in mold claims over the last several years, carriers began inserting mold exclusions in their homeowner's policies to avoid coverage for mold claims, and they did so with the expectation that any coverage would be quickly disposed of in their favor. As is often the case, the courts have expressed a different view, which has created uncertainty for insurance companies from a financial standpoint. At this stage, revisiting and possibly amending the language in these policy exclusions may make sense, as the number of mold claims continues to rise.

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September 12, 2005

What Insurers Can Do to Secure Reasonable Rates from Conflict Counsel

Containing defense costs begins by establishing a reasonable rate for the legal services to be provided by defense counsel. Even in situations where a liability insurer does not have an unrestricted right to select defense counsel or control how the case is defended, the insurer is not powerless to secure reasonable rates from the defense attorneys. This article describes what liability insurers can do to obtain reasonable rates when the selection of conflict counsel does not depend entirely upon the choice of the insurer. As discussed, *infra*, some states have enacted statutes that provide a framework for challenging the reasonableness of fees submitted by independent or conflict counsel. See Cal. Civ. Code §2860 (2001).

How the Right to Select Defense Counsel Affects the Rate Question

One of the basic obligations under general liability policies is the duty to defend the insured for potentially covered suits. The insurer's obligation to defend potentially covered claims is generally accompanied by the contractual right to select defense counsel. However, when a suit against an insured does not fall clearly and certainly within the insuring agreements of the policy, a liability insurer may reserve its right to deny coverage. A conflict of interest between the insurer and its insured can arise when a reservation of rights is asserted. When a conflict does exist, it eliminates or at least limits the insurer's right to select defense counsel.

Depending upon the laws of the particular jurisdiction, a liability insurer finding itself in such a conflict situation may have little or no control over the selection of defense counsel. When a conflict of interest exists, the insurer typically is not allowed to control the defense of the insured, but must discharge its duty to defend by reimbursing the insured for the reasonable costs of the defense. This includes the "reasonable fees" incurred by defense attorneys selected by the insured.

The practical problem is that in circumstances where a conflict of interest deprives an insurer of the right to select defense counsel, the insurer's ability to negotiate fair rates with the lawyers is greatly diminished. Yet, even when the insurer has no say in the selection of counsel, the "reasonable fee" standard represents a significant limitation on the defense costs that conflict counsel can demand of the insurer.

Conflicts of Interest and the Right to Choose Defense Counsel

In circumstances where a conflict of interest exists, state law determines the extent to which the insurer may participate in the selection of defense counsel. This is pivotal with respect to an insurer's efforts to secure a fair and reasonable rate from defense counsel, because the more control the insurer retains over the selection of defense counsel, the better able the insurer will be to negotiate rates with the attorneys who seek the assignment. Thus, the conflict rules of the governing jurisdiction largely define how much leverage an insurer will have to determine the rates that can be charged by conflict counsel.

Some jurisdictions grant the *insured* sole discretion in the selection of conflict counsel, without any consideration for the insurer's preferences. Insureds in several states enjoy relatively unfettered discretion in assigning independent defense counsel to represent them in conflict situations, including: Arkansas: *Northland Ins. Co. v. Heck's Service Co.*, 620 F. Supp. 107 (D. Ark. 1985); Illinois: *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976); New York: *Nelson Electrical Contracting Corp. v. Transcontinental Ins. Co.*, 660 N.Y.S.2d 220 (3d Dep't 1997); Mississippi: *Moeller v. Amer. Guar. And Liability Ins. Co.*, 707 So.2d 1062 (Miss. 1986); Louisiana: *Belangerr v. Gabriel Chemicals, Inc.*, 787 So.2d 559 (La. Ct. App. 2001); New Jersey: *Merchants Indem. Corp. v. Eggleston*, 179 A.2d 505 (N.J. 1962); Maryland: *Roossos v. Allstate Ins. Co.*, 655 A.2d 40 (Md. App. 1995); Utah: *Lima v. Chambers*, 657 P.2d 279 (Utah 1988). Courts in these jurisdictions preclude an insurer from having any role in the selection of counsel to ensure that the insurer exerts no influence on the way the defense is conducted in the underlying litigation. However, even in these jurisdictions, the insured is required to exercise good faith and act reasonably when selecting its defense counsel, which includes the retention of counsel who use ethical billing practices and are competent to represent the insured's interests in the litigation. *Center Foundation v. Chicago Ins. Co.*, 278 Cal. Rptr. 13 (Ct. App. 1991).

At the opposite end of the spectrum, some jurisdictions allow the *insurer* to select conflict counsel when a conflict exists. However, these courts typically impose special requirements on insurers to prevent abuse of this right to select defense counsel. For example, the insurer selecting the counsel may be precluded from raising collateral estoppel against the insured concerning coverage issues remaining after the resolution of the underlying action; the insurer may be required to select counsel for the insured who are not the insurer's usual "panel counsel;" and the insurer may have a heightened obligation to report to the insured of the progress and status of the defense, including settlement demands and other issues. See, e.g., *Tank v. State Farm Fire & Cas. Co.*, 715 P.2d 1133 (Wash.) (providing these and other requirements on the insurer); *Twin City Fire Ins. Co. v. Colonial Life & Ass.*, 839 So.2d 614 (Ala. 2002); *Federal Ins. Co. v. X-Rite, Inc.*, 748 F. Supp. 1223 (E.D. Mich. 1990).

Other jurisdictions permit the insurer and insured to *share* in the selection of conflict counsel. See *Employers Fire Ins. Co. v. Beals*, 240 A.2d 397 (R.I. 1968) (insurer provided with the right to approve the insured's selected independent counsel). By allowing the insurer a voice in the selection of the independent counsel, these jurisdictions attempt to minimize the abuses that may occur when an insured is given sole discretion to select its own counsel. Some jurisdictions define the insurer's and insured's respective roles in the selection of counsel through statutory guidelines. Cal. Civ. Code §2680 (2001); Fla. St. §627.426 (2000); Alas. St. §21.89.100 (1999). These statutes typically provide objective descriptions of the insured's and insurer's respective roles in the selection of conflict counsel. Cal. Civ. Code §2860 provides that an insurer has the right to require the counsel selected by the insured to have at least four years of experience; Fla. St. §627.426 provides that in a conflict situation, the insurer is entitled to retain independent counsel which is mutually agreeable to both the insurer and the insured; and Alaska St. §21.89.100 provides that if the insured selects counsel, the insurer may require the defense counsel to have 4 or more years experience. Courts in these jurisdictions have recognized that insurers have a legitimate interest in controlling the total costs of the litigation, so they require that the insured's selection of conflict counsel must be approved by the insurer, provided that approval is not unreasonably withheld. See *Beals, supra.*; see also *Hartford Ins. Co. v. A&M Associates, Ltd.*, 200 F. Supp. 2d 84 (D. R.I. 2000).

Determining a fair and reasonable rate for conflict counsel can be resolved through arm's length negotiations, to the extent that the insurer is permitted to select or provide input into the selection of conflict counsel. However, when an insurer is excluded from participation in that selection process, the question of a reasonable rate becomes much more difficult to resolve. Consequently, securing a reasonable rate from conflict counsel is intrinsically more difficult in some jurisdictions than it is in others.

