Foley Hoag eBook

Obligations of Insurer and Policyholder

by Martin C. Pentz, Esq. and Jeremy A. M. Evans, Esq.

FOLEY HOAG LLP

Driving Business Advantage

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§ 1.1 Introduction

The insurance relationship is primarily one of contract, with the insurance policy as the principal source of the parties' obligations. As with other types of insurance, the duties of the parties—and the consequences of breaching those duties—are affected by government regulation, primarily in the form of state statutes addressing insurer conduct. Another source of law affecting insurance obligations is the judiciary. As liability insurance disputes became a staple of the courts' civil dockets during the second half of the twentieth century, recurring issues generated a significant body of common law. Nevertheless, in any study of the obligations of insurer and insured under liability coverages, there is no avoiding the oft-used insurer admonition, "Read Your Policy."

The primacy of the contract language has important consequences for any effort to survey the parties' obligations. First and foremost, it means that those obligations will vary from case to case depending on the wording of the policy in issue. The challenge imposed by this fundamental fact is ameliorated to some degree by the practice of the insurance industry, dating back to the 1930s, of writing insurance primarily on standard forms developed by rate-making organizations such as the Insurance Services Office. In the business context, perhaps the most widely used of these forms is the "Commercial General Liability" or "CGL" form (previously called the "Comprehensive General Liability" form). This eBook focuses on the duties of insurer and policyholder under the CGL policy.

The purpose of CGL insurance is to protect the policyholder against loss occasioned by third-party liability claims. Thus, it is not surprising that, at least in the context of coverage disputes, the most important and controversial insurer and policyholder obligations are those invoked when a claim or the potential for a claim arises. Commercial General Liability policies do impose obligations on insurers and policyholders that are independent of claims. Perhaps the most obvious is the policyholder's obligation to pay policy premiums when due. The policyholder under

a standard CGL form must also submit to insurer inspections of its business premises, allow examinations of its records and undergo premium audits. The insurer under the standard form also has obligations in addition to paying claims, such as its obligation to give notice of cancellation or notice of an intent not to renew.

This eBook will focus on the obligations of the CGL insurer and policyholder in connection with third-party claims. The fundamental insurer obligations are the duty to defend and the duty to indemnify. These duties, as well as the associated insurer right to control disposition of the claim, have spawned corollary duties to investigate claims and settle those that reasonably should be settled. The first part of this eBook examines Massachusetts law with respect to each of these insurer obligations, with a special emphasis on their ramifications in the context of insurance coverage litigation.

The second part of this eBook examines claim-related duties of the policyholder. The discussion begins with the policyholder's disclosure obligations in connection with the purchase of the policy. Technically independent of claims, these obligations tend to come to the fore after the claim is made, usually in the context of "misrepresentation" disputes. The remaining policyholder obligations discussed below serve the purpose of fostering an optimal environment for the insurer's discharge of *its* claim-related responsibilities. Such is the purpose, for example, of the policyholder duty to give prompt notice of "occurrences" and claims and of the insured's duty to cooperate with the insurer in the defense of third-party lawsuits. These and related policyholder duties are addressed in the second part of this eBook with a particular focus on the effect of a policyholder breach on the insurer's obligation, if any, to continue to perform.

§ 1.2 Obligations of the Insurer

The obligations of the insurer under a CGL policy flow primarily from the "insuring agreement(s)" of the policy form. Current forms include separate insuring agreements for bodily injury and property damage liability, "personal" and "advertising injury" liability, and medical payments, but the nature of the insurer's basic undertaking is little changed from the venerable 1973 form, which was in use until 1986. The insuring agreement of that form provided:

> The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of
>
> A. bodily injury or
>
> B. property damage
>
> to which this insurance applies, caused by an occurrence, and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements.

This insuring agreement imposes on the insurer two distinct duties: (1) the duty to "pay on behalf of" the policyholder all sums the insured becomes "legally obligated to pay as damages" because of injury or damage to which the insurance applies, commonly referred to as the duty to indemnify; and (2) the duty (and *right*) to defend any suit against the policyholder alleging a covered liability. It also confers on the insurer the prerogative to investigate and settle any potentially covered claim or suit, a prerogative the insurer is duty bound to exercise reasonably. These four insurer duties—to defend, indemnify, investigate and settle—are examined in the sections that follow.

§ 1.2.1 The Duty to Defend

The defense provisions of CGL policies have been aptly referred to as "litigation insurance." *See Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. 355, 358, 708 N.E.2d 639, 642 (1999). As stated by the Supreme Judicial Court in *Rubenstein*:

> "[T]he promise to defend the insured, as well as the promise to indemnify, is the consideration received by the insured for payment of the policy premiums. Although the type of policy here considered is most often referred to as liability insurance, it is 'litigation insurance' as well, protecting the insured from the expense of defending suits brought against him."

Id. at 358, 708 N.E.2d at 642 (quoting *Brohawn v. Transamerica Ins. Co.*, 347 A.2d 842, 851 (Md. 1975)). The obligation is not merely one of reimbursement. Essential

to the CGL defense concept is the undertaking of "responsibility for defending the insured," *Id.* at 358, 708 N.E. 2d at 642, which means assuming the burden of retaining, supervising and compensating the defense team, including defense counsel.

The insurer's "litigation insurance" obligations flow not only from the liability insuring agreement quoted above, but also from the so-called "Supplementary Payments" clause. That clause, as appearing in the current standard form, requires the insurer to pay, in addition to all defense expenses it incurs, items such as the following:

- costs taxed against the insured;
- prejudgment interest awarded against the insured on the part of the judgment the insurer pays;
- all postjudgment interest on the entire amount of the judgment until the insurer pays or tenders its part of the judgment;
- premiums on appeal bonds to release attachments; and
- expenses incurred by the insured at the insurer's request.

Indeed, it is the "Supplementary Payments" section of the standard CGL policy that makes clear that the costs of defense—and of the other items listed—do not reduce (i.e., are in addition to) the policy limits of liability.

(a) Scope: The "Comparison Test"

The defense obligation arises when a defense is needed: at the outset of the suit. It follows that, unlike the duty to indemnify (which depends on the "true" facts as they are determined in the underlying action), the duty to defend arises from the facts as *alleged* in the complaint. *See Trustees of Tufts Univ. v. Commercial Union Ins. Co.*, 415 Mass. 844, 847, 616 N.E.2d 68, 71 (1993); *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. 677, 681, 195 N.E.2d 514, 516–17 (1964). The process for determining the defense duty—often spoken of as a "comparison test"—is one of "envisaging what kinds of losses may be proved as lying within the range of the allegations of the complaint, and then seeing whether any such loss fits the expectation of protective insurance reasonably generated by the terms of the policy." *Continental Cas. Co. v. Gilbane Bldg. Co.*, 391 Mass. 143, 147, 461 N.E.2d 209, 212 (1984) (quoting *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. 316, 318, 458 N.E.2d 338, 341 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984)). Once the

defense obligation arises, it ordinarily continues until the suit is resolved—notwithstanding that the facts proved at trial ultimately may show the liability to be outside the scope of coverage. *See Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 681–82, 195 N.E.2d at 516–17.

The classic formulation of the "comparison test," as articulated in *Sterilite Corp. v. Continental Casualty Co.*, 17 Mass.App.Ct. 316, 458 N.E.2d 338 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984), is as follows:

> [T]he question of the initial duty of a liability insurer to defend third-party actions against the insured is decided by matching the third-party complaint with the policy provisions: if the allegations of the complaint are "reasonably susceptible" of an interpretation that they state *or adumbrate* a claim covered by the policy terms, the insurer must undertake the defense.

Sterilite Corp. v. Continental Cas. Co., 17 Mass.App.Ct. at 318, 458 N.E.2d at 340 (emphasis added). *Webster's Third New International Dictionary* defines "adumbrate" to mean "to give a sketchy representation of; outline broadly, omitting details… or to suggest, indicate, or disclose partially and with a purposeful avoidance of precision." *See Open Software Found., Inc. v. United States Fid. & Guar. Co.*, 307 F.3d 11, 15 n.4 (1st Cir. 2002) (relying on *Webster's* definition in applying *Sterilite* test). In accord with this definition, the *Sterilite* court held as follows:

> "In order for the duty of defense to arise, the underlying complaint need only show, through general allegations, a possibility that the liability claim falls within the insurance coverage. There is no requirement that the facts alleged in the complaint specifically and unequivocally make out a claim within the coverage."

Sterilite Corp. v. Continental Cas. Co., 17 Mass.App.Ct. at 319–20, 458 N.E.2d at 341–42 (quoting *Union Mut. Fire Ins. Co. v. Topsham*, 441 A.2d 1012, 1015 (Me. 1982)). Thus, the insurer is *free* of the duty to defend only where "the allegations lie expressly outside the coverage and its purpose." *Terrio v. McDonough*, 16 Mass.App. Ct. 163, 168–69, 450 N.E.2d 190, 194 (1983).

The sources discussed seem to support the proposition that, where the complaint is *silent* on a matter that may determine the applicability of coverage, the defense obligation attaches. Having in mind the "plasticity" of notice pleading, such a rule tends to result in insurer defense obligations for many claims that will ultimately fall within

a policy exclusion. For this reason, insurers have been reluctant to fully embrace *Sterilite*'s articulation of the scope of the duty to defend. In advocating a somewhat less generous measure, insurers have contended, for example, that a complaint otherwise falling within a policy exclusion that contains an exception must affirmatively allege facts falling within the exception for a defense obligation to attach. Some of the phrasing of the Supreme Judicial Court's decision in *Liberty Mutual Insurance Co. v. SCA Services, Inc.*, 412 Mass. 330, 588 N.E.2d 1346 (1992), discussed below, seems to support such a view.

In *Liberty Mutual Insurance Co. v. SCA Services, Inc.*, the waste disposal firm SCA sought a defense in connection with a lawsuit against it seeking cleanup of a landfill to which it had transported industrial and chemical wastes for disposal. The firm's insurers disclaimed any duty to defend, relying on a pollution exclusion containing an exception granting coverage where the release of pollutants was "sudden and accidental." *Liberty Mut. Ins. Co. v. SCA Servs., Inc.*, 412 Mass. 330, 331–35, 588 N.E.2d 1346, 1347–49 (1992). In opposing a motion for summary judgment filed by its insurers, SCA, citing *Sterilite*, contended that the insurers had failed to show there was "no possibility that '[a]t least one claim against [it] may involve a 'sudden and accidental' discharge.'" *Liberty Mut. Ins. Co. v. SCA Servs., Inc.*, 412 Mass. at 337, 588 N.E.2d at 1350 (quoting *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. 316, 318–19, 458 N.E.2d 338, 340–41 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984)). The Supreme Judicial Court rejected this contention, stating, inter alia, that "[i]f the underlying complaint does not allege a 'sudden and accidental' discharge, the resulting damage is eliminated from coverage by the exclusion clause, even though the discharge might qualify as a [covered] 'occurrence' within the policy terms." *Liberty Mut. Ins. Co. v. SCA Servs., Inc.*, 412 Mass. at 335, 588 N.E.2d at 1349. Relying on this phrasing, insurers have contended that a complaint (or agency "notice of responsibility") silent as to the nature of pollutant releases—i.e., that does not specifically allege a "sudden and accidental" release—does not give rise to a duty to defend. *See, e.g.*, *Atlantic Mut. Liab. Ins. Co. v. Beatrice Cos.*, 924 F.Supp. 861 (N.D.Ill. 1996).

It appears, however, that the Supreme Judicial Court did not intend by this one sentence to change long-standing rules for determining the duty to defend. The *SCA Services* decision can be readily harmonized with the *Sterilite* "comparison test" in light of the extraordinarily specific allegations of the underlying complaint against SCA. After examining those allegations at some length, the Court concluded that "[t]he only reasonable reading of the complaint is… that the pollution of the landfill occurred gradually over several months of repeated activity and not as the result of a 'sudden

and accidental' discharge." *Liberty Mut. Ins. Co. v. SCA Servs., Inc.*, 412 Mass. 330, 336, 588 N.E.2d 1346, 1350 (1992). In other words, the Court found not merely that there was no specific allegation of a "sudden and accidental" discharge, but that the allegations were antithetical to proof of such an event. *See Landauer v. Liberty Mut. Ins. Co.*, 36 Mass.App.Ct. 177, 181–82 & n.12, 628 N.E.2d 1300, 1302–03 & n.12 (1994) (complaints asserting pollution of landfill "as a concomitant part of a regular business activity" did not allege facts reasonably susceptible of falling within exception to exclusion); *cf. Arrow Auto. Indus. v. Liberty Mut. Ins. Co.*, 8 Mass.L.Rptr. 225 (Middlesex Super.Ct. Jan. 29, 1998) (Department of Environmental Protection ("DEP") notice of responsibility under G.L. c. 21E invoked the defense duty where it did not "preclude the possibility that the releases were 'sudden and accidental.'").

The possible encroachment of the *SCA Services* opinion on the "comparison test" was at least circumscribed by the Supreme Judicial Court's decision in *Simplex Technologies v. Liberty Mutual Insurance Co.*, 429 Mass. 196, 706 N.E.2d 1135 (1999). In *Simplex*, the policyholder was confronted with asbestos products liability claims alleging, in general terms, that the claimants were injured due to exposure to Simplex products. The policies in issue contained a product hazard exclusion applicable to all Simplex divisions except the "Hitemp" division. *Simplex Technologies v. Liberty Mut. Ins. Co.*, 429 Mass. at 196–99, 706 N.E.2d at 1135–37. The claimants' complaints were silent, however, as to whether the products were manufactured by Hitemp or by one or more of Simplex's other divisions. *Simplex Technologies v. Liberty Mut. Ins. Co.*, 429 Mass. at 199, 706 N.E.2d at 1137. The Court held that Simplex was entitled to a defense despite the possibility that Hitemp products were not involved, explaining that "'the insurer's duty to defend its insured arises whenever the allegations in a complaint state a cause of action that gives rise to the possibility of recovery under the policy; there need not be a probability of recovery.'"

"It appears, however, that the Supreme Judicial Court did not intend by this one sentence to change long-standing rules for determining the duty to defend."

Simplex Technologies v. Liberty Mut. Ins. Co., 429 Mass. at 199, 706 N.E.2d at 1137 (quoting 7C John A. Appleman, *Insurance Law and Practice* § 4863.01, at 67 (West rev. ed. 1979)). The Court "decline[d] to alter this well-settled standard." *Simplex Technologies v. Liberty Mut. Ins. Co.*, 429 Mass. at 199, 706 N.E.2d at 1137.

Relying on *Highlands Insurance Co. v. Aerovox, Inc.*, 424 Mass. 226, 676 N.E.2d 801 (1997), and *SCA Services*, the insurer argued that Simplex had failed to sustain a burden "to prove that the underlying complaints pertain to Hitemp products." *Simplex Technologies v. Liberty Mut. Ins. Co.*, 429 Mass. 196, 200, 706 N.E.2d 1135, 1137 (1999). The Court held that Simplex had no such burden, noting that *Highlands* involved the duty to *indemnify* and that the *Highlands* Court allocated the burden to prove the applicability of the "sudden and accidental" exception to the policyholder for deterrent purposes not applicable to Simplex. *Simplex Technologies, Inc. v. Liberty Mut. Ins. Co.*, 429 Mass. at 200, 706 N.E.2d at 1137–38. The Court saw "no reason for placing on Simplex the burden of proving that the underlying plaintiffs allege… injuries arising from exposure to Hitemp products." *Simplex Technologies, Inc. v. Liberty Mut. Ins. Co.*, 429 Mass. at 200, 706 N.E.2d at 1138.

It is, at best, unclear whether the *Simplex* Court viewed *SCA Services* (like *Highlands*) as imposing a special burden on the policyholder in the pollution exclusion context. It did not describe *SCA Services* as requiring a policyholder, faced with a *neutral* complaint (i.e., one that describes events such that the exception to the exclusion may, or may not, apply), to unearth allegations of a sudden accident in order to invoke the defense duty. Rather, it stated only that, in *SCA Services*, "we held that the allegations of the underlying complaint did not allege a 'sudden and accidental' event covered by the policy." *Simplex Technologies v. Liberty Mut. Ins. Co.*, 429 Mass. 196, 200 n.4, 706 N.E.2d 1135, 1138 n.4 (1999). As has been discussed, this holding of *SCA Services* was based on a conclusion that the underlying complaint alleged *the contrary*. *See Liberty Mut. Ins. Co. v. SCA Servs., Inc.*, 412 Mass. 330, 336, 588 N.E.2d 1346, 1350 (1992). Particularly given the *Simplex* Court's clear endorsement of a defense duty arising based on the *possibility* of recovery under the policy, one might have expected a quite specific description of an "*SCA Services* exception" to the "possibility" standard if the *Simplex* Court had viewed that case as making such an exception.

The First Circuit's reasoning in *Barrett Paving Materials v. Continental Insurance Co.*, 488 F.3d 59 (1st Cir. 2007) supports this conclusion. On the basis of the same "possibility" standard employed in Massachusetts, the First Circuit held under Maine law that where "the complaint does not specify how the pollutants may have been released" there is a duty to defend so long as the allegations "are not entirely inconsistent with a sudden and accidental discharge." *Barrett Paving Materials v.*

Continental Insurance Co., 488 F.3d at 64. In reaching this conclusion, the First Circuit distinguished *A. Johnson & Co. v. Aetna Casualty & Surety Co.*, 9 F.2d 66 (1st Cir. 1991), in which, just as in *SCA Services*, there was no duty to defend because the allegations were entirely inconsistent with a sudden and accidental discharge.

Even if there remains any uncertainty on this point under Massachusetts law, however, what *is* clear after *Simplex* is that, any special exceptions aside, the "comparison test" remains the basic yardstick for the defense duty in Massachusetts. In certain cases, however, the "comparison test" may not be the end of the inquiry. What if information omitted from the complaint, yet available to insurer or insured, tends to contradict the outcome of the comparison test? The result depends on whether the information is coverage-affirming or coverage-defeating. As to the former scenario, even if the defense duty is not apparent on the face of the complaint, it attaches nevertheless if additional facts "known or readily knowable by the insurer" indicate that the claim is covered. *Desrosiers v. Royal Ins. Co. of Am.*, 393 Mass. 37, 40, 468 N.E.2d 625, 628 (1984). Accordingly, the *potential* for coverage—and thus the defense duty—*can* be established by facts omitted from the complaint. *See also Boston Symphony Orchestra v. Commercial Union Ins. Co.*, 406 Mass. 7, 10–11, 545 N.E.2d 1156, 1158 (1989) (insurer required to defend under liability policy covering defamation where complaint alleged only breach of contract, but additional facts known to insurer indicated allegations of harm to reputation). *But see Transamerica Ins. Co. v. KMS Patriots, L.P.*, 52 Mass.App.Ct. 189, 194–95 (2001) (insurer not required to defend absent evidence in record to demonstrate insurer was aware—and not merely in a position to learn—of interrogatory answer triggering coverage).

