

# Insurance

## **Insurance-Palooza:**

### **7th Annual Look At The Year's Ten Most Significant Coverage Decisions**

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# Commentary

## Insurance-Palooza: 7th Annual Look At The Year's Ten Most Significant Coverage Decisions

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It is a rare day that a court is called upon to address the availability of insurance coverage for a claim for alienation of affections. But in 2007, this solar eclipse of a coverage issue saw the light not just once, but twice. If you don't think that's a long shot, then how about this — both decisions came from South Dakota (the state's supreme court and the Eighth Circuit applying South Dakota law<sup>1</sup>). Those are Powerball odds. And I thought the only thing that people in South Dakota did for fun was visit Mt. Rushmore. [South Dakotans — You can send hate mail to [Maniloffr@whiteandwilliams.com](mailto:Maniloffr@whiteandwilliams.com).]

That's the kind of year 2007 was for insurance coverage — the typical landscape of important decisions dotted with entertaining and attention-grabbing

ones. *E.g.*, see *Bobby Knight v. Indiana Insurance Company* (who else), 871 N.E.2d 357 (Ind. App. 2007) (No coverage for Indiana University's famously bad-tempered basketball coach for, what else, assaulting an assistant coach); *Woo v. Fireman's Fund Insurance Company*, 164 P.3d 454 (Wash. 2007) (Coverage available for an oral surgeon that played a practical joke on a surgical assistant — inserting novelty boar tusks into her mouth while she was under anesthesia for a procedure and then photographing her with her eyes pried open); *Bituminous Casualty Corp. v. Kenway Contracting Inc.*, 2007 Ky. LEXIS 129 (Coverage available for a contractor hired to tear down a carport but mistakenly tore down half the house. Oops. “[Employee] testified that he knew something was wrong when [supervisor] got out of his truck and placed both hands to his head.” *Id.* at \*4.); *Underwriters at Lloyd's London v. Frederick Yale*, 2007 Conn. Super. LEXIS 1586 (Examining the applicability of an “athletic and sports exclusion,” the court held that there is “a genuine issue of material fact as to whether professional wrestling constitutes an entertainment event, as opposed to an athletic or sporting event.”); and *United Sugars Corp. v. St. Paul Fire and Marine Insurance Company*, 2007 Minn. App. Unpub. LEXIS 660 (Coverage addressed for cookie dough adulterated with bee parts and cigarette butts. Not exactly mix-ins you'll see at Cold Stone Creamery.)

None of these decisions made the list of the year's ten most significant (or even came close for that matter). As Sanjaya proved last year, attention-grabbing can only get you so far in the voting.

For the seventh January in a row I am grateful to Editor Vivi Gorman of *Mealey's Litigation Report: Insurance* for the opportunity to make the case for ten coverage decisions from the year gone by that are likely to have a significant impact in future disputes. 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 a coverage issue; (iii) are part of a new trend; or (iv) involve a burgeoning coverage issue.

The process for selecting the year's ten most significant insurance coverage decisions is highly subjective, shrouded in secrecy, has no accountability and follows strict tradition. It's not unlike how a new Pope is chosen, except no white smoke comes out of a chimney when I'm finished.

The following are the ten most significant insurance coverage decisions of 2007 (listed in the order that they were decided):

***Swank Enterprises, Inc. v. All Purpose Services, Ltd.*** — Montana Supreme Court gave additional insureds their coveted seat at the grown-ups table.

***Cinergy Corporation v. Associated Electric & Gas Insurance Services, Ltd.*** — Indiana Supreme Court told policyholders the inconvenient truth about coverage for global warming compliance costs.

***Continental Casualty Company v. Employers Insurance Company of Wausau*** — New York trial court let out a roar in The Mousetrap of insurance coverage issues — asbestos. Honorable mention to *In the Matter of: The Liquidation of Integrity Insurance Company* — New Jersey Supreme Court interpreted the term “absolute” straight-up, left claimants on the rocks and had reinsurers doing the twist concerning Incurred But Not Reported asbestos claims covered by an insolvent insurer.

***Home Depot U.S.A., Inc. v. Ohio Casualty Insurance Company*** — You must do it. And we can't help. Texas District Court provided no assistance to Home Depot in its effort to build a case for coverage as an additional insured. The court provided a reminder on the importance of providing timely notice of such claims.

***Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breaches)*** — Fifth Circuit was Waterloo for policyholders seeking coverage for flood damage caused by Hurricane Katrina.

***Allmerica Financial Corporation v. Certain Underwriters at Lloyd's London*** — Supreme Judicial Court of Massachusetts tried to clear up the Dirty Water in the relationship between primary and excess insurers.

***Catholic Mutual Relief Society v. Roman Catholic Archdiocese of San Diego*** — Supreme Court of California addressed the sometimes Al Capone's vault of coverage issues — discovery of reinsurance information.

***Lamar Homes, Inc. v. Mid-Continent Casualty Company*** — Texas Supreme Court addressed coverage for construction defects and settled the biggest battle over a home since the Alamo. In addition, everything is bigger in Texas and that now includes the consequences for an insurer that breached its duty to defend.

***Bradley Ventures, Inc. v. Farm Bureau Mutual Insurance Company*** — Supreme Court of Arkansas handed policyholders a get out of jail free card when seeking coverage after a guilty plea.

***Essex Insurance Co. v. H & H Land Development Corporation*** — At last, a court addressed the Montrose Endorsement. Insurers reaction to this Georgia District Court decision — Uga.

### The Ten Most Significant Insurance Coverage Decisions Of 2007

***Swank Enterprises, Inc., et al. v. All Purpose Services, Ltd., et al.*, 154 P.3d 52 (Mont. 2007).**

For as long as there have been “additional insureds,” there have been disputes over just how much coverage they are owed, if any. 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 have often disputed whether additional insureds are entitled to coverage for their independent negligence, or solely vicarious liability.

Additional insureds have frequently found themselves fighting to shed their Rodney Dangerfield status, arguing that they are “insureds” just as if their name appeared on the declarations page. Last year the Montana Supreme Court (as well as the Fifth Circuit) did just that, and then some.

In *Swank Enterprises*, coverage was sought by an additional insured under the following circumstances. Swank Enterprises and the City of Libby entered into a contract for the construction of a water treatment plant. Swank then subcontracted with All Purpose Services to paint the filter tanks and pipes at the plant. The contract between Swank and All Purpose called for All Purpose to designate Swank as an additional insured on All Purpose’s commercial general liability policy. Continental Western Insurance Company provided this insurance to All Purpose under two policies, both of which listed Swank as an additional insured. *Swank* at 54.

All Purpose selected the paint and painted the tanks. It was discovered afterwards that All Purpose had used an improper type of paint. The plant’s tanks and pipes had to be stripped and repainted and the treatment plant was shut down for the duration of the repair work. The City of Libby sued Swank for the costs associated with repainting the pipes. *Id.*

Swank tendered the City’s claim to Continental and sought defense and indemnity, based on its status as an additional insured. Continental disclaimed coverage, citing to various “business risk” exclusions [(j), (k), (l), and (m)] in its policy issued to All Purpose. Swank then tendered the City’s claim to its own insurer, St. Paul, which settled with the City for approximately \$ 150,000. *Id.*

Swank and St. Paul filed suit against Continental for coverage. Swank argued that, because certain of the “business risk” exclusions addressed “you” and “your,” which the policy defined to mean the “named insured,” such exclusions did not apply to it, as an additional insured. Specifically, the exclusions appeared to apply to property damage arising out of *your operations* and property damage to *your product*. The lower court concluded that, if applicable, the exclusions would preclude coverage for damage due to All Purpose’s botched paint job. *Id.* at 56.

However, the Montana Supreme Court agreed with the interpretation advanced by additional insured Swank, that the definition of “you” and “your” did not apply to it — at least it concluded that the policy was ambiguous. The *Swank Enterprises* Court held:

When strictly construed based on their plain language, the exclusions at issue do not exclude claims made by Swank, especially when considered in light of the severability of interests clause. On the other hand, the exclusion section is prefaced by the language “[t]his insurance does not apply to” with the list of exclusions following, which can be read to exclude coverage to *any* insured when the underlying damage triggers the exclusion.

The exclusions at issue, therefore, can be read two ways: either the exclusions only apply to All Purpose, since they specifically reference the named insured, or the exclusions arise from the actions of the named insured but apply to any insured seeking coverage. In other words, the language of the exclusions is ambiguous.

*Id.* at 57 (emphasis in original).

Therefore, based on *Swank Enterprises*, additional insureds are provided with an exclusion-free policy for purposes of the “business risk” exclusions. That’s painful medicine for insurers to swallow, especially when you consider that additional insureds are often provided with a premium-free policy as well. The Fifth Circuit also weighed in on the “you”/“your” — additional insured issue last year. See *National Union Fire Insurance Co. v. Liberty Mutual Insurance Company*, 2007 U.S. App. LEXIS 11724.

