Commentary

8th Annual Insurance Coverage Best In Show: The Ten Most Significant Decisions Of 2008

Special Report: Coverage For Dummies 2008: The Top Ten

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I was in Vegas a little while back and as I was walking into a casino I was approached by a man who looked really down on his luck. "Please sir, can you help me?," he asked. "My wife is very sick and she needs medicine. I'll take anything you can spare," he pleaded. He seemed sincere and I was getting ready to put my hand in my pocket, but then hesitated at the last second. "I'd like to help you," I said. "Really, I would. But how do I know you won't take this money and go straight into the casino and gamble with it?," I asked. "Oh, you don't have it worry about that," he assured me. "I got gamblin' money."[1]

In a way, that's how the eighth year of the third millennium was for insurance coverage professionals and hobbyists. Never once during the year did we want for decisions that left us considering their potential impact on the future coverage landscape. Indeed, even by early summer, narrowing the list to just the ten most significant would have been a challenge. But no matter how many we had, we were never content and always looking for more.

Consider that, in any year, given the sheer volume of coverage decisions issued by courts, there is an abundant crop of candidates for consideration as the ten most significant. It is inevitable that legitimate contenders will get passed over. There are simply too many choices, too few spaces and tough calls invariably have to be made.

But 2008 took the competition to a new level. Week after week brought decisions that at first seemed would be low-hanging fruit for the annual insurance coverage hootenanny. But as time went on and the number of significant decisions continued to pile up,

naturally so too did the bar that would need to be cleared for a decision to be one of the ten remaining at year's end. As a result, in 2008, many more significant coverage cases than usual were left to die on the vine.

For the eighth year running I am grateful to Editor Vivi Gorman of *Mealey's Litigation Report: Insurance* for the opportunity to make the case for the ten most significant 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. Therefore, one common reason why many unquestionably important decisions are not selected is because other states are not lacking guidance on the issue. For example, the Supreme Court of Georgia handed down a decision in 2008 concerning the scope of the pollution exclusion. This was clearly an important decision and it will undoubtedly influence numerous future claims. *See Reed v. Auto-Owners Ins. Co.*, 667 S.E.2d 90 (Ga. 2008) (plain meaning of the absolute pollution exclusion applies; clause not limited to so-called traditional environmental pollution). But since most states do not want for pollution exclusion jurisprudence, the decision is really only significant for claims involving Georgia law.

Another common reason why decisions, albeit important, are not selected is because of their redundancy. For example, the Supreme Court of New Jersey issued a decision in 2008 concerning the interpretation of the phrase "an insured," as used in a policy exclusion, and its effect on innocent co-insureds. *See Villa v. Short*, 947 A.2d 1217 (N.J. 2008) (an exclusion for the 'intentional or criminal acts of an insured person' operates to exclude coverage for all insureds, and not merely the insured who committed the intentional or criminal act). But decisions nationally on the "an," "any" and "the" insured issue are common nowadays. Thus, any state without its own precedent on this issue would have ample other jurisdictions to turn to for guidance. So while this new Garden State case may be helpful to assist other states confronting the issue, it is by no means the only game in town.

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. But just because the process has no accountability or checks and balances whatsoever does not mean that it wants for deliberativeness (it's just that only one person is deliberating). Oh, and this year it is worth noting one more thing about the process — no government bail-out money was needed to complete the task. But the money would be there need be. The annual Insurance Coverage Top Ten is too big to fail.

But before getting to the past year's ten most significant insurance coverage decisions, a few opening acts to start things off. First, a look at some of the year's offbeat odds and ends from the insurance world. Then a tribute to the Supreme Court of Texas for, well, a Texas-size year in the insurance coverage department. Lastly, Coverage for Dummies: the ten best decisions from 2008 that demonstrate that people sometimes do dumb things and then seek insurance coverage for the consequences.

Insurance Odds And Ends Department

Perhaps the most serious insurance coverage story of the year was an AIG executive and outside AIG attorney being jailed in Mexico for not paying a directors and officers claim. AIG promptly settled the coverage dispute. (*Business Insurance*; May 12). How fast would you say "What exclusion?" if faced with the prospect of a Mexican jail for denying coverage.