On the other hand, unless the potential for coverage is eliminated, the insurer ordinarily *cannot* rely on information from sources outside of the complaint to *avoid* its defense duty. As put by the *Sterilite* court:

> As to whether even solid information reaching the insurer from the insured, and indicating that claimed losses were in fact uninsured, could itself relieve the insurer of its duty to defend, [the decision in *Lee v. Aetna Casualty & Surety Co.*, 178 F.2d 750 (2d Cir. 1949)] says: "this language [requiring the insurer to defend even a baseless claim] means that the insurer will defend the suit, if the injured party states a claim, which, qua claim, is for an injury 'covered' by the policy; it is the claim which determines the insurer's duty to defend; and it is irrelevant that the insurer may get information from the insured, or anyone else, which indicates, or even demonstrates, that the injury is not in fact 'covered.'"

Sterilite Corp. v. Continental Cas. Co., 17 Mass.App.Ct. 316, 324 n.17, 458 N.E.2d 338, 344 n.17 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984) (quoting *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750, 751 (2d Cir. 1949)). Can the insurer take action itself to eliminate the potential that the third party's claim will fall within the coverage? Massachusetts law answers this question affirmatively only in limited circumstances, which are discussed in § 1.2.1(c) below.

(b) Insurer Obligation of "Reasonable Performance"

The Supreme Judicial Court has made clear that, in undertaking a duty to defend, an insurer impliedly assumes a duty of "reasonable performance" of that obligation. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. 387, 396 (2003). In the court's words, an insurer, "by undertaking the defense of its insured as mandated by contract, engage[s] in affirmative action, and that action expose[s] its insured's legally protected interests to the risk of harm. The insurer's action, therefore, [gives] rise to a duty of reasonable performance, the violation of which [is] tortious." *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 396.

In *Sullivan*, an insurer had terminated its defense of the underlying action after the complaint was amended to bring the claim outside the coverage of the policy. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 395. The court held that the termination was justified. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 395. The policyholder nevertheless pressed a breach-of-contract claim, asserting that the defense provided by the insurer *before* the amendment was deficient, and prejudicial to the insured. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 395. The court agreed that the insurer owed the policyholder a duty to conform to a standard of "reasonable performance" in the conduct of the defense, but stated that this duty sounded in tort and was separate from its contractual duty to defend. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 396–97. It held that the insurer discharged its contractual duty by hiring defense counsel, and that any claim that the insurer breached its related duty of reasonable performance was "a claim for tortious conduct, specifically negligence." *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 397. The court therefore affirmed a grant of summary judgment for the insurer on the policyholder's contract action. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 397. One practical effect of this ruling was that the damages award that the policyholder *did* secure was found subject to reduction (by 42 percent) for the policyholder's comparative negligence. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 410.

The *Sullivan* court also had occasion to discuss the nature of the insurer's duty of reasonable performance of the defense and the requisites of proof of a breach of that duty. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 402–06. It explained that, ordinarily, the standard of reasonable conduct of the defense is not a matter within the common knowledge of the lay person where that standard is not specifically set forth in the contract. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 402–03. Because the standard of care is analogous to that owed by professionals to their clients, the general rule is that expert testimony is needed to establish the insurer's negligence. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 403. Only where negligence is so gross or obvious that jurors can rely on their common knowledge to recognize or infer negligence may the case be made without expert testimony. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 403. In *Sullivan*, the court held that opinion testimony given by the insured's own claim examiners constituted admissions as to the duty of care owed by an insurance company to its insured. Such admissions, the court found, were the functional equivalent of expert testimony from which a jury could infer the elements of negligence and causation. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 403.

The damages allegedly suffered by the policyholder in *Sullivan* flowed, in large part, *not* from the supervisory activity of the insurer's personnel, but from alleged negligence on the part of the attorney appointed by the insurer. An issue therefore arose with respect to whether the insurer should be held to be vicariously liable for any negligence of appointed counsel. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 406. The *Sullivan* court answered this question in the negative, equating the attorney hired by the insurer to an independent contractor, rather than an agent of the insurer. Since an insurer is not permitted to practice law, it must rely on outside counsel for conduct of litigation. A lawyer hired by an insurer to represent an insured owes an unqualified duty of loyalty to the insured and must act at all times to protect the insured's interests. It is the lawyer who controls the strategy, conduct,

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and daily details of the defense. Since the conduct of the litigation is the responsibility of and controlled by counsel, the insurer ordinarily is not vicariously liable for the negligence of the attorney who conducts the defense for the insured. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 408–09. The *Sullivan* court found this general rule to be applicable in the case before it and therefore limited the policyholder's damages to those traceable to its claims handlers' negligent supervision of appointed counsel. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 412.

The general rule that an insurer has no vicarious liability for negligent activity of its appointed counsel will yield where the insurer directs, commands, or knowingly authorizes acts or omissions of the attorney, i.e., where the insurer so controls the attorney that it is inaccurate to characterize the attorney as an independent contractor. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 409 (citing *Trau-Med of Am., Inc. v. Allstate Ins. Co.*, 71 S.W.3d 691, 697 (Tenn. 2002)). The *Sullivan* court expressly rested its holding in the case before it on testimony by the appointed attorney that the insurer did nothing to interfere with his ability to provide a complete defense to the policyholder in the underlying action. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. at 410.

(c) Termination of the Defense Obligation

If the allegations of the third-party complaint "find apparent lodgment in the effective coverage of the policy" or facts omitted from the complaint indicate that the claim may be covered, then, absent a conspiracy to defraud the insurer, it is obligated to defend. *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. 316, 323, 458 N.E.2d 338, 343 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984). *But see Espinal v. Liberty Mut. Ins. Co.*, 47 Mass.App.Ct. 593, 598–99, 714 N.E.2d 844, 847–48 (1999) (where auto insurer believed claimant and insured had conspired to defraud insurer as to whether accident even occurred, insurer could disclaim defense duty and file declaratory action against insured and claimant seeking to establish fraud). As noted, the insurer cannot be relieved of this duty "by dint of its own assertion that there is no coverage in fact," *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. at 324, 458 N.E.2d at 344, but it "can, by certain steps, get clear of the duty *from and after* the time when it demonstrates with conclusive effect on the third party that as a matter of fact—as distinguished from the appearances of the complaint and policy—the third party cannot establish a claim within the insurance." *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. at 323, 458 N.E.2d at 343 (emphasis added). In other words, the insurer can *terminate* a defense obligation by confining the *claimant's* case to one not falling within the coverage of the policy. Until this is accomplished, however, the insurer's "initial" duty to defend must be honored.

The *Sterilite* court described "steps" an insurer might take to terminate its obligation, including "[a] declaratory action, in which the necessary interests are represented"—i.e., in which the claimant has been joined. *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. 316, 323, 458 N.E.2d 338, 344 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984). The court offered that the insurer may also "make the demonstration when brought into the third-party action upon impleader by the insured." *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. at 323, 458 N.E.2d at 343. For a variety of practical reasons, "steps" such as these are not always attractive to insurers. For example, an insurer may be reluctant to litigate directly with the claimant out of concern that doing so may cast a spotlight on the availability of insurance to satisfy a judgment. The insurer's participation also may cause the claimant to attempt to "spin" its case so as to maximize the likelihood that the policy will be found to apply. For this reason, insurers have often sought to litigate the defense question in an action solely with the insured. The potential efficacy of such an action was discussed by the Supreme Judicial Court in *Lumbermens Mutual Casualty Co. v. Belleville Industries*, 407 Mass. 675, 555 N.E.2d 568 (1990). The *Belleville* Court first endorsed generally the *Sterilite* reasoning, observing:

> The need to have the underlying claimant bound by any judicial declaration concerning the insurer's duty to defend…exists because, until there is an unalterable determination as to the nature of the underlying claim, any declaration of rights concerning the insurer's duty to defend cannot be conclusive.

Lumbermens Mut. Cas. Co. v. Belleville Indus., 407 Mass. at 686, 555 N.E.2d at 575.

The Court then went on, however, to suggest two situations in which a declaratory action *not* involving the claimant might terminate an insurer's duty to defend. Such an action, it noted, may suffice where the dispute is concerned exclusively with "the meaning of language in an insurance policy." *Lumbermens Mut. Cas. Co. v. Belleville Indus.*, 407 Mass. 675, 685, 555 N.E.2d 568, 575 (1990); *see also Dorchester Mut. Fire Ins. Co. v. First Costas Corp.*, 49 Mass.App.Ct. 651, 653, 731 N.E.2d 569, 571 (2000). The court added:

> We do not discount the possibility of an action solely between an insurer and an insured concerning the insurer's duty to defend, where the complaint in the underlying action is so general as to allege a claim arguably falling within the coverage of the policy, but *it is apparent from the event that gave rise to the underlying claim* that the loss is not covered by the insurance policy.

Lumbermens Mut. Cas. Co. v. Belleville Indus., 407 Mass. at 686, 555 N.E.2d at 575 (emphasis added) (citing *Atlantic Mut. Fire Ins. Co. v. Cook*, 619 F.2d 553 (5th Cir. 1980) (Alabama law)). Thus, *Belleville* described "the possibility" of an exception to the requirement of binding the claimant where the absence of coverage is "apparent from the event that gave rise to the underlying claim." *Lumbermens Mut. Cas. Co. v. Belleville Indus.*, 407 Mass. at 686, 555 N.E.2d at 575.

The scope of the *Belleville* endorsement of insurer/insured–only actions on the defense question has yet to be fully revealed. It is instructive, however, to examine the single decision cited by the Supreme Judicial Court as illustrating the situation in which the absence of coverage is "apparent from the event," the *Cook* case. In *Cook*, the mother of a deceased child sued her own mother—the child's grandmother—alleging that the grandmother entrusted the child to a drunkard, resulting in the child's death. *Atlantic Mut. Fire Ins. Co. v. Cook*, 619 F.2d 553 (5th Cir. 1980) (Alabama law). The complaint omitted the undisputed fact that the child was killed in a collision of an automobile driven by the drunkard. *Atlantic Mut. Fire Ins. Co. v. Cook*, 619 F.2d at 554. The grandmother sought coverage under her *homeowner's* policy, not her automobile policy, and the carrier disclaimed based on a motor vehicle use exclusion—i.e., an exclusion stating that the policy did not include automobile liability coverage. *Atlantic Mut. Fire Ins. Co. v. Cook*, 619 F.2d at 554. In a declaratory action by the homeowner's carrier, the Fifth Circuit held that "the insurer is not barred by the silence of the [tort action] complaint from establishing, by proof of the complaint-omitted but uncontroverted facts, that it had no duty to defend the tort suit." *Atlantic Mut. Fire Ins. Co. v. Cook*, 619 F.2d at 555; *see also Farm Family Mut. Ins. Co. v. Whelpley*, 54 Mass.App.Ct. 743, 747 (2002) (requirement of binding claimant inapplicable where extrinsic undisputed fact not to be litigated at the trial of the underlying action takes the case outside the coverage).

An insurer/insured–only action will *not* be an appropriate vehicle to terminate the defense duty when the insurer's coverage defense hinges on factual issues related to the issues in the underlying tort action. *See Atlantic Mut. Fire Ins. Co. v. Cook*, 617 F.2d 553, 555 (5th Cir. 1980) (citing *Smith v. North River Ins. Co.*, 360 So.2d 313 (Ala. 1978)). This is true for two reasons.

The first reason is that, because the underlying claimant would not be bound by the facts found in an insurer/insured–only action, the coverage determination would not be conclusive; it could only "relieve the insurer of a current duty to defend based on then-current circumstances." *Lumbermens Mut. Cas. Co. v. Belleville Indus.*, 407 Mass. 675, 686, 555 N.E.2d 568, 575 (1990). Cases following the *Cook* pattern are appropriate for declaratory relief precisely because the indisputable character

of the event renders the likelihood of relitigation remote, thus satisfying the teaching of the Declaratory Judgments Act that declaratory relief should be rendered only where the judgment will "terminate the uncertainty or controversy giving rise to the proceedings." G.L. c. 231A, § 3. Where the coverage issues are intertwined with facts to be determined in the underlying case, however, the coverage action becomes an uncertain exercise in predicting what facts will be proved in the underlying action, and the rendering of declaratory relief becomes inappropriate.

A second reason why a court may decline to reach coverage issues related to those of the underlying case is the potential for prejudice to the insured's defense. The leading case recognizing this problem is the decision of the Supreme Court of California in *Montrose Chemical Corp. v. Superior Court*, 861 P.2d 1153 (Cal. 1993). In *Montrose*, the insured brought an action for declaratory relief when its carriers failed to defend it against claims under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA, codified at 42 U.S.C. § 9601 et seq.), alleging environmental contamination due to the company's manufacturing of the insecticide DDT. Addressing the duty to defend, the court held that by showing a potential that the CERCLA claims would be covered, Montrose had established its entitlement to a defense, and that the insurers, having failed to foreclose the potential for coverage by undisputed facts, were not in a position to terminate their defense duty. *Montrose Chem. Corp. v. Superior Court*, 861 P.2d at 1163–64.

As to appropriate management of the declaratory and underlying cases, the court commented:

> To eliminate the risk of inconsistent factual determinations that could prejudice the insured, a stay of the declaratory relief action pending resolution of the third party suit is appropriate when the coverage question turns on facts to be litigated in the underlying action. For example, when the third party seeks damages on account of the insured's negligence, and the insurer seeks to avoid providing a defense by arguing that its insured harmed the third party by intentional conduct, the potential that the insurer's proof will prejudice its insured in the underlying litigation is obvious. This is the classic situation in which the declaratory relief action should be stayed. By contrast, when the coverage question is logically unrelated to the issues of consequence in the underlying case, the declaratory relief action may properly proceed to judgment. . . .

Montrose Chem. Corp. v. Superior Court, 861 P.2d at 1162 (citations omitted). Although the Massachusetts appellate courts have yet to confront this issue, at least three Superior Court judges have stayed coverage cases due to potential prejudice to the insured's defense of the underlying claim. *See Eastern Enters. v. Hanover Ins.* Co., No. 93-01458 (Middlesex Super.Ct. Aug. 30, 1994); *Commercial Union Ins. Co. v. RohmTech, Inc.*, No. 94-2231 (Middlesex Super.Ct. June 16, 1995); *American Policyholders Ins. Co. v. Nyacol Products, Inc.*, 4 Mass.L.Rptr. 10 (Middlesex. Super. Ct. Jan. 31, 1996). Copies of the orders issued in these three cases are reproduced as **Exhibits A**, **B** and **C**.

To recapitulate, the "initial" duty to defend under a liability policy is necessarily based on allegations, rather than facts. If the allegations of the complaint or additional information available to the insurer indicate a *potential* that the insurer ultimately will be required to indemnify the policyholder, then, absent fraud, the duty to defend attaches, notwithstanding the insurer's belief that the claim, as ultimately proved, will fall outside the coverage. Under certain circumstances, an insurer may be able to terminate its defense duty *prospectively* by means of a declaratory action or otherwise, but it is recognized that in many cases, such a determination "may not come until the third-party action is fully tried, and in that case the duty to defend continues to the end, even if the result of the action is favorable to the insured and there is no judgment against the insured that the insurer needs to make good." *Sterilite Corp. v. Continental Cas. Co.*, 17 Mass.App.Ct. 316, 323 n.15, 458 N.E.2d 338, 344 n.15 (1983), *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984).

(d) The Duty to Defend and the "Mixed Claim"

The insurer under a CGL policy must defend if the complaint shows a possibility that the claim, as ultimately proven, will fall within the scope of the policy's coverage. Frequently, however, a complaint will assert multiple claims or at least will be pleaded in multiple counts, some of which are within and some clearly outside the scope of coverage. Must the insurer defend the entire action? May the insurer confine its defense efforts to the covered counts of the complaint? The Supreme Judicial Court has not yet spoken definitively on the issue. *But see Aetna Cas. & Sur. Co. v. Continental Cas. Co.*, 413 Mass. 730, 732 n.1, 604 N.E.2d 30, 32 n.1 (1992) (observing in a footnote that "the weight of authority places the duty to defend all counts on an insurer which has the duty to defend at least one count of a complaint"). Both the Appeals Court and the First Circuit, however, have predicted that Massachusetts will embrace the majority position, which requires the insurer to defend an entire "mixed claim." *See Palermo v. Fireman's Fund Ins. Co.*, 42 Mass. App.Ct. 283, 289–90, 676 N.E.2d 1158, 1163–64 (1997) (insurer, whose defense

duty was triggered by negligence count, could not properly refuse to defend counts alleging nuisance and breach of restrictive deed covenants); *Mt. Airy Ins. Co. v. Greenbaum*, 127 F.3d 15, 19 (1st Cir. 1997) ("under Massachusetts law, if an insurer has a duty to defend one count of a complaint, it must defend them all"). If an insurer does defend an entire action, including noncovered counts, might it then be entitled to recoup any of its costs from the insured? The cases just cited provide little reason to suspect that such a right exists, and until 1997 there was scant support for such a right in the case law of other jurisdictions. The landscape changed, however, with the decision of the Supreme Court of California in *Buss v. Superior Court*, 939 P.2d 766 (1997). In *Buss*, a primary liability carrier, having

"…under Massachusetts law, if an insurer has a duty to defend one count of a complaint, it must defend them all."

defended an entire action against its insured, sought restitution of defense costs it had paid that were attributable to the 26 counts of a 27 count complaint that were *not* covered by its policies. *See Buss v. Superior Court*, 939 P.2d at 770. In a ruling that has proved controversial, the court, while affirming a primary carrier's duty to defend an entire "mixed action," nevertheless held that the insurer did have a quasi-contractual right to secure reimbursement for costs incurred in defending noncovered counts. *See Buss v. Superior Court*, 939 P.2d at 776.

It is far from clear that the *Buss* restitution concept will find favor in the Massachusetts courts. In *Metallized Products, Inc. v. Travelers Insurance Co.*, No. MICV-2002-03452, 2003 Mass.Super. LEXIS 279, at *17 (Middlesex Super.Ct. Sept. 17, 2003), the insured brought a declaratory judgment action against its insurer seeking a determination that it was liable for the insured's costs in defending and settling an underlying case. In holding that the insurer had a duty to defend, the court explained that the insured need prove only that the insurer owed the duty to defend on any claim or part of any claim or "a possibility that the liability claim falls within an insurance coverage." If that is shown, the insurer owes a duty to defend the entire action (covered and uncovered claims). *Metallized Prods., Inc. v. Travelers Ins. Co.*, 2003 Mass.Super. LEXIS 279, at *17. The court went on to order the insurer to pay the insured all of the costs of the defense in the underlying case despite the fact that only some of claims in the underlying case were potentially covered. *Metallized Prods., Inc. v. Travelers Ins. Co.*, 2003 Mass.Super. LEXIS 279, at *17–18.

Practice Note
The *Metallized Products* award of damages (in the full amount of defense costs) at least suggests that Massachusetts courts have *assumed* that the rule requiring a defense of the entire action imports a requirement that the insurer bear all defense costs.

Massachusetts authorities addressing "allocation" in the context of claims arising from injuries spanning multiple policy periods show that the courts do not readily infer that the *extent* of coverage provided by an insurance policy necessarily is limited to that which *triggers* the coverage. *See Rubenstein v. Royal Ins. Co. of Am.*, 44 Mass. App.Ct. 842, 849–50 (1998); *see also Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's*, 59 Mass.App.Ct. 646, 653–61 (2003) (determining that policy language obligated insurer to reimburse policyholder in full for defense and settlement costs incurred responding to claims arising from roughly fifty years of environmental contamination despite the fact that the policies were in effect for only nine of the fifty years).

