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PLI Can Add Significant Value to Small and Mid-Size Audit Firms

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Audit Litigation and Professional Liability Insurance

Litigation-related expenditures continue to account for a significant percentage of audit firms' costs (Advisory Committee on the Auditing Profession 2008). Such expenditures not only significantly decrease firm profitability, but when claims against accounting firms go to trial, litigation related expenditures can threaten firms' ability to operate. Prior research (Maksymov, Pickerd, Lowe, Peecher and Reffett 2018) finds that, relative to larger accounting firms, smaller firms lack the resources to internally manage the potential costs and risks associated with litigation resulting from an audit failure. Unlike larger firms, smaller firms tend not to have significant financial reserves that would allow them to self-insure against litigation risk. Furthermore, smaller firms generally lack experience and expertise in handling litigation. Finally, smaller firms do not have large numbers of attorneys on staff to manage the dispute resolution process in a manner that minimizes cost and risk. As a result, it is relatively unsurprising that experienced audit litigation attorneys suggest that audit liability insurance could play a key role in enabling non-Big-4 audit firms to perform audit work in a sustainable way over the long-term (Maksymov et al 2018).

Academic Research on PLI

Little research examines how the availability of professional liability insurance (PLI) could influence small and medium sized audit firms' ability to compete in the market for audit services. Insights from such research could be used by insurers to market their products to audit firms. Therefore, with the help of the PLUS, we surveyed 83 professionals within the PLUS network who specialize in insuring audit firms. Of these 83 professionals, 25 work in sales, 35 in underwriting, and 23 in claims resolution. We also interviewed 16 professionals across these three areas to clarify the findings of our survey. Our findings suggest many aspects of PLI that insurers could highlight when marketing their services to small and mid-size audit firms.

The Findings of Our Study

Consistent with attorneys' and auditors' perceptions, insurers believe that there are significant risks associated with entering the audit market. Approximately 2/3 of our participants believe that auditing profession is at least in the top 25% riskiest professions to insure, with 1/3 of those specializing in underwriting viewing it as the riskiest profession to insure. Therefore, it is imperative that insurers make their clients aware of the ways in which insurance services reduce the risks associated with conducted audits and provide value to the insured.

Results of our survey suggest four primary ways in which PLI reduce risk beyond the benefit audit firms receive from shifting potential litigation losses to their insurer. Specifically, PLI can benefit small to mid-size firms through: (1) incentivizing them to engage in behaviors that reduce the risk of litigation; (2) providing them with risk management consulting and CPE classes; (3) providing the firms' clients with comfort that the firm will survive should an audit failure occur; and (4) by managing audit litigation. While the latter service is what insurers are known for, the former two are also very important for auditors to be aware of and for insurers to market and explain to their prospective and current clients. We discuss each of these in turn.

Incentivizing auditors to reduce the risk of litigation. To get through the screening process and obtain coverage under favorable terms, audit firms must supply evidence that they can provide high audit quality. Our results suggest that insurers factor the quality of an audit firm's risk management and quality control practices, as well as the competence and integrity of its audit partners into coverage and premium decisions. In addition, insurers penalize firms that have faced past claims and who have received negative PCAOB inspection reports. In effect, insurers serve a quasi-governance role by incentivizing firms to perform high quality audits. Insurers also incentivize firms to avoid performing

work for clients that insurers know are particularly risky. Specifically, the insurers we surveyed stated that they consider characteristics of a firm's clients (whether they are publicly traded, in financial distress, have previously restated their financial statements, have significant operation outside the U.S., etc.) into their coverage and premium decisions. As such, insurers also serve a quasi-governance role which prevents audit firms from taking on risky clients even when those clients could provide those firms with significant revenues. Providing this quasi-governance role is a valuable service as many small to mid-size audit firms lack the resources necessary to invest in strong governance mechanisms.

Insurers provide valuable risk management training. Working with a wide customer base, insurers have first-hand knowledge of the types of factors that have proven costly to audit firms in the past. Results of our survey suggest that insurers use this knowledge train the firms they cover about risk management best practices. Insurers say they provide advice to audit firms about the types of clients they should avoid (e.g., public clients, international clients, clients in industries that tend to present high risk of claims against auditors), types of services they should provide (e.g., increase non-audit services in the revenue mix), and the types of activities they should engage in to reduce litigation risk (e.g., getting fewer issues in the PCAOB inspection reports, keep low the number of audit staff and managers per partner, increase the quality of risk management and quality control practices).

Insurers provide comfort to covered firms' clients. PLI plays an important role in protecting audit firms from having to "close up shop" in the event of an audit failure. Many states do not require firms to hold significant insurance coverage. Moreover, prior research suggests that as many as 40% of audit firms forgo insurance. Should a claim against these accounting firms go to trial, the costs associated with those claims may force them out of existence. Firms who have PLI may be better able to reassure their clients that if things go south, they won't just close their doors. This continuity allows audit firms to focus more on their reputation and brand for the long-term.

Insurers effectively manage claims and litigation. As noted previously, small and mid-size audit firms generally lack experience and expertise in handling litigation. Conversely, insurers have significant expertise in the claims resolution process, so they are well versed in how to minimize the cost and risk of litigation. Based on their prior experiences, insurers report considering factors such as whether a jury is likely to find the audit negligent and whether the plaintiff appears able to easily explain why the auditor should be held liability when making recommendation about whether an auditor should settle and for what amount.

Suggestions for Insurers

It is important that insurers communicate that they are the audit firm's partner, even in the claims settlement process. Insurers report that an audit firms' concerns about reputation may prompt them to settle at the plaintiff's terms sooner to reduce the likelihood that the firm's reputation will be harmed. Furthermore, insurers consider the audit firm's beliefs about the merits of a claim when making their recommendations. For example, when audit partners strongly believe they did nothing wrong insurers are more likely to recommend going to trial even when they face the risk of losing.

In short, our findings indicate that small to mid-size audit firms may obtain significant benefits from PLI. PLI provides marketing benefits, free risk management, and their ability to grow their brand because they won't have to close shop if a lawsuit hits them. In addition, auditors who already have insurance should take greater advantage of the marketing benefits and their relationship with their insurer to obtain free risk management advice and CPEs to educate their partners and staff on risk management practices.

FINRA Eligibility Rule is Another Hurdle to Expungement

by: Denis C. Dice, Esq

Denis C. Dice, Esq provides counseling and defends insurance companies in complex coverage litigation nationwide, involving disputes under a variety of professional liability, directors and officers, and general liability policies.

Registered representatives associated with FINRA member firms ("stockbrokers") are often times the subject of public customer complaints regarding their investments. If the customer complaint meets certain criteria it may potentially be reportable on the stockbroker's publicly available Broker-Check report, also referred to as the "CRD". The Broker-Check report is available for public inspection on the FINRA website and may also be accessed on a link from the stockbroker's website. The Broker-Check report is extremely important because customers oftentimes make decisions in regards to who they would use as his/her stockbroker based upon information contained within the Broker-Check report.

However, the stockbroker can seek to have a public customer complaint expunged from his/her CRD pursuant to FINRA Rule 2080. If the broker can establish that the claim, allegation or information is factually impossible, clearly erroneous, or false, then he/she can seek to have the customer complaint removed from his/her CRD by initiating an arbitration and participating in a telephonic FINRA hearing utilizing a sole arbitrator. The broker could also seek to establish that he/she had no involvement in the actions giving rise to the complaint. If the arbitrator finds that the stock broker was not involved in the actions giving rise to the complaint or that the complaint was factually impossible, clearly erroneous or false then the arbitrator can recommend that the complaint be expunged from the stock broker's CRD.

In March 2018, a registered representative associated with Wells Fargo Clearing Services, LLC filed an arbitration asking the arbitrator to recommend that a disclosed customer complaint should be expunged because the allegations were factually impossible, clearly erroneous, or false. (See: Oliver v. Wells Fargo Clearing Services, LLC, FINRA Dispute Resolution # 18-00942.) The occurrence or event giving rise to the claim was the public disclosure of the customer's allegations and the settlement of those claims which occurred on September 2, 2010. However, the stock broker did not file his Statement of Claim seeking expungement until March 8, 2018. The sole arbitrator denied the request for expungement on the basis that it was ineligible for arbitration because the complaint and settlement occurred more than 6 years prior to the filing of the Statement of Claim. According to FINRA Rule 13206 arbitrations must be filed within 6 years of the occurrence or event giving rise to the claim. The arbitrator determined that the eligibility period is a contractual bar to FINRA arbitration not a procedural limitation that might be extended by equitable principles.

FINRA practitioners must now contend with such eligibility issues in regards to disclosures which are reported outside of this six year time period.

It's time to renew your PLUS membership.

Renew by Friday, March 1 —we're looking forward to another great year together.

Not a member? Join us at PLUS in 2019!
Go to **plusweb.org** to see the many benefits of being a member, including access to the PLUS Journal archives."

PLUS

CONFERENCE CAUSE 2018

San Diego Armed Services YMCA

Back where we began Conference Cause 15 years ago!

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San Diego is home to the nation's largest concentration of military personnel. For over 100 years Armed Services YMCA San Diego has been uniquely positioned to improve quality of life and service for San Diego-based active duty military and their families.

the YMCA
ARMED SERVICES YMCA

- Fifty PLUS Foundation volunteers hosted a Military Appreciation Celebration for military service members and their families. Food, games and fun for 250!
- Thanks to individual donations and all of our supporters, PLUS Foundation granted over $58,000 to the San Diego Armed Services YMCA!!

Robbie Thompson
PLUS executive director

BUILDING MOMENTUM

with ***Robbie Thompson***

96% OF SURVEY RESPONDENTS RECOMMEND PLUS NATIONAL EVENTS!

Among many outstanding attributes, the PLUS brand stands for high-quality education and professional development opportunities. PLUS also stands for outstanding, high-quality events. In 2018, PLUS only strengthened its tradition of excellence. But don't just take my word for it—that's also what the PLUS members were saying about 2018 PLUS national events.

Let me share some numbers with you: 97%, 98%, 100%, 91%, 100%, and 100%. No, those aren't my test scores in Calculus III (I wish). These are the percentage of attendees at the PLUS D&O Symposium, Cyber Symposium, Healthcare & Medical PL Symposium, PLUS Conference, PLUS University, and PLUS Cyber University respectively that stated in their evaluations that they would recommend the event to their peers. More than 96% of survey respondents at PLUS national events last year said they would recommend the event to a peer. Those are simply awesome numbers! Numbers that PLUS can and should certainly be proud of. But it doesn't mean we can rest. It means we need to work even harder than ever to repeat those numbers in 2019—and we will. I hope you are there to be part of it.

I know it is not always easy to attend a national event, and that's part of why PLUS offers around 100 local events throughout the year, including chapter education and networking events, golf events, and Women's Leadership Network events. This is in addition to the numerous monthly webinars, special webinar series, and other long-distance education opportunities. But even if it's difficult to get away to a national event at times, it's always worth it. I urge you to get to at least one or more national PLUS event in 2019. Why? Because the education is excellent. The networking is fantastic. And it gives you a sense of just how vast and exciting this industry is. Sometimes you just have to be there to understand how much it's worth it. Besides, 96% of your peers who attended PLUS events in 2019 recommend that you go. I can't think of much else 96% of people would recommend.

