RECENT DEVELOPMENTS IN INSURANCE COVERAGE LITIGATION

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I. INTRODUCTION

As could doubtless be said of any area of legal practice when viewed from a countrywide perspective, there have been many developments in the law governing the resolution of insurance coverage disputes in the past year, some important, others less so. In culling through these changes, we have made an effort to identify emerging case law that may be of continuing importance to insurance coverage practitioners in the future. This article addresses recent cases that, in our best judgment, fit these criteria. We discuss significant developments arising within a wide range of insurance contexts: fidelity bonds, CGL policies, D&O coverage, and first-party property policies. We also touch on recent developments in insurance coverage law of more general applicability, such as the duty to defend and bad faith. We trust that the passage of time will verify that our identification of emerging issues of continuing significance was correct, but even if not, all of the topics addressed in this article should be of inherent interest to insurance coverage litigators.

II. RECENT DEVELOPMENTS IN FIDELITY BOND LITIGATION: "DIRECT MEANS DIRECT"

A recent decision from the U.S. District Court for the Eastern District of Wisconsin has weighed in on the "direct" causation standard under the

employee dishonesty clause of a fidelity bond, to wit: "direct means direct." In *Universal Mortgage Corp. v. Wurttembergische Versigherung, AG.*,[1] the court strictly enforced the "direct" causation requirement under a mortgage bankers bond (the "fidelity bond"),[2] and held the insured had not incurred a "direct" financial loss, nor loss "directly resulting" from its employee's dishonest conduct, where the insured mortgage loan originator was required to repurchase loans from its investors as a result of improprieties in the loan applications. The *Universal Mortgage* decision is the most recent in a line of decisions interpreting the term "direct" narrowly in fidelity bonds, and is particularly timely following the historic collapse of the real estate, credit, and mortgage-backed securities markets that followed an extended period of unsound mortgage lending practices and rampant mortgage fraud in the United States.[3]

In *Universal Mortgage*, the insured was a mortgage loan originator that sold completed loans to secondary market investors. Universal Mortgage purchased the fidelity bond at issue from Wurttembergische Versigherung, AG and certain Underwriters at Lloyd's (collectively, "Underwriters").[4] The fidelity bond afforded indemnity coverage to Universal Mortgage under Insuring Clause 1 (the "employee dishonesty clause") in relevant part for "[d]irect financial loss sustained by [Universal Mortgage] . . . directly caused by: (a) dishonest acts by any Employee of" Universal Mortgage.[5]

A Universal Mortgage manager in Florida (an "Employee" under the fidelity bond) supervised mortgage application processing and verified compliance with standards established by Federal National Mortgage Association ("Fannie Mae"). Unbeknownst to Universal Mortgage, the manager conspired with representatives of an outside mortgage broker to accept

1. No. 09-CV-1142, 2010 WL 3060655, at *1 (E.D. Wis. July 30, 2010).

2. The mortgage banker bond at issue in *Universal Mortgage* covered more than employee dishonesty (i.e., fidelity), but the employee dishonesty insuring agreement was at issue and the authors use the generic term "fidelity bond" for convenience.

3. According to the Federal Bureau of Investigation: "In 2009, the continuing deterioration of the real estate market and the dramatic rise in mortgage delinquencies and foreclosures helped fuel the financial crisis and exposed fraudulent practices that were prevalent throughout the mortgage industry." Fed. Bur. of Investigation, 2009 Financial Crimes Report (2009), http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009. "Weak underwriting standards and unsound risk management practices, which had allowed mortgage fraud perpetrators to exploit lending institutions and avoid detection, became evident once the housing market began declining in 2006." *Id.*

4. *Universal Mortg.*, 2010 WL 3060655, at *1–2.

5. *Id.* at *2. In its entirety, the employee dishonest clause afforded coverage for:

> Direct financial loss sustained by the Assured subsequent to the Retroactive Date and discovered by the Assured during the Bond Period by reason of and directly caused by: (a) dishonest acts by any Employee of the Assured, whether committed alone or in collusion with others, which dishonest acts were committed by the Employee with the manifest intent to obtain and resulted in the receipt of Improper Personal Financial Gain for said Employee, or for the persons acting in collusion with said Employee. . . .

and approve mortgage loan applications from prospective borrowers who required down payment assistance. Fannie Mae standards precluded borrowers from obtaining down payment assistance, so the subject loans were issued in violation of Fannie Mae standards.

While Universal Mortgage originated the loans, it sold them to secondary market investors under contracts that required Universal Mortgage to repurchase the mortgages in the event they were not compliant with Fannie Mae standards. Many of the subject loans went into default and the investors discovered that the mortgages did not meet Fannie Mae standards. Universal Mortgage was required to repurchase the mortgages from the investors, and incurred a loss for which it sought coverage under the employee dishonesty clause of the fidelity bond.[6] Specifically, Universal Mortgage asserted that its "loss" was covered by the dishonest acts of the manager in processing the noncompliant loans. Underwriters denied coverage in part on the basis that Universal Mortgage did not incur a "direct financial loss" that was "directly caused by" the employee's dishonest conduct as required for coverage under the employee dishonesty clause.[7] The court agreed, and held that no coverage was afforded for Universal Mortgage's claim.[8]

In analyzing the "direct" requirement in the employment dishonesty clause, the court acknowledged that courts have not always interpreted the "direct" causation standard consistently. Some courts have interpreted "direct" causation to mean "one proximately caused by the employee's actions, such that the acts need not be the 'sole' or 'immediate' cause of the loss."[9] The *Universal Mortgage* court expressly rejected that line of cases and sided with what the Illinois Appellate Court in *RBC Mortgage Co. v. National Union Fire Insurance Co. of Pittsburgh, Pa.* referred to as the "majority" position[10]—i.e., that "direct means direct."[11]

Applying the "direct means direct" standard, the *Universal Mortgage* court held that Universal Mortgage's losses were not "directly caused by"

6. *Id.* at *4.
7. *Id.* at *5.
8. *Id.* at *6. In dicta, the court held that coverage was also precluded by an exclusion of coverage for losses resulting from the insured "having repurchased or having been required to repurchase a Real Estate Loan from an Investor." *Id.*
9. *Id.* at *6 (citing Scirex Corp. v. Fed. Ins. Co., 313 F.3d 841, 848–50 (3d Cir. 2002)). *See also* Resolution Trust Corp. v. Fid. & Deposit Co. of Md., 205 F.3d 615 (3d Cir. 2000) (applying a "proximate cause" standard to fidelity bonds). *Universal Mortgage* specifically rejected *Scirex*, and the *RBC* court discussed and rejected both *Scirex* and *RTC*.
10. 812 N.E.2d 728, 736–37 (Ill. App. Ct. 2004).
11. *Universal Mortg.*, 2010 WL 3060655, at *2 (citing Vons Cos. v. Fed. Ins. Co., 212 F.3d 489, 492–93 (9th Cir. 2000); Tri-City Nat'l Bank v. Fed. Ins. Co., 674 N.W.2d 617, 624–25 (Wis. Ct. App. 2004)).

the employee's misconduct because (1) at the time the loans were issued, it was not inevitable that the borrowers would default, and hence the loss was contingent on a future event, and (2) Universal Mortgage incurred its loss only because it was required to repurchase the loans from investors.[12] The court similarly held that Universal Mortgage had not incurred a "direct financial loss" because its losses were "contingent upon several future events," including defaults and the repurchase obligation.[13]

Universal Mortgage continues an apparent trend among courts to find that the "direct means direct" standard for causation under a fidelity bond is not satisfied for losses incurred by mortgage companies and banks with respect to repurchase obligations, even where fraud and employee dishonesty are present in procuring the underlying mortgage.[14] Given the proliferation of mortgage fraud over the past decade, the "direct means direct" analysis—while not a new legal construct—may take on increased significance in the loan repurchase context as the fallout from the credit crisis continues to unfold. The legal trend exemplified by *Universal Mortgage* merits monitoring by practitioners as well as insurers and their insureds.

