A Note from the Editor

As the Summer heat turns into Autumn breezes, our thoughts start turning to such pleasant things as the start of another football season, the World Series, and of course, another great edition of “Covered Events”. This month, we are proud to feature a very fresh and insightful article from William T. Graden, Associate General Counsel for State Farm® Insurance Companies. The thoughts conveyed in this article will strike home with many of our readers. This edition also features the usual collection of important cases from around the Country, including the important Delgado decision from the California Supreme Court.

By the time you are reading this, the DRI Annual Meeting in Chicago will likely have come and gone. For those of you who attended, we hope you had the opportunity to meet up with old acquaintances and make some new ones. For those of you who could not attend, we hope you will put this event on your calendars for next year.

Lastly, we are always looking for new and fresh contributors to Covered Events. While we are grateful to those Firms that contribute on a consistent basis, it would be great to hear from voices from all over the country. Please do not hesitate to send us a submission concerning a case of interest. Preparing these short summaries and articles is a great way to get involved with the organization. Please remember that the submissions should be in Microsoft Word format and should include a web link to the case, if possible.

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A Note From The Chair

In the afterglow of the DRI annual meeting, I once again find myself thinking about the great experiences and opportunities I have had through my participation as a member of the Insurance Law Committee. Over the past two decades, the time I have spent at DRI events with colleagues and clients who share my professional focus has provided an unparalleled opportunity to expand and invigorate my interest in the practice of insurance law; and to have a lot of fun.

Our committee was well represented with more than 200 attendees and we presented two exceptional educational programs. As part of the general meeting program, Shaun Baldwin, Chris Martin, Dan Gerber and Dawn Midkiff insightfully addressed risk shifting issues in the context of the present economy. Another innovative discussion on the subject of insurance and construction law issues arising out of the "greening" of America was led by Mark Cohen, Gerry Bren, Chris Belter, and included the engineering insights of Doug Peterson.

Having served the past year as the vice chair of the Insurance Law Committee, I have seen "up close and personal" the enthusiastic commitment of scores of attorneys whose leadership efforts sustain and enhance the DRI. I have also witnessed the commitment of dozens of members of the ILC who efforts have spearheaded our programs in this year Chicago, Boston, and New York, which have kept our committee vibrant and thriving. And perhaps most importantly, I have come to appreciate the dedication of the ILC leaders who have preceded me and whose continued involvement guides our committee.

As I begin my second year as vice chair, I look forward to sharing my enthusiasm with all of you who avail yourselves of the opportunity to contribute to and grow with the Insurance law Committee. In less that two months, we will convene in New York City for the Insurance Coverage and Practice Symposium (sign up now: http://www.dri.org/open/SeminarDetail.aspx?eventCode=20090140.) This program will run concurrently with the DRI’s Law Practice Management Committee’s program, Best Practices for Law Firm Profitability, and the joint networking receptions will further enhance the opportunities for those in attendance.

Recent Cases of Interest

Recent Cases of Interest
1. FIRST CIRCUIT – Deductibles/SIR (Me)
2. SECOND CIRCUIT - WTC/Declaratory Relief (NY)
3. THIRD CIRCUIT – Bad Faith (PA)
4. FIFTH CIRCUIT - Construction Defect/Contractual Liability Exclusion (TX)
5. FIFTH CIRCUIT – Policy Formation (MS)
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7. SEVENTH CIRCUIT - Choice of Law/Coverage B/TCPA (IL/IA)
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14. TENTH CIRCUIT - MCS-90 Endorsements (UT)
15. ELEVENTH CIRCUIT – Bad Faith (FL)
16. ELEVENTH CIRCUIT – Exclusions/"Maintenance" of auto (GA)

**FIRST CIRCUIT – Deductibles/SIR (Me)**

The policyholder, was named as a defendant in a class action lawsuit brought by persons illegally strip-searched at the county jail following misdemeanor arrests. The policyholder and its insurers entered into a global settlement of the claim. One of the insurers then sought to recoup its $750,000 settlement contribution from the policyholder, arguing that because each individual claim was settled for less than $5,000, the amount of the policy’s deductible, its settlement contribution was composed entirely of deductibles. The court rejected this argument, finding that the insurer’s actions in contributing to the settlement estopped it from recovering deductibles from the policyholder. (American Nat’l Fire Ins. Co. v. York County (1st Cir.(Me.), August 5, 2009)

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**SECOND CIRCUIT - WTC/Declaratory Relief (NY)**

The U.S. Court of Appeals for the Second Circuit has issued a summary order in S.R. International Business Ins. Co., Ltd. v. Allianz Ins. Co., 2009 U.S. App. LEXIS 16564 (2nd Cir. July 28, 2009) rejecting the WTC insureds’ argument that disputes concerning their claimed priority rights to any third party recoveries against airlines or others from insurer subrogation claims arising out of the terrorist attacks on the World Trade Center in 2001 are not now ripe for adjudication.

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For a copy of the case: http://insurancecoverage.typepad.com/files/8.5.09-1.pdf

**THIRD CIRCUIT – Bad Faith (PA)**

Relying in part on Ash v. Cont’l Ins. Co., 593 Pa. 523 (Pa. 2007), which held that claims brought pursuant to the Pennsylvania Bad Faith Statute, 42 Pa. C.S.A. § 8371, are subject to a two-year statute of limitations, and Sikirica v. Nationwide Ins. Co., 416 F.3d 214 (3d Cir. 2005), which held that claims under the Bad Faith statute begin to accrue when the insurer first provides definite notice of a refusal to defend or indemnify, Judge Joy Flowers Conti of the United States District Court for the Western District of Pennsylvania dismissed an insured’s first-party bad faith claim because it was brought more than two years after the claim was denied. See Sikora v. State Farm Ins. Co., No. 08-1366, 2009 WL 2411781 (W.D. Pa. Aug. 4, 2009). In granting State Farm’s motion for partial summary judgment regarding its
alleged bad faith denial of insured’s underlying underinsured motor vehicle claim, Judge Conti reasoned that the statute of limitations had run because State Farm’s first denial of the claim, which is when the “insurer first [provided] definite notice of a refusal to indemnify”, was in December 2005 and the bad faith claim was not filed until the end of June 2008, almost six months after the statute of limitations had run. Id. at *3-4. The Court also rejected insured’s “continuous trigger” argument that a subsequent 2007 letter State Farm sent to insured – which requested further information regarding insured’s 2005 claim – acted as a “continued denial” and that “each denial was a separate act of bad faith which restarted the running of the statute.” Id. at *2, 4.

