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501 E. Camino Real
Boca Raton, FL 33432

Roundtable 3: Thursday, April 10, 2014 (3:30 pm – 4:30 pm)

Maintaining Control: How To Direct The Defense And Manage Settlement Opportunities When There Are Significant Coverage Issues

I. Step One: Tailoring the ROR to the Situation

A. Selection of coverage defenses for inclusion in ROR - Discussion

1. Does it make practical sense to reserve the right to deny coverage when doing so would then obligate the insurer to provide independent counsel? In the classic fact scenario, there are allegations that potentially trigger the "intentional acts" exclusion. An insurer should evaluate the facts and law and consider waiving the reservation in certain claims not likely to result in a finding of intentional conduct or fraud, or where the financial analysis or business considerations weigh in favor of the waiver.

2. After drafting and issuing the reservation of rights letter, what does the adjuster do with respect to monitoring or with respect to investigating whether facts are developed that impact those reservations?

B. Jurisdictional considerations

1. Does the particular state recognize a tri-partite relationship?

2. Is it worth raising the reservation where to do so requires the filing of a declaratory relief action?

3. Does the particular jurisdiction require that all potential reservations be raised, estopping the insurer from raising a late reservation?

II. Step Two: Managing the assignment of defense counsel

A. Selling a particular defense counsel to the Insured

1. The adjuster should be invested in educating the insured as to why the chosen defense counsel has the requisite skills and on point experience to competently defend the insured. Discussions should be had concerning the different attorneys on the panel list and why they were chosen to be on the panel and why they are right for the assignment.

2. Insurers should consider training adjusters in how to deal with appointing counsel when the insured, or their personal counsel, demand that someone other than panel counsel be appointed. Better communication skills may facilitate the process.

B. Converting panel counsel into independent counsel

In certain matters, the adjuster should consider instructing panel counsel that they are to serve as independent counsel with a sole duty of loyalty to the insured. Although this will change reporting obligations to the insurer, this instruction may absolve any potential conflict panel counsel may be aware of and facilitate the insured's acceptance of panel counsel.

C. Vetting the insured's choice of counsel

There are claims where the insurer should agree to retain the insured's chosen counsel to satisfy the insurer's obligation to appoint independent counsel. For example, where there is a burning limits policy with serious coverage issues. Many policies provide that the payment of insurer chosen defense counsel fees and costs and payment of independent counsel fees and costs will be charged against available policy limits. Another example is where the insurer intends to seek a judicial declaration that no coverage is owed. In this circumstance, unless the insured is looking for a counsel recommendation, appointing the insured's choice of counsel avoids a later argument that the insurer appointed counsel who set the course and then the insurer abandoned the ship.

D. Monitoring counsel option

The adjuster always has the option to retain monitoring counsel to protect the insurer's interests, especially when the adjuster has agreed to the retention of the insured's chosen counsel as independent counsel. Other examples, when the adjuster should consider appointing monitoring counsel: (1) there are significant coverage issues for which the adjuster wants monitoring counsel to have access to discovery and other litigation; and, (2) excess limits or uninsured loss is highly probable, and a policy limits demand highly likely.

E. Personal counsel option

The flip side of the monitoring counsel option is the personal counsel option. Where the insured is convinced that it needs its own advocate who understands its business or shares its view of the litigation, the adjuster can remind the insured that is always has the option to have its own counsel associate into the litigation or monitor appointed counsel – at the insured's expense. Sometime this is sufficient involvement for the personal counsel, who may not be equipped to try the case, to satisfy the insured's concerns about insurer appointed counsel.

III. Handling Rejection of the Offered Defense

Where an insurer agrees to defend an insured, but subject to a reservation of rights, who controls defense and settlement of the claim? Courts have broadly adopted three approaches to dealing with this issue:

A. One line of cases holds that an insurer loses the right to control the defense and decisions on settlement, subject only to a determination whether any settlement made by the insured is deemed fair and reasonable. *Patrons Oxford Ins. Co. v. Harris,* 905 A.2d 819 (Me. 2006); *Kelly v. Iowa Mut. Ins. Co.,* 620 N.W.2d 637 (Iowa 2000); *United Servs. Auto. Ass'n v. Morris,* 741 P.2d 246 (Ariz. 1987); *Martin v. Johnson,* 170 P.3d 1198 (Wash. Ct. App. 2007); see also *R.C. Wegman Construction Co. v Admiral Insurance Co.,* 634 F.3d 371 (7th Cir. 2011) (Illinois law).

