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Endurance Coverage 2010: The Year's Ten Most Significant Insurance Decisions Reaches The Decade Mark

3rd Annual Coverage For Dummies, Et Al.

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Commentary

Endurance Coverage 2010: The Year's Ten Most Significant Insurance Decisions Reaches The Decade Mark

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[Editor's Note: Randy J. Maniloff is a Partner in the Business Insurance Practice Group at White and Williams, LLP in Philadelphia. He concentrates his practice in the representation of insurers in coverage disputes over various types of claims. He writes frequently on insurance coverage topics for a variety of industry publications (including, for the tenth time, this review for Mealey's Litigation Report: Insurance of the year's ten most significant insurance coverage decisions). Maniloff's views on coverage issues have been quoted by numerous media including The Wall Street Journal, The New York Times, USA Today, Associated Press, Dow Jones Newswires, The Philadelphia Inquirer, The Times-Picayune and The National Law Journal. In January Maniloff will publish "General Liability Insurance Coverage: Key Issues In Every State," a book addressing the law in all 50 states on twenty key liability insurance coverage issues (Oxford University Press). (Co-authored with Professor Jeffrey Stempel of the University of Nevada Las Vegas Boyd School of Law).

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All uses of the first person are references to Maniloff. The views expressed herein are solely those of the authors and not necessarily those of White and Williams or its clients.

A sullen-faced man walks up to the counter of a flower shop. By his expression, the clerk is expecting to take an order for a funeral arrangement. But he quickly learns that he was wrong when the man asks to have a large bouquet of flowers sent to his wife for their anniversary. "And when would you like to have this delivered?" the clerk asked. "Yesterday," the customer replied.

The Year's Ten Most Significant Insurance Coverage Decisions is celebrating its 10th anniversary. That is cause for celebration. After all, think of all the much more important things — in insurance and elsewhere — that never make it to ten years. There's third-party bad faith in California (nine years), the impact of *Montrose's* "known loss" rule (six years) and The Brady Bunch (five years).

Admittedly there were times I doubted that the Top Ten would make it this long. The seven year itch was a particularly rough patch. But the ship was righted to allow this day to arrive.

I checked to see what the traditional symbolic anniversary gift is for this achievement and discovered

that it was, well, not exactly what I had been expecting. I thought ten was the silver anniversary. Or at least crystal or maybe ivory. Boy, I wasn't even close. It turns out that silver is twenty-five (twenty-five!?) and ten is tin. Huh? Say that again. Ten years of following coverage cases on a daily basis, to be able to select the ten each year that mattered most, followed by slogging through drafting the article — much of it over the Thanksgiving weekend, when I could have been shopping at Best Buy at 3 AM — and that's all ten gets you. Lousy stinkin' tin! I wish I had known this sooner. I could have bought my wife a roll of Reynolds Wrap for our anniversary.

But the Coverage Top 10 has endured for one reason — people tell me that they read and enjoy it. [Here comes the soppy part.] The feedback and kind words that readers have provided over these years is what has kept this series going. Without such encouragement I would have stopped it long ago. To the readers of this annual insurance coverage best-of: thank you for your support.

Coverage For Dummies, Et Al.

Reading a lot of insurance coverage cases makes you realize that some people do really dumb stuff. Their shocking behavior causes injury and not long after a lawsuit is filed against them. The tomfool then makes an insurance claim. Actually, at least making an effort to pass the buck for their stupidity is the only intelligence that these people demonstrate. For the past two years, the annual insurance coverage hit parade has included a special report — "Coverage for Dummies." Dummies has been a look at several examples from the year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain.

But the entertainment value of coverage cases isn't limited to this window into the world of the common-sense challenged. Coverage cases are full of all sorts of interesting observations. While perhaps not important or relevant to anything, when has that ever stopped lots of things from being published? So this year's Dummies will include a hodgepodge of random observations from coverage decisions in 2010 that, while unimportant, are just too interesting to go unnoticed. In no particular order, here is Coverage for Dummies 2010 n/k/a Coverage for Dummies, *et al.*:

1. Do you want mustard with that construction defect coverage decision? *See Oregon Mut. Ins. Co. v. Ham & Rye, LLC*, No. C10-579, 2010 U.S. Dist. LEXIS 70774 (W.D. Wash. July 14, 2010).

2. Patron of the Finger Rock Bar was standing near a door when it flew open, slammed against his left hand and broke his, get this…finger. *See Eaton v. United America Ins. Group*, 685 F. Supp. 2d 154 (D. Maine 2010), *affirmed* 2010 U.S. App. LEXIS 24049 (1st Cir. Nov. 23, 2010).

3. What not to allegedly do at a little league game — sit behind home plate, in the lowest row of the bleachers, and tell the catcher, who is *someone else's* son, that he is making too many mistakes. And especially don't do it six or seven times in one inning. And doubly especially don't do it if you need a cane to walk. *See Baggett v. Allstate Ins. Co.*, 39 So. 3d 666 (La. Ct. App. 2010).

4. What else not to allegedly do at a little league game, in particular when you are the league president — assault a spectator causing multiple facial fractures, including a broken nose, septum and permanent nerve damage. And in particular avoid doing this when the spectator is Grandmom Nellie — a player's nana. *See Nellie Ellison v. Kentucky Farm Bureau Mut. Ins. Co.*, No. 2009-CA-116, 2010 Ky. App. Unpub. LEXIS 567 (Ky. App. Ct. July 9, 2010).

5. You wouldn't think there was a risk of getting stabbed at a bar called Daiquiris & Creams. Would you like one of those little umbrellas with your flesh wound? *See Fouquet v. Daiquiris & Creams of Mandeville, LLC (Colony Ins. Co.)*, __ So. 3d __ (La. Ct. App. 2010).

6. How much pain can you endure? You don't know. Well then I'll just shoot you in the wrist and we'll find out. *See Auto Club Group Ins. Co. v. Booth*, __ N.W.2d __ (Mich. Ct. App. 2010).

7. Pollution exclusion does not apply to odors emanating from the "King of Sturgeon's" delicatessen. In support of its opinion the court noted that, according to Zagat's restaurant guide, "[t]he smells alone are worth the price of admission." *See Greengrass v. Lumbermans Mut. Cas. Co.*, No.

09 Civ. 7697, 2010 U.S. Dist. LEXIS 76781 (S.D.N.Y. July 27, 2010).

8. Whatever you do, do not try to return something to Walgreens without a receipt. Trust me or *see Benham v. S & J Security & Investigation, Inc.*, No. B207420, 2010 Cal. App. Unpub. LEXIS 1616 (Cal. Ct. App. Mar. 8, 2010) (addressing coverage issues, among others).

9. What not to say in a letter of recommendation for an anesthesiologist whom you fired after suspecting that he was diverting demerol for personal use and whom you found passed out in the break room from taking valium: an "excellent anesthesiologist" and "highly" recommended. *See Preau v. St. Paul Fire & Marine Ins. Co.*, No. 09-4252, 2010 U.S. Dist. LEXIS 77210 (E.D. La. July 30, 2010).

10. Coverage for Dummies Encore: Another decision issued in the long-running saga of coverage being sought by a husband, for eye injuries sustained by his wife, when he threw a carrot at her. Aren't carrots supposed to be *good* for your eyes? *See Safeco Ins. Co. of Am. v. Vecsey*, No. 3:08cv833, 2010 U.S. Dist. LEXIS 103503 (D. Conn. Sept. 30, 2010).

11. Insured responded to a property line dispute by attaching to the fence at issue life-sized paper targets cut into the shape of human beings and riddled with bullet holes. And that was probably his tamest response. *See Browning v. American Family Mut. Ins. Co.*, No. 09-1375, 2010 U.S. App. LEXIS 19697 (10th Cir. Sept. 22, 2010) (applying Colorado law).

12. Public storage company makes repairs to the ceiling in a storage unit. Good news doctor, we fixed the ceiling. Bad news — we accidentally disposed of those 600 boxes of medical and financial records you had in there. *See Zurich American Ins. Co. v. Public Storage*, __ F. Supp. 2d __ (E.D. Va. 2010).

13. Trust us — we really would have declined your request to back-date your policy by a few days if you had told us that the new inception date was a few days before someone was shot and killed in your bar, followed by a fire at the premises a day or two later. *See Burlington Ins. Co. v. Barefield*, No. 09CV5280 (N.D. Ill. Oct. 28, 2010).

14. Best artfully drafted complaint of the year to be successful in triggering a duty to defend: Bar patron, stabbed in the face, alleged that the defendant "caused a knife to make contact with plaintiff." Even the judge recognized the insanity of his decision, calling it one "only lawyers could love." *Gakk, Inc. v. Acceptance Cas. Ins. Co.*, No.09-6282, 2010 U.S. Dist. LEXIS 84971 (D. Or. Aug. 16, 2010).

15. In a category that always has a lot of contenders — Worst Bar Security of the Year — the award goes to *Rizzi v. United States Liability Ins. Co.*, No. 095010775S, 2010 Conn. Super. LEXIS 1808 (Conn. Super. Ct. July 13, 2010): Patron spends six hours in a gentlemen's club drinking, locks himself in the men's room for 30 minutes, emerges completely naked, after which club employees tie his pants around his waist, wrap his head in a shirt and ridicule him as he is escorted out of the establishment, whereupon he falls down an embankment and is killed.

16. Honorable Mention — Worst Bar Security of the Year — *American Best Food, Inc. v. ALEA London, Inc.*, 229 P.3d 693 (Wash. 2010): Nightclub patron is ejected by security for a confrontation with another patron; he is allowed to return to the club and reinitiates the confrontation; both patrons are ejected and the originally ejected patron shoots the other patron nine times; victim staggers back to the club and is carried inside by security; club owner instructs employees to remove the victim from the establishment and the employees "dumped him on the sidewalk." (Entire incident started when the two men brushed up against each other on the dance floor.) (Unknown if "Stayin' Alive" was playing at the time.).

17. Best line of the year by a court in a coverage decision: Quoting an arbitration panel that took judicial notice, that's right, *judicial notice*, "of the common practice in correspondence between coverage counsel and an insured's counsel to reserve rights to assert all sorts of positions — often fairly ridiculous ones — and for all parties

to accept such reservations as effective means of avoiding waivers of positions." *See Illinois Union Ins. Co. v. North County Ob-Gyn Medical Group, Inc.*, 09cv2123, 2010 U.S. Dist. LEXIS 50095 (S.D. Cal. May 19, 2010).

