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New Jersey Law on the Unavailability of Asbestos Insurance

By John T. Waldron III – August 2, 2012

By the mid-1980s, asbestos liabilities had grown dramatically in the tort system, setting off alarm bells in the insurance industry. The reaction of the insurance industry was simple and clear: An "asbestos curtain" descended across the insurance programs of corporate America, as insurers almost entirely ceased selling asbestos products insurance to insureds whose risk profile indicated that it could get swept into the emerging crisis. Around that time, a manufacturer, distributor, or installer of asbestos-containing products, particularly one with pending asbestos claims, could not have purchased meaningful risk-transfer insurance coverage for asbestos-related products claims, except perhaps in limited circumstances.

This development had, and continues to have, important consequences for policyholders seeking to access the asbestos insurance that they purchased prior to the mid-1980s. Specifically, under New Jersey law (and certain other states' laws), if asbestos insurance was not reasonably available for purchase for a given time period, the insured will not be responsible for such time periods in the calculation of who bears responsibility for the asbestos claims in question.[1]

As a result, the insurers have every economic incentive to argue that—notwithstanding their concerted abandonment of asbestos insurance—asbestos insurance was allegedly "available" to their asbestos-related policyholders after the mid-1980s. When pressed to provide support for this revisionist history, these insurers rarely can locate any relevant examples of such insurance. They were not foolish enough to sell it, but they are certain some other insurer (perhaps a now-insolvent one) did. But there are precious few examples of such insurance in the reported case law, and the handful that exist are easily explained as unique instances that do not demonstrate that asbestos insurance was reasonably available to other relevant policyholders.

Lacking actual evidence of available asbestos insurance from the mid-1980s forward, insurers recently have begun teaming up with law and economics professors who purport to provide a theoretical explanation of why asbestos insurance should have been reasonably available. Of course, these economists miss the point—whether a rational insurer should have sold asbestos insurance or not (and it is not clear that selling asbestos insurance in the face of a rising tide of asbestos claims would have been rational), they almost universally did not.

Undeterred by the facts of what actually happened, these insurers (and their selected expert witnesses) claim that, in essence, insurance is always available; it is simply a matter of adjusting the premium to reflect the correct pricing of the risk. In other words, every policy has its price, and insurance is never truly unavailable.
This vision—or, more accurately, mirage—is not innocuous. It is deliberately designed to shift a share of the substantial amount of asbestos costs from the insurers—insurers who were paid premiums to accept this very risk—to their policyholders. It is an open question whether insurers should have been permitted to abandon the marketplace in the mid-1980s and to refuse to continue selling asbestos insurance to the policyholders who needed it the most when they needed it the most. But there can be no question that the marketplace was closed for business to such policyholders. Fortunately, as discussed below, a number of courts, including the New Jersey court that has most recently addressed the issue, have rejected the insurers' revisionist history and found that asbestos insurance was not reasonably available to the insureds in question beginning in the mid-1980s.

**Why the Unavailability of Asbestos Insurance Coverage Is Relevant**

Whether asbestos insurance coverage was reasonably available during a given time period is relevant because, under the laws of New Jersey and certain other states, that fact can affect whether such time period is included in the calculation of the shares (frequently pro rata) of the involved parties.[2]

For instance, under the "continuous trigger of coverage" approach adopted by the New Jersey Supreme Court in its landmark ruling in *Owens-Illinois, Inc. v. United Insurance Co.*, an asbestos bodily injury claim is deemed to trigger all liability insurance policies in effect from the time of the claimant's first exposure to asbestos through the time of manifestation of the asbestos-related disease or injury. The New Jersey Supreme Court also explained that the amounts attributable to each such claim are to be "allocated," or spread, among the triggered insurance years on a weighted pro-rata basis that takes into account both the number of annual periods that each insurer was on the risk as well as the total limits of liability sold by that insurer.[4]

The supreme court further held that asbestos liabilities are not allocable to periods of time in which insurance coverage for such liabilities was not reasonably available to the policyholder (in contrast to periods in which such insurance was available, but the policyholder deliberately chose to self-insure).[5]

For example, assume that the policyholder purchased $2 million in asbestos products insurance in Year 1 and another $2 million in Year 2, and deliberately chose to self-insure rather than purchase another $2 million in reasonably available asbestos products insurance in Year 3. Assume further that there was one asbestos claim asserted against the insured, the claim was settled by the insured for $3 million, and the claim involved an allegation of first exposure to asbestos in Year 1 and manifestation of asbestos-related disease and claim assertion in Year 3. Under New Jersey's weighted pro rata allocation law, the insured would be responsible for $1 million because it chose to self-insure for Year 3. However, if instead of being available in Year 3, the asbestos insurance was not reasonably available, no portion of the $3 million settlement would be allocable to the insured on account of Year 3. Rather, because the absence of insurance was not a
deliberate choice by the insured, Year 3 would be excluded from the coverage period (or "block") used to determine the weighted pro rata shares of the insurers.

**Proving the Availability of Asbestos Insurance Coverage**

New Jersey law places the burden of proving the availability of insurance coverage at a specified time on the insurer.\[^6\] Placing the burden of proving the unavailability of insurance on the policyholder would be inconsistent with the New Jersey Supreme Court's reluctance to place a negative burden of proof on a party in coverage cases.\[^7\]

Insurers often contend that asbestos insurance must have been reasonably available to a given insured after the mid-1980s because certain other insureds were able to obtain asbestos coverage during that period. However, despite the fact that they have undoubtedly conducted extensive searches, insurers have generally not located many such relevant instances. The examples they proffer typically involve unique circumstances that do not speak to the availability of asbestos coverage for those insureds whose risk profiles indicated that they may be the target of asbestos claims. For that reason, the insurers' reliance on these one-off instances should be rejected.

As a threshold matter, the insurers' argument applies the wrong standard. The standard under New Jersey law is not whether it was impossible for any insured to buy any insurance covering its asbestos-related products risks. The standard is whether such insurance was reasonably available to the particular insured in question.\[^8\]

For instance, insurers have cited as evidence the fact that John Crane, Inc., was apparently able to buy primary (but not excess) coverage from Kemper from 1944 to 2001.\[^9\] But John Crane's insurance is irrelevant because it reflects circumstances that were unique to that insured:

- John Crane was apparently able to buy insurance from Kemper after 1987 because, thanks to the decades that Kemper had sold insurance to it, Kemper by 1987 would already have been responsible for a substantial percentage, if not the entirety, of John Crane's liabilities. Because John Crane's asbestos liabilities would be allocated largely to Kemper whether it stopped selling or continued to sell insurance to that insured in 1987, Kemper apparently made an underwriting decision that, by continuing to sell insurance to John Crane, Kemper would at least be paid some additional premium. Kemper apparently was trying to earn its way out of a financial hole. It failed.\[^10\]
- John Crane's post-1987 "insurance" involved virtually no risk transfer: The insurance limits were $2 million per year, but the premiums were $1.5 million per year.
- Kemper apparently sold such insurance only after the mid-1980s to John Crane; hence, this one-off situation does not support the notion that asbestos coverage was reasonably available to other insureds.
The other instances frequently cited by insurers are similarly irrelevant, involving policies issued mainly in the 1980s for small amounts of coverage to insureds with an underwriting profile that typically did not suggest significant exposure to asbestos risk:

- **Westchester Fire Insurance Co. v. Treesdale, Inc.**[11] The insured had a primary and an umbrella policy (each providing a mere $1 million in coverage) for 7/1/1990–91, but the insurer contended (supported by substantial evidence) that such policies were intended to incorporate asbestos exclusions.

- **National Union Fire Insurance Co. v. Porter Hayden Co.**[12] The insured had a primary policy for 4/1/1987–88, providing a mere $1 million in coverage, with no excess asbestos coverage.

- **Plastics Engineering Co. v. Liberty Mutual Insurance Co.**[13] The insured had one primary policy for 1/1/1986–89 ($1 million in limits) and one umbrella policy for 1/1/1986–88 ($10 million in limits), both presumably purchased in late 1985.

- **Pennsylvania General Insurance Co. v. Park-Ohio Industries, Inc.**[14] The insured had one primary policy expiring on 2/1/1988 (presumably issued in early 1987); this case involves a single asbestos claim.

In sum, the fact that a few smaller entities may have been able to buy minimal asbestos insurance during or shortly after the mid-1980s does not help an insurer carry its burden of proving that insurance was reasonably available to other insureds, particularly those with underwriting profiles that differ from the underwriting profiles of the insureds at issue in such cases.

**Available Insurance Requires Risk Transfer**

In the absence of evidence that risk-transfer asbestos insurance was reasonably available to the insured, insurers are often relegated to arguing that an "alternative" (read: no risk-transfer) approach was available. These insurers claim that *Owens-Illinois* recognized the viability of "alternatives" to "market" or "traditional" insurance in deciding whether asbestos insurance was available. This is simply a misreading of *Owens-Illinois*.

In *Owens-Illinois*, the New Jersey Supreme Court explicitly noted that insurance requires the transfer of risk.[15] Nothing in *Owens-Illinois* even hints that "available insurance" may include any "alternative" approach in which risk is not transferred.

In this regard, insurers have suggested that *Owens-Illinois* treated insurance from a captive insurer (typically a subsidiary of the insured) the same as insurance bought from an insurer. While the insured in *Owens-Illinois* used a captive insurer from 1977 to 1985, this fact is irrelevant because (1) the *Owens-Illinois* captive insurance was 100 percent reinsured with various insurers and hence did involve the transfer of risk, not self-insurance;[16] and (2) the period in question was prior to the universal inclusion of asbestos exclusions in general liability policies in the mid-1980s and hence does not undermine the notion that asbestos insurance was not reasonably available from that point forward.
In sum, nothing in *Owens-Illinois* suggests that self-insurance or other alternative approaches in which risk is not transferred can constitute "available insurance."[17] Indeed, if self-insurance or other "alternative" approach in which risk is not transferred were deemed to be "available insurance," insurance would always be "available," thus rendering meaningless the issue of whether insurance was available. The insurers' misreading of *Owens-Illinois* should be rejected.

As a corollary to their argument that the insured had alternative approaches available to it, insurers often contend that an insured's own internal accounting reserves constituted self-insurance that satisfies the standard under *Owens-Illinois* for reasonably available asbestos insurance.[18] By treating self-insurance as actual insurance, this approach would stand *Owens-Illinois* on its head.

