Daniel Webster-Batchelder
American Inn of Court
November 4, 2015

TABLE 7

PRESENTS...

PERSPECTIVES OF CLAIMS ADJUSTERS AND INSURANCE COMPANIES

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Issues Outline

November 4, 2015

1. Law Governing Construction of Insurance Contract. In general, insurance contracts are to be construed in accordance with contract construction principles. However, ambiguities are construed against the insurer. Any insurance issue always starts with an examination of the pertinent policy language.

2. Rights/Duties in event of claim

    a. *Rights/Duties of Insurer to its Insured as Tortfeasor.* Generally, a liability insurer has the obligation to investigate and defend any covered claim brought against an insured. The insured is also entitled to indemnity for covered claims within coverage limits. Under *Dumas v. State Farm Mut. Ins. Co*, 111 N.H. 43 (1971), an insurer can be liable to insured for damages beyond coverage limits in the event its failure to settle a case within such limits when presented with the opportunity to do so.

    b. *Insured as Victim.* Circumstances are a little different in the case of a claim by an insured against its insurer, such as in the case of first party insurance or a claim for uninsured motorists coverage, where the posture of insured is inherently more adversarial.

    c. *Rights/ Duties of Insured.* In general, as a condition of coverage, an insured has the obligation to provide prompt notice of a claim and to cooperate with the insurer's effort to investigate and defend the claim. In general, in the case of the

insured as tortfeasor, the insurer has the right to appoint defense counsel and authorize case settlement. There may be exceptions to this general rule warranting review of applicable policy language.

3. Issues raised by Coverage Exclusions. Exclusions are express policy provisions that identify acts and circumstances where coverage is not afforded. Where there is no coverage there is no duty to defend or indemnify. While every policy needs to be carefully examined, common exclusions include claims arising out of intentional/illegal acts, natural disasters, contractual liability, or environmental harm.

    a. *Insurers Proceeding under Reservation of Rights.* Often times, whether an exclusion will ultimately apply will depend on the evidence developed during the course of the case. Under such circumstances, it is common for an insurer to defend a claim under an express reservation of rights, meaning that it agrees to defend the case for a period of time but reserves the right to terminate the defense or deny indemnity if the evidence ultimately shows that the there is no coverage whether by virtue of an applicable exclusion, a claim outside of a policy period, or a determination that a party is not an insured, or some other basis. Where an insurer proceeds under a reservation of rights, it may be advisable for insured to hire personal counsel to protect his/her rights to coverage.

    b. *Issues raised by pleadings.* Plaintiffs crafting complaints must be mindful of how they plead claims so as not to implicate coverage exclusions which could impact ability to collect damage award. For example, a cause of action sounding in intentional tort (*e.g.* battery, intentional infliction of emotional distress, false imprisonment) will almost certainly implicate a reservation letter or outright

denial of coverage. In general, complaints sounding in negligence will be subject to coverage without reservation, absent some other applicable exclusion.

c. *Wrongful denial of coverage.* Where an insurer wrongfully fails to meet its coverage obligations (whether defense, or indemnity, or both), an aggrieved insured can assert a claim against the insurer for damages (i.e. breach of insurance contract).

4. Legal and Ethical Duties of Assigned Defense Counsel

   a. *Duties of Defense Counsel.* Assigned defense counsel is appointed to represent the interests of the insured, not the insurer. The scope of assigned counsel's representation is the defense of the covered claim only. In other words, if a case involves claims that are plainly covered by insurance and some claims which are not covered, assigned counsel will not represent the insured with respect to the non-covered claims. The insured should retain personal counsel to represent him or her with respect to those non-covered claims in the case. Within the scope of the covered claim, the insured is the client and the ethical rules will be applied as such. Under circumstances where there is dispute between insured and insurer, assigned counsel can be placed in challenging ethical position. In some instances, insurance carriers have created in-house defense firms, further complicating the ethical posture of their role as counsel for the insured.

   b. *Role of Personal Counsel.* Where there is a dispute between an insurer and its insured – such as may be the case where there is a coverage question or excess exposure – personal counsel may be hired by the insured at its own expense to advance the insured's position as adverse to the insurer, to address claims that are

not covered by the insurance policy, or to address issues of excess liability. An example of the role of personal counsel may be to assert an insured *Dumas* rights or contest a reservation of rights asserted by an insurer. The scope of personal counsel's representation is usually more broad than that of assigned defense counsel.

c. *Do ethical duties differ as between assigned counsel and personal counsel?* While they are technically subject to the same ethical rules, the postures of assigned counsel and personal counsel are very different. It would appear that the scope of their respective engagements is different, which informs application of their ethical duties.

5. Role of the Adjuster. The adjuster is the insurer's representative as it relates to meeting its obligations under the applicable policy. Careful consideration should be given as to whether or under what circumstances an adjuster's testimony may be compelled or when his/her investigatory materials or work product are discoverable or are protected by the attorney client privilege.

6. Declaratory Judgments to Resolve Coverage. Where there are questions regarding coverage, it is often prudent to bring a declaratory judgment action to resolve disputes in advance or otherwise preserve rights. New Hampshire's declaratory judgment statute is set forth in RSA 491:22, 22-a, 22-b, and 22-c. Under 491:22 (I), a declaratory judgment may be maintained by "any person claiming an present legal or equitable right"; in an insurance context, this can mean either an insurer, insured, or injured party who may be entitled to receive compensation under a liability policy. Under RSA 491:22(III) a declaratory judgment action to determine coverage of an insurance policy must be

brought within 6 months of the filing of the "writ, complaint, or other pleading initiating the action which gives rise to the question." Under RSA 491:22-a, the burden of proof in an action to determine coverage under a liability policy is on the insured, regardless of who initiates the action. Further, under RSA 491:22-b, an insured is entitled to an award of attorney's fees where he/she prevails in such an action brought under 491:22 to determine insurance coverage.

The Drunken Groomsman

The plaintiff, Frances Tambello, and his girlfriend, Diane Papelian, were attending a party for competing horse teams hosted by Rockingham Park Ventures, Inc. The party was hosted by a jockey named Brewer Adams (I kid you not!). Adams received permission to host the party directly from the president of Rockingham Park. Adams was the most successful jockey at the track, bringing in $1.2 million in prizes. Rockingham Park sells alcohol from a licensed vendor. At this party, however, Adams was allowed to bring his own alcohol which the guests were drinking. This was a violation of the track's own policies, which required all alcohol consumed at the park to be purchased from the licensed vendor.

The facts involved not simply over-service of alcohol but people were "funneling" beer, in addition to drinking hard liquor. The facts established that the park had no security on-duty at the party (even though they did have a full-time security staff). There were several park employees attending the party, including off-duty security guards. The groundskeeper for the park was so drunk that he had to be escorted out of the party.

Frances was a horse trainer for a team that competed with Adams' team. Frances alleged that Connor Flynn, a groomsman on Adams' team, was 14 years old and got very drunk and started to sexually harass Diane. Connor was groping her and saying very explicit lewd things to her.

Frances spoke to Connor to tell him to stop. Frances and Diane then decided to leave the party. As they were leaving Chris Payson, another groomsman from Adams' team, attacked the plaintiff from behind and caused him to hit his head and he received various injuries, including a concussion, lacerations, post-concussion syndrome, vertigo, anxiety, and depression. The plaintiff alleged that as a result of his injuries he could no longer train horses.

The plaintiff sued based on negligent supervision, negligent infliction of emotional distress, strict liability based on NH Dram Shop Law, RSA 507-A, and failure to follow their own policies about service of alcohol.

The park raised the defense of contributory negligence and asserted that they should not be liable for the criminal act of someone who attacked the plaintiff. The park also argued that the plaintiff waived his claim to liability because when he entered the park, he was given a

visitor badge. On the back of the badge, it contained an agreement that the visitor would not hold the track liability for any injuries which occurred while at the park.

The park introduced witnesses from Adams' horse team who testified that the plaintiff's girlfriend was drunk and she was the one who initiated the sexual contact with the 14-year old boy. They testified that when members of the competing team tried to stop her, she got mad and started a fight. The witnesses testified that the plaintiff intervened to break up the fight. As he was doing so, the plaintiff and Chris Payson exchanged words and the plaintiff struck Payson. A further scuffle occurred and during that encounter the plaintiff fell and was injured.

The plaintiff and his girlfriend adamantly denied this version of events and claimed that these witnesses were lying because they belonged to the competing team.

The plaintiff admitted on cross-examination that he had a number of pre-existing injuries from his prior career as a carpenter. He even had received disability from that work before he started his career as a horse trainer.

All of the witnesses for both parties had prior criminal records based on drinking and assaultive behavior.

The plaintiff is 58 years old.

Medical bills were $38,285.36.

Defendant's insurance co: American Specialty

Policy Limits: $1,000,000

Plaintiff worked as a carpenter for 33 years after graduating from high school. He retired from that work in 2001 for arthritis in his shoulder. He began training horses full-time at that point but had been involved in racing and training for 20 years. He made $19,500 in the first half of 2008 before the accident. He was granted SSDI after the accident and gets $529/month.

The Fishtailing Father-to-Be

After work one Thursday night, radio salesman, Jim Smith, went to a retirement celebration for one of his longtime colleagues at the Bedford Village Inn. There were heavy appetizers with complimentary wine and cocktails being served, from which Jim, who had missed lunch, eagerly ate and drank. There was also an open bar, which the sales crew, including Jim, surrounded. Around 8 pm, in the middle of the festivities, Jim received a call from his wife, Maureen, who was six and a half months pregnant with their second child. Maureen called because she thought that she was going into early labor and she needed him to come home to take her to the hospital.

Maureen and Jim live in Goffstown with their two year old daughter, and Maureen planned to give birth at Catholic Medical Center.

Worried about his wife, Jim raced home from the BVI, exceeding the speed limit. When he got home, his wife was waiting at the front door, bent over in pain. Jim helped her to the car and, again, got behind the wheel. He tore out of the driveway and drove toward Manchester on Goffstown Back Road, speeding, with his cell phone in his hand, as he tried to call his wife's obstetrician. Distracted while dialing, as he went around a curve on the dark narrow road, Jim lost control of the car and crashed into a tree, killing his 29-year old wife and unborn child and rendering him unconscious.

The Goffstown Police, Fire and EMS responded to the accident scene. Jim and Maureen were both taken by ambulance to Catholic Medical Center where Maureen and the unborn child were pronounced dead on arrival. A blood sample taken from Jim showed a BAC of .22. He was charged with two counts of aggravated DWI and two counts of negligent homicide relating to this accident. He is out on bail, pending trial and has encouraged his wife's family to make a claim under his insurance policies.

Maureen's parents and siblings have contacted you about filing a wrongful death claim against Jim on behalf of her and her unborn child. They are angry at Jim for what he did, they are grieving the loss of their daughter, and they are struggling to care for Maureen's surviving two year old daughter.

When she died, Maureen was only 32 years old. She was out of work on short term disability (66% of her base salary) due to her high risk pregnancy and related complications. She planned to remain out of work after delivering her child for at least three months on unpaid maternity leave. Before going on short term disability, Maureen worked as a registered nurse at Catholic Medical Center. She had a master's of science in nursing and had been working at CMC for seven years. She had an impeccable employment record with perfect reviews. Maureen received a base salary of $53,000 per year, with added compensation for shift differentials and overtime. In the five years prior to her death, her average annual salary was $55,000.

When Maureen learned she was pregnant with her second child, she had expressed an interest in remaining home with her kids until they were both in school, but was reserving her decision until her maternity leave ended.

This was the first marriage for Maureen, and second for Jim, whose first marriage ended due to his alcohol abuse. Maureen left behind a two year old daughter.

Maureen's medical bills from the CMC ER and the ambulance ride were $9,000. The funeral and burial bills for Maureen and her unborn child were $21,000.

Total special damages were $30,000.00.

Jim and Maureen had an automobile liability insurance policy with $250,000/$500,000 limits through Progressive Insurance, as well as an excess umbrella policy with $1 Million in available coverage.

History of NH Law Governing Actions Against Liability Insurers for Negligent Failure to Settle Tort Claims Against Their Assureds

Dumas: 1947

i. Facts:

a. In Dumas v. Hartford Accident & Indem. Co. decided in 1947 the court first outlined the standard. 94 N.H 484, 487 (1947). In that case, the policy limit for Mr. Dumas was $5,000. The insurance company refused an offer to settle for $1,500 and a verdict was awarded to the plaintiff, after trial for $13,500. Id.

b. The court noted that negligence in this type of case should be determined by using an objective reasonable person standard in that due care must be exercised to determine the facts of the case, and in appraising the danger to the insured of being obliged to pay the excess portion of the verdict. Id. at 487.

c. In so reasoning the court relied upon the contractual relationship of the insurer to the insured, noting that "when one knows or has reason to anticipate that the person, property, or rights of another are so situated . . . that they may be injured through his conduct, it becomes his duty so to govern his action as not negligently to injure the person, property, or rights of that other." Id. at 488 (quoting Attleboro Mfg. Co. v. Company, 240 F. 573, 578.)

d. Further, the court reasoned that because the insurer had exercised full control over the case, in negotiation and representation, it was clearly negligible when damage to the defendant occurred. Id.

ii. Negligence Rules established:

a. Due Care: "Due care must be exercised in ascertaining all the facts of the case both as to liability and damages, in learning the law and in appraising the danger to the insured of being obliged to pay the excess portion of a verdict. While the insurer has a reasonable right to try its case in court, it cannot be unduly venturesome at the expense of the insured. The caution of the ordinary person of average prudence should be employed."

b. Standard of Care: In deciding whether or not to settle, the insurer must be "...as quick to compromise and dispose of the claim as if it itself were liable for any excess verdict." "...at least what a reasonable man would exercise in the management of his own affairs."

c. Negligence: "If there is some probability of harm sufficiently serious that ordinary men would take precaution to avoid it, then failure so to do is negligence."

Authority: Dumas v. Hartford Accident & Indemnity Co., 94 N.H. 484, 489 (1947)

iii. Policy arguments against rule:

a. Windfall to Insurer: A policy argument against this rule is that it "...serves as a windfall to an insurer fortunate enough to have insured an insolvent."

b. Superficial Appearance of Fairness to Insured: "It does not contemplate that the actions of the insurer shall be judged solely in relation to its own interests, solely in relation to the insured's interests, nor as though coverage were unlimited. The unlimited coverage approach has a superficial appearance of fairness to the insured but in fact does not give proper consideration to the insured's interest. An unlimited risk to an insurance company with thousands of claims may in fact be minimal on the average but catastrophic to an underinsured individual with a single claim."

Authority: Schwartz v. Norwich, Union Indem. Co., 212 Wis. 593, 250 N.W. 446 (1933); Gray v. Nationwide Mut. Ins. Co., 422 Pz. 500, 506, 223 A.2d 8, 10 (1966); Alabama Farm Bureau Mut. Ins. Co. v. Dalrymple, 270 Ala. 119, 116 So.2d 924 (1959).

Dumas 1971:

i. Facts:

a. Years later, in 1971 in the second Dumas decision the court revisited the 1947 Dumas negligence standard, and addressed whether it would consider adopting strict liability when insurers fail to settle third party claims within the policy limits. See Dumas v. State Farm Mut. Auto. Ins. Co., 111 N.H. 43, 44 (1971).

b. In this case, coincidentally also involving a "Dumas", the plaintiff MacLean and defendant, Dumas were involved in a car accident. Dumas was insured through State Farm insurance with a coverage limit of $10,000. Id. at 44. Pursuant to the terms of the policy, State Farm handled all negotiation, and defense of the case for Dumas. MacLean filed suit in the federal court for injuries he alleged he sustained in the accident and was awarded damages of $25,000 after trial. Id.

c. Dumas, along with MacLean both alleged in one count a right to recover for State Farm's negligent failure to settle the MacLean claim, and in a second count they alleged that State Farm was strictly liable for its failure to settle. Id. at 45.

d. In addressing the strict liability argument the court noted that the strongest argument for strict liability "appears to be that since the assured interests generally dictate settlement within the policy limits, the insurer having control of settlement should be held to assume the risks of its acts against the insured's interests." Id. at 47-48.

e. However, the court determined that a strict liability approach would actually be more harmful than beneficial to the insured in that the current standard "requires the insurer to recognize the conflict of interest position assumed by the contract and to perform the duty arising out of the peculiar facts of the situation presented." Id.

f. The court upheld the negligence standard, and found that it typically lends to better accountability in that the defendant insurer is... "subjected to a slow motion rerun of its actions leading up to the verdict" and the current rule "imposes a heavy burden on the insurer but one inherent in the conflict of interest situation the insurer assumes under the contract." Id. at 48.

ii. In General:

Under New Hampshire law, a party may sue an insurance carrier for failure to settle a claim against that party within the policy limits. New Hampshire has specifically adopted a negligence standard-defined as how a "reasonable person might act under the same circumstances." An insurance carrier, therefore, has a duty to exercise due care in ascertaining all of the facts of the case, both as to liability and damages and in appraising the risk to the insured of being obligated to pay any portion of a verdict in excess of policy limits.

Authority: Gelinas v. Metropolitan Prop. & Liability Ins. Co., 131 N.H. 154, 161 (1988); Dumas v. Hartford Accident & Indemnity Co., 94 N.H. 484 (1947).

iii. A Question of Fact:

Whether an insurance company has acted in good faith is a question of fact.

Authority: Gelinas v. Metro. Prop. & Liability Ins. Co., 131 N.H. 154, 160 (1988); Lawton v. Great Southwest Fire Ins. Co., 118 N.H. 607, 612-13 (1978).

iv. Duty to Avoid Placing Insured Needlessly at Risk:

An insurance company should not shy away from defending cases it believes it reasonably has a basis for defending. The insurer has a reasonable right to try its case in court. It cannot, however, be "unduly venturesome at the expense of the insured." The insurance company must exercise the same caution that the ordinary person of average prudence would employ under the circumstances. Stated otherwise, "the duty an insurance company owes to its insured is to use reasonable judgment in deciding whether to run the risk of an award in excess of [the policy limits.]"

Authority: Dumas v. Hartford Accident & Indemnity Co., 94 N.H. 484, 489 (1947); Dumas v. State Farm Mutual Automobile Ins. Co., 111 N.H. 43, 46-49 (1971).

v. No Strict Liability for Failure to Settle:

The New Hampshire Supreme Court has expressly rejected the idea of holding an insurance carrier strictly liable for failing to settle within the policy limits.

Authority: Dumas v. State Farm Mutual Automobile Ins. Co., 111 N.H. 43, 46-49 (1971).

vi. The Insurance Company's Conflict:

When the settlement value of a case approaches the policy limits, the risk to the insurance company in taking the case to trial increases. Accordingly, insurance carriers must give more weight to the insured's interest as the settlement value of the claim approaches the policy limits.

Authority: Dumas v. State Farm Mutual Automobile Ins. Co., 111 N.H. 43, 48 (1971).

vii. Bad Faith Claims By Third Parties:

New Hampshire law is unsettled as to whether a third party, who is not the insured but has standing to bring a declaratory judgment action for insurance coverage, can bring a bad faith claim against the carrier. Usually, third parties take assignments of any cause of action the insured might have against the insurer to avoid this issue.

viii. Malicious or "Bad Faith" Defense:

New Hampshire recognizes the tort of malicious defense. A defendant may be found liable for malicious defense if, in defending a claim, he or she:

(i) acts without a credible basis in fact,
(ii) knowing the defense lack merit,
(iii) primarily for a purpose other than securing the property adjudication of the claim,
(iv) the previous proceeding terminated in favor of the party bringing the malicious defense action, and
(v) injury or damages have been sustained.

Authority: Aranson v. Schroeder, 140 N.H. 359 (1995)

Reservation of Rights by the Insurance Company

When it is unclear whether an exclusion in an insurance policy will preclude coverage for a claim, an insurer may choose to defend a claim under an express reservation of rights, meaning that it agrees to defend the case for a period of time but reserves the right to terminate the defense or deny indemnity if the evidence shows that the there is no coverage due to an applicable exclusion, a claim outside of a policy period, a determination that a party is not an insured, or some other basis. Where an insurer proceeds under a reservation of rights, it may be advisable for the insured to hire personal counsel to protect his/her rights to coverage. This is because even though the carrier is providing the defense, if there is a verdict against the insured, it may be responsible for paying the award out of its own assets. However, the carrier will typically still be interested in using its funds to settle a case to avoid the costs of defense.

