Tressler LLP

Volume 1, Issue 2 April 2010

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CGL Dispatch

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NEW JERSEY HIGHEST COURT CONSIDERS WHETHER COURT RULE PERMITTING AWARD OF ATTORNEYS' FEES TO A SUCCESSFUL CLAIMANT ON A DJ ACTION ALLOWS A NJ INSURED TO RECOVER ATTORNEY'S FEES INCURRED IN AN OUT-OF-STATE DJ ACTION

In Myron Corp. v. Atlantic Mut. Ins., 407 N. J. Super. 302 (App. Div. 2009), certif. granted, 200 N.J. 505 (2009), New Jersey's highest court is faced with a case of first impression, in which a successful New Jersey policyholder in a New Jersey declaratory judgment action sought to recover its attorney's fees in related declaratory judgment lawsuits brought by the insurer in another jurisdiction.

For almost 40 years now, successful claimants under a liability or indemnity policy have been able to recover their attorney's fees against an insurer under N. J. Ct. R. 4:42-9(a)(6). The Rule has permitted either policyholders or third party beneficiary claimants to obtain attorney's fees, irrespective of any good faith basis for an insurer's denial or limitation of coverage. The rationale for this procedural rule is to provide policyholders and claimants under policies with the full benefits of the policy in circumstances in which an insurer has taken a coverage position upon which it ultimately does not prevail.

Myron, a New Jersey corporation, was named as a defendant in a class-action lawsuit by an Illinois company in Illinois state court arising out of its alleged delivery of junk faxes in violation of the Telephone Consumer Protection Act ("TCPA") and other statutory and common law principles. In tendering the complaint to its insurer, Atlantic Mutual Insurance Company ("Atlantic"), Myron also advised of other TCPA claims against it in Colorado, Arizona and Missouri. Atlantic agreed to defend the Illinois class-action lawsuit under a reservation of its rights to withdraw its defense at any time.

Approximately 11 months after Atlantic undertook the defense of Myron, on December 23, 2004 the United States Court of Appeals for the 7th Circuit, interpreting Illinois law, predicted that Illinois state law would not provide coverage for TCPA claims under the advertising injury definition in a liability policy. On March 8, 2005, Atlantic filed a complaint against Myron in the United States District Court for the Northern District of Illinois seeking a declaration that there was no coverage for any of the TCPA claims against Myron under its commercial general liability policy. In August 22, 2005, Atlantic's declaratory judgment complaint was dismissed for failure to meet the $75,000

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threshold required for diversity jurisdiction.

On August 24, 2005, Atlantic re-filed its federal court complaint in Illinois, and on August 29, 2005, Myron filed a declaratory judgment action against Atlantic in New Jersey state court. The New Jersey lawsuit was dismissed pending disposition of the earlier, re-filed Illinois federal court complaint. Myron obtained a dismissal of the second Illinois federal court complaint, based upon the abstention doctrine. The federal court in Illinois determined that New Jersey had the most substantial interest in the coverage dispute because Atlantic's policy had been issued in New Jersey to a New Jersey corporation. Myron then re-filed its New Jersey declaratory judgment complaint and obtained a favorable ruling that Atlantic had a duty to defend the TCPA claims. Ironically, on November 30, 2006, the Illinois Supreme Court found coverage under Illinois law for TCPA claims.

Myron and Atlantic resolved Myron's claim for attorneys' fees incurred in successfully prosecuting the New Jersey declaratory judgment action, but Myron had to file a motion to compel Atlantic to pay $160,000 in legal fees and expenses incurred to defend the two Illinois federal court declaratory judgment actions by Atlantic. The trial judge denied Myron's claim for attorneys fees, primarily on the basis that Rule 4:42-9 was not intended to apply extraterritorially, and that even if Myron had prevailed in the Illinois declaratory judgment actions, there was no basis for Myron to recover attorneys fees under Illinois law.

On appeal, Atlantic argued that even if the Illinois federal court applied New Jersey substantive law on the issue of insurance coverage, it would have applied Illinois procedural law on the issue of attorney's fees, under which Myron would not have been entitled to a recovery because Atlantic had not acted in bad faith. Atlantic also argued that Myron was not a successful claimant in the Illinois federal court lawsuits, because they were both dismissed on procedural grounds without a decision on the merits.

