ALM
LAW JOURNAL NEWSLETTERS

The Insurance Coverage Law Bulletin®

Volume 6, Number 2 • March 2007

Litigation Conduct

Removing the 'Bad Faith' Trap

By Sheila R. Caudle and Jonathan Cohen

Pure self-interest seemingly motivates parties in the adversarial system; but insurance presents a twist on that common understanding when it comes to litigation over coverage. That is because courts have held that a coverage action does not terminate certain obligations existing between an insured and its insurer — even with respect to the particular claim at issue in the coverage dispute. With increasing frequency, aggressive attorneys representing policyholders argue that, despite traditional common law or statutory litigation and settlement privileges and protections, an insurer's conduct during a coverage lawsuit should be scrutinized with the aim of identifying evidence of "bad faith" that can be used against the insurer.

The law in this area is still developing, but a body of case law is being generated that presents a principled, "bright-line" rule that distinguishes between an insurer's conduct as a litigant seeking a judicial declaration on coverage and the insurer's conduct purely as an insurer making a coverage decision. These cases recognize that a coverage dispute that is in litigation should not provide a springboard for policyholders to generate "bad faith" allegations as a litigation strategy. These courts reason that when coverage is in dispute, an

continued on page 6

The Insurance Industry Takes Another Swing At Efficient Dispute Resolution

By Jessica F. Pardi

The widespread use of arbitration in insurance and reinsurance disputes was intended to allow parties to resolve complex disputes quickly and efficiently by having persons with knowledge of the specialized terminology, standards, and practices of the insurance industry act as decision makers. This aspiration has been superseded by protracted and voluminous discovery, continual delays and postponements, extensive briefing, and lengthy hearings. In essence, all of the foibles of litigation have crept into the world of arbitration, leaving the insurance industry once again in search of an efficient method to resolve disputes.

Last year, the International Institute for Conflict Prevention and Resolution ("CPR"), in consultation with leading insurers and law firms in the London and American insurance markets, advanced a new International Reinsurance Industry Dispute Resolution Protocol (the "Protocol") to provide the insurance industry with an alternative to litigation or lengthy arbitration. CPR has been involved in the property-casualty insurance community for more than 20 years and maintains an active Insurance Committee composed of representatives of insurance companies that meet at least twice a year to consider new tools to advocate and support alternative dispute resolution within the insurance industry. CPR also has a Corporate Insurance Coverage Committee consisting of representatives of corporate policyholders, commercial insurers, and coverage and defense counsel. This committee creates and promulgates methods for managing policyholder coverage disputes without litigation.

CPR has offered the Protocol as a statement of "best practices" to resolve disputes early and efficiently. While focused on reinsurance disputes, the Protocol is meant to apply to insurers, insureds, agents and brokers, as well as reinsurers. A copy of the Protocol and further information regarding CPR can be found at *www.InsuranceMediation.org*. While somewhat idealistic, the Protocol does offer expedited procedures to bring parties to the table. If, however, the parties to the dispute either have not adopted the Protocol or are not willing to settle their

continued on page 2

In This Issue

Dispute Resolution

continued from page 1

dispute, the Protocol may serve only as an additional layer to the dispute resolution process.

How Does the Protocol Work?

The Protocol is a four-step method comprised of the following:

1) Identifying and giving early notice of a dispute arising from a reinsurance agreement;

2) Exchanging information and documents that would permit a commercially reasonably assessment of the issues in dispute;

3) Directly negotiating with the parties to resolve the dispute; and

4) If necessary, introducing a skilled, neutral third party to facilitate those negotiations through a mediation procedure.

(Protocol, p. 2)

A company adopting the Protocol is not legally bound by such agreement nor does it waive any rights, defenses, or privileges. If a company adopts the Protocol, it must designate an executive who is responsible for implementing and monitoring the company's proactive use of the Protocol. There is, however, no cause of action for a company that initially adopts the Protocol and then fails or refuses to follow it. While this avoids further disputes regarding adoption and/or failure to abide by the Protocol, it also undercuts any commitment to this process.

CPR recognizes that any contractual provision pertaining to dispute resolution must govern the actions of the parties unless they otherwise agree. CPR notes, however, that the existence of an arbitration clause shall not, in and of itself, constitute an inconsistency with the Protocol. Any dispute as to the applicability of the Protocol to a particular disagreement must be referred to CPR, whose decision shall be final and binding on the parties. Thus, there does not appear to be any option to go to court. This likely will minimize the delays frequently experienced by parties who cannot determine the appropriate procedure (*e.g.,* litigation versus arbitration) for a resolution of their dispute.

Initiating the Process

Any party wishing to institute the Protocol shall serve upon all other parties to the dispute and to CPR a "Notice of Negotiation." The Notice of Negotiation shall include the following:

- A statement that the party wishes to institute the Protocol;
- A description of the dispute;
- A notice that all parties served with the Notice of Negotiation shall submit a "Notice of Response";
- A statement that the initiating party agrees to meet with the respondent in good faith to agree upon the documents that shall be made available for copying and inspection;
- An illustrative list of materials to be exchanged by the parties;
- A statement that all materials produced shall be returned, and no party shall retain copies;
- A listing of the claim information known about responding parties;
- A statement of the monetary amount in dispute; and
- A statement of the claim information of the initiating company.

The Notice of Response to be prepared by all respondents shall contain the following:

- A correction or supplementation to the claim information for the responding company;
- A counterstatement of the dispute and dollar amount at issue; and
- A statement as to whether the responding party has adopted the Protocol, or if it has not done so, a statement that it will abide by the Protocol.

A form for the Notice of Response is to be sent to each respondent with the Notice of Negotiation, and a response is to be provided within 30 days. Interestingly, both the Notice of Negotiation and the Notice of Response are to identify the "ADR

continued on page 10

Jessica F. Pardi is a partner in Morris, Manning & Martin LLP's Insurance Group. Pardi practices in the areas of insurance litigation, reinsurance dispute resolution, complex coverage disputes, and insurer insolvency. Her insurer insolvency practice includes representation of receivers, reinsurers, and acquiring insurers.

The Insurance Coverage Law Bulletin®

The Insurance Coverage Law Bulletin® (ISSN 1541-0773) is published by Law Journal Newsletters, a division of ALM.

The Insurance Coverage Law Bulletin 023148
Periodicals Postage Paid at Philadelphia, PA
POSTMASTER: Send address changes to:
ALM
345 Park Avenue South, New York, NY 10160
Annual Subscription: $349

Published Monthly by:
Law Journal Newsletters
1617 JFK Boulevard, Suite 1750, Philadelphia, PA 19103
www.ljnonline.com

Illegal Alien Status

Eligibility Requirements And Non-Coverage for Fraud Provisions Still Apply

By Anthony J. Golowski II and Shaun A. Bean

A significant body of case law holds that illegal aliens are not precluded, by virtue of their illegal status, from recovering insurance benefits. While that may be the law, and we do not mean to suggest otherwise, one's illegal status may not confer upon an insured or claimant *greater* rights than those enjoyed by someone who is in the United States legally. A legal insured may not make material misrepresentations in an application for insurance. A legal insured may also be required to satisfy certain eligibility requirements as a prerequisite to coverage. It could not have been anyone's intention that illegal alien status would be used as a free pass, effectively negating eligibility requirements and the insurers' right to void policies where an applicant misrepresents or conceals a material fact.

