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Hacker Attack

Data Loss Considered Covered Property Under First-Party Policy

By Robert E. Johnston

The U.S. Court of Appeals for the 4th Circuit has recently weighed in on the applicability of standard-form, first-party property policies to the loss of computer data, finding such data loss resulting from a hacker attack by a former employee of the insured to be covered property damage. *NMS Services, Inc. v. The Hartford*, No. 01-2491, 2003 WL 1904413 (4th Cir., April 21, 2003)

The insured, a software development company selling computer programs to the telemarketing industry, suffered considerable damage to vital computer files and databases necessary for the operation of its manufacturing, sales, and administrative systems as a result of the hacker attack, which had been perpetrated by a former technical systems administrator for the insured (who had been fired 21 days earlier). It was later determined that, while still an employee, the perpetrator had surreptitiously installed two hacking programs on the network that permitted him to gain access to the system and carry out the attack after his termination.

After reviewing the policy — which provided basic property coverage under a "Special Property Form" and also provided optional computer coverage under a "Computer and Media Endorsement," the court found that

continued on page 7

Insurance Company Insolvencies

A Primer for Corporate Policyholders

By John N. Ellison and Joshua Gold

The past several years have seen some major property-casualty insurance companies on the ropes and worse, far worse. Home Indemnity Company and Legion Insurance Company, two notable insolvency casualties, have left their policyholders without the full protection paid for and required. Sadly, they pale in comparison to the train wreck that is Reliance Insurance Company. The demise of Reliance has had repercussions for insurance buyers and others all over. Once a fixture in the directors' and officers' ("D&O") liability insurance marketplace, among other insurance markets, Reliance is now well underway in the liquidation process, after a brief and unsuccessful attempt at "rehabilitation." The Reliance debacle has left policyholders scrambling to protect themselves while state insurance departments wrangle with one another in an attempt to snap up a share of the inadequate pool of assets left behind in the collapse of Reliance.

The situation created by insolvencies may yet get worse for policyholders. There is already grave concern over the prospects for at least one very large U.S.-based insurance group, coupled with the specter of additional insolvencies affecting European property-casualty insurance companies. Presently, extreme concern exists over the viability of many of Europe's largest insurance companies. A recent article in the insurance trade press quoted an analyst suggesting that many European insurance companies were already "technically insolvent," with the specter of asbestos liabilities looming ever more onerous.

The above scenarios are at least a partial illustration that insolvencies occurring today differ markedly from those of the past. First, the insolvencies of the past occurred primarily among small and marginal insurance companies, most of which wrote personal lines or automobile coverage. Today, many of the insurance companies facing insolvency are those that have written huge amounts of general liability insurance and workers' compensation coverage. Second, the insolvent insurance

continued on page 2

IN THIS ISSUE

Insolvency

continued from page 1

companies of the past were local or regional companies, whereas today, many of the troubled insurance companies are licensed to write insurance in all 50 states. The implication of these differences is that insolvencies now take a much greater toll on businesses in general, as more and more companies find that one or more of their insurers is unable to pay their claims.

Unfortunately, even the most careful risk manager cannot completely avoid insolvent insurance companies. Delayed manifestation claims, such as those involving injury from asbestos exposure, drugs, and environmental pollutants, may implicate policies purchased decades ago, when the insurance company at issue may have had a robust financial outlook. Thus, it is important to know how to protect your company's interests in the event of insurance company insolvency.

It is important to note at the outset that there are two separate and equally important sources of recovery in most insurance company insolvencies. First, distributions are made from the assets of the insolvent insurance company, on a pro rata basis, in much the same way that distributions are made in a bankruptcy case. This usually results in an eventual recovery of a small percentage of a policyholder's actual losses under its policy.

Second, distributions are made by nonprofit organizations in existence in all 50 states known as state insurance guaranty associations ("state associations"). The amount of such distributions varies from state to state and rarely exceeds a few hundred thousand dollars per claim.

Recovery from either of these sources of payment may take years. Moreover, no corporate policyholder should expect to recover the full amount of its loss from the insolvent insurance company or state association. However, there are steps that corporate policyholders can, and in most cases should, take to maximize the likelihood of some recovery with respect to the insolvent insurance company in question. These steps include:

- Preservation of rights through notification of the relevant liquidators, state associations and any supplementary or ancillary proceedings that may exist.
- Ongoing correspondence and cooperation with liquidators and state associations concerning claim updates and liability conclusions.
- Negotiation of settlements with liquidators and state associations.
- Drop down of coverage of solvent excess insurers.