In reversing the trial court, the Appellate Division, held that the two dismissed Illinois federal court lawsuits were an integral part of the entire coverage litigation between the parties that culminated with a substantive decision in Myron's favor in the New Jersey declaratory judgment action. The Appellate Division also noted that allowing Myron to recover all of its attorneys fees was consistent with the underlying rationale of Rule 4:42-9(a)(6), which is to insure that successful claimants under a liability policy obtain the full benefits of the policy, undiminished by the financially burdensome costs of coverage litigation to vindicate their rights. The Appellate Division found support for its decision in New Jersey Supreme Court's decision in Westfield Ctr. Serv., Inc. v. Cities Serv. Oil Co., 86 N. J. 453 (1981), in which an award of attorneys' fees under the New Jersey Franchise Practice Act was permitted, even though some of the fees were incurred after the lawsuit was removed to the New Jersey federal court.

This case was argued before the New Jersey Supreme Court last month.

TRESSLER COMMENTS

If the questions at oral argument are any indication, Atlantic may be hard pressed to convince the Supreme Court that its decision to file declaratory judgment actions in Illinois federal court was motivated by anything other than the perceived opportunity for a favorable ruling based upon the 2004 7th Circuit decision. While Atlantic argued that its decision to file coverage lawsuits in Illinois federal court was motivated only by the fact that the most significant underlying TCPA claim against Myron was the class-action lawsuit in Illinois state court, it will be a surprise if the decision of the Appellate Division is not upheld.

Prepared by Mark R. Vespole, a partner in our Newark office.

ILLINOIS APPELLATE COURT HOLDS THAT AN INSURED MAY NOT "TARGET" A POLICY THAT PROVIDES EXCESS COVERAGE BASED ON AN "OTHER INSURANCE" CLAUSE

In River Village I, LLC v. Central Insurance Companies, 919 N.E.2d 426 (Ill. App. Ct. 2009), the Illinois Appellate Court held that a general contractor could not rely on the "targeted tender" rule to force a subcontractor's insurer to cover a claim where the subcontractor's policy, through an "other insurance" clause, applied excess of the general contractor's own primary policy.

River Village was a general contractor on a building project. Harleysville Lake States Insurance Company issued a commercial general liability policy to River Village. River Village hired First Choice Drywall to perform subcontracting work on the project. The subcontract between the parties required First Choice to procure insurance coverage and add River Village as an additional insured, but the subcontract was silent as to whether the coverage First Choice was required to obtain for River Village was to be primary or excess. Pursuant to its contractual obligations, First Choice added River Village as an additional insured on its commercial general liability insurance policy with Central Insurance Company.

The additional insured endorsement in the Central Mutual policy, however, contained an "other insurance" clause. This clause provided that the coverage under the additional insured endorsement was excess over "any other valid and collectible insurance available to the additional insured whether primary, excess, contingent or on any other basis unless a contract specifically requires that this insurance be either primary or primary and noncontributing."

While performing work at the construction site, a First Choice employee was injured. The employee sued River Village for damages. River Village tendered coverage to Central Mutual and instructed its own insurer, Harleysville, not to respond to the suit until the Central policy was exhausted. After Central denied coverage, River Village filed a declaratory judgment action against Central. Harleysville paid a settlement on River Village's behalf and was added as a plaintiff to the declaratory judgment action.

River Village argued that it was entitled to full coverage from Central Mutual under the Illinois "targeted tender" doctrine. The court noted that "The targeted tender doctrine allows an insured who is covered by multiple and concurrent insurance policies to select, or 'target,' which insurer he wants to defend and indemnify him regarding a specific claim." However, the court also found that insurers

See River Village on page 3 for conclusion

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THE ESTOPPEL DOCTRINE IS ALIVE AND WELL IN ILLINOIS AND "LATE NOTICE" DEFENSES ARE NO EXCEPTION

In Uhlich Children's Advantage Network v. National Union Fire Co. of Pittsburgh, Case No. 1-08-3400, 2010 Ill. App. LEXIS 61 (Ill. App. Ct. Feb. 3, 2010), the Illinois Appellate Court held that the estoppel doctrine precludes insurers from raising policy defenses, including late notice, when they have failed to either defend under a reservation of rights or file a declaratory judgment action to determine coverage. This applies to both claims made and occurrence based policies.