Practice Note
Cases such as *Rubenstein* and *Chicago Bridge & Iron* further suggest that Massachusetts courts may reject the reasoning of *Buss* and—absent compelling differences in policy language—may not be receptive to insurer requests for apportionment in the "mixed" claims context.

Indeed, it remains to be seen whether a restitution right, even if recognized by the courts, would be of practical value to insurers. The *Buss* court held that an insurer is entitled to reimbursement only of defense costs "that can be allocated *solely* to the claims that are not even potentially covered." *Buss v. Superior Court*, 939 P.2d at 778 (emphasis added). As to why the insurer's recovery should be so limited, the court explained:

> It is as to defense costs that can be allocated solely to the claims that are not even potentially covered that the insurer has not been paid premiums by the insured. By contrast, the insurer has in fact been paid as to costs that can be allocated solely to the claims that are at least potentially covered. So too as to costs that can be allocated jointly to the claims that are at least potentially covered and to those that are not—by definition, these costs are fully attributable to the former as well as the latter.

Buss v. Superior Court, 939 P.2d at 778 (footnote omitted). The court emphasized that "[d]efense costs which were required in any event or would have been incurred in order to defend actually or potentially covered claims, whether or not joined with noncovered claims, cannot be recovered." *Buss v. Superior Court*, 939 P.2d at 778 n.15. Accordingly, even in a jurisdiction that adopts *Buss*, if the various counts of a complaint all arise from a common fact pattern, it is unlikely that the defense benefit will be sharply curtailed by insurer reimbursement rights.

(e) Control of the Defense

The insuring agreement quoted earlier confers on the insurer not only the duty, but also the *right*, to conduct the policyholder's defense. This can be a valuable right, in that it reserves to the insurer the functions of selecting and supervising counsel, meaning that the insurer "controls" the conduct of the defense. Often, however, an insurer's reservation of a right to disclaim coverage will place the insurer's own interests in conflict with the interests of the insured, making it inappropriate for the insurer to insist on retaining control of the defense. The classic example is that of a third-party complaint alleging that the claimant was injured as a result of the policyholder's negligence or, in the alternative, by his or her commission of an intentional tort. Because liability policies exclude coverage for injuries the policyholder intended to inflict, it will be in the insurer's financial interest for the claimant to prove the intentional tort (which may not invoke the insurer's duty to indemnify), rather than negligence (which ordinarily will lead to an indemnification obligation). In such circumstances, the policyholder will be understandably reluctant to cede control of the defense to the insurer. Can the policyholder insist on retaining control and also retain the financial benefit of the insurer's defense obligation?

Well-established Massachusetts case law answers this question in the affirmative: where the insurer has a conflict of interest due to a reservation of a right to disclaim coverage, the insured will be permitted to select counsel independent of the insurer and control the defense, and the insurer will be obliged to pay the reasonable costs of that defense. The seminal decision is *Magoun v. Liberty Mutual Insurance Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964). In *Magoun*, the policyholder was sued for alleged negligence in connection with a fatal construction accident. The insurer reserved the right to disclaim coverage based on a policy "loading exclusion" but offered to defend subject to that exclusion. The policyholder declined the insurer's offer, hired independent counsel and defended the case successfully. The policyholder then sued the insurer to recover the fees charged by independent counsel. *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 678–80, 195 N.E.2d at 515–16.

The *Magoun* Court held that Liberty's "initial liability to defend" was established by the complaint, because it "was not sufficiently specific, at least in failing to mention that loading a truck was involved, to show that the case was within the loading exclusion." *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 681, 195 N.E.2d at 517. As for whether the insured was entitled to reimbursement of its defense expenses despite its refusal of the insurer's offer to defend, the Court observed that an "insurer's discretion under the covenant to defend is not unlimited." *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 684, 195 N.E.2d at 518. Reasoning that the insurer could have addressed the conflict situation in the policy but did not, the Supreme Judicial Court held that the policyholder was entitled to reimbursement. *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 685, 195 N.E.2d at 519.

"…the insurer could have addressed the conflict situation in the policy but did not, the Supreme Judicial Court held that the policyholder was entitled to reimbursement."

The *Magoun* Court emphasized that the insurer acquiesced in the defense of the insured by independent counsel. *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. 677, 685, 195 N.E.2d 514, 519 (1964). It is doubtful, however, that the Court intended to suggest that the insurer is free to object—while still maintaining its reservation—and thereby avoid coverage. It is more likely that the Court had in mind that the insurer might be entitled to continue to control the defense if, but only if, it was prepared to waive its reservation. Although it was not necessary for the Court to reach the question due to the successful defense, it pointed to case law from other jurisdictions holding that an insurer that purports to insist "both on retaining control and upon its reservation of rights" will be estopped from denying liability for any recovery by the claimant. *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 683 & n.5, 195 N.E.2d at 518 & n.5. Thus, at least where the sufficiency of policy limits is not in question, *Magoun* leaves open the possibility that an insurer may regain its right to defend by agreeing to drop an asserted reservation. *See Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. 387, 406–07 (2003) ("When an insurer seeks to defend its insured under a reservation of rights, and the insured is unwilling that the insurer do so, the insured may require the insurer either to relinquish its reservation of rights or relinquish its defense of the insured and reimburse the insured for its defense costs.") (citations omitted). Three concluding observations are in order.

- First, it is not necessarily the case under Massachusetts law that *any* reservation by the insurer will entitle the policyholder to retain independent counsel at the insurer's expense. The *Magoun* Court emphasized the existence of a conflict between insurer and insured with respect to the handling of the underlying claim. Courts in other jurisdictions have suggested that some reservations will not create a conflict. For example, in *Public Service Mutual Insurance Co. v. Goldfarb*, 425 N.E.2d 810 (N.Y. 1981), the New York Court of Appeals observed that independent counsel is necessary only where the "question of coverage is… intertwined with the question of the insured's liability." *Public Serv. Mut. Ins. Co. v. Goldfarb*, 425 N.E.2d at 815. If the basis for the reservation does not give rise to any insurer incentive to encourage establishment of liability on a noncovered ground, then independent counsel is not necessary. This argument remains open in Massachusetts.

- Second, the fact that the insured is entitled to control the defense does not mean that the insurer is entitled to no role whatever. In *Magoun*, the Supreme Judicial Court recognized that "[t]he insurer… reasonably may be reluctant to entrust its possible obligation to indemnify to counsel not of its own selection." *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. 677, 684, 195 N.E.2d 514, 519 (1964). The insured's duties of cooperation and of good faith and fair dealing still obtain and must be observed. *Cf. Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. at 685, 195 N.E.2d at 519 (emphasizing cooperation of insurer and insured in successful defense). Courts of other jurisdictions have held that these duties require the insured to retain competent counsel who will bill reasonably for his or her services. *See, e.g., CHI of Alaska, Inc. v. Employers Reinsurance Corp.*, 844 P.2d 1113 (Alaska 1993). Presumably, however, the policyholder will do just that in guarding its own best interests, particularly where the costs are incurred before a court has declared the insurer's duty to defend.

- Third, as suggested above, an insurer is responsible for paying only "reasonable" costs incurred in the defense of the insured. *See Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. 93, 97, 686 N.E.2d 989, 992 (1997); *see also Liberty Mut. Ins. Co. v. Continental Cas. Co.*, 771 F.2d 579, 582 (1st Cir. 1985) (assigning burden of proof as to reasonableness of costs to insured). The finder of fact is accorded "wide discretion" in determining whether the insured's costs were reasonable. *Rubenstein v. Royal Ins. Co. of Am.*, 44 Mass.App.Ct. 842, 850, 694 N.E.2d 381, 386–87 (1998). Despite this wide discretion, policyholders that elect to challenge an insurer's assessment of reasonableness may take some comfort in *Watts Water Techs., Inc. v. Fireman's Fund Ins. Co.*,

22 Mass. L. Rep. 659, *32 (Mass. Super. Ct. 2007), in which the Superior Court held that the reasonableness of fees should not be examined in light of the price the insurer would have paid had it assumed the defense without reservation, but rather by comparison to the rates charged by attorneys in the area to non-insurers for similar work.

(f) Defense Expenses and Policy Limits

As noted in the introduction to this section, § 1.2.1, the "Supplementary Payments" provision of the standard CGL policy indicates that costs of defense are in addition to indemnity amounts (i.e., they do not draw down the limits of liability of the policy). A distinct question is when the insurer is permitted to *stop* defending. The liability insuring agreement quoted earlier states that "the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements." Insurers have raised the question under this and similar language whether they can tender to the claimant or pay into court the full amount of their potential indemnity obligation (i.e., the amount of the applicable limit) and thereby escape from any further duty to defend. The answer in Massachusetts, as in the majority of jurisdictions, is "no": such a payment will not cut off the defense duty. Instead, the defense obligation ends only when the insurer has paid its liability limit to satisfy (in whole or in part) a judgment against the insured or a settlement with the claimant. *See Aetna Cas. & Sur. Co. v. Sullivan*, 33 Mass.App.Ct. 154, 597 N.E.2d 62 (1992) (construing automobile liability policy).

"…the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements."

In *Sullivan*, the court noted that, under this rule,

> in the case of multiple claims against the insured, good faith settlement with one claimant, or payment of all or part of a judgment favoring one claimant,… would have the effect of discharging the insurer from defending additional claims beyond the policy limits.… The insurer having exhausted the policy limits *and* provided a defense, the insured could not reasonably expect more.

Aetna Cas. & Sur. Co. v. Sullivan, 33 Mass.App.Ct. 154, 157–58, 597 N.E.2d 62, 64–65 (1992).

The court was concerned, however, that in the "tender" situation proposed by the insurer, "an insurer would be free, regardless of the merits of a… claim, to tender the coverage limits to the claimant and decline to defend further whenever the insurer anticipates that the cost of providing a defense would exceed the amount of coverage." *Aetna Cas. & Sur. Co. v. Sullivan*, 33 Mass.App.Ct. at 158, 597 N.E.2d at 65. The court rejected this approach, suggesting that if it were followed, the duty to defend would be "significantly nullified in a large number of cases." *Aetna Cas. & Sur. Co. v. Sullivan*, 33 Mass.App.Ct. at 158, 597 N.E.2d at 65. The *Sullivan* court's rationale applies with equal force to general liability policies. *See, e.g., Medical Prof'l Mut. Ins. Co. v. Newton-Wellesley Hosp.*, No. 984705C, 1999 Mass.Super. LEXIS 529, at *11–12 (Middlesex Super.Ct. Dec. 14, 1999) (under *Sullivan*, insurer's duty to defend under professional liability policy continues through conclusion of litigation). Thus, although the *Sullivan* rule has been abrogated as to automobile policies by amendment of the approved language of the standard automobile policy form, *see Thompson v. Arbella Mut. Ins. Co.*, 1999 Mass.Super. LEXIS 95, at *8 (Middlesex Super.Ct. Feb. 3, 1999), it would seem still to be valid for general liability policies.

Furthermore, an insurer's duty to defend generally encompasses an obligation to appeal from an adverse judgment against its insured, if reasonable grounds exist to believe that the insured's interest might be served by the appeal. *Davis v. Allstate Ins. Co.*, 434 Mass. 174, 180 (2001); *see also Medical Prof'l Mut. Ins. Co. v. Newton-Wellesley Hosp.*, 1999 Mass.Super. LEXIS 529, at *11–12 (insurer's duty to defend may involve the duty to fund an appeal if the policyholder has a reasonable likelihood of success on appeal). If an insurer appeals from an adverse judgment against its insured, it may be required to pay postjudgment interest under the supplemental payments provision of the policy. *Davis v. Allstate Ins. Co.*, 434 Mass. at 181.

(g) Consequences of Breach of the Duty to Defend

Where an insurer breaches a duty to defend a policyholder against a suit, the policyholder has a breach of contract claim against the insurer. In such an action, the policyholder is entitled to recover contract damages, i.e., "those that cannot be reasonably prevented and arise naturally from the breach, or which are reasonably contemplated by the parties." *Delano Growers' Coop. Winery v. Supreme Wine Co.*, 393 Mass. 666, 680, 473 N.E.2d 1066, 1075 (1985). The most obvious element of such damages is the reasonable sum incurred by the policyholder in providing for its own defense. The debate over the further consequences of the insurer's breach has focused on two questions: the effect of the breach on the indemnity obligation and the recoverability of attorney fees and expenses incurred by the policyholder in establishing the insurer's duty to defend.

Effect of Breach of Duty to Defend on Duty to Indemnify

In certain jurisdictions, an insurer that wrongly refuses to defend an insured and fails to seek a declaratory judgment as to coverage will be "estopped" from raising policy limitations or exclusions to avoid an indemnity obligation, regardless of the merit of its coverage defenses. *See, e.g., Clemmons v. Travelers Ins. Co.*, 430 N.E.2d 1104, 1109 (Ill. 1981). In *Camp Dresser & McKee, Inc. v. Home Insurance Co.*, 30 Mass. App.Ct. 318, 568 N.E.2d 318 (1991), the Appeals Court predicted that the Supreme Judicial Court would endorse a similar rule. *Camp Dresser & McKee, Inc. v. Home Ins. Co.*, 30 Mass.App.Ct. at 326, 968 N.E.2d at 636 (defense-breaching insurer "liable for the reasonable costs of both defense and settlement"). The "automatic indemnity" concept of *Camp Dresser* was repudiated, however, in the Supreme Judicial Court's decision in *Polaroid Corp. v. Travelers Indemnity Co.*, 414 Mass. 747, 610 N.E.2d 912 (1993).

Polaroid was another case involving CGL coverage for hazardous waste–related liability. After Polaroid Corporation ("Polaroid") tendered claims to its insurers for defense, the insurers simply refused to defend or indemnify, taking no further action. The trial court determined that the insurers were under a duty to defend based on the allegations of the government claimants but cut off the duty as of the date it allowed the insurers' motion for summary judgment based on the pollution exclusion. The trial court's judgment declared that the insurers had no further obligation to Polaroid. *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. 747, 749–50, 610 N.E.2d 912, 914–15 (1993). On appeal, Polaroid contended that the insurers, having breached their duty to defend, were automatically liable for the costs of its settlement with the government claimants, relying on *Camp Dresser*. The Supreme Judicial Court disagreed.

The *Polaroid* Court rejected any per se rule and "align[ed] [itself] with those authorities that treat an insurer's unjustified refusal to defend as a breach of contract and seek then to determine what is recoverable as contract damages." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. 747, 762, 610 N.E.2d 912, 921 (1993). The Court observed that, ordinarily, the failure to defend will not be the cause of any payment made in settlement or to satisfy a judgment, *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 762–63, 610 N.E.2d at 921–22, but allowed that "an obligation to pay settlement costs could result from a breach of the duty to defend." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 764, 610 N.E.2d at 922. To illustrate, the Court stated that "if an insured lacks financial resources sufficient to maintain a proper defense, an insured's losses in the underlying claim could well be the result of a breach of the duty to defend." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 764, 610 N.E.2d at 922.

Although unwilling to join the ranks of the "estoppel" courts, the *Polaroid* Court did fashion one very important nonmonetary sanction for the defense-breaching insurer. It joined the New York Court of Appeals in holding that "an insurer that wrongfully declines to defend a claim will have the burden of proving that the claim was not within its policy's coverage." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. 747, 764, 610 N.E.2d 912, 922 (1993) (citing *Servidone Constr. Corp. v. Security Ins. Co.*, 477 N.E.2d 441, 445 (N.Y. 1985)). Thus, even if the burden of proof on a particular coverage issue normally would fall to the insured, the defense-breaching insurer will bear that burden in seeking to avoid an indemnity obligation. *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 764 n.22, 610 N.E.2d at 922 n.22. *Accord Swift v. Fitchburg Mut. Ins. Co.*, 45 Mass.App.Ct. 617, 624–25, 700 N.E.2d 288, 293–94 (1998).

The Massachusetts Superior Court has begun to wrestle with the implications of the *Polaroid* burden-shifting rule. In *Arrow Automotive Industries v. Liberty Mutual Insurance Co.*, 10 Mass.L.Rptr. 380 (Middlesex Super.Ct. June 24, 1999), Judge van Gestel was confronted with a motion in limine concerning allocation of the burden of proof in a case in which another judge (Fabricant, J.) had determined that the insurer (Liberty Mutual) had breached its duty to defend the policyholder (Arrow) in connection with pollution claims by the Department of Environmental Protection. Relying on *Polaroid*, the court concluded that the burden to prove the inapplicability of indemnity coverage fell to Liberty Mutual. The court explained:

> Normally, the party having the burden of proof is required to put in its affirmative case first.... But here, to compel Liberty Mutual to do so would be requiring proof of a negative—that no covered discharges

> took place—in a vacuum. This Court is, however, fully cognizant of its wide discretion on the question of the order of the presentation of evidence.... To avoid the possibility of presenting in emptiness evidence that something did not happen, this Court will borrow from the law in the employment discrimination field... and establish a two-stage order of proof.
>
> Arrow will have the burden of producing credible evidence demonstrating that releases [of contaminants] did occur [during the policy periods]. This is a burden of *production* only, not a burden of *proof*. If such evidence is presented, then the burden of *proof* will be on Liberty Mutual to demonstrate that there is no coverage.
>
> If Liberty Mutual fails to prove that the policies it issued to Arrow... do not cover Arrow's claim,... then it will bear the burden of proving apportionment between amounts covered by such policies and amounts not covered.
>
> *Arrow Automotive Indus. v. Liberty Mut. Ins. Co.*, 10 Mass.L.Rptr. at 381 (citations omitted).

It is questionable whether this two-stage order of proof is fully consistent with *Polaroid*. It may be that the Supreme Judicial Court's intent was to allocate to the defense-breaching insurer not only the burden to show that a *given* set of circumstances falls outside the coverage, but also to show *what* set of circumstances the claimant would have set out to prove—which may be the more difficult task.

In any event, consistent with its underlying rationale to avoid presentation of evidence "in a vacuum," the insured's initial burden under *Arrow Automotive* seems limited to providing a context in which the insurer's evidence can be evaluated. The *Polaroid* rule thus retains considerable teeth even if *Arrow Automotive* is applied. As one example, where an insured seeks coverage for environmental claims under a policy excluding such claims unless they result from "sudden and accidental" causes, credible evidence of property damage during the policy period should provide a context sufficient to satisfy the insured's burden of production under *Arrow Automotive*. The burden would then shift to the insurer to prove that the causative release was not "sudden and accidental," which, in many cases, will be an extremely difficult burden to sustain. *See Goodman v. Aetna Cas. & Sur. Corp.*, 413 Mass. 807, 593 N.E.2d 233 (1992) (precise cause of tank leak unknown). Insurers also bear the similarly difficult burden of proof to allocate liability, and thus coverage, between covered and noncovered events in a "mixed claim" situation. *See Swift v. Fitchburg Mut. Ins. Co.*, 45 Mass.App.Ct. 617, 700 N.E.2d 288 (1988).

