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COMMENTARY

A trend of coverage denials under D&O and professional liability policies for contractual liability claims

Troutman Sanders attorneys Terrence R. McInnis and Melissa J. Perez analyze recent decisions upholding coverage denials under directors and officers policies and professional liability policies for claims based on contractual liability.

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CONSUMER FRAUD

Abercrombie can add to claims against insurer over gift card suits

An Ohio federal judge has ruled that Abercrombie & Fitch's Internet liability insurer must litigate in one action a dispute over whether it owes coverage for three lawsuits alleging the clothier fraudulently canceled unused gift card balances.

Abercrombie & Fitch Co. v. Ace European Group Ltd., No. 11-1114, 2012 WL 4107984 (S.D. Ohio, E. Div. Sept. 19, 2012).

U.S. Magistrate Judge Elizabeth A. Deavers of the Southern District of Ohio said Abercrombie may file a supplemental complaint in its declaratory judgment action against its insurer to add claims arising from the third fraud lawsuit because all three suits arose from the same occurrence.

In 2009 Abercrombie held a holiday gift card promotion offering $25 cards to consumers who purchased a certain amount of merchandise, according to Judge Deavers' opinion.

Abercrombie allegedly voided the balances on those cards Jan. 30, 2010, even though some of the cards had the words "no expiration date" and others had no printed information regarding their expiration.

Consumers brought two class-action complaints against Abercrombie in 2010 in Ohio and California.

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REUTERS/Fred Prouser

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Publisher: Mary Ellen Fox

Executive Editor: Donna M. Higgins

Managing Editor: Robert W. McSherry

Editors:
Kenneth Bradley, Esq.
Kenneth.Bradley@thomsonreuters.com
Melissa Sachs, Esq.
Melissa.Sachs@ thomsonreuters.com

Managing Desk Editor: Robert W. McSherry

Senior Desk Editor: Jennifer McCreary

Desk Editor: Sydney Pendleton

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Thomson Reuters
175 Strafford Avenue
Building 4, Suite 140
Wayne, PA 19087
877-595-0449
Fax: 800-220-1640
www.westlaw.com
Customer service: 800-328-4880

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A trend of coverage denials under D&O and professional liability policies for contractual liability claims

By Terrence R. McInnis, Esq., and Melissa J. Perez, Esq.
Troutman Sanders LLP

Professional liability policies afford coverage to professionals for the services they perform. Directors and officers policies afford coverage for company management. Although the particular language of the insuring provisions may differ among professional liability and D&O policies, a common thread of both is that the policies typically provide coverage for "claims" for "loss" or "damages" resulting from a "wrongful act."[1] These policies frequently afford entity coverage as well — extending coverage to claims against the corporation, partnership or other entity for which the professional, director or officer works.

Professional liability and D&O policies frequently contain contract exclusions or, in the health care or Employee Retirement Income Security Act areas, "benefits due" exclusions. Insurers often rely on such exclusions as a basis to deny coverage for claims arising from a policyholder's breach of a contractual obligation to a third party, most often in the context of the policyholder's failure to pay amounts that it owes. The rationale for this position is simple. It is nearly impossible for a professional liability insurer to underwrite coverage from an actuarial standpoint if it could be held liable as the guarantor of all the policyholder's contractual liabilities to third parties.

Even when an express contract or "benefits due" exclusion is not included in the policy, insurers have argued that liability policies should not afford coverage for the contract price of a business deal gone wrong. Insurers have advanced two primary arguments in support of this position:

- The "loss" or "damages" caused by the policyholder's breach of its pre-existing contractual obligations is not the result of a "wrongful act," but arises from its decision to enter into the contract in the first instance.
- Providing insurance for a policyholder's contractual obligations creates a "moral hazard," incentivizing an insured to breach its contractual obligations or otherwise to engage in risky behavior.

One of the seminal cases in which a court declined to afford coverage for a policyholder's contractual obligations, even without a specific exclusion, is *August Entertainment Inc. v. Philadelphia Indemnity Insurance Co.*, 146 Cal. App. 4th 565 (Cal. Ct. App., 2d Dist. 2007).

Terrence R. McInnis (L), a partner in the Irvine, Calif., office of international law firm Troutman Sanders LLP, focuses his practice on insurance, including primary and excess D&O, employment practices liability, errors and omissions, and miscellaneous professional liability policies; general liability, umbrella and pollution policies; and liability policies issued to nonprofit organizations, associations, governmental entities, public and private firms, and media companies. **Melissa J. Perez** (R), an associate in the firm, is involved in providing insurance companies with pre-litigation counseling and advice concerning complex coverage and claims-handling issues. The authors can be reached at (949) 622-2700 or at terrence.mcinnis@troutmansanders.com or melissa.perez@troutmansanders.com.

In 2012, in what appears to be a trend, a number of courts in several jurisdictions have adopted the reasoning in *August Entertainment*, in whole or in part. These courts have upheld the denial of both defense and indemnity coverage when the gravamen of the underlying claim involves the policyholder's failure to pay amounts owed under a contract, even in cases in which no contract exclusion appears in the policy.

In 2012, in what appears to be a trend, a number of courts in several jurisdictions have adopted the reasoning in *August Entertainment*, in whole or in part.

AUGUST ENTERTAINMENT

In *August Entertainment*, Robert Maclean, a corporate officer of InternetStudios.com Inc., entered into a contract with August Entertainment Inc. to obtain film distribution rights in exchange for a $2 million payment. When there was a dispute over the contract, August Entertainment sued InternetStudios.com and Maclean in the Los Angeles County Superior Court, seeking to recover the $2 million contract price. InternetStudios.com and Maclean submitted a claim to D&O insurer Philadelphia Indemnity Insurance Co., which rejected the claim.

August Entertainment, InternetStudios.com and Maclean settled the suit for $2 million plus interest, and Maclean assigned his rights and claims against PIIC to August Entertainment, which then sued the insurer for breach of contract and bad faith. The Los Angeles trial court ruled in favor of PIIC, and August Entertainment appealed.

The 2nd District Court of Appeal, however, rejected the argument that Maclean

may obtain insurance coverage for his company's contractual debt. Even without an explicit exclusion in the D&O coverage part of the policy, PIIC was not liable for the policyholder's failure to pay on a contract, the appellate court said. The settlement of contractual liability was not a "loss" resulting from a "wrongful act," as required in PIIC's policy, the court said.

The court also adopted Judge Richard Posner's well-known "moral hazard" argument from *May Department Stores Co. v. Federal Insurance Co.*, 305 F.3d 597 (7th. Cir. 2002), as an additional basis to deny coverage for the policyholder's pre-existing contractual obligation.[2] The court held that to provide coverage for such contractual obligations would encourage corporate policyholders to risk a breach, knowing that, in the event of a breach, the D&O insurer would ultimately be responsible for paying the corporate debt.