For an insurer to defend a claim under a reservation of rights, it must issue formal notice of doing so to its insured under what is commonly known as the "reservation of rights letter." The letter will have the provisions of the insurance policy that does or could exclude coverage. As discussed in detail below, the insured disagrees with or questions the carrier's analysis, it can file a Petition for Declaratory judgment, which has to be filed within 6 months of the complaint against the insured, or a breach of contract action because the policy is contract. In addition, the claimant can file a Petition for Declaratory Judgment for a determination of the defendant's coverage.

I. Why this Matters for Plaintiff's Counsel

When your client makes a claim, it is imperative to determine the total amount of all insurance coverage available to pay your client's damages. Plaintiff's counsel needs to determine not only all primary coverage available, but also any excess or umbrella coverage

available, and any personal assets the defendant holds that may also be available to pay the plaintiff's damages.

When an insurer defends a claim under a reservation of rights, the coverage available under that policy may be lost if the insurer determines that the claim is excluded, outside of the policy period, or against a defendant not insured under the policy. The plaintiff should not be surprised by this issue in the middle of litigation and plaintiff's counsel has a duty to make sure that this does not happen.

The insurer does not have a duty to voluntarily tell the plaintiff of any asserted coverage defenses or that it is defending the claim under a reservation of rights, so the plaintiff must ask, at the outset of the claim, if the insurer has asserted any coverage defenses or issued a reservation of rights letter to the defendant insured, or to defense counsel. If an insurer has not asserted coverage defenses or issued a formal reservation of rights letter after a plaintiff makes a claim under an insurance policy during an applicable policy period, the insurer may be precluded by estoppel from arguing later that there is no coverage under the policy for the plaintiff's claim. See Hinchey v. National Sur. Co., 99 N.H. 373, 381 (1955) (stating same but declining to address estoppel issue because it was not properly pleaded in trial court). However, a coverage disclaimer may issue at any time during the pendency of the lawsuit if there are facts discovered that warrant the disclaimer. A plaintiff needs to remember that a defendant's general denial of liability for a claim is not the same as a denial of coverage, which may happen at a later date. See id. at 380-381 (decided under Pennsylvania law).

Conversely, an insurer's reservation of rights letter may be issued long before a formal denial of coverage for a claim, but it certainly gives rise to the question of a coverage dispute. See Kierstead v. State Farm Fire & Cas. Co., 160 N.H. 681, 687-688 (2010). If a plaintiff waits

until coverage is formally denied, but a reservation of rights letter has already been sent, the plaintiff may lose the right to petition the Court to get a coverage determination under an insurance policy. See id. at 688.

If there is any question about whether there will be coverage applicable to a plaintiff's claim, the plaintiff needs to file a declaratory judgment petition to determine that the coverage is there. A declaratory judgment (DJ) to determine coverage under an insurance policy is a different creature than a traditional equity petition for declaratory judgment. Under RSA 491:22, III (2013), the statute governing declaratory judgment petitions to determine insurance coverage, the DJ must be filed within 6 months of the date of the complaint in the underlying action giving rise to the coverage dispute unless:

> ...the facts giving rise to such coverage dispute are not known to, or reasonably discoverable by, **the insurer** until after expiration of such 6-month period; and . . . the failure to file such petition was the result of accident, mistake or misfortune and not due to neglect.... (emphasis added)

Our Supreme Court has opined that these are the only two exceptions to the strict six month time limit for filing a DJ. See Craftsbury Co. v. Assurance Co. Of Am., 149 N.H. 717, 719 (2003).

"This statute does not require an actual denial of coverage by an insurer before an insured may seek a determination of coverage." Kierstead, 160 N.H. at 687 (quoting Binda v. Royal Ins. Co., 144 N.H. 613, 616 (2000) (internal brackets and ellipses omitted). "The statute requires only that the insured know or be able to reasonably discover the facts which form the basis of a coverage dispute." Id. (quoting Binda, 144 N.H. at 616) (internal brackets omitted).

In Kierstead, the Supreme Court found that a reservation of rights letter was enough to raise a question about the potential for a coverage dispute, as was an insurer's response to an

Insurance Department complaint stating that it referred the plaintiff's claim to the special investigative unit because of suspicious loss indicators and failure to cooperate. 160 N.H. at 688.

The timeline in Kierstead was:

November 2007 – Fire Loss - Insured Plaintiffs File Claim Under Policy.

December 2007 - Insurer Issues Reservation of Rights Letter Pending Investigation.

April 2008 - Insured Plaintiffs file Insurance Department Complaint for Lack of Response.

May 2008 - Insurance Company Responds - Case Sent for Special Investigation

September 2008 - Denial Letter - Coverage Denied for Fire Loss.

January 2009 - Petition for DJ Filed by Insured to Get Coverage.

The Supreme Court found that the plaintiffs' petition for DJ was untimely because the reservation of rights letter in December 2007 should have provided facts of the coverage dispute, but certainly the May 2008 response to the Insurance Department complaint provided that information, so the January 2009 petition for DJ was untimely.

Despite this holding, a reservation of rights letter may not necessarily preclude a DJ petition from being filed after the 6 month time limit if a plaintiff discovers and pleads new facts giving rise to a question of coverage under an insurance policy. In Binda v. Royal Ins. Co., 144 N.H. 613 (2000), the Supreme Court reversed a trial court dismissal of a DJ action for being outside of the 6 month filing period. The Supreme Court held that an amended complaint can allege sufficient new facts to give rise to a coverage dispute and trigger a new 6 month filing period. Binda, 144 N.H. at 619.

In Binda, which involved an assault, the timeline was as follows:

September 1995 - Writ filed against Binda (insured) for Assault

March 1996 - Insurer Acknowledged Writ and Sent Reservation of Rights Letter

May 1996 - Insurer Denied Coverage for Assault Under Intentional Conduct Exclusion

October 1996 - Motion to Amend Writ by Plaintiff to Add Negligence Count

November 1996 - Petition for DJ filed by Binda to get Coverage for Claim

December 1996 - Writ Amendment Allowed

The trial court dismissed the DJ for being untimely because it was filed more than 6 months after reservation of rights letter. The Supreme Court agreed with this decision but found that the amended writ changed the cause of action enough to raise a new coverage issue, since the facts now alleged unintentional conduct. Id. at 619-620. The Supreme Court gave plaintiff 60 days to file a new DJ on the amended writ, but ruled they could not raise coverage issues under original writ because that would be untimely under the statute. Id. at 620.

Notably, both of these cases involved an insured petitioning for a determination of coverage by its insurer. Neither involved a plaintiff petitioning for a determination of coverage from a tortfeasor's insurer. While the Court has addressed appeals in two declaratory judgment actions brought by an injured party against a tortfeasor's insurer, see Auclair v. Allstate Ins. Co., 118 N.H. 626 (1978) and Hinchey v. National Sur. Co., 99 N.H. 373 (1955), it has never addressed the propriety or jurisdictional allowance to do so. Our federal court has suggested that there may not be jurisdiction to do so, especially if the insured tortfeasor is not a party to the petition. See Warner v. Frontier Ins. Co., 288 F.Supp. 2d 127, 130-32 (DNH 2003). The Warner Court did recognize that there is no absolute rule allowing or forbidding a Court to exercise

jurisdiction over such a petition. Id. at 130. Nor is there any rule from the New Hampshire Supreme Court stating it is appropriate. Id. at 132.

Judge Smukler has allowed a DJ to be brought by an injured party against a tortfeasor's insurer, but noted that the injured petitioner claimed standing in conflicting manners, both as a third party beneficiary and as an insured. See Twardosky v. State Farm Ins. Co., 2008 N.H. Super. LEXIS 16 at FN 1 (Belk. Co. Super. Ct. 2008). Judge Smukler did not address the standing issue because it was not raised by the pleadings. Id.

The only New Hampshire case mentioning third party v. first party DJ claims is Andrews v. Nationwide Mut. Ins. Co., 124 N.H. 148 (1983), when the Supreme Court said that an insured can bring a first party DJ claim against its insurer without needing a third party writ to be filed against it.

It is important for plaintiffs to bring declaratory judgment claims to determine coverage because the presumption is that coverage exists when there is an applicable policy. In determining whether there is coverage for a claim, the insurer bears the burden of proving there is not coverage. See Great Am. Dining v. Phila. Indem. Ins. Co., 164 N.H. 612 (2013). An insurer's obligation to defend is determined by whether the factual allegations in the pleadings against the insured bring the action within the express terms of the policy. Martin v. Me. Mut. Fire Ins. Co., 145 N.H. 498, 500 (2000).

The bottom line is that it is just as important for plaintiff's counsel to determine if and when coverage defenses are asserted and reservation of rights letters are issued as it is for an insured. If plaintiff's counsel does not discover this information in a timely manner, he or she may lose his right to ask for a determination of coverage in a DJ petition and lose critically important available coverage for his or her client to receive compensation for damages.

Furthermore, plaintiff's counsel should know standard coverage exclusions and attempt to frame the complaint in a manner that triggers coverage and avoids exclusions. For example, a complaint in a construction defect case that only identifies problems with the insured's own work will likely result in an exclusion, but the reference to resulting property damage or damages occasioned by a subcontractor's work will trigger coverage.

II. Why this Matters for Defense Counsel.

Ascertaining the coverage available to a defendant is important for a number of reasons. An attorney always has a duty to advocate for his or her client but there are heightened duties that apply to both the insurance company and defense counsel when the defendant's own assets are exposed. This can occur when a claim is of a value that is close to or surpasses the available coverage limits or when coverage is limited to defending the case, such as when a reservation of rights has issued.

A. Tripartite relationship:

For insurance defense counsel, there are ethical pitfalls associated with coverage disputes that arise from the tripartite relationship. The tripartite relationship is the relationship between the defense lawyer, the insurer, and the insured that is created when an attorney is hired by an insurer to defend a suit against the insured. In some jurisdictions, the insured and the insurer have been considered dual clients and in others the insured is the "primary client," implying that the lawyer has at least has a secondary obligation to the insurer.

In NH, the general school of thought is that the insured is the client but at the same time, the attorney cannot take a position that is contrary to the interests of the insurer. The Restatement 3d of the Law Governing Lawyers, holds the view that "a lawyer designated to defend the insured has a client lawyer relationship with the insured" and that "[t]he insurer is not,

simply by the fact that it designates the lawyer, a client of the lawyer." RESTATEMENT 3D OF THE LAW GOVERNING LAWYERS, § 134 at 408 (2000).

How the tripartite relationship is handled boils down to the ethical considerations relating to conflicts of interest. In Rule 1.8 of the New Hampshire Rules of Professional conduct has specific rules that govern conflicts of Interest with concurrent representation of two clients. The most relevant premise is that a "lawyer shall not use information relating to representation of a client to the disadvantage of the client the event that an actual conflict does arise, the attorney must withdraw." N.H.Prof.Con., Rule 1.8(b).

In addition, issues can arise with regards privileged communications. Rule 1.6. Confidentiality of Information, provides:

> (a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation, or the disclosure is permitted by paragraph (b).
>
> (b) A lawyer may reveal such information to the extent the lawyer reasonably believes necessary:
>
> (1) to prevent reasonably certain death or substantial bodily harm or to prevent the client from committing a criminal act that the lawyer believes is likely to result in substantial injury to the financial interest or property of another; or
>
> (2) to secure legal advice about the lawyer's compliance with these Rules; or
>
> (3) to establish a claim or defense on behalf of the lawyer in controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client; or
>
> (4) to comply with other law or a court order.

N.H.R.Prof.Con., Rule 1.6.

The tripartite relationship necessitates the disclosure of relevant information, good and bad, about the case to the carrier, including client communications if that information is relevant to the merits of the case. This is because the carrier decides what, if anything, it will pay toward a settlement and/or whether the case should proceed to trial. In reality, providing the carrier with

relevant evidence about the facts and circumstances of the case is necessary to protect the client's interest even when that information demonstrates that the defendant is liable and/or that his or her credibility is subject to challenge. By not providing that information and allowing the carrier to see the case through rose colored glasses, the insurance defense attorney is encouraging the carrier to offer less money to settle the case, risking your client's assets in the event of a trial with a verdict in excess of the available coverage.

B. Duty to Cooperate:

To be clear, the client has consented to the disclosure of privileged communications to the carrier by way of the duty to cooperate clause in the insurance policy. Although the language may vary, there is a duty to cooperate clause in every insurance policy that the insured accepts when it enters into the insurance contract. See, generally, Krigsman v. Progressive N. Ins. Co., 151 N.H. 643, 864 A.2d 330 (2005). The duty to cooperate clause is designed to protect the carrier's financial interest and prevent collusion between the insured and the claimant. It mandates that the insured provide counsel with all of the information to defend the case and that insured answers discovery and otherwise submits to discovery. The duty to cooperate clause also prohibits an insured from settling directly with a claimant. In exchange for the insured's cooperation, the insurer assumes complete control and direction over resolving the case.

Remember, often times the insured is not interested in the case because he/she/it has nothing at stake since the carrier is paying for the defense and usually all of the settlement funds

and award after trial. Therefore, he/she/it sometimes lacks the incentive to be helpful and fully participate. That incentive is restored by the duty to cooperate clause because the breach of that duty can result in the withdrawal of coverage. Krigsman v. Progressive N. Ins. Co., 151 at 647, 864 A.2d at 334 (2005) (submission to an examination, if the request is reasonable, is strictly construed as a condition precedent to the insurer's liability).

As the result of the threat of withdrawal of coverage, a potential conflict of interest arises when the insured is not cooperating with the defense. Insurance defense counsel's ethical obligation prohibits counsel from reporting the failure of the insured to cooperate without first taking steps to salvage the relationship. Counsel must advise and caution the client early on about the duty to cooperate so that the client is fully aware of the risks not participating in the defense of the case. A default judgment or other discovery sanctions will force the issue, as will the inability to report to the carrier the necessary details of the defense. In other words, when counsel can no longer due his/her job because the client fails to answer discover or respond to requests for information, the carrier will undoubtedly become aware and initiate its own contact with the insured to demand cooperation and ultimately deny coverage as a last resort.

The dynamics of the duty to cooperate also impact how plaintiff's counsel handles discovery violations. A plaintiff will typically want the defendant to have available insurance coverage because that ensures that funds will be available for settlement and to pay a jury award. In contrast, many individuals and small businesses will not have the resources to pay damages, resulting in an empty verdict and an insolvent defendant. Consequently, plaintiff's counsel should take caution before seeking default judgments and sanctions for discovery violations when the cause is an uncooperative defendant. Instead, the better course of action may be to notice a deposition with a subpoena *duces tecum*.

C. Duty to Settle:

While an insurer is only obligated to indemnify when claims fall within the scope of the insurance contract, when that duty is triggered the carrier must act reasonably when fulfilling it. In particular, an insurer has a duty of reasonable care in the settlement of a third-party liability claim. Dumas v. State Farm Mut. Auto Ins. Co., 111 N.H. 43, 274 A.2d 781 (1971). The insurer's bad-faith refusal to settle or pay a claim pursuant to its contractual obligations is also a tort for which the plaintiff is entitled to recover all damages proximately caused therefrom. Lawton v. Great Southwest Fire Ins. Co., 118 N.H. 607, 613, 392 A.2d 576, 580 (1978).

The Dumas issue is discussed in more detail later on in your materials. It should be emphasized ethical considerations may arise when the carrier exposes the insured to a potential excess verdict. Counsel, too, whether insurance defense or personal counsel, must take pains to protect the client's assets from being exposed. However, only the latter can take steps directly adverse to the carrier.

Ethical Pitfalls for Plaintiff's Counsel in Insurance Cases: O'Meara's Case and the "Dumas Demand"

On September 18, 2012, the New Hampshire Supreme Court issued O'Meara's Case, 164 N.H. 170 (2012), and disbarred an attorney, Timothy O'Meara, for misconduct that arose during his representation of the plaintiffs in a personal injury suit. One of the primary issues was O'Meara's argument that his demand was actually an invitation for the insurer to make an offer to settle. Id. at 177. The issue helps illuminate the role Dumas v. State Farm Mut. Auto. Ins. Co., 111 N.H. 43 (1971), plays in negotiating settlements and the potential ethical pitfalls that could arise.

The relevant facts leading up to the disciplinary proceeding are as follows. The plaintiffs in the underlying case were Anita and James Conant. O'Meara's Case, 164 N.H. at 172. Ms. Conant's car was hit by a paving truck and as a result, she suffered a severe spinal cord injury and was rendered a ventilator-dependent quadriplegic. Id. While Ms. Conant was undergoing medical treatment, Mr. Conant returned to New Hampshire, met with O'Meara, and eventually retained his services by promising 33.33% of the amount recovered. Id. at 172-73.

O'Meara filed suit and learned that the defendant had insurance coverage totaling $11 million and that the insurer did not contest liability. Id. at 173. He then sent opposing counsel a letter that stated, "As I have indicated on numerous occasions previously, this is a policy limits case. If said limits are not paid, the Conant family has instructed me to proceed to trial." Id. At the time the letter was sent, however, O'Meara knew he was not authorized to settle the case. Id. Further settlement discussions occurred, but the Conants ultimately refused to authorize O'Meara to settle for the $11 million policy limit. Id. at 173-74. Despite this, the family was ultimately forced, due to O'Meara's unauthorized actions, to accept an offer of approximately $11.5 million

dollars from the defendant. Id. at 174. The costs to care for Ms. Conant would exceed $23 million. Id. at 174.

The matter came to the attention of the Attorney Disciplinary Office, which issued charges against O'Meara alleging that he had violated New Hampshire Rule of Professional Conduct 1.2(a) (Scope of Representation), among other rules, in his representation of the Conants. Id. at 176. Rule 1.2(a) provides that "a lawyer shall abide by a client's decisions concerning the objectives of representation, and . . . shall consult with the client as to the means by which they are to be pursued." N.H. R. Prof. Conduct 1.2(a). The Professional Conduct Committee (PCC) found that O'Meara's letter and further communications with opposing counsel constituted a demand to settle for $11 million even though his clients had not authorized him to settle. Id. at 177.

On appeal, O'Meara argued that the PCC had mischaracterized his communications with opposing counsel. Id. In his brief, O'Meara emphasized the Supreme Court's decision in Dumas and the role offers to settle within the policy limits play in determining whether the insurance company had acted negligently in failing to settle the claim. See Brief for O'Meara at 70-72, O'Meara's Case, 164 N.H. 170 (2012) (No. LD-2011-002), available at http://appealslawyer.net/do/briefs/OMeara_Timothy_brief.pdf. O'Meara argued that the plaintiff's attorney has an interest and possibly an ethical obligation, where the claim is near or in excess of the policy's coverage, to facilitate the creation of a "Dumas claim" for the insured to assure maximum payment for his client. Id. at 72. He further contended that his initial communications constituted a "Dumas demand" that served simply to put the insurer on notice that the claim may meet or exceed the policy limits and that the insurer may act negligently if it refused to settle within the policy limits. Id. at 73. He then asserted that issuing a "Dumas

demand" is the duty of the plaintiff's attorney but does not constitute an offer to settle and does not necessarily bind the plaintiff to accept any offers to settle. Id. Under O'Meara's reasoning, once the "Dumas demand" is made, the insurer can make an offer to settle, which the plaintiff can choose to accept or reject. Id. at 73-74. This is so because, in O'Meara's view, a demand, made by the plaintiff, is distinct from an offer, made by the insurer or defendant, and only acceptance of an offer binds the parties. Id. at 74-77.