III. RECENT DEVELOPMENTS IN CGL COVERAGE LITIGATION: DETERMINING THE TRIGGER OF COVERAGE IN LONG-LATENCY BODILY INJURY CASES

For nearly thirty years, the U.S. Court of Appeals for the District of Columbia Circuit's ruling in *Keene Corp. v. Insurance Co. of North America*[15] and its progeny have dictated application of the so-called continuous-trigger rule in identifying policies on the risk in a variety of settings where claimants allege bodily injury that only became discoverable after a long latency period. *Keene*, like many cases following its lead, was decided in the context of claims arising out of asbestos-related bodily injuries. Under *Keene*'s "continuous trigger" theory, coverage for asbestos-related bodily injury is triggered under each insurer's policies on the risk between the date of first exposure through manifestation.[16] At the heart of *Keene* and those decisions embracing its rationale is the presumption—based on expert medical

12. *Id*. at *3–4.
13. *Id*. at *4.
14. Direct Mortg. Corp v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 625 F. Supp. 2d 1171, 1176–78 (D. Utah 2008); *Tri-City Nat'l Bank*, 674 N.W.2d at 623–25; *RBC*, 812 N.E.2d at 736–37.
15. 667 F.2d 1034 (D.C. Cir. 1981).
16. *Id*. at 1041.

testimony at the time, or lack thereof—that "bodily injury" occurs at the microscopic level upon first inhalation of asbestos fibers and continues repeatedly at the cellular and molecular levels.[17] This long-standing medical presumption is now under attack, which can be expected to cause courts to reexamine the science that provided the "factual" basis for the continuous-trigger theory.

Our support for this assertion begins, oddly enough, with a 2010 decision by an England and Wales appellate court. The court held, in the context of an employers' liability policy, that there is no actionable injury at the time of asbestos exposure. In a consolidation of six actions, the court reversed a ruling that claimants who developed mesothelioma as a result of asbestos exposure in the workplace suffered actionable injury at the time of asbestos exposure.[18] The court based its conclusion, in large part, on its prior ruling in *Bolton Metropolitan Borough Council v. Municipal Mutual Insurance Ltd.*,[19] a case involving coverage for mesothelioma under a public liability policy. In *Bolton* the court concluded, based on evidence from five internationally recognized experts, that "actionable injury does not occur on exposure or on initial bodily changes happening at that time but only at a much later date . . . injury cannot be equated to the 'insult' received by the body when exposure first occurs."[20]

In *Butler v. Union Carbide Corp.*,[21] a Georgia trial court engaged in similar reasoning, albeit outside the context of insurance, holding that the "theory that 'any exposure' to the asbestos of Defendant's product will cause injury, also called 'the linear non-threshold' " theory, failed to meet the *Daubert* standard for admissibility of scientific evidence in the asbestos tort action.[22]

In the insurance coverage context, *Continental Casualty Co. v. Employers Insurance Co. of Wausau*[23]—known as the *Keasbey* decision after the name of the insured that brought the original action seeking coverage—

17. *See, e.g.*, Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1190, 1197 (2d Cir. 1995) (application of continuous trigger based on etiology evidence considered in 1992 trial); Owens-Ill., Inc. v. United Ins. Co., 650 A.2d 974, 978, 982–83 (N.J. 1994) (trigger decided prior to 1991 and in absence of discovery on or presentation of medical evidence); Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1215 (6th Cir. 1980), *aff'g* 451 F. Supp. 1230, 1242–43 (E.D. Mich. 1978); J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 502 (Pa. 1993) (trigger decided in 1984).

18. Employers' Liab. Ins. "Trigger" Litig., [2010] EWCA (Civ) 1096, [106]–[115] (Eng.).

19. [2006] EWCA (Civ) 50, [2006] 1 W.L.R. 1492, [18] (Eng.).

20. *Id.* at 180.

21. No. 2008CA114 (Ga. Super. Ct. June 29, 2010), *available at* http://www.dailyreportonline.com/Editorial/PDF/PDF%20Archive/0809_asbestos2.pdf.

22. *Id.*, slip op. at 8 (applying Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 593–94 (1993)).

23. 871 N.Y.S.2d 48 (App. Div. 2008) ("*Keasbey*").

applied New York's injury-in-fact trigger rule to reject the insured's claim that bodily injury occurs upon exposure to asbestos. The court noted not only that the underlying plaintiffs could not prove that injury occurred in the first year after initial exposure, but that current medical science demonstrates that asbestos can be safely inhaled without disease ever developing.[24] The *Keasbey* court observed that "one indisputable fact to emerge from medical evidence in the plethora of asbestos cases litigated in many different jurisdictions is that actual injury generally develops over time depending on a range of circumstances and conditions, but does not occur upon exposure by inhalation."[25] It concluded that insureds "are making an impermissible leap if they believe they can go forward and prove injury . . . simply by a conclusory assertion: claimant was exposed, claimant developed full-blown asbestos-related injury decades later, ergo, injury was sustained at time of exposure."[26] Since there was no proof of injury-in-fact at the time of exposure, the court held that the insured had not satisfied its burden of proving that coverage was triggered.[27]

This reappraisal of the medical evidence of asbestos-related bodily injury and the implications of that evidence in triggering insurance coverage illustrates the difficulties inherent in proving complex and, from a medical and scientific point of view, poorly understood causal relationship between exposure to a substance and emergence of a disease after a substantial latency period. Indeed, the continuing need to adopt assumptions—logical assumptions, but assumptions nonetheless—where verifiable facts are absent is epitomized by the *Bolton* court's substitution of a new presumption for the old one. The *Butler* court did not go so far; instead, it ruled that the only proof on causation available to a plaintiff with mesothelioma was inadmissible, thereby making it impossible for plaintiff to satisfy the burden of proof. For trigger-of-coverage purposes, the *Bolton* approach confines insurance coverage within a narrower time frame, while the *Butler* decision, if extended to the trigger-of-coverage context (as in *Keasbey*), would render the trigger-of-coverage question unanswerable, at least on the present state of medical knowledge. If the *Butler* outcome achieves more general acceptance, in the absence of a profound improvement in medical understanding, logically it would have the dual effect of eliminating both an underlying plaintiff's ability to recover damages for asbestos-related injuries and an insured defendant's ability to obtain a defense from its insurers.

24. *Id*. at 62.
25. *Id*.
26. *Id*. at 64.
27. *Id*.