**Case Law Rejects the Insurers' Position**

The New Jersey Supreme Court and Appellate Division have made clear that so-called self-insurance does not constitute insurance. For instance, in *American Nurses Ass'n v. Passaic General Hospital*, the Appellate Division held that a deductible or "self-insured sum" under a liability policy did not constitute insurance:

[S]o-called self-insurance is not insurance at all. It is the antithesis of insurance. The essence of an insurance contract is the shifting of the risk of loss from the insured to the insurer. The essence of self-insurance, a term of colloquial currency rather than of precise legal meaning, is the retention of the risk of loss by the one upon whom it is directly imposed by law or contract.[19]

The New Jersey Supreme Court affirmed this ruling, confirming that insurance, by definition requires the transfer of the risk of loss to an insurer whose primary business is to sell insurance:

As a matter of common understanding, usage, and legal definition, an insurance contract denotes a policy issued by an authorized and licensed insurance company whose primary business it is to assume specific risks of loss of members of the public at large in consideration of the payment of a premium.[20]

This common-sense distinction between insurance and self-insurance in *American Nurses* is consistent with other insurance principles articulated by various courts:

- For instance, courts have noted that insurance requires the transfer of risk.[21]
- Further, insurance requires a contract between an insured and an insurer.[22]
- The policy is to be "issued by an authorized and licensed insurance company whose primary business it is to assume specific risks of loss of members of the public at large."[23] Risk-shifting agreements, such as private indemnity agreements, do not constitute insurance where "affording the indemnity is not the primary business of the indemnitor and [the risk-shifting agreement] is not subject to governmental regulation."[24]
Moreover, as its name suggests, the "premium" charged is intended to be somewhat greater than the expected losses so that the insurer can profit thereby.[25]

In sum, so-called self-insurance, including the internal reserves of an insured that insurers have tried to characterize as "self insurance," cannot constitute available insurance of the kind envisioned by the Owens-Illinois court in determining how to allocate responsibility for asbestos liabilities. In essence, the insurer argument is that non-insurance is the equivalent of available insurance, which again would stand Owens-Illinois on its head.

The Insurers' Case Law Is Easily Distinguishable

Trying to avoid the inescapable conclusion that the absence of insurance does not constitute insurance, insurers have on occasion relied on several cases that have nothing to do with product liability insurance. Specifically, they cite cases in which an entity is required by statute to purchase insurance (such as automobile or workers' compensation insurance) or to qualify for an exemption to that statutory mandate and obtain a "certificate of self-insurance" from the relevant governmental agency. These insurers are trying to take advantage of the fact that, under the statutory schemes at issue, a qualified self-insurer is treated as an insurer (who issued a policy to itself). Their cases are obviously inapplicable to traditional risk-transfer product liability insurance.

First, as the American Nurses court noted, these limited instances of statutorily mandated "qualified self-insurance" are clearly distinguishable from the more common scenario in which an entity has the option to simply go uninsured (or the entity has no insurance reasonably available to purchase):

We are aware that within the general, imprecise and amorphous concept of self-insurance there is one type of self-insurance which does have a legally-recognized identity and a clearly defined consequence. We refer to the situation in which compulsory liability insurance is mandated by a statute which also provides that a person subject to the mandate may, in accordance with specified standards and upon a satisfactory showing of financial ability to bear the risk, be exempted from the obligation to purchase insurance upon issuance by a designated administrative officer or agency of a certificate of self-insurance.

. . .

. . . While there is support for the view that qualified self-insurance constitutes other insurance, we have been unable to find any authority at all for the thesis that any other kind of so-called self-insurance constitutes other insurance.[26]

Second, the insurers' cases explicitly agree with American Nurses that "so-called self-insurance is not insurance at all. It is the antithesis of insurance."[27] Like the court in American Nurses, these courts distinguish ordinary self-insurance (referring to someone such as an insured who does not or cannot obtain coverage) from qualified self-insurance (referring to an insured who meets the requirements to obtain an exemption from statutorily mandated insurance but must then stand in the shoes of such an insurer).[28]
Third, these cases involve the liability of a qualified self-insurer as an insurer, not as a tortfeasor.[29]

Fourth, the reason that qualified self-insurers are treated as insurers is to satisfy the legislative intent and public policies underlying the statutory scheme. For instance, in *Ryder/P.I.E. Nationwide, Inc. v. Harbor Bay Corp.*, the New Jersey Supreme Court noted the strong public policy to protect persons wrongfully injured by motor vehicles, as well as the rule that statutorily required coverage must be broadly construed, in ruling that the qualified self-insurer owed coverage to the tortfeasor.[30]

Indeed, these cases did not even involve the question of whether insurance was available; they all involved situations in which insurance was reasonably available, but the entity chose to qualify as a self-insurer under the statutory exemption.

In sum, the insurers' cases are clearly distinguishable and do not address (let alone refute) the New Jersey Supreme Court's ruling that self-insurance does not constitute insurance.

**Sybron Conflicts with New Jersey Law**

In the absence of evidence that asbestos insurance was reasonably available to a particular insured, insurers have adopted the tactic of trying to twist the meaning of what "reasonably available" means. Specifically, insurers—often in conjunction with law and economics professors who seek to provide expert testimony—argue that insurance can never truly be "unavailable." Instead, according to such proffered professors, insurance is always theoretically "available" if the policyholder is willing to pay a high enough premium.

One court has been sympathetic to this view. In *Sybron Transition Corp. v. Security Insurance of Hartford*, the Seventh Circuit Court of Appeals, applying New York law, noted its uncertainty regarding whether insurance can be unavailable: "Indeed, we do not know what it means (or could mean) to say that coverage for a particular risk is 'unavailable.'"[31]

But even assuming *arguendo* that the *Sybron* court were concluding that insurance cannot be unavailable, this holding would be simply contrary to New Jersey law, as the New Jersey Supreme Court has made clear that asbestos insurance coverage can be unavailable.[32]

In fact, the *Sybron* court did not even understand the purpose of insurance, thus demonstrating that that decision does not reflect New Jersey law, under which the state supreme court has noted the importance of encouraging the purchase of insurance.[33]

Ultimately, in relying on *Sybron*, insurers typically contend that the reason an entity is uninsured should not matter under a pro rata allocation method. But that is precisely why *Sybron* (applying New York law) conflicts with New Jersey law—under *Owens-Illinois*, the New Jersey Supreme Court held that the reason an entity is uninsured does matter:
"When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable."[34]

Thus, *Sybron* is irrelevant as it conflicts with New Jersey law.

**Recent Developments: The Policyholder Prevails in ** *Honeywell*

In the most recent decision by a New Jersey court to address the availability of asbestos insurance, the court in *Continental Ins. Co. v. Honeywell International Inc.* correctly held that asbestos insurance was not reasonably available to Honeywell beginning in the 1986/1987 period.[35]

In *Honeywell*, the insurers of Allied-Signal Inc. (a relevant predecessor of Honeywell International Inc.) inserted asbestos exclusions in Allied-Signal's policies beginning on April 1, 1986 (at the primary insurance level) and on April 1, 1987 (at the excess insurance level). Despite undisputed testimony by the policyholder's witnesses that asbestos insurance was not reasonably available to it at that point, the insurers disputed the unavailability of asbestos insurance. Specifically, the insurers in *Honeywell* employed all four of the tactics discussed above.

Rejecting all of those arguments, the *Honeywell* court held that the insurers had failed to create a factual dispute regarding the availability of asbestos insurance. Accordingly, on July 22, 2011, the court granted the policyholder's motion for summary judgment and ruled that asbestos insurance was not reasonably available to it beginning in the 1986/1987 period.

**Conclusion**

An important element of asbestos coverage disputes under New Jersey law is the question of when asbestos insurance coverage was reasonably available, or unavailable, to the specific policyholder at issue. Because of their own abandonment of the asbestos insurance marketplace in the mid-1980s, insurers have been scrambling in these coverage litigations to concoct a basis for claiming that asbestos insurance was nevertheless available to such insureds. These tactics have included (1) relying on a handful of cases in which small companies with unique underwriting profiles were able to purchase a limited amount of coverage for a brief period of time; (2) arguing that "alternative" approaches constituted available insurance under *Owens-Illinois* despite the lack of risk transfer involved; (3) contending that internal reserves or other mechanisms that the insurers characterize as "self-insurance" satisfy the requirement of available insurance under *Owens-Illinois*; and (4) relying on *Sybron* and the perspective that insurance can never be truly "unavailable" in an (allegedly) rational world. As demonstrated by the recent decision in *Honeywell*, courts applying New Jersey law should reject these attempts by insurers to rewrite history and to punish policyholders for the insurers' own abandonment of the asbestos insurance marketplace in the mid-1980s.

**Keywords**: insurance coverage, litigation, asbestos insurance, availability of coverage, transfer of risk, New Jersey
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[6] See Chemical Leaman Tank Lines v. Aetna Cas. Ins. & Sur. Co., 177 F.3d 210, 231 (3d Cir. 1999) (interpreting New Jersey law to hold that "the insurers should bear the burden of proving that insurance coverage was available"); Champion Dyeing & Finishing Co. v. Centennial Ins. Co., 355 N.J. Super. 262, 271–73 (N.J. Super. Ct. App. Div. 2002) (holding that insurer failed to meet its burden to show that "insurance could have been purchased that covered the precise risk that manifested, not simply that EIL insurance covering undefined risks was available" and that "insurance was available at the time of manifestation and that conditions of coverage at that time were not such as to preclude indemnification").


"available' means, 'Available to an entity such as Uniroyal using all reasonable efforts to procure same'" (quoting and following trial court opinion).


[10] Since 2003, Kemper has been in voluntary run-off under the supervision of the Illinois Department of Insurance.


[18] Insurers have claimed that Owens-Illinois supports their position that a policyholder's internal reserve is equivalent to insurance. But in Owens-Illinois, the court nowhere suggests that a reserve constitutes insurance. Indeed, the court noted in passing that the insured created a reserve in 1980 (138 N.J. at 445) but never even hints that the existence of that reserve was relevant to any allocation issue.


[20] Am. Nurses Ass'n, 98 N.J. 83, 90 (N.J. 1984) (quoting Appellate Division decision). Indeed, the New Jersey Supreme Court went on to note that, while insurance by definition involves the shifting of risk, not all risk-shifting agreements constitute insurance contracts. American Nurses Ass'n, 98 N.J. at 90.

[22] See, e.g., Group Life & Health, 440 U.S. at 211 n.7 (stating that insurance means "a contract whereby, for a stipulated consideration, called a premium, one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril, called a risk, the contract being set forth in a document called the policy" (quoting Webster's New International Dictionary of the English Language 1289 (unabr. 2d ed. 1958))).

[23] American Nurses Ass'n, 98 N.J. at 90 (quoting Appellate Division decision).


[25] See, e.g., Group Life & Health, 440 U.S. at 211 ("[S]uch losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." (quoting 1 Couch, Cyclopedia of Insurance Law 1:3 (2d ed. 1959))).


[30] Ryder, 119 N.J. at 408–11; see also Fellhauer, 838 N.E.2d at 138 (automobile financial responsibility statute "enacted for the purpose of protecting the public from negligent drivers of rented vehicles"); Loven, 626 N.W.2d at 200 (no-fault benefit statute is "based on the concept of compensation, regardless of fault" for automobile accidents).

[31] Sybron Transition Corp. v. Sec. Ins. of Hartford, 258 F.3d 595, 599 (7th Cir. 2001).

Mgmt. Corp., 73 F.3d 1178, 1204 (2d Cir. 1995) (rejecting any allocation to the insured for years after 1985 when "asbestos liability insurance ceased to be available" and stating "[t]here is no reason to believe that any bargaining occurred with respect to the asbestos exclusion clauses").

[33] Compare Sybron, 258 F.3d at 600 ("It is a little unclear why corporations buy insurance at all."), with Owens-Illinois, Inc., 138 N.J. at 472–73 ("Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not provide disincentives to parties to acquire insurance when available to cover their risks. Spreading the risk is conceptually more efficient.").

[34] Owens-Illinois, Inc., 138 N.J. at 479 (emphasis added).