B. Other courts have held that an insurer retains the right to control the defense and decisions on settlement, subject only to a determination whether the insurer was acting in good faith. *Motiva Enterps., LLC, v. St. Paul Fire & Marine Ins. Co.,* 445 F.3d 381 (5th Cir. 2006) (Texas law); *Danrik Const. Inc. v. Amer. Cas. Co.,* 314 Fed.Appx. 720 (5th Cir. 2009) (Louisiana law) (unpublished); *L & S Roofing Supply, Inc. v. St. Paul Fire & Marine Ins. Co.* , 521 So.2d 1298 (Ala. 1987); *Maine Bonding & Cas. Co. v. Centennial Ins. Co.,* 693 P.2d 1296 (Ore. 1985).

C. The third approach gives an insured a choice. The insured has the option to accept or reject the offered defense under reservation of rights. If the insured accepts the defense under reservation of rights, then the insurer controls the defense and settlement decisions, subject to its duty of good faith and fair dealing. Alternatively, if the insured rejects the offered defense under reservation of rights, the insured pays its own defense costs and makes its own settlement decisions, subject to reimbursement from the insurer if coverage is found and if the costs and settlement are deemed fair, reasonable, and non-collusive. *Babcock & Wilcox Co. v. American Nuclear Insurers*, 76 A.3d 1 (Pa. 2013); *Mid-Continent Cas. Co. v. Amer. Pride Bldg. Co., LLC,* 601 F.3d 1143 (11th Cir. 2010) [following *Taylor v. Safeco Ins. Co.,* 361 So.2d 743 (Fla. Ct. App. 1978)]; see also *Blue Ridge Ins. Co. v. Jacobsen,* 25 Cal. 4th 489 (2001); *Butters v. City of Independence,* 513 S.W.2d 418 (Mo. 1974); *Med. Protective Co. of Fort Wayne, IN, v. Davis,* 581 S.W.2d 25 (Ky. App. 1979); *Sneed v. Concord Ins. Co.,* 237 A.2d 289, 293 (N.J. Super. Ct. 1967); *Connolly v. Standard Cas. Co.,* 73 N.W.2d 119 (S.D. 1955).

IV. Step Four: Responding to Settlement Demands

A. The Texas *Stowers* situations

The *Stowers* Doctrine derives its name from the old case of *G.A. Stowers Furniture Co. v. American Indem. Co*., 15 S.W.2d 544 (Tex. Com. App 1929). In that seminal case, the court ruled that the insurer, who retained exclusive control over the defense of the case, owed its insured a duty of reasonable care in negotiating settlement of the case. The *Stowers* doctrine imposes the entire amount of any excess judgment on the insurer if the insurer fails to accept a reasonable settlement offer that is within policy limits.

In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), the Texas Supreme Court enumerated the conditions that give rise to the duty of an insurer in the context of settlement. Those conditions are as follows:

1. The claim against the insured must be within the scope of the insurance coverage;

2. The settlement demand must be within the policy limits; and

3. The terms of the demand must be such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment. *Id.* at 849.

Subsequent case law in Texas reveals that the number of *Stowers* elements enumerated in Garcia may have increased:

1. The offer of settlement must be unconditional; *See Insurance Corp. of America v. Webster*, 906 S.W.2d 77 (Tex. App.--Houston [1st Dist.] 1995);

2. The offer must be accompanied by a total release; Se*e Trinity Universal Insurance v. Bleeker,* 966 S.W.2d 491 (Tex. 1998); and

3. The insurer must be given a reasonable amount of time to consider the offer of settlement.

Other interesting issues:

1. The fact that the insured agrees that the case should not be settled is not necessarily a defense to the claim that the failure to settle was unreasonable because the standard is an objective rather than a subjective one;

2. A bona fide dispute regarding coverage may still not be an absolute defense to a *Stowers* demand; [See *LSG Technologies, Inc. v. U.S. Fire Ins. Co.*, holding that *Stowers* does not involve questions of bad faith and thus a bona fide coverage dispute is not a defense to such claims. If insurers genuinely believe there is no coverage and it is later found that there is, the insurers are still liable for amounts awarded in the underlying judgment in excess of limits, even if a reasonable insurer would have contested coverage.]