Although the Supreme Court agreed with the PCC's conclusion that O'Meara's communications with opposing counsel constituted an offer to settle—potentially a sub silentio rejection of the later part of O'Meara's reasoning regarding demands versus offers—and did not need to reach the issue of the "Dumas demand," see O'Meara's Case, 164 N.H. at 177, the case still highlighted an important issue that plaintiff's counsel must be aware of in tort claims. The Court acknowledged that "[u]nder Dumas, an insured may maintain such an action [for negligent failure to settle tort claims] when . . . the case could have been settled within the policy limits." Id. (first emphasis in original; second emphasis added). Thus, to a certain extent, O'Meara was correct because absent the plaintiff's attorney making a demand that falls within the policy limits, the insurer will not be exposed to liability in excess of the policy limit, which leaves the insured responsible for any excess liability. Nevertheless, a "Dumas demand," as contemplated by O'Meara, remains, in effect, an offer to settle for an amount within the policy limits. Accordingly, great care must be taken in deciding to make such an offer, which includes getting the authority to make such an offer, because although a rejection of the offer may lead to greater damages acquired after judgment, an acceptance of the offer may irreversibly place the parties on the path to settlement.

Direct or Derivative Right? Exploring the Primary-Excess Insurer Relationship

By James R. Tenero and Lyndon F. Bittle

A recent review of national case law indicates that only two states, New Jersey and New York, hold that a primary insurer owes a "positive" or direct duty to an excess insurer to act in good faith with respect to settlement within policy limits.[1] In contrast, the remaining states that have addressed this issue, about half the states to date, reason that an excess insurer's right to proceed against a primary insurer who unreasonably fails to settle within policy limits is a derivative right and vests through the principles of equitable subrogation.[2] One state has rejected both equitable subrogation and a direct duty to the excess insurer.[3] Roughly 20 states do not appear to have addressed this issue.[4]

By examining the legal, economic, and public interest principles articulated by courts, this article explores whether the distinction between a "positive" or direct duty and a derivative right is material or word play.

Identification of the Problem: The Self-Interested Primary Insurer

Almost universally, courts have identified a conflict of interest between the policyholder and the primary insurer when a near-policy-limits demand is made. Because a primary insurer controls the defense (and with it, settlement), self-interest may motivate a primary insurer to reject a near-policy-limits demand in the hope that a court or jury will award less. As stated by the Seventh Circuit Court of Appeals in *Twin City Fire Insurance Co. v. Country Mutual Insurance Co.*, a primary insurer may view such situation as a "[h]eads I win, tails you [the policyholder] lose" position.[5] For example:

> Suppose the claim was for $2 million, the policy limit was $1 million, the plaintiff was willing to settle for this amount, but the defendant's insurer believed that if the case was tried the plaintiff would have a 50 percent chance of winning $2 million and a 50 percent chance of losing. The insurer's incentive would be to refuse to settle, since if it lost the trial it would be no worse off than if it settled—in either case it would have to pay $1 million—but if it won it would have saved itself $1 million.[6]

In contrast, it is commonly assumed that "[o]bviously, it will always be in the insured's interest to settle within the policy limits when there is any danger, however slight, of a judgment in excess of those limits."[7] Therefore, the primary insurer's contractually created, unwavering right to control the defense coupled with a near-policy-limits demand arguably incentivizes the primary insurer's self-interested conduct to save money, i.e., to "gamble with the insured's money."[8]

A Solution to the Problem Identified

To address this problem, courts have universally reasoned that "an insurer should not be permitted to further its own interests by rejecting opportunities to settle within the policy limits unless it is also willing to absorb losses which may result from its failure to settle."[9] "It is in order to quench this kind of temptation that the liability insurer's duty to settle in good faith was read into liability insurance contracts."[10]

> An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured. This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.[11]

The foundation for this solution was long in place in most jurisdictions: "There is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement."[12] Because an insurance policy is a contract, courts did not venture too far in acknowledging its implied covenant with respect to the settlement of claims.[13] Other courts have grounded the primary insurer's settlement obligations on the special relationship by which the insurer becomes the "agent" of the insured in handling his or her defense and making settlement decisions.[14]

The self-interested primary insurer problem is not exclusive to policyholders. Courts have recognized that primary insurers' conduct affects excess insurers as well.[15] However, the solution with respect to excess insurers has been more complicated. For example, generally speaking, no contract exists between primary and excess insurers, and the primary insurer does not undertake the defense of the excess insurer. Therefore, the foundations so readily available in the policyholder-primary insurer context do not exist. Nevertheless, to date, courts have fashioned two remedies: a derivative rights approach and a "positive" or direct duty approach.

TIP
An excess insurer generally cannot assert claims against a primary insurer based on actions taken or approved by the policyholder.

Derivative Rights Approach

A majority of states conclude, at least within the context of settlement, that a primary insurer owes a duty of good faith to an excess insurer; such duty, however, is derivative. As stated by the California Supreme Court:

> This rule, however, is based on the theory of equitable subrogation: Since the insured would have been able to recover from the primary carrier for a judgment in excess of policy limits caused by the carrier's wrongful refusal to settle, the excess carrier, who discharged the insured's liability as a result of this tort, stands in the shoes of the insured and should be permitted to assert all claims against the primary carrier which the insured himself could have asserted. Hence, the rule does not rest upon the finding of any separate duty owed to an excess insurance carrier.[16]

Equitable subrogation is defined as "a legal fiction through which a person who pays a debt for which another is primarily responsible is substituted or subrogated to all the rights and remedies of the other."[17] A California court has identified the essential elements of equitable subrogation:

> (a) the insured suffered a loss for which the defendant [i.e., primary insurer] is liable, either as the wrongdoer whose act or omission caused the loss or because the defendant is legally responsible to the insured for the loss caused by the wrongdoer;
> (b) the claimed loss was one for which the [excess] insurer was *not* primarily liable;
> (c) the [excess] insurer has compensated the insured in whole or in part for the same loss for which the defendant is primarily liable;
> (d) the [excess] insurer has paid the claim of its insured to protect its own interest and not as a volunteer;
> (e) the insured has an existing, assignable cause of action against the defendant which the insured could have asserted for its own benefit had it not been compensated for its loss by the [excess] insurer;
> (f) the [excess] insurer has suffered damages caused by the act or omission upon which the liability of the defendant depends;
> (g) justice requires that the loss be entirely shifted from the [excess] insurer to the defendant [i.e., primary insurer], whose equitable position is inferior to that of the [excess] insurer; and
> (h) the [excess] insurer's damages are in a liquidated sum, generally the amount paid to the insured.[18]

Equitable subrogation, therefore, provides a literal, or at least a *more* literal, connection to the insurance policy—the contract within which the primary insurer expressly takes control of the policyholder's defense: "We will have the right and duty to defend the insured against any 'suit' seeking those damages."[19]

Why do the majority of states tie or otherwise limit an excess insurer's rights against a primary insurer to the insurance policy itself? Overall, courts have reasoned:

Excess insurer lacks standing. Absent a contract between a primary and excess insurer, an excess insurer lacks standing to sue the primary insurer directly.[20]

Contractual duty recast as tort. Judicial recasting of the *contractual* duty of good faith and fair dealing as a tort subverts proper application of equitable subrogation.[21]

Unique primary-excess insurer relationship. The reasons that support a tort-based cause of action in the policyholder against his or her primary insurer for failing to settle within the policy limits do not exist between a primary and excess insurer. For example, the policyholder "expressly relinquishes to the [primary] insurer the right to control the defense and settlement of any action," so the insured must rely on the primary insurer's good faith. However, excess insurers generally reserve in their policies the right to participate in the defense and settlement of claims.[22] Moreover, there are differences in bargaining power between the parties. The insurance policy shifts financial risk from the policyholder, with minimal litigation experience, to the primary insurer, with substantial litigation experience. However, primary and excess insurers "stand on more equal footing." Each has litigation experience. "Without a contract, there can be no contractual shifting of financial risk" between them.[23] Excess insurance, by its nature, can eliminate or at least reduce the risk the

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insurer faces with respect to excess judgments by pooling the risk of many policyholders. A policyholder cannot do that. A policyholder can only buy insurance to reduce or eliminate the risk of personally owing a judgment.[24]

Adequate remedy. Equitable subrogation provides an excess insurer an adequate remedy.[25]

Conflicting duties. Imposing on the primary insurer a direct duty to the excess insurer could impose conflicting duties, especially where the insured urges rejection of a settlement offer he or she believes is not in his or her long-term interests.[26]

Excess insurer can protect itself. "For instance, an excess insurer can provide in its contract that it may control the defense whenever potential for excess liability exists," require notice of suits, and require that all settlements be approved by it.[27]

Resistance to parentalism over insurance companies. As the Seventh Circuit queried but did not address: "Should courts strain to create novel tort duties on behalf of insurance companies? Do insurance companies need the protection of tort law against their own insureds and other insurance companies?"[28]

In sum, absent an express contract between primary and excess insurers, the majority of courts seem to resist creation of what they apparently view as a novel tort because the law already provides an adequate and firmly rooted remedy—equitable subrogation.

A core principle of equitable subrogation is that the excess insurer has only those rights against the primary insurer that are held by their mutual insured; the primary insurer can assert against the excess any defense it could assert against the insured.[29] In the settlement context, if the primary insurer's refusal to settle within the primary limits was done at the insured's insistence, or with his or her approval, neither the insured nor the excess insurer can successfully maintain a bad faith claim against the primary insurer.[30]

The Alabama Supreme Court has applied a particularly strict version of this rule. In *Federal Insurance Co. v. Travelers Casualty & Surety Co.*,[31] the excess insurer (Federal) paid $3.6 million of a $4.6 million postjudgment settlement of a case that apparently could have been settled before trial for $350,000. Federal sued Travelers, the primary carrier, for breaching its duty to settle within its $1 million primary limits. After holding Travelers owed no duty directly to Federal, the Alabama Supreme Court held that Federal also could not recover under equitable subrogation because the settlement on appeal meant that the insured was "never subject to a final judgment ordering the payment of money that [the insured] personally—and not his insurer—would have to pay."[32]

A core principle of equitable subrogation is that the excess insurer has only those rights against the primary insurer that are held by their mutual insured.

"Positive" or Direct Duty Approach

In contrast to the majority of states, New Jersey and New York have affirmatively concluded that a primary insurer owes a "positive" or direct duty to an excess insurer.

***Penn* (N.J. 1977).** The seminal New Jersey decision holding that a primary insurer owes a direct duty of good faith and fair dealing to an excess insurer is *Estate of Penn v. Amalgamated General Agencies*.[33] In *Penn*, the New Jersey Appellate Division held "that the primary carrier owes to the excess carrier the same positive duty to take the initiative and attempt to negotiate a settlement within its policy limit that it owes to its assured."[34]

Penn was sued by four individuals who alleged injury resulting from a motor vehicle accident. Penn was insured by Empire Mutual for $10,000/$20,000. On the excess level, Penn was insured by Western World for $90,000/$280,000. As the primary insurer, Empire Mutual assumed Penn's defense. Prior to trial, the claimants offered to settle for $10,875. Empire Mutual rejected the settlement demand. Following a jury trial, a $29,827 judgment was entered against Penn.

In a concurrent policyholder-insurer action, the trial court denied Western World judgment against Empire Mutual for failing to settle within the policy limits. The trial court reasoned that a primary insurer does not owe an excess insurer the same duty of good faith and fair dealing owed to the policyholder. Western World appealed. On appeal, the appellate court reversed the trial court, holding that "Western World, as the excess carrier, has precisely the same status as the assured Penn for purposes of this action."[35] The appellate court based its conclusion on *Fireman's Fund Insurance Co. v. Security Insurance Co. of Hartford*,[36] and "the general rule under which the excess carrier is subrogated to the assured's rights against the primary carrier."[37]

Interestingly, the *Penn* court provides no detailed discussion of the *Fireman's Fund* decision. Upon examination, the *Fireman's Fund* court expressly stated that the excess insurer sued as an assignee of the insured and that "[t]he parties agree that plaintiff's status is no different than that of the insured and that no additional rights flow to it because it was an excess insurer."[38] Thus, arguably, the leading New Jersey decision is based on equitable subrogation principles, not an independent tort cause of action. Further, in support of its conclusion, the *Penn* court relied on a California federal district court decision that squarely applied equitable subrogation in the primary-excess insurer context.[39] Putting aside the legal principle actually applied, the *Penn* court's reasons for its holding are plain:

No increase of risk to the primary insurer. First, the court noted that "[t]he primary carrier's duty arises by way of a contract with the insured, and this duty is not reduced merely because of another contract between the insured and its excess insurer." It reasoned that "[a]n insurance company's duty to act in good faith in settling claims within its policy limits is well established and is reflected in its premiums. That an excess insurer may recover from the primary for a breach of duty does not increase the duty or liability of the primary."[40]

Prevent increase in excess insurance premiums. Second, the court concluded that "[w]hile the interests of the primary insurer are, for the most part, unaffected by the existence of excess coverage, the interests of the excess carrier are very much affected by the actions of the primary." When the primary carrier undertakes the representation of the insured, it has the sole right to negotiate settlements. "If the primary carrier is relieved of its duty to accept reasonable offers by the existence of excess insurance, it would put an additional financial liability on the excess carrier which would be reflected in increased premiums."[41]

When the primary carrier undertakes the representation of the insured, it has the sole right to negotiate settlements.

Encourage the prompt and just settlement of claims. Third, if the existence of excess insurance relieves the primary carrier of its duty to accept reasonable offers, it would "have the effect of reducing the incentive of a primary insurer to settle when the settlement offer is near or over its policy limits. This is contrary to the interests of the public and the insured in obtaining prompt and just settlement of claims."[42]

As noted, the *Penn* court adopted these reasons from a California federal district court decision based on equitable subrogation. While these reasons may justify subrogating an excess insurer to a policyholder's rights against a primary insurer, are they sufficient to justify creation of a "positive" or direct duty?

***Warner-Lambert* (N.J. 1995).** In 1995, the Law Division of the New Jersey Superior Court affirmed and significantly extrapolated on the bases that arguably support imposing a "positive" or direct duty on a primary insurer toward an excess insurer. In *American Centennial Insurance Co. v. Warner-Lambert Co.*, the court found that the primary breached its duty to the excess by allowing their mutual insured to control "all litigation and negotiation maneuvers."[43] In sum, the court established three pillars on which the duty is based:

Unique relationship. As a first pillar supporting a direct duty, the court relied on the "unique" relationship between primary and excess insurers:

> The primary insurer has certain duties and obligations that it owes to the excess insurer as a result of the distinctive relationship between the two carriers. The unique relationship results because the excess insurer relies upon the primary carrier to act in good faith in processing claims. This includes reliance upon a primary carrier to act reasonably in: (a) discharging its claims handling obligations; (b) discharging its defense obligations; (c) properly disclosing and apprising the excess carrier of events which are likely to affect that carrier's coverage; and (d) safeguarding the rights and interests of the excess carrier by not placing the primary carrier's own interests above that of the excess insurer. The actions of the primary carrier can affect the rights of the excess carrier.[44]

A contract exists. As a second pillar supporting a direct duty, the court found what the majority of states conclude is lacking—a contract between the primary and excess insurer:

> The insurance industry has promulgated an industry contract known as . . . "The Guiding Principles for Primary and Excess Insurance Companies." The Guiding Principles offer a uniform set of rules to govern the relationships between primary and excess insurers, and both [the primary insurer] and [the excess insurer] are signatories to the Principles. The Principles provide[:] "It is implicit in these

guiding principles that the primary insurer in its dealings with an excess insurer voluntarily adopt those standards of conduct which the law imposes upon the primary insurer in its dealings with its insured."[45]

According to the court, "the Guiding Principles provide nine different obligations which define the relationship between the primary and excess carriers," five of which were relevant to the proceedings:

> 1. The primary insurer must discharge its duty of investigating promptly and diligently even those cases in which it is apparent that its policy limit may be consumed.
> 2. Liability must be assessed on the basis of all the relevant facts which a diligent investigation can develop and in the light of applicable legal principles. The assessment of liability must be reviewed periodically throughout the life of the claim.
> 3. Evaluation must be realistic and without regard to the policy limit.
> 4. When from evaluation of all aspects of a claim, settlement is indicated, the primary insurer must proceed promptly to attempt a settlement, up to its policy limit if necessary, negotiating seriously and with an open mind.
> 5. If at any time, it should reasonably appear that the insured may be exposed beyond the primary limit, the primary insurer shall give prompt written notice to the excess insurer, when known, stating the results of investigation and negotiation, and giving any other information deemed relevant to a determination of the total exposure, and inviting the excess insurer to participate in a common effort to dispose of the claim.[46]

These Principles "can be used to establish the standard of care which a primary insurer must use when settling a claim where an excess insurer may also ultimately be responsible for coverage."[47]

Common law. As a final, third pillar supporting a direct duty, the court held that common law principles warrant finding a direct duty:

> Fairness and policy require the imposition of a duty of good faith on the primary carrier. . . . The excess carrier charges the insured a premium that assumes the primary carrier will act in good faith to settle and litigate claims, thereby decreasing the excess carrier's exposure to risk. When the primary carrier does not perform its duties in good faith, the public suffers, as excess carriers will then charge higher premiums for excess coverage.[48]

***Baen* (N.J. 1999).** Two years after publication of *Warner-Lambert*, the New Jersey Appellate Division, in *Baen v. Farmers Mutual Fire Insurance Co. of Salem County*, affirmed that "[a]n insurer owes its insured the duty to exercise good faith in handling claims," and that "[t]he primary carrier owes the excess carrier the same positive duty it owes its insured, to take the initiative and attempt to negotiate a settlement within its policy limit."[49] The *Baen* court relied, in part, on the *Penn* and *Warner-Lambert* decisions. While the *Baen* court distinguished the matter before it, the court nevertheless stated it was "in accord with the reasoning and result" in the *Warner-Lambert* case.[50]

In light of *Baen* and pending further input from the New Jersey Supreme Court, New Jersey is and remains a "positive" or direct duty state for the reasons stated.

***Hartford* (N.Y. 1983).** New York is likewise a "direct duty" state, according to *Hartford Accident & Indemnity Co. v. Michigan Mutual Insurance Co.*[51] The Appellate Division held in 1983 that "the primary carrier owes to the excess insurer the same fiduciary obligation which the primary insurer owes to its insured."[52] This duty of good faith "requires a primary insurer to give as much consideration to the excess carrier's interests as it does to its own."[53] The obligation "arises as a result of the independent and direct duty to the excess insurer and is not dependent upon equitable principles of subrogation."[54] The justification for adopting the direct duty rule offered by the *Hartford* court was that it had "been recognized in [New York] and other states, as well as in the federal courts."[55] At least one New York court has held that it can be bad faith for a primary carrier to handle its insured's defense in a manner that is arguably in the insured's best interest (as well as its own) but causes the excess insurer to bear more of the loss.[56]

Conclusion

This article started with the objective of exploring whether the distinction between a "positive" or direct duty and a derivative right is material or word play.

Judge Posner in *Twin City* downplayed the difference between equitable subrogation and direct duty. He acknowledged that if the primary insurer failed to settle a lawsuit in deference to the insured's wishes, equitable subrogation would preclude a claim against the primary by the excess.[57] But he suggested that "[i]f the insured was acting irresponsibly in pressing the case to trial, the excess insurer [might] have a contract defense to the insured's claim against it," because "[t]he duty of good faith between insured and insurer is a reciprocal one."[58] He criticized as "obtuse" two courts that "had trouble seeing this"—California and Texas, both of which had found that an insured generally owes no duty to its excess insurer to settle a lawsuit for

an amount below the excess layer.[59] The only case cited for the Seventh Circuit's position was the short-lived *Spinks* decision by a California appellate court, which—besides having been disapproved by the California Supreme Court—rejected equitable subrogation and would have imposed direct duties on each of the parties, under a theory it dubbed "triangular reciprocity."[60] Unless courts widely adopt the broad statement of duties described in *Twin City* and *Spinks*, the excess insurer's inability to pursue claims against the primary insurer based on actions or positions taken by their mutual insured remains a material distinction between the direct duty approach and equitable subrogation.

In short, by exploring the legal, economic, and public interest principles articulated in case law, this article finds an apparent consensus that while under limited circumstances (namely, policyholder conduct impairing equitable subrogation rights) a material distinction may exist, it remains insufficient to warrant judicial creation of a new tort by which a primary insurer owes duties directly to the excess insurer. The majority of courts that have considered these issues have concluded an excess insurer is best situated to protect its own interests: either through equitable subrogation (preserving the public's interest in prompt and just settlements), active participation in the defense and settlement of claims, or policy language (such as consent to settlement, notice, or cooperation provisions). ■

Most courts have held an excess insurer is best situated to protect its own interests through subrogation, participation in claim defense and settlement, and policy language.