Jurisdiction and Settling with Limited Funds

By Duana J. Grage and Suzanne L. Jones* – July 30, 2012

How does an insurer comply with its obligation to settle when there are too many claims or too many insureds and insufficient limits? It depends on which jurisdiction's law applies. An approach that is safe from liability for bad faith in one jurisdiction may constitute bad faith in another. An insurer usually has to consider two issues: whether or not an insurer is allowed to resolve only some covered claims or claims against some insureds within its policy limits and, if it does, whether or not the insurer can withdraw from the defense of the remaining claims and insureds.

Unfortunately, very few courts have identified a bright-line rule for insurers to follow in these circumstances to protect itself from extra-contractual liability. In the most general terms, courts have adopted three approaches: (1) resolve claims on a first-come, first-served basis, (2) pay limits to all successful claimants on a pro rata basis, or (3) file an interpleader action. As for withdrawing the defense, an insurer should only withdraw from the defense upon payment of the limits if allowed by the policy language and applicable case law and if the insurer can demonstrate that its policy limits were paid to resolve claims against the insured, not merely paid into court in an interpleader action.

The First-Come, First-Served Approach

Under New York law, an insurer has discretion to settle multiple claims on a first-come, first-served basis as long as it acts in good faith.[1] "First-come, first-served" is the conventional rule: "[I]t has been generally held that a liability insurer can settle with some claimants although to do so may exhaust the insurance fund or so deplete it so that a subsequent judgment creditor is unable to collect his judgment in full from the remaining proceeds."[2] An insurer may settle with less than all claimants under a particular policy even if such settlement exhausts the policy proceeds.[3]

While New York law permits an insurer to settle on a first-come, first-served basis, it does not require an insurer to settle with the first insured that makes a reasonable settlement offer. For example, in In re Axis, the Southern District of New York held that the case law "does not impose a bright line obligation to settle with the first insured who tenders a reasonable settlement offer."[4] Rather, an insurer does not necessarily act in bad faith by funding the first claimant's settlement offer, nor is failure to apply the "first in time rule" substantial evidence of bad faith.[5]

The Massachusetts courts have similarly held that an insurer may settle with less than all claimants even if it results in an exhaustion of the policy proceeds. In U.S. Fire Insurance Co. v. Worcester Insurance Co., the Massachusetts Supreme Court explained that an insurer should not "squander" its policy limits: "That duty [to defend], the argument continues, precludes an insurer from squandering its policy limit and then abandoning the insured without having obtained so much as protection for its insured as is reasonably possible while leaving the insured subject to further litigation."[6] The court rejected any contention that an insurer "squandered" its policy limit by settling five claims and

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obtaining a partial settlement on the sixth.[7] Similarly, in *Scott v. Gallacher*, the Massachusetts Court of Appeals held that when multiple claims on a single policy exist, each of which are likely or certain to exceed the coverage limitations, an insurer is entitled to exercise its business judgment in settling the claims.[8] The court rejected the notion that a "first-come, first-served" settlement is a violation of the insurer's duty. [9] The court also rejected the notion that an insurer is required to effectuate a global settlement simultaneously with all potential claimants. [10]

In *Aetna Casualty & Surety Co. v. Sullivan*, the Massachusetts Court of Appeals held that an insurer would be discharged from any further duty to defend if it should make a payment equal to the maximum policy limits—either to settle a claim against the insured or in total or partial satisfaction of a judgment against the insured—upon conclusion of the litigation.[11] However, the court distinguished this result from the situation in which "an insurer seeks to pay the full amount of coverage without a judgment and without obtaining a release of the insured from at least one personal injury claimant."[12] Essentially, tendering the full amount of insurance coverage does not necessarily satisfy the insurer's duty to defend its insured if the insurer fails to secure a settlement or release.[13] Relying on a case from the Supreme Court of Illinois, the court held that if the policy limits were tendered to a claimant before any judgment or settlement, then the duty to defend had not been terminated.[14]

**Pro Rata Payment of the Limits to All Successful Claimants**

Some jurisdictions allow an insurer to pay its limits to all claimants with successful claims on a pro rata basis. Courts in Missouri have held that a pro rata approach is warranted.[15] In *Underwriters for Lloyds of London v. Jones*, the Kentucky Supreme Court distributed the insurance proceeds on a pro rata basis following adjudication of multiple claims.[16] In jurisdictions that have advocated a pro rata approach, it would be prudent for the insurer to file an interpleader action for guidance in resolving multiple claims prior to trial.

In Florida, where multiple claims arise out of one accident, the insurer may exercise its discretion in how it elects to settle claims and may choose to settle certain claims to the exclusion of others, provided that the decision is reasonable and "in keeping with its good faith duty."[17] To satisfy these requirements, the insurer must

- fully investigate all claims;
- seek to settle as many claims as possible within the policy limit;
- minimize the magnitude of possible excess judgments against the insured by reasonable claim settlement; and
- keep the insured advised of the claim resolution process.[18]

This inquiry is highly fact-specific, and whether an insurer has acted in good faith is a question for a jury to decide.[19]

**Filing an Interpleader Action** Rule 22 of the Federal Rules of Civil Procedure provides that a party may bring an action in court for "interpleader." The rule states that "persons with claims that may expose a plaintiff to double or multiple liability may be joined as
defendants and required to interplead."

An action for interpleader may also, in certain circumstances, be brought pursuant to statute. Some courts have encouraged an insurer's use of an interpleader action; other courts have required its use to avoid a claim for bad faith in these situations; and still other jurisdictions, like Florida, do not allow interpleader actions in these circumstances.

In *Boris v. Flaherty*, a New York Supreme Court encouraged the use of interpleader: "Interpleader actions, while not required in situations such as this, are to be encouraged as part of the duty of good faith of an insurer." The court commended the insurer's use of this mechanism, "rather than simply paying judgment creditors in the order that the judgments are entered until coverage is exhausted." As long as the insurer does not act in bad faith, however, it has no duty to pay out claims ratably or to consolidate them.

In *Club Exchange Corp. v. Searing*, the Kansas Supreme Court set out three alternative courses of action that an insurer can take when faced with competing claims in excess of policy limits:

1. invite all the parties to participate jointly in efforts to reach agreement as to the disposition of the available funds;
2. attempt to settle claims within the policy limits; or
3. promptly and in good faith commence an interpleader action and pay its policy limits into court.

Where an insurance carrier is faced with multiple unliquidated claims far in excess of its limits of liability, the court found that interpleader is an appropriate remedy so long as the insurer acts promptly and in good faith.

Arizona does not explicitly recognize a duty on the part of an insurer to "manage policy limits." But an insurer does have, as in most states, an "implied contractual 'duty to treat settlement proposals with equal consideration' to its interests and those of an insured." In *McReynolds v. American Commerce Insurance Co.*, the court held that where the available coverage is not adequate to resolve all claims, the insurer can find a safe harbor and avoid extra-contractual liability taking the following steps:

- the prompt, good-faith filing of an interpleader as to all known claimants;
- the payment of the policy limits into the court; and
- the continued provision of a defense for the insured as to each pending claim.

Pursuing this course is a safe harbor for an insurer against a bad-faith claim for failure to properly manage the policy limits or for failure to give equal consideration to settlement offers when multiple claimants are involved and the value of the expected claims exceeds the applicable policy limits.

Even if an insurer files an interpleader and deposits its limits into court, the insurer should not withdraw the defense unless it has clear policy language that would permit a withdrawal. In *Jenkins v. Insurance Co. of North America*, the California Court of Appeals held that use of an interpleader action can be proper, but the court cautioned that...
an insurer should not merely pay its policy limits into the court and abandon the insured.[31]

Similarly, in *American Standard Insurance Co. v. Basbagill*, the Illinois Court of Appeals demonstrated disfavor with an interpleader action if an insurer uses it to avoid providing a defense.[32] The court held that tendering the policy limit to the court in an interpleader action, without more, does not free an insurer from its duty to defend.[33] The court observed that a plaintiff has not paid its policy limit, as required under most policies in order to withdraw from the defense, if it has not delivered money to a party who is legally entitled to it.[34] The court reasoned:

We believe that our holding accords not only with a reasonable reading of the policy language but also with the reasonable expectations of policyholders. When an ordinary citizen, likely unversed in the niceties of insurance law, purchases an insurance policy, he expects to receive indemnification for damages owed and also a defense of any suit brought against him. A typical policyholder would normally expect to be defended until the claims against him have been resolved.[35]

However, generally, after the policy limits are exhausted by the payment of judgments or settlements, the insurer is discharged from its duty to defend if the policy language so allows.[36] The rationale is that "[o]nce the applicable indemnity limits of a policy are exhausted by the payment of judgments or settlements, no insurance is afforded by that policy and the insurer 'is no longer obligated to defend any actions against [the insured] whether such actions are pending at the time of exhaustion or commencement thereafter.'"[37]

**Too Many Insureds and Not Enough Limits** In situations involving multiple insureds and a claim that exceeds the policy limits, courts generally follow one of two approaches. The majority of jurisdictions allow an insurer to resolve the liability of one insured, in good faith, even if the result is that another insured is left without a defense and without remaining limits to pay a judgment. The minority of jurisdictions, on the other hand, have found that an insurer that settles the liability of only one insured to the detriment of other insureds can be exposed to a claim of bad faith.

California is in the minority. In California, as in all states, an insurer is obligated to make reasonable efforts to settle a claim against its insured within policy limits whenever there is a substantial likelihood of a recovery in excess of those limits.[38] In *Strauss v. Farmers Insurance Exchange*, the plaintiff offered to settle the limits of the policy proceeds but would release only one defendant from liability.[39] Had the insurer accepted this offer, two insureds would have been left without coverage, and the insurer would have been in violation of the implied covenant of good faith and fair dealing.[40] The insurer was not obligated to pay the demand if it did not resolve the liability for all of its insureds. The California Court of Appeals reasoned that had the insurer acted in bad faith by accepting the offer, it could not also be held in bad faith for refusing it.[41] Similarly, in *Lehto v. Allstate Insurance Co.*, the California Court of Appeals ruled that if an insurer had accepted a settlement offer that would have left one of its insureds bereft
of coverage, that would be considered an act of bad faith.[42] Accordingly, the insurer's refusal to accept such a settlement cannot itself be deemed an act of bad faith.[43]

New York follows a similar approach. In Smoral v. Hanover Insurance Co., the court observed that "[i]t is absolutely no answer for the [insurer] to say that it paid the full amount of its policy if in so doing it fully protected one of its insureds and left the other completely exposed."[44] According to the Smoral court, there was "no legal justification" for its preferring one insured over the other.[45] The insurer was therefore found to have violated its duty of good faith.[46]

In sharp contrast to the case law in California is the recent case in Texas, Pride Transportation v. Continental Casualty Co.[47] Under Texas law, as first explained in G.A. Stowers Furniture Co. v. American Indemnity Co., an insurer can be held liable for negligently failing to settle a claim within policy limits.[48] An insurer has been effectively Stowerized in Texas when three prerequisites have been met: (1) the claim against the insured is within the scope of coverage; (2) the demand is within the policy limits; and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the potential exposure to the insured. Courts in Texas have held that, in light of the Stowers duty, an insurer is entitled to enter into a reasonable settlement with one of several claimants, even though the settlement exhausts the limits of the policy. The same is true when the insurer is defending multiple insureds that share one limit applicable to the claim.