Although the court in *August Entertainment* found that the insurer was not liable for the stipulated judgment entered against the policyholder in connection with the settlement, it left unanswered the significant related issues of defense costs, the recovery of attorney fees for such claims, or both. Recent decisions, in particular *Health Net Inc. v. RLI Insurance Co.*, 206 Cal. App. 4th 232 (Cal. Ct. App., 2d Dist. 2012), and *Sauter v. Houston Casualty Co.*, 276 P.3d 358 (Wash. Ct. App., Div. 1 2012), have now provided answers to these unresolved issues.

HEALTH NET

In a published opinion written by Justice H. Walter Croskey, the author of the leading treatise on the state's insurance law, California's 2nd District Court of Appeal addressed whether an insurer owed its policyholder defense costs in this context. As in *August Entertainment*, the professional liability insurance policies issued to Health Net did not contain an exclusion for "benefits due."

The insurance coverage action arose after Health Net alleged it paid $60 million to defend against an ERISA class action, which it eventually settled for $215 million. The plaintiffs in the underlying suit sought unpaid benefits owed under health insurance plans administered by Health Net or its subsidiaries. The appeals court found, however, that Health Net's professional liability policies did not cover the defense costs and settlement amounts related to these unpaid benefits.

The court reasoned that claims for unpaid benefits do not seek "damages ... resulting from any claim or claims ... for any wrongful act" under the policies' insuring agreement, because Health Net was already contractually obligated to pay those benefits to its subscribers, independent of any wrongful act. The court relied heavily on *August Entertainment*'s reasoning to find that Health Net's professional liability insurers were not liable for Health Net's settlement because the failure to pay benefits on a contract was not a "loss" resulting from a "wrongful act."

> It is nearly impossible for a professional liability insurer to underwrite coverage from an actuarial standpoint if it could be held liable as the guarantor of all the policyholder's contractual liabilities to third parties.

Significantly, the court also found that there was no coverage for the underlying $70 million attorney fee award to the class plaintiffs' counsel to the extent that it, too, was related to the class plaintiffs' claim for unpaid benefits.[3] Health Net had argued that the class plaintiffs' claim for statutory attorney fees was itself "damages," regardless of whether the underlying claim was covered. The appeals court rejected Health Net's argument. Instead, it reaffirmed a prior California authority finding that an award of attorney fees was inconsistent with the meaning of the word "damages" in the ordinary and popular sense inasmuch as the award does not compensate a plaintiff for the actual injury that originally brought the plaintiff into court.[4]

SAUTER

In *Sauter*, Michael Sauter, S-J Management's chief executive officer, executed a personal guaranty for a $2.8 million loan to the corporation. When S-J Management defaulted on the bank loan, the bank threatened to sell Sauter's real estate properties that secured the personal guaranty. Sauter demanded indemnity from S-J Management, which then tendered the bank's demand to its D&O insurer, Houston Casualty Co. The insurer denied coverage for the claim.

The Washington Court of Appeals upheld Houston Casualty's denial, finding that Sauter had not acted in an insured capacity when executing the personal guaranty, as required by the policy. In addition, relying on *August Entertainment*, the appellate court found that Sauter's liability to the bank because of the personal guaranty was not a "loss" resulting from a "wrongful act," but instead was the result of the guaranty itself.

The court also found that the "moral hazard" considerations discussed in *August Entertainment* (that is, providing coverage for a policyholder's contractual obligations encourages corporations to breach their contractual obligations, because they know that their D&O insurer will ultimately be responsible for paying the debt) applied with equal force.

WELLPOINT

In *WellPoint Inc. v. Continental Casualty Co.*, 2012 WL 4803595 (Ind. Super. Ct., Marion County Jan. 31, 2012), WellPoint Inc. (formerly known as Anthem Inc.) and Anthem Insurance Cos. sought coverage under reinsurance certificates issued to Anthem Inc. by Continental Casualty Co. for amounts paid to settle claims against Anthem. These claims were brought by providers of health care services either pursuant to contracts directly between Anthem and the providers or pursuant to an assignment of the subscribers' rights under their health care plans. The cash payment component of the settlement fund was $198 million.

An Indiana state court granted Continental's motion for summary judgment on numerous grounds, including that Indiana public policy precludes coverage for an insured's contractual obligations.[5] Although the court does not cite *August Entertainment*, the "moral hazard" analysis is similar.

IMPLICATIONS OF RECENT DECISIONS

'Negligence' and 'wrongful act'

Some policies limit their definitions of "wrongful" acts to "negligent" acts, whereas others do not.[6] Some courts focused on the "negligent" modifier to uphold the denial of coverage for breach of contract claims. These courts said that the refusal to pay amounts contractually owed is intentional, rather than

Implications of recent decisions

- Limiting wrongful acts to negligent acts matters less and less
- Contract exclusion not necessary
- Underlying pleadings do not determine coverage
- Continuing vitality of the "moral hazard" argument

negligent. This is so, even if the initial failure to pay the obligation was due to a mistaken belief as to the terms of the contract or to simple oversight.

The policy language in *Health Net* did not expressly limit "wrongful" acts to "negligent" acts; thus, relying on this fact, Health Net argued that the policy should afford coverage for breach of contract. The *Health Net* court did not find this argument persuasive, and so the distinction between policies defining "wrongful" acts to be "negligent" acts and those that do not should no longer be relevant, at least under California law.

Contract exclusion not necessary

As discussed above, in *Health Net* and *Sauter*, the policies did not have a "benefits due" or contract exclusion. In cases in which such exclusions are present, courts have enforced them to preclude coverage for the same sort of ERISA claims for unpaid health benefits at issue in *Health Net*, because the "benefits due" exclusion precludes coverage for unpaid contract benefits.[7]

Therefore, under *Health Net*'s reasoning, it makes no difference whether the policy contains a "benefits due" exclusion. Rather, for the Court of Appeal, the pivotal question was whether the amounts sought by the class plaintiffs under their health plans were amounts that Health Net was legally obligated to pay as the result of a "wrongful act," or whether they were amounts that Health Net, its subsidiaries or both were already obligated to pay the plan subscribers pursuant to their contracts with them (the health plan), independent of any "wrongful act" (that is, the failure to pay). Thus, it does not matter whether the insured committed a "wrongful act" (breached a fiduciary duty by failing to pay) — the result of which is that the contractual amounts owed were not paid. A negligent or innocent failure to pay does not convert pre-existing contractual obligations into covered insured events.

Courts may extend the holdings of *Health Net* and *Sauter* to other cases involving a policyholder's claim for coverage under a D&O or professional liability policy for the breach of its contractual obligations.

Underlying pleadings do not determine coverage

Even claims for breach of fiduciary duty, negligence or other torts may not be covered if the claim derives from the policyholder's failure to perform its contractual obligations. That is, even if the policyholder may have been negligent in not fulfilling its contractual obligation or did not believe it had any contractual obligation to pay, the claim may still not be afforded coverage. In California, for example, it is the nature of the damage and risk involved that governs, not how parties plead the causes of action.[8] As noted by the Court of Appeal in *Health Net*, the costs of the unpaid benefits "cannot be passed onto [Health Net's] insurers simply because [Health Net] may have committed a wrongful act in its failure to pay them."

