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The Newsletter of the Insurance Law Committee

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Committee Leadership

Committee Chair
Michael M. Marick
Meckler Bulger Tilson Marick & Pearson
michael.marick@mbtlaw.com

Vice Chair
Audrey A. Seeley
Hurwitz & Fine
aas@hurwitzfine.com

Featured Article

Seventh Circuit Upholds Denial Of Professional Liability Coverage In The Absence Of Judgment Which Insured Was 'Legally Obligated To Pay'

by David G. Tomeo

The scope and extent of an insurer's responsibility to pay amounts which an insured becomes "legally obligated to pay" have been the subject of much litigation in recent decades. Many Courts have narrowly construed its meaning and, for example, have denied coverage for amounts that an insured has agreed to pay by its voluntary act.

In *Re v. Real Estate Lawyers Group, P.C.*, 509 Fed. Appx. 541 (7th Cir. 2013), the Seventh Circuit followed this trend in a case involving professional liability coverage and thus affirmed the dismissal of a suit against the insurer of a defunct law firm on the ground that the firm had no obligation to pay anything to the plaintiff suing for malpractice.

In *Real Estate Lawyers Group*, the subject law firm and/or its principal had allegedly embezzled $75,000 in connection with a 2002 real estate transaction. The firm was dissolved in 2005 and the principal attorney disbarred in 2006. However, plaintiff did not file suit until 2011 - more than six years after the dissolution. As the firm was dissolved, plaintiff was unable to serve process and thus the District Court refused to enter the firm's default. Thereafter, the District Judge granted the insurer's motion to dismiss, "reasoning that the insurer had no contractual obligation to indemnify against a claim that the [firm was] not 'legally obligated to pay'" *Id*. at 542.

The District Court's ruling was based not only on the inability to serve the firm, but also on the fact that the claims were time-barred under Illinois law (mandating a five year limit on suits against dissolved companies) as well as under the Illinois two-year statute of limitations governing claims of attorney malpractice.

The Seventh Circuit had no trouble concluding that the malpractice claims were indeed time-barred. The Court likewise quickly dispensed with plaintiff's equitable argument that because "both defendants were on notice of his demand for compensation before the professional corporation was dissolved" the statutes of limitations did not apply, ruling that the statutes were ones of repose which did not allow for the application of tolling or equitable estoppel.

The Court then turned to the question of whether the carrier could "be liable to indemnify a claim that the professional corporation [was] not legally obligated to pay." *Id*. at 543. As did the District Court, the Seventh Circuit reviewed the policy language and found it to be clear, "covering only damages that the insured is 'legally obligated to pay'" *Id*. The Circuit Court thus ruled that the insurance company had no indemnity obligation unless a judgment was entered against the insured: "We agree with the district court's conclusion that ISBA Mutual cannot be held liable in the absence of a judgment against the professional corporation." *Id*.

Real Estate Lawyers Group is in line with other federal circuits and state courts which have construed similar clauses. For example, in *Permasteelisa CS Corp. v. Columbia Gas. Co.*, 377 Fed. Appx. 260 (3rd Cir. 2010), the Third Circuit upheld a District Court decision which refused to obligate a carrier to pay for remedial work the insured voluntarily agreed to perform.

Newsletter Editor
Bryan M. Weiss
Murchison & Cumming
bweiss@murchisonlaw.com

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In that case, the insured had contracted to design, fabricate, and install an exterior decorative wall for a building under construction. Defects in the wall became apparent almost immediately after construction began. Concerned that a claim would be filed, the insured put CNA on notice under a contractor's professional liability policy. The applicable policy provided in relevant part: "We will pay all amounts…whichyou became legally obligated to pay as a result of…a wrongful act…thatresulted in a claim…" *Id.* at 262. Despite the fact that CNA advised the insured not to admit liability or agree to undertake repairs, the insured reached an agreement with the general contractor and the owner to perform $5.5 million in remediation work.

Thereafter, the insured brought various claims against CNA, including breach of contract, for CNA's refusal to cover the remedial work. Applying New Jersey law, the District Court determined that CNA was not obligated to pay for the remediation under the applicable policy's "legally obligated to pay" provision. The Third Circuit affirmed, concluding that the lower court had correctly concluded the insured was precluded from recovery as it "had voluntarily and unilaterally assumed responsibility for the repairs…" *Id*. at 263.

The starting point for both the appellate and trial courts was the decision of the New Jersey Appellate Division in *Bacon v. American Insurance Co*., 131 N.J. Super. 450 (Ch. Div. 1974) aff'd, 138 N.J. Super 550 (App. Div. 1976). In that case, the New Jersey intermediate appellate tribunal refused to hold an insurer liable for certain payments a purchaser withheld from the insured resulting from alleged defects in the insured's goods. At issue was a policy provision only covering amounts the insured became "legally obligated to pay as damages." The appellate court rejected the insured's argument that it was legally obligated to the purchaser as soon as its goods damaged the purchaser's property, holding: "the test of [legal] liability is not the existence of a remedy…buta determination of responsibility for satisfying such a remedy." *Id*. at 457.

The Third Circuit in *Permasteelisa* determined that *Bacon* not only represented New Jersey law but also "commands a palpable following and likely represents the view of a majority of courts." *Permasteelisa*, 377 Fed. Appx.at 266. In so doing the Third Circuit refused to adopt the insured's argument that "the plain meaning of 'legally obligated' includes contractual obligations…" *id.* at 265, instead preferring the majority view that "a professional liability policy does not transfer the risk of breach of contract from the insured to the insurer." *Id*.

In *Northern Illinois Gas Co. v. Home Ins. Co*., 334 Ill. App. 3d 38 (2002), the Appellate Court of Illinois considered a "legally obligated to pay" clause in the environmental context, holding that voluntary remediation efforts were outside the scope of the clause. In that case, the state instituted a "voluntary cleanup program" for contaminated material gas manufacturing sites. The insured enrolled certain of its sites in the program and, in so doing, incurred "millions of dollars in expenses for investigation and clean up at the various sites." *Id*. at 42.

The Appellate Court refused coverage, finding the insured's actions to be purely voluntary: "the IEPA never issued a…notice of potential liability…[and] no evidence demonstrated that any court action or administrative proceeding had been brought." Rather, the insured "on its own violation enrolled the sites at issue with the site remediation program." *Id*. at 55.

Summary judgment in favor of the insurers was proper as the insured "could not offer any evidence that it was obligated to pay these remediation costs by reason of liability imposed upon it by law…" *Id*. In so doing the Court declined to follow and expressly distinguished cases cited by the insured from: **Michigan** (*Upjohn Co. v. New Hampshire Ins. Co.*, 178 Mich. App. 706 (1989) (coverage found because state could have ordered a cleanup)); **Maryland** (*Bausch & Lomb, Inc. v. Utica Mutual Ins. Co*., 330 Md. 758 (1993) ("tacit threat of state intervention satisfied legally obligated to pay clause)); **Washington** (*Weyerhauser Co. v. Aetna Casualty & Surety Co*., 123 Wash. 2d 891 (1994) (claim that insured was under government mandate to comply with environmental statutes sufficient)); **Wyoming** (*Compass Ins. Co. v. Cravens, Dargon & Co*., 748 P2d. 724 (Wyo. 1988) (insurer obligated to cover where state sought reimbursement from insured for remediation costs)); and **New Jersey** (*Metex Corp. v. Federal Ins. Co*., 290 N.J. Super. 95 (1996) (statutory mandate of state Spill Act which imposed strict liability on polluters triggered coverage under "legally obligated to pay" provision)).

Given the almost limitless factual scenarios to which they may apply, "legally

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obligated to pay" clauses are likely to be the subject of future litigation, with no consensus as to their scope and meaning. However, in following cases such as *Permasteelisa* and *Northern Illinois Gas Co*., the Seventh Circuit in *Real Estate Lawyers Group* not only narrowly interpreted a "legally obligated to pay" clause in the professional liability context, but also followed the more recent trend in construing such clauses in favor of the insurer. In this regard, *Real Estate Lawyers Group* will likely be relied upon by insurance companies in disputes involving coverage outside the professional liability context for some time to come.

David G. Tomeo
Becker Meisel LLC
dtemeo@beckermeisel.com

Forward to a Friend

Leadership Notes

From the Chair

by Mike Marick

I am often asked: "How can I become involved in the Insurance Law Committee?" The answer is easy—there are two great ways to become involved ***now***.

First, strongly consider joining one of our substantive law or operational subcommittees. Whether your practice focuses on a particular area of insurance law and you would like to write about it, or your strengths are in marketing our programs, social media, or expanding our membership footprint, we offer a multitude of opportunities. You just received an email from DRI inviting you to become active in our efforts to bring the best insurance law programming and education to insurance companies and the attorneys who represent them. Your ticket to involvement is only a mouse click away!

Second, come to Chicago for the Insurance Coverage and Claims Institute, April 3-5. Your program Chair, Jennifer Muse, and Vice-Chairs, Jonathan Schwartz and Tom Lysaught, have planned an outstanding program—from the substantive programming to the various networking and social events. http://dri.org/Events/Seminars On Thursday, April 4 at 5:00 p.m., my Vice-Chair, Audrey Seeley, and I will hold a committee business meeting, when we will discuss all that the ILC offers and how you can become active in a great committee.

If you even have thought that someday you might reach out to us, there is no better time than ***now***. We look forward to hearing from you, and hopefully seeing you in Chicago in a few short weeks.

Notes from the Editor

by Tiffany Brown

I will not bore you with how unbelievably ***COLD*** it has been in Minnesota the past few months (described in the media as a "hardy" winter, but apparently not yet a record setter, except for the record number of school closures due to dangerously cold wind chills) because I know that this Winter has been tough on all of us. To keep you warm, and informed, I'm sending you the February 2014 edition of *Covered Events*, summarizing recent important insurance-related court decisions. If you are smart, you will download *Covered Events* by clicking on the " Print to PDF" link here and take it with you to read while on vacation someplace warm. If you cannot escape the cold, I suggest this edition be enjoyed with your favorite hot beverage!!

Please remember that if you are reading this newsletter, you can also help contribute to its greatness by submitting summaries of important decisions in your jurisdiction (or elsewhere) to one of our editors, which we will work to include in the next edition of Covered Events. You will be recognized for your contribution and help to keep our readership informed of significant insurance coverage cases and trends.

Despite the weather, the Insurance Law Committee is preparing for our next seminar, the Insurance Coverage and Claims Institute ("ICCI") which is happening April 2-4, 2014, in Chicago. ICCI is DRI's flagship conference for coverage counsel and insurance professionals and we hope to see you there. For more information about ICCI, and to register, please read the Note from the ICCI Chair, Jenny Muse. And,

don't forget to take advantage of the early registration date of March 13, 2014.

