

Risk

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LEGAL ISSUES IN **INSURANCE RECOVERY**



You Wanted Us to Pay for the *Whole* Defense?

By Andrew M. Reidy and Todd L. Brecher

Policyholders often purchase liability insurance in large part to protect themselves from potentially costly litigation. Often referred to as "litigation insurance" by courts,¹ these policies contain a defense obligation expressed as either a duty to defend or a duty to reimburse defense costs. Insurers, however, frequently unilaterally impose major restrictions and limitations relating to the defense costs they will pay. The insurers do this by taking deductions from legal bills based upon the insurer's litigation or billing guidelines, approving rates at amounts less than those charged by defense counsel, and delaying payments of defense costs for unreasonable periods of time. Policyholders are often left feeling as though they did not receive the benefit of the insurance with respect to defense coverage. In some cases, there is serious doubt as to whether the insurer's restrictions interfere with the policyholder's defense. Policyholders, fortunately, have means to combat these practices.

INSURERS USUALLY INSIST ON BILLING OR LITIGATION GUIDELINES

After a claim is made, the insurer will for the first time send the policyholder or its hired counsel billing guidelines or litigation guidelines. These guidelines are not part of the insurance contract. Insurers insist defense counsel comply with these rules as a pre-condition to paying defense costs. Common billing or litigation guidelines include limitations regarding the number of attorneys who may attend hearings and depositions, paying for interoffice conferencing among attorneys, the use of online legal research databases, local travel expenses, and clerical or administrative tasks.

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Insurer billing guidelines often restrict practices considered both necessary and routine in the ordinary course of litigation. Guidelines often are especially unworkable in large or complex cases. As a result, many defense counsel incur costs and expenses not allowed by the guidelines and hope the insurer or the policyholder will agree to pay these costs and expenses.

Several courts have addressed the impact of billing guidelines on the contractual relationship between the insurer and the policyholder. In *Nortek, Inc. v. Liberty Mutual Insurance Co.*, 858 F.Supp. 1231 (D.R.I. 1994), the policyholder argued that the insurer failed to meet its defense obligation by not reimbursing the plaintiff all necessary defense costs. The insurer had accepted its defense obligation subject to billing restrictions that included a cap of \$105 per hour for attorneys' fees, \$55 per hour for paralegals, no reimbursement for secretarial overtime, and no reimbursement for meals or overnight travel without pre-approval. *Id.* at 1234 n.3. The court held that the defendant breached its obligation to defend, in part, by its failure to reimburse the plaintiff policyholder for "all of the reasonable fees and expenses [it] incurred defending itself against all the claims[.]" *Id.* at 1238-39.

In *Dynamic Concepts, Inc. v. Truck Insurance Exchange*, 61 Cal. App. 4th 999 (1998), the issue before the court was whether the insurer breached its duty to defend by investigating the purported conflict of interest, and not immediately approving independent counsel. In the opinion, the court expressed skepticism towards billing guidelines, noting that "[i]nsurer-imposed restrictions on discovery or other litigation costs may well violate the insurer's duty to defend as well as the attorneys' ethical responsibilities to exercise their independent professional judgment in rendering legal services." 61 Cal. App. 4th at 1009. The court further stated:

In this regard we question the wisdom and propriety of so-called "outside counsel guidelines" by which insurers seek to limit or restrict certain types of discovery, legal research, or computerized legal research by outside attorneys they retain to represent their insureds. Some guidelines go so far as to call for the use of paralegals, rather than attorneys, to respond to "routine" discovery requests or prohibit the retention of experts

or the filing of certain pretrial motions until shortly before trial. Under no circumstances can such guidelines be permitted to impede the attorney's own professional judgment about how best to competently represent the insureds. If the attorney's representation is to be limited in any way that unreasonably interferes with the defense, it is the insured, not the insurer, who should make that decision.