Health Net's holding is particularly important in cases involving insurance coverage for unpaid benefits brought under ERISA, because plan participants and beneficiaries of ERISA plans, as in the case of Health Net, frequently assert statutory claims for breach of fiduciary under the ERISA, in addition to statutory breach of contract claims.

Continuing vitality of the 'moral hazard' argument

Courts in California and in other jurisdictions have held that allowing liability coverage for amounts due under a contract, for an insureds' pre-existing obligations (such as claims for unpaid benefits or wages), or both would create an unacceptable moral hazard by encouraging risky and socially harmful behavior by insureds.

The court in *Health Net* declined to address the "moral hazard" argument, instead relying on the insuring provisions of the policy. However, *August Entertainment* in California and numerous other cases, including the recent *Sauter* and *WellPoint* decisions, continue to stand for the proposition that coverage for an insured's contractual obligations would violate public policy.

CONCLUSION

Expect the recent trend of courts rejecting coverage for breach-of contract claims to continue. Clear precedent indicates that there is no potential for coverage for a policyholder's non-payment of its pre-existing contractual obligations, including defense costs (absent an express grant of coverage in the policy), plaintiffs' attorney fees and interest for such claims. Thus, it can be expected that insurers, both in California and other jurisdictions, will rely upon these decisions, and in particular the *Health Net* decision, to disclaim coverage for contractual damage claims involving defense and indemnity. WJ

NOTES

[1] Eric M. Holmes, ed., Appleman on Insurance 2d (2003) § 146.1, at 46-47.

[2] *August Entm't*, 146 Cal. App. 4th at 582 (quoting *May Dep't Stores*, 305 F.3d at 601). ("'It would be passing strange for an insurance company to insure a pension plan (and its sponsor) against an underpayment of benefits, not only because of the enormous and unpredictable liability to which a claim for benefits ... could give rise, but also because of the acute moral hazard problem that such coverage would create. ... Such insurance would give the plan and its sponsor an incentive to aggressive (just short of willful) interpretations of [federal pension law] designed to minimize the benefits due, safe in the belief that if, as would be likely, the interpretations were rejected by the courts, the insurance company would pick up the tab.'").

[3] However, relying on many of the same out-of-state cases that the California Court of Appeal cited, the 4th U.S. Circuit Court of Appeals (applying Virginia law) recently came to the opposite conclusion, holding, instead, that although there was no coverage for the insured's preexisting obligations to pay wages compliant with the Fair Labor Standards Act, statutory attorney fees were "damages" resulting from an insured's alleged "wrongful act" in failing to pay back wages and overtime pay. *See Republic Franklin Ins. Co. v. Albemarle County Sch. Bd.*, 670 F.3d 563, 568 (4th Cir. 2012).

[4] *Health Net*, 206 Cal. App. 4th at 256-57 (citing *Cutler-Orosi Unified Sch. Dist. v. Tulare County Sch. Dists. Liab./Prop. Self-Ins. Auth.*, 31 Cal. App. 4th 617, 632 (Cal. Ct. App., 5th Dist. 1994)).

[5] *WellPoint*, 2012 WL 4803595 ("A liability policy cannot be construed as a performance bond to pay an insured's corporate contractual obligations.").

[6] Compare *Baylor Heating & Air Conditioning v. Fed. Mut. Ins. Co.*, 987 F.2d 415, 417 (7th Cir. 1993) (policy provided coverage for "negligent act, errors or omission in the 'administration' of your 'employee benefit programs'"), and *Oak Park Calabasas Condo. Ass'n v. State Farm Fire & Cas. Co.*, 137 Cal. App. 4th 557, 562 (Cal. Ct. App., 2d Dist. 2006) ("wrongful act" defined as

"negligent acts, errors, omissions"), with *August Entm't*, 146 Cal. App. 4th at 571 ("'wrongful act' meant any 'actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty'"), and *Medill v. Westport Ins. Corp.*, 143 Cal. App. 4th 819, 826 (Cal. Ct. App., 2d Dist. 2006) ("'Wrongful act(s)' [are] 'any actual or alleged error or omission, negligent act, misleading statement, or breach of duty.'").

[7] *See, e.g., UnitedHealth Group Inc. v. Hiscox Dedicated Corp. Member Ltd.*, No. 09-CV-0210 (PJS/SRN), 2010 WL 550991 (D. Minn. 2010) (no coverage for unpaid benefits because the definition of "damages" excluded "amounts, benefits, coverages owed to any enrollee, member, subscriber, or client under any contract, healthcare plan, insurance policy, reinsurance policy, or program of self-insurance"), and *Exec. Risk Indem. v. Cigna Corp.*, 976 A.2d 1170, 1173 (Pa. Super. Ct. 2009) (exclusions "'for liability of the assured under contract or agreement, except liability which would have attached to the assured even in the absence of such contract or agreement'" and "'for benefits, coverage, or amounts due or allegedly due, including any amount representing interest thereon, from the assured as: (a) an insurer or reinsurer, under any policy or contract or treaty of insurance, reinsurance, suretyship, annuity or endowment'" barred coverage for class action settlement of breach of contract claims). *See also May Dep't Stores*, 305 F.3d 597 ("benefits due" exclusion precluded coverage for pension benefits sought under the ERISA plan), and *BOC Group v. Fed. Ins. Co.*, 2007 WL 2162437 *12 (N.J. Super. Ct. App. Div. July 30, 2007) ("benefits due" exclusion precluded coverage for plaintiff's ERISA claims, including plaintiffs' claim for statutory attorney fees under ERISA).

[8] *Vandenberg v. Super. Ct.*, 21 Cal. 4th 815, 839 (Cal. 1999) ("The nature of the damage and the risk involved, in light of particular policy provisions, control coverage.").

NEWS IN BRIEF

CALIFORNIA BILL AIMS TO FIGHT INSURANCE FRAUD

California Gov. Jerry Brown, D, has signed a bill that will increase funding for local district attorneys to combat fraud in disability and health insurance, according to a Sept. 24 statement by the state's Department of Insurance. "The individuals perpetrating this type of fraud have become more sophisticated with their efforts. This funding will aid local district attorneys as they adapt to keep pace with this increasing criminal activity," Commissioner Dave Jones said in the statement. The agency noted that from 2007 to 2010, it received more than 6,000 health and disability claims suspected of being fraudulent. Only a fraction was turned over to local district attorneys for prosecution, resulting in 656 investigations. Of those, investigators made 221 arrests and won 184 convictions on fraud totaling $223 million, it said. Assembly Bill 2138 goes into effect Jan. 1, 2013.