FIFTH CIRCUIT - Construction Defect/Contractual Liability Exclusion (TX)

While holding that in light of the Texas Supreme Court’s 2007 ruling in Lamar Homes, claims for breach of contract arising out of a building contractor must be read as alleging an “occurrence,” the Fifth Circuit has ruled in Century Surety Co. v. Hardscape Construction Specialties, Inc., No. 06-10930 (5th Cir. August 7, 2009) that the insured had failed to establish that the underlying lawsuit fell within the policy’s “insured contract” exception to the policy’s exclusion for contractual liability. Applying the “eight corners” rule, the court held that the factual allegations in the underlying suit, even when construed liberally, did not describe a liability that would be imposed by law in the absence of any contract or agreement and that the exclusion therefore applied.

FIFTH CIRCUIT – Policy Formation (MS)

Where the question is whether or not a policyholder was given notice of an amendment, the insurer does not need to provide the specific details of mailing the amendment to the policyholder. Rather, circumstantial evidence, including customary mailing practices used in the insurer’s business is sufficient to meet the burden of proof. Once that initial burden is satisfied, the policyholder must present evidence beyond a bare assertion of non-receipt that notice was not provided. (GEICO Ins. Co v. White, (5th Cir. (Miss.))

FIFTH CIRCUIT – Proof of Loss

Plaintiffs brought suit when America Bankers Insurance denied their additional claims for damages to their home caused by Hurricane Katrina. They had received both an initial and supplemental payment
from Defendant. They then sought additional benefits for damages to their foundation and to the home’s exterior plywood sheathing for which the claim was denied. They then brought suit for payment despite having failed to submit proof of loss. Plaintiffs argued that they were not required to submit a proof of loss prior to filing suit on their claims. They argued that a press release issued by FEMA waived the proof of loss requirement. The FEMA release stated in pertinent part that the National Flood Insurance Program “has waived the usual requirement that the policyholder must submit a proof-of-loss and instead where the policyholder agrees, will rely on a report by the claims adjustor.” Plaintiffs believed this to be an unconditional waiver of the ordinary proof of loss requirement. They believed that a report by a claims adjustor was a proper substitute for a sworn proof of loss even if the carrier does not agree to pay part of a submitted claim. Plaintiffs also claimed that if the proof of loss requirement has been waived that it deprives them of a meaningful opportunity to contest American Banker’s adjustment of their claims. The FEMA requirement was that the claim be filed within one year. They argued that an adjustor could spend more than one year adjusting a claim thereby leaving the insured with no avenue to challenge its adjustment decisions. The Court held that Plaintiffs knew of their disagreement with the payment of their claims well before the one year cutoff. The initial adjustor’s report in December 2005 stated that the foundation damage was excluded from coverage under their flood policy. The Court found they had ample opportunity to file a proof of loss within the one year deadline. Plaintiffs also argued that the one year proof of loss requirement violated their constitutional rights including the right to equal protection and due process. They argued that FEMA enforces the proof of loss requirement arbitrarily, granting waivers to some but not others. They believed that such FEMA conduct treats holders of federally funded flood insurance policies differently without a rational basis. They also argued that the one-year limitation for filing a proof of loss violated due process by foreclosing judicial review of adjustment decisions made more than one year after a loss. The Court found that Plaintiffs failed to cite any legal authority to support their propositions. The Court held that the few district courts to have reached similar issues have concluded that the proof of loss requirement did not violate the constitutional rights of the insured. (Wientjes v. American Bankers Insurance Co. of Florida)

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SEVENTH CIRCUIT - Choice of Law/Coverage B/TCPA (IL/IA)

The Seventh Circuit has ruled in Auto-Owners Ins. Co. v. Websolv Computing, Inc., No. 07-3286 (7th Cir. September 1, 2009) that an Illinois District Court erred in finding CGL coverage for junk fax claims. Whereas such claims are deemed to involve a covered invasion of privacy under Illinois law, the Seventh Circuit held that they are not covered under the law of Iowa, which the parties had stipulated should control the interpretation of this policy. The Seventh Circuit ruled that Judge Norgle should not have ignored the implied agreement of the parties with respect to choice of law and was additionally mistaken in his belief that he was required to apply the substantive law of the forum state (Illinois). Despite the absence of any Iowa law on this issue, the Seventh Circuit declared that it would stand by its American States analysis that such claims do not involve a “publication.” The court declined to certify the issue to the Iowa Supreme Court, noting that as insurers had adopted specific TCPA exclusions since 2005, the issue was unlikely to surface frequently enough to be worthy of certification.

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EIGHTH CIRCUIT – Additional Insured (FL)

The Court of Appeals affirmed the lower court’s decision that a general contractor was not covered as an additional insured because the underlying injuries for which the general contractor was potentially liable did not arise out of the named insured’s work. (Great American Ins. Co. v. National Union Fire Ins. Co. of Pittsburgh (11th Cir. (Fla.), July 20, 2009))

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EIGHTH CIRCUIT - Bad Faith (ND)

The U.S. Court of Appeals for the Eighth Circuit has ruled in Moore v. American Family Mut. Ins. Co., No. 08-3238 (8th Cir. August 14, 2009) that an insurer was not entitled to argue that the judge’s denial of the insurer’s motion for judgment as a matter of law at the conclusion of the insured’s case precluded the insured from arguing that the insurer did not have a good faith basis for contesting coverage where the insurer had failed to preserve the contention that it was entitled to JAML on the bad faith claim in its post-trial filings. The court likewise found that the insurer had waived its right to contest various jury instructions that it had failed to object to at the time of the charge conference. In any event, the court found that the subject matter of the disputed instruction, namely whether or not the insurer had violated the state Unfair Claims Practices Statute, was relevant evidence of bad faith. The Eight Circuit also ruled that the District Court had not erred in refusing to grant a new trial after a jury admitted that he had gone on-line and undertaken research with respect to the financial statements of American Family. The court ruled that a new trial was not needed as there was strong evidence that the other jurors had refused to hear this information and had immediately disclosed the jurors’ misconduct to the trial judge. The court also concluded that the plaintiffs had made out a claim for loss of reputation in the community and emotional distress as a consequence of the insurer’s denial on the grounds of arson.

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EIGHTH CIRCUIT - Declaratory Relief/Forum Non Conveniens (IA)

The U.S. Court of Appeals for the Eighth Circuit has ruled in Bacon v. Liberty Mutual Ins. Co., No. 08-2935 (8th Cir. August 6, 2009) that an Iowa District Court erred in dismissing an insured’s action for declaratory relief concerning the subrogation rights of a liability insurer on the grounds of forum non conveniens.

