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Coverage Issues for Non-Coverage Counsel: A Simple Primer for Issue-Spotting Some Complex Stuff

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Insurance is pervasive. It exists in all that we do and everywhere we go. Without insurance, risk would often be untenable and all commerce would almost assuredly cease. Any property owner knows that they had to obtain insurance as a requirement of the lender to acquire the property. Any business owner knows that it must have liability insurance to protect it from unexpected risks that could decimate its business. Most business transactions have certain insurance requirements contained within the contract such as who must insure against risk of loss or defend and indemnify for liability arising therefrom. Health insurance, while not the topic of this presentation, is so important that the government has spent the better part of 20 years discussing how to best provide insurance for all. Yet, as we all know, insurance is simply a contract. And the protection afforded by the insurer is subject to the terms and conditions of that contract. But, unlike many contracts, insurance policies are governed by certain unique rules that are not always obvious.

Following the Great Fire of London in 1666, Britain passed several laws to protect its citizens from future potential devastation. The World's First Insurance Company, Barry Klein, available at: https://www.irmi.com/articles/expert-commentary/the-worlds-first-insurance-company. One such law was to allow for establishment of organizations to indemnify for casualty losses. *Id*. In 1667, the first insurance company was formed, but not exactly as we know it today. *Id*. The first insurance companies established their own fire departments and were tasked to extinguish fires at insured properties – but only their own insured properties. *Id*. Once the government assumed the role of firefighting, the insurers focused on the indemnification aspect of their business model. *Id*.

Fast forward a few hundred years. As insurers developed in the United States, they would draft their own policies of insurance. Policies are not mere contracts drafted on a whim. They are complex documents that are created based on risk assessment and statistical analysis for premium rating. Insurers will analyze what is a covered loss and what its risk exposure is for such loss. For example, if an insurer provides coverage for 1000 homeowners against risk of loss by fire, the insurer will need to know what is the probability that a fire will occur to one (or more) of those 1000 homes and what will be the probable cost of such loss. Based on its statistics, it will establish a premium for those 1000 homes accordingly. This analysis is applied to every risk insured by the policy. Naturally, it is a monumental task.

In 1971 the Insurance Services Office ("ISO") was formed to aide insurers in their gathering of statistical data. See, https://www.verisk.com/insurance/brands/iso/. In order to have reliable statistical models, ISO needed to have standardized policies to establish a baseline. As a result, the insurance industry relies heavily, though not exclusively, on policy forms prepared by ISO. This provides consistency in statistical data and enables insurers to have a source of policy language compliant with the laws of all 50 states.

Notwithstanding the standardization of insurance policies, lawsuits are filed every day. Courts will interpret policies, but those interpretations are heavily fact dependent. There are many "basic" principals of insurance law, which are well known. For example, if an insurance policy is subject to more than one reasonable interpretation it will generally be construed in favor of the insured's interpretation. See, e.g., *Pharmacists Mut. Ins. Co. v. Advanced Speciality Pharm., LLC,*

2016 Ala. LEXIS 131 (2016) ("if a provision in an insurance policy is found to be genuinely ambiguous, 'policies of insurance should be construed liberally in respect to persons insured and strictly with respect to the insurer.'"); *Ameron Internat. Corp. v. Ins. Co. of State of Penn*., 50 Cal. 4th 1370, 1378 ("if, after the court evaluates the policy's language and context, ambiguities still exist, the court must construe the ambiguous language against the insurer"); *Chandler v. Geico Indem. Co*., 78 So. 3d 1293, 1300 (Fla. 2011) ("Where the policy language 'is susceptible to more than one reasonable interpretation' … [t]he ambiguous language is then construed 'against the drafter and in favor of the insured'"); *Laboy v. Grange Indem. Ins. Co*., 144 Ohio St. 3d 234, 237 (2015) ("provisions in an insurance contract that are reasonably susceptible of more than one interpretation will be construed liberally in favor of the insured").

A recent ad campaign from Farmers Insurance identifies a "Hall of Claims" in which highly unusual claims occurred and were covered losses. What is clear is that crazy, unusual claims do occur every day. Those facts are analyzed within the context of the insurance policy, basic insurance law principals, and any case law that may have considered similar facts (if possible). Because of the uniqueness of the facts of many claims, coverage disputes will always exist. To this end, we will address some issues to consider in future coverage cases.