B. The California *Johansen* situations

1. Duty to Settle

As happens often, although an insurer may be defending its insured in a third-party lawsuit under a reservation of rights, a conflict may arise when a plaintiff, whose lawsuit seeks damages exceeding policy limits, makes a settlement demand equal to those limits. Believing that the settlement offer is too high or that facts will be established undermining coverage, that insurer has an incentive to decline the settlement and proceed to trial. The insured, on the other hand, prefers to avoid a trial.

That insurer faces a difficult choice: if it accepts the settlement offer and it is later determined that there was no coverage for the claim, it risks having to seek reimbursement of the settlement payment from its insured, who oftentimes claims that he, she or it does not have the financial means to repay it. Also, although a declaratory relief coverage action may have been filed and the parties are litigating coverage issues, there is no automatic stay of any enforcement of a judgment that plaintiff may be awarded that would allow that insurer to conclude its declaratory relief action before having to face satisfying a judgment. This presumes, of course, that the appeals of the underlying judgment have been exhausted.

On the other hand, if the insurer rejects the offer and plaintiff prevails against its insured, that insurer could be liable not only for a judgment exceeding policy limits but also for additional damages its insured has sustained. In fact, it is this very conflict that gives rise to the duty to settle. (See 14 Couch

on Insurance 3d, § 203:13 at p. 20321: "The basis for the insurer's duty to settle within policy limits is the insurer's exclusive control over settlement negotiations, plus the inevitable conflict between the insurer's interest to pay as little as possible and the insured's interest not to suffer an excess judgment.")

2. "Reasonable" Offers and Acceptance

Though the exact formulation of an insurer's duty varies among the states, the California Supreme Court has directed that the only possible consideration is "whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer." (*Johansen v. California State Auto Ass'n Inter-Ins. Bureau*, 15 Cal. 3d 9 at 16 (1975).) In making this determination, the court noted that the insurer's decision-making process should not be swayed by: the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage.

The dispute in *Johansen* arose after a car accident in which a minor child of a policyholder negligently injured two individuals. The insurance carrier defended the policyholder against the injured plaintiffs. Leading up to litigation, the injured plaintiffs made a settlement demand within the $10,000 policy limit of the insurance policy. However, the insurance carrier refused to accept a settlement offer because it had a bona fide belief that the accident did not fall within the policy's coverage. After the carrier refused the demand, the case went to trial and the plaintiffs obtained a judgment against the policyholder that was in excess of the policy limit. Although the insurance carrier paid the injured claimants the policy limit, the carrier subsequently refused to pay the balance of the judgment.

Next, the policyholder assigned its claim of bad faith against the carrier to the injured plaintiffs who pursued another lawsuit against the carrier. After several appeals, the Supreme Court of California examined the obligation of the insurance carrier to accept a reasonable settlement offer even if the insurance carrier has a bona fide belief that the claim is not within the insurance policy. The Court found that the insurance carrier's "good faith, though erroneous, belief in non-coverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer." *Johansen*.

Additionally, the *Johansen* Court outlined a test for determining when an insurance carrier is obligated to accept a settlement offer within the policy limit. The Court stated the determining factor is whether the insurance carrier can foresee that the plaintiff will obtain a judgment that is in excess of the settlement offer. According to *Johansen*, the insurance carrier cannot simply rely on justifications like "a desire to reduce the amount of future settlements" or "a belief that the policy does not provide coverage" to reject a settlement demand that is within the policy limits. Instead, if the insurance carrier can predict that a claimant's judgment will exceed the policy limits, the carrier must accept a reasonable settlement demand that is at or below the policy limit.

Nevertheless, an insurance carrier does not need to blindly accept all demands. One limitation on the obligation to accept a settlement offer is that the offer must be reasonable. While there is no absolute test for reasonableness, courts have looked at the information known to the insurance carrier at the time of the demand. Additionally, courts have considered the size of the judgment recovery(?) in order to make an inference about the value of the claim. Though an insurance carrier does not automatically commit bad faith by refusing a reasonable settlement demand, it does expose itself to liability if it does. Also, an insurance carrier is not under any obligation to accept a settlement in order to protect the policyholder from exposure to uncovered risks. Furthermore, an insurance carrier is not required to settle in order to avoid a policyholder's exposure to punitive damages.