Id. at 1009 n. 9 (emphasis in original) (citations omitted). Several state bar associations have addressed billing guidelines from a legal ethics standpoint. Nearly all ethics opinions agree that billing guidelines, *at the very least*, require a case-by-case analysis to ensure that the guidelines, as applied, do not put the lawyer in a position that compromises the duties he or she owes to his or her client under the state's rules of professional responsibility. Several states, in fact, have held that certain common billing guidelines so clearly interfere with the professional judgment of the lawyer that there is no need for any case-specific analysis by the lawyer or a governing body.

The Supreme Court of Ohio's Board of Commissioners on Grievances and Discipline, in Opinion 2000-3 (June 2000), stated that certain guidelines *per se* interfere with a lawyer's professional judgment and are therefore unethical for a lawyer to follow. These include guidelines that require prior approval before performing online legal research, dictate how work is to be allocated among defense team members, require approval before conducting discovery, taking depositions, or consulting with expert witnesses, and guidelines that require the insurer's approval before filing motions and pleadings.

Similarly, the Kentucky Bar Association, in Ethics Opinion KBA E-416 (March 2001), also held that certain billing guidelines were inappropriate for a lawyer to follow. While the committee stated some guidelines would be acceptable, guidelines requiring the insurer to pre-approve discovery requests, legal research, and the filing of motions, and requiring that all investigative work be performed by the insurer or billed out at paralegal rates violated the ethical rules.

The Rhode Island Supreme Court, in Ethics Advisory Panel Opinion No. 99-18 (October 1999), also found that a fact-specific determination was unnecessary with



There are many factors generally considered when selecting appropriate defense counsel, including the complexity of the matter, the expertise required, and the venue of the action.

certain billing guidelines. The Panel stated that any guidelines which require the insurer's pre-approval for specified legal services such as conducting research, filing counterclaims and motions, visiting accident sites, and conducting depositions, among other activities, infringe upon the attorney-client relationship by "interfering with the independent professional judgment of defense counsel and ultimately with the quality of legal services provided to the insured." *Id.* at 1.

INSURERS ALSO USUALLY INSIST ON HOURLY RATES THAT ARE SIGNIFICANTLY BELOW MARKET RATES

Insurers that accept the defense of a claim fully and without a reservation of rights typically have law firms to handle such cases. These firms negotiate rates with the insurer based on a large volume of work. When the insurer reserves its rights and independent counsel is selected to represent the policyholder, insurers often unilaterally decide to pay independent counsel rates that are far below actual billing rates. Policyholders are then forced to either make up the difference in rates

themselves, despite having paid for defense coverage, or ask their defense counsel to write-off the gap between their actual rates and rates approved by the insurer.

There are many factors generally considered when selecting appropriate defense counsel, including the complexity of the matter, the expertise required, and the venue of the action. Policyholders often discover, however, that insurers will simply refuse to pay rates that exceed the levels the insurers typically pay the insurance defense firms they frequently retain in the same jurisdiction. The reality is that reasonable attorneys' fees of independent counsel, especially in complicated cases, will often exceed the rates insurers would pay to a firm that does a high volume of insurance defense work for the insurer.

In *Watts Water Technologies, Inc. v. Fireman's Fund Insurance Co.*, No. .05-2604-BL52 2007 WL 2083769 (Mass. Super. July 11, 2007), the insurer agreed to defend the policyholder under a reservation of rights. The policyholder selected independent counsel and later sought a judicial declaration that "reasonable fees" under the insurance policy included hourly rates which

exceeded those typically paid by the insurer. The insurer urged the court to impose a rate restriction similar to those found in California and Alaska statutes, limiting fees to those “which are actually paid by the insurer to attorneys retained in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended.” *Id.* at 9 (quoting Cal. Civ. Code §2860 (c) (2007) and citing Alaska Stat. §21.89.100 (2007)). The court declined to do so, noting that insurers often pay rates far below what an insured must pay for an adequate defense. The court noted that insurers purchase large quantities of legal services and can therefore negotiate low billing rates with select firms. The court also recognized that, to insurers, the cost savings of low-priced attorneys may outweigh the benefits of more competent representation, whereas to policyholders facing significant liability, the benefits of more competent counsel would surely outweigh the costs. The court reasoned that policyholders should not be bound by the “usual price paid by insurance companies,” but rather by the usual price charged for similar services by other attorneys in the same area. *Id.* at *10 (emphasis in original).