As an interesting aside, in finding coverage for Swank Enterprises based on ambiguity in the policy language, the court was also guided by the insurer’s decision to amend such language in the subsequent year’s policy, specifically extending the exclusions 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.” *Id.* at 57. Thus, *Swank Enterprises* also brought to life the concern that some insurers have about being bitten by their decision to adopt a new version of a form.

***Cinergy Corporation, et al. v. Associated Electric & Gas Insurance Services, Ltd.*, 865 N.E.2d 571 (Ind. 2007).**

I admit that I don't know much (anything, for that matter) about global warming. Maybe it is a legitimate threat to mankind's existence or maybe it's the greatest urban legend since Mikey died from eating Pop Rocks.<sup>2</sup> Either way, global warming is no longer just a scientific issue, but now firmly rooted as a business one as well. And lawyers are getting in on the act. This past year saw lots of law firms expanding their footprint to include global warming practice groups (perhaps dusting off those Y2K practice groups) and there was even a conference held on insurance-related global warming issues – sponsored by the publisher of the magazine that you are holding. “Mealey's Insurance Litigation Global Warming Conference” took place on June 6, 2007 in San Francisco.

But this much I do know about global warming — if it's the reason why the thermometer occasionally hits 60 degrees in Philadelphia in January or February, then it can't be all bad. [Environmentalists — You can send hate mail to [Maniloffr@whiteandwilliams.com](mailto:Maniloffr@whiteandwilliams.com).]

The potential for global warming insurance issues got a shot in the arm in 2007 when the United States Supreme Court decided *Massachusetts, et al. v. Environmental Protection Agency, et al.*, 127 S. Ct. 1438 (2007). In *Massachusetts v. EPA*, the U.S. high court held that “greenhouse gases fit well within the Clean Air Act's capacious definition of ‘air pollutant,’ [and] that EPA has the statutory authority to regulate the emission of such gases from new motor vehicles.” *Id.* at 1462. “Under the clear terms of the Clean Air Act, EPA can avoid taking further action only if it determines that greenhouse gases do not contribute to climate change or if it provides some reasonable explanation as to why it cannot or will not exercise its discretion to determine whether they do.” *Id.*

Take away point for insurance purposes — if manufacturers are at some time in the future obligated to upgrade their facilities to meet emission standards

for greenhouse gases — no doubt an expensive undertaking — they will likely seek coverage for such costs from their general liability insurers. While these claims are no doubt a ways off, the Indiana Supreme Court addressed this fundamental coverage issue in *Cinergy Corporation, et al. v. Associated Electric & Gas Insurance Services, Ltd.*

In *Cinergy*, the Indiana Supreme Court addressed whether coverage was owed by an insurer, AEGIS, to various power companies for a complaint filed against them by the United States, three states and several environmental organizations pursuant to the federal Clean Air Act, alleging failure to obtain permits and discharge of excess emissions from power plants, allegedly resulting in wide-spread harm to public health and the environment. *Cinergy* at 573.

Not surprisingly, *Cinergy* is a complex case. However, the Indiana Supreme Court cut right to the heart of the coverage dispute:

There is essential agreement among the parties, however, that the primary thrust of the federal lawsuit is to require the power companies to incur the costs of installing government-mandated equipment intended to reduce future emissions of pollutants and prevent future environmental harm. Their principal disagreement is thus whether the costs of installing such equipment fall within the policies' coverage for damages because of or resulting in bodily injury or property damage with respect to any accident, event, or continuous or repeated exposure to conditions.

*Cinergy* at 579.

At the start of its analysis, the Indiana Supreme Court in *Cinergy* had no difficulty identifying several prior Indiana cases that provided insurance coverage for environmental clean-up costs. And, of course, this comes as no surprise to anyone reading this. But AEGIS argued that this prior Indiana precedent allowing insurance coverage for environmental clean-up costs is readily distinguishable:

“[t]he claims here . . . do not allege cleanup costs or preventive measures ordered as part

of the clean up of a spill,” but rather “the underlying claims here seek to force [the power companies] to comply with statutory requirements that it apply for certain permits before constructing projects at its facilities, and where necessary, install modern pollution control technology as part of the construction.”

*Cinergy* at 581. The power companies did not dispute that, despite the lawsuit’s various references to seeking relief that would “remedy” past violations and harm to public health, the remedy really being sought was “to force Cinergy to install equipment to contain any further excess emissions and allow the environment to recover.” *Cinergy* at 582.

The Indiana Supreme Court turned to the language of the AEGIS policy for its decision and held as follows:

The responsibilities of AEGIS under its policies for “ultimate net loss,” including the power companies’ defense costs, is conditioned by the requirement that such loss be for damages because of bodily injury or property damage “caused by an occurrence.” Under all three policies the term “occurrence” means “an accident, event, or continuous or repeated exposure to conditions.” Due to this occurrence requirement, the policy thus applies only if damages claimed by the power companies, the costs associated with the installation of equipment to contain further excess emissions, constitute damages because of bodily injury or property damage *caused by* an accident, event, or exposure to conditions. The clear and unmistakable import of the phrase “caused by” is that the accident, event, or exposure to conditions must have preceded the damages claimed — here, the costs of installing emission control equipment.

*Id.* (emphasis in original). “We cannot read the policy requirement that covered damages result from the happening of an occurrence to mean that coverage extends to damages that result from the prevention of an occurrence.” *Id.*

While the *Cinergy* Court reached its decision by resort to the AEGIS policy language, and, specifically,

the policy’s “occurrence” requirement contained in the Insuring Agreement, it was also guided by out of state decisions that relied on a different aspect of the Insuring Agreement. In *A.Y. McDonald Industries v. Ins. Co. of North America*, 475 N.W.2d 607 (Iowa 1991) and *AIU Insurance Company v. Superior Court*, 799 P.2d 1253 (Cal. 1990), both courts concluded that the costs to pay for preventive measures taken in advance of pollution are not incurred *because of property damage*.

The *Cinergy* Court tried its best to find coverage for the cost to install the new equipment (“Notwithstanding our preference to construe ambiguous insurance policy language strictly and against the insurer. . . .” *Id.*), but was ultimately constrained by an inconvenient truth (“. . . we discern no ambiguity here that would permit the occurrence requirement reasonably to be understood to allow coverage for damages in the form of installation costs for government-mandated equipment intended to reduce future emissions of pollutants and to prevent future environmental harm.” *Id.*). It didn’t take long for an Indiana court to rely on *Cinergy* to deny coverage for the costs to install emission control equipment. See *Newman Manufacturing, Inc. v. Transcontinental Insurance Company*, 871 N.E.2d 396 (Ind. App. 2007).<sup>3</sup>

***Continental Casualty Company, et al. v. Employers Insurance Company of Wausau, et al.*, 839 N.Y.S.2d 403 (2007).**

It has been reported that the worst of the asbestos liability crisis is now behind the insurance industry.<sup>4</sup> But even if new filings are down and some courts are now looking at claims with an overdue jaundiced eye, there are still enough claims and potential coverage disputes in the system to keep the longest running insurance coverage show going well into the future.

The asbestos beast has an insatiable appetite for money. And the large number of asbestos defendants that have declared bankruptcy stand as a warning to companies that are unable to satisfy it. By necessity, this forces asbestos defendants to leave no stone unturned in their search for insurance dollars. Along those lines, there has been much talk in coverage circles over the past several years about asbestos defendants attempting to re-open previously-thought-to-be-exhausted insurance policies by arguing that

the claims paid under them were for asbestos-related "operations" and not "products liability" or "completed operations." Translation — since operations claims (unlike products and completed operations) were usually not subject to an aggregate limit, the policies are not exhausted after all. Whoa, Nelly, as Keith Jackson would say.

While there has been a lot chatter about the re-characterization of asbestos claims, the number of judicial decisions addressing the issue have been minimal (not to mention that it takes the right set of facts for an insured to be in a position to pursue this strategy). Last year in *Continental Casualty Company v. Employers Insurance Company of Wausau* ("Keasbey"), a New York trial court issued an opinion in an action involving the attempted re-characterization of asbestos claims. While trial court opinions rarely appear on the list of the year's ten most significant insurance coverage decisions, the huge financial consequences associated with the issue, and minimal case law addressing it, warranted an exception.

Indeed, as evidence of the significance of the case, consider that it was the subject of articles in *The New York Law Journal*, *National Underwriter* and *Business Insurance*. It was even the subject of the weekly cartoon in *Business Insurance* (May 21, 2007). In the cartoon, *Business Insurance* cartoonist Roger Schillerstrom depicts a terrified-looking man running from an open steamer truck, with some sort of insects swarming out of it. A puzzled-looking woman is standing nearby and asks "Pandora's Box?" The man replies in mid-stride, as if he were running for his life: "Worse . . . The latest New York court's asbestos ruling."

