

IN THE SUPREME COURT OF THE STATE OF MONTANA

Case No. DA 20-0279

DANA ROLAN, on her own behalf and on behalf of the class she represents,

Plaintiffs/Counter-Defendants/Appellees,

vs.

NEW WEST HEALTH SERVICES,

Defendant/Appellee

DARWIN SELECT INSURANCE COMPANY and ALLIED WORLD
ASSURANCE COMPANY and DARWIN NATIONAL
ASSURANCE COMPANY,

Defendant/Counterclaimant, and Appellant.

On Appeal from the Montana First Judicial District
Lewis & Clark County Cause No. CDV-2010-91
Honorable Kathy Seeley

APPELLEES' APPENDIX

Appearances:

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APPENDIX

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VIA E-MAIL ahuschka@nwHP.com

February 18, 2010

To: Angela Huschka
New West Health Services
130 Neill Ave.
Helena, MT 59601

Re: Insured: New West Health Services
Insurer: Darwin Select Insurance Company
Policy No.: 0303-5534 (MCEO Policy)
Policy Period: 04/01/2009 to 04/01/2010
Policy Limit: \$1,000,000 for each Claim made in the Policy Period and
\$3,000,000 in the aggregate for all Claims
Retention: \$50,000
Subject: Rolan, Dana
Darwin Ref. No.: 2010000725

Insured: New West Health Services
Insurer: Darwin National Assurance Company
Policy No.: 0303-5533 (HCDO Policy)
Policy Period: 04/01/2009 to 04/01/2010
Policy Limit: \$1,000,000 for each Claim made in the Policy Period and
\$3,000,000 in the aggregate for all Claims
Retention: \$50,000¹
Subject: Rolan, Dana
Darwin Ref. No.: 2010000750

Dear Ms. Huschka:

I am writing on behalf of Allied World National Assurance Company, claims manager for Darwin National Assurance Company ("DNA") with respect to the referenced Health Care Organization Directors and Officers Liability Insurance Policy Including Employment Practices Liability Coverage Policy (the "HCDO Policy") and Darwin Select Insurance Company ("DSI") in respect to the Managed Care Organization Errors and Omissions Liability Policy (the "MCEO

¹ Applies to Insuring Agreement B(1) & (2).

Policy”) (HCDO Policy and MCEO Policy collectively, the “Policies”; DSI and DNA collectively “Darwin”). This letter provides you with a summary of coverage under the above Policies in connection with the above referenced action. We previously acknowledged receipt of this matter on February 11, 2010.

This letter will refer to certain allegations asserted by the plaintiff. We recognize that such allegations are unsubstantiated contentions at this time. We cite the allegations only for analytical reasons. Nothing in this letter is intended to suggest or imply that the allegations have any legal or factual merit.

This letter does not modify any of the terms and conditions of the Policy. Please note that the words that appear in bold print below are defined in the Policy.

SUMMARY OF FACTS

We have reviewed the Complaint (the “Complaint”) captioned, *Dana Rolan v. New West Health Services*, filed on or about January 26, 2010 in the Montana First Judicial District Court, Lewis & Clark County (the “Action”). This summary of facts is based on the allegations contained in the Complaint.

Plaintiff, a resident of Montana, brings the Action on behalf of herself and on behalf of those similarly situated. The Plaintiff claims that she suffered injuries caused by the legal fault of others and has not been made whole. It is further alleged that the Defendant has avoided payment of medical bills that they are allegedly contractually obligated to pay by claiming the medical costs are the responsibility of those at fault. The Plaintiff alleges that Defendant’s failure to pay benefits violates Montana’s constitution, statutory law, common law and established public policy. More specifically, the Plaintiff alleges that the Defendant’s actions violate Montana’s “made whole” law which is enumerated in MCA §33-18-201, *et seq.*

Plaintiff Rolan alleges that that in November 2007 she was severely injured as a result of a motor vehicle collision. The person who negligently caused the accident was insured by Unitrin Services Group. It is alleged that Unitrin paid medical costs of approximately \$100,000 directly to the Plaintiff’s medical providers under its liability policy. Allegedly, upon demand by the Plaintiff, defendant New West declined to pay the benefits because the tortfeasor’s liability carrier, Unitrin, had advance paid medical costs. Plaintiff claims that New West illegally reduced the Plaintiff’s insurance coverage by approximately \$100,000 in violation of “made whole” obligations. By allegedly violating Montana’s “made whole” laws, Plaintiff claims that the Defendant was unjustly enriched at the Plaintiff’s expense.

It is alleged that the conduct of the Defendant violates MCA §33-18-201 *et seq.* which prohibits failures to pay claims on a variety of grounds, including but not limited to breach of the insurance contract, and by asserting denials or failing to pay claims due to the existence of third party liability when the defendants allegedly knew there existed no reasonable or lawful ground for doing so given Montana’s “made whole” laws. Lastly, the Plaintiffs allege that the Defendants violated MCA §33-18-201 *et seq.* sounding in unfair trade practices.

The Complaint further sets forth actions for class certification, declaratory relief and payment, and other class claims for payment and breach of contract and similar Montana statutes as those referred to above. Plaintiffs seek both monetary damages, punitive damages, attorneys' fees and costs.

SUMMARY OF COVERAGE UNDER THE MCEO POLICY

The Insuring Agreement to the MCEO Policy (§ I) states that the Underwriter will pay on behalf of any Insured Loss which the Insured is legally obligated to pay as a result of a Claim that is first made against the Insured during the Policy Period or during any applicable Extended Reporting Period. New West Health Services ("New West") is an Insured Entity and is therefore an Insured under the MCEO Policy. (Definitions §§ IV(G), (H)).

"Claim" is defined in Definitions § IV(C) as any written notice received by any Insured that a person or entity intends to hold an Insured responsible for a Wrongful Act which took place on or after the retroactive date listed in ITEM 7 of the Declarations. In clarification and not in limitation of the foregoing, such notice may be in the form of an arbitration, mediation, judicial, declaratory or injunctive proceeding. A Claim will be deemed to be made when such written notice is first received by any Insured.

"Wrongful Act" is defined as

(1) any actual or alleged act, error or omission in the performance of, or any failure to perform a **Managed Care Activity** by any **Insured Entity** or by any **Insured Person** acting within the scope of his or her duties or capacity as such;

(2) any actual or alleged act, error or omission in the performance of, or any failure to perform, **Medical Information Protection**, by an **Insured Entity** or by any **Insured Person** acting within the scope of his duties or capacity as such; and

(3) any **Vicarious Liability** for:

(a) the performance of, or any failure to perform:

(i) a **Managed Care Activity**;

(ii) **Medical Information Protection**;

(b) the rendering of, or failure to render, **Medical Services**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for the rendering of, or failure to render, **Medical Services**; or

(c) any actual or alleged **Sexual Activity**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for any **Sexual Activity**.

(Definitions §IV(W)).

The definition of "**Managed Care Activity**" means any of the following services or activities: **Provider Selection**; **Utilization Review**; advertising, marketing, selling, or enrollment for health care or workers' compensation plans; **Claim Services**; establishing health care provider networks, reviewing the quality of **Medical Services** or providing quality assurance; design and/or implementation of financial incentive plans; wellness or health promotion education; development or implementation of clinical guidelines, practice parameters or protocols; triage for payment of **Medical Services**; and services or activities performed in the administration or management of health care plans or workers' compensation plans. (Definition § IV(K)).

Specifically, "**Utilization Review**," is defined to mean "the process of evaluating the appropriateness or necessity of **Medical Services** for purposes of determining whether payment or coverage for such **Medical Services** will be authorized or paid for under any health care plan, but only if performed by an **Insured**" and "**Claim Services**" is defined to mean "the submission, handling, investigation, payment or adjustment of claims for benefits or coverages under health care or workers' compensation plans." (Definition § IV(U), (D)).

As the Complaint includes allegations sounding in a **Managed Care Activity**, and the allegations were apparently first made against an **Insured** in writing during the **Policy Period**, the conditions precedent to the Insuring Agreement appear to be satisfied. Accordingly, the MCEO Policy provides for a **Per Claim Limit of Liability** of \$1,000,000 and a **Maximum Aggregate Limit of Liability** of \$3,000,000 subject to a \$50,000 retention applicable to **Loss**, including **Defense Expenses**, for each **Claim**.

