NO.: 02-0730

IN THE SUPREME COURT OF TEXAS

EXCESS UNDERWRITERS AT LLOYD'S LONDON and CERTAIN COMPANIES SUBSCRIBING SEVERALLY BUT NOT JOINTLY TO POLICY NO. **548/ta4011f01,**
Plaintiff-Respondents,

vs.

FRANK'S CASING CREW AND RENTAL TOOLS, INC.,
Defendants-Petitioners.

On A Motion For Rehearing

BRIEF OF AMICUS CURIAE UNITED POLICYHOLDERS IN SUPPORT OF PETITIONERS FRANK'S CASING CREW AND RENTAL TOOLS, INC.

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I. STATEMENT OF INTEREST OF AMICUS CURIAE

United Policyholders was founded in 1991 as a non-profit organization dedicated to educating the public on insurance issues and consumer rights. The organization is tax-exempt under Internal Revenue Code § 501(c)(3). United Policyholders is funded by donations and grants from individuals, businesses, and foundations.

In addition to serving as a resource on insurance claims for disaster victims and commercial policyholders, United Policyholders actively monitors legal and marketplace developments affecting the interests of all policyholders. United Policyholders receives frequent invitations to testify at legislative and other public hearings, and to participate in regulatory proceedings on rate and policy issues.

A diverse range of policyholders throughout the United States communicate on a regular basis with United Policyholders, which allows us to provide important and topical information to courts throughout the country via the submission of *amicus curiae* briefs in cases involving insurance principles that are likely to impact large segments of the public.

II. QUESTION PRESENTED

Whether a court may find that a policyholder implicitly agreed to reimburse an insurance company by accepting an insurance company's payment of a settlement within policy limits under a unilateral reservation of a right to reimbursement.

III. SUMMARY OF ARGUMENT

Contrary to this Court's Opinion, in the absence of a policy provision providing for reimbursement rights, it would be contrary to the purpose of insurance to

allow the insurance company to unilaterally create a right to reimbursement where none exists. The purpose of insurance is to transfer risk. In exchange for a premium, the parties agree to transfer the policyholder's risk of loss to the insurance company. The rights and duties of the parties are set forth in the insurance agreement. This Court's decision undermines the very purpose of insurance because it shifts the risks inherent in litigation and coverage decisions back onto the policyholder's shoulders—on the basis of extra-contractual rights not contained in the insurance policy. Moreover, a policyholder's exposure to liability actually increases under this ruling in the form of higher settlement costs and longer delay in resolution of coverage issues. Far from realizing benefits, the policyholder is in a worse position than it would have been in if there had been no insurance policy.

Reversing the Court of Appeals' judgment and effectively overruling its decision in Matagorda County, the majority in this case states, "we are persuaded that a right of recoupment can arise even absent an insured's express agreement to reimburse settlement payments made by an insurer if there is no coverage." Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., Case No. 02-0730, slip op. (Tex. May 27, 2005) ("Frank's Casing"); see Texas Association of Counties County Government Risk Management Pool v. Matagorda County, 52 S.W.3d 128 (Tex. 2000), reh'g overruled (Mar. 08, 2001) ("Matagorda County").

In the absence of contract terms or favorable legal principles, the Court resorts to weighing competing policy considerations as a basis for its decision to create an extra-contractual right to reimbursement of settlement funds. On the one hand, the Court says that reimbursement rights further the public policy in fostering settlements.

See Frank's Casing, at 10. On the other hand, the Court is concerned that insurance coverage should not be created where none exists--the policyholder should not realize a benefit for which it did not bargain, namely, payment of claims that are not covered under the policy. See id.

The policyholder, however, is far from realizing the benefits for which it paid its premiums. First, while encouraging settlement admittedly inures to the benefit of injured third parties, the policyholder purchased an insurance policy primarily to protect itself, not third parties. Second, in its haste to refrain from "creating coverage where none exists," the Court creates a right for the insurance company that does not exist in the policy. Id. Illogically, the policyholder pays a premium and gets left shouldering the burden on both accounts.

This Court's decision seemingly advances the interests of the insurance company but leaves the policyholder in a worse position that it would have been in if there had been no policy. See Frank's Casing, at 10. Insurance becomes less likely to be a valuable risk management tool where there is a distinct possibility that insurance will actually increase a policyholder's liability. The public, policyholders, and insurance companies alike could face the negative effects of this Court's decision. Accordingly, this Court should revisit its decision in Frank's Casing.

IV. ARGUMENT

A. FRANK'S CASING'S MOTION FOR REHEARING SHOULD BE GRANTED.

The majority states that the insurance company should be entitled to settle with the injured party for an amount the policyholder has agreed is reasonable and then seek reimbursement from the policyholder if the claims against it are not covered. Id. at

9. According to the majority, the policyholder "is in the same, or at least no worse, position than it would have been in if there had been no policy." Id. Contrary to the Court's view, the policyholder is indeed in a worse position than it would have been without an insurance policy.

B. THE PURPOSE OF INSURANCE IS TO INSURE.

The first and fundamental rule is that the purpose of insurance is to insure. Insurance is a means of risk transference whereby a policyholder transfers the risk of loss or the responsibility for certain costs and expenses to an insurance company in exchange for payment of a premium.[1] American industry today faces many business threatening disasters. In dealing with such catastrophes—natural and man made—businesses turn to insurance companies to save the day – and save their businesses. Liability insurance is purchased by virtually every business organization in the United States as protection. It covers a broad range of claims resulting from real or imagined bodily injury or property damage. In addition, although the main objective of an insurance policy is to transfer the risk of a specified loss, an incidental benefit a policyholder obtains by shifting the risk of loss is to avoid sustaining further losses which might result in the absence of insurance, such as a forced sale of assets to meet the liability arising from a loss.[2]

Insurance is an agreement whereby parties give valuable consideration for protection from and indemnification against loss, damage, injury, or liability. The rights and duties of the parties to the insurance contract are set forth in the insurance policy.

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1 Alan I. **Widiss,** Insurance Law, at 11 (1988).

2 Id.

Unlike a regular contract however, to a policyholder, an insurance policy is not a widget and it is not simply a contract to pay money. It is a product. It is peace of mind and an expectation that the policyholder is protected. It is an obligation backed by a fiduciary duty and a duty of good faith by the insurance company which sold the policyholder the insurance coverage. It is the very nature of the insurance contract that payment is to be made automatically without the need for a lawsuit. As one court summarized it:

> The benefit contracted for by an insured under the terms of a policy is the availability of money promptly upon the occurrence of a particular event. When an insurer refuses unreasonably to make a payment of the benefit due, or when the insurer does not pay promptly, it deprives the insured of the essence of the bargain. The insured bargained for prompt payment not a right of action against the insurer.

Kanne v. Connecticut Gen. Life Ins. Co., 607 F. Supp. 899, 907 (C.D. Cal. 1985), aff'd in part and rev'd in part, 819 F.2d 204 (9th Cir. 1986), op. withdrawn, reh'g granted, 823 F.2d 284 (9th Cir. 1987), vacated, 859 F.2d 96 (9th Cir. 1988), cert. denied, 492 U.S. 906 (1989).

For the policyholder to derive the benefit of the insurance bargain, the insurance company must protect the policyholder's interests above its own. As servants of the public, insurance companies are held to the universally high standard of 'good faith.'[3] Insurance companies recognize that "[g]ood conscience and fair dealing require that the insurer not pursue a course which is advantageous to itself while

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[3] Plaintiff's Memorandum of Law For Trial, at 1 (filed Sept. 11, 1990), Continental Cas. Co. v. Great Am. Ins. Co., No. 86-C-3938, 1990 U.S. Dist. Lexis 12807 (N.D. Ill. Sept. 28, 1990). (Attached as Ex. "A").

disadvantageous to its policyholder."[4] If the insurer is motivated by selfish purpose or by the desire to protect its own interests at the expense of its insured's interest, bad faith exists, even though the insurer's actions were not actually dishonest or fraudulent.[5]

The policyholder purchases an insurance policy, pays premiums up front and expects insurance coverage when a claim is made. The policyholder does not expect its insurance company to be motivated by a selfish desire to protect its own interests. It is clear in this case that Underwriters did not seek to protect its policyholder's interests above its own. Underwriters chose, instead, to keep the policyholder at risk, even after the dispute should have been resolved entirely. Underwriters accomplished this by unilaterally creating a reimbursement right not contained in the policy, a "right" against which the policyholder had no ability to protect itself.

C. THE INSURANCE COMPANY IS IN THE BEST POSITION TO ANALYZE AND ABSORB RISK.

An insurance company is in the business of analyzing and absorbing risk. Corporations are exposed to major disaster about once every thirty years. Insurance companies, in contrast, are faced with claims for disasters every day. The insurance company is uniquely situated to deal with the uncertainty of whether a given policyholder will sustain a loss by combining the risks of loss for many ventures of a given type into a pool. Risk is uncertainty. If all the facts about a given venture could

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[4] Appellant's Reply Brief at 20, Century Indem. Co. v. Truck Ins. Exch. of the Farmers Ins. Group, 887 P.2d 455 (Wash. Ct. App. 1995) (No. 13141-6-111). (Attached as Ex. "B").

[5] Plaintiff's Memorandum of Law For Trial, at 1 (filed Sept. 11, 1990), Continental Cas. Co. v. Great Am. Ins. Co., No. 86-C-3938, 1990 U.S. Dist. Lexis 12807 (N.D. Ill. Sept. 28, 1990). (See Ex. "A").

be known and fully understood it would be possible to know whether a loss would or would not occur. However, since only a fraction of the facts that affect an endeavor can ever be known, predictions about the occurrence of a potential loss inevitably are based partly on estimates or guesswork. "This speculative aspect is generally understood as the "element of risk in an insurance transaction."[6] Through risk distribution, insurance companies are able to successfully and profitably manage risk of loss.

Many courts have recognized that "the bargaining power of an insurance carrier vis-a-vis the bargaining power of the policyholder is disparate in the extreme." Hayseeds, Inc. v. State Farm Fire & Cas., 352 S.E.2d 73, 77 (W. Va. 1986); Miller v. Fluharty, 500 S.E. 2d 310, 318, n.10 (W. Va. 1997) (noting that the disparity of bargaining power between an insurance company and its policyholder "is apparent in the fact that insurance companies spend over $1 billion annually in litigation battles against policyholders") (citing Eugene R. Anderson & Joshua Gold, Recoverability of Corporate Counsel Fees in Insurance Coverage Disputes, 20 Am. J. Tr. Adv. 1, 3 n.5 (1996)). An insurance company is a financial colossus with unmatched resources and expertise in insurance coverage litigation.[7] In contrast, after a policyholder suffers a loss it is in a vulnerable position. Once a policyholder files a claim with its insurance company it is even more vulnerable. When a policyholder gives notice of a major loss and the insurance company denies that it owes the policyholder coverage, only the

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6 Robert E. Keeton & Alan I Widiss, Insurance Law (1988).

7 THE FACT BOOK 1998: *Property/Casualty* Insurance Facts 5 Insurance Information Institute (1998) (the insurance industry "[a]ltogether . . . has responsibility for assets totaling $3.1 trillion at the end of 1996. The property/casualty segment of the business is responsible for assets totaling $802.3 billion at the close of 1996). See also, "A World View Of Insurance Insolvency Regulation III", H. Subcomm., 103 Cong. (Comm. Print 1994) (describing insurance as "a $2.3 trillion financial industry....").

insurance company is adequately prepared for the ensuing coverage dispute. Coverage issues are generally not clear cut, or drawn clearly in black and white, and as such, coverage disputes require retention of coverage counsel and experts, and consume vast amounts of time and money. With superior resources, claims experience and litigation expertise, the balance of power is overwhelmingly tilted toward the insurance company. The Court should encourage insurance companies to make reasonable coverage decisions and force full resolution of disputes at settlement, rather then foster a situation where the policyholder is always on the defensive against its own insurance company, reassuming the risk it thought it had transferred.

Unfortunately, exploiting policyholders' financial vulnerability can be a lucrative business. First, insurance companies earn investment income--a profit--during an insurance coverage dispute with a policyholder. This is done by continuing to invest the policyholder's premiums and the reserves for the duration of the dispute. Second, insurance companies are bulk purchasers of legal services; they incur proportionately lower litigation costs than their policyholders, and can reuse work product from case to case. In stark contrast to the typical policyholder's experience, litigation is the bread and butter of insurance companies. In large part, litigation is their business. Insurance companies now admit that they are waging a "war" against policyholders.[8] In this "war," insurance companies are "institutional litigants." Insurance companies boast that they have filed "tens of thousands of briefs across the country in a number of courts and in a

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[8] Memorandum of Law of CNA in Support of Motion To Strike Amended Counterclaims, Cross-Claims and Third-Party Complaint of General Battery, at 1, Continental Cas. Co. v. General Batten, Corp., No. 93C-11-008, 1994 WL 682320 (Del. Super. Nov. 16, 1994). (Attached as Ex. "C"). The CNA Insurance Group is comprised of approximately forty-seven insurance companies. See Best's Insurance Reports: Property-Casualty United States (1997 ed.).

vast variety of contents" against their policyholders.[9] According to the former president of the Alliance of American Insurers, "[t]he liability system is fuel for the insurance engine."[10] Claims exceeding $10 million are seldom resolved without litigation."[11] In fact, the insurance industry admits that it spends over $1 billion a year battling their policyholders in court.[12]

These factors, combined with the insurance industry's tremendous collective resources and litigation experience, allow insurance companies to wage wars of attrition against individual policyholders who litigate an insurance dispute once in a lifetime.[13] Insurance companies' litigation abilities, when combined with policyholders'

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9 Brief and Appendix of Amicus Curiae Insurance Environmental Litigation Association (IELA) in Support of Continental Insurance Company, Aetna Casualty and Surety Company and Fireman's Fund Insurance Company of Newark, N.J., at 25, n.21, County of Columbia v. Continental Ins. Co., 595 N.Y.S.2d 988 (App. Div. 3d Dep't 1993) (No. 65588). (Attached as Ex. "D").

10 Franklin Nutter, Search for Stability: Industry Must Solve Problems *that* Undermine a Stable Market, Bus. Inc., June 17, 1985, at 21).

11 Richard A. Archer, Preparing *For A* 'Mega-Loss', Bus. Ins., Oct. 10, 1994, at 23. Mr. Archer is the retired deputy chairman of Jardine Insurance Brokers, Inc. See also L. Brenner, The Polluted Open Box, Corp. Fin., June/July 1995 at 34, 35 ("No matter what the policy language, if there's a significant seven-digit claim, it's not going to be covered [by the policyholder's insurance company]."); See also Eugene R. Anderson, et al., Insurance Nullification By Litigation, Risk Mgmt., Apr. 1994, at 46).

12 Brief of Amicus Curiae American Ins. Assoc. at 3, Affiliated FM Ins. Co. v. Constitution Reinsurance Corp., 626 N.E.2d 878 (Mass. 1994) (No. SJC-06165) (Attached as Ex. "E"); Leslie Schism, Tight-Fisted Insurers Fight Their Customers To Limit Bid Awards, Wall St. J., Oct. 15, 1996, at A1. Moreover, the $1 billion figure includes only what the insurance industry spends on property and casualty insurance litigation. When life and health insurance litigation expenditures are added, "the legal costs of coverage battles with policyholders may far exceed $1 billion[.]" Robert H. Gettlin, Fighting The Client, Best's Rev. PIC, Feb. 1997, at 49, 50).

13 See Eugene R. Anderson, et al., Insurance Nullification By Litigation, Risk Mgmt., Apr. 1994, at 46; Eugene R. Anderson, Is Something Wrong With Claims Handling? *Plaintiff:* Insurers Profit From Delay Litigation, Claims (Apr. 1995), at 33.

financial vulnerability, virtually guarantee an insurance company victory against an aggrieved policyholder.

Texas courts recognize that the insurance company is in the business of analyzing and allocating risk and is in the best position to assess the viability of its coverage dispute. State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696, 714 (Tex. 1996); see also Shoshone First Bank v. Pacific Employers Ins. Co., 2 P.3d 510, 516 (Wyo. 2000) (stating "[t]he question as to whether there is a duty to defend an insured is a difficult one, but because that is the business of an insurance carrier, it is the insurance carrier's duty to make that decision."); Gonzalez v. Mission Am. Ins. Co., 795 S.W.2d 734, 737 (Tex. 1990) (observing that if a policy provision is vague or ambiguous, the fault lies with the insurance company as drafter of the policy). Moreover, this Court reiterated in Mataaorda County that insurance companies are "better positioned to handle this risk, either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claims in their rate structure." Matagorda County, 52 S.W.3d 128. As such, the law in Texas should encourage insurance companies to actually perform their end of the bargain, bearing the risk of litigation with third-party claimants and the risk of funding settlements with respect to its policyholders.

D. THE RESULT IN FRANK'S CASING IS CONTRARY TO THE PURPOSE OF INSURANCE.

This Court's ruling in Frank's Casing undercuts the purpose of the insurance transaction, shifting risk back onto the policyholder's shoulders at a time when it is most vulnerable and in need of certainty. At the eleventh hour and without warning, the policyholder is forced to gamble on whether it should accept the insurance

company's offer to settle under a reservation of "reimbursement rights," or whether it should assume control of the litigation on its own, later seeking a bad faith claim against its insurance company. The insurance company is thus able to control its exposure by forcing their policyholder to bear the risk of whether a claim is covered or not.

Amicus Curiae, the Complex Insurance Claims Litigation Association ("CICLA), states in its Brief that without reimbursement rights, insurance companies are in the untenable position of having to choose between two harsh outcomes: either (a) refuse to settle and potentially face bad faith claim if it is later determined that there is coverage and insurance company acted in bad faith, or, (b) settle the third-party claim with no recourse against policyholder if it is later determined there is no coverage. (Amicus Br. at 3). "[D]enying reimbursement. . . not only ignores the coverage positions of the policy, but also allows the policyholder to obtain the benefits of coverage it never purchased." Id. Because insurance companies are "better positioned to handle this risk, either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claims in their rate structure," that is a risk the insurance company should bear, not the policyholder. See Matagorda County, 52 S.W.3d 128.

Far from "untenable," it is the insurance company's job to make coverage decisions and bear the accompanying risk. The decision in Frank's Casing fails to take into account that the fundamental purpose of the insurance contract is to transfer the risk of loss or the responsibility for certain costs and expenses to an insurance company. Instead, the Court has adopted a ruling that forces the policyholder to either: (a) accept the insurance company's tender within policy limits subject to its reservation

of rights with a possible obligation to pay a settlement beyond its means; or, (b) reject settlement within policy limits, provide its own defense/indemnification and subsequently pursue a bad faith claim against its insurance company if the claims are later determined to be covered. Either way, the policyholder is without the benefit of protection from its insurance company. As this Court noted in Matagorda Countv, the policyholder should not be required "to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means at a time when it is most vulnerable." Matagorda Countv, 52 S.W.3d at 134. Indeed, the policyholder should not be faced with this kind of decision, especially when it did not "bargain" for, or even know about an insurance company's purported right to be reimbursed.

An insurance company is not required to pay an uncovered claim, but this does not create an affirmative right to recoup payments it made with full knowledge of the facts. The Court's ruling fails to recognize that the insurance company created an extra-contractual "right" to reimbursement not contained in the policy and then settled to cut its own potential exposure should its coverage position not prevail. See Medical Malpractice Jt. Underwriting Ass'n of Mass. v. Goldberg, 680 N.E.2d 1121, 1130 (Mass. 1997). The insurance company should either (a) bear the risk that it may face a bad faith claim if it acts in bad faith; (b) bear the risk by accounting for the possibility that it may occasionally pay uncovered claims; or (c) draft a policy provision creating a right to reimbursement.

1. The Court's Ruling Would Drive Up The Cost Of Settlements For Policvholders.

Settlement becomes more expensive for the policyholder where an insurance company funds a settlement then subsequently turns to the policyholder for reimbursement of the settlement funds. In fact, it is generally recognized that the very presence of insurance company funding drives up the amount of settlements. Indeed, insurance is fuel for the liability system.

It is generally recognized that most tort suits would be significantly less attractive to plaintiffs without liability insurance. See, e.g., Slotkin v. Citizens Cas. Co., 614 F.2d 301, 303 (2d Cir. 1979) (noting that "[a]ny personal injuries lawyer knows that the amount of . . . insurance coverage is generally a factor to be weighed in evaluating a case for settlement"); see also Syverud, K., *The Duty To Settle,* 76 Va. *L.* Rev. 1113, 1114 (1990). ("The value of the case, which we so often assume to be a function of the substantive tort law and costs of civil process, may be just as much a function of how much insurance coverage the defendant has purchased.").

As further evidence of the effect insurance has on settlements, the availability of insurance is vital information to litigants. Plaintiffs are entitled to discover the existence of liability insurance pursuant to the Federal Rules of Civil Procedure. According to the Advisory Committee Notes, the existence of insurance has a practical significance in the decisions lawyers make about settlement and trial preparation. Disclosure of insurance coverage enables counsel for both sides to make the same realistic appraisal of the case, so that settlement and litigation strategy are based on knowledge and not speculation. Advisory Committee Notes to Fed. R. Civ. P. 26(b)(2).

As recognized by the concurrence in this case, where a defendant lacks insurance coverage, the defendant's ability to pay becomes the paramount concern

driving settlement discussions. "If the uninsured has assets totaling $100,000, surely it would not behoove an injured plaintiff to seek a considerable larger but uncollectible judgment against him. Rather, the case will likely settle in the range of what the uninsured can pay irrespective of the amount of damages that the injured plaintiff sustained." Frank's Casing, Justice O'Neill and concurring opinion, at 4.

It follows that an insurance company's involvement in the settlement process, and seeming commitment of resources, drives up settlement amounts. The policyholder ends up with a settlement that exceeds what it would have had to pay in the absence of insurance. Even if the insurance company is in an "untenable position" of having to accept a settlement or facing bad faith liability, the insurance company should not be able to hedge its bets with the policyholder's own money. In essence, the policyholder ends up paying to undertake the insurance company's risk.

2. Time Is On Their Side--The Court's Ruling Encourages Insurance Company Delay.

Allowing an insurance company to fund a settlement prior to obtaining a determination of coverage delays resolution for the policyholder. The law should encourage vacillating insurance companies to expeditiously endorse a coverage position instead of leaving policyholders in the lurch. Since insurance companies lose profits when they defend and indemnify policyholders, their intrinsic motivation is to maximize delay and denial of their contractual obligations. "Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources . . . . " E.I. Du Pont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996).[14] As the

[14] **Mark** Pennington, *Punitive Damages For Breach of Contract: A Core Sample From The Last Ten Years,* **42 Ark.** *L.* Rev. 31, 54 (1989):

Chairman of Dow Corning has said, "it has become standard procedure for some insurance companies to procrastinate and dispute rather than honor policies with companies that become embroiled in litigation."[15]

While it is possible that a coverage dispute may not be justiciable prior to resolution of the underlying cause of action, the Texas Supreme Court has recognized that an insurance company is required to make a good faith effort to resolve any coverage disputes. Mataaorda Countv, 52 S.W.3d at 135; State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696,714 (Tex. 1996). One of the options open to an insurance company that disputes coverage is to litigate serious coverage disputes prior to acceding to a policy limits settlement demand. Indeed, Texas courts have encouraged insurance companies in Underwriters' position to seek prompt resolution of the coverage disputes in a declaratory judgment action, which does not, as Underwriters claims, necessarily expose insurance companies to bad faith claims. Mataaorda Countv, 52 S.W.3d at 135.

Delay is prejudicial to policyholders. This Court has recognized that allowing an insurance company to wait to file a declaratory judgment action benefits the insurance company, but puts the policyholder in the uncertain and precarious position of having to defend the underlying claim without knowing whether coverage exists. See

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With regard to claims for small amounts of money, the insurance company has some incentive to refuse payment because little likelihood exists that the claimant will pursue the claim. As for large claims, the insurance company may find it profitable to delay payment as long as possible to keep for itself the time value of the amount due. Finally, prolonged delays in payment may make the insured more willing to settle for less than the amount due, particularly if the insured is financially desperate.

15 Richard Hazleton, The *Tort* Monster That Ate Dow Corning, Wall St. J., May 17, 1995, at A21.

Matagorda Countv, 52 S.W.3d at 135. The situation in Frank's Casing is a good example of prejudicial insurance company delay. Underwriters determined the existence of coverage issues a full year prior to filing a declaratory judgment action against Frank's. Not only did they wait a year before bringing a declaratory judgment action, Underwriters sued their policyholder on the same day they revealed their intent to seek reimbursement of settlement funds—also the very same day that Underwriters settled the underlying action. The intent of Underwriters is clear: "The insurance company is in no hurry. It has the money. It has an army of lawyers."[16]

3. The Court's Ruling Will Have Unpredictable Results for Policvholders.

Whether a policyholder will be forced to reimburse settlement funds in the absence of a policy provision will remain very unpredictable in Texas. Frank's Casing's legacy is that courts will have to determine on a case-by-case basis whether an agreement to reimburse settlement funds is implicit in a policyholder's acceptance of settlement funds that are potentially owed under the policy. "The current jurisprudence on the issue involves a convoluted set of tangled yet important interests and policy considerations that, with slight changes in the facts, can lead to widely varying results in cases that seem quite similar." Frank's Casing, Justice Wainwright and concurring opinion, at 14 See, e.g., the difference in outcomes between Matanorda Countv and

[16] Eugene R. Anderson et al., *Why Courts Enforce Insurance Policyholders' Objectively Reasonable Expectations of Insurance Coverage,* 5 Conn. Ins. L. J. 335, 385 (1998-1999) (citing Herb Denenberg, *How Insurance Companies Avoid Payment of Claims,* Reading Eagle, May 26, 1995, at A12). Mr. Denenberg is a former Commissioner of Insurance for Pennsylvania and Professor of Insurance at the Wharton School of the University of Pennsylvania.

Frank's Casing. Uncertainty and unpredictable results are exactly what a policyholder seeks to avoid when it purchases of an insurance policy.

E. Solution

Reimbursement rights should be based on agreements between the parties. Insurance policies are contracts and the courts should not create extra-contractual rights for insurance companies that are not contained in their policies. In addition, the law in this area would be less perplexing and more predictable for courts, policyholders and insurance companies alike.

In resolving the issue of reimbursement, a factor that seems to be persuasive to the majority of courts is a policyholder's consent. See, e.g., Goldberg, 680 N.E.2d 1121 (Mass. 1997); Mt. Airy Ins. Co. v. Doe Law Firm, 668 So.2d 534 (Ala. 1995); Matagorda, 52 S.W.3d 128 (Tex. 2000); Frank's Casing. The emphasis on an agreement makes sense because the parties' relationship stems from a contract. What does not make sense is this Court's attempt to find an agreement implicit in a policyholder's acceptance of a reasonable settlement where there is a question as to coverage. An insurance company should obtain the policyholder's agreement to reimburse the insurance company up front—in the policy. This would prevent insurance companies from having to obtain a policyholder's agreement post-loss and would also relieve courts of the ability to read into a policyholder's acceptance of a fair settlement.

