Your Coverage Advisor

Considerations When a Policyholder is in Bankruptcy

Suzana K. Koch
skoch@brouse.com

Amanda M. Leffler
aleffler@brouse.com

When an insured files for bankruptcy protection, there are many questions that can arise, especially if there is a claim made during the bankruptcy proceeding. Policyholders are well-served to consider such issues early in the bankruptcy process.

> Bankruptcy courts have consistently held that the failure of a bankrupt insured to pay [a self-insured retention] will not excuse the insurer's performance.

POLICIES BECOME THE PROPERTY OF THE BANKRUPTCY ESTATE

When a company files bankruptcy, the assets become part of a new entity – the bankruptcy estate. An insurance policy is property of the estate, even if the policy has not matured, has no cash value, or is otherwise contingent. The proceeds, however, may not be property of the estate, depending on who is named as the insured. For example, a lender could be an insured, and in that case, the lender would be entitled to the proceeds.

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Considerations When a Policyholder is in Bankruptcy

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PAYMENT OF PREMIUMS

After filing bankruptcy, a company's assets and liabilities are determined as of the filing date (called the "Petition Date"). The determination of responsibility for premium payments depends largely upon the following considerations:

- Did the policy term expire pre-petition but have retrospective premiums due? Failure of the debtor to pay retrospective premiums may not excuse an insurer's performance. A debtor-insured's post-petition failure to pay does not void the insurer's obligations.
- Does the policy expire post-petition, but before any plan of reorganization has been filed and confirmed? If so, an insurance policy can be considered an executory contract which a debtor can assume or reject.
- Is the policy term still ongoing with standard premium payments due? If the debtor does not pay the premiums, the insurer may be able to cancel the policy.

DEDUCTIBLES AND SELF-INSURED RETENTIONS

A deductible or self-insured retention ("SIR") is the amount an insured is responsible to pay under the policy for a covered claim. In a bankruptcy, the inability of the debtor to pay the deductible or SIR does not excuse the insurer from paying claims. Instead, if the insurer has advanced costs that should have been paid by the policyholder, the insurer then has a bankruptcy claim against the insured debtor for that amount.

Bankruptcy courts have found insurers obligated to defend and indemnify to the extent that claims exceed the SIR. Insurers often demand actual payment of the SIR, but if the debtor includes its obligation in its plan of reorganization, bankruptcy courts may consider the SIR to be "satisfied." Bankruptcy courts have consistently held that the failure of a bankrupt insured to pay an SIR will not excuse the insurer's performance.

Insurers will argue that they have no obligation to perform until the debtor actually pays the SIR, but if a debtor in bankruptcy is incapable of funding an SIR, the inclusion of the SIR amount in a plan of reorganization is enough to trigger the insurer's obligations.

Some courts, however, have come to a contrary conclusion based upon specific policy language. In Pak-Mor Manufacturing Co., the court concluded that the policy language was "clear as daylight" that none of the insurer's obligations would arise until the insured paid the SIR. The court reasoned that to require the insurer to cover the claim just because it writes liability insurance generally would be an injustice. The court noted, however, that the best approach is a case-by-case approach in questions regarding whether or not an SIR must be exhausted by payment.

In fact, courts in other states have distinguished the Pak-Mor case based on policy language, applicable state laws, and public policy concerns. Courts in Louisiana, Indiana, Illinois, and elsewhere have generally found the public policy concerns to be strong enough to override policy language.

INSURED V. INSURED

The bankrupt debtor, unless a trustee is appointed, is in possession of the bankruptcy estate. The debtor-in-possession controls the estate's property, including its legal claims, and it is the debtor-in-possession who has the legal obligation to pursue claims or to settle them. Typical Directors and Officers insurance policies exclude coverage for claims brought by one insured against another, like claims against directors and officers brought by or on behalf of the company.

Courts are split as to the application of the exclusion when claims are brought by a debtor-in-possession, committee of unsecured creditors, or trustee against a bankrupt debtor. Some courts hold that there is a sufficient identity between the pre-petition debtor and the post-petition debtor-in-possession, committee, or trustee that such claims fall within the exclusion. Other courts have disagreed, finding the estate, committee, or trustee ("Non-Insured Entities") are a separate legal entity distinct from the pre-petition debtor. Additionally, the Non-Insured Entities owe a duty to the creditors of the debtor's estate, not to the debtor itself, and have been found to be sufficiently adverse to the officer and director defendants that claims do not raise the appearance of collusion that otherwise might arise.

Coverage determinations when an insured has filed for bankruptcy protection are case specific. The intersection of bankruptcy and insurance issues can be complex. If confronted with such issues, contacting experienced counsel is key to understanding how a bankruptcy court might rule on complex coverage issues. ■

Discounting Depreciation Defenses

Paul A. Rose
prose@brouse.com

Elizabeth E. Collins
ecollins@brouse.com

When faced with large claims, insurers occasionally will make creative "depreciation" arguments in an attempt to limit their liabilities. Such arguments are most common in first-party insurance claims, such as claims made under property insurance policies. Policyholders are well served to be wary of them.