Under the MCEO Policy the **Underwriter** has the right and duty to defend any **Claim** made against any **Insured** which is covered by this MCEO Policy even if the allegations of such **Claim** are groundless, false or fraudulent. (Insuring Agreement § I). In addition and pursuant to the MCEO Policy, the amount stated in ITEM 3(a) of the Declarations shall be the maximum aggregate **Limit of Liability** of the **Underwriter** for all **Loss**, including **Defense Expenses**, resulting from all **Claims** for which this MCEO Policy provides coverage, regardless of the number of **Claims**, the number of persons or entities included within the definition of **Insured**, or the number of **Claimants**. (Conditions § III(A)(1)). Further, "The obligation of the **Underwriter** to pay **Loss**, including **Defense Expenses**, will only be in excess of the applicable retention set forth in ITEM 4 of the Declarations." (Conditions § III(A)(3)).

Note also that under the MCEO Policy, no **Insured** may incur any **Defense Expenses** or admit liability for or settle any **Claim** without the **Underwriter's** written consent. (Conditions § III(D)(1)). The **Underwriter** will have the right to make investigations and conduct negotiations and, with the consent of the **Insureds**, enter into such settlement of any **Claim** as the

Underwriter deems appropriate. If the Insureds refuse to consent to a settlement acceptable to the claimant in accordance with the Underwriter's recommendation, then subject to the Underwriter's maximum aggregate Limit of Liability set forth in ITEM 3(a) of the Declarations, the Underwriter's liability for such Claim will not exceed:

- (a) the amount for which such Claim could have been settled by the Underwriter plus Defense Expenses up to the date the Insureds refused to settle such Claim (the "Settlement Amount"); plus
- (b) sixty percent (60%) of any Loss and/or Defense Expense in excess of the Settlement Amount incurred in connection with such Claim. The remaining forty percent (40%) of Loss and/or Defense Expenses in excess of the Settlement Amount will be carried by the Insured at its own risk and will be uninsured.

In addition, pursuant to Conditions § III(B)(1), if during the Policy Period or any applicable Extended Reporting period, any Claim is first made against any Insured, the Insureds must, as a condition precedent to any right to coverage under this Policy, give the Underwriter written notice of such Claim as soon as practicable thereafter and in no event later than:

- (a) with respect to a Claim made during the Policy Period, ninety (90) days after the end of the Policy Period; or
- (b) with respect to a Claim made during an Extended Reporting Period, ninety (90) days after such Claim is first made.

Further, pursuant to Conditions § III(D)(2) the Underwriter will have no obligations to pay Loss, including Defense Expenses, or to defend or continue to defend any Claim after the Underwriter's maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, has been exhausted by the payment of Loss, including Defense Expenses. If the Underwriter's maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, is exhausted by the payment of Loss, including Defense Expenses, the premium will be fully earned.

As we are assuming New West's defense in this matter I will be in contact with you shortly to discuss the retention of Kimberly Beatty and Leo Ward of Browning, Kaleczyc, Berry & Hoven as counsel.

Given the allegations in the Complaint, please appreciate the potential implication of the following MCEO Policy provisions, which may operate to limit or preclude coverage in this matter.

The MCEO Policy stipulates that, except for Defense Expenses, the Underwriter shall not pay Loss for any Claim brought about or contributed to by:

- (1) any willful misconduct or dishonest, fraudulent, criminal or malicious act, error or omission by any Insured;
- (2) any willful violation by any Insured of any law, statute, ordinance, rule or regulation; or
- (3) any Insured gaining any profit, remuneration or advantage to which such Insured was not legally entitled.

Determination of the applicability of Exclusion A may be made by an admission or final adjudication in a proceeding constituting a Claim, or in a proceeding separate from or collateral to any proceeding constituting a Claim. (Exclusions § II(A) as amended by Endorsement No. 6).

Section II Exclusions § (C)(6), sets forth that the Underwriter shall not pay any Loss, including Defense Expenses, for any Claim for any actual or alleged express or assumed liability of any Insured under an indemnification agreement; provided, that this EXCLUSION (C)(6) shall not apply to any tort liability that would have attached to the Insured in the absence of such agreement and is otherwise insured under the Policy.

Section II Exclusions § (C)(7), sets forth that the Underwriter shall not pay any Loss, including Defense Expenses, for any Claim based upon, arising out of, resulting from, or in any way involving any actual or alleged:

- (a) failure to obtain, implement, effect, comply with, provide notice under or maintain any form, policy, plan or program of insurance, stop loss or provider excess coverage, reinsurance, self-insurance, suretyship or bond.
- (b) commingling or mishandling of funds with dishonest intent;
- (c) failure to collect or pay premiums, commissions, brokerage charges, fees or taxes.

The MCEO Policy defines Loss as Defense Expenses and any monetary amount which an Insured is legally obligated to pay as a result of a Claim; including punitive, exemplary or multiplied damages ("Punitive Damages") awarded in connection with any Claim covered by this Policy, other than Claims for Antitrust Activity, and only if such Punitive damages are insurable under applicable law. ² Loss, however, does not include:

- 1) fines, penalties, or taxes and punitive, exemplary or multiplied damages provided that:
 - (a) if punitive, exemplary or multiplied damages (hereafter referred to as "Punitive Damages") are awarded in connection with any Claim covered by this Policy, other than Claims for Antitrust Activity, the maximum

² Endorsement No. 7 to the Policy discusses which jurisdiction's law shall apply when determining the insurability of Punitive Damages.

amount payable by the Insurer attributable to Punitive Damages for any Claim, or in the aggregate for all Claims, is \$3,000,000. This Punitive Damages Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

(b) if fines, penalties or Punitive Damages are awarded in connection with any Claim for Antitrust Activity, the maximum amount payable by the Insurer is the amount indicated in ITEM 3(b) of the Declarations. This Antitrust Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

(c) the coverage described in subparagraphs (a) and (b) above shall apply unless prohibited by law;

- 2) fees, amounts, benefits or coverage owed under any contract with any party including providers of health care services, health care plan or trust, insurance or workers' compensation policy or plan or program of self-insurance;
- 3) non-monetary relief or redress in any form, including without limitation the cost of complying with any injunctive, declaratory or administrative relief; or
- 4) matters which are uninsurable under applicable law,

(Definitions § IV(J) as amended by Endorsement No. 5).

Note that pursuant to Conditions § III(G)(1), the MCEO Policy shall be excess of and shall not contribute with:

- (a) any other insurance or plan or program of self-insurance, unless such other insurance or self-insurance is specifically stated to be in excess of this Policy; and
- (b) any indemnification to which an Insured is entitled from any entity other than another Insured.

This Policy shall not be subject to the terms of any other policy or insurance or plan or program of self-insurance.

Accordingly, please immediately (1) advise whether there are any other insurance policies available to respond to the allegations in this matter; (2) advise what steps have been taken to secure coverage on behalf of the Insured under any other potentially applicable insurance policy; and (3) send us a copy of the coverage position(s) issued by any other insurance carrier(s) in connection with this matter. We expressly reserve all rights with respect to any and all other insurance and indemnification.

In addition, Conditions § III(G)(2), if any other policy or policies issued by the Underwriter or any of its affiliated companies, or by any predecessors or successors of the Underwriter or its affiliated companies, shall apply to any Claim, then the aggregate limit of liability with respect to all Loss under this Policy and all covered loss under such other policies shall not exceed the highest applicable limit of liability, subject to its applicable deductible or retention, that shall be available under any one of such policies, including this Policy. This Condition (G)(2) shall not apply with respect to any other policy which is written only as specific excess insurance over the Limit of Liability of this Policy.

SUMMARY OF COVERAGE UNDER THE HCDO POLICY

After reviewing the foregoing materials in conjunction with the HCDO Policy, we regret to inform you that for the following reasons, there does not appear to be any coverage available for this matter under the HCDO Policy.

The Insuring Agreement to the HCDO Policy (§ I(B)(2)) states that the Insurer will pay on behalf of an Insured Entity Loss from Claims first made against an Insured Entity during the Policy Period for Wrongful Acts. New West Health Services ("New West") is identified in the HCDO Policy as the Parent Corporation and is therefore both an Insured Entity and an Insured under the HCDO Policy. Insured Entity means the Parent Corporation and any Subsidiary created or acquired on or before the Inception Date in ITEM 2(a) of the Declarations. (Policy II(H)).