Other courts in analogous situations have declined to allow reimbursement rights in the absence of an express policy provision. For example, in resolving the issue of allocation of defense costs, the Supreme Court of Wyoming stated "[r]ecognizing that in other jurisdictions allocation is allowed between the insurer and the insured, we eschew this theory, and hold that unless an agreement to the

contrary is found in the policy, the insurer is liable for all of the costs of defending the action. Shoshone First Bank v. Pacific Emplovers Ins. Co., 2 P.3d 510, 514 (Wyo. 2000). The goal of this solution would be to enforce the terms of the original bargain, not to create new "fairer" deals as the court sees fit. This goal coincides with the aims of traditional contract law. There is a difference between an insurance company's reservation of rights to disclaim coverage and an agreement by the policyholder that they will reimburse the insurance company for any reasonable settlement.

Requiring reimbursement rights to be set forth in the policy would be more predictable than the current "tangled mound of considerations" the court must traverse currently. Frank's Casing, Justice Wainwright and concurring opinion, at 14. At the outset the policyholder is on notice that the insurance company may seek to recoup funds it pays in settlement, and can plan accordingly. This would also benefit the insurance company, as it would be able to charge more for a policy that does not contain reimbursement rights. See Matagorda Countv, 52 S.W.3d at 132 ("The presence or absence of a reimbursement clause in the insurance contract could affect the premium charged."). Moreover, requiring a policy provision for reimbursement rights would be more economical for the courts. The rule in its present state requires the court to make a fact intensive case by case analysis. A rule grounded in contract would eliminate this time consuming endeavor.

V. CONCLUSION

This Court's ruling renders the insurance transaction illusory, in that it enables insurance companies to go back and perpetually second guess payments made on behalf of policyholders. Further, it encourages an insurance company to act in

its own best interest rather than on behalf of its policyholder. Policyholders buy insurance –"not a lot of vexatious, time consuming, expensive litigation with [the insurance company]." Hayseeds, Inc. v. State Farm Fire & Cas., 352 S.E.2d 73, 79 (W Va. 1986). In the absence of a policy provision, an insurance company should not be able to unilaterally create a right to reimbursement.

For the foregoing reasons, United Policyholders urges that this Court should revisit its decision in Frank's Casing.

Respectfully submitted,

Dated: August 4, 2005

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RULE 11 CERTIFICATION

I hereby certify, in accordance with Texas Rule of Appellate Procedure 11(c), that this brief was prepared on behalf of Amicus Curiae United Policyholders on a pro bono basis.

Dated: August 4, 2005

By: _____
Jocelyn A. Gabrynowicz, Esq.

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the Brief of Amicus Curiae United Policyholders in support of Petitioners Frank's Casing Crew and Rental Tools, Inc., was served on counsel of record by United States certified mail, return receipt requested, on this 4th day of August, 2005, addressed as follows:

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Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CONTINENTAL CASUALTY COMPANY, an Illinois corporation, in its own right and as Subrogee of EDWARD C. LEVY COMPANY, a Michigan corporation,

Plaintiff,

vs.

GREAT AMERICAN INSURANCE COMPANY, an Ohio corporation,

Defendant.

No. 86 C 3938

Judge Brian C. Duff

MEMORANDUM OF LAW FOR TRIAL

INTRODUCTION

Insurance is an agreement whereby parties give valuable consideration for protection from and indemnification against loss, damage, injury, or liability. As servants of the public, insurance companies are held to the universally high standard of "good faith.* Frankenmuth Mutual Insurance Company v Keeley, 433 Mich. 525, 447 N.W. 2d 691 (1989). A number of factors are considered by the courts in determining if an insurer is liable for bad faith dealing with its insured. Here, several factors show Great American's unquestionable bad faith. Among the indicia of bad faith, as defined by the Michigan Courts, are:

1) Failure to keep the insured and excess carrier fully informed of all developments in the claim or suit that could reasonably affect the interests of the insured;

2) Failure to inform the insured and excess carrier of all settlement offers that do not fall within the policy limits;

3) Failure to solicit a settlement offer or initiate settlement negotiations when warranted under the circumstances;

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4) Failure to accept a reasonable compromise offer of settlement when the facts of the case or claim indicate obvious liability and serious injury;

5) Rejection of a reasonable offer of settlement within the policy limits;

6) Undue delay in accepting a reasonable offer to settle a potentially dangerous case within the policy limits where the verdict potential is high;

7) An attempt by the insurer to coerce or obtain an involuntary contribution from the insured or the excess carrier in order to settle within the policy limits;

8) Failure to make a proper investigation of the claim prior to refusing an offer of settlement within the policy limits;

9) Disregarding the advice or recommendations of an adjuster or attorney;

10) Serious and recurrent negligence by the insurer;

11) Refusal to settle a case within the policy limits following an excessive verdict when the chances of reversal on appeal are slight or doubtful.

Commercial Union Insurance Company v. Liberty Mutual Insurance Company, 426 Mich. 127, 393, N.W. 2d 161, 1565-166 (1986). It should be noted that Courts have recognized that when an insurer breaches its contract of insurance with its insured it also breaches a duty to the excess carrier. The excess carrier then assumes the rights and obligations of the insured.[1] Valentine v. Aetna Insurance Company, 564 F.2d 292, 297 (9th Cir. 1977); Peter v. Travelere Insurance Company, 375 F. Supp. 1347 (C.D. Cal. 1974).

---

[1] Michigan, in fact, recognizes the theory of equitable subrogation. Commercial union Insurance Company v Liberty Mutual Insurance Company, 426 Mich. 127, 393 N.W. 2d 161 (1986). The excess carrier, therefore, stands in the shoes of the insured. Allstate Ins. Co. v Citizens Ins. Co. of American, 188 Mich. App. 594, 325 N.W. 2d 505 (1982).

Furthermore, bad faith can exist "even though the insurer's actions were not actually dishonest or fraudulent." Commercial Union Insurance Co. v. Liberty Mutual Insurance Co., supra, 426 Mich. at 137, 393 N.W. 2d at 164.

Here, the undisputed facts illustrate clear indicia of Great American's bad faith on numerous fronts.

Moreover, Great American breached its contract of insurance to its insured and is also liable therefore to the excess carrier under subrogation.

FACTS

The Policies

Levy, a Michigan corporation, was insured by Great American, the defendant, under both a primary Comprehensive General Liability (CGL) policy, No. XO 485 8845[2] with limits of $1,000,000 per person, bodily injury liability and $1,000,000 per person, contractual bodily injury liability, and an Employer's Liability Workmen's Compensation (EL Policy, No. 104 16 77) with a limit of $100,000 per person. Levy was also insured by Continental under excess policy No. RDU 060 900 27, 87. All of the aforementioned policies were in effect on February 22, 1969. The Continental policy provided coverage above the Great American policy limits.

The Accident

On February 22, 1969, Frederick Denlar was injured while in the employ of Levy and while working at the Ford Motor Company

[2] All policies have been filed with this court and are a part of the record.

(hereinafter "Ford") plant in Dearborn, Michigan. Denlar, a truck driver, was driving a truck full of hot slag to be weighed on a scale designed, built and maintained by Levy. Ford owned the property and Levy used the premises pursuant to a contract with Ford. A ramp was constructed so as to allow dump trucks to drive up onto the scale. After weighing the truck, the driver was to drive off the scale by going forward down a similarly constructed ramp. When parked on top of the scale, the dump truck was six to ten feet above the surrounding ground.

An Investigation by Great American showed that inadequate apace was allowed for a driver to alight and unsafe guard rails, all Levy's responsibility. Great American knew that the accident involving Denlar arose solely out of Levy's negligent operations.

Denlar was injured when he opened the door of his truck and attempted to exit. He fell and landed on concrete on his neck and severed his spinal cord. The accident rendered Denlar a quadriplegic, and ultimately resulted in his death in October, 1972.

The Indemnity Contract

Levy had contracted with Ford to haul steel slag from Ford's River Rouge Michigan plant. Pursuant to the written contract with Ford, Levy was to indemnify Ford for all personal injuries that resulted from the negligence of Levy or its agents. The contract alao provided that Levy was to indemnify Ford for any loss arising from personal injuries that resulted from the combined negligence of Levy and Ford or their agents. The contract further provided

that Levy would hold Ford harmless from liability from such claims.

Great American was advised in 1976 that the indemnification agreement between Ford and Levy was valid and applicable to the Denlar accident insofar as its terms stated if Denlar were to recover against Ford. Great American was aware of the likelihood that Levy would be subject to an indemnification action if Ford were found liable to Denlar. Great American's investigation revealed that Levy built, operated, and maintained the premises under license from Ford. Great American was further aware that Ford's liability arose out of Levy's operation, and maintenance of those premises. Great American, therefore, knew that Levy, its insured, would have to indemnify Ford for any judgment that would be rendered in the Gage/Denlar v Ford suit.

Great American had been advised on August 5, 1976, by an independent attorney that Ford could be expected to pursue its indemnification rights against Levy.

Closing the File

Great American closed its file on August 1, 1977, despite the probability that its insured, Levy, would be exposed to an indemnity action by Ford. Great American notified Continental on May 28, 1978, that it had closed its claim file and that there was no reason for Continental to keep an open file. Thereafter, Great American next notified Continental on March 21, 1980, of the Ford v Levy suit.

The Underlying Lawsuit

William Gage, Administrator for the Estate of Frederick

Denlar, filed a lawsuit in 1974 against Ford Motor Company and Buffalo Scale Company in the Circuit Court of Wayne County in the State of Michigan under Case No. 74 025 590 alleging that Denlar's injuries resulted in his death on October 25, 1972, because of the negligence and breach of warranty by Ford and Buffalo Scale Company. Buffalo Scale was subsequently dismissed from the suit. Prior to trial on April 26, 1978, Ford attempted to file a third party action for indemnity against Levy. The trial judge refused to grant leave to file because of proximity to trial.

Great American's Knowledge and Lack of Settlement Offers

By August 5, 1976, Great American's investigation indicated Levy had sole and exclusive possession and control of the scale. Great American's regional claim manager at the time of trial believed that juries in Wayne County, Michigan, had a high propensity to return high verdicts in cases involving injuries of this nature and that a verdict against Ford in Gage/Denlar v Ford would probably be in excess of what Great American believed Levy's policy limits to be. Great American never made any firm settlement offers despite the fact that the case could have been settled for substantially lees than the ultimate judgment. Great American never informed Levy of its exposure should Ford be found liable.

A $1.5 million verdict was rendered against Ford. Ford then filed suit against Levy for indemnity. Great American made no offers of settlement in this suit before summary judgment was granted in Ford's favor. (Ford v Levy)

Tender of Defense

On January 5, 1976, March 31, 1976, and November 15, 1978, Ford, through its attorney, Perry Seavitt, tendered its defense in Gage/Denlar v Ford to Levy pursuant to the contract between Levy and Ford, based upon Seavitt's representations that Denlar's injuries were sustained because of a dangerous and unsafe condition of the scale designed, built and maintained by Levy in its performance under the contract. Levy notified Great American of the tender by Ford prior to January 15, 1976, in order to comply with the provisions of the Great American policies and requested Great American to provide Levy with coverage under the applicable policies. Great American ignored the aforesaid tender until December 1, 1978, at which time it declined the tender. Such refusal to accept the tender was repeated on several subsequent dates.

On November 15, 1978, Ford made a demand on Great American to assume the defense of Ford, negotiate for settlement and pay any judgment in Gage/Denlar v Ford. At the same time, Ford informed Great American that the plaintiff's attorney, Stanley Schwartz, formally demanded $350,000 on November 7, 1978, in addition to Great American's waiver of its workmen's compensation lien in the amount of $125,000 .to settle the Gage/Denlar v Ford case. Great American never informed Continental of this settlement demand.

On December 1, 1978, Great American refused to take over the defense of Ford, failed to negotiate any settlement and refused to pay any judgment in Gage/Denlar v Ford.

Settlement Opportunities

Great American did not waive its Worker's Compensation lien as a contribution to any settlement offer. Instead, Great American's representative, Reginald Johnson, assisted Gage's counsel in his action aaainst Ford in order to collect Great American's lien, thereby working directly aaainst the ultimate best interests of its insured, Levy. To pursue its own interests in the collection of its Worker's Compensation lien, Great American did not attempt to initiate a settlement.

A trial was held and on March 23, 1979, a judgment in favor of William Gage as Administrator of the Denlar Estate was entered against Ford in the amount of $1,500,000. Ford appealed the verdict in Gage/Denlar v. Ford and during the appeal, certain costs and interest were added to the original verdict, such that Foxd satisfied a judgment in excess of $2,300,000. Part of that amount was used to repay Great American's lien plus interest on that lien. Even after the ruling against Ford in Gage/Denlar v. Ford, Great American refused to settle Ford's indemnity claim against Levy.

Ford v Lew Lawsuit

In February, 1980, Ford brought suit against Levy in the Circuit Court of Wayne County in the State of Michigan to recover what it had paid to satisfy the judgment in Gage/Denlar v. Ford. Great American provided and controlled the defense of Levy in this suit. On May 6, 1983, the trial court granted Ford summary judgment, finding that Levy was obligated to indemnify Ford in the

amount of $2,351,628.29, plus costs and interests. Great American, for Levy, appealed the summary judgment order to the State of Michigan Court of Appeals, which affirmed the order of the trial court on July 23, 1985, denying the appeal. On September 3, 1985, Great American, for Levy, applied for Leave to Appeal to the Supreme Court of Michigan. The State Supreme Court denied that application. During the pendency of the appeal process in Ford v. Lew, Great American made no attempt to negotiate a settlement.

To enable the appeal in Ford v Levy to proceed, Continental's Claim Supervisor Richard Hore signed an Affidavit of Recognizance stating that Great American had primary insurance for Levy of $1 million, that Continental had excess insurance of $4 million and further agreeing that Continental would pay that portion of the judgment over $1 million if the judgment against Levy was affirmed on appeal. Hore signed the affidavit only after repeated representations from Great American that it had only $1 million of applicable coverage. Had Hore not signed the affidavit, prepared by an attorney hired by Great American to represent Levy, the appeal could not have gone forward or Levy's assets would have been seized.

On January 17, 1984, Ted Williams of Continental advised Great American that Great.American should pay the entire judgment against Levy because of Great American's bad faith and unreasonable conduct.

During the pendency of the appeal process in Ford v. Levy, Great American did not attempt to negotiate a settlement. The

amount of the judgment, plus interest and costs, ultimately amounted to $3,899,586.37.

On January 15, 1986, Ted Williams of Continental advised Great American again that Great American's applicable liability limits for Levy should be $2.1 million. Continental again stated that Great American should pay the entire claim due to Great American's bad faith.

Great American Did Not Pay Its Full Policy Limits or a Proper Portion of Interest Due

Great American did not pay any amounts under its Bodily Injury Liability Coverage or its Employer's Liability Coverage. It paid only the $1 million in coverage owing under its Contractual Liability coverage and $644,638.05 of the interest due. Continental paid $2,254,948.32 on behalf of Levy to satisfy the judgment that was in excess of the amount Great American paid to protect the insured, Levy.

Leonard Schwartz on May 5, 1986, was a partner in the law firm of Schwartz, Schwartz, Silver and Schwartz. His partner, Stanley Schwartz, had represented the plaintiff, Estate of Denlar, in the underlying case.[3] Despite this possible conflict, on March 14, 1986, Great American retained Attorney Leonard Schwartz to analyze and calculate Great American's obligation to pay the judgment against Levy and interest thereon. On May 5, 1986, Leonard Schwartz advised counsel for Ford that he had analyzed and

[3] David Tyler the attorney hired by Great American to represent Levy in Ford v Lew, had also been a partner of Stanley & Leonard Schwartz at the time Stanley Schwartz was retained to represent the Estate of Denlar.

calculated Great American's portion of the judgment and interest against Levy to be $1,644,638.05, and tendered same to Ford. On May 7, 1986, Continental attorney Richard Tonkin advised Leonard Schwartz that the figure of $2,360,272.96 was the principal judgment in the Ford v. Levy case. Tonkin also informed Schwartz that Great American had provided no one with copies of their policy.

Continental v. Great American Lawsuit

Continental brought suit in the U.S. District Court for the Northern District of Illinois, Eastern Division, on June 2, 1986, against Great American to recover all sums paid to Ford by Continental for Levy. In its Second Amended Complaint filed August 23, 1989, Continental alleges that Great American breached its contract by failing to pay all sums owing under Great American's policy and breached its duty of good faith toward Continental as excess carrier and its duty of good faith towards Levy, the insured, for whom Continental is a subrogee.

On April 27, 1989, Judge Brian Duff entered an Order on the parties' cross-motions for summary judgment whereby he found that Levy had been entitled to receive the benefits of both the $1 million Contractual Bodily Injury coverage and the $1 Million Bodily Injury Liability coverage of the Great American policy.

The Court further found that Great American had miscalculated its share of the interest on the judgment, having based it on $1 million coverage when as the Court found two coverages totalling $2 million was the correct base to determine pro rata shares. The

Court therefore found that Great American should have paid at least 85 percent of the post-judgment interest rather than the 42.5 percent that Great American had actually paid.

The Court also ruled on August 11, 1989, that Continental could amend its Complaint to add Breach of Contract counts. An Amended Complaint was filed on August 23, 1989, containing the additional counts.

I. ARGUMENT

A. GREAT AMERICAN ACTED IN BAD FAITH WEEN IT SIDED AGAINST ITS INSURED IN ITS ATTEMPT TO RECOUP ITS WORKMEN'S COMPENSATION LIEN

It is well established in Michigan that an insurer cannot maintain a separate suit against a third-party tortfeasor to recover workmen's compensation benefits paid to an employee after that employee has instituted its suit against the tortfeaeor. Harrison v. Ford Motor Company, 370 Mich. 683, 122 N.W.2d 680 (1963). The reason for this rule is that the compensation insurer is the real party in interest and it, in essence, becomes plaintiff and defendant in the same suit. Id. "Insurer's position in the apparent role of a plaintiff ... which, as above noted, it would be to its interests to have defeated, would tend to be destructive of the adverearv theory so essential to our system of administration of justice and arriving at truth and justice." Id. In fact, some jurisdictions have held that a counsel's representation that creates an appearance of impropriety warrants disqualification of the counsel in an action. Ettinger v. Cranberry Hill Corporation, 665 F.Supp. 368 (M.D.Pa. 1986).

Here, Great American's position on the plaintiff's side of the counsel table, against its insured, was unjust and amounted to a mockery of the adversary system. Great American, Levy's insurer, was in a position to use its knowledge and inside information against Levy. The interests of the insured and insurer were antagonistic in the action. "If the insurer is motivated by selfish purpose or by a desire to protect its own interests at the expense of its insured's interest, bad faith exists, even though the insurer's actions were not actually dishonest or fraudulent." Commercial Union Insurance Company v. Liberty Mutual Insurance Company, 426 Mich. 127, 393 N.W. 2d 161, 164 (1986).

Courts have held that a party may intervene in a third party action for the purpose of protecting its worker's compensation lien; however, such intervention cannot extend to that party's right to participate in the conduct or trial of the suit without the consent of the plaintiff. See, Sjoberg V. Joseph T. Ryerson & Son, Inc., 8 Ill. App. 2d 414, 132 N.E. 2d 56 (1st Dist. 1956). The Court there, though, observed that it is not necessary for a party to intervene before trial to protect its worker's compensation lien. Rather, it is sufficient that intervention be had after a jury verdict and before entry of judgment. Id. 8 Ill. App. 2d at 417. In other words, simply put, the same party cannot be both plaintiff and defendant at the same time. "It is incongruous that the same person should direct and conduct both the prosecution and the defense of the same suit, no matter in what capacity he may appear." Swope v. Swope, 173 Ala. 157, 164, 55 S.

410 (1914); See also, Globe v. Rutuers Fire Ins. Co. v. Hines, 273 F. 774 (2d Dist. 1921). Michigan, too, has recognized the injustice which results when one party, represented by insurance company attorneys, is permitted to proceed with an interest as both plaintiff and defendant. Vernan v. Gordon, 365 Mich. 21, 111 N.W. 2d 890 (1961). At the very least, defendant's conduct is subject to closer scrutiny because of his adverse interest while still representing the insured. Tennessee Farmers Mutual Insurance Company v. Wood, 277 F.2d 21, 25 (6th Cir. 1960); Cozzens v. Bazzani Building Company, 456 F.Supp. 192, 198 (E.D.Mich. 1978).

Here, defendant insurer's conduct upon close scrutiny reveals that Great American had only selfish reasons to sit at the counsel table representing Gage against Ford and ultimately against its own insured. Rather than waive its worker's compensation lien in an effort to settle the case, a case that should be settled, if at all possible, Great American representative Reginald Johnson assisted Gage's counsel in a selfish move to protect its own lien. Clearly, Great American did not give equal consideration to its insured's interesta and acted in bad faith. Great American's success in getting its lien paid exposed Levy to the indemnity action by Ford.

B. GREAT AMERICAN ACTED IN BAD FAITH WHEN IT FAILED TO DEFEND ITS OWN INSURED IN ATTEMPTING TO RECOUP ITS WORKER'S COMPENSATION LIEN.

It is well established that a primary insurer bears the duty to defend its insured if there are any theories of recovery that fall within the policy. Dochod v. Central Mutual Ins, Co., 81 Mich. App. 63, 264 N.W. 2d 122 (1978). It is also accepted by the

courts in Michigan that when an insurer's duty of representing and defending its insured and the separate duty of assuming the burden of liabilities covered by the insurance contract come into conflict, or when the mere possibility of such a conflict becomes evident, the insurer must notify its insured clearly and promptly of the existence and nature of the conflict. Cozzens v. Bazzani Bldg. Co., 456 F. Supp. 192 (E.D. Mich. 1978). Under such circumstances, the duty to defend assumes ascendancy. Id. Failure to fulfill its duty to defend the insured means, under Michigan law, that the insurer becomes liable for the full amount of the judgment along with any fees incurred. Capitol Reproduction, Inc. v. Hartford Insurance Company, 800 F. 2d 617, 624 (6th Cir. 1986). "An insurer's duty to defend is independent of its duty to pay, and damages for breach of that duty are not limited to the face amount of the policy." Stockdale v. Jamison, 416 Mich. 217, 330 N.W. 2d 389, 392 (1982).

Courts have held that any conflicts of interest between an insurer and its insured will not relieve the insurer of its duty to provide a defense. Consolidated Rail Corporation v. Hartford Accident and Indemnity Company, 676 F. Supp. 82, 86 (E.D. Pa. 1987). One solution for an insurer is that it obtain separate, independent counselselected by the insured. Id. Purdy v. Pacific Automobile Ins. Co. 157 Cal. App. 3d 59, 203 Cal. Rptr. 524 (2d Dist. 1984). Such would have been an appropriate solution here, yet it was not done. Instead, the insurer continued to represent the insurer while sitting across the table at an adversarial

proceeding. Great American never notified Levy of the inherent conflict between its own interest in collecting on the lien and Levy's interest in avoiding any exposure to an indemnity action by Ford.

Furthermore, the American Bar Association's Model Code of Professional Responsibility[4] has stated appropriate guidance on this issue. Canon 5 states: "A lawyer should exercise independent professional judgment on behalf of a client." The Second Circuit Court of Appeals has given this Canon some definition. "Where the relationship is a continuing one, adverse representation is prima facie improper ... and the attorney must be prepared to show, at the very least, that there will be no actual or apparent conflict in loyalties or diminution in the vigor of his representation." Cinema 5. Ltd. v. Cinerama, Inc., 528 F. 2d 1384, 1387 (2d Cir. 1976). (emphasis in original.) See also, Westinghouse Electric Corp. v. Kerr-McGee Corp., 580 F. 2d 1311, 1319 (7th Cir.) cert. denied, 439 U.S. 955 (1978). Suing and representing the same entities at the same the, at a minimum, evokes the appearance of impropriety. Ettinger v. Cranberry Bill Corporation, 665 F. Supp. 368, 372 (M.D. Pa. 1986).

Here, the specific terms of Great American's policy echo its obligation to defend its insured. In pertinent part it states:

> "With respect to such insurance as is afforded by this policy, the company shall: (a) defend any suit against the insured alleging such injury, sickness, disease or destruction and

[4] The ABA Code of Professional Responsibility has been incorporated by local Court Rule 6(b)(4) in Michigan.

> seeking damages on account thereof, even if such suit is groundless, false or fraudulent; ..." (Great American policy, Insuring Agreements, Sect. II).

Here, Great American did not defend the interest of its insured. Instead, it rejected the tender of defense of Ford, despite knowing that an indemnity action against its insured was inevitable if Ford lost and that the injury arose out of Levy's negligence. Moreover, Great American then went so far as to take the opposite side of its insured in an effort to recoup its worker's compensation lien. In fact, a representative of Great American, Reginald Johnson, was seated at the counsel's table opposite to the ultimate interest of Levy in the underlying action, giving advice and support antagonistic to its own insured's best interests. Here, the appearance of impropriety indicates bad faith.

The facts here are similar to those in United States Steel Corporation v. Bartford Accident and Indemnitv Comuanv, 511 F. 2d 96 (7th Cir. 1975). There, the Court found a breach of the insurer's duty of fair dealing and duty to defend when the insurer, rather than fulfill its ,obligations when its insured became potentially liable in a third-party action, instead manipulated the theories of recovery so as to bring the third-party claim outeide the scope of policy coverage. "Such a course of action was quite clearly not in [the insured's) best interest, since it assumed a less positive legal stance in the third-party action ..." Id. 511 F. 2d at 100, quoting the District Court's opinion on the matter. Here, Great American's breach of good faith is even more apparent

in siding against its insured.

II. GREAT AMERICAN ACTED IN BAD FAITH WHEN ITS ACTIONS FORCED CONTINENTAL TO CONTRIBUTE TO THE JUDGMENT BEFORE ITS PRIHARY LIMITS WERE EXHAUSTED.

It is elementary that an excess carrier does not contribute to a judgment until its primary carrier's limits are exhausted. Valentine v. Aetna Insurance Co., 564 F. 2d 292, 297 (9th Cir. 1977). Trying to get the insured, or here, the excess carrier, to contribute to a settlement within the policy limits is generally regarded as evidence of bad faith. Lanferman v. Maryland Casualty Co., 222 Wis. 406, 267 N.W. 300 (1936).

> "Excess insurance is routinely written in the insurance industry with the expectation that the primary insurer will conduct all of the investigation, negotiation and defense of claims until its limits are exhausted ... Thus, the primary insurer acts as a sort of deductible and the excess insurer does not expect to be called upon to aseist in these details. The duty of the primary insurer is not divisible or limited to those suits that are within the policy limits and the insuring agreement creates a duty to defend any suit regardless of the amount claimed against the insured and the excess insurer is a third party beneficiary of that agreement."

Certain Underwriters of Lloyd's v. General Accident Insurance Company of America, 699 F. Supp. 732, 740 (S.D. Ind. 1988), quoting, 7C Appleman, Insurance Law and Practice, sect. 4682 (1979).