Rehabilitation versus Liquidation

Insurance companies are exempt from federal bankruptcy laws. Instead, state law governs such insolvencies. Ordinarily, a state, through its insurance department, will consult with a troubled insurance company for several months in an attempt to keep it out of delinquency proceedings. If the company's position does not improve, the insurance department will petition the state court to institute a delinquency proceeding in the form of a rehabilitation initially, and then, if necessary, a liquidation under applicable state laws.

An attempt at rehabilitation often is made prior to liquidation, although in practice, rehabilitation is often a prelude to an eventual liquidation. Policyholders stand a much better chance of maintaining coverage and receiving substantial recovery for claims in a successful rehabilitation.

Direct Recovery From An Insolvent Insurance Company

If it becomes necessary to liquidate an insurance company, the court in the state where the insurance company is domiciled enters an order of liquidation, and a liquidator, typically the state insurance commissioner of the domiciliary jurisdiction, is appointed to oversee the liquidation. The insurer is suspended from writing new

continued on page 3

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Insolvency

continued from page 2

policies and all existing policies are cancelled as of 30 days after the order of liquidation. All litigation against the company is enjoined. The liquidator marshals assets, evaluates claims and distributes assets in payment of such claims.

In theory, all creditors of an insolvent insurance company, including policyholders, are given notice of the liquidation, and are provided with proof of claim forms. These forms must be returned to the liquidator prior to a court-imposed filing deadline (the "Bar Date") in order to share in a distribution of assets of the estate. Usually, the Bar Date is one year after the date of the order of liquidation.

In New York, the failure to receive a proof of claim form from the liquidator constitutes grounds for extending the Bar Date to allow the creditor to file a timely proof of claim. However, in most other states the failure to receive a proof of claim form is immaterial. Notice of the insolvency is deemed sufficient to put a creditor on notice of the need to file a proof of claim. In these states, creditors who file late proofs of claim will not be paid until all timely filed proofs of claim are paid in full.

A policyholder should complete and file a separate proof of claim form for each insurance policy issued by the insolvent company. The proof of claim should reference every claim pending against the policy, whether liquidated or contingent.

In addition, in many states policyholders are permitted to file their claims for "policyholder protection," *ie*, for all future or contingent claims that may arise against the policyholder for which it would be entitled to coverage under the terms of the policy, up to the limits of the policy had the policy still been in effect. Policyholders should always file a proof of claim for policyholder protection even if no liquidated claims exist at the time of the filing.

As in bankruptcy cases, the available assets of an insolvent insurance company are distributed to claimants according to a priority established by statute. Under the Insurers' Supervision, Rehabilitation and Liquidation Model Act (1977) (the "Liquidation Model Act"), policyholder claims usually receive third priority status, *ie*, they are paid only after administrative and wage claims have been paid in full.

Prior to payment of policyholder claims, the liquidator reviews all such claims to determine whether they should be "allowed" in the liquidation proceeding. During the allowance process, claims are evaluated to determine their validity. The liquidator may assert any defenses available to the insolvent insurer, including policy exclusions and noncompliance with policy requirements. In order to facilitate the allowance of a claim, the policyholder should provide the liquidator with copies of all relevant documents pertaining to the claim, including documents which evidence that it has been paid by the policyholder.

Ancillary Proceedings

When the assets of an insolvent insurance company are located in more than one state, several statutes provide for the orderly transfer of the insurance company's assets between states. *See* Uniform Insurers Liquidation Act (1939), which has been adopted by 30 states, and the Liquidation Model Act (1977), which has been adopted by 10 states. A "domiciliary" proceeding will be conducted in the insurance company's home state. One or more "ancillary" proceedings will be conducted in any other states where the insolvent insurer holds significant assets. The ancillary receiver will collect the assets located in his or her state, and pay the claims of residents of that state. Residents of a state in which an ancillary proceeding has been established may file their claims with either the ancillary receiver or the domiciliary receiver. Upon payment of all residents' allowed claims, the ancillary receiver will transfer any remaining assets to the domiciliary receiver for ultimate distribution.

Recovery from State Insurance Guaranty Associations

State associations provide a second source of recovery for policyholders. State associations have been created by statute in each of the 50 states to provide limited protection to policyholders and claimants who are residents of the state.