If an insurer offers to pay defense counsel only rates significantly below the rates charged by defense counsel, the insured should check to see if any state statute would support this deduction. If not, most courts would apply a reasonableness test and be guided by what a similarly situated policyholder could obtain in the marketplace. One fertile area for discovery if the issue of reasonableness is litigated may be what rates the insurance company pays attorneys defending the insurance company itself. The newspapers are filed with examples of large, national firms defending insurance companies in connection with the current crisis in the financial markets. These firms have rates that are at the top of the market.

DELAYED DEFENSE PAYMENTS BY THE INSURER MAY ADVERSELY IMPACT THE INSURED

Another way insurers often diminish their full defense obligation is by delaying the payment of defense costs. Unlike most clients who pay legal bills within 30 to 60 days, insurers often pay very slowly, without specifying a precise timeline for payment. This makes collection and forecasting

unpredictable and can seriously damage relations between defense counsel and the insured. When the defense counsel does not know when or if he or she will be paid, counsel naturally may hesitate to incur additional expenses. Insurers also sometimes leverage these delinquent payments as a negotiating tool to further reduce legal expenses, drawing out the process to the point that the attorney will “take what he can get,” further damaging attorney-client relations.

Courts have held that insurers have a duty to pay defense costs promptly. Some courts even require that the insurer withhold any challenge as to reasonableness until after the underlying matter has concluded. In *J.R. Marketing, L.L.C. v. Hartford Casualty Insurance Co.*, No. A115846, 2007 WL 4217443 (Cal. App. 1 Dist. Nov. 30, 2007), the court affirmed a trial court order directing the insurer to pay outstanding defense bills immediately and future defense bills within 30 days of receipt in order to satisfy its duty to defend:

[W]here a duty to defend exists, enforcement of that duty necessarily includes directing immediate payment of reasonable and necessary defense bills. As such, we conclude the trial court’s order directing payment of respondents’ outstanding and future defense bills was well within its discretion. Indeed, to conclude otherwise would be to render the duty to defend meaningless, because the insured would be deprived of the very benefit of the bargain it sought in purchasing the policy. And as the trial court correctly noted, any challenge to the reasonableness or necessity of defense bills can await an action for reimbursement following the conclusion of the underlying matter.

Id. at *10 (emphasis in original)(internal citations omitted).

A POLICYHOLDER DOES HAVE RECOURSE

At the inception of a matter, policyholders should raise specific concerns with guidelines that are objectionable and not simply agree to abide by guidelines that are tendered or rates that are proposed by the insurer. Sometimes a frank discussion at the beginning of a representation can help avoid subsequent disagreements relating to the defense bills.

If the insurer does engage in the tactics described

above, policyholders have options. One option is to meet with senior claims representatives of the insurer. This is a good starting point to demonstrate dissatisfaction with the insurer unilaterally imposing billing guidelines not contained in the contract. That said, simply bringing these matters to the attention of senior representatives may well prove insufficient given that these practices may be directed by senior management.

A second option is for the policyholder to initiate proceedings with the appropriate state insurance commissioner. State agencies generally have procedures by which policyholders can file claims or complaints against insurers. The state generally investigates the merits of these complaints and, in some cases, can award relief to the policyholders. However, state commissioners are often limited in the types of relief they can provide and the matters they can decide. For example, some cannot order payment of monetary damages and are limited primarily to declaratory judgments and equitable relief. Some agencies also will not intervene in issues they consider to be factual determinations. Furthermore, policyholders may find that state agencies act slowly in conducting their investigations and awarding any relief. Policyholders must determine whether the matter is one which the appropriate state insurance commissioner is capable of resolving in a satisfactory manner.