Upcoming

Notes From the ICCI Program Chair

by Jennifer S. Muse

It's Time to Register for ICCI!

Spring will soon be in the air, so don't forget to make your travel plans to the Windy City for DRI's annual Insurance Coverage and Claims Institute ("ICCI") on April 2-4, 2014 at the Swissôtel Chicago. This year's seminar features distinguished speakers from across the country, including industry representatives, presenting on cutting edge coverage issues. Some of the topics you will learn about include:

- Good Faith Claims Handling: Minimizing Exposure to Bad Faith Claims
- Drafting Reservation of Rights Letters, in conjunction with the Insurance Law Committee's compendium on writing reservations of rights in all 50 states, the District of Columbia, and Canada
- The 2013 Changes to the ISO Forms and What They Mean for Insurers
- Relitigating Adjudicated Facts in the Coverage Action
- Recent Developments in the Duty to Defend

In addition, ICCI will feature its dual-track Friday programming, with one track dedicated to Litigating a Coverage Claim and a separate track telling you everything you need to know about claims-made and other specialty coverages. This is not to be missed!

We encourage you to take advantage of the early registration date of March 13, 2014, so that you receive course materials in advance and be listed on the attendee list. Make sure to check out DRI's registration opportunities available to in-house counsel, and the amazing benefits available to insurers that host a counsel meeting. Further information and a link to registration is available at http://dri.org/Event/20140155.

The ICCI is renowned for its networking, business development, and education opportunities, so make sure to register today!

I look forward to seeing you in Chicago!

Covered Events Editors:

Tiffany M. Brown
Meagher & Geer, PLLP
Minneapolis, Minnesota
tbrown@meagher.com

Elaine Murphy Pohl
Plunkett Cooney
Bloomfield Hills, Michigan
epohl@plunkettcooney.com

Bryan M. Weiss
Murchison & Cumming, LLP
Los Angeles, California
bweiss@murchisonlaw.com

Suzanne Young Whitehead
Zelle McDonough & Cohen
Boston, Massachusetts
syoung@zellmcd.com

Spotlight

Insurance Law Committee Member Spotlight

Amy Witt

Amy Witt is an associateat Plunkett Cooney's office in Bloomfield Hills, MI where she has a national practice specializing in insurance coverage. Amy routinely represents insurance companies in a wide variety of complex insurance coverage disputes involving products liability, construction defect, environmental contamination, toxic tort, automotive and bad faith claims. Amy also provides her clients with coverage opinions arising out of claims for bodily injury, property damage, personal and advertising injury, rescission, fraud and misrepresentation. Chuck Browning describes Amy as "an indispensable member of Plunkett Cooney's coverage team" who the firm can count on when it needs something done quickly and done right.

Amy brings the same enthusiasm and energy to DRI's Insurance Law Committee (ILC). Over the years Amy has taken on any task thrown at her. She currently serves as the Vice Chair of Membership responsible for member retention and is the Chair of the Long Tail Toxic Tort substantive law subcommittee for the ILC. Amy has also been an active participant on the steering committees for the Insurance Coverage and Claims Institute (ICCI) and the Insurance Coverage and Claims Symposium (ICP) from 2010 to the present. In 2012, Amy played an integral role in ICCI's success acting as the Marketing Chair for the program and presenting on "Business Risk Exclusions in CGL Policies."

Needless to say, the ILC is lucky to count Amy among its members. We look forward to getting the opportunity to work with her in the future.

Recent Cases of Interest

Cases of Intererst

Second Circuit — Ambiguity (NY)

Atlantic Casualty Ins. Co. v. Greenwich Ins. Co., 12/20/13, (2d. Cir)

Greenwich Insurance Company ["Greenwich"] appeals from an opinion and order of the district court, following a bench trial, granting Atlantic Casualty Insurance Company's ["Atlantic"] motion for a declaratory judgment that it need not defend or indemnify its insured, Value Waterproofing, Inc. ["Value"]. For the following reasons the United States Court of Appeals, Second Circuit ["Court"] affirmed.

The facts were laid out in detail in the decision rendered by the district court in *Atlantic Cas. Ins. Co. v. Value Waterproofing, Inc*., 918 F.Supp.2d 243 (S.D.N.Y. 2013). Atlantic is an insurance company that issued a commercial general liability insurance policy to Value Waterproofing ["Value"] for the period 5/12/09 to 5/12/10. Kentucky Fried Chicken ["KFC"] owned non-residential property located at 685 Lenox Avenue in New York ["Property"]. The building was a two story structure with a barrel vaulted roof.

A major snow storm hit New York City on February 25-26, 2010; on February 26 or 27 the roof collapsed. KFC was aware of the collapse on February 27, 2010. Value was informed of the collapse on the same day. The New York

City Department of Buildings ordered the demolition of the second floor of the property. Demolition began at the property on March 3, 2010, and was completed on March 17th.

On September 2, 2010, Greenwich, the insurer for KFC sent a letter to Atlantic notifying it of the collapse that occurred on the property. Atlantic received notice on September 8 and began its investigation on September 9. On or about October 4, 2010, Atlantic made the decision to decline coverage. The primary basis for denying coverage was Atlantic's policy endorsement limiting coverage to residential roofing. The district court had adequate evidence in the record to support a finding that the agents for Atlantic and the insured, Value, intended to issue an endorsement providing coverage for residential roofing only and that an endorsement limiting coverage to residential roofing was issued to the insured.

Before the district court, and on appeal, Greenwich argued that the language of the policy endorsement, "ROOFING-RES" is inherently ambiguous, noting that "RES" itself was a typo graphical error and the endorsement was supposed to read "ROOFING-RESD". The Court held that even if the district court erred in finding "ROOFING-RES" unambiguous on its face, the district court properly found that the extrinsic evidence presented at trial makes clear that the term is intended to refer to residential roofing. In fact, Greenwich's own expert testified that he understood that the ISO generally divides roofing covering into commercial and residential policies, and that he understood "RES" to refer to residential. Further, the agents for both the insurer and the insured testified to the same understanding. The Court found that to be sufficient record evidence to find both that the parties agreed on coverage limited to residential roofing, and that, in any event, the insurance term "RES" customarily refers to residential policies.

Although not addressed by the Court because it determined there was no coverage under the policy, the district court also found that Atlantic was prejudiced by its failure to receive timely notice of the claim. Essentially, the district court found that Atlantic showed that the late notice [six months after the collapse] materially impaired its ability to investigate the claim and defend against it. The district court determined that the late notice prevented the plaintiff from being able to independently ascertain potential causes of the collapse – information which would be highly relevant to an investigation and defense of a claim like the one made here. The district court pointed out that while Atlantic had not submitted evidence of the investigation done by KFC and its insurer before it was completed, nor shown precisely how that investigation may have been biased or incomplete, it need not do so in order to carry its burden of showing prejudice. There was no dispute that Atlantic had a right to inspect the roof; and, the defendants denied Atlantic an opportunity to make that inspection.

The district court concluded that it was unreasonable to impose upon Atlantic to burden to show precisely how it would have been advantaged by that inspection. The district court held that where the best physical evidence was available to only one side but not the other because of an unreasonable failure to provide notice, prejudice has been shown.

Katherine A. Fijal (kaf@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Third Circuit — "Occurrence"/Junk Fax (PA)

In a rare win for insurers relying on conventional ISO wordings to defeat coverage for TCPA claims, the Third Circuit has issued an unpublished opinion in *Nationwide Ins. Co. v. David Randall Assoc.*, No. 13-1515 (3d Cir. Jan. 9, 2014) declaring that allegations in a class action that "the insured knew or should have known that Plaintiff and the other class members had not given express invitation or permission for Defendants or anybody else to fax advertisements about Defendants" precluded any possibility of an unintended "occurrence" under Pennsylvania law.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Recent Case Law Updates

Alabama

Alabama — Personal Jurisdiction

The Alabama Supreme Court has ruled that an Alabama insurer could not sustain jurisdiction over a New Jersey resident while permissively operating a vehicle registered and insured in Alabama. In *Pennsylvania Nat. Mut. Ins. Co. v. Allen*, No. 1121284 (Ala. Jan. 10, 2014), the court sustained a lower court's finding that a business auto carrier could not bring a DJ against a New Jersey motorist who claimed to have been a permissive user of its car, notwithstanding Penn National's argument that there were sufficient contacts to sustain specific personal jurisdiction in Alabama since (1) at the time of the accident Allen was driving a car registered in Alabama; (2) the car was owned by an Alabama company; (3) the insurance policy covering the vehicle was issued to an Alabama named insured and was delivered to that insured in Alabama; and (4) Allen has made a claim for coverage under that "Alabama" policy. Describing these contacts as "tenuous," the court found that there was no evidence that Allen had purposely availed himself of the protection of Alabama's laws.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Alabama — Bad Faith
Metlife Auto & Home Ins. Co. v. Reid, 12/23/13, United States District Court, N.D. Alabama

This decision arises out of a claim that the insurer failed to settle within the policy limits.

Metlife issued a homeowners policy to James Certain, with a liability limit of $100,000. In way of background, in 2006, Certain was arrested and subsequently indicted for the criminal offense of kidnapping, sexual abuse and domestic violence following a sexual encounter with Christy Reid. Certain pled guilty to lesser offenses of unlawful imprisonment in the first degree and assault in the third degree (misdemeanors).

Thereafter, Reid brought suit against Certain based on five intentional torts- assault, battery, false imprisonment, intentional inflection of emotional distress and wanton misconduct- as well as a claim of negligence.

Metlife provided a defense in the action subject to a reservation of rights based on the lack of an occurrence, and exclusions for intentional loss, abuse and emotional and mental anguish. Metlife also commenced this declaratory judgment action. Separate attorneys and claims adjusters were assigned to each suit.

In the underlying action, Certain's defense counsel advised Metlife that she did not see a chance of prevailing at trial, and that a verdict would likely be far in excess of the policy limit.

Reid's counsel made a policy limits demand. Metlife countered with an offer of $5,000, which was rejected. No additional money was offered.

Before trial, Certain died, and the Estate was substituted into the action. Thereafter, Reid was awarded $2.2 million ($1 million in compensatory damages and $1.2 in punitive damages) at trial. Following the verdict, the Estate filed an answer in the declaratory judgment action and set forth four counterclaims: breach of contract, breach of the enhanced obligation of good faith, negligent failure to settle and bad faith failure to settle. The Estate entered into a forbearance agreement with Reid wherein Reid agreed not to execute on the judgment, and the Estate agreed not to appeal the judgment, until the present declaratory judgment proceeding was resolve.

