

Commentary

2004: The Year's Ten Most Significant Insurance Coverage Decisions

4th Annual Insurance Coverage Hit Parade

By
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For the insurance industry, 2004 was the year of the hurricane — four in Florida: Charley, Frances, Ivan and Jeanne and one in New York: Eliot. The past year was certainly one in which more of the industry's news than usual received ink from publications that do not have the word *Insurance* in their title. Thankfully, the industry responded quickly to get houses in the Sunshine State, as well as its own, back in order.

Even the insurance coverage corner of the industry, normally ignored by the main stream press for being

inside-baseball, enjoyed a rare moment in the national spotlight in 2004 when New York juries were tasked with deciding the amount of coverage owed for the destruction of the World Trade Center. Many of the year's insurance coverage cases that didn't have \$3.5 billion and the future map of lower Manhattan riding on their outcome were also worth taking note. Even if fewer did.

I am once again grateful to *Mealey's Litigation Report: Insurance* for the opportunity to make the case for ten decisions from the year gone by that are likely to play a part in shaping the insurance coverage landscape in the years ahead. As stressed in prior editions of this commentary, there is nothing scientific or democratic about the method used to select these cases. It is an entirely subjective process, based generally on the following criteria. Each decision (i) is (for the most part) from a state supreme court or circuit court of appeal; (ii) addresses a coverage issue that has the potential to affect a large number of future claims; and (iii) either alters a previously held position or sheds light on a burgeoning issue.

The following were the ten most significant insurance coverage decisions in 2004 (listed in the order that they were decided):

- *Benjamin Moore & Co. v. Aetna Casualty & Surety Company* — Supreme Court of New Jersey applies another coat to *Owens-Illinois*. At issue — treatment of deductibles in the context of a continuous trigger and pro-rata allocation.

Insurer wins. And even the dissent provides a primer that insurers can applaud.

- *RJC Realty Holding Corp. v. Republic Franklin Insurance Company* — New York Court of Appeals issues a head-scratcher concerning the all-important insurance policy phrase “arising out of.”
- *Haynes v. Farmers Insurance Exchange* — California Supreme Court addresses its principle that ANY PROVISION THAT TAKES AWAY OR LIMITS COVERAGE REASONABLY EXPECTED BY AN INSURED MUST BE CONSPICUOUS, PLAIN AND CLEAR.
- *Aetna Health, Inc. v. Davila* and *CIGNA Healthcare of Texas, Inc. v. Calad* — In consolidated cases, the Supreme Court of the United States issues a unanimous and sweeping decision concerning the scope of ERISA pre-emption. The result: many state claims arising out of ERISA-regulated employee benefit plans, including for bad faith and malpractice, will remain precluded.
- *L-J, Inc. v. Bituminous Fire and Marine Insurance Company* — South Carolina Supreme Court eliminates a large hammer for policyholders in construction defect coverage disputes.
- *Minnesota Fire and Casualty Company v. Greenfield* — One justice of the Supreme Court of Pennsylvania provides a useful reminder to insurers on the importance of the “occurrence” requirement.
- *In re: The Wallace & Gale Company* — Good news for insurers — Fourth Circuit affirms that “once an operations claim, not always an operations claim.” Bad news for insurers — get ready for the “abandoned or unused materials” exception to the completed operations hazard.
- *Simonetti v. Selective Insurance Company* — New Jersey Appellate Division splits spores and continues a trend that mold can be both a “loss” and a “cause of loss.”
- *Royal Insurance Company v. Hartford* — Fifth Circuit addresses the “other insurance” clause.

As is often the case with this policy provision, what you see is not what you get.

- *Travelers Indemnity Company v. PCR Incorporated* — Supreme Court of Florida finds employer’s liability coverage for tort claims that satisfy — on an objective basis — the substantially certain prong of the intentional tort exception to the exclusive remedy of workers’ compensation.

The Ten Most Significant Insurance Coverage Decisions of 2004

Benjamin Moore & Co. v. Aetna Casualty & Surety Company, et al., 179 N.J. 87, 843 A.2d 1094 (2004).

In *Benjamin Moore*, the Supreme Court of New Jersey wrote the next chapter in its *Owens-Illinois* “How-to Guide:” Deductibles.

First, a brief recap of earlier lessons. In *Owens-Illinois, Inc. v. Admiral Insurance Company*, 650 A.2d 974 (N.J. 1994), the Supreme Court of New Jersey adopted a continuous trigger for purposes of progressive environmental damage. The fundamental premise of *Owens-Illinois* is that each year of progressive injury is an individual occurrence. The Supreme Court has remained German Shepard-loyal to its *Owens-Illinois* underpinning:

The multiple occurrence template is a matter of substance that is at the heart of *Owens-Illinois*. It is what triggers multiple policies, thus maximizing resources available for toxic tort cases. It is what encourages the purchase of insurance. It is what voids “other insurance” clauses. It is what makes “non-cumulation” clauses inapplicable. It is what requires a calculation of the loss that occurred during each policy period. It is our effort to regularize the essentially irregular progressive environmental damage case and make it amenable to disposition in accordance with the undertakings in the insurance contract.

Benjamin Moore at 1105.

Benjamin Moore sought coverage in connection with class action law suits alleging bodily injury and prop-

erty damage as a result of exposure to lead paint that it had distributed. Lumbermens Mutual Casualty Company issued five comprehensive general liability policies to Benjamin Moore covering the eleven year period from 1990 to 2001. Each policy contained a \$1,000,000 per occurrence limit and a deductible of \$250,000 or \$500,000 per occurrence.

Lumbermens sought a declaration that Benjamin Moore must satisfy the full amount of the per occurrence deductible in each triggered policy before coverage is owed. Benjamin Moore had other plans. It initially argued (before changing colors at oral argument and adopting the proposal of an *amicus* party) that deductibles in multiple-triggered policies should be prorated in accordance with the percentage of loss allocated to the policy under the *Owens-Illinois* allocation formula. Thus, since each policy was assigned a one-eleventh share of the loss under *Owens-Illinois*, Benjamin Moore sought to pay one-eleventh of each triggered deductible.

The Supreme Court disagreed. And it didn't break a sweat reaching its decision. On one level, the *Benjamin Moore* court's decision was methodical, making certain that it remained faithful to the underpinnings of *Owens-Illinois*. On another level, the *Benjamin Moore* court painted with a broader brush and rested on the adage that one can not have its cake and eat it too: "Benjamin Moore and CSR [an *amicus* party] cannot have it both ways. There is simply no principled basis to treat progressive environmental damage as separate occurrences in order to access insurance coverage but as a fractionalized single occurrence in determining the applicability of deductibles." *Benjamin Moore* at 1106.

Insureds purchase policies with deductibles that are directly related to their premiums, risking the possibility that the loss will be low and that the deductible will equal or exceed it. When that occurs, the insured gets exactly what it has bargained for. Sometimes, when losses are in parity with deductibles, the insurer receives the benefit of the bargain. But it is equally true that when a significant environmental loss occurs, *Owens-Illinois* gives the insured the limits of coverage of a series of policies that would not otherwise be available.

Id.

Policyholders, particularly in settlement discussions concerning long-tail claims that trigger multiple policy years, frequently approach deductibles with the attitude of: surely they *all* can't apply, otherwise there would be no coverage. Indeed, two justices of the New Jersey Supreme Court said just that in their dissent. *Benjamin Moore* provides a useful reminder that deductibles don't appear on liability policies by accident. "Deductibles constitute a bargained-for aspect of the insurance contract that affects the premiums the insured pays." *Id.*

It is ironic that policyholders are fond of advocating that certain terms of a policy should not apply because they were not bargained for, but, rather, presented to them by the insurer on a take-it-or-leave-it basis. Then, when an issue comes up concerning a provision that was undoubtedly bargained for — the deductible — somehow it shouldn't apply either.