The Uhlich suit arose out of a discrimination lawsuit filed by Andrew Leonard, a former employee of Uhlich Children's Advantage Network (UCAN). When UCAN tendered the complaint to the insurers, they denied coverage for the claims based upon late notice under a claims made policy. The insurers never filed a declaratory judgment action to determine their coverage obligations. Nearly two years later, UCAN filed a declaratory judgment action seeking a determination of whether the insurers had a duty to defend it in the underlying lawsuit.

UCAN argued that the insurers owed it a duty to defend because the Leonard claims fell within the policy coverage, and, additionally, because the insurers breached this duty to defend, they were estopped from asserting any policy-based defenses, including "late notice." The court found Employers Ins. v. Ehlco Liquidating Trust, 186 Ill. 2d 127 (Ill. 1999) to be controlling. In that case, the Illinois Supreme Court concluded that a "late notice" defense was not an exception to the estoppel doctrine and held that when an insurer disclaims coverage, it must either defend its insured under a reservation of rights or file a declaratory judgment action to determine its coverage obligations. While UCAN did not provide the insurers with timely notice, the insurers were barred from asserting any coverage defenses based upon the estoppel doctrine because they failed to either represent UCAN under a reservation of rights or file a declaratory action to determine their coverage obligations. The court stated that providing an insurer with timely notice of a claim is not a condition precedent to coverage and once an insurer breaches its duty to defend, the estoppel doctrine has broad application and operates to bar the insurer from raising policy defenses to coverage, even those defenses that may have been successful had the insurer not breached its duty to defend.

The court agreed that there are some instances in which an insurer may decline to defend an entity that claims to be an insured. Before a court applies the estoppel doctrine set forth in Ehlco, the purported insured must actually be an insured. Here, UCAN was an insured under the policy. The court further noted that there is nothing in Ehlco limiting the estoppel doctrine to occurrence-based policies.

TRESSLER COMMENTS

This decision reiterates the importance of the estoppel doctrine and highlights the fact that coverage defenses based on "late notice" are not an exception. If an insurer believes that it received notice too late to trigger coverage, it must be mindful of its obligations and either proceed with a defense under a reservation of rights or file a declaratory action to determine whether "late notice" will relieve it of its coverage obligations, regardless of whether the policy provides occurrence or claims made coverage.

Prepared by Jessica Swaysland, an associate in our Chicago office.

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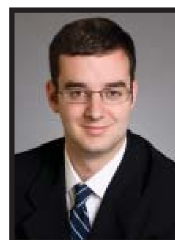
However, the court also found that insurers developed "other insurance" clauses as "an effort to override this right of the insured to choose among co-insurers."

River Village argued that the Central Mutual policy was primary and that Central Mutual and Harleysville were "concurrent primary co-insurers of River Village." The Illinois Appellate Court, however, disagreed. Relying on the language in the additional insured endorsement in the Central Mutual policy, the Appellate Court found that Central Mutual's coverage of River Village "is only excess over and above any other insurance River Village would be able to collect in the event of a loss." Because Harleysville had in fact paid the settlement on River Village's behalf, there was "no question that the Harleysville policy comprised 'other valid and collectible insurance' available to River Village." Because the subcontract was silent regarding the type of insurance First Choice was required to obtain for River Village, the Appellate Court held the Central Mutual policy applied excess of the Harleysville primary policy and held that Central Mutual owed no obligation to pay the claim or to reimburse Harleysville for the settlement it paid to the underlying plaintiff.

Significantly, the Harleysville policy also contained an "other insurance" clause and Harleysville and River Village argued that the "other insurance" clauses in each policy were mutually repugnant and cancelled each other out, thus making both policies primary and allowing them to force Central Mutual to pay the whole claim under the "targeted tender" rule. Because Harleysville had refused to produce its policy during discovery in the trial court and had not made the policy part of the record in the trial court, the Illinois Appellate Court refused to consider the "other insurance" clause in the Harleysville policy.