Fee Shifting

"The usual rule in Massachusetts is to prohibit successful litigants from recovering their attorney fees and expenses except in a very limited class of cases." *Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. 93, 95, 686 N.E.2d 989, 991 (1997) (citing *Waldman v. American Honda Motor Co.*, 413 Mass. 320, 597 N.E.2d 404 (1992)). In other words, Massachusetts follows the "American Rule," requiring litigants to bear their own fees and expenses. *Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. 93, 95, 686 N.E.2d 989, 991 (1997). Until 1997, Massachusetts courts had given scant indication that the "very limited class of cases" excepted from this rule would include suits seeking to enforce an insurer's duty to defend. The landscape was altered dramatically, however, with the Supreme Judicial Court's release of *Gamache*.

"The usual rule in Massachusetts is to prohibit successful litigants from recovering their attorney fees and expenses except in a very limited class of cases."

The *Gamache* case involved a claim under a homeowner's policy for a defense against a suit by a police officer alleging that the insured had injured the officer in the course of the insured's arrest. *Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. 93, 93, 686 N.E.2d 989, 990 (1997). The insurer filed a declaratory action seeking to establish that the policy's "intentional act" exclusion excused it from furnishing a defense. *Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. at 93, 686 N.E.2d at 990. The Supreme Judicial Court, having concluded that the insurer did have a duty to defend, addressed the insured's request for recovery of fees and expenses incurred in establishing that duty. After acknowledging its general adherence to the "American Rule," the Supreme Judicial Court nevertheless concluded that an exception was warranted in suits concerning the defense obligation, because the absence of such a rule would "permit[ ] the insurer to do by indirection that which it could not do directly." The Court went on to explain:

> That is, the insured has a contract right to have actions against him defended by the insurer, at its expense. If the insurer can force him into a declaratory judgment proceeding and, even though it loses in such action, compel him to bear the expense of such litigation, the insured is actually no better off financially than if he had never had the contract right mentioned above.

Preferred Mut. Ins. Co. v. Gamache, 426 Mass. at 96–97, 686 N.E.2d at 992 (quoting 7C John A. Appleman, *Insurance Law and Practice* § 4691, at 283 (West rev. ed. 1979)). Thus, the Court held that "an insured under a homeowner's policy… is entitled to the reasonable attorney fees and expenses incurred in successfully establishing the insurer's duty to defend under the policy." *Preferred Mut. Ins. Co. v. Gamache*, 426 Mass. at 98, 686 N.E.2d at 993.

Because the *Gamache* decision was carefully limited to homeowner's policies, many insurers contended that it did not apply to CGL insurance and, further, that it did not apply to coverage actions instituted by the insured. These positions were advanced by the insurer in *Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. 355, 708 N.E.2d 639 (1999). The Supreme Judicial Court was not persuaded, however, that these distinctions should change the result. *Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. at 357, 708 N.E.2d at 641. The Supreme Judicial Court emphasized that its benefit-of-the-bargain analysis in *Gamache* spoke to the nature of liability insurance, not the character of the policyholder, whether homeowner or business entity. *Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. at 357–59, 708 N.E.2d at 641–43. The Court further saw "no logical reason to distinguish between insureds who successfully establish their liability insurer's duty to defend… by hinging recovery on whether the insured or the insurer initiated the coverage action." *Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. at 358, 708 N.E.2d at 642.

Finally, the *Rubenstein* Court observed that the *Gamache* fee-shifting rule applies without any need of showing bad faith or other wrongful conduct on the part of the insurer. *Rubenstein v. Royal Ins. Co. of Am.*, 429 Mass. 355, 359–60, 708 N.E.2d 639, 642–43 (1999). According to the Court:

> "The entitlement of an insured to attorneys' fees and costs incurred in establishing contested coverage depends exclusively on whether or not that coverage is ultimately determined to exist. It does not depend on whether the denial of coverage by the insurer was reasonable or unreasonable, justified or unjustified, a close question of fact or a matter not even subject to legitimate dispute. The focus is exclusively on the bottom line."

Rubenstein v. Royal Ins. Co. of Am., 429 Mass. at 360, 708 N.E.2d at 643 (quoting *Commercial Union Ins. Co. v. Porter Hayden Co.*, 698 A.2d 1167, 1219 (Md.Ct.Spec. App. 1997)).

In *Hanover Insurance Co. v. Golden*, 436 Mass. 584 (2002), the Supreme Judicial Court made clear that the fee-shifting principle of *Gamache* and *Rubenstein* applies not only where the insurer announces withdrawal from the third-party action and sues for a declaration (as in *Gamache*) or refuses to defend, forcing the insured to sue to establish the insurer's duty to defend (as in *Rubenstein*), but also where the insurer brings a declaratory action and provisionally maintains defense of the third-party action pending instruction by the declaration. *Hanover Ins. Co. v. Golden*, 436 Mass. at 586–88. The fee-shifting rule thus applies in any situation in which the insured must incur attorney fees to secure *or maintain* a defense. *Hanover Ins. Co. v. Golden*, 436 Mass. at 588; *see also Western World Ins. Co. v. Meridian Builders*, 23 Mass.L.Rptr. 365, *3 (Mass. Super. 2007) (insured entitled to fees for prevailing on insurer's premature declaratory judgment action).

Although an insured's entitlement to attorneys' fees for establishing the duty to defend is well-established, the related question of whether an insured could recover fees for establishing an insurer's duty to indemnify long remained open. This changed with the Supreme Judicial Court's decision in *Wilkinson v. Citation Ins. Co.*, 447 Mass. 663, 674-76, 856 N.E.2d 829, 838-39 (2006), which declined to extend the *Gamache* fee-shifting rule where an insured successfully establishes a duty to indemnify.

§ 1.2.2 The Duty to "Indemnify"

The two fundamental insurer obligations under a CGL policy are commonly referred to as the duty to defend and the duty to "indemnify." The latter designation may be a bit of a misnomer to the extent that an "indemnity" obligation is understood to be an obligation merely to reimburse the insured for amounts the insured has already paid. The promise of the CGL insurer is to "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages." Thus, the policy contemplates that the insurer's obligation will be triggered when the insured's legal obligation to pay damages is established, and that the insurer will then make the payment on the insured's behalf, such that the insured is never "out of pocket." This can be a very important benefit, particularly where the damage award is of sufficient magnitude to threaten the insured's solvency.

Under Massachusetts law, this result would obtain in the case of CGL policies (with respect to coverage for bodily injury or property damage) even if the policy language did not so provide. Section 112 of G.L. c. 175 provides, in pertinent part:

> The liability of [an insurer]… under any… policy insuring against liability for loss or damage on account of bodily injury or death… or on account of damage to property, shall become absolute whenever the loss or damage for which the insured is responsible occurs, and the satisfaction by the insured of a final judgment for such loss or damage shall not be a condition precedent to the right or duty of the [insurer] to make payment on account of said loss or damage. No such contract of insurance shall be cancelled or annulled by any agreement between the [insurer] and the insured after the said insured has become responsible for such loss or damage, and any such cancellation or annulment shall be void.

G.L. c. 175, § 112. This provision prevents either the insolvency of the insured or any post-loss agreement between insurer and insured from absolving the insurer of its obligation to satisfy a covered claim; it effectively confers on the injured party a beneficial interest in the policy. *See Lorando v. Gethro*, 228 Mass. 181, 187, 117 N.E. 185, 188 (1917); *Mayer v. Medical Malpractice Joint Underwriting Ass'n*, 40 Mass.App.Ct. 266, 272–73, 663 N.E.2d 274, 278 (1996); *see also* G.L. c. 175, § 113 (authorizing action to reach and apply proceeds of liability policy to satisfy judgment against insured).

As noted in the discussion of the duty to defend, the duty to indemnify is determined by reference not to allegations but to "facts." The scope of the duty to indemnify is said to be narrower than the scope of the duty to defend, because one is no longer interested in the various sets of facts the claimant *might* prove (consistent with his or her allegations); the inquiry now is into the *single* set of facts the claimant *did* prove. In practice, however, the coverage question cannot always be answered by reference

"…one is no longer interested in the various sets of facts the claimant might prove (consistent with his or her allegations); the inquiry now is into the single set of facts the claimant did prove."

to findings of fact or a jury verdict from the underlying case. The underlying case may settle, of course, in which case no "facts" will have been established. Even if the underlying case is fully litigated, the coverage question may turn on facts that are not determined in the underlying action because they are not germane to the insured's liability. Much of the law concerning determination of the indemnity obligation addresses this problem.

(a) The "Facts" for Purposes of Indemnity

It is a fundamental principle of indemnity that the indemnitor (here, the insurer) is "bound by the result of the trial [of the underlying case], as to all matters decided in that action that bear on the coverage issue." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. 747, 763 n.20, 610 N.E.2d 912, 921 n.20 (citing *Miller v. United States Fidelity & Guar. Co.*, 291 Mass. 445, 448–49, 197 N.E. 75, 77–78 (1935)). Thus, for purposes of the indemnity obligation, the "facts" are those determined in the underlying action; neither insurer nor policyholder is free to claim in the coverage action that the "true" facts are different and to avoid or secure coverage on that basis. *See Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 763 n.20, 610 N.E.2d at 921 n.20. As the Supreme Judicial Court further commented in *Polaroid*, "[w]hen the underlying claim is settled, the circumstances of the underlying claim are not aired in an adversary proceeding, and, therefore, a different approach may be required." *Polaroid Corp. v. Travelers Indem. Co.*, 414 Mass. at 763 n.20, 610 N.E.2d at 921 n.20. The Court has not had occasion to date to spell out what that "different approach" would entail.

Courts of at least a few other jurisdictions have considered this question. One case that contains a fairly comprehensive treatment of the issue is *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1243–44 (Ill.App.Ct. 1994). The *Gypsum* case arose out of claims against United States Gypsum Company ("Gypsum") for property damage resulting from the installation of asbestos-containing acoustical finishing plasters in public and other buildings. Gypsum's liability insurers refused to cover these claims, and Gypsum filed suit. The case went to trial on the insurers' duty to indemnify Gypsum with respect to eight underlying cases, one of which Gypsum tried to an adverse verdict and seven of which Gypsum had settled. *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d at 1229–30, 1232. The trial court ruled that to determine whether Gypsum would be entitled to indemnification, it would consider "whether the jury [in the tried case] either found, or U.S. Gypsum reasonably believed the jury would be likely to find [in the settled cases], that U.S. Gypsum's asbestos containing materials caused tortious property damage to the underlying plaintiffs' property." *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d at

1236. After examining evidence adduced in the tried case and developed in discovery in the settled cases, the trial court concluded that "Gypsum proved, by a preponderance of the evidence, that the underlying cases each involved allegations of and evidence from underlying claimants of actual physical damage caused by its products to other property, the building and building contents." *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d at 1236.

The insurers appealed, arguing, inter alia, that Gypsum was required to offer "actual facts" showing that property damage was present in each of the underlying cases. *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1241–42 (Ill.App. Ct. 1994). The court dismissed the notion that Gypsum could be required to prove "actual property damage" in the case that had been tried, stating:

> Gypsum[,] as an insured in a declaratory judgment action, does not have to prove *de novo* the existence of damage in the underlying action, *i.e.*, its own liability. The adverse verdict returned by the jury and subsequent entry of judgment conclusively established Gypsum's liability with respect to the [tried] case....
>
> The challenge by the insurers in a coverage action may therefore not address the issue as to whether the underlying plaintiffs sustained damage for which the insured is liable. That was the subject of the underlying action.... The determination to be made in a coverage action which proceeds after the insured's liability has been conclusively determined by the underlying action is whether the type of injury claimed is within the policies' ambit of coverage, not whether any damage occurred in the underlying action... "A policyholder, therefore, does not have to prove its actual liability as a prerequisite to obtaining coverage."

United States Gypsum Co. v. Admiral Ins. Co., 643 N.E.2d at 1242–43 (emphasis added) (quoting *Dayton Indep. Sch. Dist. v. National Gypsum Co.*, 682 F.Supp. 1403, 1406 (E.D.Tex. 1988).

The *Gypsum* court also held that proof of "actual facts" was not required with respect to the cases Gypsum settled. The court was concerned that, otherwise, "an insured will be deterred from entering into a settlement agreement when it would have to offer full proof that property damage existed in the coverage action when that proof has not yet been established in the underlying action." *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1244 (Ill.App.Ct. 1994). The court recognized

also that if proof of actual property damage is required, "'settling defendants [would be placed] in the hopelessly untenable position of having to refute liability in the underlying action until the moment of settlement, and then turn about face to prove liability in the insurance action.'" *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d at 1244 (quoting *Uniroyal, Inc. v. Home Ins. Co.*, 707 F.Supp. 1368, 1378 (E.D.N.Y. 1988)). The court concluded that the task in the coverage action is to review "the evidence from the underlying cases [to determine]… whether [the insured] had a reasonable anticipation of liability in the cases which it settled and whether the damage was the type of damage covered by the policy." *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d at 1244.

The *Gypsum* case strikes an appropriate balance between the right of the policyholder to settle cases without conceding liability and the right of the insurer to contest coverage based on a view of the facts not inconsistent with the evidence the claimant would have adduced had the underlying claim gone to trial. Because the version of the facts proved by the claimant will control if the claim *does* go to trial, what should matter in the case of a settlement is what the claimant would have sought to prove had the case not settled. In other words, if the policyholder's settlement is reasonable, the insurer should not be free to avoid coverage by seeking to prove a set of facts materially at variance with the case the claimant sought to make. It seems reasonable to expect the Massachusetts courts, building on the foundation set in *Polaroid*, ultimately to embrace such a view. *Cf. Liquor Liab. Joint Underwriting Ass'n v. Hermitage Ins. Co.*, 419 Mass. 316, 323–24, 644 N.E.2d 964, 968–69 (1995) (case settled after jury verdict; verdict did not differentiate between counts covered by different insurers; *held*, under *Polaroid*, defense breaching insurer had burden to allocate settlement but would not be permitted to attempt to do so due to general verdict).

(b) Limits of Liability; Insurer Responsibility for Interest and Costs

The *scope* of the insurer's indemnity obligation is determined by reference to the insuring agreements, definitions and exclusions of the policy applied to the facts of the third-party claim, determined in accordance with the principles discussed in the preceding section. The *magnitude* of the insurer's indemnity obligation is measured by the amount of the claimant's recovery and limited by the limits of liability stated in the "declarations" of the policy. Standard CGL policies may contain several types of limits, including so-called "per occurrence" and "aggregate" limits, that can operate in various ways, depending on when the policy was written and whether it was written on a standard form.

Generally, a "per occurrence" limit sets the maximum amount the insurer will be obligated to pay for all damages arising out of one event or resulting from substantially the same injurious exposure. In the case of "bodily injury" and "property damage" liability, the present standard form "per occurrence" limit applies, regardless of the number of insureds or claims made, or persons or organizations making the claims, although policies issued before 1973 may impose a separate "per person" limit for "bodily injury" liability. The policy may have separate "per occurrence" limits for "bodily injury" and "property damage" claims, or it may provide a "combined single limit" for all liability arising out of a single "occurrence." Limits for "personal or advertising injury" may operate on a "per occurrence" basis or, as in the present standard form, by reference to the number of persons or organizations suffering such injury as a result of an "offense" described in the policy definitions.

An "aggregate" limit of liability is the most the insurer will pay during a designated term, regardless of the number of otherwise covered "occurrences" for which the insured is liable. The term is usually a 12-month period, with the aggregate limits of multi-year policies renewing annually. It is important to note that many older CGL policies may contain *no* aggregate limit applicable to certain kinds of liabilities. For example, standard CGL polices written before 1986 imposed an aggregate limit with respect to "bodily injury" liability, but only if it arose from the "products hazard" or the "completed operations hazard"—that is, the products liability or liability associated with finished work, as of a construction contractor. Standard form CGL policies issued before 1966 would also set forth separate aggregate limits for several different kinds of "property damage" liabilities.

Limits of liability provisions tend to refer to the amount of "damages" the insurer will pay. The issue has arisen whether the term "damages" does or does not include prejudgment interest incorporated into an award. In *Mayer v. Medical Malpractice Joint Underwriting Ass'n*, 40 Mass.App.Ct. 266, 633 N.E.2d 274 (1996), an Appeals Court panel held that the term "damages" *does* encompass prejudgment interest, such that the policy limit applies, capping insurer liability for the entire award (damages and prejudgment interest) at the policy limit. *Mayer v. Medical Malpractice Joint Underwriting Ass'n*, 40 Mass.App.Ct. at 270–71, 633 N.E.2d at 277–78 (citing *Factory Mut. Liab. Ins. Co. v. Cooper*, 262 A.2d 370 (R.I. 1970)). Importantly, the policy before the court made no express reference to prejudgment interest, although it did provide, in a "Supplementary Payments" provision, for insurer payment of postjudgment interest in addition to the limit of liability. *Mayer v. Medical Malpractice Joint Underwriting Ass'n*, 40 Mass.App.Ct. at 271, 663 N.E.2d at 278.

The *Mayer* decision should not be taken as establishing that a liability insurer *never* will be responsible to pay prejudgment interest in excess of the policy limit. Indeed, since 1986, the standard CGL policy (in the "Supplementary Payments" section) has expressly provided coverage, over and above the policy limit, for "[p]rejudgment interest awarded against the insured on that part of the judgment [the insurer] pay[s]," provided that if the insurer offers to contribute the full policy limit to a settlement, it will not pay prejudgment interest for the time between the offer and the judgment. This approach acknowledges the potential effect of the insurer's handling of the defense on the exposure to prejudgment interest, while limiting the insurer's contractual obligation to amounts attributable to its coverage layer and to settlement decisions that are within its control.

Moreover, as discussed in § 1.2.3 below, an insurer may be liable to its policyholder for a negligent failure to settle a claim for an amount falling within the policy limit, and the damages awarded can include prejudgment interest the policyholder must pay because of the insurer's breach of its duty to settle. *See Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 118–21, 628 N.E.2d 14, 16–18 (1994) (discussing the relationship between an insurer's contract-based duty to settle and the G.L. c. 93A "bad faith" standard); *DiMarzo v. American Mut. Ins. Co.*, 389 Mass. 85, 89, 92, 101, 449 N.E.2d 1189, 1193, 1195, 1199 (1983) (prejudgment interest included in failure-to-settle damages awarded under G.L. c. 93A, § 9). The *Mayer* decision did not purport to disturb this state of affairs.

The "Supplementary Payments" provision of the current standard CGL form imposes additional extra-limits obligations, beyond payment of prejudgment interest. Under this clause, the insurer must pay, for example, costs incurred to acquire a bond to release a real estate attachment, expenses incurred by the insured to assist the insurer in the investigation or defense of the claim and court costs taxed against the insured. The "Supplementary Payments" provision also requires the insurer to pay postjudgment interest that accrues on the *full* amount of any judgment before the insurer has paid, offered to pay or deposited in court the part of the judgment that is within the applicable limit of liability. Accordingly, under the current standard form (and most earlier versions), if an insurer insists on an appeal from an adverse judgment, it will bear the risk, regardless of its policy limit, that an unsuccessful appeal will result in substantial postjudgment interest.