Notes

1. *See, e.g.*, Estate of Penn v. Amalgamated Gen. Agencies, 372 A.2d 1124, 1127 (N.J. Super. Ct. App. Div. 1977); Am. Centennial Ins. Co. v. Warner-Lambert Co., 681 A.2d 1241, 1246 (N.J. Super. Ct. Law Div. 1995); Hartford Accident & Indem. Co. v. Mich. Mut. Ins. Co., 462 N.Y.S.2d 175, 178 (App. Div. 1983), *aff'd*, 463 N.E.2d 608 (N.Y. 1984).

2. *See, e.g.*, Steadfast Ins. Co. v. Agric. Ins. Co., 548 F. App'x 544, 546 (10th Cir. 2013) (applying Oklahoma law); Nat'l Sur. Corp. v. Hartford Cas. Ins. Co., 493 F.3d 752, 755–57 (6th Cir. 2007) (applying Kentucky law); Evanston Ins. Co. v. Stonewall Surplus Lines Ins. Co., 111 F.3d 852, 858–59 (11th Cir. 1997) (applying Georgia law); Puritan Ins. Co. v. Canadian Universal Ins. Co., 775 F.2d 76, 80–81 (3d Cir. 1985) (applying Pennsylvania law); Gebremedhin v. Am. Family Mut. Ins. Co., No. 13-cv-02813-CMA-NYW, 2015 U.S. Dist. LEXIS 42177 (D. Colo. Mar. 31, 2015); Auto-Owners Ins. Co. v. Am. Yachts, Ltd., 492 F. Supp. 2d 1379, 1386 n.6 (S.D. Fla. 2007); Electric Ins. Co. v. Nationwide Mut. Ins. Co., 384 F. Supp. 2d 1190, 1194 (W.D. Tenn. 2005); PHICO Ins. Co. v. Aetna Cas. & Sur. Co. of Am., 93 F. Supp. 2d 982, 989 (S.D. Ind. 2000); Vencill v. Cont'l Cas. Co., 433 F. Supp. 1371, 1376–77 (S.D. W. Va. 1977); Fed. Ins. Co. v. Travelers Cas. & Sur. Co., 843 So. 2d 140, 143 (Ala. 2002); Twin City Fire Ins. Co. v. Superior Court, 792 P.2d 758, 760 (Ariz. 1990); Commercial Union Assurance Cos. v. Safeway Stores, Inc., 610 P.2d 1038, 1041 (Cal. 1980); Infinity Ins. Co. v. Worcester Ins. Co., No. CV000597436, 2000 Conn. Super. LEXIS 3392, at *3–4 (Dec. 4, 2000); U.S. Fire Ins. Co. v. Zurich Ins. Co., 768 N.E.2d 288, 299–300 (Ill. App. Ct. 2002); Great Sw. Fire Ins. Co. v. CNA Ins. Cos., 557 So. 2d 966, 967 (La. 1990); Fireman's Fund Ins. Co. v. Cont'l Ins. Co., 519 A.2d 202, 204 (Md. 1987); Hartford Cas. Ins. Co. v. N.H. Ins. Co., 628 N.E.2d 14, 19 & n.7 (Mass. 1994); Commercial Union Ins. Co. v. Med. Protective Co., 393 N.W.2d 479, 485 (Mich. 1986); Cont'l Cas. Co. v. Reserve Ins. Co., 238 N.W.2d 862, 864 (Minn. 1976); Scottsdale Ins. Co. v. Addison Ins. Co., 448 S.W.3d 818, 833 (Mo. 2014); Allstate Ins. Co. v. Reserve Ins. Co., 373 A.2d 339, 340 (N.H. 1976); Centennial Ins. Co. v. Liberty Mut. Ins. Co., 404 N.E.2d 759, 762 (Ohio 1980); Me. Bonding & Cas. Co. v. Centennial Ins. Co., 693 P.2d 1296, 1301–02 (Or. 1985); Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 483 (Tex. 1992); Truck Ins. Exch. v. Century Indem. Co., 887 P.2d 455, 460 (Wash. Ct. App. 1995); Kranzush v. Badger State Mut. Cas. Co., 307 N.W.2d 256, 260–61 (Wis. 1981); *see also* Hartford Accident & Indem. Co. v. Aetna Cas. & Sur. Co., 792 P.2d 749, 752–53 nn. 2–3 (Ariz. 1990) (surveying national case law as of 1990).

3. Stonewall Surplus Lines Ins. Co. v. Farmers Ins. Co. of Idaho, 971 P.2d 1142, 1148–49 (Idaho 1998).

4. Alaska, Arkansas, Delaware, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, and Wyoming have not addressed whether an excess insurer may bring a cause of

action against a primary insurer for failure to settle a claim against the insured within the policy limits. The District of Hawaii has certified the question to the Hawaii Supreme Court, which has yet to decide the issue. St. Paul Fire & Marine Ins. Co. v. Liberty Mut. Ins. Co., No. 13-00361 HG-BMK, 2014 U.S. Dist. LEXIS 47385, at *10–11 (D. Haw. Mar. 31, 2014).

5. 23 F.3d 1175, 1179 (7th Cir. 1994) (applying Illinois law).

6. *Id.*

7. Crisci v. Sec. Ins. Co., 426 P.2d 173, 176–77 (Cal. 1967). That insureds do not *always* consider settlement within primary limits to be in their interest is shown by later decisions by the same court. *See, e.g.*, *Safeway Stores*, 610 P.2d at 1042–43.

8. *Crisci*, 426 P.2d at 177; *see also Twin City*, 23 F.3d at 1179 ("A standard provision in liability-insurance contracts gives the insurer control over the defense of any claim against the insured, and an implied correlative of this right is the duty not to gamble with the insured's money by forgoing reasonable opportunities to settle a claim on terms that will protect the insured against an excess judgment.").

9. *Crisci*, 426 P.2d at 177.

10. *Twin City*, 23 F.3d at 1179.

11. Auto-Owners Ins. Co. v. Am. Yachts, Ltd., 492 F. Supp. 2d 1379, 1382 (S.D. Fla. 2007) (quoting Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 785 (Fla. 1980)).

12. Comunale v. Traders & Gen. Ins. Co., 328 P.2d 198, 200 (Cal. 1958) (citing Brown v. Superior Court, 212 P.2d 878 (Cal. 1949)).

13. *Id.* at 200–01 (citing Hilker v. W. Auto. Ins. Co., 231 N.W. 257, 258 (Wis. 1930), *aff'd on reh'g*, 235 N.W. 413 (Wis. 1931), for the proposition that "the rights of the insured 'go deeper than the mere surface of the contract written for him by the defendant' and that implied obligations are imposed 'based upon those principles of fair dealing which enter into every contract'").

14. *See, e.g.*, Ranger Cnty. Mut. Ins. Co. v. Guin, 723 S.W.2d 656, 659 (Tex. 1987). Texas has steadfastly refused to impose a duty of good faith and fair dealing on the parties to every contract. *See* FDIC v. Coleman, 795 S.W.2d 706, 709 (Tex. 1990); English v. Fischer, 660 S.W.2d 521, 522 (Tex. 1983).

15. *See, e.g.*, *Twin City*, 23 F.3d at 1179 ("[B]y virtue of an excess insurance policy the victim of the behavior that we have described is the excess insurer rather than the insured[.]"); Am. Centennial Ins. Co. v. Warner-Lambert Co., 681 A.2d 1241, 1246 (N.J. Super. Ct. Law Div. 1995) ("The actions of the primary carrier can affect the rights of the excess carrier.").

16. Commercial Union Assurance Cos. v. Safeway Stores, Inc., 610 P.2d 1038, 1041 (Cal. 1980) (citation omitted), *overruling* Transit Cas. Co. v. Spink Corp., 156 Cal. Rptr. 360 (Ct. App. 1979).

17. Commercial Union Ins. Co. v. Med. Protective Co., 393 N.W.2d 479, 482 (Mich. 1986).

18. Fireman's Fund Ins. Co. v. Md. Cas. Co., 77 Cal. Rptr. 2d 296, 302–03 (Ct. App. 1998).

19. *See, e.g.*, Ins. Servs. Office, Inc. (ISO), Commercial Gen. Liab. Coverage Form CG 00 01 04 13, ¶ I.A.1.a.

20. *See, e.g.*, Infinity Ins. Co. v. Worcester Ins. Co., No. CV000597436, 2000 Conn. Super. LEXIS 3392, at *3–4 (Dec. 4, 2000) ("It is well settled that one who [is] neither a party to a contract nor a contemplated beneficiary thereof cannot sue to enforce the promises of the contract[.]"); *see also* Evanston Ins. Co. v. Stonewall Surplus Lines Ins. Co., 111 F.3d 852, 858 (11th Cir. 1997) (quoting Kranzush v. Badger State Mut. Cas. Co., 307 N.W.2d 256, 260–61 (Wis. 1981), for the proposition that "our cases indicate that the insurer's duties of diligent investigation, notice of excess liability potential, and communication of settlement offers runs to the insured, and the cause of action upon their breach belongs to the insured[; in] every one of our excess liability bad faith cases the plaintiff is either the insured or the assignee of the insured's claim").

21. Twin City Fire Ins. Co. v. Country Mut. Ins. Co., 23 F.3d 1175, 1180 (7th Cir. 1994) ("[M]any courts have recast the implied contractual duty of good faith settlement as a tort duty. Once the duty is thus preconceived, it is easy to imagine it running to any excess insurer as well as to the insured, at least if the primary insurer knows . . . that there is an excess insurer in the picture. When this step is taken, the doctrine of equitable subrogation falls out of the picture." (citations omitted)).

22. *See, e.g.*, Fed. Ins. Co. v. Travelers Cas. & Sur. Co., 843 So. 2d 140, 143 (Ala. 2002) (finding no evidence that the excess insurer relinquished the right to control defense and settlement; in fact, the excess insurer expressly reserved such right).

23. *Id.*

24. *Twin City*, 23 F.3d at 1179 ("[T]he insured, at least if an individual, will be risk averse—that is why he buys insurance—while the insurance company eliminates risk by pooling the risks of many insureds.").

25. *See, e.g.*, Twin City Fire Ins. Co. v. Superior Court, 792 P.2d 758, 759–60 (Ariz. 1990) (but stating "[a]dmittedly, there may be times when equitable subrogation is not an adequate remedy for the excess carrier"; for example, "recovery by the excess insurer may be barred in the event of wrongful conduct of the insured"); *see also* Auto-Owners Ins. Co. v. Am. Yachts, Ltd., 492 F. Supp. 2d 1379, 1385 (S.D. Fla. 2007) (holding that where the insured is released and no rights are reserved, the excess insurer cannot maintain a claim against the primary insurer).

26. *See, e.g.*, *Twin City*, 23 F.3d at 1180 (noting that imposing a direct duty to the excess insurer on the primary insurer "would place the latter in the uncomfortable position of facing a tort suit for bad faith if it settled the case and a tort suit for bad faith if it tried the case"); Int'l Ins. Co. v. Dresser Indus., Inc., 841 S.W.2d 437, 446 (Tex. App. 1992) ("We decline to impose upon [the primary insurer] a duty to wrench control of the . . . lawsuit away

from [the insured] and settle it against [the insured's] will on terms favorable to [the excess insurer's] interest.").

27. *Twin City v. Superior Court*, 792 P.2d at 760 (relying on Commercial Union Assurance Co. v. Safeway Stores, Inc., 610 P.2d 1038, 1041 (Cal. 1980), for the proposition that "[i]f an excess carrier wishes to insulate itself from liability for an insured's failure to accept what it deems to be a reasonable settlement offer, it may do so by appropriate language in the policy").

28. *Twin City*, 23 F.3d at 1180–81 ("We need not answer these questions. It is enough that the arguments in favor of the direct duty are not so compelling that we could responsibly predict that the Supreme Court of Illinois would buck the national trend and declare that under the common law of Illinois a primary insurer has a direct duty, actionable in tort, against the excess insurer.").

29. *See* Evanston Ins. Co. v. Stonewall Surplus Lines Ins. Co., 111 F.3d 852, 859 (11th Cir. 1997) (applying Georgia law); *Twin City*, 23 F.3d at 1180; Puritan Ins. Co. v. Canadian Universal Ins. Co., 775 F.2d 76, 80–81 (3d Cir. 1985) (applying Pennsylvania law); *Safeway Stores*, 610 P.2d at 1041.

30. *Stonewall Surplus Lines*, 111 F.3d at 860; *Puritan*, 775 F.2d at 80; *Twin City v. Superior Court*, 792 P.2d at 759–60; *Safeway Stores*, 610 P.2d at 1041; Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 483 (Tex. 1992).

31. 843 So. 2d 140 (Ala. 2002).

32. *Id.* at 145.

33. 372 A.2d 1124, 1127 (N.J. Super. Ct. App. Div. 1977).

34. *Id.*

35. *Id.* at 1126.

36. 367 A.2d 864, 866–67 (N.J. 1976).

37. *Penn*, 372 A.2d at 1126.

38. *Fireman's Fund*, 367 A.2d at 866 n.1.

39. *Penn*, 372 A.2d at 1126 (quoting Peter v. Travelers Ins. Co., 375 F. Supp. 1347, 1350–51 (C.D. Cal. 1974)).

40. *Id.*

41. *Id.* at 1127.

42. *Id.*

43. 681 A.2d 1241, 1248 (N.J. Super. Ct. Law Div. 1995). Apparently the excess was not aware of the insured's role in "processing the claim." *Id.* at 1248 n.3. Although not expressly relying on it, the *Warner-Lambert* decision mirrors the reasoning applied in the 1979 California appellate court decision in *Transit Casualty Co. v. Spink Corp.*, 156 Cal. Rptr. 360 (Ct. App. 1979), *overruled by Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 610 P.2d 1038 (Cal. 1980). In *Spink*, due to a policyholder's refusing to consent to a settlement, the primary insurer argued that it had a complete defense to the excess insurer's equitable subrogation claim for failing to settle. In response, the *Spink* court reasoned that "[e]nforceable norms of conduct need not depend upon the ancient artificiality of equitable subrogation. Good conscience was its progenitor. Good conscience is satisfied when reciprocal care forms the law's prime demand." 156 Cal. Rptr. at 366. The *Spink* court then founded a direct duty on the unique relationship of policyholder, primary insurer, and excess insurer (coining the term "triangular reciprocity"). *Id.* at 367. However, the *Spink* decision was overruled one year later by the California Supreme Court in the *Safeway Stores* decision.

44. *Warner-Lambert*, 681 A.2d at 1246.

45. *Id.*

46. *Id.*

47. *Id.* A Texas court, noting that the Guiding Principles direct the excess insurer never to "make formal demand upon a primary insurer that the latter settle a claim within its policy limit," held that "the Guiding Principles do *not* impose upon the primary insurer . . . a duty to the excess insurer to settle underlying litigation within primary limits." Int'l Ins. Co. v. Dresser Indus., Inc., 841 S.W.2d 437, 442–43 (Tex. App. 1992) (emphasis added).

48. *Warner-Lambert*, 681 A.2d at 1247.

49. 723 A.2d 636, 639 (N.J. Super. Ct. App. Div. 1999).

50. *Id.* at 642.

51. 462 N.Y.S.2d 175 (App. Div. 1983), *aff'd*, 463 N.E.2d 608 (N.Y. 1984).

52. *Id.* at 178.

53. Fed. Ins. Co. v. N. Am. Specialty Ins. Co., 921 N.Y.S.2d 28, 29 (App. Div. 2011).

54. *Hartford*, 462 N.Y.S.2d at 178–79.

55. *Id.* at 178 (citing cases).

56. *Fed. Ins. Co.*, 921 N.Y.S.2d at 29; *see also id.* at 32–33 (McGuire, J., dissenting).

57. Twin City Fire Ins. Co. v. Country Mut. Ins. Co., 23 F.3d 1175, 1180 (7th Cir. 1994).

58. *Id.*

59. *Id.* (citing Commercial Union Assurance Cos. v. Safeway Stores, Inc., 610 P.2d 1038, 1041–42 (Cal. 1980), and Int'l Ins. Co. v. Dresser Indus., Inc., 841 S.W.2d 437, 444–45 (Tex. App. 1992)). As noted above, Texas does not impose reciprocal "good faith" obligations on all contracting parties; the insurer's duties arise from the agency relationship resulting from the policy. *See supra* note 14 and accompanying text. The California Supreme Court, while acknowledging "that a duty of good faith and fair dealing in an insurance policy is a two-way street," insisted that the scope of each party's duty "is dependent upon the nature of the bargain struck . . . and the legitimate expectations of the parties which arise from the contract." *Safeway Stores*, 610 P.2d at 1041.

60. *Twin City*, 23 F.3d at 1180 (citing Transit Cas. Co. v. Spink Corp., 156 Cal. Rptr. 360, 364–65 (Ct. App. 1979)).

LAYERS AND GAPS: CONFLICTS BETWEEN PRIMARY AND EXCESS INSURERS

By Eric Hermanson and Jonathan [illegible]

Large companies generally purchase liability insurance coverage in layers. The first layer is a primary policy that responds initially to an insured's covered loss. Above that are excess policies that respond to covered losses exceeding the primary policy limits. The two types of policies present insurers with different (though overlapping) concerns. A primary insurer is usually most concerned about the coverage provided in its policies—i.e., whether it has a duty to defend the allegations in the complaint and indemnify the insured for an eventual settlement or judgment, and if so, how it can carry out those obligations most effectively and efficiently.

Excess insurers share primary insurers' concerns about the coverage their policies provide, and how best to carry out their coverage obligations when the policies are triggered. In addition, however, an excess insurer must consider whether an allegedly covered loss has actually exhausted the underlying limit, so as to trigger the excess coverage, and it must consider how to appropriately protect its interests *before* the policy is triggered—while the primary carrier is controlling the handling and defense of the claim.

These different perspectives and concerns may give rise to conflicts of interest between insureds, excess carriers, and primary carriers. In this article, we consider several such conflicts. These include: (1) conflicts in the provision of notice, when it appears a claim may exceed the primary limits and penetrate the excess layer; (2) conflicts in the defense of a claim, when the primary carrier is defending the claim in a way the excess carrier considers inadequate; (3) conflicts during settlement negotiations, when a primary carrier is given the opportunity to settle within its policy limits but is reluctant to do so; (4) conflicts after settlement, if the primary insurer settles for less than the full limits of its policy and seeks to transfer responsibilities to the excess carrier; and (5) conflicts when an excess carrier issues coverage over a self-insured retention, or "retained limit," with the insured itself agreeing to provide primary coverage, or its equivalent.

These are not the only conflicts that may exist, but they usefully illustrate a few of the issues insurers and their counsel may confront in this area of law.

Primary vs. Excess Insurance

Insurance, as noted above, is generally issued in layers, with a series of insurers writing coverage, each in excess of lower limits written by other insurers. The first layer, known as the "primary" layer, consists of "coverage that attaches immediately upon the happening of an occurrence that is covered under the terms of the policy."[1] The primary insurer, in exchange for a premium, agrees to pay claims up to the limits of its primary policy; it also agrees to defend the insured against liability for any "potentially covered" claims until its primary limits are exhausted.[2] In most jurisdictions, if an action includes both covered and uncovered claims, the primary insurer is required to defend both—at least until the covered claims are dismissed or resolved.[3]

The primary carrier, in carrying out its contractual duties, is subject to an implied duty of good faith and fair dealing to its insured. The contours of this duty vary from state to state. As a rule, the primary carrier must properly acknowledge the insured's communications, investigate claims appropriately, provide timely and adequate descriptions of its coverage positions, and keep the insured properly informed of the progress of a case. More generally, the primary carrier must give appropriate consideration to the insured's interests—not just its own—when defending, litigating, and settling claims. If a case presents a substantial likelihood of a recovery beyond the primary limits, and the opportunity arises to settle the case within those limits, the primary carrier (with some exceptions) must do so, to avoid exposing the insured to an "excess verdict."[4]

Excess coverage involves fewer obligations. It is "coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted."[5] By issuing coverage on these terms, the excess carrier generally avoids any first-dollar defense obligation and "greatly reduces [its] risk of loss. This reduced risk is reflected in the cost of the policy."[6] In effect, "[e]xcess liability insurers contract to provide inexpensive insurance with high policy limits by requiring the insured to contract for primary insurance with another carrier. The premium is also held down by the fact that the duty to defend rests primarily on the primary insurer."[7]

Primary Carrier's Obligation to Notify Excess Carrier

When the allegations of a complaint fall within the terms of a primary carrier's policy, the primary carrier must generally defend the action—including both covered and uncovered claims—until its primary limits are exhausted or all covered claims are resolved.[8] During this period, the excess carrier has no obligation to investigate or defend. As a rule, the excess carrier's obligation does not arise until the primary carrier's limits have been paid; the premiums charged by the excess carrier reflect this diminished defense obligation.