The Entitlements of Illegal Aliens

It is well settled that illegal aliens have the right of access to the courts and are eligible to sue to enforce contracts and redress civil wrongs. *See, e.g., Arteaga v. Literski*, 83 Wis. 2d 128, 265 N.W. 2d 148, 149 (1978); *Torres v. Sierra*, 89 N.M 441, 553 P.2d 721, 724 (Ct. App. 1976); *Commercial Standard Fire and Marine Co. v. Galindo*, 484 S.W. 2d 635, 637 (Tex. App. 1972); *Martinez v. Fox Valley Bus Lines*, 17 F. Supp. 576, 577 (N.D. Ill. 1936). The theory behind these holdings is the use of the word "person," as opposed to "citizen," in the Fifth and Fourteenth Amendments to the U.S. Constitution to describe the intended beneficiaries of the rights enumerated therein. *Montoya v. Gateway Ins. Co.*, 168 N.J. Super 100, 103-04 (App Div. 1979). It is generally understood that allowing access to the courts will not subvert the public policy of discouraging illegal immigration because illegal aliens do not enter this country for the purpose of litigating. *Id.* at 104.

Additionally, the vast majority of states addressing the issue hold that illegal aliens are entitled to benefits under state workers' compensation statutes. *See, e.g., Mendoza v. Monmouth Recycling Corp.*, 288 N.J. Super. 240 (App. Div. 1996); *Gene's Harvesting v. Rodriguez*, 421 So.2d 701 (Fla. Dist. Ct. App.1982); *Commercial Standard Fire & Marine Co. v. Galindo*, 484 S.W.2d 635 (Tex. App.1972); *Testa v. Sorrento Rest., Inc.*, 197 N.Y.S.2d 560 (N.Y. App. Div. 1960).

Thus, it should come as no surprise that many courts hold that undocumented aliens also have the right to sue for insurance benefits. For example, in *Maldonado v. Allstate Ins. Co.*, 789 So.2d 464, 466 (Fla. Dist. Ct. App. 2001), the claimant was an illegal alien who suffered serious injuries after being struck by a car while riding a bicycle. Despite his illegal status, Maldonado applied for personal injury protection ("PIP") benefits under the Allstate policy covering the car that struck him. *Id.* Allstate denied coverage on the ground that Maldonado was not a resident of Florida, and the trial court entered judgment on a jury verdict in favor of the insurer. *Id.* at 466-67.

The Florida Court of Appeals, differentiating between "residency" and "citizenship," held that despite being an illegal alien the claimant still qualified as a resident under Florida's no-fault insurance statute, making him eligible to receive PIP benefits. *Id.* at 468-70. The court held that the "evidence and instruction at trial concerning Maldonado's illegal alien status was unfairly prejudicial because it made Maldonado's alien status, rather than his residency, the focus of the jury's attention." *Id.* at 470. The court would not allow Allstate to use the happenstance of Maldonado's alien status as a means of escaping liability for a risk it insured against and for which it was paid a premium.

A New Jersey court reached a similar result 22 years earlier in *Montoya v. Gateway Ins. Co.*, 168 N.J. Super. 100 (App. Div. 1979). There, an illegal alien who was seriously injured in an automobile accident brought suit against his insurer challenging its denial of PIP medical benefits and income continuation benefits. *Id.* at 103. The insurer argued that it was not liable under the policy because the insured's status as an illegal alien precluded any recovery. *Id.* The trial court held in favor of the insured, viewing his illegal status as irrelevant. *Id.*

The New Jersey Appellate Division held that the insured's status as an illegal alien did not preclude him from recovering PIP medical benefits. *Id.* at 105. The court rejected the insurer's suggestion that the receipt of benefits is conditioned upon the legality of the insured's presence in the United States, explaining that it would not "imply such a condition based upon some obscure considerations of public policy." *Id.* Forecasting the rationale employed by the *Maldonado* court, the *Montoya* court emphasized that the insurer may not seize on the serendipitous circumstance of the insured being an undocumented alien. "Gateway issued the policy and accepted from plaintiff a premium to assume the described risks; neither it, nor its successor, can, we conclude, be now heard to urge absolution from liability for medical expenses by the fortuity that plaintiff's presence in this country was not authorized by law." *Id.*

Regarding the insured's claim for income continuation benefits, the insurer argued that the insured's illegal status rendered his employment illegal, thereby rendering him ineligible to receive such benefits. *Montoya*, 168 N.J. Super. at 105. To bolster this argument, the insurer analogized to cases where illegal aliens were denied unemployment benefits. *Id.* at 107. In holding that Montoya's illegal alien status would not preclude him from receiving income continuation benefits, the court distinguished these benefits from the case of unemployment compensation. Unemployment compensation, the court noted, is a matter of public law, while the income continuation benefits sought by the

continued on page 4

Anthony J. Golowski II is a partner at Podvey, Meanor, Catenacci, Hildner, Cocoziello & Chattman, P.C., in Newark, NJ, whose practice areas include insurance coverage litigation, alcoholic beverage law, and commercial transactions. **Shaun A. Bean** is an associate at the firm. His practice areas include insurance coverage litigation, and labor and employment litigation.

Illegal Alien

continued from page 3

insured, though governed by legislation setting minimum standards, are a matter of private contract. *Id.* at 108. The difference is significant because "[s]hould [the insurer] be held liable on the policy, the State would not be subsidizing and indeed aiding the alien to continue his illegal presence in this country. Rather, an insurance company compensated for the risks it described and assumed would be paying in accord with its agreement." *Id.*

Illegal Alien Status May Be Used As a Sword, But Not a Shield

As we have seen in the cases of *Maldonado* and *Montoya*, an undocumented alien's illegal status will not operate to deny him the benefit of his bargain with an insurance company. Where insurance is concerned then, the insured's suit for benefits will sound in contract. *Montoya*, 168 N.J. Super. at 105. Thus, although a court will not condone a state's subsidizing and aiding an alien's bid to remain in this country illegally, insurance companies may be *required* to do so where they have accepted a premium to assume the described risks. While a discussion of whether this result makes for sound public policy is outside the scope of this article, it does highlight courts' willingness to enforce insurance policy terms regardless of the illegal alien status of one of the contracting parties.

Accordingly, insurance policies' eligibility requirements and non-coverage for fraud provisions should be enforced even as against illegal aliens. In other words, just as the fortuity of illegal alien status will not absolve an insurance company from liability for accepted risks, neither will the fortuity of an illegal alien's status shield him from an insurer's ability to void policies where its provisions are violated. Just as a person who is legally in this country cannot violate these terms and expect to receive benefits, neither can an illegal alien. In short, illegal alien status can be used as a sword — to enable illegal aliens to receive the same benefits as legal U.S. residents — but not as a shield to insulate them from eligibility requirements and fraud prevention measures to which legal residents are bound.