§ 1.2.3 The Duties to Investigate and to Settle

Under the CGL policy, the insurer promises to defend any suit alleging a liability potentially within the policy coverage and to indemnify the insured for damages it must pay for a claim that is, in fact, covered. In the same insuring agreement, through language that has changed little over the past six decades, the insurer also reserves for itself the *prerogative* to "'make such investigation, negotiation and settlement of any claim or suit as it deems expedient.'" *Murach v. Massachusetts Bonding & Ins. Co.*, 339 Mass. 184, 186, 158 N.E.2d 338, 340 (1959) (quoting the policy). It has been recognized, however, that an insurer's failure to exercise this prerogative with proper regard for the insured's interests can result in undue prejudice to the insured. *See, e.g., Abrams v. Factory Mut. Liab. Ins. Co.*, 298 Mass. 141, 145, 10 N.E.2d 82, 84 (1937). Accordingly, the Supreme Judicial Court has stated that the insurer's reservation of a privilege to control investigation and settlement of claims "imports a reciprocal obligation for its exercise"—i.e., an obligation to investigate and settle claims in satisfaction of its implied covenant of good faith and fair dealing. *Murach v. Massachusetts Bonding & Ins. Co.*, 339 Mass. 184, 186–87, 158 N.E.2d 338, 340–41 (1959).

The classic formulation of the duty to settle is found in the *Murach* decision, where the Court stated that "[t]o mitigate the danger…that the insurer will favor its own interest to the exclusion of the insured's, good faith requires that it make the decision (whether to settle a claim within the limits of the policy or to try the case) as it would if no policy limit were applicable to the claim." *Murach v. Massachusetts Bonding & Ins. Co.*, 339 Mass. 184, 187, 158 N.E.2d 338, 341 (1959) (citing Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 Harv.L.Rev. 1136, 1148 (1954)). The corollary with respect to the duty to investigate is that "[g]ood

"…if an insurer insists on an appeal from an adverse judgment, it will bear the risk, regardless of its policy limit, that an unsuccessful appeal will result in substantial postjudgment interest."

faith also requires that [the insurer] exercise common prudence to discover the facts as to liability and damages upon which an intelligent decision [whether to settle] may be based." *Murach v. Massachusetts Bonding & Ins. Co.*, 339 Mass. at 187, 158 N.E.2d at 341.

Although often paired, the duties to investigate and settle deserve separate analysis, as a breach of one does not invariably involve a breach of the other. Although a precise formulation of the duty to investigate may remain elusive, it is clear that an insurer must conduct some independent investigation before denying coverage, and a failure to do so may constitute an unfair claim settlement practice, actionable under chapter 93A. In *Federal Ins. Co. v. HPSC, Inc.*, 480 F.3d 26, 35-36 (1st Cir. 2007), for example, the First Circuit held an insurer in breach of its duty to investigate (in violation of chapter 93A) where the claims examiner performed "no investigation of the available facts before denying coverage," but instead based her coverage determination solely on materials submitted with the claim. Evidently, the insured could have recovered on the basis of this breach alone, even if the court had not also held the insurer in breach of its duty to settle.

By the same token, even if an insurer conducts an adequate investigation, it may be liable under contract for unreasonably failing to settle a claim for a sum within the policy limits. *Murach v. Massachusetts Bonding & Ins. Co.*, 339 Mass. 184, 187, 158 N.E.2d 338, 341 (1959). In addition, at least in the case of "consumers," an insurer's failure "to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear" (in violation of G.L. c. 176D, § 3(9)(f)) may yield liability under G.L. c. 93A, § 9, potentially resulting in multiple damages and attorney fees. *See, e.g., Federal Ins. Co. v. HPSC, Inc.*, 480 F.3d at 36; *DiMarzo v. American Mut. Ins. Co.*, 389 Mass. 85, 93–102, 449 N.E.2d 1189, 1195–1200 (1983). Until 1994, however, it was unclear whether an insurer could incur common law *tort* liability for a failure to settle, albeit tort liability for negligence in the conduct of the *defense* has long been recognized. *See Abrams v. Factory Mut. Liab. Ins. Co.*, 298 Mass. 141, 144, 10 N.E.2d 82, 84 (1937) ("Although the duty [to defend] arises out of the contract and is measured by its terms, negligence in the manner of performing that duty as distinguished from mere failure to perform it, causing damage, is a tort."). This issue—which may be important at least to policyholder businesses ineligible to sue under Section 9 of Chapter 93A—was resolved by the Supreme Judicial Court in *Hartford Casualty Insurance Co. v. New Hampshire Insurance Co.*, 417 Mass. 115, 628 N.E.2d 14 (1994).

In the *Hartford Casualty* case, a primary carrier with a $500,000 policy limit (New Hampshire Insurance) refused to settle a claim that then went to trial, resulting in

a verdict requiring an excess carrier (Hartford Casualty) to pay $1.5 million to satisfy the judgment in excess of the primary coverage. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 116, 628 N.E.2d 14, 14 (1994). Hartford Casualty, subrogated to its insured's rights, sued New Hampshire Insurance, arguing that New Hampshire Insurance was liable for the excess payment because it improperly failed to settle the claim within the limits of the primary coverage. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 116, 628 N.E.2d at 14. Hartford Casualty's tort claim for negligence and its contract claim under *Murach* were tried to a jury, which found for New Hampshire Insurance on both theories. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 116–17, 628 N.E.2d at 14–16. Hartford Casualty appealed, claiming error principally in the judge's instructions on the contract count. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 117, 628 N.E.2d at 16.

The Supreme Judicial Court declined to reach Hartford Casualty's claims of error in the jury instructions, because the jury, on substantially unchallenged instructions, found that New Hampshire Insurance was not negligent. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 117, 628 N.E.2d 14, 16 (1994). The Court reasoned that, if a negligence claim would lie, then the jury's finding that New Hampshire Insurance was not negligent would render any error in the instructions on the contract claim harmless, because the standard for "objective" bad faith is the same as, or less strict than, a negligence standard, and there was no claim of "subjective" bad faith (i.e., improper motive) on New Hampshire Insurance's part. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 121, 628 N.E.2d at 18. In holding that a negligence claim *will* lie, the Court observed that the national trend was to apply a negligence standard and that such a standard would differ little from the good faith test that had evolved in Massachusetts. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 121, 628 N.E.2d at 18.

By the same token, the Court reiterated that it will not suffice to show that the insurer failed to settle when a reasonably prudent insurer, exercising due care, would have done so. *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 121, 628 N.E.2d 14, 18 (1994). The required showing, instead, is that "*no* reasonable insurer would have failed to settle the case within the policy limits." *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 121, 628 N.E.2d at 18 (emphasis added). The Court explained as follows:

> This test requires the insured… to prove that the plaintiff in the underlying action would have settled the claim within the policy limits and that, assuming the insurer's unlimited exposure (that is, viewing

> the question from the point of view of the insured), no reasonable insurer would have refused the settlement offer or would have refused to respond to the offer.

Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. at 121, 628 N.E.2d at 18. Accordingly, while the *Hartford* case makes clear that a tort action for negligence may lie against an insurer for breach of the duty to settle, and thus that the broader range of damages available in tort cases will be in play, the *standard* for insurer negligence will be particularly exacting and "not significantly different" from a bad faith standard. *See Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. at 121, 628 N.E.2d at 18.

Since *Hartford Casualty*, a policyholder prejudiced by a CGL carrier's failure to settle within the policy limits may assert both contract and tort claims and may also have claims under G.L. c. 93A, § 9 and G.L. c. 176D, § 3(9), in the case of consumers, or G.L. c. 93A, § 11, in the case of businesses. *See Kiewit Constr. Co. v. Westchester Fire Ins. Co.*, 878 F.Supp. 298, 302 (D.Mass. 1995) ("To say… that Section 11 of 93A does not incorporate 176D is not to say that conduct that happens to violate 176D may never be 'unfair or deceptive' within the meaning of Section 2 of 93A, and, thus, actionable under Section 11."). Despite the variety of theories available, however, the claim often will be difficult to prove. The problems of proof these claims can present are illustrated by Judge Keeton's decision in *RLI Insurance Co. v. General Star Indemnity Co.*, 997 F.Supp. 140 (D.Mass. 1998).

In *RLI Insurance Co. v. General Star Indemnity Co.*, an umbrella carrier (RLI) contended that the failure of a primary carrier (General Star) to more promptly investigate and resolve a tort action for a sum within its policy limit resulted in an acrimonious relationship with the claimants and the need, ultimately, to settle the case for $1 million in excess of the $1 million primary limit. *RLI Ins. Co. v. General Star Indem. Co.*, 997 F.Supp. 140, 142–43 (D.Mass. 1998). In a discussion showing the importance of the duty to investigate that accompanies the duty to settle, the court found General Star's performance in the handling of the claim deficient due to its "failure to recognize, promptly after it received notice of the injury, that the… claim required intensive and early attention to establishing a favorable relationship among General Star, its insured, and the [claimants] (or their attorney if they were already represented by counsel)." *RLI Ins. Co. v. General Star Indem. Co.*, 997 F. Supp. at 147. In making this finding, the court observed as follows:

> The liability insurer's duties and rights are not confined to aggressive defense; they extend as well to responsibility for reasonably prompt and reasonably effective investigation that will enable the insurer to have an adequate basis for making a decision about settlement, even if that decision itself is to be judged by a good faith rather than a negligence standard.

RLI Ins. Co. v. General Star Indem. Co., 997 F.Supp. at 147. In effect, the court found, consistent with RLI's contention, that General Star had failed to adequately explore the prospects for a favorable early settlement opportunity.

General Star argued that notwithstanding its deficient performance, RLI was not entitled to recover, because the claimants never offered to settle the case for a sum within the General Star limit. *RLI Ins. Co. v. General Star Indem. Co.*, 997 F.Supp. 140, 149–50 (D.Mass. 1998). The court rejected this contention, believing it to be a natural extension of the Supreme Judicial Court's precedents to find a breach of the duty to settle where the primary carrier "could have settled within its policy limit had its 'handling' of the claim measured up to the prescribed standard of performance in investigation and other steps that would have enabled it to decide at a relatively early date that the claim was one as to which 'liability has become reasonably clear.'" *RLI Ins. Co. v. General Star Indem. Co.*, 997 F.Supp. at 149–50 (quoting G.L. c. 176D, § 3(9)(f)). Nevertheless, the court concluded that RLI was *not* entitled to recover because, by the time General Star ought to have concluded that liability was reasonably clear, the claimants were sufficiently educated about the value of the claim that they would not have accepted the $1 million General Star had to offer. *RLI Ins. Co. v. General Star Indem. Co.*, 997 F.Supp. at 150. The court was careful to note that RLI had *not* argued that General Star's conduct caused the "loss of an opportunity to settle sooner or at a lower figure above the primary insurer's limits." *RLI Ins. Co. v. General Star Indem. Co.*, 997 F.Supp. at 151.

Cases such as *RLI* seem to uncover a paradox that severely limits insurer accountability for settlement decisions made without proper regard for the insured's interests: If the failure to settle is actionable only where *no* reasonable insurer would have failed to offer its policy limit, then, for liability to attach, presumably the magnitude of the likely liability must be *very* clearly sufficient to consume the policy limit—otherwise, reasonable minds might differ and the heightened negligence standard will not be reached. Where the exposure *is* clearly sufficient to consume the limit, however, a payment just equal to that limit, standing alone, rarely will be sufficient to settle the claim.

This problem may one day lead to a reassessment of the heightened negligence standard adopted in *Hartford Casualty*, or, more likely, the Massachusetts courts may recognize the validity of claims that a failure by the primary carrier to offer its policy limit caused the loss of an opportunity to settle at a lower figure *above* that limit. In

"Cases such as RLI seem to uncover a paradox that severely limits insurer accountability for settlement decisions made without proper regard for the insured's interests…"

any event, counsel responsible for protecting the interests of the insured should be vigilant in valuing the case and sharing that valuation—and the supporting analysis—with all parties whose funds may be needed to effect a settlement, including primary and excess carriers. An insurer that has such an evaluation in its file may be less likely to find a safe harbor in the vagaries of the heightened standard.

§ 1.3 Obligations of the Policyholder

The insurance bargain is the transfer of a risk of loss to the insurer in exchange for the payment of premiums by the insured. The chief obligation of the purchaser of insurance, therefore, is to pay premiums when due. Other obligations of the insured under a liability policy arise in two contexts: underwriting and claims handling. In the underwriting process, the obligation of the applicant for insurance is to answer truthfully and completely all questions put by the underwriter, at least where the questions are drafted with reasonable particularity. In this way, the underwriter is put in a position to make an informed decision as to whether to issue the policy and, if a policy is to be issued, to fix an appropriate premium.

The obligations of the insured in the claims-handling context are varied, but most are directed to one objective: placing the insurer in an optimal position to determine its coverage obligations and perform those obligations (e.g., to investigate and defend or settle covered claims). Thus, among the requirements that the policy imposes on the insured are the following:

- to notify the insurer of events or conditions (i.e., "occurrences") that may give rise to claims;
- to advise the insurer if a claim or suit in fact is brought; and
- to cooperate with the insurer in its investigation and handling of the defense.

Two additional claims-related policyholder obligations—the duty to mitigate damages and the duty to preserve insurer subrogation rights—help the insurer contain or spread the loss.

As the focus of this eBook is on claims-related obligations of insurer and insured, the discussion that follows will not address issues related to premium payment, but it will at least touch on all of the referenced policyholder duties that arise in the context of claims. In addition, since alleged breaches of the insured's underwriting disclosure obligations tend to be raised in the context of claims—in the guise of a misrepresentation coverage defense—those obligations will also be discussed. The natural starting point is at the outset of the insurance relationship, with the (prospective) insured's disclosure obligations.

§ 1.3.1 The Policy Application and the Insured's Disclosure Obligations

In insurance contracts, as with any contract, each party is entitled to rely on the other's warranties and representations and may be excused from performance if induced to enter into the contract by means of the other party's false warranty or representation as to a material matter. Although, in principle, both parties are obliged to avoid misrepresentations in the course of negotiation of the policy, as a practical matter, the burden of disclosure falls mainly on the applicant (or prospective insured), largely because of its superior knowledge regarding the risk to be insured. Therefore, in Massachusetts, as elsewhere, the case law concerning misrepresentation in the policy placement process is dominated by instances in which insurers have sought to avoid coverage on the basis of an alleged misrepresentation by the insured in the policy application.

Much of the early case law in Massachusetts was concerned with the nice distinction between "warranties" and "representations." *See, e.g., Daniels v. Hudson River Fire Ins. Co.*, 66 Mass. (12 Cush.) 416, 424 (1853). The consequences of making a false warranty apparently were dire indeed:

> If any statement of fact, however unimportant it may have been regarded by both parties to the contract, is a warranty, and it happens to be untrue, it avoids the policy; if it be construed a representation, and is untrue, it does not avoid the contract if not wilful, or if not material.

See Daniels v. Hudson River Fire Ins. Co., 66 Mass. (12 Cush.) at 424. Often, the difficulty was in determining whether the statement was a warranty or a representation. *See Daniels v. Hudson River Fire Ins. Co.*, 66 Mass. (12 Cush.) at 423–26 (discussing rule that "a warranty must be embraced in the policy itself" and various circumstances in which this will, or will not, be deemed to be the case).

This problem was laid to rest with the legislature's enactment of a statute on the subject, now codified at G.L. c. 175 § 186. Section 186 provides:

> No oral or written misrepresentation or warranty made in the negotiation of a policy of insurance by the insured or in his behalf shall be deemed material or defeat or avoid the policy or prevent its attaching unless such misrepresentation or warranty is made with actual intent to deceive, or unless the matter misrepresented or made a warranty increased the risk of loss.

G.L. c. 175, § 186.

In effect, Section 186 stripped "warranties" of their special status and made all of the insured's statements of fact subject to the rules formerly applicable only to "representations." *Metropolitan Life Ins. Co. v. Burno*, 309 Mass. 7, 11, 33 N.E.2d 519, 520 (1941). Of course, misrepresentation doctrine is not concerned exclusively with false statements of fact but also with "concealment." In this context, "concealment" has a very specific meaning. In the words of the *Daniels* Court:

> "Concealment" is the designed and intentional withholding of any fact material to the risk, which the assured, in honesty and good faith, ought to communicate to the underwriter; mere silence on the part of the assured, especially as to some matter of fact which he does not consider it important for the underwriter to know, is not to be considered such a concealment.

Daniels v. Hudson River Fire Ins. Co., 66 Mass. (12 Cush.) 416, 425 (1853). Accordingly, mere nondisclosure of a fact will not enable the insurer to avoid coverage unless the insured, as applicant, was chargeable with a "designed and intentional" withholding of information.

Nevertheless, insurers have contended that the insured's failure to disclose a material fact will void the policy, even where the insurer has made no inquiry specifically seeking the information in question, so long as the "reasonable insured" would have believed the fact to be something the insurer would deem material. *See, e.g.*, Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 3.01[b], at 86 (Aspen Law & Business 9th ed. 1998) (citing *Christiana Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268 (2d Cir. 1992)). This argument typically is accompanied by citations to cases from the reinsurance context, in which a duty to disclose, even absent specific inquiry, is said to arise from the special relationship of "utmost good faith" (uberrimæ fidei) between reinsurer and reinsured. *See, e.g., Christiana Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d at 278–80 (applying doctrine in reinsurance dispute, but rejecting misrepresentation claim for failure to allege that reinsured in fact knew that reinsurer would consider information material).

Whatever the vitality of the "utmost good faith" doctrine in other jurisdictions, it is not the law of Massachusetts in the direct insurance context. Beyond the statement in *Daniels* that the withholding of information must be "designed and intentional" (clearly a subjective test),the argument seems to be foreclosed by the Supreme Judicial Court's decision in *Washington Mills Emery Manufacturing Co. v. Weymouth & Braintree Mutual Fire Insurance Co.*, 135 Mass. 503 (1883). In *Washington Mills*, the defendant insurer had issued two successive fire insurance policies to the plaintiff. The property insured was certain buildings on a parcel of land the policyholder owned at the time the first policy was issued. Before the second policy was issued, the insured conveyed the land, but not the buildings, to the City of Boston, agreeing to remove the buildings and contents before a date certain and stipulating that, if the buildings were not removed by that date, they would then become the city's property. The buildings were consumed in a fire before the removal deadline had arrived. *Washington Mills Emery Mfg. Co. v. Weymouth & Braintree Mut. Fire Ins. Co.*, 135 Mass. at 504–05.

"…insurers have contended that the insured's failure to disclose a material fact will void the policy, even where the insurer has made no inquiry specifically seeking the information in question, so long as the "reasonable insured" would have believed the fact to be something the insurer would deem material."

The insurer sought to avoid coverage on the ground of misrepresentation. The Court rejected this contention, explaining as follows:

> The plaintiff made no misrepresentations and no concealment as to its title. The policy is upon the buildings. The defendant saw fit to issue this policy without any specific inquiries of the plaintiff as to the title to the land, and without any representations by the plaintiff on this point. It was its own carelessness, and it cannot avoid the policy without proving intentional misrepresentation or concealment on the part of the plaintiff. An innocent failure to communicate facts about which the plaintiff was not asked will not have this effect.