Here, it is without question that Continental, as the excess carrier, was forced to contribute to the judgment before Great American's primary policy limits were exhausted. Not only did Great American misinform Continental of its policy limits, it would

not provide copies of its policies to Continental so that the excess carrier could determine the true primary limits. Great American understated its policy coverage despite the clear language in its own policies and endorsements. It then had affidavits of written recognizance drawn to that effect, upon which Continental relied to its detriment. Great American claimed it provided only $1 million in applicable primary coverage when, in reality, it had provided $2 million. The amount of the judgment plus interest and coats ultimately amounted to $3,899,586.37. Great American paid only $1 million and $644,638.05 of the interest due. Continental, though, paid $2,254,948.32 on behalf of its insured, contributing $1 million that should have been paid by Great American plus a disproportionate amount of the interest thereon. Such conduct on the part of Great American amounted to bad faith.

III. GREAT AMERICAN ACTED IN BAD FAITH WHEN IT FAILED TO ENTER INTO SETTLEMENT NEGOTIATIONS AND EFFECTUATE A SETTLEMENT.

The Supreme court of Michigan has defined the bad faith of a primary insurer for failing to settle a claim against the insured as the insurer acting arbitrarily, recklessly, indifferently or with intentional disregard of the interests of the excess insurer, Commercial Union Insurance Company v. Liberty Mutual Insurance Company, 426 Mich. 127, 393 N.W. 2d 161 (1986); see also, Jackson v. Saint Paul Mercury Indemnity Company, 339 F. 2d 40 (6th Cir. 1965). In fact, in Michigan, it is well settled that an insurer is duty bound to settle the claim which its investigation shows is meritorious. Riley v. State Farm Mut. Automobile Insurance

Company, 420 F. 2d 1372 (6th Cir.), cert. denied, 399 U.S. 928 (1970). In other words, a primary insurer has an affirmative duty to explore settlement possibilities and it acts in bad faith when it does not do so. Self v. Allstate Insurance Company, 345 F. Supp. 191 (M.D. Fla. 1972). The covenant is implied in an insurance contract that neither party will do anything to injure the rights of the other in receiving the benefits of the agreement; such covenant includes a duty to settle claims without litigation in appropriate cases. Koyman v. Farm Bureau Mutual Insurance Co., 315 N.W. 2d 30 (Iowa 982). In fact, Michigan courts have held that when an insurer has the independent or exclusive negotiating power of the insured to settle the claim, the insurer has a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy coverage. Jones v. National Emblem Insurance Company, 436 F. Supp. 1119 (E.D. Mich. 1977).

The Sixth Circuit has put it as:

> *An* insurer, having assumed control of the right of settlement of claims against the insured, may become liable in excess of its undertaking under the policy provisions, if it fails to exercise good faith in considering offers to compromise the claim for an amount within the policy limits; and it is liable for an excess over the policy limit, where it has exclusive control over the investigation and settlement of claims, and its refusal to eettle within the policy limit is in bad faith. [citations]

Tennessee Farmers Mutual Insurance Company v. Wood, 277 F. 2d 21, 24 (6th Cir. *1960).*

Here, Great American's policy provided for the insurer to have exclusive control to settle claims. It provided, in pertinent

part:

> II. Defense, Settlement, Supplementary Payments
>
> With respect to such insurance as is afforded by this policy, the company shall: (a) defend any suit against the insured alleging such injury, sickness, disease or destruction and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; but the company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient;

The policy goes on to read:

> The insured shall cooperate with the company and, upon the company's request, shall attend hearings and trials and shall assist in effecting settlemente, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of suits. The insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense ...

Great American's policy, Condition No. 12. (emphasis added.)

It is clear from this language that although Great American maintained full control over settlement negotiations, it never properly considered viable and reasonable settlement offers in a case that clearly involved a probable excess verdict. Nor did Great American initiate any negotiations. Such conduct amounts to bad faith under Michigan law. In the underlying case, plaintiff's attorney made a demand to aettle the case for $350,000 plus waiver of the Worker's Compensation lien. Great American never accepted the reasonable offer. Great American attempts to isolate the waiver of the lien from the "fresh money" portion of the demand. They claim that the failure to waive the lien did not in and of itself prevent settlement of the case. This reasoning, however, is

specious because after Great American failed to waive their lien, all settlement negotiations broke off and were never resumed. Their conduct, therefore, eliminated all possibility of settling the case.

IV. GREAT AMERICAN ACTED IN BAD FAITH WHEN IT FAILED TO INFORM CONTINENTAL OF ALL SETTLEMENT DEMANDS PRIOR TO TRIAL, OF ITS CONFLICT OF INTEREST REGARDING THE WORKER'S COMPENSATION LIEN, AND OF ITS PRIMARY POLICY LIMITS.

Courts have recognized and protected certain interests of an insurance contract either by implying a duty in the insurance contract or by establishing a common law duty. Duty is defined generally as conformity to a legal standard of reasonable conduct in light of the apparent risk. W. Prosser and W. Keeton, Handoob of the Law of Torts, Ch. 9 Sect. 53 at p. 356 (5th ed. 1989). Among such duties of an insurer is the obligation to inform the insured of all settlement possibilities.

In Jones v. National Emblem Insurance Company, 436 F. Supp. 1119 (E.D. Mich. 1977), the Court found that in situations where bad faith may be an issue, certain standards should be heeded by insurance companies:

> [I]t is clear that the insurer has a duty promptly and clearly to inform the insured of: (1) the possibility of a judgment in excess of the policy limits; (2) the insured's right to retain independent counsel; (3) the limits of the insurer's interest in the lawsuit; and (4) all settlement offers, including the insurer's response to such offers and the legal significance of those responses expressed in terms of the insured's liability. The'extent and clarity of such notice by the insurer to the insured is a substantial factor to be weighed in determining whether the insurer handled settlement negotiations in good faith.

Id., 436 F. Supp. at 1124-1125. (Emphasis added.)

A majority of courts have held that the failure to advise is sufficient to allow recovery.[5] State Farm Mutual Auto Insurance Company v.. Jackson, 346 F. 2d 484 (8th Cir. 1965); Critz v. Farmers Insurance Group, 41 Cal. Rptr. 401, 230 C.A. 2d 788 (1964); Northwestern Mutual Insurance Co. v Farmers Insurance Group, 76 Cal. App. 3d 1031, 143 Cal. Rptr. 415 (1978); Gins v. American Libertv Insurance Company, 423 F. 2d 115 (5th Cir. 1970); Kooyman v. Farm Bureau Mutual Insurance Co., 315 N.W. 2d 30 (Iowa 1982); Roberie v. Southern Farm Bureau Casualtv Insurance Company, 250 La. 105, 194 So. 2d 7713 (1967); Larson v. Anchor Casualty Comwany, 249 Minn. 339, 82 N.W. 2d 376 (1957); National Farmers Union Property & Caeualtv Company v. O'Daniel, 329 F. 2d 60 (9th Cir. 1964); Kaudern v. Allstate Insurance Co,, 277 F. Supp. 83 (D.N.J. 1962); Goings v. Aetna Casualtv & Surety Company, 491 S.W. 2d 847 (Tenn. 1972); Howard v. State Farm Mutual Auto. Insurance Company, 60 Wis. 2d 224, 208 N.W.2d 442 (1973); Western Casualtv & Suretv Company v. fowler, 390 P. 2d 602 (Wyo. 1964). Some courts have considered the failure to advise the insured of settlement as evidence of bad faith. Koppie v. Allied Mutual Insurance Company, 202 F. 2d 599 (6th Cir. 1952); Younger v. Lumberman's Insurance Company, 202 N.W. 2d 844 (Iowa 1973); Strode v. Commercial Casualty Insurance

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In cases where the duty to advise extends to the insured, under principles of equitable subrogation, the excess carrier atanda in the shoes of the insured and is afforded the same protections and rights. Mich. Comp. Laws Ann. Sect. 600.1405 (1967); Allstate Insurance Company v Citizens Ins. Co. of America, 118 Mich. App. 594, 325 N.W. 2d 505 (1982).

Company, 202 F. 2d 599 (6th Cir. 1952); Younuer v. Lumberman's 174 So. 2d 672 (La. 1965). Failure to advise the insured of settlement demands also may be indicative of indifference and, thus, of bad faith. Henke v. Iowa Home Mutual Casualtv Co., 250 Iowa 1123, 1131-32, 97 N.W.2d 168, 179 (1959); 7C Appleman, Insurance Law & Practice, S. 4712 at pp. 432, 444, 470, 487 (1979).

A primary insurer also has the duty to provide its insured, and, thus, the excess carrier with sufficient information to allow them to make intelligent decisions concerning their exposure, See, eg., Bailey v. Prudence Mutual Casualtv Co., 429 F. 2d 1388 (7th Cir. 1970); cf., Radcliffe v. Franklin National Insurance Company of New York, 298 P. 2d 1001 (Ore. 1956). Notice to an excess carrier is of critical importance. Sisters of Divine Providence v. Interstate Fire & Casualtv Co., 117 Ill. App. 3d 158, 453 N.E. 2d 36 (5th Dist. 1983). See also, Greyhound Corp. v. Excess Insurance Co., 233 F. 2d 630 (5th Cir. 1956); Home Indemnity Co. v. Williamson, 183 F. 2d 572 (5th Cir. 1950). This is particularly the case, as here, where the strong possibility of an adverse verdict in excess of the primary limits exists. See, Domanaue v. Henry, 3954 So. 2d 638 (La. App. 1980); Daw v. Public National Insurance Company, 5 Cal. Rptr. 488, 181 Cal. App. 2d 387, (1960). The insurer must keep its insured informed of any adverse developments in the investigation. Ivy v. Pacific Auto Ins. Co., 156 Cal. App. 2d 652, 320, p. 2d 140 (1958); Boward v. state Fam. Mutual Auto Ins. Co., 208 N.W. 20442 (Wisc. 1973).

Michigan courts as well have recognized the insurer's duty to

inform the insured of all settlement offers and to advise of its policy limits. Jones v. National Emblem Insurance Co., 436 F. Supp. 1119 (E.D. Mich. 1977). These same rights extend to the excess carrier who may sue a primary carrier directly as the real party in interest. (See Section IX herein.) An insurer's failure to do so is a factor constituting bad faith. Commercial Union Insurance Company v. Liberty Mutual Insurance Co., 4226 Mich. 127, 393 N.W. 2d 161 (1986).

Here, the underlying case involved a quadriplegic plaintiff who ultimately died. The verdict reasonably was expected to exceed the primary insurer's limits. Yet, Great American did not inform CONTINENTAL of all offers of settlement nor even of its policy limits. On November 7, 1978, Stanley Schwartz, plaintiff's attorney in Gage/Denlar v. Ford, demanded $350,000 and waiver of Great American's worker's compensation lien amounting to about $125,000, in order to settle the case. Great American never informed Continental of this settlement demand. Continental, therefore, was deprived of an opportunity to protect its interests.

The facts here are startingly similar to those in Roberie v. Southern Farm Bureau Casualty Insurance Company, 250 La. 105, 194 So. 2d 713 (1967), where the court held the insurer acted in bad faith.

> [H]e [the insured] was never apprised of the offers of compromise nor warned of his potential liability; he was ignored. He needed information and advice on the point of his potential liability, which he was not given by his representative, his insurer. A conflict of interest arose between the insurer and the insured. The insurer failed to

> discharge its duty towards its insured, thereby precluding any decisive action on his part." Id., 194 So.2d at 716.

Here, the insured and excess carrier were treated by Great American in much the same way.

The duty to inform also extends to the insurer's potential adverse interests. Herges v. Western Casualty and Surety Company, 408 F. 2d 1157, 1162, n. 7 (8th Cir. 1969), and cases cited therein. Great American did not inform Levy or Continental of its potential adverse interest in collecting its worker's compensation lien. This also amounted to bad faith.

V. THE POSSIBILITY OF AN ADVERSE VERDICT WAS GREAT HERB IN THAT THE TORT PLAINTIFF SUFFERED SEVERE INJURIES, YET GREAT AMERICAN IGNORED ITS DUTY TO SETTLE.

It is a well recognized principle that when the probability of an adverse finding on liability is great and when the amount of damages would greatly exceed the coverage, the insurer has a duty to settle. Kavanaugh v. Interstate Fire & Casualty Co., 35 Ill. App. 3d 350, 342 N.E. 2d 116 (1st Dist. 1975); Phelan v. State Farm Mutual Automobile Insurance Co., 114 Ill. App. 3d 96, 448 N.E. 2d 79 (1st Dist. 1983). The Sixth Circuit has recognized that where the weight of evidence is against the insured on the issues of damages, liability is an important factor determining whether the insurer ahould have settled. Noshey v. American Automobile Ineurance Co., 68 F. 2d 808 (6th Cir. 1969). In fact, under Michigan law, part of the definition of bad faith is whether the primary carrier refueed to accept a settlement offer within its policy limits when the risks of rejecting settlement were out of

proportion with the chance of a favorable verdict. Commercial Union Insurance Company v. Liberty Mutual Insurance Company, 137 Mich. App. 381, 357 N.W. 2d 861, 866 (184). aff'd, 426 Mich. 127, 393 N.W. 2d 161 (1986). As a California court put it:

> When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interests requires the insurer to settle the claim. Its unwarranted refusal to do so constitutes a breach of the implied covenant of good faith and fair dealing.

Commercial Union Assurance Companies v. Safeway Stores, Inc., 26 Cal. 3d 912, 164 Cal. Rptr. 709, 712, 610 P.2d 1038 (1980).

Here, as stated earlier, the tort plaintiff was paralyzed and ultimately died from his injuries. Great American also was aware of the propensity of juries in Wayne county to grant extraordinary verdicts in such cases. Yet, Great American rejected a reasonable settlement offer within its policy limits. It initiated no serious settlement talks and never informed Continental of settlement offers. Clearly, such conduct constitutes bad faith under Michigan law.

VI. GREAT AMERICAN, AS THE PRIMARY CARRIER, DID NOT GIVE EQUAL CONSIDERATION TO THE INTERESTS OF ITS INSURED OR THE EXCESS CARRIER, CONTINENTAL.

It has been held that an insurer who issues a policy of the type at issue here is under a fiduciary duty to look after the intereets of the insured as well as its own interests. National Farmers Casualty Co. v. O'Daniel, 329 F. 2d 60 (9th Cir. 1964). "Failure to do so is bad faith and renders the company liable for

its breach of fiduciary duty in the amount of any judgment over the policy limits." Id., 329' F. 2d at 64-65. This level of consideration is often expressed by the courts as whether the insurer gave equal thought to the insured's interests, Tennessee Farmers Mutual Ins. Co., , 277 F. 2d 21 (6th Cir. 1960); Continental Casualtv Company v. Reserve Insurance Company, 307 Minn. 5, 238 N.W. 2d 862 (1976). This is particularly the case where the primary policy limits may be exceeded, Ballard v. Citizens Casualtv Co. of New York, 196 F. 2d 96, 102 (7th Cir. 1952); Cernocky v. Indemnity Ins. Co. of North America, 695 Ill. App. 2d 196, 216 N.E. 2d 198 (2d Dist. 1966). The question to ask here is whose interests were deemed paramount, the insurer's or the insured's, when the company rejected an offer of settlement. It is clear here that the insured's interests were sacrificed.

Here, the matter could have been settled for much less than the verdict prior to trial by the primary insurer, Great American. On November 7, 1978, the attorneys for the injured plaintiff's estate, Stanley Schwartz, submitted a formal demand for settlement of the underlying action on behalf of the estate in the amount of $350,000 plus a waiver of the $125,000 worker's compensation benefits paid to or on behalf of the injured employee, the tort plaintiff in the underlying action. Great American rejected this offer, a demand well within its limits. A verdict of $1.5 million was rendered. Great American itself collected its entire lien plus interest out of that verdict. Therefore, a significant part of Continental's payout was made to reimburse Ford for amounts paid to

Great American.

Great American knew and was fully aware of the probability of an excess verdict, particularly given previous jury awards in Wayne County, the very serious injuries and ultimate death as a result of thoee injuries. Mr. Denlar *left* a wife and five children. Yet, Great American did not respond affirmatively to a reasonable settlement offer within its primary limits. It did not inform Levy or Continental of the offer. Rather, in an arbitrary, reckless, indifferent and intentionally selfish manner, it disregarded the interests of plaintiff, the excess carrier, knowing that it would be Continental who would carry the loss of Great American's bad faith. It was Continental's money with which Great American was gambling, knowing that its losses would be finite if it could cover up its bad faith actions well enough. See, La Rotunda v. Royal Globe insurance Co., 87 Ill. App. 3d 446, 408 N.E. 2d 928 (1st Dist. 1980). "The size of the judgment recovered ... when it exceeds the policy limits, although not conclusive, furnishes an inference that ... acceptance of an offer within those limits was the most reasonable method of dealing with the claim." Northwestern Mut. Ins. Co. v. Farmers' Ins. Group, 76 Cal. App. 3d 1031, 1054, 143 Cal. Rptr. 15 (1978), and cases cited therein.

Here, Great American neglected its duty, under Michigan law to settle a meritorious claim. In examining the reasonable valuation of the case, particularly given the propensity of juries in Wayne county to award exorbitant verdicts in such cases, Great American

acted indisputably in bad faith in failing to effectuate a settlement. In doing so, the financial interests of the excess carrier or insured were given no consideration.

VII. CONTINENTAL DID NOT WAIVE ANY RIGHTS IN SIGNING THE AFFIDAVITS OF WRITTEN RECOGNIZANCE.

In order for a party to waive its rights, it must have intentionally and knowingly relinquished those rights. American Locomotive Co. v. Chemical Research Corp., 171 F.2d 115 (6th Cir. 1948); Commercial Union Insurance Company v. Medical Protective Co., 136 Mich. App. 412, 356 N.W. 2d 648 (1984), aff'd in pertinent part, 426 Mich. 109, 393 N.W. 2d 479, (1986). When one party has done something having the effect of deceiving and misleading the other party, courts consider it inequitable to enforce against the latter the alleged right of such other party. Shean v. U.S. Fidelity & Guaranty Company, 263 Mich. 535, 248 N.W. 892 (1933).

Here, Continental did not waive its right to claim that $2 million of coverage existed. First of all, it was Great American's lawyers who drew up the affidavits of written recognizance upon which Continental reasonably relied to its detriment. To enforce this right against CONTINENTAL now would be inequitable. This is particularly the case in that Great American representatives have admitted that the affidavits held no legally enforceable rights but, rather, were done so only to expedite the appeals process for the insured. Continental was forced to sign the Affidavit in order to protect its insured.

For Continental to waive its right to claim the proper amount of coverage, it must do so intentionally and knowingly. It signed the affidavits at a time when Great American would not even provide CNA with copies of the appropriate policies. Therefore, CNA could not knowingly relinquish any rights without having the proper information before them, information which had been repeatedly requested but denied by Great American. Therefore, Great American's argument is not only improper but it only serves to lend credence to CNA's contention of Great American's bad faith exhibited throughout this case.

The policy forms were Great American's forms. Great American at all times knew or should have known what coverage it provided. It cannot be logically assumed that anything Continental did could have mislead Great American about its own coverage. Great American's refusal to supply its own policy forms to Continental or even its own field personnel should be taken as an indication of intentional concealment.

Moreover, it is inconsequential what Great American representatives thought about the affidavits because waiver involves the act and conduct of only one of the parties regardless of the attitude of the other party. See, Estoppel and Waiver, 28 Am. Jur. 2d Sect. 30 at p. 634 (1966). Continental representatives never intended the signing of the affidavits to constitute a waiver of any rights. Because of Great American's concealment of its policy forms, Continental could not know what rights it had and no waiver was even possible.

EVIDENCE OR INSTNUATION OF CONTRIBUTORY NEGLIGENCE OR COMPARATIVE FAULT ON THE PART OF CONTINENTAL IS INADMISSIBLE AND MUST BE PROHIBITED FROM THE JURY'S CONSIDERATION

Evidence or insinuation of contributory negligence or comparative fault on the part of Continental is inadmissible. Caselaw specifically addressing the issue prohibits the introduction of such evidence, and by implication, removes consideration of this issue from jury deliberation.

Although no reported Michigan case has addressed the admissibility of evidence of contributory negligence against an excess insurance carrier in an action for bad faith, other jurisdictions considering the issue have held such evidence is not admissible.[6] Most recently in Continental Casualty Company v. Royal Insurance Company of America, 219 Cal. App. 3d 111, 268 Cal. Rptr. 193 (1990) the California Court of Appeals held that a primary liability insurer which has reserved to itself the right and duty to defend could not raise an excess insurer's lack of participation in the underlying defense, and alleged acquiescence at an affirmative defense to an action brought by an excess insurer for the primary insurer's bad faith in conducting settlement negotiations. continental v. Royal, 268 Cal. Rptr. at 197.

[6] As this Court is no doubt well aware, the Michigan Supreme Court, particularly in the area of bad faith litigation has relied heavily upon the decisions of other jurisdictions in considering numerous issues which arise in such litigation. See e.g., Commercial Union Insurance Company v. Liberty Mutual Insurance Company, 476 Mich. 127, 393 N.W. 2d 161, 164-166 (1986).

Specifically the Court in Continental v. Royal held:

> There is no authority that holds an excess carrier should be charged with making sure the primary carrier fulfills its good faith obligations to the insured. Evidence of Continental's conduct including evidence of industry custom and practices was not relevant under these circumstances.

Continental v. Royal, 268 Cal. Rptr. at 197.

In Continental v. Royal, the Court relied in part upon Certain Underwriters of Llovds v. General Accident Insurance Company, 699 F. Supp. 732 (S.D. Indiana 1988). In that case the trial court, interpreting Indiana law held that in an action for bad faith brought by an excess insurer the affirmative defenses of comparative fault and contributory negligence were not available to the primary insurer. Certain Underwriters v. General Accident, 699 F. Supp. at 741-742. In particular, the Court specifically held that there simply is no duty upon the excess insurer to actively participate in settlement negotiations. The introduction of evidence of the excess carriers conduct is irrelevant, and the admission of such evidence would only serve to confuse and prejudice the jury. Certain Underwriters v. General Accident, 699 F. Supp. at 742; see also, Continental v. Roval, 268 Cal. Rptr. at 197. Similarly, in the instant case the introduction of such evidence must be barred.

Respectfully submitted,

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Exhibit B

No. 13141-6-III

COURT OF APPEALS
DIVISION III
OF THE STATE OF WASHINGTON

CENTURY INDEMNITY COMPANY,
a foreign corporation,

Plaintiff-Appellant,

v.

TRUCK INSURANCE EXCHANGE OF
THE FARMERS INSURANCE GROUP,
a reciprocal or inter-insurance exchange,

Defendant-Respondent.

APPELLANT'S REPLY BRIEF

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APPELLANT'S REPLY BRIEF

PRELIMINARY COMMENT. For ease of reference, this reply brief follows the format and numbering system used in Truck's answering brief.

A. REPLY TO TRUCK'S STATEMENT OF THE CASE

Century takes issue with Truck's assertion (Ans Br at 1) that "Farmers [Truck] provided WECo with a defense of the Fox case pursuant to its obligation under its policy of primary insurance." In fact, Truck breached its defense obligation by withdrawing from the defense of its insured. Truck was obligated to defend unless and until its policy limits were "exhausted by payment of judgments or settlements." Policy Part I, ¶ 2 - CP 71, 326. Truck jumped the gun by abandoning its insured after the jury verdict and before important post-trial issues had been resolved. See argument and authorities in Op Br at 12-18.

1. Century's Monitoring of the Fox *Case* Does Not Alter the Nature or *Extent* of Truck's Obligation of Good Faith and Fair Dealing.

Truck argues (Ans Br at 1-3) that it should be absolved of all responsibility for its conduct simply because Century took the prudent step of assigning someone to monitor Truck's handling of this multi-

million dollar claim. It is one thing, however, to monitor someone else's claims handling and it is another to be the person or entity with primary responsibility for the claim. Nothing that Century did relieved Truck of its legal obligations to defend, to act in good faith, and to give its insured's interests at least the same consideration it gave its own interests. The insurer's duties, in this regard, are discussed more fully in Op Br at 19-21.

2. Neither Truck Nor Its Appointed Defense Counsel Needed Century's Approval or Authority to Commence Settlement Negotiations.

Truck argues (Ans Br at 3-4) that it was relieved of its duties because no representative of the excess insurer ever instructed or authorized Truck to accept a particular settlement demand or to make an offer or counteroffer. Truck forgets, it was the one that, in its policy of insurance, accepted the duty to defend. It was the one that agreed to investigate the claim and to settle, or not, as it saw fit. And Truck also forgets that, as long as it controlled the defense (which it did here), it had the obligation to, in good faith, view the case as if there were no policy limits applicable to the claim. See discussion in Op Br at 19-21.

What that means in the context of this case is that Truck had an obligation to evaluate the claim, recognize that it was a case with

significant excess exposure, and recognize that it would require its policy limits, as well as some part of the excess insurer's limits, to settle the claim. With that understood, it was incumbent upon the primary insurer to release its policy limits to the excess insurer so that settlement negotiations could begin in earnest.

None of that happened. Although Fox's defense counsel forthrightly opined that this case bad a multi-million dollar potential and that there was no better than a 50/50 chance of a defense verdict, Truck simply stuck its head in the sand. It chose to try the case. It made no settlement overtures to Fox or Fox's counsel. It never offered a dime. It never released its limits to the excess insurer, despite numerous requests. It tied the excess insurer's hands. See discussion in Op Br at 41-42.

Why did Truck behave in this manner? It did so because it was putting its interests ahead of all others. It had a substantial sum invested in defense costs. It had very little to lose if the case were lost because its aggregate policy limits were eroded down to $166,000. And it had a lot to gain by risking its insured's money and/or the money of the excess insurer. It is easy to gamble witb other people's money--but such unreasonable risk-taking also constitutes bad faith.

3. Liability Was Disputed--So What?

Truck argues (An Br at 4-5) that somehow its obligations are lessened because liability in the underlying case was disputed. Imagine that! A case of disputed liability. So what?

The only cases where liability is not disputed are cases where liability is admitted. Is it only in cases of admitted liability that a primary insurer is obliged to take steps toward settlement in an effort to avoid injuring its insured? That would be a novel rule. Yet that is essentially what Truck argues: Because liability was not crystal clear, there was no obligation to try to settle this $7 million dollar dispute. Apparently, under Truck's contorted logic, the existence of a dispute gives the insurer a license to gamble with others' money in an effort to better its own position.

Lest the court be taken in by this argument, and by Truck's selective citations to the record, the following should also be noted:

> Ken Smith of WECo testified that his views regarding the defensibility of the case were based on the science, not the law.

- Truck gave Smith no options regarding trial versus settlement.
- Truck never told Smith that defense counsel was of the opinion that there was a 50% chance of losing the case.

Smith Dep - CP 222-23. Thus, it is no defense for Truck to now argue

that it was simply doing what its insured wanted it to do. Its insured was not knowledgeable as to Truck's legal obligations. Truck did not give its insured all the facts. And Truck's obligations extended beyond the duty to protect just its insured in this excess exposure case.