This principle is perhaps best illustrated where an insured makes material misrepresentations on an application for insurance. Under New Jersey law, for example, a person violates the New Jersey Insurance Fraud Prevention Act if he knowingly conceals or misrepresents any material fact when applying for an insurance policy. *See* N.J. Stat. Ann. §17:33A-4(a). Where an insured's misrepresentation is deemed "material" the insurer can void the policy. *Palisades Safety & Ins. Assoc. v. Bastien*, 344 N.J. Super. 319 (App. Div. 2001). In *Longobardi v. Chubb Ins. Co. of N.J.*, 121 N.J. 530, 541-42 (1990), the New Jersey Supreme Court held that "[a]n insured's misstatement is material if, when made, a reasonable insurer would have considered the misrepresented fact relevant to its concerns and important in determining its course of action." Courts of many other states also hold that material misrepresentations entitle the insurer to rescind an insurance policy *ab initio*. *See, e.g., W. Coast Life Ins. Co. v. Ward*, 33 Cal. Rptr. 3d 319, 323 (Cal. Ct. App. 2005); *Zilkha v. Mut. Life Ins. Co. of N.Y.*, 732 N.Y.S. 2d 51 (N.Y. App. Div. 2001); *Rohm and Haas Co. v. Cont'l Cas. Co.*, 566 Pa. 464, 476 (2001).

Recognizing that these provisions apply to both illegal and legal applicants is significant because an illegal alien may attempt to shroud his fraudulent endeavors by claiming that the insurer is denying benefits due to his illegal status. *See e.g., Perez v. Ohio Cas. Ins. Co.*, 2005 WL 2363828 (N.J. App. Div. Sept. 29, 2005); *cert. denied*, a case in which we successfully defended against just such an attempt. In the *Perez* situation, unlike *Montoya*, the insurer was not using the insured's illegal status as a basis for arguing that benefits should be denied. Instead, the insured argued that his illegal status somehow justified his knowing submission of material misrepresentations. An insured should not be permitted to use his undocumented status to camouflage material misrepresentations (or other legitimate bases for policy rescission).

An illegal alien should not be permitted to use his status in this manner. If an illegal alien is concerned that divulging information requested by the policy application will increase the risk of deportation, he can simply leave that field blank, which may result in a concealment of material fact. When false information is provided, we move from an omission to an affirmative misrepresentation.

For instance, in *Matilla v. Farmers New World Life Ins.*, 960 F. Supp. 223, 224 (N.D. Cal. 1997), an illegal alien misrepresented his immigration status on an application for a life insurance policy. After his death, the insurer denied benefits to his wife and children on account of the misrepresentation, which the insurer and the court considered to be material. *Id.* In holding that the insurer did not breach the insurance contract, the Northern District of California emphasized that "[the insured] gave an affirmatively false answer to a closed question. The logical inference from his misrepresentation is that he knew that his immigration status was important." *Id.* at 226-27 (citations omitted). While illegal aliens may not have proper identification information, they may not argue that they are required to submit false information.

Conclusion

An illegal alien may not circumvent insurance fraud safeguards simply because of his or her illegal status. The case law holding that illegal aliens are entitled to insurance benefits was meant to level the playing field, not elevate undocumented aliens to a status greater than that of their legal counterparts. Provisions that void coverage based on eligibility requirements or for material misrepresentations may not be cast aside simply by virtue of the fact that the party making the misrepresentation is an illegal alien. Strict adherence to these provisions is particularly important where, as is the case with insurance fraud, the provisions are required by public policy promulgated by state legislatures.

—❖—

PA Court Refuses to Expand Scope of Third-Party Bad Faith Liability

By William P. Shelley, Jacob C. Cohn, and Samantha M. Evans

Traditionally, courts have found bad faith in two contexts — when an insurer wrongfully denies coverage in a first-party claim and when an insurer's improper refusal to settle a third-party claim results in an excess verdict against the insured. Courts have recognized bad faith causes of action under these circumstances in light of the type of policy involved and the nature of the insured's interests that are at stake.

Under a first-party policy, an insured seeks coverage for damage or loss to the insured's own property. When an insurer denies coverage for that loss, the denial has a direct pecuniary effect on the insured. The interest of an insured seeking protection from a third party's claim under a liability policy, however, is more tenuous. So long as the insurer resolves the claim for an amount within the insurer's policy limits, its decision of whether to settle, when, or for how much, typically does not impact the insured. Of course, if the insurer's refusal to settle results in an excess verdict, the insured is exposed directly to pecuniary harm because the insured becomes legally obligated to pay those amounts beyond the policy's limits.

But what if an insured claims that the insurer's litigation and settlement conduct and decision-making has harmed it even though the insurer ultimately settles a claim *within* policy limits? Can there be a bad faith cause of action based solely on the insurer's behavior during settlement? Would the answer change if the insured claims that it lost business opportunities or suffered damage to its reputation because the insurer delayed settling the claim? The U.S. District Court for the Eastern District of Pennsylvania recently confronted these issues in *Fuss Builders-Contractors, Inc. v. Assurance Co. of Am.*, 2006 WL 2372226 (E.D. Pa., 2006), and according to that court, the answer to both questions is no.

William P. Shelley is a member of Cozen O'Connor and chair of firm's National Insurance Department. **Jacob C. Cohn** is a member of Cozen O'Connor's Insurance Coverage Practice Group. **Samantha M. Evans** is an associate in the firm's Insurance Coverage Practice Group.

MAKING A BIG *FUSS*

In *Fuss*, the district court held that settlement of a third-party claim within policy limits, irrespective of both the insurer's protracted delay in settling and harm to the insured's business, does not give rise to a bad faith cause of action. In so holding, the court "predicted" how a Pennsylvania state court would rule on the issue, citing the absence of state and federal law on point.

Fuss built an addition to the basement of the home of Morgan, a long-time client. However, Fuss failed to properly grade the floor to guard against excess water accumulating in the basement in the event of a rainstorm. After a heavy rainstorm caused extensive damage to Morgan's basement, Fuss conceded its negligence in failing to properly construct the basement. Morgan then hired Fuss to repair the damage at a cost in excess of $168,000.

Fuss tendered Morgan's claim to Assurance Insurance Company. After Assurance refused to budge from a $70,000 offer for 10 months, Morgan sued Fuss. Although Assurance appointed defense counsel, the court found that counsel employed delay tactics, failed to update Fuss on the litigation, and continued to deny any liability despite Fuss' acknowledgment of negligence and repeated pleas that Assurance settle the claim.

After counsel made two additional settlement offers, neither of which exceeded $127,000, the trial judge advised counsel to pay the full amount of the loss. But instead of settling, counsel delayed the trial by filing numerous motions *in limine*. In the face of protracted four-year litigation, Morgan stopped doing business with Fuss. Fuss claimed that it was harmed by this loss of revenue and, additionally, was forced to incur additional attorneys' fees. Assurance eventually settled the claim.