NEW CALIFORNIA LAW SAFEGUARDS LIFE POLICIES

A new California law will provide safeguards for life insurance policyholders, according to a Sept. 18 statement by the state's Department of Insurance. "This legislation will further protect California consumers and many seniors by ensuring that they are provided sufficient notice before their life insurance policy is canceled," Insurance Commissioner Dave Jones said in the statement. Currently, life insurance policyholders in the state can lose policy protection if they miss a single premium payment. If a policyholder seeks reinstatement, he or she might have to have a new physical exam, which could result in a more expensive policy with higher premiums, the statement said. AB 1747 requires insurers to send a "pending lapse notice" to policyholders within 30 days of nonpayment and allow for one or more designees to receive the notice. The law goes into effect Jan. 1, 2013.

OXFORD HEALTH TAGGED WITH $665,000 FINE

New York's Department of Financial Services has fined Oxford Health $665,000 for failing to explain coverage to policyholders and tell them how to challenge claim denials, according to a Sept. 20 statement. The agency said it cited Oxford Health Plans NY Inc. and Oxford Health Insurance Inc. for a total of about 300,000 instances of failing to provide explanation-of-benefits statements. "Insurers must provide their members with clear descriptions of their benefits each and every time a claim is processed. Consumers have every right to know what their health plans cover, what the plans don't cover and what they can do when their claims have been denied improperly," Superintendent Benjamin Lawsky said in the statement. The agency said Oxford has agreed to take all necessary steps to correct its conduct.

California law rules in Costco insurance dispute

A coverage dispute between bulk retailer Costco and a cheese vendor's insurer cannot be decided under Washington law, a federal judge in Seattle has ruled.

Costco Wholesale Corp. v. Nationwide Mutual Insurance Co., No. C11-1550, 2012 WL 4320715 (W.D. Wash. Sept. 20, 2012).

Washington-based Costco had moved for partial summary judgment in its lawsuit against Nationwide Mutual Insurance Co., contending that Washington law should apply.

But U.S. District Judge Richard A. Jones of the Western District of Washington denied the motion and, instead, dismissed the wholesaler's Washington-law-based claims because the policy had been purchased in California and coverage decisions had been made there.

The judge noted some of the underlying claims also arose in California, while none had taken place in Washington.

According to the judge's order, Costco had entered into a vendor agreement with Bravo Farms Cheese to sell its products in the wholesaler's stores. In accordance with Costco policy, Bravo added Costco as an additional insured on a commercial general liability policy it had purchased from Nationwide, the order says.

In October 2010 Costco learned of E. coli outbreaks related to Bravo products in Nevada, California, New Mexico, Arizona and Colorado. As injury claims for the outbreaks came in, Costco tendered them to Nationwide, according to the order.

While adjusting those claims, Nationwide claims specialist David Davis allegedly assured Costco four times that Bravo's excess umbrella policy would be available to the wholesaler. In April 2011 Davis told Costco for the first time that Bravo had canceled its policy in March 2010, the order says.

Costco sued Nationwide in Washington's King County Superior Court in July 2011, claiming the insurer violated the state's Insurance Fair Conduct Act by representing for five months that the wholesaler was covered under Bravo's umbrella policy.

Costco also asserted a violation of the state's Consumer Protection Act and a "bad-faith coverage by estoppel" claim alleging that Nationwide acted in bad faith and therefore had to pay the "full measure of the policy coverage that it misrepresented to Costco."

REUTERS/Richard Clement

Ohio-based Nationwide removed the case to the federal court based on diversity jurisdiction.

Costco moved for summary judgment, seeking a ruling that Washington insurance law applied.

The insurer filed a cross-motion for summary judgment, asking the court to dismiss the case.

Judge Jones noted that Washington courts use a "most significant relationship" test to determine controlling state law in diversity cases, based upon the most significant contacts that took place in the dispute.

Costco had argued that Washington law should control, saying the injury occurred in that state — that is, the financial impact on the wholesaler from being informed the policy had been canceled.

Nationwide argued that Costco provided no evidence of a "financial injury" in Washington and that none of the underlying actions took place there. The insurer noted that Bravo had purchased its policy and added Costco as an insured in California, that Davis was located in Northern California, and that California was where coverage decisions were made.

The judge agreed with the insurer, finding the evidence "overwhelmingly" supported a finding that the most significant contacts between Costco and Nationwide occurred in the Golden State and that California law therefore applies.

Judge Jones granted Nationwide's motion for summary judgment and dismissed Costco's claims under Washington law. Though California's insurance-regulating statute and consumer protection law do not allow for private causes of action, the judge gave Costco permission to file an amended complaint with proposed claims under California law. WJ

Attorneys:
Plaintiff: Daniel J. Von Seggern, Lee Smart PS, Seattle

Defendant: Lawrence Gottlieb, Betts Patterson & Mines, Seattle

Related Court Document:
Order: 2012 WL 4320715

Insurer liable for $4 million of electronics destroyed in fire

An insurer cannot recover from a manufacturer whose warehouse caught fire, destroying over $4 million in electronic goods that its policyholders had consigned for assembly and processing, a California appellate court has affirmed.

Foveon Inc. et al. v. Advanced Semiconductor Inc. et al., No. H037082, 2012 WL 4458647 (Cal. Ct. App., 6th Dist. Sept. 27, 2012).

Foveon Inc., Entropic Communications Inc. and Airgo Networks Inc. sell digital cameras and wireless home entertainment systems and outdoor speakers, respectively.

The companies contracted with Advanced Semiconductor Engineering Inc. to assemble their silicon wafers into final electronic products, the 6th District Court of Appeal opinion explained.

Foveon, Entropic and Airgo had policies with St. Paul Fire & Marine Insurance Co. when a fire at ASE's Taiwan warehouse destroyed all of the goods consigned for processing, Judge Eugene M. Premo wrote for the three-judge panel.

ASE never bought insurance, the opinion said.

St. Paul, therefore, paid more than $4 million to its policyholders for the consigned goods, the opinion says.

Foveon and Entropic, which each only received $100,000 from the insurer, sued ASE in the Santa Clara County Superior Court for breach of contract, bailment and negligence. They said ASE was liable for the fire and sought reimbursement for their uninsured losses.

St. Paul, as subrogee for its three policyholders, was also named as a plaintiff in the suit. The insurer sought to recover the money it paid out to the companies.

REUTERS/Valentin Flauraud

The plaintiffs contracted with Advanced Semiconductor Engineering Inc. to assemble silicon wafers, like the one shown here, into final electronic products. When ASE's warehouse caught fire, the plaintiffs suffered over $4 million in losses.

Judge Peter Kirwan found that the manufacturing contracts specifically included risk-allocation provisions that required the electronics companies to bear the risk or obtain insurance coverage for the materials and equipment they consigned to ASE.