Washington Mills Emery Mfg. Co. v. Weymouth & Braintree Mut. Fire Ins. Co., 135 Mass. 503, 505 (1883). In theory at least, a concealment defense may lie even absent a specific application question if it can be proved that the applicant deliberately withheld information he or she, in fact, knew to be important to the underwriter. *See Hanover Ins. Co. v. Leeds*, 42 Mass.App.Ct. 54, 57, 674 N.E.2d 1091, 1094 (1997) (burden to prove misrepresentation defense is on insurer). Otherwise, however, the applicant will not be at risk of forfeiting coverage for failing to divine what the insurer would *like* to know but has not asked. As recently stated in the renewal context in *Quincy Mut. Fire Ins. Co. v. Quisset Properties, Inc.*, 69 Mass. App.Ct. 147, 154-55, 866 N.E.2d 966, 971 (2007), "the onus is on the insurer to indentify the information that it considers material and request from the insured updated information concerning any changes… Absent such [a] request, the insured's silence is not a misrepresentation…"

Where an insurer makes a request for information, determining whether or not the insured's response constitutes a misrepresentation begins, of course, with analysis of the question asked. Just as with ambiguous policy terms, ambiguous underwriting questions are construed in the policyholder's favor. Accordingly, where an insurer's request for information "lends itself to more than one reasonable interpretation, an honest answer to one of those reasonable interpretations cannot be labeled a misrepresentation." *Hingham Mut. Fire Ins. Co. v. Mercurio*, 71 Mass.App.Ct. 21, 24, 878 N.E.2d 946, 949 (2008).

An allied question of increasing importance is when an insurance purchaser must disclose circumstances that *may* give rise to claims in the future. In *TIG Insurance Co. v. Blacker*, 54 Mass.App.Ct. 683 (2002), a case involving professional liability insurance, an insurer sought to rescind a policy based on the policyholder's response to an application question asking whether the applicant had "a reasonable basis to

foresee" that a claim would be made, regardless of the validity of the claim. *TIG Ins. Co. v. Blacker*, 54 Mass.App.Ct. at 684. The policyholder answered this question in the negative, despite the fact that, prior to filling out the application, he had received a letter stating that he was a potential target for legal action. *TIG Ins. Co. v. Blacker*, 54 Mass.App.Ct. at 685–86. The policyholder contended that he thought the letter contemplated only a suit for securities-law violations, rather than a claim of professional negligence. *TIG Ins. Co. v. Blacker*, 54 Mass.App.Ct. at 688. The court affirmed the rescission of the policy, holding that, while the inquiry focused on the policyholder's subjective knowledge, the policy called for an objective inquiry into "what a reasonable attorney would foresee given [such] knowledge." *TIG Ins. Co. v. Blacker*, 54 Mass.App.Ct. at 688. While the court tied this analysis firmly to the policy language, it seems reasonable to expect that a similar test would be applied unless the policy clearly called only for the applicant's actual subjective expectations.

Indeed, in *Chicago Insurance Co. v. Lappin*, 58 Mass.App.Ct. 769 (2003), the court applied the "objective-subjective approach" of *Blacker* in considering a policy application that asked whether the applicant was aware of "circumstances which may result in a claim." *Chicago Ins. Co. v. Lappin*, 58 Mass.App.Ct. at 778. There, the court refused to disturb the trial judge's conclusion that, despite the existence of certain "warning signs," the attorney-applicant did not have sufficient knowledge concerning an embezzlement scheme undertaken by an administrative assistant that he should have identified the "warning signs" in response to the quoted question. *Chicago Ins. Co. v. Lappin*, 58 Mass.App.Ct. at 778. While the insurer contended that the "warning signs" placed the attorney on "inquiry notice," such that he could be charged with knowledge of all those matters a reasonably diligent inquiry would develop, the court refused to impute such knowledge to the attorney as a matter of law. *Chicago Ins. Co. v. Lappin*, 58 Mass.App.Ct. at 779. Rather, it observed that "[w]hether notice is sufficient constructively to charge one with specific knowledge is a question ordinarily reserved to the fact finder." *Chicago Ins. Co. v. Lappin*, 58 Mass. App.Ct. at 779.

Assuming that a misrepresentation has been shown, it will excuse the insurer's performance only if it was made with "actual intent to deceive" or if it "increased the risk of loss." *See Barnstable County Ins. Co. v. Gale*, 425 Mass. 126, 127–28, 680 N.E.2d 42, 43–44 (1997). For purposes of Section 186, "[a] fact 'must be regarded as material, the knowledge or ignorance of which would naturally influence the judgment of the underwriter in making the contract at all, or in estimating the degree and character of the risk, or in fixing the rate of the premium.'" *Employers' Liab. Assurance Corp. v. Vella*, 366 Mass. 651, 655, 321 N.E.2d 910, 913 (1975)

(quoting *Daniels v. Hudson River Fire Ins. Co.*, 66 Mass. (12 Cush.) 416, 425 (1853)). The Supreme Judicial Court has made clear that a misstatement of fact or a failure to disclose requested information will be deemed material if disclosure would have resulted in a higher premium, irrespective of any after-the-fact argument by the insured that the actual risk of loss was not increased. *See Barnstable County Ins. Co. v. Gale*, 425 Mass. at 128–29, 680 N.E.2d at 44 (insured's failure to disclose ownership of second automobile voided coverage where disclosure would have resulted in higher premium; insured's use of only one vehicle at a time held irrelevant). Furthermore, in *Blacker*, the court indicated in dicta that materiality sometimes can be inferred, stating that "accurate information about an applicant's exposure to potential claims is so fundamental to claims-made underwriting, that a misrepresentation on this score may be said to increase the risk of loss as a matter of law, without proof of subjective reliance by the insurer." *TIG Ins. Co. v. Blacker*, 54 Mass.App.Ct. at 689.

§ 1.3.2 The Notice Obligation

In Massachusetts, there are two quite distinct lines of authority dealing with the insured's duty to notify the insurer in the event of a potentially covered "occurrence" or of a claim or suit resulting from such an occurrence. One of these addresses the notice obligation under so-called "occurrence" basis policies—i.e., policies that are called into play, or "triggered," if all or part of the "bodily injury" or "property damage" at issue took place during the policy period, or if the "offense" on which a "personal or advertising injury" claim is based took place during the policy period. The second line of authority addresses the notice obligation under so-called "claims-made" policies, an alternative form introduced broadly in 1986, under which the policy is triggered if the claim against the insured is made during the policy period or during an "extended reporting period." The two forms, and the "late notice" cases decided under them, are discussed separately below.

(a) Notice Under "Occurrence"-Basis Policies

Except for language reflecting the 1986 incorporation of coverage for "personal and advertising injury" liability into the CGL policy, the notice provision appearing in the "occurrence" basis form has remained substantially the same for several decades. The insured's notice duties are set forth in the current form at Condition 2, entitled "Duties in the Event of Occurrence, Offense, Claim or Suit." This condition contains two notice requirements: one calling for notice of any potentially covered "occurrence" (or, in the case of "personal and advertising injury" liability, any potentially covered "offense"), and a second requiring notice of any claim or suit

arising from such an occurrence or offense. Because most of the authorities discussing the notice question were decided under pre-1986 policies, the focus here is on "occurrences" rather than "offenses," but there should be little difference in the treatment of these coverage-triggering events for notice purposes.

The formulation of the notice provision in the 1973 CGL standard form states:

> (a) In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable.
>
> (b) If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons, or other process received by him or his representatives.

The CGL policy thus requires that a policyholder give the insurer notice of an occurrence as soon as practicable and notice of a claim or suit "immediately." (It should be emphasized that this notice provision is found in *primary* liability policies; notice provisions in "occurrence"-basis excess and umbrella policies are tied to the insured's assessment of whether the loss is of such magnitude as to exhaust underlying coverage, which calls for a different analysis. *See Employers' Liab. Assurance Corp. v. Hoechst Celanese Corp.*, 43 Mass.App.Ct. 465, 472–74, 684 N.E.2d 600, 605–07 (1997).

The Common Law Rule: Strict Compliance; Excuses for Delay

Until the late 1970s, Massachusetts followed the so-called common law rule, holding that a failure of strict compliance with notice requirements results in a forfeiture of coverage, regardless of whether the untimeliness of the notice had any effect on the carrier's ultimate exposure. *See Spooner v. General Accident Fire & Life Assurance Corp.*, 379 Mass. 377, 378, 397 N.E.2d 1290, 1290 (1979). Under this rule, virtually the only way an insured could escape forfeiture if notice was delayed was to establish that giving more timely notice was "impracticable." Although most cases decided since the 1980s have dealt with notice obligations under the regime created by G.L. c. 175, § 112, which requires a showing of prejudice from late notice (see the section entitled, "G.L. c. 175, § 112: The Prejudice Requirement," below), the "practicability" issue remains pertinent because notice must first be shown to have been untimely before the prejudice issue is reached.

Many of the "practicability" disputes involved the question whether a delay in giving notice was excusable where the insured lacked knowledge that the occurrence could give rise to liability. The cases rejected this argument. *See, e.g., Powell v. Fireman's Fund Ins. Cos.*, 26 Mass.App.Ct. 508, 514–16, 529 N.E.2d 1228, 1231–32 (1988) (four month delay in providing notice untimely). As stated in a frequently cited opinion, "the fact [that] the [insured] has a reasonable and bona fide doubt as to the existence of any injury or of any liability…cannot be used to deprive the insurer of his contractual right to have an immediate notice of the occurrence of an accident, regardless of the damages that may be claimed to flow from that accident." *McCarthy v. Rendle*, 230 Mass. 35, 39, 119 N.E. 188, 189 (1918); *see Eastern Prods. Corp. v. Continental Cas. Co.*, 58 Mass.App.Ct. 16, 22 (2003); *Powell v. Fireman's Fund Ins. Cos.*, 26 Mass.App.Ct. at 514, 529 N.E.2d at 1231; *Fireman's Fund Ins. Co. v. Valley Manufactured Prods. Co.*, 765 F.Supp. 1121 (D.Mass. 1991), *aff'd per curiam*, 960 F.2d 143 (1st Cir. 1992).

Some excuses policyholders have advanced have fared better. The more recent cases interpret "as soon as practicable" to mean "within a reasonable time" and review all the circumstances in deciding whether notice is timely. *See LaPointe v. Shelby Mut. Ins. Co.*, 361 Mass. 558, 565, 281 N.E.2d 253, 257 (1972) (conduct of the insurer's agent excused untimely notice); *Ratner v. Canadian Universal Ins. Co.*, 359 Mass. 375, 383, 269 N.E.2d 227, 231 (1971) (vague policy terms excused untimely notice). Moreover, if the insured has no reason to believe that an occurrence in any way involves the insured, the notice obligation does not arise. *See Leveille v. Aetna Cas. & Sur. Co.*, 353 Mass. 716, 719, 234 N.E.2d 761, 763 (1968).

G.L. c. 175, § 112: The Prejudice Requirement

In response to concerns over the harshness of the strict notice rule, the Massachusetts Legislature passed legislation, effective October 16, 1977, requiring carriers issuing certain classes of liability insurance (including CGL) to demonstrate prejudice before disclaiming coverage on grounds of late notice. This statute, codified at G.L. c. 175, § 112, provides:

> An insurance company shall not deny insurance coverage to an insured because of failure of an insured to seasonably notify an insurance company of an occurrence, incident, claim or of a suit founded upon an occurrence, incident or claim, which may give rise to a liability insured against unless the insurance company has been prejudiced thereby.

G.L. c. 175, § 112 (as amended by 1977 Mass. Acts 437).

In *Johnson Controls, Inc. v. Bowes*, 381 Mass. 278, 409 N.E.2d 185 (1980), the Supreme Judicial Court extended the prejudice requirement to cases arising under liability insurance forms not covered by the statute. *Johnson Controls, Inc. v. Bowes*, 381 Mass. at 282, 409 N.E.2d at 187. Accordingly, in cases governed either by the statute or by *Johnson Controls*, an insurer now must prove that its interests have been prejudiced in order to escape coverage for "late notice."

The Supreme Judicial Court has stated that to satisfy the prejudice requirement, "the delay in notice must be accompanied by a showing of some other facts or circumstances (such as, for example, the loss of critical evidence or testimony from material witnesses despite diligent good faith efforts on the part of the insurer to locate them) which demonstrates that the insurer's interests have been actually harmed." *Darcy v. Hartford Ins. Co.*, 407 Mass. 481, 486, 554 N.E.2d 28, 31 (1990). While the length of delay is relevant in determining whether actual prejudice has been shown, it is only one factor in the analysis, and the insurer must point to some actual harm before coverage can be disclaimed. *Darcy v. Hartford Ins. Co.*, 407 Mass. at 486, 554 N.E.2d at 31.

The nature of the necessary showing was described by Justice Kaplan in *Employers' Liability Assurance Corp. v. Hoechst Celanese Corp.*, 43 Mass.App.Ct. 465, 684 N.E.2d 600 (1997), as follows:

"While the length of delay is relevant in determining whether actual prejudice has been shown, it is only one factor in the analysis, and the insurer must point to some actual harm before coverage can be disclaimed."

> [The inquiry is into] what prejudice the insurer has incurred, and could not by its own actions reasonably avoid, in consequence of the late notice—any such prejudice having to relate to the insurer's general object of defeating fraudulent, invalid, or exaggerated claims. And the prejudice shown, to relieve the insurer, must have been material and specific. The insurer is challenged to show that it suffered "actual prejudice," not just a "possibility" of it; that there has been "actual harm" to its interests; that it has been relegated to a "substantially less favorable position than it would have been in had timely notice been provided." Further, the insurer has "the burden of identifying the precise manner in which its interests have suffered."

Employers' Liab. Assurance Corp. v. Hoechst Celanese Corp., 43 Mass.App.Ct. at 476, 684 N.E.2d at 608 (quoting *Darcy v. Hartford Ins. Co.*, 407 Mass. 481, 486–87, 554 N.E.2d 28, 31–32 (1990)).

Unavailability of information surrounding the events of the claim is one potential consequence of late notice that Massachusetts courts have found to constitute adequate prejudice to defeat coverage. In *Eastern Products Corp. v. Continental Casualty Co.*, 58 Mass.App.Ct. 16, 23 (2003), the insured operated a rubber-manufacturing business for several decades. During operations, several fires broke out on the business property, burning large volumes of rubber. The Department of Environmental Protection designated the property as a confirmed disposal site approximately seven years after the last fire on the property. The insured first notified its insurers a year and a half after the DEP designation and the discontinuation of operations. The court found that between the time the insured's duty to provide notice "as soon as practicable" had arisen and the time the insured actually provided notice, the insured's president (who had the most knowledge about the fires) had died and the insured, in winding up its operations, had destroyed all of its correspondence and business records. The court found this to be sufficient prejudice to defeat coverage. *Eastern Prods. Corp. v. Continental Cas. Co.*, 58 Mass.App.Ct. at 23.

Under "occurrence"-basis CGL policies, then, the insured is not at risk of a technical forfeiture if its notice to the insurer is delayed; the insurer must show that the *purpose* of the notice clause was frustrated before coverage will be lost. Obviously, the best course for the policyholder is to comply with the letter of the clause and give the insurer prompt notice when it becomes aware of circumstances that could result in a lawsuit or liability. In cases in which notice is delayed, however, the prejudice issue ordinarily will be fact sensitive, and an insurer who is otherwise obliged to defend will be required to do so until the notice question is resolved. *See generally Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. 295, 304–05, 636 N.E.2d 247, 252–53

(1994) (insurer, having reserved right to disclaim coverage, cannot then "sit back and essentially do nothing," but must investigate and defend claim until the question of coverage can be determined).

(b) Notice Under Claims-Made Policies

A claims-made liability policy is called into play where the claim is made against the policyholder during the policy period. These policies usually also provide that a claim made during the policy period will be covered only if the injury or damage at issue did not occur before a "retroactive date" specified in the declarations. A variation on the claims-made concept, frequently employed in professional "errors and omissions" liability policies, explicitly requires *both* that the claim be asserted against the insured *and* that the insured report the claim to the insurer during the policy period. Both straight claims-made and "claims-made and reported" policies also may provide for an "extended reporting period" that comes into play if the coverage is cancelled or will not be renewed, or if the renewal or replacement policy to be issued has a later retroactive date than the expiring policy or will not be written on a claims-made basis. In those circumstances, the "extended reporting period" permits the insured to notify the insurer of occurrences or claims during a short period following policy expiry, thereby "locking in" coverage under the policy for certain claims and avoiding an unintended coverage "gap" resulting from the change in insurer or coverage.

Specifically, under the current claims-made CGL form, the basic "extended reporting period" permits the policyholder to give the insurer notice, not later than 60 days after the end of the policy period, of any bodily injury or property damage that took place before the end of the policy period but not before the retroactive date, in which case any claim resulting from that injury or damage may be reported to the insurer within five years of policy expiration. Similarly, the insured is permitted to notify the insurer, not later than 60 days after the end of the policy period, of any "offense" committed before the end of the policy period but not before the retroactive date, in which case any "personal and advertising injury" claim resulting from that "offense" may be reported to the insurer within five years of policy expiration. Finally, the insured is permitted to report to the insurer, within 60 days of the end of the policy period, any claims arising from "occurrences" or "offenses" not previously reported to the insurer, again provided that the injury or damage, or "offense," took place before the end of the policy period but not before the retroactive date.

The Supreme Judicial Court first addressed the "late notice" issue under a claims-made policy in *Chas. T. Main, Inc. v. Fireman's Fund Insurance Co.*, 406 Mass. 862, 551 N.E.2d 28 (1990). The particular policies at issue in *Chas. T. Main* were

professional liability policies, and the Court's discussion suggests that the policies were of the "claims-made and reported" variety. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 863–64, 551 N.E.2d at 28–29 ("A claims-made policy covers the insured for claims made during the policy year *and reported within that period or a specified period thereafter* regardless of when the covered act or omission occurred.") (emphasis added). It was undisputed that the underlying claim was made against the insured during the policy period and that the insured reported the claim to the primary carrier during the policy period. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 863, 551 N.E.2d at 28. It was also undisputed that the plaintiff insured did not report the claim to the defendant excess carrier until long after its policy expired. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 863, 551 N.E.2d at 28. The trial court granted the excess insurer's motion for summary judgment on late notice grounds and the insured appealed. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 862–63, 551 N.E.2d at 28.

The Supreme Judicial Court affirmed, ruling that neither Section 112 nor *Johnson Controls* applies to claims-made policies, and thus the insurer need *not* show prejudice from the insured's late reporting of a claim. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. 863, 865, 551 N.E.2d 28, 30 (1990). The Court based its conclusion on its view of the differing purposes of "as soon as practicable" notice provisions and claims-made policy reporting requirements. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 864, 551 N.E.2d at 29. The Court explained that the move to claims-made coverage was designed to achieve "fairness in rate setting" by reducing the time lag between "the insured event and the insurer's payoff," thereby diminishing the uncertainties that accompany the passage of time. *See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 864–65, 551 N.E.2d at 29–30. Under a claims-made policy, according to the Court:

> [T]he insured event is the claim being made against the insured during the policy period and the claim being reported to the insurer within that same period or a slightly extended, and specified period. If a claim is made against an insured, but the insurer does not know about it until years later, the primary purpose of insuring claims rather than occurrences is frustrated. Accordingly, the requirement that notice of the claim be given in the policy period or shortly thereafter in the claims-made policy is of the essence in determining whether coverage exists.

Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 406 Mass. at 865, 551 N.E.2d at 30. Based on this premise, the Court felt that imposition of a prejudice requirement would

"defeat the fundamental concept" underlying claims-made coverage, with the likely result that claims-made policies "would vanish from the scene." *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 865, 551 N.E.2d at 30. The Court was unwilling to believe that the legislature intended such a result in enacting Section 112. *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. at 865, 551 N.E.2d at 30.