Also involving AIG, CNBC "Mad Money" host Jim Cramer responded to AIG's financial difficulties by calling on his viewers to harass the company's employees, stating "We should hound them in the supermarket, we should hound them in the ballpark, we should hound them everywhere they are." Describing such comments as "outrageous," AIG Chairman and CEO Edward Liddy demanded a retraction and an apology, stating that it is one thing to criticize AIG's executive leadership, but out of bounds to incite people to harass the hard-working and dedicated

AIG employees who are committed to the company's success. Cramer apologized on-air, calling 99.9% of AIG employee's "fabulous" and blaming the company's problems on the "old guys." "Sorry, regular AIG guys. I did not mean you," Cramer said. (*Business Insurance*; October 27).

In the you-can-buy-insurance-for-anything category: Swett & Crawford Group, Inc. introduced an insurance policy that pays legal expenses in the event of an insurance company's denial of coverage. (*Business Insurance*; June 9). Of course, the obvious question — what happens if a claim under *that policy* is denied? It reminds me of that Suave Shampoo commercial from the 1970s — "And they'll tell two friends and so on and so on . . . "

And in a rare instance of divine intervention mixing with insurance coverage — the Vatican declared pollution as a new sin. (Reuters; March 10). Insurers have generally struggled to win on the "expected or intended" defense for environmental claims. Perhaps this will help them to turn the tide.

Cowboy Hat's Off To
The Supreme Court Of Texas

The Supreme Court of Texas has always been a friend to the annual insurance coverage hit parade. The court has been one of the most frequent contributors to the past seven editions of this commentary. Indeed, this year's offering includes two decisions from Texas's top court. When it comes to liability insurance coverage, the court has a keen appreciation for those issues that arise with frequency. This is clearly evident by its agreeing to hear cases that involve overarching issues. The court's decisions are thorough, frequently review the national landscape on an issue as part of its decision making process and are often accompanied by concurring and dissenting opinions. Agree or disagree with its results, there is no denying that the Supreme Court of Texas is not afraid of hard work.

But there seems to be a price to be paid for such thoroughness. The Justices sometimes, but not always, take an eternity to issue an opinion — two to three years from the time of oral argument can not be ruled out. For example, on February 15, 2008 the court issued its decision in *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, addressing whether Texas public policy prohibited insurance coverage of exemplary damages. Oral argument had been held three years and three months earlier (November 9, 2004). In other words, it took longer for the court to issue its decision than to get a law degree.

In any event, while the Lone Star State's top court can always be counted on for a few important coverage decisions every year, the court worked overtime in 2008, issuing at least nine opinions addressing insurance coverage (not counting automobile and heath insurance). Two were issued following re-argument (one of which followed two grants of re-argument). The court also granted re-argument in one of its important coverage decisions from last year. The court's own Top 10 list for 2008 is as follows (in the order that they were decided):

PAJ, Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008) — Court addressed late notice and the prejudice requirement.

Excess Underwriters at Lloyd's London v. Frank's Casing Crew & Rental Tools, Inc., 246 S.W.3d 42 (Tex. 2008) — In its second opinion in the case, the court addressed whether an insurer that settles a claim when coverage is in dispute may seek reimbursement from the insured if it is determined that coverage was not owed.

Fairfield Ins. Co. v. Stephens Martin Paving, LP, 246 S.W.3d 653 (Tex. 2008) — Court addressed whether the public policy of Texas prohibited insurance coverage of exemplary damages for gross negligence in the workers' compensation context.

National Union Fire Insurance Company v. Crocker, 246 S.W.3d 603 (Tex. 2008) — Court addressed notice issues for additional insureds.

Unauthorized Practice of Law Comm. v. Am. Home Assur. Co., 261 S.W.3d 24 (Tex. 2008) — Court addressed whether liability insurers may use "staff counsel" to defend claims against their insureds.

Entergy Gulf States, Inc. v. Summers, 2008 Tex. LEXIS 301 — Court agreed to re-hear its 2007 decision addressing the workers compensation exclusive remedy protection for a premises owner that is sued by a subcontractor's employee.

Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc., 2008 Tex. LEXIS 575 — In its *third* opinion in the case, the court addressed the inter-play between additional insured and contractual indemnity issues.

Zurich Am. Ins. Co. v. Nokia, Inc., 2008 Tex. LEXIS 766 — Court addressed the duty to defend cell phone radio frequency biological injury actions.

Don's Building Supply, Inc. v. OneBeacon Insurance Company, 2008 Tex. LEXIS 753 — Court addressed trigger of coverage for construction defects. (discussed *infra*).

Ulico Casualty Company v. Allied Pilots Association, 2008 Tex. LEXIS 769 — Court addressed the creation of coverage by waiver or estoppel. (discussed *infra*).

Special Report: Coverage For Dummies: The Top Ten

Reading a lot of insurance coverage cases makes you realize that some people do really dumb stuff. Their not-to-be believed behavior causes injury, a lawsuit is filed and then comes the inevitable insurance claim. The results are mixed, but more often than not courts do not allow these tomfools to pass the buck.

In past years I'd come across one of these bizarre cases, shake my head in disbelief, maybe send it to a colleague under the heading — *You won't believe this one* — and then move on to whatever it was I was doing. But this year, instead of dismissing these curiosities, I collected them, with the idea of using them for a new segment in the annual insurance coverage Top Ten. In no particular order (except the first one happens to be my favorite), here are ten decisions from 2008 that demonstrated that mom was right — you won't be happy until you poke an eye out.

1. General liability coverage not available to a motivational speaker for injuries sustained by a program participant when, at the repeated urgings of the speaker, the participant attempted to break a board with her hands. Ouch. *Reese v. Alea London Ltd.*, 2008 U.S. Dist. LEXIS 29951 (D.S.C.) (Participant Exclusion and Professional Services Exclusion precluded coverage).

2. Coverage owed under a homeowner's policy to an insured who miscalculated the force needed to throw someone in a swimming pool and the person instead landed on the pool's step and sustained serious injury. *State Farm Fire & Casualty Co. v. Superior Court*, 164 Cal. App. 4th 317 (2008) (coverage owed because the insured was only intending to get the person wet).

3. No coverage owed under a general liability policy for an insured who injured an old friend by saying hello to him using his "signature greeting" — placing him in a headlock and squeezing while simultaneously asking how he was doing. *Sanford v. Century Surety Company*, 2008 U.S. Dist. LEXIS 25729 (S.D. Miss.) (coverage precluded because the injury was not caused by an accident and the assault and battery exclusion applied).

4. Homeowners coverage not available for injuries sustained by a party guest when the host used gunpowder as a propellant to fire a potato gun (and another guest was killed). *Kiser v. Coffee*, 2008 Ohio App. LEXIS 4350 (coverage precluded because injury was reasonably expected to result from an intentional or criminal act).[2]

5. No coverage owed to an insured restaurant for injuries caused by the explosion of a gas grill at a tailgate party at a Jimmy Buffet concert. Just because it is called a "gas grill" does not mean that you pour gasoline on it when it does not light. *United States Liability Insurance Co. v. Harbor Club, Inc.*, 2008 Mass. Super. LEXIS 152 (injuries did not arise out of the ownership, maintenance or use of the policy's designated premises).

6. Defense owed to a middle school student, under his parents homeowners policy, for injuries that he caused to a teacher's aide when she was struck by a garbage can that he threw during a food fight in the cafeteria. Son, it's called a food fight for a reason. *Medrano v. State Farm Fire & Casualty Co.*, 863 N.Y.S.2d 480 (A.D. 2008) (defense owed because the allegations of negligence in the complaint implied that the injuries were unintentional).

7. No coverage owed to an insured minor, under his parents' homeowners policy, for kicking his

friend twice in the groin after learning that his friend's sister did not like him. Yup, that should make the sister like him now. *American National Property and Casualty Company v. Hanna*, 2008 U.S. Dist LEXIS 17986 (coverage precluded because the injury was not caused by an accident).