TRESSLER COMMENTS

This decision addresses a perceived conflict between the insured's right to target a particular primary policy under the Illinois "targeted tender" doctrine and an insurer's right to limit its risk through the use of an excess "other insurance" clause. The Illinois Appellate Court affirmed the right of an insurer to rely on an excess "other insurance" clause to deny coverage. However, had the Illinois Appellate Court considered the "other insurance" clause in the Harleysville policy, the court may well have found that the "other insurance" clauses in the policies were mutually repugnant and cancelled each other out. Had the court made such a finding, it might well have concluded that the Central Mutual policy was a concurrent primary policy and that the "targeted tender" rule therefore applied.



Prepared by Michael DiSantis, an associate in our Chicago office.

NEW YORK TRIAL COURT UPHOLDS EMPLOYEE EXCLUSION AND CONTRACTOR'S EXCLUSION IN FAVOR OF INSURERS

In Sigma Contracting Corp. v. Everest National Ins. Co. and Utica First Ins. Co., 2010 NY Slip Op 50331U, 2010 N.Y. Misc. Lexis 405 (N.Y. Sup. Ct. January 30, 2010), the court granted summary judgment in favor of general liability insurers based on the plain exclusionary language of the policies at issue.

Plaintiff Sigma Contracting Corp. ("Sigma"), a general contractor, entered into a contract with Joseph Norton Realty Corp. ("JNRC") to perform renovations on a property owned by JNRC. Sigma also entered into a subcontract with MCH Construction LLC ("MCH") to perform construction work on JNRC's property. The Subcontract required MCH to purchase and maintain general liability insurance and to list Sigma as an additional insured. As such, in May 2008, MCH purchased a general liability policy from defendant Utica First Insurance Co. ("Utica"). The Utica Policy contained a "blanket additional insured" provision applicable to all contractors. Sigma secured a general liability policy from defendant Everest National Insurance Co. ("Everest").

In June 2008, Guzman, a MCH employee fell from a ladder while performing carpentry work at the premises. Guzman filed suit alleging negligence against Sigma and others (the "underlying action"). Sigma notified its insurer Everest of Guzman's accident and requested a defense and indemnification (D&I) under the Everest Policy. Soon thereafter, Everest wrote to Sigma to acknowledge receipt of Sigma's notice and request for D&I, request agreements pertaining to the construction project, and notify Sigma that it was tendering Sigma's claim to Utica, as Sigma was entitled to additional insured status and liability coverage under the Utica Policy. Everest tendered Sigma's claim for coverage as an additional insured under the Utica Policy, and based on contractual indemnification language contained in the Subcontract. The following month, Utica disclaimed coverage to Sigma noting that, among other things, the Utica Policy did not provide coverage to Sigma or MCH for contractual liability claims, or for bodily injury to an employee of an insured if same occurs during the course of employment. Thereafter, Everest disclaimed coverage for Sigma based on a Contractor's Exclusion contained in the Everest Policy, noting that MCH failed to obtain coverage for Sigma that would provide Sigma with a defense and/or indemnification with respect to the underlying action filed by Mr. Guzman.

Sigma commenced the instant declaratory judgment action ("DJ Action") seeking a declaration that Everest and Utica (collectively the "defendants") have an obligation to defend, indemnify ad provide insurance coverage to Sigma in the underlying action, and alleging that Sigma is entitled to coverage as a named insured under the Everest Policy, and as an additional insured under the Utica Policy. Both insurers filed motions to dismiss, and Sigma cross moved for summary judgment seeking a declaration that Everest and Utica are obligated to defend and indemnify it.

At the onset, the court rejected Utica's argument that Sigma had failed to establish its entitlement to additional insured status, finding that that argument had been completely refuted by Sigma's submission, in its cross motion, of an "Additional Insured Certificate" (which lists Sigma as an additional insured) and a written subcontract with MCH, referred to in Sigma's verified complaint. Hence, the court reasoned that the Blanket Endorsement in the Utica Policy conferred 'additional insured' status to Sigma.