Putting aside a mountain of procedural issues, the heart of the coverage dispute was as follows. Robert A. Keasbey Company was a small New York state insulating company founded in 1885. Keasbey used asbestos materials in insulating contracting operations at various job sites in New York, New Jersey and Connecticut. The work involved cutting, sawing, mixing and removing of asbestos containing materials, which led to exposure of asbestos by individuals at the job site. *Keasbey* at 409-410. Lo and behold, Keasbey became the subject of claims by 20,000 individuals alleging asbestos-related personal injuries. *Id.* at 407.

Keasbey's insurers defended the company against the personal injury actions and eventually exhausted a long list of primary policies. Keasbey's excess carriers also made payments of over \$100 million. But when it comes to asbestos, no amount of money ever seems to be enough. The attorneys for the asbestos claimants asserted that most of the claims against Keasbey related to exposure during Keasbey's asbestos installation activities. Thus, they argued that the products/completed operations aggregate limits did not apply to these allegedly non-products claims. *Id.* at 408. If they did, it was undisputed that the products aggregates of the primary policies were exhausted. *Id.* at 412.

But the plaintiffs maintained that the *Keasbey* claims fell under the premises/operations coverage of the primary and excess policies, which were not subject to aggregate limits, but, rather, only a per occurrence limit. The result — the actual value of Keasbey's insurance coverage was alleged to be greater than the policies' aggregate limits *and could even be perpetual*. It was estimated that approximately \$100 million to \$250 million (on top of the enormous sums already paid) turned on the issue. *Id.* at 408.

The New York trial court concluded that the claims at issue were for "operations," and, thus, not subject to aggregate limits:

Here, the claims by all of the claimants in the underlying actions were that they were injured away from the premises of defendant Keasbey. Plaintiffs have not demonstrated that the injuries occurred after relinquishment of the asbestos products or after the operations were complete. To the contrary, the evidence has shown that the injuries happened while the installation operations of defendant Keasbey were ongoing, which were covered under the operations coverage provisions of the subject insurance policies[.]

*Id.* at 411 (extraneous text omitted).

To achieve the alchemy that comes from re-characterization of asbestos claims from products to operations is in fact a two-step process. Even if it is determined that the claims are for un-aggregated operations, the totality of such claims may still be

subject to the policy's per occurrence limit (if all claims are deemed to be the same occurrence). If so, the policies would still be exhausted, just on a different basis.

Therefore, the second hurdle for insureds or claimants seeking the benefits of re-characterization is to secure an interpretation of the policy that each claimant's exposure to asbestos constitutes a separate occurrence, and, hence, is subject to a separate occurrence limit (hence, the *Keasbey* Court's characterization of the policies' limits being perpetual). Here too the *Keasbey* claimants were successful:

[H]ere the events that led to the injuries to members of the defendant class all took place at various work sites over the course of many years. Thus, the class defendants are entitled to a declaration that each individual class members' exposure to conditions resulting in bodily injury constitutes a separate occurrence under the "occurrence" definition and "per-occurrence" limits of the subject insurance policies.

*Id.* at 419.

For a detailed and harshly critical look at *Continental Casualty Company v. Employers Insurance Company of Wausau*, see the May 15, 2007 write-up of the case by Simpson Thatcher.<sup>5</sup> The firm's paper argues that the *Keasbey* decision is flawed because, among other things, the court focused on the timing of the risk of the injuries (during *Keasbey's* operations), which is irrelevant. Instead, the proper inquiry should have been "whether 'bodily injury during the policy period' arose from an ongoing or completed operation, as the plain language of the policies requires[.]" *Id.* at 3. Moreover, Simpson Thatcher called the court's failure to even mention the Fourth Circuit's directly-on-point decision in *Wallace & Gale* (2004) as "inexplicable." *Id.*

In *Wallace & Gale*, the court stated: "Nor does it matter whether an injury is viewed as occurring both upon initial exposure before operations are completed as well as thereafter. The portion of the injury extending beyond completion would still, by definition, occur post-operations and thus remain subject to the completed operations hazard aggregate limit."

*Aetna Casualty & Surety Co. v. The Wallace & Gale Co.*, 275 B.R. 223, 238 (D. Md. 2002), *aff'd*, *In re: The Wallace & Gale Company*, 385 F.3d 820 (4th Cir. 2004). In simple terms, the *Wallace & Gale* Court stated, "[C]ontrary to the argument of the intervenors — once an operations claim, not always an operations claim." *Id.* at 240.

If the name of the game in asbestos is money, then an honorable mention must go to *In the Matter of: The Liquidation of Integrity Insurance Company*, 2007 N.J. LEXIS 1425, decided on December 13, just as this article was being finalized. While *Continental Casualty Company v. Employers Insurance Company of Wausau* served to make more money available for asbestos claims, *Integrity Insurance Company* did the opposite.

In *Integrity Insurance Company*, the New Jersey Supreme Court held in a 3-2 decision that asbestos claims that have been incurred but not reported (so called "IBNR") are not "absolute" claims under N.J.S.A. 17:30C-28(a)(1), and, therefore, cannot share in the distribution of an insolvent insurer's estate. Asbestos claims are of the IBNR type, given the injury's long latency period. However, because it had been held that they are not "absolute" — despite the ability to perform a complex actuarial analysis to calculate the value of such future claims — they are not claims against the insolvent insurer's estate. As a result, future asbestos claimants have lost of significant source of insurer funding.

What does that mean in terms of actual dollars? Reinsurers, who remain liable for obligations owed to an insolvent insurer, have therefore been relieved of any liability for the future asbestos claims that would have been made against *Integrity Insurance*. The future claims against *Integrity* were valued at over \$2 billion. Reinsurers would have had responsible for a significant portion of those claims.

*Integrity Insurance Company* will certainly get a look by future courts addressing this issue, especially in states that have a statutory insurer liquidation scheme that resembles New Jersey's. The dissent called on the legislature to address the difficulty that IBNR claims present in liquidation, noting that the Missouri and Illinois legislatures have done so. *Integrity Insurance Company* at \*42-43 (Long, J., dissenting).



***Home Depot U.S.A., Inc. v. Ohio Casualty Insurance Company*, 2007 U.S. Dist. LEXIS 52996 (N.D. Tex.).**

*Home Depot* is a simple story, with a simple moral. It is a fable of a coverage case. Homeowners sued Home Depot and its contracted installer for negligence and fraud for the faulty installation of four replacement windows that they had purchased from Home Depot. The complaint alleged that Home Depot's contractor installed the windows upside down and backwards, leading to water intrusion and mold-related health problems. *Home Depot* at \*2 - \*3.

It is a head-scratcher to try to reconcile that blunder with the following statement on Home Depot's website: "Have New Windows in 4 Easy Steps. You can count on The Home Depot to do the job right. We want to exceed your satisfaction by offering you a complete solution in four simple steps."<sup>6</sup> Apparently, there is a fifth step involved in the process — litigation.

In any event, Home Depot sought coverage as an additional insured under its installer's general liability policy issued by Ohio Casualty. Ohio Casualty asserted a timing-based trigger of coverage defense, as well as late notice. Specifically, the homeowners filed suit against Home Depot and the installer in federal court in April 2004 and then, following a voluntary dismissal, filed suit in state court in November 2004. Home Depot provided notice to Ohio Casualty in June 2005.

After concluding that Tennessee law applied, the Texas District Court held that, under the Volunteer state's late notice standard, "the burden is not on Ohio to show that it was prejudiced; the burden falls on Home Depot to show that Ohio's ability to further investigate the claim, once suit was filed, was not hampered by its untimely notice. While Home Depot has argued that no prejudice occurred, it has not provided any competent summary judgment evidence that no prejudice occurred." *Home Depot* at \*26-27.

But *Home Depot* was not selected for inclusion in this year's list of the Top Ten Coverage Cases of the Year because of the specific facts of the late notice dispute. Rather, the case was selected because of Home Depot's argument that it should be held to a less stringent notice standard because of its status as an additional insured. The court swiftly rejected this argument:

[T]he court agrees with Ohio that such an argument is disingenuous under the circumstances. As Ohio points out, Home Depot required its installer, Davis, to purchase liability insurance and to include it as an additional insured. Home Depot, therefore, knew of the existence of the policy, *and, as a sophisticated corporate entity*, should have familiarized itself with the terms of the policy.

*Id.* at \*29 (emphasis added and citation to brief omitted).

