COVERAGE OPINIONS
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The Cover-age Story

My daughter, like most seven year olds I suspect, is terrified of bees. The other day we were walking out of the house and she started to freak out. I said, "Ella, what's wrong!?" "A bee!," she screamed. "Where?" She pointed, but it didn't do much good since she was running in circles. I looked all over and could not see any bee. I said, "I don't see a bee." "But I hear it!," she insisted. Then it started to make sense. "Ella, there is no bee. You're hearing all of the buzz surrounding the Minnesota federal court's recent decision in Unitedhealth Group, Inc. v. Columbia Casualty Co." She looked at me and gave her usual response: "I'm telling mommy."

Unitedhealth Group, Inc. v. Columbia Casualty Co., No. 05-1289 (D. Minn. Apr. 25, 2013) has been the bee's knees lately in coverage circles. The decision is a sting for policyholders and a keeper for insurers. While I'll wax on about the decision below, here is what the buzz is about in case it would be a pain in the nectar for you to comb through it.

The case involves allocation between covered and uncovered claims in an underlying settlement reached by an insured.

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Declarations: The *Coverage Opinions* Interview With Amy Bach, Executive Director of United Policyholders

You can't read coverage decisions, especially from supreme courts, without frequently seeing United Policyholders as an *amicus* party. So I've always been under the impression that the organization was one that filed *amicus* briefs in support of commercial policyholders. Boy was I wrong. UP is much more than that. Friend of the court briefs are just the tip of the iceberg and UP is also a loud voice for consumer policyholders. Amy Bach, Executive Director of United Policyholders, set me straight on the organization's many functions.

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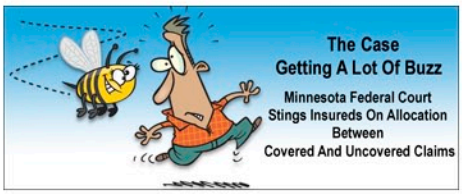

It is axiomatic that the insured bears the initial burden of proving that a claim is within a policy's grant of coverage. It is also a safe bet that the insurer bears the burden of proving that a claim falls within a policy exclusion. The parties in Unitedhealth Group did not dispute these general principles. But they disputed other, related, issues. Following a review of these issues the court held: "United has not offered any reason to impose the burden of allocation on the insurers beyond the general rule that insurers bear the burden of proving that a policy exclusion applies. The Court agrees with the insurers, however, that coverage questions-such as whether a claim falls within a policy exclusion—are distinct from allocation questions. Thus, the fact that the insurers bear the burden to prove that a claim is within a policy exclusion does not dictate that the insurers must also bear the burden to prove how much of the settlement should be allocated to that claim."

So the court held that the insured bore the burden of proving the extent to which a settlement should be allocated between covered and uncovered claims, including claims that are uncovered because they fall within a policy exclusion.

The settlement at issue in Unitedhealth Group was no small amount. It was $350 million. It arose out of some very complex underlying litigation, which, in very simple terms, involved claims that United was not properly reimbursing medical providers for services covered under United's health-insurance policies. The corresponding coverage case was also highly complex, involving a primary insurer and nine of United's excess insurers. Also in uber-simplified terms, at issue was coverage under an Antitrust Endorsement that provided coverage for antitrust claims and the applicability of various policy exclusions. [It took me 45 minutes to figure this out, requiring a look at other decisions in the case, and even after that I'm still not sure I have it right.]

Putting aside a few years of litigation, a key issue came down to this. United did not allocate the $350 million settlement between covered and uncovered claims—either at the time that the settlement was reached or at any time thereafter. The insurers argued that, because of this failure, United was precluded from seeking coverage for any part of the settlement. The court rejected the insurers' argument that contemporaneous allocation is required by insureds on "pain of forfeiture."

Having rejected the insurers' take nothing approach, allocation was now available for United. With this issue on the table, it became necessary to determine who had the burden of proof on this exercise.

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About The Editor

Randy Maniloff

Randy J. Maniloff is an attorney in the Philadelphia office of White and Williams, LLP. He concentrates his practice in the representation of insurers in coverage disputes over primary and excess obligations under a host of policies. Randy is the co-author of "General Liability Insurance Coverage: Key Issues In Every State" (Oxford University Press, 2nd Edition, 2012). For the past twelve years Randy has published a year-end article that addresses the ten most significant insurance coverage decisions of the year completed. Randy has been quoted on insurance coverage topics by such media as The Wall Street Journal, The New York Times, USA Today, Dow Jones Newswires and Associated Press. For more biographical information visit www.whiteandwilliams.com. Contact Randy at Maniloff@coverageopinions.info or (215) 864-6311.