So I want to encourage all PLUS members to attend at least one national PLUS event in 2019. And, if you attended a 2018 event, I encourage you to not only return in 2019, but to also recommend to a peer that they attend a 2019 PLUS event. Like most all 2018 PLUS national events attendees, you'll be glad you did. I'll see you there.

D&O Symposium, February 6-7 | New York

Cyber Symposium, February 6-7 | New York

Healthcare Symposium, March 12-13 | Chicago

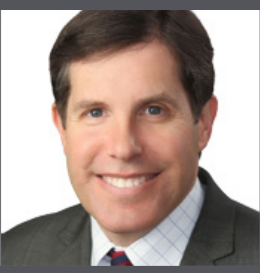
PLUS Conference, November 11-13 | National Harbor, MD

Cyber University, February 5 | New York

PLUS University, August 5-6 | LA
August 13-14 | New York
August 19-20 | Chicago

INSURANCE AGENT and BROKER E&O 2018: THE YEAR IN REVIEW

By: Peter J. Biging, Esq.



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I. INTRODUCTION

The evolution of insurance agent and broker errors and omissions ("E&O") law has been highlighted in recent years by: continued erosion of the "duty to read" defense; increasing perceptions of agents and brokers as possessive of specialized experience and expertise necessary to advise and guide their customers with respect to their insurance coverages and overall risk management; and ever expanding E&O risk concerns. In 2018, while these trends did not abate, there were a number of positive developments for insurance agents and brokers as well. These include: decisions touching on choice of law analysis in resolving conflict of law issues; accrual of failure to procure claims for statute of limitations purposes; the continued vitality of the "duty to read" defense in a number of states; and even the continued viability, in certain jurisdictions, of the absolute defense of contributory negligence on the part of the insureds.

Additionally, there were some helpful decisions in regards to defining the parameters of what constitutes an "interaction with regard to a question of coverage" sufficient to give rise to a duty to advise, and what is necessary to establish "special circumstances" or a "special relationship" based on an "extended course of dealing". Another decision addressed the limited exceptions to the requirement in states requiring the filing of an affidavit of merit as a prerequisite to commencement of a professional liability claim in the context of alleged agent/broker negligent failure to procure. There was also a decision that should be of particular note to agents/brokers forced to defend frivolous E&O claims based on alleged breach of contractual agreement to procure coverage, where the court relied on a state law providing for discretionary award of attorney's fees to victorious defendants in an agent/broker failure to procure lawsuit.

The following is a summary of some of the more interesting and significant developments in insurance agent/broker E&O in 2018.

II. SUMMARY OF THE YEAR'S HIGHLIGHTS

A. Choice of Law

In an important decision addressing the question of which state laws apply to claims against a broker where the alleged broker misconduct is claimed to have occurred in one state and the alleged injury occasioned thereby in another, the U.S. District Court for the Southern District of New York held that, under New York choice of law rules the court must look to the law of the state where the alleged misconduct occurred. This appears to have resolved some significant confusion on the issue, and is expected to clarify that no longer should federal district courts venued in New York look to the place of injury in determining choice of law for conduct-regulating based issues.

In Holborn Corp. v. Sawgrass Mut. Ins. Co.,[1] Sawgrass Mutual was an insurer which wrote homeowners insurance coverage in Florida. It retained Holborn to procure reinsurance for same, but terminated the agreement a couple of years later, after which Holborn brought suit for breach of contract, alleging Sawgrass had failed to pay its full share of brokerage on all reinsurance procured or placed. In response, Sawgrass asserted counterclaims alleging negligence, breach of fiduciary duty and breach of contract based on Holborn's alleged failure to recommend "Top and Drop" reinsurance coverage, a multi-layer insurance product which allows the insured to re-use the top excess-of-loss layer of reinsurance if it is not breached by the first loss event. Sawgrass alleged that had Holborn recommended this coverage, it would have saved hundreds of thousands of dollars.

Holborn moved to dismiss the first and second counterclaims on the grounds that they were barred by the economic loss doctrine under New York law. In opposition, Sawgrass argued that Florida law should apply, and thus that the economic loss rule should not apply in this instance (as under Florida law the economic loss doctrine only applies to product liability claims). Because the law at issue was "conduct regulating" as opposed to "loss-allocating," the court concluded that New York law should apply based on the alleged negligence and breach of fiduciary duty taking place in New York, where Holborn's brokers were located. In so doing, the court noted some confusion in past precedent on the issue, as a number of courts had previously concluded that conduct-regulating laws should be applied utilizing the law of the state where the last event necessary for liability took place: i.e., the situs of the injury. But applying the Second Circuit Court of Appeals' decision in Licci ex rel. Licci v. Leb. Can. Bank, SAL,[2] the court concluded that, in fact, where the alleged wrongful conduct and the alleged injury do not take place in the same jurisdiction, "[I]t is the place of the allegedly wrongful conduct that generally has superior 'interests in protecting the reasonable expectations of the parties who relied on [the laws of that place] to govern their primary conduct and in the admonitory effect that applying its law will have on similar conduct in the future.'"[3] Accordingly, because New York law applied, Sawgrass' counterclaims for

negligence and breach of fiduciary duty were barred by the economic loss doctrine, and the claims dismissed.[4]

B. Statute of Limitations

In American Fam. Mut. Ins. Co. v. Krop,[5] the Illinois Supreme Court dismissed a negligence claim against an agent for allegedly failing to procure homeowner's insurance providing coverage "equal" to the plaintiffs' prior coverage. Because the replacement policy only provided coverage for liability arising from bodily injury or property damage, the insurer (American Family) had denied coverage for claims alleging defamation, invasion of privacy and intentional infliction of emotional distress not involving any alleged bodily injury.

As the policy in issue had been received by the plaintiffs more than 2 years prior to the plaintiffs' lawsuit, the agent moved to dismiss the claim as barred by Illinois' two year statute of limitations provided for under 735 ILCS 5/13-214.4 (West 2014). After the motion was initially granted, then reversed on appeal, the Illinois Supreme Court reversed the appellate court ruling, and dismissed the claim.

In issuing its decision in this regard, the Illinois Supreme Court rejected the plaintiffs' argument that the claim against the agent shouldn't accrue until the discovery of the failure to procure the requested coverage occasioned by the denial of the insureds' claim. In so doing, the court noted that, under Illinois law, an alleged negligent failure to procure doesn't involve the breach of fiduciary duty.[6] And "[b]ecause a claim for negligent failure to procure insurance does not involve a fiduciary duty, insurance customers' obligation to read their policies controls."[7]

Detailing its rationale for why this constituted good public policy, the Court explained: Customers generally know their own goals better than an insurance agent does, but determining if a policy achieves those goals will be difficult when customers do not read their policies. Expecting customers to read their policies and understand the terms incentivizes them to act in good faith to purchase the policy they actually want, rather than to delay raising an issue until after the insurer has already denied coverage. Moreover, insurance customers frequently maintain the same insurance policy for years, perhaps decades, at a time. If the cause of action did not accrue until the insurance producer notified the customer of an uninsured liability, insurance customers would benefit from the policy throughout the intervening period, while evidence potentially relevant to the insurer's defense would be at risk of deterioration.[8]

In issuing this ruling, the Illinois Supreme Court noted that other courts in other states (including Alaska, Massachusetts, Maryland and Pennsylvania) had applied the "discovery rule," and still others had found that the cause of action only accrues when the insured incurs losses because of an uninsured liability.[9] However, the American Family Court stated that these courts had relied on two key premises which the Court rejected: "that the injury for which the plaintiffs sought a remedy was a liability that their policy did not cover and that the plaintiffs could not assert their claim until they encountered such a liability."[10] Instead, the Court held that the failure to procure insurance is a tort arising out of breach of contract, and thus should be treated as a tort which accrues when the breach occurs.[11]

Recognizing that there will be "a narrow set of cases in which the policyholder reasonably could not be expected to learn the extent of coverage simply by reading the policy," such as where the insurance policies contain contradictory provisions, fail to define key terms, or the circumstances of the loss in issue are so unusual that they could not likely have been imagined by the insureds when they purchased their policy, the Court indicated there could be exceptions to the rule.[12] But where, as here, the policy specifically contained a definitions section detailing the fact that "bodily injury" didn't cover emotional or mental distress, mental anguish or mental injury "unless it arises out of actual bodily harm to the person," the Court concluded no such exception should be applied.[13]

Applying a different approach, in Lederer v. Gursey Schneider LLP,[14] a California appellate court considered the question of when a negligent failure to procure claim accrued in connection with alleged failure to procure requested uninsured/underinsured automobile insurance. In Lederer, the evidence was undisputed that the insured had requested $5 million in limits, but a policy with a limit of only $1.5 million was purchased. This was discovered shortly after the policyholder's adult son was severely injured in a motorcycle accident. More than 2 years after this—but less than 2 years after the insurer for the other driver had tendered the $15,000 limits on the other driver's policy and the plaintiff's insurer had tendered the $1.5 million limit of the underinsured motorist policy—the plaintiff policyholder and her son brought suit against the agent. Because the statute of limitations was 2 years, the agent moved for summary judgment, arguing that the plaintiffs' cause of action had accrued when plaintiffs had been alerted to the fact that the insurance coverage that had been purchased was less than what had been requested. The trial court granted the motion. On appeal, however, the ruling was reversed.

In reversing the trial court on this issue, the appellate court concluded that the trial court had conflated the question of when the discovery of the alleged negligence had occurred with the question of when the plaintiffs had incurred actual injury. Because actual harm is required before a cause of action for negligence accrues, the appellate court concluded it was only when the plaintiffs suffered harm as a result of the failure to procure the requested coverage limits that the cause of action accrued. In this case, although the plaintiff son clearly suffered damages from the

motorcycle accident in February 2010, and plaintiffs discovered the negligent failure to procure shortly thereafter, the plaintiffs did not suffer damages caused by the agent's negligence until the son received the diminished benefit payment in June of 2012 — less than a year prior to the institution of the lawsuit. Significantly, in reaching this ruling the appellate court pointed to the fact that, under the governing statute, a right to underinsured motorist coverage does not accrue until the insured has reached a settlement or judgment exhausting the underinsured policy. In this case, the right to underinsured motorist coverage was not a given, because the cause of the accident was heavily disputed, and the police report of the accident wasn't favorable. It wasn't until the claim was settled with the underinsured motorist and the underinsured motorists coverage was tendered, in January 2012, that the injury caused by the failure to procure the requested underinsured motorist coverage limits was incurred.