PA PRECEDENT SUPPORTS *FUSS*

Fuss thereafter filed suit against Assurance for breach of its contractual duty to act in good faith and for statutory bad faith under 42 Pa. Cons. Stat. §8371 — a claim the district court labeled as "novel." In considering Assurance's motion to dismiss, the court noted that although Pennsylvania courts recognize a bad faith cause of action for denial of coverage under a first-party claim or when an insurer's refusal to defend results in an excess verdict under a third-party claim, no Pennsylvania court, state or federal, had addressed bad faith for delay when settlement was within policy limits. Finding no case on point, the court held that there is "no recognized cause of action against an insurer for delaying settlement of a third party claim."

The court refused to hold that an insured has a cause of action for bad faith in the absence of an excess verdict. This ruling was correct and compatible with existing Pennsylvania law addressing the scope of bad faith. In *Cowden v. Aetna Casualty and Surety Co.*, 134 A.2d. 223 (1957), the Pennsylvania Supreme Court first recognized a bad faith cause of action in the third-party context. In *Cowden*, the insured tendered its defense to Aetna after an auto accident. Although Aetna knew the case could result in a verdict that exceeded the policy limits and cause financial harm to Cowden, the insurer refused to settle the case based upon a belief of no liability. Ultimately the jury returned a verdict in excess of the policy limits.

The *Cowden* court analyzed the bad faith claim by focusing on the financial impact on the insured. The court found that the insurer had a duty not to injure the insured's financial well-being unless the insurer's decision to expose the insured to a loss was based on the insurer's *bona fide* belief of success in the underlying action. Importantly, the *Cowden* court did not suggest that liability might exist for collateral injuries an insured might suffer from the litigation and/or negotiation process itself, such as Fuss' loss

continued on page 6

Bad Faith

continued from page 5

of business. Rather, *Cowden* recognized potential bad faith liability to remedy the economic injury resulting from an excess verdict.

While *Cowden* supports the *Fuss* decision not to find bad faith when settlement is within policy limits, the district court also had to address the potentially inconsistent precedent of *The Birth Center v. St. Paul Companies, Inc.*, 787 A.2d. 376 (2001). *Birth Center* involved claims of catastrophic injuries to a child allegedly due to The Birth Center's negligence during her delivery. Despite numerous settlement demands within policy limits, court recommendations to settle, and the serious possibility of a large verdict, St. Paul repeatedly refused to engage in settlement negotiations. Following an excess verdict against the insured, St. Paul agreed to indemnify The Birth Center for the full excess amount. The Birth Center nevertheless sued for bad faith, claiming business injury. The Pennsylvania Supreme Court held that St. Paul had acted in bad faith and that The Birth Center could recover compensatory damages resulting from the bad faith.

Fuss argued that *Birth Center's* finding of bad faith where the insured had not actually been exposed to any payment obligation meant that *Birth Center* had "eliminated the prerequisite of an excess verdict to establish a statutory or contractual bad faith claim for unreasonable failure to settle a third party claim." Fuss therefore argued the district court should find a bad faith cause of action even though Assurance settled the Morgan claim within policy limits. Without addressing Fuss' argument, the district court instead adopted Assurance's "more narrow reading of *Birth Center*," and distinguished *Birth Center* on the grounds that it involved an insurer's *refusal* to settle a third-party claim and not a mere *delay* in settlement. This result is also consistent with Pennsylvania cases refusing to recognize bad faith liability to third-party claimants themselves in the liability insurance context.

Because it accepted Assurance's narrow interpretation of *Birth Center*'s holding, the *Fuss* court did not reach the issue of whether *Birth Center* eliminated the need for an excess verdict as a precondition to a viable bad faith claim in the third-party setting. This is unfortunate because, properly understood, *Birth Center* did not eliminate the prerequisite of an excess verdict. Rather, *Birth Center* only held that the insurer's payment of an excess verdict does not insulate the insurer from liability for other damages the insured has suffered as a result of the entry of that verdict.

Conclusion

The *Fuss* court was asked to extend the scope of third-party bad faith under Pennsylvania law to permit an insured to bring a bad faith cause of action against an insurer for delay during settlement despite the lack of an excess verdict. Like most jurisdictions addressing the scope of bad faith, Pennsylvania courts continue to find a bad faith cause of action when an insurer exposes the insured to the financial harm of an excess verdict or settlement. However, no Pennsylvania court, state or federal, has found bad faith on facts involving delay of settlement within policy limits. By rejecting Fuss' attempt to expand the scope of third-party bad faith, the district court reaffirmed that bad faith should be used to protect the same interests protected under the policy itself: The insured's interest in not having to pay in excess of the policy limits does not displace an insurer's right to defend against third-party claims even where the insured would prefer that a claim be settled quickly.

—❖—

Litigation Conduct

continued from page 1

insurer has a right to bring or defend against a coverage action. They view evidence of post-litigation conduct as irrelevant or, if not, of limited probative value at best. These courts also recognize that procedural and ethical rules are the proper means to address inappropriate litigation conduct. As a result, insureds are not permitted to use even improper litigation behavior as evidence of "bad faith."

Rules-Based Approach: Litigation Conduct Rejected As 'Bad Faith' Evidence

Timberlake Construction Co. v. U.S. Fidelity & Guarantee Co., 71 F.3d 335 (10th Cir. 1995), exemplifies the judicial rejection of an insurer's litigation conduct as evidence of "bad faith." In *Timberlake*, the Tenth Circuit considered the insurer's appeal of an adverse jury verdict based on both Fidelity's alleged breach of a builder's risk policy and alleged "bad faith." *Id.* at 337. Fidelity argued that the trial court erroneously admitted 1) a letter from Fidelity's counsel to its adjuster stating that "[i]t looks like we have Timberlake [the insured] squirming pretty good"; 2) the fact that Fidelity filed a counterclaim against Timberlake; and 3) the fact that Fidelity moved to include another company as a third-party defendant. *Id.* at 338. Timberlake argued that these facts demonstrated the insurer's "malicious intent." *Id.*

Applying Oklahoma law, however, the Tenth Circuit held that it was error to admit evidence of such post-litigation conduct, observing "that such evidence should rarely, if ever, be allowed to serve as evidence of bad faith." *Id.* at 340. The *Timberlake* court provided sound public policy reasons for its decision. The Tenth Circuit noted that "an insurer's litigation tactics and strategy in defending a claim are not relevant to the decision to deny coverage[.]" 71 F.3d at 340 (quotation omitted). And, "[a]llowing litigation conduct to serve as evidence of bad faith would undermine an insurer's right to contest questionable claims and defend itself against such claims." *Id.* at 341. *See also Sims v. Travelers Ins. Co.*, 16 P.3d 468, 471 (Okla. Ct. App. 2000) (following *Timberlake* to conclude that insurer's motion to dismiss, discovery objections, and refusal to mediate could not constitute "bad faith").

The Tenth Circuit explained in *Timberlake* that "[i]nsurers' counsel would be placed in an untenable position if legitimate litigation conduct could be used as evidence

continued on page 7

Litigation Conduct

continued from page 6

of bad faith," because attorneys could not zealously represent insurers without risking that such aggressive representation would expose their clients to "bad faith." *Id.* In the Tenth Circuit's view, "bad faith" allegations are unnecessary because "[w]here improper litigation conduct is at issue, generally the Federal Rules of Civil Procedure provide adequate means of redress, such as motions to strike, compel discovery, secure protective orders, or impose sanctions." *Id.* (citation omitted).