Insureds sometimes do not seek coverage as an additional insured until late in the game, or at all, if their own insurer is defending them. Therefore, the real beneficiary of additional insured coverage is often the additional insured's own insurer, especially given its likely ability to take an excess position under ISO's standard CGL policy. But if the *Home Depot* Court rejected Home Depot's argument that it should be held to a less stringent notice standard because of its status as a "sophisticated corporate entity," one can only imagine what a court would say about an insurance company's level of sophistication when it comes to the timely pursuit of additional insured rights.

The moral of the story is simple — insurers must not count on their insureds to pursue additional insured rights, but, rather, must take that initiative themselves as soon as they begin to handle a claim. And, of course, preventing a late notice defense is just the tip of the iceberg of the benefits that can come from following such a sound claims handling practice.

***Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breaches)*, 495 F.3d 191 (5th Cir. 2007).**

A lot of hand wringing went into deciding whether any of the several Katrina coverage decisions in 2007 were appropriate for this list. Of course those decisions involved a lot of money, affected a lot of people and were the subject of wide publicity. But did they involve the type of coverage issues likely to surface again anytime soon? That's really the question. After all, the two hurricane seasons following Katrina have resulted in no similar claims. Moreover, hurricane coverage claims are not unique and have been around in abundance long before Katrina struck in 2005. It was the massive storm surge along the Mississippi coast and the flooding of

New Orleans from the levee failures that made the Katrina claims so complex and subject to such dispute.

Nonetheless, one such decision was selected for inclusion as one of the Top 10 of 2007: *Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breaches)*. I was privileged to author a brief article about the decision for The Washington Legal Foundation (Legal Opinion Letter, October 19, 2007). The text of that article — “The Thrilla in MaNOLA: Court Resolves Heavyweight Insurance Battle in Louisiana” — is set out below, followed by an update on the case and an explanation why it was ultimately selected as one of the year's ten most significant.

It was an insurance coverage case with all the trappings of a heavyweight title fight: (1) pre-fight publicity (The Associated Press ran a set-up story the day before oral argument.); (2) tickets nearly impossible to obtain (The courtroom was packed with 120 lawyers, paralegals and law clerks.); (3) one of the most coveted prizes in sports on the line (At issue, insurance coverage for thousands of New Orleans residents whose homes were damaged by Hurricane Katrina); (4) unquestionable muscle in both corners (One of the appellate briefs had 59 lawyers on the service list.); (5) the fighters brought an entourage (There was a lot of *amicus* involvement.); and (6) the aura of a re-match hung over the ring (The policyholders had scored a stunning upset just seven months earlier and the insurers were hungry for redemption.).

Such was the atmosphere surrounding the May 6, 2007 oral argument before the U.S. Court of Appeals for the Fifth Circuit in *Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breaches)*. Before the court was a review of a November 2006 decision by Judge Stanwood Duval, Jr. of the Eastern District of Louisiana that several insurance companies' flood exclusions that did not distinguish between man-made and naturally occurring floods were ambiguous and, therefore, did not preclude coverage for damage caused by the New Orleans levee breaches associated with Hurricane Katrina. See *In re Katrina Canal Breaches*, 466 F. Supp. 2d 729 (E.D. La. 2006).

On August 2, after promising a quick decision, three judges on the Fifth Circuit unanimously reversed Judge Duval, holding that “The flood-control measures, i.e., levees, that man had put in place to prevent

the canal's floodwaters from reaching the city failed. The result was an enormous and devastating inundation of water into the city, damaging the plaintiffs' property. This event was a ‘flood’ within that term's generally prevailing meaning as used in common parlance, and our interpretation of the exclusions ends there.” *Katrina Canal Breaches*, 2007 U.S. App. LEXIS 18349, \*79-80.

Given the significant length of the opinions from the District Court and Fifth Circuit, there is no short answer to the question: why did the courts disagree? For starters, both courts at least agreed on one thing — that their task in discerning the meaning of the flood exclusion must be guided by Louisiana's established rules of insurance policy interpretation, which follow the maxims of contract interpretation generally. However, agreeing on the ground rules is not the same as agreeing on their application. And that is where the courts parted ways.

It does not take a lot of effort for a court to conclude that an insurance policy provision is ambiguous. Insurance policies are complex documents, governed by a large body of case law, the determination of ambiguity is inherently subjective and the one making the call has years of experience in a profession in which finding more than one meaning in a word is a core skill. For these reasons, the District Court did not struggle to conclude that the flood exclusion was susceptible to two meanings and, therefore, ambiguous. In general, the court hung its hat on the following hooks (albeit in a 30-page discussion): that the word “flood” has numerous dictionary meanings and has been the subject of differing case law interpretations. *Katrina Canal Breaches* at 756.

The Fifth Circuit looked at the same arguments and concluded that they did not give rise to an ambiguity. It takes more effort for a court to conclude that an insurance policy provision is not ambiguous, and that's what the Fifth Circuit brought to the task. The court reviewed and rejected the various arguments advanced by the policyholders that the flood exclusion was ambiguous.

For example, the Fifth Circuit concluded as follows: The fact that a term used in an exclusion is not defined in the policy alone does not make it ambiguous. If so, “an insurer would have to define every word in

its policy, the defining words would themselves then have to be defined, their defining words would have to be defined, and the process would continue to replicate itself until the result became so cumbersome as to create impenetrable ambiguity." *Id.* at \*40-41.

The court also held that: "[T]he fact that an exclusion could have been worded more explicitly does not necessarily make it ambiguous." *Id.* at \*43. "Nor does the fact that other policies have more explicitly defined the scope of similar exclusions." *Id.* at \*44. And, just as the District Court did, the Fifth Circuit looked at numerous dictionary definitions of the term "flood." The Court of Appeals concluded that the dictionaries it reviewed "make no distinction between floods with natural causes and those with non-natural causes." *Id.* at \*61.

But perhaps the biggest difference between the two opinions was the Fifth Circuit's adherence to La. Civ. Code Ann. Art. 2049, directing it to interpret a term with a meaning that renders the term effective. In doing so, the Fifth Circuit made the following sage observation about the District Court's distinction between man-made and naturally occurring floods: "Because levees are man-made, one could point to man's influence nearly any time a levee fails. If a levee fails despite not being overtopped by the floodwaters, it is because the levee was not adequately designed, constructed, or maintained. If a levee fails due to the floodwaters overtopping it or loosening its footings, it is because the levee was not built high enough or the footings were not established strongly or deeply enough. . . . Any time a flooded watercourse encounters a man-made levee, a non-natural component is injected into the flood, but that does not cause the floodwaters to cease being floodwaters." *Id.* at \*69.

In both boxing and litigation, when it's over, those on the losing side never agree with what's on the judges' scorecards. What's more, just as boxers never seem to retire, neither do unsuccessful litigants. The policyholders have filed a Petition for Certiorari with the United States Supreme Court (No. 07-711 and 07-713).

The "man-made" versus "naturally occurring" flood issue is also bobbing around in the Louisiana state court system. On November 19th, the Louisiana Court of Appeal issued a split decision in *Sher v. Lafayette*

*Insurance Company*, No. 2007-CA-0757, which held that the flood exclusion was ambiguous because it did not distinguish between man made and naturally occurring floods. In what seems to have been a snub to the Fifth Circuit, the state appeals court did not even mention that court's unanimous, and far more detailed, decision on the issue in *Katrina Canal Breaches*. An attempt is being made to have *Sher* reviewed by the Louisiana Supreme Court. Surely there is a better chance of *Sher* getting before the Louisiana high court than there is of the United States Supreme Court agreeing to hear *Katrina Canal Breaches*.

*Katrina Canal Breaches* was selected for inclusion as one of the year's ten most significant insurance coverage decisions because the "man-made" versus "naturally occurring" flood issue is not yet over and its final resolution has the potential to affect a huge number of people. This stands in contrast to the Fifth Circuit decisions in 2007 involving interpretation of the anti-concurrent causation clause. See *Tuepker v. State Farm Fire and Casualty Company*, 2007 U.S. App. LEXIS 25786 and *Leonard v. Nationwide Mutual Insurance Company*, 2007 U.S. App. LEXIS 25786. These were important decisions, but many of the claims affected by them have been resolved.

***Allmerica Financial Corporation v. Certain Underwriters at Lloyd's London*, 871 N.E.2d 418 (Mass. 2007).**

Coverage disputes involving excess insurers come in two general types — First, just as in the case of primary policies, issues arise whether a particular loss is covered under the terms of the excess policy. The second type are cases where the coverage question itself is not in dispute, but, rather, the *relationship* between the primary and excess insurers, and how their policies should inter-react, is tested. The second type often give rise to complex decisions, tied to specific policy language and circumstances surrounding the claim. For this reason, these cases do not always leave behind general rules that are easily applied to future disputes.