In arguing in favor of affirmance of the trial court ruling, defendant argued that, in fact, the son had "suffered actual injury when he sustained severe bodily injuries exceeding his available insurance coverage, without any right to obtain any greater liability protection to fully compensate him for his injuries," and this "diminution of right" was sufficient to trigger the claim.[15] The appellate court rejected this argument, concluding that unless and until the son's right to receive any coverage under the underinsured motorist protections of the policy was extant, the mere "threat of future harm — not yet realized — does not suffice."[16]

In Jackson v. QBE Specialty Ins. Co.,[17] a Louisiana federal district court considered whether a case involving a dispute with respect to insurance coverage under a homeowners' policy for mold remediation was properly removed to federal court on the basis of fraudulent joinder of the homeowners' insurance agent. The plaintiffs had asserted claims against QBE for breach of contract in refusing to pay for the mold remediation, and against their insurance agent for failing to procure coverage for mold. The insurer (QBE) argued that the claim against the agent—whose presence destroyed diversity — was barred by the 1 year statute of limitations, given that the coverage was bound on July 12, 2016, the policy language clearly provided no coverage for mold, and the lawsuit wasn't filed until September 15, 2017. In opposing remand, plaintiffs argued that the defendant broker had voluntarily adopted a policy wherein an agent or other employee would review the entire insurance application with the prospective buyer and explain the available options for additional coverage; yet no such review had occurred in this instance. Plaintiff asserted that, had the agent followed this policy, they would have been told that a mold coverage rider was available and that most insureds purchase/obtain the rider given that homes in the area are at high risk for mold. Accepting this argument for purposes of the remand motion, the court concluded that, if an assumed duty was found to exist, the peremptive statutory period would not likely have begun to run until October 11, 2016, when plaintiffs only first became aware of the agent's policy in this regard.[18]

Lastly, in Penn v. 1st S. Ins. Servs., Inc.,[19] a Virginia federal district court, applying Virginia law, dismissed a claim for breach of contract in failing to procure the requisite minimum liability coverage for a truck engaged in interstate commerce. Although the federal minimum is $750,000, and it was alleged the owners relied on the broker's promised experience and expertise in insuring truckers to purchase the requisite coverage, the defendant broker purchased liability limits of only $100,000 for the truck. After two individuals were severely injured in an accident caused by the driver of the company's truck, they were awarded, collectively, $2.725 million in damages. The company assigned its claims against the broker to the injured parties, and the injured individuals brought suit against the broker for, among other things, breach of contract in failing to procure the required coverage. Because the claim was brought more than 5 years after the alleged breach of contract — i.e., the failure to purchase the correct coverage — on motion to dismiss the claim as time-barred, the court granted the motion. In reaching this holding, the court noted that, under Virginia law, a cause of action accrues when injury is sustained. In this case, the court concluded the owners of the truck sustained injury when they received the wrong coverage.[20]

As the lawsuit had been commenced within a year after the plaintiffs obtained their verdicts against the company, the plaintiffs argued that, because the company was being defended in the personal injury action, it didn't suffer an actual injury resulting from the alleged failure to procure the proper coverage until after judgments against it were obtained. However, in reasoning similar to that adopted by the Illinois Supreme Court in the American Family case discussed above, the Penn court pointed to the fact that, under Virginia law, in the case of a failure to procure a policy, the right to recover is fully matured when the agreement is violated and the insured has been harmed in paying premiums for coverage that wasn't obtained.[21] Accordingly, while further injury was suffered when the judgments were obtained for which there was only $100,000 in coverage, the claim against the broker had accrued years earlier, "When the legally insufficient policy was placed by Defendants."[22]

This ruling, and the American Family ruling, are significant in the ongoing debate about accrual of negligent failure to procure claims in that, as courts that have struggled with the issue have noted, the fact that the requested coverage was not obtained may not make itself readily known until a loss occurs. Not surprisingly, the rule in a number of states is that the statute of limitations does not begin to accrue on such claims until a loss occurs evidencing the lack of coverage, because

only then has the insured suffered injury. But the policy argument relied upon by the Illinois Supreme Court holds significant appeal, and the analysis in the Penn case supports the argument that, in fact, harm has been suffered immediately upon receipt of the wrong coverage. In light of the continuing evolution of the case law on this issue, it would not be surprising if, even in jurisdictions with apparently "settled" law on the issue, there may be further changes coming.

C. Defense of Unavailability of Coverage

In Madison Cnty. v. Evanston Ins. Co.,[23] the court considered the viability of a defense of unavailability of coverage to a failure to procure claim insofar as it is based on an alleged breach of a contractual promise to procure specific coverage under Alabama law. Finding this defense to be lacking, the court noted that in connection with breach of contract claims, Alabama "'has not recognized the defense of impossibility or impracticability. Where one by his contract undertakes an obligation which is absolute, he is required to perform within the terms of the contract or answer in damages, despite an act of God, unexpected difficulty, or hardship, because these contingencies could have been provided against by his contract.'"[24] Accordingly, under Alabama law, absent a contractual provision addressing the contingency of the requested coverage being unavailable, the defense that the coverage wouldn't have been available—which is regularly raised as a defense to negligent failure to procure claims—is apparently not a viable defense to a breach of contract based failure to procure claim.[25]

D. Duty to Read

As regular readers of this annual review will note, the defense of "duty to read" has been under assault, and there are fewer and fewer jurisdictions which continue to view the "duty to read" as an absolute defense to negligent failure to procure and fraud or negligent misrepresentation claims. But there are still some jurisdictions in which the defense remains alive and well. A couple of decisions in Mississippi and Georgia reflect this, while at the same time highlighting the availability of exceptions to the rule even where it remains in place.

In Am. Zurich Ins. Co. v. Guilbeaux,[26] the court reaffirmed that, under Mississippi law, claims of negligent procurement, or fraudulent or negligent misrepresentation against a broker or agent must fail, as a matter of law, if the insured received and had an opportunity to review its insurance policy and a review of same would have clarified the actual coverage procured, based on Mississippi's "duty-to-read" and "imputed-knowledge" doctrines. However, the court noted that, "[f]or an insurer to get the benefit of a presumption of receipt of an insurance policy, the insurer must tender evidence of mailing—such as an affidavit of an employee demonstrating the insurer's records acknowledging mailing."[27] As the insured claimed to have been misled that the builder's risk policy he purchased would provide coverage for more than 30% of the completed work on the home he was constructing and there was no documentary evidence he had been provided with a copy of the policy, the court denied the broker's motion to dismiss on summary judgment.

The duty to read as an absolute defense to an insurance agent/broker negligent failure to procure claims remains viable in Georgia as well. But there are exceptions. Bush v. AgSouth Farm Credit, ACA[28] provides an illustrative example.

As a general rule, Georgia law provides that: An insurance agent who undertakes to procure a policy of insurance for his principal but negligently fails to do so may be held liable to the principal for any resulting loss. However, where the agent does procure the requested policy and the insured fails to read it to determine which particular risks are covered and which are excluded, the agent is thereby insulated from liability, even though he may have undertaken to obtain full coverage.[29]

However:

an exception to this rule applies where the agent, acting in a fiduciary relationship with the insured, holds himself out as an expert in the field of insurance and performs expert services on behalf of the insured under circumstances in which the insured must rely upon the expertise of the agent to identify and procure the correct amount or type of insurance.[30]

In AgSouth Farm Credit, a farmer ("Bush") who had purchased crop insurance for his wheat and soybean crops, suffered a loss in 2013 to his wheat crop as a result of excessive moisture. He was paid $102,986 for his loss, which he assigned to AgSouth to put towards several loans he had received towards the purchase of farm machinery and equipment. Afterwards, the insurer conducted an audit of his claim, and determined that he had misrepresented his actual production history ("APH"), and he was not entitled to the claim payment he received. The insurer demanded repayment of same, in order for him to remain eligible to participate in the crop insurance program. Because he had used the funds to make payment towards his loan, he couldn't repay the insurer. Without the ability to purchase crop insurance, he contended he lost the ability to operate his farm in 2015 and 2016, had to sell off his cattle, and was forced to lease land and equipment to another farmer — causing him alleged damages of at least $145,000.

In pursuing claims for both negligence, negligent misrepresentation and fraud, Bush argued that the AgSouth agent he utilize to purchase crop insurance had agreed to calculate his APH each year beginning in 2011, and he presumed she had done so based on the "weight tickets" he had provided to her. The agent acknowledged she had prepared the APH calculations based on the information she was provided, and told him he was not required to submit supporting documentation with his policy application. But she claimed she had warned him that he would be subject to audit and if he was ever

audited he would "have to document" what was reported in the insurance application. Further, Bush had signed the insurance application certifying that to the best of his knowledge and belief the information contained therein was correct; he signed the production and yield report submitted therewith certifying its correctness; the application stated "I also understand that failure to report completely and accurately may result in sanctions under my policy, including but not limited to voidance of the policy"; and, in signing the production report, he acknowledged "this form may be reviewed or audited and that information inaccurately reported or failure to retain records to support information on this form may result in recomputation of the APH yield."[31] Based thereon, AgSouth and the agent moved for summary judgment dismissing the claims, and the motion was granted.

On appeal, the decision was reversed. Although Bush admittedly had not read the policy and other related documents, the court noted that Bush had alleged that the agent had held herself out as a crop insurance expert. Further, viewing the evidence in the light most favorable to Bush, the court concluded there was evidence the agent had undertaken to calculate the APH for him, and Bush had relied on her expertise in this regard because he knew nothing about crop insurance, having never previously farmed his land for the purpose of selling the produce, and thus never having previously purchased such insurance. As such, Bush depended on the agent to ensure that his crop was adequately insured against loss, which necessarily required the agent to properly calculate the APH based on proper documentation as governed by federal rules set out in a voluminous Crop Insurance Handbook with which the agent was quite familiar.[32] As such, the court determined "[i]t is for a jury to decide whether [the agent's] alleged failure to ask Bush for records to support the APH and her alleged failure to use written verifiable records to calculate the APH constituted negligence and/or negligent misrepresentation."[33]

Significantly, while the defendants argued that the documentation requirement was readily apparent on the face of the application documents and policy, and Bush's admitted failure to read these documents preclude recovery, the court concluded that the fact that the expert exception to the general "duty to read rule" applied took the legs out from under that argument. In fact, the court noted, the policy referred to "written verifiable records," and relied upon reference to a federal regulation to define the term. As such, the court determined, "[i]t would not have been readily apparent to Bush, on the face of the policy, that the weight tickets or other information he provided to Meeks were not adequate to meet the definition of 'written verifiable record.'[34] Moreover, "[e]ven if Bush had read the policy from beginning to end, he would not have known that the calculation was not properly done in accordance with federal regulations. Calculating the APH was up to the expert agent and governed by the rules set out in the Crop Insurance Handbook."[35]

E. Affidavit of Merit

In Ehrhardt v. Amguard Ins. Co.,[36] the court upheld the dismissal of broker negligence and breach of contract claims for failure to serve an Affidavit of Merit pursuant to N.J.S.A. 2A: 53A-26 to 29 attesting that defendants' conduct did not comport with applicable professional standards of care. What is significant about this is the court's rejection of the argument, under the particular facts of this case, that this was such a "common knowledge" negligent act that expert testimony, and thus an Affidavit of Merit, was unnecessary.