Based on these provisions, Judge Kirwan concluded that the electronics companies and ASE agreed that St. Paul's policies would cover any damages to the goods, even if the manufacturer's negligence caused the losses. Therefore, he granted ASE's motion for summary judgment.

Foveon, Entropic and St. Paul appealed, arguing that the provisions only required that the electronics companies buy insurance for their own benefit. They said they never explicitly or implicitly agreed to relieve ASE of liability if the manufacturer's negligence damaged or destroyed the goods.

If ASE intended for the insurance to provide mutual benefits, it could have explicitly stated that in the contract, which the manufacturer drafted, the companies added.

The appellate panel, however, upheld the lower court's decision.

The contracts required Foveon, Entropic and Airgo "to insure the goods for the benefit of both parties," the panel's opinion said.

> The contracts required the plaintiffs to insure the goods for the benefit of both parties, the opinion says.

"Any other interpretation would make the clause inoperative or illusory," Judge Premo added.

Therefore, Foveon, Entropic and Airgo could only recover from St. Paul, and Foveon and Entropic could not recover their uninsured losses from the manufacturer, the appellate opinion concludes.

"If the insured customers have no claim against ASE, St. Paul has no claim either," the opinion said, adding that, as a subrogee, the insurer steps into the policyholders' shoes. WJ

Attorneys:
Plaintiffs-appellants: Joshua E. Kirsch, Gibson Robb & Lindh, San Francisco

Defendants-respondents: Kathleen M. DeLaney, Rudloff Wood & Barrows, Emeryville, Calif.

Related Court Document:
Opinion: 2012 WL 4458647

See Document Section B (P. 24) for the opinion.

Insurer fulfilled policy by repairing car rather than 'totaling' it, panel says

A California appellate court has upheld a bench ruling in favor of an insurer that spent nearly $19,000 to repair a Honda Accord rather than declare it a total loss and give the owner its book value of $25,000.

Carson v. Mercury Insurance Co., No. G045795, 2012 WL 4337539 (Cal. Ct. App., 4th Dist. Sept. 24, 2012).

The 4th District Court of Appeal held that Melody Carson lost her case in the trial court because she could not prove her claims that her insurer's decision to repair the nearly new 2008 Honda constituted breach of contract or the implied covenant of good faith and fair dealing.

Carson could not show that Mercury Insurance Co. failed to restore her car to its safe pre-accident condition, the appeals court said. Given the clear policy language, she also could not show that Mercury was obligated to pay her for the "diminished stigma value" of the car, the panel added.

The plaintiff purchased her new 2008 Honda Accord in September 2007 for $31,000. Less than a year later she was involved in an accident in Victorville, Calif., when she was struck by a pickup truck, according to the opinion by Judge Kathleen O'Leary, writing for the appeals panel.

The car was taken to a Mercury-approved repair facility in Victorville, which estimated repair costs at about $8,000. Carson chose to have the vehicle repaired at another shop, Specialty Body Works, which initially estimated the cost of repairs at between $8,600 and $10,700, the opinion said.

In the end, Specialty discovered more damage than its original estimates and performed $18,800 worth of repairs. Mercury paid for the repairs in full, including Carson's deductible, Judge O'Leary said.

Carson filed suit in the Orange County Superior Court, alleging that Mercury acted in bad faith by repairing the car rather than declaring the car totaled because the damage was so substantial that it could not be restored to its pre-accident condition with respect to safety, reliability, mechanics and performance.

She also asserted that Mercury should have taken into account the fact that the car had lost significant resale value as a result of having been in a major accident.

Judge Kirk H. Nakamura bifurcated the trial. He heard the first issue of whether Carson's vehicle could have been adequately repaired. Had he found for Carson on that issue, a jury would have determined whether Mercury had shown bad faith and should have paid punitive damages.

> "Mercury was only obligated to pay the amount necessary to restore the car to its pre-accident condition, and it did so," the court held.

The judge found for Mercury on the first issue, and the case did not go to a jury.

Mercury argued that the car could have been properly repaired within Honda's repair specifications if it had been done at Mercury's approved body shop.

Carson countered that because the integrity of the car's "unibody" construction had been compromised by the massive damage, no amount of repairs by any repair shop could have restored it to its pre-crash condition.

Judge Nakamura ruled that Carson failed to prove the car could not be repaired to its pre-accident safe, mechanical and cosmetic condition. He concluded that even if the vehicle was not repaired to that standard, Mercury was not liable because Carson chose her own repair facility.

REUTERS/Gary Cameron

Less than a year after Melody Carson purchased a new Honda Accord in September 2007, she was involved in an accident in Victorville, Calif. The Accord coupe model is shown here.

The appellate court affirmed, holding that Carson did not offer any authority to support her contention that restoring the car to a nearly factory-new condition was the appropriate standard.

Honda has published repair specifications to be used by insurance companies and repair shops, the court noted, and Judge Nakamura applied those standards in determining whether the car could be adequately repaired.

"It would be unfair to allow Carson to select a poor repair facility and then ask Mercury to pay for a redo of the same repairs. Mercury was only obligated to pay the amount necessary to restore the car to its pre-accident condition, and it did so," Judge O'Leary wrote.

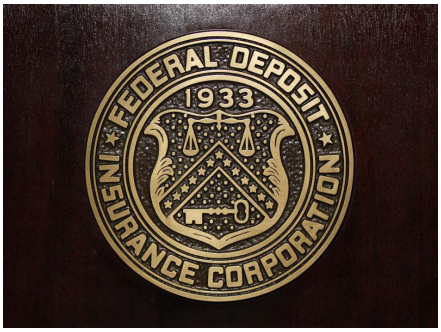
The panel also rejected Carson's argument that Mercury should have paid her for the diminished value of the car. Mercury's policy expressly excluded coverage for diminution in value of any motor vehicle repaired under its comprehensive or collision coverage, the appeals court said.

That exclusion was expressed in "plain and understandable language," it said. WJ

Related Court Document:
Opinion: 2012 WL 4337539

Federal judge wants closer look at 'insured vs. insured' exclusion

Discovery is needed to determine whether the "insured vs. insured" exclusion in a failed Michigan bank's D&O policy bars coverage for regulators' breach-of-duty charges against an ex-officer who allegedly made risky commercial loans, a federal judge in Detroit has ruled.



REUTERS/Jason Reed

Progressive Casualty Insurance Co. v. Federal Deposit Insurance Corp. et al., No. 11-14816, order entered (E.D. Mich. Sept. 24, 2012).

U.S. District Judge Bernard Friedman of the Eastern District of Michigan denied Progressive Casualty Insurance Co.'s motion for a summary judgment ruling that there was no coverage for the Federal Deposit Insurance Corp.'s suit against former Michigan Heritage Bank officer Timothy Cuttle.

The director-and-officer insurance policy Progressive wrote for Heritage included an insured-vs.-insured exclusion that bars any claim brought by one insured party against another.

That exemption often excuses an insurer from paying when the FDIC takes over a failed bank and sues the lender's officers and directors.