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EIGHTH CIRCUIT – Notice (OK)

The standard products-completed operations hazard exclusions are generally held to be unambiguous as a matter of law. The Tenth Circuit has held that a provision that applies when all the work is completed applies only when all the work has been completed. Therefore, the exclusion does not apply when the worker was injured while project was still in progress. (Orthopedic Resources, Inc. v. Nautilus Ins. Co., (N.D.Ok., August 6, 2009)

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NINTH CIRCUIT - Coverage B/Internet Exclusion (CA)

The U.S. Court of Appeals for the Ninth Circuit has issued an unpublished opinion declaring in Netscape Communications Corp. v. Federal Ins. Co., No. 08-15120 (9th Cir. August 27, 2009) that a California District Court erred in ruling that a St. Paul policy exclusion for “providing Internet access to third parties” barred “personal injury” coverage for suits brought against American Online for allegedly intercepting and disseminating private online communications. The Court of Appeals ruled that the underlying claims were not only for invasion of privacy within the scope of the policy’s “personal injury” coverage but that the exclusion in question only applied to instances in which the insured actually provided an Internet connection as distinguished from the instant case where the customers already had such connections and merely used a “Smart Download” software program supplied by the insured that permitted downloading personal information.

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NINTH CIRCUIT - Excess/Proof of Exhaustion (AZ)

The Ninth Circuit has ruled in U-Haul International, Inc. v. Lumbermens Mut. Cas. Co., No. 07-16187 (9th Cir. August 12, 2009) that an Arizona District Court did not err in allowing a policyholder to admit into evidence certain computer-generated summaries of payments made by Lumbermens on insurance claims in support of the insured’s contention that the products aggregate limits underlying Lumbermens’ excess coverage had become exhausted. Despite Lumbermens’ arguments that the exhibits were inadmissible hearsay, the court held that they fell within a hearsay exception pursuant to Rule 803(6) as involving records of regularly-conducted business activity since the information came from the electronic database maintained by the primary insurer for this purpose and were not prepared solely for purposes of the litigation.

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TENTH CIRCUIT - MCS-90 Endorsements (UT)

In a lengthy opinion analyzing the history of the MCS-90 endorsement and the case law that has developed concerning it since 1980, the Tenth Circuit has reconsidered its 1989 holding in Empire that the MCS-90 endorsement could make a policy containing it "co-primary" with respect to a trucking loss and embraced the analysis that most other federal circuits have since adopted, whereby the MCS-90 endorsement is treated as making the insurer a surety rather than as effecting a modification of the underlying policy. In Carolina Cas. Ins. Co. v. Yeates, No. 07-4019 (10th Cir. September 3, 2009), the Tenth Circuit ruled en banc that an MCS-90 endorsement in a policy only applies where (1) the underlying policy to which the endorsement is attached does not provide coverage for the motor carrier’s accident and (2) the coverage is either not sufficient to satisfy the federally-prescribed minimum levels of financial responsibility or is nonexistent. As a result, the Court of Appeals held that a Utah District Court and an earlier panel of the Tenth Circuit had erred in requiring a general liability insurer to pay its $1 million limit in a case where the insured’s auto carrier had already tendered its $750,100 limit. Rather, the court ruled that the MCS-90 endorsement did not apply since the insured had already received benefits equal to the minimum amount required by the MCS-90 endorsement.

ELEVENTH CIRCUIT – Bad Faith (FL)

Plaintiff’s estate agreed to release defendants for death caused by motor vehicle accident in exchange for policy limits of $25,000 and a schedule of the defendants’ assets. Defendants-insureds refused to provide the asset schedule, and a $3M judgment was rendered against them in the subsequent lawsuit. Plaintiffs then sued defendants’ insurer for bad faith by "stepping into the shoes of insured," alleging that the excess judgment was rendered because of insurer’s unwillingness to pay limits. The district court found no bad faith, since the failure of the insurer to tender limits was caused by insured-defendants’ unwillingness to provide asset schedule. On appeal, estate of plaintiff, in the shoes of the insured, claimed that the wrong standard of care was applied by the lower court in determining existence of bad faith. The court of appeals affirmed the lower court decision, even though lower court added an element to the standard bad-faith test; specifically, the lower court required proof that the insurer put its interest above the insured in order to show bad faith, in addition to the core elements. Because the insurer nonetheless acted in good faith under the core elements and the extra element would not have changed the outcome, the court of appeals upheld the decision. (Maldonado v. First Liberty Insurance Corp.)

ELEVENTH CIRCUIT – Exclusions/"Maintenance" of auto (GA)

The Court of Appeals affirmed the lower court’s ruling that the undisputed facts demonstrated that policyholders’ injuries arose out of the “maintenance” of an automobile that was being “operated” by
policyholder through its agent. (Nationwide Property & Casualty Ins. Co. v. Clyde Osburn, Liberty Auction Inc. et. al., (11th Cir. (Ga.))

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ALABAMA – Other Insurance

One policy’s other insurance clause refers only to first-party coverage, whereas the other insurance clause in the other policy contains additional language creating a category for third-party liability coverage for which there is no comparable provision in the first policy. Thus, the court held that because the excess insurance clause in each policy contained a different classification of risk, the clauses cannot be mutually repugnant, and therefore, the first policy provided the primary coverage. (Colony Ins. Co. v. Georgia Pacific, LLC. et. al.)

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CALIFORNIA - Bad Faith/Absolute Pollution Exclusion

In an opinion that is as noteworthy for its length (51 pages), wry humor and erudite asides (a “congeries of cerebrates”) as for its devastating rejection of an insured’s effort to transform a coverage dispute into a bad faith claim, the Fourth District has ruled in Griffin Dewatering Co. v. Northern Ins. Co., G036896 (Cal. App. July 31, 2009) that a trial judge erred in granting the insured’s motion in limine that, as a matter of law, Zurich’s denial of coverage for sewage claims on the basis of an absolute pollution exclusion. Rather, the Court of Appeal held that its 2003 opinion in Morris v. Paul Revere Life Ins. Co. makes clear that the lack of “settled” law at the time of a claim denial does not support a bad faith claim, even if a subsequent Supreme Court decision (ie. Mackinnon) settles the issue adversely to the insurer, so long as there was substantial legal authority for the insurer’s position at the time of denial. The court also ruled that the jury’s $10 million award of punitive damages was clearly unjustified, as Zurich, in fact, reversed its denial only three months later, had paid all of the insured’s defense costs and ended up paying to settle the underlying case.