In Pride Transportation, the insured, Pride, sued its insurers Lexington Insurance Company and Continental Insurance Company for breach of contract and violation of the Unfair Claims Settlement Practices Act after the insurers paid their combined policy limits of $5 million to resolve a lawsuit against Pride's employee and withdrew its defense.[49] The settlement left Pride, which was also a defendant in the case, with no coverage.[50] The Northern District of Texas court held that despite the problems this created for Pride, the insurers acted reasonably in accepting the claimants' demand for policy limits, which had been directed to one, but not both, of the insureds.[51] Pride had no claim against its insurers.[52]

In reaching its decision, the court held that the test is whether "an ordinary and prudent person would have accepted the [claimants'] demand."[53] Given the potential personal liability faced by Pride's employee if the insurers not settled the action, and all the parties to the case considered it to be a "limits case," the court held that the insurers acted reasonably in accepting the demand even though the result was that their other insured remained exposed.[54]

Most states embrace the approach used in Texas.[55] In Anglo-American Insurance Co. v. Molin, the Pennsylvania Commonwealth Court held that "given the dilemma faced by an insurer when faced with a reasonable settlement offer for less than all of the insureds, we conclude that the insurer should not be precluded from accepting that offer."[56] The court reasoned that "[b]y accepting an offer, the insurer will avoid being subjected to a liability exceeding the policy limits due to its rejection of a reasonable offer" and all
insureds will benefit from the settlement by decreasing the total amount of liability in the underlying action. Similarly, in Elliott Co. v. Liberty Mutual Insurance Co., the Northern District of Ohio observed that "an insurer can settle or pay claims in good faith to one insured, even if this results in actual exhaustion of the policy limits to the detriment of another insured."[57] An exception to this rule "is when a first insured has already agreed to a settlement of claims with the insurer prior to the insurer exhausting the policy limits by paying a later claim of a second insured."[58] In Millers Mutual Insurance Ass'n of Illinois v. Shell Oil Co., the Missouri court of appeals concluded that where a policy allows for the termination of the duty to defend upon exhaustion of the policy's limits, an insurer is not obligated to defend an additional insured after paying its limits in a reasonable settlement on behalf of the named insured.[59]

Under Florida law, an insurer can be held liable for bad faith arising out of its refusal to accept an offer to settle on behalf of one insured but not the other.[60] In Contreras v. U.S. Security Insurance Co., the insurer tried but was unable to obtain a release of liability for both of its insureds.[61] Because the insured could have settled on behalf of one of the insureds and refused, it faced liability for bad faith.[62] Another Florida court noted, in In re GunnAllen Financial, Inc., that in cases where "multiple insureds are covered by a policy that has insufficient funds to pay all claims, then the insurer has a duty to try to settle as many claims as possible within policy limits."[63] The court observed that "an insurer could be deemed to act in bad faith towards its insured if it refuses to settle simply because all other insureds are not being released as part of the settlement."[64]

Long before the settlement conference or mediation is scheduled, an insurer should consider what obligations it has under the applicable case law to resolve claims if presented with the opportunity to settle on behalf of one but not all of its insureds or to resolve some but not all claims presented. An insurer should always first make attempts to resolve all of the claims or the claim on behalf of all of its insureds. If the insurer is unsuccessful, it is essential to review the applicable case law to determine how and on whose behalf the insurer may or must settle the claim.

Practice Pointers

- Explain the problem of potential excess exposure to the insured early on and in writing.
- Keep the insured advised as claims are settled and limits are exhausted.
- Notify all excess insurers and keep them apprised of the investigation and settlement efforts.
- Consider immediately filing an interpleader action if the jurisdiction allows it. Deposit the money into court and continue defending until those funds are disbursed to claimants. In some states, an insurer must file an interpleader to avoid a claim for bad faith. Other courts do not allow an interpleader action in these circumstances.
- Investigate all the known claims. Develop and attempt to implement a strategy to resolve all the claims.
Never artificially inflate the value of any claims, particularly the first claims that are made. Do not overpay a claim with the intention of exhausting the limit as soon as possible to justify withdrawing from the defense.

Pay the limits to claimants to resolve claims and obtain releases of liability for the insured; do not pay the limits to the insured in an attempt to "buy out" the coverage or the defense obligation. While this may be warranted in certain circumstances, usually the claimants wise up and commence litigation, meritorious or otherwise, directly against the insurer. By then, the insurer may not have the right to reclaim the money it paid to the insured, the insured may not have the funds to repay the insurer, and the insurer may be exposed to liability in excess of its limits.

**Keywords**: insurance coverage, litigation, obligation to settle; interpleader; first come, first served

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[19] See Farinas, 850 So. 2d 555.


[34] American Standard Insurance Co., 775 N.E.2d at 262.


[40] Strauss, 31 Cal. Rptr. 2d at 813.

[41] Strauss, 31 Cal. Rptr. 2d at 813.


[43] Lehto, 36 Cal. Rptr. 2d at 822.


[53] Pride Transportation, 804 F. Supp. 2d at 530.

[54] Pride Transportation, 804 F. Supp. 2d at 530.


[61] Contreras, 927 So. 2d at 18–19.

[62] Contreras, 927 So. 2d at 21–22.

[63] In re GunnAllen Fin., Inc., 443 B.R. 908, 917 (M.D. Fla. 2011).

[64] In re GunnAllen Financial, 443 B.R. at 917.
Excess Policies May Be Obligated to Defend or Reimburse Defense Costs

By Pamela J. Tillman* – July 30, 2012

It probably goes without saying that there are a myriad of differences between the scope of coverage offered by a primary and an excess policy. After all, the higher premiums associated with primary policies usually bring with them the added duty to defend, lower attachment points, and the increased likelihood of coverage being triggered by a loss or claim against the insured. However, it would be naive to think that an excess policy could never come with defense obligations. This article explores some of the unique circumstances under which an excess or umbrella carrier can find itself saddled with a duty to defend or to reimburse its insured for defense costs associated with an underlying claim.

The general rule still remains true: An excess policy generally does not provide a duty to defend.[1] Some significant exceptions, however, do exist. While some of these exceptions may not be the "majority" rule among all jurisdictions, practitioners should be aware of how and when these issues can arise. Given what appears to be an ever-present choice of law conundrum arising in coverage disputes, one can nevertheless find oneself contending with one of these minority rules.

The "Silent" Excess Policy

In coverage litigation, the court most typically turns first (and sometimes only) to the words of the particular insurance contract to discern the scope and nature of the parties' respective rights, what the parties intended, or both. Nonetheless, various jurisdictions have focused on what the insurance contract does not say, or remains silent on, to clarify whether an excess policy is required to defend its insured. In fact, some courts have held that if an insurance contract does not contain a provision negating an excess insurer's duty to defend, the insurer may, under certain circumstances, be obligated to defend.[2]

For example, the Wisconsin Supreme Court, in resolving an issue of first impression under Wisconsin law, held in Johnson Controls, Inc. v. London Market, that an excess liability policy contained a duty to defend by virtue of a follow form[3] provision that incorporated a duty to defend found in the underlying policy issued by Travelers.[4] In support of its assertion that the policy provided only for indemnification, the insurer, London Market, pointed to the Insuring Agreement language that promised "subject to the limitations, terms and conditions hereinafter mentioned, to indemnify the Assured for all sums which the Assured shall be obligated to pay by reason of" certain liabilities.[5] The court acknowledged that the London Market policy itself was silent as to the duty to defend, but instead pointed to the follow form provision incorporating the "terms, definitions, exclusions and conditions" of the underlying Travelers policy that contained both a duty to defend and duty to indemnify. [6] Based on this, the court found as follows:
Given that Travelers imposes a duty to defend, and London Market's silence regarding that duty, a reasonable person in the position of the insured would interpret London Market's policy as incorporating the duty to defend found in the Travelers policies.[7]

Had there been a conflict in language related to the duty to defend between the Travelers and London Market policies, the outcome in Johnson Controls would likely have been different. In fact, the court pointed to a case, Home Insurance Co. v. American Home Products Corp.,[8] in which the Second Circuit held that an excess policy did not provide a defense, despite an underlying policy to which it followed form that provided for the payment of defense costs.[9] The Second Circuit in Home Insurance was concerned with trying to give effect to the underlying policy provision that conflicted with the excess policy itself (the underlying policy covered defense costs; the excess excluded "legal costs").[10] It ultimately found that these conflicts could not be reconciled and that the language of the excess policy controlled. It was the absence of any express language negating that defense obligation in the London Market policy that led the court in Johnson Controls to the contrary result.

On the other hand, courts have decided that certain clauses negate a duty to defend.[11] These courts have typically found provisions that provide the policy follows form "except for any obligation to investigate or defend" as sufficiently declaring it has no defense obligation.[12] Correspondingly, some courts have determined that "options to defend" clauses (right but not duty) are provisions designed to protect excess insurers, negating the insureds' attempts at creating an implied duty to defend.[13]

The key to understanding when an excess policy may be required to provide a defense is not only examining what the policy itself provides but, more important, what the underlying policies say if the excess policy follows form. Be mindful that there may be various follow form policies underlying the excess policy. Therefore, each and every underlying policy should be obtained and examined to discern whether it provides a duty to defend and whether any such provision reasonably conflicts with language of the excess policy. Only then can the excess policy's "silence" be attacked to show that no reasonable insured would expect an excess insurer to provide a duty to defend under any factual scenario. Finally, to the extent the excess policy contains a "consent to incur" provision, the insurer may be able to limit some of these defense costs if it can prove they were incurred without its consent.[14]

**Excess Policy above a Self-Insured Retention**

To most, self-insurance is the functional equivalent of a liability policy. Rather than paying premiums to an insurer to transfer risk, entities that self-insure voluntarily retain risk in exchange for lower or no premiums. In conjunction with a growing number of insureds using various methods of self-insurance to cover part of their initial risk, some courts have confronted the issue of whether these self-insurance mechanisms constitute "other valid and collectible insurance." This issue most often arises in the context of an insured seeking to avoid payment of its self-insured retention (SIR)—often a hefty one—by arguing it is "uninsured" and that the excess policy should therefore be considered next in line with a corresponding duty to defend. The issue of self-insurance can have a
detrimental effect on an excess insurer that did not anticipate or properly defend its insured (especially if the dispute arises in a jurisdiction that imposes harsh penalties on insurers that outright refuse to defend).[15] Not all courts have followed what appears to be the majority of jurisdictions that have held that an insurer excess of an SIR has no duty to defend until the SIR is exhausted by the payment of judgments or settlements.[16]

In one such contrary case, *Cooper Laboratories, Inc. v. International Surplus Line Insurance Co.*,.[17] an insured argued that the insurer was obligated to reimburse it for defense costs relating to the settlement and defense of a claim against a drug manufacturer. The products liability insurer, International Surplus Lines Insurance Company (ISLIC), had issued an excess policy to the insured in excess of a $1 million SIR. Upon settlement of the claim, the insured sought reimbursement related defense expenses, which ISLIC denied, claiming that because its policy was excess of the SIR, the insured had "the obligation to defend as do primary insurers as a matter of industry custom."[18] The Third Circuit disagreed:

This contention may be dismissed rather quickly. [The insured] is neither a primary insurer nor an insurer at all. A duty to defend is a matter of contract, and the reason why primary insurers provide a defense is that their policies require that they do so. An industry custom allocating responsibility when two carriers both may have a contractual duty is not applicable when one of the parties bears no obligation.[19]

The insured further contended that the insurer's obligation to defend arose when the personal injury plaintiff submitted its first demand of $3.5 million to the insured, an amount within the insurer's policy limits. The insured was not arguing that the "right and duty to defend" language of the excess policy imposed an unlimited obligation; instead, it was arguing that the language restricted its demand to claims "seeking damages in excess of the [SIR]."[20] The Third Circuit did, however, articulate when the insurer's duty arose:

It is clear enough that if the judgment sought against the insured is one that the carrier would be required to pay, then the duty to defend exists. . . . Application of that rationale leads to the conclusion that ISLIC's obligation arose when it was confronted with the demand which put its coverage at stake.[21]

On the other hand, given the realities of the relationship between an excess insurer and an insured with a "substantial retention," the court recognized there had to be some allocation of defense fees to reflect these competing interests.