All of the state association statutes, with the exception of New York's, are based on a Model Act adopted by the National Association of Insurance Commissioners (the "Model Act"). Despite this common genesis, many significant differences exist among the 50 state associations. Accordingly, the following discussion is based primarily on the Model Act. Questions regarding a particular state association can be answered only by reference to the applicable state statute.

The key element of all state association statutes is the obligation to pay "covered claims." The Model Act defines a covered claim as "an unpaid claim, including one for unearned premiums, which arises out of and is within the coverage of a policy issued by an insolvent insurance company." In addition, the statute provides that either the policyholder or the claimant must be a resident of the state at the time of the insured event, or the property giving rise to the claim must be permanently located there. Under the Model Act, the association in the state where the policyholder resides has primary responsibility for claims against the policy at issue. Only if such claims are rejected by that association, or the policyholder is not a resident of any state, will coverage be provided by the state association in the state where the third-party claimant resides, or where the property is permanently located. Multiple recoveries from more than one state association are not permitted.

A necessary requirement for recovery from most state associations is the timely filing of a proof of claim. It is often not sufficient to file a proof of claim with the liquidator of the insolvent insurance company. In many instances, a copy of the proof of claim must be filed with the appropriate guaranty funds as well. Most state associations have instituted deadlines for filing proofs of claim. Usually, the association's deadline will be the same as the insolvent insurer's Bar Date, but

continued on page 4

Insolvency

continued from page 3

some associations have adopted longer or shorter deadlines.

Generally, claims filed with the state associations after the deadline will not be accepted. *See Satellite Bowl. Inc. v. Michigan Property & Casualty Guar. Ass'n*, 165 Mich. App. 768, 419 N.W.2d 460 (Mich. Ct. App.), appeal denied, 430 Mich. 888 (1988); *Jason v. Superintendent of Ins.*, 67 A.D. 2d 850, 413 N.Y.S.2d 17 (1st Dep't 1979), aff'd, 49 N.Y.2d 716, 402 N.E.2d 143, 425 N.Y.S.2d 804 91980). *But see Middleton v. Imperial Ins. Co.*, 34 Cal. 3d 134, 666 P.2d 1, 193 Cal. Rptr. 144 (Cal. 1983), where a policyholder was permitted to file a late claim because the California Insurance Commissioner had failed to send timely notice of the insolvency to the policyholder.

Numerous courts have held that state associations have the same rights and obligations as the insolvent insurance company within the parameters of the statutes that created them. The state association "steps into the shoes" of the insolvent insurer with respect to all covered claims. *See Biggs v. California Ins. Guar. Ass'n*, 126 Cal. App.3d 641, 179 Cal. Rptr. 16 (Cal. Ct. App. 2d Dist. 1981). In other words, the state association assumes all of the duties of the insolvent carrier, including the duty to indemnify and defend the policyholder. *Martino v. Florida Ins. Guar. Ass'n*, 383 So.2d 942 (Fla. Dist. Ct. App. 1980). As a corollary, state associations have all of the same contractual defenses to coverage as the insolvent insurance company and the liquidators. All notice provisions and cooperation clauses, for example, are still effective despite the insolvency. Moreover, many state associations have taken the position that they may act independently from the liquidator of the insolvent insurance company in denying claims, *eg*, denying coverage for a claim already accepted by the insolvent insurance company.

In addition, all state association statutes have placed a dollar limitation on the amount they will pay on covered claims. This statutory "cap" varies from $50,000 to over $1 million per covered claim, although most states apply a cap of $300,000. At least one court has held that the phrase "covered claim" applies to every claim made under a policy up to the limits of the policy. *See Connecticut Ins. Guar. Ass'n v. Raymark Core.*, 215 Conn. 224, 575 A.2d (Conn. 1990). However, despite the *Raymark* court's ruling, many state associations continue to insist that where multiple claims are made under a policy, the statutory cap should be applied per policy and not per claim.

Numerous state associations have imposed "net worth" limitations designed to prevent large insured businesses and wealthy individual policyholders from recovering under the statutes. In *Borman's v. Michigan Prop. & Cas. Guar. Ass'n*, 925 F.2d 160 (6th Cir. 1991), the 6th Circuit Court of Appeals held that Michigan's net worth limitation was a constitutional method of limiting coverage under the statute. Although the *Borman's* court has ruled this way, there still seems to be a reasonable basis to challenge restrictions of this type.