First-party insurance claims may be subject to varying valuation approaches, which is the circumstance that gives rise to potential mischief. These varying approaches often will depend upon whether the policyholder repairs or replaces the subject damaged property and the range of valuation options will be established by the policy language, as it is construed under applicable law. Although parties may agree upon the history of a claim and the provisions of the policy that will apply, valuation disputes may still arise. When they arise, the considerations discussed below may be helpful in effectively addressing them.

If a policyholder does not repair or replace damaged property or has not purchased a policy that would cover the full costs to repair or replace, insurers often will be required to pay only a reduced amount determined through application of some depreciation approach. While depreciation arguments may be valid and have proven successful for insurers in many cases, depreciation is not a wild card. Depreciation is not always applicable to property losses and, even when applicable, it may not apply in the manner an insurer contends.

The limits on depreciation reductions typically are clearly defined. For instance, depreciation often is not considered if a policyholder purchases replacement cost coverage and proceeds to replace the damaged property. Similarly, depreciation is not to be applied when the measure of the loss is the cost of repair. As repair costs usually are expenses to be incurred after the loss, this distinguishes

them from property values, which often derive from past valuations that have depreciated over time. If such limitations are not evident in the language of the policy, depreciation nonetheless, may be inapplicable if a court finds that an ambiguity exists, which it will resolve in favor of the policyholder.

In Ohio, for example, it is important that insurers not overreach in their depreciation arguments because of Ohio's insurance contract interpretation rules. Ohio law does not require that a policyholder establish that its interpretation is the only reasonable interpretation or even that its interpretation is more reasonable than its insurers'. Rather, a policyholder will prevail merely if its interpretation is a reasonable interpretation, even if only one among many. Accordingly, any overreaching on the part of an insurer is likely to result in a finding in favor of the policyholder. If the policyholder merely can establish that a provision relating to depreciation is ambiguous – often not a challenging undertaking – and that some reasonable interpretation favors the policyholder, it likely will win the argument.

For instance, in *Peterson v. Progressive Corp.* (*"Peterson"*), the Eighth District Court of Appeals rejected an insurer's attempt to depreciate repair costs, finding that the insurer's limitations on depreciation were clearly defined in the insurance contract. In *Peterson,* the court did not permit insurers to deduct depreciation from the cost it incurred to repair a boat to its pre-loss condition. The court reasoned that such depreciation was not specifically provided for in the policy; instead, the insurer elected to repair the boat, which was one of several options available to the insurer under the insurance contract. Thus, the court determined that the cost of depreciation was improperly deducted.

As demonstrated by *Peterson* and many other cases, courts can be quite wary of insurers' depreciation arguments. Because courts tend to take the view that the purpose of insurance policies is to make policyholders whole, they generally will apply depreciation deductions to the full extent insurers might wish only if the language of the policies at issue clearly and explicitly permit such outcomes. Accordingly, insurer forbearance from asserting creative depreciation arguments very well may save the insurer and policyholder significant litigation expenses, may save the court system considerable burden, and likely will preserve a fair amount of good will between insurer and policyholder. When a policyholder, its broker or counsel is discussing with insurers resolution of contested "depreciation" claims, these can be very useful points to raise. ■

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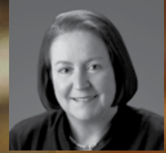
Decision Points

Sallie Lux
slux@brouse.com



Legal decisions interpreting laws, statutes, and insurance policies provide guidance on the meaning of various provisions in insurance policies and whether or not a particular happening may or may not be covered. A few recent legal decision points of note follow:

MUSTARD V. OWNER'S INS. CO.

The Court of Appeals for Ross County considered whether a liquor liability exclusion was applicable to a not-for-profit policyholder. The plaintiffs were injured in a collision with another driver, who was under the influence of alcohol served by the local American Legion Post. The plaintiffs filed suit against the other driver, the Post, and others. An agreed judgment was entered against the Post, with the plaintiffs agreeing to satisfy the judgment from the Post's insurer.

The Post's insurance policy contained a liquor liability exclusion that excluded coverage where the policyholder is "in the business of" serving or selling alcohol. The Post, a nonprofit entity, argued the exclusion inapplicable because a nonprofit entity could not, by its very nature, be "in the business of" selling alcohol or that, at minimum, the exclusion was ambiguous and should be construed to mean "an underlying profit motive."