Legal Standards Defining the Duty to Defend

Regardless of who selects the defense attorney, an insurer is responsible for reimbursing only the *reasonable* attorneys' fees and costs that are actually incurred in the underlying defense. *First Jefferson Associates v. Ins. Co. of N. America*, 691 N.Y.S.2d 506 (1st Dep't 1999); *Chicago Title Ins. Co. v. F.D.I.C.*, 172 F.3d 601 (8th Cir. 1999) (interpreting Minnesota law and recognizing a duty to reimburse reasonable fees); *Aetna Cas. & Sur. Co. v. Dow Chemical Co.*, 44 F. Supp.2d 847 (E.D. Mich. 1997); *Chatterson v. Walker*, 938 P.2d 255 (Utah 1997); *Nisson v. Amer. Home Assur. Co.*, 917 P.2d 488 (Okla. Civ. App. 1996); *Northern Ins. Co. of N.Y. v. Allied Mut. Ins. Co.*, 955 F.2d 1353 (9th Cir. 1992); *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976). This is a substantive standard of limitation on the rates that conflict counsel can charge and on the rates that the insurer may be expected to pay. This standard binds insurers, the defense attorneys who seek payment from the insurers, and the insureds who have selected the defense attorneys. The "reasonable fee" standard arises from state insurance law, and it is also a central tenet of the rules of professional responsibility that bind defense lawyers throughout the country. On one side of the coin, state insurance law principles provide that an insurer is not required to pay rates in excess of what is reasonable; on the other side of the coin, the rules of professional

responsibility prohibit an attorney from attempting to charge and collect more than a reasonable fee.

A related rule is that an attorney may not unilaterally raise his or her rates during the course of litigation. See, e.g., *Perez v. Pappas*, 659 P.2d 475 (Wash. 1983) (modified fee agreement to increase attorney's compensation during course of representation is unenforceable unless attorney demonstrates new consideration to support the increase). This rule of professional responsibility is based on the concern that a lawyer seeking a rate increase in the midst of litigation would have an unfair advantage over the client in negotiating a rate increase, inasmuch as it may be difficult and expensive for a litigant to change defense counsel during the course of litigation.

Because disputes often arise concerning what constitutes a reasonable rate for a given case, the burden of proof can be critical. Ordinarily, insurers do not have the burden of proof on the reasonable rate issue. Under state insurance laws, the insured has the initial burden of establishing the reasonableness of the fee for which reimbursement is sought, as the insurer's obligation to reimburse incurred defense costs is limited and defined by the reasonable fee. *International Ins. Co. v. City of Chicago Heights*, 643 N.E.2d 1305 (Ill. Ct. App. 1994) (initial burden of demonstrating reasonableness of fees is on the party seeking recovery of the fees). As explained in *City of Chicago Heights*, the burden shifts if the party seeking reimbursement shows: 1) the services performed; 2) who performed each service; 3) the time spent; and 4) the hourly rate. See also *Curtis v. Nutmeg Ins. Co.*, 681 N.Y.S.2d 620 (3d Dep't 1998) (burden is on the insured to demonstrate reasonableness of the fees); *Benoit v. Fuselier*, 195 So.2d 679-83 (La. Ct. App. 1967) (same). Under the rules of professional responsibility, the burden of establishing the reasonableness of the fee rests upon the attorneys who charge the fee. Rule 1.5 of the ABA Model Rules for Professional Conduct provides that "a lawyer's fee must be reasonable." The ABA Formal Opinion 1993-379 explains that it is the attorney's responsibility to explain any changes to the client and convey the content of the legal invoice in a meaningful manner.

How to Determine a Reasonable Rate

The "reasonable fee" standard is a flexible standard. Because the standard is flexible, it is often misunderstood as a subjective measure lacking substance and vitality. To the contrary, the "reasonable fee" standard is actually a composite of several discrete objective criteria. It is a flexible standard, because it requires analysis of several factors that vary with the circumstances of each particular case. However, the criteria of the standard themselves are clear and objective.

A check list of the criteria relevant to determining a reasonable rate for conflict counsel include the following:

- the experience, reputation and ability of the particular defense attorneys;
- the undesirability of the case;
- the hourly rates of other attorneys doing similar work in the same or a comparable venue;
- the nature and length of the attorney's professional relationship with the client and rates customarily paid by that client;
- the preclusion of other employment by the attorney due to acceptance of the particular case;
- the skill required by the defense attorney to properly perform the requested legal services;
- the attorneys' customary fees charged to other clients;
- the time limitations imposed by the client or by the circumstances;
- the amount in controversy and the results obtained;
- the novelty and difficulty of the questions involved in the litigation;
- the time and labor required of the defense attorney;
- fee awards in similar cases; and

- the importance of the litigation to the client.

See *Patrick v. Head of the Lakes Cooperative Electric Association*, 295 N.W.2d 205 (Wis. Ct. App. 1980); *Baghrmain v. MFA Mutual Ins. Co.*, 315 So.2d 849 (La. Ct. App. 1975); *Ripepi v. American Insurance Companies*, 234 F. Supp. 156 (W.D. Penn. 1964).

Implementing the “Reasonable Fee” Standard

When the party who selects defense counsel is also the party who will pay for the services of the attorney, the market largely determines the reasonable rate through arm’s length negotiations. See *Vanguard Ins. Co. v. Guagenti*, 599 N.Y.S.2d 215 (N.Y. Sup.Ct. 1993) (finding the insured is entitled to select its own independent counsel to be paid only at the standard insurance defense rates). Absent a conflict of interest, if the insurer and the attorney seeking the assignment cannot agree on a rate, the insurer can simply find another attorney who shares the insurer’s views on the appropriate rate. However, in instances where local law permits the insured to select defense counsel at the insurer’s expense, this market influence is not active.

In situations in which the insured selects defense counsel but the insurer pays, the insured has virtually no interest in conserving defense expense. Instead, the insured’s interest is in getting the best defense that money can buy, because he wants to be well represented and does not have to worry about paying the defense bills. This dynamic is even more pronounced where the party who demands a defense is not a named insured on the policy issued by the insurer, but an additional insured or a defined insured who is unconcerned about whether a big defense bill might increase future policy premiums.

Unfortunately (from the insurer’s perspective), the defense attorney who is selected by the insured also has little interest in charging a conservative rate, because his or her loyalties run to the insured and he or she may have no preexisting relationship with the insurer. Conflict counsel stands to gain most by imposing an aggressive rate upon his or her client’s insurer. It is more costly for an insurer to hire conflict counsel than to retain its own panel counsel because insurers have less ability to negotiate the rates of conflict counsel.

Yet, even against this backdrop, a liability insurer with a recognized duty to defend can gain bargaining power by enforcing the “reasonable fee” standard. Under the “reasonable fee” standard, an insurer should never be at the mercy of the insured’s conflict counsel to pay whatever rate the defense attorney chooses to impose. A liability insurer’s right and duty is to pay only the reasonable costs of the defense, which means that only a reasonable rate need be paid for defense counsel. Success in this effort requires a familiarity with the applicable standards. It also requires early action on the part of the insurer to insist that the insured and defense counsel sustain their respective burdens to establish the objective reasonableness of the attorney’s rates.

As soon as the insured makes its selection of conflict counsel known, the insurer should begin the process of establishing a reasonable and acceptable rate. The first step is to make prompt and direct inquiry into the proposed rate to be charged by the insured’s chosen defense attorney. If the quoted rate appears suspect in light of the nature of the case and qualifications of defense counsel, the insurer should immediately advise the insured that the rate is being questioned. The insurer should remind the insured that under the terms of the insurance policy, the jurisdiction’s insurance law and applicable rules of professional responsibility, the insurer has no obligation to pay more than a reasonable fee. The best practice is to state this in writing, as a reservation of rights.