Many policyholder counsel will likely shrug-off *Benjamin Moore* as a decision that is limited to pro-rata allocation states. They will likely remain secure in the knowledge that, when it comes to states that resolve allocation on a joint and several liability ("all sums") basis, deductibles will not saddle their clients with a significant portion of any loss. After all, the policyholder will be able to so-call "pick" one year to respond to its claim and, hence, limit its liability for deductibles to one.

While that may be so, there is still no reason why — even in a joint and several liability context — a policyholder should not be responsible for paying the full deductible in *each year*, if the limits of more than one year are required to satisfy the full extent of a loss. Even the dissent in *Benjamin Moore*, which could not have been more clear in its desire to find in the policyholder's favor — citing reasons of "enlightened public policy," "justice" and "fairness" — agreed.

In supporting the *amici* approach to the "number of deductibles" issue, the dissenters in *Benjamin Moore* provided the following illustration: a policyholder suffers a loss of \$2,500,000 as a result of environmental contamination spanning twenty years. A policy is in place in each year that provides \$1,000,000 in coverage, subject to a \$25,000 deductible. Under

the dissent's solution, since the policyholder needs three policy limits to satisfy the loss, it should only be responsible for a \$75,000 deductible — \$25,000 for each of the three responding policies. Then, the insurance payout of \$2,425,000 is divided equally over the twenty triggered policies. Thus, under an approach that the dissent characterizes as being based on a "joint and several and pro rata methodology," the policyholder still can not escape the reality that, to tap the limits of a policy, first requires full satisfaction of any corresponding deductible.

***RJC Realty Holding Corp. v. Republic Franklin Insurance Company, et al.*, 2 N.Y.3d 158, 808 N.E.2d 1263 (2004).**

RJC Realty was billed as an "expected or intended" case, but it was the court's handling — or lack thereof — of the all-important phrase "arising out of" that earned it a place on 2004's list of most significant insurance coverage decisions.¹

In *RJC Realty*, the New York Court of Appeals addressed coverage for a claim brought against a beauty salon/health spa alleging that an employee of the salon, a masseur, had improper sexual contact with a customer during the course of a massage. The plaintiff in the underlying action alleged that the salon was liable for negligently hiring and retaining the masseur and for failing to supervise his activities. At issue were the potential applicability of policy exclusions for "bodily injury' . . . expected or intended from the standpoint of the insured" and "bodily injury' . . . arising out of . . . body massage other than facial massage."

On the subject of the "expected or intended" exclusion, the court held that, "Since the masseur's actions here were not RJC's actions for purposes of the respondeat superior doctrine, they were 'unexpected, unusual and unforeseen' from RJC's point of view, and were not 'expected or intended' by RJC." *RJC Realty* at 1266. The ultimate outcome reached by New York's highest court concerning the "expected or intended" exclusion (and the "occurrence" issue), in the context of allegations of negligent hiring and supervision, is not unremarkable. It is one that many other courts around the country have reached.

The *RJC Realty* court next addressed the policy's exclusion for "bodily injury' . . . arising out of . . . body

massage other than facial massage." While acknowledging that it was a closer call than the "expected or intended" exclusion, the court nonetheless held that the "body massage" exclusion was inapplicable:

It is true that the alleged act for which the Harrisons sued RJC occurred during a body massage. The insurance policy, however, does not exclude coverage for all alleged conduct during a body massage, but only for "injury . . . arising out of . . . body massage." We think the words of the exclusion are most plausibly read to refer to a bruise or similar injury inflicted on the customer by a massage itself, not to the emotional or physical injury resulting from a sexual assault by a masseur. At least that is a reasonable reading of the words, and an exclusion in an insurance policy can negate coverage only where it is stated "in clear and unmistakable language [and] is subject to no other reasonable interpretation."

RJC Realty at 1266-1267 (citation omitted).

The New York Court of Appeals is known for brevity in its opinions. But this is one time when the court would have been well-served to use a second paragraph to analyze the issue. If it had, the court may not have ignored the fact that the exclusion applied to "bodily injury" (which the court acknowledged existed) *arising out of* body massage. The *RJC Realty* court overlooked its decision in *Mount Vernon Fire Insurance Company v. Creative Housing, Ltd., et al.*, 668 N.E.2d 404 (N.Y. 1996), holding that "arising out of" means "but for." "[I]f no underlying cause of action could exist but for the existence of the excluded activity or state of affairs, the exclusion applies and there is no coverage." *Incorporated Village of Cedarhurst v. Hanover Insurance Company*, 675 N.E.2d 822, 827 (N.Y. 1996) (Levine, J., dissenting) (citing *Mount Vernon, supra* and *U.S. Underwriters Ins. Co. v. Val-Blue Corp.*, 85 N.Y.2d 821).

If the *RJC Realty* court had followed its prior decision that "arising out of," as used in a policy exclusion, means "but for," it seems likely that the court would have had no choice but to conclude that the "body massage" exclusion applied to preclude coverage. After all, "but for" the body massage, the bodily

injury cause of action could not have existed. What's more, the court's conclusion that the exclusion refers to a bruise or similar injury inflicted on the customer by a massage itself, not to the emotional or physical injury resulting from a sexual assault by a masseur, is a curious one, considering that the policy specifically defined "bodily injury" to include "shock, mental anguish or mental injury." *RJC Realty* at 1264, n.2.²

By acknowledging that the "body massage" exclusion was a close call, the Court of Appeals may have been sending a message that it was not completely convinced of its decision, perhaps for the reasons described above. A desire to ensure compensation for an act of sexual abuse may have clouded the court's decision making. In other words, as Justice Hecht of the Supreme Court of Texas put it (incidentally, in what was the best insurance coverage quote that I saw all year): "I remain troubled by the way the Court goes about reading insurance policies, which we constantly reiterate must be interpreted and construed like other contracts, but which hardly ever are because courts approach them, not as neutral arbiters of words on a page, but in hopes there will be coverage." *Utica National Insurance Company v. American Indemnity Company, et al.*, 141 S.W.3d 198, 206 (Tex. 2004) (Hecht, J., dissenting).³

It remains to be seen if subsequent courts in New York, intent on finding coverage, but hamstrung by what should be a broad interpretation of the phrase "arising out of" in an exclusion, will follow *RJC Realty's* lead and simply ignore the coverage impediment.

***Haynes v. Farmers Insurance Exchange*, 32 Cal. 4th 1198, 89 P.3d 381 (2004).**

In *Haynes*, the Supreme Court of California set out to interpret a Farmers Insurance Exchange "E-Z Reader Car Policy." At issue was the extent of coverage available for injuries sustained by Joshua Haynes when he was riding as a passenger in a car driven by Christopher Morrow, which had been borrowed from William Gallahair, Farmers' insured. The policy provided bodily injury limits of liability of \$250,000 per person and \$500,000 per occurrence. However, the policy contained an endorsement that the limits of liability for a permissive user were only up to the minimum required limits of the state's Financial Responsibility Law (\$15,000 per person and \$30,000 per occurrence

for bodily injury). Morrow, having borrowed Gallahair's car, was a permissive user. Haynes, in an effort to recover more than the statutory minimum, sought to have the endorsement limiting the extent of coverage for a permissive user declared unenforceable. The California Supreme Court said, "Right this way."

At issue in *Haynes* was the principle under California law that "to be enforceable, any provision that takes away or limits coverage reasonably expected by an insured must be 'conspicuous, plain and clear.' Thus, any such limitation must be placed and printed so that it will attract the reader's attention. Such a provision also must be stated precisely and understandably, in words that are part of the working vocabulary of the average layperson." *Haynes* at 385 (citations omitted).