IV. RECENT DEVELOPMENTS IN D&O COVERAGE LITIGATION: "BUMP-UP" EXCLUSIONS EFFECTIVE IN LIMITING COVERAGE

This past decade has seen a marked increase in shareholder lawsuits. There also has been an increase in lawsuits alleging that shareholders did not receive enough consideration for the sale or purchase of securities by their companies. These lawsuits arise from financial transactions whereby companies merge or otherwise dispose of their securities to raise capital. Many directors and officers ("D&O") policies contain what is referred to as an "inadequate consideration" exclusion or a "bump-up" exclusion. There is very little case law interpreting "bump-up" provisions. A recent Third Circuit decision, *Delta Financial Corp v. Westchester Surplus Insurance Co.*,[28] is particularly significant given the increased prevalence of bump-up exclusions in D&O policies and the paucity of case law interpreting this type of exclusion.

Applying New York law, the Third Circuit held that a bump-up exclusion barred coverage for a lawsuit against a subprime mortgage lender, Delta Financial.[29] The underlying action arose out of a debt restructuring transaction involving Delta Financial's securities. The transaction was a two-step process. "First, Delta Financial debt holders surrendered their unsecured notes and senior secured notes to Delta LLC, an entity formed solely to facilitate the transaction. In exchange, the note holders received certain interests in Delta LLC."[30] "Second, in exchange for Delta LLC's surrender of the notes, Delta Financial transferred to Delta LLC 'excess cashflow certificates' that it valued at approximately $153 million. Delta Financial represented the value of the excess cashflow certificates and other assets transferred to Delta LLC would equal the outstanding balance of the surrendered notes."[31] Delta LLC and others filed suit in state court alleging that the excess cashflow certificates were worth only $40 million at the time the restructuring closed.[32]

Delta Financial's D&O policies excluded claims "for Loss on account of any Claim made against any Insured: . . . based upon, arising out of, or attributable to the actual or proposed payment by the Company of allegedly inadequate . . . consideration in connection with the Company's purchase of securities issued by any company."[33] The Third Circuit held that the exclusion was unambiguous, noting that "Delta Financial has neither sug-

28. 378 F. App'x 241 (3d Cir. 2010).
29. *Id.* at 244–45.
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.* at 243.

gested an alternative, narrower meaning of the exclusion, nor pointed to any relevant extrinsic evidence of the parties' actual intent with respect to the Inadequate Consideration Exclusion."[34] Delta Financial argued that underlying claims did not fall "solely and squarely" within this exclusion because the transaction could be interpreted as a discharge of debt through a strict foreclosure on collateral under the New York Uniform Commercial Code. The Third Circuit rejected this argument, however, because the underlying complaint did not include all of the elements of a "strict foreclosure" action under New York law, nor could the unsecured creditors be deemed to have foreclosed on collateral.[35]

Lastly, the Third Circuit rejected Delta Financial's argument that an underlying cause of action for breach of the management agreement was outside the "bump-up" exclusion because "[t]hat claim could have been brought, and damages recoverable, regardless of what the Cashflow Certificates and other assets were worth at the time of the exchange."[36] Delta Financial cited to the fact that "the Underlying Plaintiffs seek only $500,000 in damages under the second cause of action, whereas they seek $110 million in damages throughout the remainder of the complaint."[37] The Third Circuit held that this cause of action, like the other underlying claims, arose from an "'actual . . . payment by the Company of allegedly inadequate . . . consideration in connection with the Company's purchase of securities issued by any company'" and was properly excluded.[38]

The *Delta Financial* decision is a timely analysis of an exclusion that is of ever-increasing importance in D&O coverage. In addition to reinforcing the general principle that courts will uphold unambiguous contractual provisions and will not entertain strained and unreasonable interpretations of insurance policies, the case also stands for the proposition that courts will enforce "bump-up" exclusions in appropriate circumstances.

V. RECENT DEVELOPMENTS IN FIRST-PARTY PROPERTY INSURANCE LITIGATION: THE MEANING OF "PHYSICAL LOSS OR DAMAGE"

The insuring clause in most property insurance policies requires that there be "physical loss or damage" to insured property.[39] This threshold require-

34. *Id*. at 244.
35. *Id*. at 245.
36. *Id*. (alteration in original).
37. *Id*.
38. *Id*. (alteration in original).
39. *See, e.g.*, ISO Standard Property Policy (CP 00 99 06 07); ISO Building and Personal Property Coverage Form (CP 00 10 06 07). *See generally* 10A Lee A. Russ & Thomas F. Segalla, Couch on Insurance § 148:46 (3d ed. 2010). "Physical" is defined to mean "of or

ment is clearly satisfied when insured property has been physically altered by perils such as fire or water. But when the structure of the property itself is unchanged, at least to the naked eye, and the insured claims the property's value, usefulness, or functionality has been destroyed or diminished, questions arise as to whether coverage is triggered under a property insurance policy.

Court interpretations of the "physical loss or damage" requirement in these types of cases have not been uniform. Some courts have found that physical loss or damage requires a physical alteration of the insured property and that mere loss of use is not physical loss or damage.[40] But other courts have found that the loss of use or functionality can, under certain circumstances, constitute physical loss or damage.[41] Recently, several courts have analyzed the "physical loss or damage" requirement, again with seemingly nonuniform results.

A. MRI Healthcare

In *MRI Healthcare Center of Glendale, Inc. v. State Farm General Insurance Co.*,[42] the Second District California Court of Appeal found that there must be some physical change or alteration in the condition of the property for

relating to things perceived through the senses as opposed to the mind; tangible or concrete." New Oxford American Dictionary 1282 (2d ed. 2005). Courts generally agree that the word "physical" modifies both "loss" and "damage." *See, e.g.*, Meridian Textiles, Inc. v. Indem. Ins. Co., No. CV 06–4766 CAS, 2008 WL 3009889, at *3 (C.D. Cal. Mar. 20, 2008); Se. Mental Health Ctr., Inc. v. Pac. Ins. Co., 439 F. Supp. 2d 831, 837 (W.D. Tenn. 2006); AFLAC, Inc. v. Chubb & Sons, Inc., 581 S.E.2d 317, 319 (Ga. Ct. App. 2003); Ward Gen. Ins. Servs., Inc. v. Emp'rs Fire Ins. Co., 7 Cal. Rptr. 3d 844, 849 (Ct. App. 2003).

40. *See, e.g.*, Yale Univ. v. CIGNA Ins. Co., 224 F. Supp. 2d 402, 412–13 (D. Conn. 2002) ("mere presence of asbestos-and lead-containing materials" is not physical loss or damage); Great N. Ins. Co. v. Benjamin Franklin Fed. Sav. & Loan Ass'n, 793 F. Supp. 259, 263 (D. Or. 1990), *aff'd*, 953 F.2d 1387 (9th Cir. 1992) (no coverage for the cost to remove asbestos from a commercial building because presence of asbestos was an economic loss and not direct physical loss or damage); Ward Gen. Ins. Servs., Inc. v. Emp'rs Fire Ins. Co., 7 Cal. Rptr. 3d 844, 851 (Ct. App. 2003) (loss of electronically stored data was not a "direct physical loss of or damage to" covered property); Pirie v. Fed. Ins. Co., 696 N.E.2d 553, 555 (Mass. App. Ct. 1998) (no coverage for the cost to remove lead paint from a 154-year-old house because presence of lead paint was not a "physical loss"); Glens Falls Ins. Co. v. Covert, 526 S.W.2d 222, 222–23 (Tex. App. 1975) (no coverage for eighty-one safety stabilizers that fell to the floor at the insured's auto supply store where there was no evidence of any physical damage to them even though the manufacturer withdrew its warranty and the units lost their merchantability).