"Claim" is defined in § II(B) of the HCDO Policy in relevant part as (1) any written demand for monetary relief; or (2) any civil proceeding in a court of law or equity, which is commenced by the filing of a complaint, motion for judgment or similar proceeding. Section II(Z)(5) of the HCDO Policy defines Wrongful Act as including "any other actual or alleged act, error, omission, misstatement, misleading statement or breach of duty by any Insured Entity".

As the Complaint is a written demand for monetary damages and is a civil proceeding, was first made against an Insured Entity during the Policy Period, and is based, in part, on the actions of an Insured Entity, the conditions precedent to the Insuring Agreement appear to be satisfied. However, certain specific exclusions to the HCDO Policy preclude coverage for this Claim in its entirety.

Exclusion III(C)(5) provides:

- C. This Policy shall not provide coverage for any Claim based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving:
 - (5) any actual or alleged act, error or omission in the performance of, or failure to perform, Managed Care Organization Business Activities by any Insured or by any individual or entity for whose acts, errors or omissions an Insured is legally responsible, except that this Exclusion

C(5) shall not apply to Claims for Provider Selection Practices performed solely for an Insured Entity, and provided that the Insured Entity is not a Managed Care Organization.

"Managed Care Organization Business Activities" means "services or activities performed in the administration or management of healthcare plans; **Provider Selection Practices, Utilization Review**; case management; disease management; advertising, marketing or selling healthcare plans or healthcare insurance products; handling, investigating, or adjusting claims for benefits or coverages under healthcare plans; establishing healthcare provider networks; and reviewing the quality of **Medical Services** or providing quality assurance." (Policy §II(N)). **"Utilization Review"** means "the process of evaluating the appropriateness, necessity, or cost of **Medical Services** for purposes of determining whether payment or coverage for such **Medical Services** will be authorized or paid for under any health care plan. **Utilization Review** shall include prospective review of proposed payment or coverage for **Medical Services**, concurrent review of ongoing **Medical Services**, and retrospective review of already rendered **Medical Services** or already incurred costs." (Policy §II(X)).

The allegations in the Complaint indicate that the Claim arises from and is directly related to New West's conduct of **Managed Care Organization Business Activities**, including but not limited to, **Utilization Review** services, handling, investigating or adjusting claims for benefits or coverages under healthcare plans. As such, there is no coverage for the Claim under the HCDO Policy.

As it appears that there is no coverage for this Claim in its entirety under the HCDO Policy, we are not providing any additional comment regarding other coverage issues that may exist with respect to this Claim. If you possess any additional information that you believe would bear on coverage in this matter, please forward that information to me at your earliest convenience.

DNA's position with respect to this matter is based on the information provided to date, and is subject to further evaluation should additional information become available. DNA continues to expressly reserve all rights and defenses under the HCDO Policy, and available at law and in equity, with respect to this matter, including but not limited to, the right to assert additional terms and conditions of the HCDO Policy which may become applicable as new information is learned, and the right to deny coverage for this matter on additional and/or alternative bases.

CONCLUSION

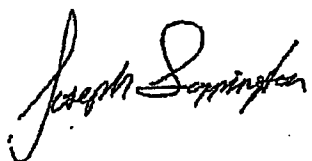
Please keep us advised of any significant developments in this matter, and send us copies of significant motions, pleadings, orders, correspondence and other documents.

Darwin National Assurance Company and Darwin Select Insurance Company respectfully reserve all of their rights and defenses under the Policies and available at law with respect to this matter.

Please feel free to contact me if you have any questions.

February 18, 2010
Page 10 of 10

Very truly yours,

A handwritten signature in black ink, appearing to read "Joseph Sappington". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Joseph Sappington

September 30, 2013

VIA E-MAIL & U.S. MAIL

Joseph Sappington, Esq.
Senior Claims Analyst
Allied World National Assurance Co.
9 Farms Springs Rd.
Farmington, CT 06032

Re: Insured: New West Health Services
Insurer: Darwin Select Insurance Co.
Policy No.: 0303-5534 (MCEO Policy)
Policy Period: 04/01/2009 to 04/01/2010
Policy Limit: \$1,000,000 for each Claim made in the Policy Period and
\$3,000,000 in the aggregate for all Claims
Retention: \$50,000
Subject: Rolan, Dana
Darwin Ref. No.: 2010000725

Dear Mr. Sappington:

As I indicated in my voicemail to you on September 17, 2013, we represent New West Health Services. I called you to discuss New West's insurance coverage in the Dana Rolan matter. More specifically, I called to discuss coverage under the Managed Care Organization Errors and Omissions Liability Policy (the "MCEO Policy"). The MCEO Policy is policy number 0303-5534 and the Darwin reference number is 2010000725.

Pursuant to your letter dated February 18, 2010, it appears that you agree there is coverage under the MCEO policy, unless New West committed willful misconduct or willfully violated a state law. Please contact me to confirm this.

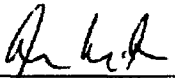
The MCEO policy also apparently includes defense expenses as part of the policy limits. Thus, to determine the amount of coverage New West has remaining, please provide me with a detailed report of the defense expenses paid to date, and please confirm the remaining policy limits.

Please also provide me with a certified copy of the MCEO policy.

As I am sure you are aware, in Montana, an insurer is required to acknowledge and act reasonably promptly upon communications. Mont. Code Ann. § 33-18-201(2). Please contact me at your earliest convenience to discuss New West's insurance coverage under the MCEO policy.

Sincerely,

CROWLEY FLECK PLLP



Ian McIntosh

IM/wma

cc: Angela Huschka (via e-mail)

UGRIN, ALEXANDER, ZADICK & HIGGINS, P.C.

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JAMES R. ZADICK

NEIL E. UGRIN
1945 - 2007

November 2, 2016

File No.: NE41-03

Via Email Only: michelle.querijero@awac.com

Michelle L. Querijero
Senior Claims Analyst
Allied World Insurance Company
1690 New Britain Ave., Suite 101
Farmington, CT 06032

Re: Rolan v. New West
Claim #: \$2010000725\$

Dear Ms. Querijero:

I am counsel for your insured New West with respect to coverage for New West under the Allied World MCEO policy. A reservation of rights letter was issued on February 18, 2010 by Joseph Sappington on behalf of Allied World. I have attached a copy for your convenience.

In the reservation of rights letter, Mr. Sappington advised Allied was assuming the defense of New West. With respect to the MCEO policy Mr. Sappington acknowledged that the conditions precedent "appear to be satisfied." February 18, 2010, page 4 of 10. Mr. Sappington raised Exclusion A – willful misconduct, willful violation or gaining a profit which the insured was not legally entitled. Pursuant to the policy endorsements and the law of Montana, these determinations are made in the underlying action. As you are aware, the Complaint alleges additional conduct that would constitute a "wrongful act" and would be covered.

There has been no supplemental reservation of rights issued. However, Ian McIntosh, on behalf of your insured New West, wrote to Mr. Sappington on September 30, 2013 confirming his understanding that New West was covered except to the extent of any willful misconduct or willful violation of state law. Mr. McIntosh and Kevin

Michelle L. Querijero
November 2, 2016
Page 2

Heaney of New West also spoke with Mr. Sappington and he confirmed to them that those were the only grounds upon which Allied World was contesting coverage.

Of course, it is far too late to assert any additional ground for challenging coverage. Allied World has been defending the case for six years under the February 18, 2010 reservation of rights. Allied World would be estopped to raise any additional defenses at this late date.

Your insured is concerned, however, because of a comment you made in an email to defense counsel Robert C. Lukes of October 5, 2016 in which you stated: "We issued a reservation of rights letter with respect to this matter, and our position is that there is no indemnity obligation under the policy." This comment is directly contrary to Allied World's reservation of rights letter of February 18, 2010 in which Mr. Sappington acknowledged that there would be coverage except only to the extent of any conduct that would fall within Exclusion A. Proof of "willful violation of law, willful misconduct, fraudulent conduct, criminal or malicious conduct" is a very high burden and it is very likely that there will be coverage and that there will not be proof of willful conduct or fraudulent conduct.

I also remind you that Allied World owes a fiduciary responsibility to its insured to protect it and to place its interests at least as high as its own even when defending under a reservation of rights.

Therefore, New West expects that Allied World will continue to provide a defense and indemnify New West with respect to any recovery that is not within the scope of the very stringent limitations of Exclusion A. I further request that I be included on all correspondence between Allied World and defense counsel.