The Supreme Court undertook a painstaking analysis of the Farmers policy to determine if it satisfied the "conspicuous, plain and clear" standard. The court noted that the policy was 39 pages long and that the endorsement in question was located on the policy's 24th page. While listed on the declarations page, the endorsement was not designated by name, but, rather, a five digit alphanumeric entry (S9064 — the eighth such alphanumeric entry out of eleven listed). The court also pointed out that a "Dear Customer" letter included with the policy did not mention the permissive user limitation and nor did the "Index of Policy Provisions," which did include entries for "Coverage," "Exclusions," "Limits of Liability" and "Other Insurance," referencing page numbers for each.

The *Haynes* court determined that the Farmers E-Z Reader Car Policy was not E-Z enough. Concluding that the endorsement at issue did not meet the conspicuousness test, the court stated: "[N]othing on the declarations page alerts a reader to the fact that endorsement S9064 contains a paragraph limiting coverage for permissive users to amounts less than the policy coverages prominently displayed in specific dollar amounts on the same page." *Haynes* at 387. "[W]ithin endorsement S9064, the language of the permissive user limitation 'is not bolded, italicized, enlarged, underlined, in a different font, capitalized, boxed, set apart, or in any other way distinguished from the rest of the fine print.'" *Id.* (citations omitted).

The *Haynes* court also concluded that the permissive user limitation was not “plain and clear:”

Although the term “permissive user” appears in the title of the endorsement containing the limitation, the term is nowhere defined, neither in the policy nor the endorsement, for the average lay reader. While an attorney or an insurance professional likely could deduce from close examination of the entire document that permissive user refers to “an insured person, other than you, a family member or a listed driver” (the phrase that appears in the permissive user limitation itself) and, by cross-referencing to the definition of insured person in the liability section, that such an “insured person” is “Any person using your insured car” but not “Any person who uses a vehicle without having sufficient reason to believe that the use is with the owner’s permission,” the average lay reader encountering the term in the title of endorsement S9064 would not necessarily understand its significance.

Haynes at 390.

Finally, the *Haynes* court rejected Farmers’ argument that the permissive user limitation need not be conspicuous, plain and clear because it does not defeat the insured’s reasonable expectations. The court concluded that “even if an insured does not specifically seek out high limits of coverage for permissive users, he generally expects that any increase in liability limits will apply to everyone covered.” *Haynes* at 392. In support of this conclusion, the court noted that automobile insurers advertising on billboards at Interstate 880 South near the 23rd Avenue exit in Alameda and at 10th and Folsom Streets in San Francisco state “We Cover Your Friends Like We Cover You.” *Id.*, n.13.⁴ As a consolation prize, the *Haynes* court acknowledged that it did not quarrel with Farmers that “perfection in presentation is unattainable.” *Haynes* at 389.

There is nothing new about the rules articulated in *Haynes*. Indeed, the court cited a 1910 California Supreme Court case for the proposition that “It is a matter almost of common knowledge that a very small percentage of policy-holders are actually cognizant of the provisions of their policies The in-

sured usually confides implicitly in the agent securing the insurance, and it is only just and equitable that the company should be required to call specifically to the attention of the policy-holder such provisions as the one before us.” *Haynes* at 390, citing *Raulet v. Northwestern etc. Ins. Co.*, (1910) 157 Cal. 213, 230.

The difficulty presented by *Haynes*, and cases like it, is that there is inadequate notice provided to insurers whether a particular policy provision will satisfy the vague “conspicuous, plain and clear” requirement. For example, as noted by a dissenting justice in *Haynes*, “an exclusionary clause in the same size print and intensity as the rest of the policy and appearing under an appropriate heading was found conspicuous as a matter of law, even though it appeared 21 paragraphs after the insuring clause and was the last of eight exclusions.” *Haynes* at 394 (Baxter, J., dissenting) (citing *National Ins. Underwriters v. Carter*, 551 P.2d 362 (Cal. 1976). What’s more, asking after the loss has occurred whether the coverage at issue was “reasonably expected by an insured” is unlikely to produce any surprising answers.

Without any meaningful standard, the “conspicuous, plain and clear” requirement forces insurers to guess whether a particular policy provision will comply. It is only after one of them has guessed wrong, as in *Haynes*, do insurers get some instructions on how to make a policy provision pass muster in the future.

Before shrugging off *Haynes* as nothing more than a product of California’s ultra pro-consumer climate, consider that not long ago two justices of the Pennsylvania Supreme Court were prepared to rule similarly in an absolute pollution exclusion case. In *Wagner v. Erie Insurance Exchange*, 847 A.2d 1274 (Pa. 2004), the Pennsylvania Supreme Court affirmed the Superior Court that the absolute pollution exclusion applied to preclude coverage for clean-up costs incurred when the rupture of an underground pipe at a service station released gasoline into the soil and under neighboring properties. While the Supreme Court affirmed without opinion, Justice Nigro, with Justice Newman joining, was not prepared to go away so quietly. In a brief dissent, he stated the following:

I simply cannot accept the Superior Court’s position that an insurance company providing general liability coverage for an insured’s

operation of a gasoline station can deny coverage for damages from a gasoline leak based on a general pollution exclusion, when that exclusion is buried on page twenty-five of the policy and the policy's definition of "pollutant" does not specifically reference gasoline.

Wagner at 1275.

***Aetna Health, Inc., et al. v Julian Davila, et al. and CIGNA Healthcare of Texas, Inc. v. Calad*, 124 S. Ct. 2488 (2004).**

It is a rare event for an insurance coverage issue to reach the Supreme Court of the United States. One that does get an occasional glimpse of the high court's marbled-interior is ERISA. In *Davila* and *Calad* (consolidated cases and hereinafter referred to collectively as "*Davila*") the U.S. Supreme Court reaffirmed that a variety of state causes of action, including for bad faith and malpractice, arising out of ERISA-regulated employee benefit plans, are pre-empted by ERISA and removable to federal court.

Ironically, one of the cases arose when Julian Davila sued his HMO, Aetna Health, Inc., for its refusal to pay for Vioxx that had been prescribed by his treating physician for arthritis pain. Instead, Davila began taking Naprosyn, from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization. Ruby Calad was denied coverage by CIGNA for an extended hospital stay following surgery. She experienced post-surgery complications that forced her to return to the hospital. Calad alleged that these complications would not have occurred had CIGNA approved coverage for a longer hospital stay.

Davila and Calad each brought suit in a Texas state court arguing that their respective insurer's actions violated the Texas Health Care Liability Act's "duty to exercise ordinary care when making health care treatment decisions." The insurers removed the cases to federal district court, arguing that the causes of action were pre-empted by §502(a) of ERISA.

Justice Thomas, writing for a unanimous court, agreed with the insurers, holding that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts

with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila* at 2495. The court noted that "Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA §502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim." *Id.* at 2499-2500.

Counsel for managed care plans and health maintenance organizations no doubt view *Davila* as old news, on the basis that the court didn't tell them anything that they didn't already know from reading *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), which held as follows:

[T]he detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in §502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."

Davila at 2495, quoting *Pilot Life* at 54-56, quoting *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

It did not take long for *Davila's* impact to be felt around the country. In just the first six months since its issuance, *Davila* has been cited by virtually every circuit court of appeal, including no shortage of reversals tied directly to it. For example, in *Barber v. UNUM Life Insurance Company of America*, 383 F.3d 134 (3rd Cir. 2004), the court concluded that *Davila* compelled its decision that Pennsylvania's bad faith statute is subject to ERISA pre-emption. The *Barber*

court held that, because the statute is a state remedy that allows an ERISA-plan participant to recover punitive damages for bad faith conduct of its insurer, it supplements the scope of relief granted by ERISA, and, therefore, is subject to pre-emption. The *Barber* court also held that Pennsylvania's bad faith statute does not "regulate insurance" within the meaning of ERISA's saving clause. Another example of *Davila's* impact can be seen in *Cicco v. John Does 1-8*, 385 F.3d 156 (2nd Cir. 2004). Citing *Davila*, the court vacated its earlier opinion and held that the plaintiff's state malpractice claim was completely pre-empted by ERISA.