However, the court agreed with Utica that Sigma was not entitled to a D&I in the underlying action pursuant to an Employee Exclusion in the Utica Policy, and rejected Sigma's argument that the Blanket Endorsement and the Employee Exclusion in the Utica Policy were inconsistent and therefore ambiguous. The Blanket Additional Insured Endorsement in the Utica Policy provided, in relevant part: "[i]nsured also includes . . . any person or organization whom you are required to name as an additional insured on this policy under a written contract or written agreement." Further the Blanket Additional Endorsement provides that: "[w]e" do not pay for "bodily injury" or "property damage" . . . occurring after . . . or arising out of any act or omission of the additional insured or any of its "employees", other than the general supervision of the work 'you' performed for the additional insured." The Employee Exclusion in the Utica Policy provided, in relevant part, that "[t]his insurance does not apply to (i) bodily injury to any employee of any insured, to any contractor hired or retained by or for any insured or to any employee of such contractor, if such claim for bodily injury arises out of and in the course of his/her employment or retention of such contractor by or for any insured, for which any insured may become liable in any capacity[.]" Utica argued that any additional insured under the Utica Policy is subject to the Employee Exclusion, and that the language of both provisions are unambiguous and operate to preclude coverage to an insured or additional insured alike. The court agreed with Utica, finding that the record failed to support Sigma's contention that these provisions were inconsistent and ambiguous. Rather, the court noted that the plain language of the exclusionary language relieved Utica of liability when the insured or the additional insured was sued or contribution was requested for damages arising out of bodily injury to an employee sustained in course of their employment.

As to Everest, the court reasoned that the determination that Utica has no coverage obligations to Sigma triggers the Contractor's Exclusion in the Everest Policy, which excludes coverage for Sigma if the latter fails to have "in force commercial general liability insurance including contractual liability coverage for the benefit of the contractor . . . and [Sigma] for indemnification and/or contribution claims to the fullest extent permissible by applicable law in the event of a loss." In doing so, the court rejected Sigma's arguments that the endorsement in question contains a blank signature line and that the version contained in Everest's opposition papers is a different and undated version. The court found that these arguments were completely unsupported by reference to any authority or affidavit.

Accordingly, the court granted summary judgment in favor of Everest and Utica, and denied Sigma's cross motions.

TRESSLER COMMENTS

This trial level decision strongly supports the argument routinely advanced by insurers, but often reluctantly applied by the courts, that when a policy is clear, including policy exclusions, there should be no basis for the court to rewrite the policy and find coverage owed. We note, however, that the time within which an appeal from these orders can be filed has not yet expired.

Prepared by Elizabeth Caraballo, an associate in our New York office.

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CALIFORNIA COURT OF APPEAL HOLDS THAT WHERE PARTICIPATING INSURERS AGREED TO A METHOD OF ALLOCATING DEFENSE AND INDEMNITY COSTS, THE SAME METHODOLOGY MUST BE USED IN CALCULATING THE AMOUNT A NON-PARTICIPATING INSURER WILL OWE IN AN EQUITABLE CONTRIBUTION ACTION

In Scottsdale Insurance Company v. Century Surety Company, 182 Cal. App. 4th 1023 (2010), the California Court of Appeal reversed the trial court's ruling on how defense and indemnity costs were to be allocated in an equitable contribution action that Scottsdale Insurance Company ("Scottsdale") filed against Century Surety Company ("Century.")

The Court of Appeal held that Scottsdale must prove it paid more than its "fair share" of the defense and indemnity costs and must meet its burden of producing evidence necessary to calculate its "fair share." Furthermore, the Court of Appeal held that the allocation methodology used by Scottsdale and the other insurers who participated in the defense and settlement of the underlying claims should apply to the allocation methodology to be used in calculating what Scottsdale's "fair share" was and in calculation the damages it would be entitled to recover in contribution from Century.

Scottsdale filed an equitable contribution action against Century to recover defense and indemnity costs that Scottsdale paid in some 300 underlying actions involving 17 common insureds. Century had disclaimed coverage on several grounds, while Scottsdale and several other insurers agreed to participate in the defense and settlement of the claims. The trial court concluded that Century did not have any valid defenses to coverage and should have participated in the defense and settlement of the claims. The trial court then ruled that Scottsdale could recover one-half of the amounts it paid on approximately 80 of the underlying claims.