18. On Halloween eve the Wisconsin Court of Appeals ruled that bat guano is not a pollutant. *See Hirschhorn v. Auto-Owners Insurance Company*, __ N.W.2d __ (Wis. Ct. App. 2010). December 24th decision will address whether reindeer guano is distinguishable.

19. Bad, bad idea to use gasoline to clean the floor of a food truck that contains a stove with a pilot light. *See Employers Mut. Cas. Co. v. Bonilla*, 613 F.3d 512 (5th Cir. 2010) (applying Texas law).

20. Proof that the legal system is broken: *Scottsdale Ins. Co. v. Shageer*, No. 10-80418, (S.D. Fla. Dec. 1, 2010): An exotic dancer at Cheetah's was walking along the top of the bar collecting tips when she was groped by a male patron. Her leg instinctively kicked out and struck the patron. Guess which one got sued?

The Ten Most Significant Insurance Coverage Decisions of 2010

I am once again grateful to *Mealey's Litigation Report: Insurance* and Editor Gina Cappello for the opportunity to make the case for the ten most significant insurance coverage decisions from the year gone by. The selection process operates throughout the year to identify coverage decisions (usually, but not always, from state high courts) that (i) involve a frequently occurring claim scenario that has not been the subject of many, or clear-cut, decisions; (ii) alter a previously held view on an issue; (iii) are part of a new trend; (iv) involve a burgeoning issue; or (v) provide a novel policy interpretation. Admittedly, some of these criteria overlap.

In general, the most important consideration for selecting a case as one of the year's ten most significant is its potential ability to influence other courts nationally. That being said, the most common reasons why many unquestionably important decisions are not selected is because other states are not lacking for guidance on the particular issue or the decision is tied to something unique about the particular state. Therefore, a decision may be hugely important for its own state, but is nonetheless very likely to be passed over as one of the year's ten most significant, because it has little chance of being called upon in the future by other states confronting the issue.

For example, in *Minkler v. Safeco Ins. Co.*, 232 P.3d 612 (Cal. 2010), the Supreme Court of California held that a policy containing a severability-of-interests provision, and an exclusion for bodily injury expected or intended by "an" insured, did not preclude coverage for an innocent co-insured. Given the frequency in which the "an insured" versus "the insured" issue arises, *Minkler* is a hugely significant decision that will undoubtedly affect numerous California claims. However, because this issue is so well-developed nationally, it is unlikely to have much influence on courts outside of the Golden State.

Another example is *American Best Food, Inc. v. ALEA London, Inc.*, *supra*, where the Washington Supreme Court held that an insurer's failure to defend, based upon a questionable interpretation of law, was unreasonable and, therefore, the insurer acted in bad faith as a matter of law. *American Best* set the bar for bad faith about as low as it can go. However, the decision is so inconsistent with national bad faith standards that its impact is likely to be limited to Washington state and not have any impact on the other forty-nine. For these reasons, while *Minkler* and *American Best* were hugely significant decisions in 2010, both remained on the sidelines when the year's ten most significant coverage decisions were being selected.

As I remind readers every year, the process for selecting the year's ten most significant insurance coverage decisions is highly subjective, not in the least bit scientific, and in no way democratic. So, if you think a decision should have made the list, but didn't, I probably wouldn't argue with you too much. But just because the selection process has no accountability or checks and balances whatsoever does not mean that it lacks deliberation. In fact, a lot of deliberation goes into the process. It's just that only one person is deliberating.

Below are the ten most significant insurance coverage decisions of 2010 (listed in the order that they were decided):

Pharmacists Mutual Ins. Co. v. Myer — Vermont Supreme Court prescribed tough medicine for insurer that failed to take action to allocate damages between those that are covered and uncovered.

Medical Protective Co. v. Bubenik — Insureds will scream over losing the right to remain silent. Eighth Circuit held that insured that "takes the fifth" in a civil case, because of possible criminal liability, forfeits coverage for lack of cooperation.

Gilbane Building Co. v. Empire Steel Erectors, L.P. — ISO **I**n **S**earch **O**f an additional insured endorsement that operates as it intended. Texas District Court rejected the organization's latest additional insured offering in one important context.

Travelers Prop. & Cas. Co. v. Hillerich & Bradsby Co., Inc. (Louisville Slugger) — Sixth Circuit ended the policyholder squeeze-play for demands on insurers to settle in the face of coverage defenses.

Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C. — North Carolina Supreme Court told manufacturer of insect repellant apparel to, what else, buzz-off for coverage claims that resemble "greenwashing."

World Harvest Church, Inc. v. Guideone Mut. Ins. Co. — Georgia Supreme Court held that insurer didn't have a prayer after issuing an ineffective reservation of rights to a church.

Pekin Ins. Co. v. Wilson — Supreme Court of Illinois: Insureds are not down for the count when facing the "expected or intended" exclusion for an assault and battery claim. [Supreme Court of Virginia did the same.]

C.R.S.A. § 13-20-808 ("An Act Concerning Commercial Liability Insurance Policies Issued to Construction Professionals") — Botox injection: Colorado General Assembly eliminated the lines that have been drawn over the faulty workmanship as an "occurrence" debate.

Flomerfelt v. Cardiello — The death and taxes of insurance no more: New Jersey Supreme Court rejected broad interpretation of "arising out of."

State Automobile Mut. Ins. Co. v. Flexdar, Inc. — Indiana Appeals Court gives the Heisman to insured's argument that insurer's amendment of a policy provision is admissible to interpret the meaning of a prior version.

Discussion Of The Ten Most Significant Insurance Coverage Decisions Of 2010

***Pharmacists Mutual Ins. Co. v. Myer*, 993 A.2d 413 (Vt. 2010)**

Further down in this article is a discussion of *World Harvest Church, Inc. v. Guideone Mut. Ins. Co.* and the importance for insurers, looking to preserve coverage defenses, to issue not just a reservation of rights letter, but an *effective* one. In *Pharmacists Mutual Ins. Co. v. Myer,* the Supreme Court of Vermont took this lesson a step further: Even the best-written reservation of rights letter is not self-enforcing. In other words, sometimes an insurer must take affirmative steps to ensure that the reservation of rights letter achieves the purpose for which it was written. And in those states where such an affirmative act by the insurer is a requirement, the consequences for failing to do so can be severe — the waiver of the coverage defenses that the reservation of rights letter was designed to prevent.

The challenge for insurers is that, because a reservation of rights letter is written in a sterile environment — at someone's desk — it can easily spell out, in black and white terms, those claims and damages at issue in the underlying suit for which coverage may not be owed. The underlying litigation, on the other hand, is likely proceeding in a manner that is anything but as neat and tidy.

It will frequently be the case that the underlying litigation is simply not capable of producing an outcome that makes it possible for the insurer and insured to compare its results, with the reservation of rights letter, and easily decide which claims and damages are covered and which are not. To the contrary, the underlying litigation may result in a verdict that does not specify the extent to which it represents this or that type of damage or the claims on which the relief is based. In this situation, often-times referred to as a "general verdict," the policyholder is likely to argue that, because the basis for jury's verdict cannot be determined, it must be presumed that the entirety of the jury award represents covered claims and damages. Adding to the difficulty for insurers is that it cannot

ask appointed defense counsel to seek special jury interrogatories which would go a long way toward solving this problem.

Courts have accepted the policyholder argument that because the insurer created the problem, it must therefore bear the consequences. *See Butterfield v. Giuntoli*, 670 A.2d 646 (Pa. Super. Ct. 1995); *Herrera v. C.A. Seguros Catatumbo*, 844 So. 2d 664 (Fla. Ct. App. 2003); *TIG Ins. Co. v. Premier Parks, Inc.*, No. Civ.A.02C04126JRS, 2004 Del. Super. LEXIS 80 (Del. Super. Ct. March 10, 2004). At the heart of these decisions is the placing of blame on the insurer for being aware that the underlying litigation may result in a verdict that does not enable a determination to be made between covered and uncovered claims and/or damages, yet it took no steps to prevent such outcome. In such situation, the fact that the insurer issued a Felix Unger-like reservation of rights letter, spelling out in detail its precise position on what is and what's not covered, is no protection against the consequences of failing to prevent a general verdict and the consequences that it causes.

In *Pharmacists Mutual Ins. Co. v. Myer*, the Supreme Court of Vermont made this point about as clear as possible. The genesis of the underlying litigation was the loss of a $49,000 deposit after the sale of a condominium at the Topnotch Resort and Spa ("Topnotch") fell though. The insured, Myer, had paid half of the forfeited deposit and initiated an unsuccessful action against Topnotch to recover his money. *Id.* at 415. While that action was pending, Reggie Cooper, then president and general manager of Topnotch, commenced a defamation action against Myer, alleging that Myer had falsely accused Cooper of stealing $47,000 in connection with the condominium transaction, of embezzling $100,000 from Topnotch, and of being under a criminal investigation and about to be fired. *Id.*

Nearly two years after Cooper had commenced his suit, Myer tendered his defense under his homeowner's policy, which included an endorsement providing coverage for "personal injury." "Personal injury" was defined to include "misrepresentation, libel, slander [and] defamation of character," but excluded coverage for personal injury caused by statements made by the insured "if the insured knew or had reason to believe that the … statement was false." *Id.* at 415-16. Pharmacists responded to the tender by acknowledging covered and non-covered claims in the complaint and agreeing to fund Myers's defense under a reservation of rights. Pharmacists also monitored the underlying trial through a "litigation specialist." *Id.* at 416.

The trial went to verdict, and a special verdict form instructed the jury to address separately "two types of statements": (1) those related "to the various disputes and claims that [Myer] had with and against Topnotch," including the ill-fated purchase-and-sale agreement; and (2) "a second category of statements ... concern[ing] the allegations that Mr. Cooper had stolen money, or was embezzling from Topnotch itself." *Id.* at 417. As to the former category of statements, the court instructed that Myer enjoyed a "qualified privilege" to speak about matters affecting his own interests, and therefore required a showing by clear and convincing evidence that Myer knew or should have known that the statements were false. The second category of statements, in contrast, required a mere showing that Myer was "simply negligent." *Id.*

Thus, for purposes of coverage, while the first category of statements was excluded by the policy, the second category of statements was not. The jury ultimately entered a verdict against Myer, but did not apportion damages between the two categories of statements. *Id.* at 415. Pharmacists sought a declaration of no coverage under the policy's personal injury exclusion. *Id.* at 415-16. The trial court agreed and entered summary judgment for Pharmacists; the Vermont Supreme Court ultimately reversed.