41. *See, e.g.*, W. Fire Ins. Co. v. First Presbyterian Church, 437 P.2d 52, 54–55 (Colo. 1968) (gasoline vapor accumulation inside church rendering it uninhabitable and dangerous "equates to a direct physical loss"); Matzner v. Seaco Ins. Co., No. 96-0498-B, 1998 WL 566658, at *3–4 (Mass. Super. Ct. Aug. 12, 1998) (carbon monoxide contamination of apartment building was direct physical loss or damage); Farmers Ins. Co. of Or. v. Trutanich, 858 P.2d 1332, 1336 (Or. Ct. App. 1993) (odor produced by methamphetamine "cooking" that infiltrated house was a direct physical loss); Murray v. State Farm Fire & Cas. Co., 509 S.E.2d 1 (W. Va. 1998) (home rendered unsafe and uninhabitable because of the danger of falling rocks and boulders suffered direct physical loss).

42. 115 Cal. Rptr. 3d 27 (Ct. App. 2010).

coverage to apply. There, and as a result of storms, MRI Healthcare's landlord had to repair the roof over the room housing MRI Healthcare's MRI machine.[43] These repairs could not be undertaken until the MRI machine was demagnetized, or "ramped down."[44] But once the machine was ramped down, it failed to ramp back up.[45] MRI Healthcare claimed that this failure constituted "damage" to the MRI machine and a resulting business income loss.[46] The State Farm policy's insuring clauses required "accidental direct physical loss" to property "caused by an insured loss."[47] MRI Healthcare claimed that the storms were covered perils and were the cause of the loss so that it was entitled to recover both the cost to repair the MRI machine and the income loss sustained while the machine was inoperable.[48] But State Farm disagreed and denied coverage.[49]

In affirming summary judgment for State Farm, the court concluded that for a loss to be covered, there must be a "distinct, demonstrable, physical alteration of the property."[50] The court, quoting from a Georgia decision, reasoned that a direct physical loss "'contemplates an actual change in insured property then in a satisfactory state, occasioned by accident or other fortuitous event directly upon the property causing it to become unsatisfactory for future use or requiring that repairs be made to make it so.'"[51]

Here, the court found that there was no "distinct, demonstrable [or] physical alteration" of the MRI machine.[52] Rather, the court found that the failure of the MRI machine to satisfactorily "ramp up" was due to "the inherent nature of the machine itself" and not actual physical damage.[53] In other words, the fact that the machine was turned off and could not be turned back on did not "constitute a compensable 'direct physical loss' under the policy."[54] The court reiterated that for coverage to apply, "some *external force* must have acted upon the insured property to cause a *physical change* in the condition of the property."[55]

43. *Id.* at 31.
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.* at 32.
50. *Id.* at 37.
51. *Id.* (quoting AFLAC, Inc. v. Chubb & Sons, Inc., 581 S.E.2d 317, 319 (Ga. Ct. App. 2003)).
52. *Id.* at 38. Because the accidental direct physical loss requirement was part of the policy's insuring clause, the court noted that MHC bore the burden of proof. *Id.* at 36.
53. *Id.* at 38.
54. *Id.*
55. *Id.* (emphasis in original).

B. Universal Image

In *Universal Image Productions, Inc. v. Chubb Corp.*,[56] a federal district judge in Michigan also found that there must be some physical change or alteration in the condition of the property for coverage to apply. There, after a heavy rainfall, a foul odor began to permeate the building occupied by Universal, a television production firm.[57] Subsequent testing revealed bacterial contamination in the air and water inside the duct work. Universal's landlord shut down and cleaned the air-handling system and ductwork and installed temporary cooling units. Universal claimed that this work caused a major disruption of its business activities.[58] Universal's policy with Federal Insurance Co. covered "direct physical loss or damage to building or personal property caused by or resulting from a peril not otherwise excluded."[59] Universal argued that it suffered a direct physical loss in the form of a pervasive odor and mold and bacterial contamination.[60] Federal, however, denied coverage, asserting that there was no physical loss or damage.[61]

In the subsequent coverage litigation, the trial court granted summary judgment to Federal, finding that Universal did not suffer a physical loss. First, the court noted that the term "physical" is defined "as something which has a 'material existence: perceptible especially through the senses and subject to the laws of nature.'"[62] Next, the court found that Universal had not shown that it suffered "any structural or any other tangible damage to the insured property."[63] In rejecting Universal's argument that the strong odors and the presence of mold and bacteria in its building rendered the premises useless, the court concluded that even physical damage that occurs at the molecular or microscopic level must be "distinct and demonstrable."[64] Although Universal claimed its premises had been engulfed by an appalling odor, the court found that "there is

56. 703 F. Supp. 2d 705 (E.D. Mich. 2010).
57. *Id.* at 708.
58. *Id.*
59. *Id.* at 709.
60. *Id.* There is no mention of any contamination exclusion.
61. *Id.*
62. *Id.* (quoting Merriam Webster's Online Dictionary, http://www.merriam-webster.com/dictionary/physical) (last visited Mar. 26, 2010)).
63. *Id.* at 710.
64. *Id.* (quoting Columbiaknit, Inc. v. Affiliated FM Ins. Co., No. 98–434-HU, 1999 WL 619100, at *7 (D. Or. Aug. 4, 1999)). In *Columbiaknit*, rainwater entered a building occupied by a clothing manufacturer. The rainwater saturated some of the insured's garments and fabrics, and the remaining contents of the building, including other garments and fabrics, were exposed to high humidity and mold spores for a prolonged period while the building was being dried out. *Columbiaknit*, 1999 WL 619100, at *1. The court found that garments and fabrics that were water-soaked, moldy, or on which there was a "pervasive, persistent or noxious odor" sustained physical loss or damage. *Id.* at *7.

no evidence that this stench was so pervasive as to render the premises uninhabitable."[65]

C. Ward

In *TRAVCO Insurance Co. v. Ward*,[66] a federal district judge in Virginia found that physical change or alteration to property was not necessary and that a "direct physical loss" occurred where property was rendered unusable because of the presence of a noxious odor. In *Ward*, the insured sought coverage claiming that his home had been rendered uninhabitable because the walls built with "Chinese Drywall" emitted sulfide gases and other toxic chemicals through "off-gassing" that created noxious odors and caused damage and corrosion.[67] TRAVCO, whose policy provided coverage for "direct physical loss" to insured property, denied coverage, asserting that physical damage required some physical alteration or injury to the property's structure.[68]

In TRAVCO's declaratory relief action, the court found that the Ward residence had suffered a direct physical loss.[69] The court reasoned that the majority of cases on this issue appeared to support Ward's position that physical damage to the property was not necessary "where the building in question has been rendered unusable by physical forces."[70] The court found TRAVCO's cases distinguishable because they did not involve situations in which the property in question was rendered unusable.[71] The court found that, in contrast to TRAVCO's cases, Ward's home had been rendered uninhabitable by the toxic gases released by the Chinese Drywall.[72]

65. *Universal Image*, 703 F. Supp. 2d at 710.

66. 715 F. Supp. 2d 699 (E.D. Va. 2010).

67. *Id.* at 703. "Chinese Drywall" is a drywall manufactured in China that emits odors and can corrode copper piping and wiring. *See generally* Ctrs. for Disease Control & Prevention, Imported Drywall and Your Home, http://www.cdc.gov/nceh/drywall/docs/ImportedDrywallandYourHome.pdf (last visited Oct. 29, 2010).