On appeal, Century argued that the trial court abused its discretion in its calculation of the amounts owed. The Court of Appeal agreed and held that because Scottsdale and the other participating insurers had previously agreed upon an allocation methodology based upon equal shares for defense costs and time on the risk for indemnification costs, that same methodology must be used in calculating the amount that Century owed Scottsdale. While the Court of Appeal briefly discussed various ways in which defense and indemnity costs can be allocated, and while it noted that costs must be allocated equitably in a way that is fair, the Court of Appeal noted that Scottsdale had "presented no authority for the proposition that it can agree to one method of allocation with every other insurer on the risk, but obtain a different method of allocation of its allocated share, when seeking equitable contribution from a non-participating insurer."

The Court of Appeal also reasoned that the trial court's ruling requiring Century to pay Scottsdale one-half of what it had paid would have given Scottsdale a windfall and would not have equitably allocated the costs. By way of example, the Court of Appeal noted that if Scottsdale and three other participating insurers had agreed to allocate costs equally, then each would have paid 25%. Had Century participated, each insurer would have paid 20%. The methodology used by the trial court, however, would have resulted in Scottsdale and Century paying only 12.5% each, while the other participating insurers, who were not parties to the contribution suit, would still have paid 25%. The Court of Appeal noted that in an equitable contribution action, an insurer is only allowed to recover what its fair share would have been had all insurers participated. As the equal shares allocation was previously agreed to by the participating insurers, the Court of Appeal found that the equal shares allocation was "patently reasonable" and that "Scottsdale should be bound by its choices." Because the trial court's ruling would have allowed Scottsdale to recover more than what its fair share would have been had Century participated in the defense and settlement of the claims, the Court of Appeal reversed and remanded back to the trial court to recalculate damages under the allocation methods agreed to by Scottsdale and the participating insurers.

TRESSLER COMMENTS

While California trial courts, in general, will exercise discretion in choosing an equitable method of allocation, they are likely to choose the method of allocation previously agreed to among participating insurers when allocating to a non-participating insurer in a subsequent contribution action.

Prepared by Linda Corrie, an associate in our Orange County office.

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CALIFORNIA COURT OF APPEAL CLARIFIES INSURER'S ENTITLEMENT TO INTERVENE WHEN DEFENDING UNDER A RESERVATION OF RIGHTS

In Gray v. Begley et al., No. B212082, 2010 Cal. App. LEXIS 373 (Cal. Ct. App. March 22, 2010), the California Court of Appeal clarified that if an insurer is defending under a reservation of rights, and the insured enters into a private settlement with the third-party claimant, without the insurer's consent, the insurer is entitled to intervene in the litigation to protect its interests.

Plaintiff, Steven Gray, was injured in an automobile accident caused by Dameon Begley, who was employed by Granite Construction Company. Gray brought suit against both Begley and Granite. Granite was insured by CNA and Westchester who reached a settlement agreement with Gray on behalf of Granite, but not Begley. The agreement released Granite from liability in exchange for an amount in excess of $8 million. Gray proceeded to trial against Begley and obtained a jury verdict and judgment against him for $4.5 million. Begley was represented by attorneys provided by CNA under a reservation of rights. After the verdict, Begley's counsel moved to vacate the judgment so that it could be offset against the $8 million settlement, pursuant to Cal. Civ. Code § 877.

Thereafter, Begley, without his counsel's participation, reached a private agreement with Gray to assign his rights against CNA and withdraw his motion to offset the judgment in return for a covenant not to execute. CNA moved to intervene in order to proceed on its own motion to vacate the judgment and apply the offset. The trial court granted CNA's motion to intervene. On appeal, Gray argued that CNA did not have a sufficient interest to intervene because it was defending under a reservation of rights. The Court of Appeal affirmed the trial court's grant of CNA's motion to intervene.

The Court of Appeal held that when an insurer provides an insured a defense under a reservation of rights, and the insured subsequently reaches a private settlement with the third party claimant without the participation of the insurer, the insurer has a sufficient interest to intervene in the underlying litigation.