A third option for policyholders is to litigate the matter as the policyholders did in the *Nortek*, *Watts Water*, and *J.R. Marketing* cases. There are many potential causes of action against an insurer in these circumstances including claims for breach of contract, declaratory relief, injunctive relief, violations of state insurance practices acts, violations of state business statutes, and bad faith. Some state unfair insurance practices acts authorize a private cause of action, providing for recovery of damages and attorneys' fees. Bad faith also is a powerful claim because an insurer could be liable for punitive or exemplary damages in many states for providing the policyholder with an inadequate defense. Importantly, many jurisdictions will award attorneys' fees the policyholder incurs in forcing an insurer to honor its full defense obligation. *McRory v. Northern Ins. Co. of New York*, 980 P.2d 736, 738 (Wash. 1999). Therefore, the litigation options are

diverse and potentially carry extra-contractual remedies.

Insurers engage in the aforementioned tactics far too frequently in an effort to minimize the costs of defending policyholders. The deductions the insurers take are a windfall to the insurers, as few policyholders actually challenge the insurers' conduct, often because the deductions make up a small percentage of the overall defense costs. There are, however, ways for policyholders to challenge these practices and realize the benefit of their bargain with respect to defense coverage.

¹ See, e.g., *Rubenstein v. Royal Insurance Co. of America*, 708 N.E.2d 639, 642 (Mass. 1999); *Universal Underwriters Ins. Co. v. Lowe*, 761 A.2d 997, 1012 n.15 (Md. App. 2000).

H



Roadblocks to Transfer of Insurance Policies Between Predecessor and Successor Corporations:

The Importance of Recognizing Potential Fundamental Barriers to Coverage Before a Deal is Completed

By Amy J. Fink



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The pressure to close a deal can cause companies to overlook or cursorily dismiss issues concerning the transfer of insurance. However, whether insurance policies will transfer to the successor is a significant issue that should not be overlooked.

DO NOT ASSUME THAT INSURANCE ASSETS WILL TRANSFER AS A RESULT OF A DEAL

Companies should not assume that policies will automatically transfer in conjunction with a reorganization or acquisition absent specific proactive steps. Many insurance policies contain express “anti-assignment” provisions or are excess policies, subject to the terms and conditions of the underlying policies, which in turn may include “anti-assignment” provisions. These provisions purport to prohibit assignment of the policy without the insurer’s consent (e.g., “Assignment of interest under this policy shall not bind the insurer until its consent is endorsed hereon”). See *Henkel Corp. v. Hartford Acc. & Indemn. Co.*, 29 Cal. 4th 934, 944 (2003). The purpose of such provisions is to “prevent an increase of risk and hazard of loss by a change of ownership without

Israel, 354 F.2d 488 (2d Cir. 1965). Arguably, this applies both to attempted assignments of the policy by sale as part of the insured’s business, or by operation of law through corporate mergers or successor liability. Some entities have learned the hard way that if a policy contains a provision requiring consent to any assignment, an assignment without such consent voids the policy. See *Dallas County Hosp. Dist. v. Pioneer Cas. Co.*, 402 S.W. 2d 287 (Tex. Ct. App. 1966).

THE NATURE OF THE LOSS AND THE NATURE OF SUCCESSION CAN HAVE A PROFOUND IMPACT ON TRANSFER OF INSURANCE.

Under certain circumstances, courts will decline to enforce anti-assignment provisions. An insurer may waive the consent requirement or be estopped from denying a valid assignment. *National Discount Shoes, Inc. v. Royal Globe Ins. Co.*, 99 Ill. App. 3d 54 (1981). Further, anti-assignment language may not be enforced where, at the time of assignment, the insurance benefit had been reduced to a claim for money due or to become due. See *Henkel*, 29 Cal. 4th at 945. Similarly,

Some entities have learned the hard way that if a policy contains a provision requiring consent to any assignment, an assignment without such consent voids the policy.

the knowledge of the insurer.” *Quemetco Inc. v. Pacific Auto. Ins. Co.*, 24 Cal. App. 4th 494, 503 (1994).