But what if it appears that the covered (or potentially covered) portions of the claim will exceed the primary limits and implicate the excess carrier's coverage? In that case, the two carriers' interests may not coincide. The defending primary carrier may have little direct interest in the outcome of the litigation. It may believe its limits will be consumed no matter what it does. The carrier may be tempted to put on a lackluster defense: paying counsel and experts as little as possible, and settling early to avoid continuing payments or potential conflicts with its policyholder. The excess carrier, by contrast, may have a stronger interest in the litigation. It may want a vigorous defense, so as to minimize the amount of the potentially covered damages that penetrate its layer.

The opposite conflict may also arise. In some cases, where a marginally defensible claim has high value and the primary policy has high limits, the primary carrier may be tempted to defend the case vigorously: rejecting settlement, "rolling the dice," and testing the insured's defenses at trial. If the strategy succeeds, the primary carrier will pay only the costs of defense, and will not have to pay anything in indemnity. If the strategy fails, the excess carrier will bear the brunt of the liability. The excess carrier, understandably, may prefer a more conservative approach: it may have less interest in defending through trial and may want the primary carrier to settle within the primary limits, if the opportunity arises.

At a minimum, in either situation, the excess carrier will want to carefully monitor the litigation and be kept apprised of all relevant developments. For this

TIP

Excess insurers have various options for monitoring a primary's handling, defense, and settlement of an underlying claim and for attempting to limit penetration into the excess carrier's layer

reason, most excess policies obligate the insured to provide notice directly to the excess insurer if the claim "might involve" or is "reasonably likely to reach" the excess policy. But what if a policyholder is defunct, or careless, and fails to provide the excess carrier with notice? Under these circumstances, does the primary carrier have an obligation to apprise the excess insurer directly of these claims?

This situation is anticipated in the "Guiding Principles for Insurers of Primary and Excess Coverage" (Principles), promulgated 40 years ago by the American Insurance Association and American Mutual Insurance Alliance. Principle Five states:

> If at any time, it should reasonably appear that the insured may be exposed beyond the primary limit, the primary insurer shall give prompt written notice to the excess insurer, when known, stating the results of investigation and negotiation, and giving any other information deemed relevant to a determination of the exposure, and inviting the excess insurer to participate in a common effort to dispose of the claim.

Some courts recognize these Principles as setting forth "general standards of industry practice," which may, in turn, serve as a basis for liability against primary carriers who fail to conform—even when those insurers did not sign on to the Principles directly.[9] As one New Jersey court held:

> The primary insurer has certain duties and obligations that it owes to the excess insurer as a result of the distinctive relationship between the two carriers. The unique relationship results because the excess insurer relies upon the primary carrier to act in good faith in processing claims. This includes reliance upon a primary carrier to act reasonably in: (1) discharging its claims handling obligations; (2) discharging its defense obligations; (3) properly disclosing and apprising the excess carrier of events which are likely to effect that carrier's coverage; and (4) safeguarding the rights and interests of the excess carrier by not placing the primary carrier's own interests above that of the excess insurer. The actions of the primary carrier can affect the rights of the excess carrier. This duty then is protected by industry custom and the common law.[10]

Other courts, by contrast, have declined to impose a direct duty on primary carriers to notify excess carriers of claims. However, even these courts acknowledge an implied "duty of good faith" owed by the primary insurer to its insured, which the excess carrier can assert by means of equitable subrogation.[11] If no excess policy existed, these courts reason, the primary insurer would have a duty to keep the insured informed. If the primary insurer failed to do so and the insured's position was prejudiced, the insured could sue the primary carrier. If an excess carrier rather than the policyholder ends up covering the exposure, the excess insurer is subrogated to the insured's right to sue the primary insurer for the consequences of the failure.

In the final analysis, where excess coverage is potentially implicated by a claim, the safest course for both insureds and primary insurers is to involve the excess carrier. Even if a policy places the notice obligation on the insured, the primary carrier should request all policy information, make sure the excess carrier is on notice, and keep the excess carrier involved in the handling of the claim. Conversely, an insured should not assume that its primary carrier has notified the excess carrier—the insured should notify the excess insurer itself of any claims that potentially implicate the excess carrier's limits.

Primary Carrier's Obligation to Adequately Defend Claim

What can the excess carrier do if, having received notice of a claim, it believes the primary carrier is not putting on an adequate defense, with the result that the insured is at risk of an excess exposure? An obvious first step is for the excess carrier to register objections with the primary carrier and the insured.[12] If the insured ignores these objections, it risks breaching the cooperation clauses in its policies. If the primary carrier ignores the objections, it risks a later action in equitable subrogation, by which the excess carrier seeks to recover the portion of any judgment or settlement that it attributes to the primary carrier's mishandling of the claim.[13]

In some cases, a second (though less appealing) option is for the excess carrier to "associate" counsel in the defense of the claim. Most excess policies give the excess carrier the "right, but not the duty," to

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participate in an insured's defense if the carrier believes its interests will be affected by litigation. In some cases, it may be appropriate for the excess carrier to exercise this right, leaving the primary carrier's appointed counsel in place—with all of the duties the primary insurer and counsel may have to their insured in carrying out that defense—but introducing separate "associated" counsel at the excess carrier's expense to advise and consult in that defense.[14] Note, however, that the costs of this associated counsel may be substantial. These costs are in tension with the principle of a deferred defense obligation, on which the excess carrier's lower premiums were generally based. Given the choice, most excess carriers would prefer to have claims handled competently, in the first instance, and vigorously defended by the primary carrier at that carrier's sole expense.

A third, related option—often proposed by primary carriers—is for the excess carrier to accept a tender of the primary carrier's limits to be applied toward settlement, and take over the defense itself. In effect, this proposal shifts to the excess carrier the primary carrier's duty of defense—and whatever related obligations the defending carrier may owe its insured—even though the excess carrier's policy has not yet been triggered, and there has not yet been an adjudication or settlement of the underlying claim. In some cases, this proposal may make sense, from an excess carrier's perspective. More often, it does not. In almost all cases, it is the excess carrier's option whether to accept such a tender.[15] If the excess carrier refuses, a primary insurer cannot shift the burden of defense by paying its policy limits to the third-party claimant without some adjudication or compromise of the third-party claim.[16]

Suppose a primary carrier's appointed defense counsel mishandles a claim, and an excess carrier is exposed to an excess verdict as a result. What remedies does the excess carrier have? Some courts recognize a "tripartite relationship" between the primary insurer, the insured, and the attorney, sufficient to make the primary insurer a "client," but few courts have yet extended that concept to excess carriers. Can the excess carrier nonetheless sue the appointed defense counsel directly, on an equitable subrogation theory?

Authority is divided. Some courts—probably a slight majority—have refused to recognize an equitable subrogation claim. These courts hold the defense counsel's duties run only to the insured and (in some circumstances) the primary carrier. In these courts' view, allowing the excess carrier to sue the attorney directly

> would . . . acknowledge a direct duty owed by the insured's attorney to the excess insurer and would be tantamount to saying that insurance defense attorneys do not owe their duty of loyalty and zealous representation to the insured client alone. Such a holding would contradict the personal nature of the attorney-client relationship, which permits a legal malpractice action to accrue only to the attorney's client.[17]

But other courts do allow excess carriers to pursue such a claim. For example, in *Great American E&S Insurance Co. v. Quintairos, Prieto, Wood & Boyer, P.A.*, a resident of a nursing home sued for substandard care, and the nursing home's primary insurer hired lawyers to defend the suit.[18] The lawyers failed to timely designate expert witnesses. With no expert witnesses to testify, the settlement value of the case greatly increased. At that point, the primary carrier paid its policy limits, and the excess carrier was forced to step in, defend the nursing home, and ultimately settle the suit. The Mississippi Supreme Court upheld the excess insurer's claim against the law firm. Although it declined to recognize a direct claim for malpractice—because the law firm represented the insured and the primary carrier, not the excess carrier directly—it found that the excess carrier could "step into the shoes" of the insured and pursue the law firm for malpractice toward the insured on a theory of equitable subrogation. "[W]hen lawyers breach the duty they owe to their clients, excess insurance carriers, who—on behalf of the clients—pay the damage, may pursue the same claim the client could have pursued."[19]

Where excess coverage is potentially implicated, the safest course for both insureds and primary insurers is to involve the excess carrier.

Primary Carrier's Obligation to Settle Claim within Primary Limits

What are the obligations of a primary carrier who is offered an opportunity to settle within its limits, where excess coverage is available? Under most states' laws, if the case presents a substantial likelihood of a recovery beyond the primary limits, and the opportunity arises to settle the case within those limits, the primary carrier must do so to avoid exposing the insured to an "excess verdict." If the primary carrier declines such a settlement and the plaintiff ultimately recovers an amount in excess of the primary limits, the insured has a right to recover the excess. If the excess judgment has been paid by an excess carrier (and not the insured), the

excess carrier is equitably subrogated to the rights of the insured and has the right to recover from the primary carrier to the same extent the insured might otherwise have done.[20]

However, a claim for equitable subrogation has important limitations, including the requirement that "the insured [have] an existing, assignable cause of action against the defendant which the insured could have asserted for its own benefit had it not been compensated for its loss by the [excess] insurer."[21] Given this requirement—and the fact that some insureds have ceased operations and have little interest in the outcome of the litigation—could a settling primary carrier insulate itself from liability to an overlying excess carrier by simply asking that the insured execute a bad faith release? Will such a release, cutting off the insured's rights of recovery from the primary carrier, cut off the excess carrier's subrogation rights as well?

In some circumstances, yes. In *Fireman's Fund Insurance Co. v. Maryland Casualty Co.*, an excess carrier (FFIC) challenged an insured's voluntary settlement with a primary carrier (Maryland), which called for settlement payments to be allocated to particular policy years, leaving certain earlier years untouched.[22] (The insured and Maryland also entered a release as to those other, untouched years.) Ultimately, FFIC entered a separate settlement with the claimant and sought recovery from Maryland for the sums it had paid. FFIC argued, among other things, that Maryland's settlement allocation amounted to a "wrongful refusal" to settle within the primary limits of the untouched policy years. It argued that it was entitled, as the excess carrier, to sue Maryland directly for a violation of the "covenant of good faith and fair dealing" that was implied in the policies Maryland issued to its insured.[23]

The court of appeal disagreed. It noted that FFIC was not a party to, or a third-party beneficiary of, the policies on which it based its claim for breach of the implied covenant of good faith and fair dealing. The court held that in the context of Maryland's allegedly wrongful settlement, the primary insurer's obligation of good faith was owed to its insured, not an excess insurer. Moreover, FFIC's claim for equitable subrogation was defeated by the release Maryland had obtained from its insured:

> [The insured] expressly released Maryland from all claims, including bad faith. . . . Since the subrogated insurer stands in the shoes of its insured, the insurer has no greater rights against the third party than did the insured and is subject to all defenses the third party could have asserted against the insured. [W]hen an insured has released a third party, neither the insured nor the subrogated insurer has any rights to recover from the third party.[24]

However, other courts have reached different results, particularly in circumstances that suggest the release was obtained by coercion, duress, or undue influence, or was the result of overreaching by the primary carrier or third parties. For example, in *Lexington Insurance Co. v. Sentry Select Insurance Co.*, the court found that a settling primary insurer could not rely on a release to cut off the rights of an excess carrier, where the primary insurer negotiated the release with knowledge of an excess carrier's impending subrogation claim.[25] The court relied on the doctrine of "known subrogation rights," which bars an insured from cutting off an insurer's subrogation rights by executing a release, running to a tortfeasor, "where the tortfeasor settles with the insured with knowledge that the insured has been indemnified by an insurer."[26] According to the court, the same rule should apply when a primary carrier—facing a claim for equitable subrogation by an excess carrier—chooses to "settle" with its insured and obtain a release in an effort to cut off the excess carrier's known subrogation rights. In these circumstances, the court held, "[b]arring [the excess carrier's] subrogation rights would constitute a fraud on it."[27] The release could not preclude the excess carrier's claim.

Would it not be easier for the court to simply find a direct right of action, by the excess carrier against the primary carrier, under these circumstances? This is the question posed in *Transit Casualty Co. v. Spink Corp.*[28] Spink, an engineer, consulted on a construction project owned by a third party. It was covered by two policies: a primary policy with a $100,000 limit, and an umbrella policy, issued by Transit, covering claims above $100,000. A construction accident resulted in deaths and injuries, and suits were brought against several defendants, including Spink. The plaintiffs offered to settle the case. Spink's share of the proposed settlement would have been $76,000—a sum within the primary policy limits. Spink refused the offer, based on its broker's advice that a settlement would impair its own future insurability. A trial produced an excess verdict, and Transit ended up paying $175,000 to the plaintiffs. Transit then sued Spink and the primary insurer, charging that their earlier rejection of the settlement offer was unreasonable and had caused it to pay sums it otherwise would not have had to pay.

The trial court found for Transit, and the court of appeals affirmed. Although the court acknowledged that no contractual privity existed between the primary carrier and the excess carrier, the court found that the purchase of an excess insurance policy created a relationship between these insurers. In these circumstances, the court

concluded, equitable subrogation was an unnecessary fiction—an "ancient artificiality" that did not serve justice.[29]

In place of equitable subrogation, the court postulated a system of "triangular reciprocity," under which the excess carrier, the primary carrier, and the insured owed reciprocal duties of care, and could sue each other directly for breach of those duties.

> The three-way duty concept harmonizes with settlement realities. . . . Self-interest will impel the primary carrier to take the lead when settlement value is well within its policy limits, the excess carrier when the claim invades its own policy exposure. When settlement value hovers over the fringes of both policies, both carriers may collaborate. . . . The primary carrier's conflict of interest with the excess carrier is no more acute than its conflict with a policyholder without excess coverage. Either may sue it for a bad faith refusal to settle. Neither carrier is likely to be intransigent if both know that intransigence will be a factor for consideration in a later refusal-to-settle lawsuit. Triangular reciprocity advances the public interest in extrajudicial settlement.[30]

A year later, in *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*,[31] the California Supreme Court "disapproved" *one aspect of Spink:* finding *the insured did not* owe a duty of good faith *to its insurers* in settling claims. Nearly 15 years later, the court of appeals in *Fireman's Fund* pressed this ruling still further, citing *Commercial Union* to suggest that equitable subrogation should be the sole recourse for excess carriers in these circumstances; the doctrine of "triangular reciprocity," it held, had been "impliedly overruled."[32]

Nonetheless, a few courts have continued to cite *Spink*,[33] and it remains unclear whether that decision has been overruled entirely, or whether it retains life in at least some circumstances.[34] Tellingly, while one concurring judge in *Commercial Union* suggested that *Spink* be depublished in its entirety,[35] the rest of the *Commercial Union* majority rejected that approach and elected instead to leave *Spink* in place.

The doctrine of known subrogation rights bars an insured from releasing a tortfeasor that settles knowing that the insured is indemnified by an insurer.

Settling for Less Than Policy Limits Does Not Trigger Excess Carrier's Obligations

What if a primary carrier—after contesting coverage—reaches a compromise with its insured, under which it contributes less than its full policy limits toward a settlement, receiving in exchange a complete policy release? Does that settlement "functionally exhaust" the primary carrier's limits, and trigger the overlying excess carrier's policy, even though the underlying carrier has paid less than its full limits? If it does not, can the insured (or someone else) agree to contribute an amount up to the remaining balance of the underlying policy limits, so as to reach the attachment point of the excess carrier's policy?

The issue depends (to some extent) on the language of the excess policy in question. And until recently, case law could appropriately be described as split. On one side stood cases like *Comerica Inc. v. Zurich American Insurance Co.*, which rejected "functional exhaustion," finding "actual payment" was necessary where excess policies required the primary insurance be exhausted or depleted by the actual payment of losses.[36] According to *Comerica*, "[p]ayments by the insured to fill the gap, settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer 'credit' against a judgment or settlement up to the primary insurer's liability limit are not the same as actual payment."[37]

On the other side stood *Zeig v. Massachusetts Bonding & Insurance Co.*,[38] an 85-year-old Second Circuit decision, which courts cited for the proposition that an insured's settlement with a primary carrier for less than the full limits of a primary policy could exhaust primary coverage, and trigger an excess policy, so long as the total amount of the insured's settlement with a claimant exceeded the primary limits. In reaching this result, *Zeig* observed that the term "payment"—used in an excess policy to denote exhaustion of primary limits—could encompass satisfaction of a claim through compromise, as well as "actual payment" in cash. It held that an excess insurer:

> had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable.[39]

Some courts followed *Zeig*'s rationale, finding a below-limits settlement

with an underlying primary insurer established exhaustion, so long as the insured (or someone acting on his or her behalf) was prepared to "fill the gap."[40]

Recently, however, in *Ali v. Federal Insurance Co.*, the Second Circuit revisited *Zeig*, finding *Zeig's* rationale applied only to first-party property claims, where "the insured suffered out-of-pocket losses," and not to the commercial general liability context, involving an excess carrier's "obligations to pay third parties."[41] In the wake of *Ali*, the clear trend now appears to be against functional exhaustion and in favor of enforcing policy language that requires actual payment of the underlying primary limits before an excess carrier's obligations can be triggered.[42] An insured (or a claimant) who reaches a compromise with a primary insurer, allowing the primary carrier to pay less than the full limits of its policies, faces a significant risk that the overlying excess coverage will not be triggered, and that the excess carrier's obligations will not arise. To the extent prior authority reached a contrary conclusion in reliance on *Zeig*, that authority must now be reexamined in light of the Second Circuit's limitation of *Zeig* to first-party disputes.[43]

Excess Carrier's Obligations If Underlying Policy Is Self-Insured Retention

A final interesting variation arises when an excess policy does not sit over an underlying policy of primary insurance, but over a self-insured retention (sometimes referred to as a "retained limit"). IRMI defines "self-insured retention" (SIR) as:

> [a] dollar amount specified in a liability insurance policy that must be paid by the insured *before* the insurance policy will respond to a loss. Thus, under a policy written with a SIR provision, the *insured* (rather than the insurer) would pay defense and/or indemnity costs associated with a claim until the SIR limit was reached. After that point, the *insurer* would make any additional payments for defense and indemnity that were covered by the policy.[44]

Most courts treat policies with self-insured retentions as a species of excess insurance; in other words, they treat these policies as secondary coverage in which the insurer's obligation only arises after the policyholder has first satisfied its own obligations with respect to the alleged loss. Thus, under this construction, a policy with a retained limit is analogous to "traditional" excess policies in which coverage begins only after a predetermined amount of underlying primary insurance has been exhausted.[45]

How do self-insured retentions differ from deductibles, which set out an amount of money that the insured must repay to its primary carrier once a claim is resolved? As a general rule—while the terms of a policy always control—insurers whose policies contain deductibles have an immediate obligation to defend claims; and the insurer alone controls the settlement of these claims, subject only to its obligation of good faith toward the policyholder. Unless the policy language provides otherwise, the insurer does not need to obtain the policyholder's consent before reaching these settlements. It can settle a claim within the deductible amount, even if it knows that in the end the policyholder will need to pay the settlement amount due to the policy's deductible provisions.[46]

In contrast, under an excess policy with a self-insured retention, the insurer usually has no obligation to defend until the *insured* has exhausted the retention by payment of covered claims. In these types of policies, the insured can usually handle its own defense. It can make its own settlement decisions—up to the amount of the retention—which some policyholders find desirable.[47]

The other side of the coin is that the insured cannot call on the insurer for defense until the self-insured retention is satisfied. Sometimes policyholders—accustomed to the proposition that the duty to defend is broader than the duty to indemnify—will argue that an insurer has an immediate duty to defend any claim that could exceed the amount of the retention. Most courts reject this argument. They observe, correctly, that a policy with a retention is a type of excess policy. Like an excess policy, such policies generally require exhaustion of an underlying amount—the retained limit—as a precondition to generating any obligation. So, regardless of the severity of the underlying claim, the policyholder must satisfy that condition to trigger the insurer's defense obligations.[48] While a few courts have departed from this principle,[49] they generally have done so only after finding the retention provisions of a policy to be ambiguously or vaguely worded.[50]

Just as the limits of primary policies may create a potential conflict of interest for primary insurers, self-insured retentions may present a conflict for insureds. The policyholder is responsible for defending the claim, but it knows its liability will be capped at the amount of the retained limit. It knows the insurer will pay for any judgment or settlement beyond that amount. If a claimant offers to settle with the policyholder for an amount near the retention, the policyholder may have an incentive to "roll the dice" and try the case: if it loses at trial, the excess insurer will bear the costs, but if it wins, its own exposure may decrease, perhaps to zero. These are the same tensions one sometimes sees between primary and excess carriers; but they are

exacerbated, in the context of self-insured retentions, by the fact that most courts do not impose on policyholders a good-faith obligation to consider an excess insurer's interests during settlement discussions.[51]

What can an insurer do to protect itself in this situation? Again, information is key. Most excess policies with self-insured retentions allow the insurer to request reports on claims that are likely to exceed the retention. Most give the insurer a "right, but not duty," to associate in the defense and settlement of these claims. Once an insurer invokes that right, the policyholder has a duty to cooperate,[52] and it may not refuse to contribute its retained limit to allow the insurer to enter an otherwise reasonable settlement.[53]

As a final question, what happens when the insured is insolvent or judgment proof and cannot satisfy the amount of the retention? This situation is not unusual. It is, for example, a common problem in construction defect litigation, where many developers and contractors did not survive the downturn that followed the housing boom and ceased operations or went out of business.