The second step is to ask the insured and defense counsel for information supporting the objective reasonableness of the proposed rate. Neither the insured nor the insured’s chosen counsel is entitled to impose a suspect rate or unreasonable fee upon an insurer by fiat. The insured and its counsel have the initial burden of showing the reasonableness of the rates, and, upon proper inquiry, can be required to answer appropriate questions concerning the foundation for the rates to be charged to the insurer. A general inquiry will most likely elicit a general response, which will probably be of little assistance in the insurer’s efforts to secure a reasonable rate. The better practice is for the insurer to ask the insured to identify the attorneys who are being retained for the work, and then to request the insured and defense counsel to justify the proposed rate in terms of specific criteria, including the following factors:

- The particular defense attorneys’ experience, reputation and ability. Specific request may be made for each attorney’s professional resume, jury verdict reports and a description of the attorney’s experience in handling the particular type of case at issue ;
- The rates of other attorneys for similar work in the same or comparable venues;
- The rates charged by each retained attorney to other clients for similar work in the same or comparable venues;
- The nature and length of the attorneys’ professional relationship with the client and the rate paid to the attorneys by that client in the past;
- The level of skill required by the defense attorneys to adequately perform the

requested legal services;

- Any notable time limitations imposed by the circumstances;
- The amount in controversy;
- The novelty and difficulty of the questions involved in the litigation;
- The time and labor that will be required of the defense attorneys; and
- The amount of time the proposed rate will remain in effect.

The third step depends upon the response that the insurer receives to its rate information request. If the insured and/or its chosen defense counsel respond to the information request, the insurer should evaluate the substance of the response to determine whether the provided information fairly and objectively supports the proposed defense counsel rate. If the response to the information request supports the proposed rate, the inquiry will end and the insurer should advise the insured and its counsel that there is agreement as to the proposed rates.

If the response to the rate information request does not appear to justify the proposed rate, the insurer should propose an alternative rate and provide its rationale. This process is best started by informing the insured and its chosen defense counsel of the rate that the insurer typically pays to attorneys in the ordinary course of business to defend similar actions in the same venue. Comparison of the market rate to the conflict counsel's proposed rate is one widely recognized objective measure to determine the reasonableness of the proposed rate. Cal. Civ. Code §2860 provides that "the insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended." *Id.* Additionally, several cases, outside of the insurance context, have discussed the impact of the "market rate" for the hourly rate, including *Moriarty v. Svec*, 233 F.3d 955 (7th Cir. 2000) (finding that the lawyer's regular rate is strongly presumed to be the market rate for his or her services); *Arquest Inc. v. Tracy*, 2003 WL 22012688 (N.D. Ill. 2003) (discusses elements involved in analysis of hourly rate and fees); *Glover v. Johnson*, 934 F.2d 703, 716 (6th Cir. 1991) (hourly rate can be established by proving that the rates sought are rates charged for similar services by lawyers of comparable skill, experience and reputation); *Blum v. Stenson*, 465 U.S. 886 (1984) (establishing that market rates are the appropriate basis for determining appropriate hourly rates). Under the California statute, this is the ultimate measure of the rate applicable to conflict counsel, but in most jurisdictions it is the only beginning point for the determination of an appropriate rate.

Beyond reference to the market rate, the insurer should attempt to use the information provided by the insured in response to the rate justification request as the substantive basis for negotiating an acceptable rate. Absent bargaining power in a conflict situation, an insurer's primary tool in rate negotiations is information. For every point offered by the insured and its conflict counsel in support of a proposed rate, the insurer may develop a counterpoint as grist for the negotiation. If reasonable counterpoints cannot be developed, the insurer should carefully consider whether any objective reason exists for declining to accept at the proposed rates of conflict counsel.

A more challenging situation is presented if the insured and its defense counsel fail to respond to the insurer's rate information request. The insurer should inform the insured that its failure to provide a response will be considered to be a waiver of any right to reimbursement for defense counsel fees under the insurance policy. This done, the insurer has essentially three options: 1) to abandon efforts to secure a reasonable rate and simply pay the proposed rate; 2) to pay the proposed rate under a reservation of rights, including the right to seek a refund of the amount of fees paid in excess of the reasonable rate; or 3) to file a declaratory judgment action to resolve the rate question as a component of the broader duty to defend issue. How an insurer should proceed depends upon a number of case-specific variables, including the disparity between the proposed rate and a reasonable rate, the anticipated amount of defense counsel's time and labor, the other grounds on which the insurer has reserved its rights, and the degree to which the particular jurisdiction enforces the "reasonable fee" standard.

If the insured has overreached in proposing a rate for defense counsel, the insurer's reservation of rights or filing of a declaratory judgment action on the "reasonable fee" issue may influence the insured to compromise rather than contest the issue. The primary concern of the insured should be to obtain effective assistance of defense counsel, not to enrich its defense lawyers. Thus, the insured may be interested in finding alternatives to the risk and cost associated with a prolonged dispute on the rate issue, such as selecting less expensive defense counsel, or negotiating a better rate with its chosen defense counsel, or reaching a compromise on the rate to be paid by the insurer. In the absence of some early resolution of the issue, the rate issue will remain an unwanted cost and distraction for the insured, when its primary attention is upon achieving success in the underlying litigation.

Conclusion

While the particulars differ from case to case, the important thing is for the insurer to take early steps to affirmatively assert its expectation that the rate charged by conflict counsel must be an objectively reasonable rate. If the insurer fails to clearly assert this expectation and demand, by default the determination of the applicable rate

will be left entirely to the insured and its counsel, neither of who have any interest in establishing a conservative rate. Insurers are not powerless to secure reasonable rates from conflict counsel. The duty to defend arising under public liability policies encompasses rights as well as obligations.

It is the right of a liability insurer to defend its insured under reservation, if the insurer believes there are genuine questions concerning coverage. It is also the right of a liability insurer to pay no more than a reasonable fee for the defense of its insureds. While the insurer's assertion of a reservation of rights may affect its right to select defense counsel, it does not diminish its right to demand a reasonable rate. Yet, the right to pay only a reasonable rate is not self-executing. It is a right that is lost unless asserted promptly.

Contrary to common belief, there is a lot that insurers can do to ensure reasonable rates from conflict counsel. If the insurer seeks a reasonable rate, the law is emphatically in support. All that is required is that the insurer be prepared to do what is necessary to enforce its rights.

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September 12, 2005

•Life Insurance/Death Benefits

In a case of first impression, the Alabama Supreme Court held that Ala. Code §27-14-24 protected an insurance company that paid death benefits under a forged beneficiary form. See *Fortis Benefits Ins. Co. v. Pinkley*, ___ So. 2d ___, 2005 WL 1793346 (Ala. July 29, 2005). The insurance company received a telephone call from an individual identifying himself as the insured and who provided the policy number and social security number of the insured. After a change of beneficiary form was sent to the insured's address, the insurance company received a completed change of beneficiary form that designated the insured's daughter-in-law as the primary beneficiary and the insured's wife, who had been previously listed as the primary beneficiary, as the contingent beneficiary. The insurance company mailed a copy of the stamped form to the insured's address and did not receive any objection to the change of beneficiary. The daughter-in-law filed a claim for benefits after the insured's death and the insurance company paid her. Almost two years later, the wife filed a claim for benefits and then filed suit alleging that the insurance company was guilty of negligence, wantonness, breach of contract and acted in bad faith in refusing to pay her claim.