Thereafter, presumably due to concern about the outcome of this action, Metlife and Reid reached a settlement agreement. Metlife agreed to pay $1.1 million to Reid in full satisfaction of the judgment, and Reid agreed to release all property liens and claims against the Estate. In light of this settlement, Metlife moved to dismiss and/or for summary judgment on Estate's counterclaims. While the parties agreed that the breach of contract claims were moot, the Estate maintained its position that Metlife had acted in bad faith.

In granting Metlife's motion for summary judgment, the court noted that the presence of insurance coverage is a prerequisite for liability for a bad faith failure to settle a claim with the insurance company's money. Here, the plain language of Certain's homeowner's insurance policy excluded coverage for this loss. The undisputed facts in the case established that Certain's acts were intentional, criminal and of a sexual nature.

Jennifer A. Ehman (jae@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Alabama — Bad Faith

State Farm v. Brechbill, 9/27/13, Alabama Supreme Court

The Alabama Supreme Court held that an insurance company's scrutiny of a wind damage claim was sufficient to avoid "abnormal" bad faith liability. Mr. Brechbill purchased a house in Alabama in 2007, and then claimed in January 2008 the house was damaged by a windstorm which damaged the roof and allegedly caused interior walls to crack and buckle. State Farm concluded that the roof damage was covered, and had an engineer investigate the interior damage. State Farm's engineer determined that the interior damages were caused by longstanding movement and settlement of the structure, and coverage was denied under policy exclusions for wear and tear and otherwise. After more inspections and re-inspections, State Farm again denied the claim, although home inspectors hired by the property owner disputed the findings of State Farm's engineers.

The policyholder sued State Farm for breach of contract, and both "normal" bad faith failure to pay and "abnormal" bad faith failure to investigate. State Farm moved for summary judgment, and the trial court granted the motion on the claim for the "normal" bad faith refusal to pay noting that the insurance company had a legitimate reason for failing to pay the claim. However, the trial court allowed the policyholder to proceed with the "abnormal" bad faith claim for failure to investigate, ostensibly ruling that there were factual issues whether State Farm conducted an adequate claims investigation.

After a jury trial, a jury returned a verdict in favor of the policyholder of $150,000.00 on the contract claim, and $150,000.00 on the "abnormal" bad faith claim which consisted of $150,000.00 compensatory damages and $50,000.00 in punitive damages. State Farm appealed the judgment on the "abnormal" bad faith claim.

The policyholder argued that State Farm's investigation was "flawed" because the insurer allegedly failed to take into consideration evidence regarding the house's condition before the alleged loss event. The Supreme Court disagreed and reversed the judgment on the "abnormal" bad faith claim. The Court ruled that, even if State Farm had disregarded or omitted some aspects of a complete claims investigation, more than bad judgment or negligence was required to sustain a bad faith claim. The Court added that the "abnormal" bad faith claim also failed because the trial court found that State Farm had a legitimate reason for denying the claim. In addition, State Farm did repeatedly review and re-evaluate the claim as engineering reports and other information were received, and it was not liable for "tortious failure" to investigate the claim.

Earl K. Cantwell (ekc@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Arizona

Arizona — Priority of Coverage

Lexington Insurance Company v. Scott Homes Multifamily, Inc., 1/22/14, United States District Court of Arizona

In another action involving construction defect coverage, the court in *Lexington Insurance Company v. Scott Homes Multifamily, Inc.* addressed issues related to the Lexington insured for claims involving construction defects. The court was asked to determine priority of coverage as between the Lexington excess policy

to Scott Homes Multifamily, Inc. and other primary policies issued to subcontractors of Scott Homes Multifamily, under which Scott Homes qualified as an additional insured.

The pertinent facts of the underlying action are as follows. Silverbell contracted with Scott Homes for the construction of apartments for Silverbell. Scott Homes was insured under a primary general liability policy issued by Evanston Insurance Company, which maintained liability limits of $1,000,000. They were also insured under an excess liability policy issued by Lexington, which followed form to the Evanston policy. Scott Homes qualified as an additional insured on some of the subcontractors' primary policies.

After Silverbell sued Scott Homes and its subcontractors for damages, Evanston, who had been affording Scott Homes a defense subject to a reservation, entered into a settlement agreement, whereby Silverbell and Scott Homes stipulated to a $6,000,000 judgment against Scott Homes. Evanston paid Silverbell the policy limit of $1,000,000 in exchange for a release and Silverbell agreed not to execute the judgment against Scott Homes. Scott Homes assigned to Silverbell all of their rights for claims arising out of the apartments against subcontractors, subcontractors' insurers and excess insurers. The judgment stated that the $6,000,000 was awarded for claims related to and/or damages caused by the work of seven subcontractors who Scott Homes had hired.

The initial dispute amongst the parties involved which policies must be exhausted before Lexington was obligated to provide coverage under its excess policy. Lexington contended that the underlying policies were the Evanston policies, as well as any policies issued to Scott Homes' subcontractors, under which Scott Homes qualified as an additional insured.

After examining the Lexington excess policy, which specifically referred to the Evanston policy as the applicable underlying policy and specifically identified the $1,000,000 limit of the Evanston policy, the court ultimately concluded that, based upon the specific language of the Lexington policy, it was excess only over the Evanston policy. In doing so, the court rejected Lexington's argument that excess coverage is transitive and that if the Evanston policy was excess to the subcontractor policies and the Lexington policy excess to the Evanston policy, then the Lexington excess policy must be excess to the subcontractor policies. In doing so, the court found that such a position would contradict the Lexington excess policy's plain language.

The parties also disagreed as to whether the Evanston policy had been exhausted, with Lexington attempting to construe the settlement agreement as including payment for uncovered damages because the term "claims" was defined as including repair and replacement of defective construction and resulting damages. Lexington argued that construction defects of this type cannot satisfy the definition of occurrence and, thus, Evanston must have paid on uncovered claims. Lexington concluded, thus, that the Evanston policy was not exhausted. The court, however, rejected this contention, noting that Lexington may not attempt to re-litigate Evanston's coverage decision.

Finally, the court addressed Lexington's argument that the portion of the judgment allocable to Scott Homes' liability for subcontractors was not recoverable, as the Evanston policy limited coverage for property damage arising out of the acts of independent contractors, setting forth certain conditions which must be met to allow the coverage, including that independent contractors must name the named insured as an additional insured. Lexington's argument was that even if the policies were exhausted, the failure of the subcontractors to procure insurance for Scott Homes excludes their liability from coverage under the Evanston policy. Since the Lexington excess policy follows form to the Evanston policy, Lexington asserted that nearly $5,000,000, the portion of the judgment allocable to property damage arising out of the acts of the subs, was not covered under the excess policy.

The court similarly rejected this argument, finding that it was an attempt to add terms to Evanston's policy since the policy provided that Scott Homes must obtain Certificates of Insurance from independent contractors providing evidence of primary insurance, and declining to find that the subcontractors' insurers' failure to defend Scott Homes equated to Scott Homes not obtaining Certificates of Insurance. The court thus denied, in its entirety, Lexington's motion for summary judgment.

Elizabeth A. Fitzpatrick (eaf@hurwitzfine.com)

Hurwitz & Fine
Buffalo NY

California

California — Coverage B/Privacy Claims

In one of the first rulings addressing the scope of liability insurance coverage for zip code claims, a state trial court in California has ruled in *Arch Ins. Co. v. Michaels Stores, Inc.* (Cal. Super. December 20, 2013), that a liability insurer did not owe coverage for allegations that Williams-Sonoma and other merchants violated the state Song-Beverly Act by requiring customers to provide zip codes in conjunction with credit cards transactions. Because the damages sought under the act were in the nature of civil penalties, the trial court held that they were precluded from coverage. Further, notwithstanding Williams-Sonoma's claim that coverage was required as involving "oral or written publication, in any manner, a material that violates a person's right of privacy," the court found that the underlying lawsuit failed to seek recovery for common law invasion of privacy. Kudos to Matt Foy of Gordon & Rees for this significant victory.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

California — Pollution/Additional Insureds

Notwithstanding its ruling in *Legacy Vulcan Corp. v. Superior Court,* 185 Cal.App.4th 677 (2010) that the reference to "underlying insurance" in Transport's umbrella policy was ambiguous and required the insurer to accept coverage for various pollution liability claims against a PCE manufacturer (Vulcan), the Second District has ruled that the same analysis does not apply with respect to the efforts of a PCE distributor (Street) to obtain coverage for the same claims under the same umbrella policies. Instead, the Court of Appeal held in *Transport Ins. Co. v. Superior Court*, B249470 (Cal. App. Jan. 13, 2014) that "for purposes of determining whether an additional insured to an excess and umbrella general liability insurance policy is entitled to a defense by the insurer, the reasonable expectations of the additional insured may be different than the reasonable expectations of the named insured." As a result, the court held that the earlier disposition of its duties to its named insured did not collaterally estop it from disputing the putative additional insured's claims and that the trial court had erred in considering Vulcan's objectively reasonable expectations of coverage instead of Street's.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Colorado

Colorado— Construction Defects/CGL Policy

The Travelers Indemnity Co. v. AAA Waterproofing, Inc., 1/17/14, *United States District Court, District of Colorado*

In yet another action addressing coverage issues arising out of claims involving construction defects, the District Court of Colorado grappled with the issue of the appropriate method for allocating defense costs amongst various insurers in an action which was begun in 2003 and ultimately settled in March 2005 for $39,500,000. The general contractor, DRH, allegedly incurred some $1,200,000 in fees and costs. Following the settlement of the construction defect litigation, DRH attempted to negotiate with Travelers and other subcontractors' insurers seeking to recover their $200,000 deductible and the amount that DRH's insurer paid in defense fees and costs.

The court noted that a liability insurer's duty to defend is a joint and several duty, such that an insurer who breaches this duty can be found liable for the entire amount of defense fees and costs and can then seek equitable contribution from any coinsurers owing the same duty to defend, citing, in addition to California,

Montana and Texas, New York. The issue before the court was, under Colorado law, whether allocation should be based upon policy limits or equal shares and whether such allocation applied to all 54 subcontractors that were implicated in the underlying state court case (and their respective insurers) or only the 23 that were represented as parties in the action before the court.

After considering the policy limits based method of allocation, the court found that an equal share method would result in the most equitable allocation, particularly as numerous parties had failed to obtain the requisite insurance policies, making them, *de facto,* self-insurers without policy limits upon which to base their allocation. Thus, the contribution amounts would be divided into equal shares per subcontractor.

Turning to the issue of which subcontractors should be included in the allocation, the court found that Travelers' proposal of allocating only to subcontractors represented in the case was the proper method and declined to consider allocation to nonparties. Otherwise, the court noted that, with respect to certain subcontractors from whom Travelers did not seek contribution, Travelers would, in effect, be obligated to bear those shares.