The Vermont Supreme Court held that it could "discern no basis to interpret the special verdict … as finding that all of the defamatory statements were made by Myer with knowledge of their falsity or reckless disregard thereof." *Id.* at 417. Therefore, the exclusion did not apply. Noting that "[i]n the absence of special interrogatories, it is impossible … to reliably allocate the defamation damages," the Vermont Supreme Court nevertheless concluded that "judicial economy" precluded a re-trial of the damages. *Id.* at 419. For the absence of special interrogatories, a "problem [that] could-have and should-have been avoided," the court pinned blame squarely on Pharmacists. *Id.*

> While Pharmacists did not control the litigation — having perceived a conflict and

> deferred to independent counsel — it nevertheless continued to monitor the *Cooper* trial through its "litigation specialist" and remained in regular contact with defense counsel. Indeed, Pharmacists remained the most informed party concerning coverage issues and the potential difficulties of parsing a general verdict as between covered and uncovered claims.
>
> Therefore, to protect its interests and meet its burden it was incumbent upon Pharmacists to notify the trial court and the parties of the potential apportionment issue and of the need for special interrogatories allocating damages, to seek permission if necessary to attend the charge conference to propose such interrogatories, or even to intervene in the litigation if all else failed.

Id. at 420 (emphasis added).

Because Pharmacists had failed to seek an allocated verdict on the defamation award, the entire verdict fell within coverage even if just one statement fell within coverage.

> Here, similarly, Pharmacists failed to seek an allocated verdict on the defamation award and thus cannot meet its burden to demonstrate that the award was for statements entirely excluded from coverage under the policy.
>
> Pharmacists, therefore, would remain responsible for the defamation award in its entirety in the event that any of the statements are ultimately found to fall within the policy coverage.

Id. at 420.

Pharmacists adds to a growing digest of case law, whose message to insurers is clear: when it comes to litigation involving both covered and uncovered claims — you must not sit on your hands, but, rather, must act. Even if your actions are unsuccessful, *e.g.*, the court is not willing to allow the special interrogatories you requested, you will have still taken an important step toward preventing waiver of otherwise applicable coverage defenses.

***Medical Protective Co. v. Bubenik*, 594 F.3d 1047 (8th Cir. 2010) (applying Missouri law)**

Nobody can claim complete ignorance about the American legal system. This is because everyone, even kids, know at least one thing: upon being arrested, a person has the right to remain silent. As a technical matter, this principle stems from the Constitution's prohibition against self-incrimination — specifically that no person shall be compelled to testify against himself. There are no shortage of judicial opinions characterizing this Constitutional protection as fundamental, bedrock and a cornerstone of our adversarial criminal judicial system. It is as black letter as coal. Indeed, the concept traces its roots to English common law and Oliver Cromwell in the 1600s.

It is for this reason that some policyholder counsel may be puzzled, and perhaps incensed, by the Supreme Court of Georgia's decision in *Medical Protective Co. v. Bubenik* that if "taking the Fifth" violates the insured's duty to cooperate, it may eviscerate coverage. Granted, as a general principle, the Fifth Amendment "does not forbid adverse inferences against parties to civil actions when they refuse to testify in response to probative evidence offered against them." *Baxter v. Palmigiano*, 425 U.S. 308, 318 (1976) (quoting 8 J. Wigmore, *Evidence* 439 (McNaughton 1961)). But that may still not prevent policyholder shock and awe at the decision.

The insured, Bubenik, was a dentist specializing in conscious sedation dentistry. MPC provided his medical malpractice insurance. A patient, Marlon Jaudon, died in July 2004 during a procedure at Bubenik's office. Six months later, Bubenik performed the same procedure on Henry Johnston, who also died. *Id.* at 1050. Malpractice actions followed. In both cases, Bubenik asserted his Fifth Amendment right against self-incrimination, and refused to answer interrogatories, submit for a deposition, or testify at trial. *Id.*

During the *Jaudon* litigation, MPC repeatedly warned Bubenik that his refusal to testify might jeopardize his insurance coverage because he would be in material breach of the cooperation clause in his policy, which provided that "[t]he Insured shall at all times fully cooperate with the Company in any claim hereunder and shall attend and assist in the preparation and trial of any such claim." *Id.* On the morning of the

Jaudon trial, the presiding judge disqualified Bubenik's expert witness because her opinion was based on information which had been given to her by Bubenik, but which was not in the record. MPC settled the Jaudon case that day. (It was unable to contest coverage at that point because it had not sent Bubenik a reservation of rights letter. (*See World Harvest Church, supra*)).

During the course of the *Johnston* litigation, MPC also repeatedly informed Bubenik that his refusal to provide information in assistance of his defense constituted a breach of his duty to cooperate. Although Bubenik informed MPC that the case was defensible, he refused to discuss why. He also refused to release a state dental board report that detailed what had occurred on Johnston's visit and contained Bubenik's opinion as to the cause of his death. *Id.* MPC ultimately reserved its right to deny coverage based on his failure to cooperate, and, after judgment was entered against Bubenik, MPC sought a declaration that the judgment was not covered. *Id.* at 1051. The federal district court agreed, entering judgment in favor of MPC. The Eighth Circuit affirmed.

The Eighth Circuit initially rejected outright arguments that the cooperation clause was ambiguous and, therefore unenforceable, stating that "[a] common sense interpretation" of the provision requiring Bubenik to "fully cooperate" and "assist in the preparation and trial of any [claims]" included the duty "to assist MPC in its defense strategy, provide relevant documents, answer interrogatories, submit to depositions, and testify at trial if necessary." *Id.* at 1052.

The court thereafter rejected the heart of the matter: that the provision could not be enforced because "it amount[ed] to a waiver of constitutional rights." *Id.* In rejecting the argument, the Eighth Circuit reasoned that the MPC policy did not require an actual waiver of Bubenik's constitutional rights, but rather gave him a choice of either to assert them or cooperate with his insurer. His argument, therefore, was based on a false premise:

> [T]he MPC insurance policy did not require an actual waiver of Dr. Bubenik's constitutional rights. He retained the choice whether to invoke his Fifth Amendment rights at the price of losing his insurance coverage or to cooperate with the defense attorneys provided him and retain his coverage. Both options remained available to him throughout the pendency of the Johnston case. We conclude that the district court did not err in concluding that Dr. Bubenik materially breached the cooperation clause in his insurance policy.

Id. at 1052. Thus, like a litigant in a civil action, although Bubenik could invoke his Fifth Amendment right, there would be consequences. The choice was his.

The court also easily found that Bubenik's material breach of the cooperation clause substantially prejudiced MPC and that MPC had acted diligently in its communication with Bubenik to secure his cooperation in order to support a declaration of no coverage. *Id.* at 1053. Thus, there was no coverage.

The logic of the opinion and Fifth Amendment case law in general suggest that other courts will follow the *Bubenik* decision. As civil and coverage litigation continues in the fallout of Wall Street scandals and the criminal prosecutions that followed, it is an issue worth watching.

***Gilbane Building Co. v. Empire Steel Erectors, L.P.*, 691 F. Supp. 2d 712 (S.D. Tex. 2010)**

For as long as there have been "additional insureds," there have been disputes over just how much coverage they are owed, if any. The cases are legion. And like fingerprints — no two are identical.

The debate often centers on the relationship between the additional insured and the named insured and whether the additional insured's liability arises out of the named insured's work. To put it another way, insurers and additional insureds often have disputed whether additional insureds are entitled to coverage for their sole negligence, vicarious liability only, or somewhere in between.

Historically, insurers have not done well in this area. For a long period, and throughout the country, courts concluded that, even when the additional insured endorsement provided coverage only for an additional insured, with respect to liability *arising out of* the named insured's operations performed for the additional insured, the additional insured was entitled to coverage for its sole negligence.

ISO described this problem as follows in the Background section of the filing memorandum that accompanied revisions it made in 2004 to its additional insured endorsements:

> ISO's additional insured endorsements typically respond to the additional insured's liability *arising out of* operations performed for the additional insured by the named insured. ISO has monitored various court decisions and found that courts in many disputes between insurers and insureds have construed broadly the phrase "arising out of." The central issue in much of the litigation is whether the endorsements provided coverage only for the additional insured's vicarious liability arising out of the named insured's negligent acts, or did coverage extend to the additional insured's sole negligence. Some courts have ruled that, in the absence of specific language limiting coverage, the current additional insured endorsements do respond to injury or damage arising from the additional insured's sole negligence. This is contrary to the original intent of the additional insured endorsements.

"Revisions to Additional Insured Endorsements," ISO Commercial General Liability Forms Filing GL-2004-OFGLA, at 2 (emphasis in original).

In essence, these decision interpreted "arising out of" as requiring only a "but for" causation. As such, courts concluded that "for liability to arise out of operations of a named insured, it is not necessary for the named insured's acts to have caused the accident; rather, it is sufficient that the named insured's employee was injured while present at the scene in connection with performing the named insured's business, even if the cause of the injury was the negligence of the additional insured." *Admiral Insurance Company v. Trident NGL, Inc.,* 988 S.W.2d 451, 454 (Tex. Ct. App. 1999).

In 2004, ISO introduced revisions to its additional insured endorsements that took direct aim at those courts that interpreted such "arising out of" endorsements based on the nature of the relationship between the named insured and additional insured—without consideration of the named insured's fault. ISO set out to achieve a fault-based additional insured coverage grant by revising several of its additional insured endorsements. For example, ISO's 2004 version of its workhorse form CG 20 10 attempted to achieve a "fault based" coverage grant by eliminating the phrase "arising out of your [named insured's] ongoing operations performed for that [additional] insured" and instead linked potential coverage for the additional insured directly to the acts or omissions of the named insured.

ISO's solution to the additional insured problem was described as follows in the Explanation of Changes section of the filing memorandum for its 2004 additional insured endorsement revisions:

> Because the phrase "arising out of" has been interpreted broadly by some courts, we are revising several of the additional insured endorsements to add specific language to provide an additional insured with coverage for their vicarious or contributory negligence only. The additional insured will only have coverage for bodily injury, property damage or personal and advertising injury that is caused in whole or in part by the acts or omissions of either the named insured or those acting on behalf of the named insured. A *major effect* of that wording will be to prevent any alleged coverage for the additional insured's sole negligence. These revisions will better reflect the intent of these endorsements.

Id. at 2-3 (emphasis added).

If a "major effect" of the 2004 additional insured wording was to prevent coverage for the additional insured's sole negligence, a decision this year from a Texas federal court suggests that this significant objective may not be achieved in a certain (common) claim scenario.