In Ehrhardt, plaintiffs were the owner/operators of a medical practice and nutritional business in New Jersey ("Body Mind Nutrition") who learned, after Superstorm Sandy struck in October 2012, that much of their losses caused by the storm—including for inventory and business personal property—would not be covered under the commercial general liability policy their broker had procured for them. In addition to suing their insurer (against whom the claims were at some point voluntarily dismissed), they sued their broker, alleging negligence and breach of contract based on failure to procure the coverage requested, and to inform and advise them about the coverage obtained. Among other things, plaintiffs alleged the broker had been requested and failed to obtain coverage comparable to the coverage they had to replace because their prior insurer had advised it would no longer be offering the coverage they previously had in place.

In New Jersey, before a lawsuit alleging professional negligence can be brought against a licensed professional, plaintiffs must obtain and serve an Affidavit of Merit ("AOM") on the defendant from an expert attesting that defendants' conduct did not comport with applicable professional standards of care, pursuant to N.J.S.A. 2A:53A-26 to 29. Because the plaintiffs had admittedly failed to serve an AOM on defendants, at the conclusion of discovery the defendants moved to dismiss the claims against them on summary judgment, and the motion was granted.

Citing to Hubbard ex rel. Hubbard v. Reed,[37] Plaintiffs appealed from the trial court decision on the grounds that, while suits against licensed professionals generally require service of an AOM in New Jersey, there is a "common knowledge" exception that applies where expert testimony is not needed to establish whether the defendants' "care, skill or knowledge . . . fell outside acceptable professional or occupational standards or treatment practices.'"[38] For example, in the Hubbard case, a jury didn't need an expert to explain that a dentist had been negligent in extracting the wrong tooth. Here, plaintiffs argued that, because the broker defendants had been asked to replace the coverage they previously had with coverage

"as comprehensive as those [in the policies] previously issued" to them and had failed to do so, no expert testimony was necessary.[39] The appellate court rejected this argument, noting that "the assessment of what coverage in a certain insurance policy is equally 'comprehensive' as the coverage provided in another insurer's policy can readily entail a sophisticated assessment of policy-specific language, definitions, exclusions, exemptions, and the like. Lay jurors are simply not equipped to make those assessments."[40] Further, the court rejected the argument that the breach of contract claim should be treated differently because plaintiffs had failed to offer evidence that they had requested identical coverage to what they previously had, nor a reciprocal promise by defendants to fulfill such requests. In fact, at least one of the emails exchanged between the parties "suggest[ed] a desire to explore a 'cheaper' premium, indicating a possible willingness by the insured to accept non-identical coverage for a lower cost."[41] As such, the court concluded, "[P]laintiffs have failed to demonstrate that these issues of replacement coverage can be litigated fairly and sensibly in the absence of supporting expert opinion."[42]

F. Recovery of Attorneys' Fees

In 11333, Inc. v. Certain Underwriters at Lloyd's, London,[43] the court considered an application by a victorious insurance broker (HUB) for reimbursement by plaintiff of its reasonable legal fees incurred in defending against allegations of professional negligence, breach of contract and breach of the duty of good faith and fair dealing pursuant to an Arizona statute providing that, "In any contested action arising out of a contract, the court may award the successful party reasonable attorney's fees."[44] Under this statute, the award of attorney's fees is discretionary, and the courts may consider a variety of factors in determining whether to award same, including: "the merits of the unsuccessful party's case, whether the litigation could have been avoided or settled, whether assessing fees against the unsuccessful party would cause an extreme hardship, the degree of success by the winning party, any chilling effect the award might have on other parties with tenable claims or defenses, [and] the novelty of the legal questions presented."[45]

In granting HUB fees totaling nearly $90,000, the court took note of the fact that plaintiff had alleged an oral agreement that HUB would procure insurance for the plaintiff's errors and omissions in overseeing an LLC which had taken ownership of an oceanfront subdivision in Galveston, Texas, and had failed to do so. Yet in the course of litigation, the plaintiff had failed to offer evidence that HUB had represented to Plaintiff that the policy it had procured for Plaintiff would provide such coverage, or that it would even have been possible for HUB to have obtained a mortgage bankers/brokers insurance policy that would have provided coverage for the loss (uncovered flood loss).[46] The court also noted that it need not try to allocate defense costs incurred as among the tort-based and contract based claims, because they were so inextricably intertwined.[47]

This decision is significant because it offers hope to brokers in states with similar such statutes that, where a wholly unmeritorious broker breach of contract claim based on alleged failure to procure has been brought, some measure of justice can be meted out to the broker for having to defend same.

G. Contributory Negligence

In Kane v. Atlantic States Ins. Co.,[48] the court issued a reminder of the fact that the contributory negligence doctrine is still alive and well in Pennsylvania in regards to negligent failure to procure insurance coverage claims against insurance agents and brokers. While, by statute, the courts must look to and apply the parties' respective comparative levels of negligence in cases involving alleged injuries to person or property,[49] this does not apply to the loss of an alleged right to an insurance recovery.[50] Thus, the contributory negligence of an insured found to have been a substantial factor in or proximate cause of the lack of insurance will serve to bar the insured from any recovery.[51]

H. Breach of Fiduciary Duty

In Trusted Transportation Solutions, LLC v. Guarantee Ins. Co.,[52] applying New Jersey law, a New Jersey federal district court dismissed a broker "breach of fiduciary duty" claim as duplicative of the plaintiff's broker negligence claim. The court held that "the sole duty of care owed by an insurance broker to an insured is to refrain from engaging in conduct giving rise to a claim for broker malpractice."[53] "To the extent an insurance broker owes a 'fiduciary duty' to an insured," the court stated, "such duty arises only in the context of a broker malpractice and/or negligence claim."[54] However, it should be noted that the court acknowledged a separate claim for failure to act in accordance with a higher duty of care can be brought where a "special relationship" can be shown.[55]

I. Duty to Advise

In Hansmeier v. Hansmeier,[56] the Nebraska Court of Appeals affirmed the dismissal of claims against an insurance agent on summary judgment asserting that the agent had been negligent in failing to advise a farmer regarding his coverage options. Although he had a right under Nebraska law not to purchase workers compensation insurance for his employees, he could only do so if he provided them written notice, signed by the employees, that they would not be covered by the Nebraska Workers Compensation Act. In this case, the farmer knew he didn't have to purchase such insurance if he had ten employees or less, but wasn't aware that he had to provide this notice, and failed to do so, thus opening himself up to liabilities for an employee whose thumb was detached while using an auger on the job.

The appellate court found that the insurance agent's failure to advise the farmer of this notice obligation could not give rise to a negligent failure to advise claim, because the agent had

no duty to anticipate what coverage the farmer should have. The court acknowledged the agent did not contradict the farmer when he advised he didn't think he needed workers' compensation insurance. But it concluded this did not amount to a negligent misrepresentation, because it was true. In other words, reading between the lines of the decision, while it certainly would have been helpful to raise the question of whether the farmer had taken the requisite steps necessary to lawfully proceed without workers compensation insurance, the agent had no duty to anticipate that the farmer wasn't aware of or properly complying with the law, and as such anticipate his coverage needs based thereon.

In Luzzi v. Hub International Northeast, Ltd.,[57] in denying summary judgment the defendant agent ("Fidelity") for alleged negligence in providing advice to an insured with regard to renter's insurance for her personal property, the court noted that under New Jersey law, both insurance agents and brokers owe a duty of care in connection with the procurement of insurance coverage beyond merely procuring the insurance he or she undertook to supply. Quoting from the New Jersey Supreme Court decision in Aden v. Fortsh,[58] the court pointed out that "[l]iability resulting from the negligent procurement of insurance is premised on the theory that a broker 'ordinarily invites [clients] to rely upon his expertise in procuring insurance that best suits their requirements."[59] Thus, because plaintiff alleged failure on the part of the agent to ask about the types and value of the personal property she owned, plaintiff had a right to a jury determination of whether the agent breached her duty of care. The court so ruled notwithstanding the fact that plaintiff had been provided with a policy containing a declarations page evidencing only $15,000 in property limits, and plaintiff knew she was paying only $126 in annual premiums. The question of her credibility in believing this entitled her to coverage for $270,000 in alleged losses was deemed to be one for the jury to determine.[60]

In Sesztak v. Great Northern Ins. Co.,[61] the court concluded that, in addition to there being "no common law duty of a carrier or its agents to advise an insured concerning the possible need for higher and higher policy limits upon renewal of a policy,[62] "[w]e see no reason why such a duty would arise when an insured is [first] obtaining coverage" absent a 'special relationship', such as where "an insured 'knew nothing about the technical aspects of insurance policies, [and] placed faith in,' and relied on, the broker's expertise."[63] Accordingly, the court affirmed a trial court ruling finding for the broker after trial that the broker could not be found liable for failing to advise a homeowner to purchase greater than $1.5 million in homeowner's insurance when the evidence made clear the homeowner was well aware that the home—which the plaintiff had listed for sale at over $3 million—was valued at substantially more than the limits requested.

J. Special Relationship/Duty to Advise

In New York, there are three "exceptional situations" recognized by the courts as giving rise to a "special relationship:" "(1) [where] the agent receives compensation for consultation apart from the payment of the premiums; (2) there was some interaction regarding a question of coverage, with the insured relying on the expertise of the agent; or (3) there is a course of dealing over an extended period of time which would have put objectively reasonable insurance agents on notice that their advice was being sought and specially relied on."[64] While this is fairly straightforward and has long been the law in New York, the precise contours of what may constitute an "interaction with regard to a question of coverage" have not been specifically defined. As a result, arguments have been made that all sorts of "interactions" can form the basis of a special relationship, and the courts have had to grapple with this issue. Two federal court decisions applying New York law in 2018 have offered some guidance.

In Holborn Corp. v. Sawgrass Mut. Ins. Co.,[65] discussed above with regard to the choice of law issue, above, the court considered an alleged negligent failure to advise claim against a broker ("Holborn") for failing to advise an insurance company with a homeowner's insurance program to purchase "Top and Drop" reinsurance, a multi-layer insurance product which allows the insured to reuse the top excess-of-loss layer of reinsurance if it is not breached by the first loss event. As above noted, Sawgrass alleged that, had Holborn recommended this coverage, it would have saved Sawgrass hundreds of thousands of dollars. In rejecting Sawgrass' argument that there was a special relationship based on an "interaction regarding a question of coverage," the court noted that, "In order to satisfy this requirement, courts have generally required that the insured make a specific request about the feature of the proposed insurance at issue in the subsequent suit."[66] Yet, here Sawgrass had failed to allege that a particular conversation about the insurance coverage at issue had ever occurred, or that it had relied on Holborn to procure that coverage. Sawgrass had merely alleged that it had required the broker "to carefully analyze Sawgrass' potential exposure . . . [and] design a specific reinsurance program custom tailored to Sawgrass' unique business needs."[67] Similarly, the court noted, Sawgrass argued that Holborn had recommended a reinsurance policy "that it represented as having been the most advantageous for its unique business needs."[68] In rejecting this as an appropriate basis for a "special relationship" claim, the court stated: An alleged conversation in which the parties discussed 'the most advantageous' policy—without either party specifically mentioning Top and Drop insurance—is insufficient to create a special relationship . . . . All insurance customers are seeking the most advantageous insurance policy, and as a result, a discussion generally about what policy will be the most advantageous does not suggest 'that the Plaintiff enjoyed anything other than an ordinary consumer-agent insurance relationship.'[69]

Subsequently, in Spinnato v. Unity of Omaha Life Ins. Co.,[70] the court cited Holborn in dismissing a claim based on alleged negligent advice by an insurance agent, who allegedly had advised the plaintiffs to purchase insurance policies they ultimately couldn't afford, and caused them to be harmed as a result. In rejecting their special relationship claim based on an alleged interaction with regard to a question of coverage, the court noted that "[t]he Plaintiffs have failed to allege that a conversation occurred between themselves and [the agent] regarding the applicability of the policies to their particular financial situation, the affordability of the premiums, or the suitability of the death benefits."[71] Further, the court stated, the vague allegation that the Plaintiffs agreed to purchase the policies at issue based on the agent's recommendations was "too vague and common to create a special relationship."[72] If the court was to rule otherwise, it concluded, the courts would be compelled to find a special relationship in nearly every instance, and "'th[is] exception would swallow the general rule.'"[73]

K. Measure of Damages

In Lexington Club Cmty. Ass'n, Inc. v. Love Madison, Inc.,[74] two condominium associations had paid the premiums on a performance bond purchased in connection with repair work to be done after Hurricane Wilma. In violation of the specific contractual requirements for the purchase of such a bond, the bond had been issued by a surety that wasn't licensed to do business in Florida. While there ended up being no cause to collect on the bond, the associations sued to recover the cost of the premiums from both the contractor and the insurance agent that had procured the bond, with the claim against the agent based on alleged negligence in failing to procure the requisite coverage.