4. Truck Misconstrues the Evidence.

First, the March 30, 1989 letter requesting release of Truck's limits (so that settlement negotiations could commence) was not the first or only time that Century's representative inquired as to if, and when, Truck was going to make its limits available. Prior to that time, Mr. Emery requested a release of limits on numerous occasions, and he also raised the topic of settlement in his first or second meeting with Truck's claims manager in early 1988. See Op Br at 36-39, 41-42.

Second, the letter makes clear that Century was unable to make an offer to the claimant "without a commitment from Farmers [Truck] for the balance of their limit." Where the underlying demand is in excess of the primary carrier's limits, the burden is on the primary carrier to approach the excess carrier, express the primary carrier's decision to release limits, and inquire about the excess carrier's willingness to contribute toward settlement. The question of whether such a contribution is needed, however, does not even arise unless and

until the primary carrier has decided it is willing to release its limits. [1] Continental Cas. Co. v. United States Fidelity & Guaranty Co., 516 F Supp 384, 388-89 n 3 (ND Cal 1981). Here, of course, Truck never offered to release its limits until after the jury returned its $2.8 million verdict.

Third, Truck's reliance on the March 30 letter is misplaced and takes the language of that letter out of context. The letter seeks Truck's limits and confirms that if Truck will release limits, and if the case is settled, then Century would take over all remaining liability claims from Truck, the primary insurer. The reason Century made this statement is clear from the context of the letter, but not from the argument set forth in Truck's brief. The letter states: "[Century] acknowledges that if your indemnity limits are exhausted in the Fox case, [Century] then takes over all remaining liability claims." Why? Because, by so doing, Truck would have exhausted its policy limits by payment of claims. That is the condition, pursuant to the policy language quoted on page 1 of this brief, that discharges Truck's duty

[1] Part of Truck's problem, apparently. was that it could not even make a timely, accurate, ascertainment of its own remaining aggregate limits. Truck gave Century inaccurate information in this regard and took more than a year to resolve what should have been readily available in a matter of days. See Op Br at 33-34.

to defend. Obviously, then, if Truck pays its limits toward a settlement, its duties are fulfilled and the duty shifts to Century. However, this latter point does not mean, as Truck argues (Ans Br at 5-6), that Century was agreeing to take over the continued duty to defend where no settlement was achieved. Furthermore, regardless of what claims people and insurance brokers put in their letters to one another, the nature and extent of Truck's duty to defend is dictated by the clear, unambiguous language of the policy--nothing more, nothing less. In this regard see Op Br at 12-18.

5. Century Did Not Appeal the Fox Judgment--Again, So What?

Truck correctly points out (as did Century in its Op Br at 9-10) that the Fox case was settled for a $700,000 discount, after the jury returned its verdict, after Truck abandoned its insured, after partially successful post-trial motions were decided, and before the filing of a notice of appeal. Apparently, under Truck's theory of the case, a plaintiff in a bad faith case can only perfect its cause of action if it stands idly by and suffers the full brunt of the errors committed by the primary insurer. In other words, under Truck's approach, if the insured *or* its excess insurer lifts one finger in an effort to mitigate its damages, it forfeits its right to seek redress for the damage caused by

the primary insurer's negligence or bad faith.

The policy of the law is, of course, 180 degrees to the contrary. Settlements are encouraged and potential plaintiffs have an affirmative obligation to mitigate their damages. Century's post-verdict conduct in this case was, quite obviously, motivated by these appropriate goals. Truck should not now be handed a bonus defense as a result of Century's responsible conduct.

6. Procedure Below

Whether or not WECo "expressed complete satisfaction" (Ans Br at 8) with Truck's handling of the defense is of no moment. That statement is true, generally, where an insurer provides a defense to its insured under an insurance policy such as that issued by Truck, and even in the absence of any excess exposure, because the insurer, not the insured, has the right and obligation to defend the case and to settle the claim. CP 71, 326.

The statement is just as true, and of much greater significance, where, as here, the primary insurer is handling a claim that has excess exposure and that is covered by excess insurance. In that situation, the insured's declaration of "complete satisfaction" becomes essentially irrelevant, because the primary insurer's mishandling of the claim does not create risk for the insured, but, rather. creates risk for the excess

insurer. Truck does not claim, nor could it, that Century ever expressed "complete satisfaction" with the handling of the Fox case.

B. REPLY TO TRUCK'S ARGUMENTS

1. Century's Evidence, Offered in Opposition to Truck's Motion for Summary Judgment, Was Not Only Admissible. It Was a Necessary Element of the Cause of Action.

Truck is wrong when it argues (Ans Br at 10) that Century's evidence was "inadmissible speculation." First, Truck conveniently forgets that all elements of Century's claim were supported by the expert witness testimony of John Partlow, an insurance executive with many decades of claims-handling experience. See Op Br at 26-28.

Second, recent case law makes clear that, where a plaintiff seeks to prove that certain action would have been taken that would have prevented the plaintiff from being damaged if the defendant had acted properly, the plaintiff must establish causation by offering testimony as to what that certain action would have been. See Van Buskirk v. Carey Canadian Mines, Ltd., 760 F2d 481, 492-93, 493 n 7 (3d Cir 1985), which further held that "assessing the credibility of plaintiffs' assertions is a matter left to the jury." 760 F2d at 493 n 7. See also Hoaglund v. Raymark Industries, Inc., 50 Wash App 360, 370-71, 749 P2d 164, 170-71 (1987) (quoting Van Buskirk v. Carey Canadian

Mines. Ltd. with approval); **Mazur** v. Merck & Co.. Inc., 742 F Supp 239,262 (ED Pa 1940). Thus, the very evidence which Truck attacks was not only appropriate, it was **necessary.**[2]

2. Truck's Tender of Its Limits Did Not Extinguish Its Contractual Duties.

Only by misconstruing the evidence, reading exhibits out of **context,** and misquoting the key language in the insurance policy, can **Truck** support its argument that it could unilaterally relieve itself of the promises it made in its insurance policy.

First the policy does **not** state that Truck "shall not **be** obligated to pay any claim or judgment or to defend any suit after the applicable limit of liability has been *extended* . . . " as quoted in Ans Br at 13 **(emphasis** added). Rather, **Truck's** policy states that it is only relieved of its obligations after its limit of liability has been *exhausted* by payment of judgments or settlements. Policy Part I, ¶ 2 · CP 71, 326. This is a key distinction. It is true that Truck extended or tendered its policy limits post-verdict. However, such extension was not **sufficient**

[2] Truck is also wrong when it argues (Ans Br at 10) that statements regarding Fox's state of mind (as to what amount Fox would have accepted to settle **the** case) were inadmissible hearsay. It is well established that statements showing a person's state of mind are not hearsay and are admissible. **See** State v. Hamilton, 58 Wash App 229, 231-32, 792 P2d 176, 177-78 (1990).

to pay the judgment and it was not tendered as part of a settlement proposal or settlement agreement. No such proposal was pending at the time—largely because there had been no settlement negotiations. And, there had been no negotiations because Truck tied Century's hands by stubbornly refusing to release its policy limits at any time before the jury reached its verdict.

Truck misconstrues the evidence and refers to exhibits out of context when it argues that "Century's responsible officials . . . stated that Century expected [Truck] to tender its limits and the defense . . . ." (Op Br at 12-13). One of the supposed "responsible officials" was actually the insured's insurance broker, Ms. Arie Hupp of March & McLennan. CP 342. And she did nothing more than observe that if there was no appeal, and if Truck chose to proceed with payment of the judgment, then Truck's policy limits would be exhausted. There is really no dispute about that. That, however, did not happen.

The second letter (CP 341) likewise, merely recites wbat would happen if, per its policy, Truck exhausted its policy limits through payment of judgments or settlements. Again, however, that simply did not bappen. Instead, Truck extended its policy limits and took the position that, by simply expressing its willingness to put its money on the table, it could be freed of its duty to defend. If that was the law,

then insurers could and should feel free to pay remaining policy limits at any time during litigation. Neither the law nor the insurance contract allows an insurer to leave its insured in the lurch in that manner. The reason is that the insured is not only entitled to its indemnity limits, the insured is also entitled to the cost of defending the claim.

As is pointed out in Op Br at 12-18, the insurer's duty to defend includes the duty to fund all post-judgment activity, including appeal. Truck breached this duty and sbould be required to reimburse Century for the damage caused by the breach.

Nor is Viking Ins. Co. v. Hill, 57 Wash App 341,787 P2d 1385 (1990) to the contrary as suggested by Truck (Ans Br at 13-14). First, Truck is wrong wben it asserts (Ans Br at 14) that the "policy language [is] similar to that here at issue." In Viking Ins. Co. v. Hill, the policy stated:

> However, we won't be obligated to pay for the cost of any further investigation or arrangement for settlement or to defend you further after we've paid our entire limit of liability for damages.

Thus, the quoted policy only required the insurer to pay its limits "for damages." Truck's policy, on the other hand, required the insurer to exhaust its limits by payment of judgments or settlements.

Neither of those events had occurred when Truck abandoned its insured.

Second, the Viking court acknowledged that an insurer's attempt to withdraw from the defense of an insured by depositing its limits into court "requires the insurer to act in good faith in the interest of the insured." 57 Wash App at 349. Here, there is no evidence that Truck had any interests other than its own in mind. Did it act in WECo's or Century's interests when it stopped payments to its retained defense counsel right at the time when counsel was recommending post-trial motions and an appeal? Clearly, Truck was motivated only by the well-being of its own pocketbook, not by what might be best for its insured.

Third, Viking Insurance Company satisfied its duty to defend by bargaining with its insured for the release of that duty. Id. at 351-352. Here, however, there was no such bargain and no such release. Truck simply walked away, leaving WECo and Century to clean up the mess it had created.

3. Aetna Ins. Co. v. Borrell-Bigby Elec. Co. Is on Point.

Truck strives mightily (Ans Br at 15-18) to distinguish Aetna Ins. Co. v. Borrell-Bigby Elec. Co., 541 So2d 139 (Fla App 1989), but ignores the eight other consistent "foreign" authorities cited by Century

on this same point. See Op Br at 16-17. Truck's criticism of Borrell-Bigby is misplaced. There, the court was faced with the same policy language as is contained in Truck's policy (contrast the language in Viking Ins. Co. v. Hill, supra, which Truck asserts is "similar" to Truck's policy). Further, in both cases, the primary insurer refused to follow up with a recommended appeal, and, in both cases, the primary insurer tried to free itself of its duty by tendering its policy limits into court, thus leaving the excess carrier to pursue post-trial relief. As a result, Century was required to incur $13,905.07 in defense costs which rightly should have been borne by Truck.

4-5. Equitable Subrogation Applies Under the Facts of This Case.

Truck made a rather novel, albeit successful, argument in the trial court which, in essence, amounted to arguing that it was entitled to summary judgment because no Washington appellate court had yet decided whether or not principles of equitable subrogation should be employed to allow an excess insurer to "stand in the shoes" of its insured for the purpose of pursuing a bad faith/negligence claim against a primary insurer. In other words, Truck's argument was that equitable subrogation does not apply in this type of case because the Washington appellate courts have not yet had the occasion to address

the issue (until now).

Contrary to Truck's assertion (Ans Br at 18), Century does not "concede that equitable subrogation is not a valid legal basis for a cause of action in Washington." Just as there is no case law expressly on point stating that equitable subrogation is available, there is no case law prohibiting application of the doctrine under appropriate circumstances. As is explained more fully in Op Br at 22-24, this is an appropriate case for this Court to recognize and apply the doctrine.

The vice of not providing an excess insurer any remedy against a primary insurer that has acted negligently or in bad faith is that it rewards the wrongdoer based upon the fortuity of the insured having had the foresight to purchase excess insurance. Under Washington law, in an otherwise identical situation, where the insured has no excess insurance, the insured is free to pursue a bad faith claim against the primary insurer. The question, then, should not be whether or not the primary insurer will be allowed to escape the consequences of its acts, but, rather, which device (equitable subrogation, direct duty, or both) this Court will adopt to allow the injured party to pursue relief.

Truck either misunderstands Century's discussion of the Washington authorities (Op Br at 19-22) which form the foundation for the natural extension of the law to allow an excess insurer to be

equitably subrogated to the insured's rights against the wrongdoing primary carrier, or it hopes that this Court will. For example, Century does not contend that Nyby v. Allied Fidelity Ins. Co., 42 Wash App 543, 548, 712 P2d 861, 865 (1986) affected the adoption of equitable subrogation in this state. Nor did Century so argue. The case is simply cited for the basic premise that one who is within the class of persons intended to be protected by insurance, not just the named insured, may bring an action against a primary carrier. This concept is consistent with the notion that an excess insurer may have such a right because excess insurers are within the class of persons who may be harmed if a primary insurer is negligent or acts in bad faith in the handling of a claim with excess exposure.

Similarly, Kagele v. Aetna Life and Cas. Co., 40 Wash App 194, 197, 698 P2d 90, 93 (1985) is cited for nothing more than the proposition that there is no prohibition against the assignment of a claim against an insurer. Thus. if an assignment as a matter of fact is not against public policy, is there any reason such an assignment cannot and sbould not be accomplished as a matter of law--such as when the real person injured by a primary insurer's bad faith claims handling is the excess insurer, rather than the insured. Under principles of equitable subrogation, an assignment in fact is not

required because equity holds that the excess insurer stands in the shoes of the insured.

Truck makes the argument (Ans Br at 20 and throughout its brief) that subrogation would not be equitable because WECo was "completeiy satisfied with its insurance carrier." As is pointed out on pages 7 and 8 of this brief, it takes quite a stretch to reach this conclusion from the record. In any event, it really misses the point. When an excess insurer, rather than the insured, is the one damaged by the primary carrier's mishandling of the claim, why shouldn't the insured profess "complete satisfaction"? It has not been damaged because the damage has been absorbed by the excess carrier. If Truck's point is worth examining at all, it should be scrutinized based upon the assumption that WECo, not Century, had to bear the burden of a $2.8 million dollar judgment and/or a $2.1 million settlement. If that were the case, would Truck be able to proclaim that its insured was "completely satisfied with its insurer"? Certainly not.

6. Xenophobia Is Not A Good Basis Upon Which to Reject An Appropriate Legal Principle.

Truck apparently is prepared to invite this Court to reject Century's appeal based upon the notion that Century relies on "foreign" cases. Indeed, Century has cited cases from Arizona,

California, Minnesota, Indiana, Michigan, South Dakota, Florida, Ohio, Oregon and Louisiana, all of which bave adopted and applied equitable subrogation to allow a claim by an excess insurer against a primary insurer for damages caused by the primary carrier's negligence or bad faith. Op Br at 22-24. In response, Truck has failed to cite one case--domestic or foreign--where the doctrine was rejected.

The fact that a case is from out-of-state is not a reason to reject it. These cases are offered because they address an issue which this Court has not yet had an opportunity to consider. Truck is shortsighted if it truly believes that this Court, or any self-respecting court, would let xenophobic paranoia get in the way of *the* thoughtful consideration of new ideas.

7. Direct Duty--Another Approach

As with its discussion of equitable subrogation, Century has attempted to bring to the Court's attention cases from outside the state which have discussed and adopted the concept of a direct duty owed to the excess carrier by the primary carrier. Op Br at 25. As with the equitable subrogation issue, Truck persists in arguing that, since there is not yet a Washington appellate case on point, the legal theory must be a nonentity. If this sort of thinking prevailed in our courts, the common law would look just as it did several hundred years

ago. "Landmark" cases would not exist. The law would not develop and change with the times.

8. There Are Genuine Issues of Material Fact As To Both Causation and Damages.

If anything, this portion of Truck's brief (Ans Br at 25-27) makes clear that the trial court erred in granting Truck's motion for summary judgment. It is fundamental that a motion for summary judgment must be denied if there exists any genuine issue of material fact. With that though! in mind, it is worthwhile to scrutinize what Truck contends are the undisputed facts which entitled it to summary judgment.

Truck argues that there is no evidence that the case could have ever been settled for less than $3.5 million. Is this an undisputed fact? See, generally, Op Br at 26-45. In particular, it is worthwhile noting that Fox's lawyer, acting in his authorized, representative capacity, told Fox's banker that the case was likely to settle and that the case had a value in the low six figure range. Ex 18 - CP 251; Ex 99 - CP 284-90. This admission, coupled with Century's own evaluation of the claim and its reserve makes clear that the case could have been settled early on if Truck had not erected numerous barriers to settlement.

Similarly, Fox's other lawyer (who tried the case) indicated the

case could have been settled for $500,000 or less and that Fox never lowered his demand because Truck never approached Fox's trial lawyer about settlement. Tirdel Dep. CP 236-38.

The opportunities to settle were numerous. Early on, the case could have settled for $500,000 or less. Six months before trial it could have settled for $1,000,000, and similar opportunities existed while the trial itself was in progress. Considering that it was Truck's own intransigence that was the major factor hindering and inhibiting the settlement process, it seems a bit ironic that Truck may now actually become the beneficiary of its own stubbornness and neglect.

Truck argues that there is no evidence that a reasonable primary insurer would have taken the steps that would have led to a settlement in an amount substantially lower than the amount Century paid to extricate itself from the bind Truck created. Truck's argument does not square with the evidence.

For example, Truck's claims manager never sought authority to make an offer greater than the $20,000 local authority he had over all claims. Ex 147 - CP 309; Johnson Dep. CP 197. Nor did he ever offer any part of his $20,000 local authority. When plaintiff made his first settlement offer, Truck never even responded. Fox Dep. CP 162; Ex 93 - CP 276. Thus, Fox's first offer was the only offer. That is not,

as Truck suggests, evidence that the case could not be settled. Rather, it is evidence of stonewaliing on Truck's part.

It is apparent from claims manager Chester's comments and writings that he decided, early on, that this case was going to be tried, regardless of the facts and regardless of defense counsel's frank. if less than rosy, evaluations. Attorney Tenney's letters are littered with such prophetic words as "dangerous case," "tremendous" and "astronomical" damages. Claims manager Chester's evaluations, on the other band, had one common theme--the case would be tried.

If Century's burden is to demonstrate that the Fox case could have been settled for an amount equal to or less than the primary carrier's limits, then Truck is right--that was not demonstrated and it could not be because Truck's limits had eroded to such an extent that this claim could not have been settled without some contribution from the excess carrier. However, the fact is that Truck's unwillingness to release its limits to be used toward a settlement meant that no money could be offered and no settlement could be reached. See Hartford Ins. v. General Acc. Group Ins., 578 NYS2d 59 (1991), which held that the trial court erred in granting summary judgment to the defendant primary carrier, where there was evidence that the defendant negotiated in bad faith by not timely offering its policy limits, thereby

depriving the plaintiff excess carrier of an opportunity to negotiate a more favorable settlement.

There is substantial evidence in this record from which the jury could conclude that (1) the case could have been settled for an amount between $500,000 and $1,000,000 (see Op Br at 7-10); (2) Century was motivated to settle the case and would have contributed the amount necessary, in addition to Truck's underlying limits, to accomplish a settlement (see Op Br at 37-38); (3) Truck's steadfast refusal to release its limits was the causal factor which prevented such a settlement from corning together (see Op Br at 36-39); and (4) in so doing, Truck was motivated by a desire to protect its own interests at the expense of WECo and/or Century. See Op Br at 6-7. The existence of evidence supporting all of these elements entitles Century to a jury trial of its claims. The trial court erred when it ruled to the contrary and entered judgment in favor of Truck.

9-12. Century is Not Equitably Estopped.

Truck forgets that its obligations to its insured, or to an excess insurer, are the same whether the insured agrees with Truck's plan of action, disagrees, or is oblivious to it. Under each scenario, the primary insurer has the duty to act reasonably for the protection of its insured and not to put its own financial interests ahead of all others.

This duty of good faith and fair dealing, in fact, is the same whether or not there is any excess insurance in place.

Despite this broad, pervasive obligation on Truck's part, it persists in contending that Century's conduct, or lack of conduct, or level of conduct, absolves it of the legal obligations it undertook when it accepted the insured's premium dollars and entered into the policy of insurance. Truck has lost its focus. It is the one upon whom the obligation to act reasonably rested. And it is the one that has breached that obligation.

Truck argues (Ans Br at 30) that somehow Century or the insured induced it to "proceed[] to trial as it was bound to do." Nothing could be further from the truth. First, the policy of insurance gave it control over the defense. It was entitled to try or settle the case as it saw fit, limited only by the requirement that it act reasonably and that it not put its own interests ahead of its insured. Second, a review of the record makes clear that one person, and one person only, ordained that this case would go to trial. That person was Truck's claims manager Bob Chester. Ex 38 - CP 259; Ex 44 - CP 263-65; Ex 58 - CP 266; Op Br at 6-7.

Truck argues (Ans Br at 31-32) that Century "knowingly refused" to respond to Truck's equitable estoppel argument, and that

Truck detailed "all elements necessary to the defense" in its memorandum of law in support of its motion. In fact, the words "equitable estoppel" do not even appear in Truck's motion or in its memorandum in support of the motion. Nor did Truck plead equitable estoppel as an affirmative defense. Rather, Truck's attorney chose to raise that issue for the first time in his reply memorandum. Apparently pleased with this trick, counsel did the same thing at the motion hearing, raising estoppel in his reply argument only (RP 69), whereupon the trial court denied Century's counsel the opportunity to respond. RP 75-76.

Contrary to the implications in Truck's brief (Ans Br at 32-33) Century did object to the presentation of *the* judgment, to the extent it was based on Truck's unpled, unbriefed, unargued equitable estoppel defense. See Objection to Proposed Order Presented by Defendant. CP 44-46. The equitable estoppel defense was not properly before the court, should not have been a basis for the trial court's decision, and should not be a basis for this Court's resolution of this appeal.

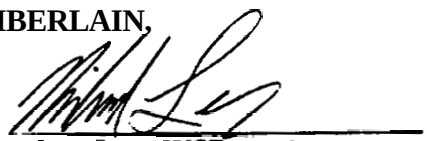
CONCLUSION

The trial court erred when it decided this case in Truck's favor based upon Truck's motion for summary judgment. There are genuine issues of material fact which create jury questions and are not

appropriate for summary disposition. This Court should reverse and remand so that Century may have its day in court.

Respectfully submitted,

BODYFELT MOUNT STROUP & CHAMBERLAIN,

By 

Richard A. Lee, WSB 17537
Of Attorneys for Plaintiff
Century Indemnity Company

Exhibit C

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

CONTINENTAL CASUALTY COMPANY, et al.,	)	
Plaintiffs,	)	
v.	)	C.A. No: 93C-11-008-WCC
GENERAL BATTERY CORPORATION, et al.,	)	
Defendants.	)	
EXIDE CORPORATION, et al,	)	
Counterclaimants, Cross-Claimants, and Third-Party Plaintiffs,	)	
v.	)	
CONTINENTAL CASUALTY COMPANY, et al.,	)	
Counterclaim Defendants,	)	
AETNA CASUALTY & SURETY COMPANY, et al.,	)	
Cross-Claim Defendants,	)	
and	)	
CNA FINANCIAL CORPORATION, et al.,	)	
Third-Party Defendants.	)	

MEMORANDUM OF LAW OF CNA IN SUPPORT OF MOTION TO STRIKE AMENDED COUNTERCLAIMS, CROSS-CLAIMS AND THIRD-PARTY COMPLAINT OF GENERAL BATTERY

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Dated: February 2, 1996

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I. INTRODUCTION

Anderson, Kill, Olick & Oshinsky, on behalf of General Battery Corporation, Exide Corporation, Dixie Metals, Inc., and GBC Newco, Inc. (collectively "General Battery") and many other insureds is at war with the insurance industry. Legal wars are fought with words but they are wars nonetheleee. General Battery's Amended Counterclaims, Cross-claims, and Third-Party Complaint ("Amended Counterclaim") is both Anderson, Kill's declaration of war on behalf of General Battery, as well as its declaration to this Court that in the battle of words, quantity, not quality, and blunderbuss, not reason, will be its methods of attack.

The Amended Counterclaim is 424 pages and 1073 paragraphs long, not including exhibits. It is redundant, immaterial, impertinent, scandalous, inadmissable, and haraesing. It should be struck in its entirety.

If. PROCEDURAL BACKGROUND

On November 1, 1993, Continental Casualty Company, Transportation Insurance Company, American Casualty Company of Reading, and Columbia Casualty Company (collectively "CNA"), filed a Complaint in this Court (Dkt. No. 21 seeking declaratory judgment pursuant to Del. Code *Ann.* tit. 10, § 6501 et seq. As stated in the introduction to the Complaint, CNA seeks

> this Court's determination concerning the scope and nature of [CNA's] obligations, if any, and the obligations, if any, of certain insureds with respect to certain claims against General Battery

> Corporation ("General Battery"), and/or its affiliates under insurance policies allegedly issued to defendants General Battery and Northwest Industries, Inc.

See Complaint at p. 3. In accordance with the Delaware declaratory judgment statute, the Complaint names as party defendants General Battery, Fruit of the Loom, Inc., p/k/a Northwest Industries, Inc. (at one time the owner of General Battery Corporation), and every insurer of General Battery in order to ensure that all entities with any potential interest in the outcome of the controversy are parties before the Court. The Complaint lists the insurers, the insurance policies, and the sites that CNA believed were at issue when it filed the Complaint. The Complaint places the question of insurance coverage for all of General Battery's environmental claims at issue for all parties.[1] The Complaint includes 98 paragrapha (75 of which set forth the parties and the jurisdiction of the Court) in 23 pages.

In response to the Complaint, certain of the defendant insurance companies filed cross-claims against General Battery seeking declaratory relief as to their policies *of* insurance. Since that time, various stipulations, motions, and Orders filed with or by the Court have, by agreement of the parties, limited and particularized the policies, the insurers and the 43 sites

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[1] CNA's Complaint does not seek a declaration of "no obligations" on the part of CNA. Rather, in accordance with the principles of the Delaware declaratory judgment statute, the Complaint seeks a declaration of what obligations, if any, exist as to CNA and the other insurers.

which remain the subject of this litigation. See Stipulation and Order dated December 1, 1995 (Dkt. No. 759), and related motions for and Orders granting dismissal.

On September 7, 1995, General Battery filed its Answer, Counterclaims, Cross-Claims and Third-Party Complaint (Dkt. No. 688). The Answer, consisting of 102 paragraphs in 14 pages, reeponded to the allegations of the Complaint and to the other insurers' cross-claims. There followed, then, General Battery's 435 page, 1069 paragraph undifferentiated "Counterclaims, Cross-claims, and Third-Party Complaint" (the "Counterclaim"). The first 90 pages came apparently by way of introduction to the counts of the Counterclaim, and purported to describe "insurance history" beginning in 1940. This "history" consisted of excerpts from statements and writings by various entities (some parties, many not) concerning insurance generally and the introduction of what is known as the "qualified pollution exclusion" in 1970. It further contained opinions and conclusions as to the "proper" interpretation of insurance policies generally and the motives of the "insurance industry" in the second half of the 20th century.