But Judge Friedman said it is too early to decide whether the FDIC was standing in Heritage's shoes and seeking recovery for a covered loss when it alleged Cuttle violated bank lending practices by recklessly approving 11 commercial loans that resulted in $8.2 million in losses.

In the underlying suit, the FDIC claimed that Cuttle's actions pushed Heritage into bankruptcy.

After that underlying suit was filed, both Cuttle and the FDIC turned to Progressive for coverage, but the insurer declined, claiming that the underlying action was barred by the insured-vs.-insured exclusion and did not generate a covered loss.

In the underlying suit, the FDIC claimed that the "reckless" actions of former Michigan Heritage Bank officer Timothy Cuttle pushed the institution into bankruptcy.

Progressive brought this coverage action, seeking to obtain a court ruling that affirmed its position. In response, the FDIC argued that the move is premature because certain terms in the policy are ambiguous, and discovery is needed to determine their meaning.

In his opinion, Judge Friedman noted that the policy does not include a "regulatory exclusion," which usually pairs with the insured-vs.-insured exclusion to conclusively bar suits by government regulators who are operating a failed bank.

In addition, he said, the insurer's marketing materials could be read to indicate that the particular type of loan Cuttle made was covered.

He also observed that there has been very little discovery in the case so far, and it is unusual in courts in the 6th U.S. Circuit Court of Appeals to grant summary judgment where there has been no opportunity for discovery.

Therefore, he denied the summary judgment motion and allowed the FDIC to conduct limited discovery.

Kevin LaCroix, who edits the prominent D&O Diary blog, said in a posting that the ruling stands out because decisions on insured-vs.-insured exclusions are usually based on the law.

"The ruling does represent to some extent a determination that the question of whether or not the insured-vs.-insured exclusion applies to an FDIC failed bank lawsuit may not be a strictly legal issue but could involve factual issues on which discovery is required," he said.

"If this coverage question is a factual issue — if there is 'some ambiguity' regarding the insured-vs.-insured exclusion — it could complicate insurers' efforts to rely on the exclusion in order to contest coverage for FDIC failed-bank claims." WJ

Software company's insurer owes no coverage for cop's death

An insurer owes no duty to defend or indemnify its policyholder against a wrongful-death lawsuit alleging the company's negligence in installing or updating software monitoring police vehicles led to a police officer's death, a Florida federal judge has ruled.

Maryland Casualty Co. v. Smartcop Inc., No. 4:11–cv–10100, 2012 WL 4344571 (S.D. Fla. Sept. 21, 2012).

According to the underlying wrongful-death suit filed in Monroe County, Fla., the county's Sheriff Deputy Melissa Powers was killed in a car accident while responding to a call to locate her immediate supervisor.

Powers needed to locate her supervisor because his car's GPS system that Smartcop Inc. had provided did not function properly, the suit said.

In other words, the suit alleged, Powers died because Smartcop failed to comply with its obligations to ensure that the computer public safety software products it had licensed to the sheriff's office worked as promised.

After Powers' estate sued Smartcop, the computer software company submitted a claim to its professional liability insurer, Maryland Casualty Co.

The insurer agreed to defend Smartcop under a reservation of rights but sought a declaratory judgment in the U.S. District Court for the Southern District of Florida that its policy provided no coverage for the underlying wrongful-death suit.

In its complaint, Maryland Casualty said its policy excluded any bodily injuries "arising out of the rendering of, or failure to render, electronic data processing, computer consulting or computer programming services, advice or instruction."It argued that the underlying wrongful-death suit alleged that Smartcop negligently failed to update its software, provide telephone support and otherwise ensure that its public safety computer products functioned properly.

The policy specifically excluded coverage for those allegations, Maryland Casualty maintained.

Although Smartcop filed a motion to dismiss the insurer's lawsuit in July, U.S. District Judge K. Michael Moore found that an actual controversy existed and denied the computer software company's motion to dismiss.

The insurer then asked the District Court to grant summary judgment.

Smartcop admitted that its policy excluded coverage for bodily injuries arising from its alleged negligence to provide professional services, but filed a brief opposing summary judgment. The software company argued that the policy still covered negligence claims related to "off-the-shelf completed software products."

Additionally, the underlying complaint alleged the software company was negligent about upgrading and maintaining the products it licensed to the sheriff's department, Smartcop maintained. The underlying suit never attacked Smartcop's "professional services" — its initial installation, set up and license of the software.

Therefore, the policy's exclusions did not apply, and the District Court must construe the policy in favor of coverage, Smartcop argued.

"Even with Florida's preference for insurance coverage, this court simply cannot re-write the policy to limit the computer software exclusion to only preclude coverage for the initial setup or sale," the judge wrote.

Therefore, he granted Maryland Casualty's summary judgment motion. WJ

Attorneys:
Plaintiff: Sina Bahadoran and John J. Cavo, Hinshaw & Culbertson, Coral Gables, Fla.

Defendants: Martin H. Levin, Levin Papantonio Thomas Mitchell Echsner & Proctor, Pensacola, Fla.

Related Court Document:
Order: 2012 WL 4344571

‘Fairly debatable’ defense need not be resolved at summary judgment

A bad-faith claim need not be resolved at the summary judgment stage when an insurer argues that it is “fairly debatable” that a coverage claim is valid, Utah’s highest court has ruled.

Jones v. Farmers Insurance Exchange d/b/a Farmers Insurance Co., No. 20100951, 2012 WL 3677052 (Utah Aug. 28, 2012).

“It is not the law in Utah that, when the insurance company argues a claim was fairly debatable, the case must be resolved by the court as a matter of law,” the state Supreme Court said in the unanimous ruling.

As a result, the court allowed a policyholder to proceed with a lawsuit alleging that his insurer acted in bad faith in handling a claim for underinsured-motorist benefits.

According to the court’s written opinion, Chad Jones was involved in a motor vehicle accident in 2001 and injured his back, knee, ankle and wrist. He accepted the $25,000 liability limit of the insurance policy belonging to the at-fault driver, the opinion says.

Jones was insured by Farmers Insurance Exchange under a policy that included $30,000 in UIM benefits. He sought the UIM policy limit in 2005, the opinion says.

The parties disagreed about a bill for dental repairs submitted four years after the accident. Because Jones did not report a mouth injury at the time of the accident, Farmers contended that it was fairly debatable whether the UIM claim was valid.

Jones’ dentist said he cracked several teeth in the accident and later needed extensive work, including porcelain onlays, a root canal and crowns as a result, the opinion says.

Farmers offered Jones $5,000 to settle his claim.

Ultimately, the case went to arbitration, and the arbitrators awarded Jones $18,500, which Farmers paid, the opinion says.

Jones then sued Farmers for bad-faith breach of contract, and both parties moved for summary judgment.