The question turns on the language of the policies in question and, in some cases, on considerations of public policy. In *Rosciti v. Insurance Co. of Pennsylvania*, an insured was sued for defects in motor homes it manufactured.[54] Soon afterward, the insured filed for bankruptcy. The insured had an excess policy sitting above a $500,000 retained limit. The claimants sued the excess insurer directly, under Rhode Island's direct action statute, claiming their damages exceeded the retained limit. Although the excess insurer's policy required complete payment of the retained limit as a condition precedent to coverage, the claimants argued that the policy's "bankruptcy or insolvency" provision negated that requirement, stating that bankruptcy or insolvency "shall not relieve [the insurer] from the payment of any claim covered by this Policy."[55] The excess insurer countered that the provision only applied where the claim was "covered"; unless and until the retained limit was exhausted, there was no coverage.

As to the policy language, the federal district court and the First Circuit agreed with the excess insurer's interpretation. They found the policy unambiguously required

Tensions are exacerbated in the context of self-insured retentions.

exhaustion of the retained limit to trigger coverage. They found the "bankruptcy or insolvency" provision only applied where coverage was triggered. The First Circuit, however, went further. It held that Rhode Island's direct action statute embodied a public policy "to preserve a tort victim's right of recovery when the insured became insolvent."[56] Because the "ultimate effect" of the retained limit provision would be to absolve the excess insurer of liability above $500,000 whenever an insured was bankrupt, the court held that enforcement of this provision would violate the public policy of the state.[57]

Conclusion

The questions above are illustrative, not exhaustive. They represent just a few of the issues that arise when claims trigger both primary and excess coverage. Many variations exist, based on the circumstances of specific cases and the differing language of different policies. As excess and primary insurers continue to handle losses, encounter tensions, and litigate their different approaches on these issues, the case law in this area will continue to develop and expand. ■

Notes

1. Barry R. Ostrager & Thomas R. Newman, Handbook on Insurance Coverage Disputes § 6.03[a] (7th ed. 1994).

2. Policies differ as to whether costs spent on defense apply toward exhaustion of limits. Where they do not, the primary insurer may end up paying hundreds of thousands (or even millions) of dollars toward its insured's defense, even though the total indemnity limits of the policy are only a fraction of this amount. These defense-cost exposures are factored into the primary policy's premiums. Associated Wholesale Grocers, Inc. v. Americold Corp., 941 P.2d 65, 81 (Kan. 1997). Cost-erosive primary policies—in which defense costs erode the limits of primary coverage—are significantly less expensive but provide significantly less security to an insured. *See* Intel Corp. v. Am. Guar. & Liab. Ins. Co., 51 A.3d 442, 449 (Del. 2012) (holding that excess policy was only triggered after exhaustion of the underlying limit through settlements or judgments, even though underlying policy was itself cost-erosive).

3. *See, e.g.*, Conway Chevrolet-Buick, Inc. v. Travelers Indem. Co., 136 F.3d 210 (1st Cir. 1998); Wackenhut Servs., Inc. v. Nat'l Union Fire Ins. Co., 15 F. Supp. 2d 1314 (S.D. Fla. 1998); Meadowbrook, Inc. v. Tower Ins. Co., 559 N.W.2d 411 (Minn. 1997); Benjamin v. Amica Mut. Ins. Co., 140 P.3d 1210 (Utah 2006).

4. *See, e.g.*, Kransco v. Am. Empire Surplus Lines Ins. Co., 2 P.3d 1 (Cal. 2000).

5. Cont'l Marble & Granite v. Canal Ins. Co., 785 F.2d 1258, 1259 (5th Cir. 1986). There are several different types of excess coverage, including: (1) "follow-form" coverage, in which the excess policy covers all of the same risks as the underlying policy, and responds

according to the primary policy's terms; (2) specific excess, in which the excess policy provides coverage for only some risks covered by an underlying primary policy; (3) umbrella coverage, in which the excess carrier may be called upon to "drop down" and fulfil the duties of primary carriers for certain risks that the primary coverage doesn't cover; and (4) "stand-alone" excess, in which coverage is provided for specified risks, above specified limits, as set out in the excess policy itself, without reference to any underlying policy or self-insured retention. In addition, when two primary policies cover the same risk, one will sometimes be deemed "excess" over the other through operation of the policies' "other-insurance" clauses. This article focuses principally on follow-form and stand-alone coverage.

6. *Cont'l Marble & Granite*, 785 F.2d at 1259.

7. Nat'l Union Fire Ins. Co. v. CNA Ins. Cos., 28 F.3d 29, 31 n.1 (5th Cir. 1994).

8. Some states allow a carrier who has defended both covered and uncovered claims to seek reimbursement from the insured, after the case is resolved, for fees and expenses "paid in defending [the insured] against claims for which there was no obligation to defend." *See, e.g.*, Buss v. Superior Court, 939 P.2d 766, 776 (Cal. 1997); Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 826 A.2d 107 (Conn. 2003); Colony Ins. Co. v. G&E Tires & Serv., Inc., 777 So. 2d 1034 (Fla. Dist. Ct. App. 2000). *But see, e.g.*, Timberline Equip. Co. v. St. Paul Fire & Marine Ins. Co., 576 P.2d 1244 (Or. 1978) (finding the insurer liable for the total amount of defense costs in a mixed action); Med. Protective Co. v. McMillan, No. Civ.A 501CV00073, 2002 WL 31990490 (W.D. Va. Dec. 16, 2002) (similar). Of course, if the insured is insolvent or defunct, the so-called *Buss* right may turn out to be a hollow one.

9. *See, e.g.*, Royal Ins. Co. of Am. v. Reliance Ins. Co., 140 F. Supp. 2d 609 (D.S.C. 2001); U.S. Fire Ins. Co. v. Nationwide Mut. Ins. Co., 735 F. Supp. 1320 (E.D.N.C. 1990); Am. Centennial Ins. Co. v. Warner-Lambert Co., 681 A.2d 1241 (N.J. Super. Ct. Law Div. 1995); Monarch Cortland v. Columbia Cas. Co., 626 N.Y.S.2d 426, 431 (Sup. Ct. 1995), *rev'd on other grounds*, 646 N.Y.S.2d 904 (App. Div. 1996).

10. *Warner-Lambert*, 681 A.2d at 1246.

11. *See, e.g.*, Certain Underwriters of Lloyd's v. Gen. Accident Ins. Co. of Am., 909 F.2d 228, 231 (7th Cir. 1990); Hartford Accident & Indem. Co. v. Aetna Cas. & Sur. Co., 792 P.2d 749, 753–54 (Ariz. 1990); Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 483 (Tex. 1992); Truck Ins. Exch. of Farmers Ins. Grp. v. Century Indem. Co., 887 P.2d 455, 458 (Wash. Ct. App. 1995).

12. Indeed, one court has suggested the excess carrier *must* make its objections known, and that failure to do so may constitute acquiescence in the primary carrier's inadequate defense, preventing the excess carrier from objecting to that defense later. PHICO Ins. Co. v. Aetna Cas. & Sur. Co., 93 F. Supp. 2d 982 (S.D. Ind. 2000).

13. *See, e.g.*, *Canal Ins.*, 843 S.W.2d 480 (allowing equitable subrogation claim against primary carrier and its law firm).

14. *See, e.g.*, Inst. of London Underwriters v. First Horizon Ins. Co., 972 F.2d 125 (5th Cir. 1992); Cont'l Cas. Co. v. Pittsburgh Corning Corp., 917 F.2d 297 (7th Cir. 1990); Ins. Co. of W. v. Cnty. of McHenry, No. 02 C 2291, 2002 WL 1803743 (N.D. Ill. Aug. 6, 2002); Gen. Motors Acceptance Corp. v. Nationwide Ins. Co., 828 N.E.2d 959 (N.Y. 2005).

15. Signal Cos. v. Harbor Ins. Co., 612 P.2d 889, 894 (Cal. 1980).

16. Cnty. of Santa Clara v. U.S. Fid. & Guar. Co., 868 F. Supp. 274, 278 (N.D. Cal. 1994); Chubb/Pac. Indem. Grp. v. Ins. Co. of N. Am., 233 Cal. Rptr. 539, 543 (Ct. App. 1987); Colo. Farm Bureau Mut. Ins. Co. v. N. Am. Reinsurance Corp., 802 P.2d 1196, 1198 (Colo. App. 1990).

17. Am. Cont'l Ins. Co. v. Weber & Rose, P.S.C., 997 S.W.2d 12, 14 (Ky. Ct. App. 1998). In a variation on this approach, some courts have also reasoned that allowing legal malpractice claims through equitable subrogation (even by primary insurers) would violate the principle that such claims are nonassignable. *See* Essex Ins. Co. v. Tyler, 309 F. Supp. 2d 1270, 1274 (D. Colo. 2004); Querrey & Harrow, Ltd. v. Transcon. Ins. Co., 885 N.E.2d 1235, 1236 (Ind. 2008); *see also* Great Am. Ins. Co. v. Dover, Dixon Horne, P.L.L.C., 456 F.3d 909 (8th Cir. 2006) (applying Arkansas law); St. Paul Ins. Co. of Bellaire, Tex. v. AFIA Worldwide Ins. Co., 937 F.2d 274, 276, 279 (5th Cir. 1991) (applying Louisiana law and disallowing claim); Cont'l Cas. Co. v. Pullman, Comley, Bradley & Reeves, 929 F.2d 103, 107 (2d Cir. 1991) (applying Connecticut law and predicting that it would not recognize an excess insurer's equitable subrogation claim against a defense attorney).

18. 100 So. 3d 420, 424 (Miss. 2012).

19. *Id.*; *see also* Nat'l Union Ins. Co. v. Dowd & Dowd, P.C., 2 F. Supp. 2d 1013, 1022 (N.D. Ill. 1998) (recognizing an excess insurer's equitable subrogation claim against the insured's defense attorney); Atlanta Int'l Ins. Co. v. Bell, 475 N.W.2d 294, 298 (Mich. 1991) (allowing claim); Allianz Underwriters Ins. Co. v. Landmark Ins. Co., 787 N.Y.S.2d 15, 18 (App. Div. 2004) (allowing claim); Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 485 (Tex. 1992) (allowing claim).

20. *See, e.g.*, Kransco v. Am. Empire Surplus Lines Ins. Co., 2 P.3d 1, 4 (Cal. 2000); Truck Ins. Exch. of Farmers Ins. Grp. v. Century Indem. Co., 887 P.2d 455, 458 (Wash. Ct. App. 1995).

21. Fireman's Fund Ins. Co. v. Md. Cas. Co., 77 Cal. Rptr. 2d 296, 303 (Ct. App. 1998).

22. 26 Cal. Rptr. 2d 762, 765 (Ct. App. 1994).

23. *Id.* at 765–66.

24. *Id.* at 768 (citations omitted).

25. No. CV F 08-1359, 2009 WL 1586938 (E.D. Cal. June 5, 2009).

26. *Id.* at *12.

27. *Id.* at *13.

28. 156 Cal. Rptr. 360 (Ct. App. 1979).

29. *Id.* at 365–66.

30. *Id.* at 367.

31. 610 P.2d 1038, 1043 (Cal. 1980).

32. Fireman's Fund Ins. Co. v. Md. Cas. Co., 26 Cal. Rptr. 2d 762, 771 n.13 (Ct. App. 1994).

33. *See, e.g.*, U.S. Fire Ins. Co. v. Zurich Ins. Co., 768 N.E.2d 288, 299 (Ill. App. Ct. 2002).

34. Hocker v. N.H. Ins. Co., 922 F.2d 1476, 1487 n.12 (10th Cir. 1991) (finding "the California Supreme Court [in *Commercial Union*] did not overrule the *Spink* theory of triangular reciprocity").

35. *Commercial Union*, 610 P.2d at 1043 (Newman, J., concurring).

36. 498 F. Supp. 2d 1019, 1022 (E.D. Mich. 2007).

37. *Id.* at 1032; *see also* Citigroup, Inc. v. Fed. Ins. Co., 649 F.3d 367 (5th Cir. 2011); Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 73 Cal. Rptr. 3d 770 (Ct. App. 2008); Intel Corp. v. Am. Guar. & Liab. Ins. Co., 51 A.3d 442 (Del. 2012).

38. 23 F.2d 665 (2d Cir. 1928).

39. *Id.* at 666.

40. *See, e.g.*, Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996); Maximus, Inc. v. Twin City Fire Ins. Co., 856 F. Supp. 2d 797, 801–02 (E.D. Va. 2012); Stargatt v. Fid. & Cas. Co. of N.Y., 67 F.R.D. 689 (D. Del. 1975); Rummel v. Lexington Ins. Co., 945 P.2d 970 (N.M. 1997).

41. 719 F.3d 83, 93–94 (2d Cir. 2013).

42. Of course, careful review of the policy language is necessary. Some policies *do not* expressly require "exhaustion" by "payment" of the underlying limits; rather, they simply provide coverage "in excess of" the underlying limits. In that event, a court is more likely to allow gap-filling, because liability exists that "exceeds" the underlying limits. Trinity Homes LLC v. Ohio Cas. Ins. Co., 629 F.3d 653 (7th Cir. 2010). Conversely, some policies expressly require actual payment "by the underlying insurer," thereby precluding a court from adopting the *Zeig* court's creative interpretation of "exhaustion" and "payment." *See, e.g.*, *Citigroup*, 649 F.3d 367; Quellos Grp., LLC v. Fed. Ins. Co., 312 P.3d 734, 744 (Wash. Ct. App. 2013). The controversy primarily consists of the "middle ground" of policies requiring simply "exhaustion" of underlying limits by "payment" of claims.

43. *See also* Comerica, Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007) (holding that "exhaustion" means full payment by underlying insurer); Intel Corp. v. Am. Guar. & Liab. Ins. Co., 51 A.3d 442 (Del. 2012) (applying California law). As a variation on this theme, what if the primary carrier settles (for the full policy limits) a claim that involves both covered and uncovered losses? Can a follow-form excess carrier challenge exhaustion, and assert that its policies are not triggered, despite the primary carrier's settlement? Generally speaking, yes. Even where excess policies "follow form" to underlying primary coverage, the excess carrier has only agreed to follow the terms of the primary policy; it has not agreed to follow the primary insurer's interpretation of those terms. Shy v. Ins. Co. of Pa., 528 F. App'x 752 (9th Cir. 2013) (unpublished). However, "as a practical matter, following form excess insurers are reluctant to veer from underlying insurers' coverage interpretations out of the concern that the other insurers' positions will make them appear to be unreasonable, which may work to their detriment in coverage litigation or otherwise impair their relationships with their insureds." *See* Douglas R. Richmond, Excess to Primary: You're Not Exhausted, You're Just Tired, Paper Presented at ABA-TIPS 22nd Annual Insurance Coverage Litigation Committee Midyear Program 7 (Feb. 21, 2014).

44. *Self-Insured Retention (SIR)*, IRMI, www.irmi.com/online/insurance-glossary/terms/s/self-insured-retention-sir.aspx (last visited Sept. 1, 2015).

45. *See* Spaulding Composites Co. v. Aetna Cas. & Sur. Co., 819 A.2d 410, 417 n.4 (N.J. 2003).

46. *See* Am. Prot. Ins. Co. v. Airborne, Inc., 476 F. Supp. 2d 985 (N.D. Ill. 2007); Hartford Accident & Indem. Co. v. U.S. Natural Res., 897 F. Supp. 466 (D. Or. 1995).

47. *See* Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Lawyers' Mut. Ins. Co., 885 F. Supp. 202 (S.D. Cal. 1995) ("[U]nlike a deductible, 'the excess insurer's [defense] obligations do not arise until after the amount of the self-insured retention has been paid.'").

48. *See* Hormel Foods Corp. v. Northbrook Prop. & Cas. Ins. Co., 938 F. Supp. 555 (D. Minn. 1996); City of Oxnard v. Twin City Fire Ins. Co., 44 Cal. Rptr. 2d 177 (Ct. App. 1995); Allianz Ins. Co. v. Guidant Corp., 884 N.E.2d 405 (Ind. Ct. App. 2008); U.S. Fire Ins. Co. v. Scottsdale Ins. Co., 264 S.W.3d 160 (Tex. App. 2008).

49. *See, e.g.*, Cooper Labs., Inc. v. Int'l Surplus Lines Ins. Co., 802 F.2d 667 (3d Cir. 1986).

50. *See, e.g.*, Legacy Vulcan Corp. v. Superior Court, 110 Cal. Rptr. 3d 795 (Ct. App. 2010).

51. Commercial Union Assurance Cos. v. Safeway Stores, Inc., 610 P.2d 1038, 1043 (Cal. 1980) (holding that "a policy providing for excess insurance coverage imposes no implied duty upon the policyholder to accept a settlement offer which would avoid exposing the insurer to liability").

52. N.Y. City Hous. Auth. v. Hous. Auth. Risk Retention Grp., Inc., 203 F.3d 145 (2d Cir. 2000).

53. Harbor Ins. Co. v. City of Ontario, 282 Cal. Rptr. 701 (Ct. App. 1991).

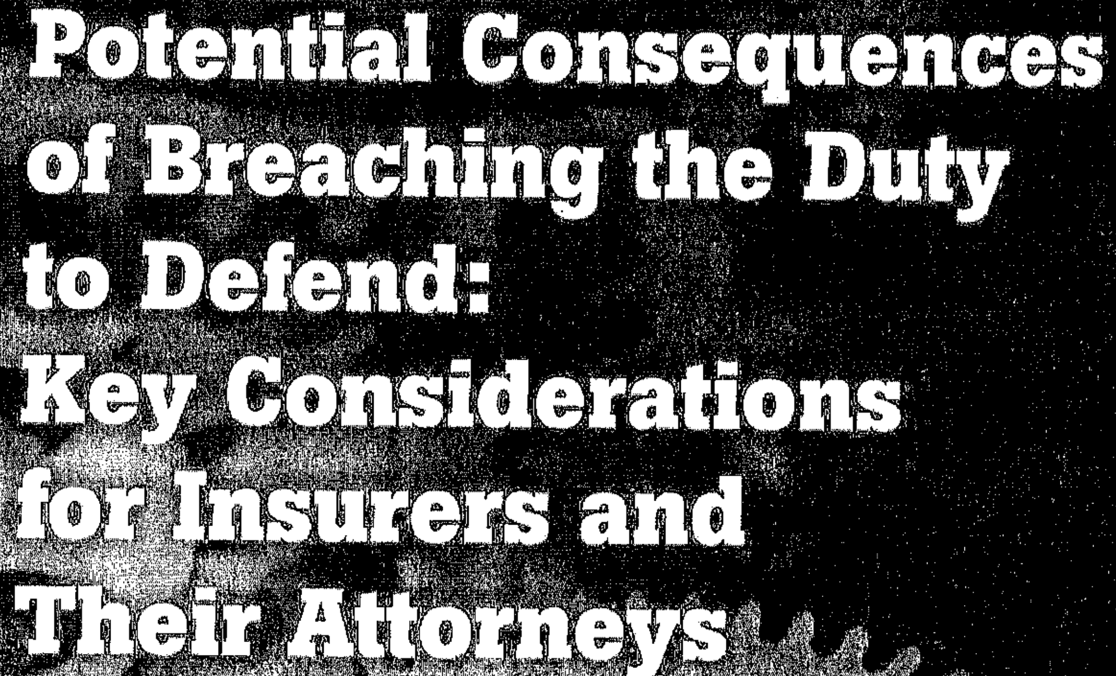
54. 659 F.3d 92 (1st Cir. 2011).