Finally, with respect to those insurers who had previously paid some amount of the defense costs of DRH, the court held that their equitable share would be offset by the amount of such payment.

Elizabeth A. Fitzpatrick (eaf@hurwitxfine.com)
Hurwitz & Fine
Buffalo NY

Connecticut

Connecticut — Data Claims/"Suit"/Invasion of Privacy

In a case where a vendor lost tapes containing confidential information about IBM employees, the Connecticut Court of Appeals has refused to find that a two year period of settlement negotiations between the insured and IBM was a "dispute resolution proceeding" triggering an insurer's duty to defend "suits." In *Recall Total Information Management, Inc. v. Federal Ins. Co.,* AC 34716 (Conn. App. Jan. 14, 2014), the court declared that the insured's proposed construction would conflate "claim" with "suit." The Appeals Court also affirmed the lower court's declaration that the policy's "personal injury" coverage had not been triggered as there was no suggestion that any of the personal information of the tapes had ever been accessed by anyone or "published" to a third party. The court also declined to find that violations of privacy statutes in New York and Connecticut requiring employers to notify their employees in the event of a data loss created a "presumptive evasion of privacy."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Connecticut — Professional Liability/"Medical Incident"

The Connecticut Supreme Court has rejected an E&O carrier's argument that separate law suits filed by residents of a nursing home who were injured in a fire could be grouped together as involving "related medical incidents." In *Lexington Ins. Co. v. Lexington Healthcare Group, Inc.,* SC18681 (Conn. Jan. 28, 2014), the court ruled that "the phrase related medical incidents does not clearly and unambiguously encompass incidents in which multiple losses were suffered by multiple people, when each loss has been caused by a unique set of negligent acts, errors, or omissions by insured, even through there may be a common participating factor." Nevertheless, while agreeing with the trial court that the insured's recovery was not capped at a single $250,000 "medical incident" limit, the Supreme Court also ruled that the lower court had erred in declaring that the insured's rights were subject to a $10 million limit. The Supreme Court ruled that this endorsement set forth the aggregate limit for claims involving all of the insured's nursing homes, whereas the applicable aggregate for individual facilities was only $1 million. Finally, the Supreme Court affirmed the lower court's declaration that the insured itself (which is now insolvent) was responsible for the first $250,000 in damages for each "medical incident"

pursuant to the self-insured retention in the policy but disagreed with the trial court that the SIR had the affect of producing Lexington's obligations for any damages over that amount to $250,000. Rather, while rejecting the claimants' argument that Lexington must "drop down" to pay all of the loss, the court ruled that Lexington was still liable for $500,000 for each medical incident over the $250,000 SIR.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Delaware

Delaware — D&O/Settlements

The Delaware Supreme Court has ruled in *Nicholas v. National Union Farm Insurance Company of Pittsburgh*, No. 209 (Del. December 20, 2013) that a trial court erred in holding that former corporate officers and directors of Broadcom were precluded from pursuing bad faith claims against Broadcom's D&O carriers by the terms of its 2011 settlement agreement. The court concluded that the scope of the agreement had a protection afforded to the insureds under it were ambiguous and that the plaintiff should therefore be entitled to obtain discovery with respect to the intent of the parties and negotiate it and, in particular, with respect to an earlier 2009 agreement.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Florida

Florida — Dog Bites/Number of Occurrences

Maddox v. Florida Farm Bureau, 1/17/14, District Ct. of Appeal of Florida, Fifth District

On a motion for rehearing, the appellate court reversed the trial court's finding of only one "occurrence" under a homeowner's insurance policy after a child and mother were bitten by the same dog during the same dog attack. Ms. Maddox's boyfriend owned two dogs, Dixie and Sugar. Ms. Maddox, her boyfriend, the two dogs and Ms. Maddox's two sons, Logan and Ivan, resided in the boyfriend's home. While Ms. Maddox was dressing Logan, Ivan began screaming. Upon rushing to the source of the screaming, Dixie was seen biting Ivan in the face. Once Dixie released her grip on Ivan's face she then bit Ms. Maddox in the face. Both Ivan and Ms. Maddox sustained injuries.

Ms. Maddox's homeowners insurance policy, issued by Florida Farm Bureau General Insurance Company ("Florida Farm"), contained the following pertinent insuring grant for personal liability:

All 'bodily injury' and 'property damage' resulting from any one accident or from continuous or repeated exposure to substantially the same general harmful conditions shall be considered to be the result of one 'occurrence.'

"Occurrence" was defined as:

An accident, including continuous or repeated exposure to substantially the same general harmful conditions, which results, during the policy period, in... 'bodily injury'; or … 'property damage.'

Ms. Maddox commenced a bodily injury action against her boyfriend seeking damages from injuries she sustained in the dog attack. Florida Farm commenced a declaratory judgment action seeking a declaration that there was only one occurrence under the homeowner's insurance policy and the per occurrence limit was exhausted after payment of the policy limits for Ivan's bodily injury claim.

The Court held there were two occurrences under the homeowner's insurance policy. The Court reasoned that in the absence of policy language to the

contrary, *Koikos v. Travelers Ins. Co.* is applied which adopts a "cause theory" for determining number of "occurrences." In *Koikos*, Mr. Koikos rented his restaurant to a fraternity for a graduation party which resulted in an intruder shooting two guests with a single bullet as well as injuring three others. The court determined there were two occurrences for purposes of insurance coverage as each shooting of a separate victim was a separate occurrence.

Audrey Seeley (aas@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Illinois

Illinois — Auto Policies/Arbitration

The Appellate Court has ruled in *Interstate Bankers Casualty v. Hernandez*, 2003 WL App. (1st) 123035 (Ill. App. December 18, 2013) that recently enacted amendments to the Illinois Insurance Code that require auto property damage claims to be resolve through arbitration are unconstitutional because they eliminate the right to a trial by jury and actions to which that right has historically attached.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Illinois — TCPA

On remand from the Illinois Supreme Court, the Appellate Court has ruled in *Standard Mut. Ins. Co. v. Lay,* 2014 IL App (4th)110527 (4th Dist. Jan. 27, 2014) that junk fax claims involve an "occurrence" and are not subject to a "professional services" exclusion. The Fourth District rejected the insurer's argument that coverage was excluded just because the insured was a professional that used faxes to advertise its business, declaring that the insured was a real estate agent, not an advertising agency. The Appellate Court also held that Coverage B applied, despite the insurer's argument that corporations were not "persons" unlike the unincorporated businesses that were involved in Swiderski. Finally, the court ruled that the insured's consent judgment was enforceable, despite the insured's assignment of its claims without the insurer's permission.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Illinois — Notice of Change in Coverage (OH)

*Windmill Nursing Pavilion, Ltd. v. Cincinnati Ins. Co.*___ N.E.2d ___, 2013 WL 6578786 (Ill. Ct. App. Dec. 13, 2013)

Windmill Nursing Pavillion, Ltd. (Windmill) initiated a class action lawsuit against Unitherm, Inc. (Unitherm) alleging violations of the Telephone Consumer Protection Act (TCPA), violations of the Illinois Consumer Fraud and Deceptive Business Practices Act and a claim for conversion arising out of alleged junk fax advertisements. At the time Unitherm sent the blast fax advertisements, it was insured under a CGL policy issued by Cincinnati Insurance Company (Cincinnati), which was later renewed for one year after the initial three-year policy expired. The renewal policy contained a TCPA exclusion. Unitherm denied all liability but Windmill, Unitherm and Cincinnati entered into a settlement agreement which resolved the class action lawsuit, whereby "the parties agreed to a $7 million consent judgment against Unitherm, which was collectible from Cincinnati under the insurance policies." Cincinnati agreed to pay $3 million toward the initial settlement fund, but the agreement permitted Cincinnati to reserve further payment until a determination could be made on two "carved-out" issues. The parties filed cross motions for summary judgment on the issues of whether notice of the TCPA exclusion in the renewal policy was sufficient and whether the products-completed operations limits in the original or the renewal policy were available in addition to the general aggregate limits. The trial court, applying Ohio law, granted summary judgment in Cincinnati's favor and dismissed the case.

On appeal, the Appellate Court of Illinois determined that the trial court properly applied Ohio law to the notice requirements of the TCPA exclusion in the Cincinnati policy and, therefore, the choice of law outcome also dictated the outcome of the case. While Cincinnati conceded that its notice of the TCPA exclusion would be insufficient under Illinois law, the court's determination that Ohio law applied ultimately resulted in a judgment in Cincinnati's favor. Windmill argued that notice of the TCPA exclusion to Unitherm was insufficient because it was untimely, it was not separately attached and it did not apply to the umbrella policy. Addressing Windmill's argument, the court presented the terms of the endorsements as they appeared in the Cincinnati renewal policy, including the TCPA exclusion. The court noted that the endorsement page containing the TCPA exclusion was separate from the policy. Further, the language of the endorsement was in bold, capital, and enlarged letters as required under Ohio law. Therefore, the court found that Cincinnati's notice to Unitherm was sufficient.

Next, Windmill argued separate coverage for the TCPA claims was available under the "products-completed operations hazard" because the faxed advertisements constituted Unitherm's "goods" or "products." The court addressed this argument only with respect to the original policy because, as the court held, the TCPA exclusion applied to the renewal policy and, therefore, excluded coverage regardless of Windmill's alternate argument. Windmill asserted that because the fax advertisements made warranties and representations with respect to the quality of its iron on labeling system, the advertisements satisfied the Cincinnati policy's definition of "your product."

However, the court found that Windmill's claims as set forth in its complaint alleging TCPA violations "did not arise out of any representations or warranties" regarding Unitherm's products "and Windmill made no assertions that any representations or warranties were false or caused property damage." Further, under the terms of the original policy, the court rejected Windmill's argument and upheld the trial court's determination that "[t]he faxes were not Unitherm's goods or products and they did not constitute its work or operations, and they were not materials, parts, or equipment furnished in connection with its operations." In other words, as the court found, "Unitherm was not in the business of selling the advertisements themselves." "As such, the faxes clearly fell under the definition of 'advertisements' set forth in the policy. Thus, the faxed advertisements did not fall within the products-completed operations hazard coverage. Finally, the court held that the terms "your product" and "your work" were unambiguous and deemed it unnecessary to address whether coverage would be afforded under the advertising injury provision. Therefore, the court affirmed the trial court's ruling finding in Cincinnati's favor.