The Fourth District issued a further opinion on August 31 denying the insured’s petition for rehearing but reversing its earlier order awarding Zurich’s its costs for the appeal. In an unusual step, however, Justice Sills authored an unpublished 21 page Supplemental Opinion refuting each and every “fact” (with record references) that the insured had relied on in seeking rehearing.

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CALIFORNIA – Cancellation/Rescission

Defendant presented uncontested evidence that the policyholder failed to properly disclose that it was under a multi-year investigation for pollution by the County of Los Angeles resulting in part from discharges from its vehicles at the time it applied for the marine pollution insurance policies. Accordingly, the insurer was entitled to rescind its policy. (Pringle v. Water Quality Ins. Syndicate, (C.D.Cal., August 6, 2009)

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CALIFORNIA – Intervention

Plaintiff commenced personal injury action in 1994. In her original complaint, she alleged the Defendant was the lessee of real property and that the Plaintiff was helping the Defendant gather and sort cows and calves on the property. The Plaintiff was trying to keep a gate closed when a cow ran into the gate, taking the gate off of its hinges causing it to strike the Plaintiff and seriously injure her. Defendant’s insurance carrier denied coverage for the Plaintiff and refused to defend. The Plaintiff agreed not to execute any judgment against the Defendant in return for an assignment of the Defendant’s rights against his insurance company, Grange. After the Plaintiff could not get a judgment against Grange, the Plaintiff served judgment on the Defendant and Grange moved to intervene. The Supreme Court held that the issue here was whether an insurer may deny coverage and a defense to its policyholder when the policyholder is sued by an injured plaintiff, and later intervene in the action between the plaintiff and the policyholder. In response to this issue, the court found that the insurer had waived its opportunity to litigate fault or damages when it denies coverage and refuses to defend. Therefore, the court affirmed the Plaintiff’s motion to strike the insurer’s motion to intervene because the insurer had no direct interest in the litigation. (Hinton v. Beck)

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CALIFORNIA – Occurrence

After an assault and battery by the policyholder, the injured party sued, alleging that the policyholder had acted under the unreasonable belief of having to defend himself, an act that according to the injured party, fell within the policy’s coverage of “an accident”. The court disagreed and ruled that the insurer does not have a duty to defend the action. (Delgado v. Interinsurance Exchange of the Automobile Club of Southern California)

Richard J. Cohen
CALIFORNIA - Subrogation/"Made Whole" Doctrine

The California Supreme Court has ruled in 21st Century Ins. Co. v. Superior Court, S154790 (Cal. August 24, 2009) that the principle that an insurer’s right to reimbursement for sums recovered by a policyholder from third parties does not arise until the insured has itself been “made whole,” does not extend to attorney’s fees incurred by the insured in making those recoveries. Rather, the court ruled that the insurer only owes a pro rata share of the fees pursuant to the “common fund” rationale.

COLORADO – Occurrence

There was no duty to defend where the underlying complaint alleged knowing misrepresentation. The fact that there are titular negligence claims is irrelevant. (General Security Indemnity Co. of Arizona v. Century Surety Co.)

ILLINOIS - Privileges

In a declaratory action against an insurer, a trial court in Illinois imposed a monetary sanction after finding the insurer in contempt of court for refusing to produce documents containing communications between the insurer and its coverage counsel on the ground that they were protected by the attorney-client privilege. The appellate court reversed the order and remanded for further proceedings, holding that while the attorney-client privilege between an insurer and its coverage counsel is generally preserved, the court should conduct an in camera inspection to distinguish between privileged communications regarding coverage issues from non-privileged communications regarding the underlying litigation. (Illinois Emcasco Insurance Co. v. Nationwide Mutual Insurance Co.)
LOUISIANA – Policy Construction

A party is under an obligation to read a contract before signing it and will not as a general rule be heard to complain of an oral misrepresentation when the error would have been disclosed by reading the contract. A policyholder’s reliance on representations by an insurance agent that contradict the policy language is unreasonable. (Colony Ins. Co. v. Pearl River Basin Land & Development Co.)

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For a copy of the case: http://www.state.il.us/court/Opinions/AppellateCourt/2009/1stDistrict/August/1081625.pdf

MASSACHUSETTS - “Controlled Substance” Exclusion/Arising Out of

The Appeals Court has ruled in MPIUA v. Gallagher, No. 08-P-1301 (Mass. App. August 24, 2009) that an exclusion in a homeowner’s policy for injuries “arising out of the use, sale, manufacture, delivery, transfer or possession by any person of a Controlled Substance . . .” precluded a wrongful death action against a homeowner who was alleged to have negligently left prescription drugs in an area where the decedent could access them despite knowing of his fragile emotional state. Despite the fact that the Propoxyphene had been legitimately obtained by the insured pursuant to a prescription, the court held that the exclusion’s exception for “the legitimate use of prescription drugs by a person following the orders of a licensed physician” did not apply since it was the decedent’s own use of the drug that resulted in his suicide and any causal contribution by the insured was decidedly remote.

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MINNESOTA - Allocation/Pollution

A divided panel of the Minnesota Court of Appeals has ruled 2-1 that a trial court did not err in applying Minnesota law to clean up claims involving former manufactured gas plants in Wisconsin. In an unpublished opinion, the majority declared in St. Paul Mercury Insurance Co., et al. v. Northern States Power Co. d/b/a Xcel Energy Inc., No. A07-1775 (Minn. App. August 25, 2009) that under Minnesota’s “time on the risk” approach to allocation, the losses would not reach the insured’s excess layers. Writing in dissent, Judge Minge contended that Wisconsin law should have applied.
MONTANA – Bad Faith

The court held that plaintiff’s attorney fees and costs incurred in settling the underlying claim are not recoverable as an element of damages in a bad faith claim. An individual’s position as plaintiff in litigation will normally preclude application of the exception to the American Rule that a prevailing party in a lawsuit is not entitled to attorney fees absent a specific contractual provision or statutory grant. Additionally, plaintiff was not a party to the insurance contract, making the insurance exception to the American Rule inapplicable as well. (Jacobsen v. Allstate Ins. Co.)