The *Chas. T. Main* decision was most clearly justified in the context of "claims-made and reported" policies. In these policies, the risk insured against *is* that claims will be made *and reported* during the policy period. To the extent that the Supreme Judicial Court assumed that *all* claims-made policies require policy period claim reporting, however, it was mistaken. To illustrate this point, it should suffice to note that the standard claims-made CGL policy has *never* been a "claims-made and reported" form since its 1986 introduction. According to a widely used reference work:

> There is no requirement in the claims-made CGL… that a claim must be *reported to the insurer* during the policy period, if such a report is not "practicable." Issues of late notice and prejudice in the context of claims-made CGL coverage are essentially the same as those that would apply to occurrence coverage.

J.P. Gibson, M.C. McLendon & W.J. Woodward, *Commercial Liability Insurance* at II.O.4 (International Risk Management Institute, 1999). Thus, it remained an open question in Massachusetts whether the *Chas. T. Main* ruling on the prejudice question would also apply to claims-made policies that do not require policy period reporting.

The question appears to have been resolved by the Supreme Judicial Court's decision on further appellate review in *Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. 678, 677 N.E.2d at 1144677 N.E.2d at 1145677 N.E.2d at 1145677 N.E.2d at 1145. The trial court allowed the insurer's motion, relying on *Chas. T. Main. Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. at 679, 677 N.E.2d at 1145.

The Appeals Court reversed, finding that the claims-made policy before it did *not* require claims to be reported during the policy period, but only that the insured provide "prompt written notice" of claims or suits and "immediately send [the insurer] copies of any demands, notices, summonses or legal papers received in connection with the claim or 'suit,'" just as did the policy at issue in *Johnson Controls. Tenovsky v. Alliance Ins. Group*, 40 Mass.App.Ct. 204, 206, 662 N.E.2d 716, 717 (1996) (citing *Johnson Controls, Inc. v. Bowes*, 381 Mass. 278, 279 n.2, 409 N.E.2d 185, 186 n.2 (1980)). The Appeals Court declined to follow *Chas. T. Main*, finding that "the policy in that case differed materially from the policy before us" due to its requirement

that the claim be reported during the policy period. *Tenovsky v. Alliance Ins. Group*, 40 Mass.App.Ct. at 207, 662 N.E.2d at 718. It rejected the insurer's argument that the "extended reporting period" clause of its policy—which was operative because the policy had been cancelled—brought the case within the reasoning of *Chas. T. Main. Tenovsky v. Alliance Ins. Group*, 40 Mass.App.Ct. at 207 n.5, 662 N.E.2d at 718 n.5.

The Supreme Judicial Court granted further review and affirmed the trial court's grant of summary judgment in favor of the insurer. *Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. 678, 679, 677 N.E.2d 1144, 1145 (1997). The Court quoted at length from the *Chas. T. Main* opinion's discussion of the underwriting benefits of claims-made policies. *Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. at 680–81, 677 N.E.2d at 1145–46. It noted the "prompt" notice requirement of the policy conditions, observing that, "[s]urely, 'prompt' notice of 'claims made' requires that notice be given to the insurer no later than sixty days following the expiration of the policy period." *Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. at 681, 677 N.E.2d at 1145–46. On this basis, the Court concluded that the policy before it was "not materially different from the policy considered in *Chas. T. Main*, above. Both policies require that the claim, the insured event, be reported to the insurer during the term of the policy or at least promptly after its expiration." *Tenovsky v. Alliance Syndicate, Inc.*, 424 Mass. at 681, 677 N.E.2d at 1146. The Court did not specify the policy language on which it relied for its finding that the policy at issue in *Tenovsky* contained such a reporting requirement.

The reasoning of the *Tenovsky* opinion is arguably a departure from the Supreme Judicial Court's established approach to insurance policy interpretation, in which the policy language is paramount. *See, e.g., Trustees of Tufts Univ. v. Commercial Union Ins. Co.*, 415 Mass. 844, 849, 616 N.E.2d 68, 72 (1993) (discussing insurance contract interpretation principles). The Court seems to have relied on a conception of the essential nature of claims-made coverage, as articulated in *Chas. T. Main*, to find an implied reporting requirement where the policy language did not impose such a requirement. The "extended reporting period" provision cannot serve to supply the necessary "essence," since it does not even become operative except in the narrow circumstances (e.g., cancellation) described above. Decisions such as *Tenovsky*, which have excepted straight claims-made policies (as opposed to "claims-made and reported" policies) from an otherwise applicable prejudice rule, have been criticized as ascribing to the claims-made approach a focus on reporting that it simply does not possess. *See, e.g.*, J.W. Stempel, *Law of Insurance Contract Disputes* § 9.01[c], at 9-13 to 9-17 (2d ed. 2000).

Even assuming that *Tenovsky* remains the law of Massachusetts, it is still unclear whether Section 112 will be held to apply to a case in which notice, albeit given within the policy period of a claims-made policy, is still "late" within the meaning of the notice condition. Surely neither *Chas. T. Main* nor *Tenovsky* stands for the proposition that notice will *always* be timely so long as it is given during the policy period. This being so, it would seem reasonable to expect that Section 112 *will* be held to apply to claims involving delayed notice given during the policy period even where coverage is on a claims-made basis. Such a result would do no violence to the underwriting concepts discussed in *Chas. T. Main*.

§ 1.3.3 The Duty to Cooperate

(a) In General

In addition to imposing an obligation to provide the insurer with prompt notice of "occurrences," "offenses," or claims and suits, CGL policies also require the policyholder to cooperate with the insurer in the defense and settlement of the claim and the pursuit of any right of contribution or indemnity against third parties. In addition, the insured "must do nothing after loss" to impair the insurer's subrogation rights. The 1966 and 1973 standard provisions for CGL policies include, as Condition 4(c), the following language:

> The insured shall cooperate with the company and, upon the company's request assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of injury or damage with respect to which insurance is afforded under this policy; and the insured shall attend hearings and trials and assist in

"The 'extended reporting period' provision cannot serve to supply the necessary 'essence,' since it does not even become operative except in the narrow circumstances (e.g., cancellation) described above."

> securing and giving evidence and obtaining the attendance of witnesses. The insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

Subsequent iterations of the standard provisions impose the same obligations, albeit in a somewhat different format.

Duty-to-cooperate issues arise frequently in two distinct guises. The first involves the exchange of information that commonly takes place shortly after the insurer has been notified of the "occurrence" or "claim." Insurers often contend that Condition 4(c) requires the policyholder not only to share information pertinent to the claim, but also to respond fully to detailed requests for information and documents pertinent *only* to coverage issues. For example, where the policyholder seeks coverage for underlying hazardous waste claims, the insurer often will seek information on the question whether the releases of contaminants that form the basis of the claim were "sudden and accidental" within the meaning of the "qualified" pollution exclusion.

Policyholders sometimes have espoused a more narrow view, contending that the exclusive purposes of Condition 4(c) are:

- to enable an insurer *that has assumed the defense* to call on the insured to cooperate in the conduct of that defense; and

- to permit an insurer *that has agreed to indemnify* to determine whether, and on what terms, the claim will be settled.

These policyholders contend that Condition 4(c) simply does not speak to the exchange of information on coverage issues and is not to be used as a one-sided discovery tool to enable the insurer to develop information to support a disclaimer. Arguably, the insurer's information needs with respect to determining whether it must defend are satisfied by the complaint (see § 1.2.1(a) above), and the determination of any indemnity obligation is premature prior to disposition of the underlying claim (see § 1.2.2(a) above).

The author is not aware of any Massachusetts decisional authority resolving the issue of whether Condition 4(c) requires the policyholder to provide information to the insurer for purposes of its "coverage analysis." It would appear, instead, that the question most often is dealt with through *mutual* cooperation between insurer and insured—each cognizant of their implied covenant of "good faith and fair dealing"

under the contract, *see Sarnafil, Inc. v. Peerless Ins. Co.*, 34 Mass.App.Ct. 248, 255, 609 N.E.2d 1234, 1238 (1993), *on further review*, 418 Mass. 295, 303–04, 636 N.E.2d 247, 252 (1994)—*regardless* of what the "cooperation clause" may or may not require. Practical considerations often are paramount. For example, while it may be doctrinally defensible for the policyholder to contend that the indemnity question is premature pending the outcome of the claim, if the policyholder desires the insurer to *fund* a settlement—as opposed to merely making reimbursement at a later date—the insurer must be in a position to evaluate its indemnity position at the time the settlement opportunity arises.

Other considerations likewise militate in favor of disclosure. A policyholder must carefully weigh the potential consequences of resisting or postponing compliance with an insurer's request for information. Suppose, for example, that a key witness to coverage-pertinent events dies after the insurer requests information but before disclosure is made. The insurer may then claim prejudice to its position by reason of the insured's nondisclosure, potentially supporting a forfeiture of coverage either on a "failure to cooperate" or a "late notice" theory. *Cf. Fireman's Fund Ins. Co. v. Valley Manufactured Prods. Co.*, 765 F.Supp. 1121 (D.Mass. 1991) (Massachusetts law), *aff'd per curiam*, 960 F.2d 143 (1st Cir. 1992) (*post*-notice death of key witness to alleged accident defeats coverage on "late notice" grounds).

The second context in which the cooperation obligation frequently is cited is the one for which it was most clearly designed: the relation between insurer and policyholder during the course of defense of the underlying claim. As the express language of the condition contemplates, the policyholder must make himself or herself available to testify and must comply with the insurer's reasonable requests for assistance in developing evidence. While a breach of the cooperation condition will not relieve the insurer of its obligations in the absence of actual prejudice to its interests, *see Darcy v. Hartford Ins. Co.*, 407 Mass. 481, 488–89 (1990), an insured's failure to cooperate clearly can cause such prejudice. For example, in *Metlife Auto & Home v. Cunningham*, 59 Mass.App.Ct. 583 (2003), the insured's invocation of the Fifth Amendment in response to questions about the death of the plaintiff's decedent in a wrongful death action was found to be "the quintessence of prejudice," justifying a forfeiture of coverage. *Metlife Auto & Home v. Cunningham*, 59 Mass.App.Ct. at 591–92.

Finally, although more common in the first-party insurance context, insurer requests for examination under oath deserve special mention because failure to comply with such a request may constitute a defense to coverage even without evidence of prejudice to the insurer. *Hanover Ins. Co. v. Cape Cod Custom Home Theater, Inc.*, 72 Mass.App.Ct. 331, 336, 891 N.E.2d 703, 707 (2008).

(b) The "Voluntary Payments" Clause

Another critical issue arising under Condition 4(c) concerns the impact of its second sentence, which provides that the insured "shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense." The so-called "voluntary payments" question often comes to the fore in environmental claims where the policyholder agrees to undertake some aspect of the investigation or cleanup of a contaminated site without first consulting the insurer—either where notice had yet to be given or where the insured is controlling the defense because the insurer has reserved the right to disclaim. Assuming a commitment was in fact made, absent advance consultation with the insurer, the question arises whether this fact alone relieves the insurer of any obligation to pay the costs at issue, or whether the insurer must demonstrate prejudice to its interests resulting from the insured's commitment. The Supreme Judicial Court had occasion to address this question in *Augat, Inc. v. Liberty Mutual Insurance Co.*, 410 Mass. 117, 571 N.E.2d 357 (1991).

In *Augat*, the policyholder, faced with an environmental claim resulting from a discharge of contaminated water into a municipal sewer system, entered into a consent order with the Commonwealth, requiring it to conduct the entire cleanup at its own expense. *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. 117, 118–19, 571 N.E.2d 357, 358 (1991). Augat gave notice to the insurer only after it had signed the consent order and the consent order had been entered as a judgment in a suit filed by the Commonwealth. *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. at 118–19, 571 N.E.2d at 358. In response to the insurer's disclaimer based on the "voluntary payments" provision, Augat argued, inter alia, that the insurer was required to demonstrate prejudice to its position in order to make out a forfeiture of coverage. *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. at 122, 571 N.E.2d at 358.

The Court acknowledged that the purpose of the "voluntary payments" language—to allow the insurer an opportunity to protect its interests—was the same as that of other provisions with respect to which a showing of prejudice is required, including the notice and consent-to-settlement provisions and the cooperation clause itself. *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. 117, 122–23, 571 N.E.2d 357, 358 (1991) (citing *Johnson Controls, Inc. v. Bowes*, 381 Mass. 278, 282, 409 N.E.2d 185, 187 (1980) (notice); *MacInnis v. Aetna Life & Cas. Co.*, 403 Mass. 220, 223, 526 N.E.2d 1255, 1257 (1988) (consent –to settlement); and *Darcy v. Hartford Ins. Co.*, 407 Mass. 481, 491, 554 N.E.2d 28, 34 (1990) (cooperation)). In the peculiar circumstances of *Augat*, however, the Court concluded that the undisputed facts demonstrated a complete frustration of the purpose of the "voluntary payments" language, obviating any need for a further showing of prejudice. *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. at 123, 571 N.E.2d at 358. In the words of the Court:

> After Augat agreed to a settlement, entered into a consent judgment, assumed the obligation to pay the entire cost of the cleanup, and in fact paid a portion of that cost, it was too late for the insurer to act to protect its interests. There was nothing left for the insurer to do but issue a check. We conclude, therefore, that no showing of prejudice is required in this case.

Augat, Inc. v. Liberty Mut. Ins. Co., 410 Mass. at 123, 571 N.E.2d at 358; *see also Atlas Tack Corp. v. Liberty Mut. Ins. Co.*, 48 Mass.App.Ct. 378, 383–86, 721 N.E.2d 8, 12–14 (1999) (insured's undertaking, without consulting insurer, to remove "all pollutants" from a waste site established prejudice as a matter of law and forfeited coverage for claims by state and federal agencies).

After *Augat*, insurers frequently argued that a showing of prejudice is not required in the context of the voluntary payments clause. Policyholders interpreted the decision as simply finding prejudice on the undisputed facts due to the extreme nature of the circumstances. Recent cases indicate that the latter view is correct. In its *Sarnafil* opinion, for example, the Supreme Judicial Court specifically cited *Augat* as standing for the proposition that prejudice must be shown before an insurer will be relieved of its obligations for breach of a policy condition. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. 295, 302, 305, 636 N.E.2d 247, 251, 253 (1994). *Accord New England Extrusion, Inc. v. American Alliance Ins. Co.*, 874 F.Supp. 467, 470–71 (D.Mass. 1995); *Employers' Liab. Assurance Corp. v. Hoechst Celanese Corp.*, 43 Mass.App. Ct. 465, 479–81, 684 N.E.2d 600, 609–10 (1997).

Where the opportunity remains open, it is most prudent for the policyholder to consult with the insurer in advance of making any commitment that will result in costs for which coverage is desired. The *Augat* opinion at least suggests that such consultation should be sufficient, even if the insurer does not expressly assent to the undertaking; indeed, the *Augat* Court deemed the insured's commitment in that case to be "voluntary" precisely because the insured "had an alternative—it had the right to demand that [the insurer] defend the claim and assume the obligation to pay for the cleanup." *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. 117, 122, 571 N.E.2d 357, 358 (1991). Presumably, where such a demand is made and refused, the insurer ordinarily will *not* be heard to claim that the payment was "voluntary." *See Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. 295, 305 n.6, 636 N.E.2d 247, 253 n.6 (1994) (citing *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. 777, 779 (D. Mass. 1977) (where insurer has reserved rights, it is *obligated* to consent to reasonable voluntary action by insured)); *Berke Moore Co. v. Lumbermens Mut. Cas. Co.*, 345 Mass. 66, 70–71, 185 N.E.2d 637, 639–40 (1962) (insurer that improperly declines to defend may not avoid liability in reliance on policy provision that limits its obligation to the amount of a settlement consented to by it).

(c) Pre-Tender Costs

The "voluntary payments" clause often is invoked by insurers (together with policy notice provisions) in refusing to reimburse for costs the insured has incurred in response to a claim or suit before notifying the insurer or "tendering" the defense. Insurers often refuse to reimburse "pre-tender costs" even where they do not otherwise disclaim coverage. They contend that, since they had no opportunity to have any influence at all on the decisions leading to the expenditures, this alone should suffice for a showing of prejudice, assuming such a showing is required.

No Massachusetts appellate decision has yet addressed a situation in which a policyholder sought reimbursement for costs incurred before the insurer had any notice *at all* regarding a claim. Nevertheless, the *Sarnafil* decision is very nearly on point and may signal that Massachusetts will require a prejudice showing to justify an insurer's refusal to reimburse pre-tender costs. *Sarnafil* was a dispute between a roofing manufacturer and its insurer over defense coverage for claims asserted against the manufacturer by an installer of its roofing products. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. 295, 298 (1994). The insured manufacturer advised the insurer of the installer's claim when it first received a claim letter from the installer. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 298–99. The insurer reserved rights and eventually advised the insured by letter that, although it did not believe the allegations in the installer's claim letter to be covered, it would review this position "as further developments… occur and more specific claims are made." *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 299–301. After the insurer reserved rights, the insured filed an arbitration proceeding against the installer as a preemptive measure, in response to the installer's threat to file a lawsuit. The installer promptly filed a counterclaim in the arbitration. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 300. The insured then handled the entire arbitration proceeding, which involved twenty-six days of hearings, with its own counsel, and did not notify the insurer of the installer's arbitration counterclaim—the matter defended—until after the proceedings were completed. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 301. When the insurer refused to reimburse the costs its insured incurred in connection with the arbitration, the insured filed a coverage action seeking reimbursement of defense costs. *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 296–301.

"…the Sarnafil decision is very nearly on point and may signal that Massachusetts will require a prejudice showing to justify an insurer's refusal to reimburse pre-tender costs."

The *Sarnafil* court reversed a grant of summary judgment in favor of the insurer with regard to the counterclaim defense costs, finding, inter alia, that there were factual disputes over "whether [the insurer] actually suffered any prejudice as a result of [the insured's] actions," and thus whether the insured's "violations frustrated the purposes of the notice and voluntary payment provisions." *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 302. The court later reiterated that, "before [the insurer] could be relieved of responsibility based on [the insured's] violations of insurance provisions, [the insurer] would have to show that it incurred actual prejudice." *Sarnafil, Inc. v. Peerless Ins. Co.*, 418 Mass. at 305. Thus, notwithstanding that the *Sarnafil* insurer did not receive notice of the "suit" (the arbitration counterclaim) until after it was resolved, the court nevertheless required a showing of prejudice in order for the insurer to avoid reimbursement of defense costs. Given that standard policies have independent requirements for claim and suit notification, and that only a "suit" invokes the duty to defend, it is arguable that the insurer's prior receipt of a claim notice in *Sarnafil* was irrelevant to the result, and that *Sarnafil* should control in the more typical "pre-tender costs" case dealing with expenditures made before any notice was given.