There is sometimes no love lost between primary and excess insurers, as once observed by the Third Circuit Court of Appeals:

The relationship between the primary and excess carrier is an unusual one; each has a

separate contract with the insured, but they have none with each other. Conflicts of interest invariably arise when the underlying tort injury is of such severity that a recovery over the limits of the primary policy is possible. In that circumstance, the excess carrier wishes the primary insurer to dispose of the case within its limits and is not unduly impressed with the primary insurer's desire to save some or all of its policy limits by a favorable verdict at trial. Conversely, the primary carrier is unlikely to have such paternalistic feelings as will induce it to concede its limits when there is some chance of obtaining a favorable verdict. In each instance, one carrier is to some extent gambling with the other's money.

*Puritan Insurance Company v. Canadian Universal Ins. Co.*, 775 F.2d 76, 78 (3rd Cir. 1985). While a demand by an excess insurer that a primary insurer settle a claim within its limits is a common source of dispute between these insurers, it is certainly not the only one.

Last year the Supreme Judicial Court of Massachusetts resolved a dispute over an excess insurer's obligation. While the decision was not complicated, it involved both types of issues that arise in the excess claims arena — the excess insurer's coverage obligation and its relationship with the primary insurer. The decision also provided a general principle that future courts may consider when confronted with excess policy issues. Indeed, the Illinois Supreme Court did just that a few months later.

*Allmerica Financial* involved coverage for a class action filed against Allmerica, a life insurer, alleging improper practices in the sale of life policies. Allmerica sought coverage from its primary insurer, Columbia Casualty, under an Insurance Company Professional Services Liability policy, covering wrongful acts committed by the company and its agents. The primary policy was subject to a \$20 million limit of liability (above a \$2.5 million self-insured retention). Allmerica was also insured under an excess "follow form" policy issued by Lloyd's and subject to a \$10 million limit of liability. *Allmerica Financial* at 421-422. The class action was eventually settled for \$39.4 million — with \$35.5 million of the settlement going for attorney's fees and settlement administration. *Id.* at 423. Nice.

Columbia Casualty was involved in the claim from the beginning and eventually agreed to pay its \$20 million limit toward the settlement (subject to a no admission of coverage clause in the settlement agreement). Allmerica was also in contact with Lloyd's during the pendency of the class action. While not directly involved in the settlement process, Lloyd's was provided with periodic reports on their progress. Lloyd's had reserved its rights as to coverage. *Id.*

Eight months after the order approving the settlement of the class action, Lloyd's sent a letter to Allmerica disclaiming coverage. Lloyd's did so on the basis of the policy's exclusions for wrongful acts alleged in claims prior to the effective date of coverage and claims based upon promises of future performance. Allmerica filed suit against Lloyd's. The trial court concluded on summary judgment that Allmerica was not bound by the coverage decision made by Columbia Casualty and that coverage was, in fact, precluded by the Lloyd's policy's exclusion for wrongful acts alleged in claims prior to the effective date of the policy. *Id.* at 424.

The issue before the Supreme Judicial Court of Massachusetts, one of first impression in the Commonwealth, was whether a "follow form" excess insurer was bound by the decision of the primary insurer to settle a claim. Allmerica argued that Lloyd's, by using a "follow form" clause in its policy, adopted not only the language used by Columbia Casualty to describe the coverage and exclusions, but also the "intent of the parties to the primary policy." Thus, Allmerica maintained that Lloyd's intended to be bound by both Columbia Casualty's interpretations of the policy, as well as any decisions Columbia Casualty made about coverage and settlement. *Id.* at 428.

The Massachusetts high court disagreed:

An excess carrier's intent to incorporate the same words used in a separate agreement between the primary insurer and the insured does not imply an intent by the excess carrier to accept decisions made by the primary carrier about the extent of its obligations under its own agreement. By adopting the form of words used by Columbia Casualty, the underwriters did not also cede to it the right to make decisions about the underwriters' obli-

gation to perform in various circumstances. *To conclude otherwise would undermine the distinct and separate nature of each insurer's contract with Allmerica.*

*Id.* (emphasis added). The *Allmerica Financial* Court also reversed the decision of the trial court to grant summary judgment on the basis of the prior claims exclusion. *Id.* at 431.

There was nothing exciting, or surprising, about the Supreme Judicial Court of Massachusetts's decision in *Allmerica Financial*. Indeed, I hemmed and hawed about including it here. However, while the court addressed a rudimentary issue, its lesson is an important one. Disputes between primary and excess insurers (or, in this case, between an insured and its excess insurer, but tied to the primary policy), come in a variety of shapes and sizes. *Allmerica Financial* serves as a useful reminder that, whatever the specific issue, the overarching consideration is that primary and excess insurers issued different policies. Therefore, the immediate reaction to a dispute should not be that their fates are somehow tied. Of course, there may be exceptions under certain circumstances — such as the issue of settlement within limits — but the first line of analysis should be that the policies are separate contracts.

For example, late in the year the Supreme Court of Illinois issued its decision in the closely watched case of *Kajima Construction Services, Inc. v. St. Paul Fire and Marine Insurance Co.*, 2007 Ill. LEXIS 1702. In *Kajima*, the Boyz from Illinois held that, despite the state's fondness for the "targeted tender" rule, an exception must be made in the excess context: "[T]argeted tender can be applied to circumstances where concurrent primary insurance coverage exists for additional insureds, but to the extent that defense and indemnity costs exceed the primary limits of the targeted insurer, the deselected insurer or insurers' primary policy must answer for the loss before the insured can seek coverage under an excess policy." *Kajima* at \*23.

The reason for the court's decision: "This holding preserves the distinction between primary and excess insurance policies." *Id.* "Given the clear distinctions between primary and excess insurance coverage, we decline to extend the targeted tender doctrine to require one insurer to vertically exhaust its primary and excess coverage limits before all primary insurance

available to the insured has been exhausted. Extending the targeted tender rule to require an excess policy to pay before a primary policy would eviscerate the distinction between primary and excess insurance." *Id.* at \*22.

***Catholic Mutual Relief Society, et al. v. Roman Catholic Archdiocese of San Diego, et al.*, 165 P.3d 154 (Cal. 2007).**

When an insurer's reinsurance information becomes the subject of a discovery request, it is a good bet that it will soon thereafter become the subject of a discovery dispute. But does reinsurance information really provide anything of value to the party seeking it, especially considering the effort that it may take to get it? The Supreme Court of California concluded that it doesn't, and, thus, there was no basis for it to be discoverable. Of course, the issue is not always so cut and dry, as evidenced by other decisions in 2007, including from a Massachusetts trial court that relied upon the California court's decision to conclude that reinsurance information *was discoverable*.

In *Catholic Mutual*, the California high court, in a 4-3 decision, settled a dispute over the discoverability of reinsurance insurance in underlying priest abuse litigation against the Roman Catholic Archdiocese of San Diego.

The trial court issued a case management order which directed the Archdiocese to turn over copies of all insurance policies that might provide coverage for the underlying plaintiffs' claims. Catholic Mutual Relief Society (a nonprofit corporation that administers a self-insurance fund for more than 300 archdioceses and other Catholic Church entities in the United States and Canada) produced copies of its liability insurance policies. *Catholic Mutual* at 157.

Plaintiffs contended this information was insufficient and that they also needed to know whether the Church's insurers were financially sound enough to cover their policy obligations. The settlement judge issued an order permitting plaintiffs to serve deposition subpoenas on the insurers in an attempt to secure broad categories of financial documents, including a request for all writings reflecting the total amount of funds available from reinsurance "to satisfy any defense expenses or indemnify losses in connection with sexual abuse claims against the [Church]." *Id.*

The insurers moved to quash the subpoenas, arguing that, to the extent the document requests sought information about the overall strength of their financial condition, they were not reasonably calculated to lead to the discovery of admissible evidence and were therefore beyond the permissible scope of discovery. The settlement judge denied the motions to quash, finding that the subpoena requests — aimed at determining whether the Church's insurers were financially able to pay any judgment that might be entered against their insured — were “clearly relevant and discoverable” to inform and facilitate settlement. *Id.* at 158. The California Court of Appeal vacated the settlement judge's order. The Supreme Court of California granted review of the limited question whether *California Code of Civil Procedure* § 2017.210, “which authorizes limited discovery of a defendant's liability insurance coverage as a matter of right [i.e., no need to prove relevancy and admissibility as required under the general discovery statute], likewise authorizes discovery of the nonparty liability insurer's reinsurance agreements, assertedly for purposes of facilitating pre-trial settlement of underlying tort claims.” *Id.* at 159 (emphasis in original).