An appeal occurred after the trial court denied the insurance company's motion for summary judgment. The Alabama Supreme Court examined Ala. Code § 27-14-24 and held that the statute barred the wife's claims against the insurance company. The Court held that the statute "expressly insulates the insurer from liability for double payment 'unless, before payment is made, the insurer has received at its home office written notice by, or on behalf of, some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.'" The Court rejected the wife's claim that the forgery of the change of beneficiary form prevented application of the statute. The Court held that the statute "does not cast upon the insurer a duty to investigate and discover whether a change of beneficiary has been procured by forgery, and that where an insurer in good faith pay life-insurance benefits upon a forged change-of-beneficiary request form, which appears regular in all respects, the insurer is fully discharged 'from all claims under the policy or contract.'"

September 12, 2005

CALIFORNIA

•Insolvencyxml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

On certified questions from the Ninth Circuit, the California Supreme Court has ruled that assets to which the Insurance Commissioner acquires title from an insolvent insurance company are not "state funds" for which the state Attorney-General can pursue civil claims under the California False Claims Act (CFCA). In *State of California v. Altus Finance*, S119046 (Cal. xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" /> August 15, 2005), the Attorney-General has challenged the Commissioner's sale of the assets of Executive Life, which was taken over in 1991, to various French investment groups that are allegedly controlled by Credit Lyonnais. The Supreme Court ruled that the Insurance Commissioner holds the insolvent insurer's assets in trust for private parties, primarily the insurer's policyholders and that they therefore do not become "state funds" within the meaning of Government Code section 12650. While holding that the CFCA did not apply since it is only intended to prevent false requests or demands that impact the public treasury, the court nonetheless ruled that the

Attorney-General could pursue a claim for injunctive remedies under Section 179200 claim (California's unfair competition law) but could not sue under the UCL for restitution or any civil remedy.

For a copy of the case, go to <http://www.courtinfo.ca.gov/opinions/documents/S119046.PDF>

- Arbitration Clause

In *Boghos v. Certain Underwriters at Lloyd's of London* (Cal. July 18, 2005), the court considered the effect and enforceability of an arbitration clause in a contract for disability insurance. The Supreme Court reversed the lower court and remanded the case for further proceedings. The insured had contended that the arbitration clause was unenforceable because it required him to pay costs he would not have had to pay were he suing in court. The court, in reaching its decision that the insured was required to arbitrate, stated that "[a] reasonable person reading the application and policy would understand that it would be required to arbitrate all disputes arising under the policy" (i.e. contract and tort claims).

September 12, 2005

xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />**FLORIDA**xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

- Workers Compensation / Bad Faith

In *Aguilera v. Inservices, Inc.*, 905 So.2d 84 (Fla. June 16, 2005), the Florida Supreme Court invoked their jurisdictional authority under the provision of Florida's constitution that addresses misapplication of decisional law. The court held that the appellate court misapplied their holding in *Sibley v. Adjustco, Inc.* In *Aguilera*, an employee sustained injuries in a workplace accident that led him to develop fistula. Although several doctors causally-related his condition to the accident and recommended that the employee immediately undergo surgery, the workers' compensation carrier refused to approve any treatment. Ultimately, after suffering ten months with the condition, the carrier approved surgery. The appellate court granted the insurer's motion to dismiss, finding that the carrier was immune from suit. The Supreme Court, however, ruled that the appellate court misapplied its decision in *Sibley* and stated that "the statutes do not contemplate and this Court has never permitted compensation insurance carriers to cloak themselves with blanket immunity in circumstances where the carrier has not merely breached the duty to timely pay benefits, or acted negligently, but has actually committed an intentional tort upon an employee." In view of *Sibley*, the Supreme Court held that the employee's allegations were sufficient to preclude dismissal under a theory of immunity as a matter of law.

For a copy of the case: <http://www.floridasupremecourt.org/decisions/opinions.shtml>

September 12, 2005

xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />**GEORGIA**xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

- Misrepresentation by Agent

In *Coffield v. Allstate Ins. Co.*, Case No. A05A0964, (Ga.App., July 26, 2005), the defendant condominium insurance company was entitled to summary judgment on the plaintiff's negligent misrepresentation and fraud claims because any representations by Allstate agents that Coffield had adequate coverage were not sufficient to raise a question of fact concerning the plain terms of her policy. "Statements made by an insurer or its agent concerning coverage 'amount[] to mere opinions . . . which cannot change the unambiguous terms of the policy.' . . .

. Even when the insurer's agent holds himself out as an expert under circumstances in which the insured must rely on that expertise, the insured's 'duty to read remains where an examination of the policy would have made it readily apparent that the coverage contracted for was not issued.'" Since the policy stated its limits of coverage on its face, the trial court did not err in granting summary judgment to Allstate.

- Professional Liability Policy

In *Fidelity Title National Insurance Company of New York v. OHIC Insurance Company* (Ga. App. July 29, 2005), a professional liability insurer filed declaratory judgment action against title company, alleging that it had no obligation to defend and indemnify its insured for claims that the insurer misappropriated trust funds into which the title company wired money for closings. The insured denied any participation or knowledge of any wrongdoing. The court held that the professional liability insurance company expressly excluded all claims arising out of misappropriating client funds. As such, it reversed the judgment of the trial court and granted judgment in favor of the insurer.

- Duty to Read Policy

In *Coffield v. Allstate Ins. Co.*, (Ga. App. July 26, 2005), the insured brought suit against her insurer for negligent misrepresentation and fraud arising from the insurer's issuance of an insurance policy for the insured's condominium, which was damaged by fire. Insured appealed from the trial court's grant of summary judgment to the insurer on the ground that representations by the insurer's agents that insured had adequate coverage were not sufficient to raise a question of fact concerning the plain terms of her policy. The Court of Appeals affirmed, stating that even when the insurer's agent holds himself out as an expert under circumstances in which the insured must rely on that expertise, the insured's duty to read remains where an examination of the policy would have made it readily apparent that the coverage contracted for was not issued. Since the policy stated its limits of coverage on its face, the insurer was entitled to judgment.

September 12, 2005

xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />INDIANA

- Arbitration Clausexml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

In *Hemocleanse, Inc. v. Philadelphia Indemnity Insurance Company*, (Ind. App. July 26, 2005), the insured brought suit against insurer for breach of contract and breach of covenant of good faith and fair dealing after insurer denied coverage under directors' and officers' liability policy. The complaint was ultimately dismissed on forum non-conveniens. The insurer moved to stay the complaint and to compel arbitration of the insured's claims. The trial court entered its order compelling the insured to arbitrate its breach of contract claim, denying the insurer's motion to compel arbitration of the claim for breach of the covenant of good faith and fair dealing, and ordering that the latter claim be stayed pending the results of the arbitration. The Court of Appeals affirmed the trial court's ruling, finding that the insured's request for a defense constituted a "coverage dispute" which was subject to the binding arbitration provision of the policy. Furthermore, the court held that the insurer did not waive its right to arbitrate by failing to defend under a reservation of rights or to seek a declaratory judgment.

September 12, 2005

LOUISIANA

- UIM Coverage / Stackingxml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

In *Richards v. State Farm Mut. Auto. Ins.* xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarttags" />Co., (La. App. June 29, 2005), the plaintiff was involved in an auto accident while driving his wife's car. The car was her separate property and insured by State Farm. State Farm also provided coverage for the underlying tortfeasor. Plaintiff received the policy limits from the underlying tortfeasor and \$10,000 under his wife's policy. Plaintiff then attempted to recover under his UM coverage policy on his truck, which he owned as separate property from his wife and insured with State Farm. The court affirmed the district court's dismissal of the case, rejecting the plaintiff's attempt to "stack" coverages under the policies.