Lastly, please advise me whether Allied World has separated its file between coverage and defense. Based upon the email correspondence, it is my assumption that you are overseeing both the defense and coverage of the litigation on behalf of Allied World. I look forward to your prompt response.

Michelle L. Querijero
November 2, 2016
Page 3

Sincerely,

UGRIN, ALEXANDER, ZADICK & HIGGINS, P.C.


Gary M. Zadick

GMZ/ajc
Enclosure

cc: Robert C. Lukes

THUESON LAW OFFICE

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ELAYNE M. SIMMONS
Legal Assistant
elayne@thuesonlawoffice.com

April 6, 2017

Mr. Randall Nelson
Nelson Law Firm
2619 St. Johns Ave., Ste. E
Billings, MT 59102

RE: *Rolan v. New West*

Dear Mr. Nelson:

Thank you for attending the mediation. As I understand it, Allied has made an offer of \$50,000. On behalf of my client and the class, I reject it.

We make a policy-limits demand, subject to Court approval under M. R. Civ. P. 23. Our reasoning is set forth below.

First, I have now had the opportunity to review the insurance situation. (Like NW's current counsel, I was not informed there was a coverage issue until October of last year.) According to my reading of the coverage letter Allied sent to NW in February 2010, and the applicable policy, there is coverage under both the individual and aggregate limits.

The coverage letter of February 18, 2010 states coverage exists under the MCEO policy but not the HCDO policy. It contains only a warning that intentional misconduct determined by a final adjudication might not be covered. That exception does not apply because we are relinquishing claims for intentional misconduct on the part of New West. Furthermore, the MCEO policy has a class action endorsement stating both the individual and aggregate coverages apply.

Mr. Randall Nelson
April 6, 2017
Page 2

If you have any additional information concerning coverage, please provide it in writing immediately, but this is how I read Allied's letter and policy.

Second, notwithstanding the District Court's holding, it is at least reasonably clear that liability has been established. As discussed in detail in the brief to the Montana Supreme Court, virtually all—if not literally all—authorities from the United States Supreme Court on down recognize an insurer who receives premiums from an ERISA employer is subject to the state's made-whole law. NW received premiums and therefore, is subject to Montana's made-whole law.

Third, this eight-year-old case is not a model of the swift and proper administration of justice. Most of the delays can be attributed to the mistake or decision to treat this as a non-ERISA case at the outset, only correcting the matter after the case was certified and affirmed on appeal years later. Whether by error or design, the attorneys who initially denied ERISA status are agents of Allied, who assumed defense of the case. We believe this increases the urgency of the situation.

We would appreciate a prompt written response, including your position on the issues raised by this settlement letter. May we have your response on or before April 15, 2017?

Thank you for your consideration.

Sincerely yours

THUESON LAW OFFICE

A handwritten signature in black ink, appearing to read 'Erik Thueson', with a long horizontal flourish extending to the right.

Erik Thueson

EBT:ems

cc: Gary Zadick
Robert Lukes

Law and
Practice
of
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Litigation

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A ABA Tort and Insurance Practice Section

LAW AND PRACTICE OF INSURANCE COVERAGE

- § 8:22 —Estoppel
- § 8:23 —Waiver
- § 8:24 —The general rule regarding waiver of the late notice defense
- § 8:25 Accommodating an insured prior to issuing a coverage position by answering the complaint
- § 8:26 Trial considerations
- § 8:27 Summary and practice pointers checklist
- § 8:28 Illustrative forms—Sample reservations of rights letter

KeyCite®: Cases and other legal materials listed in KeyCite Scope can be researched through the KeyCite service on Westlaw®. Use KeyCite to check citations for form, parallel references, prior and later history, and comprehensive citator information, including citations to other decisions and secondary materials.

§ 8:1 Scope note

Research References

West's Key Number Digest, Insurance ¶3080 to 3182, 3546, 3554
Insurer's tort liability for consequential or punitive damages for wrongful failure or refusal to defend insured, 20 A.L.R.4th 23
Am. Jur. 2d, Insurance §§ 1336, 1384, 1405 to 1429, 1921
Couch on Insurance (3d. ed.) §§ 171:28, 195:45, 195:50, 202:47
Estoppel to Assert Limitation of Insurance Coverage, 26 Am. Jur. Proof of Facts 2d 137
Insured's "Reasonable Expectations" as to Coverage of Insurance Policy, 20 Am. Jur. Proof of Facts 2d 59

This Chapter discusses the effect of the reservation of rights letter which may be issued by an insurer in response to an insured's request for coverage. It also sets forth circumstances under which the insurer is barred from asserting defenses to coverage.

Insurance policies generally provide that if an insured individual or company is sued or is aware that a lawsuit is about to be commenced, the insured must give the insurer notice as soon as practicable or within a reasonable time.

When the insurer receives notice, it must issue a coverage position. It can disclaim coverage, if, as a matter of law, there is no possible factual or legal basis on which the insurer might have to indemnify the insured under any provision of the policy. Alternatively, the insurer can acknowl-

edge coverage, appoint counsel, defend and indemnify the insured. Or, the insurer can take an intermediate position and reserve its rights.

The insurer will reserve its rights if some causes of action in the complaint are covered and some are not covered under the policy, either because the allegations are not covered under the insuring agreement or because they are excluded from coverage pursuant to one or more policy exclusions. If the insurer reserves its rights it must inform the insured in detail of every potential denial or limitation of coverage. The reservation of rights letter will advise the insured that the insurer will defend the action but that it may ultimately disclaim coverage. If the insurer reserves its rights it may create a conflict between the insurer and the insured; and the insured will be entitled to appoint counsel.

This Chapter addresses the consequences of the insurer's reservation of rights. It discusses the purpose and contents of the reservation of rights letter, the time requirements in issuing of the reservation, the conflicts raised by the reservation, and the solutions to the conflict, including the appointment of *Cumis* counsel in California or appointment of counsel of the insured's choice whose reasonable fees are paid by the insurer, in other states. The Chapter also includes a sample reservation of rights letter.

The Chapter addresses the excess carrier's obligation (or lack thereof) to participate in the defense, and the relationship among the insured, primary and excess carrier. It also discusses what happens to defenses not raised in the reservation of rights, as well as estoppel and waiver of rights. Additionally, the Chapter discusses the insurer's accommodations to its insured by answering the complaint prior to issuing a coverage opinion.

§ 8:2 Purpose of the reservation of rights letter

A reservation of rights letter explains the insurer's coverage position. The letter should inform the insured in detail, quoting from the policy, of every reason for the insurer's position concerning the possible disclaimer of coverage. If the policy obligates the insurer to provide the insured with a defense, (*e.g.*, Directors & Officers policies frequently do not obligate the insurer to provide a defense) the insurer must explain that if the allegations in the complaint allege both

In *Foust v. Ranger Ins. Co.*,⁴ a Texas Court of Appeals limited the reach of *Griffin*, holding that it would be premature to bring a declaratory judgment action as to liability when the insurer has an uncontested duty to defend. The court in *Foust* affirmed the lower court's decision that damages to a cotton crop attributable to aerial spraying of herbicides constituted a single occurrence under the insurance policy at issue, which determined that the insurer's potential liability would be limited to \$100,000 by the terms of the policy. The court reasoned that such a declaration was not a determination of liability but rather established that the insurer had a duty to defend its insured and the limits of such liability if liability was established.

§ 8:9 The contents of the reservation of rights letter

Research References

West's Key Number Digest, Insurance ⇨3110(3)

Business and Commercial Litigation in Federal Courts § 58.19

(Robert L. Haig ed.) (West Group & ABA 1998 & Supp. 1999)

Upon receipt of a request for coverage from its insured, the insurer has, essentially, three choices: It can respond by accepting coverage completely; by disclaiming coverage; or by agreeing to provide a defense subject to a reservation of rights. The "reservation of rights" means that the insurer agrees to indemnify for some, but not all, of the claims in the complaint. The reservation of rights letter is a critical document in the determination of coverage. If a declaratory judgment action is commenced, by either the insurer or the insured, the reservation of rights letter, along with the complaint and the policy itself, will be the evidence on which the court determines the parties' rights and obligations.

In the declaratory judgment action, the insurer will have to prove that it asserted all defenses to coverage which were known—and which it could reasonably have been expected to know—at the time the letter was written. The insured will try to prove that the allegations of the complaint fall within the policy's coverage and that there is no uninsured exposure.

(Tex. 1997).