The next 345 pages of the Counterclaim pleaded 113 counts alleging:

(1) a request for the same declaratory relief requested in CNA's Complaint as to the sites and policies at issue;

(2) breach of contract by all of the insurers, including CNA, as to all of the sites and policies at issue;

(3) breach of contract separately and again

by CNA as to four of the sites[2];

(4) bad faith by CNA with respect to theae same four aitee under Illinois and Pennsylvania law;

(5) violation by CNA of the Illinoie Consumer Fraud statute with respect to these same four sites;

(6) conspiracy by all the insurers to misrepresent or conceal facts;

(7) negligent inepection and provision of loss control services by CNA;

(8) sale of a defective product by all insurers;

(9) breach of a warranty of uniformity by all insurers;

(10) breach of an implied warranty of fitness for intended purposes by all insurers;

(11) estoppel against all insurers; and

(12) a right to recover attorneys' fees.

The requests for declaratory relief and damages for breach of contract were separately and repeatedly stated in individual counts for each of the forty-three sites at issue.

In response to this Counterclaim, CNA, joined by other insurers, filed a motion to strike the pleading in its entirety and motions to dismiss particular counte (Dkt. No. 717). CNA also informally advised General Battery that CNA believed that the Counterclaim was improperly pleaded and included claims for which there was no legal basis.

Thereafter, on January 22, 1996, General Battery filed

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[2] The four sites are: Berks Landfill, Browns Battery, N.L. Taracorp, and Wortham.

an Amended Answer, Answer to Cross-Claims, Counter-Claims, Cross-claims, and Third-Party Complaint ("Amended Counterclaim") (Dkt. No. 829). Thie pleading deleted the bad faith claims against CNA under the Illinois Consumer Fraud Act, and all three of the UCC type claims against the inaurere, including sale of a defective product, breach of warranty of uniformity and breach of warranty of fitness for intended purpose. It also deleted certain factual averments from the remaining bad faith counts against CNA. On January 24, 1996, CNA, joined again by other insurers, filed a motion to strike the entire Amended Counterclaim as well ae motions to dismiss particular counts (Dkt. No. 833).

Despite the amendments, the Amended Counterclaim, as a pleading, is just as objectionable as the original Counterclaim. It is still 410 pages and 971 paragraphs long. It still contains 90 pages of "history", opinion. and argument completely unrelated to the facts of the case before this Court. The entire monstrous exercise, denominated a "pleading", cannot be read in a single day, much less a single sitting. It is redundant, immaterial, impertinent, scandalous, inadmissable, harassing and frivolous. This Court should strike it in its entirety.

III. ARGUMENT

A. The Delaware Standard.

No one should be required to respond to what General Battery calls its Amended Counterclaim. It is not a pleading in accord with the Delaware rules. It is harassing by virtue of its length alone and its content is irrelevant,

repetitive and argumentative. The Delaware Superior Court Civil Rules provide that:

> A pleading which sets forth a claim for relief, whether an original claim, counterclaim, cross-claim or a third-party claim, shall contain (1) a short and plain statement of the claim showing that the pleader is entitled to relief and (2) a demand for judgment for the relief to which the party deems itself entitled.

Rule 8(a)(1) (emphasis added). Rule 8 goes on to provide that:

> [e]ach averment of a pleading shall be simple, concise and direct.

Rule 8(e)(1) (emphasis added). The Delaware Rules further provide that:

> Upon motion made by a party before responding to a pleading ... the court may order stricken from any pleading any insufficient defense or any redundant, immaterial, impertinent, or scandalous matter.

Rule 12(f). A motion to strike will be granted "where a plea upon its face appears to be frivolous, dilatory, vexatious or nugatory". pack & Process, Inc. v. The Celotex Corp., Del. Supr., 503 A.2d 646 (1985) (citations omitted).[3] And, although

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[3] "The Court must consider whether the pleaded matter has some relevancy to the cause of action, is directly in reply to the matter which is pleaded and is offered in support of a direct issue. ...Thus, 'a plea which does not set out any issuable fact ... will be ordered stricken out.'"

Id. at 660 (Citations omitted).

Delaware courts have not often dealt with such motions,[4] the circumstances of this case support the grant of a motion to strike in this matter.

B. **General Battery's "Factual" Introduction to its Amended Counterclaim Consists of Immaterial, Harassing, and Inadmissible Material.**

The purported factual premise for General Battery's Amended Counterclaim, the first 90 pages, provides no facts describing any alleged wrongdoing by the parties to this lawsuit concerning the policyholder, the policies or the sites at issue in this matter. Instead, General Battery's predicate for its claims is a lengthy assault on what it calls the "insurance industry" and how it believes the insurance industry has acted in the past and how it ought to act in the future.

The first section of this "factual" introduction outlines in the broadest, sweeping terms, the insurance companies' conduct. Without referring to any particular

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[4] CNA has found no reported decisions in Delaware on motions to strike since the Pack & Process decision. However, unreported decisions make clear that Delaware courts can and do grant motions to strike. See, James River-Pennington Inc. v. CRSS Capital, Inc., Del. Ch., No. 13780, 1995 WL 106554, Steele, V.C. (Mar. 6, 1995); poore v. Fox Hollow Enter., Del. Super., No. 93A-09-005, 1994 WL 150872, Steele, J. (Mar. 29, 1994); Moffett v. Zitvogel, Del. Super., No. 89C-OC-27, 1990 WL 123068, Graves, J. (Aug. 1, 1990); Vets Welding Shop, Inc. v. Nix, Del. Super., No. 86C-JA-82, 1988 WL 67703, Gebelein, J. (June 20, 1988); Myer v. Dyer, Del. Super., No. 86C-MY-96, 1987 WL 9669, Martin, J. (Apr. 10, 1987); recent unreported decisions granting motions to strike. While these cases do not concern insurance, the grant of such motions in matters where the challenged pleading contained only a fraction of the volume challenged here is informative for the Court's decision on CNA's motion to strike here.

insurance company, General Battery alleges that all of them have failed or will fail in their dutiea, contractual and otherwise, and that they have engaged in a nationwide practice of "nullification of insurance coverage through litigation against policyholders" and a practice of refusing to pay large claims regardless of merit. General Battery then speculates as to the economic motivations of the insurance companies and concludes by avering "on information and belief" that the insurance companies in this case have or will repudiate representations they or their agents made in state insurance department regulatory filings or in judicial filings (¶¶ 140-150). The "pleading" then goes on, for nearly 100 pages, to argue: the legal duties of insurance companies; the purpose of state regulators; and General Battery's version of the history of the development of insurance policy language. This broadbrush characterization of the "insurance industry" is based on assorted comments and statements of individuals, companies, insurance organizations, authors, lawyers, courts and others, made over a fifty year period in letters, briefs, speeches, articles, internal memoranda, advertisements, and other sources. Interspersed are arguments and conclusions as to the meaning of these comments and statements. General Battery (or more properly, its counsel) has submitted a discourse in place of a pleading'.

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[5] Paragraphs 147 through 370 and 1021 through 1048 (250 paragraphs) are paragraphe of the type regularly stricken by courts as not proper pleadings. These detailed "evidentiary" and legal arguments do not belong in a notice pleading. Burks,

(continued...)

A look at a sampling of the "headings" in this part of the Amended Counterclaims demonstrates the nature of the discourse:

> The Standardization of Insurance Policy Language was Intended to Promote Uniformity of Interpretation.. Amended Counterclaim, p. 33;
>
> The Illinois and Pennsylvania Insurance Regulatory Programs and the Insurance Industry Rating Organizations. Amended Counterclaim, p. 35;
>
> The Development of the Standard Form CGL Insurance Policy and Insurance Company Representations Regarding its Coverage. Amended Counterclaim, p. 51;
>
> The Standard Form CGL Ineurance Policy was Intended and Represented by the Insurance Industry to Provide Insurance Coverage for All Risks, Including Unknown Risks, Not Specifically Excluded. Amended Counterclaim, p. 51;
>
> The Development of the 1966 Standard Form CGL Insurance Policy. Amended Counterclaim, p. 62;
>
> The Standard Form CGL Insurance Policy was Intended to Provide Insurance Coverage for Gradual Pollution Damage That Was Neither Expected Nor Intended by the Policyholder. Amended Counterclaim, p. 64;
>
> The "Polluters' Exclusion" was a Mere Clarification of the "Occurrence" Definition.

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[5](...continued)
et al v. City of Philadelphia, 904 F. Supp. 421, 424 (E.D. Pa. 1995).

Counterclaim, p. 71;

Insurance Industry Representations About the General Principles of Interpreting Insurance Policies. Amended Counterclaim, p. 78;

These are not the averments of a pleading. They are a narrative of "history" and argument divided into numbered paragraphs. In fact, these same allegations have been repeatedly published by Anderson, Kill. lawyers (or cooperating counsel) as the advocative exercise they so obviously are.[6]

The "allegations" on which this discourse is based are not case specific, not party specific, and not policy specific. Instead, the presentation assumes that every statement made by whomever, whenever and in connection with whatever, can be attributed to every insurance carrier in this case. The presentation quotes sentences and even partial sentences out of context; many of these are then connected by ellipses to create new statements that may or may not accurately reflect the original message. The result is a collage of bits and pieces of information. If the collage refers to insurance carriers in this action, it is only a passing coincidence. Instead, the information is connected to the insurance carriers in this case

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6 See, e.g., Eugene R. Anderson & William G. Passannante, *Insurance Industry Doublethink: The Real and Revisionist* Meanings *of "Sudden* and Acci*dental"*, INSURANCE LITIGATION, May, 1990, at 186; Eugene R. Anderson & William G. Passannante, *'Dishonesty'* and the *'Sudden* and *Accidental' Con* Game: *It's a Beautiful Thing*, the *Destruction of* Words, MEALEY'S LITIGATION REPORTS INSURANCE, March 5, 1991, at 11; Eugene R. Anderson and Maxa Luppi, *Environmental* Risk *Insurance: You* Can Count *on It*, MEALEY'S LITIGATION REPORTS INSURANCE, January 26, 1988, at 21.

by inserting the worde "the Counterclaim, Cross-claim and Third Party Defendants..." before general allegations about the insurance industry.

Taken as a whole, this presentation of fragments of evidence and arguments that precedes the Counts of the Amended Counterclaim is not about this case. It is not about this insured, General Battery, which is not mentioned even once in its own right.' It is about Anderson, Xill, Olick & Oshinsky, which files an ever expanding version of this "pleading" in all of the environmental coverage cases in which it represents an insured.'

Significantly, while the discourse goee to great length on immaterial issues (such as statements of non-parties allegedly made to state regulatory agencies of states other than those at issue in this matter), it is silent on material issues. No allegation is made as to any representation, much lees any misrepresentation, to General Battery. The closest the "pleading" comes to alleging anything connected to General Battery are its allegations that some of the insurance carriers

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The only references to General Battery, and they are sporadic, are referencee to the public, to policyholders, and to insureds generally, after which a phrase like "such as GBC" is inserted. Such referencee are not actual allegations about General Battery. They are generic, and as to General Battery, hypothetical.

[8] What 'becomes apparent when you look at the cases prosecuted by General Battery's counsel is that each subsequent claim grows. Regardless of its relevance to the particular case, every bit of information which they garner from each preceding case is grafted onto their succeeding pleading. Point in fact, the court should note that the allegations raised by General Battery in its Amended Counterclaim involve numerous entities not even parties to this action.

belonged to certain insurance organizations that allegedly made misrepresentations to certain insurance regulators whose alleged function wae the protection of the citizens of their states in insurance matters. Since General Battery was at all times a citizen of Pennsylvania and its prior parent, Northwest Industries, Inc., was a citizen of l l i n o s these are the only two states as to whom any allegations, even under General Battery's scenario, can be relevant. It is, therefore, necessary to look at what the Amended Counterclaim actually says about alleged misrepresentations to the regulatory agencies of Pennsylvania and Illinois. These allegations are contained under the heading "Insurance Industry Representations to the Illinois and Pennsylvania Insurance Commissioners", (¶¶ 193-200).

First, the allegations are made "on information and belief". Second, what is alleged is that,

> [t]he MIRB submitted a form of polluters exclusion to the Illinois and Pennsylvania Insurance Commissioners that was either identical to or similar, to certain of the polluters' exclusions at issue in this action.

This allegation is then followed, without a break, by the following purported description of what the MIRB said

> [t]he MIRB explained that it was filing the polluters' exclusion to clarify that the 1966 standard form CGL Insurance Policy did not cover pollution or contamination damage that was expected or intended by the policyholder:

However, the actual quote of what the MIRB said, which follows the colon, is not a quote from the MIRB's submission to

Pennsylvania or Illinois. It is not a quote from any communication to Pennsylvania or Illinois. It is a quote from an internal memorandum from the MIRB to its members and subscribers. And notwithetanding General Battery's amazing conclueion to the contrary, it makes no mention of nor even any reference to a state agency submission, let alone any Illinois or Pennsylvania submission. See, Amended Counterclaim ¶¶193-195.

The paragraphs that follow, under this heading, argue that the representation (by the MIRB to its members) was not true when made (¶ 196); that by making it, the filings with Pennsylvania and Illinois confirmed what the polluters' exclusion covered (¶ 197); that a counsel for Aetna in an internal Aetna memorandum commented on whether or not the polluters' exclusion reduced coverage (¶ 199); and finally, that the "representations" now referred to as "made in the regulatory filings to the · Illinois and Pennsylvania Insurance Commissioners" are implied terms of the policies that contain the polluters' exclusion (¶ 200). General Battery has taken two internal memoranda · one from an insurance organization, the other from Aetna and, by first.juxtaposing them with an allegation that the polluters' exclusion was submitted to Pennsylvania and Illinois, and by then falsely alleging that the representations in them were made in the regulatory filings to Pennsylvania and Illinois, has made it look as though it has identified a misrepresentation concerning the meaning of the polluters' exclusion to Pennsylvania and Illinois. It has not done so.

The above is the sum total of "substantive" allegations contained in the section of General Battery's "pleading" called "Insurance Industry Repreeentatione to the Illinois and Pennsylvania Insurance Commissioners". There is no other allegation in the pleading concerning any representation to. Pennsylvania or Illinois.

The rest of the "introduction" to the Counts is the same except that it is, by its own terms, not focused on Pennsylvania or Illinois. When all of the paragraphs of general historical narrative are removed; when all of the paragraphs of allegations concerning statements to persons and organizations not associated with General Battery or Pennsylvania or Illinois regulators are removed; when all of the paragraphs of allegations concerning statements by carriers other than CNA are removed; when all of the paragraphs of argument are removed; there is nothing left. The Emperor has no clothes. But we, the Court and the insurance carriers, are being asked to pay for all the cloth, tinsel and gilt, if the insurers must answer the allegations of the Amended Counterclaim.

To respond to this narrative would defeat the very purpose of notice pleading. The purpose of a pleading is to place the opposing party on notice of facts upon which a claim is based. If an allegation does not "pertain to something specific to the parties [to the) action," it does not belong in a pleading. Robeson Indus. Corp. v. Hartford A m , Bankr. D. N.J., No. 93-33265, Adv. No. 94-3362TF, Ferguson,

J., (Oct. 17, 1994) (TRANSCRIPT OF MOTION TO STRIKE) (emphasis added). Instead of placing the ineurers on notice of the grounds for General Battery's claims, General Battery'pleads endleae legal conclusions and the conduct of those who are not even parties to this action.'

' By way of example, General Battery alleges:

> In the 1940's, E.W. Sawyer, an attorney for the NBCU, a rating organization, wrote an article in The Casualty Ineurance Educator extolling the virtues of the standard form CGL Ineurance Policy. Sawyer wrote:
>
> > Within the limitations established by the standard insuring clauses and by the standard exclusions, it is obvious that the policy covers all hazards of liability loss whether such hazards are or are not known to exist. The significance of this radical change from past practices lies in the fact that the insurer assumes the burden of discovering and charging premium for all hazards, and provides insurance against such hazards whether or not they are discovered; No longer is the insurance limited to hazards for which the ineured has asked protection and paid premiums. The hazards embraced by the comprehensive liability policy are, therefore, not only the known hazards but the unknown hazards.
>
> E.D. Sawyer, Comprehensive Liability Insurance, The Casualty Ineurance Educator, Ser. II (Woodhull Hay ed., 1943), at 29.

See, 1223. General Battery also avers that:

> The unique exemption from the application

(continued...)

To provide a good faith responee to these and countlees other allegations like them would require each insurer to engage in extensive research regarding legal principles and events that span several decades.

Courts faced with this sort of rhetoric regularly strike such allegations. The court in Trustees of Princeton Univ. v. Aetna Casualty and Sur. Co., N.J. Super., No. L-5106-94, Rebeck, J.S.C. (Sept. 23, 1994) (TRANSCRIPT OF PROCEBDXNGS), facing exactly this sort of "pleading" by Anderson, Kill (but on a much smaller scale), struck these types of allegations, holding, with a certain sense of outrage, that:

> You expect them [the insurers] to respond to what the industry did in 1940. You expect them to respond to articles written in 1940. ...You tell me how this is appropriate. ...[T]hat may very well be something that's relevant in discovery. It may be relevant at the time of trial but where does it fit into this complaint? ...Why should it be in the complaint? Basically in a complaint you set forth facts upon which you base your complaint.... I don[8]t believe that comports with our rules

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'(...continued)

> of federal antitrust laws for members of the insurance industry rests on the recognition that insurance companies have public as well as private obligations. In particular, standardized insurance policy terms are designed to serve the public interest by facilitating uniformity of insurance coverage and consistency in the interpretation of the terms of insurance policies.

See ¶ 168.

> regarding the manner in which a complaint should be plead and to which you expect eomeone to respond. It may very well be that the material contained within those paragraphs are relevant in terms of discovery, in terms of trial, but not in a complaint and I'm not going to ask them to respond to that.

Id. (emphasis added).

In Robeson Indus. Corp. v. Hartford Accident and Indem. Co., the court, when recently Faced with a similar Anderson, Kill insurance industry discourse, stated:

> All of the allegations pertaining to standard policy language, the regulatory history, patterns and practices in the industry, etc., may well be relevant evidence, but they are not properly included in the complaint. . . . [T]hey are entirely extraneous to a short and plain atatement of the cause against these defendants.

Robeson Indus. Corp. v. Hartford Accident and Indem. Co., Bankr. D. N.J., No. 93-33265, Adv. No. 94-3362TF, Ferguson, C.J., (TRANSCRIPT OF MOTION TO STRIKE) (Oct. 17, 1994). In yet another case by Anderson, Kill in the New Jersey courts, another judge similarly struck these allegations as inappropriate pleadings. Am. Employers Inc., et al. v. Elf Atochem N. Am., et al., N.J. Super. Ct. Law Div., UNN-L-5333-94, Weisa, J., (Mar. 10, 1995) (ORDER). Similarly, in Samuels Recycling Co. v. CNA Ins. Co., Wis. Cir. Ct., No. 93-CV-1480, Bartell, C.J. (Jan. 6, 1994) (ORDER), the Wisconsin court struck complaint paragraphs describing "insurance industry regulatory and marketing history" because they were not a "concise and direct averment of facts identifying the transaction, occurrence or event out of which the

claim arises." See also, HM Holdings, Inc. v. Aetna Casualty & Sur. Co., N.J. Super., No. L-5685-94, Rebeck, J.S.C. (Nov. 29, 1993) (TRANSCRIPT OF MOTION) (Anderson, Kill - plaintiff'a counsel); Grantors to the Diaz Refinery PRP Comm. Site Trust: 20th Century Fiberglass Inc., et al. v. Sentry Ins. Co., et al., A . Cir., No. Civ-91-56, Erwin, J., (June 3, 1992) (ORDER); and Goodyear Tire & Rubber Co. v. Aetna Casualty & Sur. Co., et al., Ohio App., C.A. No. 16993, Slaby, J. (July 12, 1995) {DECISION AND JOURNAL ENTRY) (Anderson, Kill counsel).[10]

Only a few months ago, Judge Bechtel of the Federal District Court for the Eastern District of Pennsylvania was faced with a motion to strike an entire complaint pursuant to Fed. R. Civ. P. 8, upon which the Delaware Rule is modeled."[11] While that case was factually dissimilar, it is instructive in that, just as with this Amended Counterclaim, the party attempted to have its pleading serve as a narrative of its argument instead of a notice of its claims. The Court struck the entire Complaint

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[10] Comparison of the paragraphs struck in these other cases in which Anderson, Kill was also counsel to the insured discloses that the paragraphs are verbatim repetitions from case to case. The "pleadings" generated by Anderson, Kill are the height, or perhaps more accurately the nadir, of the word processing, data processing computer era.

[11] The Superior Court's Civil Rules are patterned upon the Federal Rules of Civil Procedure. Burkhart v. Davies, Del. Supr., 602 A.2d 56, 59 (1991), citing Hoffman v. Cohen, Del. Supr., 538 A.2d 1096, 1097 (1988). Delaware courts "have repeatedly noted that construction of .identical rules by the federal judiciary is accorded 'great persuasive weight' in our interpretation of the Delaware counterparts. (citations omitted)". Smith v. State of Delaware, .Del. Supr., 647 A.2d 1083, 1088 (1994).

finding that:

> Plaintiff's complaint is a fact laden, thirty-mix page, 128 paragraph narrative that describes in unnecessary, burdensome, and often improper argumentative detail, every instance of alleged [wrongdoing] perpetuated by defendants over the period of 1993 and 1994.... [T]he complaint reads more like a novel than the legal pleading it purports to be.... [T]he complaint improperly and amateurishly repeate, more than a dozen times, . . . bold allegation[s].... To shift the factual emphasis from the discovery stage back to the pleading stage distorts both the purposes and the function of the Federal Rules of Civil Procedures and the administration of this civil case.... Thie pleading represents a gross departure from both the letter and the spirit of Rule 8(a). ...This court will strike the complaint in its entirety.

Burks, et al. v. City of Philadelphia, 904 F. Supp. 421, 424 (E.D. Pa. 1995).

Just as in Burks, General Battery inappropriately uses its pleading as a vehicle for presenting "unnecessary, burdensome, and often improper argumentative detail", reading "more like a novel than the legal pleading it purports to be."[12]

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[12] Were this filed as a memorandum of law, General Battery would have been limited by Delaware's Rules to 35 pages, See, Delaware Superior Court Civil Rule 107(g). By filing it as a "pleading", General Battery hopes to introduce hundreds of pages of argument to the Court. The time will come for the filing of briefs--after this Court rules on the admissibility of the "evidence" General Battery includes in its "pleading" and, to the extent admissible, after that evidence is of record. When that time comes, the briefs will be expected to conform to the Delaware rules.

Only General Battery's pleading is more than ten times ae long as Burks' and unlike Burke', it pleada no specific alleged wrongdoing by CNA. If Judge Bechtel was concerned that "to shift the factual emphasis from the discovery stage back to the pleading stage distorts both the purposes and the function of the, Federal Rules of Civil Procedure and the administration of [the] civil case", this Court should be even more concerned when the "facts" shifted may not be relevant or admissible, were they properly evaluated in the discovery stage. The "facts" that General Battery inserts at this pleading stage relate to matters extrinsic to the actual dealings between General Battery and its insurers. They are the first propaganda salvo in the campaign to turn a contract case into a referendum on the "insurance industry".

This use of pleadings to circumvent the rules of discovery and evidence is not, like Burks', "amateurish". It is a calculated strategy designed to force CNA and the other insurers to respond to allegations and issues before this Court has had an opportunity to determine whether the allegations and issues are a proper subject of this action. What makes this strategy even more troublesome is that General Battery has incorporated all of these paragraphs into each and every count of its Amended Counterclaim, tainting the entire pleading with the inadmissable and irrelevant. This Court should strike General Battery's Amended Counterclaim in its entirety and direct General Battery to file a proper pleading that includes a specific

factual basis for the claims against CNA and that does not include general and unrelated factual and legal argument.

C. The Counts of tho Amended Counterclaim Are Repetitive, Redundant, and Lack Substance.

The defects in General Battery's Amended Counterclaim are not limited to the 250 paragraphs of immaterial and improper "factual" introduction and argument. The rest of the Amended Counterclaim consists of separate counts. More than ninety percent of the 721 paragraphs setting forth the counts are redundant. More importantly, they are boilerplate counts that contain virtually no substantive allegations particular to this case or to any interaction between these insurers and this insured and add nothing of substance to the requested relief.

First, forty-three counts (constituting 301 paragraphs and 86 subparagraphs) seek the same declaratory relief as is sought in the Complaint and the Crossclaims.[13] These paragraphs should be stricken as redundant and frivolous. These counts are also redundant as to each other. The only variation from count to count is in the name of the site to which it applies and a single line which alleges what General Battery feels are the applicable policy years, an issue which is already the subject of the requested declaratory relief. While a count as to each site might be acceptable or necessary if General Battery were providing specific site data which differs from

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[13] Counts 1, 3, 9, 15, 17, 19, 21, 23, 25, 27, 29, 31, 33, 35, 37, 39, 45, 47, 49, 55, 57, 59, 61, 63, 65, 67, 69, 71, 73, 75, 77, 79, 81, 83, 85, 87, 89, 91, 93, 95, 97, 99, and 101.

count to count, such is not the case here. Theee 301 paragraphe request the same relief sought in the Complaint and Crossclaims and do so in the most repetitive, redundant and burdensome manner.

Second, Exide pleads an additional 43 counts (constituting another 215 paragraphs and 129 subparagraphs) for breach of contract for each of the 43 sites." Again, these counts are completely redundant as to each other. The only difference from count to count is the naming of a site and appparently the same single allegation of applicable policy periods as set forth in the above referenced declaratory judgment counts.. To the extent that these policy period averments are necessary to put the insurers on notice of its claims, they can and should be pleaded succinctly, and once.

Third, although CNA is a named party in each of the 43 "breach of contract" counts, Exide pleads four more breach of contract counts (5, 11, 41 and 51) (involving an additional 25 paragraphs and 12 subparagraphs) against CNA alone, re-alleging breach of contract claims against CNA for 4 of the 43 sites. These 4 counts are completely redundant and similarly unnecessary. Either a breach of contract claim was stated against CNA in the first breach of contract count on each of these sites, in which case a second count is unnecessary, or, if

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[14] Counts 2, 4, 10, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 46, 48, SO, 56, 58, 60, 62, 64, 66, 68, 70, 72, 74, 76, 78, 80, 82, 84, 86, 88, 90, 92, 94, 96, 98, 100, and 102.

the first time around the claim was insufficient, then restating it virtually verbatim does not help.

These declaratory judgment and breach of contract counts constitute 540 paragraphs of unnecessary, repetitive pleadings which add nothing to the case, are burdensome for each of the carriers to respond to and waste time and trees. General Battery's Amended Counterclaim, if not stricken, will require this court to review literally fifteen thoueand or more paragraphs of responsive pleadings once all of the remaining insurers have responded to all of these paragraphs.

More important, however, is the fact that General Battery's assault of worde gives only the semblance of substance to its counts. Once the redundant allegations are removed, what is left are insufficient facte to put CNA or anyone else on notice of the substance of the claims. In each of the breach of contract counts, General Battery alleges that "some or all of the insurers received notice"; "some or all refused to pay"; "each failed and refused to determine, reaeonably and promptly, whether coverage exists"; or that "each failed and refused to investigate, defend, or mitigate losses and pay". General Battery does not put any individual insurer on notice of its alleged conduct which would support a breach of contract claim and to which it can respond. Certainly, it doesn't take 43 counts to make boiler plate, non-specific breach of contract allegations.