8. Choice of law will determine if coverage is owed to insured corporations for injury and death caused by violent offenders that they hired to sell magazines door-to-door. *Nautilus Insurance Company v. Reuter*, 537 F.3d 733 (8th Cir. 2008) (coverage dependent upon interpretation of "occurrence," which is based on a choice of law determination to be resolved on remand).

9. No coverage owed to an insured whose hand became stuck in a sliding glass patio door during an altercation. Insured shot the glass only in an effort to free his hand (insured's version) and the bullet ricocheted, hitting a woman inside the house in her chest. *Shelter Mutual Insurance Company v. Wheat*, 2008 U.S. App. LEXIS 193 (10th Cir.) (coverage precluded because the injury was not caused by an accident).

10. Defense owed to a karaoke singer, under a homeowners policy, for injuries caused by an ice cream scoop that flew out of her hand while dancing and waving it (at least that's the singer's version of the incident). *Nationwide Mutual Fire Insurance Company v. Kim*, 2008 Ga. App. LEXIS 1241 (defense owed because of the negligence allegations — which the court acknowledged were suspicious).

The sad thing is that there will surely not be any problem finding ten cases, just like these, for the 2009 edition of this commentary.

The Ten Most Significant Insurance Coverage Decisions Of 2008

The following are the ten most significant insurance coverage decisions of 2008 (listed in the order that they were decided):

D. Jere' Webb v. Gittlen — Supreme Court of Arizona put the heat on insurance agents, making their E&O policies insurance of last resort. Supreme Court of Florida raised the temperature as well.

Elacqua v. Physicians' Reciprocal Insurers — New York Appellate Division: Tough medicine for insurer that failed to address an insured's right to independent counsel. If the decision made it there, it can make it anywhere.

Auto-Owners Insurance Company v. Pozzi Window Company — Supreme Court of Florida was a pane for general contractors seeking coverage under the "subcontractor exception" to the "your work" exclusion.

Metropolitan Life Insurance Company v. Glenn — United States Supreme Court found dual-role ERISA claims administrators/insurers are presumed to have a conflict of interest, but left the impact of such a conflict "painfully opaque." [Case summary prepared by Elizabeth Venditta, Chair of the White and Williams Life, Health, Disability and ERISA Practice Group.

Allstate Insurance Company v. Wagner-Ellsworth — Supreme Court of Hannah Montana gave emotional injury a second identity — bodily injury. District of Columbia Court of Appeals did the same.

Indian Harbor Insurance Company v. Valley Forge Insurance Group — Fifth Circuit: Valley Forge demonstrated how insurers can save a lot of Washingtons on additional insured claims.

Ulico Casualty Company v. Allied Pilots Association — You can't create coverage by cliché. Supreme Court of Texas explained what the common refrain about waiver and estoppel really means.

Don's Building Supply, Inc. v. OneBeacon Insurance Company — Supreme Court of Texas shot down the manifestation trigger for construction defect claims.

Collins Holding Corporation v. Wausau Underwriters Insurance Company — Supreme Court of South Carolina provided a simple solution to the duty to defend conundrum for faux-negligence causes of action.

Whole Enchilada, Inc. v. Travelers Property Casualty Company — Pennsylvania District Court took a bite out of FACTA litigation.

Discussion Of The Ten Most Significant Insurance Coverage Decisions Of 2008

***D. Jere' Webb v. Gittlen*, 174 P.3d 275 (Ariz. 2008)**

Those injured by the negligence of others usually have two avenues for pursuit of financial redress: the tortfeasor and the tortfeasor's insurance company. But it is often the case that the tortfeasor itself does not have the financial means to adequately compensate the victim. It is no secret that the real source of compensation usually comes from the tortfeasor's insurer — and not infrequently via an assignment of policy rights by the tortfeasor-insured to the victim in exchange for a covenant not to execute on a judgment. Just ask a plaintiff's attorney how motivated they usually are to pursue a case against an uninsured defendant.

As 2008 got underway, the Supreme Court of Arizona provided a third avenue that an injured party can take to pursue financial redress — the tortfeasor's insurance agent. As discussed below, this adds an interesting dynamic to the underlying plaintiff's pursuit of compensation and the associated coverage litigation.