⁴*Foust v. Ranger Ins. Co.*, 975 S.W.2d 329 (Tex. App. San Antonio), reh'g overruled, (Mar. 27, 1998) and review denied, (Aug. 13, 1998).

In most cases, as a practical matter, disagreements over reservations of rights are negotiated, rather than litigated to a conclusion. Where there are issues raised by the insurer's reservation of rights, the parties start from the common understanding that there is *some* coverage; and thus are usually inclined to work on their differences.

The reservation of rights letter must inform the insured in detail of every reason of which the carrier is aware, or should be aware, supporting a denial or limitation of coverage.¹ As discussed at § 8:21, an insurer may lose any potential defense it does not include in the letter.

General statements that purport to reserve all rights a carrier might have under its policy are inadequate. The insurer must specifically identify and quote all relevant policy language and all of the coverage defenses upon which it is relying. If there is a need to assert further defenses after the original letter is sent, a supplemental reservation should be sent within a reasonable time, and as soon as the insurer learns of the defense. The supplemental reservation of rights letter incorporating new reasons, or potential reasons, for denying coverage that arise from newly discovered facts should be effective in preserving coverage defenses absent prejudice to the insured; but many courts nevertheless hold the carrier is precluded from raising the later asserted defenses.²

[Section 8:9]

¹United Nat. Ins. Co. v. Waterfront N.Y. Realty Corp., 948 F. Supp. 263, 268 (S.D.N.Y. 1996) ("A reservation of rights letter must give fair notice to the insured that the insurer intends to assert defenses to coverage or to pursue a declaratory relief action at a later date.").

See Konami (America) Inc. v. Hartford Ins. Co. of Illinois, 761 N.E.2d 1277 (Ill.App. 2 Dist. 2002) (comprehensive general liability (CGL) insurer's letter stating that a coverage question existed, but that the insurer was not waiving any policy defenses, did not estop the insurer from denying a duty to defend; the letter was not an admission of a duty to defend, and the insured hired an attorney and was not prejudiced).

²Home Indem. Co. v. Reed Equipment Co., Inc., 381 So. 2d 45, 50 (Ala. 1980); Provident Life & Acc. Ins. Co. v. Adie, 176 F.R.D. 246, 249-50 (E.D. Mich. 1997); Boren v. State Farm Mut. Auto. Ins. Co., 225 Neb. 503, 507, 406 N.W.2d 640, 643 (1987); Armstrong v. Hanover Ins. Co., 130 Vt. 182, 188-89, 289 A.2d 669, 672-73 (1972); Potesta v. U.S. Fidelity & Guar. Co., 202 W. Va. 308, 504 S.E.2d 135, 144 (1998). Answer to certified

Thus, in *Boren v. State Farm Mut. Auto. Ins. Co.*,³ a Nebraska court held that an insurer that gives one reason for its conduct and decision as to a matter in controversy cannot, after litigation has begun, defend upon another and different ground. The court reasoned that since the insurer had based its denial of liability on its policy being excess, it could not later assert that its policy provided no coverage for an automobile accident. This was especially true since the insurer did not attempt to disclaim coverage until a judgment had been entered in the underlying action.

Similarly, in *Armstrong v. Hanover Ins. Co.*, a Vermont court held that an insurer was estopped from asserting additional defenses to coverage when those defenses were not included in its original notice of disclaimer.⁴ In *Armstrong* the insurer denied coverage because the vehicle that was involved in an accident was not included in the definition of "non-owned" vehicle under the policy. However, it was not until two years later that the insurer attempted to raise an employment based exclusion as a second defense. The court declared that the insurer was estopped from raising the second defense.

The carrier must advise the insured specifically why it is covering some causes of action and not others and why there is a potential denial of coverage. It is not sufficient just to cite to the pertinent policy provisions without explanation. A reservation of rights letter should, to the extent feasible, be written in lay terms and should not only set forth the potential coverage defenses but also explain why they apply.

The insurer must avoid ambiguity, since any ambiguity in the reservation of rights will be resolved against the insurer.⁵

The reservation of rights letter must include the following:

question conformed to: *Potesta v. U.S. Fidelity & Guaranty Co.*, 153 F.3d 721 (4th Cir. 1998).

See *Waller v. Truck Ins. Exchange, Inc.*, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995), as modified on denial of reh'g, (Oct. 26, 1995), where the court declined to follow *Armstrong v. Hanover Ins. Co.*, holding there is no waiver if insurer's disclaimer did not show intention to relinquish additional reasons for its denial to defend.

³*Boren v. State Farm Mut. Auto. Ins. Co.*, 225 Neb. 503, 507, 406 N.W.2d 640, 643 (1987).

⁴130 Vt. 182, 188, 289 A.2d 669, 673 (1972).

⁵*Danzig v. Dikman*, 53 N.Y.2d 926, 440 N.Y.S.2d 925, 423 N.E.2d

**YOUNG MEN'S CHRISTIAN
ASSOCIATION OF PLATTSBURGH,
Plaintiff,
v.
PHILADELPHIA INDEMNITY
INSURANCE COMPANY, Defendant.**

8:18-CV-0565 (LEK/DJS)

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK**

November 30, 2018

**MEMORANDUM-DECISION AND
ORDER**

I. INTRODUCTION

This insurance coverage dispute is before the Court following its removal from New York State court on diversity of citizenship pursuant to 28 U.S.C. §§ 1441(a), 1446, and 1331. Dkt. No. 1 ("Notice of Removal"). The former executive director of Plaintiff, the Young Men's Christian Association ("YMCA") of Plattsburgh, failed to properly implement its employee benefits program for approximately fifteen employees, resulting in underpayment to the YMCA Retirement Fund. Dkt. No. 2 ("Complaint") ¶¶ 7, 14. During the relevant period, Plaintiff had an employee benefits insurance policy with defendant Philadelphia Indemnity Insurance Company, which has largely denied coverage for the funds Plaintiff owes to the Retirement Fund. Id. ¶¶ 4-6, 9-16. Seeking declaratory relief and damages, Plaintiff alleges that Defendant has violated its contract as well as certain state statutory duties. Id. ¶¶ 19-35.

Defendant now moves to dismiss the suit for failure to state a claim. Dkt. Nos. 6 ("Motion to Dismiss"), 6-2 ("Memorandum"), 17 ("Reply"). Plaintiff opposes the motion. Dkt.

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No. 14 ("Opposition"). For the following reasons, the Motion to Dismiss is granted in part and denied in part.

II. BACKGROUND

The following facts are taken from the allegations in the Complaint, which are assumed to be true when deciding a motion to dismiss. Bryant v. N.Y. State Educ. Dep't, 692 F.3d 202, 210 (2d Cir. 2012).

Plaintiff is a non-profit organization existing under the laws of New York State, with its principal place of business in Plattsburgh, New York. Compl. ¶ 1. Defendant is a corporation incorporated, and with its principal place of business in Pennsylvania. Id. ¶ 2.

In April 2015, Defendant issued to Plaintiff a "comprehensive Commercial Lines (insurance) Policy" ("CL Policy"), with a policy period of May 1, 2016 through May 1, 2017. Compl. ¶ 4. Among the endorsements included in the policy was one providing "Employee Benefits Administration Errors and Omissions Insurance" ("Benefits Insurance Policy"). Id. ¶ 5. Plaintiff paid an additional premium for this coverage. Id.

Among its provisions, the Benefits Insurance Policy provided that Defendant "will pay those sums that you become legally obligated to pay as damages because of a negligent act, error or omissions in the administration of your employee benefits program." Id. ¶ 6. The Benefits Insurance Policy defines "administration" as follows:

Administration means performance of the ministerial functions of your employee benefits program and could include:

- a. applying the program rules to determine who is eligible to participate in benefits;

b. calculating service and compensation credits of employees;

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c. preparing messages to tell employees about their benefits;

d. maintaining service and employment records of those employees participating in your employee benefits program;

e. preparing reports required by government agencies;

f. calculating benefits;

g. informing new employees about your employee benefits program;

h. implementing enrollment instructions from your employees in your employee benefits program;

i. advising, other than legal advice, employees who are participating in your employee benefits program of their rights and options;

j. collecting contributions and applying them as called for under the rules of your employee benefits program;

k. preparing benefits reports for your employees participating in your employee benefits program;

l. processing claims.

Id.