NEVADA - Bad Faith

The court held that the covenant of good faith and fair dealing includes a duty to adequately inform the insured of settlement offers, including reasonable offers in excess of the policy limits. However, the insurer does not have a duty to file an interpleader action, nor is an insurer required to agree to a proposed stipulated judgment beyond the policy limits. (Allstate Ins. Co. v. Miller)

NEW JERSEY – Directors and Officers

The policyholder sought coverage under both primary and excess fiduciary liability policies for several suits against it relating to a stock-option plan. The suits alleged that the policyholder breached its contractual obligations relating to stock options in its acquisition of a company. In addition to liabilities arising out of breach of a fiduciary duty, the policies provided coverage for negligent acts in the administration of certain employee-benefit plans. The court held that the insurers were not obligated to provide a defense or coverage for the suits since they did not allege a negligent act in the administration of benefits, but rather a breach a contract. (AT&T Corp. v. Certain Underwriters at Lloyd’s London)
NEW YORK - Brokers and Agents

A party who has engaged a person to act as an insurance broker to procure adequate insurance is entitled to recover damages from the broker if the policy obtained does not cover a loss for which the broker contracted to provide insurance, and the insurance company refuses to cover the loss. Claims for breach of the duty of loyalty and breach of fiduciary duty were properly dismissed. What is involved here is a dispute between insureds and their broker over whether the broker failed to obtain coverage requested and whether the broker is liable for damages as a result of that failure. Without a special relationship, an agent or broker does not have a continuing duty to advise, guide or direct a client to obtain additional coverage. Likewise, a claim for punitive damages is dismissed, since they are not recoverable for an ordinary breach of contract or for ordinary negligence. (Bruckmann, Rosser, Sherrill & Co., L.P., v. Marsh USA, Inc.)

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NEW YORK - Brokers and Agents

Tully sued Marsh and Allied North America Insurance Brokerage (Allied). Marsh had been Tully's insurance broker, succeeded by Allied in May 2002.

In November 2000, an automobile collided with a parked backhoe owned by Tully, and both the owner and the operator of the automobile died from injuries sustained in the accident. Tully claims that in May 2001, it instructed Marsh to notify TIG Insurance Company, Tully's excess carrier of the accident but Marsh did not do so. Tully also claims that that Allied negligently failed to notify TIG of lawsuits that were commenced against Tully in 2002 by the estates of the owner and operator of the automobile. TIG ultimately disclaimed coverage on the ground that it was not notified of the accident until June 2004. In an earlier lawsuit, TIG was successful in sustained its disclaimer on late notice.

Marsh claimed that notice given in May 2001 would have been late anyway so that its failure to give notice when instructed caused no harm to the insured. However, the Appellate Division found that contrary to the finding of the lower court, Tully raised a triable issue of fact as to whether notice to TIG would have been timely if provided pursuant to Tully's May 9, 2001, request to Marsh that it provide such notice.

However, Allied demonstrated that Tully never requested that it notify TIG of the underlying lawsuits, so the claims against Allied are dismissed. (Tully Construction Co., Inc., v. Marsh USA, Inc.)
NEW YORK – Burden of Proof

In response to a medical provider’s claim for assigned, first-party no-fault benefits, the insurance company denied coverage on the ground that there was no covered “accident.” The insurer maintained that the alleged automobile accident was “staged” and, therefore, intentional. The Appellate Division, Second Department, affirmed the trial court’s finding of no coverage. The court reasoned that the insurer properly premised its defense upon a lack of coverage, which is proven by a “preponderance of the evidence” rather than by a “clear and convincing evidence” standard for fraud. The insurer was “not required to establish that the subject collision was the product of fraud,” merely that the collision was an “intentional occurrence” that put it outside the scope of the no-fault policy. (V.S. Med. Servs., P.C. v. Allstate Ins. Co.)

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NEW YORK – Exclusion/Water Damage

The plaintiffs’ in-ground swimming pool, which had been drained by a contractor hired to perform maintenance work, sustained damage after heavy rains fell in the area. Subsurface water pressure lifted the pool several inches out of the ground. The plaintiffs made a claim under their homeowners’ policy, and their insurer disclaimed coverage under an exclusion for loss caused “directly or indirectly” by “[w]ater damage, meaning . . . [w]ater below the surface of the ground, including water which exerts pressure on . . . a swimming pool or other structure.” Losses due to “water damage” were excluded “regardless of any other cause or event contributing” to the loss. The Appellate Division, Second Department, concluded that the exclusion applied, even through the subsurface water pressure was precipitated by the drainage of the pool and heavy rainfall. (Jahier v. Liberty Mut. Group)

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NEW YORK – Faulty Workmanship

The plaintiff, an excavation contractor, contended that its commercial general liability insurer was obligated to defend and to indemnify it in two actions arising from the plaintiff’s allegedly defective work. The insurer disclaimed coverage based upon the exclusion for damage to “that particular part of real property on which you . . . are performing operations . . . or [t]hat particular part of any property that must be restored, repaired or replaced because ‘your work’ was incorrectly performed on it.” The Appellate Division, Third Department, found that the causes of action for breach of contract, breach of
warranty and negligence were based upon allegedly faulty workmanship within the exclusion, stating that CGL policies are “never intended to provide indemnification to contractors from claims that their work product was defective.” (J. Lucarelli & Sons, Inc. v. Mountain Val. Indem. Co.)

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NEW YORK – Late Notice

The insured’s employee allegedly was injured in a construction accident. The insured learned of the injury within days but failed to notify its insurer for nearly 15 months; its excuse for the delay was that it believed that the employee intended to assert only a workers’ compensation claim. The Appellate Division, Fourth Department, found that the insured’s excuse was “unreasonable as a matter of law.” Moreover, the court concluded that the insurer provided the insured with timely written notice of its disclaimer given that it had issued its disclaimer letter upon completion of its investigation, 24 days after receiving the insured’s notice of claim. (Sevenson Envtl. Servs., Inc. v. Sirius Am. Ins. Co.)

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NEW YORK – Late Notice

The insurer was granted summary judgment in claimant’s declaratory judgment action seeking indemnification for the judgment secured against the policyholder. The court found a delay of nearly 22 months in providing notice of the claim by the policyholder was untimely as a matter of law. (Colon v. US Liability Ins. Group)

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NEW YORK – Late Notice

Insurer had no obligation to indemnify the plaintiff for payment of settlement monies in the underlying action because of policyholder’s late notice of the claim, which was given three years after the auto accident. (Key Bank U.S.A., N.A. v. Interboro Ins. Co.)

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NEW YORK – Partial Payments of Benefits

In 2006, plaintiffs’ presented a claim under their homeowners’ coverage for damage to their garage. Soon thereafter, the carrier paid the policy limit under the coverage for damage to “other structures” which the garage fell under. The policy limit under the other structures was the actual cash value of the loss.