68. *TRAVCO*, 715 F. Supp. 2d at 709.

69. *Id.* at 708.

70. *Id.* at 709 (citing Hughes v. Potomac Ins. Co., 18 Cal. Rptr. 650, 655 (Ct. App. 1962); Essex v. BloomSouth Flooring Corp., 562 F.3d 399, 406 (1st Cir. 2009); Motorists Mut. Ins. Co. v. Hardinger, 131 F. App'x 823, 825–27 (3d Cir. 2005); W. Fire Ins. Co. v. First Presbyterian Church, 437 P.2d 52, 55 (Colo. 1968); Farmers Ins. Co. v. Trutanich, 858 P.2d 1332, 1336 (Or. Ct. App. 1993); Murray v. State Farm Fire & Cas. Co., 509 S.E.2d 1, 17 (W. Va. 1998)).

71. *Id.* TRAVCO had relied on *Port Authority v. Affiliated FM Insurance Co.*, 311 F.3d 226 (3d Cir. 2002); *Whitaker v. Nationwide Mutual Fire Insurance Co.*, 115 F. Supp. 2d 612 (E.D. Va. 1999); and *Great Northern Insurance Co. v. Benjamin Franklin Federal Savings & Loan Association*, 793 F. Supp. 259 (D. Or. 1990). *TRAVCO*, 715 F. Supp. 2d 709.

72. *TRAVCO*, 715 F. Supp. 2d 709. Interestingly, the court also found that its conclusion was strengthened by the fact that "Property Damage" in the liability section of the policy was defined to include "loss of use of tangible property." *Id.* The court observed that "this definition suggests that the parties intended to define 'direct physical loss' to include total loss of use." *Id.*

But Ward's victory on the physical loss or damage issue was a hollow one because the court also found that the latent defect, faulty materials, corrosion, and pollution exclusions barred coverage for the cost of removing and replacing the Chinese Drywall and for all of the damages claimed to have been caused by the Chinese Drywall.[73]

D. *Conclusion*

As demonstrated by the *MRI Healthcare*, *Universal Image*, and *Ward* cases, disputes continue to arise between insurers and insureds as to the meaning of "physical loss or damage." In all three cases, the courts confirmed that direct physical damage was a necessary predicate to insurance coverage.

That necessary predicate was clearly absent in *MRI Healthcare*. There, the MRI equipment, after first being turned off, simply would not restart. That is not physical loss or damage. The outcomes in *Universal Image* and *Ward*, both of which involved primarily damage from odors, seemed to turn on the effect of those odors. In *Ward*, the insured's home became uninhabitable, but in *Universal Image*, there was no evidence that was the case.

Some insureds may argue that *Ward* stands for the broad proposition that any loss of use or functionality of insured property constitutes "physical loss or damage." But the case cannot be read that broadly. In *Ward*, there was physical damage (in the form of excluded corrosion) to wiring and copper components of the home. Furthermore, the noxious odor was sensory and in that sense "physical."

In sum, the interpretation of the physical loss or damage requirement can vary by jurisdiction. As such, insurers and insureds must be aware of the law on this issue in the applicable jurisdiction.

VI. RECENT DEVELOPMENTS IN BAD FAITH LITIGATION: BAD FAITH MAY APPLY TO AN INSURER'S FAILURE TO SETTLE WITHIN AN INSURED'S DEDUCTIBLE

In *Roehl Transport, Inc. v. Liberty Mutual Insurance Co.*,[74] the Wisconsin Supreme Court unanimously extended the common law tort of bad faith beyond "the three fact patterns described in the existing case law"[75] to an insurance company that failed to settle within its insured's high deductible amount, holding that an insured has a viable claim for bad faith when the insurance company "fails to act in good faith and exposes the insured to liability for sums within the deductible amount."[76] The court analogized

73. *Id.* at 712–18.
74. 784 N.W.2d 542 (Wis. 2010).
75. *Id.* at 552.
76. *Id.* at 555. The court thus determined that an excess liability judgment is not "a necessary prerequisite for an insured to bring a third-party bad faith claim under Wisconsin law." *Id.* at 551.

the circumstances in *Roehl* to a third-party case in which a claim exceeds the policy limits,[77] observing "[i]n both instances, the insurance company has control over settlement, the insured has direct financial exposure as a result of the insure[r]'s conduct, and the interests of the insurance company and the insured diverge."[78] The court opined, "an insurance company may not burden the insured with payment of the deductible through its failure to negotiate settlement or conduct its investigation of the claim in good faith."[79]

A Truckers/Auto Insurance Policy issued by Liberty Mutual insured Roehl Transport, Inc., up to $2 million in liability coverage.[80] The policy had a $500,000 deductible and included a provision giving Liberty the right and duty to defend Roehl and to investigate and settle any claim or suit as Liberty deemed appropriate.[81] Roehl paid a claim-handling fee and negotiated "Special Handling Instructions" that obligated Liberty to discuss and obtain Roehl's agreement "on all bodily injury settlements."[82]

Roehl's bad faith claim arose from a personal injury claim brought by a third party whose car had been rear-ended by a Roehl truck. When no settlement was reached, the injured third party sued Roehl and obtained a jury verdict in the amount of $830,400.[83] Roehl subsequently filed a bad faith claim against Liberty, alleging Liberty mishandled the claim by conducting an inadequate investigation, assigning inexperienced and high-turnover staff, and failed to make good faith efforts to achieve a settlement.

On cross motions for summary judgment, the Wisconsin circuit court determined Roehl had asserted a viable bad faith claim against Liberty under Wisconsin law.[84] Roehl's bad faith claim proceeded to jury trial. At trial, Roehl contended Liberty should have settled the third-party claim for $100,000 and sought damages for the difference in the $100,000 potential settlement and Roehl's $500,000 deductible ($400,000). Liberty argued there was no bad faith and thus no damages.

The jury determined Liberty had breached its duties owed to Roehl, that such breach "demonstrate[d] a significant disregard" of Roehl's interests, and that the failure to settle was in bad faith, awarding Roehl $127,000 in damages.[85] Both parties filed post-trial motions that the circuit court

77. *Id*. at 555.
78. *Id*.
79. *Id*.
80. *Id*. at 546.
81. *Id*. at 548.
82. *Id*. at 548 & n.8.
83. *Id*. at 548.
84. *Id*. at 549.
85. *Id*.

denied, which prompted the appeal and cross-appeal to the state supreme court.[86]

On appeal, Liberty argued that, despite a good faith duty, a corresponding cause of action for bad faith does not exist, even if an insurer breaches that duty, if policy limits are not exceeded.[87] The Wisconsin Supreme Court rejected this argument, opining that Roehl's interests (exposure of its substantial deductible) were within Liberty's control, which vested Roehl with a bad faith tort claim against Liberty for breach of its duty of good faith.[88]

While fact specific, the Wisconsin court's holding relies upon the well-accepted rationale that, when an insurance company's interests conflict with those of its insured, the insurer's failure to handle all aspects of a claim with the utmost good faith, including potential settlement opportunities, may give rise to a claim of bad faith.[89] The court noted that "[i]n the past, an insurance company's decision to settle within policy limits generally cost an insured little because the deductible was modest."[90] Many jurisdictions have yet to be presented with a bad faith claim when a judgment within policy limits is entered against an insured. However, such claims of bad faith against insurers who fail to settle and thereby burden their insureds with payments of high deductibles may become more prevalent, given the increasing number of policies with high deductibles.