For a copy of the case: <http://www.lacoa2.org/39868ca.pdf>

September 12, 2005

xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarttags" />**MARYLAND**xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

- Uninsured Motorist Coverage

In *Johnson v. Nationwide Mut. Ins. Co.*, 878 A.2d 615 (Md. July 15, 2005), the Maryland Court of Appeals held that, under §19-509 of the Insurance Article, an insurer is not required to provide uninsured motorist coverage for the wrongful death of a person who was not an insured under the policy.

Jaedon Johnson brought an action against his mother's insurance company, Nationwide Mutual Insurance Company, for the wrongful death of his father, who was a passenger in a vehicle driven by an uninsured motorist. The decedent was not a named insured on the mother's policy, was not married to the policyholder, and did not live with the policy holder. Section 19-509(c)(2) makes it clear that if a person who is insured under the policy dies as a result of a motor vehicle collision with an uninsured motorist, the surviving relatives of that insured can recover for the wrongful death of the insured under the insured's policy.

Jaedon Johnson was entitled to recovery under the father's policy, but as the father was not a named insured under the mother's policy, the Court determined that Nationwide was under no obligation to pay benefits for a party that was not their insured. To rule otherwise would require "every policy to provide uninsured motorist coverage to an unknown number of people, not named in the policy, who are related to (but not living with) someone who is protected by the policy, in the event that those unknown people should be involved in an accident with an uninsured motor vehicle."

For a copy of the case: <http://www.courts.state.md.us/opinions/coa/2005/125a04.pdf>

- Surety Contracts

In *National Union Fire Insurance Company of Pittsburgh, Pa., et al. v. David A. Bramble, Inc.*; *National Union Fire Insurance Company Of Pittsburgh, Pa., et al. v. Wadsworth Golf Construction Company of the Midwest* 879 A.2d 101 (Md. July 21, 2005), Maryland's highest court held that the subcontractors were entitled to summary judgment when the surety failed to detail disputed claims within the time frame set out in the contract. The Court held that the language of the surety bond required the surety to outline the disputed portions of the claim within a 45-day period, and that a failure to do so, under the language of the bond, resulted in the entire claim being undisputed. The decision highlights the dangers of a surety's failure to document its efforts to meet an explicit deadline contained in a standard surety contract.

This case arose from two underlying sub-contractor suits against National Union Fire Insurance Company of Pittsburgh PA, et al. (hereinafter the "Surety"). In November 1999, Clark Construction Group was contracted by Maryland Economic Development Corporation (hereinafter "MEDCO") to serve as the general contractor in the construction of a resort in Maryland. Clark executed a surety bond in favor of MEDCO to secure Clark's obligation to pay its subcontractors. The bond was a "form" surety bond, and no changes were made to the original language. Paragraph 4 of the bond provided that claimants were required to provide notice of their claim to the Surety and to MEDCO. Paragraph 6 provided that, after successful completion of the requirements of Paragraph 4, the Surety would, within 45 days, pay the undisputed portion of the claim and notify the claimants of the disputed amounts and the basis for the dispute.

Both Wadsworth Golf Construction (hereinafter "Wadsworth") and David A. Bramble, Inc. (hereinafter "Bramble") were subcontractors of Clark, hired to complete different aspects of the Maryland Resort. Wadsworth and Bramble submitted claims under the bond to the sureties. The sureties responded and required each subcontractor to complete a Proof of Claim, which they did. The sureties never responded to the subcontractors. The subcontractors filed suit against the sureties for breach of contract. The trial court granted the subcontractors' motions for summary judgment, finding non-compliance with Paragraph 6 of the surety bond. The Court of Special Appeals affirmed trial court's decisions.

The Surety petitioned for a writ of certiorari in both cases, and the Court of Appeals affirmed the decision of the Court of Special Appeals as to each. In affirming, the Court stated that its decision was based purely on their interpretation and application of the language of the surety bond. The Surety had argued that its failure to answer Wadsworth's and Bramble's claims within the 45 day period implied that it was disputing the entirety of the subcontractors' claims. The Court held that surety bonds are to be construed according to the familiar rules applicable to insurance contracts. As such, the terms of the insurance contract are to be given their usual, ordinary meaning unless there is evidence that the parties intended to give it a special or technical meaning. Additionally, the Court noted that a contract must be construed in its entirety, giving effect to each clause of the contract if possible.

The Surety did not contest that it had breached the requirements under Paragraph 6. However, it argued that the failure to answer within the 45-day period indicated that the entire claim was disputed. The Court of Appeals disagreed, noting that there were three requirements under Paragraph 6 of the bond: to answer the claimant's claim; to define the disputed amounts; and, to list the basis for challenging payment for the disputed amounts. This necessitated that the Surety communicate with the subcontractors. However, the Surety did not clarify which parts of the claims were disputed within the 45-day time period, instead ostensibly relying upon its silence to convey both the disputed amounts and the basis for rejecting such amounts by implication.

Not surprisingly, the Court noted that acceptance of the Surety's argument would render the 45-day time period requirement meaningless. This would go against a long standing principle of contract interpretation, i.e., that contracts should be interpreted so as to give effect to all contract provisions, if possible. Moreover, the essence of the Surety's argument was that silence, rather than implying acquiescence, was instead the equivalent of communicating the total rejection of all claims. In the absence of some affirmative statement in the claim indicating the subcontractors' understanding that a failure to reply would be taken to constitute a rejection, such a contention is difficult to sustain. This is particularly so where silence simply could not imply the basis for rejection, even if it could reasonably be said to imply rejection of the entire claim.

In support of its holding, the Court cited *Moore Bros., Co. v. Brown & Root, Inc.*, 207 F.3d 717 (4th Cir. 2000), where the US Court of Appeals for the Fourth Circuit held that the purpose of obtaining a surety bond was to ensure that claimants are paid for their work. To propose that non-payment by the owners relieves the surety of its obligation is irrational, as it goes against the very purpose of the surety bond. Based on this holding, and the language of Paragraph 6 of the bond, Maryland's high Court held that the 45-day time period and the specific procedures outlined in Paragraph 6 directly exemplified the purpose of surety bonds. As courts tend to construe contracts involving compensated sureties in favor of the party who is the beneficiary under the bond, construction of Paragraph 6 in favor of the beneficiaries in this instance was proper under Maryland law. The Court of Appeals accordingly held that the Surety's failure to delineate the disputed portions of the claim resulted in the entire claim being undisputed, and required the Surety to pay the subcontractors' claims in full.

For a copy of the case, go to: <http://www.courts.state.md.us/opinions/coa/2005/150a04.pdf>

- Named Driver Exclusions

In *Zelinski v. Townsend*, 878 A.2d 623 (Md. App. July 8, 2005), the Court of Special Appeals of Maryland held that a named driver exclusion in a commercial motor vehicle insurance policy is void. The right to exclude a driver under an automobile policy issued in Maryland is limited to policies of private passenger motor vehicle liability insurance. See Md. Code Ann., Ins. §27-606(a)(1).

For a copy of the case: <http://www.courts.state.md.us/opinions/cosa/2005/2087s03.pdf>

- Notice

In *Prince George's County v. Local Government Insurance Trust*, 879 A.2d 81 (Md. July 21, 2005), the Maryland Court of Appeals affirmed that an excess insurer was entitled to compliance with the notice requirements of the policy, and an insured who was late in reporting a claim may be denied coverage under the terms of an excess policy. The Court added that a showing of prejudice is necessary to prevail, pursuant to §-110 of the Insurance Article.