I. General Policy Analysis

Every coverage issue begins with the facts of the case. When a claim is presented, the facts will provide the basis for the analysis. As noted above, ISO has formulated standard policies forms. Those forms are prepared from a statistical risk perspective, which indicates that the insurer has an expectation of what type of claim is intended to be covered. Insurers will have relied on and analyzed those forms thousands of times over. Insureds, on the other hand, have likely only experienced the policy on that particular occasion. As a result, the parties are approaching the matter from completely different perspectives.

An insurer would find it useful to approach every coverage case from the perspective of the insured. It begins with never assuming the answer. Although the insurer may have seen something similar, an insurer should analyze every possible nuance that might alter a previous outcome. In that analysis, the insurer should read the policy. It may sound simplistic, but it is a task often overlooked. An insurer has reviewed the policy many times. They may have a strong understanding of what they intend to insure from a risk perspective. However, the insured is starting from scratch. It does not have any assumptions. It has no concern about risk perspective and premium ratings. It is concerned with one thing, and one thing only: Are they insured?

Such a nuance can be found in the form of an article placed before the word "insured" in a policy. Courts have grappled with the distinction between "an insured" and "the insured." Is "the insured" singularly focused on the particular individual? Is "an insured" inclusive off any person who claims to be insured? In *Safeco Ins. Co. of Am. v. White*, 122 Ohio St. 3d 562, 577 – 78 (2009), Ohio Supreme Court Justice O'Donnell writing in concurrence noted the distinction:

> Courts are divided on the question whether the phrase "an insured," … means "the" insured or "any" insured. Some courts have concluded that the phrase "an insured" is ambiguous and should be construed against the insurer because it could mean

either "the insured" or "any insured." See, e.g., *Michigan Millers Mut. Ins. Corp. v. Benfield* (C.A.11, 1998), 140 F.3d 915, 926 (Florida law); *McFarland v. Utica Fire Ins. Co*. (S.D.Miss.1992), 814 F.Supp. 518, 525-526 (Mississippi law).

A majority of courts, however, hold that the phrase "an insured" should be interpreted as "any insured." As the Supreme Court of Michigan explained in *Allstate Ins. Co. v. Freeman* (1989), 432 Mich. 656, 443 N.W.2d 734, "' "[a]" or "an" is an indefinite article often used in the sense of "any" and applied to more than one individual object; whereas "the" is an article which particularizes the subject spoken of" *Id*. at 698, quoting *Allstate Ins. Co. v. Foster* (D.Nev.1988), 693 F.Supp. 886, 889. Thus, the court in *Freeman* stated that "if we place the word 'a' or 'an' in front of the word 'insured,' then we must conclude that 'an insured' unambiguously means 'any insured.'" *Id*. at 699; see also *Utah Farm Bur. Ins. Co. v. Crook* (Utah 1999), 1999 UT 47, 980 P.2d 685, 688; *Vance v. Pekin Ins. Co*. (Iowa 1990), 457 N.W.2d 589, 593; *Woodhouse v. Farmers Union Mut. Ins. Co*. (1990), 241 Mont. 69, 72, 785 P.2d 192; *Farmers Ins. Co. v. Hembree* (1989), 54 Wash.App. 195, 203-204, 773 P.2d 105; *Foster*, 693 F.Supp. at 889; *Bryant v. Allstate Ins. Co*. (E.D.Ky.1984), 592 F.Supp. 39, 41; *Travelers Ins. Co. v. Blanchard* (La.App.1983), 431 So.2d 913, 914-915.

The one thing that an insurer should assume is that an insured is likely to be creative in its search for coverage. As such, the insurer should be creative as well. Think like an insured desperate for coverage. For example, can a homeowners' policy provide liability coverage for an automobile accident caused by an insured? Imagine an accident caused by a person driving an automobile while texting. Liability is clear on the driver. However, an insurer should evaluate whether the person on the other end of the text might be liable as well. If that person knew the driver was texting while driving, then does that establish liability for the accident. *See, e.g., Kubert v. Best*, 432 N.J. Super. 495, 503 (N.J. App., 2013) ("[w]e hold that the sender of a text message can potentially be liable if an accident is caused by texting, but only if the sender knew or had special reason to know that the recipient would view the text while driving and thus be distracted."); B*ut See, Vega v. Crane*, 55 Misc. 3d 811, 817 (N.Y. Sup. Ct., 2017) (holding that it is not reasonably foreseeable for a texting party to be the proximate cause of an accident). If so, does the homeowner sitting on their couch have coverage for their liability in causing the accident by distracting the driver? That homeowner is not operating a motor vehicle from inside the confines of their living room.