At trial, the parties disputed the applicable jury instruction to be given on damages, with the associations contending that the jury should be instructed that, "[I]n an action for negligent procurement of insurance, . . . [w]hen no loss has occurred that would have been covered, if the insurance had been properly obtained, the measure of damages is the amount paid for the premium."[75] In contrast, the agent argued that the jury should be instructed that the measure of damages should be solely limited to the amount of uncovered loss that would have been covered had the insurance been properly obtained.[76] Because the court gave the insurance agent's instructions and there had been no loss, the jury concluded the associations had suffered no damages based on the agent's negligent failure to procure.

On appeal, the appellate court concluded the jury instruction was proper. The court noted that both Louisiana, Mississippi and Virginia had concluded the insured's damages in such instance should be measured by the amount paid in premium for the deficient coverage. However, the court found that by statute Florida provides that if a loss occurs under a policy issued by a non-authorized insurer, the policy would still be enforceable.[77] Thus, because the Florida Legislature had "expressly made the unauthorized insurer's policies enforceable in a negligent procurement action," the associations could not be held to have been injured by the purchase of the surety bond in issue.[78] In so finding, the court stated, "We decline to adopt the damages law of foreign states where our Legislature has provided statutory remedies."[79]

L. Applying the Factors to Assess Special Relationship Claims

Lastly, a couple of decisions this past year are noteworthy for the manner in which they analyzed the question of whether "special circumstances" or a "special relationship" existed sufficient to give rise to a duty to advise.

First, in an unpublished decision by the California Court of Appeal, Second District in Randle v. Farmers New World Life Insurance Co.,[80] the court considered the question of the ongoing duties and responsibilities of an insurance broker to provide advice and guidance to the beneficiary of a life policy after her divorce from the individual whose life was being insured. In Randle, it was alleged that, in 2004, 12 years after the policy had been issued, the plaintiff, Judy Randle, had divorced her husband, Alan McConnell, but continued to be the named beneficiary of the policy. While the terms of her divorce decree provided that she would only be entitled to a ¼ interest in the policy proceeds, and the couple's 3 children would be entitled to the remainder, it also provided that should Mr. McConnell choose to discontinue paying his share of the premiums, and Ms. Randle pick up the payments, Ms. Randle would be entitled to 100% of the policy proceeds. She subsequently did so, in 2008, and believed that, as a result, she was the sole beneficiary. However, apparently, unbeknownst to Ms. Randle, in 2006 Mr. McConnell had filled out a policy form changing the beneficiaries to her and the couple's 3 sons, dividing their beneficial interests in the policy proceeds into equal parts. While the change didn't take effect immediately, because he failed to provide the insurer with a full copy of the divorce decree, by the policy's terms it was to take effect upon the insurer's receipt of same, even if after Mr. McConnell's death.

When Ms. Randle began making all the premium payments on the policy, she claimed to have discussed with her broker, Mark Hebson of defendant Hebson Insurance Agency, Inc. ("Hebson"), the fact that, per the terms of her divorce decree, since she was paying all of the premiums she would be the sole beneficiary. She also claimed to have repeatedly contacted Mr. Hebson to confirm she was the sole beneficiary under the policy, and received confirmation each time that this was the case. However, after Mr. McConnell died the sons sent Farmers a complete copy of the divorce decree. Because this now triggered the policy form providing for equal ¼ division of the beneficial interests of the policy as among Ms. Randle and her 3 sons, Farmers paid out the policy proceeds in that fashion.

In her suit as against Hebson, Ms. Randle asserted a claim for negligence as against Hebson for failing to advise her, after her divorce, that it was necessary to change the ownership of the policy to ensure that she would remain the sole beneficiary. The claim was dismissed, on the grounds that Hebson owed no duty to advise in this regard. On appeal, the decision was affirmed. In reaching this decision, the California Court of Appeals noted that "a broker's duty is limited, even in the procurement context, absent special circumstances. And plaintiff offers no evidence of any special circumstances in this case."[81] "That is, there is no evidence the broker misrepresented the terms of the policy, or expressly agreed to assume an additional duty to plaintiff, or held himself out to plaintiff as an expert in life insurance."[82] The court concluded that "[a] client cannot, merely by telling her broker about changed circumstances after her divorce, impose on the broker a duty to give what amounts to legal advice on how best to protect her interests, unless the broker has held himself out as a life insurance expert."[83] And while Ms. Randle attested that Mr. Hebson had held himself out as an expert, and always gave advice on specific questions and concerns raised about her and her husband's various policies, this averment, alone, was not sufficient to raise an issue of fact on this point.[84] There was no evidence, beyond her allegation in this regard, that he had held himself out as an expert on life insurance.

Interestingly, Randle argued that a duty should be found to have arisen because the cases in California (and throughout the U.S. generally) hold that once an insurer or agent elects to respond to an insured's questions about coverage, a special duty arises which requires them to use reasonable care to provide accurate information. Nonetheless, the court stated that this didn't help Randle in this instance because the cases giving rise to this duty of care all involved misrepresentations about the coverage of policies at the time of purchase or renewal that induced the insured to purchase the policy. And "[n]othing in these cases suggests the existence of a duty, for the duration of a life insurance policy, to advise clients how to protect their interests in those policies."[85] "That," the court stated, "is the job of a lawyer, not an insurance broker."[86]

Because this is not a published decision, it cannot be relied upon as precedent, and thus is of limited utility to defense lawyers in insurance agent/broker E&O cases. Nevertheless, the case is noteworthy in the manner in which it analyzed the issues, and specifically the question of whether there were ongoing duties to advise on the part of the broker in the circumstances presented. But even in this regard, the analysis may not hold up to close scrutiny. The fact is that, in responding to the question as to whether she remained the sole beneficiary, without investigating whether a form had been filed with Farmers that could conceivably effect a change of her beneficial interest, the broker made a representation that lulled Ms. Randle into a false sense of security, based on partial information that was misleading, if not inaccurate, at the time given. Arguably, in agreeing to respond to the request for information on this issue, the defendant broker undertook a duty to exercise reasonable care to determine if the information being provided might be rendered inaccurate based on filed forms with Farmers in the event a triggering event occurred.

Second, in Bear, LLC v. Marsh USA, Inc.,[87] after the bottom of the hull of his yacht (the "Polar Bear") was damaged, the owner of the yacht had it brought to a shipyard for repairs. His insurance policy contained a maintenance and repair clause ("Repair Clause"). The Repair Clause provided that as a condition precedent to coverage for any "hot work" done at a shipyard or work done where the shipyard requires the owner to sign a waiver of subrogation agreement, the owner must first obtain agreement from the underwriters. The repairs required welding, and after the yacht was brought to the shipyard the ship's captain signed an agreement containing a waiver of subrogation provision. While welding work was being performed, the yacht caught on fire and was destroyed. Although the owner was able to collect $9.2 million in settlement from the shipyard, it was unable to collect on any portion of its $17.25 million agreed value hull coverage policy because the claim was denied by its insurer based on violation of the Repair Clause. In denying the claim, the insurer relied on the fact that the yacht owner had agreed to a waiver of subrogation provision in its contract with the shipyard for the repairs, and performance of hot work on the vessel without receiving prior agreement from the participating insurers underwriting the coverage. In the course of litigation of the denial, the denial was upheld on the grounds that the owner had breached conditions precedent to coverage for the loss.

In an effort to recoup the lost insurance, the owner sued his insurance broker (Marsh), alleging that Marsh had been negligent in failing to advise and recommend that the owner purchase a different policy that wouldn't have included the Repair Clause's provisions with regard to coverage for "hot work" and waiver of subrogation, or a separate Ship Repairer's Liability Policy. After a bench trial, the court found for Marsh.

In reaching its findings, the court discussed the fact that, under the applicable Florida law, Marsh would have no duty to advise absent evidence of a special relationship. Examining the evidence presented, the court concluded that the plaintiff had failed to meet its burden in demonstrating a special relationship with Marsh.

What's particularly interesting about this decision is how it discusses the evidence presented on the special relationship issue, and how the court weighed the competing evidence in reaching its determination. For example, the court looked at the evidence that the parties had had a long-term relationship, with Marsh acting as the owner's broker for nearly 10 years prior to the loss. While the court acknowledged that there were a number of communications in connection with the procurement of coverage for the Polar Bear, the court found that "a review of those communications reveals that it was not a deep working relationship beyond what is expected between an insurance

broker and his or her client."[88] It was not disputed that the broker assigned to the account had made a number of inquiries regarding the progress of the construction of the Polar Bear and its anticipated delivery date. However, the court concluded that these were "routine" inquiries to ensure that Marsh went to market for terms and secured insurance in time for the delivery date.[89] Otherwise, the broker generally only spoke with the owner and captain of the vessel, (who was designated as the broker's contact by the owner) via email, during the annual renewal process, once a year. In fact, she never met the owner in person, and only met the captain once in nearly 10 years of work on the account.[90] And while the broker visited the shipyard where the Polar Bear was being constructed in 2010, she and a colleague were already in town to visit other shipyards for marketing purposes.[91]

The plaintiff pointed to the fact that Marsh held itself out as an expert on yacht insurance and prepared a Risk Management Review and Yacht Insurance Proposal for the owner and captain of the vessel to review which discussed a number of insurance options for the Polar Bear when it was being constructed, as well as yearly insurance proposals thereafter and the broker held the title of "client advisor". However, the court discounted the value of these facts in establishing a special relationship. The court noted that Marsh provided these services to all it clients, and every broker in Marsh's Yacht Practice holds the same "client advisor" title.[92] Significantly, the court noted, "[a]t every step during the original placement and subsequent renewals, [the broker] checked in with [the owner and the captain] and acted only after being directed to do so."[93]

Additionally, the court addressed the argument that "the mere nature of the policy, namely its complexity and the need for a broker to serve as a liaison between an insurer and insured, should demand a finding of a special relationship."[94] In rejecting this argument, the court concluded that "Bear is effectively asking the Court to find that all brokers within Marsh's Yacht Practice maintain a special relationship given the nature of the policy and the services rendered."[95] Mindful that a special relationship is the exception, not the rule, found in only rare circumstances, the court concluded that "such a categorical finding would contravene the purpose of the exception."[96]

III. CONCLUSION

As 2018 has again shown, like its predecessors, the law of insurance agent/broker E&O continues to evolve in ways that provide both opportunity and peril for both sides of the "v" in agent/broker E&O litigation. Where there may be obvious mistakes made, defenses — even complete defenses — may still be available. And the statute of limitations battleground appears far from fully resolved, with the "discovery rule" enduring some setbacks. On the other hand, where the coverage issues are complex, the agent/broker has touted his expertise, and reliance thereon can be credibly argued, agent/brokers continue to face increasing risk. This said, courts that have confronted the issues of when "special circumstances" or a "special relationship" exist giving rise to a duty to advise have consistently shown that they will, in fact, consider and carefully weigh each factor necessary to reaching this determination. Blanket assertions of "special relationships," and reference to an extended course of dealing, by themselves, will not be sufficient. This provides a vivid reminder of the need for insurance agents and brokers to watch what they promise, make sure they have done all they can to confirm the understanding and acceptance of the coverage offered, and consistently document their interactions in this regard.