Charles W. Browning (cbrowning@plunkettcooney.com)
Kenneth C. Newa (knewa@plunkettcooney.com)
Plunkett Cooney
Bloomfield Hills, MI

Indiana

Indiana — Absolute Pollution Exclusion (MD)

The Court of Appeals has ruled that a trial court erred in finding that a flare manufacturer was entitled to coverage for sums that it voluntarily paid to remediate perchlorate contamination at two of its facilities. Applying Maryland law, which limits the scope of absolute pollution exclusions to "traditional environmental contamination," the court ruled in *Chubb Custom Ins. Co. v. Standard Fusee Corp.*, No. 49A02-1301-PL-91 (Ind. App. Jan. 23, 2014) found that "Standard Fusee's claim is based on a hazardous pollution contamination, resulting from the cumulative effect of numerous releases which occurred on an ongoing basis during the regular course of business over an extended period of time, up to the point where the pollution became concomitant to Standard Fusee's regular business activity." Further, the court found that pollution claims do not trigger "personal injury" coverage because they do not arise out of any of the enumerated "offenses."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Iowa

Iowa — Statute of Limitations/UIM

Osmic v. Nationwide Agra Business Ins. Co., 01/10/14, Supreme Court, Iowa

On May 23, 2009, Esad Osmic and his children were passengers in a Ford Explorer owned and operated by Osmic's brother, Selin. While Selin was driving down the highway, Ms. Rochelle Heasley entered the highway by cutting across two lanes of traffic, which forced Selin to take evasive action to avoid an accident. As a result, Selin lost control of the Explorer and it rolled over into the grass embankment near the highway. Selin, Osmic, and Osmic's two children were ejected from the vehicle.

Heasley was insured by Progressive Insurance Company with limits of $50,000 per claim and $100,000 per occurrence. Selin was insured by Nationwide Agra Business Insurance Company ("Nationwide") which provided underinsured motorist coverage.

Osmic began treatment for right shoulder pain in October, 2009, and eventually underwent arthroscopy in November, 2012. Approximately 13 months post-accident, Osmic's counsel sent a letter of representation to Nationwide and, thereafter, constant communication between Osmic's counsel and Nationwide occurred for the next 8 months. Progressive advised Nationwide on September 13, 2010, that it settled Selin's claim for $65,000, which left only $35,000 of insurance coverage for the accident.

On March 7, 2011, Osmic's counsel sent a demand to Progressive on behalf of Osmic and his two children. The letter sought over $175,000 for Osmic and $13,000 for each child. At that point, there was approximately 10 weeks remaining before the two year statute of limitations to commence a personal injury action against Heasley. In response, Progressive advised Osmic's counsel of the $35,000 remaining on the policy and offering same.

Osmic's counsel only then initiated contact with Nationwide regarding underinsured motorist coverage. Nationwide requested a copy of Osmic's counsel's demand letter to Progressive as well as copies of medical records. Osmic's counsel provided same on March 28, 2011, together with a demand for a copy of the policy's declaration page to confirm the underinsured limits. On April 1, 2011, Osmic's counsel sent Nationwide additional medical records and reiterated his request for the policy's declaration page.

On April 12, 2011, Nationwide responded consenting to the settlement with Progressive and declining to provide a copy of the declaration page at that point without consent of the insured to provide the information. Nationwide further indicated that upon its review of this matter, the offer from Progressive with regard to each child was sufficient to adequately indemnify them for their injuries. Osmic's injuries were being reviewed.

On May 27, 2011, Nationwide advised Osmic's counsel that pursuant to the underinsured motorist portion of the policy, any claim against Nationwide was barred as it must have been filed within two years after the date of the accident.

Osmic commenced suit against Nationwide as well as his own insurer on June 23, 2011, seeking recovery under Nationwide's underinsured motorist coverage. Nationwide subsequently moved for summary judgment on the basis that Osmic failed to timely file his claim within two years from the date of accident as required under the contract.

After Nationwide's summary judgment motion being denied and affirmed at the Appellate level, the Supreme Court granted application for further review. The Court began its review with the policy's language. A review of the policy's insuring grant revealed that Osmic was an insured for purposes of the underinsured motorist coverage. Next, the Court reviewed whether the two year contractual limit on filing suit against the underinsured motorist insurer was reasonable and enforceable. Generally, under Iowa code since an underinsured motorist claim is contractual, it is presumptively subject to a ten year statute of limitations. However, under common law, an insurance contract can modify that ten year statute of limitations for bringing a suit. That statutory deadline would be enforceable if it was reasonable. The Court went on to further indicate that in the past, it had upheld a two year contractual limit for underinsured and uninsured

motorist claims and found that limitation to be reasonable.

Since the two year contractual limitation was reasonable, the question became whether there was a barrier to Osmic in providing or commencing the action within two years from date of accident. The Court held that there was no barrier as Osmic's counsel contacted Nationwide nearly a year before the two year statute of limitations ran. Therefore, Osmic could have commenced a suit for underinsured motorist benefits during that time frame. Also, this was not a case where Osmic did not appreciate the extent of his injuries since at least six months prior to the two year statute of limitations expiring; Osmic knew the extent of his injuries.

The Court further rejected Osmic's argument that since he was not the policy holder or named insured, he could not be bound by all of the terms of Selin's contract with Nationwide. The Court recognized that a contract can benefit and provide rights to third parties. However, a third party beneficiary's rights are controlled by the terms of the contract. That third party beneficiary is afforded no greater rights than the named insured. Thus, the two year statute of limitations on bringing an action against the insurer for underinsured motorist benefits applied to Osmic.

Finally, the Court held that Nationwide had no affirmative obligation to disclose the two year statute of limitations deadline for filing suit to Osmic's counsel. The Court, relying upon prior case law, stated that an insurer does not have a duty to warn its policy holder that a time frame to file suit against it is running out. Accordingly, the Court vacated the Court of Appeals decision, reversed the District Court's judgment, and remanded it with direction to enter summary judgment in Nationwide's favor.

Audrey Seeley (aas@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Maryland

Maryland — Asbestos/Excess/Horizontal Exhaustion

In one of the longest running asbestos cases still pending, Judge Blake has ruled in *National Union Ins. Co. of Pittsburgh, PA v. Porter Hayden Company*, No. 03-3408 (D. Md. January 2, 2014) that the insured may access excess coverage over primary policies that are partially exhausted with respect to the PCOH aggregate even though coverage may remain for "operations" claims that are not subject to an aggregate limit. In an effort to reconcile Maryland's "horizontal exhaustion" rule with the correlative principal that insurer is only liability for their pro rata share of long term claims, the District Court held that excess insurance should be available in situations where some primary coverage is exhausted even if other years or periods are not. In such circumstances, any excess policy over the exhausted primary policy must pay back pro rata share.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Massachusetts

Massachusetts — Asbestos/Trigger/Horizontal Exhaustion (IL)

While holding that an insured must horizontally exhaust all primary insurance and SIRs before it can access excess coverage for its excess liabilities, a state trial judge has predicted *Mueller Co. v. Commercial Union Ins. Co.,* 2009-00826 (Mass. Super. Jan. 13, 2014) that the Illinois Supreme Court would thereafter permit the insured to access coverage on an "all sums" basis. Further, Judge Sanders ruled that the definition of "ultimate net loss" London excess policies only covered defense costs that were paid in connection with cases that result in a judgment or settlement triggering indemnity duties. MM's John Harding is local counsel for LMI.

Michael Aylward (maylward@morrisonmahoney.com)

Morrison Mahoney
Boston, MA

Massachusetts — Attorney's Fees for Suits by Insured

The court in *Barletta Heavy Division v. Travelers Insurance Company*, 2013 WL 5797612 (D. Mass. Oct. 25, 2013.) ruled that the insurer had no duty to reimburse the policyholder for fees in an action commenced by the policyholder.

The policyholder was a general contractor performing construction work for the MBTA, the local transit authority. The general contractor had contracted with a sub-contractor for drilling work. The sub-contractor damaged property of the transit authority and of two abutters. These parties claimed against the general contractor and the general requested that his insurer pay the claims.

The insurer responded that it did not "pay and chase claims". It also stated that it would assign counsel to file a declaratory judgment action against the sub-contractor and its insurer. The insurer retained counsel for this purpose. The general contractor then filed its action for indemnification against the sub-contractor using the counsel retained by the insurer. Based upon the file notes of the claim manager, the Court found that the insurer initially authorized the filing of the action against the sub-contractor and then decided not to pursue it.

The Court ruled that the insurer's duty is to defend, "which suggests that this is limited to 'defending' against claims and does not encompass lawsuits launched offensively." [page 7.] The Court cited to *Wilkinson v. Citation Ins. Co.*, 447 Mass. 663, 856 N.E. 2d 829, 834-835 (Mass. 2008) which declined to cover fees incurred in the pursuit of indemnification from an insurer having a duty to defend. This signals, in the Court's opinion, "an intent to limit recovery to encompass only litigation costs incurred in a suit against an insurer that successfully establishes an insurer's duty to defend."

The Court went on to rule that there were good reasons to decline to extend the duty to defend coverage to include suits voluntarily filed by the policyholder. To do so would risk spawning marginal litigation. A policyholder would have every incentive, and little disincentive, to file suit. The policyholder would know "that it could reap the benefits of success - however unlikely - while transferring the costs of an otherwise predictably unsuccessful suit onto its insurer."

The subrogation provision in the Policy gave the insurer the right, but did not create an obligation, to launch offensive litigation to recover damages covered by the Policy. While the insurer had initially authorized the filing of the action against the sub-contractor and subsequently reversed that decision, that "was a business decision made at [the insurer's] discretion - not a contractual obligation. Reversing course and deciding not to pursue the litigation ... was likewise a business decision." The policyholder will be limited to seeking repayment of fees for legal work performed by counsel before the insurer decided it would no longer pay fees in the action against the sub-contractor.

Philip M. Howe (phowe@lecomtelaw.com)
Lecomte, Emanuelson and Doyle
Quincy MA

Massachusetts — Crime Coverage/Third Party Beneficiary

The court in *Pollak v. Federal Insurance Company*, 2013 WL 6152335 (D. Mass. Nov. 21, 2013) ruled that there was no obligation to pay the creditor of the Insured under a policy covering losses due to computer fraud where the creditor was an incidental, not an intended, beneficiary.

The creditor had contracted with the Insured, an escrow company, to hold $1.3 million in escrow. The creditor insisted that the escrow company increase its coverage, which it did. But, the policy made no mention of the creditor. A third party stole all of the funds.

The Court ruled that under Massachusetts law only "intended beneficiaries" could enforce a contract. Incidental beneficiaries could not. Restatement (Second) of Contracts, Section 302 (1981) and Miller v. Mooney, 431 Mass. 57, 62 725 N.E. 2d 545 (2000). The Court further ruled that there was no "clear and definite intent that plaintiff was an intended beneficiary of the policy." [page 3.] The insurer had agreed to pay the Insured if it suffered losses from a third party's computer fraud.