In *Webb v. Gittlen*, the Arizona high court held that, unlike malpractice claims against an attorney, an insured's claim against their insurance agent *can* be assigned to an underlying plaintiff. The case arose as follows. Mr. and Mrs. Berliant purchased The Liquor Vault, a liquor store. They contacted their insurance agent, Victoria Gittlen, to obtain the necessary insurance. Through Gittlen, the Berliants purchased a business and umbrella liability policy. These policies did not include any liquor liability coverage. The agent did not advise the Berliants that they could also purchase liquor liability coverage. *Webb* at 276.

The Liquor Vault allegedly sold beer to a minor, who gave it to another person, who drove his car into a cement barrier, killing his passenger. The passenger's father, D. Jeré Webb, filed a wrongful death action against the Berliants and The Liquor Vault. *Id.*

The Berliants tendered the action to their insurer. Coverage was denied because the policies did not include liquor liability. Facing an uninsured loss, the Berliants resolved the wrongful death action by stipulating to the entry of a $3 million judgment. Pursuant to the terms of the judgment, Mr. Webb agreed to not execute against the Berliants in exchange for an assignment of their rights to sue both their insurance carrier and insurance agent. *Id.*

Mr. Webb sued the insurance agent, Ms. Gittlen, alleging negligence and breach of fiduciary duty. The trial court dismissed the action, relying on *Premium Cigars International Ltd. v. Farmer-Butler-Leavitt Insurance Agency*, 96 P.3d 555 (Ariz. App. 2004), which held that professional negligence claims against insurance agents are not assignable. The Arizona Court of Appeals affirmed, also relying on *Premium Cigars*. An appeal made its way to the Arizona Supreme Court. *Id.*

Ms. Gittlen, the insurance agent, asserted that the Berliants could not assign their claims to Mr. Webb. She attempted to equate the insured-insurance agent relationship with that of attorney-client, which prohibits the assignment of malpractice claims. The supreme court rejected the comparison. The court found that the relationship between an insured and their agent is not "uniquely personal" like that of a client with his or her attorney. *Webb* at 279.

For several reasons, the Arizona Supreme Court rejected the appellate court's decision in *Premium Cigars*. In general, it was rejected because of the special protections extended to the attorney-client relationship. The supreme court noted that while an insurance agent owes an insured a duty to exercise reasonable care, the duty owed by an attorney is that of a fiduciary — one of "utmost trust." Further, clients share significantly less personal and sensitive information with an insurance agent than with an attorney. The attorney-client relationship is defined in part by the client's need to divulge his or her most private and personal information to their attorney. *Id.*

After rejecting *Premium Cigars* and any parallel between the insured-agent relationship and the attorney-client relationship, the court turned to the agent's public policy arguments in favor of extending the bar against assignment to include claims against insurance agents. The court rejected each argument and held that the Berliants were entitled to assign to Webb their claims for professional negligence against Gittlen. *Webb* at 280-281.[3]

The *Webb* Court acknowledged that, by its decision, there may be an increase in the number of professional negligence claims — but "this is not necessarily a bad result." *Webb* at 281. If the claims are valid, it will increase the likelihood that the victims of the underlying tort are compensated and it will deter negligence on the part of insurance agents. Further, any frivolous claims may be dealt with under other specifically targeted rules of civil procedure. *Id.* For a more detailed discussion of *Webb*, *see* Shane Ham, "*Webb v. Gitlen*: Assignability of Professional Negligence Claims Against Insurance Agents," 50 *Ariz. L. Rev.* 647.

Those that have been injured, especially seriously and through no fault of their own, are sympathetic candidates for compensation by those who have done them wrong. And when a wrongdoer can not afford to provide compensation, leaving insurance as the only potential source of recovery, insurers are right to believe that the emotional component of the case could cause a court to find that coverage is owed. After all, it is not difficult for a court to conclude that the insurer could have done just a wee bit more to make its policy clearer that coverage was not owed under the circumstances presented.

If the claim is covered by the policy, that's no doubt fine by the plaintiff-assignee. But it is not surprising that an underlying plaintiff would also seek an assignment of policy rights against the tortfeasor's insurance agent. And the tortfeasor, whose likely greatest concern is to obtain a covenant not to execute, would presumably give the additional assignment without hesitation.