55. *Id.* at 94.

56. *Id.* at 98.

57. *See also* Gulf Underwriters Ins. Co. v. Burris, 674 F.3d 999, 1006 (8th Cir. 2012) (reaching similar conclusion under Wisconsin's direct action statute). *But see, e.g.*, Pinnacle Pines Cmty. Ass'n v. Everest Nat'l Ins. Co., No. CV-12-08202-PCT-DGC, 2014 U.S. Dist. LEXIS 65011, at *15 (D. Ariz. May 9, 2014) (holding that "the bankruptcy of [the insured and its] resulting inability to pay the SIR do not absolve [the insurer] from its responsibility to provide insurance coverage" in excess of the SIR amount).

Potential Consequences of Breaching the Duty to Defend: Key Considerations for Insurers and Their Attorneys



By Gary L. Gassman, Seth D. Lamden, and Le G. Trieu

An insurer in breach of its duty to defend faces liability for the reasonable legal expenses incurred by its insured in defending the underlying claim. This liability is based on traditional breach of contract remedies principles: the consequential damages flowing from a breach of the duty to defend are the insured's costs of its self-funded defense. However, jurisdictions throughout the United States recognize, at least to some degree, that reimbursement of defense expenses alone may not be sufficient to make the insured whole due to the unique benefits and protections to the insured of a prompt and conflict-free defense. In such jurisdictions, a breaching insurer may also be estopped from raising certain defenses to coverage or from denying coverage for a settlement or judgment against the insured. The consequences of a breach of the duty to defend vary among jurisdictions in which estoppel or estoppel-like principles are recognized, and estoppel is a risk in numerous situations that may not be immediately evident to an insurer or insured.

Depending on the jurisdiction, even an insurer that defends its insured may suffer adverse consequences or be estopped from declining coverage if it issued a defective reservation of rights letter, improperly interfered with the defense of a claim, provided an ineffective defense, or waited too long to start defending a claim or filing a declaratory judgment action. This article discusses some of the potential consequences faced by an insurer that wrongfully declines to defend its insured, and also provides an overview of the law of estoppel or estoppel-like principles across the country. This article also addresses some of the situations in which estoppel can arise other than a flat refusal to defend. We also provide several suggestions for insurers and counsel to consider when evaluating whether to defend a claim, while providing a defense, and in reserving the right to deny coverage. Please note that this is a basic, brief, and nonexclusive summary of some of the key issues that should be considered and addressed in the context of the duty to defend, and each situation must be addressed on a case-by-case basis with consideration of specific facts presented and the state of the law in the applicable jurisdiction.

When the Duty to Defend Arises

Most liability insurance policies impose two separate contractual obligations on the insurer: (1) the duty to defend the insured against a potentially covered underlying claim, and (2) the duty to indemnify the insured for sums that the insured becomes legally obligated to pay as covered damages. Although the precise wording of the duty to defend standard may vary slightly from jurisdiction to jurisdiction, courts generally are in agreement that "[t]he duty to defend arises if any of the allegations in the complaint, if proven true, create the potential that the insured can be held liable for damages covered by the policy."[1]

Because defense and indemnity coverage provide fundamentally different protections, standards vary with respect to determining when the insurer is obligated to perform each of these separate obligations. The key difference between the duty to defend and the duty to indemnify is that the duty to indemnify arises only when the insured incurs covered liability based on actual facts that fall within the scope of coverage. The duty to defend, however, arises when the insured is sued in an action or presented with a claim where there is a possibility—no matter how remote—that the insured may incur liability based on facts that fall within the scope of coverage.[2] As mere allegations of potentially covered facts trigger the duty to defend, the defense obligation arises even when such facts alleged against the insured are false or groundless.[3]

Typically, the duty to defend is based primarily on a comparison of the facts alleged in the complaint and the terms of the insurance policy; whether the alleged facts are true is immaterial to this determination. Although a few jurisdictions restrict the duty to defend analysis to the factual allegations and policy provisions contained within the "eight corners" of the policy and underlying complaint,[4] many jurisdictions require an insurer to provide a defense if it is aware of evidence that potentially brings a claim within the scope of policy coverage, even when such facts are not alleged in the underlying complaint.[5]

Insurer's Options When Insured Requests a Defense

An insurer has three options when its insured requests a defense against an underlying lawsuit or a claim/demand. In evaluating these options, the insurer must consider whether the allegations in the underlying suit give rise to a duty to defend. Does the complaint, on its face, allege a potentially covered claim? Will the facts, if ultimately proven, support coverage? If the answer to either of these questions is clearly "yes," the insurer is contractually obligated to acknowledge coverage and assume the defense of the suit or claim. And, as noted above, even if the answer is "no," in many jurisdictions, the insurer must defend if it is aware of facts not alleged in the complaint that create the potential for covered liability.

Defend without reservation of rights. One option an insurer has when faced with a tender of the underlying lawsuit by its insured is to assume the defense of the insured without reserving its rights. However, an insurer that chooses this option should be aware that in many jurisdictions, defending without a reservation of rights leads to a waiver of the right to later deny coverage for a judgment in the underlying action.[6]

estoppel principles similar to Illinois and other jurisdictions in its closely watched decision in *K2 Investment Group, LLC v. American Guarantee & Liability Insurance Co. (K2 I)*.[47] In *K2 I*, the plaintiffs sued Goldan LLC and its two principals, Mark Goldman and Jeffrey Daniels, for damages arising out of unpaid loans issued to Goldan. The plaintiffs asserted claims for legal malpractice against Daniels on the basis that Daniels had allegedly acted as their attorney in the loan transaction. Daniels notified his legal malpractice carrier, American Guarantee, of the malpractice claims. American Guarantee declined coverage. Daniels subsequently defaulted and the plaintiffs obtained a default judgment in excess of the $2 million policy limit on the legal malpractice claims only. After the judgment was entered, Daniels assigned to the plaintiffs all of his rights against American Guarantee. The plaintiffs then brought an action against American Guarantee for breach of contract and bad faith failure to settle. American Guarantee moved for summary judgment on the basis of two policy exclusions. The trial court held that the exclusions on which American Guarantee relied were inapplicable to the malpractice claims, and American Guarantee's breach of its duty to defend estopped it from denying coverage.[48]

The *K2 I* court agreed that American Guarantee breached its duty to defend Daniels and was estopped from denying coverage, explaining that "when a liability insurer has breached its duty to defend its insured, the insurer may not later rely on policy exclusions to escape its duty to indemnify the insured for a judgment against him."[49] As the *K2 I* court explained:

> This rule will give insurers an incentive to defend the cases they are bound by law to defend, and thus to give insureds the full benefit of their bargain. It would be unfair to insureds, and would promote unnecessary and wasteful litigation, if an insurer, having wrongfully abandoned its insured's defense, could then require the insured to litigate the effect of policy exclusions on the duty to indemnify.[50]

However, acknowledging its failure to consider controlling precedent, *Servidone Construction Corp. v. Security Insurance Co. of Hartford*,[51] in reaching its holding in *K2 I*, the court of appeals reversed itself in *K2 II*.[52] *Servidone* held that an insurer that breaches its duty to defend is not liable to indemnify the insured for a settlement.[53] Thus, according to the court, the holdings in *K2 I* and in *Servidone* were in conflict and could not be reconciled. The court rejected the plaintiffs' attempt to distinguish *Servidone* on the basis that it involved a *settlement* between the insured and the underlying plaintiff—while the plaintiffs had a *judgment* against Daniels—as the distinction had no bearing on the issue of whether the insurer could rely on policy exclusions to defeat coverage.[54] The court also distinguished *Lang v. Hanover Insurance Co.*,[55] on which the *K2 I* court had relied, because the *Lang* court did not have the opportunity to consider whether an insurer may lose its right to rely on policy exclusions.[56] The court concluded that in light of the rule of *stare decisis*, the fact that other jurisdictions follow the *Servidone* approach, and the fact that it had not been presented with any evidence that the *Servidone* rule was unworkable or caused significant injustice or hardship for insureds, it did not have any justification for overruling *Servidone*.[57] Accordingly, the court vacated its decision in *K2 I*, and New York remains a jurisdiction that does not apply the estoppel doctrine to an insurer's breach of the duty to defend.

Another jurisdiction of note is Indiana. The Indiana Supreme Court has yet to directly rule on the issue of estoppel but suggested that Indiana has not adopted the estoppel doctrine when it stated, in a footnote, that "an insurer may choose at its own peril not to defend or seek a declaratory judgment, and failure to do either is not a waiver of defenses."[58] However, an older, appellate court decision appeared to indicate that the estoppel doctrine may be applicable in Indiana.[59]

The estoppel doctrine generally prohibits the insurer from relying on policy defenses, as opposed to all coverage defenses.

Rights the Breaching Insurer Is Estopped from Asserting

Jurisdictions differ with respect to the consequences and parameters of "estoppel" or estoppel-like principles. Generally, estoppel cannot be used to create or extend the scope of coverage of an insurance contract.[60] The rationale for the general rule is that an insurance company should not be made to pay a loss for which it has not charged a premium.[61] Thus, the estoppel doctrine generally prohibits the insurer from relying on *policy* defenses, as opposed to all *coverage* defenses (although these

concepts are sometimes confused and broadened depending on the facts and claim at issue). Policy defenses are generally thought of as defenses based on conditions or requirements of the insurance policy, such as notice or cooperation clauses.[62] Conversely, as the name indicates, coverage defenses are defenses based on the insuring agreement requirements and exclusions, e.g., that no coverage exists because the insuring agreement requirements have not been satisfied.

Estoppel principles apply equally under occurrence-based and claims-made policies. Policy defenses that insurers have been prevented from asserting include late notice,[63] defenses based on a notice of cancellation,[64] a defense that the insured was not driving the insured vehicle at the time of the accident,[65] and a defense that a putative additional insured did not constitute an insured under the policy because it did not meet the blanket additional insured endorsement requirement requiring a written contract between the putative additional insured and the insured.[66] Recently, the Appellate Court of Illinois determined that limitations on additional insured coverage may constitute "policy defenses" that an insurer can be estopped to raise should it breach its duty to defend.[67] Where an insurer has wrongfully refused to defend, it may also lose the right to dispute the insured's entry into a settlement without its consent as long as the settlement is reasonable and negotiated in good faith.[68]

In jurisdictions that preclude or estop an insurer from relying on *coverage* defenses, the insurer may be found liable for the entire amount of the judgment entered against the insured, as well as costs and attorney fees incurred by the insured in defending the underlying claim.[69] The insurer may also be liable for damages in excess of the policy limits.[70] However, in general, absent evidence of the insurer's bad faith, the insurer is only liable for the insured's settlement of the underlying claim up to the insurer's policy limits.[71] In addition, an insurer may be barred in any subsequent suit from contesting or challenging all issues that were decided in the underlying action.[72] Moreover, in some jurisdictions, an insurer that breaches the duty to defend may also be liable for the costs incurred by the insured in prosecuting the declaratory judgment action.[73]

Interestingly, under Georgia law an insurer may not deny coverage on certain issues while simultaneously reserving rights on other issues.[74] Insurers are estopped from asserting coverage defenses not included in original denial letters.[75] In *Hoover v. Maxum Indemnity Co.*, the insured's employee fell from a ladder and suffered injuries. The insurer denied coverage for the personal injury lawsuit under the employer's liability exclusion in the commercial general liability policy at issue. The declination letter generally reserved the insurer's rights to claim other defenses, including the policy's notice provisions. The insurer filed a declaratory judgment action seeking a declaration of no coverage on the exclusion but did not rely on the late notice defense. The action was dismissed as it did "not lie following an outright denial of coverage."[76] The Georgia Supreme Court stated that the "proper and safe course of action" is for an insurer "to enter upon a defense under a reservation of rights and then proceed to seek a declaratory judgment in its favor."[77]

In *Hoover*, the Georgia Supreme Court explained that a reservation of rights is effective only when an insurer agrees to defend and later files a declaratory judgment action. Because the insurer denied and refused to defend, it waived its right to assert a late notice defense even though it referred to the notice requirement in its denial letter. A federal court, relying on *Hoover*, recently held that an insurer is precluded from denying coverage for reasons not stated in its original coverage denial letter, even where the insurer reserved rights to assert other defenses before denying coverage.[78] Thus, a pre-denial reservation of rights will not insulate an insurer from estoppel resulting from the failure to include certain defenses in a subsequent coverage denial.

Other Applications of Estoppel or Waiver

Defective reservation of rights letter. The estoppel doctrine has also been applied in other instances, such as when the insurer who chooses to defend issues a defective reservation of rights letter. A reservation of rights must adequately inform the insured of the rights the insurer intends to reserve, because it is only when the insured is adequately informed of the potential policy defense that the insured can intelligently determine whether to retain his or her own counsel or accept the tender of defense counsel from the insurer.[79] If the insurer has adequately informed the insured of its position, and the insured accepts the tender of defense counsel, the insurer has not breached its duty of loyalty and is not generally equitably estopped from denying its obligation to indemnify.[80]

In some jurisdictions, a reservation of rights may create a conflict allowing the insured to choose independent counsel.[81] The failure to disclose a potential or actual conflict in the reservation of rights letter may result in estoppel.[82] The failure to advise the insured about a conflict of interest, and misrepresenting the right to independent counsel,[83] also has been held to be a breach of the duty to defend under Illinois law, resulting in estoppel.[84]

A conflict of interest that may prejudice the insured exists if, when comparing the allegations of the complaint to the policy terms, the interest of the insurer would be furthered by providing a less than vigorous defense to those allegations.[85] Prejudice resulting from a conflict of interest will not be presumed, and the burden of establishing it rests with the insured and must be proved by clear, concise, and unequivocal evidence.[86] An insurer's interest in negating policy coverage does not in itself give rise to a conflict of interest.[87]

Failure to timely issue reservation of rights letter. An insurer's delay in issuing a reservation of rights letter may also, under certain circumstances, support a claim for estoppel. An insurer is required to give the insured such notice of its intention to deny liability and of its refusal to defend as will give the insured a reasonable time to protect himself or herself.[88] The insurer's notice must be prompt, as timely notice of the denial of coverage is essential so that the insured may promptly undertake his or her own defense.[89] Once an insurer has reason to believe that a coverage dispute may exist, it should reserve rights and notify the insured of potential coverage problems before continuing its investigation and obtaining information from the insured.[90] The insured has the burden of demonstrating that a reservation of rights letter was untimely such that the insurer should be estopped from denying coverage.[91] Additionally, the insured must typically demonstrate prejudice or detrimental reliance in order to succeed on an estoppel claim in this circumstance.[92]

Failure to timely disclose specific coverage defenses in reservation of rights letter. Estoppel can also act to prevent an insurer from asserting defenses for which it failed to timely reserve its rights in the initial reservation of rights letter.[93] The insured must generally demonstrate detrimental reliance in order to succeed on an estoppel argument.[94] In some jurisdictions, an insurer waives the right to raise coverage defenses that are not communicated to the insured in the initial reservation of rights letter.[95]

> **The insured has the burden of demonstrating that a reservation of rights letter was untimely such that the insurer should be estopped from denying coverage.**

Failure to timely file declaratory judgment action. An insurer's failure to file a declaratory judgment action within a reasonable amount of time may result in estoppel. There is no bright-line rule regarding the length of time that is deemed reasonable or timely. A declaratory judgment action filed after the underlying action has been resolved by a judgment or a settlement has been found untimely as a matter of law.[96] However, an insurer will not be estopped solely because the underlying case is resolved before the declaratory judgment action has been completed.[97] Thus, in order to avoid estoppel, a declaratory judgment action should be commenced before the underlying suit has been resolved, but the declaratory action need not outrace the underlying litigation to the judgment "finish line."[98] One Illinois court held that the insurer's filing of a declaratory judgment action 10 months after it received notice of claims against the insured and six months after the insurer had acknowledged its duty to defend estopped the insurer from relying on policy defenses.[99]

Liability for Insured's Reasonable Defense Fees and Costs

At present, the estoppel doctrine is the minority rule. In a majority of jurisdictions, an insurer that breaches the duty to defend is only liable for damages that "naturally flow" from the breach of the insurance contract such as reasonable attorney fees and costs incurred by the insured in the underlying action.[100] The general principle underlying the majority rule is that the consequences imposed as a result of the breach of the duty to defend cannot broaden the insurer's contractual obligation to the insured.[101]

Conclusion

It is important to reiterate that this article merely provides some basic duty to defend and estoppel considerations and by no means should be viewed as the authority on those issues in every scenario or jurisdiction. There are many things to consider when determining whether a duty to defend is potentially implicated under an insurance policy and what action should be taken in any given circumstance. There are also a number of exceptions to the estoppel doctrine or the imposition of estoppel-like consequences in various jurisdictions. Thus, each set of facts and the applicable law must be considered in the analysis of an insurer's defense obligations and the potential consequences that could result from its actions. ■

Notes

1. *See generally* 3 New Appleman on Insurance Law Library Edition § 17.01[2][a] (Jeffrey E. Thomas & Francis J. Mootz III eds., 2012).

2. *See* Burlington Ins. Co. v. Oceanic Design & Constr., Inc., 383 F.3d 940, 944 (9th Cir. 2004) (Hawaii law).

3. *See* Curtis-Universal, Inc. v. Sheboygan Emergency Med. Servs., Inc., 43 F.3d 1119, 1122 (7th Cir. 1994) (Wisconsin law); Emp'rs Mut. Cas. Co. v. Cedar Rapids Television Co., 552 N.W.2d 639, 641 (Iowa 1996).

4. *See, e.g.*, GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church, 197 S.W.3d 305 (Tex. 2006).

5. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168, 176 (Cal. 1966) (en banc) (stating that the insurer "cannot construct a formal fortress of the third party's pleadings and retreat behind its walls"); Talen v. Emp'rs Mut. Cas. Co., 703 N.W.2d 395, 406 (Iowa 2005) (recognizing that evaluation of the duty to defend requires the insurer to consider "the pleadings of the injured party *and any other admissible and relevant facts in the record*"); Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co., 799 P.2d 1113, 1116 (N.M. 1990) (acknowledging that "[t]he duty of an insurer to defend arises from the allegations on the face of the complaint or from the known but unpleaded factual basis of the claim").

6. *See, e.g.*, Athridge v. Aetna Cas. & Sur. Co., 510 F. Supp. 2d 1 (D.D.C. 2007); Aloha Pac., Inc. v. Cal. Ins. Guar. Ass'n, 93 Cal. Rptr. 2d 148 (Ct. App. 2000); World Harvest Church, Inc. v. GuideOne Mut. Ins. Co., 695 S.E.2d 6, 9 (Ga. 2010).