The Insured could, but was not required, to use that money to pay its own creditors. The Court further ruled that, without rights under the Policy, the creditor had no claim under c. 93A, the consumer protection statute, or under the implied covenant of good faith and fair dealing.

Philip M. Howe (phowe@lecomtelaw.com)
Lecomte, Emanuelson and Doyle
Quincy MA

Massachusetts — Right to Seek Reimbursement for Disability Benefits Paid

The court in *Ginsberg v. Provident Life and Accident Insurance Company*, 2013 WL 6008937 (D. Mass. Nov. 7, 2013), permitted an insurer to file a counterclaim to recover disability benefits in response to the insured's suit seeking additional benefits. The insurer had paid total disability benefits for years and then discovered the Insured had concealed that he had been working for years as a property manager of two apartment complexes in North Carolina.

The Policy did not address the insurer's ability to bring an action to recover benefits paid. The Court ruled that this did not protect the Insured from a counterclaim. The Court further wrote that to do otherwise would "result in an inability by the Insurer to raise or challenge any issues in Court."

The Court also ruled that c. 175, Section 110A did not protect the Insured from the counterclaim. It creates an exemption for disability benefits from attachment by creditors.

Philip M. Howe (phowe@lecomtelaw.com)
Lecomte, Emanuelson and Doyle
Quincy MA

Massachusetts — Disability Benefits/Statute of Limitations

The court in *Riley v. Metropolitan Life Insurance Company*, 2013 WL 5009618, __F. Supp. 2d __(D. Mass. Sept. 11, 2013) found that an insured's action to re-calculate his long term disability benefits was barred by the statute of limitations.

The parties agreed that the six year statute of limitations applied. The Insured began receiving disability benefits in April 2005. The Court ruled that he should have known that there was an underpayment of benefits at that time given his salary and the related benefit formula. The Court ruled that the Insured had a "single cause of action that accrued in 2005, when he should have known that [the insurer] had clearly repudiated his entitlement to a greater amount of long-term disability benefits..." As a result, the action filed in 2012 was untimely as it was beyond the expiration of the six year statute of limitations.

Philip M. Howe (phowe@lecomtelaw.com)
Lecomte, Emanuelson and Doyle
Quincy MA

Massachusetts — ERISA/Discovery of Claims Guidelines

The court in *Al-Abbas v. MetLife Insurance Co.*, 2013 WL 5947996 (D. Mass. Nov. 4, 2013) permitted plaintiff's requested discovery of the claims guidelines in an ERISA long term disability claim denial case. Citing *Glista v. Unum Life Insurance Co. of America*, 378 F. 3d 113, 122-23 (1st Circuit 2004) the Court allowed the Plaintiff's request for "...[insurer's] procedural and substantive rules in effect when making the benefit determination ...Such documents, if they exist, likely were 'considered' in the course of making the benefit determination..." 29 CFR Sections 2560.503 - 1(b)(5), (h)(2)(iii), (m)(8)(ii), (m)(8)(iii). In addition the Insured may discover any rules regarding fibromyalgia, Lyme disease and undiagnosed neurological conditions.

However, the Court denied the Plaintiff's request for additional information relating to the insurer's relationships with its paid medical consultants and claims reviewers to explore the nature, magnitude and effect of the insurer's alleged conflict of interest. The insurer was both the plan administrator and made decisions on claims. The Court ruled that the Plaintiff had not made out any "colorable claim of bias" by the insurer. The Plaintiff had failed to point to any evidence to indicate any colorable theory that compensation or performance of the claims handler was linked to the number of claims denials.

Philip M. Howe (phowe@lecomtelaw.com)
Lecomte, Emanuelson and Doyle
Quincy MA

Minnesota

Minnesota — "Occurrence" and Intentional Act Exclusion

American Family Mut. Ins. Co. v. Donaldson, 2013 WL 6842023 (D. Minn. December 27, 2013).

Minnesota's federal district court recently held that an insured's decision to drink heavily, drive at high speeds on residential streets, and flee from the policy is sufficient to establish the requisite intent to injure, so as to bring an accident caused by the insured's behavior outside of the definition of "occurrence," as well as within an intentional act exclusion in an umbrella policy.

On April 10, 2011, the insured was driving his father's vehicle after both the insured and his passenger had been drinking heavily. After the insured sped through his residential neighborhood, a neighbor called the police. When the police attempted to pull the insured over, the insured led them on a high speed chase, which ultimately ended with the insured crashing into a tree and the passenger sustaining severe injuries. The vehicle driven by the insured was insured under both an automobile policy and an umbrella policy with American Family.

The passenger sued the insured, and American Family provided a defense under a reservation of rights. American Family also commenced a declaratory action, seeking a declaration that there was no coverage under the umbrella policy. The parties brought cross-motions for summary judgment on the issue of whether the passenger's injuries sustained on April 10, 2011 arose from an "occurrence" under the umbrella policy, which defined "occurrence" as an "accident." Under Minnesota law, "accident" has been defined as "an unexpected, unforeseen, or undersigned happening or consequence." The policy also excluded all coverage for intentional acts, defined as "injury caused by or at the direction of any insured even if the actual injury is different than that which was expected or intended from the standpoint of any insured" and injury caused by "fraudulent, criminal, or malicious conduct."

The court first noted that, if the injury was an "occurrence" (and therefore an "accident"), it could not be an intentional act excluded under the policy. The court went on to conclude that the insured's voluntary intoxication and reckless driving were sufficient to infer the intent to injure as a matter of law, and that there was therefore no coverage under both the "occurrence" definition and the "intentional act" exclusion. The court reasoned that the intent sufficient to establish that injuries resulted from an intentional act rather than an accident could be demonstrated by a specific intent to injure, which in turn could be established when the "insured's actions were such that the insured knew or should have known that a harm was substantially certain to result from the insured's conduct." The court rejected the insured's argument that he obviously had not intended to crash the car and injure his friend, and instead concluded that the insured's decision to drive at high speeds on residential streets while intoxicated and flee the police is sufficient to establish an intent to injure, regardless of whether the insured intended to crash the vehicle. The court also rejected the insured's argument that he lacked the requisite intent to injure because he was too intoxicated, noting that the insured's voluntary intoxication was a key factor establishing his intent, not a mitigating factor.

Janine M. Loetscher (jloetscher@bassford.com)
Bassford Remele, PA
Minneapolis, MN

Minnesota — UIM, Timeliness Condition

Larson v. Nationwide Agribusiness Insurance Co., --- F.3d ----, 2014 WL 128694 (8th Cir. January 15, 2014).

An insured under a Nationwide policy providing underinsured motorist ("UIM") coverage was injured in an accident on May 9, 2007, while driving a grain truck

that was unable to stop at a railroad crossing, and ultimately crashed into a train, because another truck had leaked liquid fertilizer near the track. On May 5, 2009, the insured served the fertilizer truck's operator with a lawsuit seeking damages for bodily injury the insured sustained in the accident. The insured, however, did not file the lawsuit until June 16, 2009. That lawsuit ultimately settled for $500,000.

On May 30, 2012, the insured filed a separate lawsuit seeking UIM coverage from Nationwide. The policy limited the period in which an insured could bring a lawsuit seeking UIM benefits under the policy as follows:

[3.]b. Any legal action against us under this Coverage Form must be brought within two years after the date of the "accident". However, this Paragraph 3.b. does not apply if, within two years after the date of the "accident", the "insured" has filed an action for "bodily injury" against the owner or operator of a vehicle described in Paragraph b. of the definition of "uninsured motor vehicle", and such action is:

(1) Filed in a court of competent jurisdiction; and

(2) Not barred by the applicable state statute of limitations.

In the event that the two year time limitation identified in this condition does not apply, the applicable state statute of limitations will govern legal action against us under this Coverage Form.

The UIM endorsement defined the phrase "uninsured motor vehicle" as a motor vehicle "for which the sum of all liability bonds or policies at the time of the 'accident' do not provide at least the amount an 'insured' is legally entitled to recover as damages resulting from 'bodily injury' caused by the 'accident.'"

Nationwide moved for summary judgment, arguing that the lawsuit against it was untimely under the specified two-year time period because it was brought more than five years after the date of the accident. Nationwide also argued that the exception to the two-year requirement did not apply, because the insured's lawsuit against the operator of the vehicle was not filed until June 16, 2009—more than two years after the date of the accident. The insured, however, argued that the exception was ambiguous because, though it expressly applies where an action is "filed" within two years after the date of the action, "filed" may reasonably mean either "delivery of a legal document to the court," or "commencement of a lawsuit." (citing Black's Law Dictionary, 660 (8th Ed. 2004)). Under the latter construction, the lawsuit would be timely because lawsuits are "commenced" in Minnesota upon service of the complaint, not upon filing. Accordingly, the insured argued, the exception was ambiguous, and must be construed in his favor and against the insurer.

The district court granted summary judgment to Nationwide and the Eighth Circuit affirmed. The Eighth Circuit concluded that the exception at issue was unambiguous. While the court agreed that the term "filed" could be read as "commenced" *if* the provision was viewed in isolation, Minnesota law requires that courts, when construing an insurance policy, must read the policy as a whole. The court reasoned that other sections of the policy established that the term "filed" referred to the filing of a document with a court. First, the exception itself subsequently contained the term "filed," in that it specified that the exception requires that the insured's action be "[f]iled in a court of competent jurisdiction." Second, the court noted that the general two-year time period limitation in the provision at issue specified that actions be "brought" within two years. Therefore, if the exception was intended to merely require the insured to "bring" or "commence" a lawsuit within two years, it would have used the term "brought" in place of "filed" in the exception.