The effect, if not the purpose, of recent efforts of many state association administrators appears directed toward limiting coverage for the corporate policyholder through restrictive legislation and administrative interpretation of statutory language. In the future, it will likely become increasingly difficult for corporations to recover from state associations absent litigation. A failure of state associations to improve efforts to cooperate and to protect a corporate claimant in the event of its insurer's insolvency may also result in the insolvency of the corporate policyholder.

Contingent and Unliquidated Claims

One of the most challenging issues facing liquidators and state associations today is the treatment of contingent and unliquidated claims. Generally, such claims arise in two contexts: (a) claims which have been refused coverage prior to insolvency and which are in litigation on the date of insolvency, and (b) claims for incurred but not reported losses, such as undiagnosed asbestos claims and long-tail products liability claims. In order to expedite the completion of the insolvency proceeding, liquidators have imposed contingent claim bar dates. Any claim that has not become fixed and liquidated by this date will be automatically disallowed. However, many insolvent insurance companies need to "prove up" these contingent claims in order to recover reinsurance proceeds for these claims. These companies may choose to allow contingent claims. Unfortunately for policyholders, the reinsurance collected on behalf of these allowed claims has been held to be a general asset of the insolvent insurance company's estate to be distributed pro rata to all creditors, and not an asset of the individual policyholder whose claim has been paid by the reinsurer.

Similarly, many state associations are grappling for the first time with multiple contingent and long-tail claims that are so large as to potentially threaten the viability of the associations. Under most state statutes, the association is obligated to pay covered claims "existing prior to the determination of insolvency" or arising within 30 days thereafter. *See* Section 8(1)(a) of the Model Act. Despite this broad language, which arguably includes contingent and unliquidated claims, *see In re Johns-Manville Corn.*, 57 B.R. 680 (Bankr. S.D.N.Y. 1986), most state associations will contest contingent or unliquidated claims.

Gaining Influence by Forming Policyholders' Committees

It is vital for policyholders to maintain an active role in insolvency proceedings. One way to do this is through the formation of a policyholder committee. Liquidators and receivers will try to keep all interested parties as far away from the proceedings as possible, in both actual proximity and knowledge. Accordingly, it is the well-informed policyholders who will have a better chance of determining that their rights are being adequately protected in the proceedings. It is important to investigate who else is affected by the insolvency. Attempt to band together and exchange information because policyholders as a group are naturally more

continued on page 5

Insolvency

continued from page 4

active and assertive and therefore better equipped to exert a powerful influence on the course of a liquidation proceeding.

One way to ascertain who else is affected by an insolvency is to contact the appointed liquidator of the company and ask for a list of corporate policyholders or creditors. Insurance brokers or agents may also be contacted and informed of a desire to pinpoint other interested policyholders to form a committee. Brokers and/or agents may have the ability to aid in the formation of these groups that can in turn aid in maximizing recovery.

Insurance company liquidations usually operate relatively free from the influence of policyholders. Reinsurers, on the other hand, are frequently able to influence the course of liquidation proceedings, since recoverable reinsurance is often the largest single asset of an insolvent insurer. Since the goal of the liquidator and its reinsurers is to reduce the number and the size of the claims against the estate, it is especially important for all policyholders to maintain a strong voice in the insolvency proceedings. One option is for the policyholder group to seek official status from the court overseeing the liquidation. Policyholders were appointed to an Official Creditors Committee in the rehabilitation of the Mutual Fire, Marine and Inland Insurance Company. In the liquidation of Integrity Insurance Company, policyholders were permitted to participate through an informal committee.

In addition to participation in the liquidation proceedings, policyholders should form committees for the purpose of negotiating with the state associations. In this way, they may be persuaded to pool their resources to pay policyholders' claims in a uniform manner, rather than waste their resources finding evermore creative methods of denying claims.

Drop Down of Excess General Liability Coverage

"Drop down" occurs when excess insurance policies fill the gap in coverage left by an insolvent underlying insurance company. Under very limited circumstances, a policyholder may obtain drop down recovery from its excess insurers, thereby entirely avoiding the complex and often frustrating process of attempting to recover from insurance liquidations and state associations. This is purely a result of state law interpretations of the language of the contract.