In "early 2017," Plaintiff "discovered" that its previous executive director had "committed errors and made omissions that caused [Plaintiff] to fail to implement its employee benefits program with the YMCA Retirement Fund" for approximately fifteen employees. Id. ¶ 7. Specifically, the previous executive director had failed to (1) determine who was eligible for benefits; (2) calculate the "service and compensation credits" for those employees; (3) prepare messages to employees about their benefits; (4) calculate the benefits of employees; (5) inform new employees about the benefits program; and (6) collect contributions and apply them as called for under the program rules. Id. ¶¶ 7, 11. Most importantly, the executive director failed to

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pay the employer portion of pension contributions, and likewise failed to withdraw contributions from employees' paychecks to pay the employee contribution to the pension fund. Id.

Plaintiff "promptly" advised Defendant of these errors, inquiring as to coverage and assistance. Id. ¶ 8. On May 30, 2017, Defendant issued its first partial coverage disclaimer ("First Disclaimer"). Id. ¶ 9. In its First Disclaimer, Defendant explained that "[t]o the degree that there is coverage available for this type of claim, it would be limited to lost profits only." Id. ¶¶ 10-12. In effect, Defendant disclaimed coverage for any principal amounts that Plaintiff may be found liable to pay into its employee benefit program, including contributions that the impacted employees would have made but for the error. Id. The First Disclaimer did not explain whether "lost profits" encompassed interest that the Retirement Fund would have earned on the contributions, had they been properly collected and paid. Id. ¶ 12

In June 2017, Defendant issued a second partial coverage disclaimer ("Second

Disclaimer") to Plaintiff. Id. ¶ 13. Defendant advised that it had received a letter from the Retirement Fund demanding full payment of all amounts due from Plaintiff. Id. ¶ 14. Defendant reiterated its position that only "lost profits coverage" would be available for such a claim, but advised Plaintiff that Defendant's counsel would be available to represent Plaintiff in defending against the Retirement Fund's claim. Id.

On June 30, 2017, Plaintiff wrote to Defendant inquiring as to the basis for its position that the Benefits Insurance Policy did not cover the principal amounts due to the Retirement Fund. Id. ¶ 15. Defendant responded that its position was based on Baylor Heating & Air v. Federated Mut., 987 F.2d 415 (7th Cir. 1993). Id. ¶ 16.

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As a result of Defendant's denial of coverage, Plaintiff has had to borrow "substantial funds" to pay the employer and employee contributions owed to the Retirement Fund. Id. In addition, Plaintiff is "likely to experience negative publicity that will diminish its ability to raise funds within the community." Id. ¶ 17.

Plaintiff alleges that Defendant's decision to deny coverage was made in "bad faith," and that Defendant was aware of the financial harm that denial would cause Plaintiff. Id. ¶¶ 25-30. Plaintiff further alleges that Defendant has engaged in "Unfair Trade Practices" under General Business Law ("G.B.L.") § 349 and Insurance Law § 2601, by "knowingly misrepresenting" to Plaintiff and other New York insured the provisions relating to the coverage at issue and by "not attempting in good faith to resolve" Plaintiff's claim. Id. ¶¶ 31-35. Plaintiff further alleges that Defendant's "unreasonable and arbitrary interpretation of its policy provisions could result in many small businesses and not-for-profits being held individually liable for amounts that they cannot afford, and that

they reasonably believed were covered." Id. ¶ 32.

Plaintiff seeks a declaration that the Benefits Insurance Policy provides coverage for all amounts that Plaintiff owes to the Retirement Fund as a result of the errors, including the "principal amounts owed, employee contributions, and the interest that would have accrued had those payments been made." Id. ¶ 24, and at 10.¹ Plaintiff also seeks an order requiring Defendant to settle the claim made by the Retirement Fund in full. Id. at 10. In addition, Plaintiff seeks reimbursement for expenses and loss of good will, three times actual damages up to \$1,000,

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punitive damages against Defendant based on a pattern of tortious conduct aimed at its New York insureds, and attorneys' fees. Id. at 11.

III. LEGAL STANDARD

To survive a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), "a complaint must contain sufficient matter . . . 'to state a claim to relief that is plausible on its face.'" Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Id. In assessing whether this standard has been met, courts take "all factual allegations contained in the complaint" as true, Twombly, 550 U.S. at 572, and "draw all inferences in the light most favorable to the non-moving party," In re NYSE Specialists Sec. Litig., 503 F.3d 89, 95 (2d Cir. 2007) (internal citation omitted).

IV. DISCUSSION

A. Applicable Law in Diversity

A federal court sitting in diversity jurisdiction, as here, must apply the substantive law of the state in which it is sitting, including the state's choice of law rules. Erie R.R. Co. v. Tompkins, 304 U.S. 64 (1938). The dispute here must be resolved under New York Law, as the policy was issued to a New York entity insuring activities and property in New York. See Ethicon, Inc. v. Aetna Cas. & Surety Co., 688 F. Supp. 119, 123 (S.D.N.Y. 1988) ("New York courts have traditionally resolved choice of law issues involving insurance policies by applying the law of the state which the parties understood would be the principal location of the risk and the state most intimately concerned with the outcome of the litigation.").

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B. Employer and Employee Pension Contributions

The parties dispute whether the Benefits Insurance Policy covers two types of funds Plaintiff now owes the Retirement Fund for the relevant period: (1) the employer portion of the pension contributions, equivalent to 7% of eligible employees' wages (the "Employer Contribution"); and (2) the employee portion of the pension contributions, totaling 5% of eligible employees' wages, which should have been withheld from those employees' paychecks (the "Employee Contribution"). Compl. ¶ 11; Mem. at 12-15; Opp'n at 14-17.

Under New York law, a court must construe an insurance policy, like other contracts, to give effect to the parties' intent as expressed by their words. Dicola v. Am. S.S. Owners Mut. Prot. & Indem. Assoc., 158 F.3d 65, 77 (2d Cir. 1998). If the language of the policy is clear and unambiguous, the court must enforce it as written. Vill. of Sylvan Beach v. Travelers Indem. Co., 55 F.3d 114, 115 (2d Cir. 1995). An unambiguous contract provision is one with "a definite and precise meaning, unattended by danger of misconception in the purpose of the

[contract] itself, and concerning which there is no reasonable basis for a difference of opinion." Sayers v. Rochester Tel. Corp., 7 F.3d 1091, 1095 (2d Cir. 1993) (citations omitted). Moreover, New York follows the "hornbook rule that policies of insurance . . . are to be liberally construed in favor of the insured." Miller v. Continental Ins. Co., 358 N.E.2d 258, 260 (N.Y. 1976).

1. Employer Contribution

As alleged, Plaintiff's obligation to make the Employer Contribution did not arise "because of a negligent act, error or omission in the administration of [Plaintiff's] employee benefits program," as the Benefits Insurance Policy requires. Compl. at 14. Rather, as Plaintiff acknowledges in its Opposition, "[u]nder the terms of the YMCA Retirement Plan" (i.e. a pre-

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existing contract), Plaintiff itself would pay the Employer Contribution. Opp'n at 7, 12. The negligence of the executive director in administering benefits no doubt delayed the Employer Contribution, but the obligation to make that contribution existed already, because of the terms of the YMCA Retirement Plan, not because of any negligent error in administration. See, e.g., Pac. Ins. Co., Ltd. v. Eaton Vance Mgmt., 369 F.3d 584, 590 (1st Cir. 2004) ("The refusal to pay an obligation simply is not the cause of the obligation, and the [insured's] wrongful act in this case did not result in their obligation to pay; [its] contract imposed on [it] the obligation to pay.") (quoting Am. Cas. Co. of Reading, Pa. v. Hotel & Rest. Emps. & Bartenders Int'l Union Welfare Fund, 942 P.2d 172, 176-77 (Nev. 1997)). See also Coregis Ins. Co. v. Am. Health Found., Inc., 241 F.3d 123, 130 n.7 (2d Cir. 2001) (not deciding the "potentially serious question" of whether an insured may ever seek coverage under an insurance policy for amounts it was contractually obligated to pay, but citing Am. Cas. Co.). Accordingly, the

Benefits Insurance Policy did not cover the Employer Contribution, and Plaintiff's claims for recovery of that sum from Defendant must be dismissed.