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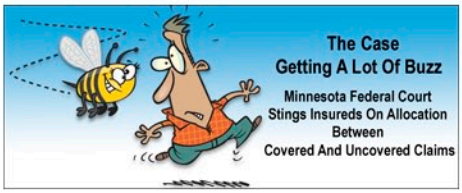

Again, while nobody disputed that the insured bears the burden of proving that a claim is covered and the insurer bears the burden of proving that a claim falls within a policy exclusion, the question was how these principles apply to allocation between covered and uncovered claims.

The insurers argued that United bore the burden of proving how the $350 million settlement should be allocated between the covered claims and all of the uncovered claims. United saw it differently. It conceded that it bore the burden of proving how the settlement should be allocated between claims that are within a grant of coverage and those that are not within a grant of coverage. However, United argued that the insurers had "the burden of proving how the … settlement should be allocated between, on the one hand, claims that are within a grant of coverage and not within an exclusion … and, on the other hand, claims that are within a grant of coverage and within an exclusion."

The court sided with the insurers, following another decision on this issue in Executive Risk Indem., Inc. v. CIGNA Corp. (Phila. Cty.C.C.P. 2012). It did so for two general reasons. First, the court concluded that requiring United to allocate between covered and excluded claims was simply a specific application of the general principle that an insured, like any plaintiff, bears the burden of proving its damages.

The court's second reason: "[T]here are compelling reasons to impose the allocation burden on United in this case. United controlled the underlying litigation, and it negotiated the AMA/Malchow settlement. The insurers did not play a meaningful role in those settlement negotiations. For that reason, United is not only in a better position to know how the settling parties valued the claims, but United was able to shape the record on that issue—and to do so at a time when United knew that allocation would almost certainly become a crucial issue in coverage litigation. See Schiller Decl., Jan. 9, 2013 [ECF No. 1338] Ex. 12 (letter from insurer explicitly requesting that United allocate the settlement). Despite all of this, United chose not to allocate the settlement. Under these circumstances, it hardly seems fair to force the insurers to bear the burden of proof on allocation."

In general, the court's decision was premised on its conclusion that, no matter what can be said about the burden to prove coverage and exclusions, "coverage questions—such as whether a claim falls within a policy exclusion—are distinct from allocation questions." While an insurer may bear the burden to prove that a claim is within a policy exclusion, that is not to say that the insurer must also bear the burden to prove how much of the settlement should be allocated to such claim.

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Randy Spencer's Open Mic

"Iname" Observations About Insurance Companies

[Randy Spencer is on vacation. This was his first Open Mic column, from the October 17, 2012 issue of *Coverage Opinions*. You may have missed it since *CO* had so few readers at that time.]

There are a lot of property-casualty insurance companies – nearly 2,700 according to the Insurance Information Institute's last count. While they all have one thing in common -- accepting risks in exchange for premium, they differ a lot in name. A review of a list of United States P&C companies reveals a wide-ranging thought process in how they've chosen to be identified.

Some companies take the bland approach – Accident Insurance Co. On the other end of the spectrum is Lightening Rod Mutual Insurance Company. Nothing bland about those guys. Other companies choose names so you have no doubt where they are located. No problem finding San Antonio Reinsurance Company. Others, like Alamo Title Insurance, tell you where you can find them, but you just need to think about it for a second. Lots of insurance compa nies seem to like the name Farmers.

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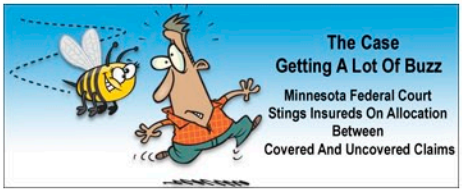

One final point is worth mentioning -- important to the case but not in any general take-away category. The court also ruled that United's expert, while unquestionably an expert in antitrust law, could opine on the strength and settlement value of the antitrust claims, but would not be permitted to opine as to how the settlement should be allocated between the antitrust claims and the others that were settled.

I've spent a lot of time in *Coverage Opinions* and annual Top 10 coverage cases articles addressing the issue of allocation between covered and uncovered claims. Most of that discussion has involved post-verdict situations and possible consequences for insurers that allowed a case to go to verdict without taking some pre-trial action to address resolution of covered and uncovered claims (i.e., avoiding a general verdict). But, of course, most cases do not go to trial. They settle. That's what makes Unitedhealth Group so significant – it's potential applicability to so many claims scenarios. Are there things about Unitedhealth Group that make it unique and may prevent its applicability to other cases? Yes, there are. But you could say that about every case. Putting that issue aside, the court's adoption of the principle, that coverage questions are distinct from allocation questions, tags Unitedhealth Group with a significant label.