Most courts have ruled that an excess insurer does not have to drop down when the primary insurance company is insolvent. These courts frequently reason that the premium charged for an excess insurance policy does not take into account the risk of being forced to drop down. *See Ambassador Associates v. Corcoran*, 143 Misc. 2d 706, 541 N.Y.S. 2d 715 (N.Y. Sup. Ct. 1989).

The Supreme Court of Louisiana's decision in *Kelly v. Weil*, 563 So.2d 221 (1990), provides a useful overview of the three main types of clauses that address an excess insurance company's responsibility to drop down in the event of a primary insurance company's insolvency. They are as follows:

1. Some insurance policies provide for coverage in excess of "collectible" or "recoverable" primary insurance. Courts construing such polices may require the excess insurance company to drop down to indemnify the insured for any amount not actually recovered. *See, eg, Reserve Ins. Co. v. Pisciotta*, 30 Cal.3d 800, 180 Cal. Rptr. 628, 640 P.2d 764 (1982).

2. Other insurance policies describe the excess coverage as the excess of the limits of the policies that are "covered" in the schedules attached to the policy. Courts typically do not require the excess insurance company to drop down based on such language. This conclusion follows from the plain meaning of the insurance policy that defines its limits by reference to the stated limit in the underlying policy. The collectibility or recoverability of the underlying insurance is irrelevant for the purpose of the excess carrier's liability. *See, e.g., Mission Nat'l. Ins. Co. v Duke Transportation Co., Inc.*, 792 F.2d 550 (5th Cir. 1986).

3. In the third category of cases, the policyholder's liability or retained limit is defined as the greater of the "applicable limits of the scheduled underlying insurance ... plus the applicable limits of any other insurance collectible by the insured." This language, or variations of it, has received very inconsistent treatment by the courts. The court concluded, as have the majority of courts, that the excess insurance company had no duty to drop down because the proper interpretation of the policy language does not require the underlying insurance to be collectible. *See, e.g., Transco Explor. Co. v. Pacific Employers Ins. Co., 869 F.2d 862 (5th Cir. 1989)*. However, other courts have concluded that this clause is ambiguous, and thus, should be construed in favor of the policyholder, *See, e.g., Geerdes v. St. Paul Fire & Marine Ins. Co.*, 128 Mich. App. 730, 341 N.W.2d 195 (1983).

Based upon the foregoing, it is essential to review both the language of the insurance policy and the jurisdiction in question to determine whether a particular policy may be interpreted to require the excess insurance company to drop down.

Conclusion

The most important concept corporate policyholders should retain from the foregoing is that there are definite steps which can be taken in an effort to maximize recovery in insurance company insolvency proceedings. Although the obstacles faced by policyholders may appear insurmountable, actively involved policyholders stand a better chance of recovery in liquidation proceedings. While it is true that most liquidation and receivership proceedings appear large and unwieldy, policyholders need not succumb to the somewhat passive role that has historically been expected of them.

The single most important asset a policyholder can possess that will aid in maximizing recovery in insolvency proceedings is his amount of knowledge and willingness to remain active in all phases of the proceedings.

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CASE BRIEFS

No Reimbursement For Counsel Fees When Insurer Reserves Right To Deny Coverage

In *Trinity Universal Insurance Co. v. Stevens Forestry Service Inc.*, No. 02-30442 (5th Cir. 6/18/03), the U.S. Court of Appeals for the 5th Circuit, affirming the district court, recently held that an insurer is not obligated to reimburse its insured for attorneys' fees the insured incurred to hire separate counsel to represent it in a lawsuit where the insurer provided the insured with counsel but reserved the right to deny coverage and withdraw from the defense.

Stevens Forestry Service Inc. ("Stevens") hired a lawyer to assist it in handling a dispute with a customer. When Stevens received a formal demand for $1.1 million from the customer, Stevens tendered the claim to its liability insurer, Trinity Universal Insurance Co. ("Trinity"). Trinity advised Stevens that it agreed to provide Stevens with counsel and begin investigation of the matter, but that Trinity reserved the right to later deny coverage and withdraw from the defense. Trinity also expressly advised Stevens that because of the coverage dispute and the possibility that Trinity might withdraw from the defense, Stevens might wish to continue to retain an attorney at Stevens' expense to protect its interest in the litigation.

Trinity appointed Caldwell Roberts as Stevens' defense counsel in the action and, in conformity with Trinity's recommendation, Stevens continued to employ separate counsel, Michael Percy. Both counsel represented Stevens throughout the litigation and participated in all aspects of the litigation. The underlying suit went to trial and resulted in a jury verdict for Stevens.