The Local Government Insurance Trust was established by Maryland local governments to pool together to provide insurance protection to themselves and their employees. In the present case, Prince George's County was a member of the Trust and participated in the Excess Liability Program. Pursuant to a civil action involving the Prince George's County Police Department, wherein officers entered an individual's home without a warrant and savagely beat him, the County was required to notify the Trust of the incident. The County failed to notify the Trust of the incident until ten (10) days after a verdict was issued in the civil action. The court held that when the notice comes after the adverse verdict, the insurer has, as a matter of law, been prejudiced.

For a copy of the case: <http://www.courts.state.md.us/opinions/coa/2005/127a04.pdf>

September 12, 2005

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- E&O/Malpractice/Subrogation/Staff Counsel

A federal magistrate has ruled *St. Paul Fire & Marine Ins. Co. v. Birch Stewart, et al.*, 01-10327 (D. Mass. August 1, 2005) that St. Paul was subrogated to the malpractice claims of its policyholder against a lawyer whose erroneous advice caused the insured to be sued for trade libel and the defense counsel in Florida who failed to plead advice of counsel as a defense. In denying the attorneys' motions for summary judgment, the Magistrate noted that Massachusetts is among a minority of states that allow such claims to be assigned and saw no reason to conclude that an insurer could not therefore be subrogated to such claims if it had to pay to settle a claim due to counsel's negligence. The court also refused to find that the negligence of defense counsel be imputed to St. Paul through its assignment of staff counsel to associate in the defense of the Florida suit. Not only had defense counsel made the decision to not plead advice of counsel without consulting St. Paul or staff counsel, the court found that under Massachusetts law, all defense counsel, including staff counsel, are presumed to be independent contractors whose negligence cannot be vicariously imputed to the insurer that retains them to represent a policyholder.

September 12, 2005

**xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />MICHIGAN
xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />**

- Tolling One-Year Back Provision

In *Devillers v Auto Club Ins. Ass'n*, --- N.W.2d ----, 473 Mich. 562, 2005 WL 1793738 (Mich. July 29, 2005), the plaintiff suffered a traumatic brain injury in an automobile accident. The plaintiff's no-fault insurer paid for home health care through February 2001. On February 15, 2001, following a physician's report that the insured no longer needed close supervision, the insurer discontinued home health care benefits. On October 7, 2002, the insurer sent correspondence memorializing the termination of the plaintiff's personal protection insurance (PPI) benefits. On November 12, 2002, the plaintiff sued the insurer seeking payment of PPI benefits accruing after February 16, 2001. The insurer moved for partial summary disposition with respect to the period from February 16, 2001 to November 12, 2001, arguing that M.C.L. 500.3145(1) expressly provides that an insured may only seek unpaid benefits dating back one year prior to the filing of the Complaint. The trial court denied the insurer's motion for partial summary disposition, relying on the Michigan Supreme Court's decision in *Lewis v DAIIE*, 426 Mich 93; 393 NW2d 167 (1986), which allowed for "judicial tolling" of the one-year back provision of M.C.L. 500.3145(1) during any period between the insured making a claim for benefits and the insurer failing to formally deny the claim. In *Devillers*, the Michigan Supreme Court overruled *Lewis* and its progeny, opining that the unambiguous language of M.C.L. 500.3145(1) expressly prevents the recovery of PPI benefits accruing more than one year before filing the Complaint. Thus, without regard to the date a claim is formally denied, an insurer will not be liable for PPI benefits accruing more than one year before a Complaint is filed.

For a copy of the case:

http://courtofappeals.mijud.net/documents/OPINIONS/FINAL/SCT/20050729_S126899_31_devillers8apr05-op.pdf

September 12, 2005

**xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />MINNESOTA
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- Assault and Battery Exclusion

In *Borchardt v. Premier Security, Inc.*, (Minn. App. July 5, 2005), plaintiff brought action against employer after a coworker sexually assaulted her. The employer tendered its defense to its insurer, which ultimately denied coverage and refused to participate in the action. Before trial, the plaintiff and the employer entered into a settlement agreement wherein the employer admitted liability, agreed to pay \$10,000 in damages, and stipulated to an order pursuant to which the plaintiff could recover \$65,000 from the employer's insurer. The plaintiff thereafter filed action against the insurer in an effort to determine coverage. The court granted the plaintiff's motion for summary judgment, finding that the assault and battery endorsement was ambiguous and should be construed against the insurer. Because the insurer failed to defend or indemnify its insured, it could challenge the settlement only on grounds that it was unreasonable, imprudent, or the product of fraud or collusion. Since it did not raise any of these grounds, it could not challenge the judgment.

September 12, 2005

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- Concealment Clause

In *Craig v. State Farm Fire & Cas. Co.*, 2005 WL 1719331 (5th Cir. July 25, 2005), the court upheld the grant of summary judgment in the insurer's favor. The insureds submitted a claim for a house fire at their residence; however, a neighbor revealed during the insurer's investigation that the insureds had leased another apartment where they were storing some of their personal property that they claimed was destroyed in the fire. The National Insurance Crime Bureau ultimately searched the insured's apartment and found a number of items that the insured's alleged had been destroyed in the fire. They were arrested and indicted, pleading guilty to conspiracy to commit false pretense. The court observed that under Mississippi law an insurance company may avoid a policy based on a concealment clause like the one in the applicable policy.

September 12, 2005

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- Occurrence/Expected Intended Exclusion

In *Tangney v. Burke*, (N.Y. App. 2d. Dept. Aug. 1, 2005), the insured brought suit against insurer after insurer refused to defend and indemnify him in an underlying action to recover damages for bodily injury. The insurer disclaimed coverage based upon untimely notice and because the incident was not an accident or occurrence under the policy and resulted in bodily injury excluded as "expected or intended" by the insured. After being impleaded, the insurer moved for summary judgment. The lower court granted the motion on the ground that Burke's conduct constituted an assault, which was not an "occurrence", covered by the policy. The Second Department affirmed, finding that the plaintiff's injuries were inherent in the activity the insured engaged in, and the insured's assault could not be construed as an accident within the definition of "occurrence" for which the insurer's policy affords coverage.

- Agent Liability

In *Duratech Industries, Inc. v. Continental Insurance Company*, (N.Y. App., 2nd Dept., Aug. 1, 2005), the court held that the insurer met its burden of establishing entitlement to judgment as a matter of law by demonstrating that the insured failed to provide prompt notice of covered losses, as required under the policy, and that the subject losses were not covered by the policy, or were excluded from coverage. In addition, the court dismissed the insured's cause of action for breach of contract against its insurance agent, holding that an insurance agent does not owe a common-law continuing duty to advise, guide, or direct its clients in terms of proper insurance coverage, absent some special relationship of trust and confidence.

September 12, 2005

**xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarts" />NORTH CAROLINA
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•Life Insurance / Substance Abuse Exclusion

The North Carolina Court of Appeals has affirmed the grant of summary judgment in favor of the insurer in connection with the substance abuse exclusion in a life insurance policy. In *Duncan v. CUNA Mutual Ins. Society*, 614 S.E.2d 592 (N.C. App. July 5, 2005), plaintiff and Michael Duncan ("Duncan") were married in 1987 and separated in 1998. Duncan had several DWI convictions and a history of substance abuse. In October 1998, Duncan purchased a \$150,000 life insurance policy (the "Policy") from defendants, and named plaintiff as the beneficiary. On 8 April 2000 Duncan's body was found on a couch in his living room. Although plaintiff and Duncan separated in July, 1998, they were still married at the time of Duncan's death. An autopsy was performed, determining the cause of death to be "methadone toxicity." The autopsy report, death certificate, and medical examiner's report all list the cause of death as "methadone toxicity." The Policy contained the following exclusion: "Exclusions. We will not pay a benefit for any Loss to an Insured Person caused by or resulting from . . . 8. Voluntary use of any drug, medicine, or sedative, except as prescribed by a physician."