In *Gilbane Building Co. v. Empire Steel Erectors, LP*, the Southern District of Texas addressed the availability of additional insured coverage in a textbook third-party "action over" situation. Parr, an employee of Empire Steel, was seriously injured when he fell while climbing down a ladder at a construction site. *Gilbane Building* at 714. Parr filed suit in Texas state

court claiming negligence by Gilbane Building Company, the general contractor at the job site and Baker Concrete, the party responsible for installing and maintaining the ladders at the construction site. *Id.*

Gilbane sought coverage as an additional insured under a general liability policy issued by Admiral Insurance Company to Empire Steel. *Id.* at 715. However, Admiral refused to defend and indemnify Gilbane based on the allegations in Parr's complaint and Admiral's interpretation of the additional insured endorsement. *Id.* Gilbane filed an action for declaratory judgment and breach of contract against Empire Steel and Admiral. *Id.*

The additional insured endorsement at issue — one of ISO's 2004 revisions — provided as follows:

> A. Section II — Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury," "property damage" or "personal & advertising injury" caused, in whole or in part, by:
>
> 1. Your acts or omissions; or
>
> 2. The acts or omissions of those acting on your behalf; in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

Gilbane Building at 719.

Admiral argued that it had no duty to defend Gilbane because the additional insured endorsement limited coverage to injury "caused, in whole or in part, by" Empire Steel or those acting on its behalf. *Id.* at 721. Parr's third amended complaint alleged that it was Gilbane's negligence that caused Parr's injuries. *Id.* As such, Admiral argued that, under Texas's eight corners rule, the complaint did not trigger coverage because it did not allege that Empire Steel or someone acting on its behalf caused Parr's injuries. *Id.*

Gilbane disputed Admiral's position on the basis that Parr, as an employee of Empire Steel at the time of the accident, was statutorily barred from naming Empire Steel as a liable party because the company had a worker's compensation policy in place. *Id.* Gilbane also argued that, under Texas's comparative responsibility statute, Parr's own negligence is always at issue, even in the absence of an allegation in his pleading to that effect. *Gilbane Building* at 721. Gilbane argued that the additional insured endorsement was triggered because someone acting on behalf of Empire Steel potentially caused, in whole or in part, Parr's injury. *Id.*

The Texas District Court noted that the dispute before it was one of first impression and provided a history of ISO's experience with additional insured endorsements – examining the problems associated with the "arising out of" version that led to the 2004 adoption of the fault-based versions. *Id.* at 721-23.

The court noted that, under the terms of the 2004 additional insured endorsement, "in the absence of fault of the named insured, there should be no coverage for the additional insured." *Id.* at 722. However, the court appreciated that, in the context of "action-over" cases, there is a practical problem in applying the additional insured endorsement as it is written:

> [A] general contractor with additional insured status in the subcontractor's CGL policy has historically been covered for these claims. Since the employee is barred by the worker's compensation statute from bringing a suit against his own employer, these suits will generally not mention the employer, alleging only negligence against the general contractor additional insured. The concern is that, since the suit does not allege any degree of fault against the named insured employer, CGL insurers will take the position that the employee's injuries were not "caused, in whole or in part, by" the subcontractor (named insured). ¶ Of course, the subcontractor usually will have been partially at fault, even though the suit does not contain allegations against it.

Id. at 722 (quoting BRUNER & O'CONNOR ON CONSTRUCTION LAW, § 11:63.50) (quoting Jack P. Gibson & Jeff Woodward, *2004 ISO Additional Insured Endorsement Revisions, ABA Forum on the Construction Industry Winter Meeting* (Jan. 27, 2005)).

The court was mindful that this practical problem, and one other, existed in the situation before it, noting that (1) the complaint alleged that the injuries occurred when Parr was walking down the ladder with muddy boots, which at least raised an inference that Parr himself could have been partly at fault; and (2) the fact that Parr's complaint did not mention Empire Steel's possible negligence spoke only to the fact that Empire was statutorily immune from suit, not that it was without fault. *Id.* at 724. The *Gilbane Building* Court responded to these practical problems associated with the additional insured endorsement by concluding that coverage was owed to Gilbane as an additional insured.

Therefore, notwithstanding that the 2004 version of the additional insured endorsement was created to prevent coverage for the additional insured's sole negligence, and that the Parr complaint alleged that the additional insured was, in fact, solely negligent, additional insured coverage was still owed by the insurer.

***Travelers Prop. & Cas. Co. v. Hillerich & Bradsby Co., Inc.*, 598 F.3d 257 (6th Cir. 2010) (applying Kentucky law)**

For various reasons, coverage litigation between insurers and insureds is not played on a level field. For example, many coverage disputes involve the duty to defend. Insureds clearly have the advantage here because the duty to defend is usually determined against a backdrop that it is exceedingly broad. But this can be justified. Since liability insurance is "litigation insurance," coverage for defense is a fundamental aspect of the product being sold. For this reason, the duty to defend should necessarily be broad. Further, ambiguities in an insurance policy are generally construed against the insurer.

This provides a monumental advantage to insureds since the question of whether a policy provision is ambiguous is about as subjective of a determination as there is. But this rule of policy interpretation is justified on the basis that the insurer was the one who drafted the policy. And, of course, unless the policyholder is BP, insurers are almost certainly never going to win the sympathy vote. In general, all things being equal on the merits, these intangible factors make insurers about a seven point underdog in a lot of coverage litigation.

But if there is one situation where the playing field deserves to be perfectly level, it is this one. An insurer is defending its insured in an underlying action. There are potential coverage defenses. Accordingly, the insurer is providing its defense under a reservation of rights. The insurer has done exactly what the law asks of it when faced with such a situation.

At some point further down the road, perhaps after the insurer has spent a significant sum on the insured's defense, an opportunity to settle the case within policy limits arises. And when this happens, it has a way of being close to trial. The insurer is getting tremendous pressure from its insured to settle the case to avoid any risk of a verdict in excess of policy limits. The insured is also threatening that, given the potential liability and damages at issue, any excess verdict will be the responsibility of the insurer on account of its failure to accept the demand within limits. And based on the relevant bad faith "failure to settle" standard, the insured may very well be correct.

But if the insurer does what its insured is demanding, and settles the case, what happens to the insurer's coverage defense? Did the insurer just pay to settle an uncovered claim and now has no recourse? Was the insured able to use the risk of saddling the insurer with liability for an excess verdict as a means to obtain (read as, extort) coverage for uncovered claims? Having done exactly what was asked of it — defended its insured under a reservation of rights — the insurer does not deserve to have to forego its coverage defenses as the price to pay to avoid exposure for an excess verdict. It is the proverbial damned-if-you-do and damned-if-you-don't for the insurer.

The Supreme Court of Texas described this situation for insurers as an untenable one and even went so far as to say that insurers could account, in their rate structure, for the possibility that they may occasionally pay uncovered claims. *Texas Ass'n of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000).

However, in *Travelers Prop. & Cas. Co. v. Hillerich & Bradsby Co., Inc.,* the Sixth Circuit was not so quick to throw up its hands and dismiss the issue as just a cost of doing business for insurers. Rather, the court recognized the risk of unfairness for insurers facing

this settlement quandary and devised a solution that attempted to keep the playing field level.

At issue in *Hillerich & Bradsby Co.* was coverage for a claim made by Baum Research and Development Co. against Hillerich & Bradsby Company [surely best known as the manufacturer of Louisville Slugger baseball bats] with respect to the Baum Bat and Baum Hitting Machine. *Hillerich & Bradsby* at 262. The underlying claims generally involved antitrust violations and tortious interference. *Id.* at 262. Hillerich & Bradsby sought coverage from Travelers under Coverage B, Personal and Advertising Injury, of its Commercial General Liability policies. *Id.* at 263. Travelers initially refused to defend Hillerich & Bradsby because the complaint did not allege personal and advertising injury. Travelers then undertook the defense, under a reservation of rights, following the filing of a second amended complaint that alleged disparagement. *Id.*

In 2005, after trial in the underlying action had commenced, the parties settled. *Id.* at 262. Hillerich & Bradsby's portion of the settlement was $500,000. *Id.* In the time leading up to the settlement, Travelers informed Hillerich that it would only fund settlement costs while reserving a right to seek reimbursement for any contribution found to be funding noncovered claims. *Id.* at 263.

Needless to say, Hillerich did not agree to this condition:

> Hillerich acknowledged Travelers' claim of a right to seek reimbursement but expressly objected to this right, instead arguing that the claims at issue in the *Baum* litigation should be covered by Travelers. Hillerich demanded that Travelers settle the case while still refusing to recognize a right to reimbursement, which Travelers again invoked as a condition for funding settlement. Hillerich threatened to sue Travelers for bad faith for defending under a reservation of rights if Travelers did not settle the underlying litigation. Travelers again invoked its reservation of rights to seek reimbursement for noncovered claims included in the settlement while it funded the settlement on March 18, 2005.

Id. at 264.

Travelers initiated coverage litigation seeking reimbursement of its settlement if it were determined that funds were paid to resolve uncovered claims. *Id.* The Kentucky District Court concluded that Travelers had such right to reimbursement. *Id.* The case was appealed to the Sixth Circuit, which framed the issue as follows: "[W]hether Travelers can seek reimbursement of settlement for noncovered claims when it funded the settlement under a reservation of rights, when Hillerich was given notice of its intent to seek reimbursement, and when Hillerich retained meaningful control of the defense and negotiation process." *Hillerich & Bradsby* at 265.

The Sixth Circuit — following a review of the issue nationally — affirmed the lower court, allowing "reimbursement for an insurer after a unilateral reservation of rights by the insurer over the objection of the insured in at least the narrow circumstances posed in this case." *Id.* at 268. The court concluded that a right to reimbursement exists under an implied-in-law/unjust enrichment theory. In other words, the insured only paid premiums for coverage of the specified claims in the policy and the insured had full knowledge of the consequences of accepting the defense and settlement under the insurer's reservation of rights. *Id.* at 266-67 (discussing *Blue Ridge Ins. Co. v. Jacobsen*, 22 P.3d 313 (Cal. 2001)).

The Sixth Circuit specifically held that "this reimbursement right arises under an implied-in-law contract theory to allow an insurer to seek reimbursement when '(1) the insurer has timely asserted a reservation of rights; (2) the insurer has notified the insured of its intent to seek reimbursement; and (3) the insured has meaningful control of the defense and negotiation process.'" *Id.* at 268 (quoting District Court's opinion).