The underlying plaintiffs argued that § 2017.210 authorizes discovery of reinsurance agreements because the statute specifically permits discovery of “any agreement under which any insurance carrier' may be liable to satisfy a judgment 'or to indemnify or reimburse for payments made to satisfy the judgment.” *Id.*

The Supreme Court of California disagreed, relying in part on the fact that an essential feature of reinsurance is that it does not alter the terms, conditions or provisions of the policy that it is reinsuring. The court also observed that “the amounts of policy limits directly available to respond to the underlying judgment are not increased by the existence of reinsurance agreements.” *Id.* at 160. Further, while liability insurance is a factor in the manner in which a case is prepared for trial, reinsurance information, in contrast, would be of no relevance. *Id.* at 163.

Interestingly, in arriving at its conclusion that the reinsurance information was not discoverable, the court concluded that § 2017.210 was actually ambiguous on this point. In other words, an argument existed that the reinsurance information was in fact

discoverable under the statute. Confronted with this ambiguity, the court turned to extrinsic evidence to interpret the statute. The conclusion here was that, based on the legislative history, context and purpose of the statute, it was specifically intended to be limited to discovery of a defendant's liability insurance only. *Id.* at 163. The *Catholic Mutual* Court did acknowledge an exception for situations in which the liability insurer is “fronting” for a reinsurer that is the de facto primary insurer.

As noted above, the underlying plaintiffs argued that the reinsurance information was needed to know whether the Church's insurers were financially sound enough to cover their policy obligations. But even if the Church's liability insurers were not, any reinsurance payments owed to an insolvent insurer are sometimes considered general assets of the insurer's estate and not assigned to the specific claims that they were reinsuring. Thus, this further calls into question whether reinsurance information serves any purpose for a plaintiff that is concerned about the financial strength of a defendant's liability insurers.

For a different take on the issue in 2007 (in addition to the three justice dissent filed in *Catholic Mutual* that argued for broad discovery of reinsurance information), see *United States Fire Insurance Company v. Bunge North America, Inc.*, 2007 U.S. Dist. LEXIS 38754 (D. Kan.). After citing several decisions nationally on both sides of the issue (i.e., We're not in Kansas anymore), the court concluded that reinsurance information — both policies and communications between insurers and reinsurers — was discoverable in an underlying environmental coverage action.

And the year wasn't even over before another court addressed the discovery of reinsurance information and cited both *Catholic Mutual* and *Bunge North America* in the process. In *Neles-Jamesbury, Inc. v. Liberty Mutual Insurance Company*, 2007 Mass. Super. LEXIS 473, a Massachusetts trial court noted that the insurer relied upon *Catholic Mutual* to preclude discovery of reinsurance information. However, the court concluded that the California Supreme Court decision actually favored the insured: “The court [*Catholic Mutual*] stated that discovery for the purpose of finding relevant admissible evidence would be allowed (citing *Catholic Mutual*). Where the reinsurance agreement is directly relevant to the issue at hand, it

may be discoverable (citing *Catholic Mutual*). If this court were to apply the California Supreme Court's holding in this case, the decision would be in favor of the plaintiffs. The areas of dispute in this case relate directly to the language of the policies and the time of notice. Relevant evidence may be gathered from reinsurance agreements that may resolve these disputes." *Neles-Jamesbury* at \*6.

*Catholic Mutual* established a rule that reinsurance information is not discoverable by underlying plaintiffs. This may be followed by other courts addressing this issue. And they'll no doubt at least look to the California Supreme Court's decision for guidance. But the moral of the story from 2007 is that courts confronting the issue of reinsurance discovery will examine the context in which the information is being sought.

***Lamar Homes, Inc. v. Mid-Continent Casualty Company, et al., 2007 Tex. LEXIS 797.***

Not long ago it was big news when a state supreme court issued a decision addressing the scope of coverage for construction defects. Those days are long gone as these decisions have now reached ho-hum status. Indeed, by my count, in 2007 alone there were six decisions issued by state supreme courts addressing coverage for construction defects.<sup>7</sup> Last year had plenty too. And you'd be hard-pressed to keep up with the staggering number of construction defect coverage decisions coming from trial and intermediate appellate courts.

For this reason, a coverage decision of this type seems an unlikely candidate for inclusion as one of the year's ten most significant. However, an exception can be made for the right case, and the Supreme Court of Texas's decision in *Lamar Homes v. Mid-Continent Casualty Company* was just such case.

First, Texas's size makes it a candidate for a significant number of coverage disputes over construction defects. Indeed, the supreme court noted at the outset of its opinion that similar issues were pending in six separate petitions for review before it. And there's no doubt that Texas Court of Appeals decisions addressing coverage for construction defects had been all over the place. Clarification from the Texas high court was sorely needed. In addition, when a coverage case includes eleven *amicus* parties, it has to be taken

seriously for selection as one of the year's ten most significant, even if the issue is not groundbreaking. The *Lamar Homes* Court also addressed an important duty to defend issue.

*Lamar Homes* involved coverage for defects in a new home purchased by the DiMares from Lamar. Several years after the purchase of the home, the DiMares encountered problems that they attributed to their foundation. The DiMares sued Lamar and its subcontractor for the defects. Lamar sought coverage from Mid-Continent Casualty Company under a commercial general liability policy. Mid-Continent refused to defend, Lamar filed a declaratory judgment action and the parties were off to the races. *Lamar Homes* at \*2-3.

The coverage dispute reached the Texas Supreme Court on the following certified questions from the Fifth Circuit:

1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?
2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?

*Lamar Homes* at \*1-2. A third certified question, and one that will have consequences far beyond the construction defect arena, asked whether the Texas "Prompt Payment of Claims" statute, formerly codified as Article 21.55 of the Texas Insurance Code, applies to an insurer's breach of the duty to defend.

Mid-Continent made the arguments often advanced by insurers in these types of cases: a CGL policy's purpose is to protect the insured from claims for tort liability; and defective work cannot be an "occurrence" because it is not accidental. In other words, a general contractor should expect that faulty workmanship

will result in damage to the project itself. And if an injury is expected, it is not accidental.

The Texas Supreme Court concluded that the insurer made a false assumption when it concluded that an accident can never exist apart from a tort claim. Citing to a law review article, the court noted that the author observed that “the argument has some intuitive appeal but conclude[d]: Yet, on even a moment’s reflection, we all understand that contracts are broken, many times, for reasons that we would call ‘accidental.’ The wrong number of boxes was shipped because someone made a mistake in the counting.” *Id.* at \*12-13, quoting Ellen S. Pryor, *The Economic Loss Rule and Liability Insurance*, 48 ARIZ. L. REV. 905, 917 (2006), quoting *Anthem Electronics, Inc. v. Pacific Employers Ins. Co.*, 302 F.3d 1049, 1056 (9th Cir. 2002). In addition, the Texas high court noted that no one alleged that Lamar intended or expected its work or its subcontractors’ work to damage the DiMares’ home. *Lamar Homes* at \*17.

Contrary to the carrier’s contentions, the CGL policy makes no distinction between tort and contract damages. The insuring agreement does not mention torts, contracts, or economic losses; nor do these terms appear in the definitions of “property damage” or “occurrence.” The CGL’s insuring agreement simply asks whether “property damage” has been caused by an “occurrence.” Therefore, any preconceived notion that a CGL policy is only for tort liability must yield to the policy’s actual language.

*Id.* at \*27.

Much more could be said about how the court addressed these issues, including the majority’s point-counterpoint with the dissent’s arguments. However, better to get to the real issue in the case. Lamar conceded that the “your work” exclusion would have eliminated coverage, but for the exclusion’s “subcontractor exception.” *Id.* at \*21. Thus, by concluding that faulty workmanship that results in damage to the project itself is an “occurrence,” the court was able to reach the “subcontractor exception” to the “your work” exclusion. This exception purportedly provides coverage in those instances in which

the faulty workmanship was caused by the insured’s subcontractor. Compare that to the decisions holding that faulty workmanship that results in damage to the project itself is not an “occurrence,” which then stops the case in its tracks, thereby never allowing the insured to reach the “subcontractor exception” to the “your work” exclusion. The applicability of the “subcontractor exception” to the “your work” exclusion is often what is at the center of construction defect coverage cases.

It’s remarkable how much coverage litigation is taking place over what are essentially the same basic issues. What’s more, the disputes concern contract-based claims under policies issued to companies that often have the word “contractor” in their name. In other words, there is nothing surprising about the types of claims being made. Yet they continue to confound courts and defy consensus.

Turning to the third certified question, the *Lamar Homes* Court addressed whether the Texas “Prompt Payment of Claims” statute applies to an insurer’s breach of the duty to defend. The statute provides that an insurer, who is “liable for a claim under an insurance policy” and who does not promptly respond to, or pay, the claim as the statute requires, is liable to the policy holder or beneficiary not only for the amount of the claim, but also for “interest on the amount of the claim at the rate of eighteen percent a year as damages, together with reasonable attorney’s fees.” *Id.* at \*36-37.