Farmers argued that if Jones cannot prove he is entitled to summary judgment on the merits of his bad-faith claim, the claim is “fairly debatable,” which relieves the insurer of its duty to pay any damages resulting from the suit.

The West Jordan County District Court agreed with the insurer and granted it summary judgment. Jones appealed.

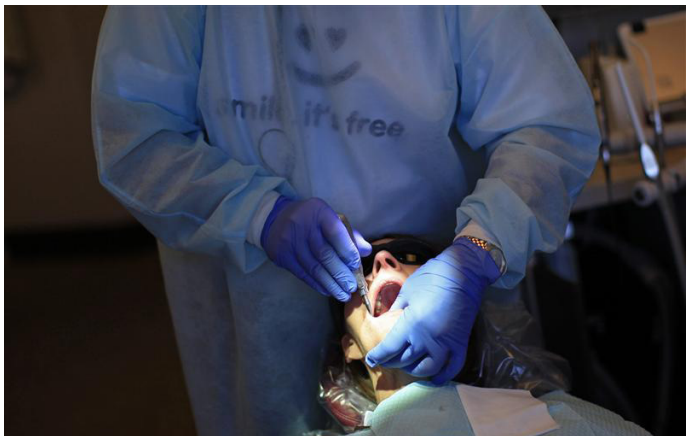
The Utah Supreme Court, claiming appellate jurisdiction, reversed.

“Such a rule would require that all bad-faith claims against insurance agencies be resolved through summary judgment if the insurer raises the fairly debatable defense,” the court said.

When an insurer raises such a defense, the case can still present questions of fact for a jury, the justices said, and summary judgment is appropriate only when there are no fact issues.

When determining whether a claim is fairly debatable, the Supreme Court said judges should take into account an insurer’s implied duties to:

- Investigate claims in a diligent manner.
- Evaluate claims fairly.



REUTERS/Jim Young

The parties disagreed about a bill for dental repairs submitted four years after the accident.

- Settle or deny claims reasonably and promptly.

After finding that not all cases dealing with the fairly debatable defense can be resolved at the summary judgment stage, the court concluded that Jones’ case presents triable fact issues.

Farmers maintained that Jones’ claim is fairly debatable because he did not report a mouth injury at the time of the accident.

Jones countered that his teeth were cracked in the accident and remained badly damaged until he was able to undergo extensive dental work to repair them after dealing with his other injuries.

The court said Jones’ failure to complain about the injury in a more timely fashion “throws his credibility into question but does not destroy it completely” when considering the other injuries he suffered in the accident.

“Reasonable minds could differ regarding whether Mr. Jones’s failure to complain of tooth damage earlier rendered his claim fairly debatable,” the high court said. WJ

Attorneys:
Plaintiff: L. Rich Humphries and Kara J. Porter, Christensen & Jensen, Salt Lake City, Utah

Defendant: John R. Lund and Julianne P. Blanch, Snow, Christensen & Martineau, Salt Lake City

Related Court Document:
Opinion: 2012 WL 3677052

See Document Section C (P. 29) for the opinion.

Failure to pay fees for general contractor doesn't add up to bad faith

State Farm did not act in bad faith when it failed to pay extra fees for a general contractor to coordinate repairs on an Oklahoma City home damaged by wind and hail, a federal judge has ruled.

Hammer et al. v. State Farm Fire & Casualty Co., No. CIV-11-0157, 2012 WL 4023839 (W.D. Okla. Sept. 12, 2012).

There was "a legitimate dispute" regarding whether the insurer should have paid an additional amount — the general contractor's overhead and profit — for a contractor to oversee the covered repairs, U.S. District Judge Joe Heaton of the Western District of Oklahoma said in a Sept. 12 order.

The case involves Larry and Renay Hammer, who insured their Oklahoma City home through a State Farm Fire & Casualty Co. policy that provided $171,000 in coverage.

The house was damaged by wind and hail in 2010.

After the Hammers filed a claim, State Farm sent out a representative to inspect the property. The representative determined that the roof was a total loss and needed to be replaced. He also found hail damage to various other exterior components, including gutters, siding, windows and a shed, the order says.

State Farm paid the Hammers more than $11,000 for the actual cash value of the loss, according to the order.

At issue is State Farm's failure to pay the couple an additional amount for a general contractor to coordinate the repairs. The Hammers said they should have been allotted an extra 20 percent for the general contractor's overhead and profit, known as GCOP. The insurer claimed that the repairs were not complex enough to warrant a general contractor, the order says.

The Hammers hired a company to perform the repairs but did not hire the company to act as a general contractor. Ultimately, they were unhappy with the repairs, the order says.

After the repairs were completed, State Farm paid the policyholders an additional $3,500 for recoverable depreciation pursuant to the terms of the policy.

The Hammers sued for breach of contract and bad faith, arguing that State Farm should have included an additional 20 percent to its payment for GCOP when it made the initial estimate and paid the actual cash value settlement amount.

Their expert testified that multiple trade skills were required to complete the repairs and that someone was needed to coordinate those repairs. The expert also testified that neighbors whose homes sustained similar damages in the storm received GCOP, the order says.

Judge Heaton ruled that the Hammers can proceed with their claim for breach of contract. He found fact issues as to whether it was "reasonably likely" that a general contractor was needed to coordinate the repairs.

REUTERS/Valentin Flauraud

The plaintiffs' home was damaged by wind and hail during a 2010 storm.

But the judge dismissed the bad-faith claim on the basis that there is a genuine dispute as to whether GCOP was warranted.

The judge also found no evidence that State Farm performed an inadequate investigation. The insurer contacted the Hammers a week after they filed their claim and completed a full investigation of the property less than a month after the storm, he said. WJ

Attorneys:
Plaintiffs: David K. Petty, Guyman, Okla.

Defendant: Benjamin G. Kemble, Jones Andrews & Ortiz, Oklahoma City

Related Court Document:
Order: 2012 WL 4023839

Nursing home sues therapy provider over alleged false billing

A nonprofit nursing home in Iowa alleges that its rehabilitation services provider fraudulently inflated billing rates for residents on Medicare and then refused to defend the home from federal false-claims allegations.

Bethany Lutheran Home v. RehabCare Group East et al., No. 1:12-cv-26, complaint filed (S.D. Iowa Sept. 10, 2012).

RehabCare Group East breached the terms of its contract to provide Bethany Lutheran Home with the information it needed to "properly" bill Medicare for therapy services and defend and indemnify Bethany from any loss caused by the negligence of its employees, the complaint says.

Bethany filed negligence, breach-of-contract and misrepresentation claims against RehabCare Group East in the U.S. District Court for the Southern District of Iowa.

The suit also names as defendants parent company RehabCare Group and Kindred Healthcare, which merged with RehabCare in June 2011.

According to the complaint, Bethany contracted with RehabCare to provide therapy services to residents at its facility in Council Bluffs, Iowa, from 2005 through early 2012.