While the appeals court couched its decision in legal doctrine, the case's money paragraph indicates that the court's decision was also based on what it perceived as fundamental fairness for insurers. The Sixth Circuit clearly appreciated the conundrum facing insurers:

> Travelers was in a difficult position — either settle the claim without an agreement on reimbursement when Travelers was contesting coverage or delay settlement when that would

> increase defense costs that it had already waived the right to recoup and might lead to liability on a bad faith claim. Kentucky favors fair and reasonable settlements, and all parties agree that the underlying settlement was fair and reasonable. Allowing insurers to reserve a right to seek reimbursement in at least some limited circumstances where it is done expressly and where the insured retains meaningful control over the defense encourages settlements when coverage is uncertain, while not permitting unjust enrichment to the insured who demands settlement but refuses to recognize a right to reimbursement. Here the insured was arguing that coverage was afforded for both defense and settlement costs, but refused to allow the insurer to seek reimbursement if a court later determined that the insured's position was incorrect. It would seem to be an unjust outcome for the insurer if this Court were to sanction that position. The insured would be both getting the settlement at the time it preferred and having that settlement funded by the insurer when no coverage was afforded under the policy. It is unlikely Kentucky would approve such a position.

Id. at 269.

The Sixth Circuit then held that disparagement was not a part of the litigation at the time of the settlement. *Id.* at 272. Therefore, Travelers was entitled to reimbursement of the settlement funds it paid on Hillerich & Bradsby's behalf. *Id.*

***Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C.,* 692 S.E.2d 605 (N.C. 2010)**

Now, more than ever, consumers may pick and choose between products touted as "organic," "all-natural," "eco-friendly," or "green." A recent survey reported that 17% of U.S. consumers are willing to pay more for environmentally-friendly or "green" products. That number is growing. Eco-labeling, a system by which consumers may determine whether products are grown, manufactured or processed in an environmentally-friendly manner, also is on the rise. When testifying before Congress, the Federal Trade Commission characterized the onslaught of green marketing as a "virtual tsunami." But despite such claims, consumer protection groups believe that well-over 90% of all green marketing is in fact false, a practice called "greenwashing." In early 2010, the FTC warned 78 companies that it might be liable for greenwashing in violation of the Federal Trade Commission Act, which prohibits false and deceptive advertising.

Greenwashing can lead to claims of various types, such as an insured's competitor may allege injury from loss of business and unfair competition caused by the insured's false advertisements exaggerating its product's environmental attributes. Or a consumer may initiate a class action because he and other members of the consumer class have paid higher prices in return for environmental attributes that do not exist.

And experience teaches us that when there are claims made for damages, it is usually not long before another type of claim is made — for coverage. Greenwashing claims are likely to result in litigation between insurers and insureds over the availability of coverage for such damages.

Although *Buzz Off* is not a pure greenwashing case, the Supreme Court of North Carolina provided insight into some issues to anticipate in greenwashing coverage litigation and whether the "Quality or Performance of Goods — Failure to Conform to Statements exclusion ("Failure to Conform exclusion"), commonly found in the "Personal and Advertising Injury" section of CGL policies, will apply to preclude coverage for greenwashing claims.

In *Buzz Off*, the insureds processed clothing manufactured and marketed by others, such as Orvis and L.L. Bean, to add insect repellant to the apparel. The insureds promoted the insect repellant apparel through various advertisements on its websites, claiming the apparel provided its wearers with protection against insect bites that was superior to "messy" topical insect repellant. *Id.* at 608-09. The insureds also suggested that the insect repellant used in the apparel was "natural" and obviated the need to apply "greasy," "nasty," "unappetizing" and "oily chemicals to your skin." *Id.* at 608-09, 622. The apparel also was promoted by manufacturers and retailers who sold it. *Id.* at 608-09.

S.C. Johnson ("SCJ"), which manufactures and sells various topical insect repellants under the Off! product

line, commenced an action against the insureds, alleging false advertising and unfair competition claims under the Lanham Act and violation of the Illinois and North Carolina Consumer Fraud and Deceptive Business Practices Acts. *Id.* at 609. SCJ alleged that the Buzz Off advertising campaign, concerning the efficacy of its apparel, was false and that its business was damaged because the false advertisements diverted sales from SCJ's Off! products. *Id.*

The insurers, Harleysville Mutual and Erie Exchange, denied coverage under the Failure to Conform exclusion, which barred coverage for "'personal and advertising injury' arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your 'advertisement.'" *Id.* at 609-10. The trial court disagreed and the North Carolina Appeals Court affirmed, both holding that the insureds' advertising campaign had disparaged SCJ's own goods and, therefore, fell within coverage. The North Carolina Supreme Court disagreed and reversed.

In reversing the trial court's decision, the North Carolina Supreme Court first disagreed that Buzz Off had disparaged SCJ's goods. Although the insureds' advertising campaign had placed SCJ's products in a negative light, the court concluded that "the alleged falsity of that portrayal lies solely in the alleged failure of defendants' products to be of the quality and as effective as defendants claimed." *Id.* at 622. "Conspicuously absent" from SCJ's complaint was any statement from SCJ that it intended to prove anything about its own products or the insureds' statements that characterized them. *Id.* Instead, SCJ intended to place Buzz Off's product on trial, not its own. *Id.* Therefore, there was no product disparagement.

The court then held that the Failure to Conform exclusion applied because:

> [T]he Failure to Conform exclusion envisions a scenario in which a plaintiff shows that an insured's product is, in reality, something different from what the insured has advertised …. Thus, this exclusion removes from coverage "personal and advertising injury" proximately caused by a false statement an insured had made about its own product.

Id. at 613. In so holding, the court rejected the insureds' attempt to confine the exclusion's scope to any particular context or scope based on its perceived "purpose." The court rejected the argument that the exclusion was ambiguous in the present circumstance because the exclusion really had been created to preclude coverage for products liability claims disguised as false advertising claims. *Id.* at 613-14. It also rejected the insureds' argument that the exclusion should not apply because the alleged damage was not the failure of their product to conform, but instead, was the competitive impact of the advertising campaign complained of. *Id.* Importantly, the court observed that drawing a distinction between an injury caused by a product and an injury caused by a false advertising campaign for the product, for purposes of coverage, was "untenable." *Id.* The exclusion still applied.

Because the court held that the Failure to Conform exclusion applies to competitive injuries caused by false advertising, and not just to injuries suffered by consumers who purchase products that fail to live up to their hype, the ruling — and the rulings of other courts of alike mind — will surely bring the exclusion into play in the context of greenwashing litigation. Typically, a plaintiff in a greenwashing case alleges damages caused by the promotion of the offending product and its effect on competition in the marketplace, and not by the product itself. Thus, *Buzz Off* leaves open the possibility that the Failure to Conform exclusion may apply to such litigation. This could reduce far-stretched claims and litigation where coverage under CGL policies clearly was not contemplated. It also could bring would-be perpetrators of greenwashing into line. And all of this would be good for the trees.

For more information, *see* Mooney, Joshua A., "The Failure to Conform Exclusion: How Will It Apply to the 'Virtual Tsunami' of Green Marketing and Tide of Greenwashing Litigation?" *Mealey's Emerging Insurance Disputes*, Volume 15, No. 10, May 20, 2010. Copy available upon request (mooneyj@whiteandwilliams.com).

***World Harvest Church, Inc. v. Guideone Mut. Ins. Co.*, 695 S.E.2d 6 (Ga. 2010)**

"What's in a name? That which we call a rose by any other name would smell as sweet." William Shake-

speare, "Romeo and Juliet," Act II, Scene 2. But the same cannot be said of reservation of rights letters. In fact, just the opposite. A letter that is actually called a reservation of rights may be nothing of the sort.

The purpose of a reservation of rights letter is not disputed. When an insurer agrees to defend its insured it is making that decision based on a duty to defend standard — which is, in virtually all cases, broader than the test for determining if it has a duty to indemnify. If the insurer agrees to defend its insured, but may not have a duty to indemnify, it is incumbent upon the insurer to send a letter to the insured that effectively sends the following message — "We're providing you with a defense in this case, but don't read too much into that as there are policy provisions that may apply to preclude coverage for some or all of any settlement or damage award. It is too soon to know for sure and we'll have to see what facts develop as the case progresses. So while we are providing you with a defense, please understand that coverage may not be owed for damages — and here are the reasons why."

But despite how common-place reservation of rights letters are for insurers in the claims context, some courts have taken issue with the quality of such letters — concluding that, while a letter with the name "reservation of rights" may have been issued, the notice provided to the insured in such letter, of the reasons why coverage may not be owed for some claims or damages, was not sufficiently specific to be adequate. One court described the situation as follows:

> In this case, the Court finds that Safeco's reservation of rights letter did not "fairly inform" Liss of the reasons it was reserving its rights and that the letter was inadequate as a matter of law to preclude application of the estoppels doctrine. The only factual reference contained within the policy is: "As you are aware, this lawsuit arises out of a gunshot incident on July 10, 1997." More importantly, the letter sets forth pages of policy provisions but does not explain why Safeco believed the insurance policy would possibly not cover Liss for the shooting incident. In other words, Safeco did not "apply" the sole fact stated to the policy's legal terms.

Safeco Ins. Co. of Am. v. Liss, No. DV 29-99-12, 2005 Mont. Dist. LEXIS 1073, at *41 (Mont. Dist. Ct. Mar. 11, 2005); *see also Osburn, Inc. v. Auto Owners Ins. Co.*, No. 242313, 2003 Mich. App. LEXIS 2887 (Mich. Ct. App. Nov. 18, 2003) ("[W]e conclude that, because Auto Owners' reservation-of-rights letter was not sufficiently specific to inform plaintiffs of the policy defenses the insurer might assert, the letter did not constitute 'reasonable notice.'") (comparing an example of sufficiently specific reservation of rights language to that which was not).

Considering the tremendous frequently in which insurers issue reservation of rights letters, not to mention their importance, it is imperative that they do so effectively. To do it ineffectively is to not do it at all. This lesson was taught this year by the Supreme Court of Georgia in *World Harvest Church, Inc. v. Guideone Mut. Ins. Co.* While *World Harvest* involved a situation that was akin to an insurer that defended its insured without any reservation of rights, the court's decision made clear that, to be effective, a reservation of rights letter must do more than simply say it's a reservation of rights letter. The letter must inform the insured of the specific bases for the insurer's reservations about coverage.