Endnotes

1. 304 F.Supp.3d 392 (S.D.N.Y. 2018).
2. 739 F.3d 45 (2d Cir. 2013).
3. Holborn, 304 F.Supp.3d at 399 (quoting Licci, 739 F.3d at 50–51).
4. Interestingly, a different analysis applies with respect to loss-allocating rules. Under New York law, there is a three step analysis to consider. See Newmeier v. Kuehner, 31 N.Y.2d 121, 612 N.E.2d 177 (NY 1972). There is still another analysis to consider with regard to applicable statutes of limitations. See N.Y. Civ. Prac. Law § 202 (2018).
5. Docket No. 122556, 2018 WL 5077145 (Ill. Oct. 18, 2018).
6. Id. at *5.
7. Id. at *6.
8. Id.
9. Id.
10. Id.
11. Id. at *7.
12. Id.
13. Id.
14. 22 Cal.App.5th 508 (Cal. Ct. App. 2018).
15. Id. at 522.
16. Id. at 522–523 (quoting Adams v. Paul, 904 P.2d 1205, 1208 (Cal. 1995).
17. No. 17-11730, 2018 WL 3408182 (E.D. La., July 13, 2018).
18. Id. at *9.
19. 324 F.Supp.3d 703 (E.D. Va., 2018).
20. Id. at 713.
21. Id. at 710–711 (citing Autumn Ridge, L.P. v. Acordia of Virginia Ins. Agency, 613 S.E.2d 435, 440 (Va. 2005).
22. Id. at 712.
23. No. 5:15-cv-01997, 2018 WL 4680213 (N.D. Ala., Nov. 2, 2018).
24. Id. at *31 (quoting Silverman v. Charmac, Inc., 414 So. 2d 892, 894 (Ala. 1982) (internal quotations omitted).
25. Id.
26. No. 2018 WL 1661629, 2018 WL 1661629, at *5 (S.D. Miss., Apr. 5, 2018).
27. Id.
28. 816 S.E.2d 728 (Ga. 2018).
29. Atlanta Women's Club v. Washburne, 207 Ga. App. 3, 4, 427 S.E.2d 18 (1992) (citations omitted).
30. Id.
31. AgSouth Farm Credit, 816 S.E.2d at 733.
32. Id. at 736.
33. Id.
34. Id.
35. Id.
36. No. A–2128–16T2, 2017 WL 6048119 (N.J. Super. Ct., App. Div., Dec. 7, 2017).
37. 168 N.J. 387, 390 (N.J. 2001).
38. Ehrhardt, 2017 WL 6048119 at *3 (quoting Hubbard, 168 N.J. at 390).
39. Id. at *4.
40. Id. at *4.
41. Id.
42. Id.
43. No. CV-14-02001, 2018 WL 1576863 (D. Ariz., Mar. 30, 2018).
44. A.R.S. § 12-341.01(A).

Endnotes

45. 11333, Inc., 2018 WL 1576863 at *2.
46. Id. at *4.
47. Id. at *3.
48. No. 1242 MDA 2017, 2018 WL 5725238 (Pa. Super, Nov. 1, 2018).
49. 42 Pa. C.S.A. §7102(a).
50. 2018 WL 5725238 at *4 (citing to Wescoat v. Nw. Sav. Ass'n.., 548 A.2d 619 (Pa. Super. Ct. 1988)).
51. Id. at *5. There aren't many left, but additional jurisdictions where the contributory negligence of the insured can be offered as a complete defense to the alleged negligence of the insurance agent/broker include North Carolina and Alabama. SeePiraino Bros. v. Atl. Fin. Grp., Inc., 712 S.E.2d 328, 334 (N.C. Ct. App. 2011); William v. Delta Int'l Mach. Corp., 619 So.2d 1330, 1333 (Ala. 1993).
52. No. 16–7094, 2018 WL 2926167 (D. N.J. June 11, 2018).
53. Id. at *4.
54. Id.
55. Id. at *5.
56. 25 Neb. App. 742 (Ct. App. NE, Apr. 10, 2018).
57. Civ. No. 15-6064, 2018 WL 3993450 (D. N.J., Aug. 21, 2018).
58. 169 N.J. 64 (2001).
59. 2018 WL 3993450 at *7 (quoting Aiden, 169 N.J. at 79).
60. Id.
61. No. A-2846-15T4, 2018 WL 5930554 (N.J. Super. Ct. App. Div., Nov. 14, 2018).
62. Id.at *8 (quotingWang v. Allstate Ins. Co., 125 N.J. 2, 11–12 (1991)).
63. Id. (quoting Sobor v. Prudential Prop. & Cas. Ins. Co., 200 N.J. Super. 333, 339 (N.J. Super. Ct. App. Div. 1984)).
64. Voss v. Netherlands Ins. Co., 22 N.Y.3d 728, 735 (2014).
65. 304 F.Supp.3d 392 (S.D.N.Y. 2018).
66. Id. at 404.
67. Id.
68. Id. at 405.
69. Id. (quoting Long Beach Road Holdings, LLC v. Foremost Ins. Co., 75 F.Supp.3d 575, 590 (E.D.N.Y. 2015)).
70. 322 F.Supp.3d 377 (E.D.N.Y. 2018).
71. Id. at 393.
72. Id.
73. Id. (quoting Holborn, supra, 304 F.Supp.3d at 405).
74. 253 So.3d 632 (Fla. Dist. Ct. App., 2018).
75. Id. at 635.
76. Id.
77. Id. at 636 (referencing Fla. Stat. §§ 626.901(3) and 627.418(1) (2017)).
78. Id.
79. Id. at 637.
80. 2018 WL 2276347 (Cal. Ct. App., Second Dist., Div. 8, May 18, 2018).
81. Id. at *4.
82. Id.
83. Id.
84. Id. at *5.
85. Id. at *6.
86. Id.
87. No. 15-cv-00630, 2018 WL 1905458 (S.D. CA, Apr. 20, 2018).
88. Id. at *5.
89. Id.
90. Id.
91.Id.
92. Id. at *6
93. Id.
94. Id.
95. Id.
96. Id.
97. Id.

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Defense Cost Issues under D & O Policies

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INTRODUCTION

An insurer's duty to defend, based on policy language and interpretive case law, is well established. In most states, the duty to defend is broader than the duty to indemnify and is based on potential coverage as opposed to actual coverage for the claims asserted. Most courts utilize a version of the four corners rule to analyze the scope of the duty to defend. There are significant consequences for an insurer who breaches the duty. For this reason, it is important to be familiar with the duty to defend under the law of the state implicated by the policy at hand.

Many directors & officers liability policies ("D & O policies") are different than general liability policies, primarily because they do not include a duty to defend the insured. D & O policies expressly state that the insured and not the insurer has the responsibility to defend a covered claim and provide that the insurer will reimburse the insured for defense costs incurred. The insured is given the right to select counsel, subject to the reasonable approval of the selection by the insurer. Defense costs, either by definition or allocation clauses are limited to covered claims.

Specific state case law interpreting D&O policies is sparse. Thus, this article explores how jurisdictions across the country have applied the traditional duty to defend rules to the agreement to reimburse defense costs in D & O policies and other policies with similar language, answering the following questions:

- How is a D &O insurer's obligation to reimburse triggered?
- Once triggered, when must reimbursement occur?
- When multiple claims are asserted, must the insurer reimburse the insured for the defense of all claims or only covered claims?
- If the obligation only extends to covered claims, how are defense costs allocated?
- What rights, if any, does the insurer retain over the selection of counsel, the control of the defense and settlement of the underlying claim?
- Finally, what issues arise surrounding exhaustion of D & O policy limits?

Determination of the Obligation to Reimburse Defense Costs

Most courts that have addressed the issue have recognized that the duty to defend and the duty to reimburse defense costs are discreet concepts imposing different obligations on the insurer.[1] However, courts assessing the duty to advance defense costs generally do so using standards that are the same or similar to those employed to ascertain whether an insurer has a duty to defend, i.e., by looking at whether the allegations of the complaint in the underlying lawsuit assert a potentially covered claim.[2]

For example, under New York law, where a contract of insurance includes the duty to pay for the defense of its insured, that duty is a "heavy" one. The duty is independent of the ultimate success of the suit against the insured. The duty to pay defense costs exists whenever a complaint against the insured alleges claims that may be covered under the insurer's policy. The duty to pay defense costs is construed liberally and any doubts about coverage are resolved in the insured's favor.[3]

California courts have determined that the rules establishing a duty to defend are not applicable for determining a duty to advance defense costs.[4] In Jeff Tracy, Inc. v. U.S. Specialty Ins. Co., the policy at issue disclaimed the duty to defend, only allowed consented to defense costs to be considered a loss, and provided for allocation of defense costs when covered and uncovered losses were involved. The insured was obligated to provide its own defense. The court determined these conditions were inconsistent with the broad duty to defend standard and rejected the insured's argument that the "potential for coverage" standard should govern. Instead, the court held that an insured must establish that the underlying claims were within the basic scope of coverage before the insurer was required to advance defense costs.[5]

It is difficult to ascertain how the California standard differs from the traditional four corners rule. A subsequent decision, Legacy Partners, Inc. v. Clarendon American Ins. Co., allowed a form of the "potentiality" standard to be applied for a duty to pay for defense costs.[6] There, the court distinguished Jeff Tracy and found that an insured bears only the burden of proving potential coverage in order to receive reimbursement of defense costs.[7]

The primary difference between a duty to defend policy and a duty to advance defense costs policy relates to the defense of uncovered claims. A duty to defend policy requires that the insurance company advance all of its insured's defense costs, even if only a portion of the lawsuit alleges covered claims. In contrast, a duty to advance defense costs policy only obligates the insurer to pay the pro-rata share of the costs based on the percentage of litigation attributable to covered entities and covered claims.[8] The issues arising from the allocation clause allocate are discussed later on in this article.