Few courts have addressed this precise issue, and those that have are not in agreement.[91] The common law of bad faith may continue to develop as a

86. *Id*. at 550. The Wisconsin Supreme Court determined five issues on Roehl's appeal and Liberty's cross-appeal, the first of which is analyzed herein. The court also determined that the jury's finding of bad faith and award of damages were supported by the evidence; judicial public policy did not preclude Roehl's bad faith claim; Roehl was entitled to attorney fees as a matter of law upon the jury's bad faith finding; and the circuit court did not err in denying Roehl's punitive damages claim. *Id*. at 578. Thus, the court affirmed the circuit court's judgment and order awarding Roehl damages on its bad faith claim and denying punitive damages, reversed the circuit court's denial of attorney fees, and remanded the determination as to the amount of fees recoverable by Roehl. *Id*. at 578–79.

87. *Id*. at 561.

88. *Id*.

89. *Id*. at 553–54.

90. *Id*. at 546.

91. *Id*. at 563–64 & nn.41–42 (citing to the jurisdictions of New York, Texas, and Illinois). An Illinois federal district court rejected the insured's claim of bad faith under facts that had required the insured to pay a large deductible upon settlement within policy limits, opining, "[w]hile [the insured] certainly risked significant personal liability in this case because of the large deductible, that risk was exactly what it had contracted for," in *American Protection Insurance Co. v. Airborne, Inc*., 476 F. Supp. 2d 985, 995 (N.D. Ill. 2007). *But see Roehl*, 784 N.W.2d at 555 ("An insurance company's bad faith conduct exposes an insured to a set of harms not covered by the policy."). *See also* Commerce & Indus. Ins. Co. v. N. Shore Towers Mgmt. Inc., 617 N.Y.S.2d 632, 634 (Civ. Ct. 1994) ("[c]ases involving settlements within a deductible also present a potential conflict between the insured's interest in paying as small a part of the deductible as possible"); Carlisle Ins. Co. v. Twin Cnty. Recycling Corp., 2001 WL 856472, at *1–2 (Dist. Ct. May 21, 2001) (limiting *North Shore* to its facts).

natural expansion of the concept that an insurer owes to its insured a good faith duty to handle claims against its insured in a manner that places the insured's interests, at a minimum, on par with the insurer's.[92] Equating the risk of "significant personal liability" because of a large deductible to a risk that was exactly what the insured had contracted to bear provides another perspective in evaluating this issue.[93]

Courts of other jurisdictions will likely weigh the conflict between insurers and insureds created by large deductibles and settlements within policy limits within the framework of well-established tenets that allow parties the freedom to contract and to assume known financial risks (large deductibles) in order to gain financial benefits (smaller premiums). Given the proliferation of liability policies with large deductibles, it seems unavoidable that courts will be presented with increasing numbers of bad faith claims premised upon *Roehl*'s rationale. The Wisconsin Supreme Court decision in *Roehl* portends the further extension of the common law tort of bad faith to insurance companies that fail to settle within their insureds' deductible amounts. Whether the *Roehl* holding ultimately will represent the majority view or a minority opinion remains to be seen.

VII. RECENT DEVELOPMENTS IN LITIGATION OVER THE DUTY TO DEFEND

A. *CGL Carrier's Duty to Defend No-Injury Consumer Class Action Complaints*

When does a CGL insurer have a duty to defend a so-called no-injury consumer class action complaint premised on a dangerous or defective product? The Seventh Circuit recently answered that question in *Medmarc Casualty Insurance Co. v. Avent America, Inc.*,[94] holding that no duty to defend is triggered absent allegations of actual physical harm to the plaintiffs.[95] The ruling in *Avent* is significant because it curtails an insured's ability to secure a defense for consumer class action complaints unless the relief sought in the class action complaint is for damages for actual physical harm.

The facts considered by the Seventh Circuit were not atypical for consumer class actions. Avent America, Inc. ("Avent") was named as one of several defendants in a series of class action complaints relating to the

92. *See, e.g.*, Rocor Int'l Inc. v. Nat'l Union Fire Ins. Co., 966 S.W.2d 559, 569 (Tex. App 1998) (affirming jury award against insurer for settling a catastrophic automobile liability claim negligently and in bad faith).

93. *Am. Prot. Ins. Co.*, 476 F. Supp. 2d at 995.

94. 612 F.3d 607 (7th Cir. 2010).

95. *Id.* at 609.

presence of Bisphenol-A ("BPA") in baby bottles and related products Avent sold.[96] The plaintiffs and putative class members were the parents of children who purchased the BPA bottles and related products unaware of the dangers BPA exposure presented to human health.[97] The various complaints, later consolidated into multidistrict litigation, asserted the same general claim: Avent manufactured products containing BPA; Avent was aware of the large body of research that showed the BPA is harmful to humans and human health, particularly to children; and Avent marketed its products as superior in safety despite its knowledge of the dangers of BPA; parents would not have purchased the products had they been aware of the dangers associated with BPA; and on hearing of the dangers, parents stopped using the products, not receiving the full economic benefit of their purchase.[98] Since the class actions were consolidated into multidistrict litigation, the court evaluated the duty to defend by examining the allegations in the representative complaint.[99] The representative complaint defined the class as all persons who purchased Avent products containing BPA. The complaint then listed, in exhaustive detail, the health risks associated with BPA exposure.[100]

The court observed that, despite a stated concern about the health risks because of exposure to BPA, there were no allegations that any child allegedly exposed to the BPA-containing products suffered any ill effects from that exposure. There were also no allegations that the children were actually exposed to BPA. The "uniform injury" as observed by the court was that the plaintiffs in all the complaints purchased "an unusable product."[101] The complaints universally sought relief under various state consumer protection statutes, alleged breach of express and implied warranty, intentional and negligent misrepresentation, and unjust enrichment.[102]

Avent tendered defense of the class actions to Medmarc Insurance Company, Pennsylvania Insurance Company, and State Farm Fire and Casualty Company, its liability insurers. Each of these insurers issued policies that agreed to "pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage'. . . ."[103] These policies defined "bodily injury" as "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any

96. *Id*. at 609–10.
97. *Id*.
98. *Id*. at 609.
99. *Id*. at 610.
100. *Id*.
101. *Id*.
102. *Id*.
103. *Id*. at 612.

time."[104] The trial court granted the insureds' motions for summary judgment and concluded no duty to defend existed.

Avent's argument on appeal focused on the known dangers of BPA exposure.[105] Avent reasoned that, because it allegedly manufactured and distributed products known to be harmful to human health, any liability it faces in the underlying class actions is liability "*because of* bodily injury" as contemplated by the coverage grant.[106] The Seventh Circuit disagreed.

The court noted that the "problem" with Avent's argument was the absence of any allegation of actual physical harm: "Even if the underlying plaintiffs proved every factual allegation in the underlying complaints, the plaintiffs could not collect for bodily injury because the complaints do not allege any bodily injury occurred."[107]

The court also rejected Avent's contention that the decision not to allege actual harm was based on the plaintiff's whim to be able to proceed as a class action.[108] The court acknowledged the rule that insureds are generally not at the mercy of the draftsmanship skills or whims of the underlying plaintiff. But the court reasoned that the BPA class action plaintiffs' universal decision not to allege actual physical harm was no whim at all. It was instead the "strategic decision" to pursue what amounted to be a solely economic claim.[109] The court found support for this conclusion in rulings by the district court in the multidistrict litigation based on the BPA plaintiffs' admission that they sought economic damages only and not relief for physical harm.[110]

Finally, the court rejected Avent's contention that finding no duty to defend required too narrow a construction of the generally broad phrase "*because* of bodily injury" that is usually applied to the phrase "for bodily injury."[111] The court explained that even with a broadly construed "because of bodily injury" there was no allegation that tied the damages sought to physical harm caused by a BPA product.