Other courts have underscored that an insurer — like every other litigant — is entitled to an aggressive defense, and if litigation behavior becomes improper, the rules of civil procedure and professional conduct provide sufficient means of control. In *Knotts v. Zurich Insurance Co.*, 197 S.W.3d 512 (Ky. 2006), for example, the Kentucky Supreme Court held that allowing litigation conduct as evidence of insurer "bad faith" "threatens to turn our adversarial system on its head." *Id.* at 522. As the *Knotts* court explained, "We are confident that the remedies provided by the Rules of Civil Procedure for any wrongdoing that may occur within the context of the litigation itself render unnecessary the introduction of evidence of litigation conduct." *Id.* The court also recognized that ethical rules permitted sanctions for unethical behavior. *Id. See also Int'l Surplus Lines Ins. Co. v. Univ. of Wyo. Research Corp.*, 950 F. Supp. 1509, 1529 (D. Wyo. 1995) (admitting evidence of litigation conduct against insurers could lead to a "chilling effect" and inhibit their counsel from zealous and effective representation) *aff'd*, 52 F.3d 901 (10th Cir. 1991).

Tomaselli v. Transamerica Insurance Co., 31 Cal. Rptr.2d 224, 226 (Cal. Ct. App. 1994), is another case focusing on the distinction between conduct purely as an insurer and behavior as a litigant. There, the insured obtained a judgment reflecting both contract and tort damages based on the insurer's failure to pay a homeowner's claim. The insurer would not pay the adverse judgment. The insured then alleged a "bad faith" claim. *Id.* The *Tomaselli* court, however, concluded that because the right to the judgment did not arise under the policy, it could not form the basis for a "bad faith" claim. *Id.* at 229. Effectively, the insurer's refusal to pay the judgment was conduct as a litigant, not improper conduct within the realm of the insurer's duties as an indemnitor. *See also Ridgeway v. U.S. Life Credit Life Ins. Co.*, 793 A.2d 972, 978 (Pa. Super. Ct. 2002) (holding that the insured's "remedy for non-payment of the judgment is provided for by the Pennsylvania Rules of Civil Procedure for the enforcement of money judgments," rather than through a "bad faith" action).

Under *Tomaselli* and similar authority, the distinction between litigation conduct and insurer conduct means that discovery violations, even serious ones, cannot support a "bad faith" claim. *See, e.g.*, *Ferrar & Dimercurio v. St. Paul Mercury Ins. Co.*, 169 F.3d 43, 57 (1st Cir. 1999) (insurer's failure to timely produce important documents "might more accurately be described as a possible abuse of the discovery process than an unfair or deceptive 'business practice'"); *O'Donnell v. Allstate Ins. Co.*, 734 A.2d 901, 908-09 (Pa. Super. Ct. 1999) (holding that the "bad faith" statute "clearly does not contemplate actions for bad faith based upon allegation of discovery violations," including dilatory conduct or frivolous requests, and that the statutory "bad faith" remedy covers conduct "by an insurer in its capacity as an insurer and not as a legal adversary").

Courts also have concluded that when an insurer acts as a litigant in non-discovery areas, such as when it files pleadings and when its counsel confers with opposing lawyers, its conduct is protected. *See, e.g.*, *Amtel Corp. v. St. Paul Fire & Marine Ins. Co.*, 421 F. Supp.2d 1265, 1273 (N.D. Cal. 2006) (finding "no support ... for the proposition that counsel's statements in a meet and confer session are admissible as evidence of bad faith") (citation omitted); *Cal. Physicians' Serv. v. Superior Court*, 12 Cal. Rptr. 95, 100 (Cal. Ct. App. 1992) ("Defensive pleading, including the assertion of affirmative defenses ... even though allegedly false, interposed in bad faith, or even asserted for inappropriate purposes, cannot be used as the basis for allegations of ongoing bad faith.").

Insurance coverage litigation is fundamentally a dispute over the insurance contract's terms, but policies do not contain language that regulates the parties' litigation behavior. Ordinary "litigant behavior" such as taking depositions, promulgating discovery requests, filing responsive pleadings, and engaging in motion practice cannot fairly constitute evidence of "bad faith." The rules-based approach to prevent insureds from using litigation conduct to support "bad faith" is a principled one that relies on traditional and tested protections of the rules of procedure and ethics to ensure fairness in the litigation arena. This approach brings a "bright-line" certainty to the process and recognizes that it is unfair to hobble one of the parties to the adversarial process just because that party happens to be an insurance company.

The Ad Hoc Approach to Evidence of Litigation Conduct

Some courts appear to reason that because a coverage action does not negate contractual obligations, insurer conduct during coverage litigation can, in some circumstances, be used as evidence of "bad faith." Unlike the rules-based approach, this *ad hoc*, case-by-case treatment of litigation conduct appears to have no principled basis and tends to deny a level playing field to insurers.

For example, some cases hold that litigation conduct can be relevant to a "bad faith" claim, but only when the litigation conduct is a continuation of the insurer's wrongful pre-litigation behavior. The leading example is *White v. Western Title Ins. Co.*, 710 P.2d 309 (Cal. 1985), a widely criticized case, in which the California Supreme Court considered a first-party title insurance action brought by the insured after coverage was denied. The insured's appraiser estimated a $62,947 diminution-in-value loss because of an easement that had not been disclosed. When

continued on page 8

Sheila R. Caudle is a partner and **Jonathan Cohen** is an associate in the Washington, DC, office of Ross, Dixon & Bell, LLP. They represent insurance companies in complex coverage and other matters, including "bad faith" litigation.

Litigation Conduct

continued from page 7

coverage was denied, the insureds sued for breach of policy. After the insurer lost a summary judgment motion, it appraised the loss at $2000 and offered a $3000 settlement, which was refused. *Id.* at 312. Later, but still before trial on the breach of policy claim, the insurer offered $5000, which also was declined. *Id.* After the insurer lost phase one of the trial on liability, it offered $15,000 in settlement, which was declined. *Id.* In the trial's damages phase, the settlement offers of $3000 and $5000 as well as evidence of the insurer's litigation conduct that the insured contended was designed to delay payment on the claim were admitted to show the insurer's alleged lack of good faith (the post-liability verdict offer of $15,000 was not admitted). *Id.* at 312. Ultimately, the jury awarded $8400 for breach of contract and $20,000 for "bad faith." *Id.* at 311.

The *White* court reasoned that the carrier's narrow "duty to settle" under the policy remains in effect during litigation. Thus, settlement offers, no matter when made, reflect the insurer's conduct as an insurer, *i.e.*, activity in which the insurer would have to engage regardless of coverage litigation. The court claimed it could "draw a careful distinction between a cause of action based squarely upon a privileged communication ... and one based upon an underlying course of conduct evidenced by the communication." *Id.* at 318. Even as it recognized that the settlement offers themselves could not be the basis of an independent "bad faith" cause of action, the court nevertheless deemed them admissible to show a "course of conduct" — that the insurer "was not evaluating and seeking to resolve the [ ] claim fairly and in good faith." *Id.*; *see also Tuscon Airport Auth. v. Certain Underwriters at Lloyd's London*, 918 P.2d 1063, 1066 (Ariz. 1996) (adopting *White*).