Thereafter, Stevens filed a motion for summary judgment against Trinity seeking recovery of Percy's attorneys' fees and expenses. Trinity filed a cross-motion for summary judgment arguing, *inter alia*, that it had discharged any duty to defend by providing Roberts as defense counsel for Stevens. The district court found in Trinity's favor, holding that "even when the insurer reserves the right to deny coverage, it is not obligated to pay for an attorney that the insured unilaterally decides to hire as an extra defense counsel." Stevens appealed.

The 5th Circuit succinctly phrased the question before it as "whether Trinity, as insurer, must reimburse Stevens, as insured, for attorneys' fees and costs Stevens incurred by hiring independent counsel to represent it in the Underlying Action, where Trinity provided Stevens with counsel, but reserved the right to deny coverage and withdraw from Stevens' defense." As neither the Louisiana legislature nor the Louisiana Supreme Court had spoken on this issue, the court looked to other appellate court decisions for guidance.

The court noted that the 5th Circuit held in *Nat'l Union Fire Ins. Co. v. Circle, Inc.*, 915 F.2d 986 (5th Cir. 1990) that an insured may recover fees for an attorney hired by the insured, as opposed to the insurer, if the attorney provided by the insurer fails to "vigorously and adequately" defend the insured. However, as Stevens made no such contention with regard to Roberts, the court found *Circle, Inc.* inapposite. The court also rejected Stevens' reliance upon *Smith v. Reliance Ins. Co.*, 807 So.2d 1010 (La. App. 5 Cir. 2002) and *Belanger v. Gabriel Chems., Inc.*, 787 So.2d 559 (La. App. 1 Cir. 2001), which both held that in certain circumstances an insurer who contests coverage is liable for the attorneys' fees if the insured hires separate counsel. The court distinguished these decisions on the basis that both of those cases involved insureds who wished to reject the insurer's proffered counsel and instead employ independent counsel.

Finding no decision directly on point, the court concluded that Trinity was under no obligation to reimburse Stevens for Percy's fees. The court reasoned: "what matters in this case is that Trinity provided Stevens with competent defense counsel in the Underlying Action, not whether Percy's contribution as independent counsel to Stevens was beneficial or whether the litigation was especially complex. ... The fact that Trinity reserved the right to later deny coverage does not negate the fact that it fulfilled its duty of providing Stevens with adequate counsel.

Multiple Plumbing Leaks Considered Separate Occurrences

In *U.E. Texas One-Barrington, Ltd. v. General Star Indemnity Company; Fireman's Fund Insurance Company of Ohio* (5th Cir. 5/19/03) 2003 WL21143063, the U.S. Court of Appeals for the 5th Circuit (applying Texas law) affirmed a lower court's grant of summary judgment in favor of two insurers holding that: 1) access costs were not recoverable under a policy that did not cover the water damage caused by long-term water leaks; and 2) plumbing leaks under each of 19 buildings were separate occurrences as a matter of Texas law for the purpose of determining the deductible under an excess policy.

U. E. Texas One-Barrington, Ltd. ("Texas One") owned the Oak Meadow Apartment Complex consisting of multiple residential and office buildings in San Antonio, TX. Several of the buildings suffered from foundation movement and above-ground damage resulting from plumbing leaks beneath the foundation. Texas One sued General Star Indemnity Company ("General Star") and Fireman's Fund Insurance Company ("Fireman's Fund") for breach of contract arising out of the insurers' refusal to pay Texas One's claims under a commercial property policy and an excess policy, respectively. General Star and Fireman's Fund removed the matter to federal court and subsequently moved for summary judgment.

General Star. Texas One argued that the General Star policy language required payment of the cost to access the underground plumbing even though payment for the damage caused by the leaks was barred by the 14-day continuous leakage exclusion and further argued that General Star admitted it was obligated to pay for the access cost because it made a partial payment of Texas One's access costs. The 5th Circuit rejected both arguments in short

continued on page 7

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Case Briefs

continued from page 6

order citing *Gen. Accident Ins. Co. v. Unity/Waterford-Fair Oaks, Ltd.*, 288 F.3d 651, 656 (5th Cir.2002) (Cost of accessing underground pipes was not covered and the parties' course of conduct cannot be considered to determine the meaning of an unambiguous contract.)