2. Employee Contribution

With respect to the Employee Contribution, however, Plaintiff's claims survive. As alleged, the Employee Contribution was to come from employee funds, not Plaintiff's funds, though Plaintiff would have facilitated the payments by withdrawing these sums from paychecks. Compl. ¶ 11. The Court lacks documents memorializing the exact obligations Plaintiff owed to the Retirement Fund, but at this stage, the Court must accept the Complaint's factual allegations as true, and draw all inferences in the light most favorable to Plaintiff. *In re NYSE Specialists Sec. Litig.*, 503 F.3d at 95. Plaintiff has plausibly alleged that, in the absence of the executive

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director's errors, it would not have "become legally obligated" to pay from its own funds the Employee Contribution. *Id.* Based on the facts alleged, that legal obligation arose only "because" of the Executive Director's "negligent act, error or omission in the administration of [Plaintiff's] employee benefits program," and not because of a pre-existing contractual obligation.

Defendant counters that Plaintiff is not, in fact, "legally obligated to pay as damages" the Employee Contribution, because Plaintiff is entitled to reimbursement of this amount from the employees themselves in a claim for unjust enrichment. Reply at 5-6. Defendant's theory of unjust enrichment here is that employees received a paycheck without an Employee Contribution withdrawn, but nevertheless get their full pension benefits as if they had made these contributions, since the Employee Contribution has now been paid by Plaintiff directly. *Id.*

Plaintiff has plausibly pled that the Retirement Fund has sought funds from Plaintiff for the Employee Contribution, which Plaintiff is now legally obligated to pay. Whether Plaintiff has a viable unjust enrichment suit against current and former employees does not change whether or not Plaintiff is "legally obligated" to pay the Employee Contribution to the Retirement Fund. By Defendant's logic, if a party were insured for a tort, and had insurance to cover that tort, the party would not be deemed to have any legal obligation to pay the victim for damages resulting from that tort. Obviously, though, if Plaintiff does recover Employee Contributions from employees, Plaintiff's potential claim against Defendant would decrease correspondingly. Defendant also notes that it may exercise subrogation rights under the policy to recoup the Employee Contribution from the employees. Reply at 17.

Defendant also argues for dismissal of the Employee Contribution claim because the Employee Contribution liability is "contractual in nature," Mem. at 12, and under New York law,

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"liability policies do not provide coverage where the complaint sounds in contract and not in negligence," *Royal Ins. Co. of Am. v. Ru-Val Elec. Corp.*, No. 92-CV-4911, 1996 WL 107512, at *2 (E.D.N.Y. Mar. 8, 1996). Defendant points to a number of cases, though none from the New York Court of Appeals, for the proposition that liability coverage does not cover damages stemming from a breach of contract. Mem. at 13-14. But in those cases, the insured plaintiffs had pre-existing contractual obligations independent of any wrongful act. *See, e.g., Health Net, Inc. v. RLI Ins. Co.*, 141 Cal. Rptr. 3d 649, 665 (Cal. Ct. App. 2012) (finding no liability coverage for unpaid benefits because health insurers were "obligated to pay their insureds by contract, independent of any Wrongful Act"); *see also Am. Cas. Co.*, 942 P.2d at 176-

77. With regard to the Employee Contribution, however, Plaintiff seeks coverage not for pre-existing contractual obligations, but for damages that it did not owe until negligent benefits administration caused them.

Defendant also argues for dismissal on public policy grounds, in that an "undeserved gain" would accrue to Plaintiff, and the contract would present a moral hazard if the Employee Benefits Insurance covers the damages at issue here. Mem. at 13. But at least with regard to the Employee Contribution, there is no gain or windfall to Plaintiff directly. The Plaintiff is now obliged to pay the Employee Contribution to the Retirement Fund directly, rather from employees' paychecks; it would not have been required to do so but for the wrongful act. Therefore, insurance coverage will simply make Plaintiff whole. As for moral hazard, the Court is confident that sophisticated insurance companies are capable of drafting contracts and conducting due diligence regarding an insured's pension policies to avoid such pitfalls. "Absent unequal bargaining power or unconscionability . . . a court will not rewrite a contract." Burke v.

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PriceWaterHouseCoopers LLP Long Term Disability Plan, 537 F. Supp. 2d 546, 552 (S.D.N.Y. 2008), aff'd, 572 F.3d 76 (2d Cir. 2009).

Accepting the alleged facts as true, the Court finds, "liberally constru[ing] the policy in favor of the insured," Miller, 358 N.E.2d at 260, that "those sums that [Plaintiff] [has] become legally obligated to pay as damages because of a negligent act, error or omission in the administration of [Plaintiff's] employee benefits program" include the Employee Contribution. Accordingly, Defendant's Motion to Dismiss Plaintiff's claim for the Employee Contribution is denied.

C. Bad Faith

1. Claim for Bad Faith Denial of Coverage

Plaintiff brings a claim for bad faith denial of insurance coverage. Compl. ¶¶ 25-30.

To maintain a cause of action for bad faith against an insurer under New York law an insured must allege a violation of a duty independent of the insurance contract. N.Y. Univ. v. Cont'l Ins. Co., 662 N.E.2d 763, 767-68 (N.Y. 1995). It is well established that, under New York law, "parties to an express contract are bound by an implied duty of good faith, but breach of that duty is merely a breach of the underlying contract." Harris v. Provident Life & Accident Ins. Co., 310 F.3d 73, 80 (2d Cir. 2002). New York law "does not recognize . . . an independent cause of action for bad faith denial of insurance coverage." Woodhams v. Allstate Fire and Cas. Co., 748 F. Supp. 2d 211, 223 (S.D.N.Y. 2010), aff'd, 453 F. App'x 108 (2d Cir. 2012).

Plaintiff's independent cause of action for "Bad Faith Coverage Denial" is based entirely on the denial of coverage under the contract, unrelated to any separate duty, Compl. ¶¶ 25-30, and must therefore be dismissed as a separate claim. Harris, 310 F.3d at 80.

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2. Consequential Damages

Though it is not an independent cause of action, bad faith may justify the recovery of consequential damages in addition to the loss insured by the policy at issue so long as the consequential damages were "within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting." Panasia Estates, Inc. v. Hudson Ins. Co., 886 N.E.2d 135, 137 (N.Y. 2008) (quoting Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y., 886 N.E.2d 127,

130 (N.Y. 2008). In breach of contract actions, consequential damages are those damages that do not directly flow from the contract breach. Bi-Economy, 886 N.E.2d at 130. Defendant moves to dismiss all "extra-contractual damages." Mem. at 15.

In order to determine whether consequential damages were within the contemplation of the parties at the time of contracting, New York courts take into consideration whether there was a specific provision in the policy itself permitting recovery for the loss. Cont'l Info. Sys. Corp. v. Fed. Ins. Co., No. 02-CV-4168, 2003 WL 145561, at *5 (S.D.N.Y. Jan. 17, 2003). Here, the Complaint contains no allegation suggesting that the parties contemplated consequential damages at the time of contracting. Indeed, the Benefits Insurance Policy attached to the Complaint makes clear that, at the time of contracting, the parties contemplated stark limits on the potential recoveries. The agreement states that beyond those sums that Plaintiff "become[s] legally obligated to pay as damages because of a negligent act, error or omission" in employee benefits administration, "[n]o other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments² of this coverage form."

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Compl. at 14. Further, the Complaint specifies that Defendant "will not be liable for damages that are not payable under the terms of this Coverage Part or that are in excess of the applicable limits of insurance." Id. at 18.

As Plaintiff's pleadings lack plausible allegations that consequential damages were within contemplation of the parties at the time of contracting, consequential damages are unavailable here. Therefore, Plaintiff's bad faith claim cannot survive even in the more limited form of support for consequential damages.

D. Deceptive Acts under Insurance Law § 2601 and G.B.L. § 349

Plaintiff alleges that Defendant's deceptive acts violated Insurance Law § 2601 and G.B.L. § 349. Compl. ¶¶ 31-35.

As a preliminary matter, § 2601 affords no private right of action. Rocanova v. Equitable Life Assurance Society, 634 N.E.2d 940, 944 (N.Y. 1994). Therefore, to the extent Plaintiff alleges a claim for deceptive acts under § 2601, that claim is dismissed with prejudice.