The *White* court was itself divided on the issue, and the case has since been limited to its facts. *See, e.g., California Physicians' Service v. Superior Court*, 9 Cal. App. 4th 1321, 1328, 1330 (1992) ("We have some doubt as to the current vitality of *White*"; "*White* stands for the proposition that ridiculously low statutory offers of settlement may be introduced in a bifurcated trial, after liability has been established, as bearing on the issue of bad faith of the insurance company."). Indeed, other courts have deemed evidence of settlement offers made during coverage litigation inadmissible. *See Premium Fin. Co. v. Employers Reinsurance Co.*, 761 F. Supp. 450, 452 (W.D. La. 1991) (allowing introduction of insurer's post-litigation settlement conduct would be "absurd"); *The Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334, 351 (Haw. 1996) (holding settlement offers inadmissible to show liability).

Some other courts employing the *ad hoc* approach have found certain post-litigation events to be relevant to pre-litigation conduct or mindset. *See, e.g., Gooch v. State Farm Mut. Auto. Ins. Co.*, 712 N.E.2d 38, 43 (Ind. Ct. App. 1999) (holding post-litigation conduct relevant when insurer stopped evaluating evidence of coverage after litigation; "State Farm intentionally refused to further investigate a matter brought to its attention in order to give its counsel the factual predicate upon which to rest its Motion to Dismiss.").

Similarly, other cases tend to involve unique alleged insurer misconduct. In *Downey Savings & Loan Ass'n v. Ohio Cas. Ins. Co.*, 234 Cal. App.3d 1072 (Cal. Ct. App. 1987), the court found that the insurer's use of depositions could support a "bad faith" claim. *Id.* at 1099. The evidence was that Ohio Casualty's claims manual instructed claims personnel to "create a climate for settlement" by using depositions "to cause harassment, embarrassment, inconvenience or expense." *Id.* The insurer scheduled 18 depositions shortly before a mandatory settlement conference. *Id. See also Krisa v. Equitable Life Assurance Society*, 109 F. Supp.2d 316, 321 (M.D. Pa. 2000) (concluding that insured could proceed with "bad faith" claim based in part on an insurer's counterclaim when the counterclaim allegations were deemed "false, baseless and fraudulent"); *Fed. Mut. Ins. Co. v. Anderson*, 991 P.2d 915, 922 (Mont. 1999) (holding insurer's decision to file a meritless appeal could support a "bad faith" claim when the insurer previously was sanctioned for filing an appeal because of inconsistent positions taken on appeal, inaccurate citations to authority, and lack of merit in its appellate claims); *Commercial Union Ins. Co. v. Seven Provinces Ins. Co.*, 217 F.3d 33, 42 (1st Cir. 2000) (concluding that the insurer's assertion of "plainly barred" arguments at trial supported a "bad faith" claim when this was an "egregious manifestation of [an] obstructionist strategy ... of constantly shifting objections to payment"). Again, however, these unique-fact cases generally involve allegations of very unusual facts.

Courts themselves appear uncomfortable with an *ad hoc* approach. Even while purportedly refusing to prohibit evidence of post-filing litigation conduct outright, some courts have cautioned that such evidence is not very probative of an insurer's pre-litigation behavior or claims handling "course of conduct." *See, e.g., Graham v. Gallant Ins. Group*, 60 F.Supp.2d 632, 635 (W.D. Ky. 1999) (allowing discovery into insurer's litigation tactics, but stating that such evidence will not be admissible absent a "smoking gun"; observing that a broad application of *White* "could expand the tort of bad faith beyond its intended scope and impair the right of the insurer to defend itself"); *Palmer v. Farmers Ins. Co.*, 861 P.2d 895, 915 (Mont. 1993) (declining to impose a "blanket prohibition" on evidence of post-filing conduct, but stating that such evidence is "at best marginally probative").

The Case for Exclusion

The parties' litigation behavior in the event of a coverage dispute is not something that either party usually contemplates when entering into an insurance contract. The rules-based, "bright line" rule that excludes evidence of an insurer's litigation conduct in such disputes brings clarity and fairness to an adversarial process that some policyholder counsel have attempted to use as a setup for "bad faith." Improper litigation conduct is not without remedy in the face of procedural and ethical rules.

An *ad hoc*, case-by-case approach, in contrast, will lead only to a "chilling effect" on legitimate advocacy and representation as insurer litigants

continued on page 9

Class Action Claims

The Duty to Defend Before A Class with Covered Claimants Is Certified

By Marc S. Mayerson

A liability insurer's promise to defend its insured is at the core of the protection purchased by policyholders and, in most states, the insurer will be required to defend any suit alleging facts that possibly could result in a judgment against the insured that would be covered by the policy's duty to indemnify. A duty to defend will be found where the undisputed facts surrounding a claim — typically the language of the policy and the allegations of the complaint — permit proof of a claim potentially covered by the duty to indemnify. The complaint-allegations test, or what some jurisdictions term the eight-corners rule, results in the duty to defend being easily found by courts, commensurate with the broad contract language, and the policy's intention to afford the insured "litigation insurance" protecting against the risk and burden of litigation.

In any given liability case, the insured defendant might win, in which event no indemnity would be required, or the insured defendant might lose the case on a ground that is outside the scope of coverage; notwithstanding the possibility of results where the insurer will not have a duty to indemnify the policyholder, the insurer still has a duty to assume the defense, which duty matures at the outset of the liability case. Because the duty to defend arises based on the possibility of the duty to indemnify a complaint, rather than based on a prediction of the likely outcome or indeed the actual outcome, we typically say that the duty to defend is broader than is the duty to indemnify.

Although an insurer's duty to defend will be triggered if the allegations raise the possibility of a duty to indemnify, sometimes the complaint is unclear as to whether nestled within the allegations is a potentially covered claim. An interesting take on the issue arose in a recent 11th Circuit decision, *Hartford Acc. & Indem. Co. v. Beaver* (11th Cir. Oct. 16, 2006).

In *Beaver*, the question presented was whether an insurer has a duty to defend a putative class action where the claim of the named plaintiff would not be covered but the class was defined in a fashion so as to include covered claims by other class members — if the class were certified.

The Hartford argued that the complaint could not be deemed to include covered claims, at least until the class in fact was certified. The 11th Circuit rejected this argument, based on both class action law principles and insurance law rules. As a matter of civil procedure, the court relied on the Florida rule that putative class members' claims can be aggregated to satisfy various jurisdictional requirements. *Id.* at 11, *citing Johnson v. Plantation Gen'l Hosp., Ltd.,* 641 So.2d 58, 60 (Fla. 1994).