The bottom line is that an insured owes it to itself and its insured to provide a thorough and fair analysis of the facts of every case. Those facts may establish that there is coverage. Or, it may establish that there is no coverage. Either way, the insured will have provided a fair and thoughtful coverage decision, which will go a long way in warding off any bad faith claims that might be raised as well.

II. Computer/Technology Usage with Endorsements

In 1971 when ISO began providing standardized forms technology was in its infancy. One endorsement could be drafted, but it would apply to many types of policies. As a result, the endorsement would have a typical header indicating that it applies to a host of forms, coverages, or provisions regardless of whether or not those forms, coverages, or provisions were part of the policy or not. For example, a policy may reflect the following:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

[TITLE OF ENDORSEMENT]

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
COMMERCIAL AUTOMOBILE COVERAGE PART
GARAGEKEEPERS LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS COVERAGE PART

[Insert Endorsement Language]

Obviously technology has evolved since 1971. However, insurers still use that same format. They still have headings that indicate the endorsement applies to forms, coverages, or provisions that may not be part of the actual policy. The problem is that such usage can create ambiguities.

In *The Burlington Ins. Co. v. Eden Cryogenics LLC*, 126 F. Supp. 3d 947 (S.D. Ohio, 2015), the Court considered whether the "coverage part" headings were ambiguous thereby resulting in coverage for the insured. The endorsement was similar to the example noted above and provided as follows:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXCLUSION – INTELLECTUAL PROPERTY

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

Id. at 953.

The dispute in the case centered on whether the endorsement modified all of the CGL coverages as well as the products/completed operations coverage or if it only modified the products/completed operations coverage. *Id*. at 955 – 57. Because Products/Completed Operations

Liability Coverage was part of Coverage A of the CGL Coverage Part, the Court concluded that it was ambiguous if the heading modified ALL of the CGL Coverage Part. *Id*. There was be no need to include the Products/Completed Operations reference if it was already included in the CGL coverage part. *Id*. The text of the Endorsement did not provide any guidance as to what section was being modified. *Id*. at 953. Thus, the Court held that the heading was ambiguous and the insured's interpretation was reasonable thereby affirming coverage. *Id*. at 955 – 57.

Although not addressed in the Court's Decision, there is a separate ISO form for Products/Completed Operations Liability Coverage. However, that form was not a part of the Eden policy. It is possible that the Endorsement in Eden was meant to apply to two different forms (the CGL form and the separate Products/Completed Operations Liability form). The insurer used a blanket form applicable to many types of coverage, which potentially created the ambiguity. Today, an insurer could use technology to specify that the endorsements clearly identify that they apply to forms, coverages, or provisions that are applicable to the policy. Insurers should remove useless references. It could create ambiguities where none should exist. But until they do, an insurer would be wise to review the headings to see if there is something there that could alter their assessment.

III. The Stray Comma

Just like any other contract, words and punctuation matters. While typos might happen in a vacuum (and might be found in these materials notwithstanding the proof-reading efforts), such should not occur in an insurance form used in potentially hundreds of thousands of policies. ISO is useful in preparing documents, of course, but insurers often modify standard ISO forms. When they do so, and even when relying on ISO, they need to be mindful of possible typos. More to the point, they should be mindful of punctuation.

Recently, a policy was encountered that contained an odd placement for a comma. The provision containing the oddly placed comma was not pertinent to the dispute at hand. Thus, it was not litigated. The policy appeared to indicate what it meant to cover, but the placement of the comma may well have inadvertently modified the policy. The policy provided a definition of persons who would be considered insureds for purposes of coverage. Per the policy, "insured" includes:

> Any person (other than your 'employee' or 'volunteer worker'), or any organization while acting as your real estate manager.

The comma at issue follows "worker')". The natural question is: why is it there? The intent appears to be that the definition of "insured" includes any person or organization while acting as the named insured's real estate manager. However, the comma could also be read as to create two classes of insureds in this one sentence: 1) any person (other than your 'employee' or 'volunteer worker'), and 2) any organization while acting as your real estate manager. Under this potential scenario, one could argue that any person is an "insured" entitled to coverage under the policy. Naturally, there would likely have to be some connection between the named insured and the person seeking "insured" status. Nevertheless, the presence of the comma seems to be unnecessary and could create an ambiguity.