Although plaintiff could have rebuilt, and submitted a claim for replacement cost, no such claim was ever presented. Rather, nearly one year later, plaintiffs’ commenced the present action alleging that the carrier had breached the terms of the homeowners’ agreement.

The carrier moved to dismiss on the basis that plaintiff’s acceptance of the ACV barred any future litigation. Although the trial court granted plaintiff’s application, the Second Department unanimously reversed by holding that the previous acceptance of coverage may serve as a set off of any award of future damages. However, acceptance of the ACV payment, in and of itself, does not bar plaintiff’s attempts to recover under the policy. (Hopper v. McCollum)

NEW YORK – Umbrella

Steely sought insurance coverage for a boating accident under a New York Central policy and an RLI umbrella policy. NY Central claimed that Steely owned the boat and denied coverage based on policy exclusion dealing with owned boats. RLI claimed that NY Central’s disclaimer was improper because Steely did NOT own the boat. It claimed that its coverage was excess over the NY Central policy.

The issue in the case is whether an excess carrier has the right to challenge a disclaimer by an underlying insurer. NY Central claimed that RLI did not have an interest in its policy so it lacked standing to challenge the disclaimer.

The Second Department found that the umbrella carrier did in fact have standing to challenge the denial of coverage by the primary insurer, even though it was not in “privity” with New York Central. RLI stands to benefit from the policy and thus has sufficient interest in it to challenge the coverage denial (RLI Insurance Company v. Steely)
OKLAHOMA – Completed Operations

The standard products-completed operations hazard exclusions are generally held to be unambiguous as a matter of law. The Tenth Circuit has held that a provision that applies when all the work is completed applies only when all the work has been completed. Therefore, the exclusion does not apply when the worker was injured while project was still in progress. (Orthopedic Resources, Inc. v. Nautilus Ins. Co.)

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OKLAHOMA – Occurrence

An intentional assault does not constitute an occurrence or accident within the terms of the policy even if it was negligent hiring, supervision or retention that created the potential for the assault. Even if negligent hiring or supervision was an occurrence, the claim for damages would be excluded under the “expected or intended injury” exclusion as the underlying complaint alleged that the policyholder knew or should have known of its employee’s penchant for sexually assaulting other workers. (Murchison v. Progressive Northern Ins. Co.)

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For a copy of the case: http://www.dri.org/dri/webdocs/committees/coveredevents/Murchison.pdf

PENNSYLVANIA – Bad Faith/Attorneys Fees

In Jurinko v. Medical Protective Co., NO. 03-CV-4053 (E.D. Pa. July 30, 2009), the district court was hearing motions over attorney’s fees awarded in a bad faith case. Years earlier, at trial, the jury had found bad faith, and the court awarded attorney’s fees based on the state law lodestar rule, and upheld the jury’s punitives award in a 4:1 ratio. The Third Circuit reduced the punitives to 1:1 and affirmed the attorney’s fees. The plaintiff’s effort to get more fees for post-trial motion work was rejected as untimely.
under the F.R.C.P., and his effort to get fees for appellate work should have been raised in the Third Circuit, under its local appellate rules, not the district court. The Court refused to reduce the attorney’s fees on the basis that punitives had been reduced on appeal, because those fees had been based on the lodestar method, not on the amount of punitives.

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PENNSYLVANIA – Summary Judgment

In Young Sook Pak v. Alea London Ltd., No. 08-CV-0824 (M.D. Pa. July 30, 2009), the U. S. District Court for the Middle District of Pennsylvania denied the insurers summary judgment on breach of contract and bad faith claims against them. There remained a coverage issue as to whether decay that caused a wall collapse was known to the insured prior to collapse. On bad faith, there were disputes of fact on whether the insurers and their various agents had investigated in bad faith by failing to fully interview the insureds, relying too much on their own expert and missing the portion of the policy that provided coverage for wall collapses in the denial letter sent to the insured.

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PENNSYLVANIA – Uninsured Motorists

In Wutz v. Smith and State Farm Insurance Company, No. GD07-021766 (Court of Common Pleas, Allegheny County Sept. 9, 2009) (Wettick, J.), this breach of contract and bad faith UIM case involved the issues of (1) staying discovery on a bad faith claim; and (2) delaying the bad faith trial in light of the late provided discovery. The Court found that State Farm should not be required to furnish discovery information on how it valued the UIM case, and the strengths and weaknesses of the UIM case, until after the breach of contract claim went to the jury. As soon as the case went to the jury, State Farm would have to provide that discovery. Once the jury returned its verdict, the trial court judge would then begin trying the bad faith claim. [It should be observed here that at this time, statutory bad faith claims go to juries in Pennsylvania’s federal courts, but are tried only by judges in Pennsylvania state courts.] If the plaintiff believes that it will not have time to prepare for the bad faith trial in light of the stay of discovery order, counsel should promptly file a Rule 213 motion to stay the bad faith trial. If the plaintiff fails to act until actually getting the discovery, the Court might still postpone the bad faith trial, but the plaintiff must offer compelling explanations (1) for not filing the Rule 213 motion after the order delaying discovery and (2) why the trial cannot proceed at that time.

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RHODE ISLAND – Exclusions

An insurer filed suit against its policyholder, a nightclub, and an additional insured, the owner and lessor of property on which the nightclub was located, seeking a declaration that it was not obligated to defend or indemnify them in an underlying action for personal injuries arising from a shooting at the nightclub. The insurer argued that the policy’s exclusion for assault and battery barred coverage. The policyholder and additional insured responded that the underlying complaint alleged negligence independent of the shooting—negligent parking lot design that delayed paramedics and caused the claimants’ injuries to worsen—and, therefore, that they were entitled to coverage. The court held that the assault and battery exclusion precluded coverage for the claim because the claimant’s injuries, while worsened by the parking lot design, were caused by the shooting. (Mount Vernon Fire Ins. Co. v. Stagebands, Inc.)