7. *See, e.g.*, Whitney v. Cont'l Ins. Co., 595 F. Supp. 939 (D. Mass. 1984); *see also* Athridge v. Aetna Cas. & Sur. Co., 604 F.3d 625, 629–30 (D.C. Cir. 2010) (holding that the insured may be entitled to a rebuttable presumption of prejudice, depending on the amount of control the insurer exercised over the defense under District of Columbia law); Standard Mut. Ins. Co. v. Lay, 989 N.E.2d 591, 596 (Ill. 2013); Safeco Ins. Co. v. Ellinghouse, 725 P.2d 217 (Mont. 1986) (recognizing that prejudice is presumed under Montana law); Gen. Accident Ins. Co. of Am. v. Metro. Steel Indus., Inc., 780 N.Y.S.2d 128, 129 (App. Div. 2004); Fortune Ins. Co. v. Owens, 512 S.E.2d 487, 489–90 (N.C. Ct. App. 1999), *aff'd*, 526 S.E.2d 463 (N.C. 2000); Turner Liquidating Co. v. St. Paul Surplus Lines Ins. Co., 638 N.E.2d 174, 179 (Ohio Ct. App. 1994).

8. Med. Malpractice Joint Underwriting Ass'n of Mass. v. Goldberg, 680 N.E.2d 1121, 1129 n.31 (Mass. 1997).

9. *See, e.g.*, Transamerica Ins. Grp. v. Beem, 652 F.2d 663, 666 (6th Cir. 1981) (Tennessee law).

10. *See* Graper v. Mid-Continent Cas. Co., 756 F.3d 388, 392 (5th Cir. 2014) (Texas law); Cont'l Cas. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 940 F. Supp. 2d 898, 928 (D. Minn. 2013); San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc., 208 Cal. Rptr. 494, 506 (Ct. App. 1984), *superseded by statute*, CAL. CIV. CODE § 2860; Md. Cas. Co. v. Peppers, 355 N.E.2d 24, 31 (Ill. 1976); Pub. Serv. Mut. Ins. Co. v. Goldfarb, 425 N.E.2d 810, 815 (N.Y. 1981).

11. *See* Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122, 1135 (Ill. 1999); Bruce-Terminix Co. v. Zurich Ins. Co., 504 S.E.2d 574, 579 (N.C. Ct. App. 1998); Liebovich v. Minn. Ins. Co., 728 N.W.2d 357, 360–61 (Wis. Ct. App. 2007), *aff'd as modified*, 751 N.W.2d 764 (Wis. 2008).

12. *Ehlco Liquidating Trust*, 708 N.E.2d at 1135; Hunt v. State Farm Mut. Auto. Ins. Co., 994 N.E.2d 561, 566 (Ill. App. Ct. 2013).

13. *Ehlco Liquidating Trust*, 708 N.E.2d at 1138.

14. *See* Lloyd's & Inst. of London Underwriting Cos. v. Fulton, 2 P.3d 1199, 1206–09 (Alaska 2000).

15. *See, e.g.*, Underwriters at Lloyds v. Denali Seafoods, Inc., 927 F.2d 459, 463 (9th Cir. 1991) (Washington law).

16. *See infra* text accompanying notes 60–73.

17. Sauer v. Home Indem. Co., 841 P.2d 176, 183 (Alaska 1992); *see also* Makarka *ex rel.* Makarka v. Great Am. Ins. Co., 14 P.3d 964, 969 (Alaska 2000).

18. Black v. Goodwin, Loomis & Britton, Inc., 681 A.2d 293, 298–99 (Conn. 1996).

19. Capstone Bldg. Corp. v. Am. Motorists Ins. Co., 67 A.3d 961, 998–99 (Conn. 2013).

20. Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122, 1134–35 (Ill. 1999); FCCI Ins. Co. v. Westfield Ins. Co., No. 1-13-1598 (Ill. App. Ct. June 27, 2014); Uhlich Children's Advantage Network v. Nat'l Union Fire Co. of Pittsburgh, Pa., 929 N.E.2d 531 (Ill. App. Ct. 2010). .

21. Conway v. Country Cas. Ins. Co., 442 N.E.2d 245, 248–49 (Ill. 1982).

22. Swank Enters., Inc. v. All Purpose Servs., Ltd., 154 P.3d 52, 57–58 (Mont. 2007); Staples v. Farmers Union Mut. Ins. Co., 90 P.3d 381, 387 (Mont. 2004).

23. *Staples*, 90 P.3d at 386–87 (concluding that an insurer that refused to defend based on its unilateral decision that the insured did not own the horse that caused the injures breached its duty to defend because there was a genuine dispute as to ownership and thus was estopped from denying coverage).

24. Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co., 799 P.2d 1113, 1117–18 (N.M. 1990); Garcia v. Underwriters at Lloyd's London, 156 P.3d 712, 723 (N.M. Ct. App. 2007).

25. *See* Winters v. Transamerica Ins. Co., 194 F.3d 1321 (10th Cir. 1999) (unpublished); Valley Improvement Ass'n v. U.S. Fid. & Guar. Corp., 129 F.3d 1108, 1125–26 (10th Cir. 1997).

26. Pulte Home Corp. v. Am. S. Ins. Co., 647 S.E.2d 614, 617 (N.C. Ct. App. 2007); Ames v. Cont'l Cas. Co., 340 S.E.2d 479, 485 (N.C. Ct. App. 1986).

27. *See* St. Paul Fire & Marine Ins. Co. v. Vigilant Ins. Co., 919 F.2d 235 (4th Cir. 1990) (rejecting the insurer's argument that its breach of the duty to defend only prevented it from relying on the policy's "forfeiture" provisions (e.g., notice or voluntary payments provisions), and interpreting *Ames* as holding that an insurer that breaches its duty to defend is estopped from relying on the policy's coverage provisions); St. Paul Fire & Marine Ins. Co. v. Hanover Ins. Co., No. 5:99CV164BR-3, 2000 WL 34594777, at *10 (E.D.N.C. Sept. 19,

2000) (finding that the insurer's breach of duty to defend a putative additional insured precluded the insurer from arguing that the policy otherwise precluded indemnity coverage for additional insured).

28. Truck Ins. Exch. v. Vanport Homes, Inc., 58 P.3d 276, 281 (Wash. 2002); Kirk v. Mt. Airy Ins. Co., 951 P.2d 1124, 1127–28 (Wash. 1998).

29. *Kirk*, 951 P.2d at 1126.

30. *See, e.g.*, Se. Wis. Prof'l Baseball Park Dist. v. Mitsubishi Heavy Indus. Am., Inc., 738 N.W.2d 87, 107 (Wis. Ct. App. 2007); Liebovich v. Minn. Ins. Co., 728 N.W.2d 357, 360–61 (Wis. Ct. App. 2007), *aff'd as modified*, 751 N.W.2d 764 (Wis. 2008).

31. Ala. Farm Bureau Mut. Cas. Ins. Co. v. Moore, 349 So. 2d 1113, 1116 (Ala. 1977) ("[W]e reject the proposition that an insurer's liability to pay for damages may stem from a breach of its duty to defend. . . . [S]uch a breach in a suit lost by the insured does not automatically mean that the insured will be liable for total damages; the latter will turn on whether the insured had coverage.").

32. Hogan v. Midland Nat'l Ins. Co., 476 P.2d 825, 832 (Cal. 1970).

33. McGowan v. State Farm Fire & Cas. Co., 100 P.3d 521, 527 (Colo. App. 2004) ("[W]e agree with decisions of a majority of the courts in other jurisdictions holding that a breach of the duty to defend does not preclude an insurer from contesting its duty to indemnify.").

34. Deluna v. State Farm Fire & Cas. Co., 233 P.3d 12, 17 (Idaho 2008).

35. Lee Builders, Inc. v. Farm Bureau Mut. Ins. Co., 104 P.3d 997, 1005 (Kan. Ct. App. 2005).

36. Arceneaux v. Amstar Corp., 66 So. 3d 438, 452 (La. 2011).

37. Elliott v. Hanover Ins. Co., 711 A.2d 1310, 1313 (Me. 1998).

38. Balt. Gas & Elec. Co. v. Commercial Union Ins. Co., 688 A.2d 496, 514 (Md. Ct. Spec. App. 1997).

39. Polaroid Corp. v. Travelers Indem. Co., 610 N.E.2d 912, 922 (Mass. 1993) (holding that estoppel does not apply where the insurer breaches its duty to defend; however, the insurer has the burden of proving that the claim is not within the policy's coverage).

40. Kirschner v. Process Design Assocs., Inc., 592 N.W.2d 707, 710 (Mich. 1999).

41. Shannon v. Great Am. Ins. Co., 276 N.W.2d 77, 78 (Minn. 1979).

42. Ross v. Home Ins. Co., 773 A.2d 654, 658 (N.H. 2001).

43. Med. Protective Co. v. Fragatos, 940 N.E.2d 1011, 1015 (Ohio Ct. App. 2010).

44. Nw. Pump & Equip. Co. v. Am. States Ins. Co., 925 P.2d 1241, 1243 (Or. Ct. App. 1996).

45. Am. States Ins. Co. v. State Auto Ins. Co., 721 A.2d 56, 64 (Pa. Super. Ct. 1998) ("[W]e will not adopt a blanket rule that if there is a breach of a duty to defend and a settlement, then it automatically requires the breaching insurer to indemnify.").

46. Potesta v. U.S. Fid. & Guar. Co., 504 S.E.2d 135, 150 (W. Va. 1998) (holding that estoppel may not be used to extend insurance coverage beyond the terms of an insurance contract, except where the insured has been prejudiced).

47. 993 N.E.2d 1249 (N.Y. 2013). However, after rearguments, the court of appeals vacated *K2 I* in light of controlling precedent that it previously failed to consider. *See* K2 Inv. Grp., LLC v. Am. Guar. & Liab. Ins. Co. (*K2 II*), 6 N.E.3d 1117 (N.Y. 2014); *see also infra* notes 51–57 and accompanying text.

48. *K2 I*, 993 N.E.2d at 1252–53.

49. *Id.* at 1251.

50. *Id.* at 1254.

51. 477 N.E.2d 441 (N.Y. 1985).

52. *K2 II*, 6 N.E.3d 1117.

53. *Id.* at 1119.

54. *Id.*

55. 820 N.E.2d 855 (N.Y. 2004).

56. *K2 II*, 6 N.E.3d at 1119–20.

57. *Id.* at 1120.

58. Tri-Etch, Inc. v. Cincinnati Ins. Co., 909 N.E.2d 997, 1001 n.2 (Ind. 2009) (failing to define or explain the meaning of "at its own peril").

59. *See* Emp'rs Ins. of Wausau v. Recticel Foam Corp., 716 N.E.2d 1015, 1029 n.16 (Ind. Ct. App. 1999) ("If an insurer fails to defend under a reservation of rights or to seek a declaratory judgment that there is no coverage and is later found to have wrongfully denied coverage, the insurer may be estopped from raising policy defenses to coverage." (citing with approval Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122 (Ill. 1999))); *see also* Fed. Ins. Co. v. Stroh Brewing Co., 127 F.3d 563, 571 (7th Cir. 1997) (holding that, under Indiana law, an insurer that delayed six months before notifying the insured that it was declining coverage was estopped from relying on a policy exclusion because an insurer that wrongfully denies coverage cannot "hide behind the language of the contract in an attempt to avoid its duty to insure").

60. Nationwide Mut. Ins. Co. v. Filos, 673 N.E.2d 1099, 1103 (Ill. App. Ct. 1996) ("Illinois courts have followed the general rule that the doctrine of estoppel cannot be used to create primary liability or to increase coverage provided under an insurance policy."); Transcon. Ins. Co. v. J.L. Manta, Inc., 714 N.E.2d 1277, 1280 (Ind. Ct. App. 1999); Maxwell v. Hartford Union High Sch. Dist., 814 N.W.2d 484, 493 (Wis. 2012).

61. *Filos*, 673 N.E.2d at 1103; *J.L. Manta*, 714 N.E.2d at 1281.

62. Sauer v. Home Indem. Co., 841 P.2d 176, 183 (Alaska 1992).

63. Uhlich Children's Advantage Network v. Nat'l Union Fire Co. of Pittsburgh, Pa., 929 N.E.2d 531, 541–43 (Ill. App. Ct. 2010).

64. Am. Standard Ins. Co. of Wis. v. Gnojewski, 747 N.E.2d 367, 374–75 (Ill. App. Ct. 2001).

65. Chandler v. Doherty, 702 N.E.2d 634, 640 (Ill. App. Ct. 1998).

66. W. Am. Ins. Co. v. J.R. Constr. Co., 777 N.E.2d 610, 620 (Ill. App. Ct. 2002).

67. *See* Mt. Hawley Ins. Co. v. Certain Underwriters at Lloyd's, London, 19 N.E.3d 106, 111 (Ill. App. Ct. 2014).

68. Valley Improvement Ass'n v. U.S. Fid. & Guar. Corp., 129 F.3d 1108, 1125 (10th Cir. 1997) (New Mexico

law); Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co., 799 P.2d 1113, 1117 (N.M. 1990).

69. *See* Bellefonte Ins. Co. v. Wayson, 489 F. Supp. 58, 60–61 (D. Alaska 1980) (holding that the insurer that breached the duty to defend without responding to the claim of the insured was precluded from contesting coverage in a subsequent action on the policy and was liable for the entire amount of the jury verdict against the insured, including punitive damages); Se. Wis. Prof'l Baseball Park Dist. v. Mitsubishi Heavy Indus. Am., Inc., 738 N.W.2d 87, 107 (Wis. Ct. App. 2007) ("Wisconsin case law has taken the 'harsh view' that 'an obligation to pay the entire settlement or judgment is the *automatic* consequence of a finding of a breach of the duty to defend.'").

70. *See Se. Wis. Prof'l Baseball*, 738 N.W.2d 87 at 107.

71. State Farm Fire & Cas. Co. v. Ruiz, 36 F. Supp. 2d 1308, 1311 (D.N.M. 1999).

72. *See* Black v. Goodwin, Loomis & Britton, Inc., 681 A.2d 293, 302 (Conn. 1996) ("It is well settled that when an insurer improperly fails to defend an insured who subsequently settles the case with the injured party, the insurer is estopped from raising the issue of the insured's liability as a defense to an action arising from the insurer's failure to defend."); Eclipse Mfg. Co. v. U.S. Compliance Co., 886 N.E.2d 349, 357 (Ill. App. Ct. 2007) (finding the insurer estopped in subsequent citation proceedings by a judgment creditor as to all issues decided in the underlying class action).

73. *See* Olympic Steamship Co. v. Centennial Ins. Co., 811 P.2d 673, 681 (Wash. 1991); Liebovich v. Minn. Ins. Co., 728 N.W.2d 357, 361 (Wis. Ct. App. 2007), *aff'd as modified*, 751 N.W.2d 764 (Wis. 2008).

74. Hoover v. Maxum Indem. Co., 730 S.E.2d 413, 416 (Ga. 2012) (citing Morgan v. Guar. Nat'l Cos., 489 S.E.2d 803 (Ga. 1997)), *reh'g denied* (July 26, 2012).

75. *Id.* (citing Browder v. Aetna Life Ins. Co., 190 S.E.2d 110 (Ga. 1972)).

76. *Id.* at 416 n.3.

77. *Id.* at 417.

78. Moon v. Cincinnati Ins. Co., 920 F. Supp. 2d 1301, 1304 (N.D. Ga. 2013).

79. Am. Family Mut. Ins. Co. v. Westfield Ins. Co., 962 N.E.2d 993, 999 (Ill. App. Ct. 2011).

80. Cowan v. Ins. Co. of N. Am., 318 N.E.2d 315, 326 (Ill. App. Ct. 1974).

81. *See supra* note 10.

82. Royal Ins. Co. v. Process Design Assocs., Inc., 582 N.E.2d 1234, 1240 (Ill. App. Ct. 1991); Cent. Mut. Ins. Co. v. Kammerling, 571 N.E.2d 806 (Ill. App. Ct. 1991).

83. Md. Cas. Co. v. Peppers, 355 N.E.2d 24 (Ill. 1976).

84. *See* Utica Mut. Ins. Co. v. David Agency Ins., Inc., 327 F. Supp. 2d 922, 931 (N.D. Ill. 2004).

85. *Process Design*, 582 N.E.2d at 1240.

86. W. Cas. & Sur. Co. v. Brochu, 475 N.E.2d 872, 879 (Ill. 1985).

87. *Process Design*, 582 N.E.2d at 1240–41.

88. *See* Sauer v. Home Indem. Co., 841 P.2d 176, 182 (Alaska 1992) (citing 7C John Alan Appleman & Jean Appleman, Insurance Law and Practice § 4686 (1979)).

89. *See id.*; Lloyd's & Inst. of London Underwriting Cos. v. Fulton, 2 P.3d 1199, 1204 (Alaska 2000).

90. *Fulton*, 2 P.3d at 1204.

91. Clunie-Haskins v. State Farm Fire & Cas. Co., 855 F. Supp. 2d 380, 389–90 (E.D. Pa. 2012).

92. *See* Ins. Co. of N. Am. v. McCleave, 462 F.2d 587, 588 (3d Cir. 1972) (New Jersey law); 206-208 Main St. Assocs., Inc. v. Arch Ins. Co., 965 N.Y.S.2d 31, 35 (App. Div. 2013).

93. All Am. Ins. Co. v. Broeren Russo Constr., Inc., 112 F. Supp. 2d 723, 730 (C.D. Ill. 2000).

94. *Id.* (finding the insurer not estopped from asserting "no occurrence" policy defense due to its failure to specifically indicate that defense until 16 months after its initial reservation of rights letter where the insured did not establish prejudice by the delay in receiving the more detailed reservation of rights letter).

95. *See, e.g.*, First Ala. Bank of Montgomery, N.A. v. First State Ins. Co., 899 F.2d 1045, 1063 (11th Cir. 1990) (Alabama law); Nat'l Cas. Ins. Co. v. Stella, 601 A.2d 557, 559 (Conn. App. Ct. 1992); Enoka v. AIG Haw. Ins. Co., Inc., 128 P.3d 850, 869 (Haw. 2006).

96. Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122, 1138 (Ill. 1999).

97. State Farm Fire & Cas. Co. v. Martin, 710 N.E.2d 1228 (Ill. 1999).

98. L.A. Connection v. Penn-Am. Ins. Co., 843 N.E.2d 427, 432 (Ill. App. Ct. 2006).

99. Cent. Mut. Ins. Co. v. Kammerling, 571 N.E.2d 806, 810–11 (Ill. App. Ct. 1991); *see also* Fed. Ins. Co. v. Stroh Brewing Co., 127 F.3d 563, 571 (7th Cir. 1997) (Indiana law).

100. *See, e.g.*, Babcock & Wilcox Co. v. Parsons Corp., 430 F.2d 531, 539 (8th Cir. 1970) (Nebraska law); Bainbridge, Inc. v. Travelers Cas. Co. of Conn., 159 P.3d 748, 756 (Colo. App. 2006), *as modified on denial of reh'g* (Nov. 30, 2006); Aetna Cas. & Sur. Co. v. Commonwealth, 179 S.W.3d 830, 841 (Ky. 2005), *as modified on reh'g* (Jan. 19, 2006); Arceneaux v. Amstar Corp., 66 So. 3d 438, 452 (La. 2011); Mesmer v. Md. Auto. Ins. Fund, 725 A.2d 1053, 1064 (Md. 1999); Cooley v. Mid-Century Ins. Co., 218 N.W.2d 103, 105 (Mich. Ct. App. 1974); First Bank of Turley v. Fid. & Deposit Ins. Co. of Md., 928 P.2d 298, 305 (Okla. 1996); Mace v. Atl. Ref. & Mktg. Corp., 785 A.2d 491, 497 (Pa. 2001).

101. Miller v. Elite Ins. Co., 161 Cal. Rptr. 322, 330 (Ct. App. 1980) ("Estoppel cannot be used to create coverage under an insurance policy where such coverage did not originally exist."); *see also* McKnight v. USAA Cas. Ins. Co., 871 A.2d 446, 451–52 (Del. Super. Ct. 2005), *aff'd*, 900 A.2d 101 (Del. 2006); Fla. Mun. Ins. Trust v. Vill. of Golf, 850 So. 2d 544, 551 (Fla. Dist. Ct. App. 2003); Ulico Cas. Co. v. Allied Pilots Ass'n, 262 S.W.3d 773, 787 (Tex. 2008).