To be sure, ERISA is just a little more complex than the continuous trigger and a discussion of the full impact of *Davila* is well beyond the scope of this brief write-up. For more on *Davila's* potential consequences, albeit skewed toward the patient's perspective, see 118 *Harv. L. Rev.* 456, November 2004. For a less detailed, but more neutral, assessment of *Davila*, see Tanya Albert, "Lawsuits against health plans crumble in wake of Supreme Court ruling," *Amednews.com*, November 15, 2004.⁵

Many legal observers are calling it a lock that President Bush will be required to fill at least one seat on the United States Supreme Court during his second term. It is also a safe bet that, while the nomination process will include visceral debate between the right and left over a variety of issues, ERISA pre-emption will not be one of them. This actually makes little sense, since a decision concerning ERISA will likely have a tangible impact on more Americans than all of the cable news- and litmus test-worthy issues combined.⁶

***L-J, Inc., at al. v. Bituminous Fire and Marine Insurance Company*, 2004 S.C. LEXIS 190.**

There were scores of construction defect coverage decisions in 2004, including at least six from supreme courts,⁷ but none as significant as the Supreme Court of South Carolina's in *L-J, Inc., et al. v. Bituminous Fire and Marine Ins. Co.* In *L-J*, the court addressed coverage for the faulty workmanship of a contractor-insured that had been hired to perform site development work and construct roads for a subdivision. The work was completed in 1990. By 1994, the roads had begun to deteriorate.

The South Carolina Supreme Court noted that, according to the deposition testimony of witnesses, the only "occurrences" were various negligent acts by the insured during road design, preparation and construction that led to the premature deterioration of the roads. Reversing the court of appeals, the Supreme Court stated, "We find that all of these contributing factors are examples of faulty workmanship causing damage *to the roadway system only*, which does not fall within the contractual definition of 'occurrence' under Bituminous's CGL policy." *L-J* at *7 (italics in original). The court went on to explain that an accident causing bodily injury or property damage to another is the type of insurable loss contemplated by the CGL policy's definition of "occurrence." The court concluded:

We disagree with the court of appeals that the contractual definition of "occurrence" — "an accident, including continuous or repeated exposure to substantially the same general harmful conditions" — includes the road damage caused by continuous exposure to surface water runoff. In our view, the sole cause of the deterioration was the Contractor's faulty workmanship in designing and constructing the road system. That the roads were subject to surface water damage was not an "accident" as the court of appeals held. Rather, the damage was caused by the Contractor's negligently designed drainage system to handle the water runoff and failure to properly compact the road's subgrade.

L-J at *10.

Cases addressing whether faulty workmanship of a contractor-insured constitutes an "occurrence" under a CGL policy are not novel. However, while the issue has long been the subject of judicial opinions, it has become increasingly popular of late as construction defect coverage litigation has skyrocketed. And for as long as courts have been looking at the question, they have produced a variety of answers. Indeed, the Ninth Circuit recently concluded that there are at least four possible interpretations of the term "occurrence" under a CGL policy. *Southwest Metalsmiths, Inc. v. Lumbermens Mutual Casualty Company*, 2004 U.S. App. LEXIS 5734, **5, *withdrawn* by 2004 U.S. App. LEXIS 6391 (withdrawn on account of settlement).

Thus, on one hand, *L-J* could be viewed as just another case to weigh-in on the faulty workmanship — “occurrence” debate. However, *L-J* gets the nod as 2004’s most significant construction defect coverage decision for a different reason. Virtually all construction defect coverage cases have one thing in common — none provide coverage for damage to the insured’s *own work* — given the application of the CGL policy’s “your work” exclusion. That point is usually not in dispute in even the most acrimonious of construction defect coverage litigation.

The “your work” exclusion, however, is often subject to an exception that likely states “This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.” Policyholders frequently assert that, notwithstanding the “your work” exclusion, they are entitled to coverage for damage to their own work because it was performed by a subcontractor. The South Carolina Supreme Court in *L-J* did not see it that way. Having concluded that there was no “occurrence,” the Supreme Court determined that there was no need to address whether the damage at issue fell under the “subcontractor exception” to the “your work” exclusion.

Therein lies the significance of the South Carolina Supreme Court’s decision in *L-J*. The court provided a useful reminder that the “subcontractor exception” to the “your work” exclusion can not be used to restore coverage that did not exist in the first place because there was no “occurrence.” Indeed, the *L-J* court specifically wrote to reverse the court of appeals’ determination that an exception to an exclusion can “restore” coverage. “In stating that the exception to the exclusion ‘restores’ coverage, the court of appeals overlooks existing law, which states that ‘an exclusion does not provide coverage but limits coverage.’” *L-J* at *12-*13.⁸ *L-J* demonstrates that policyholders who immediately point to the “subcontractor exception” as a basis for coverage for damage to their own faulty workmanship are putting the cart ahead of the horse and must first establish that the damage at issue was caused by an “occurrence.” As it frequently is not, *L-J* eliminates the use of a popular policyholder tool in construction defect coverage disputes.⁹

***Minnesota Fire and Casualty Company v. Greenfield, et al.*, 855 A.2d 854, 2004 Pa. LEXIS 1926.**

An “expected or intended” exclusion typically appears in both homeowners and commercial general liability policies. There are also virtually unlimited factual scenarios in which its potential applicability can arise. The “expected or intended” exclusion is therefore at issue in a significant number of claims and, consequently, judicial opinions. For various reasons,¹⁰ when it comes to the “expected or intended” exclusion, insurers do not win as frequently as they believe they should. In *Greenfield*, one justice of the Supreme Court of Pennsylvania provided some useful, yet sometimes overlooked, advice on the issue.

Greenfield involved coverage under a homeowners policy for an insured that provided heroin to a houseguest. The guest voluntarily injected herself with heroin and died of an overdose. The decedent’s parents filed a wrongful death and survival action against the insured. The insurer filed an action seeking a declaratory judgment that it did not owe a defense or indemnity for the underlying complaint.

The Pennsylvania Superior Court concluded that, for two reasons, coverage was not owed. First, even though the insured may not have intended to cause the death, the known risks of heroin use make an adverse reaction an “expected occurrence.” In other words, the court applied the doctrine of “inferred intent,” “presumably for the reason that it was unable to establish *actual* intent, given the absence of allegations that Greenfield [the insured] expected or intended Smith [the decedent] to lose consciousness or die.” *Greenfield* at 863 (emphasis in original). Second, the public policy of the Commonwealth of Pennsylvania should preclude insurance for the sale of such a notoriously dangerous and illegal narcotic.

The Pennsylvania Supreme Court affirmed, but only for the reason that Pennsylvania public policy precludes insurance coverage for damages — even those unexpected or unintended — that arise out of an insured’s criminal acts with respect to a Schedule I controlled substance. The Supreme Court rejected the Pennsylvania Superior Court’s reliance on “inferred intent” as an additional basis to disclaim coverage, concluding that Pennsylvania’s jurisprudence does not support the extension of “inferred intent” to cases other than ones involving child sexual abuse. While the policyholder in *Greenfield* lost, Pennsylvania policyholders in general secured a significant victory when

the Supreme Court refused to extend the doctrine of "inferred intent" beyond its current application.