A common theme among the courts that have found a defense obligation above an SIR is the fundamental belief that SIRs are truly incomparable to other types of insurance. For instance, the North Carolina Court of Appeals in *Cone Mills Corp. v. Allstate Insurance Co.* reasoned that "under a self-insurance scheme, no written insurance policy is issued by another individual or entity nor is a premium paid because obviously a business which is self-insured does not need to pay itself to protect against its own risk of loss."[22] The Louisiana Court of Appeals in *Alwell v. Meadowcrest Hospital* went so far as to find that
an SIR "is in the nature of a deductible."[23] Although technically accurate, these comparisons neglect to account for the fact that an insured that makes use of SIRs is still making a conscious decision to absorb an initial assumption of risk for itself in exchange for not paying premiums to a third party—two necessary components of any insurance relationship. The insured should not receive a windfall for a gamble that ultimately does not pay off.

In any event, as a practical matter, these cases are often resolved on the basis of various factors including public policy implications and considerations (e.g., protection of the public versus allocation of loss among insurers); applicable state insurance statutes; whether the insured made a voluntarily decision to self-insure and took affirmative measures to set aside funds for this express purpose; and whether the SIR, when considered in the context of the excess policies above it, is in essence a deductible.[24] The best defense is first determining which factors the particular court typically finds most compelling in other insurance coverage cases and building from there.

Refusal to Defend by the Underlying Insurer
A final category of cases in which excess insurers have encountered—or have been pressured to accelerate—a defense obligation are cases in which a primary insurer has outright refused to defend. While most jurisdictions still adhere to the premise that a primary insurer's denial of coverage does not trigger an excess insurer's duty to defend, some courts have found that an excess insurer owes a duty to defend where the primary insurer refused to do so as long as the claim against the insured is potentially covered under the excess policy.

This was the holding by the Eighth Circuit in *Hawkins Chemical, Inc. v. Westchester Fire Insurance Co.*,[25] which involved a primary insurer, North River, and an excess insurer, Westchester, each of whom initially relied on pollution exclusions to deny a duty to defend a class action lawsuit filed against their insured, Hawkins, arising from a warehouse fire. The court in *Hawkins* was initially focused on North River's and Westchester's attempts to remove a hostile fire exception from their respective pollution exclusions, ultimately finding these attempts invalid under Minnesota law.[26] It then went on to address Westchester's contention that its defense obligation was not triggered due to the fact that North River, as the primary carrier, owed the primary duty to defend and had breached that duty. The court rejected this argument:

[T]he facts surrounding North River's refusal to defend [the insured] against the class action bring that lawsuit within the arguable scope of Westchester's umbrella policy. Although Westchester's policy unequivocally disclaims the duty to defend [the insured] when [its] underlying insurer breaches its own duty to defend, it was at least arguable that North River had breached no such duty to [the insured]. When North River refused to defend [the insured] against the class action, it relied upon the language of its pollution exclusion, which contained no hostile fire exception. The validity of that exclusion was not finally determined until we issued our opinion today. . . .North River's breach therefore does not excuse Westchester's refusal to defend [the insured] against the class action.[27]
The court ultimately held that because North River, the primary, had arguably abided by its contract with the insured and because Westchester did not validly remove the hostile fire exception from its own pollution exclusion, Westchester was obligated to defend Hawkins in the class action.

In a similar vein, the Wisconsin Supreme Court's somewhat recent holding in *Johnson Controls v. London Market*, discussed above, could have devastating effects for excess insurers if widely followed by other jurisdictions confronted with similar environmental coverage disputes. There, in addition to finding a second-level excess insurer had a duty to defend by virtue of an excess policy that contained no duty to defend provision (imported from an underlying follow form policy), the court held that such duty arose immediately upon the refusal of the underlying insurers to defend the pollution liability. The court pointed to nonstandard language in the underlying Travelers policy that provided if "the insurer affording other insurance to the named insured denies primary liability under its policy, [Travelers] will respond under this policy as though such other insurance were not available."[28]

While the majority in *Johnson Controls* refuted that their holding would encourage larger systemic issues such as encouraging primary insurers to try to avoid their defense obligations and more broadly obligating excess insurers to defend in many cases, the dissent predicted these exact results.[29] Pointing out that the majority's holding places the burden on the excess carrier to assume the defense, the dissent hits at the heart of the problem with the majority's reasoning for conditioning the defense on the underlying carrier's refusal because it now makes an excess carrier essentially a surety for the performance of the underlying insurer's policy or policies—even if a primary insurer has breached its duty to defend.[30] It remains to be seen whether other state appellate courts will follow this lead.

One of the reasons that courts may be more inclined to find such a defense obligation is the fact that such disputes are strictly between a primary and an excess insurer and should not result in an insured forfeiting its contractual rights to a defense. This was the impetus behind the Washington Supreme Court's decision in *New Hampshire Indemnity Co. v. Budget Rent-A-Car Systems*, which held that "if a primary insurer fails to assume the defense, for any reason, the excess insurer which has a duty to defend should provide the defense and, to do justice, should be entitled to recoup its costs from the primary insurer."[31] Allowing an excess carrier to seek recoupment of such defense costs at least, in theory, lessens the financial impact for an excess insurer saddled with this burden. The practical reality, however, may be to prolong the dispute between the primary and excess insurers through a secondary recoupment action.

**Conclusion**

While there are various circumstances under which an excess carrier can find itself encumbered with a duty to defend—even though its policy contains no explicit defense obligation—the circumstances discussed here can present obstacles for the unwary practitioner. Luckily, these cases generally do not serve as the majority rules among state
and federal jurisdictions. Nonetheless, there is every reason to be aware of the unique circumstances under which these issues can crop up. A coverage practitioner representing an excess carrier at all levels of coverage must thoroughly locate and investigate all potentially applicable policies including those that offer primary coverage and to which the excess insurer follows form. Gone are the days when an excess carrier could comfortably monitor the underlying litigation from afar. In fact, passivity must give way to direct and proactive involvement to discern what the underlying insurers' coverage positions are and react accordingly. Otherwise, the duty to defend may be riding on such a gamble.

**Keywords:** insurance coverage, litigation, excess policy, duty to defend, defense costs, settlement

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[3] "Following form" is a term used in the insurance industry to describe the type of policy form wherein an excess carrier insures the same risk covered by the underlying policy. In general, a "follow form" policy is "relatively brief," "incorporates by reference the terms of the underlying policy and is designed to match the coverage provided by the underlying policy." *Johnson Controls, Inc. v. London Mkt.*, 2010 WI 52, 34, 325 Wis. 2d 176, 784 N.W.2d 579 (Wis. 2010).


[15] See, e.g., Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust, 708 N.E.2d 1122 (Ill. 1999) ("If the insurer fails to take either of these steps [defend under a reservation of rights or seek a declaratory judgment] and is later found to have wrongfully denied coverage, the insurer is estopped from raising policy defenses to coverage."); Prof'l Office Bldgs., Inc. v. Royal Indem. Co., 145 Wis. 2d 573, 580, 427 N.W.2d 427 (Wis. Ct. App. 1988) (an insurer that breaches the duty to defend generally is held to have waived the right to raise coverage defenses).

(8th Cir. 1997) ("The difference between a self-insured retention and a deductible is usually that, under policies containing a self-insured retention, the insured assumes the obligation of providing itself a defense until the retention is exhausted."); USF&G v. Commercial Union Midwest Ins. Co., 430 F.3d 929 (8th Cir. 2005).


[18] Cooper Laboratories, 802 F.2d at 675.

[19] Cooper Laboratories, 802 F.2d at 675.

[20] Cooper Laboratories, 802 F.2d at 675.

[21] Cooper Laboratories, 802 F.2d at 676.


[25] 159 F.3d 348 (8th Cir. 1998).

[26] Hawkins Chemical, 159 F.3d at 351–52.

[27] Hawkins Chemical, 159 F.3d at 355.

[28] Johnson Controls, Inc. v. London Mkt., 2010 WI 52, 63, 325 Wis. 2d 176, 784 N.W.2d 579 (Wis. 2010).


[31] 64 P.3d 1239, 1243 (Wash. 2003).
Contingent Time Element Coverage

By Christopher R. Paar and Elizabeth V. Kniffen* – August 2, 2012

In the context of an all-risk first-party property policy, "time element" coverage generally refers to insurance for business interruption and extra expense losses that are measured by "the interval of time during which the insured's business is interrupted."[1] In other words, time element coverage exists for losses that occur during a specific period of time, typically the "period of indemnity" or "period of interruption," as defined in the policy, and typically calculated by the theoretical time necessary to return an insured to normal operations. Deductibles for time element losses may also be calculated using a specific period of time, typically by deducting the time element loss incurred during the first 24 hours after the loss or damage occurred. (This is often referred to as a waiting period deductible.) As with most first-party property coverage, time element coverage can be triggered only upon a showing of a "loss proximately caused by a covered peril such as direct physical damage to, or loss or destruction of, the insured property."[2]

A related form of time element coverage, known as "contingent time element" coverage, insures against business interruption or extra expense losses caused by physical loss or damage to the property of a third party, typically a supplier or a customer of the insured. Courts have acknowledged that "[t]he word 'contingent' is something of a misnomer" in that it simply refers to time element coverage that is dependent on damage to a third-party's property.[3] It is important to note that although the physical damage occurs to the property of a third party, to be compensable, the contingent time element loss still must have been caused by physical damage to or destruction of real and/or personal property by a peril insured against under the policy. Contingent time element losses are also measured during a period of interruption or period of indemnity.

To better understand the difference between time element coverage and contingent time element coverage, it is instructive to consider the following contrasting hypothetical loss scenarios:

**Time Element**
Assume that an earthquake damaged the taconite mining operation of Taconite Inc. Subject to Taconite's other policy provisions, it was insured for physical damage and time element losses caused by earthquake. During the period when the mine is not operational, Taconite could recover its loss of business income. To the extent that Taconite is required to incur extra expenses during that period—to purchase taconite on the open market to fulfill its contracts, for example—such extra expenses may also be covered. These losses are recoverable only during the period of interruption, which typically is the time it should take an insured operating with due diligence and dispatch to return to normal operations. It is because the business interruption and extra expense losses are measured during this period of interruption that they are considered a part of the time element coverage.
Contingent Time Element
Assume that the insured is Steel Inc., a steel mill that relies exclusively on taconite to produce a certain grade of steel for its customers. Assume also that Steel's primary supplier was Taconite, Inc., and an earthquake damaged Taconite's mine. Although Steel suffered no property damage to its own insured property as a result of the earthquake, its business was interrupted because of the physical damage to Taconite's mine caused by the earthquake. To fulfill the orders of its own customers, Steel had to purchase taconite on the open market (assuming Taconite, Inc., was not required to), in an attempt to continue normal operations and minimize its loss. Because Steel's policy provided contingent time element coverage, and because earthquake was a covered cause of loss under its policy, Steel could pursue a claim for the business interruption losses and extra expenses it incurred during the period of interruption. As with Taconite's own time element claim, Steel's contingent time element claim would be compensable during the period of interruption.