Janine M. Loetscher (jloetscher@bassford.com)
Bassford Remele, PA
Minneapolis, MN

Nebraska

Nebraska — First Party/'Theft"

The Nebraska Supreme Court has ruled in *Peterson v. Homeslide Ind. Co.*,

S-12-875 (Neb. December 20, 2013) that a trial court adhered in finding that a homeowner did not suffer a loss of personal property due to "theft" when he entrusted his household guns to a shipping agent to deliver them to his new home in Florida. While agreeing with the trial court that "theft" encompassed "any unlawful or wrongful taking …with criminal intent", the court had erred in finding that the existence of abailment precluded any possibility of criminal intent in this case. The court ruled that the fact that the movers had initially obtained possession of the insured's property with his consent, did not preclude the possibility that they may have intended to convert the property for their own use at some later time. Accordingly, in the absence of some specific exclusion, the court found that the homeowner's policy encompasses "theft by conversion."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

New York

New York — *Sexual Torts/"Claim"*

The Appellate Division has issued a two sentence order summarily affirming Judge Greenwood's March 2013 ruling in *Syracuse University v. National Union Fire Insurance Company of Pittsburgh, PA* that AIG must pay for the cost of responding to subpoenas that the university had received in connection with an investigation of such molestation by former assistant basketball coach Bernie Fine. Judge Greenwood had ruled that the investigative subpoena satisfied the policy requirement of a "claim" rejecting "the insurers' view of the nature of a subpoena as a mere discovery device…"

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

New York — *Pollution Insurance*

Where a pollution legal liability policy excluded coverage for claims "based upon or arising out of the existence of any underground storage tank(s) and associated piping" except where listed on a specific schedule but further stated in a separate endorsement that these scheduled locations are subject to a $1 million sublimit, a federal district court has ruled in *Two Farms, Inc. v. Greenwich Ins. Co.,* No. 12-0050 (S.D.N.Y. January 7, 2014) that the insurer's legal liability was capped by the sublimit. In rejecting the insured's claim that it was entitled to the full $5 million policy limit, Judge Koeltl ruled that the term "underground storage tanks and associated piping" must be given the same meaning in the policy exclusion and sub-limit endorsement and rejected the insured's argument that the sublimit was endorsement because "underground storage tanks and associated piping" could also include other equipment that comprised the insured's UST system.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

New York — *Estoppel*

The Court of Appeals heard oral argument on January 15 in an insurer's appeal of *Country-Wide Ins. Co. v. Preferred Trucking Services Corp.*, 2012 NY Slip Op 7036 (App. Div. October 18, 2012). At issue is the First Department's ruling that an insurer waited too long (4 months) to disclaim coverage, even though the insurer argued that it had no basis for disclaiming coverage until it became apparent that the operator of the subject truck would not cooperate with the defense of the underlying personal injury action.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

New York — Direct Action/Default

Lema v. New York Central Mutual Fire Insurance Company, 12/26/13, New York Appellate Division, Second Department

On November 10, 2005, Lema was hurt in a car accident with a vehicle insured by New York Central Mutual ("NYCM"). A suit was commenced against NYCM's insureds and judgment was taken in the Civil Court of the City of New York, in the sum of $33,396.03, constituting the principal sum of $25,000, plus interest ("underlying judgment").

This is the second Direct Action commenced by Lema under Insurance Law § 3420(a)(2) to recover the proceeds of the underlying judgment against the defendant's insureds from the carrier.

In the first action, the lower court denied Lema's motion for summary judgment on the complaint on the ground that the underlying judgment was "not properly served" upon the insurance carrier. However, while that action was pending, the plaintiff's attorney re-served the defendant with a copy of the underlying judgment against the insureds but that action was thereafter dismissed when the parties failed to appear at a compliance conference.

Once that action was dismissed, Lema started this action, alleging that the underlying judgment was served upon the defendant, 30 days had elapsed, and the judgment remained unsatisfied, which are the facts that need to be alleged to comply with the 3420(a)(2) Direct Action statute.

After the time to answer this second action had lapsed, NYCM moved to dismiss the complaint on the ground that there was another action pending. Since the motion was made after the time to answer had lapsed, and no answer had been served, Lema cross-moved for leave to enter a default judgment.

The lower court granted NYCM's motion and denied Lema's cross motion, on the ground that "this action is duplicative of a previous, currently pending matter."

This court found that (a) the NYCM's motion to dismiss the second action was untimely and without merit because the dismissal of the first lawsuit was not on the merits and could be recommenced; (b) that NYCM failed to establish a reasonable excuse for its default; and (c) a lack of merit to the defense.

Dan Kohane (ddk@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

New York — Assault and Battery Exclusions

Martinez v. OEL Realty Corp, 01/09/14, Appellate Division, First Department

The policy contained an "Assault and Battery" exclusion and the allegations alleged assault and battery. Because the complaint's negligence allegations could not survive except for the assault, those claims are deemed to have arisen from the assault and are thus subject to the assault and battery exclusion under the 1996 *Creative Housing* decision.

The declarations page advised of the "Assault and Battery Exclusion." The fact that it was not countersigned makes no difference.

Dan Kohane (ddk@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

New York — Attorney-Client Privilege

Old Republic Ins. Co. v United Natl. Ins. Co., 12/30/13, Supreme Court, New York County

This decision arises out of a motion to compel production of attorney communications. The communications were relevant to Old Republic's decision to fund the settlement in the underlying action, which was allegedly due to oral assurances that United National would contribution up to its $5 million policy limit to the settlement on behalf of STS (a mutual insured) before Old Republic would be obligated to contribute any money. These assurances formed the basis of Old Republic's breach of contract and equitable estoppel claims in this action.

United National requested the communications allegedly to fully understand the scope of the parties' alleged oral agreement and to see if and how Old Republic

changed its position regarding the settlement based on United National's representations. As this was the central issue of this case, it argued that it would make these documents while otherwise privileged not so.

In considering the question, the court reminded the parties that simply because a privileged communication contains information relevant to issues the parties are litigating does not, without more, place the contends of the privileged communication "at issue." Citing to the 1994 Southern District of New York decision in Ackwright Mut. Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., even where a party's state of knowledge is particularly at issue, such as in this case, waiver of a privilege should not be implied because the relevant question is not what legal advice was given or what information was conveyed to counsel, but what facts the party knew and when. Accordingly, the court found that United National was not entitled to the privileged document unless Old Republic sought to use them.

The court cautioned Old Republic however that its decision not to utilize the subject communications somewhat periled its case, which rested entirely on its contention that the parties–highly sophisticated insurance companies—orally agreed as to the parameters of the funding to settle an extremely contentious litigation. The refusal to produce attorney communications prior to United National's promise may result in Old Republic being unable to meet its burden in the case. Ergo, it cannot prove it changed its position.

Jennifer A. Ehman (jae@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

New York — Life Insurance/Oral Cancellation

Dabrowski v. Metropolitan Life Insurance Company, 01/29/14, Appellate Division, First Department

In September 2003, the decedent applied for a life insurance policy with his wife as beneficiary, from Metropolitan through a fellow named Pajak. Metropolitan advised the applicant, that the underwriting process revealed that he did not qualify for the "preferred" rating and that he would be required to pay a higher premium for the "standard" rating. The policy was issued giving the insured with a right to cancel the policy and obtain a refund of any premiums already paid.

The decedent died on January 11, 2004, and his wife sought to recover under the subject policy. Metropolitan claimed that in December, the insured canceled the policy because of the higher premiums. This suit followed.

The court found that the plaintiff's claim, that no notice of cancellation was received prior to the decedent's death was without merit. As the cancellation was initiated by the decedent-insured, the defendant was not required to provide notice in order to effectuate cancellation of the subject.

Dan Kohane (ddk@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Ohio

Ohio — Personal & Advertising Injury/Breach of Fiduciary Duty

Assurance Company of America v, Waldman, 12/18/13, (S.D. Ohio) 2013 WL 666 9249

The dissolution of one accounting firm and formation of new firms by the principals spawned a series of lawsuits, which led to the coverage decision which the court addressed in *Assurance Company of America v. Waldman*, 2013 WL 666 9249. In *Waldman*, the court determined that there was no coverage available for damages resulting from lawsuits alleging that one of the principals in a newly formed firm, Kenneth Pitcher, breached his fiduciary duty as trustee of the profit-sharing trust in the prior firm and another lawsuit involving the disclosure of confidential information to the IRS for the purpose of causing the principals of one of the newly firms difficulties with the IRS.

The parties had agreed that the only coverage which might be available under a commercial general liability policy and umbrella policy would be pursuant to Coverage B of the policies, which insured against losses due to personal and advertising injuries. The insurer contended that the damages did not constitute "bodily injury" or "property damage" and neither were they caused by an "occurrence," and sought a declaration that it owed neither defense nor indemnity in connection with the suits. The insured counterclaimed for breach of contract and bad faith in connection with its refusal to defend or indemnity them in the suits.

The Court discussed the policy's definition of "personal and advertising injury" defined as oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services and oral or written publication of materials that violates a person's right of privacy.

While the Court noted that initially, the cited provisions appeared to provide coverage to the insured because the litigation involved the insured's alleged disparagement of the former principals of the accounting firm in his alleged disclosure of information in which they had privacy interests, the Court found that another section of the CGL Policy excluded coverage of the claim. In particular, the Court cited the exclusion for injury "caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict 'personal and advertising injury'." The Courts found that the exclusion precluded coverage.

With respect to the claim for breach of the insured's fiduciary duty, the Court, similarly found that the policy did not afford coverage, both because the suit did not constitute a claim by an "employee, former employee or the beneficiaries or legal representatives thereof," but rather was a lawsuit by a former trustee of the plan and, more importantly, that the insured's decision to sue was not a negligent act, error or omission in the administration of the benefit program, but rather was an intentional act and, therefore, not afforded coverage under the policy.

Ultimately, thus, the Court determined that no coverage was available under Coverage B of the policies.

Elizabeth A. Fitzpatrick (eaf@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Pennsylvania

Pennsylvania — DonkeyBall/"Sponsor'

Judge Robreno has ruled in *Sciolla v. Westband Mut. Ins. Co.,* No. 11-5604 (E.D. December 18, 2013) that injuries suffered by two local school teachers while playing basketball atop donkeys was covered under the school district liability policy notwithstanding a Sports Participants Exclusion which stated that the policy did not apply to "bodily injury to any person while practicing for or participating in any sport or athletic contest or exhibition that you sponsor." Leaving aside the issue of whether Donkey Ball was a "sport", the court found that the insurer has failed to establish that the insured had "sponsored" this event. The court noted diverse interpretations of "sponsor" and the case law with respect to similar exclusions but found that the most common meaning of the terms was an individual who "finances a project or an event carried out by another person or group" which had not occurred here.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Pennsylvania — Bad Faith

A federal district court has ruled in *Williamson v. Chubb Indemnity Ins. Co.*, No. 11-6476 (E.D. Pa. December 19, 2013) that Chubb might potentially have acted in bad faith in relying on a third-party adjuster's use of a program called "Exactimate" to estimate the amount of the insured's loss rather than the "Symbility" program that Chubb conventionally uses. In declining to dismiss the

bad faith claims against Chubb, Judge Baylsom ruled that the insured had presented a colorable claim that Chubb had acted in bad faith by engaging an adjusting firm knowing that it would use software that would result in a lower estimate of damages then Chubb's own in-house database would have generated. The court ruled that bad faith is not limited to an insurer's decision to deny benefits but may also result from the manner in which an insurer investigates and adjusts a loss. While leaving the door open for Chubb to present evidence to support its matter for adjustment, the court found that "departing from standard practice in order to generate a lower estimate may prove the dishonest purpose and self-interest that is the hallmark of bad faith."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Pennsylvania — Asbestos