A concurring opinion by Justice Castille noted that there were narrower grounds than public policy for resolving the dispute, namely, "no 'occurrence.'" Indeed, the majority also made the observation that "no 'occurrence'" may have been an easier road for the insurer to take than "expected or intended," but concluded that the insurer failed to brief the position, instead choosing to rely on the "expected or intended" exclusion. *Greenfield* at 861, n.6. On this point, Justice Castille's concurring opinion stated as follows (as well as came to the insurer's counsel's rescue by pointing out that the insurer did adequately present the "no 'occurrence'" issue to the court):

[T]he homeowners' policy at issue here promises personal liability coverage for, *inter alia*, bodily injuries which are caused by a covered "occurrence." The policy then unambiguously defines an occurrence as "an accident" which results in bodily injury or property damage. The unfortunate teenage victim in this case, Angela Smith, did not trip down the stairs in Michael Greenfield's home, or fall upon a knife, or die in a fire. Rather, Smith and Greenfield engaged in a common, commercial transaction of a criminal nature, which just happened to occur in the home: Greenfield delivered heroin to Smith in exchange for a quantity of marijuana and, possibly, a small amount of cash. Smith then voluntarily injected herself with the heroin, thereby causing her own death from heroin intoxication. Greenfield did not inject Smith with the drug; instead, the basis for his liability was premised upon the simple fact of his delivering the narcotic to Smith, and her later dying from it while still in Greenfield's home. Whatever else Greenfield's delivery to Smith may have been, it was not an accident.

Greenfield at 870. "Following upon the heels of the intentional and illegal activities of both Greenfield and Smith, the fortuity of the fatal overdose, while tragic, can hardly fall into the category of a covered 'accident.'" *Id.*

In *Greenfield*, the insurer's decision (at least as the majority saw it) to pursue an "expected or intended"

defense, instead of arguing "no 'occurrence,'" was no harm-no foul, given the public policy rationale ultimately adopted by the court. However, another Pennsylvania decision from 2004 demonstrates that sometimes a court's failure to adequately consider "no 'occurrence'" as a defense to coverage can be consequential. In *Erie Insurance Exchange v. Muff, et al.*, 851 A.2d 919 (Pa. Super. 2004), the Pennsylvania Superior Court held that a babysitter's conviction for first degree murder of a one-year old girl in her care did not preclude coverage because the conviction did not conclusively establish her intent regarding certain negligent acts alleged in the complaint. You read that right — first degree murder conviction and coverage was not precluded.

In *Muff*, the argument was made that the babysitter was negligent, careless or reckless before and after she intentionally caused the death of the infant. Specifically, the babysitter allegedly dropped the infant twice and then failed to provide care to or summon assistance for the injured child. The Superior Court stated, in matter of fact fashion, that such allegations were sufficient to support a negligence action against the babysitter, and, thus, qualified as an "occurrence" or "accident" under the policy.

But were such allegations really an accident or occurrence? Justice Castille, based on his concurring opinion in *Greenfield*, may not have seen it that way. He noted that it was alleged that the insured was negligent for not caring for the overdose victim, presumably when there were signs of trouble caused by the heroin. While this was not pursued as a separate ground for limited relief, Justice Castille made clear that, even if it were, it wouldn't have affected the coverage outcome: "Greenfield's failure to inquire after Smith's condition or to seek assistance for her may have been indifferent, or even callous, but it was hardly 'accidental.'" *Greenfield* at 870, n.3. Thus, at least to the extent that *Muff* involved separate allegations of negligence on account of the babysitter's failure to summon assistance for the injured infant, the Superior Court may have erred by summarily concluding that such allegations qualified as an accident or occurrence.

The South Carolina Supreme Court's decision in *L-J* demonstrates that, in the construction defect context, policyholders sometimes overlook the critical

requirement of a CGL policy that bodily injury or property damage must be caused by an "occurrence." The Supreme Court of Pennsylvania's decision in *Greenfield* reveals that the "occurrence" requirement is sometimes overlooked in the "expected or intended" context as well.

***In re: The Wallace & Gale Company*, 385 F.3d 820 (4th Cir. 2004).**

As if the insurance industry's share of the total bill for asbestos claims wasn't large enough, about four years ago rumblings began that the situation was about to get a whole lot worse. The buzz — "operations" claims. Most plaintiffs in asbestos cases allege that their injury was caused by exposure to the defendant-insured's asbestos containing *product*. Hence, the claims are subject to the policy's "products" aggregate limit of liability. Thus, while the "products" bill for insurers may be significant, at least there is a cap. But what about when the plaintiff alleges exposure to asbestos being used by the defendant-insured during the course of its work involving installation activities. Under this scenario, many have predicted even more doom and gloom for insurers, given that such claims may not be for "products liability," but, rather, "operations," which typically are not subject to an aggregate limit.¹¹ In reality, the issue isn't all that new. See *M.H. Detrick Co. v. Century Indemnity Co.*, et al., 701 N.E.2d 156 (Ill. App. 1998) (Policyholder argued, unsuccessfully, in 1995 that the products aggregate limit of its policies was not exhausted because certain installation claims were improperly included in the calculation of the aggregate limit.)¹² It is only recently, however, that this issue has gained appreciation by a broader audience.

While much has been made of the potential liability of insurers for "operations" claims, judicial pronouncements addressing this issue are few and far between. For this reason, the Fourth Circuit's decision in *Wallace & Gale* caught the attention of many.¹³ In *Wallace & Gale*, the court addressed the "operations" issue under the following circumstances. From approximately 1930 to the early 1970s, Wallace & Gale supplied and installed asbestos containing insulation materials at various industrial and commercial buildings throughout Maryland. In the course of its work, Wallace & Gale personnel regularly cut asbestos materials, generating asbestos dust and other debris,

some of which was inhaled by individuals on-site, several of whom filed claims against Wallace & Gale for alleged asbestos-related diseases. *In re: The Wallace & Gale Company*, 275 B.R. 223, 228 (S.D. Md. 2002).

The *Wallace & Gale* court addressed the extent to which Wallace & Gale's operations fell within the "completed operations hazard," thereby subjecting such claims to aggregate limits in certain policies. The specific coverage issue before the court arose on account of the fact that, while plaintiffs were exposed to asbestos during the time of Wallace & Gale's installation work, their injuries also continued to occur even after Wallace & Gale's operations were completed. The plaintiffs argued that if their initial exposure to asbestos occurred during the time of Wallace & Gale's operations, then no portion of their claim can come within the "completed operations hazard," and be subject to an aggregate limit. The lower court sided with the insurers, holding as follows:

It remains true that asbestos-related injury can occur at any time from exposure onward and that it cannot be said with certainty when or to what extent it actually occurs. But whatever injury — theoretical or real — is assumed to have occurred after Wallace and Gale's operations were completed will always — by definition — be covered by the completed operations clause. The injury occurs after operations were completed. Nor does it matter whether an injury is viewed as occurring both upon initial exposure before operations are completed as well as thereafter. The portion of the injury extending beyond completion would still, by definition, occur post-operations and thus remain subject to the completed operations hazard aggregate limit.

Id. at 238. In simple terms, the *Wallace & Gale* court stated, "[C]ontrary to the argument of the intervenors — once an operations claim, not always an operations claim." *Id.* at 240.

The Fourth Circuit affirmed *Wallace & Gale's* lesson that, while asbestos claims against installers may not be subject to an aggregate cap for "products liability," that is not the only type of aggregate limit that may be available.