Fireman's Fund: Texas One argued that although each building was damaged by different leaks, there was only one occurrence for purposes of the Fireman's Fund policy. Texas One's argument rested upon the contention that all of the leaks could be traced back to defects in the materials and installation of the underground plumbing system. The Fireman's Fund policy provided "excess over and above $1,000,000 ultimate net loss to the insured in each and every loss occurrence. ... The term loss occurrence means the total loss by perils insured against arising out of a single event." Neither party contended that "occurrence" was ambiguous as used in the contract or that the determination of the number of occurrences required a resolution of a factual dispute. Accordingly, the court found that the interpretation of "occurrence" was a question of law.

The 5th Circuit held that each leak constitutes a separate occurrence as a matter of law. The court reasoned that under Texas law, "the proper focus in interpreting 'occurrence' is on the events that cause the injuries and give rise to the insured's liability, rather than on the number of injurious effects." Texas One maintained that the leaks could be traced back to defects in materials and installation of the underground plumbing system. Focusing on the specific event that caused the loss, the court found that the loss arose when the pipes broke, not when they were installed. Since no one building suffered a $1 million net loss, Texas One did not meet the $1 million per occurrence threshold under the Fireman's Fund policy.

The majority dismissed the dissent's lengthy distinction between the interpretation of "occurrence" in liability policies from "occurrence" in property loss policies stating that the court had already rejected the dissent's distinction in *Ran-Nan Inc. v. General Accident Ins. Co.*, 252 F.3d 738, 739 (5th Cir.2001) (per curiam).

Policy Provision Applies To Claim of Each Separate Class Member

In *Musmeci v. Schwegmann Giant Super Markets, Inc.*, No. 02-30246 (5th Cir. 6/11/03), the U.S. Court of Appeals for the 5th Circuit held that the self insured retention (SIR) in United States Fidelity & Guaranty's (USF&G) General Liability Policy which provided Excess Employee Benefits Liability Coverage applied to each plaintiff class member's claim and overturned the lower court's ruling that the SIR applied one time to the collective claims of each plaintiff class member. While the collective claims of the plaintiff's class exceeded the $250,000 SIR, no individual claim exceeded the SIR, and the judgment against USF&G was vacated.

In 1985, Schwegman Giant Super Markets, Inc., (SGSM) implemented a grocery voucher plan (the "Voucher Plan") designed to supply SGSM retirees with a portion of their monthly food needs. Under this plan, SGSM issued vouchers to retirees, and these vouchers could then be used in lieu of cash to purchase goods in SGSM stores. In 1997, SGSM terminated the Voucher Plan one week before Mr. Schwegman sold SGSM. After being informed of the termination of the Voucher Plan, plaintiffs filed a class action suit under ERISA and Louisiana state law claiming that they were vested in a pension benefit plan.

The district court issued findings of fact and conclusions of law, ruling that the grocery Voucher Plan was a pension benefit plan under ERISA, that SGSM breached its fiduciary duty under ERISA, that Mr. Schwegmann was liable as a fiduciary to the plan, that the plaintiffs were entitled to monetary relief for benefits denied after SGSM's sale, and

continued on page 8

Hacker Attack

continued from page 1

the attack was a "Covered Cause of Loss" and also held that the erasure of data from the computer system constituted "direct physical loss or damage" to the insured's property. *See*, 2003 WL 1904413 at *3 (Widener, J. concurring).

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Accordingly, the court found there to be coverage for the insured's lost income (under the "Business Income" coverage provision), expenses incurred by the insured as a result of the attack (under the "Extra Expense" coverage provision), and the cost of restoring the erased files and data (under the "valuable papers and records" coverage extension).

The court also considered whether coverage was barred by the Dishonesty exclusion, which precluded coverage for "loss or damage caused by or resulting from" dishonesty — defined as any dishonest or criminal act undertaken by the insured or its employees. The carrier argued that this exclusion applied because the hacker had placed the two programs used during the attack on the insured's computer system during his employment. The court agreed with respect to the version of the dishonesty exclusion contained in the computer coverage endorsement, but held that the exception to the version of this exclusion found in the Special Property Form — which restored coverage for "acts of destruction by your employees" — mandated coverage for the hacker's destruction of data.

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Case Briefs

continued from page 7

that USF&G's policy covered SGSM's liability, and that the policy's SIR applies once to the plaintiffs' claims collectively. On appeal, the 5th Circuit agreed with the district court except with respect to USF&G.