On the other hand, the court explained that an insurer who denies coverage and refuses to defend does not have a direct interest in the litigation to warrant intervention because it has lost its right to control the litigation. However, where an insurer defends, it maintains control of the litigation and thus is not bound by an agreement reached by the insured without its participation. The court stated that the operative inquiry to determine whether an insured is bound by a settlement reached without the insurer's participation is whether the insurer provides a defense, not whether it denies coverage. With this principle in mind, the court reasoned that an insurer providing a defense, even subject to a reservation of rights, may intervene in the action when the insured attempts to settle the case to the potential detriment of the insurer. Contrary to a non-defending insurer, an insurer defending under a reservation of rights has not lost its right to control the litigation, and thus has a sufficient interest in the litigation to intervene.

Moreover, the court noted that Begley and Gray's agreement, in conjunction with their suit alleging bad faith on the part of CNA by subjecting Begley to a judgment in excess of $4,500,000.00, raises the possibility of collusion and illustrates the necessity of allowing the insurer to intervene to protect its interest in this situation.

TRESSLER COMMENTS

This case is significant because it clarifies an area of confusion under California law concerning the right of an insurer to intervene when it is defending under a reservation of rights. Moreover, it establishes that an insurer who is defending under a reservation of rights has the ability to intervene to protect its interests, particularly when the potential for collusion is present.

Prepared by Carrie Law, an associate in our Orange County office.

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THE FIFTH CIRCUIT, APPLYING TEXAS LAW, HOLDS THAT INSURERS MAY SEEK CONTRIBUTION FROM CO-PRIMARY CARRIERS FOR DEFENSE PAYMENTS, BUT NOT FOR INDEMNITY PAYMENTS

In the recent case, Trinity Universal Insurance Co. v. Employers Mutual Casualty Co., 592 F.3d 687 (5th Cir. Jan. 4, 2010), the Fifth Circuit held that pro rata "other insurance" clauses do not apply to defense payments, and that insurers have a joint obligation to defend. Accordingly, insurers may bring a contribution action against co-primary carriers for defense payments.

Previously, the Texas Supreme Court in Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co., 236 S.W.3d 765 (Tex. 2007), interpreted the "other insurance" clauses requiring contribution by equal shares to mean that each insurer's duty to indemnify is "several and independent." Under Mid-Continent, each insurer on the risk has an obligation to pay only its own pro rata share. Because indemnifying insurers have no overlapping payment obligations, they cannot seek contribution from each other.

In Trinity, four insurers, including Employers Mutual Casualty Company, issued liability insurance policies to Lacy Masonry, Inc. Each policy required the issuing insurer to defend Lacy Masonry in suits seeking payment for "property damage" caused by an "occurrence." Each policy also contained a pro rata "other insurance" clause, which provided that "each insurer [on the risk] contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains ...." Lacy Masonry was a defendant to a suit alleging construction defects and resulting property damage. Except for Employers Mutual, all insurers agreed to defend Lacy Masonry, paying equal shares.

The three defending insurers sued Employers Mutual, seeking contribution for defense payments. The district court found that Employers Mutual had a duty to defend, but relying on Mid-Continent, found that the defending insurers had no right to seek contribution.

The Fifth Circuit agreed with the district court that Employers Mutual had a duty to defend. However, the Fifth Circuit found that the district court erred in prohibiting the plaintiff insurers from seeking contribution. The Fifth Circuit reasoned that Mid-Continent did not prohibit contribution actions for defense payments, but only contribution actions for indemnity payments. Under the applicable "other insurance" provisions, each insurer pays a pro rata share of "loss." The Fifth Circuit found that "loss" refers to indemnity, not defense. Therefore, although insurers have a several and independent obligation make indemnity payments, they have a joint obligation to make defense payments. The insurers here (including Employers Mutual) had a joint, overlapping obligation to defend Lacy Masonry; therefore, the Fifth Circuit ruled that they could bring a contribution action for defense payments.

TRESSLER COMMENTS

In Texas, where the relevant insurance policies contain pro rata "other insurance" clauses, the duty to indemnify is "several and independent." The Fifth Circuit has now ruled that the duty to defend is joint. Insurers should keep in mind that no Texas state court has ruled on this issue; however, for now, carriers may file contribution claims against co-primary carriers for defense expenses.

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