Plaintiff filed suit against defendants, alleging that defendants had breached the insurance contract, and seeking benefits under the policy. In their answer, defendants denied the material allegations of the complaint and asserted various defenses, including the policy's exclusion for non-prescribed drugs. Summary judgment was granted in favor of the insurer. On appeal, the Court of Appeals stated that the dispositive issue is whether the evidence raised a genuine issue of material fact regarding the policy's exclusion for loss resulting from the "voluntary use of any drug, medicine, or sedative," or the exclusion's exception for the use of such drugs "as prescribed by a physician." The uncontradicted evidence was that the immediate cause of Duncan's death was "methadone toxicity." Neither party disputed that methadone is a "drug, medicine, or sedative," or that Duncan had a history of alcohol and substance abuse. Duncan's body was found in his own living room, with no evidence of forced entry or foul play. The Court of Appeals concluded that defendants met their burden to show that the exclusion bars plaintiff from recovering under the policy. The Court rejected plaintiff's argument that defendants must "disprove her claims" with affirmative proof that Duncan took methadone 'voluntarily,' basically requiring defendants to prove Duncan was not 'involuntarily' forced to take methadone. The Court concluded the record evidence shows that plaintiff was unable to offer evidence raising an issue of fact regarding the exclusion or its exception.

For a copy of the case: <http://www.aoc.state.nc.us/www/public/coa/opinions/2005/041176-1.htm>

September 12, 2005

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•Asbestos/"Occurrences"/Non-Cumulation

The Third Circuit has affirmed a Pennsylvania District Court's ruling that numerous asbestos claims against the manufacturer of products containing asbestos all arose out of a single "occurrence" and, furthermore, that a non-cumulation clause in the Liberty Mutual umbrella policies precluded the insured from obtaining more than a single excess limit. In *Liberty Mutual Ins. Co. v. Treedale, Inc.*, --- F.3d ---, 2005 WL 1939794 (3d Cir. August 15, 2005), the court ruled that its 1981 analysis in *Appalachian* compelled a finding the "cause" of the underlying losses was the insured's manufacture and sale of asbestos-containing products. The court also rejected the insured's argument that it could avoid the effect of the non-cumulation clause by choosing to exhaust the Liberty Mutual umbrella policies in reverse chronological order.

For a copy of the case, go to <http://caselaw.lp.findlaw.com/data2/circs/3rd/044172p.pdf>

SOUTH CAROLINA

•Impaired Property Exclusion

In *Auto-Owners Ins. Co. v. Essex Homes Southeast Inc.*, (4th Cir. June 29, 2005), the builder/developer of residential development were sued by purchasers of lots on the basis that the builder/developer failed to disclose that the land had previously been used by the Department of Defense as a training site for aerial bombing. The complaint alleged loss of use. The builder/developer insurer denied coverage. On appeal, the Fourth Department held that although “negligence” under South Carolina law is an “occurrence,” the claims fell within the exclusion for loss of use of impaired property.

For a copy of the case:

<http://pacer.ca4.uscourts.gov/opinion.pdf/041700.U.pdf>

September 12, 2005

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•“Diminishment in Value” as Measure of Damages in Mold Cases

In *Swiercinsky v. Nationwide Insurance Enterprise*, 2005 WL 1432910, No. 05-04-00124-CV (Tex.App. June 22, 2005), Michael and Caprice Swiercinsky (the “plaintiffs”) claimed that their house sustained mold damage between July 1999 and July 2001, while it was covered by a homeowners’ insurance policy issued by Nationwide. In their lawsuit against Nationwide, the plaintiffs sought \$150,000 in damages (the opinion does not specify the causes of action asserted by the plaintiffs). At trial, the jury found that the house was “physically damaged by mold” during the policy period; however, when asked the difference in the actual cash value of the damage to the house, the jury answered “\$0.” The jury also found that mold damage did not make the house untenantable. The trial court entered a take-nothing judgment based upon the jury’s findings, and the plaintiffs appealed.

The only evidence that the plaintiffs offered to support their house’s diminishment in value was the testimony of Mr. Swiercinsky. He testified that he sold the house for \$150,000, and that the house would have been worth \$300,000 without mold damage. Mr. Swiercinsky estimated that it would cost approximately \$150,000 in remediation costs to remove the mold. The jury had before it evidence that the house had been damaged even before the Nationwide policy went into effect. Recognizing that there was evidence that the remediation cost was already \$150,000 even before the policy period, the court upheld the jury’s finding that the plaintiffs suffered no further loss in value of the house during the policy period. On the issue of “untenantability,” the court again upheld the jury’s finding. Although the plaintiffs relied upon Mr. Swiercinsky’s testimony and the testimony of an air-quality expert, the court found that this evidence was insufficient to prove “objective personal injuries.” Accordingly, the court again found that the jury’s decision was not against the great weight and preponderance of the evidence, and therefore affirmed the trial court’s take-nothing judgment.

For a copy of the case:

<http://www.courtstuff.com/5th/OPINLIST.HTM>

- Insurer Not Liable for Breach of Contract Simply Because Policy Limits Had Not Been Paid

In *Betzel v. State Farm Lloyds*, 2005 WL 1500826 (N.D. Tex. June 15, 2005), the plaintiff, Kurt Betzel, reported to State Farm Lloyds, his homeowners' insurance carrier, that he had black mold around his air conditioning registers and that the sheetrock around the registers was soggy and deteriorated. State Farm Lloyds opened one claim in response to Betzel's demand and later opened three other claims (regarding a leak in the kitchen sink, a sewer leak, and a shower drain leak). The earliest two claims (the mold claim and the kitchen sink claim) were made under one policy, while the later claims (the sewer leak claim and the shower drain leak claim) were made under the subsequent policy. State Farm Lloyds paid \$162,962.12 to remove or remediate the mold, but did not pay the amount needed to complete the job. Betzel sued in state court for breach of contract, breach of the duty of good faith and fair dealing, unfair insurance practices under Article 21.21, and violation of Article 21.55. After the case was removed, State Farm Lloyds filed a motion for summary judgment, and Betzel withdrew his claims for violation of Article 21.21 and for breach of the duty of good faith and fair dealing.

The court first noted that, although the Texas Supreme Court has not determined whether a homeowners' policy provides coverage for mold contamination, Betzel could not prevail on his claim for breach of contract. State Farm Lloyds' motion for summary judgment contended that there was no evidence to support Betzel's contractual claims. Betzel's only evidence was the testimony of his general contractor, who stated that it would cost \$212,260.92 to rebuild Betzel's home. However, because Betzel apparently failed to comply with a pre-trial order regarding expert reports, even this evidence was excluded. Betzel's only argument was that State Farm Lloyds had not paid its policy limits as to each of the losses and had therefore not met its obligations under the two policies. The court noted that Betzel failed to cite any authority that liability can be established merely by showing that policy limits had not been paid. As to the claim under Article 21.55, the court simply stated that, because Betzel could not establish liability under the policies at issue, damages under Article 21.55 are not available. Accordingly, the court granted State Farm Lloyds' motion for summary judgment on all claims.