Ken Feinberg Appointed Administrator Of The One Fund Boston

I had the privilege of interviewing Kenneth Feinberg for the April 10th issue of *Coverage Opinions*. Mr. Feinberg is the foremost expert on deciding how to share the proceeds of a victim compensation fund, having done so for the common funds created after September 11th, the Gulf oil spill and Virginia Tech, among others. So it was no surprise that Massachusetts Governor Patrick and Boston Mayor Menino tapped Mr. Feinberg to serve as Administrator of The One Fund Boston, the fund set up immediately after the Boston bombings to assist individuals affected by the horrific events. Mr. Feinberg will design and administer the fund entirely pro bono.

As of May 4 there is nearly $29 million in the fund. While that may seem like a lot of money, it isn't when you consider the number of victims, including fatalities, extent of injuries and long-term care that will be required in many cases. As he has done in other cases, Mr. Feinberg will have to weigh a host of factors in deciding "who gets what" (the title of his book on this issue). From what I learned about the process of victim compensation from a common fund,

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Randy Spencer's Open Mic

I'm sure there isn't too much confusion between those 60 or so companies. Some insurers want to leave no doubt about what they insure. Guess what kind of insurance The Dentists Insurance Company sells. I wonder if Balboa Insurance Company and Lewis & Clark LTC RRG, Inc. ever get together and share exploring tips. There are insurance companies that want you to know that they are strong. Don't even think about messing with Olympus Insurance Company. The nation's oldest insurance company might just also have the longest name – Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, Inc. Some insurer's names are just fun to say, like Pymatuning Mutual. And some insurers choose names that make you scratch your head… Elephant Auto Insurance Company. I guess they sell their policies for peanuts.

That's my time.

I'm Randy Spencer.

Contact Randy Spencer at
Randy.Spencer@Coverageopinions.info

Ken Feinberg:

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in the course of preparing for the *Coverage Opinions* interview, some of these factors are likely to be fatalities versus non-fatalities; single and double amputations versus non-amputations; length of hospitalization; permanent injury and long-term care requirements; how to address psychological injuries; impact of health insurance; any donations made to individual victims, and several others.

Just as in other cases, Mr. Feinberg is not likely to make too many friends in the course of serving in this role. But he'll do it, for free, nonetheless. The natural reaction when you hear of someone's appointment to such an important position is to say congratulations. But that just doesn't seem like the right word under these circumstances. Thank you is more fitting.

Illinois Federal Court: Duty To Defend Not Triggered By Throw-away Term In Prayer For Relief

I've never liked this situation. You are reading a complaint to determine if a duty to defend is owed. You are up to the last page and have concluded, as certain as you can be, that it is not. But then there it is – some amorphous term in the prayer for relief that now makes you question your conclusion. For example, nothing in the first nineteen pages of the complaint seeks covered damages. But then the Wherefore clause pleads not only the non-covered relief, but also "such other relief as the court deems appropriate," or something like that.

You know that such statement is a throw-away, just boilerplate and probably only there because it was cut and pasted by the drafter from some other complaint. But, still, you are forced to pause. After all, the duty to defend is broad, it is tied, at a minimum, to the allegations of the complaint, and you can't say for sure that "such other relief" does not include covered damages.

Such was the situation before the court in City of Marion, Illinois v. U.S. Specialty Ins. Co., No. 12-0999 (S.D. Ill. Apr. 30, 2013). The City of Marion was sued by the Marion School District for wrongfully withholding tax revenue to which the school district was entitled. The school district sought the return of the tax money. The City of Marion, in turn, sought coverage for the school district's complaint under an errors and omissions policy.

In general, the insurer declined to provide a defense to the City on the basis that, while the policy covered Loss, the definition of Loss excluded "return of taxes, assessments, penalties, fines." It was not disputed that this policy language would bar indemnity for return of the tax money. What was at issue was whether the insurer nonetheless had a duty to defend on the basis that the school district's suit requested additional relief other than the return of taxes. Specifically, the prayer for relief in the school district's complaint requested "[j]udgment against Marion in an amount equal to the real estate tax and other funds the School District is due ..."