The statute defines “claim” as “a first party claim made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract [that] must be paid by the insurer directly to the insured or beneficiary.” Thus, the dispute was over whether a claim for defense costs under a liability policy is a “first party” claim, as that term is used (but not defined) in the statute. *Id.* at \*37.

The court acknowledged the argument by insurers that “first party claim” is synonymous with a claim under a first-party policy, such as a life, accident or health policy. However, the *Lamar Homes* Court was not persuaded that the term had such a limited meaning as used in the “Prompt Payment of Claims” statute:



As already noted, the statute does not define "first-party claim," but we have previously distinguished first-party and third-party claims on the basis of the claimant's relationship to the loss. Thus, we have said that a first-party claim is stated when "an insured seeks recovery for the insured's own loss," whereas a third-party claim is stated when "an insured seeks coverage for injuries to a third party." Based upon that distinction, a defense claim is a first-party claim because it relates solely to the insured's own loss. Without the defense benefit provided by a liability policy, the insured alone would be responsible for these costs. Unlike the loss incurred in satisfaction of a judgment or settlement, this loss belongs only to the insured and is in no way derivative of any loss suffered by a third party. The claim for defense costs then is a first-party claim because the insured is the only party who will suffer the loss or benefit from the claim.

*Id.* at \*40-41 (citation omitted).

On December 14th, in a dissenting opinion on the Article 21.55 issue, filed three plus months after the majority opinion was handed down (filed as part of the denial of a Motion for Rehearing), Justice Brister (with Justices Hecht and Willett joining) observed in the opening paragraph: "Since Reconstruction, prompt-payment penalties applied to some insurance claims in Texas, but never to a liability carrier's duty to defend. Now the Court discovers the Legislature accidentally changed all that when it tinkered with the statute in 1991, although no one apparently recognized it at the time. Nor could anyone have done so, as the three words the Legislature added in 1991 ("first-party claim") have never been used by anyone familiar with the insurance business to refer to the duty to defend."

The Article 21.55 aspect of *Lamar Homes* is likely to have a significant impact on the manner in which duty to defend decisions are made in Texas. Carriers may now be more reluctant to deny a defense and policyholders may be more willing to pursue a claim for breach of such duty. After all, where else can you get 18% on your money?

***Bradley Ventures, Inc. v. Farm Bureau Mutual Insurance Company*, 2007 Ark. LEXIS 525.**

It is an issue that arises all the time. An insured commits an illegal offense and is subjected to the criminal justice system. In addition, the victim of the criminal offense institutes a civil action for damages against the insured. Because of the underlying criminal conduct, the civil complaint alleges that the insured committed acts of an intentional nature, as well as conduct that may be characterized as less than intentional, such as negligent or some other degree of culpability. The complaint is tendered to the insurer, who is now confronted with the question whether it is obligated to provide a defense to its insured.

On one hand, based on the four corners of the complaint, a defense is owed because the negligence allegation gives rise to the possibility of coverage. On the other hand, the insurer can point to the insured's criminal conviction or guilty plea and argue that, while such information is outside the four corners of the complaint, it conclusively proves that the negligence allegations in the complaint are unfounded. Thus, the insurer argues that it should be entitled to disclaim coverage for a defense. In general, courts have been receptive to this argument by insurers that a finding in a criminal action serves as an exception to the four corners rule for purposes of making a defense determination.

But even if such a general exception is held to exist, that is not always the end of the story. Insurers must then establish that the elements of the crime for which the insured was convicted or plead guilty satisfy the standard for whatever intentional injury-based exclusion the insurer seeks to rely upon to disclaim coverage. And that is not always easy to do. Many courts go through a painstaking analysis of the elements of the criminal statute at issue to determine whether they have been established by the conviction or plea, in order to satisfy the intentional act-based exclusion.

For example, just because the court was willing to consider a criminal conviction as an exception to the four corners rule, the insurer in *Stidham v. Millvale Sportsmen's Club*, 618 A.2d 945 (Pa. Super. 1992) was still unable to rely upon a guilty plea, even for third-degree murder, to disclaim a defense obligation. The *Stidham* Court held:

The malice necessary for [the insured's] conviction of third degree murder arose from his failure to perceive that his actions might create a substantial and unjustifiable risk of death or serious bodily injury. Such malice does not, however, conclusively establish his conscious awareness or intent to bring about the resulting harm to Brett Stidham. Thus, [the insured's] guilty plea to third degree murder, where the criminal proceedings did not establish the extent, if any, of his conscious awareness of his action or the substantial likelihood of the results, cannot conclusively establish a bar to recovery under his homeowner's policy [expected or intended exclusion].

*Stidham* at 955-56.

A review of the many decisions on this issue reveals that courts do not act with a knee-jerk and automatically conclude that a criminal conviction or guilty plea must mean that the "expected or intended" or some like-minded exclusion is applicable. Nonetheless, despite the thoughtfulness that courts bring to this issue, the Arkansas Supreme Court in *Bradley Ventures* chose to take a different approach. In cases involving a guilty plea, the court simply adopted a blanket rule that, no matter what the circumstances, it is not an admission of the elements of the offense that can be used against the insured in a subsequent coverage action.

The issue in *Bradley Ventures* arose under the following circumstances. The AQ Chicken restaurant in Bentonville, Arkansas was destroyed by a fire. Joseph Trybulec, Jr. was charged with arson. The prosecutor negotiated a plea agreement with Trybulec. In exchange for a reduction from the charge of arson, Trybulec pled guilty to the charge of reckless burning, a Class D felony. *Bradley Ventures* at \*1-2.

A civil action was filed against Trybulec for the damages caused. At the time of the fire, Trybulec lived with his parents, who had a homeowners' insurance policy with Farm Bureau which carried a \$100,000 personal liability limit. However, the policy excluded personal liability coverage for property damage that was caused by intentional acts or claims arising from activities involving an illegal purpose. *Id.* at \*2. Farm

Bureau sought a declaratory judgment that, based on these exclusion, it had no duty to defend or indemnify Trybulec. Farm Bureau's motion for summary judgment on these issues was granted by the trial court.

On appeal, the Arkansas Supreme Court characterized the issue as follows: "While it is undisputed that Trybulec pled guilty to the offense of reckless burning, his plea was negotiated and agreed to in exchange for the charge being reduced from arson. The question before this court is whether or not that plea precluded the argument in a subsequent civil case that Trybulec did not intentionally start the fire." *Id.* at \*9.

For purposes of making this determination, the court examined the doctrine of collateral estoppel or issue preclusion. Such doctrine "bars the relitigation of issues of law or fact *actually litigated* by the parties in the first suit, provided that the party against whom the earlier decision is being asserted had a full and fair opportunity to litigate the issue in question and that issue was essential to the judgment." *Id.* at \*9-10 (emphasis added).

The Arkansas Supreme Court held that a guilty plea in a criminal case is not the same as a criminal conviction that has been actually litigated. The court held that "'actually litigated' means actually litigated." *Id.* at \*15. Therefore, because the issue of intent was not actually litigated, the court held that a genuine issue of material fact still remained as to whether Trybulec intentionally started the fire at AQ Chicken, making summary judgment inappropriate. *Id.*

The *Bradley Ventures* Court's rationale for its decision seemed to be based on a perceived unfairness to Trybulec because he may not have been sufficiently motivated to challenge the criminal allegations. The court observed that "[w]hen a defendant is given the option to plead guilty to a lesser offense rather than proceeding to trial at the risk of being found guilty by a jury of a more serious offense, seemingly that defendant has a serious motivation to enter a guilty plea." *Id.* at \*14.

Most criminal convictions are reached through a plea agreement and not an *actually litigated* trial. Given how complex collateral estoppel can be, especially in the context of sometimes murky "expected or intended" standards, the Arkansas Supreme Court's de-

cision -- adopting a blanket rule preventing its use in coverage actions following a guilty plea — may be an attractive solution for other courts confronting the issue. At a minimum, the decision will have a profound impact in the Natural State.

***Essex Insurance Co. v. H & H Land Development Corporation*, 2007 U.S. Dist. LEXIS 89904 (M.D. Ga.).**

Insurance Services Office, Inc. adopted the so-called Montrose Endorsement in 1999 and in 2001 it became part of ISO's bread and butter commercial general liability terms and conditions (Form CG 00 01 10 01, *et seq.*). In brief terms, the endorsement was drafted to respond to the California Supreme Court's decision in *Montrose Chemical Corporation v. Admiral Insurance Corporation*, 913 P.2d 878 (Cal. 1995), which held that the insured's knowledge of "bodily injury" or "property damage," prior to the policy period, did not preclude coverage, so long as the imposition of liability upon the insured had not been established. "[T]he loss-in-progress rule will not defeat coverage for a claimed loss where it had yet to be established, at the time the insurer entered into the contract of insurance with the policyholder, that the insured had a legal obligation to pay damages to a third party in connection with a loss." *Montrose* at 906.