As a matter of insurance law, the court relied on the allegations setting forth claims that were potentially covered, even though the claimants were yet to be formally joined, finding analogous authority in *LensCrafters, Inc. v. Liberty Mut. Fire Ins. Co.*, 2005 WL 146896 (N.D. Cal. 2005). As the court analogized, if "the duty to defend arises in spite of the uncertainty and impracticality of defending wholly meritless individual claims, we think it equally clear that the duty to defend is not defeated by some uncertainty as to the merits of a class certification." Slip op. at 15.

The *Beaver* court observed that "Hartford would have ignored this basic truth about class action litigation: the fight over class certification is often the whole ball game." *Id.* at 12. Given the purpose of the litigation insurance provided pursuant to the promise to defend, "[t]he overwhelming importance of class certification to the ultimate resolution of the case militates strongly against leaving the insured without a defense until after a decision on class certification." *Id.* at 14.

The 11th Circuit furthermore sought to apply a principle of enlightened self-interest to protect the insurer from the tactical arguments of its lawyers. "Thus, the rule Hartford advocates would not only deny an insured the defense it contracted for, but also would lock insurers out of the litigation until after the critically important issue of class certification had been decided." *Id.* While an insurer's right to defend is not unfettered, the absolutist position of The Hartford of denying a defense until covered claimants are added to the case via certification "would poorly serve insurers and insureds alike." *Id.* at 15.

—❖—

Marc S. Mayerson is a partner at Washington DC's Spriggs & Hollingsworth, where he leads its national practice representing policyholders. He authors the blog *www.insurancecrawl.com*.

Litigation Conduct

continued from page 8

and their counsel attempt to avoid litigation-based allegations of "bad faith." This seriously impairs an insurer's right to have its day in court and is fundamentally unfair to insurer litigants, who have no meaningful way to identify in advance litigation behaviors that could lead to a "bad faith" claim. Indeed, the problem with such an unprincipled approach is that it tends to reflect judicial whims or unique facts rather than a clear principle or policy objective.

Finally, any approach that allows post-filing evidence to support "bad faith" claims is problematic because it allows the fact-finder to speculate about or second-guess litigation strategy. Juries are poorly equipped to understand and analyze what particular litigation behaviors indicate. It is difficult to conclude that a jury could distinguish between legitimate aggressive defense tactics and those that ostensibly reflect alleged "bad faith."

—❖—

Dispute Resolution

continued from page 2

Executive" for the initiating and responding companies, thereby making that executive responsible for compliance.

No later than the earlier of: a) 45 days from delivery of the Notice of Negotiation; or b) 15 days from delivery of the last delivered Notice of Response, corporate representatives of each party shall meet at a mutually acceptable time and place and as many times thereafter as is necessary to attempt to resolve the dispute. If the parties have not resolved the dispute within 14 days from the commencement of the first meeting, then the parties must attempt to resolve the dispute by mediation. Any insurers who have not adopted the Protocol will be invited to participate in the mediation. If one or more of the non-adopting insurers refuses to mediate, the other parties are to continue with the process unless the absent party or parties are indispensable.

A question arises here as to whether a mediation with fewer than all of the parties could ever be useful or could ever result in a final resolution of the dispute. Parties to a mediation can always either blame the absent parties or withhold settlement funds in the hopes that the absent parties will make up the difference. Additionally, even if one party were to obtain rights of action against an absent party, there are still additional and separate disputes to be resolved.

CPR recognizes that to preserve rights, a party to the dispute may need to initiate arbitration, litigation, or some other type of proceeding for any of the following reasons:

- To preserve rights under statutes of limitation or repose;
- To claim venue;
- To seek provisional relief;
- To avoid irreparable injury; and
- To preserve the status quo.

In the event it is necessary to institute arbitration or litigation, CPR believes the Protocol could act as a parallel action with insurers continuing to participate in good faith in the procedures of the Protocol. This suggestion does not seem to advance the goal of efficient resolution.

The Mediation

If the parties cannot resolve the dispute on their own within 14 days of their initial negotiation session, they are to engage in a mediation. The mediation is to be confidential, as is any proposed or final resolution. Any party that has adopted the Protocol shall be obligated to mediate in good faith "or to provide good reason for not doing so." The Protocol is riddled with the term "good faith" and often empowers each party to determine what is a "good reason" or what is appropriate. As is now common in arbitrations, it seems likely that the parties will dispute the meaning of these terms and whether conduct qualifies as "good faith" or was done with "good reason."

Truncated Discovery

Prior to the mediation, the parties are to meet in good faith and agree upon what information and documents shall be made available for copying and inspection. Under the terms of the Protocol, the parties must make available all information that is: a) in control of the parties and their agents, b) not privileged, and c) relevant to the dispute, "with the aim that such disclosure be reasonably calculated to permit an informed assessment of the basis for the claims and defenses in dispute." (Protocol, p. 11) Thus, there is wide latitude for the parties to manipulate what is produced. This too seems to be the beginning of a new battleground.

CPR has provided examples of documents that are "presumptively accessible, non-privileged and relevant, and should be made available." These include the following:

A) All underwriting files relating to the underlying claim, including those relating to the direct policy giving rise to the loss;

B) All underwriting files relating to the Agreement of Reinsurance pursuant to which the claim is being made by the Ceding Insurer;

C) All claims files of the Ceding Insurer that relate to the underlying claim, except for any opinions from in-house or outside counsel addressing the underlying claim or the reinsurance claim;

D) All documents that would be relied upon by any reinsurer to support its denial of coverage in whole or in part;

E) All documents, including policies of insurance, which may inure to the benefit of any reinsurer who is a party to the dispute.
(Protocol, p. 11)

At least seven days prior to the first session of the mediation, the parties are to deliver the Notice of Negotiation and Notice of Response, as well as any supplementation "to the degree the submitting party may consider appropriate," along with accompanying documents and other information the party deems necessary to familiarize the mediator with the dispute. (Protocol, p. 14) While this encourages organization and may aid in dispute resolution, CPR has left open the door for extensive briefing.

If a party believes it has substantial need for further document production or other materials from the opposing parties, and such parties cannot agree as to the scope of production, the parties may request a joint meeting with the mediator to resolve the discovery dispute. While the mediator cannot compel any production, CPR believes this may aid in resolving the discovery dispute. This is certainly not standard mediation practice, though it may be effective if the parties are hesitant to refuse, in front of the mediator, to produce materials.

Because the Protocol mandates that all parties shall return all materials at the conclusion of this process, the parties may find themselves in a second round of discovery if the Protocol does not result in a final resolution, and they then must litigate or arbitrate.