Thus, the question was whether the request for "other funds" was sufficient to trigger a defense because it was something other than the return of tax revenue. The court cited Illinois's rules for determining if an insurer has a duty to defend. As expected, the test was broad and tied to the allegations in the complaint. Nonetheless, the court was not persuaded that the request for "other funds," in addition to the return of tax revenue, was sufficient to trigger a defense.

Notwithstanding the duty to defend rules, the court noted that it has "limits" "and any facts that bring a complaint within the policy limits must be explicitly alleged, not merely possible or hypothetical." On this basis, the court held that the request for "other funds," in addition to the return of tax revenue, was not sufficient to trigger a defense.

The City of Marion Court held: "Here, use of the term 'other funds' in the prayer for relief does not create the type of factual allegation that is specific enough to trigger the duty to defend. Without linking the term 'other funds' to specific facts that would create a claim for something other than the return of tax revenue, the Court would be left to speculate and guess as to what factual scenarios would require recovery from 'other funds.' Without more, 'other fund' requires the Court to examine the type of hypothetical facts the court found unavailing in [Amerisure Mutual Ins. Co. v. Microplastics, Inc., 622 F.3d 806 (7th Cir. 2010)].

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The City proposed two hypotheticals for what "other funds" could mean. But the court noted that, even if it were to accept the hypotheticals, it was clear that neither would trigger the duty to defend. What's more, it does not appear that the court would have even allowed the hypotheticals to trigger a defense in any event. As I read the case, the court was simply rejecting the hypotheticals as a possible basis for a different decision. It was not adopting a rule that reasonable hypotheticals can trigger a defense, even in the absence of an actual link between a non-specific request for relief and facts that would create a covered claim.

I like this decision – but not because the insurer won and I happen to represent insurers. I like it because the court took a difficult issue and reached its decision by adopting a test that could prove useful in other cases. And that test could just as easily benefit policyholders in the next case. The court's solution to this problem was to require a "link" between the non-specific request for relief (other funds) and specific facts in the complaint to which the non-specific relief could be referring. Is this a scientific test? No. Will it prove useful in every case? No. But the court did more than simply decide the case by concluding, without any reasoning, that the inclusion of "other funds" was not enough to trigger a defense.

Despite the guidance from City of Marion, the "throw-away Wherefore clause," as I call it, remains a challenging issue. Some insurers will still likely look at the strict duty to defend standard, conclude that they can't rule out that the throw-away terms do not include covered damages, and feel compelled to defend. But, as City of Marion noted, the duty to defend has limits. And the court did what it could to find where to draw the line. Again, while the insurer won, the case could also prove quite beneficial to policyholders.

South Dakota Supreme Court Addresses Rare Issue: 12:01 A.M. On The Dec Page

There are some aspects of an insurance policy that just never seem to arise in the course of analyzing coverage issues. Indeed, you could spend your entire career looking at claims and never have occasion to address the elevator maintenance agreement or sidetrack agreement portions of the "insured contract" definition. I never have. And I've never had to wonder if a watercraft is less than 26 feet, for purposes of the exception to the watercraft exclusion.

Also in this category could be the language on the declarations page of a liability policy stating that the policy expires not just on the date provided but at 12:01 a.m. on such date. While this issue comes up every now and then, and some readers have no doubt dealt with it, it is definitely not the pollution exclusion or definition of "occurrence." Here too I can imagine someone going an entire career without ever having to think about the issue. But 12:01 a.m. was at the center of the Supreme Court of South Dakota's decision in Alpha Property and Casualty Ins. Co. v. Ihle, No. 26436 (S.D. Apr. 17, 2013).

On Sunday, September 23, 2007, at noon, Tamara Bradford, while intoxicated, ran into and seriously injured four children that had been riding their bikes or standing alongside the road. She pleaded guilty to two counts of vehicular battery. Alpha Property and Casualty Insurance Company contested a duty to defend her in any negligence suit brought on the children's behalf.

To make a long story short, Ms. Bradford had a less than perfect on-time record when it came to paying her auto insurance premium to Alpha. On a couple of occasions she received a cancellation notice and then made the required payment. Then, on September 5, 2007, Alpha sent Bradford an invoice and notice of an option for renewal. The invoice and notice provided: "If payment of at least $358.03 is postmarked on or before 09/22/07, coverage will continue without interruption. If payment is not made, your policy will expire and coverage will cease at 12:01 a.m. on 09/23/07." Bradford did not make the required payment on or before September 22, 2007.

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South Dakota Supreme Court: - *Continued*

Thus, according to Alpha, Bradford's policy expired almost twelve hours before the September 23rd accident. Alpha contested its duty to defend Ms. Bradford in any negligence suit brought on the children's behalf.