As part of its services, RehabCare therapists assessed Bethany's Medicare-eligible residents' functional capabilities and provided the facility with information it was required to submit to the federal government, the suit says.

The assessments were also used to calculate each resident's "resource utilization group" level, which corresponds to their level of medical needs. Nursing facilities and service providers generally receive a higher Medicare reimbursement rate for providing care to residents with a high RUG, the complaint says.

> Bethany Lutheran Home alleges that RehabCare Group East improperly assessed nursing home residents' needs in order to raise billing rates under Medicare.

Bethany claims that it received a letter from the U.S. attorney's office for the Southern District of Iowa in 2011 about a pending investigation of its Medicare billing practices for therapy services.

The results of the investigation showed there was a "seismic shift" in the volume of Bethany's billing at the highest RUG rates after it hired RehabCare to perform its therapy services, according to the suit.

The U.S. attorney's office later determined that Bethany had received as much as $3 million in Medicare overpayments and gave it the option to negotiate a settlement with the government or defend itself against federal false-claims allegations, the complaint says.

Bethany claims it forwarded the information to Kindred Healthcare, but the company refused to participate in any negotiations with the government.

Kindred was responsible for RehabCare's obligations and liabilities as a result of the merger, according to the suit.

The nursing home eventually settled with the government for $675,000 to avoid facing triple damages for false claims or possible exclusion from Medicare and Medicaid, the complaint says.

Bethany alleges that RehabCare breached their contract by failing to provide the quality of services specified and refusing to defend and indemnify the nursing home from losses caused by the negligent acts or omissions of RehabCare and its employees.

The company fraudulently supplied Bethany with false billing information while knowing that Bethany would incorporate that data into its Medicare claims, the suit says.

The nursing home seeks a declaratory judgment that Kindred is obligated to defend and indemnify it for losses related to the U.S. attorney's office's investigation and settlement.

It also requests unspecified damages, attorney fees, interest and costs. WJ

Attorney:
Plaintiff: Heidi A. Guttau-Fox, Baird Holm LLP, Omaha, Neb.

Related Court Document:
Complaint: 2012 WL 4043835

See Document Section D (P. 38) for the complaint.

EU watchdog bemoans stagnant talks on insurer rules

(Reuters) – The European Union's powerful insurance watchdog EIOPA blasted stagnant political talks to finalize new risk capital rules for the insurance sector, saying delay was undermining EU credibility internationally.

The rules, known as Solvency II, are aimed at better protecting consumers by forcing sweeping improvement in insurers' risk management systems and capital strength.

But the regulation is now stuck in talks between the commission, the European Parliament and EU national governments.

Gabriel Bernardino, chairman of the European Insurance and Occupational Pensions Authority, told EU Commissioner Michel Barnier in a letter that national supervisors had "major worries" that there was still no clear and credible timetable for the rules.

In the absence of new rules, European supervisors would be forced to come up with their own procedures for monitoring insurers, and conflicting national solutions would emerge, he added.

A spokesman for Barnier said the commissioner had made suggestions to unlock the stalemate between the European Parliament and national governments to win clarity on the timing of the rules.

"The commission remains convinced that this project needs to be concluded as quickly as possible," spokesman Stefaan De Rynck said.

> A study by Ernst & Young showed that 34 percent of German, 17 percent of Italian and 13 percent of Spanish insurers expect they would only be ready to fulfill Solvency II requirements by 2015.

The regulations were to go into force this month but have now been delayed at least until 2014.

Supervisors would be left using outdated rules if EU political institutions did not come to agreement quickly, Bernardino said.

"If we have to continue with supervision on that basis, there is a huge danger that supervisors will not be able to identify and analyze risks correctly and will not be able to take the necessary supervisory actions in time, which may have serious consequences for policyholder protection," Bernardino wrote.

USEFUL DELAY

Big insurers like Axa or Generali are seen as better prepared than many small insurers, which have only just begun to grapple with the management and information technology changes needed to comply.

Europe's biggest insurer, Allianz, declined comment on Bernardino's letter but said a postponement would allow insurers to test the system and resolve remaining questions before the rules go fully into force.

Bronek Masojada, chief executive of Bermuda-based insurer Hiscox, agreed.

"I'd rather it be delayed and made better than have it rammed through and have to be changed later," Masojada said.

British and Dutch insurers have a strong tradition of using risk capital models to steer their insurance portfolios and are seen to be ahead in preparations for Solvency II.

However, a study by accounting and consultancy firm Ernst & Young showed that 34 percent of German, 17 percent of Italian and 13 percent of Spanish insurers expect they would only be ready to fulfill Solvency II requirements from 2015.

Solvency II was also seen as a potential model for insurance supervision worldwide, but Bernardino said uncertainty over the project was "undermining EU credibility in international discussions."

Once a realistic timetable for the rules is agreed upon, policymakers should consider earlier implementation of some aspects of the rules, Bernardino said. WJ

(Reporting by Jonathan Gould; additional reporting by Myles Neligan in London; editing by David Holmes and David Cowell)

Abercrombie

CONTINUED FROM PAGE 1

Abercrombie sought coverage for those two suits from Ace European Group Ltd., which had insured it for Internet liability, but Ace rejected the demand.

Because Abercrombie is based in New Albany, Ohio, it filed a declaratory judgment action against Ace in the state's Franklin County Court of Common Pleas. The coverage action was removed to the U.S. District Court for the Southern District of Ohio.

A third fraud suit arising from the gift card promotion, *Seaver v. Abercrombie & Fitch*, was filed in December 2011 in Ohio state court. Abercrombie notified Ace of that suit, but the insurer did not respond, according to the opinion.

Abercrombie then moved to supplement its complaint against Ace to add claims arising from its refusal to provide coverage for the *Seaver* suit.

Ace opposed the motion, arguing that the proposed supplemental claims were futile because, according to the policy language, Abercrombie should have notified it of the third suit during the policy period (September 2009 to September 2010) or during any extended reporting period.

Judge Deavers rejected that argument, finding that Abercrombie had timely notified Ace of the first two suits during the policy period.

While the *Seaver* suit was filed after the policy period ended, it arises from the same event as the other two suits, she said, and the policy's definition of "claim" requires that the court interpret all three actions as a single claim.

Judge Deavers also dismissed Ace's allegations of prejudice and undue delay. The supplemental complaint merely parallels the allegations made in Abercrombie's complaint concerning the first two fraud suits and is not raising any new subject matter, she said.

The coverage litigation is still in its infancy, and it would be more efficient for the court to consider all the possible related issues and claims in one action, Judge Deavers concluded. WJ

Attorneys:
Plaintiff: William J. Pohlman, Vorys, Sater, Seymour & Pease, Columbus, Ohio

Defendant: James M. Roper, Isaac, Brant, Ledman & Teetor, Columbus

Related Court Document:
Opinion: 2012 WL 4107984

See Document Section A (P. 19) for the opinion.

CASE AND DOCUMENT INDEX