3. Consequences of an insurance carrier's refusal to accept a settlement offer

In the classic coverage-refusal case, the carrier is deemed to be acting "at its own risk." (*Comunale v. Traders & Gen. Ins. Co.*, 50 Cal. 2d 654 at 660 (1958).) Having failed to accept a reasonable settlement offer from the claimant on the ground that the claim against its insured was not covered, the insurer will be at risk for any excess judgment-and possibly additional damages-if it is later determined that the insurer's coverage determination was incorrect.

This is potentially dangerous from the carrier's perspective. First, the threshold for liability is extremely low. To be liable for the excess judgment, the carrier need only to have been "incorrect" in connection with its evaluation of coverage. (See *Johansen*, 15 Cal. 3d at 16, fns. 4 and 5.) No finding of bad faith, unreasonableness, or other culpable conduct is necessary.

Second, in the event that a settlement demand is rejected and the eventual judgment against the policyholder is greater than the policy limit, both the policyholder and the claimant may have potential claims against the insurance carrier. This is because an insurance carrier is exposed to bad faith liability if its refusal to settle was unreasonable and the judgment is in excess of policy limits. See also *R.C. Wegman Construction Co. v Admiral Insurance Co.,* 634 F.3d 371 (7th Cir. 2011) (applying Illinois law)

A policyholder can recover damages suffered by the insurance carrier's breach by initiating a bad faith action. In the event of a favorable bad faith recovery, an insurance carrier that wrongfully denies coverage for a policyholder is liable for the full amount that will compensate the policyholder for all the detriment caused by the insurance carrier's breach. The claimant also has rights against the insurance carrier if there is a wrongful denial of a settlement offer if the claimant acquires the original policyholder's rights under the principles of contract assignment. *See Crisci v. Security Insurance Co.*

Once a claim of wrongful denial of a settlement offer is initiated, the policy limits are considered to be 'opened up.' This means that, if the carrier has refused a reasonable settlement demand within limits, the carrier is no longer protected by the policy limit and will be required to pay the full extent of the insured's liability. When a carrier has spurned an offer within policy limits, and a verdict is rendered in excess of that offer, the liability carrier will face a claim for the breach of the implied covenant of good faith and fair dealing. In California, such a claim will also give rise to both contract and tort damages.

A key peril that a liability insurer then faces is that once it declines the claimant's "reasonable" offer, neither its belated payment of policy limits nor its belated acceptance of the claimant's settlement offer will discharge its bad faith liability.

4. Carrier Reimbursements

An insurer seeking to avoid the "coverage refusal" scenario might wish to accept a policy-limits demand from the claimant and then, after the underlying lawsuit is resolved, seek to recoup the settlement amount from its insured.

But not all states allow this. However, in *Blue Ridge Insurance Company v. Jacobsen* (25 Cal. 4th 489 (2001)), the California Supreme Court held that an insurer defending its insured under a reservation of rights may settle with the claimant even over its insured's objections and then obtain recoupment of the settlement payment from its insured following a determination that there was no coverage.

In *Blue Ridge*, the court conditioned the insurer's right to pursue recovery of the settlement payment from its insured on a timely and express reservation of rights, an express notification to the insured that the insurer intended to accept the claimant's settlement offer, and an express offer to the insured that it may assume its own defense arising from the parties' dispute about whether to accept the

settlement offer.

From the carrier's standpoint, this scenario has the advantage of insulating it from potential bad faith claims that could be asserted by its insured if the underlying lawsuit went to trial and an excess judgment were rendered. But such protection comes at a cost: the insurer bears the economic risk that its insured may be incapable of reimbursing it for the settlement payment that the insurer has advanced. However, this serves the societal interest of transferring the risk of nonpayment from the injured party to the insurer. (*Blue Ridge*, 25 Cal. 4th at 503.)