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For a copy of the case: http://www.rid.uscourts.gov/Opinions/Recent/07212009_1-08CV0224S_MOUNT_VERNON_FIRE_INSURANCE_COMPANY_V_STAGEBANDS_INC_P.pdf

SOUTH CAROLINA – CGL/Construction Defect Coverage/Occurrence

The South Carolina Supreme Court issued a 4-1 revised opinion in Auto-Owners v. Newman, Op. No. 26450,(S.C.Sup.Ct. re-filed September 8, 2009) (Shearouse Adv.Sh. No. 39 at 12), which retreats from some of the Court’s earlier broad holdings of coverage for general contractors. The Court held that a subcontractor’s negligence can result in an “occurrence” which triggers coverage for resulting “property damage.” It regarded the negligence of a subcontractor and the resulting property damages as “accidental” from the perspective of the general contractor. The Court also justified this result by stating that it gave effect to the subcontractor exception to the “your work” exclusion. However, it revised its earlier opinion which held that the costs to remove and replace the subcontractor’s faulty workmanship were covered and held that the “your work” exclusion prohibited coverage for such costs. Nevertheless, because the arbitrator had not specifically identified these costs, the Court held that the insurer had to pay the full arbitration award. In a dissenting opinion, Justice Pleicones stated that because the general contractor’s work product was the entire residence, there was no “occurrence,” only faulty workmanship which did not trigger the CGL policy.

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For a copy of this case: http://www.sccourts.org/opinions/displayOpinion.cfm?caseNo=26450

Auto exclusion is not applicable where the automobile simply provided the power for the instrument that ultimately caused the accident. (Mid-Continent v. Global Enercom Management, Inc.)

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TEXAS - Coverage B/"Advertising"

A federal district court has ruled in Continental Cas. Co. v. Consolidated Graphics, Inc., No. 4:08-CV-02383 (S.D. Tex. August 28, 2009) that claims that a former executive of the insured misappropriated trade secrets by stealing customer lists containing proprietary pricing information failed to trigger “personal and advertising injury” coverage under CGL policies. Judge Johnson ruled that the pricing information, which could include information about past promotions and sales activity, could be interpreted as involving an “advertising idea” since it involved a concept that is related to the promotion of a product to the public. However, the District Court held that there was no allegation that such information was used in the course of the insured’s advertising.

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TEXAS - Coverage B/Trademark Infringement

The insurer denied the policyholder’s tender for defense and indemnification for a trademark infringement claiming that it did not fall within the definition of personal and advertising injury within the policy. The court held that the definition of advertising does not include trademarks and therefore trademark infringement claims do not fall within the meaning of personal and advertising injury. Since the only allegations within the complaint involve trademark infringement, the insurer had no duty to defend and indemnify the policyholder. (America's Recommended Mailers Inc. v. Maryland Casualty Co.)

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TEXAS – Economic Loss

A purely economic loss does not trigger coverage or the duty to defend. If the underlying claim does not seek recovery for value lost but rather seeks recovery for value of investment, the claim is purely an economic claim and not within the scope of the insurance policy. (Daneshjou Daran, Inc. v. Truck Ins. Exchange)

Richard J. Cohen
TEXAS – Employee Exclusion

The policy’s employee exclusion does not exclude coverage for a worker hurt on the job regardless of whether he is classified as an employee of an independent contractor of an independent contractor or an independent contractor of an independent contractor. The employee exclusion only excludes coverage of employees or independent contractors for the policyholder and not all independent contractors. (Wellington Specialty Ins. Co. v. James Ling d/b/a Ranger Enterprises)

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TEXAS – Late Notice

Texas law provides that an insurer is prejudiced as a matter of law when the insurer, without notice or actual knowledge of suit, receives notice after entry of default judgment against the policyholder; and when the insurer receives notice of a default judgment against its policyholder after the judgment has become final and nonappealable. (Windham v. Assurance Co. of America)

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UTAH – Late Notice
Court held that where the policy is a claims-made policy, the court will not expand the scope of the policy’s coverage by adding a requirement that the insurer show prejudice before disclaiming for late notice.  (Westport Ins. v. Quinney)

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VERMONT – Excess/UM/UIM

Like most, if not all, states, Vermont has a mandatory un/underinsured motorist (UM/UIM) statute. It provides that “no policy insuring against liability arising out of the ownership, maintenance, or use of any motor vehicle may be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided therein” for the protection of an insured “from owners or operators of uninsured, underinsured, or hit-and-run motor vehicles. 23 V.S.A. § 941(a). Vermont’s statute further provides that an insured’s UM/UIM coverage limits will be the same as his/her liability limits, unless the insured directs otherwise. (Thus, if a motorist purchases insurance with liability coverage of $25,000/$50,000 (Vermont’s statutory minimum), he/she automatically acquires UM/UIM coverage in the same amount.) Because of this mandate, the Vermont Supreme Court has just held in Insurance Company of the State of Pennsylvania v. Johnson, 2009 VT 92 (Aug. 21, 2009), that any excess or umbrella policies issued in Vermont that provide coverage over an automobile liability policy also provide UM/UIM coverage in the amount of the excess/umbrella limits. The court noted that there is nothing in the language of the UM/UIM statute that limits its application to primary policies only. The excess/umbrella carriers argued that the Vermont legislature, in enacting the UM/UIM statute, did not intend for the UM/UIM mandate to apply to excess/umbrella policies. As evidence of this fact, the carriers pointed to the fact that there have been bills proposed in the legislature that would explicitly require UM/UIM coverage in excess/umbrella policies. But the court was not persuaded that this was evidence that the legislature had not already intended such coverage to be included in excess/umbrella policies.

It should be noted that there was a vigorous dissent by two of the five justices. The dissent made a strong case that the legislative history shows that the Vermont legislature had not intended for the UM/UIM mandate to apply to excess/umbrella policies.

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WASHINGTON – Policy Construction

Because the term “dwelling” in the policy is unambiguous, the court finds that the plaintiffs’ claim for loss of a building used for business purposes only is not covered by the policy, and defendants request for declaratory judgment on that issue was granted. (Grooms v. Liberty Mutual Fire Ins. Co.)

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WASHINGTON – Equitable Estoppel

A fire destroyed the City’s fire station, and subsequent to the last payment, the City informed the insurer that it believed it was entitled to further payments. The City failed to comply with the policy’s two year suit limitation condition, precluding further claims. Equitable estoppel did not apply even though the insurer encouraged the City to provide additional information and indicated a readiness to review additional information. (City of Ilwaco v. Affiliated FM Ins. Co.)

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WASHINGTON - “Occurrences”/Employee Theft

The Washington Court of Appeals has ruled in S&K Motors, Inc. v. Harco National Ins. Co., No. 62828-3-I (Wash. App. August 17, 2009) that a series of thefts committed by an employee of a car dealership involved a single “occurrence,” rejecting the insurer’s contention that losses suffered as a result of thefts occurring after the insured learned of the dishonesty should not be included in the calculation of the loss. While agreeing that the termination provision eliminated coverage for any thefts occurring after the insured learned of the dishonesty but elected to continue employing the worker, the full amount of the thefts should be taken into account in determining whether the partial recovery that the employer had obtained from the thieving employee had fully compensated it for its loss so as to preclude coverage.