Bradford made several arguments before the South Dakota Supreme Court in support of coverage for the accident. However, all of them were rejected. For example, Bradford argued that she reasonably expected that, in return for her initial premium payment on March 23, 2007, she would receive coverage for the entirety of the last day of the policy period, September 23, 2007. However, the South Dakota Supreme Court noted that it has never adopted the doctrine of reasonable expectations.

Bradford also argued that, because September 23rd was a Sunday, she had until September 24th to renew her policy – which her mother tried to do on that date -- based on the South Dakota statute stating that when an act under contract is to be performed on a particular day, and it falls on a holiday, the act may be performed on the next business day, with the same effect as if it had been performed on the appointed day. However, the court rejected this argument, noting that, to continue her coverage, Bradford was not required to act on Sunday, September 23, but, rather, on Saturday, September 22. But she did not do so. Thus, Bradford's coverage expired on September 23, 2007 at 12:01 a.m., under the express and unambiguous terms of the insurance contract.

Interestingly, the Declarations Page of a liability policy usually states that the policy expires not just at 12:01 a.m. on the expiration date, but 12:01 a.m. Standard Time. But what happens if such date is not one in which Standard Time is in effect. For example, for more than half the year, it is not Standard Time at all, but, rather, Daylight Savings Time. Does that mean that policies in fact expire at 11:01 p.m. on the day before the expiration date, thereby providing one fewer hour of coverage between generally March and October? Thankfully this issue is less likely to arise than even the length of a watercraft.

California Appeals Court: The Duty To Defend Is Not "Coverage"

There is a great quote from an old Supreme Court of Pennsylvania case about how to define an "accident." "Everyone knows what an accident is until the word comes up in court. Then it becomes a mysterious phenomenon, and, in order to resolve the enigma, witnesses are summoned, experts testify, lawyers argue, treatises are consulted and even when a conclave of twelve world-knowledgeable individuals agree as to whether a certain set of facts made out an accident, the question may not yet be settled and it must be reheard in an appel late court." Brenneman v. St. Paul F. & M. Ins. Co. (Pa. 1963). The Brenneman court's cynicism about the legal system instantly came to mind as I read the Court of Appeal of California's decision in Diamond Blue Enterprises, LLC v. Gemini Ins. Co., No. B244426 (Cal. Ct. App. April 22, 2013). But in Brenneman, when talking about what is an "accident," the observation was somewhat justified. Diamond Blue is different. There, the only one that made the issue a mysterious phenomenon and enigma was the appeals court.

At issue in Diamond Blue was whether a dispute between an insurer and its insured, over payment for defense costs, was subject to an arbitration clause in the policy at issue. The arbitration provision stated: "If we and the insured do not agree *whether coverage is provided* under this Coverage Part for a claim made against the insured, then either party may make a written demand for arbitration." (emphasis added). So the question became this: does "whether coverage is provided" encompass whether a duty to defend is owed? As Gemini saw it, of course it does, as "the duty to defend is not something different from coverage."

But the California Court of Appeal did not see it so simply. Not at all. Here are the steps to how the court arrived at this decision. First, "coverage in the insurance context denotes risks covered by an insurance plan. The term 'coverage' is commonly defined as 'protection by insurance policy' or 'inclusion within the scope of a protective beneficial

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plan ... against liability claims.' This commonly understood meaning of coverage delimits types of risks covered under the insurance." So far I can follow this.

In the CGL context there are three types of coverage: (1) bodily injury and property damage; (2) personal and advertising injury liability; and (3) medical payments. Then, in addition to defining coverage this way, the policy separately defines and limits the insurer's duty to defend. "The duty to defend is triggered if a third party sues the insured seeking damages for a covered risk, but is not triggered if the lawsuit seeks damages for a risk "to which this insurance does not apply. Under the terms of the policy, coverage defines the risks and the duty to defend is triggered by the scope of coverage. Thus, the duty to defend and coverage are related but not synonymous." Did you get that? I'm not sure I did.

The court also supported its decision on the basis that the duty to defend and the duty to indemnify are "not coterminous" and they differ in their triggering, substance and scope. In general, they differ because there may ultimately be no coverage for a claim even though the insurer has an obligation to defend the claim. This part I do get. But simply because the duty to defend and the duty to indemnify are not the same thing does not mean that the duty to defend is not part of the "coverage" provided under the policy.