5. Splitting the Settlement

In a case involving both covered and noncovered claims, a carrier's duty to settle does not extend to the noncovered portions of the injured party's claim. (*Camelot by the Bay Condo. Owners' Ass'n, Inc. v. Scottsdale Ins. Co.*, 27 Cal. App. 4th 33 (1994).) The "reasonableness" of the carrier's settlement offer is measured by the insured's potential exposure in respect to the covered, as opposed to the noncovered, claims. (*Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co.*, 724 F.2d 1343 (9th Cir. 1983).)

A carrier therefore does not breach its duties to its insured by requesting that the insured contribute to a settlement when there is a bona fide dispute about the extent of the carrier's obligations. (Croskey, et al., CALIFORNIA PRACTICE GUIDE: INSURANCE LITIGATION (Rutter Group 2006);§ 12:449 at p. 12B-65.)

The difficulty here for a carrier is that by suggesting that its insured contribute to an overall settlement, it is walking the razor's edge: on the one hand, from the perspective of the insurer, the reasonableness of any settlement offer made by the claimant will be measured against the magnitude of the covered, as opposed to noncovered, claims. On the other hand, any effort by the carrier to "coerce" the insured to contribute to a settlement might be invoked later by the insured as evidence of the carrier's bad faith. (*See J.B. Aguerre, Inc. v. American Guar. & Liab. Ins. Co.*, 59 Cal. App. 4th 6 (1997).)

An insured pressured by its carrier to partially fund a settlement has an important resource. According to the California Supreme Court, when faced with the insurer's unreasonable refusal to pay a settlement demand within policy limits, "the insured may recover the amount of payment from the insurer in an action for bad faith failure to settle." (*Hamilton v. Maryland Cas. Co.*, 27 Cal. 4th 718 at 731 (2002).)

6. Is the Expected Settlement Demand “Reasonable”?

The test, as enunciated by the California Supreme Court and adopted by the official California Jury Instructions in CACI 2334, is as follows:

> A settlement demand is reasonable if Darwin knew or should have known at the time the settlement demand was rejected that the potential judgment was likely to exceed the amount of the settlement demand based on Susan Murphy’s injuries or loss and Friedman & Friedman’s probable liability. [should we substitute in brackets [carrier] [plaintiff] and [insured] for the names?]

C. Reverse hammer letters

For the purposes of this section, we define a "hammer" letter as correspondence from an insured (or excess carrier) to a primary insurer, demanding that the latter settle a claim within policy limits. Many times the insured’s “hammer” letter is a radical departure from the insured’s prior position that the

claim is not worth as much as the plaintiff is demanding and/or that the insurer should proceed to trial "at all costs."

According to one commentator, there are many reasons why insureds decided to send hammer letters, such as:

- They did not buy enough insurance
- They only just realized they faced significant exposure
- Late-stage adverse developments "cratered" the defense of the case
- There is a chance of an uninsured excess award
- This is their attempt to set-up an insurer or uncap policy limiits
- They have grown tired of the distraction
- They need to send a wake-up message to the adjuster who does not appreciate the dangers or value of a case.

D. Reverse Hammer Letter Responses

1. Acknowledge the letter and secure more time to renegotiate all time-oriented deadlines. Most jurisdictions recognize the insurers need and necessity to have the time to properly evaluate the hammer letter.

2. Consider retaining coverage or monitoring counsel to review the file and make recommendations, and opine on the following factors: (a) is there an alternative to tendering policy limits in response to the insured's demand; (b) is there any law in that particular jurisdiction to consider in responding to the insured's demand; (c) should the insurer consider relying on an "advice of counsel" defense; (d) does local coverage law presume bad faith if the ultimate verdict is in excess of the policy limits?

3. Engage the insured in a dialogue as to why the insured believes he, she or it is liable for the full policy limits. Evaluate the details and specifics proffered by the insured, including them in the claim file. Explore with the insured whether they have fully considered the factors that would weigh against the demanded settlement (such as loss history and future insurability, required reporting to licensing board, or reputation)?

4. Assuming defense counsel had already provided an evaluation and it did not then support the tendering of limits to settle the claim, solicit input from defense counsel as to the value of the claim. The strategy, ultimately, is to make the decision on the probability of an excess verdict, putting the insured's interests above those of the insurer.

5. In many situations alerting the underwriter to "hammer" letters makes sense if the adjuster believes she or he is forced to pay a settlement premium because the insured purchased policy limits lower than exposures faced.