Liberty Mut. Ins. Co. v. Black & Decker Corp., 383 F.Supp.2d 200, 207 (D.Mass. 2004), supports this approach. Reasoning that "[t]he widely-followed late notice doctrine under which post-notice costs are recoverable absent prejudice, but pre-notice costs are *per se* excluded, is in tension with the underpinnings of Massachusetts's analysis of the notice clause," the *Black & Decker* court predicted that the Supreme Judicial Court would permit recovery of pre-notice defense costs absent prejudice. *Liberty Mut. Ins. Co. v. Black & Decker*, 383 F.Supp.2d at 207; *see also Pacific Ins. Co. v. Eaton Vance Mgmt.*, 260 F.Supp.2d 334 (D.Mass. 2003) (costs covered); *Amtrol v. Tudor Ins. Co.*, 2002 U.S. Dist. LEXIS 18691 (D.Mass. Sept. 10, 2002) (costs covered). Other trial court decisions on the issue have reached the opposite conclusion, however. *Managed Health Care Sys., Inc. v. St. Paul Fire & Marine Ins. Co.*, 2001 U.S. Dist. LEXIS 18302 (D.Mass. Sept. 28, 2001) (costs not covered); *American Mut. Liab. Ins. Co. v. Beatrice Cos.*, 924 F.Supp. 861 (E.D.Ill. 1996) (Massachusetts law) (costs not covered); *Hoppy's Oil Serv. v. Insurance Co. of N. Am.*, 783 F.Supp. 1505 (D.Mass. 1992) (pre-*Sarnafil* decision holding costs not covered).

§ 1.3.4 The Duty to Mitigate Damages

The 1966 version of the standard CGL form contained, as part of the same condition imposing notice and cooperation duties, a clause providing that, in the event of an "occurrence," "[t]he insured shall promptly take at his expense all reasonable steps to prevent other bodily injury or property damage from arising out of the same or similar conditions, but such expense shall not be recoverable under this policy." The quoted sentence, which might be described as a mitigation-of-damages clause, was dropped in 1973. It would be a mistake, however, to conclude that, under more recent policies, the insured has no mitigation duty. If the insured is aware of a defect or other condition in its products, premises or operations that is causing injury or damage, then, at least to the extent that the damage-causing agent has yet to escape from the insured's actual control, the insured must correct the problem or coverage for further injury or damage will be lost.

The appropriate limit of an insured's mitigation duty under the 1966 form was examined in *Chemical Applications Co. v. Home Indemnity Co.*, 425 F.Supp. 777 (D. Mass. 1977). In that case, the insured sought coverage for costs incurred to clean up an oil spill in navigable waters. *Chemical Applications Co. v. Home Indem. Co.*, 425 F. Supp. at 778. As soon as the insured learned of the spill, it notified its insurer and requested that the insurer fund an emergency cleanup. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 778–79. The insurer did not respond. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 779. Rather than await government intervention at a cost expected to exceed the limit of the policy, the insured conducted a partial cleanup itself and sought reimbursement from the insurer. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 779. The insurer finally responded by disclaiming coverage in reliance on the mitigation clause and the voluntary payments clause discussed above. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 779. The insured sued to recover its costs. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 778.

The court easily disposed of the insurer's contention that the mitigation provision required the insured to incur the cleanup expenses and that, under that provision, the costs were not recoverable under the policy. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. 777, 778 (D.Mass. 1977). The court (Aldrich, J.) reasoned as follows:

> In terms, and concept, [the mitigation clause] imposes a duty on plaintiff to take steps to prevent further injury—to correct the fault—

> not to repair or restore what has already occurred. If the insured had to repair at its own expense the damage that had already occurred, the policy would be meaningless.

Chemical Applications Co. v. Home Indem. Co., 425 F.Supp. at 778. The court also rejected the insurer's "voluntary payments" defense, relying on *Murach v. Massachusetts Bonding & Insurance Co.*, 339 Mass. 184, 187, 158 N.E.2d 338, 341 (1959), and the insurer's duty to settle. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 779. In the court's view, under "the principle of good faith and reasonableness," the insurer could not be permitted to deny liability in the circumstances. *Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. at 779.

Judge Aldrich's view of the purpose of the mitigation clause is confirmed by a memorandum promulgated by a predecessor of the Insurance Services Office that explains the changes in the 1973 standard CGL form. According to that memorandum, the mitigation clause was deleted because it "had been read by some as a policy limitation although it was not intended as such but rather was directed only toward emphasizing that any steps taken would be at the expense of the insured." The memorandum noted a related change to the "Supplementary Payments" provision, making clear that the policy would reimburse the insured for reasonable expenses incurred at the company's request in assisting the insurer in the investigation or defense of any claim or suit. It emphasized that, "as heretofore, the definition of 'occurrence' would be relied upon in an appropriate case as to whether the injury or damage was expected or intended from the standpoint of the insured."

This passage shows that the *Chemical Applications* interpretation of the mitigation provision was correct, in addition to showing why a mitigation duty—or its functional equivalent—remains even after the clause was eliminated. That the clause was not intended as a "policy limitation" suggests that it was not intended to do what the insurer in *Chemical Applications* sought to accomplish with its invocation—to shift a loss otherwise chargeable to it back to the policyholder. *See Chemical Applications Co. v. Home Indem. Co.*, 425 F.Supp. 777, 779–80 (D.Mass. 1977). That the clause was not necessary to compel the insured to "correct the fault" is pointed up by the reference to the requirement that the harm resulting from an occurrence not be "expected or intended" by the insured. Once the insured is aware that a fault exists (for example, that an oil pipe has sprung a leak and is contaminating a waterway), if the insured nevertheless fails to repair the fault (in this case, the leak), the damage resulting from the fault ceases to be unexpected, and coverage is lost. *Cf. Lumbermens Mut. Cas. Co. v. Belleville Indus.*, 407 Mass. 675, 681 n.6, 555 N.E.2d 568, 572 n.6 (1990) (in construing the "sudden and accidental"

exception to a pollution exclusion, the Court noted that, if a "discharge, initially both accidental and sudden, continues for an extended period, …at some point, presumably, it would likely cease to be accidental or sudden (even in the sense of unexpected)"). Whether express or implied, a duty to mitigate of the sort described in *Chemical Applications* would appear always to exist under a CGL policy.

EXHIBIT A - Court's Order Staying Litigation in *Eastern Enterprises v. Hanover Insurance Co.*

COMMONWEALTH OF MASSACHUSETTS
COUNTY OF MIDDLESEX
THE SUPERIOR COURT

DOCKET# **MICV93-01458F**

RE: Eastern Enterprises v Hanover Insurance Co et al

TO: Jonathan Z Pearlson
Nutter, McClennen & Fish
1 International Place
Boston MA 02110

NOTICE OF DOCKET ENTRY

You are hereby notified that on 04/29/96 the following entry was made on the above referenced docket:

Request For Clarification and/or Qualified Stay of All Proceedings by Hanover Insurance Co, Affidavit of Scott J. Nathan, and Opposition to above request by Eastern Enterprises, (received in Middlesex Superior Crt from Judge Lopez 2 May 1996), and; After hearing and consideration of the papers, this Court orders a stay of litigation of coverage defenses as to Hanover. SCA v. Transportation Ins. Co. 419 Mass. 528(1995) distinguishable on grounds that there actual knoweledge based on an adjudication existed. Some prejudice to insured allowed since that is part of the risk it takes. Haskel, Ins. v. Superior Court, 33 Cal App 4th 963(1995). (Lopez, J.) notices sent 5/2/96

Dated: 2nd day of May, 1996

Edward J Sullivan
Clerk of the Courts

BY:
Wayne Emerson, Asst Clerk
Telephone: 617-494-4281

EXHIBIT B -
Court's Order Staying Discovery in *Commercial Union Insurance Co. v. RohmTech, Inc.*

12

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
DEPARTMENT OF THE
TRIAL COURT
CIVIL ACTION NO. 94-2231F

COMMERCIAL UNION INSURANCE COMPANY,

Plaintiff,

v.

ROHMTECH, INC.,

Defendants.

ROHMTECH, INC.'S MOTION FOR A PROTECTIVE ORDER OR, IN THE ALTERNATIVE, TO STAY FURTHER PROCEEDINGS AND REQUEST FOR HEARING

Pursuant to Mass. R. Civ. P. 26(c), defendant RohmTech, Inc. ("RohmTech") respectfully moves the Court for a protective order from discovery propounded by the plaintiff, Commercial Union Insurance Company, Ltd. ("CU"), consisting of Interrogatories, a Document Request, and the deposition of a non-party witness, Dr. James Critser (which has been noticed for June 20, 1995). CU's discovery is not appropriate at this stage of the proceedings. Recent case law demonstrates that CU's discovery should be stayed. Moreover, the discovery requires RohmTech to disclose privileged, confidential and prejudicial information regarding the Environmental Protection Agency's ("EPA's") theories of RohmTech's liability and RohmTech's defenses thereto in the ongoing administrative proceeding that forms the basis for CU's declaratory judgment action. Under well-settled legal principles, the potential claim by RohmTech on excess policies

issued by CU's predecessor, the Employers Liability Assurance Company ("ELAC"), is speculative and contingent; this claim is not ripe for adjudication prior to any liability imposed by the EPA.

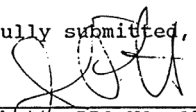
In the alternative to the issuance of a protective order, RohmTech respectfully moves the Court for an order staying discovery in this action pending final determination of the issues raised by the EPA investigation and RohmTech's potential liability. Formal mediation proceedings have commenced with respect to the potential EPA claim; a stay of discovery is necessary to avoid duplicative litigation, the unnecessary expenditure of fees and costs by the parties, and waste of this Court's resources.

The Court's attention is respectfully invited to the accompanying memorandum in support of this motion.

REQUEST FOR HEARING

Pursuant to Superior Court Rule 9A(c)(2), RohmTech respectfully requests a hearing on the within motion. RohmTech believes that a hearing will be of material assistance to the court in deciding the motion.

Respectfully submitted,



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Dated: May 26, 1995

MOTION

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the above document was served upon the attorney of record for each party by first class mail/hand on this date.

June 16, 1995

Motion allowed as to all discovery by the plaintiff which has the potential to establish the defendants' liability on the EPA claim or to remove any limitation on the extent of such liability (as in 42 USC § 9607) including the deposition of Dr Jos. Cuitas. See Haskel, Inc v Superior Court, 33 Cal. App. 4th 963. The insurer was paid to take the risk so that if between two parties prejudice due to loss of evidence or otherwise is to be suffered, the insurer must be the one to suffer. It cannot act for its own benefit to the prejudice of its insured. All such discovery is ordered stayed. If there is discovery with absolutely no potential for prejudice to the insured, it may be pursued but the court will evaluate any such proposed discovery from the viewpoint of protecting the insured from prejudice.

June 16, 1995 O F Bonnett. J

EXHIBIT C - Court's Allowance of Protective Order in *American Policyholders Insurance Co. v. Nyacol Products, Inc.*

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

SUPERIOR COURT
CIVIL ACTION
No. 91-8667

97

AMERICAN POLICYHOLDERS INSURANCE COMPANY

vs.

NYACOL PRODUCTS, INC., et al.[1]

vs.

COMMERCIAL UNION INSURANCE COMPANY, et al.[2]

95 JAN 31 AM 9:28

MEMORANDUM OF DECISION AND ORDER
ON DEFENDANTS' MOTION FOR PROTECTIVE ORDER

Plaintiff American Policyholders Insurance Company (American) brings this action seeking a declaratory judgment that it is not obligated to defend or indemnify defendants Nyacol Products, Inc. (Nyacol), Robert Lurie (Lurie), or Thomas L. O'Connor (O'Connor) (collectively NPI) for claims brought against NPI by the Massachusetts Department of Environmental Protection (DEP) and the United States Environmental Protection Agency (EPA). The defendants filed counterclaims for declaratory judgment against American and also filed third party claims seeking similar declaratory relief against their other insurers, Commercial Union

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[1] Robert Lurie, Thomas L. O'Connor, Daniel S. Greenbaum, as he is Commissioner of the Commonwealth of Massachusetts Department of Environmental Protection.

[2] National Union Fire Insurance Company, and Utica Mutual Insurance Company as third party defendants.

Insurance Company (CU), National Union Fire Insurance Company (National), and Utica Mutual Insurance Company (Utica). NPI now moves for a protective order from discovery noticed and proposed by American on the grounds that such discovery will prejudice NPI in the EPA/DEP proceedings.[3] Based on the following, NPI's motion is allowed.

BACKGROUND

This case involves insurance coverage for environmental claims arising out of the Nyanza Superfund Site in Ashland, Massachusetts (the site). Nyacol, Lurie and O'Connor have been named as potentially responsible parties (PRP's) for the multimillion dollar cleanup being undertaken by the state and federal governments.

API brought the current action seeking declaratory relief in 1991. In 1994, CU filed two separate actions in Suffolk Superior Court seeking declarations that it is not obligated to defend or indemnify two other PRP's connected with the site, one of which is Nyacol's parent corporation (the Suffolk cases).

After CU noticed the deposition of James Critser, the former plant manager of Nyanza, Inc., in the Suffolk cases, the defendants in those actions moved for protective orders. The protective orders were allowed and discovery in the Suffolk cases was stayed pending resolution of the underlying EPA proceedings.

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[3] Although the protective order is sought only against American, the third party defendants have indicated, through their briefs, an interest in conducting discovery in this declaratory action. To avoid any future confusion as to the same issues raised here, the court will treat the motion as applying to both the plaintiff and third party defendants and its decision will be binding on each of these parties.

API has noticed the deposition of James Critser in this case and API has indicated that it intends to notice the depositions of Lurie and O'Connor in the near future.

DISCUSSION

In Commercial Union Insurance Company v. RohmTech, Inc., Civ. No. 94-2231 (Suffolk Super. Ct. June 16, 1995), the court allowed the protective order against CU as to all discovery, including the deposition of James Critser, which has the potential to establish the defendants' liability on the EPA claim or to remove any limitation on the extent of such liability. The court stated that "the insurer was paid to take the risk so that if, between two parties, prejudice due to loss of evidence or otherwise is to be suffered, the insurer must be the one to suffer. It cannot act for its own benefit to the prejudice of its insured." In Commercial Union Insurance Company v. PQ Corporation, Civ. No. 94-2232 (Suffolk Super. Ct. June 20, 1995), a similar motion for protective order involving nearly identical facts was allowed without opinion.

In the Suffolk cases, CU, like American in the present case, is seeking declaration as to its duty to defend and indemnify its insured.[4] All three cases involve the same site and the same proceedings by EPA and DEP.

American argues that it must continue to pay defense costs

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[4] Although NPI brought the third-party actions seeking declaratory relief against CU, Utica and National, NPI's position as plaintiff as opposed to defendant does not affect the court's analysis and determination concerning the protective order. See Haskel, Inc. v. Superior Court, 39 Cal.Rptr.2d 520, 523 (Cal.App.2 Dist. 1995).

while being prevented from demonstrating that it is not obligated to do so. An insurer's duty to defend is antecedent to, independent of, and broader than its duty to indemnify. Boston Symphony Orchestra, Inc. v. Commercial Union Insurance Company, 406 Mass. 7, 10 (1989). The duty to defend is based on facts alleged in the complaint and such obligation is not and cannot be determined by reference to facts proven at trial. Id. at 10-11. The merits of the claim are not grounds upon which an insurer can refuse to defend the insured. Id. at 13.

American argues that it has expended time and money to defend claims which may not be covered under the terms of the policy. If such is the case, American may be able to show that it has no duty to indemnify NPI for any losses incurred as a result of the EPA proceedings. Where, however, the underlying complaint is reasonably susceptible of an interpretation that it states or adumbrates a claim within coverage, the insurer has a duty to defend. Id. at 11-12; SCA Services v. Transportation Insurance Co., 419 Mass. 528, 532-533 (1995) (no duty to defend where site was ordered closed before effective date of policy).

American states that it has initiated discovery for the sole purpose of supporting its position that the site became contaminated through intentional dumping of hazardous waste and thus the EPA/DEP claims are not covered under the American policies. American argues that the manner by which the site became contaminated is well-known to EPA and DEP and the intentional nature of the contamination is irrelevant to the government

agencies.

American, CU, National, and Utica were paid to insure NPI. The insurers have a special relationship with NPI and a duty to defend NPI until the underlying EPA suit is resolved or the coverage issue can be determined without prejudice to NPI. Haskel, Inc. v. Superior Court, supra at 528.

To eliminate any risk of inconsistent factual determinations that could prejudice NPI, a stay of discovery, which may be prejudicial to NPI, pending resolution of the EPA action is appropriate when the coverage question turns on facts which may be determinative in the underlying proceeding. Id. NPI should not be required to fight a two front war against both its own insurers and EPA. Id. at 529. Despite American's claims that no prejudice to NPI will result from its discovery, the information American seeks as to NPI's intent and knowledge concerning hazardous waste dumping at the site is so logically related to the issues in the underlying EPA action that further pursuit of that discovery would prejudice NPI's interest in that action. Id. at 530.

ORDER

Based on the foregoing, it is **ORDERED** that defendants/third party plaintiffs' motion for a protective order is **ALLOWED**. It is further **ORDERED** that the plaintiffs may proceed with any discovery which is not logically related to the issues in the underlying EPA action and thus not prejudicial to NPI's interests.

Wendie I. Gershengorn
Justice of the Superior Court

Dated: January 25, 1996

About Foley Hoag LLP

Foley Hoag LLP is a leading national law firm in the areas of dispute resolution, intellectual property, and corporate transactions for emerging, middle-market, and large-cap companies. With a deep understanding of clients' strategic priorities, operational imperatives, and marketplace realities, the firm helps companies in the biopharma, high technology, energy technology, financial services and manufacturing sectors gain competitive advantage. The firm's 225 lawyers located in Boston, Washington, and the Emerging Enterprise Center in Waltham, Massachsetts join with a network of Lex Mundi law firms to provide global support for clients' largest challenges and opportunities. For more information visit foleyhoag.com.

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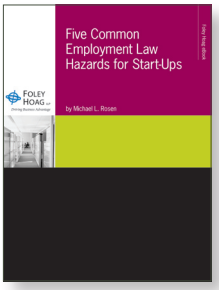

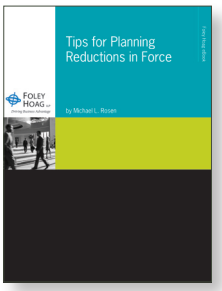

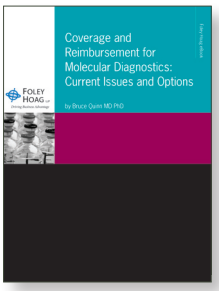

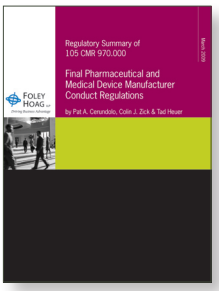

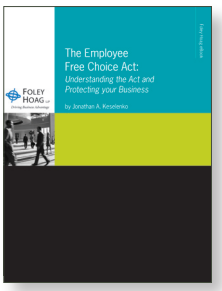

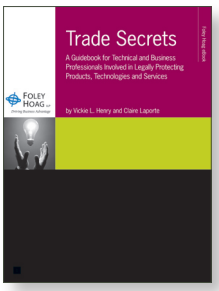

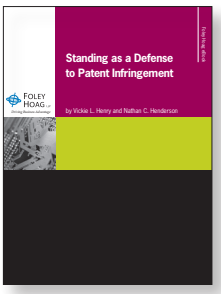

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