While the above is purely hypothetical, grammar is often at issue in coverage disputes.

> "Patent" ambiguities often involve grammatical structure, placement of commas and such. The failure to insert a comma or to restructure the sentence creates an inherent ambiguity no matter what factual situation underlies the dispute over coverage. *See American Nat'l*, 107 F.3d at 458. The exclusion itself is confusing. *Id.* In such a case, Indiana's general rules favor coverage. *See Eli Lilly and Co. v. Home Ins. Co.*, 482 N.E.2d 467 (Ind. 1985); *Asbury v. Indiana Union Mut. Ins. Co.*, 441 N.E.2d 232 (Ind. Ct. App. 1982). Specifically, a patent ambiguity in an insurance contract is to be interpreted so as to disregard the exclusion. *Sur v. Glidden-Durkee*, 681 F.2d 490 (7th Cir. 1982)(citing, *Huntington Mut. Ins. Co. v. Walker*, 181 Ind. App. 618, 392 N.E.2d 1182 (Ind. Ct. App. 1979)).
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> *Scott Hoffer Chevrolet-Geo v. Federated Mut. In. Co*., 1997 U.S. Dist. LEXIS 9430, fn 5 (N.D. Ind., 1997).

However, in *Certain Interested Underwriters at Lloyds, London v. LeMons*, 85 Mass. App. Ct. 400 (2014), the Court held that the placement of a comma did not create an ambiguity. The provision at issue excluded coverage for bodily injury and property damage "arising out of an assault or battery, provoked or unprovoked, or out of an act or omission in connection with the prevention or suppression of an assault or battery, committed by an Insured or an employee or agent of the insured." *Id*. at 401. The issue surrounded the phrase "committed by" and what it was intended to apply toward. The insurer claimed it applied to the section immediately preceding the comma – i.e. "an act or omission in connection the prevention or suppression of an assault or battery." *Id*. at 403. The insured argued the "committed by" language applied to the initial reference to "assault or battery." *Id*. If the insurer was correct, then all claims arising from an "assault or battery," whether caused by an insured or someone else, would be excluded. If the insured was correct, then "assaults or batteries" committed by someone other than an Insured would be covered. The Court held that the comma placed before "committed by" attached that phrase to the section immediately preceding the comma. *Id*. at 404. Thus, the oddly placed comma was sufficient to clarify that the exclusion contained two separate and distinct coverage exclusions.

Based on this, it is wise for the insurer to pay close attention to punctuation and grammar. The reality is that grammar does indeed serve a purpose. Commas mean something. Grammar matters. The context of the comma in the sentence provides guidance. Simply stated, do not ignore the punctuation.

IV. Late Notice

The law on Late Notice is largely consistent, but not entirely so. Typically, an insurer can deny coverage for late notice if the insurer was prejudiced by the late notice. *See*, *Ferrando v. Auto-Owners Mut. Ins. Co*., 98 Ohio St. 3d 186, 208 (2002) (courts must conduct a two-step approach to determine the effect of a claim denial based on late notice: 1) was the notice late, and 2) was the insured prejudiced). Courts are split as to who has the burden of proof on the prejudice prong. Some courts place the burden on the insured to prove the insurer was not prejudiced.

Ferrando, 98 Ohio St. at 208 ("[u]nreasonable notice gives rise to a presumption of prejudice to the insurer, which the insured bears the burden of presenting evidence to rebut."); *Bankers Ins. Co. v. Macias*, 475 So. 2d 1216, 1218 (Fla. 1985) ("If the insured breaches the notice provision, prejudice to the insurer will be presumed, but may be rebutted by a showing that the insurer has not been prejudiced by the lack of notice."); *Gerrard Realty Corp. v. American States Ins. Co*., 277 89 Wis. 2d 130, 146 – 47 (Wisc. 1979) ("where notice is given more than one year after the time required by the policy, there is a rebuttable presumption of prejudice and the burden of proof shifts to the claimant to prove that the insurer was not prejudiced by the untimely notice."). Other courts, however, view late notice as a defense to coverage, which places the burden on the insurer to establish that it was prejudiced. Brakeman v. Potomac Ins. Co., 472 Pa. 66, 76 – 77 (Pa. 1977) ("where an insurance company seeks to be relieved of its obligations under a liability insurance policy on the ground of late notice, the insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position").