A federal jury in Philadelphia reportedly ruled last week in *General Refractories Co. v. First State Ins. Co.*, No. 04-03509 that there was no long standing policy of the Pennsylvania Insurance Department that would have precluded insurers from relying on asbestos exclusions to refuse to accept coverage for asbestos BI claims. Earlier, the jury heard testimony from Linda Conley, the state's former insurance commissioner, that her department had never adopted such a policy.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Pennsylvania — Duty to Settle/Conflicts

The Pennsylvania Supreme Court announced last Friday that it would grant review in *The Babcock and Wilcox Company v. American Nuclear Insurers*, 2013 WL 3456969 (Pa. Super. July 10, 2013), a case in which the Superior Court ruled that an insured has the choice of either accepting the insurer's defend under a reservation of rights, in which event it must abide by the consent to settlement provision in its policy and cannot settle over the insurer's objections, or may undertake its own defense from the outset, in which event it is free to settle as it chooses and may still seek reimbursement from the insurer for its defense costs as well as any settlement so long as those costs are deemed to be fair, reasonable and non-collusive.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

South Carolina

South Carolina — Advertising and Personal Injury

The Episcopal Church in South Carolina v. Church Insurance Company of Vermont & The Church Insurance Company, 06/01/14, (D. S.C.) 2014 WL 37225

The underlying action from which the coverage action derived involved a doctrinal dispute between the Diocese, TEC, and plaintiff, TEC-SC. Evidently, although the Diocese disassociated from the Episcopal Church also known as the Protestant Episcopal Church, the Diocese continued to use the same intellectual, real, and personal property it used prior to the split. The Diocese filed the underlying action seeking a declaration from the state court that the Diocese's existence and continued use of the disputed property were proper. They also sought an Order enjoining the Episcopal Church from their continued use of the same property.

The Episcopal Church was insured by a policy issued by Church Insurance Company of Vermont, which included coverage for advertising injury liability, defined in pertinent part as "injury other than bodily injury, property damage or personal injury, arising out of one or more of the following offenses: … b. Misappropriation of advertising ideas or style of doing business or c. infringement of copyright, title, slogan, trademark or trade name." Damages were defined as compensation in the form of money for a person who claims to have suffered an injury.

After the underlying action was commenced, the Episcopal Church requested that Church Insurance Company of Vermont defend and indemnify it in the underlying action. Church Insurance Company denied coverage on numerous grounds, including that the claims were not covered by the policy or were subject to exclusion. The Episcopal Church sued, seeking coverage for the underlying action.

The court found that because the second cause of action sought reasonable attorneys' fees and because damages were defined within the policy as compensation in the form of money for a person who claims to have suffered an injury, attorneys' fees constituted monetary compensation and were alleged in connection with a claim of trademark infringement. Noting that the policy provided that damages due to advertising injury would be afforded coverage, the court found that the underlying action did, in fact, allege an advertising injury as defined in the policy. The court further found that the Intentional and False Acts Exclusion of the policy did not preclude coverage, as the governing statute allowing for an award of attorneys' fees did not limit same to situations where the court found the other party committed the wrongful acts with knowledge or in bad faith, but included the catchall phrase "or otherwise according to the circumstances of the case."

Unable to conclude that the allegations in the underlying complaint clearly fell within one of the policy exclusions, Church Insurance Company of Vermont had a duty to defend plaintiff because the underlying complaint alleged both an advertising injury, as defined by the policy, and attorneys' fees, which fell within the policy's definition of damages. The court denied summary judgment on the bad faith claim, finding that the elements were established, but sufficient evidence to demonstrate that Church Insurance Company of Vermont's refusal to defend was an unreasonable action or made in bad faith, was not presented.

Elizabeth A. Fitzpatrick (eaf@hurwitzfine.com)
Hurwitz & Fine
Buffalo NY

Texas

Texas — Construction/Contractual Liability Exclusion

On a certified question from the Fifth Circuit, the Texas Supreme Court ruled last week in *Ewing Construction Co. v. Amerisure Ins. Co.*, No 12-0661 (Tex. Jan. 17, 2014) that "a general contractor that enters into a contract in which it agrees to perform its construction work in a good and workmanlike manner, without more specific provisions enlarging this obligation, does not 'assume liability' for damages arising out of the contractor's defective work so as to trigger the contractual liability exclusion."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Wisconsin

Wisconsin — Criminal Acts Exclusion

Estate of Dobry v. Wilson Mut. Ins. Co., 2013 WL 6418930 (Wis. Ct. App. Dec. 10, 2013)

On June 18, 2010, while his parents were out of town, 19-year-old Jordan Walker (Jordan) hosted a party at his parents' house, which was attended by, among others, Jordan's younger brother, Lucas Walker (Lucas), and Jordan's friend, Shawn Dobry (Dobry). During the party, Jordan retrieved a gun from his bedroom, removed the ammunition, and began "dry firing" the gun at people. Jordan subsequently loaded and unloaded the gun multiple times throughout the night. Jordan raised the gun over his shoulder at which point it discharged while loaded. The bullet struck Dobry, who died as a result. Jordan was charged and found guilty of negligent homicide.

The Estate of Shawn Dobry, through its Special Administrator Christopher Dobry,

Cynthia Stodghill, and Christopher Dobry (collectively, the Dobrys) sued Jordan, Lucas, and their parents, Robert and Sande Walker, alleging their negligence caused Dobry's death. The complaint also named Wilson Mutual Insurance Company (Wilson Mutual), which issued a homeowner's policy to Robert and Sande Walker. Wilson Mutual moved for summary judgment, arguing that insurance coverage was not available because there was not an occurrence and because the policy's criminal acts and intentional acts exclusions applied to bar coverage. The trial court granted Wilson Mutual summary judgment and dismissed the case, concluding that both the criminal acts and intentional acts exclusions applied.

The Wisconsin Court of Appeals affirmed the trial court's decision, holding that the criminal acts exclusion in the Wilson Mutual policy, which stated that Wilson Mutual would not cover bodily injury "that is the result of a criminal act of an insured[,]" "unambiguously bar[red] coverage for the Dobrys' claims." In reaching its decision, the court noted that although "[t]he policy does not define the term 'criminal act,' . . . the only reasonable interpretation of that term is an act that violates the criminal code." The court reasoned that because "Jordan was convicted of homicide by negligent handling of a dangerous weapon . . . [t]he bodily injury Dobry sustained was therefore 'the result of a criminal act' of an insured. Consequently, the criminal acts exclusion preclude[d] coverage for the Dobrys' claims." In addition, the court rejected the argument that the exclusion was ambiguous because it could be read to apply only to intentional criminal acts. Instead, the court concluded that "[n]othing in the exclusion requires that the criminal act be intentional" and that "[i]f we adopted the Dobrys' interpretation, we would be rewriting an unambiguous exclusion to bind Wilson Mutual to a risk it did not contemplate and for which it did not receive a premium. That is something we may not do."

The court also rejected the argument that the exclusion was "contextually ambiguous because it [was] located between two exclusions that preclude coverage for intentional harm and intentional and malicious acts." On this point, the court stated that the "exclusions the Dobrys cite are not grouped under a single heading stating, 'Intentional Acts Exclusions.' There is no reason for an insured to conclude the criminal acts exclusion requires intentional conduct simply because the exclusions before and after it refer, respectively, to intentional harm and intentional and malicious acts." Accordingly, the court held that the criminal acts exclusion barred coverage for the Dobrys' claim, and affirmed the trial court's grant of summary judgment in favor of Wilson Mutual.

Charles W. Browning (cbrowning@plunkettcooney.com)
Kenneth C. Newa (knewa@plunkettcooney.com)
Plunkett Cooney
Bloomfield Hills, MI

Wisconsin — Asbestos

The Wisconsin Supreme Court has ruled in *Phillips v. Parmelee*, 2013 WI 105 (Wis. December 27, 2013) that an asbestos exclusion ambiguously precluded coverage for allegations that the insured failed to disclose the existence of asbestos in a property before it was sold to the plaintiffs. Notwithstanding the plaintiffs' argument to the exclusion was ambiguous, the Supreme Court agreed with American Family that it must be given a broad meaning in light of its prefatory language excluding coverage for "any loss arising out of" exposure to or the use of asbestos. The court declined to find ambiguity based on the fact that the exclusion did not expressly state that it applied to losses arising out of the "dispersal" or "presence" of asbestos. The Supreme Court ruled that "the scope of the asbestos exclusion does not depend on the type of tort from which the loss arose; the exclusion's language concerns the loss itself arising out of asbestos."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Wisconsin — Intentional Acts Exclusion

The Wisconsin Court of Appeals has ruled in *Fetherston v. Parks*, 2012AP1920 (Wis. App. December 12, 2013) that injuries resulting from a high speed chase in which the insured tried to escape police pursuit were not subject to a policy exclusion for injuries "caused intentionally by, or at the direction of, and substantially certain to follow from the act of an insured person." The fact that the insured may have acted criminally or recklessly did not, in the court's view,

support a finding that the insured had subjectively intended to cause bodily injury to any third party.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Wisconsin — Absolute Pollution Exclusions/"Septage"

The Wisconsin turd wars took another turn last Tuesday when the Court of Appeals ruled in *Preisler v. Kuettel's Septic Service LLC,* 2012AP2521 (Wis. App. Jan. 14, 2014) that "septage"-- a combination of water, urine, feces, and chemical that a dairy farmer sprayed on his land as fertilizer—was a "pollutant." In holding that various general liability insurers had no duty to defend the insured against claims by a neighboring property owner that overspraying of the septage had contaminated his well water and killed his cows, District III declared that "this is not a case in which the pollution exclusion threatens to swallow the reasonable expectations of the insured…Certainly reasonable insureds involved in hauling and disposing of septage should be presumed to know the dangers of the substances they carry. These activities are highly regulated, require careful planning, and carry the potential for significant liability…A reasonable insured would not view spreading or injecting septage on farmland as an ordinary, wholly unremarkable event."

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA

Wisconsin — Policy Cancellation

The Court of Appeals has rejected a UIM carrier's argument that an auto insurer violated the notice provisions required by Wis. Stat. § 631.36(2) when it acted on the named insured's request to have his wife's vehicle removed from the policy. In *Spice v. Molz*, 2012AP144 (Wis. App. Jan. 16, 2014), the court held that the statute only applies to situations in which a policy is actually cancelled, not just amended.

Michael Aylward (maylward@morrisonmahoney.com)
Morrison Mahoney
Boston, MA