Although contingent time element coverage has been available for many years, little case law involving the interpretation of contingent time element coverage provisions exists. In 2005, the Eighth Circuit predicted that contingent time element coverage would "doubtless become more common and significant as companies increasingly out-source component parts manufacturing and rely on so-called 'just in time' inventory systems."[4] As predicted, the number of litigated claims involving contingent time element coverage has increased; however, the total number of cases analyzing this type of coverage still remains relatively small. This article provides a brief overview of the key cases that have addressed contingent time element coverage to date.

Who Is a Supplier or Customer?
In *Archer-Daniels-Midland Co. v. Phoenix Assurance Co. of New York*, one of the first cases to analyze contingent time element coverage issues, a federal district court in Illinois addressed a basic question that arises in contingent time element claims—what entity qualifies as a supplier or customer?[5] In *ADM*, the insured made a claim for more than $40 million in contingent business income and extra expense losses as a result of increased transportation costs and increased raw material costs it incurred after the 1993 flooding of the Mississippi River. According to ADM, it incurred increased transportation costs when it was forced to transport grain products by railcar after the barge traffic on the Mississippi was halted by the Army Corps of Engineers due to flooding. ADM also contended that it incurred increased raw material costs because of the inability of Midwest farmers to supply the necessary grain due to the flooding of their fields.

The contingent time element provision in ADM's policy stated:

> This policy covers against loss of earnings and necessary extra expense resulting from necessary interruption of business of the insured caused by damage to or destruction of real or personal property, by the perils insured against under this policy, of any supplier of goods or services which results in the inability of such supplier to supply an insured locations [sic].[6]
According to ADM, because the Army Corps of Engineers operated and maintained the Mississippi River waterway system, it was a supplier of a service to ADM. Likewise, ADM argued that the Midwest farmers qualified as a supplier of goods to ADM, although ADM typically purchased grain directly from brokers.

ADM's insurers rejected the contingent time element claim, however, contending that the federal government and Midwest farmers were not "suppliers of goods and services" as required by ADM's policy. As to the Army Corps of Engineers, the insurers argued that the government was providing a public service generally, not supplying a direct service to ADM as it had no contract with ADM. With respect to the farmers, the insurers argued that because ADM did not obtain its raw materials directly from the farmers, but instead purchased 90 percent of its wheat from licensed grain dealers, the farmers were not suppliers of goods to ADM.

The court agreed with ADM, concluding that the construction of physical improvements on the Mississippi River was indeed a service and that, although it had no contract with ADM, the government served a dual function that included being a market participant. In finding that the Army Corps of Engineers qualified as a supplier under ADM's policy, the court looked to dictionary definitions and determined that the policy "term 'supply' means 'to furnish with what is needed or desired'" and, therefore, "the phrase 'any supplier of goods or services' denotes an unrestricted group of those who furnish what is needed or desired." The court held, therefore, that "by constructing improvements on the Mississippi River, the Corps is undoubtedly providing a service.""[10]

With respect to the Midwest farmers, the court held that the term "any supplier" applied to both direct and indirect suppliers, which included the amorphous and unidentified Midwest farmers. The court found it persuasive that the policy did "not state that coverage [was] limited to principal suppliers or suppliers with whom ADM has a written contract, rather, they apply to 'any' supplier." As a result, the court found that ADM was entitled to seek coverage under its contingent time element provision for losses arising from the lack of raw materials and the impassable condition of the Mississippi River.

Subsequently, at least one court has refused to extend the holding in ADM when deciding what constitutes a "supplier." In Pentair, Inc. v. American Guaranty and Liability Insurance Co., an insured sought time element coverage after an earthquake in Taiwan disabled power substations that supplied electric power to two Taiwanese factories that, in turn, supplied goods to the insured. In that case, the insured, Pentair, contended that its situation, as in ADM, involved suppliers to suppliers and that the Taiwan power substations supplied goods to Pentair's suppliers in the same way that the Midwest farmers supplied goods to ADM's suppliers. The court disagreed, concluding that the power substations were not "a supplier of goods and/or services" in the same way that the farmers ultimately supplied goods to ADM:

Here, on the other hand, though the substations supplied power to the Taiwanese factories, the Taiwanese power company did not supply a product or service
ultimately used by Pentair. Thus, it was not a Pentair supplier for purposes of [the contingent time element provision] because it supplied no goods or services to Pentair, directly or indirectly.[13]

Because the Taiwanese factories sustained no physical loss or damage of their own, the loss of electrical supply at upstream suppliers was not sufficient to trigger coverage under Pentair's contingent time element provision.[14]

Decisions such as ADM and Pentair highlight one of the unique aspects of contingent time element coverage—namely, that when an insurance company issues contingent coverage for loss or damage to the property of a third party, it is difficult to identify all of the entities who may qualify as a "supplier or customer." Manufacturers are often dependent not only on their own immediate suppliers and customers but also on the customers and suppliers of others in the stream of commerce. As one moves further up or down the supply chain, an insurer has less and less control over the type of risks and property insured. In certain cases, insurers have taken steps to control the more remote exposures by including contingent time element provisions that draw a distinction between a "direct" supplier or customer and an "indirect" supplier or customer. In those cases, policies may provide coverage only for losses caused by physical damage to the property of direct suppliers and customers, or they may impose a smaller sublimit or higher deductible for the losses caused by physical damage to the property of indirect suppliers or customers. These types of contingent time element provisions have not yet been the subject of interpretation by the courts.

Decisions Increasing
The number of contingent time element decisions has increased in recent years and will likely continue to increase. Until the law interpreting contingent time element provisions has been fully developed, there is limited case law to rely on when interpreting these provisions. In those instances where case law does not exist, the obvious analogy is to look at the way in which courts have decided issues related to traditional time element coverage. Practitioners can seek guidance from decisions on traditional time element coverage issues such as the calculation of the period of interruption or assessing what constitutes "normal operations." These types of traditional time element issues are often analogous to the issues raised in contingent time element claims and provide guidance in the absence of specific case law interpreting contingent time element coverage provisions.

Keywords: insurance coverage, litigation, business interruption, contingent time coverage, guidance, supplier

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[4] Pentair, 400 F.3d at 615.


[12] 400 F.3d at 614.


[14] In some cases, the issue is not whether an entity is a customer or supplier, but rather the nature of the insured's relationship with the entity that incurred physical loss or damage. In *Zurich American Insurance Co. v. ABM Industries, Inc.*, 397 F.3d 158 (2d Cir. 2005), the court found that although the damaged World Trade Center was leased by a different company, the property was "operated" by the insured and, therefore, did not fit within the contingent time element coverage in the policy. In *CII Carbon, LLC v. National Union Fire Insurance Co. of Louisiana, Inc.*, 918 So. 2d 1060 (La. Ct. App. 2005), the court concluded that the contingent time element coverage applied where an explosion damaged both the insured's property and its customer's property in the same incident, but the insured's property was repaired first. In that case, the insured operated a facility that processed coke for use in the aluminum smelting industry and sold excess
steam to an adjoining facility. The court held that business interruption coverage was available during the time that the insured's operation was being repaired. However, once the insured property was repaired, but while the customer's business remained out of operation, the insured was entitled to contingent business interruption coverage. *CII Carbon, LLC*, 918 So. 2d at 1067–68.
Insurance 101: Considerations for Declaratory Judgment Actions

By Shanda K. Pearson* – July 30, 2012

Declaratory judgment actions are one of the most common procedural mechanisms by which policyholders and insurers can proactively seek a determination regarding their respective rights and obligations under an insurance policy. In the words of the Georgia Court of Appeals, a declaratory judgment action "permit[s] one who is walking in the dark to ascertain where he is and where he is going, to turn on the light before he steps rather than after he has stepped in a hole."[1]

Although declaratory judgment actions are commonplace in insurance coverage litigation, there are a number of threshold issues and strategy concerns that should be considered before commencing such an action.

History, Applicable Statutes, and Rules
Declaratory judgments were recognized as remedies in the United States in the early 1900s. In 1922, the Commissioners on Uniform State Laws first adopted the Uniform Declaratory Judgments Act (UDJA). The UDJA states:

Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declarations shall have the force and effect of a final judgment or decree.[2]

The majority of states have adopted some version of the UDJA, providing for some level of national standardization of the declaratory judgment process. Most, but not all, states that have declined to adopt the UDJA have statutes that provide for declaratory judgments.[3] In states in which some form of the UDJA has been adopted, state rules of civil procedure generally govern declaratory judgment actions brought under state statute.[4]

In 1934, Congress enacted a federal statute, similar to the UDJA, which authorized federal courts to grant declaratory judgment relief,[5] although the Federal Declaratory Judgments Act does not provide an independent basis for federal jurisdiction.[6] The Federal Rules of Civil Procedure generally govern the procedure for obtaining a declaratory judgment in federal court.[7]

The Purpose of a Declaratory Judgment Action
Declaratory judgments are actions designed to resolve disputes "before the commission of wrongs"[8] and to "settle uncertainties prior to full-blown development."[9] Black's Law Dictionary defines "declaratory judgment" as follows:
[A] [s]tatutory remedy for the determination of a justiciable controversy where [a party] is in doubt as to his legal rights. A binding adjudication of the rights and status of litigants even though no consequential relief is awarded.[10]

In short, the purpose of a declaratory judgment action is to "settle important questions of law before the controversy has reached a more critical stage."[11] One commentator has observed that the declaratory judgment action recognizes that "[c]ourts should operate as preventive clinics as well as hospitals for the injured."[12]

Relevant to insurance coverage actions, the UDJA expressly provides that declaratory judgment actions are an appropriate mechanism for construing and interpreting contracts:

Any person interested under a . . . written contract or other writings constituting a contract, or whose rights, status, or other legal relations are affected by a . . . contract . . . may have determined any question of construction or validity arising under the . . . contract . . . and obtain a declaration of rights, status, or other legal relations thereunder.[13]

The UDJA further provides that "[a] contract may be construed either before or after there has been a breach thereof."[14]

Thus, declaratory judgment actions can be used to resolve a variety of insurance coverage issues. Among such issues are whether an insurer has a duty to defend,[15] the existence of coverage for a particular claim,[16] whether a policy exclusion is applicable,[17] or the priority of coverage between two or more insurers.[18] In some jurisdictions, however, a declaratory judgment action is not an acceptable mechanism for seeking reformation of a policy.[19] In addition, some jurisdictions—despite the above provision in the UDJA—have held that a declaratory judgment action is not appropriately brought by an insurer where the insurer has already denied coverage under an insurance policy.[20]

Declaratory Relief

A threshold issue that must be addressed prior to the commencement of a declaratory judgment action is whether a justiciable controversy exists.[21] While states may differ on what facts are required to determine that a justiciable controversy exists, all states require that a "justiciable controversy" exist before a party is entitled to commence a declaratory judgment action. To establish a justiciable controversy, a litigant must generally establish there is a present, substantial controversy between adverse parties with "legal interests susceptible to immediate resolution and capable of present judicial enforcement."[22] The UDJA "does not give a court the power to render advisory opinions or determine questions not essential to the decision of an actual controversy."[23]
When the policyholder has been sued and has tendered the claim to its insurer for a defense, the presence of a justiciable controversy is usually apparent. A more difficult issue arises, for example, when an insurer is aware of an accident that will likely give rise to a claim and wants to resolve the coverage question early, even before a claim is formally brought.