The insured, World Harvest Church ("World Harvest"), received approximately $1.8 million in donations from a donor who ultimately was charged with securities fraud for operating a large Ponzi scheme. The donor entered into a consent judgment and pled guilty to criminal charges, and a Receiver demanded that World Harvest return the money donated to it. World Harvest refused, and, in 2002, the Receiver commenced an action against it, asserting claims of fraudulent transfer and unjust enrichment. *Id.* at 8.

World Harvest informed its general liability insurer, GuideOne Mutual Insurance Company ("GuideOne"), of that lawsuit. A sister-company of GuideOne responded with a written reservation of the right to deny any and all liability, and ultimately concluded that the policy did not cover the lawsuit. That action later was dismissed for lack of personal jurisdiction. *Id.* at 8.

In 2004, the Receiver commenced a new action against World Harvest in Georgia. Upon being informed of the new lawsuit, GuideOne split the file

between two claims adjusters, one of whom verbally advised World Harvest that "we didn't see coverage but we would have to evaluate what we have currently to see if there would be coverage issues." *Id.* at 8. Without issuing a further reservation, GuideOne assumed the insured's defense for ten months, before ultimately concluding that there was no coverage and withdrawing the defense. Judgment was entered against World Harvest, which then settled the action for $1 million. *Id.*

In the declaratory judgment action that followed, the parties did not dispute that the lawsuit and judgment were not covered under the policy. Instead, World Harvest argued that GuideOne was equitably estopped from denying coverage because it had assumed World Harvest's defense without a reservation of rights. *Id.* at 9. The District Court rejected World Harvest's argument on the basis that World Harvest had not shown prejudice. On appeal, the United States Court of Appeals for the Eleventh Circuit certified three questions to the Georgia Supreme Court:

1) Does an insurer effectively reserve its right to deny coverage if it informs the insured that it does "not see coverage," after the insured had received a written reservation of rights from the insurer's sister company in a similar lawsuit in another jurisdiction, or is a written or more unequivocal reservation of rights required?

(2) When an insurer assumes and conducts an initial defense without notifying the insured that it is doing so with a reservation of rights, is the insurer estopped from asserting the defense of noncoverage only if the insured can show prejudice, or is prejudice conclusively presumed?

(3) If the insured must show prejudice, do the facts and circumstances of this case show it?

Id. (citing *World Harvest Church v. GuideOne Mut. Ins. Co.*, 586 F.3d 950, 961 (11th Cir. 2009)). The Georgia Supreme Court held that GuideOne had not effectively reserved its rights and that prejudice was presumed; therefore, it was estopped from denying coverage.

As a preliminary matter, the Georgia Supreme Court rejected the notion that a verbal reservation of rights was inadequate. *Id.* at 9. The court stated that such a proposition "is without legal authority, and we are unpersuaded that *actual* notice of a reservation of rights is ineffective without a confirming letter." *Id.* (emphasis in original). To qualify as an adequate reservation of rights, the communication must "fairly inform the insured of the insurer's position." *Id.* The notice must not be a "statement of future intent," or a mere contention by the insurer of non-coverage, *without detail or support*. *Id.* at 10. The problem for GuideOne was that its statement did not satisfy the criteria.

> At a minimum, the reservation of rights must fairly inform "the insured that, notwithstanding [the insurer's] defense of the action, it disclaims liability and does not waive the defenses available to it against the insured." … The reservation of rights should also inform the insured of the specific "basis for [the insurer's] reservations about coverage, …." The statement of a claims adjuster for GuideOne that it did not see coverage but would have to see if there would be coverage issues failed to comply with those requirements and, therefore, failed to "fairly inform" [World Harvest] of GuideOne's position.

Id.

Nor did the prior reservation of rights given by GuideOne's sister-company cure this defect. For one, the prior reservation of rights letter involved an earlier policy; therefore, it was ambiguous because it "effectively reserved the rights of an insurer to withdraw" only for "a different, though related, insurance company in a separate action which involved a distinct policy." *Id.* In addition, GuideOne's decision to undertake the defense without a reservation of rights reasonably indicated to World Harvest its intent to waive its coverage defenses. *Id.*

The Court also dismissed the argument that GuideOne should not be estopped because World Harvest had failed to demonstrate that GuideOne's temporary provision of a defense had prejudiced it. The Court held that where an insurer assumes a defense without a reservation of rights, with actual or presumed knowledge of coverage defenses, prejudice to the insured by virtue of the insurer's assumption of the defense is

conclusively presumed. Alternatively, the loss of the insured's right to control the defense, by virtue of the insurer's actions, in and of itself constitutes prejudice without need of any further proof. *Id.* at 11-12.

The message for insurers from *World Harvest* and other similar cases is a simple one — a reservation of rights letter must fairly inform the insured of the insurer's position. Just because a letter is ten pages long does not mean that it satisfies this test.

***Pekin Ins. Co. v. Wilson*, 930 N.E.2d 1011 (Ill. 2010)**

A lot of ink has been spilled over the years addressing the availability of coverage for people who beat the terms and conditions out of each other. Such cases often include some discussion of the "expected or intended" exclusion. Expected or intended has never been an easy road for insurers to traverse. For example, proving that one person expected or intended to hit another person is generally not a difficult task. But that is not always the test for the applicability of the "expected or intended" exclusion in an assault and battery claim. Rather, sometimes insurers must prove that the insured "expected or intended" to cause the specific injury that he or she (usually it's a he) inflicted. That can frequently prove to be a difficult task since people often claim that they didn't mean to cause as much harm as they did.

But there are still times when, based on the nature of the conduct at issue, the only conclusion that can conceivably be reached is that the insured did in fact expect or intend to cause the resulting injury. In some cases the facts are just too egregious that they can't support any other conclusion. Here the "expected or intended" exclusion should serve as a bar to coverage. But the Supreme Court of Illinois's decision in *Pekin Ins. Co. v. Wilson* teaches that, even when insureds cannot possibly argue that they didn't mean to cause as much harm as they did, they may still not be down for the count when facing the "expected or intended" exclusion for an assault and battery claim.

In *Pekin*, the insured, Wilson, was sued for assault and battery after he allegedly attacked the claimant with a steel pipe. *Id.* at 1013-14. Wilson answered the amended complaint filed against him and counterclaimed, alleging that he had acted in self-defense. *Id.* at 1014. In particular, Wilson alleged that, because the claimant was larger than him, he had grabbed a pipe to defend himself. Thereafter, the claimant grabbed Wilson, snatched away the pipe, and "smashed his head and face into the wall." *Id.* at 1014-15.

Pekin Insurance, which insured Wilson, denied coverage under the policy's intentional act exclusion, which barred coverage for "'bodily injury' … expected or intended from the standpoint of the insured." Excepted from the exclusion was "'bodily injury' resulting from the use of reasonable force to protect persons or property" (the "self-defense exception"). *Id.* at 1014.

In the declaratory judgment action that followed, Pekin moved for judgment on the pleadings, arguing that under the amended complaint, it did not owe Wilson defense coverage. *Id.* at 1015. The trial court agreed, but the appellate division reversed. In doing so, the court looked not only at the allegations of the amended complaint, but also to Wilson's counterclaim of self-defense. The court determined that, given the claim of self-defense, and the exclusion's self-defense exception, the exclusion did not apply and Pekin owed defense coverage. *Id.* at 1016. The Illinois Supreme Court affirmed. *Id.*

Pekin argued that the appellate court should not have reversed the trial court's decision, because the determination of the duty to defend must be based solely upon the allegations of an underlying complaint. Therefore, whether the self-defense exception applied to preclude application of the intentional act exclusion could be decided only by reviewing the four corners of the complaint and not the insured's own pleadings that raised the self-defense exception. *Id.* The Illinois high court disagreed. It rejected the premise that courts are confined to review solely the allegations of an underlying complaint and noted that, procedurally, when considering a motion for judgment on the pleadings, a court was required to consider all of the pleadings, not just the complaint. *Id.* at 1020-22.

The court also believed that there were "unusual or compelling circumstances" that required consideration of Wilson's counterclaim with the complaint. Agreeing with the appellate court, the Illinois Supreme Court concluded that, because a plaintiff would not plead facts demonstrating that the defendant had acted in self-defense, restricting the determination

of the duty to defend to a review of the complaint only would make the self-defense exception illusory because it could never be invoked. *Id.* at 1022.

> [W]e agree with the appellate court below that it is "unlikely" that the underlying complaint would set forth allegations supporting a basis for defending Pekin's insured under its self-defense exception. There is no possible reason for Johnson, suing in tort for the intentional conduct of Wilson, to allege that Wilson's actions were excused by, as the policy states: " 'bodily injury' resulting from the use of reasonable force to protect persons or property." Thus, unless Wilson, as the defendant-insured in the underlying lawsuit, is allowed to plead facts alleging that the plaintiff's injury occurred through Wilson's reasonable use of self-defense, there is no way for the self-defense exclusion to be triggered, and the coverage is illusory.

Id. at 1022-23.

In other words, failing to review an insured's own allegations of self-defense would prevent a triggering of the exception and make the intentional act exclusion applicable even to those actions in which the insured had acted in self-defense. The court did not believe that the parties intended such a result. "Indeed, if Pekin actually desired to exclude coverage for *all* lawsuits arising from the intentional conduct of its insured, it would be illogical for it to have included the self-defense exception in the policy to begin with." *Id.* at 1023 (emphasis in original). Therefore, the appellate court was correct to examine Wilson's counterclaim and conclude that the exclusion did not apply to preclude Pekin's duty to defend.

Another state high court in 2010 reached a similar conclusion. *See Copp v. Nationwide Mutual Insurance Company,* 692 S.E.2d 220 (Va. 2010) (holding that, despite the duty to defend determination being limited to the four corners of the complaint, the insurer had a duty to defend — based on the insured's argument that he acted in self-defense — notwithstanding that nothing to that effect appeared in the complaint). *But see Wilkinson v. Arbuckle*, No. 2009AP2868 (Wis. Ct. App. Oct. 13, 2010) ("Acuity's obligation to defend under the self-defense clause will rarely, if ever, be triggered given that self-defense is an affirmative defense.").

C.R.S.A. § 13-20-808 (Colorado): 'An Act Concerning Commercial Liability Insurance Policies Issued To Construction Professionals'

There may be no greater enigma in insurance coverage than construction defect claims. Consider this. When it comes to claims for latent injuries and damages, such as asbestos and hazardous waste, some would say that they were never contemplated under the historic policies that were later — sometimes decades later — called upon to respond. It is not surprising, therefore, that questions such as trigger of coverage and allocation have been viewed by courts as particularly vexing. As a result, case law lacks unanimity as different schools of thought have developed in response to the issues.