The Court rejected the Post's argument, determined the language unambiguous, and found the exclusion to apply, holding that the "focus should be on the activities of the insured, rather than its corporate status." The Court observed that the fact that an entity is organized as a nonprofit does not bear upon whether it engages in pursuing business activities. Here, the Post had a liquor license and sold alcohol for a profit. Accordingly, the Post was "in the business of" selling or serving alcohol, an activity that was excluded from coverage.

VIETZEN V. VICTORIA AUTOMOBILE INS. CO.

In this case, the Lorain County Court of Appeals considered whether or not a combined bill, notice of non-payment of premium, and notice of cancellation sent in advance of the premium due date and, thus, in advance of the non-payment itself, is effective to cancel an automobile policy.

A judgment was obtained against the policyholder for injuries resulting from an automobile accident. Victoria Insurance declined to pay the judgment because it claimed to have canceled the policy for non-payment of premium the day that the accident occurred. Approximately two weeks before, Victoria mailed a bill stating that a payment was due the day before the accident happened as well as a "cancellation notice" that if the payment was not received, the policy would cancel for non-payment at 12:01 a.m. the day after payment was due. The payment was not made by the specified due date.

An insurer must comply with R.C. 3937.32 when canceling an automobile policy. The court found the statute ambiguous, and therefore considered the legislative intent, including protecting "insureds from unilaterally being left without the protections . . . by requiring that insurers provide an adequate method of notification when canceling insurance policies." It further noted that non-payment of premium cannot be grounds for cancellation where the due date for payment has not passed, and that the statute includes a 10-day grace period during which an insured may cure and avoid cancellation. Consequently, an insurer cannot mail a cancellation before the insured has failed to make payment, and the cancellation will not be effective until 10 days after the notice of cancellation is mailed.

PRIORE V. STATE FARM FIRE & CASUALTY CO., ET AL.

Priore was an owner and managing member of an LLC that owned an apartment building. Property and Comprehensive Business Liability insurance was procured, with the LLC as the Named Insured. Ice and snow accumulated on the roof on the apartment building, causing it to fail. Priore sued State Farm for property losses he personally suffered as a consequence of the roof failure under various theories. Of interest here are two.

> ...an insured has a duty to read the policy; equity only assists the vigilant.

Priore alleged that the policy should be reformed to include him as a Named Insured under the policy. The bases for this claim were alleged discussions between Priore and the agent that Priore would be covered under the policy. The Court recognized that reformation is an equitable remedy that may be available to alter a written instrument and correct a mistake under certain circumstances. However, an insured has a duty to read the policy; equity only assists the vigilant. Priore never read the insurance policy and thus reformation of the policy was prohibited. The takeaway is, of course, that the insured should always read the policy in order to make relevant inquiries, maximize the ability to recover, and rescind or correct errors in issuance.

Priore also asserted claims against the agent for failure to procure proper coverage to protect his interests, including a failure to recognize Priore's insurable interests and advise him accordingly. In considering this claim, the Court recognized that an agent has a duty to exercise reasonable care in obtaining the insurance requested by the insured. An agent's duty does not, however, rise to the level of a fiduciary that, absent a specific request or request for general advice by the insured, includes the higher fiduciary duty to advise the insured about the types of coverage that the insured may need. ■

Office Locations

AKRON
388 South Main Street
Suite 500
Akron, OH 44311-4407
Phone: 330.535.5711

CLEVELAND
600 Superior Avenue East
Suite 1600
Cleveland, OH 44114-2604
Phone: 216.830.6830

LORAIN COUNTY
5321 Meadow Lane Court
Suite 7
Sheffield Village, OH 44035-0601
Phone: 440.934.8080

INSURANCE RECOVERY ATTORNEYS
Lucas M. Blower
Nicholas P. Capotosto
Christopher J. Carney
Alexandra V. Dattilo
Lisa S. DelGrosso
Clair E. Dickinson
Keven Drummond Eiber
Matthew K. Grassoff
Kerri L. Keller
Gabrielle T. Kelly
Amanda M. Leffler
Sallie Conley Lux
Caroline L. Marks
Meagan L. Moore
Charles D. Price
Paul A. Rose

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Attorney Highlights

Keven Eiber, Gabrielle Kelly, Caroline Marks, and Paul Rose attended the ABA Insurance Coverage Litigation Committee's CLE Seminar in Tucson, AZ from March 5-8, 2014.

On March 19, 2014, Amanda Leffler was presented the Ohio State Bar Foundation Community Service Award for Attorneys 40 and Under at the OSBA District 11 annual luncheon meeting.

Amanda Leffler spoke on Indemnification, Insurance and Bonds at the Lorman AIA Contracts Seminar, on April 15, 2014 in Cleveland, OH.

On May 30, 2014, Keven Eiber will be presenting at the CMBA, Insurance Law Section's seminar, Risk Happens: How Corporate In-House Counsel Can Protect and Maximize Insurance Assets.