In *Wallace & Gale*, the Fourth Circuit gave the insurance industry some much needed good news on the “operations” front. Two commentators addressing *Wallace & Gale* recently noted that “[T]he straightforward application of the aggregate limit of liability for ‘completed operations’ will preclude any claim for additional coverage in most cases since installation operations involving asbestos generally ceased by no later than the early 1970s.”¹⁴ Given the paucity of courts that have examined the “operations” issue, it would not be surprising if *Wallace & Gale* becomes a model that is adopted by other courts and settling parties in this area.¹⁵

While *Wallace & Gale* is unquestionably good news for insurers, it is certainly not likely to be the last word on “non-products” claims either. *Wallace & Gale* did not reject unaggregated limits for some or some part of “operations” claims. It also did not speak to another type of “non-products” asbestos claim — “premises liability” (a discussion of which is beyond the scope of this brief summary). What’s more, at the same time that the Fourth Circuit handed insurers a significant victory in the “operations” battle, it may have also handed policyholders instructions for avoiding its own impact. While the *Wallace & Gale* court did not address the issue because it concluded that it was raised for the first time on appeal, it noted that an exception to the “completed operations hazard,” and, thus, an exception to the aggregate limit, applied to bodily injury arising out of abandoned or unused materials. Wouldn’t you know it, the plaintiffs were trying to argue that they incurred bodily injury as a result of inhaling asbestos that was abandoned during the installation process.

***Simonetti, et al. v. Selective Insurance Company, et al.*, 859 A.2d 694 (N.J. Super. App. Div. 2004), 2004 N.J. Super. LEXIS 384.**

Simonetti addresses first-party property coverage for mold caused by water intrusion into a residence following a heavy rainstorm — plain vanilla facts as far as mold coverage decisions go. By itself, the New Jersey Superior Court Appellate Division’s opinion would not have been chosen for discussion here. However, the rationale relied upon by the *Simonetti* court to reach its decision makes this coverage case one of the year’s most significant.

The insurer in *Simonetti* concluded that the water intrusion was caused by poor workmanship during the construction of the insured’s house. As such, the insurer disclaimed coverage for the mold damage on the basis of the following policy exclusions:

We do not insure, however, for loss:

2. Caused by:

. . .

e. Any of the following:

Wear and tear, marring, deterioration;
Inherent vice, latent defect, mechanical breakdown; Smog, rust or other corrosion, mold, wet or dry rot . . . []”

2. We do not insure for loss to property described in Coverages A and B caused by any of the following. However, any ensuring [sic] loss to property described in Coverage A and B not excluded or excepted in this policy is covered.

c. Faulty, inadequate or defective:

(1) Planning, zoning, development, surveying, siting;

(2) Design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction;

(3) Materials used in repair, construction, renovation or remodeling;

(4) Maintenance;

of part or all of any property whether on of [sic] off the “residence premises.”

The trial court upheld the disclaimer on the basis that the mold was caused by faulty construction, for which an exclusion existed in the policy. The New Jersey appeals court reversed, accepting the insured’s argument that “mold damage is covered in contrast to damage caused by mold.” Citing *Liristis v. American Family Mutual Ins. Co.*, 61 P.3d 22 (Ariz. App. Div. 2002), *review denied* 2003 Ariz. LEXIS 8, the court held as follows:

This distinction between mold damage and loss caused by mold is supported by the very language of Selective’s policy: “we do not insure, however, for loss caused by . . . mold . . .” (emphasis added). This language does

not exclude all mold. Rather, it excludes loss “caused by” or resulting from mold. The language clearly focuses on “cause” of the loss, conveying the intention to exclude mold as a cause of loss. But mold which is the loss is not mentioned. If Selective had intended to exclude not only losses caused by mold, but also mold itself, it could have easily expressed that intention.

Simonetti at *11-12. Thus, the court held that if the insured can prove that the mold resulted from a covered peril, then the cost of removing the mold is not a loss separate from, or caused by, the mold itself, but, rather, is within the coverage provided. *Simonetti* represents a continuation of what may be a developing trend in first party mold coverage — courts relying on the rationale adopted in *Liristis* that mold can be both a *loss* and a *cause of loss*.

To appreciate the significance of this rationale requires an understanding of how mold coverage cases frequently play out. In a typical mold coverage case, the policyholder argues that, notwithstanding the existence of a mold exclusion in the policy — and there usually is one, always has been — coverage is nonetheless available if the mold was caused by a “covered cause of loss.” This is known as the “efficient proximate cause” rule. Insurers often respond to this argument by noting that, notwithstanding the doctrine of efficient proximate cause, the existence of an anti-concurrent causation lead-in clause in the policy still defeats coverage. Such a clause would likely read as follows: “We do not cover loss to the property . . . resulting directly or indirectly from or caused by one or more of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss.”

In *Liristis*, the Arizona Court of Appeals concluded that, even in the face of an anti-concurrent causation lead-in clause, coverage was still potentially available if it could be determined that the mold was a “loss” and not a “cause of loss.” The *Liristis* court noted that, to exclude coverage for both losses caused by mold *and* mold itself, the insurer could have easily used language in its exclusion stating that no coverage exists for loss *either consisting of* or caused by mold.

Simonetti was not the first court outside of Arizona to take notice of the *Liristis* rationale. To the contrary, *Liristis* has been discussed, although not always accepted, by the Western District of Oklahoma, the Texas Court of Appeals, the Washington Court of Appeals and the Wisconsin Court of Appeals.¹⁶ If the *loss* versus *cause of loss* rationale adopted in *Liristis* continues to gain acceptance, some insurers may find that their normally reliable and water-tight anti-concurrent causation lead-in clauses are still not enough to relieve them from liability for certain property damage for which coverage was clearly never intended.¹⁷

***Royal Insurance Company of America v. Hartford Underwriters Insurance Company*, 2004 U.S. App. LEXIS 24070.**

The “other insurance” clause is frequently interpreted by courts in a manner that differs from its apparent plain meaning. Normally, when that happens, it escapes nobody’s notice — commentators write articles, Mealey’s develops a seminar and ISO thinks about tinkering. Yet, the “other insurance” clause gets nowhere near the attention that one would expect from such an enigmatic policy provision. This is probably the case because most “other insurance” clause disputes are *between insurers*. As such, the clause is a significant and controversial policy provision, but one that goes about its business in relative obscurity.

Dozens of cases were decided in 2004 addressing the “other insurance” clause. Many of them reached decisions that appear inconsistent with the seemingly clear language of the clause. For example, in *Hartford Casualty Insurance Company v. Executive Risk Specialty Insurance Company*, 2004 Tex. App. LEXIS 9542, the court declined to apply an excess “other insurance” clause in an E&O policy over a primary “other insurance” clause contained in a GL policy, concluding that, “The provisions of an ‘other insurance’ clause apply only when the ‘other’ insurance covers the same property and interest therein against the same risk in favor of the same party.” *Id.* at *5. However, it was the Fifth Circuit’s decision in *Royal v. Hartford* that did the best job of demonstrating that, when it comes to the “other insurance” clause, what you see is not always what you get.

Royal v. Hartford involved the apportionment of coverage for the settlement of an underlying action

involving nursing home liability. Hartford and Royal each issued policies to a health care facility, Riverside, that contained coverage parts for commercial general liability and professional liability. The CGL coverage parts were identical and their "other insurance" clauses afforded pro rata coverage. However, the Professional Liability coverage parts contained differing "other insurance" clauses. Royal's "other insurance" clause provided for pro rata coverage and Hartford's provided for excess coverage. Thus, if the claim was governed by the CGL coverage part, then the liability was clearly to be shared pro rata. However, if the liability was governed by the Professional Liability provisions, then each company's respective liability turned on the interpretation of the interrelationship between the "other insurance" clauses. The Fifth Circuit concluded that the underlying lawsuit implicated the Professional Liability coverage, and, hence, was required to address the "other insurance" provisions.

While the *Royal v. Hartford* court noted that an interpretation that Royal's "other insurance" clause, "by its own terms" is primary and that Hartford's clause, "by its own terms," is excess, is "plausible," it was contrary to controlling Fifth Circuit precedent. *Royal v. Hartford* at *9. Instead of applying the "other insurance" clauses *by their own terms*, the court was constrained to follow the Texas Supreme Court's decision in *Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch.*, 444 S.W.2d 583 (Tex. 1969), which announced the following rule concerning the interpretation of competing "other insurance" clauses:

When, from the point of view of the insured, she has coverage from either one of two policies but for the other, and each contains a provision which is reasonably subject to a construction that it conflicts with a provision in the other concurrent insurance, there is a conflict in the provisions.