Illinois Appeals Court Provides Test For Coverage For Post-Employment Termination Defamation

Like many defamation-based cases, American Economy Ins. Co. v. Haley Mansion, Inc., No. 3-12-0368 (Ill. Ct. App. Apr. 23, 2013) is ugly. It involves serious allegations of wrongdoing and name calling. But then again, I guess that's what defamation cases are about. Defamation claims have a way of arising in the employment context. Employment-related defamation can then give rise to coverage issues because a commercial general liability policy may provide coverage for such claims, unless excluded by an Employment-Related Practices exclusion, which is not uncommon to see on a CGL policy. So the question whether defamation arises out of an employment related practice is sometimes the basis for a coverage dispute.

What's more, when allegations of wrongdoing and name calling take place on the job, it may lead to the termination of the employment relationship, but not the end of the allegations of wrongdoing and name calling. In other words, the vitriol between the parties may continue even after the employment relationship has been formally severed. This is a further reason why the question whether defamation arises out of an employment related practice can be the basis for a coverage dispute.

This was the issue in Haley Mansion. Jullya Molburg, the general manager of the Mansion, a facility that hosts special events, allegedly told employees that her boss, Jeffrey Bussean, installed hidden surveillance cameras and was secretly taping employees and female guests undressing in the bridal suite. Molburg also allegedly told employees that Bussean repeatedly made sexually graphic and vile statements to her about each of them.

This resulted in a suit against Molburg. Molburg filed a counterclaim against Bussean and the Mansion alleging, among other things, that Bussean consistently made lewd comments about women's physical features and would become enraged if women in his employ rejected him. Molburg also alleged that, after her termination, Bussean told others that she was "mentally unstable," "incompetent," "untrustworthy," "engaged in criminal activity," a "dishonorable woman" and an unprintable term.

Now cut to the coverage case. American Economy filed an action seeking a declaration that it had no duty to defend the Mansion or Bussean, with regard to Molburg's counterclaim, on the basis of the CGL policy's employment-related practices exclusion. American Economy's argument went like this: "[A]n employer's alleged defamatory statements need not be related to the employee's performance for the exclusion to apply. American Economy suggests that when an employer shares no other relationship with the employee outside of the workplace, an alleged defamatory remark by the employer should

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be automatically considered to arise out of the employment relationship, and the defamation is therefore employment-related."

The Illinois appeals court was unwilling to apply such a broad interpretation to the employment-related practices exclusion. The court concluded that, with regard to the act of defamation, the exclusion applies if the statement relates to the employ ment of the alleged defamed person. The court's money line was this: "[W]e focus on the content of the statement, not the nature of the relationship between the parties, to determine if the exclusion applies to Bussean's actions. We conclude the policy, by its own terms, is clear that the exclusion applies to any employment-related statement by Bussean that gives rise to a defamation claim."

Applying this test, the court noted that the counterclaim did not include any allegation that Bussean told others that Molburg was fired because she was a "dishonorable woman" or "mentally unstable." Rather, Bussean's alleged defamatory remarks involved personal insults that had no bearing on Molburg's employment or previous work performance. Therefore, because some of these statements did not come within the employment-related practices exclusion, the court held that American Economy had a duty to defend its insureds.

Coverage Opinions is a bi-weekly (or more frequently) electronic newsletter reporting and providing commentary on just-issued decisions from courts nationally addressing insurance coverage disputes. Coverage Opinions focuses on decisions that concern numerous issues under commercial general liability and professional liability insurance policies. For more information visit www.coverageopinions.info.

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You can't read coverage decisions, especially from supreme courts, without frequently seeing United Policyholders as an *amicus* party. So I've always been under the impression that the organization was one that filed *amicus* briefs in support of the interests of commercial policyholders (some of them gigantic corporations). Boy was I wrong. UP is much more than that. Friend of the court briefs are just the tip of the iceberg and UP is also a loud voice for consumer policyholders. United Policyholders' web address is UPhelp.org, which says a lot about its mission.

According to its website, United Policyholders is a non-profit organization whose mission is to be a trustworthy and useful information resource and an effective voice for consumers of all types of insurance in all 50 states. UP speaks for a diverse range of policyholders from low income drivers to international energy companies to domestic manufacturers. The organization has filed more than 300 *amicus* briefs in state and federal cases, including the U.S. Supreme Court. UP hosts a dynamic library of such things as publications, links,reports and sample documents.

Elected officials, academics and journalists throughout the U.S. routinely seek United Policyholders' input. UP has helped change laws in favor of consumers, exposed and corrected wrongdoing and helped bring about successful claim settlements after fires, hurricanes, earthquakes, floods, business interruption losses, and disabling injuries and illnesses.