The theory of relief in the underlying complaint is that the plaintiffs would not have purchased the products had Avent made certain information known to the consumers and therefore the plaintiffs have been economically injured. The theory of the relief is not that a bodily injury occurred and that damages flow from that bodily injury.[112]

104. *Id*.
105. *See id*. at 614.
106. *Id*.
107. *Id*.
108. *Id*. at 615.
109. *Id*.
110. *Id*.
111. *Id*. at 616.
112. *Id*. at 616.

Citing to *Healthcare Industry Liability Insurance Program v. Momence Meadows Nursing Center*,[113] the court observed that the allegations relating to the damage BPA can cause supported the economic loss claim plaintiffs asserted. It was significant that to succeed in the class action, the plaintiffs did not need to conclusively prove that BPA causes any injury.[114]

Avent was decided under Illinois substantive law. However, given that Illinois is a pro-insured duty to defend jurisdiction, *Avent* can be cited as clear authority for the proposition that insurers have no duty to defend consumer class actions asserted by disappointed purchasers seeking economic damages—even where those complaints include extensive allegations depicting the dangers to human health posed by a product. Given the reality that consumer class actions will rarely include individualized allegations of physical harm for fear of jeopardizing class certification, the *Avent* opinion represents a significant limitation on an insurer's duty to defend obligations.[115] An issue left unresolved by *Avent* is whether a claimed element of damages for medical monitoring relief constitutes damages "because of bodily injury."

In examining the lack of allegations of bodily injury in the BPA class actions, the *Avent* court noted that the BPA complaints did not allege that the plaintiffs had an increased risk of bodily injury for which they should be compensated.[116] The court also distinguished *Ace American Insurance Co. v. RC2 Corp*.[117] (in which a duty to defend was found based on exposure to lead) because that case "specifically alleged that the named plaintiffs and class members 'suffered an increased risk of serious health problems making periodic examinations reasonable and necessary.' "[118] Insureds will seize on this language to argue that, where a class action complaint includes a request for establishment of a medical monitoring fund, the complaint alleges damages "because of bodily injury" sufficient to trigger a duty to defend.[119]

113. 566 F.3d 689 (7th Cir. 2009).

114. *Avent*, 612 F.3d at 617.

115. The issue is not wholly resolved. The *Avent* court declined to follow two cases reaching the opposite conclusion finding that the analysis in those cases permitted consideration of the fact that a complaint could be amended in evaluating the duty to defend—a rule contrary to Illinois law. *Id.* at 617–18 (citing N. Ins. Co. of N.Y. v. Baltimore Bus. Comm., Inc., 68 F. App'x 414 (4th Cir. 2003); Plantronics, Inc. v. Am. Home Assur., 2008 WL 4665983 (N.D. Cal. Oct. 20 2008)). The *Northern* opinion was criticized in *Steadfast Insurance Co. v. Purdue Frederick Co*., 2006 WL 1149202 (Conn. Super. Ct. Apr. 10, 2006).

116. *Avent*, 612 F.3d at 614.

117. 568 F. Supp. 2d 946 (N.D. Ill. 2008).

118. *Avent*, 612 F.3d at 615–16.

119. The Seventh Circuit reversed *RC2* on other grounds and did not determine whether the exposure to lead paint without manifestation of physical injury constituted damages because of bodily injury. *See* Ace Am. Ins. Co. v. RC2 Corp., Inc., 600 F.3d 763 (7th Cir. 2010); *Avent* 612 F.3d at 616 n.3.

Consistent with the *Avent* court's holding requiring actual physical harm before the duty to defend attaches, insurers will argue that a claim for a medical monitoring fund—which by its very nature concedes no physical injury has yet (or may ever) occur—does not trigger the duty to defend. Without an "occurrence" there should arguably be no coverage for a fund established to ascertain if physical harm is sustained in the future—unless that relief is sought in conjunction with damages for bodily injury allegedly sustained by some of the plaintiffs. This question was addressed by the Illinois Appellate Court in *HPF, LLC v. General Star Indemnity Co*.[120]

The insured in *HPF* was sued in connection with the sale of Phen-Fen products.[121] The class action complaint sought to establish a medical monitoring fund for persons who used Phen-Fen.[122] The insured argued that the request for medical monitoring constituted damages "because of bodily injury." The Illinois Appellate court disagreed and reasoned that, because the request was in the prayer for relief, it was not allegation of bodily injury. The court also noted that the purpose of medical monitoring is to monitor the products' effects. The court declined the invitation to presume that the products caused bodily injury.[123]

Taken together, *Avent* and *HPF* appear to strictly limit, if not eliminate, the duty to defend consumer class action complaints absent allegations of damages for physical harm sustained by members of the putative class.

B. *Carrier's Right to Reimbursement of Defense Costs After a Determination of No Coverage*

Insurers that fund their insured's defense while contesting coverage often face the question of whether they may recoup those defense costs from the insured if it is later determined that the claims against the insured are not covered. The answer to this question varies; pro-reimbursement jurisdictions usually allow reimbursement as long as the insurer's reservation of rights letter specifically states that the insurer may later seek to recoup defense costs.[124] Anti-reimbursement jurisdictions typically hold that a reservation of rights letters cannot "create" a right of reimbursement; instead,

120. 788 N.E.2d 753 (Ill. App. Ct. 2003).
121. *Id*. at 754–55.
122. *Id*. at 755.
123. *Id*. at 756–58.
124. *See*, *e.g.*, Buss v. Superior Court, 939 P.2d 766, 778 (Cal. 1997). *Buss* is one of the cases cited most frequently as endorsing the view that a right of reimbursement may be premised on a reservation of rights letter.

an insurer may only obtain reimbursement where the policy contains an express provision to that effect.[125] Although courts have labeled the pro-reimbursement line of cases as the "majority view,"[126] no clear consensus appears to be emerging. If anything, the split is deepening, with several recent decisions espousing the so-called minority view.[127] Here we discuss two recent decisions that exemplify the split, a Tenth Circuit Court of Appeals decision allowing an insurer to recoup defense costs and a ruling by the Pennsylvania Supreme Court rejecting an insurer's attempts at reimbursement.

1. Pro-Reimbursement View

Valley Forge Insurance v. Health Care Management Partners[128] followed the familiar fact pattern under which most cases of this type arise. Zurich and Valley Forge agreed to defend their mutual insured, Health Care Management, in a lawsuit brought by various governmental agencies alleging Medicare fraud.[129] Both insurers agreed to defend their insureds under a reservation of rights that specifically included a reservation of the right to recoup defense costs in the event a court later agreed there was no duty to defend.[130] While the underlying lawsuit was proceeding, the insurers filed a declaratory judgment action.[131] The district court ruled in favor of the insurers, finding no coverage and that the insurers were entitled to reimbursement of defense costs.[132]

On appeal the Tenth Circuit affirmed, ruling that under Colorado law, insurers are entitled to recoup defense costs if they have reserved the right to do so.[133] The court rejected the insured's argument that allowing insurers to reserve the right to obtain reimbursement absent an express provision in the policy was contrary to Colorado law and public policy.[134] In doing so, the court relied on two decisions by the Colorado Supreme Court that

125. *See*, *e.g.*, Gen. Agents Ins. Co. of Am. v. Midwest Sporting Goods Co., 828 N.E.2d 1092, 1104 (Ill. 2005); Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1219–20 (3d Cir. 1989).