Alternatively, consider a situation in which a policyholder who is being provided a defense by one carrier indicates an intent to claim coverage against a second carrier. Under such circumstances, whether a justiciable controversy exists with respect to the second carrier is a close question. With respect to a declaratory judgment action brought by a policyholder against its excess insurer, the court's decision will likely turn on whether it is reasonably likely that the claims against the excess carrier will mature. For example, in In re Pettibone Corp.[24] the court held there was no justiciable controversy with respect to a duty to defend where it was improbable, based on the facts of the case, that the excess insurer would be called upon to undertake the defense.[25] Where the declaratory judgment action is between two insurers, courts have reached different conclusions.[26]

**Commencing a Declaratory Judgment Action**

Assuming there is a justiciable controversy, a party commencing a declaratory judgment action should consider the forum in which the action should be commenced and what state's law will apply. If, for example, a Minnesota resident is involved in an accident in Wisconsin potentially governed by a policy issued in Arizona, forum and choice of law become critical concerns, particularly where state law differs on an outcome-determinative issue.

**Choice of Law**

Assuming the insurance contract itself does not designate what state's substantive law will be applied in the event of a dispute between the parties, the first step in any choice of law analysis is to determine whether a conflict exists between the potentially applicable insurance coverage laws of different states. A choice of law analysis is necessary only when the "choice of one state's law over another's creates an actual conflict"[27] or when the law of one state is uncertain and there is a potential for conflict. In addition, a choice of law analysis is necessary only if the law of both states is capable of being constitutionally applied.[28]

The choice of forum, further discussed below, may have a major impact on what state's law will be applied to a controversy because of the possibility that a court may be inclined to apply the law of its own forum. In addition, different states use different tests to determine what state's law will govern where there is a conflict of law. Among these tests are the *lex loci contractus* doctrine, the "choice influencing" test, and the test from the *Restatement (Second) of Conflict of Laws*. 
Under the *lex loci contractus* doctrine, the court would apply the law of the state where the insurance contract had been entered into. While the doctrine has been criticized as being outdated and inflexible,[29] at least 10 states still apply it—Alabama, Arkansas, Florida, Georgia, Kansas, Maryland, New Mexico, South Carolina, Tennessee, and Virginia.[30]

Since 1973, a few courts, including Minnesota, have adopted Professor Robert Leflar's five-factor choice-of-law test in contract cases. This test, sometimes referred to as the "choice influencing consideration" test or the "better-law" approach, requires a court to consider five factors to determine which state's law to apply: (1) predictability of results, (2) maintenance of interstate and international order, (3) simplification of the judicial task, (4) advancement of the forum's governmental interests, and (5) application of the better rule of law.[31]

The first two factors are generally the most significant. The first factor, predictability of results, is intended to fulfill the parties' "justified expectations" about what law they believed would be applied to a controversy.[32] Under this factor the residency of the insured and the place where the insurance policy was entered into are seen as factors that would have affected the parties' expectations about what law would be applied. This first factor often weighs heavily toward applying the law of the insured's domicile in a coverage declaratory judgment action.[33] As to the second factor, courts frequently look to what state has the most significant contacts with the facts of the case and analyze the issue of forum shopping.[34]

The majority of jurisdictions, however, have adopted the *Restatement (Second) of Conflict of Laws* test in contract actions.[35] Some of the states that have adopted at least some portion of the *Second Restatement* test are Arizona, Connecticut, Iowa, Michigan, Ohio, Utah, and Washington. Although the framework for a choice of law analysis is set forth in section 6 of the *Restatement (Second) of Conflict of Laws*,[36] when applied to insurance contracts, the principles from section 6 are of secondary importance to *Restatement (Second) of Conflict of Laws* sections 188 and 193.[37] Section 193 provides that the validity of rights created under a fire, surety, or casualty insurance policy are determined by the local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy, unless with respect to the particular issue, some other state has a more significant relationship . . . to the transaction and the parties . . .

In the absence of a principal location of the insured risk, section 188 sets forth the following factors to consider: the place of contracting; the place of negotiation of the contract; the place of performance; the location of the subject matter of the contract; and the domicile, residence, nationality, place of incorporation, and place of business of the parties. In some situations, the section 188 factors may even outweigh the principal location of the insured risk.[38] Of note, under the *Second Restatement* test, a choice of law provision in an insurance contract may not necessarily govern.[39]
States not adopting one of the aforementioned tests generally use combinations and variations of the *lex loci* and choice-influencing rules or rely on a "significant contacts" test similar to the minimum contacts analysis used in determining personal jurisdiction.[40]

Regardless of the test actually used, however, courts' decisions on choice of law issues are sometimes hard to predict. Frequently, the substantive law of the policyholder's domicile, which is normally where the insurance contract was entered into, will apply to an insurance coverage declaratory judgment action. It is also important to remember that procedural matters, such as the applicable statute of limitations, will be governed by the law of the forum state irrespective of the outcome of any choice of law questions.

*Choice of Forum*

After determining which state is most likely to apply the law that is favorable to a party's position, it is also necessary to consider whether that forum state has the requisite personal jurisdiction over the parties. Personal jurisdiction and choice of law inquiries are not the same.[41] Personal jurisdiction is the power of the tribunal to subject and bind a particular entity to its decisions.[42] If the party against whom the action is brought is domiciled within the state, the court will have jurisdiction. When the party is a nonresident, courts will look to the state's long-arm statute to determine whether personal jurisdiction exists.

In addition to whether the forum has personal jurisdiction over the parties, consideration should be given to whether the opposing party will be able to successfully move for dismissal or a change of venue on forum non conveniens grounds. A party moving to dismiss on forum non conveniens grounds must show two things: (1) the existence of an adequate alternative forum and (2) that the balance of private and public interest factors favor dismissal.[43] Whether or not there is an alternative forum will depend on whether the defendant is "amenable to process in the other jurisdiction."[44] When balancing the private and public interest factors, the private factors that may be considered include the residence of the witnesses and parties; costs of bringing witnesses and parties to the place of trial; access to sources of proof; and "other practical issues that make trial of a case, easy, expeditious and inexpensive."[45] The public interest factors include local interest in resolving the controversy, administrative difficulties for local courts, and preference for having a forum apply law with which it is familiar.[46]

Under 28 U.S.C. 1406, a federal case may be transferred to a more convenient forum, rather than dismissed, if the transfer is in the interest of justice. Transfer is limited to districts in which the case could have originally been brought.

*Naming Parties in a Declaratory Judgment Action*

Most declaratory judgment statutes provide that all persons having an interest in the outcome of a declaratory action should be included in the action. What constitutes "having an interest" in the outcome, and whether a party is a necessary party or just a proper party, is often unclear.
Section 11 of the UDJA provides, in pertinent part:

When declaratory relief is sought, all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding.

The UDJA does not distinguish between persons who are necessary parties and persons who are merely proper parties. The cases applying section 11 to varying factual situations, however, do make that distinction and have raised some confusion as to whether section 11 is mandatory in jurisdictions that have adopted it.[47] Regardless, some courts in jurisdictions that have adopted section 11 view a failure to name as parties all persons whose interests would be affected as a non-waivable jurisdictional flaw.[48] Others have held that that a court may not enter judgment in a declaratory judgment action until all persons who have an interest in the controversy are named as parties.[49]

In the typical case, the policyholder who would be affected by the relief sought would have to be named as a defendant in a declaratory judgment action. More difficult is determining whether to name other parties—including but not limited to the plaintiff or other defendants in the underlying lawsuit, and other primary or excess insurers—in the declaratory judgment action.

Whether the plaintiff in the underlying action is a necessary party in an insurance coverage declaratory judgment action is the subject of much debate. Some argue that because the plaintiff's ability to recover from the defendant insured may be dependent on whether there is insurance available, the plaintiff has an "interest" in the outcome and so is a necessary party in an insurance coverage declaratory judgment action.[50] Pennsylvania courts, and many other jurisdictions, routinely dismiss declaratory judgment actions if the plaintiff in the underlying action is not a named party in the declaratory action.[51]

There are arguments in support of the opposite conclusion. Most declaratory judgment statutes require the joinder of all persons with "any interest that would be affected by the declaration," but because the declaratory judgment action is a contract action and because the plaintiff in the underlying action is not a party to the contract, one could argue that the plaintiff has no interest in the declaratory judgment action. In addition, because the plaintiff's interest in finding coverage is adequately protected by the presence of the policyholder, who is equally interested in establishing coverage, it could be argued that naming the plaintiff is unnecessary.

Failure to name the plaintiff, however, could result in two separate declaratory judgment actions or otherwise relitigating identical coverage issues. In Krohn v. Gardner,[52] the Nebraska court held that the claimant was not bound by a previous finding of no coverage in a declaratory action between the insurance company and the policyholder. The court reasoned that although the policyholder and the claimant had similar goals (establishing coverage), this did not make them "privies" and so the claimant was not bound.[53]
In addition to satisfying concerns stemming from section 11 of the UDJA, there are other factors that should be considered when deciding whether to name additional parties in a declaratory judgment action. The preferred forum for the declaratory judgment action may lack jurisdiction over the plaintiff or defendants in the underlying action. But if the preferred forum is federal court, a greater number of parties increases the possibility of destroying diversity jurisdiction. Finally, litigating a case with fewer parties can be easier and less costly.

In short, the decision of what parties to name in a declaratory judgment action should involve a careful legal and costs-benefit analysis.

**Timing and Coordination of Actions**

Additional issues that may need to be considered when deciding whether to bring a declaratory judgment action involve the timing of and coordination between the declaratory judgment action and the underlying liability action. One question that frequently arises is whether issues raised in the underlying action may be resolved first in the declaratory judgment action. Consider a situation in which an insurer has accepted defense under a reservation of rights in a claim that alleges both negligence and intentional conduct against the insured. The insurer may want to initiate a declaratory judgment action and proceed quickly to a determination that the conduct of the insured was intentional and thus not covered under the policy, thereby ending its defense obligation. May the issue of intent be resolved in the declaratory judgment action before the underlying action is concluded?

The majority of jurisdictions hold that where the question to be resolved in the declaratory judgment action between the insurer and the insured will be decided in the main, underlying action, the trial court may not resolve that issue in the declaratory judgment action; it must be left for resolution in the underlying action.[54] Thus, a declaratory judgment action can proceed before the insured's liability is determined in the underlying action when the issues in the two actions are independent and separable.[55] For example, if an individual is sued for injuring someone, and a coverage dispute arises over whether the defendant is a resident of the named insured's household and so qualifies as an insured, the residency issue could be resolved in the declaratory action before the underlying case is complete because the issue of residency is unrelated to the issue of liability in the underlying lawsuit.[56] If the issues in the two cases are not exactly the same, though closely related, the parties are entitled to a declaratory judgment establishing coverage or the lack thereof.