The SIR provision contained only one line reading: "$250,000 each claim." Neither the SIR nor any other section of the policy defined the term "claim." The district court ruled that the failure to define this term rendered the policy ambiguous as a matter of law. Construing the policy against USF&G, the district court concluded that the term "claim" referred to the single demand for coverage by the insured, SGSM, rather than the many claims made against SGSM.

The court found that this was too narrow of an interpretation of the policy. The court reasoned that under the basic tenets of Louisiana's law of contract interpretation, each of the policy's provisions must be read in light of the others. The court found that the meaning of "claim" for the purposes of the SIR provision could be gleaned by reference to the use of the word in numerous other provisions of the policy. The court looked at other provisions of the USF&G policy that applied both to all coverages and those that applied to the specific coverage at issue and determined that the policy consistently referred to claims made "against the insured" or claims "by the employee." Accordingly, the court held that the term "claim" in the SIR provision, when read in light of these other provisions of the policy, was clear and unambiguous and provided that a "claim" is the assertion of a legal right against the insured by a third party.

Having disposed of the theory that there was only a single claim for coverage, the court next considered whether or not there was a single claim on behalf of the plaintiff class or whether there were multiple claims on behalf of each member of the class. Relying on *Colbert County Hospital v. Bellefonte Insurance Co.*, 725 F.2d 651 (11th Cir. 1985) and *Maxim Manufacturing Corporation v. Alliance General Insurance Co.*, 911 F.Supp. 239 (S.D. Miss. 1995), the court concluded that the SIR had to be applied to individual class members' claims because each individual claimant could have filed their own separate claim against SMSG. Where no individual claim exceeded the $250,000 SIR, the judgment against USF&G was vacated.

Stacking of Policy Limits Permitted For Occurrence Over Multiple Years

In *Employers Insurance of Wausau v. Granite State Insurance Co.*, 2003 U.S. App. LEXIS 11111 (9th Cir. June 4, 2003), the 9th Circuit Court of Appeals addressed the question of whether the limits of multiple insurance policies could be "stacked" to create coverage greater than one annual "per occurrence" limit. Two insurance carriers argued over whether California law permitted such "stacking." The 9th Circuit relied on *Stonewall Insurance Co. v. City of Palos Verdes Estates*, 46 Cal. App. 4th 1810, 54 Cal. Rptr. 2d 176 (1996) to support its conclusion that such stacking was permissible. The court rejected an insurer's argument that *Stonewall* conflicted with another California court of appeal decision, *FMC Corp. v. Plaisted & Cos.*, 61 Cal. App. 4th 1132, 72 Cal. Rptr. 2d 467 (1998). In *FMC*, the court held that when an occurrence takes place in multiple years, an insured may not recover an amount any greater than the highest occurrence limit for one policy period, reasoning that if the insured were entitled to stack policy limits, it would receive more coverage for an occurrence than the parties had bargained for. The 9th Circuit held that *FMC* was distinguishable from *Stonewall* and the facts before it. The court noted that another California court of appeal had reached a different decision from *FMC*. While the publication of that decision, *Alpha Therapeutic Corp. v. The Home Insurance Co.*, 90 Cal. App. 4th 1330, 109 Cal. Rptr. 2d 698 (2001), was suspended by operation of law when the California Supreme Court granted review, the 9th Circuit concluded that it "may consider unpublished state decisions, even though such opinions have no precedential value." It noted that *Alpha Therapeutic* "rejects a broad anti-stacking rule, holding that where an insured suffered for several years from injuries caused by a single 'occurrence,' recovery should not be limited to a single year's policy limit." The 9th Circuit noted that the *Alpha Therapeutic* decision supported its conclusion that "*Stonewall* accurately represents California law." It concluded by noting that "California courts have not broadly rejected 'stacking' in a primary insurer context. To the contrary, California courts have expressly approved stacking successive 'per occurrence, per year' policy limits where, as here, a single occurrence extends through more than one policy period." The 9th Circuit also noted that its conclusion was consistent with the so-called "horizontal exhaustion" rule, under which an excess policy will not attach until all primary insurance is exhausted. Therefore, by its decision, the 9th Circuit has answered a question subject to extensive debate — does California permit stacking of primary policy limits when an occurrence takes place in more than one year? According to the 9th Circuit, the answer to that question is "yes."

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