Royal v. Hartford at *11, citing *Hardware Dealers* at 589. The court in *Hardware Dealers* had concluded that an escape "other insurance" clause versus an excess "other insurance" clause conflicted and apportioned liability pro rata between the two insurers.

The Fifth Circuit held that the fact that Hartford's policy contained an escape clause and Royal's con-

tained a pro rata clause did not distinguish the case from *Hardware Dealers*:

Viewed from the perspective of Riverside, the insured, one finds that Hartford provides coverage for the underlying suit if Royal's policy did not exist. Similarly, one sees that Royal provides full coverage for the underlying suit if Hartford's policy did not exist. A "reasonable construction" of the two policies from this perspective yields a conflict. Therefore, the substantive step of *Hardware Dealers* applies: both Royal and Hartford are liable proportionally, and both had a duty to defend Riverside.

Id. at *13. In a nutshell, the aversion that the Texas Supreme Court in *Hardware Dealers* had to giving effect to "other insurance" clauses was based on its conclusion that the insured still has a stake in the dispute between the competing insurers, even though the court noted that the insured is not permitted to lose anything in the fight, is hardly considered, unnamed and largely unheard. *Hardware Dealers* at 589.

Hardware Dealers is a 35 year old decision that was last cited by the Supreme Court of Texas 34 years ago (see *Allstate Ins. Co. v. Zellars*, 462 S.W.2d 550 (Tex. 1970)). Perhaps the time has come for the Texas Supreme Court to decide if the rationale of *Hardware Dealers*, which prevents insurers from handling disputes *among themselves* as they see fit, is still valid.

Disputes concerning the interpretation of competing "other insurance" clauses are difficult to predict. In *Royal v. Hartford*, the court noted that the interpretation that it declined to adopt was, nonetheless, "plausible." In another "other insurance" case from 2004, the South Dakota Supreme Court reversed a trial court's decision that competing "other insurance" clauses were mutually repugnant, but not before stating that the lower court's decision was "not unreasonable." See *National Farmers Union Property and Casualty Company v. Farm and City Insurance Company*, 2004 S.D. LEXIS 195.

***Travelers Indemnity Company v. PCR Incorporated, et al.*, 2004 Fla. LEXIS 2243.**

In *Travelers v. PCR*, the Supreme Court of Florida addressed employer's liability coverage arising out of its

prior decision in *Turner v. PCR, Inc.*, 754 So. 2d 683 (Fla. 2000). In *Turner*, Florida's high court expanded the substantial-certainty method for satisfying the intentional tort exception to the exclusive remedy provision of the Workers' Compensation Law. The *Turner* court held that satisfaction of "substantial-certainty" calls for an objective inquiry: "[T]he relevant question is not whether the employer actually knew that its conduct was substantially certain to result in injury or death but, rather, whether the employer should have known that its conduct was substantially certain to result in injury or death." *Travelers v. PCR* at *6, citing *Turner* at 688.¹⁸ At issue in *Turner* were claims for damages by PCR employees that had been killed and seriously injured in an explosion at PCR's chemical plant.

After the Florida Supreme Court's decision in *Turner*, Travelers brought a declaratory judgment action to determine whether it was obligated under Part Two of a Workers Compensation and Employer's Liability Policy to defend or indemnify PCR against the claims brought in the underlying tort suits. The specific issue before the Supreme Court in *Travelers v. PCR* was as follows:

[D]oes an employer's liability insurance policy, which provides coverage for "bodily injury by accident" and excludes from coverage "injuries intentionally caused" by the insured, extend coverage to a claim brought under *Turner's* objectively-substantially-certain standard, where the injured employee does not allege that the employer actually intended to cause injury.

Travelers v. PCR at *11-*12.

In a tedious decision, the Florida Supreme Court held that Part Two of Travelers' Workers Compensation and Employer's Liability policy extends coverage to a claim brought against PCR under the objectively-substantially-certain standard articulated in *Turner*. The court put itself through three hoops to reach this decision.

First, the court rejected Travelers' argument that the underlying claims, by virtue of the fact that they are not barred by the exclusive remedy provision of workers compensation, are not, by definition, claims for "bodily injury by accident," and, hence, are not

covered under the policy. The court concluded that Travelers' reliance on *State Farm v. CTC Development Corp.*, 720 So. 2d 1072 (Fla. 1998) was misplaced. There, the court extended the definition of "accident" to include damages resulting from intentional or volitional acts as long as the insured actor neither intended nor expected the resulting damages. In other words, *CTC Development* evaluated intent or expectation from the insured's subjective point of view. However, under *Turner*, an injured employee only needs to demonstrate that his or her employer should have expected that injury would result. The *Travelers v. PCR* court held as follows:

[U]nder *Turner*, an injured employee only needs to demonstrate that his or her employer should have expected that injury would result. At the least, therefore, the policy's "by accident" coverage clause, if interpreted in accordance with our *CTC Development* definition, would provide coverage for a *Turner* claim unless the injured employee demonstrated that the insured employer actually expected (with expectation measured to the degree of substantial certainty) that its conduct would result in injury. Interpreting the coverage clause in this way probably would preclude coverage of a claim brought under the newly enacted, virtual-certainty standard, but it does not, as a matter of law, preclude coverage under the more liberal, objectively-substantially-certain standard articulated in *Turner*.

Travelers v. PCR at *26.

Second, the *Travelers v. PCR* court turned to the potential applicability of the exclusionary clause, holding that, for it to apply, the insured must have acted with the specific intent to cause injury. Lastly, the court concluded that public policy does not prohibit an employer from insuring against the risk of liability arising under *Turner's* objectively-substantially-certain standard.

There is no denying that the potential impact of *Travelers v. PCR* was significantly diminished when the Florida legislature adopted a "virtually-certain" standard in place of *Turner's* "substantially-certain" standard for purposes of the intentional-tort excep-

tion to the exclusive remedy provision of the workers' compensation law (see note 18).

Nonetheless, as recently noted by the Supreme Court of Vermont, a growing number of jurisdictions have broadened the definition of specific intent to include instances where the employer not only intends to injure the worker, but engages in conduct with knowledge that it is substantially certain to cause injury or death. *Mead v. Western Slate, Inc., et al.*, 848 A.2d 257, 261 (Vt. 2004).

While "substantial certainty" is a relaxed intent standard, it nonetheless remains a difficult one to meet, especially without the benefit of *Turner's* objective standard. No doubt plaintiffs' lawyers think long and hard before agreeing to take a case, on a contingency fee, in which they are required to prove an employer's conduct that has been described as: "just below the most aggravated conduct where the actor intends to injure the victim," "more than mere knowledge and appreciation of a risk," and "beyond gross negligence." *Id.* (citations omitted).

However, if courts see the Florida Supreme Court's decision in *Travelers v. PCR* as a means to provide insurance for claims that satisfy the intentional tort exception to the exclusive remedy provision of workers' compensation on an objectively-substantially-certain basis, they may be inclined to consider following *Turner's* lead and adopt such an objective test for their already existing substantial certainty standard.