Fourth, General Battery pleads a set of three bad faith counts against CNA alone. It pleads the same set four times, raising identical allegations as to each of four sites for bad faith under Illinois common law, the Illinois Insurance Code, and Pennsylvania's bad faith insurance statute.[15] Each set of counts repeats identical formulaic allegations, changing only the name of the site. This repetition accounts for a further redundancy of 108 paragraphs, assuming that a single recitation of the 27 "non-repetitive" paragraphe are necessary to put CNA on notice of these claims.

Finally, each count in the Amended Counterclaim incorporates all previous paragraphs. Therefore, the counts not only repeat each other verbatim, but they also incorporate each other. Neither the repetition nor the incorporation is necessary: certainly not both. The results of what General Battery has done are clear. General Battery's repetitions and incorporations create a geometric increaee in the size of each count; each count is tainted with the problems that came before it; and response to each count necessarily requires response to all previous paragraphs. Attempts to evaluate the sufficiency of each count requires reference to the hundreds of pages and hundreds of paragraphs that precede it. Second, each count incorporates indiscriminately all 250 paragraphs of "factual" introduction that precede the counts. The result is that it is

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[15] Set (1) Counts 6, 12, 42 and 52, Set (2) Counts 7, 13, 43 and 53, and Set (3) Counts 8, 14, 44 and 54).

impossible to evaluate any claim becauee there is no way to know which, if any, preceding paragraph really is offered to support that claim.

IV. CONCLUSION

General Battery's "pleading" is lazy. Rather than thinking selectively about what to plead and how, Anderson, Kill cut, pasted, borrowed from other cases, and then called it General Battery's Amended Counterclaim.[16] Neither the other parties nor this Court should be forced to do General Battery's work for it.

Striking the "pleading" will force General Battery to consider what, if any, factual basis exists for its claims and to put each insurance carrier on proper notice of the claims against it. It will require General Battery to substitute a proper pleading for the barrage of irrelevant, argumentative, and repetitive paragraphs that, like white noise, are intended to obfuscate and confuse communication. *An* Order striking General Battery's Amended Counterclaim, with direction to do it right, will be an important step in the management of this complex coverage case and in the resolution of the actual issues in this

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[16] The Amended Counterclaim is more or less the same as the Illinois Complaint filed by General Battery when the motivation was presumably to make the Illinois Complaint appear more comprehensive than the Delaware matter. When the time came to respond to the Complaint in this matter, after having withdrawn their opposition to the Delaware forum, General Battery apparently took the path of least resistance: they made minor changes to their Illinois Complaint (to which no reeponse beyond motions to dismiss was ever required or made) and utilized it as the basis for their response here.

case.

For all the reasons set forth in this Memorandum of Law, in any affidavits subsequently filed in support hereof, or asserted by any other carrier in this lawsuit which are applicable to CNA, plaintiffs, Continental Casualty Company, Columbia Casualty Company, Transportation Insurance Company, and American Casualty Company of Reading, PA, request this Court to strike General Battery's Counterclaims, Cross-Claims and Third-Party Complaint in their entirety.

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Dated: February 2, 1996
docket no. 876/2/2/96/8:31 p.m.

Exhibit D

Supreme Court Of The State Of New York
Appellate Division: Third Department

Third Department Index
No. 65599

THE COUNTY OF COLUMBIA, NEW YORK,

Plaintiff-Appellant,

against

CONTINENTAL INSURANCE COMPANY, AETNA CASUALTY & SURETY COMPANY and FIREMEN'S INSURANCE COMPANY OF NEWARK, N.J.,

Defendants-Appellees.

BRIEF AND APPENDIX OF AMICUS *CURIAE* INSURANCE ENVIRONMENTAL LITIGATION ASSOCIATION IN SUPPORT OF CONTINENTAL INSURANCE COMPANY, AETNA CASUALTY & SURETY COMPANY AND FIREMEN'S INSURANCE COMPANY OF NEWARK, N.J.

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August 24, 1992

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INTEREST OF AMICUS CURIAE

The Insurance Environmental Litigation Association ("IELA") is a trade association of major property and casualty insurers, IELA was formed, in part, to appear as amicus curiae in environmentally-related insurance coverage cases and to assist courts in the determination of important insurance coverage questions presented in such litigation, IELA members have entered into insurance contracts in New York and throughout the nation containing provisions similar to those at issue in the instant case. IELA is therefore vitally interested in the judicial. interpretation of these coverage provisions.

Because of its members' extensive experience with the interpretation and application of the contract provisions before the Court, IELA has a unique perspective on the issues presented, Drawing on this experience, IELA's brief will show that enforcing the terms of insurance contracts as written is essential to the integrity of the insurance underwriting process and to the promotion of long-term environmental goals,

IELA files this brief on behalf of Allstate Insurance Co., American International Group, Chubb Group of Insurance Companies, CIGNA Property & Casualty Companies, Crum & Forster Corporation, Fireman's Fund Insurance Companies, Hanover Insurance Company, Hartford Insurance Group, Home Insurance Company, Liberty Mutual Insurance Company, Maryland Insurance Group, Prudential Reinsurance Company, Royal Insurance Co., St. Paul Companies, Selective Insurance Group of America, State Farm Fire & Casualty Company, The Travelers Insurance Companies, and United States Fidelity & Guaranty Company. Appellsea Aetna Casualty & Surety Co. and Continental Insurance Co. are IELA members; this brief is not submitted on their behalf.

STATEMENT OF FACTS AND PROCEEDINGS[1]

This case involves a policyholder that intentionally deposited harmful wastes at a dumpsite. Barred from obtaining insurance coverage by the pollution exclusions contained in its policiee, the policyholder turns to the policies' personal injury provisions in an attempt to create coverage for this clearly excluded liability. This Court should reject the policyholder's stratagem and uphold the trial court's denial of coverage.

The policyholder, appellant County of Columbia, New York (the "County"), brought this action against appellees Aetna Casualty & Surety Company ("Aetna"), Continental Insurance Company ("Continental"), and Firemen's Insurance Company of Newark, New Jersey ("Firemen's") (collectively, the "Insurers"). The County seeks a declaration that the Insurers are obligated under various general liability insurance policies to defend and indemnify the County against an underlying claim for pollution-related injury resulting from the County's intentional dumping of harmful materials onto the ground at a landfill.

In December 1981, the County and the Town of Claverack, New York (the "Town"), entered into the Columbia County Solid Waste Management Agreement, pursuant to which the County intentionally deposited refuse and other solid waste onto the land at a dumpsite. Slip op. at 2, The County subsequently leased the dumpsite, where it continued its polluting activity. *Id.* at 2. On May 16,1986, the County signed a New York State Department of Environmental Conservation Order on Consent (the "Consent Order"), admitting to the discharge of "leachate into the

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[1] IELA's statement of facts is drawn from the trial court's opinion of September 30,1991 ("Slip. op."), unless otherwise noted.

ground water . . . in violation of Section[s] 360.8(a)(3) and 703.5 of 6 NYCRR." Id, at 2.

On January 30,1989, the H.K.S. Hunt Club, Inc. (the "Hunt Club"), a neighboring landowner, brought the underlying action against the County and the Town, citing the Consent Order as proof that the dumpsite was discharging leachate into the groundwater in violation of New York law. Slip op. at 2-3. The Hunt Club alleged that the continued dumping by the County and the Town had caused permanent damage to its soil, surface water, and groundwater. Id. at 3, The Hunt Club also alleged that the operation of the landfill constituted trespass, nuisance, and interference with the use of property. In its answer to the Hunt Club's complaint, the County admitted that it had signed the Consent Order and that it had intentionally deposited the refuse and solid waste on the land. Id. at 2-3.

On March 28,1990, the County brought the instant action against Aetna, Continental, and Firemen's, seeking coverage under various general liability policies issued between 1981 and 1989. In response, the Insurers moved for summary judgment on the grounds that the pollution exclusion clauses contained in their policies precluded coverage for the underlying action, The County subsequently filed a cross motion for partial summary judgment.

On September 30,1991, the Supreme Court, County of Columbia (Connor, J.), granted summary judgment to the Insurers. The trial court denied the County coverage on three separate grounds. First, the trial court held that a pollution exclusion barring coverage for pollution except where the polluting discharge was both "sudden" and "accidental" precluded coverage because the deliberate deposit of waste in a landfill could not be considered "accidental." Slip op. at 6-7. Second, the court denied the County coverage under an "absolute" pollution exclusion barring coverage for property damage "arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants," since the underlying action

alleged "property damage arising from actual discharges of pollutants." *Id.* at 8. Finally, the trial court rejected the County's contention that 'personal injury" provisions in the policies covering liability for the enumerated torts of "wrongful entry or eviction or other invasion of the right of private occupancy" extended to the underlying allegations of trespass, nuisance, and interference with use of property. *Id.* at 7.

SUMMARY OF ARGUMENT

The trial court correctly found that liability arising from the County's long-term, intentional dumping of refuse and solid waste is precluded under the pollution exclusion barring coverage for all but "sudden and accidental" discharges, because the County's intentional polluting can not be considered "accidental" under the Court of Appeals' mandate in *Technicon, infra,* and Powers *Chemco, infra.* Similarly, the absolute pollution exclusion, barring coverage for all pollution-related claims without any exception, precludes any coverage to the County. Because the underlying action is about pollution-related property damage, these pollution exclusione control this case.

The County nevertheless attempts to create coverage through a roundabout reading of the policies' personal injury coverage for liability for 'wrongful entry or eviction or other invasion of the right of private occupancy." The County contends that these provisions afford coverage for the underlying claims of trespass, nuisance, and interference with the use of property — counts evidently included in the underlying complaint to capitalize on a New York statute offering treble damages for such offenses.

Courts have repeatedly repudiated the County's stratagem of linking environmental property damage with personal injury coverage, The enumerated

torts of "wrongful entry" and "eviction" are fat different from the underlying claims of trespass, nuisance, and interference with the use of property. Both "wrongful entry" and "eviction" require purposeful acts aimed at the infringement of possessory rights. Under the principle of *ejusdem generis*, long recognized in New York, the phrase "other invasion of the right of private occupancy" must also be interpreted to include the element of the purposeful infringement of possessory rights. The County's "willful violation" of New York environmental regulations is, as the trial court held, an additional reason to deny personal injury coverage in this case.

This Court should ignore the improperly introduced and nonprobative extrinsic evidence that the County and Opposing Amici seek to inject into this appeal, as well as the Opposing Amici's far-fetched argument that the doctrine of judicial estoppel has any application here. Instead, public policy dictates that the insurance contracts be enforced as written — with neither the pollution exclusion clauses nor the personal injury provisions affording any coverage for the County's intentional polluting activities.

ARGUMENT

I. THE POLLUTION EXCLUSIONS IN THE INSURERS' POLICIES PRECLUDE COVERAGE OF ANY LIABILITY ARISING OUT OF THE COUNTY'S LONG-TERM AND INTENTIONAL DISCHARGE OF WASTE.

As the trial court correctly found, the pollution exclusions contained in the policies preclude coverage for any liability arising from the County's long-term, intentional dumping of refuse and solid waste onto the land.

All of the policies in this case contain pollution exclusions. The pollution exclusion in certain of the policies bare coverage for pollution with a narrow

exception for pollution caused by discharges that were both "sudden" and "accidental."[2] As the Court of Appeals hae stated in unmistakably clear terms:

> [s]ince the exception is expressed in the conjunctive, both requirements must be met for the exception to become operative. Stated conversely, discharges that are either nonsudden or nonaccidental block the exception from nullifying the pollution exclusion.

Technicon Electronics Corp. v. American Home Assur. Co., *74* N.Y.2d 66, 75, 542 N.E.2d 1048, 1050, 544 N.Y.S.2d *531,633* (1989), *recon. denied,74* N.Y.2d *843,645* N.E.2d 874 (1989). *See also Pourers Chemco, Inc. v. Federal Ins. Co.*, *74* N.Y.2d 910, 911,648 N.E.2d 1301,1302,549 N.Y.S.2d 650,651(1989) [the "exception to the exclusion for liability arising from pollution is not operative unless the occurrence in question was *both* 'sudden' and 'accidental'"). Following *Technicon* and *Powers Chemco*, this *Court* has recognized that, under New York law,'it is now unmistakably clear" that the application of the "sudden and accidental" exception to the pollution exclusion'consists of two distinct inquiries, each of which must be satisfied independently as a prerequisite to coverage? *Borg-*Wamer *Corp. v. Insurance Co.* of North *America*, 174 A.D.2d 24, 30-31, 577 N.Y.S.2d 953,957 (3d

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[2] Other policies at issue in this case contain a so-called "absolute" pollution exclusion, which bare coverage for *all* pollution-related claims. This exclusion provides in part that:

> 1. {Coverage is precluded for] bodily injury or property damage arising out of actual, alleged or threatened discharge, dispersal, release or escape of pollutants,
>
> A At or from premises owned, rented, or occupied by the named insured;
>
> B. At or from any site or location used by or for the named insured or others for the handling, storage, disposal, processing or treatment of waste.

The trial court correctly held that "[s]ince the underlying action Complaint alleges property damage arising from actual discharges of pollutants, coverage is expressly excluded" under the policies containing the absolute pollution exclusion. Slip op. at 8.

Dep't 1992), *leave to appeal denied*, 3-14 Mo. No. 554, slip op. (N.Y. July 2,1992) (attached hereto as Exhibit 1).[3]

Here, it is undisputed that the County intentionally discharged polluting waste onto the land, Slip op. at 3. By definition, such discharges are not "accidental" and are therefore not covered. As the trial court properly held, 'the depositing of refuse and other solid waste material cannot be viewed as 'accidental' within the meaning of the exception" to the pollution exclusion. *Id.* at 6-7. The trial court's decision is required by binding, directly applicable precedent from this Court and the Court of Appeals, See, *e.g.*, *Technicon*, 74 N.Y.2d at 76 ("[i]nasmuch as the underlying complaint alleges and [the policyholder's] answer concedes that its dumping of wastes was deliberate, the occurrence cannot be 'accidental' within the meaning of the policy").[4] Earlier this year, this Court recognized the weight of this precedent by holding that "[w]here ... the discharge itself was intentional, *coverage* is *unavailable* as a matter *of* law." *Borg-Warner*, 174 A.D.2d at 32 (emphasis added).

The trial court's conclusion that the County's discharge of pollution was not "accidental" is dispositive of this issue. Even if this Court were to focus upon the applicability of the "sudden" prong of the exception, however, the result would be the same. Indeed, this Court recently recognized the temporal meaning of the term "sudden," holding that, "for a release or discharge to be 'sudden' within the meaning

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[3] Because it involves an exception to an exclusion, the burden of proving a sudden and accidental discharge is on the policyholder. As this Court recognized earlier this year, 'although an insurer generally must prove the applicability of an exclusion, it is the insured's burden to establish the existence of coverage. Here, because the existence of coverage depende entirely on the applicability of the exception to the exclusion, the insured has the duty of demonstrating that it has been satisfied," *Borg-Warner*, 174 A.D.2d at 31 (citing precedent from New York and other jurisdictions),

[4] *Accord EAD Metallurgical, Inc. v. Aetna Cas. & Sur. Co.*, 905 F.2d 8, 10-11 (2d Cir. 1990) (discharge non-accidental when complaint alleged that manufacturer, *inter alia*, arranged for the disposal of waste in town landfill).

of the pollution exclusion, it must occur abruptly or quickly or 'over a short period of time."' *Borg-Warner*, 174 A.D. 2d at 31 (citing *Technicon* and other cases). Here, as in *Borg-Warner*, "it is undisputed that the discharges took place over a period of many years" and were therefore "nonsudden." Id. at 31.6

In an attempt to escape the weight of this precedent, the County boldly asserts that the pollution exclusion is either "ambiguous" or somehow irrelevant in thie case because the policiee containing the exclusion include among the risks covered "garbage or refuse dumps." The discharge of pollutants excluded by these policies, claims the County, "cannot be construed to mean the covered act of placing wastes into a landfill." See Appellants' Brief ("County Brief") at 47-48.

The County's argument is wholly without merit. As the trial court correctly held, "[t]he fact that the dump is a covered location doee not obviate the application of the pollution exclusion clause for claims of property damage due to contaminant discharges from the dump," Slip op. at 7-8. Other courts have agreed, See, *e.g.*, *Ludlow's Sand & Gravel Co. v. General Accident* Ins., No. 87-CV-1239, transcript at 22-23, 30040 (May 13, 1991) (attached hereto as Exhibit 3) (rejecting the policyholder's contention that the policy covered the escape of pollutants from a landfill and denying coverage to the policyholder because the discharge of pollutants was not 'sudden" under the exception to the pollution exclusion). While the policies

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5 The legislative history of the two New York statutes that first mandated the use of the pollution exclusion, 1971 N.Y. Laws, Ch. 765, and then repealed that requirement, 1982 N.Y. Laws, Ch. 856, confirms that, in conformity with New York public policy, the pollution exclusion was intended to bar coverage for all forms of non-sudden pollution. See, *e.g.*, Statement of Chairman of State Senate Committee on Conservation and Recreation, 1982 N.Y. Laws Ch. 856 (Bill Jacket) (Exhibit 2 attached hereto at A-9) ("[a]t present, New York is alone in the country in its restriction of permitting insurance *to* be issued to cover *gradual or non-sudden* pollution") (emphasis added); Memorandum of Attorney General Robert Abrams (Exhibit 2 at A-14-16) ("[t]he purpose of this bill is to amend the Insurance Law to remove the prohibition against liability insurance for environmental pollution resulting from *gradual release of pollutants*") (emphasis added).

at issue provide coverage for a number of risks associated with the landfill, pollution is not one of them.

Moreover, the County's argument violates the fundamental principle that "exclusion clauses subtract from coverage." *Weedo v. Stone-E-Brick*, 81 N.J. 233,405 A.2d 788,795 (1979). As the New Jersey Supreme Court recognized, the function of an exclusion "is to restrict and shape the coverage otherwise afforded," *Weedo*, 405 A.2d at 790. *See also Upjohn Co. v. New Hampshire Insurance Co.*, 438 Mich. 197, 205-207, n.6, 476 N.W.2d 392, 396-397, n.6 (1991) {"simply stated, it is our belief that exclusions exclude"); *American Motorists Ins. Co. v. General Host Corp.*, 667 F. Supp. 1423, 1429 (D. Kan. 1987), *aff'd*, 946 F.2d 1482(10th Cir. 1991) ("[i]t is not a novel idea that exceptions to a broad blanket of coverage can be made"). The County's argument is merely an attempt to distract the Court from the relevant New York law that governs the issue, This Court should reject the County's far-fetched argument.

II. THE HUNT CLUB'S UNDERLYING COMPLAINT ACTUALLY SEEKS RELIEF NOT FOR PERSONAL INJURY BUT FOR POLLUTION DAMAGE CLEARLY EXCLUDED BY THE POLICIES.

Frustrated by the obvious applicability of the pollution exclusion clauses to the underlying claims,[6] the County turns to the personal injury provisions contained in each of the policies, which provide coverage for liability for "wrongful

[6] The County apparently concedes that the absolute pollution exclusion bare coverage in this case, since it fails to discuss this exclusion in its brief to this Court. Indeed, it must: as the trial court noted, other New York courts have refused to find coverage in the face of similar pollution exclusions. Slip op. at 8. *See also Alcolac, Inc. v. California Union Ins. Co.*, 716 F. Supp. 1646,1549 (D. Md. 1989) (the "absolute" pollution exclusion "is just what it purports to be — absolute").

entry or eviction or other invasion of the right of private occupancy."[7] Both the County and Opposing Amici attempt to squeeze the alleged injury resulting from the County's intentional dumping of pollutants into the limited definition of "personal injury." As the trial court recognized, however,

> [t]he complaint in the underlying action also does not allege the offenses of wrongful entry or eviction or any other invasion of the right of private occupancy. Courts have conatrued this coverage narrowly and rejected finding coverage thereunder for allegations of trespass, nuisance, and interference with the use of property resulting from waste handling, disposal practices and contaminant migration.

Slip op. at 7.

The underlying case is about pollution and property damage, not personal injury. The Hunt Club's complaint actually seeks recovery for environmental property damage, even though it is partially cast in terms of trespass, nuisance, and interference with use of property.[8] It is the essential character of the underlying claims that governs coverage. See, *e.g.*, *Western Casualty & Sur. Co. v. Palmyra*, 650 F. Supp. 981, 984 (E.D. Mo. 1987) (no personal injury coverage since "the mere casting of [the causes of action of the underlying complaint] as claims for damages for invasion of privacy does not alter their character as 'arising out of' the [uncovered] unlawful wiretap"; *Pleasure Driveway & Park Dist. v. Aetna Casualty &*

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[7] All of the relevant policies at issue contain an endorsement providing personal injury liability coverage, "Personal injury" is defined in relevant part as follows:

> "Personal Injury" means injury arising out of one or more of the following offensescommitted during the policy period
>
> * * *
>
> wrongful entry or eviction or other invaeion of the right of private occupancy.

[8] The Hunt Club'e complaint appears to have been artfully drafted to take advantage of Section 853 of the New York Real Property Actions And Proceedings Law, which offers the allure of treble damages. N.Y. Real Prop, Acts. § 853 (McKinney 1992). In fact, the Hunt Club's complaint explicitly requests treble damages under this statute.

Sur. Co., 80 Ill. App. 3d 1093,400 N.E.2d 651,653 (1980) (no personal injury coverage since "when read in context" the underlying complaint refers to uncovered wrongful termination and antitrust violations); and *Nichols* v. *Great American Ins. Co.*, 169 Cal. App. 3d 766,216 Cal. Rptr. 416 (1985) (no personal injury when the underlying claim was for uncovered airwaves piracy).

The County and Opposing Amici urge this Court to recognize a type of coverage that the County neither bargained nor paid for. Black-letter insurance law, however, dictates that courts cannot rewrite insurance contracts to expand coverage beyond that agreed upon by the parties to the contract, See *Adorable Coat Co. v. Connecticut Indemn. Co.*, 157 A.D.2d 366,369,556 N.Y.S.2d 37, 39 (1st Dep't 1990) ("[a] court may not create policy terms by implication or rewrite an insurance contract"), and *Bretton v. Mutual of Omaha Ins. Co.*, 110 A.D.2d 46, 49, 492 N.Y.S.2d 760,763 (1st Dep't 1985) ("[a]n insurer is entitled to have its contract of insurance enforced in accordance with its provisions and without a construction contrary to its express terms"). See *also Weedo*, 405 A.2d at 796 (insurance contracts cannot be construed to "afford[ ] indemnity in an area of insurance completely distinct from that to which the policy applies in the first instance"),

That is precisely what the County seeks to do here, Because "property damage" coverage is barred by the pollution exclusions, the County has turned elsewhere in a desperate search for coverage. It has turned to an entirely distinct type of coverage -- personal injury -- in an attempt to create precisely that coverage excluded by the clear terms of the pollution exclusions, the provisions which govern the property damage claims under the policies at issue.

A. The Personal Injury Endorsements Provide The County With Coverage Only for The Enumerated Torts, Not For Claims Of Trespass, Nuisance, And interference With The Use Of Property,

Even if the pollution exclusions did not control the outcome of this case,[9] the personal injury provisions would not afford the County any coverage under the policies, As the trial court recognized, these provisions provide coverage only for liability for the enumerated torts of "wrongful entry or eviction or other invasion of the right of private occupancy" — not the Hunt Club's underlying allegations of trespass, nuisance, and interference with the use of property. Slip op. at 7.

Personal injury coverage does not provide a general grant of coverage. Instead, coverage under these provisions ia limited solely to the enumerated torts. Personal injury coverage'builds from the ground up: It affords coverage only for defined risks." *Martin v. Brunzelle*, 699 F. Supp. 167,170-71 (N.D. Ill. 1988). See *also Aetna Casualty & Sur. Co. v. First Sec. Bank*, 662 F. Supp. 1126,1132(D. Mont. 1987) (holding that "'personal injury' coverage applie[s] only to claims actually arising out of the enumerated torts"), and American *& Foreign Ins. Co. v. Church Schools*, 645 F. Supp. 628, 633-34 (E.D. Va. 1986) (personal injury coverage applies only to claims arising out of the torts listed), Quite plainly, for coverage to be afforded, it must be baeed an one of the specific'offenses" listed in the policy. Personal injury coverage "does not contain a general promise of coverage but specifies coverage-triggering offenses," Puritan *Ins. Co. v. 1330 Nineteenth St.*

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[9] This Court need not determine whether the general pollution exclusion clauses apply to these personal injury provisions, barring coverage here. *See Thompson-Starrett Co. v. American Mut. Liab. Ins. Co.*, 276 N.Y. 266, 270, 11 N.E.2d 905, 906 (1937) ("in construing an endorsement to an insurance policy the endorsement and policy must be read together and . . . the policy remains in full force and effect except as altered by the worde of the endorsement").

Corp., 1984 Fire & Casualty Cas. 1149,1153 (D.D.C. 1984). *See generally*, Appleman, 7 *Insurance Law* § 4501.14.

In the instant case, if Aetna, Continental, and Firemen's had intended to provide coverage to the County for trespass, nuisance, or interference with the use of the property, they would have included these specific torts within the definition of personal injury in the policies. They did not. Because personal injury coverage is clearly limited only to those specific torts which are within the policy definition, personal injury coverage is not provided for trespass, nuisance, or interference with the use of property.

Courts have regularly repudiated the stratagem used here by the County, rejecting claims for insurance under personal injury provisions when the underlying action does not involve wrongful entry or eviction, but instead, damage caused by environmental pollution. For instance, in *Morton Thiokol, Inc. v. General Accident Insurance Co., No, C-3956-85,* slip op. at 28 (N.J. Super. Ct., Ch. Div. Aug. 27,1987) (attached hereto as Exhibit 4), a decision whose logic persuaded the trial court, the policyholder sought coverage for common law public nuisance and New Jersey Spill Act claims arising from the release of mercury from a mercury processing plant into a nearby creek, The policyholder argued that the finding of a nuisance in the underlying action brought the case within the personal injury provisions of its policies, which, like the ones issued to the County, insured against damages due to "wrongful entry or eviction or other invasion of the right of private occupancy.' The court squarely rejected the policyholder's claim, According to the court:

> The plaintiff has confused the concept of trespass with wrongful entry. Its argument that the common law distinction between nuisance and trespass has been blurred has no relevance to the insurance contract clause with respect to "personal injury". . . The seepage of toxic

> waste has nothing at all to do with the possession of Berry's Creek. The personal injury clause[s] of the policiee do not provide coverage to plaintiff.