Courts typically recognize the validity of contractual provisions against assignment of contracts, including insurance policies. See *Employers Mut. Liab. Ins. Co. v. Mich. Mut. Auto. Ins. Co.*, 101 Mich.App. 697, 702 (1980). Thus, courts generally uphold “anti-assignment” provisions so that an insurer is not liable to indemnify or defend claims against an assignee of the policy as to whom it has not consented. *Travelers Indem. Co. v.*

insurer consent may not be required where the assignment concerns the right to policy proceeds. *Young v. Chicago Fed. Sav. & Loan Ass’n*, 180 Ill. App. 3d 280 (1989). Additionally, in many jurisdictions the law does not prevent assignment – in spite of anti-assignment policy language – where the assignment takes place after the loss for which coverage is being sought. *Ardon Constr. Corp. v. Firemen’s Ins. Co.*, 16 Misc. 2d 483, 488 (1959). When a loss occurs before the transfer, the rationale behind the anti-assignment clause does

not apply because the insurer has not incurred any unforeseen or increased risk.

Generally, in corporate mergers the predecessor's assets (including its insurance coverage) and liabilities are transferred to the successor or a matter of law. Numerous courts have held that the surviving corporation of a merger is entitled to insurance coverage under policies issued to the predecessor corporation for claims arising out of the pre-acquisition activities of the merged corporation, even where an anti-assignment provision was purportedly violated. See *Northern Ins. Co. v. Allied Mut. Ins. Co.*, 955 F.2d 1353 (9th Cir. 1992); *Brunswick Corp. v. St. Paul Fire & Marine Ins. Co.*, 509 F. Supp. 750 (E.D. Pa. 1981). Arguably, the risk contemplated by the insurers is not substantially altered by requiring them to provide coverage for the pre-acquisition activities of the merged corporation.

However, in other transactions, such as asset purchase agreements, the purchaser is not generally liable for debts or obligations of its predecessor. In instances where the successor entity is not a "mere continuation" of the predecessor entity, recourse to the predecessor is available, or the two entities (successor and predecessor)

have separate identities, courts are inclined to uphold the validity of anti-assignment provisions. Accordingly, companies involved in these types of transactions may have a difficult time avoiding application of an anti-assignment clause.

Legal issues regarding transfer of assets and liabilities as well as validity of any so-called "anti-assignment" provisions are complex and vary from state to state. For instance, some courts have held that the right to recover under an insurance policy follows the liability for which the coverage is sought. See *Northern Ins. Co. of New York*, 955 F. 2d at, 1357-1358. Other courts have held to the contrary on the theory that "[t]he law can impose tort liability on a successor corporate entity; it cannot impose a contractual insurance relationship between an insurer and a stranger to the insurance contract." *General Acc. Ins. Co. v. Sup. Ct.*, 55 Cal. App. 4th 1444, 1455 (1997). Because of the wide ranging legal opinions and the potential impact of the issue of insurance, these issues should be analyzed during the course of the deal in order to avoid large uninsured losses post-closing.

H



Case Highlights

By Douglas DeWitt

WASHINGTON



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Washington Supreme Court Holds that an Insurer is Generally Bound by the Results of the Underlying Trial or any Judicial Finding of a Settlement's Reasonableness.

Mutual of Enumclaw Ins. Co. v. T & G Const., Inc., 2008 WL 4670256 (Wash. Oct. 23, 2008)

In *Mutual of Enumclaw Insurance Co. v. T & G Construction, Inc.*, 2008 WL 4670256 (Wash. 2008), the court balanced “the interests of an insured defendant in reaching a reasonable settlement with a claimant against the insurer’s interest in fully litigating its insured’s legal obligation to that claimant.” In doing so, the court held that if a coverage question turns upon the same facts or law at issue in the underlying dispute between the claimant and the insured, the insurer will be bound by the results of the underlying trial or any judicial finding of a settlement’s reasonableness, barring a showing of collusion or fraud by the insured.