Amy, thank you for sitting down to explain to me what United Policyholders is all about. You are more than the Executive Director of UP. You are a co-founder. What sparked the decision to start UP?

The basic concept of insurance – spreading and pooling risks and financial planning for adversity – is a great idea. So great that it became an essential economic safety net for people and businesses. Preserving the integrity of that safety net requires that the interests of insurance company shareholders and executives not be disproportionately represented to the detriment of the competing and very important interests of their policyholders. A shared conviction that this was happening in the 1980s sparked UP.

UP was founded when a consumer advocate and a whistleblower met and decided to fill a gap by creating a non-profit dedicated solely to empowering the insured. Ina DeLong was the whistleblower. She'd recently left a 22 year career with State Farm to protest what she viewed as a pattern of intentional disregard for structural damage and underpayments on Loma Prieta earthquake claims. I was the consumer

Amy Bach

advocate, fresh off a stint representing Harvey Rosenfield in Proposition 103 implementation proceedings and honing my insurance litigation skills under the tutelage of San Francisco bad faith lawyer Ray Bourhis.

DeLong had seen Bourhis' name in the papers. This was due to his genius idea to get free publicity for his campaign for California Insurance Commissioner by suing the current Commissioner for ignoring and prematurely throwing away consumer complaint files. Ina was out of a job, determined to tell her story and ready to start a fire. Bourhis sent her down the hall to my office. Ina and I shared a passion for insurance justice. We had complementary skills and a similar vision, and began brainstorming the creation of United Policyholders. She was a perfect counterpart for an East Coast young progressive lawyer. She could explain the difference between an HO-3 and an HO-4, had a big heart and was a charismatic public speaker with a ready supply of folksy sayings from her home state of Oklahoma.

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The *Coverage Opinions* Interview With Amy Bach

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My first exposure to consumer advocacy had been trying to talk people into donating money to a non-profit while canvassing door to door. After college I worked my way up from an intern to a Legislative Staff Director in the NYS Assembly, then moved over to the NYS Consumer Protection Board - an executive agency under then Governor Mario Cuomo. New kid on the block, I drew the banking and insurance analyst position no one else wanted. Lucky for me, it was the year insurers decided to have Girl Scouts and public ice skating arenas be their poster children for a tort reform campaign in New York. Otherwise known as the "liability insurance crisis." The Governor created a high level Advisory Commission to examine the "crisis" and issue findings, and things got interesting.

The head of the agency I was working for at the time was an *ex officio* member of the Commission and by default I was his (and consumers') representative. Other Commission members included Maurice "Hank" Greenberg, John Creedon (CEO of Met Life), Frederick A.O. Schwartz, Jr. (NYC Corporation Counsel), and other heavy hitters.

Although I didn't know a tort from a tart when the proceedings began, it quickly became clear this was a high stakes war with two clear sides; insurers versus policyholders. It was equally clear that insurers had the upper hand; armed with glossy, well packaged and persuasive data and ably represented by influential and numerous representatives. The consumer side was sorely lacking in data, resources and coordination. Inspired by the advocacy work of Bob Hunter, Ralph Nader and Consumers Union's Rhoda Karpatkin, I thought I could make myself useful as a policy-holder advocate. Law school needed to be my next stop.

Fast forward five years, it was 1991, I'd relocated to San Francisco, was into my second job post-law school and met Ina. We'd picked the name "United Policyholders" and had a rough business plan when the largest urban area wildfire in U.S. history destroyed 3,000 homes just across the Bay. UP swung into action educating and organizing the devastated community, and our first "Roadmap to Recovery" operation began. To assist residents whose rebuilding efforts were being hindered by the building code or ordinance exclusion, UP filed our first brief amicus curiae in 1992 and our "Amicus Project" was born.

Within a year of our meeting, Ina was featured on 60 Minutes as the "Grandma of the insurance wars." When she left the organization in 1997, and with help from the legendary Gene Anderson and many others, I continued to build UP into what it is today: A respected voice and a trusted information resource for insurance consumers in all 50 states.

What are UP's principal functions?

The Roadmap to Recovery™ program gives individuals and businesses free tools and resources to help solve the insurance problems that can arise after an accident, loss, illness or other adverse event. These include a library of claim tips, sample forms, educational videos, professional help directories, and articles written by leading experts in personal finance, construction and the law.

The Roadmap to Preparedness program teaches financial and disaster preparedness through insurance literacy outreach and education in partnership with civic, faith based, business and other non-profit associations.