6. Respond quickly to all demands and communications, with thoughtful and complete explanations.

7. Initiate settlement discussions with plaintiff if they had not already been initiated, perhaps securing a settlement for less than the insured demanded or negotiating a high low agreement that allows the litigation to continue but protects the insured from excess exposure.

E. The Arizona *Damron* and *Morris* situations

In Arizona, there are three different types of agreements into which an insured and a plaintiff can enter. The first is triggered by an insurer's refusal to defend and denial of coverage. The Arizona Supreme Court case of *Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969) applies to this case. The second is triggered where an insurer agrees to defend, but reserves its right to challenge its duty to indemnify. *See United Services Automobile Association v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987).

In *Damron v. Sledge,* 105 Ariz. 151, 460 P.2d 997 (1969), the insurer denied coverage under an auto policy and declined to defend the insured. The insured entered into an agreement with the plaintiff under which the plaintiff gave him a covenant not to execute in return for his stipulation to a default being entered against him and an assignment of his bad faith claim against the insurer. A default judgment was entered against the insured after a default hearing.

The Arizona Supreme Court held that the insured's action was a proper self-protective response to the insurer's denial of a defense. It held that the agreement was not collusive under the circumstances even though it resulted in a significant *ex parte* judgment against the insured. It placed the risk of ultimately having to pay an unduly large judgment on the insurer that refuses to defend.

In *United Services Automobile Ass'n. v. Morris,* 154 Ariz. 113, 741 P.2d 246 (1987), the insurer defended an insured under a reservation of rights. The insured entered into an agreement with the plaintiff under which the plaintiff gave him a covenant not to execute in return for a stipulation to allow the entry of a $100,000 judgment against him and an assignment of his rights against his insurer.

The Arizona Supreme Court held the agreement did not constitute a breach by the insured of the cooperation clause because the insurer had not extended unreserved coverage. But it concluded that the stipulated judgment would not be binding on the insurer if it could ultimately prove that there was no coverage. In addition, the insurer could attack a judgment on the basis that the insured's settlement was not fair and reasonable under the circumstances. It could also attack a judgment that was collusive or fraudulent. *Morris* also requires that an insurer be given reasonable notice of a proposed settlement and the opportunity to withdraw its reservation of rights.

Based on *Damron* and *Morris* and some of the subsequent related cases, there has developed an impression that an insurer could be held strictly bound by a stipulated judgment of any amount entered in connection with a *Damron* agreement (refusal to defend), but could only be bound by a judgment of a reasonable amount entered in connection with a *Morris* agreement (defense under a reservation of rights). *See, Arizona Prop. & Cas. Guar. Fund. V. Helme,* 153 Ariz. 129, 735 P.2d 451 (1987).

Recent re-examination of language in *Helme* (which came before *Morris*), however, suggests that a *Damron* settlement also has to be for a reasonable amount. Thus, whether an insurer refuses to defend or defends under a reservation of rights, the insured should only be able to stipulate to a judgment that is "reasonable." *See discussion at 153 Ariz. 138, 735 P.2d 460 (note 14).*

On January 5, 2012, the Arizona Court of Appeals confirmed in *Colorado Casualty Ins. Co. v. Safety Control Co., Inc.*, 1 CA-CV 10-0871 that a *Damron* agreement is permissible in certain situations where the insured is not exposed to personal liability. When an insurer breaches the insurance agreement by not defending an insured the Arizona Supreme Court has held that the insured's duty of cooperation owed to the insurer does not bar it from settling the claim, agreeing to the entry of a stipulated judgment and assigning its rights under the policy, including available causes of action, to the claimant for a covenant not to execute. The insurer loses its right to contest all issues resolved by the stipulated judgment as long as the agreement is not fraudulent or collusive.

However, the Court also held that a stipulated judgment does not create coverage if the insured did not otherwise have coverage under the policy. The issue is whether the stipulated judgment or material supporting the judgment contained facts that create indemnification liability within the policy coverage. In *Colorado Casualty*, there remained an issue as to whether the trial court was presented with facts necessary to adjudicate the requisite facts to give rise to coverage under the insurance policy. The Court remanded the matter to the trial court to take whatever proceedings it deemed appropriate to resolve these issues, including a determination of other facts necessary to resolve the coverage dispute.