Id. at 28.10

In *Ludlow's*, a case remarkably similar to the instant one, the policyholder waa the owner and operator of a landfill that had accepted for disposal hazardous industrial wastes for a number of years, thus allegedly contaminating the surrounding groundwater. The underlying suit sought damages for the leaching of the hazardous wastes from the landfill. The policyholder claimed personal injury coverage. *Ludlow's*, transcript at 4-6. The United States District Court for the Northern District of New York granted summary judgment to the insurers. In doing so, the court rejected the policyholder's claim that coverage was provided by the personal injury provisions of the general liability policiee, *Ludlow's Sand & Gravel Co., Inc. v. General* Accident *Inc. Co.*, No. 87-CV-1239, order (N.D.N.Y. May 16, 1991) (attached hereto as Exhibit 5). *See also Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, No. 86-MR-308, transcript at 9 (Ill. Cir. Ct., Lake County May 17, 1989) [attached hereto as Exhibit 6) (discounting the applicability of the personal injury clause of the policy because the case revolved around the pollution exclusion), and *Gregory v. Tennessee Gas Pipeline Co.*, 948 F.2d 203,209 (6th Cir. 1991) (denying personal injury coverage for pollution claims, as such coverage would render the pollution exclusion meaningless").

Both the County and Opposing Amici ignore the logic of these well-reasoned decisions. Instead, they rely heavily upon *Titan* Holdings *Syndicate, Inc. v. Keene*,

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10 Although *Morton Thiokol* is a New Jersey case, the trial court explicitly adopted its reasoning., Nevertheless, both the County and Opposing Amici attempt to distinguish *Morton Thiokol* from the instant factual situation on the grounds that alleged environmental damage in *Morton Thiokol* took place on public land, not private land. County Brief at 33-34; Brief of Opposing Amici at 17-18, n. 17. This alleged distinction is a red herring: the holding of *Morton Thiokol* was *not* predicated on any sort of public/private distinction, Even the County concedes that the *Morton Thiokol* court merely "noted" this fact. County Brief at 33.

898 F.2d 265 (1st Cir. 1990). County Brief at 26-27 and Brief of Opposing Amici at 15. The *Titan* court, however, erred in concluding that nuisance was "[an]other invasion of the right of private occupancy? *Id.* at 272. This holding ignores the principle of contract construction known as *ejusdem generis*. See *infra* at 19-20. Moreover, *Titan* is based on a perceived expanaive definition of invasion of the right of private occupancy under New Hampshire law as noted in Town of *Goshen v. Grange Mut.* Ins. Co., 120 N.H.916,424 A.2d 822 (1980) (deciding that under New Hampshire law an invasion of the right of private occupancy need not involve "an appreciable and tangible interference with the physical property itself"), New York law, however, takes a much more restrictive approach. See *infra* at 16-18.[11]

Since trespass, nuisance, or interference with the use of property are not torts enumerated in the insurance contracts at issue, there is no coverage under the personal injury provisions of these contracts.

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[11] Other courts have similarly found *Titan* unpersuasive. See, *e.g.*, *Gregory*, 948 F.2d at 209 (rejecting policyholder's argument that *Titan* supports personal injury coverage for pollution claims.)

The other cases cited by the County are also unpersuasive. For instance, *Napco v. Fireman's Fund Ins. Co.*, No, 90-0993, slip op. (W.D. Pa. May 22,1991) (attached hereto as Exhibit 7), on *appeal*, involved a policy that, unlike those here, explicitly deleted the exclusions to the policy and focused on property rights. The court in High *Voltage Engineering Corp. v. Liberty Mutual Ins. Co.*, No. 90-00566, slip op. (Mass. Super. Ct. Jan. 24,1992) (attached hereto as Exhibit 8), as a Massachusetts court, felt itself bound by the First Circuit's decision in *Titan*. The court in *Northrop* Corp. *v. American Motorist* Ins. *Co.*, *No.* C 710571, slip op. (Super. Ct. Cal. April 8,1992) (attached hereto as Exhibit 9), *on appeal*, incorrectly finding an ambiguity in the personal injury provisions at issue, applied California's special rule that unless there is evidence of "specially crafted language" all ambiguities should be construed against the insurer.

1. Wrongful Entry And Eviction Are Fundamentally Different Torts From Trespass, Nuisance, And Interference With The Use Of Property.

The personal injury provisions in the policies at issue specifically cover "wrongful entry" and 'eviction." These two torts are significantly different from trespass, nuisance, and interference with the use of property, the three torts enumerated in the Hunt Club's underlying complaint. In particular, none of the underlying claims requires *purposeful* acts aimed at the infringement of a possessory interest in property, the key elements of the torts of "wrongful entry" and 'eviction,"

The County points out that "wrongful entry or eviction or other invasion of the right of private occupancy" are undefined in the policies at iseue. County Brief at 19, 22. However, the common law provides dear, steadfast definitions of these torts.

Coverage for "wrongful entry or eviction or other invasion of the right of private occupancy"is designed for claims arising from landlord-tenant relationships, Wrongful entry is committed when the current possessor of property is dispossessed by someone else who, without title, claims or acquires a possessory interest in the property. As haa long been recognized in New York, "[w]henever one person enters upon and takes *permanent possession* of the real property of another, claiming title thereto . . , an unlawful entry and ouster has been made." *Leprell v. Kleinschmidt*, 112 N.Y. 364, 369, 19 N.E. 812, 814 (1889) (emphasis added).[12] See

[12] *Leprell's* "unlawful entry*is synonymous with the term "wrongful entry," showing that New York courts *do* recognize the tort of unlawful entry, notwithstanding the County's suggestions to the contrary, *County* Brief at 23. Moreover, "unauthorized entry* is not synonymous with "wrongful entry," as the County asserts in its roundabout attempt to link trespass with wrongful entry. *Id.* at 23. "Unauthorized" refers instead to a withholding of authority or approval; it does not mean "wrongful" or "unlawful."

also Railroad Co. v. Perkins, 49 Ohio St. 326, 332, 31 N.E. 350, 351 (1892) (a person commits wrongful entry when he "wrongfully enters *and possesses* without *any* title") (emphasis added); *Davis v. Dennis*, 43 Wash. 54, 85 P. 1079 (1906) (explaining that 'gist of the action" was "wrongful entry of the appellants on the possession of the respondents"); and *Raymond* v. *The T., St. L. & K.C.R.R. Co.*, 57 Ohio St. 271, 48 N.E. 1093 (1897) (wrongful entry claim filed against railroad company which dispossessed the claimant who was thereby put "out of possession"),

In the instant action, wrongful entry's requisite element of interference with possessory rights is lacking: the Hunt Club has not alleged either that it no longer retains possession of its property or that the County has taken possession of the Hunt Club's land. In *Morton Thiokol*, the court rejected the policyholder's attempt to equate trespass with wrongful entry for this very reason:

> Wrongful entry with respect to real estate is the going upon land for the purpose of taking possession of it. Here, no one sought to take possession of Berry's Creek, neither the land that forms its bed, nor the waters flowing through it.
>
> The plaintiff haa confused the concept of trespass with wrongful entry. Its argument that the common law dietinction between nuisance and trespass has been blurred has no relevance to the insurance contract clause with respect to "personal injury." Wrongful entry, eviction and occupancy all have to do with the possession of property . . , The personal injury clause of the policies do not provide coverage to plaintiff,

Morton *Thiokol*, slip op, at 28. *See also Gregory v. Tennessee Gas Pipeline Co.*, 948 F.2d 203 (6th Cir. 1991) (no personal injury coverage for pollution migrating from insured municipality's lake where underlying complaints did not allege the active, intentional conduct required for wrongful entry).

Like wrongful entry, eviction also requires that the tortfeasor dispossess the property-holder and acquire possession of the property itself'. In New York, an

eviction "occurs only when the landlord wrongfully ousts the tenant from *physical possession* of the leased premises. There must be a ***physical expulsion or exclusion.***" *Barash v. Pennsylvania Terminal Real Estate Corp.*, 26 N.Y.2d 77, 82, 256 N.E.2d 707,709,308 N.Y.S.2d 649,653 (1970) (citations omitted) (emphasisadded). *See also* Union ***Dime Savings Bank v. Frohlich***, 67 A.D.2d 862,394 N.Y.S.2d 265 (2d Dep't 1977) (holding that eviction did not occur when "tenants were not physically expelled or excluded from the demised premises").[13]

Moreover, it is well settled that a *temporary* trespass by a landlord on the premises that is.not intended to deprive the tenant of possession does not amount to wrongful eviction. Rather, eviction is an "act of permanent character." *Kahn v. Bancamerican-Blair Corp.*, 327 Pa. 209,193 A. 905,906 (1937). See also Morton *Thiokol*, dip op. at 28 (holding that 'eviction means a dispossession through legal process. The State was not dispossessed of the waters of Berry's Creek"). Unlike wrongful entry and eviction, trespass, nuisance, and interference with the use of property do not purposefully infringe upon possessory rights. Besides, these torte are of a temporary rather than permanent nature. *See, e.g., Carr v. Town of Fleming, 122* A.D.2d 540, 541, 504 N.Y.S.2d 904,906 (4th Dep't 1986) (noting that a "trespass is temporary in nature").

Since trespass, nuisance, and interference with the use of property are wholly different from wrongful entry and eviction, there ia no coverage for these torts in the personal injury provisions contained in the Insurers' policies,

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[13] Courts in other jurisdictions agree that in order that 'there be an eviction by the landlord, in the legal sense, it is necessary that the tenant no *longer retain possession of the premises . . .*" Manifold *v. Schuster*, 67 Ohio App. 3d 261,259,686 N.E.2d 1142,1147 (1990) (quoting 2 Tiffany, *Landlord and Tenant* § 185(d) and 1263 and citing Ohio precedent) (emphasis added), See *also Kuriger v. Cramer, 346* Pa. Super. 596,498 A.2d 1331, 1338 (1985) (wrongful eviction is an act by a landlord that "interferes with a tenant's possessory right to the demised premises") (citations omitted).

2. Under The Principle *Of Ejusdem Generis,* "Other Invasion Of The Right Of Private Occupancy" Also Refers To Dispossession of Property.

The phrase "other invasion of the right of private occupancy" in the grant of personal injury coverage for 'wrongful entry or eviction or other invasion of the right of private occupancy" does not open the door to a flood of coverage for torts alien to the policies, such as the underlying allegations of trespass, nuisance, and interference with the use of property. Instead, basic principles of contract construction require that this phrase be limited to offenses, like wrongful entry and eviction, that involve the wrongful *dispossession* of property.

Under the doctrine of *ejusdem generis*, long recognized in New York, when general words follow a specific classification, the general terms are construed to include only those things of equal or inferior *rank* to the enumerated class. See, *e.g.*, *Forward* Industries *v. Rolm of New York Corp.*, *123* A.D.2d 374,376,506 N.Y.S.2d 453,455 (2d Dep't 1986) (specific terms in contract restrict meaning of compreheneive worda that follow them under principle of *ejusdem generis*); *Traylor v. Crucible* Steel *Company*, 192 A.D. 445,183 N.Y.S. 181 (let Dep't 1920), *aff'd*, 232 N.Y. 583,134 N.E. 581 (1922) (rule of *ejusdem generis* applies to construction of contract, limiting general phrase to the specific terms which precede it); and 22 N.Y. Jur. 2d, Contracts §223 (1082)('rule of *ejusdem generis* is applied in the construction of contracts" in New York).

When applying the doctrine of *ejusdem generis*, the general term "other invasion of the right of private occupancy" can only mean an offense in which the offender interferes with the occupier's possessory right in the property. As one court has explained:

> 'Other invasion of the right of private occupancy' is simply *part* of a more complete definition of 'personal injury,'

> following directly on the heels of 'wrongful entry or eviction.' Ejusdem generis principles draw on the sensible notion that words such as 'or other invasion of the right of private occupancy' are intended to encompass actions of the same general type as, though not specifically embraced within, 'wrongful entry or eviction,'

Martin v. Brunzelle, 699 F. Supp. at 170. See *also Nichols*, 215 Cal. Rptr. at 421-22 (1985) (meaning of phrase 'other invasion of the right of private occupancy" is reinforced by its conjunction with the words 'wrongful entry or eviction''; no coverage where there is "no invasion of any interest attendant to the possession of real property") (emphasis added); Red *Ball Leasing, Inc. v. Hartford Acc. & Indem. Co., 915* F.2d *306,312* (7th Cir. *1990)* (applying rule of *ejusdem generis* to find 'other invasion" language limited to invasions of real property); *Morton Thiokol*, slip op. at 28 ("[w]rongful entry, eviction and occupancy all have to do with the possession of property").[14]

Thus, just as coverage for wrongful entry or eviction must involve an interference with possession of real property, so too coverage for "other invasion of the right of private occupancy" must involve at least this minimum requirement. Because the Hunt Club's complaint does not allege that the County attempted to take possession of the Hunt Club's property or to oust the Hunt Club from possession of its own property, there is no coverage under this personal injury provision.

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[14] The County ignores this fundamental common law canon of contract construction. Instead, the County asserts that nuisance is clearly contemplated by the "other invasion" language, arguing that "[i]nterference with the use and enjoyment of property resulting from pollution constitutes a nuisance under New York law." County Brief at 24 (citing Boomer *v. Atlantic Cement Co., 26* N.Y.2d 219, 267 N.E.2d *870,309* N.Y.S.2d 312 *(1970))*. The County's argument is irrelevant. Boomer decidedly did not hold, nor could it, that either "nuisance" or "interference with the use of property" are interchangeable with the torts of wrongful entry or eviction or other invasion of the right of private occupancy,"

B. The County's Willful Violation Of A Penal Statute Provides An Additional Reason To Refuse The County Any Personal Injury Coverage Under The Policies,

The trial court held that a further, alternative or supplementary reason[15] for denying personal injury coverage to the County stems from its "willful violation of a penal statute or ordinance."

The personal injury endorsements to the policies explicitly provide that coverage does not apply to personal injury'arising out of the willful violation of a penal statute or ordinance committed by or with the knowledge or consent of the insured." The County has admitted to signing the Consent Order with the New York Department of Environmental Conservation confessing that it was 'currently discharging leachate into the groundwater and is thus in violation of Sections 360.8(a) and 703.5 of 6 NYCRR." Slip op. at 2-3. Because the Hunt Club's complaint alleged that the County violated the Consent Order, the trial court properly held that the County was not entitled to any personal injury coverage. Id. at 7.

The County and Opposing *Amici* attempt to undermine the trial court's reaeoned finding. For instance, the County asserts that the environmental regulations encompassed by the Consent Order were not 'penal," since they involved *civil* violations rather than *criminal* violations, County Brief at 44-45. Them is no basis in New York law for this arbitrary civil/criminal decision — as the

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[15] The trial court implicitly acknowledged that the County's "willful violation of a penal statute" was a *supplementary* reason to deny personal injury coverage to the County. Indeed, as demonstrated above, the fact that the underlying torts do not correspond with the policies' enumerated torts is sufficient to rule against the County on personal injury coverage.

County implicitly concedes by failing to cite a single New York case in support of this proposition.[16]

Both the County and Opposing Amici also argue that the term "willful" is ambiguous under New York law. County Brief at 45-46 Brief of Opposing Amici at 24. These bald assertions ignore the definition of 'willful" that the Court of Appeals put forth less than two years ago in an insurance context:

> The term "willful" is not defined in the Insurance law or regulations, but we find some guidance as to its unremarkable meaning in a civil regulatory context as "no more than intentional and deliberate."

American Transit Ins. Co. v. Corcoran, 76 N.Y.2d 977,979,666 N.E.2d 485,487,563 N.Y.S.2d 736,738 (1990)(citing a long line of New York cases), Here, the County has admitted that ite activities at the dumpsite were intentional and deliberate — thus fulfilling *Corcoran's* precise definition of "willful."

C. The Selected, Extra-Record Extrinsic Materials That The County And Its Amici Seek To Inject Into This Appeal Are Inadmissible And Irrelevant.

Seeking to distract attention from the unambiguous meaning of the personal injury provisions, both the County and especially Opposing Amici rely upon alleged interpretations of those provisions by the 'insurance industry." Thew materials are misleading and unpersuasive, since the County and Opposing Amici are seeking to apply selected broad propositions allegedly asserted by insurers in different contexts

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16 Instead, the County cites the Penal Law, contending that it relates exclusively to criminal offenses. County Brief at 44. In fact, the Penal Law never mentions the civil/criminal distinction, but instead defines "offense" as 'conduct for which a sentence to a term of imprisonment or to a fine is provided by. . . any order, rule or regulation of any governmental instrumentality." N.Y. Penal Law § 10.00 (McKinney 1992). Thus, if the Penal Law is relevant to the policy language, the County's violation of the environmental regulations fulfills this definition.

to the discrete facts and circumstances of this case, with its unique "personal injury" issue.

The use of this material is also improper. In the first place, most of the extrinsic materials introduced by the County and Opposing Amici on appeal were not admitted into evidence below. It is a fundamental canon of appellate procedure that "matters not raised below will not be considered for the first time upon appeal." *Van Alstyne on Behalf of "P" v.* David "Q", 92 A.D.2d 971,972,460 N.Y.S.2d 848, 850 (3d Dep't 1983).

Moreover, most of the materials that tho County and Opposing Amici seek to introduce on appeal violate New York's rules governing the use of extrinsic evidence and are therefore not admissible. As this Court held loss than five months ago, when parties to a contract set down their agreement in a clear and complete manner, extrinsic evidence is generally inadmissible to add to or vary the agreement. *Serna v. Pergament* ***Distributors, Inc.*, 582 N.Y.S.2d 550, 552** (3d Dep't 1992) (evidence outside the four corners of the document as to what was really intended but unstated is generally inadmissible). Even when ambiguity exists, the extrinsic evidence must be of a certain caliber: it must aid the court in resolving the ambiguity in the policy. See, *e.g.*, *Klein* ***v. Empire* Blue *Cross & Blue Shield*, 173 A.D.2d 1006,1010,669** N.Y.S.2d 838,842-843 (3d Dep't 1981) (holding that where tendered extrinsic evidence on interpretation of ambiguous contract is "conclusory and cannot resolve the equivocality of the language of the contract," contract interpretation remains a question of law for the court).

Here, there is no ambiguity in the policies at issue and, more specifically, in the terms "wrongful entry or eviction or other invasion of the right of private occupancy." As demonstrated above, these terms have precise meanings well grounded in the common law. See *supra*, p. 16-20. Even if the Court were to hold that ambiguities exist in the policies, however, the various strands of extrinsic

material offered by the County and its Amici would not clear up these ambiguities. Instead, this 'evidence" attempts to bind Aetna, Continental, and Firemen's to alleged "pro-coverage" statements unrelated to the contractual language at issue, statements allegedly made in the past by an undefined "insurance industry."

For example, both the County and Opposing Amici cite a brief alleged to have been filed by a non-party insurance company in a different proceeding in another jurisdiction, as well as an article written by Kirk A. Pasich (an attorney who regularly represents policyholders in coverage disputes), as "proof" that the "insurance industry" has previously represented that personal injury coverage encompasses trespass and nuisance claims. County Brief at 35-36; Brief of Opposing Amici at 11-12. It would be grossly unfair to hold Aetna, Continental, and Firemen's accountable for statements made by different insurers in different proceedings, or to consider the opinions of an author whose bias is glaringly obvious.[17] Besides, these strands of 'evidence" do not explain any ambiguities in the policies, as they must under New York law, *Sera*, 682 N.Y.S.2d at 652; *Klein*, 173 A.D.2d at 1010.[18]

Similarly, Opposing Amici cite four briefs allegedly written by other insurers in different cases to support Opposing Amici's irrelevant, yet sweeping proposition that "the insurance industry has represented that exclusions must be read narrowly

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17 For an article with a different viewpoint on personal injury coverage, see Foggan, Lawrence, and Renberg, Looking For *Coverage In All The Wrong Places: Personal Injury Coverage In Environmental Actions*, 3 Environmental Claims Journal 291 (Spring 1991) (attached hereto as Exhibit 10). The authors represent insurers in environmental coverage disputes.

18 In an attempt to avoid the fact that the County has no personal injury coverage for liability from ite "willful violation of a penal statute: the County's Amici dwell on a brief allegedly filed by Aetna in a different case two years ago, allegedly asserting that the term 'willful" requires a 'preconceived design," The County's Amici ignore the New York Court of Appeals' recent decision in *Corcoran* that holds that "willful* means 'no more than intentional and deliberate." See *supra*, p. 22.

in favor of coverage." Brief of Opposing Amici at 21-23. Aetna, Continental, and Firemen's had *nothing whatsoever* to do with these briefs, nor is there any indication of the factual contexts of these cases or the policy provisions involved.[19] Claiming "judicial estoppel,"[20] Opposing Amici assert that the Insurers should not be allowed to 'contradict themselves." Brief of Opposing Amici at 30-33.

The doctrine of judicial estoppel, however, applies only to factual positions, Expressions of opinions and legal conclusions — the type of "pro-coverage" statements alleged here -- do not trigger application of the doctrine, *See, e.g., Bates v. Cook, Inc.*, 616 F. Supp. 662,672 (M.D. Fla. 1984) (judicial estoppel generally does not apply to legal conclusions). Besides, most of these alleged 'pro-coverage" statements were made by entities other than Aetna, Continental, and Firemen's. The doctrine of judicial estoppel can apply only to prior statements made by parties, not by nonparties (such as the "insurance industry" continually referred to by Opposing Amici).[21]

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[19] Both the County and Opposing Amici argue that, because a drafting committee allegedly did not make certain revisions to a so-called standard policy, the "insurance industry" reached the conclusion that the pollution exclusion does not apply to personal injury coverage. County Brief at 40-41; Brief of Opposing Amici at 12-13. Of course, neither the committee nor the "insurance industry" ever made such an affirmative statement.

[20] The doctrine of judicial estoppel does not encompass 'widely recognized principles," as Opposing Amici assert, Brief of Opposing Amici at 30. Instead, judicial estoppel is recognized as a 'rather vague" doctrine. 1B Moore's Federal Practice, ¶ .405[8] (Bender 1988).

[21] Considering that insurance companies have filed tens of thousands of briefs across the country in a number of courts and in a vast variety of contexts, it would not be surprising if Opposing Amici were able to find a few briefs from the 'insurance industry" asserting contrary positions to the ones taken here by Aetna, Continental, and Firemen's. This is mere gamesmanship. The purpose of judicial estoppel is to promote "common law views of fair dealing." 18 Wright, Miller & Cooper, *Federal Practice and Procedure*, Jurisdiction 2d § 4477 (1981). In the instant case, there is no indication that Aetna, Continental, and Firemen's have not dealt honestly and fairly with the County.

Opposing Amici thus fail to allege the requisite elements of the doctrine of judicial estoppel. This Court should disregard Opposing Amici's groundless argument that the doctrine should apply to the Insurers in this proceeding.

III. PUBLIC POLICY SUPPORTS APPLICATION OF THE CONTRACTUAL LANGUAGE AS WRITTEN.

Sound public policy dictates that the insurance contracts at issue be enforced as written. The policyholder here is a county that repeatedly and deliberately deposited harmful waste on land. Other entities that seek to benefit from rulings that disregard clear contractual language to create non-contractual coverage for environmental cleanup costs are giant industrial corporations, major long-term polluters now asking courts across the country to transfer the costa of their past environmental practices to insurers who never agreed to bear them. Accepting the contentions of these policyholdere, small and large, undermines the function of insurance contracts and retards the attainment of environmental goals.

Insurers recognize that, under CERCLA and similar federal and state statutes enacted in recent years, waste generators and other polluters face huge retroactively imposed cleanup costs. But the possible harshness of the fundraising mechanisms imposed by these statutes and the needs of governmental entities for cleanup funds provide no basis for expanding and distorting insurers' contractual obligations. See, *e.g.*, *Finci v. American Casualty Co.*, 323 Md. 358, 593 A.2d 1069 (1991) (state agency's goal of collecting funds provides no legal basis for invalidating policy exclusion).

Ignoring or twisting the meaning of language used in the policies — like "wrongful entry or eviction or other invasion of the right of private occupancy" — harms the public interest, affecting the future of insurance in New York. When insurers are faced with uncertainty that contracts will be enforced as written,

rational underwriting becomes impossible. This uncertainty may result in increased rates, as underwriters must compensate for uncertainty as to how courts will treat contractual language in the future. In the context of environmental claims, such a transformation of the liability insurance contract could expose insurers to liabilities many times greater than their surplus and indeed greater than the capacity of the industry as a whole.[22] Judicially created pollution coverage for industrial polluters could have a serious effect on the cost and availability of all types of insurance for other policyholders in New York and elsewhere.*

Forcing polluters to pay for environmental cleanup, rather than permitting them to foist such costs onto their liability insurers, accords with legislative intent and is the most effective way to protect the environment. CERCLA imposed the costs of cleaning up the environment on polluters — those who had "profited or otherwise benefitted from commerce involving [hazardous] substances."[24] Current public policy as enacted by Congress and New York requires that those whose activities resulted in pollution shoulder the burden of correcting and preventing environmental injury. Undoubtedly this retroactively imposed obligation creates problems for many polluters. But there is simply no legal basis for courts to shift those obligations to insurers who did not contract to assume them and whose ability

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22 See, e.g., United States General Accounting Office, *Insurance Liability for Cleanup Costs at Hazardous Waste Sites: Hearings Before the Subcomm. on Policy Research and Insurance of the Comm. on Banking, Finance and Urban Affairs, House of Representatives*, 101st Cong., 2d Sess, 50 (1990) ('Potential Liability of Property/Casualty Insurers for Costs of Cleaning Up Hazardous Waste Sites").

23 The EPA itself has explained that the limited availability of insurance for CERCLA contractors is based in part on the fact that "[c]ourts in key jurisdictions have imposed retroactive liabilities on insurers for pollution damages and cleanup costs that were never intended to be covered," *EPA, Superfund Response Action Contractor Indemnification*, 54 Fed. Reg, 46012,46013 (Oct. 31, 1989).

24 *Environmental Emergency Response Act*, S. Rap. No. 848, 96th Cong., 2d Sess. 1, 98, *reprinted in 1 A Legislative History of the Comprehensive Environmental Response, Compensation and Liability Act of 1980* (statement of EPA Administrator Costle).

to carry out their socially beneficial insurance function could be seriously threatened if they were forced to do so,

CONCLUSION

For the foregoing reasons, the decision of the trial court should be affirmed,

Respectfully submitted,

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Exhibit E

Commonwealth of Massachusetts

Supreme Judicial Court
for the Commonwealth

No. SJC-06165

Norfolk County

AFFILIATED FM INSURANCE COMPANY

Plaintiff, Appellant

v.

CONSTITUTION REINSURANCE CORPORATION

Defendant, Appellee

On Appeal From A Judgement Of The Superior Court

BRIEF OF *AMICUS CURIAE* AMERICAN INSURANCE ASSOCIATION

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JHTEREST OF AMICUS CURIAE

The American Insurance Association ("AIA") is a national trade organization representing 252 companies writing property and casualty insurance contracts in every state and jurisdiction of the United States. These companies together write more than $60 billion in combined premiums annually.' Together, AIA member companies are affiliated with thousands of independent insurance agents nationwide. A substantial portion of AIA member companies' business is commercial liability insurance. This form of coverage enables American businesses to provide the goods, services, jobs, and investments vital to the country's economic health. In addition, AIA member companies employ more than 145,000 people and contribute $2.2 billion in state taxes and fees [including payroll taxes) to state governments each year.