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For a copy of the case: http://www.dri.org/dri/webdocs/committees/coveredevents/SK.pdf
WASHINGTON – Selective Tender

Plaintiff settled three asbestos bodily injury lawsuits and sought reimbursement for those settlements from its excess carrier. The excess carrier impleaded another insurer, claiming it failed to pay its allocable share. The court held that because of plaintiff's selective tender to that insurer under only one policy, it was excused from indemnifying plaintiff through other policies. (Weyerhaeuser Company v. Ins. Co. of the State of Pennsylvania)

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WASHINGTON – Self-insured Retention

The parties dispute the number of self insure retention payments that apply to a single construction occurrence spanning multiple policy periods. While plaintiffs contend that the policies specifically promised that they would never need to pay more than a $1 million SIR on any one claim, the policy language clearly states that plaintiffs are responsible for a new SIR for each annual period. (Polygon Northwest Co., LLC v. Steadfast Ins. Co.)

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WISCONSIN - “Known Loss”

The Wisconsin Court of Appeals has ruled in Obermeier v. Toonen, 2008 AP 2103 (Wis. App. August 18, 2009) that a suit by a neighboring property owner alleging that construction activity on the insured’s property was excluded from the policy’s insuring agreement as involving the “continuation, change or resumption” of property damage that had begun before the policy was issued and of which the insured had knowledge before the policy was issued. In this instance, the court found that the insured had received prior complaints from the property owner and had in fact taken steps to dig a ditch on the plaintiff’s property in an unsuccessful effort to remediate the problem. The Court of Appeals rejected the insured’s contention that the “property damage” was a subsequent decision by the Wisconsin Department of Natural Resources to delineate a portion of the plaintiff’s property as wetlands that occurred during West Bend’s policy period.
The Wisconsin Court of Appeals has ruled in Stewart v. Farmers Ins. Group, 2008 AP 1605 (Wis. App. August 25, 2009) that where a homeowner accepted a $5,000 offer of judgment to resolve its bad faith claims against Farmers, it was precluded from separately seeking taxable costs exceeding $46,000. The Court of Appeals declared that the offer of judgment encompassed the insured’s attorney’s fees and other compensatory damages that might have been recovered in the bad faith action.

Feature Articles

How hard is it really, to draft a car insurance policy? A commentary from In House Counsel.

by William T. Graden

In private practice, early in my career, I had occasion to review insurance policies for coverage opinions, most often Auto, but some commercial. It struck me that whoever wrote those policies must have enjoyed the torture of college English classes to come up with what seemed like arcane terms, twisted prose and sometimes even gobbledygook.

Which prompted the question that heads this article, is it really that hard to write an insurance policy? Why not use simple terms everyone can understand? Well, for those of you that have tried it, you understand the rhetorical nature of the questions. It is a lot harder than it seems. Even some great coverage attorneys that have tried their hand at it, found it quite challenging.

On top of this, is the general perception that insurance companies draft the policy, allegedly to “limit” coverage or to avoid it all together. The current political climate has fostered further insurance company bashing. But if an insurance company writes policy language designed to just deny coverage, it will not be in business very long. Lost in the current debate are personal responsibility, public policy and price.

An insurance company could draft a policy that covers everything and probably price it pretty accurately. Of course, no one would buy it because no one could afford it. The greater the demand for “coverage” by courts, legislators and the public – the greater the cost. So when a judge finds an
ambiguity and then coverage that was not contemplated by the company, there is a short term hit to that company’s bottom line – but there is a long term cost that ultimately gets passed onto the insurance consumer in the form of higher premiums.

As a matter of personal responsibility, the insured should have a stake in the outcome. There are deductibles and exclusions to discourage bad behavior. For example, a car policy generally does not cover mechanical failure – so the insured needs to perform routine maintenance on the car. It has been axiomatic that good public policy does not allow insurance coverage for intentional acts. Yet recent cases have found ways to expand coverage to those “liable” for the intentional acts of others. There are many more examples that I could recite, but you get the point.

Most states have statutory requirements regarding some aspects of car insurance. Even with “model” laws, the variation among states is incredible. A few states actually prescribe policy language. Quite a few require state approval of policy forms. Given these factors, the ability to draft a policy form is quite constrained, far more than most seem to realize. Once drafted, counsel and courts get their turn in arguing the meaning of terms like “the”, “that” and even “is”.

Two cases come to mind as examples. I need to overly simplify and gloss them a bit. The basic facts are, an adult child, not a resident relative or an insured, is killed in a motor vehicle accident. The parents had a wrongful death claim. The tortfeasor was uninsured. The parents made a claim for uninsured motorist benefits on their policy. In one case, no coverage. In another state with similar facts, law and policy language, coverage. (A car policy became a life insurance policy). This outcome creates a conundrum for in house counsel. Do you advise to change the policy language in one state? All states? Only those states where the language has not been (mis)interpreted? Leave the language and raise rates? Seek legislation to change the law? All or some of the above? The short answer is yes. There are significant costs associated with the process though. There is also a resource drain to legislatures updating and changing laws due to court decisions. It is a burden on the legal system as a whole because uncertainty and unpredictability foster more legal disputes (Full employment for lawyers too!)

For the attorney trying to counsel business units that draft and rate policies, this volatility and variability creates a challenge in giving advice. For an insurance company, there are these cost benefit considerations:

- Maintaining one policy form compared to multiple forms
- Training a work force on one form or many forms
- Predictable results compared to unpredictable outcomes in deciding on rates
- Issuing endorsements
- Paying claims not covered
- Not paying claims that are covered
- The ability to remain price competitive

A single case that results in coverage for a claim where it was not intended, based on the turn of a phrase, can add significant costs beyond that case. Yet this cost benefit analysis rarely, if ever, is found in the published opinion.

Hopefully, you have a little more insight into the challenges of drafting policy language than I had in my outside practice. Perhaps this cost/benefit analysis does not belong in legal briefs. Maybe it could be persuasive in oral argument. Perhaps it is best saved for discussion with judges and regulators generally. From my viewpoint today, too many are unaware of the significant impact a single “coverage” decision may have. The result can be bad public policy, higher costs to consumers, and it makes my
job harder. As our colleagues across the bar proclaim themselves “consumer advocates” that just want “coverage” for the consumer, they may just end up with that policy that covers everything, but that no one can afford.

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Seminar

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