For instance, in New Jersey, the insurer bears burden of showing late notice and "appreciable prejudice." The insurer must show that substantial rights regarding defense against claim have been irretrievably lost and it would likely have had a meritorious defense had timely notice been given. *Gazis v. Miller*, 892 A.2d 1277 (N.J. 2006); *Pfizer, Inc. v. Employers Ins. of Wausau*, 712 A.2d 634 (N.J. 1998); *Green v. Selective Ins. Co. of Am.*, 676 A.2d 1074 (N.J. 1996); *Transportes Ferreos de Venezuela II CA v. NKK Corp.*, 239 F.3d 555, 561 (3d Cir. 2001); *Amentler v. 69 Main St., LLC*, Case No. 08-0351, 2009 U.S. Dist. LEXIS 55475, at *24 (D.N.J. June 30, 2009).

Prejudice can come in the form of lost evidence or increased liability based on subsequent events. While there is no universal rule, courts often look to the effect of the late notice on the insurer. For example, "[a]n insurer is prejudiced by late notice when, for example, it cannot investigate the facts necessary to determine whether coverage should be provided and when it has been denied the opportunity to have input into the manner in which the underlying claim is being defended." *Fireman's Fund Ins. Co. v. Bradley Corp*., 261 Wis. 2d 4, 38 (Wisc. 2003). In *Petosky Mfg. Co. v. Commercial Union Ins. Cos*., 1992 U.S. Dist. LEXIS 14929, * 11 (W.D. Mich., 1992), the Court (citing Michigan law) stated "[p]rejudice will be found where the delay 'materially' impairs an insurer's ability to contest its liability to an insured or the liability of the insured to a third party." The *Petosky Mfg.* court further held "[l]ate notice is prejudicial where an insurer is denied the opportunity to make a prompt investigation while the facts are fresh in the minds of the witnesses before physical evidence has been obliterated." *Id*. at * 12.

Exceptions to the Prejudice Rule

While the majority rule across the country is that an insurer must demonstrate prejudice in order to deny coverage on the basis of late notice, there are exceptions to majority rule depending on the specific type of policy and language involved. As noted above, New Jersey law generally requires that an insurer demonstrate prejudice to rely on a late notice defense. However, a recent decision from the New Jersey Supreme Court clarified that the prejudice requirement does not apply to claims made insurance policies. In *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co.*, 224 N.J. 189, 129 A.3D 1069 (2016), the Court held that, regardless of whether the insurer suffered prejudice, the insured's six month delay did not satisfy the policy's requirement that the

insured report any claims as soon as practicable, and the insured accordingly forfeited coverage under the policy.

Therefore, under New Jersey law the "appreciable prejudice" standard does not apply to "claims-made" policies. Where the parties to a "claims-made" policy are "sophisticated," the policy's notice requirement should be given strict effect, and "appreciable prejudice" need not be asserted. *Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304, 309-310 (1985); *See Templo Fuente de Vida Corp.* at 209-210 (2016).

Most corporate policies outside of general liability are claims-made, such as errors and omissions, directors and officers, and employment practices liability insurance. Given same, while a filed complaint is easily recognized as a "claim," if dealing with a claims-made policies the applicable notice provision may be triggered by an angry letter from a shareholder or a letter from a former disgruntled employee, thus triggering the notice and reporting duties within the a policy.

Late notice, like everything else, can be jurisdictionally dependent. It is important to review the law applicable to the jurisdiction in which the action is to be brought. As noted above, do not assume general insurance law principals are universally held.

V. Right to Independent Counsel

The right of an insured to have independent counsel is generally based on an attorney's ethical obligations to his client to avoid conflicts of interest and on the insurer's obligation to defend its insured. When there is a genuine concern that the insurer might not provide a vigorous defense because of its very limited indemnity exposure, a court may find that the insured has the right to assume control of its own defense. In those instances, the insurer must reimburse the reasonable and necessary costs incurred by the insured in defending the action with the counsel of his own choosing. Different states have different requirements triggering the insured's right to independent counsel and the insurer's corresponding duty to pay independent counsel's reasonable attorneys' fees.