But claims for coverage for construction defects, and the damage they cause, present a vastly different situation. It is unquestionably contemplated that such claims will be made under commercial general liability policies — especially when the insured is in the construction business. For this reason, it is surprising that so much disparity has developing around the country in the case law over the treatment of such claims, especially those involving relatively similar facts and oftentimes identical policy language.

The dispute at the heart of construction defect claims is whether faulty workmanship, to an insured's own work, constitutes an "occurrence" under a CGL policy. Compare *Essex Ins. Co. v. Holder*, 261 S.W.3d 456, 460 (Ark. 2007) ("[O]ur case law has consistently defined an 'accident' as an event that takes place without one's foresight or expectation—an event that proceeds from an unknown cause, or is an unusual effect of a known cause, and therefore not expected. Faulty workmanship is not an accident; instead, it is a foreseeable occurrence, and performance bonds exist in the marketplace to insure the contractor against claims for the cost of repair or replacement of faulty work.") (citation omitted) *with Bituminous Cas. Corp. v. Kenway Contracting, Inc.*, 240 S.W.3d 633, 639–40 (Ky. 2007) (holding that a claim against a contractor, who was supposed to demolish carport, but instead also demolished half of attached residential structure, qualified as

"occurrence" because such outcome was not planed, designed, or intent of the insured).

The number of cases addressing the "occurrence" issue have become too many to count, and there appears to be no end in sight. Litigation over this issue is on its way to becoming as abundant and fiercely fought as the pollution exclusion. The staggering abundance of construction defect litigation was summed up perfectly this year by a California appeals court's characterization of a construction company's description of it: "It is not too much of an exaggeration to say that as soon as the last nail in a project is hammered and the keys are handed over to the homeowners, the ink on the first lawsuit over the construction of the homes is starting to dry." *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal. App. 4th 1466, 1482 (2010).

Interestingly, despite this battle royale over the "occurrence" issue, a CGL policy does not provide coverage for the cost to repair or replace an insured's own work that is faulty. After all, even if an insured succeeds in establishing that faulty workmanship to its own work qualifies as an "occurrence," coverage would still be precluded by the policy's "your work" exclusion. The staunchest policyholder counsel would have a hard time disputing this.

Then why is so much time and money being spent in litigation over the "occurrence" issue? Because while damage to the insured's own completed work product is not covered, the rationale a court employs to reach this conclusion — no "occurrence" or the "your work" exclusion — can make a world of difference. This is because the "your work" exclusion also contains what is commonly referred to as the "subcontractor exception," which restores coverage for "property damage" to the insured's own work, that would otherwise be excluded by the "your work" exclusion, if the cause of the damage to the insured's work was the operations of the insured's subcontractor.

However, many courts hold that, if damage to an insured's defective workmanship is not covered, because it does not qualify as an "occurrence," then the insured has not satisfied the requirements of the insuring agreement. As a result of the insured's failure to satisfy the insuring agreement, coverage is excluded and the court's analysis ends there, without any need for the court to address the potential applicability of policy exclusions. In other words, by resting its decision on the insured's failure to satisfy the insuring agreement, it becomes unnecessary for the court to reach the "your work" exclusion. Translation — policyholders are therefore denied the opportunity to invoke the "subcontractor exception" to such exclusion to restore coverage for damage to their own work that was caused by the operations of a subcontractor.

In its simplest terms, the "occurrence" battle is all about whether the "subcontractor exception" to the "your work" exclusion comes into play. *See Nabholz Constr. Corp. v. St. Paul Fire & Marine Ins., Co.*, 354 F. Supp. 2d 917, 923 (E.D. Ark. 2005) ("The Court need not reach CONARK's argument that coverage exists based on the Policy's completed work exclusion, or more accurately, based upon an exception to this exclusion. Because the Court's finding is based upon its conclusion that coverage is lacking under the basic insuring clause, it is unnecessary to consider this exclusion. An exception to an exclusion cannot create or extend coverage where none exists under the terms the policy's basic insuring agreement.")

There was no shortage of decisions in 2010 that addressed whether an insured's faulty workmanship qualified as an "occurrence." But given that the battle lines over this issue are so clearly drawn, and the number of decisions legion, it is not surprising that none of them met the criteria to qualify as one of the year's ten most significant insurance coverage decisions.

Nonetheless, the "occurrence" issue still finds a spot on the 2010 Coverage Top 10. This is because of the May 21st enactment by the Colorado General Assembly of "An Act Concerning Commercial Liability Insurance Policies Issued to Construction Professionals," H.B. 10–1394. *See* C.R.S.A. § 13-20-808. The Colorado Act addresses several issues relevant to coverage for construction defects, most notably declaring that: "In interpreting a liability insurance policy issued to a construction professional, a court shall presume that the work of a construction professional that results in property damage, *including damage to the work itself* or other work, is an *accident* unless the property damage is intended and expected by the insured." *Id.* at § 3 (emphasis added).

In other words, the Colorado legislature did what courts all across the country have been doing in con-

struction defect coverage cases – it decided whether an insured's own work that is faulty qualifies as having been caused by an accident, *i.e.*, an "occurrence." The Colorado General Assembly concluded that it did.

But the General Assembly, just as courts nationally have done, was also quick to point out that, even if damage to an insured's own work qualifies as having been caused by an "occurrence," coverage remains unavailable for damage to the insured's own work. Specifically, the Colorado Act states that nothing "[r]equires coverage for damage to an insured's own work unless otherwise provided in the insurance policy; or [c]reates insurance coverage that is not included in the insurance policy." *Id.* at § 3(a), (b).

The Act also leaves nothing to chance when it comes to ensuring that the "subcontractor exception" to the "your work" exclusion is reached. The Act states: "If an insurance policy provision that appears to grant or restore coverage conflicts with an insurance policy provision that appears to exclude or limit coverage, the court shall construe the insurance policy to favor coverage if reasonably and objectively possible." *Id.* at § 5.

The Colorado Act specifically described the Colorado Court of Appeals's decision in *Gen. Sec. Indem. Co. of Ariz. v. Mountain States Mut. Cas. Co.*, 205 P.3d 529 (Colo. Ct. App. 2009) as the motivation for its passage. In *Gen. Sec.*, the Colorado Court of Appeals held that a claim for damages arising from defective workmanship, standing alone, does not qualify as an "occurrence," regardless of the underlying legal theory pled (tort, contract, or breach of warranty). However, the court also adopted a "corollary" to such rule — an "accident" and "occurrence" are present "when consequential property damage has been inflicted upon a third party as a result of the insured's activity." *Id.* at 535. The Colorado Act blames the *Gen. Sec.* Court for not properly considering a construction professional's reasonable expectation that an insurer would defend the construction professional against a construction defect claim. *Id.* at § (1)(b)(III).

It is interesting that *Gen. Sec.* is a 2009 decision. One would think that it would have taken a few more years of policyholder frustration over the consequences of the decision before the legislature stepped in.

While another pronouncement from a court on the "occurrence" issue would have been ho-hum, and certainly not one of the year's ten most significant coverage decisions, this same message, delivered by a state legislature, is just the opposite. The decision by the Colorado General Assembly, to boldly go where no legislature has gone before in the "faulty workmanship as an 'occurrence' debate," is a potentially significant development concerning the scope of construction defect coverage.

This is because, once the "occurrence" issue has been decided in a particular state, via the judicial route, it is difficult to change the outcome, especially if the issue has been decided by the state's highest court. And even if it remains an open issue with the highest court, the right case still needs to come along, not to mention that the judicial system is not known for its speediness. But the legislative route — especially for insureds who did not find success in the judicial branch — would offer the proverbial second bite at the apple and a speedier one at that. Further, while lobbying judges has significant restrictions — being limited to skillful advocacy, in public and under very precise conditions — lobbying legislators is a whole different kettle of fish. And construction trade associations are no strangers to legislative hallways. Needless to say, Colorado's action begs the question whether other states will follow its lead and legislate whether an insured's own faulty workmanship qualifies as having been caused by an "occurrence."

***Flomerfelt v. Cardiello*, 997 A.2d 991 (N.J. 2010)**

There are very few insurance policy provisions construed as consistently as the phrase "arising out of." It has been a steady-Eddy issue, with most courts construing it broadly, generally interpreting it to mean "originating from," "growing out of," or having a "substantial nexus with." These courts reject a legal causation test and instead employ a "but for" test to determine whether damage or liability "arises out of" a particular event, whether used in an insuring provision or an exclusion clause. Because this broad interpretation of "arising out of" has been so consistent — even in New Jersey — the New Jersey Supreme Court's decision in *Flomerfelt v. Cardiello,* which rejects it in some instances, is significant.

In *Flomerfelt*, the underlying plaintiff, Wendy Flomerfelt, suffered temporary and permanent injuries

after she overdosed on alcohol and drugs during a party hosted by the insured while his parents were out of town. Flomerfelt had little recollection of what she drank or ingested, either before she arrived at the party or during the party. Her complaint, however, asserted that her injuries were caused by the insured, who provided her with drugs and alcohol, served her alcohol when she was visibly intoxicated, and failed to promptly summon paramedics when he found her unconscious on the porch the next day. *Id.* at 993. The use of drugs was one clear cause of the injuries; Flomerfelt's own expert concluded in the underlying case that her injuries "were caused by the ingestion of multiple drugs and alcohol, and that the injuries were exacerbated by a delay in receiving medical attention." *Id.* at 994.

Pennsylvania General Insurance Company ("PGI"), which had issued a homeowners' policy to the insured's parents, declined to defend or indemnify the insured based on a policy exclusion precluding coverage for claims "[a]rising out of the use, ... transfer or possession" of controlled substances. *Id.* at 993-94. PGI argued that, under the expansive meaning of "arising out of," which was not limited to causation, but, instead, equates with concepts such as "incident to" or "in connection with," there was no coverage for Flomerfelt's claims. As PGI saw it, all of the evidence tied her injuries at least in part to her ingestion of illegal drugs at the party; therefore, the exclusion precluded coverage. *Id.* at 995.

The insured, on the other hand, argued that because Flomerfelt's complaint also alleged that injuries were caused by alcohol and the insured's failure to promptly summon help, the exclusion could not apply until those causes were ruled out as inflicting her injuries. *Id.* The trial court agreed, but the Appellate Division reversed, employing a broad interpretation of the phrase "arising out of" and utilizing a substantial nexus test for purposes of evaluating coverage. The panel concluded that because the experts had linked Flomerfelt's injuries to both drugs and alcohol, those injuries "arose out of" the excluded acts of "use, ... transfer or possession" of illegal drugs exclusion. *Id.* at 996. The New Jersey Supreme Court, in a 7-0 opinion, reversed the Appellate Division.