The Advocacy and Action program advances pro-consumer laws and public policy related to insurance matters.

What has been keeping you busy most recently?

The devastating impact that flood and anti-concurrent causation exclusions in homeowners policies are having on Superstorm Sandy victims, helping refine the concept of a coastal reinsurance band and figuring out what I'm going to cook for my family's dinner. I'm still making up for my last business trip.

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Declarations:

The *Coverage Opinions* Interview With Amy Bach

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What are some of the most satisfying experiences that you've had with UP?

• Seeing UP's *amicus* contribution expressly acknowledged by Justice Ginsburg in a U.S. Supreme Court decision

• Delivering documents to the CA Senate from an anonymous source that led to the ouster of a corrupt Insurance Commissioner

• Having our proposed amendments adopted into the Colorado Homeowners Insurance Reform Act of 2013

• Getting emails like this one "You have two allies in this confrontational dance with Big Insurance: your personal fortitude and United Policyholders. UP is THE non-profit insurance advocacy group supporting consumers in situations of total loss. Their approach of empowering the consumer with education and personal support to make YOU the best advocate for your own claim is organized and hits the ground running, proven successful, available and accessible to anyone, and staffed with fellow survivors who understand. United Policyholders is THE roadmap to recovery." Jacques Lord, 2007 Witch Fire Survivor

What are some of the things that UP does to raise funds for its programs?

We prepare grant applications and we solicit donations. We occasionally host an event – but we're not feeding starving children or saving cute animals so parties aren't a big source of fundraising support for us…

UP has filed 300+ amicus briefs between 1991 and 2011. I count about 200 attorneys that have done this work for UP virtually all on a pro bono basis. You are obviously very persuasive.

I'm a friendly gal with a sense of humor. I've been around this business for a long time and I'm very respectful of volunteers' time. I keep track of people's areas of interest and experience and try not to hit up anyone too often so it's not too much of a burden. Policyholder advocates are generally a brainy and compassionate bunch. UP is blessed with an incredible volunteer corps for which I am grateful every single day.

What are the considerations that go into UP choosing to get involved in a case as an amicus party.

Is there an insurance issue that's likely to impact a substantial number of policyholders in the future? Is there an important principle that needs to be stated, and most importantly – can we assist the court by supplementing the parties' briefs without being repetitive?

It seems like UP and the Complex Insurance Claims Litigation Association have a Yankees–Red Sox-like rivalry when it comes to amicus participation. Is that an accurate description?

A better analogy might be the A's-Yankees. Go team!

What's the biggest difference between Brooklyn and San Francisco?

People in Brooklyn know how to drive. And, they were smart enough to preserve their amusement park. But we've got the Giants.

Late-r Notice:
A Look At Decisions To Come

9th Circuit Rules In Ticketmaster Fees Case

Well that didn't take long.

The point of the Late-r Notice column is to look at decisions coming down the road. But I never anticipated that the road would be more like a driveway. Late-r Notice in the last issue of *Coverage Opinions* discussed Ticketmaster, LLC v. Illinois Union Insurance Co., a case before the Ninth Circuit and one in which oral argument took place on April 11th. Imagine my surprise when I saw that the Court of Appeals issued its ruling on April 26th.

At issue in the case is coverage, under an E&O policy, for an underlying class action that alleges that Ticketmaster misrepresented UPS delivery fees and other processing fees concerning the sale of tickets on the internet. It has been reported by Law360 that the suit, pending since 2003, is awaiting final approval of a settlement from a California state judge and there are $4 million in defense costs at issue. The trial court found for Illinois Union, concluding that it properly disclaimed coverage based on an exclusion in its policy that precludes coverage for "any dispute involving fees, expenses or costs paid to or charged by the insured."

The Ninth Circuit reversed, holding that Exclusion E., the "fees exclusion," "is reasonably susceptible to at least two meanings, particularly in light of the Policy's other 27 exclusions, and is thus, ambiguous: (i) Exclusion E may refer narrowly to a dispute regarding the monetary amount paid to or charged by Ticketmaster for uncontested services, or (ii) more generally, Exclusion E may refer to any dispute regarding a fee or charge for professional services, including a dispute regarding the relationship between services provided and the fees charged." The court held that Illinois Union failed to satisfy its burden of showing that its interpretation of the "fees exclusion" was the only reasonable one.

As an example that the suit did not only involve the amount charged for uncontested services, the court pointed to the allegation that Ticketmaster performed no services in exchange for its order-processing charge. This, the court observed, was not a dispute over the amount charged, but, rather, the relationship between any fee at all and the services provided.