Reimbursement of Defense Costs Are Due When Incurred

Many D & O policies provide that the insurer shall advance defense costs prior to the final adjudication of the

underlying claim. Others are silent as to when reimbursement is due. Cases which have addressed the timing of reimbursement of defense costs when the policy is silent have uniformly held that the insurer's obligation to reimburse attaches as soon as the defense costs are incurred. The rationale is that to hold otherwise would not provide insureds with protection from financial harm that insurance policies are presumed to give.[9]

Consistent with the above rationale, the courts have held that the failure to receive defense costs under a professional liability policy at the time they are incurred "constitutes 'an immediate and direct injury'" sufficient to satisfy the irreparable harm requirement for purposes of receiving injunctive relief.[10]

D & O policies contain criminal acts and personal profit exclusions which pursuant to their express terms do not apply until a final and non-appealable judgment or adjudication establishes the insured committed the excluded conduct. Is the insurer obligated to advance defense costs where only excluded conduct is claimed? This issue was addressed in Little v. MGIC Indemnity Corp., et al.[11] The plaintiff was a former corporate officer who was suing for advancement of defense costs under a D & O policy. The court in Little found that the policy in question was a standard liability policy, which provided that certain activities would be covered by the insurer, subject to exclusions. Specifically, the policy provided for the payment of all Loss which the insured became legally obligated to pay by reason of a wrongful act. The term "Loss" meant any amount which the insured was legally obligated to pay for a claim made against the insured and included the defense of legal actions.[12] The relevant exclusion in Little stated the insurer shall not be liable to make any payment for Loss in connection with any claim made against the insured brought about or contributed to by the dishonesty of the insured. The exclusion did not apply until a final and non-appealable judgment or adjudication established the insured committed the excluded conduct.[13] The court in Little determined the insurer's duty to pay defense costs arose contemporaneously with the insured's obligation to pay those costs. The court, reading the language of the exclusion, found that the dishonesty exclusion's language supported this conclusion, as it protected the insured from exclusions from coverage until a final adjudication of dishonesty occurred.

The D & O policy at issue in Little also provided that in the event it was finally established that insurer has no duty to indemnify, the insured agreed to repay to the insurer the advanced defense costs.[14] The insurer contended that this clause meant that the insurer had the discretion to advance defense costs, while the insured contended that the insurer still had the obligation to pay costs as they were incurred. The court found that each side's reading of the policy was a reasonable one and, as a result, there was ambiguity in the policy language. As any legitimate ambiguity must be resolved against the insurer, the court in Little concluded the policy must be construed against the insurer to require it to pay Little's defense costs as they come due, subject to its conditional right to reimbursement."[15] The contemporaneous advancement principle outlined in Little has been followed in federal courts.[16]

Defense of Covered and Uncovered Claims and the Duty to Allocate

D & O liability policies often include provisions that limit the insurer's obligation to pay "loss" (damages and defense expenses) to amounts incurred in the defense or resolution of covered claims. Accordingly, if an action incorporates both covered and uncovered claims, the parties must apportion the costs so that that insurer "need only pay for amounts generated in the defense of covered claims."[17]

Given that D & O policies differentiate between covered and non-covered claims, courts have recognized that insurers may "contract out" of the default rule of contemporaneous advancement of all defense costs incurred.[18]

An insurer may contract out of the default rule by specifically and explicitly excluding the underlying claims from coverage with unambiguous policy language.[19] For example, in Am. Cas. Co. of Reading, Pennsylvania v. Rahn, the D & O policy required that the claims be made during the coverage period for the policy to apply. The underlying claims were made after the policy period expired, consequently, they were "specifically and explicitly" excluded from coverage and the insurer properly refused to pay the expenses.[20]

Additionally, if a lawsuit only seeks damages that are uninsurable, the insurer is not liable to reimburse any defense costs spent defending the claims, even if the claims are eventually determined to be meritless.[21]

Although D & O policies differentiate between covered and non-covered claims, some courts have found that when coverage of the underlying claims is disputed the default rule of contemporaneous payment applies.[22] However, such advances of defense costs are subject to recoupment by the insurer if it is ultimately determined no coverage is afforded.[23]

Some courts have allowed the insurer to allocate defense costs between covered and uncovered claims while the lawsuit and defense is ongoing. The term "allocation" refers to the process of determining the amount of defense costs, settlements, or judgments attributable to covered claims. Allocation provisions were originally incorporated into policies that provided coverage for claims against the directors and officers, but not policies that provided coverage for claims against the corporation. These provisions have resulted in litigation between insurers and insureds. Disputes can arise where a lawsuit against the insured includes covered and uncovered claims or where both the insured and other uninsured parties are found liable. In such cases it can be difficult to determine the

amount of defense costs, settlements, or judgments attributable to covered claims. Allocation provisions were originally incorporated into policies that provided coverage for claims against the directors and officers, but not policies that provided coverage for claims against the corporation. These provisions have resulted in litigation between insurers and insureds. Disputes can arise where a lawsuit against the insured includes covered and uncovered claims or where both the insured and other uninsured parties are found liable. In such cases it can be difficult to determine the amount of the eventual award that is attributable to the insured. Moreover, this determination can also be difficult where cases are settled out of court, and one lump sum is paid to the plaintiffs.

Early D & O polices contained allocation provisions under which the insurer and the insured were merely required to "use their best efforts to determine a fair and proper allocation." Because such provisions lacked clarity, courts fashioned their own approaches in determining the proper allocation of defense costs.

The Maryland Court of Appeals first announced the "reasonably related rule" in Continental Cas. Co. v. Board of Educ. of Charles County.[24] Under this rule, "[s]o long as an item of service or expense is reasonably related to the defense of a covered claim, it may be apportioned wholly to the covered claim."[25] The court articulated the following standard for when an expense is "reasonably related" to a covered claim: "Legal services and expenses are reasonably related to a covered count if they would have been rendered and incurred by reasonably competent counsel engaged to defend a suit against the [insured] arising out of the same factual background as did the [actual] suit but which alleged only the matters complained of in [covered] counts."[26] Stated another way, under the reasonably related rule, a D & O insurer must show that costs do not relate to the defense of a covered claim in any way to avoid the obligation of providing a particular defense cost.

In addition to the reasonably related rule, the courts have adopted one of two distinct approaches for calculating reimbursement for plaintiffs seeking recovery for settlement costs under D & O policies.[27] On one hand, the "the relative exposure" rule allocates settlement amounts according to the relative risk of exposure and proportional fault of the parties.[28] The relative exposure rule involves "a somewhat elaborate inquiry into what happened in a settlement and who really paid for what relief."[29] On the other hand, the "larger settlement" rule, a variation of the reasonably related rule, involves a simpler inquiry.[30] The larger settlement rule allows allocation of settlement costs "only where the settlement is larger by virtue of wrongful acts of uninsured parties."[31] Under this rule, allocation is appropriate only if a corporate entity's independent exposure accounts for a portion of the settlement sum, in which case said portion is excluded from coverage.[32]

The Ninth Circuit applied the larger settlement rule in Nordstrom, Inc. v. Chubb & Son, Inc., affirming a 100% allocation of a settlement to the insured on the grounds that the corporation's liability was based on the actions of the directors and officers.[33] This decision expanded the nature D & O insurance protection, and resulted in the D & O insurer being liable for the uninsured corporation's exposure.

In response to the advent of the larger settlement rule, the D & O industry responded in two ways. First, many D & O policies now include entities coverage, which essentially renders allocation unnecessary when the corporation and directors and officers are named in a lawsuit. Second, D & O policies typically include detailed allocation clauses that require the parties to negotiate an allocation agreement. In the event that the parties are unable to reach an agreement, the insurer may be required to advance the percentage of loss not in dispute and submit to arbitration on the allocation amount in dispute. As a result of these modifications, litigation involving allocation provisions has decreased significantly.

The Eighth Circuit recently clarified the method of allocating coverage where settlement costs arose out of two separate suits in UnitedHealth Group Inc. v. Executive Risk Specialty Insurance Co. et al.[34] Where an insured settles two cases, one of which is not covered, the insured must establish an allocation that goes beyond speculation. The insured may prove allocation by providing (a) testimony from the attorneys in the underlying actions; (b) other evidence from the underlying lawsuits; (c) expert testimony evaluating the underlying lawsuits; (d) a review of the underlying transcripts; or (e) "other admissible evidence." These factors are considered to determine how a reasonable party would have allocated the claims at the time of settlement.

Right to Select Counsel and Control the Defense of the Underlying Claim

Under a D & O policy an insured has the responsibility of selecting and appointing counsel from the onset of the claim. Most policies give the insurer the right to associate with the defense and approve defense strategies, expenditures, and settlements. However, these polices typically provide that the insurer may not unreasonably withhold approval of the insured's choice of counsel. Where a breach of the duty to defend has occurred, the insured is free to choose any a reasonable type of representation.[35] An insurer who breaches the duty to defend is "in no position to object to defense-related expenditures that are supported by the record and that are not patently unreasonable."[36]

Additionally, D & O policies often include a pre-approved panel of counsel, and if the policy holder sticks to the list, the selection is automatically approved. Many policies provide that the insurer's consent is needed to go off the list, and sometimes such consent is absolute, while other times it is not to be unreasonably withheld.

By extricating themselves from involvement in the underlying action, and preserving their right to subsequently disclaim expense reimbursement for non-covered claims, D & O carriers can

and do charger lower premiums than their duty to defend counterpart. However, as mentioned, D & O insurers generally have the right to maintain some involvement in the litigation and participate in the selection of counsel. Thus, D & O policies provide insurers the dual advantage of exercising some control over the litigation, while also avoiding the duty to provide the defense.

Exhaustion of Policy Limits

Most D & O policies are written on a defense cost "inside the limits" basis, meaning that covered defense costs erode the policies' liability limits as they are incurred.[37] Moreover, defense costs and other loss, which typically includes damages, judgments, and settlements, are typically subject to the D & O policy's limit of liability. Because defense costs tend to be high in lawsuits involving claims against director and officers, this frequently results in defense costs totally exhausting the D & O policy's limit of liability before any damages, judgments, or settlements may be paid.[38]

Provided that the applicable D & O policy language regarding payment of defense costs against the limit of liability is clear, courts have recognized that a D & O insurer is not required to continue to pay the cost of defending underlying claims after defense costs have exhausted the limit of liability set forth in the policy.[39] If the policy is ambiguous as to whether defense costs are included in the limit of liability, however, courts have declined to permit a D & O insurer to discontinue paying defense costs or coverage after the policy limit is reached.[40]

It is worth noting that other D & O policies contain separate limits for defense and indemnification. Thus, a carrier could find itself in a situation where the defense limits have been exhausted, but it still has a duty to indemnify.