Endnotes

1. For a discussion of the "expected or intended" aspect of *RJC Realty*, written between the time of oral argument and the issuance of the opinion, see Evan H. Crinick, "Insurance Coverage for Sexual Assaults at Issue Before Top Court," *Mealey's Emerging Insurance Disputes*, February 17, 2004, at 29.
2. "Arising out of" is a common and often outcome determinative phrase used in insurance policies. To cite just a few examples from 2004, the Fifth Circuit relied upon the phrase "arising out of" to preclude coverage under a pollution exclusion contained in a director's and officer's policy for securities and derivative suits that, it was argued, were unrelated to pollution. See *National Union Fire Ins. Co. v. U.S. Liquids, Inc.*, 88 Fed. Appx. 725 (5th Cir. 2004). The Texas Supreme Court relied upon the absence of the phrase "arising out of" to conclude that a general liability insurer was obligated to provide a defense for a claim that the insurer believed fell within its professional liability exclusion. See *Utica National Insurance Company v. American Indemnity Company, et al.*, 141 S.W.3d 198 (Tex. 2004). And dissatisfaction with courts' interpretation of the phrase "arising out of" was at the heart of the Insurance Services Office's decision to amend its additional insured endorsements effective July 1, 2004.
3. Justice Nathan Hecht's opinions should not be missed by anyone who appreciates entertaining legal writing, even if they do not agree with them.
4. Last year's Top Ten Coverage Cases article noted that in *Mackinnon v. Truck Insurance Exchange*, the California Supreme Court turned to the *Chicago Sun-Times*, *Los Angeles Times*, *San Diego Union-Tribune*, *San Francisco Chronicle* and National Public Radio's "All Things Considered" for assistance in defining the terms "discharge" and "dispersal" as used in the pollution exclusion. Once again the California Supreme Court left no stone unturned in its source material to reach a decision.
5. *Amednews.com* is sub-titled "The Newspaper for America's Physicians."
6. I am grateful to firm partner Elizabeth Venditta, an ERISA authority and co-editor of the *ERISALaw Case Digest*, for having the patience to discuss *Davila* with an ERISA-novice such as myself.
7. In addition to the Supreme Court of South Carolina's decision in *L-J*, construction defect coverage issues were addressed by the following Supreme Courts in 2004: *American Family Mutual Insurance Company v. American Girl, Inc., et al.*, 673 N.W.2d 65 (Wisc. 2004); *Wanzek Construction, Inc. v. Employers Insurance of Wausau*, 679 N.W.2d 322 (Minn. 2004); *Auto-Owners Insurance Company v. Home Pride Companies, Inc., et al.*, 684 N.W.2d 571 (Neb. 2004); *Grinnell Mutual Reinsurance Company v. Lynne, et al.*, 686 N.W.2d 118 (N.D. 2004); and

United National Insurance Company, et al. v. Frontier Insurance Company, et al., 2004 Nev. LEXIS 103.

8. *L-J* was not the only Supreme Court in 2004 to make this observation concerning the “subcontractor exception” to the “your work” exclusion:

As an initial matter, we note that Home Pride appears to argue that coverage exists because the policy contains a subcontractor exception to the “your work,” or “I,” exclusion found in section 2. We disagree. The provision Home Pride relies on is merely an exception to an exclusion and, therefore, incapable of providing coverage. Stated otherwise, the exception contained within exclusion “I” is irrelevant until two conditions precedent are met: (1) There is an initial grant of coverage and (2) exclusion “I” operates to preclude coverage. *If, and only if, these two conditions are met may the subcontractor exception to the exclusion be applicable.*

Auto-Owners Insurance Company v. Home Pride Companies, Inc., et al., 684 N.W.2d 571, 575 - 576 (Neb. 2004). See also *Amerisure, Inc. v. Wurster Construction Co., Inc.*, 2004 Ind. App. LEXIS 2460, *16 (“In simplistic terms, the process is such: if the insuring clause does not extend coverage, one need look no further. If coverage exists, exclusions must then be considered. If an exclusion excludes coverage, an exception to the exclusion may re-grant coverage. However, the entire process must begin with an initial grant of coverage via the insuring clause; otherwise, no further consideration is necessary. Therefore, in the present case, we do not address any arguments regarding exclusions or exceptions to exclusions because here there is no initial coverage due to the lack of ‘property damage’ and an ‘occurrence.’”)

9. For a discussion of why *L-J* was wrongly decided, see Patrick J. Wielinski, “Sore Knees: Recent Case Law Ignoring the Subcontractor Exception,” *IRMI Expert Commentary*, November 2004 (available at www.irmi.com).
10. In simple terms, “expected or intended” is an “easier said than done” exclusion for insurers on account of the adoption by many courts of a *subjective* standard for determining whether the bodily injury or property damage was *expected or intended* by the insured.

11. Consider what Standard & Poor’s had to say about this in an August 1, 2001 report on asbestos:

Today, an increasing number of asbestos claims related to installation activities are being filed under the premise or operations section of the general liability policy. Unlike product policies, these policies typically have no aggregate limit and unlimited defense cost. The potential cost to the insurance industry is apparent.

Matthew T. Coyle, “Asbestos Claims Pose Significant But Not Catastrophic Threat to U.S. Insurers,” Standard & Poor’s Insurance Commentary, August 1, 2001. As *Wallace & Gale* demonstrates, the potential cost to the insurance industry for operations claims wasn’t so unaggregated after all.

12. See also *Fibreboard Corporation v. Hartford Accident and Indemnity Company*, 16 Cal. App. 4th 492 (1993).
13. The Fourth Circuit’s discussion in *Wallace & Gale* of the “operations” issue was brief. For a fuller explanation and appreciation of the issue, see the lower court’s decision at 275 B.R. 223 (S.D. Md. 2002). That opinion is used herein to discuss the case. The Fourth Circuit in *Wallace & Gale* also adopted pro rata time on the risk allocation, a somewhat unremarkable aspect of the case given that the court was simply following *Mayor and City Council of Baltimore v. Utica Mutual Insurance Co.*, 802 A.2d 1070 (Md. App. 2002).
14. Tancred V. Schiavoni and Gerald A. Stein, “The Fourth Circuit Re-Installs Limits on Coverage for Asbestos Personal Injuries,” *Mealey’s Litigation Report: Insurance*, October 26, 2004, at 19.
15. *Id.* at 20 (“The Fourth Circuit’s well-reasoned decision should guide other courts and decision-makers in evaluating claims that policyholders are entitled to unlimited insurance coverage for asbestos-related bodily injury claims. *** In considering the bigger picture, the Fourth Circuit’s decision is also significant because it is one of the few reported decisions that addresses a topic that has otherwise been the subject of mostly theory and speculation.”)
16. See *Kelly v. Farmers Insurance Company*, 281 F. Supp. 2d 1290 (W.D. Okla. 2003); *DeLaurentis v.*

- United Services Automobile Association*, 2004 Tex. App. LEXIS 8758; *Wright v. Safeco Insurance Company of America*, 2004 Wash. App. LEXIS 2176; and *Vvalther v. American Family Insurance Company*, 673 N.W.2d 412 (Wis. App. 2003).
17. Another note-worthy mold coverage decision from 2004 was *Fiess v. State Farm Lloyds*, 2004 U.S. App. LEXIS 25134. This was a closely watched case interpreting an “ensuing loss” provision under Texas law. It is not everyday that a homeowners claim involving relatively few dollars captures the attention of five *amicus* parties. At issue — whether an “ensuing loss” provision extends coverage for mold resulting or ensuing from covered water damage. The Fifth Circuit’s decision came without an answer. As a further testament to the significance of the issue, the court certified the question to the Supreme Court of Texas.
 18. Subsequent to the Supreme Court of Florida’s decision in *Turner*, the Florida legislature modified the standard to the intentional-tort exception to the exclusive remedy provision of the workers’ compensation law to provide as follows: proof by clear and convincing evidence that the employer deliberately intended to injure the employee or that the employer engaged in conduct that the employer knew, based on prior similar accidents or on explicit warnings specifically identifying a known danger, was virtually certain to result in injury or death to the employee, and the employee was not aware of the risk because the danger was not apparent and the employer deliberately concealed or misrepresented the danger so as to prevent the employee from exercising informed judgment about whether to perform the work. *Travelers v. PCR* at *7, n.5, citing §440.11(1)(b)(2), Fla. Stat. (2003). ■