Under the principle that an exclusion must be narrowly construed and the insurer bears the burden of proving its application, the court observed that although the phrase "arising out of" has been "read expansively to define the link between the conduct and the covered activity as 'originating from,' 'growing out of' or having a 'substantial nexus,'" *id.* at 1002, "the circumstances presented in this appeal reveal an inherent and heretofore unseen ambiguity that requires us to consider the phrase in a new and different context. At a minimum, the facts before us demonstrate the complexity of interpreting the exclusion when a claim for a personal injury asserts multiple possible causes and theories for recovery against the insured." *Id.* at 1003. The court thereafter held that, given the alleged concurrent causes of Flomerfelt's injuries between covered and excluded risks, it was premature to determine that the exclusion applied.

In doing so, the court first rejected PGI's interpretation of "arising out of" as too expensive and unsupported by prior precedent:

> the insurer's proposed construction that we read the phrase in the exclusion to mean "incident to" or "in connection with" cannot be correct. That reading would expand the phrase "arising out of" to mean that the injury is connected in any fashion, however remote or tangential, to the excluded act, rather than one that "originates in," "grows out of" or has a "substantial nexus" to the excluded act. It is a suggested reading so at odds with our case law that we decline to embrace it.

Id. at 1005.

The court then concluded that it was too early to determine whether there existed a substantial nexus between Flomerfelt's ingestion of drugs at the insured's party and her injuries:

> The procedural posture in which this matter has reached us therefore does not permit a definitive answer to the question, as a matter of fact, about the cause or causes that led to plaintiff's injuries, either temporary or permanent. Nor can we determine the sequence of events that led to the injuries or whether drugs provided or used at the party, that is,

> the excluded acts, had a substantial nexus to those injuries.
>
> * * *
>
> If, for example, the finder of fact were to conclude that alcohol ingestion, either in the context of the social host serving plaintiff when she was visibly intoxicated [citation omitted], or in combination with a delay in summoning aid, was the cause for the injuries, or set the chain of events in motion, and that there was not a substantial nexus between drugs at the party and the injuries, the claim would fall within the coverage of the policy and would not be barred by the exclusion. If the finder of fact were to conclude that plaintiff's injuries were caused by use of drugs before she arrived at the party, by genetic predisposition, or by long-term drug use such that the injuries did not "originate in," "grow out of" or have a "substantial nexus" to her use of drugs at the party, the claim would also be covered.

Id. at 1005-06.

Is *Flomerfelt* the beginning of a narrower construction of the phrase "arising out of" when read in an exclusion, especially where concurrent causation of injuries are alleged (as is sometimes the case)? It is too early to draw such conclusions; however, the reaction of policyhoders and other courts to this decision certainly is worth watching.

***State Automobile Mut. Ins. Co. v. Flexdar, Inc.*, __ N.W.2d __, No. 49A02-1002-PL-00111, 2010 Ind. App. LEXIS 2170 (Ind. Ct. App. Nov. 22, 2010)**

Insurance coverage disputes are generally about one thing — interpreting the meaning of insurance policy provisions. In the typical case, static policy provisions are applied to factual scenarios that vary. Even if two claim scenarios appear the same, no two are ever *exactly* alike.

But in some claims it is the policy language that is not so static. Just about all insurers change their policy language over time — some more frequently than others. When a coverage dispute involves the interpretation of policy language that has subsequently undergone change, it is not surprising that policyholders, when they can, will cite to the new version of the policy as support for the meaning of the prior version that they are advocating. The competing arguments in this situation are easy to predict.

If an insurer adopts a new version of a policy provision that restricts coverage for a certain situation, policyholders will no doubt argue that, by definition, the old version must have been intended to grant coverage for that situation. *See Swank Enterprises, Inc. v. All Purposes Services, Ltd.*, 336 Mont. 197, 203-04 (2007) ("As further evidence of ambiguity, we need only consider the amended endorsement to the 1998 policy, entitled 'Additional Insureds,' which expressly provides, unlike the 1997 policy, that 'all exclusions' apply to 'additional insureds.' Logic dictates one of two reasons for the change. Continental changed the policy so that the exclusions referring to 'you' and 'your' would also apply to additional insureds, which implies that the exclusions did not apply to additional insureds under the 1997 policy, or Continental sought to clarify that the exclusions apply to additional insureds, which indicates that the 1997 policy was ambiguous.").

For insurers, the counter-argument is that a change in policy language can be made for purposes of clarification without it being tantamount to an admission that the prior version was ambiguous. In other words, making something clearer does not mean that the prior version was necessarily unclear. *See Penton Media, Inc. v. Affiliated FM Ins. Co.*, No. 1:03 CV 2111, 2006 U.S. Dist. LEXIS 64387, *11 (N.D. Ohio Aug. 29, 2006) (citing court's prior order) ("The mere fact that Affiliated FM decided to clarify future policies when faced with a lawsuit is not proof that the previous language meant what Penton asserts it does, or is even ambiguous."). *But see Fortunato v. Highlands Ins. Group*, 345 N.J. Super. 529, 535 (App. Div. 2001) ("If an insurance company changes language in a policy in order to clarify language in the prior policy, this implies that the earlier policy needed clarification. Language which needs clarification is ambiguous and must be construed against the insurer.").

Right or wrong, the "coverage by admission" (at least tacit admission) argument is one that insurers should expect to hear it from policyholders. The risk of coverage by admission is a particularly important factor

for insurers to consider if a policy provision being considered for change will continue to be subject to numerous claims still in the pipeline, notwithstanding the incorporation of the new version in policies going forward.

Courts in this situation also disagree over what impact Federal Rule of Evidence 407 has on the issue. In general, for purposes of proving negligence, this rule renders inadmissible any evidence of a subsequent remedial repair. The rationale for the rule is simple. It is good social policy to encourage people to make repairs in furtherance of safety. It would discourage people from doing so if it could be used against them as evidence of negligence for a pre-repair accident. It is not difficult to see how the use of an insurer's decision to amend policy language, to interpret the meaning of prior policy language, could be analogous to this rule of evidence.

In 2010, the Court of Appeals of Indiana weighed in on the impact that a change in policy language has on the interpretation of a prior version of such language. While *State Automobile Mut. Ins. Co. v. Flexdar* is not from a state high court, it was selected for inclusion as one of the year's ten most significant coverage decisions for two reasons: (1) there is a general dearth of decisions addressing this important issue; and (2) the rationale for the court's decision was the Indiana version of Federal Rule of Evidence 407. Being a "rule," it may be an attractive rationale for some courts to adopt when deciding whether a change in policy language is the equivalent of an admission that the prior version was ambiguous.

In *Flexdar,* the insured, Flexdar, Inc., manufactured rubber stamps and printing plates with machinery that utilized the industrial solvent trichloroethylene ("TCE"). In 2003, investigators for the Indiana Department of Environmental Management ("IDEM") discovered that Flexdar's plant had leaked TCE into the subsoil and groundwater over multiple years. IDEM informed Flexdar that it would be liable for the costs of environmental remediation; Flexdar, in turn, notified its insurer, State Auto, requesting a defense and indemnification under the CGL policies State Auto had issued to it. *Id.* at *4-5. State Auto thereafter sought a declaration that the claims were excluded under the policies' pollution exclusion, which defined "pollutants" to mean "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." *Id.* at 5.

The parties cross-moved for summary judgment. In its motion, Flexdar tendered to the trial court a revised version of the exclusion contained in a subsequent policy, whch specifically listed TCE in its definition for "pollutants." Flexdar argued that the revision demonstrated that State Auto believed its prior definition of pollutants, which did not list TCE, was ambiguous and needed clarification. Therefore, the pollution exclusion should not bar coverage for its claims. The trial court struck the evidence as irrelevant, but nevertheless held that the pollution exclusion was ambiguous and unenforceable. State Auto appealed.

Although the Indiana Court of Appeals affirmed the trial court's decision that the pollution exclusion was ambiguous and unenforceable, the court relied upon the principles that underlie Rule 407 of the Indiana Rules of Evidence, which the court noted is "substantially similar" to Rule 407 of the Federal Rules of Evidence, and affirmed the trial court's decision to strike the subsequent policy revision as irrelevant to the interpretation of earlier versions of the pollution exclusion. *Id.* at *10-11. In so doing, the court agreed with the reasoning of a recent Seventh Circuit decision which held that an insured's reliance on a subsequent version of a policy provision to support an interpretation is impermissible:

> The subsequent version of the clause … which State Farm describes as a clarification, [the insured] deems a confession that her interpretation of the original clause is correct. Obviously it is not a confession. And to use at a trial a revision in a contract to argue the meaning of the original version would violate Rule 407 of the Federal Rules of Evidence, the subsequent-repairs rule, by discouraging efforts to clarify contractual obligations, thus perpetuating any confusion caused by unclarified language in the contract....

Id. at *9-10 (quoting *Pastor v. State Farm Mut. Auto. Ins. Co.*, 487 F.3d 1042, 1045 (7th Cir. 2007)).

In the case before it, the *Flexdar* Court held that the same evidentiary bar should apply. The revision to the

definition for the term "pollutants" lacked probative value as to the interpretation of the prior definition, and, further, the use of such measures would deter remedial clarification of policy language:

> We agree with *Pastor* and conclude that Rule 407 may bar evidence of subsequent policy revisions offered to resolve ambiguity in an executed insurance contract. Here, Flexdar and State Auto executed several CGL policies subject to a pollution exclusion. The parties now disagree as to whether the term "pollutant" in the exclusion is ambiguous or contemplates a leakage of TCE. State Auto apparently revised its standard policy forms in 2004 to specify TCE as a pollutant. In line with the foregoing, we conclude that any modifications that State Auto made to its policy forms in 2004 constitute subsequent remedial clarifications which are not admissible to interpret Flexdar's insurance contract and prove State Auto's liability.

Id. at *10-11.

Flexdar was an important win for insurers as some courts may rely on FRE 407 to flat-out preclude consideration of a subsequent policy amendment on the interpretation of its prior version. But no matter what a court does on the FRE 407 issue, it does not end the parties' dispute over the meaning of the prior version of the policy. Just look at *Flexdar*, where the insurer succeeded in using FRE 407 to keep a subsequent version of a policy provision out as evidence of the meaning of the prior version, but still lost on its interpretation of such provision. ■

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