Courts cite several reasons for the rule that the declaratory judgment action may not resolve issues that will be decided in the main action. The majority rule "prevents duplicative proceedings, may allow the insured his choice of forum, and avoids the danger of inconsistent judgments."[57]

Additional reasons for the majority rule arise from fundamental notions of fairness. First, courts have prohibited the insurer from proceeding in a declaratory judgment action while
the underlying action is unresolved because, by proceeding, the insurer defeats its insured's expectation of protection for which it paid a premium.[58]

Second, courts are concerned about the possible collateral estoppel or prejudicial effect that a judgment or finding in the declaratory judgment action might have on the underlying action. In effect, if the insurer was permitted to establish the insured's liability in the declaratory action, the insurer would be providing the plaintiff in the underlying action the tools to seek a directed verdict against the insured in the underlying action.[59] General notions of fairness are of particular concern when the insurer is representing an insured in the underlying matter at the same time it is attempting to establish facts that may lead to the insured's liability. This frequently comes into play in situations in which an insurer argues that an intentional acts exclusion bars coverage for a claim. One commentator explains this concern as follows:

In a nutshell, the problem is that if the insurer is permitted to pursue the declaratory action prior to the disposition of the underlying claim, then the insurer will be seeking to prove in the declaratory action that the insured committed an intentional tort, which is contrary to the insured's interests in the tort action.[60]

In fact, in some jurisdictions, an insurer that raises coverage defenses in a declaratory judgment action may lose its right to control the defense and any settlement of the underlying claim.[61] This is because of an apparent conflict between the policyholder and the insurer.

Third, courts are concerned about the possible prejudice to the insured by being placed in the position having to fight a two-front war—one against the plaintiff in the underlying action and one against the insurer in the declaratory judgment action.[62]

There is, however, contrary authority. In some jurisdictions, courts will allow a declaratory judgment action to proceed first even though it involves resolution of the same issues involved in the underlying action.[63] In Metro Property & Liability Insurance v. Kirkwood, an insurer brought a declaratory judgment action against an insured's widow and estate seeking a determination that the insured acted intentionally, not negligently, in shooting his stepson and wife. The First Circuit allowed the declaratory judgment action to proceed, despite a pending tort suit brought by the insured's wife against his estate, because resolving the coverage matter first would avoid any conflict of interest between the insurer and the insured at the underlying trial.[64]

In sum, it is important to determine how a potentially applicable jurisdiction resolves this issue to avoid a potential stay or dismissal of, and incurring unnecessary costs related to, a declaratory judgment action.

Conclusion
Declaratory judgment actions are a commonly used vehicle for policyholders and insurers to seek important legal determinations regarding their rights and obligations under insurance policies. Rather than falling into routine practices in commencing such actions,
however, insurance coverage litigants must remember to give significant consideration to
the above issues, prior to commencing suit, to improve their chances of success and
decrease the possibility of—or at least be able to anticipate—motion practice seeking
dismissal of the action or other remedies with respect to the action.

**Keywords:** insurance coverage, litigation, Declaratory judgment actions, declaratory
judgment relief, Uniform Declaratory Judgments Act, choice of forum

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(citation and quotation omitted).


(dismissing claim because jurisdiction did not specifically authorize declaratory
judgment).


Declaratory Judgments Act, Congress sought to place a remedial arrow in the district
court's quiver; it created an opportunity, rather than a duty, to grant a new form of relief
to qualifying litigants."); Brillhart v. Excess Ins. Co. of Am., 316 U.S. 491, 494 (1942)
("Although the District Court had jurisdiction of the suit under the Federal Declaratory
Judgments Act, . . . it was under no compulsion to exercise that jurisdiction.").


1994).

[9] Holiday Acres No. 3 v. Midwest Fed. Sav. & Loan Ass'n of Minneapolis, 271 N.W.2d
445, 447 (Minn. 1978).
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[10] *Black's Law Dictionary* 846 (7th ed. 1999); *see also* Colonial Pipeline Co. v. Morgan, 263 S.W.3d 827, 836 (Tenn. 2008) (citing 26 C.J.S. *Declaratory Judgments* 1 (2001)) ("Declaratory judgments' are so named because they proclaim the rights of the litigants without ordering execution or performance.").


[22] Prof'l Firefighters Ass'n of Omaha v. City of Omaha, 803 N.W.2d 17, 26 (Neb. 2011).


[34] Jepson, 513 N.W.2d at 470–71.


[38] Maniloff & Stempel, *supra* note 29, at 20 (citations omitted).

[39] Maniloff & Stempel, *supra* note 29, at 21 (citing *Restatement (Second) of Conflicts of Law* 193 cmt. e ("Effect will frequently not be given to a choice-of-law provision in a contract of fire, surety, or casualty insurance which designates a state whose local law gives the insured less protection than he would receive under the otherwise applicable law."); Industrial Indem. Ins. Co. v. United States, 757 F.3d 982 (9th Cir. 1985)
(declining to apply Illinois choice-of-law clause to policy having no relationship to Illinois).


[41] Allstate Ins. Co. v. Hague, 449 U.S. 302, 320 n.3 (1981) ("The two questions presented by the choice-of-law issue arise only after it is assumed or established that the defendant's contacts with the forum State are sufficient to support personal jurisdiction.").


[44] Lockman Foundation, 930 F.2d at 768.


[46] Lockman, 930 F.2d at 771.


[48] Henry, supra note 47.

[49] Henry, supra note 47.

[50] See Fire Ins. Exch. v. Basten, 549 N.W.2d 690, 698–99 (Wis. 1996) (requiring the plaintiff and anyone else with a claim against the insured in the underlying action to be named as a party in the declaratory judgment action); see also Soc'y of Mt. Carmel v. Nat'l Ben Franklin Ins. Co., 643 N.E.2d 1280, 1284–85 (Ill. Ct. App. 1994) (the tort claimant in an underlying action is a necessary party to a declaratory judgment action brought to determine insurance coverage for that claim); Royal Indem. Co. v Hartford Accident & Indem. Co., 155 A.2d 270, 272 (N.J. 1959) (holding judgment in a declaratory judgment action involving two potential insurers should not have been entered without the joinder as parties of persons who had been riding in the vehicle and were injured in the accident).

[51] See Vale Chem. Co. v. Hartford Accident & Indem. Co., 516 A.2d 684 (Pa. 1986) (dismissing lawsuit for lack of subject matter jurisdiction because the injured party was not joined); see also Davis J. Howard, "Declaratory Judgment Coverage Actions: A


[53] *Krohn*, 471 N.W.2d 391; see also Howard, *supra* note 51, at 33 (discussing *Krohn*).


[56] See Haskel, Inc. v. Superior Court, 39 Cal. Rptr. 2d 520, 529 (Cal. Ct. App. 1995). ("It is only where there is no potential conflict between the trial of the coverage dispute and the underlying action that an insurer can obtain an early trial date on resolution of its claim that coverage does not exist.").


[58] See, e.g., *Hartford*, 625 P.2d at 1016 ; Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1225 (3d Cir. 1989) ("The insured could not possibly have anticipated that the very resources for which he bargained would be turned against him and used to establish his liability whenever [an] intentional tort was alleged.").


[64] *Kirkwood*, 729 F.2d at 63–64 (citing *Stout v. Grain Dealers Mut. Ins. Co.*, 307 F.2d 521 (4th Cir. 1962) (upholding district court's decision not to dismiss a declaratory judgment action when a conflict of interest existed that would have prevented the insurance company from managing the insured's defense in an underlying tort suit)).
Message from the Chairs

Changing of the Guard

The adage “Time flies when you are having fun” could not be more true. The end of my three year term as cochair of the Section of Litigation Insurance Coverage Litigation Committee (ICLC) comes with surprise, pride, and no small degree of sadness. Surprise that three years has passed so quickly. Pride that the ICLC is such a strong and diverse force—referred to repeatedly by Section leadership as the “gold standard” for quality activities, outreach, and benefits to our members. And sadness that my term is almost over. I am happy to announce that the Section of Litigation leadership has appointed Sheri Pastor of McCarter & English as our new policyholder-side cochair. Sheri will serve alongside my friend and confidant Ron Kammer, who has been such a supportive and positive factor for the ICLC, with our great Vice Chair Laura Hanson. With our time-honored tradition of policyholder-side chairs serving alongside insurer-side chairs at all leadership levels, our ICLC will continue to grow as we celebrate our 25th Anniversary in 2013.

Many others deserve a note of thanks. Erik Christiansen and our Coverage managing editors produce one of the finest substantive journals available. We have moved from a print version to electronic distribution of Coverage, now available to more than 60,000 members of the Section of Litigation. Coverage continues to be our trademark of excellence.

Our Website Editors John Buchanan, Rina Carmel, Jim Davis, and Jayson Sowers troll for—and catch—remarkable articles, case notes, and other substantive content authored by our tireless Subcommittees. In the upcoming Bar year, the website editors-in-chief and website managing editors will provide new materials as an added benefit of Section of Litigation membership. Our “Take Five” summaries and Sound Advice recordings will be rolled out to the entire Section of Litigation membership in a monthly newsletter that contains articles on key subjects, Litigation 101, 50-state surveys, and special links to a variety of hot topics.

There are many other accomplishments. Our fabulous Annual Meeting chairs and vice chairs produce unparalleled meetings. Thanks to our many law firm sponsors, our Tucson meetings have grown to 330 plus attendees with networking events for women, young lawyers, in-house and minority lawyers, and early bird and farewell receptions to meet colleagues from around the country. Our Practice Development Subcommittee has produced panels focusing on business development. Nearly 200 insurance coverage specialists are active in leadership roles through our Long Range Planning Subcommittee, Membership and Programming Committees, new Women in Insurance and Social Networking Subcommittees, and substantive subcommittees. Our timely Distance CLE programs address issues ranging from the banking crisis to the tremendous property losses caused by the BP Gulf Spill, and our Women in Insurance Networking Conference...
will debut October 18 in Washington, DC, chaired by Ruth Kochenderfer, Angela Elbert, Cara Tseng Duffield, and Marla Kanemitsu,”

It has been an honor to serve as an ICLC cochair, and I am grateful for the opportunity to work with and count so many of you as friends. We have accomplished so much. I will be working with Section of Litigation committees as a division director, and know that the ICLC will continue to excel. Thank you, and see you in Tucson.

Mary Craig Calkins
Cochair, Section of Litigation
Insurance Coverage Litigation Committee

Editor’s Notes

Write Now

For those who did not attend the annual meeting of the Insurance Coverage Litigation Committee (ICLC) in Tucson, Arizona, in March, the event was a great success at its new location. For those who did attend the event, if you came away with some great new ideas for articles, don’t let those ideas go to waste. Take some time and write a unique and original article for Coverage. To steal and paraphrase the immortal words of the great skier Warren Miller, if you don’t do it this year, you’ll just be another year older when you finally do decide to write an article for Coverage. If you don’t have the time to do an article this year, please consider doing an ICLC website post. Posts to the ICLC website can be as short as 250 words.

If you are a member of the ICLC and have never attended the ICLC’s annual meeting, I would encourage you to do so. The quality of the panel presentations in Tucson, as well as the quality of the social networking opportunities, are unsurpassed in insurance coverage litigation professional circles. The weather also is great, and the scenic desert is beautifully stark and surprisingly full of life. After all, the unofficial logo of Coverage is a giant saguaro cactus. Hopefully, we will see you next year. Until then, the summer travel season, and take a moment to write an article for Coverage or to submit a short piece for the ICLC website.

Erik A. Christiansen
Editor in Chief—Coverage
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