In conjunction with exhaustion of a primary policy's limits, it is important to consider the relationship between the primary and any excess D & O insurance policies. To protect against exposure to large losses, large corporations frequently buy "towers" of coverage, meaning they have a primary policy and multiple excess insurance policies.[41]

The concept of "bridging the gap" may arise when excess policies are implicated. There may be a gap in coverage created by a settlement contribution from a primary policy insurer that does not exhaust the primary policy's limit of liability, although the total settlement amount exceeds the limit of liability because the insured pays a portion of the settlement. Courts have enforced language in some D & O excess policies requiring "actual payment" of losses by the primary insurer, such that the insured cannot bridge the gap to trigger excess coverage.[42] However, some D & O policies do not contain "actual payment" language, so the insured could bridge any gaps in coverage if necessary.[43] In addition, some types of D & O excess policies offer coverage that "drops down" under certain circumstances.[44]

Conclusion

D & O policies present unique issues for claims handlers and attorneys. Given the relative dearth of state-specific case law regarding D & O policies, decisions from various jurisdictions provide guidance on handling the issues commonly presented by D & O policies.

Endnotes

1. See Langdale Co. v. National Union Fire Ins. Co. of Pittsburgh, Penn., 110 F. Supp. 3d 1285, 1301 (N.D. Ga. 2014), aff'd at 609 Fed. Appx. 578 (11th Cir. 2015); Liberty Mut. Ins. Co. v. Pella Corp., 650 F.3d 1161, 1170 (8th Cir. 2011); American Legacy Found., RP v. National Union Fire Ins. Co. of Pittsburgh, Pa., 623 F.3d 135, 141 (3d Cir. 2010).
2. See Worthington Federal Bank v. Everest Nat. Ins. Co., 110 F. Supp. 3d 1211, 1221-22 (N.D. Ala. 2015); Liberty Mut. Ins. Co. v. Pella Corp., 650 F.3d 1161, 1170 (8th Cir. 2011); W Holding Co., Inc. v. AIG Ins. Co.-Puerto Rico, 748 F.3d 377, 384 (1st Cir. 2014); Julio & Sons, 591 F.Supp.2d at 659–60; Federal Ins. Co. v. Kozlowski, 18 A.D.3d 33, 40–41, 792 N.Y.S.2d 397, 402–03 (N.Y. Sup. Ct. 2005); American Chem. Soc. v. Leadscope, Inc., 2005 Ohio 2557, ¶¶ 7-22 (Ohio Ct. App. 2005).
3. See In re WorldCom, Inc. Securities Litigation, 354 F. Supp. 2d 455, 464-65 (S.D.N.Y. 2005); see also Langdale Co. v. National Union Fire Ins. Co. of Pittsburgh, Penn., 110 F. Supp. 3d 1285, 1296 (N.D. Ga. 2014) (The duty to defend and the duty/obligation to pay costs of litigation should be treated as analogous.)
4. See Jeff Tracy, Inc. v. U.S. Specialty Ins. Co., 636 F. Supp. 2d. 995, 1003 (C.D. Cal. 2009).
5. Id. at 1004.
6. Legacy Partners, Inc. v. Clarendon American Ins. Co., Case No. 08cv920 BTM (CAB), 2010 U.S. Dist. LEXIS 36966, at *15 (S.D. Cal. Apr.14, 2010.)
7. Id. at *14-15.
8. See QBE Americas, Inc. v. ACE American Ins. Co., 2014 NY Slip Op 51330(U), ¶5, 44 Misc. 3d 1224(A), 997 N.Y.S.2d 670 (N.Y. Sup. Ct. 2014); Commercial Capital Bankcorp. Inc. v. St. Paul Mercury Ins. Co., 419 F. Supp. 2d 1173, 1185 (C.D. Cal. 2006); Health Net, Inc. v. RLI Ins. Co., 141 Cal. Rptr. 3d 649, 670-71, 206 Cal. App. 4th 232, 259 (Cal. Ct. App. 2012); Okada v. MGIC Indem. Corp., 823 F.2d 276 (9th Cir. 1986).; Federal Ins. Co. v. Kozlowski, 792 N.Y.S.2d 397, 402-04, 18 A.D.3d 33, 40-42 (N.Y. Sup. Ct. 2005).
9. In re WorldCom, Inc. Securities Litigation, 354 F. Supp. 2d 455, 464-65 (S.D.N.Y.,2005).
10. See In re WorldCom, Inc., Sec. Litig., 354 F. Supp. 2d 455, 469 (S.D.N.Y.2005); see also In re Adelphia Commc'ns Corp., No. 02–41729, 2004 U.S. Dist. LEXIS 19478, at *21–22 (S.D.N.Y. Sept. 27, 2004) (upholding, despite asset freeze during bankruptcy proceeding, release of funds to pay for defense of serious criminal charges, because failure to do so would likely result in irreparable harm); In re CyberMedica, Inc., 280 B.R. 12, 18–19 (Bankr. Ct. D. Mass. 2002) (granting relief from automatic stay in bankruptcy because directors and officers would suffer irreparable harm if prevented from exercising rights to legal defense payments under D & O policy).
11. 836 F.2d 789 (3d Cir.1987)
12. Id. at 792.
13. Id. at 792–793.
14. Id. at 793.
15. Id.
16. See XL Specialty Ins. Co. v. Level Global Investors, L.P., 874 F. Supp. 2d 263 (S.D.N.Y. 2012).
17. Okada v. MGIC Indem. Corp., 823 F. 2d 276, 282 (9th Cir. 1986); QBE Americas, Inc. v. ACE Am. Ins. Co., 2014 NY Slip Op 51330(U), ¶5, 44 Misc. 3d 1224(A), 997 N.Y.S.2d 670 (N.Y. Sup. Ct. 2014) ("[A] duty to advance defense costs merely obligates the insurer to pay a pro-rata share of the costs based on the percentage of litigation attributable to covered entities and covered claims").

Endnotes

18.See e.g., Commercial Capital Bankcorp. Inc. v. St. Paul Mercury Ins. Co., 419 F. Supp. 2d 1173, 1180-81 (C.D. Cal. 2006) ("[A] properly-drafted contract provision … abrogate[s] the default rule of contemporaneous payment"); Pan Pac. Retail Properties, Inc. v. Gulf Ins. Co., Case No. 03–CV–679 WQH, 2004 U.S. Dist. LEXIS 28534, at *42 (S.D. Cal. July 14, 2004) (holding that insurer was entitled to allocate defense costs because policy language contracted out of the default rule where policy stated "Insurer shall advance on a current basis Defense Costs which the Insurer in its discretion believes to be covered under this Policy") reversed in part on other grounds at 2006 U.S. App. LEXIS 26669 (9th Cir. 2006); Clifford Chance Ltd. Liab. P'ship v. Indian Harbor Ins. Co., 14 Misc.3d 1209(A), 836 N.Y.S.2d 484 (N.Y. Sup. Ct.2006) (holding that insurer was entitled to allocate defense costs because policy language contracted out of the default rule where policy stated "the insured and insurer will use their best efforts to determine a fair and appropriate allocation of Loss between that portion of Loss that is covered under the Policy and that portion of Loss that is not covered under this Policy").
19. Bd. of Trustees of Michigan State Univ. v. Cont'l Cas. Co., 730 F. Supp. 1408 (W.D. Mich. 1990); Am. Cas. Co. of Reading, Pennsylvania v. Rahn, 854 F. Supp. 492, 504 (W.D. Mich. 1994).
20. Rahn, 854 F.Supp. at 503-04.
21. State Farm Fire & Cas. Co. v. Drasin, 152 Cal. App. 3d 864, 199 Cal. Rptr. 749 (Cal. Ct. App. 1984) (holding that an insurer lacked any duty to defend or indemnify a malicious prosecution claim because any recovery would necessarily require proof of uninsurable wilful conduct).
22. See e.g., Gon v. First State Ins. Co., 871 F.2d 863, 868 (9th Cir. 1989); Okada v. MGIC Indem. Corp., 823 F.2d 276, 282 (9th Cir. 1986); Great Am. Ins. Co. v. Geostar Corp., Case Nos. 09-12488-BC, 09-12608-BC, 09-14306-BC, 2010 U.S. Dist. LEXIS 20258, at *50 (E.D. Mich. 2010) ("While the dispute over coverage of the underlying claims persists, [the insurer] cannot avoid its duty to pay defense costs associated with those claims"); Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Ambassador Grp., Inc., 157 A.D.2d 293, 299, 556 N.Y.S.2d 549, 553 (N.Y. Sup. Ct. 1990) ("[I]nsurers are required to make contemporaneous interim advances of defense expenses where coverage is disputed").
23. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 157 A.D.2d at 299, 556 N.Y.S.2d at 553 (1990); Federal Ins. Co. v. Kozlowski, 792 N.Y.S.2d 397, 402-04, 18 A.D.3d 33, 40-42 (N.Y. Sup. Ct. 2005).
24. 302 Md. 516, 489 A.2d 536 (1985)
25. Id. at 534.
26. Id. at 532.
27. Piper Jaffray Companies Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, 38 F. Supp. 2d 771, 774 (D. Minn. 1999).
28. PepsiCo, Inc. v. Continental Cas. Co., 640 F.Supp. 656, 662 (S.D.N.Y. 1986).
29. Caterpillar, Inc. v. Great American Ins. Co., 62 F.3d 955, 961 (7th Cir.1995).
30. Telxon Corp. v. Fed. Ins. Co., 309 F.3d 386, 390 (6th Cir. 2002).
31. Caterpillar, 62 F.3d at 960.
32. Nordstrom, Inc. v. Chubb & Son, Inc., 54 F.3d 1424, 1432 (9th Cir. 1995).
33. Id.
34. 870 F.3d 856 (8th Cir. 2017).
35. See Lyda Swinerton Builders, Inc. v. Okla. Sur. Co., 903 F.3d 435, 453 (5th Cir. 2018).
36. Id.
37. See 3-37 New Appleman Insurance Law Practice Guide, § 3728 (2017), Checklist: Evaluating Defense Obligations Under Directors' and Officers' (D&O) Insurance Policies.
38. See 3-37 New Appleman Insurance Law Practice Guide, § 37.18 (2017), Evaluate the Policy's Limit of Liability.
39. See, e.g., Helfand v. National Union Fire Ins. Co., 10 Cal. App. 4th 869, 880-84, 13 Cal Rptr. 2d 295 (Cal. Ct. App. 1992); In re Enron Corp. Secs. v. Belfer, Civil Action No. H-01-3624, 2006 U.S. Dist. LEXIS 38845, at *28-40 (S.D. Tex. June 12, 2006) (finding that the D & O insurer was permitted under the policy language and Texas law to terminate its participation in the defense of the insured's claims upon settlement of actions involving other directors and officers that would have the effect of exhausting the limit of liability under the policy, and rejecting a pro se motion for coverage by an insured former officer seeking an equitable share of the insurance proceeds).
40. See, e.g., Branning v. CNA Ins. Companies, 729 F. Supp. 728, 733 (W.D. Wash. 1989).
41. See 3-37 New Appleman Insurance Law Practice Guide, § 37.22 (2017), Consider the Relationship Between Primary and Excess D&O Insurance Policies and its Impact on Coverage.
42. See Comerica Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019, 1021 (E.D. Mich. 2007).
43. See New Appleman, § 37.22.
44. See id.

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