The insurance dispute arose from a homeowners’ association’s lawsuit against its developer relating to the poor installation of siding on recently-constructed

Because the homeowners’ association filed its lawsuit more than two years after T&G’s dissolution, T&G moved for summary dismissal of the claim on statute of limitations grounds.

homes, which resulted in, rot and mold problem. The developer then filed a third-party action against its general contractor, who, in turn, filed a third-party action against its subcontractors, including a siding subcontractor, T&G Construction (“T&G”). After receiving notice of the lawsuit, T&G’s commercial general liability insurer, Mutual of Enumclaw (“MOE”), agreed to defend T&G under a reservation of rights.

A year into the underlying litigation, T&G’s defense counsel discovered that the state had administratively dissolved T&G three years prior, thus barring any lawsuits brought against T&G more than two years after T&G’s dissolution. Because the homeowners’ association filed

its lawsuit more than two years after T&G’s dissolution, T&G moved for summary dismissal of the claim on statute of limitations grounds. The trial court denied the motion, finding that the limitations period did not apply to dissolved corporations, such as T&G, that had notice of claims against it prior to dissolution.

After a series of mediations, the majority of the parties settled their respective differences and T&G settled with its subcontractors. But T&G did not participate in the larger, global settlement with the other parties, likely because MOE balked at making any large contributions to the global settlement on behalf of T&G. After the trial court ordered T&G to participate in the global settlement negotiations, T&G finally agreed to settle the remaining claims against it for \$3.3 million.

MOE—despite its decision to not participate in the settlement negotiations—appeared at the trial court’s reasonableness hearing for the settlement, where it objected to T&G’s settlement. After determining that a jury would likely reject T&G’s statute of limitations defense and enter a significant damages award against T&G, the trial court concluded that T&G’s settlement was reasonable. After a motion to reconsider by MOE, the court reduced the settlement to \$3 million.

In a subsequent declaratory judgment action, MOE asked the court to find that the statute of limitations had expired on the claims against T&G, that T&G’s damages were outside the scope of coverage, and that, by settling, T&G breached its duty to cooperate. According to MOE, the insurance policy obligated it to pay only those sums that T&G became legally obligated to pay as damages because of property damage, thereby entitling MOE to an independent determination of the facts establishing T&G’s liability. MOE argued that “the liability suit did not resolve whether its insured was in fact legally obligated to pay damages because there was no final decision on whether the statute of limitations had run before the case was filed.”

The Washington Supreme Court rejected MOE’s request to re-litigate the validity of T&G’s statute of limitations defense, opining that, for better or worse, “what the insured is legally obligated to pay is the exact issue to be determined in the liability suit.” In the lawsuit, T&G—whose interests were aligned with MOE

at the time of the underlying lawsuit—raised its liability defenses, including its statute of limitations defense, and lost. The court believed that public policy prohibited MOE’s request to re-litigate the very same defenses in the coverage action that had already been evaluated by the underlying trial court in the context of the request for summary dismissal and the subsequent approval of the settlement.

...“what the insured is legally obligated to pay is the exact issue to be determined in the liability suit.”

The court also addressed whether a reasonable and good-faith settlement establishes the fact of liability and the presumptive amount of damages in the absence of an insurer’s bad faith. The court, answering in the affirmative, found that absent fraud or collusion, when an “insurer had an opportunity to be involved in a settlement fixing its insured’s liability, and that settlement is judged reasonable by a judge, then it is appropriate to use the fact of the settlement to establish liability and the amount of the settlement as the presumptive damage award for purposes of coverage.” Of course, “presumptive damages” are not the same as “covered damages” under the policy; accordingly, the court left open the possibility that an insurer, like MOE, could properly litigate the extent to which the “presumptive damages” fell within the scope of the insurance policy’s coverage.

Finally, the court rejected MOE’s argument that T&G violated the policy’s cooperation clause which required T&G to obtain the consent of MOE before it settled the underlying lawsuit. The court indicated MOE was not prejudiced by the settlement because MOE had prior knowledge of the negotiations, refused to participate in the negotiations, and had notice of and participated in the reasonableness proceedings. The court also pointed out that MOE owed T&G a “fiduciary-type duty” and that MOE’s refusal to participate in the settlement negotiations puts its own financial interests above T&G’s interests and placed T&G at significant financial risk.