F. Whether a DJ is really a viable alternative

Some considerations:

1. Is the jurisdiction one that the mere filing of a DJ action would support a bad faith claim?

2. Is the issue in the DJ central to issues in the underlying case and prosecution of that DJ might prejudice the insured's defense?

3. Is the insured able to fund representation in the DJ and/or satisfaction of a judgment should the insurer succeed in the DJ?

4. Is the jurisdiction one that requires appointment of independent counsel if the insurer files the DJ while still defending the insured?

5. Will it be possible to avoid having the matter remanded to state court in a jurisdiction where the state court is a disadvantageous venue for the insurers?

6. Does the jurisdiction require the filing of a DJ action, or a stipulation of non-coverage, where the insurer has denied coverage?

7. Will the jurisdiction permit bifurcation and allow the insurance determination to be tried first?

V. HYPOTHETICALS/CASE STUDIES

Hypothetical No. 1 - Realtor employed several sales people. One of the sales people sold his own home under the listing with the broker. Claim for improper disclosures and defects in the house followed closing. Buyer alleged seller (realtor) knew of the defects and failed to properly disclose them.

SECTION V-EXCLUSIONS

This policy does not apply to any "Claim:"

L. **Buying, Selling Property Owned by Insured**

Based on or arising out of the purchase of property or the sale, leasing or appraisal or property developed, constructed, or owned:

1. by any "Insured;" or

2. by any entity in which the "Insured" has a financial interest; or

3. by any entity which has a financial interest in the "insured;" or

4. by any entity which is under the same financial control as the "Insured."

This exclusion shall not apply to any "Claim" based on or arising out of:

a. the actual or attempted sale of an "Insured's" primary or secondary residence provided that only those "Insureds" who are not the owners of such primary or secondary residence will be provided coverage hereunder and provided further that the primary or secondary residence owner is not the selling, listing or closing agent; or

b. the actual or attempted sale or leasing of real property that the "Insured" did not construct or develop in which an "Insured's" ownership interest is less that 10%; or

c. the sale of real property 100% owned by the "Named Insured" if all of the following conditions are met:

1. the property was acquired by the "Named Insured" under a written "Guaranteed Sale Listing Contract;" and

2. from acquisition to resale:

(i) the title to the property was held by the "named Insured" for less than twelve (12) months; and

(ii) the property was continually offered for sale by the "Named Insured;" or

d. the actual or attempted sale of an "Insured's" primary or secondary residence provided that the "Insured" has owned such "Residential Property" for more than 180 days prior to its actual or attempted sale and all of the following conditions are met in connection with such sale:

1. a written Home Inspection Report is issued by an ASHI or NAHI accredited inspector who maintains current, in force, Professional Liability Error and Omissions Insurance coverage with per claim and aggregate limits equal to or greater than the $100,000; and

2. a home warranty policy was purchased prior to closing; and

3. all state required property transfer disclosers were properly completed, signed and delivered; and

4. that the most current version, in effect at the time, of a state or board approved standard purchase/sale contract was utilized.

Primary or secondary residence under **SECTION V – EXCLUSIONS**, paragraph L. means "Residential Property" that a) the "Insured" occupies as their primary home or, b) which the "Insured" maintains as their secondary home, and c) neither the "Insured's" primary or secondary home has not been rented out to others for a period of 180 days prior to its actual or attempted sale.

Hypothetical No. 2 – The claim involves a legal malpractice and malicious prosecution law suit against an insured law firm. Policy provides for defense within limits. There is a very real possibility that the insured knew that an error had been made prior to inception of the policy period, although it is possible that the statute of limitations attendant to that error has run. The insurer determines that coverage litigation is likely, a conflict may arise, and agrees to the retention of the insured's chosen counsel as independent counsel. The insurer also determines that the insured did not disclose anything having to do with the claim on the application.