However, under the Montrose Endorsement, the insuring agreement was amended to provide that there is no coverage for "bodily injury" or "property damage" if, prior to the policy period, the insured knew of its existence. In other words, under the policy provision drafted to respond to *Montrose*, "known loss" is based simply on the insured's knowledge of the existence of bodily injury or property damage, and is not tied to the insured's potential liability for such injury or damage.

In November 2003, I published an article in *FC&S Bulletins* that addressed the Montrose Endorsement and made the following prognostication: "It is likely that, over time, as claims arise under the known loss provision in the CGL Form, so too will disputes, and a body of case law interpreting it will develop."

Well, things have been slower-going than I thought. It took until 2007 for a court to finally interpret the Montrose Endorsement. And that *body of cases* I mentioned — Twigg size — two. This is surprising, con-

sidering that the Montrose Endorsement amended the CGL policy's insuring agreement, thereby giving it the potential to be a factor in claims of all stripes. But like Linus waiting for the Great Pumpkin, I never gave up hope that the decisions would appear. And in 2007 they did.

In *H & H Land Development*, the Middle District of Georgia addressed the availability of coverage under the following scenario. Essex Insurance Company insured H & H Land Corporation, a developer of a residential subdivision in Peach County, Georgia. Best line in the case — "The subdivision was named 'The Orchard,' in memory of a peach orchard that was bulldozed to make way for the new houses." *Id.* at \*2.

Construction of The Orchard began in 1999. In 2004, Malone and Blair, owners of property adjacent to the subdivision sued H & H, alleging that the development resulted in an increase in surface water run-off, causing damage to their property by the excess storm water, silt and sediment that accompanied it. *H & H Land Development* at \*2-3.

The Essex policy period began on February 28, 2004. A March 9, 2000 letter from the City of Byron to Ron Carter, another complaining homeowner, represented that city officials met with H & H on February 22, 2000 "to discuss off-site drainage concerns from the Orchard subdivision." *Id.* at \*3-4. Based upon this documentation, Essex disclaimed coverage to H & H for the Malone and Blair action on the basis of the policy's "known loss endorsement." *Id.* at \*4.

The *H & H Land Development* Court did not use the term Montrose Endorsement to describe the "known loss endorsement," but that is clearly what was at issue: "The policy provides coverage for property damage only when 'prior to the policy period, no insured . . . knew that the . . . 'property damage' had occurred, in whole or in part.' As such, a loss that was known to have occurred prior to the policy period is not covered." *Id.* at \*3.

In the most curious aspect of the opinion, the court noted that the Malone and Blair action settled at a mediation for \$195,000, with H & H contributing \$25,000 of its own funds, and two other insurers, not involved in the coverage action, paying the rest.

While H & H never contested Essex's denial of coverage, and never made a demand for its \$25,000 contribution to the settlement or its defense costs, Essex nonetheless filed a declaratory judgment action. *Id.* at \*4. Something here just doesn't add up. Maybe Essex, like me, was growing impatient with the absence of decisions addressing the Montrose Endorsement and decided to take matters into its own hands.

In any event, Essex moved for summary judgment. The court first noted that there were no Georgia cases applying or construing a "known loss" exclusion similar to the one in the Essex policy. *Id.* at \*8. Agreed. But despite the absence of case law, the court concluded that the language of the exclusion was simple and unambiguous. Under the terms of the policy, property damage is deemed to be known when any insured: (1) Reports all, or any part, of the . . . "property damage" to [Essex] or any other insurer; (2) Receives written or verbal demand or claim for damages because of the . . . "property damage"; or (3) Becomes aware by any other means that . . . "property damage" has occurred or begun to occur. *Id.* at \*8-9.

Noting that the third definition of known loss was the one relevant, the court concluded that Essex must show that there is undisputed evidence that H & H was aware that property damage to the Malone and Blair properties had occurred or begun to occur prior to February 28, 2004 (the inception date of the Essex policy). *Id.* at \*9. The court held that Essex could not meet this burden:

Essex's evidence that H & H knew of the property damage relates entirely to complaints by a neighboring landowner, Ron Carter, in 2000 and 2001. There is no evidence of any complaints by Malone or Blair.

\* \* \*

The evidence before the Court does not compel the conclusion that H & H was aware that the alleged property damage to the Malone and Blair properties had occurred prior to the policy period. A jury would be entitled to draw its own inferences from this evidence and determine for itself whether the complaints expressed by Ron Carter were sufficient to make H & H aware that prop-

erty damage *was occurring on the Malone and Blair properties as well*. Given the absence of evidence of complaints after March 2001, the jury would also be authorized to consider whether H & H had reason to believe its remedial measures had eliminated the problem of excess runoff from the Orchard.

*Id.* at \*9-11 (emphasis added).

While the *H & H Land Development* Court's decision was made based on a summary judgment standard, it clearly held the insurer to a high burden – prove that the damage for which coverage is being sought is the same damage that was known by the insured prior to the policy period.

Incidentally, while Essex did not succeed on the Montrose Endorsement, or its "no occurrence" position, its third summary judgment argument was a charm — the pollution exclusion (storm water run-off and the resulting sediment deposits are a "contaminant"). *Id.* at \*27.

In 2007, another federal district court weighed in on the Montrose Endorsement. In *Transportation Insurance Company v. The Regency Roofing Companies, Inc.*, 2007 U.S. Dist. LEXIS 74364 (S.D. Fla.), the Southern District of Florida interpreted the endorsement narrowly and declined to apply it to preclude coverage on the basis of known loss, holding that the insured's pre-policy knowledge of water intrusion was not tantamount to knowledge of mold damage.

In 2007, the long wait for decisions addressing the Montrose Endorsement ended. In both cases the endorsement was strictly construed and did not preclude coverage on the basis of known loss because the property damage for which coverage was being sought was not the *same* property damage that was known by the insured to exist prior to the policy period.

This is not to say that the Montrose Endorsement won't achieve its purpose. But so far, in order for the endorsement to operate to exclude coverage, courts have required a close relationship between the damage known by the insured to exist before the policy period and the damage for which coverage is being sought. *Very close*, in fact, when you consider that in *Regency Roofing*, the water damage that was clearly

known by the insured to exist before the inception of the policies was simply a continuation of the same damage, but in a different form — mold.

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## Endnotes

1. See *State Farm Fire & Casualty Co. v. Harbert*, 2007 S.D. LEXIS 175 (No coverage available because injury caused by alienation of affections was “expected or intended” and to insure for alienation of affects is also contrary to South Dakota public policy); and *Pins v. State Farm Fire & Casualty Co.*, 476 F.3d 581 (8th Cir. 2007) (S.D. law) (No coverage available because injury caused by alienation of affections was “expected or intended”).
2. For the full history of the story that Mikey died from eating Pop Rocks, go to “Death of Little Mikey” at <http://www.snopes.com/horrors/freakish/poprocks.asp>.
3. For a more in-depth look at *Cinergy*, see Michael D. Lichtenstein and Adam B. Lavinthal, “*Cinergy v. AEGIS*: Are Climate Change Costs Insured by CGL Policies?,” *Environmental Claims Journal*, Volume 19, Number 3, July-September 2007 at 186.
4. See the Insurance Information Institute’s June 2007 “Asbestos Liability” report, available at <http://www.iii.org/media/hottopics/insurance/asbestos>, citing to a March 2007 report by A.M. Best.
5. “*Continental Casualty Company v. Employers Insurance Company of Wausau*: New York Court Decides Significant Asbestos Coverage Issues Against Insurer,” Simpson Thatcher & Bartlett, LLP, Available at <http://www.simpsonthacher.com/content/publications/pub605.pdf>.
6. Available at <http://www.homedepot.com>. Click on Home Services and then Windows under Exterior Beauty.
7. *Lamar Homes, Inc. v. Mid-Continent Casualty Company, et al.*, 2007 Tex. LEXIS 797; *Supreme Servs. & Specialty Co. v. Sonny Greer, Inc.*, 958 So. 2d 634 (La. 2007); *Travelers Indem. Co. of Am. v. Moore & Assocs.*, 216 S.W.3d 302 (Tenn. 2007); *Webster v. Acadia Ins. Co.*, 2007 N.H. LEXIS 185; *Bituminous Cas. Corp. v. Kenway Contr., Inc.*, 2007 Ky. LEXIS 129; *Blair v. Mid-Continent Cas. Co.*, 167 P.3d 888 (Mont. 2007). ■

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