An Insured’s Cause of Action for Bad Faith Claims Handling is not Dependent on any Duty to Defend, Indemnify, or Settle.

St. Paul Fire and Marine Insurance Company v. Onvia, Inc., 196 P.3d 664 (Wash. November 26, 2008)

The United States District Court for the Western District of Washington certified two questions to the Washington Supreme Court: first, does an insured have a cause of action against an insurer for bad faith despite a judicial declaration that the insurer had no contractual duty to defend, settle, or indemnify the insured; and second, is an insured obligated to prove that an insurer’s bad faith conduct actually harmed the insured or is there a presumption of harm. The Washington Supreme Court held that the existence of a ruling in favor of the insurer regarding the duty to defend, settle, or indemnify does not bar an insured’s claims for bad faith claim-handling; however, the court held that the insured must prove actual harm caused by the alleged bad faith conduct.

The insured, Onvia, sold a service called “Demand-Star,” which provided businesses with notices of opportunities to bid for government contracts. Onvia purchased liability insurance from St. Paul Fire and Marine Insurance Company (“St. Paul”). Responsive Management Systems (“RMS”) sued Onvia in a class action complaint (the “underlying action”), alleging that Onvia engaged in “fax blasting” in violation of state and federal law.

On February 25, 2005, Onvia tendered its defense in the underlying action to St. Paul. On August 5, 2005, after St. Paul failed to respond to its initial tender, Onvia re-tendered its defend in the underlying action and then, at some point in September 2005, Onvia forwarded St. Paul a copy of the amended complaint in the underlying action. St. Paul did not respond to Onvia’s tenders until November 4, 2005, when it denied coverage.

From February 2005 through the conclusion of the underlying action, Onvia defended itself with its own counsel and, in April 2006, while a motion for class certification was pending, Onvia and RMS entered into a settlement agreement whereby Onvia stipulated to class certification, entry of a judgment in favor of the class in the amount of approximately \$17 million, and an assignment of its right against St. Paul to RMS. In

exchange, RMS agreed to execute the judgment only against St. Paul. Shortly thereafter, St. Paul sought a declaratory judgment against RMS that it had no duty to defend, settle, or indemnify Onvia in the underlying action. In response, RMS counterclaimed that St. Paul breached its contractual duties to defend, indemnify, and settle, that St. Paul breached, in bad faith, its duties to defend, indemnify, and settle the underlying action, and that St. Paul's handling of the Onvia tender constituted procedural bad faith and violated of the state Consumer Protection Act.

After the trial court found that St. Paul had no duty to defend, indemnify, or settle the underlying action against Onvia and that St. Paul did not commit common law bad faith when it refused to defend Onvia, the only remaining claims were RMS' claims for common law "procedural" bad faith and violation of the Consumer Protection Act. RMS argued that St. Paul committed procedural bad faith and violated the Consumer Protection Act by failing to timely acknowledge and act upon Onvia's tender of defense and by failing to reasonably investigate the underlying action. Conversely, St. Paul argued that in the absence of a duty to defend, it could not be liable for any alleged procedural missteps relating to its handling of Onvia's insurance claim.

With respect to the first certified questions, the Washington Supreme Court noted that "Washington's insurance bad faith law derives from statutory and regulatory provisions, and the common law" and an insurer owes its insured a duty of good faith, akin to a fiduciary duty, when dealing with addressing an insured's request for coverage under either a first or third-party liability policy. The state insurance commissioner promulgated administrative regulations governing the claims-handling process, and any violation of the insurance code or a regulation promulgated thereunder constitutes an unfair practice under the CPA.