As for G.B.L. § 349, it prohibits "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service." To state a claim under § 349, a plaintiff must allege "(1) acts or practices that are 'consumer-oriented;' (2) that such acts or practices are deceptive or misleading in a material way; and (3) that plaintiff has been injured by reason of those acts." DePasquale v. Allstate Ins. Co., 179 F. Supp. 2d 51, 58 (E.D.N.Y.) (citing Gaidon v. Guardian Life Ins. Co. of America, 725 N.E.2d 598, 603-04 (N.Y. 1999)), aff'd, 50 F. App'x. 475 (2d Cir. 2002). The New York Court of Appeals has clarified that under the "consumer-oriented" prong, a plaintiff must demonstrate harm directed at consumers or the public at large; "[p]rivate contract disputes unique to the parties . . . would not fall within the

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ambit of the statute." N.Y. Univ., 662 N.E.2d at 770. "The conduct need not be repetitive or recurring, but defendant's acts or practices must have a broad impact on consumers at large." Id. (internal citations omitted).

Section 349 does not require Plaintiff to allege fraud, and therefore the particularity requirements of Rule 9(b) of the Federal Rule of Civil Procedure are not triggered. However, to state a claim under § 349 Plaintiff must

still allege with some specificity the allegedly deceptive acts or practices that form the basis for the claim. Thus, conclusory allegations, even of the existence of a claim settlement policy designed to deceive the public, are not sufficient to state a claim under § 349 in the absence of supporting factual allegations. See Northwestern Mutual Life Ins. Co. v. Wender, 940 F. Supp. 62, 65 (S.D.N.Y. 1996) (denying § 349 claim where "there [we]re no specific allegations of an impact on consumers at large, or that Plaintiff employed deceptive practices" because "[c]onclusory allegations are insufficient to withstand a motion to dismiss."); MaGee v. Paul Revere Life Ins. Co., 954 F.Supp. 582, 586 (E.D.N.Y. 1997) (allegations that insurer's refusal to pay benefits "is part of a national policy to terminate unprofitable disability insurance policies by denying benefits to insureds," were inadequate to state a claim under § 349, because "any other conclusion would effectively permit a plaintiff to convert almost any garden variety breach of contract cause of action into a violation of section 349").

"Several courts have considered whether disputes between policy holders and insurance companies concerning the scope of coverage can amount to conduct falling within Section 349. Almost uniformly, those courts have held that such disputes are nothing more than private

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contractual disputes that lack the consumer impact necessary to state a claim pursuant to Section 349." DePasquale, 179 F. Supp.2d at 61 (collecting cases).

Here, Plaintiff alleges simply that Defendant violated § 349 by "knowingly misrepresenting to [Plaintiff] and, on information and belief, its other New York insured, the provision relating to the coverage at issue," and claims that Defendant's "unreasonable and arbitrary interpretation of its policy provisions could result in many

small business and not-for-profits being held individually liable for amounts that they cannot afford, and that they reasonably believed were covered." Compl. ¶¶ 31-35. Such conclusory allegations are insufficient to support the "consumer oriented" prong of § 349. See Ticheli v. Travelers Ins. Co., No. 14-CV-172, 2014 WL 12587066, at *3 (N.D.N.Y. Dec. 23, 2014) (dismissing § 349 claim because of speculative, conclusory allegations that insurance's company's conduct was in keeping with its practices toward "the public at large" and "its policyholders").

Accordingly, Defendant's Motion to Dismiss Plaintiff's claim for deceptive acts under § 349 is granted.

E. "Extra-Contractual" Damages

In the Complaint, Plaintiff makes claims for what Defendant terms "extra-contractual damages," Mem. at 15. These include punitive damages, triple damages up to \$1000, attorneys' fees, and reimbursement for "expenses and loss of good will it has incurred" as a result of Defendant's denial of coverage. Compl. at 10-11. Defendant moves to dismiss these claims. Mem. at 20-24.

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1. Punitive Damages

To state a claim for punitive damages, a plaintiff must allege conduct actionable as a tort independent of the breach of contract. N.Y. Univ., 662 N.E.2d at 316. As noted above in the Court's discussion of Plaintiff's bad faith claim, no tort independent of the breach of contract has been alleged here, and so the claim for punitive damages must be dismissed.

2. Triple Damages up to \$1,000

G.B.L. § 349(h) permits a plaintiff to recover three times its actual damages up to \$1,000, if a defendant has willfully or

knowingly violated § 349. But since Plaintiff's § 349 claim has been dismissed, this particular form of damages is unavailable to Plaintiff.

3. Attorneys' Fees

It is true that a Court may award reasonable attorneys' fees to a prevailing plaintiff in a § 349 action. § 349(h). However, Plaintiff's § 349 claim has been dismissed, so attorneys' fees are not available via that route.

Neither the New York Court of Appeals' holdings in Panasia or Bi-Economy suggest that it intended to alter in the insurance context the traditional American rule that each party should bear its own attorneys' fees. Stein LLC v Lawyers Title Ins. Corp., 953 N.Y.S.2d 303, 304 (N.Y. App. Div. 2012); see Mighty Midgets, Inc. v. Centennial Ins. Co., 389 N.E.2d 1080, 1085 (N.Y. 1979) ("It is the rule in New York that [an award of attorneys' fees] may not be had in an affirmative action brought by an insured to settle its rights."); see also Globecon Gr., LLC v. Hartford Fire Ins. Co., 434 F.3d 165, 177 (2d Cir. 2006) ("Under New York law, an insured may not recover the expenses incurred in bringing an affirmative action against an insurer to settle its rights under the policy." (internal quotation marks omitted)).

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The New York Court of Appeals has suggested that an exception to the general rule prohibiting claims for attorneys' fees may exist when the insured can make "a showing of such bad faith [on the part of the insurer] in denying coverage that no reasonable carrier would, under the given facts, be expected to assert it." Sukup v. State, 227 N.E.2d 842, 844 (N.Y. 1967). But "[i]t would require more than an arguable difference of opinion between carrier and insured over coverage to impose an extra-contractual liability for legal expenses in a controversy of this kind." Sukup, 227 N.E.2d at 844.

As Plaintiff has alleged no underlying facts to support a finding of bad faith, other than "an arguable difference of opinion between carrier and insured over coverage," Sukup, 19 N.Y.2d at 522, and conclusory allegations that Defendant "knowingly misrepresented" coverage and knew that denial of coverage would hurt Plaintiff's finances and reputation, the Court will not "impose extra-contractual liability" for attorneys' fees. Sukup, 227 N.E.2d at 844. Plaintiff's claim for attorneys' fees is therefore dismissed.

4. Reimbursement for Expenses and Loss of Good Will

As explained above, consequential damages are unavailable here, as this is an insurance contract dispute in which the governing contract does not suggest that consequential damages were "within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting." Panasia, 886 N.E.2d at 137. Loss of "good will" is a form of consequential damages. Dupont Flooring Sys., Inc. v. Discovery Zone, Inc., No. 98-CV-5101, 2004 WL 1574629, at *7 (S.D.N.Y. July 14, 2004). Accordingly, Plaintiff's claim for loss of good will is dismissed.

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As for Plaintiff's demand for reimbursement of undefined "expenses," "it is well established that an insured may not recover the expenses incurred in bringing an affirmative action against an insurer to settle its rights under the policy." N.Y. Univ., 662 N.E.2d at 772. Accordingly, Plaintiff's claim for an award for expenses is also dismissed.

V. CONCLUSION

Accordingly, it is hereby:

ORDERED, that the Motion to Dismiss is **GRANTED** as to Plaintiff's following

claims and forms of relief, which are **DISMISSED without prejudice**: (1) declaratory relief claim regarding the Employer Contribution owed by Plaintiff to the YMCA Retirement Fund; (2) bad faith coverage denial claim; (3) unfair trade practices claim under G.B.L. § 349; (4) punitive damages; (5) triple damages up to \$1000; (6) attorneys' fees; (7) reimbursement for loss of good will; and (8) reimbursement of expenses; and it is further

ORDERED, that the Motion to Dismiss is also **GRANTED** as to Plaintiff's unfair trade practices claim under Insurance Law § 2601, which is **DISMISSED with prejudice**; and it is further

ORDERED, that the Motion to Dismiss is **DENIED** as to Plaintiff's declaratory relief claim regarding the Employee Contribution; and it is further

ORDERED, that the Clerk of the Court shall serve a copy of this Memorandum-Decision and Order upon the parties in this action.

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IT IS SO ORDERED.

DATED: November ____, 2018
Albany, New York

/s/_____
LAWRENCE E. KAHN
United States District Judge

Footnotes:

¹ The cited page numbers for documents refer to those generated by the Court's Electronic Case Filing (ECF) system.

² The Supplementary Payments section does not suggest any of the sorts of liability in dispute here. Compl. at 15.