A majority of states that have analyzed the right to independent counsel follow the analysis utilized in the New York Court of Appeals case, *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401, 425 N.E.2d 810, 815 (1981). Pursuant to *Goldfarb*, an insured's right to independent counsel is triggered when the attorney's duty to the insured would be to defeat liability on any ground, but his duty to the insurer would be to defeat liability on only those grounds for which the insurer might be liable. Put another way, a policyholder has a right to independent counsel paid for by the insurance company, where a conflict of interest arises because a complaint contains allegations possibly both within and outside the coverage of the insurance policy. *Hartford Acc. & Indem. v. Hempstead, 48 N.Y.2d 218, 397 N.E.2d 737, 422 N.Y.S.2d 47(1979); Pub. Serv. Mut. Ins. v. Goldfarb, 53 N.Y.2d 392, 425 N.E.2d 810, 442 N.Y.S.2d 422 (1981); San Diego Navy Federal Credit Union v. Cumis Ins. Society, Inc., 162 Cal.App.3d 358, 208 Cal.Rptr. 494 (1984). see also, National Cas. Co. v. Forge Indus. Staffing, Inc.*, 567 F.3d 871, 875 (7th Cir. 2011) (stating that conflict counsel must be appointed when the underlying complaint contains two mutually exclusive theories of liability, one which the policy covers and one which the policy excludes).

Contrast that with the so-called "Burd Rule," in New Jersey based on the holding in *Burd v. Sussex Mut. Ins. Co.* 56 N.J. 383, 386, 267 A.2d 7, 8 (1970). The Burd Rule holds that, where a conflict exists between an insurer and its insured by virtue of the insurer's duty to defend mutually exclusive covered and non-covered claims, the duty to defend is translated into a duty to reimburse the insured for the cost of defending the underlying action if it should ultimately be determined, based on the disposition of that action, that the insured was entitled to a defense. Thus, in New Jersey, an insurer is not required to defend or pay independent counsel fees for uncovered claims where the underlying plaintiff alleges covered and non-covered claims against the insured. However, where the insured was defended by independent counsel and the loss is found to fall within coverage, the insurer must pay reasonable and necessary costs of the insured's defense.

Furthermore, an insured can only make an informed decision about whether to accept the defense counsel selected by the insurer if the insured knows all of the options available. Therefore, the insured must be told of the right to independent counsel and the obligation of the insurer to pay for independent counsel. Otherwise, the insured may accept defense counsel selected by the insurer on the mistaken assumption that the defense costs of independent counsel would not be reimbursed. Along this line a number of jurisdictions, including New York, have found that insurance companies also have a duty to inform regarding the right to independent defense counsel. In the event of a conflict of interest, the insurance company has a duty to inform an insured about their right to independent counsel. *Elacqua v. Physicians' Reciprocal Insurers*, 52 A.D.3d 886, 860 N.Y.S.2d 229 (3d Dept. 2008) (finding a duty); *Jones v. Nat'l Emblem Ins.*, 436 F. Supp. 1119 (E.D. Mich. 1977) (finding a duty). As a result of the imposition of the duty to inform of the right to independent counsel, the failure of an insurance company to advise as to this right may subject an insurer to a claim that they have breach their obligations under the insurance contract.

The rights and obligations of both the insurers and insureds will be guided by jurisdiction specific case law and/or statutes when the right to independent counsel is triggered. Insurers and insureds must be attentive and sensitive to the subtle distinctions which may exist in different jurisdictions. However, even if the right to independent counsel is triggered and the insured has the option to select counsel of its' own choosing, this right is not limitless. Insureds should be mindful of the fact that even if they do have the right to select counsel of their choice, case law in most states only obligates the insurer to pay reasonable and necessary attorneys' fees, which may be substantially lower than the cost of independent counsel, leaving the insured responsible for the difference. See *Szelc v. Stanger*, 2010 U.S. Dist. LEXIS 73600 (N.J. Dist. Jul. 10, 2010). (An "insurer is not required to pay whatever fee the insured's retained attorney happens to charge; rather, the insured is required to pay a reasonable fee for those services reasonably related to the defense of any covered claims."); *Int'l Ins. Co. v. City of Chicago Heights*, 643 N.E.2d 1305 (Ill. App. 1994); *Behnke v. State Farm General Ins. Co.*, 196 Cal. App. 4th 1443 (2011).