The insuring agreement provides an Insuring Agreement that the Insurer:

> . . . will pay on behalf of an **Insured**, subject to the Limits of Liability shown in the Declarations, all amounts in excess of the Retention shown in the Declarations, that an **Insured** becomes legally obligated to pay as **Damages** and **Claim Expenses** because of a **Claim** arising out a **Wrongful Act**, . . .that is first made during the **Policy Period** . . . . It is a condition precedent to coverage under this Policy that the **Wrongful Ac**t upon which the **Claim** is based occurred:
>
> > 1. during the **Policy Period**; or
> >
> > 2. on or after the **Retroactive Date** and prior to the **Policy Period**, provided that all of the following three conditions are met:
> >
> > (a) the **Insured** did not notify any prior insurer of such **Wrongful Act** or **Related Act or Omission**; and
> >
> > (b) prior to the inception date of the first policy issued by the **Insurer** if continuously renewed, no Insured had any basis (1) to believe that any
> >
> > Insured had breached a professional duty; or (2) to foresee that any such **Wrongful Act** or **Related Act or Omission** might reasonably be expected to be the basis of a **Claim** against any **Insured**; and
> >
> > (c) there is no policy that provides insurance to the **Insured** for such liability or **Claim**.

During the litigation, discovery reveals documents that conclusively establish that the insured knew he had breached a professional duty months before the policy incepted. The insurer files a declaratory relief action. For purposes of this hypothetical, assume that the chances of success of the declaratory relief is 95%.

A policy limits settlement demand is made by plaintiff, for both the malpractice and malicious prosecution causes of action. Excess exposure, and possible punitive damages are likely to be awarded to plaintiff.

How should the insurer respond?

Hypothetical No. 3 – Lawsuit against architect for defective design of building which allegedly causes financial injury and emotional distress to elderly client who needs to have second architect redesign the wall of sliding glass doors to prevent water from seeping into the living area. Suit includes claims under California's elder abuse statute which places matter on speedy trial docket and raises intentional acts and punitive damages coverage issues.

The policy applies to the insured's legal obligation "to pay as Damages or Defense Costs because of Claims arising out of a Wrongful Act in performing Professional Services for others," provided that prior to the policy inception, the Insured "had no knowledge of such Wrongful Act or any fact, circumstance, situation or incident which may have led a reasonable person in the Insured's position to conclude that a Claim was likely." The policy excludes from coverage any Claim "based upon, arising out of, or in any way involving conduct of the Insured or at the Insured's direction that is intentional, willful, dishonest, fraudulent or constitutes a willful violation of any statute or regulation."

If insurer reserves rights on allegations of intentional or willful acts and violation of any statute or regulation, it will lose control over litigation which is headed to trial quickly. If insurer waives the intentional acts/statutory violation exclusion in its reservation, is it really likely that the design professional will be found to have wilfully harmed the plaintiff? Since punitive damages are not insurable in California, there is no need to reserve on this damage claim and no Cumis counsel rights arise from the punitives damages coverage issue in this claim.

Hypothetical No. 4 – Restaurant manager allegedly commits a sexual assault on a server during working hours. The manager is criminally charged and the server files suit against the employer, its corporate parent, and the manager. The insurer for the parent corporation provides employment practices coverage for the restaurant and its employees, but the policy has an exclusion for conduct that is committed with "wanton, willful, reckless or intentional disregard of any law" or with "criminal or malicious purpose or intent." This intentional acts policy exclusion excepts out the strictly vicarious liability of any insured.

The policy defines a "Wrongful Employment Practice" to include conduct of an Insured with respect to "a current or former employee that culminates in constructive discharge and commission of a common law tort arising out of and in the course of employment *except* to the extent that the tort allegedly results in Bodily Injury". An "Insured" is defined in the policy to be any "partner, officer, director, stockholder or employee of the Insured solely while acting within the scope of his duties as such." The policy defines "Bodily Injury" to mean "bodily injury, sickness or disease sustained by a person" but it does not include "emotional distress, mental anquish or humiliation arising solely from a Wrongful Employment Practice."

If the insurer refuses to defend the manager he may default or otherwise make the defense more difficult. If the insurer defends the manager the conflict of interest between the manager and the corporation requires that separate counsel be retained, but not independent counsel. In the insurer defends the manager with separate counsel under reservation of rights that no duty to indemnify exists, if the policy is a defense within limits form then the named insured's limits will be depleted by the defense of the arguably uncovered manager. Declaratory relief against the manager cannot likely be brought to conclusion prior to the criminal trial. What if the manager pleads no contest to the charges or enters into a plea agreement? Can either of these events be used to withdraw a defense? Can settlement discussions be limited to the vicarious liability of the corporation?