The court found that every insurer is obligated to act in good faith and promptly, in both communication and investigation, in response to a claim or tender of defense and that this obligation exists regardless of the existence of coverage. For this reason, the court held that if St. Paul handled Onvia's insurance claim

Put another way, an insured's cause of action for bad faith claims handling is not dependent on the insurer's duty to indemnify, settle, or defend.

in bad faith, a cause of action based on this conduct remained viable regardless of the availability of the benefits to Onvia under the St. Paul insurance contract (i.e., defense, settlement, and payment). Put another way, an insured's cause of action for bad faith claims handling is not dependent on the insurer's duty to indemnify, settle, or defend.

With respect to the second certified question, the court held that no rebuttable presumption of harm from an insurer's bad-faith conduct arises in the absence of a reservation of rights or failure to defend; rather, an insured must prove that the insurer's bad-faith conduct caused actual harm. The court further held that while a remedy of coverage by estoppel is not recognized in this context, an insured can still recover general tort damages and any amounts it has incurred as a result of the insurer's bad faith. **H**

HOWREY INSURANCE IN THE NEWS

ACCOLADES

Howrey congratulates its 2009 Super Lawyers:

Jill B. Berkeley (Chicago): The Top 100, The Top 50 Women, Insurance Coverage; **Scott T. Schutte** (Chicago): Insurance Coverage, Class Action/Mass Torts; **Les Brown** (Los Angeles): Business Litigation; **Mary Craig Calkins** (Los Angeles): Insurance Coverage; **Ty Childress** (Los Angeles): Insurance Coverage; **Amy J. Fink** (Los Angeles): Insurance Coverage; **Thomas M. McMahon** (Los Angeles): Insurance Coverage; **Curtis D. Porterfield** (Los Angeles): Insurance Coverage; **David W. Steuber** (Los Angeles): Insurance Coverage.

On December 29, 2008, *Business Insurance* published its 2009 Market Source Book and ranked Howrey as the 4th largest Insurance Recovery law firm in the nation.

On November 6, 2008, **Mary Craig Calkins** (Los Angeles) was honored as a Distinguished Alumna at Loyola Law School's Alumni Grand Reunion at Sony Pictures Studios in Culver City, CA.

Benchmark Litigation recognized **Jill B. Berkeley** (Chicago) and **Scott Schutte** (Chicago) in its second annual guide to America's leading business litigation firms and attorneys.

Christine Davis (Washington DC) was recently named co-chair of the Insurance Coverage

Litigation Committee's subcommittee on D&O insurance. The Insurance Coverage Litigation Committee is one of the major committees in the Tort, Trial & Insurance Practice Section of the ABA.

ARTICLES

"Anticipating TSCA Compliance and the Risk of Potential Liabilities," co-authored by **Amy J. Fink** (Los Angeles) and James B. Boles was published in the January 2009 issue of *Nano Letters*.

"Beware D&O Subprime Coverage" by **Keith A. Meyer** (Los Angeles) was posted on October 30, 2008 on the home page of ABA Banking Journal, www.ababj.com, and is copyright 2008 by the American Bankers Association.

"Anti-assignment Clauses Require Close Attention," by **Amy J. Fink** (Los Angeles) was published on October 27, 2008 in *Business Insurance*.

SPEAKING ENGAGEMENTS

On Wednesday, April 22, 2009, **Ty Childress** (Los Angeles) will present "Who Owes Whom What? Indemnity and Additional Insured Issues" at the RIMS Annual Conference in Orlando, Florida.

On Tuesday, April 21, 2009, **Mary Craig Calkins** (Los Angeles) will present "Gotcha! Top 10 Litigation Traps for Risk Professionals" at the RIMS Annual Conference in Orlando, Florida.

On October 28, 2008, **Helen Michael** (Washington DC) spoke on the topic "Allocation Issues in Construction Defect Claims," at the International Risk Management Institute's 28th Annual Construction Risk Conference, Las Vegas.

On October 27, 2008, **Jill B. Berkeley** (Chicago) spoke on the topic "Defense Issues under Wraps Ups: Avoiding Conflicts of Interest," at the International Risk Management Institute's 28th Annual Construction Risk Conference, Las Vegas.

Howrey's Insurance Recovery group would like to welcome their new Construction Practice partners.

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