AIA's purposes include promoting the economic, legislative and public interests of its members and the insurance industry, providing a

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I All financial figures are from 1990, the most recent year for which figures are available,

forum for discussion of problems that are of common concern to its members, and serving the public interest through appropriate activities including the promotion of safety and security of persons and property.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

Whether a reinsurer is contractually obliged to pay a proportionate share of the litigation expenses incurred by the reinsured company in opposing an insured's demand for coverage,

STATEMENT OF THE CASE

Amicus incorporates by reference the Statement of the Case set forth in the Brief of the Plaintiff-Appellant Affiliated FM Insurance Company ("Affiliated") on pages 2-4..

STATEMENT OF THE FACTS

Amicus adopts the Statement *of* Facts set forth on pages 4-9 of Affiliated's brief.

SUMMARY OF ARGUMENT

This case presents a single question: whether a reinsurer is contractually obliged to pay a proportionate share of the litigation expenses incurred by the reinsured company in successfully opposing an insured's demand for coverage? Ignoring the plain language of the applicable agreement, an unbroken line of authority in bath this country and Great Britain (including a seminal decision by this Court), the uniform view of treatise writers, and an ancient and heretofore unquestioned practice between and among reinsurers and reinsured, the trial court answered that question in the negative. (Pp. 10-20.)

The Superior Court's conclusions were more than merely erroneous. If permitted to stand, the decision is likely to have staggering consequences for the domestic insurance industry. While the sums *at* issue in this case are relatively minor, direct (i.e., primary and excess) insurers spend (conservatively) a billion dollars a year in so-called "coverage litigation," typically in the

form of declaratory judgment actions. Permitting reinsurers to escape paying their fair share of these costs confers an unwarranted and historically unprecedented windfall while saddling reinsureds with massive, completely unanticipated costs that inevitably will be borne by policyholders In the form of increased premiums. (Pp. 20-26.)

Such a radical reorientation of the relationship between reinsurers and reinsured has no basis in law. As a result of the historical tradition that reinsurance transactions are a matter of the "utmost good faith between the parties," reinsurance contracts are remarkably short and notably lacking in the legalisms that characterize other complex commercial arrangements. (Pp. 10-12.) Accordingly, from the very advent of reinsurance several centuries ago, dispute resolution has always centered around the guiding principle of "good faith" as informed by the historic customs and traditions of the business. (Pp. 32-13.)

Read in this light, Constitution Re's effort to dissociate itself from the coverage action is plainly unsupportable. Where the denial of coverage is sustained, a reinsurer -- which has contractually accepted a portion of the risk in consideration for a premium paid by the ceding insurer -- is a direct beneficiary of the coverage dispute. (Pp. 13-14.)

But even when a court rules that coverage is required, the reinsurer is inextricably associated with the judgment. Under the express terms of the agreement, a reinsurer agrees to "follow the fortunes" of the reinsured company -- i.e., to link its fate to that of the reinsured. Nonetheless, the reinsurer's obligations are "subject to" the terms and conditions of the policy issued to the insured. Put differently, to the extent the direct insurer has a legitimate coverage defense, that defense automatically inures to the benefit of the reinsurer as well. For this reason, reinsurers frequently urge the reinsured to resist coverage when there is a substantial basis for doing so. (Pp. 14-15.)

Moreover, if the reinsured ignores those exhortations -- or simply fails to litigate the coverage issue -- it does so at its peril. With increasing frequency, courts are ruling that the reinsurer Is not liable to the reinsured to the extent the latter pays out under a policy where coverage was precluded "as a matter of law."

In short, as reflected by industry custom and as universally approved by courts and commentators alike, reinsurers have a vital stake in coverage litigation and, for that reason, should be required to pay for it. (Pp. 15-20.) Any other interpretation would allow reinsurers to become a "free rider." (Pp. 20-21.) Moreover, it would foment an adversarial relationship between reinsured and reinsurer in a manner at odds with the basic premise of the reinsurance transaction that their interests are aligned. (Pp. 21-22.) In cases of uncertain coverage, a direct insurer often will choose simply to pay out the claim. If, however, the reinsurer is not "on the hook" for declaratory judgment expenses, it has every reason to insist that the company resist coverage

as vigorously as possible -- or risk a fight over reimbursement down the line, The end result is a de facto conflict of interest between reinsured and reinsurer, as well as powerful impetus to invoke scarce judicial resources to resolve coverage issues. Neither consequence is in the public interest. (Pp. 22-23.)

Not surprisingly, the pertinent language of the reinsurance certificate is entirely consistent with these principles. Focusing on Clause A, the Superior Court found that the reinsurer's "liability" was "subject" to the "terms and conditions" of the Campbell Soup policy. (Pp. 23-24.) As the structure of the agreement makes plain, that language merely reflects the basic indemnity relationship of the parties: The reinsurer has the same duties, as well as the same coverage defenses, as the reinsured. Hardly, however, does it follow that "Affiliated's [litigation) expenses are not covered . . . because they would not be covered under the Affiliated/Campbell policy." Affiliated FM Ins. Co. v. Constitution Reinsurance Corp., No. 89-

2411, slip op. st 4 (Mass. Sup. Ct., Norfolk County Sept. 1, 1992) [hereinafter "Op. at __"]. To the contrary, Clause D expressly states that "in addition" to its basic obligation to reimburse Affiliated for losses associated with the underlying litigation (the EEOC/Campbell suit), the reinsurer "shall pay its proportion of expenses . . . incurred by [Affiliated] in the investigation and settlement of claims." (Pp. 24-25.) Indeed, Constitution Reinsurance Corporation's ("Constitution Re") recognition that the certificate requires it to pay some investigation expenses is fatal to its theory: If it has a duty to pay some expenses above and beyond those directly required by the Campbell Soup policy, then that policy does not set out *the* full universe of its obligations. (P. 26.)

Thus, the only real ,interpretive question presented in the case is whether the costs of a declaratory judgment coverage action qualify as "expenses incurred in the investigation and settlement of claims." (Pp. 26-27,) The language of the certificate -- which is supported by the

practices of the industry and the caselaw reflecting it -- compel the conclusion that they do. (Pp. 27-28.) In any event, the trial court's holding that such expenses are not covered as a matter of law is insupportable. At most, the phrase "investigation and settlement expenses" is sufficiently ambiguous as to warrant development of a fuller record concerning industry practice and the parties' intent. While AIA believes such an approach to be unnecessary in light of the clarity of the language and the nature of the reinsurer/reinsured relationship, a remand of this nature is the only even theoretical alternative to outright reversal.

ARGUMENT

The nature of the reinsurer/reinsured relationship, as reflected in longstanding, judicially-endorsed industry practice, compels the conclusion that both entities share in the cost of obtaining a judicial declaration of coverage obligations. This relationship, together with the historical expectation that parties to the

reinsurance transaction conduct thenselves with "the utmost good faith," necessarily provide essential insight into the meaning *of* the applicable language in the agreement. Moreover, even if that language were viewed in isolation, it plainly obligates a reinsurer such as Constitution Re to bear Its share of the costs associated with resolving the coverage dispute.

I. The Nature of the Reinsured/Reinsurer Relationship, Longstanding Industry Expectations and Associated Considerations *of* Public Policy support Affiliated's contractual Right to Reimbursement of Coverage Litigation Expenses.

As with any contract dispute, careful parsing of the actual language of the Affiliated/ Constitution Re agreement is central to the correct resolution of this case. Nonetheless, the sometimes arcane nuances of the reinsurance transaction as it has evolved over the centuries make it both important and appropriate to put that language in its proper context.[2] Indeed, the

2 Reinsurance has been described as "a mystery not worth the solving." Henry T. Kramer, (continued...)

legitimacy of this interpretive approach derives from the nature and history of the reinsurer/reinsured relationship. The rather informal arrangements that constitute tho origins of modern reinsurance quickly gave rise to an "established tradition that reinsurance transactions are a matter of 'utmost good faith' between the parties," Robert F. Salm, Reinsurance Contract Wording, in Strain, supra, at 79.[3] Reflecting that tradition, a reinsurance agreement typically is "a relatively short, concise document, noticeably lacking in the legalisms" characteristic of other contracts. Id. For this reason, interpretive questions under an agreement traditionally are "settled . . . according to the

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[2](...continued)
Nature of Reinsurance, in Reinsurance 1 (Robert W. Strain ed. 1980) [hereinafter "Strain"]. More to the point. the general absence of standard forms, together with the arcane nature of the transaction, has led one writer to observe that the "wordings [of the reinsurance agreement) do not readily speak for themselves." Id.

[3] See generally Reinsurance Law § A.2 (Robert Merkin ed. 1992) (tracing the history of reinsurance agreements from the fourteenth century).

customs and traditions of the business." Id.[4]

These "customs and traditions" virtually compel an interpretation of the pertinent contract language in the manner urged by Affiliated. In most respects, a reinsurance cession represents a specialized form of an indemnity agreement. American Ins. Co. v. North American Co. for Property & Casualty Ins., 697 F.2d 79, 81 (2d Cir. 1982). In exchange for a premium, the reinsurer agrees to reimburse the ceding insurer for a specified portion of any liability that may arise out of one or more contracts of insurance. The reinsurer further agrees to "follow the fortunes" of the reinsured -- that is, to link its fate to that of the ceding insurer provided that the ceding insurer conducts itself reasonably and in good faith.

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[4] See also James V. Schibley, The Life Reinsurance Contract, in Resolving Reinsurance Disputes: Contracts, Arbitration, Litigation 4 (A.B.A. Torts & Ins. Prac. Sec. 1987) (noting that one important reason that reinsurance functions successfully without extensive legal authority is "the existence of a common body of insurance practices that are generally accepted within the industry.")

Notwithstanding this commitment, however, the reinsurer's obligations are made expressly "subject to" the terms and conditions of the underlying policy. The effect of this provision is to make the reinsurer a derivative beneficiary of any legitimate coverage defense possessed by the reinsured company, e.g., a particular policy exclusion or the insured's failure to satisfy a condition precedent to coverage. Indeed, as courts have frequently observed, the "subject to" clause operates as a potentially significant limitation on the otherwise broad sweep of the reinsurer's general obligation to follow the reinsured's "fortunes." See, e.g., Michigan Millers Mut. Ins. Co. v. North American Reinsurance Corp., 452 N.W.2d 841 (Mich. Ct. App. 1990).

The net effect, and indeed the purpose, of these provisions, viewed together, is to align the respective interests of reinsurer and reinsured closely, When the reinsured denies coverage, and that denial is sustained in a declaratory judgment action, the reinsurer necessarily benefits from

that course of events. Where, however, the insured pays out a claim despite a clear lack of coverage, it does so at its "peril." New York State Marine Ins. Co. v. protection Ins. Co., 18 F. Cas. 160, 160 (C.C.D. Mass. 1841) (Story, J.). As numerous decisions now hold, a reinsurer is not liable to the reinsured to the extent the latter pays out under a policy where coverage was precluded "as a matter of law." Hiscox v. Outhwaite, 1990 Folio No. 2491 (U.K. Commercial Ct. App. Nov. 3, 1991) (Ex, 1).[5]

for these reasons, reinsurer and reinsured have a mutual interest in reaching an expeditious and correct determination of coverage. Not surprisingly, therefore, the reinsurer typically is more than a passive observer in this process. Pursuant to the express terms of the reinsurance agreement as well as the duty of "utmost good

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[5] See also American Ins. Co. v. North American Co. for Property & Casualty Ins., 697 F.2d 79, 81 (2d Cir. 1982); State Auto. Mut. Ins. Co. v. American Re-insurance Co., 748 F. Supp. 556 (S.D. Ohio 1990); Reliance Ins. Co. v. General Reinsurance Co., 506 F. Supp. 1042, 1050 (E.D. Pa. 1980); Michigan Millers Mut. Ins. Co., 452 N.W.2d 841, 842-43 (Mich. Ct. App. 1990).

faith," the reinsured company must notify the reinsurer of any claim that may trigger the latter's indemnity obligation.[6] Moreover, the reinsurer specifically reserves the right to be "associated" with the reinsurer in the defense and control of any claim. As a practical matter, reinsurers often use this relationship to convey their views on the validity of the insured's demand for coverage and the proper response to it. When the demand is doubtful, reinsurers frequently encourage the reinsured company to resist it. That intimation can be explicit or it can be conveyed as a veiled suggestion that reimbursement might not be forthcoming if the reinsured company pays out on the claim.

Taken together -- this close relationship, the shared interest in correctly evaluating and, where appropriate, resisting demands for coverage, and the imbalance of assigning to the reinsured the risk of an incorrect coverage determination -- make the question presented here, in Justice

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[6] See, for example, Clause C in the Affiliated/Constitution Re contract.

Story's words, not "of any intrinsic difficulty." New York State Marine Ins. Co., 18 F. Cas. at 160. With complete unanimity, courts and commentators alike have concluded that the reinsurer is contractually obliged to bear its proportionate share of the legal costs associated with investigating and, where appropriate, resisting demands for coverage. Because the cost and expenses of coverage litigation are "incurred for the benefit or the reinsurers and are indispensable for the protection of the reinsured," any other conclusion would be so unreasonable as to be plainly beyond the intent and expectations of the parties. Id.[7]

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[7] All of the leading commentators and treatise writers have spoken with one voice on this issue. See 13A John L. Appleman & Jean Applenan, Insurance Law & Practice § 7700, at 566-67 (1976) (reinsured is contractually obliged to pay proportionate share of declaratory judgment costs); 19 George J. Couch, couch on Insurance 2d § 80:68, at 675 (2d ed. 1983) (same); 44 Am. Jur. 2d Insurance § 1837, at 828 (1982) (same); Jonathan A. Bank et al., The Reinsurance of Environmental Claims: Shades of Grey, Mealey's Litig. Rep.: Reinsurance, Dec. 12, 1991, at 16, 29 (same). For a representative analysis, see Kenneth R. Thompson, Reinsurance 328-30 (4th ed. 1966):

(continued...)

The holding of this Court in Faneuil Hall Ins. Co. v. Liverpool & London Globe Ins. Co., 153 Mass. 63, 26 N.E. 244, 246 (1891), is illustrative, particularly in light of the technical (and incorrect, see infra pp. 23-26) arguments urged by Constitution Re on the basis of the policy language. In Faneuil Hall, as here, the Court construed a reinsurance contract that obligated the reinsurer to reimburse the reinsured for "all losses or damages arising under the[] [underlying] policies . . . subject to the came risks, conditions . . . as the policies reinsured.' Id. at 66, 26 N.E. at 245. Rather than finding this language somehow limiting, the

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[7](...continued)
Since the reinsured is bound at his peril that the claim against him is valid, after he has given notice to the reinsurer, he is justified in submitting the claim to the decision of the court and the costs which necessarily arise in such a suit might be considered as incurred upon reasonable grounds, and are allowed as composing part of a claim for indemnity against the reinsurer.

See also Robert F. Salm, Reinsurance Contract Writing, in Strain, supra, at 105 (reinsured should be encouraged to incur as much legal expense as necessary in resisting a claim where circumstances dictate).

Court held that the contract obligated the reinsurer to pay the reinsured "not only for the amount of the original loss [and the insured's defense costs], but also for the cos'ts and expenses incurred by the [reinsured] in defending itself against the [insured]." Id. at 68, 26 N.E. at 246 (emphasis added).[8] Other decisions reaching precisely this conclusion -- both in this country and in Great Britain -- are legion.[9]

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[8] The Superior Court therefore was simply wrong to brush aside this decision on the ground the pertinent policy language had not been presented or analyzed. Op. at 8-9.

[9] See peerless Ins. Co. v. Inland Mut. fns. Co., 251 F.2d 696, 703 (4th Cir. 1958); New York State Marine Ins. Co., 18 F. Cas. at 160; Central Nat'l Ins. Co. v. Devonshire Coverage Corp., 426 F. Supp. 7, 26 (D. Neb. 1976); Owens S.S. v. Aetna Ins. Co., 121 F. 882, 888-89 (S.D. Ga. 1903); Gantt v. American Central Ins. Co., 68 Mo. 503 (1878) (Ex. 2); Strong v. Phoenix Ins. Co., 62 Mo. 289, 295-98 (1876) (Ex. 3); Hastie v. De Peyster, 3 Cai. R. 190 (N.Y. 1805) (Ex. 4). For an especially instructive British case reaching the same conclusion, see Insurance Co. of Africa v. Scor (U.K.) Reinsurance Co., 1 Lloyd's Rep. 312, 325 (3985) (Ex. 5) (reinsured's right to reimbursement of coverage costs is an Implicit term of the contract whether or not found in an explicit term of the agreement); see also British Dominions Gen. Ins. Co. v. Duder, 2 L.J.K.B. 394 (1915) (Ex. 6).

So uniform is the commentary and caselaw on this point that Constitution Re cannot reasonably suggest that it expected the pertinent contract language to have been interpreted any other way.[10] See Central Nat'l Ins. Co. v. Devonshire Coverage Co., 426 F. Supp. 7, 26 (D. Neb. 1976) (finding that coverage determination expenses were reimbursable, because "whether that 'standard practice' is one based on the express or implied terms of the contract," it was "within the

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[10] The only two cases relied on by Constitution Re do not even remotely support its position. The only question at issue in Bellefonte Reinsurance Co. v. Aetna Casualty & Surety Co., 903 F.2d 910 (2d Cir. 1990), was whether the reinsured company could recover defense costs in *excess* of the limits set out in the insurance agreement, i.e., the *costs* of defending the insured in the underlying litigation. Id. at 911-912, 914. *Thus*, the case did not even involve coverage litigation expenses. Nor, of course is the modest sun Affiliated is seeking from Constitution Re anywhere near the limits set out in the Certificate. McKeithen v. S.S. Frosta, 430 F. Supp. 899 (E.D. La. 1977), is equally inapposite, and indeed did not even concern reinsurance. The issue there was whether an insurer could recover from its insured the costs of bringing an interpleader action to resolve their respective rights and liabilities. Because the court answered that question solely with regard to the language of the insurer/insured policy, the case has no bearing whatever on the reinsurance question at issue here.

contemplation of the parties"); Insurance Co. of Africa v. Scor (U.K.) Reinsurance Co., 1 Lloyd's Rep. 312, 325 (1985) [Ex. 5). Indeed, in the experience of AIA member companies, reinsurers routinely pay their proportionate share of the expenses associated with coverage litigation. Thus, to the extent that "customs and traditions" of the business shed light on the meaning of the policy language, see supra pp. 10-12, they overwhelmingly cut against constitution Re's already strained interpretation of the contract language.

So too do considerations of both elemental fairness and sound public policy. "It has long been held . . . that when a right to indemnity is conferred . . . the indemnitee may recover reasonable legal fees and costs in resisting a claim within the compass of the indemnity." Amoco Oil Co., Inc. v. Buckley Heating, Inc., 22 Mass. App. Ct. 973, 495 N.E.2d 875, 876 (1986). That general principle applies with particular force when the indemnity arises in the context of a reinsurance agreement. Any other conclusion

would allow the reinsurer to assume the position of a "free rider" -- to stand by idly while the reinsured company, on its own nickel, litigates a coverage defense for the reinsurer's benefit or, if the reinsured declines to Litigate, to refuse to indemnify on the ground that the reinsured failed to resist coverage with sufficient vigor.

Moreover, an interpretation that forces reinsured companies to make this Hobson's choice would foment an adversarial relationship between reinsured and reinsurer directly at odds with the basic premise of the reinsurance transaction that their interests are aligned."[11] Unless the

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[11] See Great American Surplus Lines Ins. Co. v. Ace Oil Co., 320 F.R.D. 533, 538-39 (E.D. Ca. 1988) (recognizing the common interest and cooperation between the primary insurer and the reinsured]: Vera Democrazia Soc'y v. Bankers' Nat'l Life Ins. Co., 10 N.J. Misc. 632, 633-34, 160 A. 767, 768-69 (1932) (noting that the reinsured and reinsurer must conmunicate freely and candidly to each other]; Cecil E. Golding, The Law and Practice of Reinsurance 69 (5th ed. 1987) ("[T]he intention [of 'follow the fortunes doctrine] is to set up a kind *of* community of interest in treaty matters, so that whatever fortune, good or bad, should befall the ceding company should be shared by the reinsurer and whatever the ceding company should decide to do in relation to any treaty matter should be equally binding on the reinsurer, even though it had not been consulted.").

reinsurer bears some responsibility for declaratory judgment expenses, it has no incentive to take anything other than a hard line on arguable demands for coverage. Specifically, it has every incentive to insist that the reinsured company resist coverage as vigorously as possible -- or risk a fight over reimbursement down the line. In contrast, the reinsured company often has an incentive simply to pay the claim (whether covered or not) rather than sustain the full expense of contesting coverage.

Thus, if Constitution Re's position were to prevail, these countervailing incentives would result in a de facto conflict of interest between reinsured and reinsurer. for the same reasons, sparing the reinsurer the costs of coverage litigation, while leaving it every incentive to insist on it, creates a powerful impetus to invoke scarce judicial resources to resolve coverage issues. Surely any such consequence is not in the public interest.

II. The Language of the Reinsurance certificate Requires Constitution Re to Pay its proportionate Share of the Costa *of* the Coverage Action.

These more general considerations find ample support in the express terms of the Reinsurance Certificate. Clause A provides that "[t]he liability of the Reinsurer shall follow that of the Conpany [Affiliated FM] and shall be subject in all respects to all of the terms and conditions of the Company policy [the Affiliated/Campbell Soup policy]." Relying on this provision, the trial court concluded that Affiliated is barred from recovering declaratory judgment expenses from the reinsurer because such expenses "would not be covered under the Affiliated/Campbell policy." Op. at 7. Stated differently, the trial court posited the following syllogism: (1) the reinsurer's obligations are coextensive with those of the reinsured company under its policy; [2) the reinsured company's investigation and declaratory judgment expenses are not covered under the Campbell Soup policy; and, therefore, (3) the

reinsurer has no obligation to reimburse the reinsured company for these expenses.

This reasoning is demonstrably incorrect, as any reading of the full Certificate readily confirms. By providing that the reinsurer's "liability" is "subject to" the "terms and conditions" of the Campbell Soup policy, Clause A merely articulates the basic indemnity relationship between the parties. That is, the reinsurer's obligations, being derivative, are "subject to" the sane limitations on coverage set out In the underlying policy -- for example, the reinsurer cannot be called upon to indemnify the reinsured company if the latter pays an insured for property damage under a life insurance policy.[12]

It simply does not follow, however, that the underlying policy defines the entire universe of the reinsurer's duties to the reinsured. To the

[12] Cf. American Ins. Co. v. North American Co. for Property & Casualty Ins., 697 F.2d 79, 81 (2d Cir. 1982); State Auto. Nut. Ins. Co. v. American Re-Insurance Co., 748 F. Supp. 556 (S.D. Ohio 1990); Employers Reinsurance Corp. v. American Fidelity & Casualty Co., 196 F. Supp. 553, 561 (W.D. Mo. 1959).

contrary, Clause D expressly states otherwise. Thus, Clause D provides that "in addition" to its obligation to indemnify Affiliated for losses associated with the underlying litigation, Constitution Re "shall pay its proportion of expenses . . . incurred by [Affiliated] in the investigation and settlement of claims." The intent of the phrase "in addition thereto" could not be plainer: The obligations set out in Clause D are supplemental to -- not limited by -- the more general provisions of Clause A.[13]

Any doubt about this construction is removed by the inclusion of "expenses incurred in the investigation" of claims among the obligations accepted by Constitution Re. That provision must refer to "expenses" entirely apart from any

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[13] Although the lower court cited to the preamble of the policy, quite appropriately it did not rely on it. The preamble provides that "in consideration of the payment *of* the premium and subject to terms, conditions, and limits of liability set forth herein . . . , the reinsurer does hereby reinsure the ceding company . . . in respect of the Companies' policies." As the underscored language shows, the "subject-to" language in the preamble references the reinsurance agreement rather than the underlying policy.

"terms" or "conditions" of the underlying Campbell Soup policy. Neither that policy -- nor any other of which AIA Is aware -- assigns the insurer's coverage-determination expenses to the policyholder. Thus, as the introductory phrase again confirms, such expenses must be "in addition" to any obligations emanating directly from the underlying policy. Any other interpretation would render the provision for investigation expenses entirely superfluous.

Indeed, Constitution Re essentially concedes as much. Its standard practice is to reimburse its reinsureds for investigation expenses, including legal expenses, up to the point that they make the decision to deny coverage, If, however, Constitution Re has a recognized duty to pay some expenses beyond those arising directly under the Campbell Soup policy, then that policy does not define the entire set of Its obligations. For this reason as well, the lower court's understanding of the interrelationship of Clauses A and D clause was plainly in error.

The only remaining question then is whether declaratory judgment expenses constitute "expenses [other than office expenses and payments to any salaried employee) incurred by the [reinsured) Coxpany in the investigation and settlement *of* claims." For several reasons, that question should be answered in the affirmative. As an initial matter, the phrase In parentheses suggests an intent to cover all forms of expenses "other than" those specifically excepted. At the very least, that provision demonstrates that the parties to the agreement knew how to exclude certain forms of expenses when that was their intent. Their failure to exempt litigation expenses thus conveys an expectation that they would be included.

Moreover, drawing the line at pre-litigation expenses simply makes no sense. The line between hiring private counsel to render a coverage opinion and hiring them to defend a coverage action is blurry at best -- and certainly finds no support in the policy language, which references both "investigation and settlement" expenses.

Particularly in an era where contested commercial decisions frequently get resolved in a judicial forum, it is naive to draw the line in that fashion. Whether arising in the context of an on-site inspection, a pre-litigation analysis or an adjudication, all monies expended by the reinsured in a good faith effort to resolve the existence of coverage constitute "expenses incurred . . . in the investigation and settlement of claims."

Finally, the nature of the reinsurer] reinsured relationship -- as reflected in both industry practice and nearly two centuries of caselaw -- weigh decisively in favor of interpreting the language In that fashion. As explained in Part I, the structure, purpose, and practical operation *of* the reinsurance transaction all presuppose that the burdens of coverage litigation will be borne by reinsurer and reinsured alike.

For all of these reasons, the trial court's holding that declaratory judgment expenses are not reimbursable as a matter of law is unsupportable. To the extent the Court finds the phrase

"investigation and settlement expenses" to be less than entirely self-evident, at most this would justify development of a more complete record concerning industry practice and the parties* intent. While AIA believes such an approach to be unnecessary in light of both the clarity of the language and the structural backdrop against which it is set, a remand for these limited purposes is the only even theoretical alternative to outright reversal.

CONCLUSION

For the reasons set forth above, amicus curiae American Insurance Association respectfully requests this Court to reverse the decision below.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 25, 1993, a true and correct copy of the foregoing Motion for Leave to File Brief of the American Insurance Association as Amicus Curiae in Support of Plaintiff-Appellant Affiliated PM Insurance Company was served by first-class U.S. mail, postage prepaid, upon the following persons:

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