126. *See* Am. & Foreign Ins. Co. v. Jerry's Sport Ctr., Inc., 2 A.3d 526, 532 (Pa. 2010) (discussing "majority" and "minority" views).

127. *Id*.; Zurich Am. Ins. Co. v. Pub. Storage, No. 1:09cv1394, 2010 WL 3992222 (E.D. Va. Sept. 17, 2010); Blue Cross of Idaho Health Serv., Inc. v. Atl. Mut. Ins. Co., No. 1:09-CV-246-CWD, 2010 WL 3326930 (D. Idaho Aug. 23, 2010).

128. 616 F.3d 1086 (10th Cir. 2010).

129. *Id*. at 1089–90.

130. *Id*.

131. *Id*. at 1090.

132. *Id*. at 1089.

133. *Id*. at 1094.

134. *Id*. at 1091–93.

indicated that recoupment of defense costs is appropriate if a court determines that no duty to defend exists.[135] In those decisions the Colorado Supreme Court "premise[d] the insurer's entitlement to reimbursement on its having reserved that right when it provided a defense to its insured, not on any reimbursement provision in the contract itself."[136] The Tenth Circuit reasoned that the right of recoupment need not appear in the policy, citing statements by the Colorado Supreme Court that it intended to "*create a remedy* for insurers that provided defenses to insureds when coverage ultimately did not exist."[137] The Colorado approach is a compromise that balances the interests of insurers and insureds.[138] It protects insureds by encouraging insurers to defend potentially uncovered claims, while also protecting insurers as they "won't be left holding the bag if it turns out they had no duty to provide" a defense.[139] The court concluded that "[n]othing in these rules or their underlying rationales appears to turn on whether a reservation of rights clause does or doesn't appear in a particular insurance contract."[140]

2. Anti-Reimbursement View

The Pennsylvania Supreme Court took the opposite view in *American & Foreign Insurance v. Jerry's Sport Center, Inc.*[141] The underlying coverage question arose when the NAACP filed a lawsuit against Jerry's and other members of the gun industry, arguing that defendants were liable for injury resulting from a public nuisance created by the industry's failure to sell firearms in a safe manner.[142] Jerry's insurer provided a defense to Jerry's in the NAACP lawsuit under a reservation of rights, including the right to seek reimbursement of defense costs.[143] The policy itself did not contain any language providing for reimbursement.[144] The insurer then filed a lawsuit seeking a declaration that it had no duty to defend or indemnify the NACCP action, arguing that the lawsuit did not allege "bodily injury."[145]

135. *Id.* at 1091–92 (citing Hecla Mining Co. v. N.H. Ins. Co., 811 P.2d 1083, 1089 (Colo. 1991); Cotter Corp. v. Am. Empire Surplus Lines Ins. Co., 90 P.3d 814, 828 (Colo. 2004)). The Tenth Circuit also observed that the insured did not object to the reservation of rights letters and accepted the defense, although this does not appear to have been crucial to the court's holding. *Id.* at 1090.
136. *Id.* at 1092.
137. *Id.*
138. *Id.* at 1092–93 (quoting *Cotter*, 90 P.3d at 828).
139. *Id.*
140. *Id.* at 1093.
141. 2 A.3d 526 (Pa. 2010).
142. *Id.* at 529.
143. *Id.* at 530.
144. *Id.* at 544.
145. *Id.* at 530–31.

The trial court granted summary judgment for the insurer and the ruling was affirmed on appeal.[146] The insurer then filed a motion seeking reimbursement of defense costs incurred in the underlying action from the date it filed the coverage lawsuit.[147] The trial court found that the insurer was entitled to recoup its defense costs based on the doctrine of unjust enrichment.[148] The appellate court reversed, holding that the parties' relationship was governed by the terms of the insurance policy, which could not be altered by reservation of rights letters.[149]

The Supreme Court affirmed the appellate court, holding that Jerry's had no obligation to reimburse its insurer.[150] The court reasoned that a resolution in favor of the insurer does not "retroactively eliminate the insurer's duty to defend during the period of uncertainty" in cases where coverage is in question.[151] The court held that such a result would "amount to a retroactive erosion of the broad duty to defend in Pennsylvania" by making the defense obligation essentially co-extensive with the duty to indemnify.[152] The policy in question provided that the insurer would pay, with respect to "any suit against an Insured we defend . . . [a]ll expenses we incur."[153] The court observed that this language "arguably answers the question before us" because it obligated the insurer to pay "all expenses" for those claims where it provides a defense, regardless of whether it was obligated to defend under the policy.[154] Because there was no right to reimbursement in the policy, the insurer could not reserve the "right" in letters to the insured.[155] Permitting reimbursement based only on a reservation of rights letter would be "tantamount to allowing the insurer to extract a unilateral amendment" to the policy.[156]

Finally, the court considered whether an equitable right to reimbursement existed based on an unjust enrichment theory.[157] Because an insurer defends its insured at least in part to protect itself, the court reasoned that the insured had not been unjustly enriched.[158] By exercising its right to defend, an insurer is enriched by enabling it to select defense counsel and effectively control the defense so as to mitigate any future indemnity

146. *Id*. at 531.
147. *Id*.
148. *Id*. at 531–32.
149. *Id*. at 532.
150. *Id*. at 546.
151. *Id*. at 542.
152. *Id*. at 544.
153. *Id*. at 543 n.14 (alteration in original).
154. *Id*.
155. *Id*. at 544–45.
156. *Id*. at 544.
157. *Id*. at 545–46.
158. *Id*. at 545.

obligation.[159] Additionally, by defending, the insurer protects itself from the potential for a bad faith claim.[160]

3. Conclusion

In the last year, courts continued to reach conflicting decisions concerning an insurer's ability to recoup defense costs following a determination of no coverage. The pro-reimbursement view has traditionally been described as the "majority" position and while from a numerical point of view that still may be true,[161] the anti-reimbursement position appears to be on the rise. In *Jerry's Sport Center*, the Pennsylvania Supreme Court described the anti-reimbursement view as "growing," a sentiment that was echoed in a recent opinion by the District Court for the District of Idaho.[162] Indeed, the Tenth Circuit in *Valley Forge* did not use the terms "majority" or "minority"; the court observed only that state courts are "divided on how best to handle insurers' recoupment claims."[163] Of course, this division can present claims-handling difficulties for primary insurers issuing policies in multiple jurisdictions. The safest practice for those insurers who wish to recoup defense costs is to address the issue in the policy itself rather than at the claims-handling stage.

159. *Id*.
160. *Id*. at 546.
161. *See id*. at 538–39 (citing multiple cases on either side of the discussion).
162. Blue Cross of Idaho Health Serv., Inc. v. Atl. Mut. Ins. Co., No. 1:09-CV-246-CWD, 2010 WL 3326930, at *8 n.5 (D. Idaho Aug. 23, 2010).
163. *Valley Forge Ins*. 616 F.3d at 1091.