Selection of the Mediator

The parties are to attempt in good faith to agree upon a mediator. If this is not done promptly, they are to contact CPR, which shall confer with the parties and, within 14 calendar days, provide the names of at least five candidates. If the parties cannot

continued on page 11

Dispute Resolution

continued from page 10

agree to a mediator from the CPR list within seven days of receipt, then the parties are, on the next business day, to submit to CPR the list of the candidates ranked in descending preference. The candidate with the lowest combined score shall be the mediator. Interestingly, CPR takes responsibility for vetting conflicts and the impartiality of all candidates:

> Before proposing any mediator candidate, CPR will request that the candidate disclose any circumstances known to the candidate that would cause reasonable doubt regarding the candidate's neutrality, independence or impartiality.
>
> If such circumstances are disclosed, the individual will not serve unless all parties agree. A party may challenge a mediator candidate if it knows of circumstances giving rise to a reasonable doubt regarding that candidate's neutrality, independence or impartiality. However, any such challenge that is not asserted promptly upon learning of the basis of the challenge shall be waived. (Protocol, pp. 12-13)

As with most mediations, the Protocol mediation is nonbinding and controlled procedurally by the mediator. CPR expressly allows the mediator to obtain assistance and independent expert advice subject to the agreement and at the expense of the parties. This too could be a battleground in and of itself as the parties are put in a position to agree upon an expert.

Termination of the Mediation

In the absence of a resolution, the mediation will be deemed terminated if:

A) 90 days have expired from the date of the selection of the mediator; and

B) a written resolution has not been agreed upon by the parties; and

C) a party has given written notice to the mediator and the other parties of its intention to withdraw.
(Protocol, p. 14)

Alternatively, the mediator may conclude that further efforts would not be useful, and the mediation is then terminated. (Protocol, p. 14) While it seems unusual to terminate a mediation without the consent of the parties, this power of the mediator may be used as a threat to force the parties to agree.

If the mediation concludes without a resolution of the dispute, the mediator, with the consent of all parties, may provide an evaluation of the dispute including his or her view of the likely outcome of the dispute if brought to final arbitral award or judgment and/or his or her final proposal for a settlement. (Protocol, p. 15) While this may be helpful, it may also cement the parties' positions as the dispute proceeds to arbitration or litigation.

COMPARISON WITH OTHER DISPUTE RESOLUTION MECHANISMS

While litigation timelines vary depending upon the forum and the judge, if successful, the Protocol would greatly reduce the time and cost associated with litigation. The emphasis, however, should be on the phrase "if successful." When the parties fail to resolve their dispute at mediation, they then find themselves back at square one, having spent weeks or even months attempting to resolve their dispute through the Protocol. They then must either prepare and file litigation or begin the process of naming arbitrators.

The Protocol, if successful, does address much of the delay and increased expense now found in arbitrations. For example, when using the AIDA Reinsurance & Insurance Arbitration Society ("ARIAS") Rules, typically a panel of three arbitrators will decide the timeline for resolution of the dispute. Into this timeline are built delays for discovery disputes, expert discovery, and both initial and pre-hearing briefs and reply. Indeed, ARIAS goes so far as to suggest possible appointment of a "special master" to determine discovery disputes. ARIAS does, however, have a section of streamlined procedures wherein parties serve and respond to discovery requests before an organizational meeting so that discovery disputes may be addressed at the organizational meeting. This seems similar to the exchange of documents prior to the mediation contemplated by the Protocol. The streamlined procedures of ARIAS, however, contemplate depositions and other discovery that is avoided by the Protocol.

The rules of the American Arbitration Association ("AAA") contemplate mediation prior to arbitration if the parties so desire. Indeed, AAA suggests that the concept of mediation be included in arbitration clauses. As with ARIAS, AAA also has expedited procedures wherein a dispute is heard by a single arbitrator, extensions are limited, claims cannot be amended after an arbitrator is in place, parties may agree to resolve the dispute on briefs without a hearing, and any hearing would be only a single day. While these procedures are, in theory, efficient and cost saving, the AAA intends for them to apply only to lower-dollar disputes.

The Protocol provides an outlet to resolve a dispute more efficiently than either litigation or arbitration. It does not, however, have the teeth necessary to mandate acceptance or compliance. Additionally, it contains the seeds for tangential procedural disputes based upon the level of discretion provided to the parties.

—❖—

CASE BRIEFS

OHIO APPEALS COURT ENFORCES ABSOLUTE POLLUTION EXCLUSIONS

An insurer did not waive its right to deny coverage by defending an insured and settling a number of claims alleging damages from lead contamination, an Ohio appeals court held in enforcing absolute pollution exclusions. *The Cincinnati Insurance Co. v. Thomas*, Case No. CA2005-12-518, 2006 Ohio App. LEXIS 6449, Court of Appeals of Ohio, 12th Appellate District, Butler County (decided Dec. 11, 2006).

The case arose from development of an old skeet shooting range that was contaminated from lead pellets. The developer, Lexington Manor, Inc., learned of the contamination through an environmental assessment and retained an environmental engineering group to address the soil contamination. As part of the remediation plan, the soil was treated and buried on site, with the environmental firm certifying that the property was suitable for residential development. Lexington Manor sold 46 lots to a homebuilder, which knew of the contamination and remediation, but did not disclose this information to prospective homeowners. Some of the would-be homeowners sued when tests performed on the lots disclosed residual lead contamination.

Cincinnati Insurance Company had issued general liability and umbrella policies to Lexington Manor's owner, Harry Thomas Jr., and his company, H.T. Investments. However, Lexington Manor was not a named insured. Cincinnati defended Thomas, employees, and H.T. Investments (collectively, the "Thomas entities") and contributed funds to settle the majority of the cases against them. However, it did so pursuant to explicit reservation of rights and a non-waiver agreement.

Cincinnati then filed a declaratory judgment action seeking a judgment that it did not and does not owe a defense or indemnification to the Thomas entities for the litigation arising out of the Lexington Manor subdivision problems. The trial court granted Cincinnati's summary judgment motion, and Thomas appealed. The appeals court affirmed the judgment.

[W]aiver and estoppel cannot be invoked to create coverage under a policy where coverage otherwise does not exist.

On appeal, the Thomas entities contested Cincinnati's reliance on similar "absolute" pollution exclusions in its general liability and umbrella policies. The umbrella policy, for example, states that it does not apply to "[a]ny liability arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants … [a]t or from any premises, site or location on which any insured or any contractors or subcontractors working directly or indirectly on any insured's behalf are performing operations … to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of pollutants."

The appeals court observed that such exclusions are commonly used to eliminate all pollution claims; the majority rule is that the exclusions are unambiguous. In the court's view, the Cincinnati exclusions were unambiguous and prohibited coverage: "Thomas admittedly hired [the environmental firm] to test for and treat the lead pollution in the Lexington Manor subdivision soil. Under the plain terms of the insurance contract, such conduct clearly triggers the pollution exclusion."

The court found "no merit" in the Thomas entities' argument that the insurer waived its right to deny coverage by defending and settling a number of claims. First, waiver and estoppel cannot be invoked to create coverage under a policy where coverage otherwise does not exist. Second, Cincinnati entered into a non-waiver agreement with the insured and issued reservation of rights letters before defending the entities in each of the suits. The court observed, "Furthermore, the fact that CIC defended Thomas in litigation, alone, is not indicative of coverage because an insurance carrier may provide a defense under a reservation of rights to avoid a claim of bad faith ... The fact that CIC settled the homeowners' lawsuits does not constitute a waiver because payment of disputed coverage is left to the carriers' discretion."

—❖—

Sheila R. Caudle of Ross, Dixon & Bell, LLP, contributed this month's case brief.