- Late Notice / Prejudice Requirement

In *Ridgley Estate Condominium Association v. Lexington Insurance Company*, 415 F.3d 474 (5th Cir. July 1, 2005), the Fifth Circuit recently applied a prejudice requirement to a late notice policy defense arising under a first-party commercial property policy. The Court first observed that an insurer's total denial of liability on any grounds, after the time for filing a proof of loss had expired, would not constitute a waiver of the defense of late filing of the proof of loss. According to the Court, where the insured provides notice of loss after the period for prompt notice had expired, the insurer's subsequent general denial of liability likewise comes after the time limited for giving notice and thus does not constitute waiver of the late notice defense.

The Court then examined whether prejudice was an element of the late notice defense under Texas law. The Court relied upon the Fifth Circuit's holding in *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658-9 (5th Cir. 1999) and reasoned that because the prejudice requirement does not apply as to "claims-made" policies but is fully applicable to all "occurrence" policies, the first-party commercial property policy at issue carried an implied requirement of prejudice before the carrier could invoke the notice provision. As such, the Fifth Circuit determined that the district court erred as a matter of law in failing to require a showing of prejudice.

For a copy of the case:

<http://caselaw.lp.findlaw.com/data2/circs/5th/0410447p.pdf>

September 12, 2005

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•UIM Coverage / Stacking

In *Mena v. Safeco Ins. Co.*, 412 F.3d 1159, 2005 WL 1427669 (10th Cir.(Wyo.), Jun 20, 2005), the plaintiff was insured under a single policy covering three vehicles, and sought a declaratory judgment that would allow her to stack her UIM coverage for each vehicle to compensate for bodily injuries suffered in an auto accident. After tendering the UIM limit for a single vehicle, the insurer denied additional coverage. On cross motions for summary judgment, the district court denied the plaintiff's claim of additional coverage and granted summary judgment to the defendants. The Tenth Circuit Court of Appeals affirmed the district court's grant of summary judgment to the insurer by noting that the subject insurance policy does not authorize intra-policy stacking of underinsured motorists coverage.

For a copy of the case:

<http://pacer.ca10.uscourts.gov/cgi-bin/getopn.pl?OPINION=04-8022.wpd>

September 12, 2005

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•“Occurrence” / Work Product Exclusions

In *Webster County Solid Waste Authority v. Brackenrich & Associates, Inc.*, (W.Va. June 30, 2005), the court held that faulty work does not constitute an “occurrence.” Insured was engineering firm retained to design and upgrade a landfill. The Authority responsible for the landfill later commenced action against engineering firm, asserting that firm was negligent in designing and constructing the landfill. The engineering firm's CGL insurer disclaimed coverage, asserting that there was no “occurrence” and the work product exclusions applied. The Authority asserted that the professional missteps were negligent, and therefore constituted “occurrences.” The court rejected that argument. The court also rejected the Authority's argument that the particular instance, because it involved design and not construction, did not fall within the ambit of the “faulty workmanship” line of cases.

For a copy of the case: <http://www.state.wv.us/wvsca/docs/spring05/31861.pdf>

Thanks to Matthew S. Foy, Mary Reyes and Michael A. Hamilton, co-editors of DRI's Insurance Law Committee Newsletter, *Covered Events*, as well as contributors Michael F. Aylward, Carlos A. Braxton, James W. Bryan, Anthony F. Caffrey III, B. Gerard Cordelli, James W. Lampkin II, Courtney G. Meade, Kevin T. Merriman, Lynn M. Roberson and Thomas F. Segalla for their efforts in assembling the “Recent Cases of Interest.”

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HB 3360: Tax incentives.

- To amend the Internal Revenue Code of 1986 to enhance tax incentives for small property and casualty insurance companies.
- xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smrttags" />07/20/2005 – Introduced; referred to Committee on Ways and Means.

HB 3297: State High Risk Pool Funding Extension Act of 2005.

- To extend Federal funding for operation of State high risk health insurance pools.
- 07/29/2005 – Referred to the Subcommittee on Health.

HB 804: Flood insurance.

- To exclude from consideration as income certain payments under the national flood insurance program.
- 07/29/2005 – Reported out of Committee; placed on Senate Legislative Calendar under general orders.

HB 804: Excluding payments as income.

- To exclude from consideration as income certain payments under the national flood insurance program.
- 09/08/2005 – Passed Senate without amendment by unanimous consent; cleared for White House.

HR 3669: National Flood Insurance Program Enhanced Borrowing Authority Act of 2005.

- To temporarily increase the borrowing authority of the Federal Emergency Management Agency for carrying out the national flood insurance program
- 09/12/2005 - Passed Senate without amendment by unanimous consent.

SB 1293: Consolidation of life insurance companies.

- A bill to amend the Internal Revenue Code of 1986 to permit the consolidation of life insurance companies with other companies.
- 06/23/2005 – Introduced.

State

California

CA HB 817: Insurance.

- An act to amend Sections 1063.1 and 1063.3 of the Insurance Code, relating to insurance. This bill would expand the definition of "covered claims" to include the obligations of an insolvent insurer to indemnify a permissibly self-insured employer for its liability to pay workers' compensation benefits, as specified.
- 09/02/2005 – From inactive file to second reading by Rules Committee; amended; to third reading.

California

CA HB 817: An act to amend Sections 1063.1 and 1063.3 of the Insurance Code.

- This bill would expand the definition of "covered claims" to include the obligations of an insolvent insurer to indemnify a permissibly self-insured employer for its liability to pay workers' compensation benefits, as specified.
- 09/07/2005 – In Assembly; concurrence in Senate amendments pending.

Florida

FL SB 1486: Property insurance.

- Revises retention of losses for which insurer is not entitled to reimbursement from Florida Hurricane Catastrophe Fund; requires that department establish low-interest loan program and pilot project for hurricane loss mitigation; creates Task Force on Long-Term Solutions for Florida's Hurricane Insurance Market; requires board of governors of Citizens Property Insurance Corporation to submit report to Legislature, etc.
- 06/01/2005 – Approved by Governor.

Maryland

MD HB 666: Delinquency proceedings against insolvent insurers—financial contracts

- Providing that a person may not be stayed or otherwise prohibited from exercising specified rights in delinquency proceedings brought under specified provisions of law against specified insurers; requiring specified net or settlement amounts due to any insurer subject to a specified delinquency proceeding to be transferred to or on the order of the receiver for the insurer; specifying the manner in which a receiver in a delinquency proceeding must transfer specified netting agreements and qualified financial contracts; etc.
- 05/26/2005 – Signed by Governor.

New Jersey

NJ HB 4335: Carrier disclosures.

- Requires certain disclosures from carriers; establishes new health care claims payment and appeals process; limits use of utilization management under certain circumstances.
- 06/30/2005 – Introduced; referred to Financial Institutions and Insurance Committee.

Texas

TX HB 2157: Receivership of insurers.

- An Act relating to the receivership of insurers in this state; providing penalties.
- 06/18/2005 – Signed by Governor; effective 09/01/2005.

TX SB 14: Market conduct.

- An Act relating to rates for certain property and casualty insurance and regulation of insurer market conduct.
- 06/17/2005 – Signed by Governor; effective 09/01/2005.

Washington

WA HB 1034: Conducting the administrative supervision of financially distressed insurers.

- An Act relating to the administrative supervision of financially distressed insurers; amending RCW 48.31.020 and 48.31.115; and adding new sections to chapter 48.31 RCW.
- 05/13/2005 – Governor signed; effective 07/24/05.

Wisconsin

WI SB 137: "All Sums" Bill.

- An Act relating to environmental claims under general liability insurance policies, fees related to removal of contaminated material from a navigable water, and making an appropriation.
- 09/02/2005 – Senate Committee voted 6 – 1 against bill.

October 06, 2005



Auto Liability and Coverage Seminar Renaissance Chicago Hotel November 10-11, 2005

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