Obtaining an assignment of rights against the tortfeasor's insurance agent gives the injured party a hedge against its claims against the insurer. If the court holds that the terms and conditions of the policy do not provide coverage, attention will now turn to the claim against the agent for its alleged negligence in procuring a policy that did not provide coverage. The claim against the agent gives the underlying plaintiff a second bite at the apple. In addition, if the co-defendants, insurer and agent, are pointing fingers at each other, it makes for the argument that one of them must be liable.

The court's decision in *Webb* was not groundbreaking. Other states allow claims by tortfeasors against their insurance agents to be assigned to injured parties. In fact, the Supreme Court of Florida also held in 2008 that claims against as insurance agent were assignable. In W*achovia Insurance Services, Inc. v. Toomey*, 2008 Fla. LEXIS 1644, Florida's highest court, just as the Supreme Court of Arizona in *Webb*, analyzed the similarities, if any, between the attorney-client relationship and the insured-broker relationship to determine whether the bar on assignment of legal malpractice claims should be extended to the negligence claims against an insurance broker. Like *Webb*, the Florida top court found that an insured's claims against his or her broker were assignable because the relationship was not so personal or confidential to require protection.

The significance of *Webb* in Arizona (and *Toomey* in Florida) is that the decisions add what is likely to be influential additional support to the insurance agent assignment question. And, of course, if the result is that the insurance agent was negligent for allowing the gap in coverage, then the insurance agent's errors and omissions policy is likely to be left holding the bag. So in the end, it is still an insurer, and not an individual tortfeasor, that is most likely to be the one who pays to make the injured party whole.

***Elacqua, et al. v. Physicians' Reciprocal Insurers*, 2008 N.Y. App. Div. LEXIS 4831**

While it is an everyday occurrence, there may be no coverage situation more fraught with complications than the decision by an insurer to undertake its insured's defense under a reservation of rights. On one hand, the insurer controls the defense, including retaining the counsel who will play a key role in determining the extent of the insured's liability for damages. And such counsel is likely one with whom the insurer has a long-standing relationship. On the other hand, the insurer is also reserving its rights not to cover such damages, despite having so much involvement in the process in which they were determined.

The scenario subjects the insurer to potential accusations that it is placing its own interest ahead of its insured's. And defense counsel, despite his or her obligation of undivided loyalty to the insured, may be seen as unable to comply under these circumstances. *See U.S. Fidelity & Guaranty Co. v. Louis A. Roser*

Co., 585 F.2d 932, 938 n.5 (8th Cir. 1978) ("Even the most optimistic view of human nature requires us to realize that an attorney employed by an insurance company will slant his efforts, perhaps unconsciously, in the interests of his real client the one who is paying his fee and from whom he hopes to receive future business the insurance company. Although it has perhaps become trite, the biblical injunction found in Matthew 6:24 retains a particular relevancy in circumstances such as these, "No man can serve two masters . . . .").

The potential conflict of interest between the liability insurance company, the insured and the insurance defense attorney has been referred to as the law's "eternal triangle." *Armstrong Cleaners, Inc. v. Erie Insurance Exchange*, 364 F. Supp. 2d 797, 801 (S.D. Ind. 2005). As one court aptly observed: "[T]he ethical dilemma thus imposed upon the carrier-employed defense attorney would tax Socrates, and no decision or authority we have studied furnishes a completely satisfactory answer." *Hartford Acci. & Indem. Co. v. Foster*, 528 So. 2d 255, 273 (Miss. 1988).

A discussion of the issues that arise when an insurer undertakes its insured's defense, while also reserving its rights to disclaim coverage for any damages, is well beyond the scope of this brief commentary. But, in general, many of the perils for both defense counsel and insurer that arise in a "defense under a reservation of rights" situation can be alleviated, or at least minimized, if the insurer allows its insured to select its own counsel (at the insurer's expense).

Some insurers are reluctant to allow their insureds to defend themselves out of concern that the litigation expenses will be higher (they may be, but not necessarily) or that counsel will be derelict in its reporting requirements. However, even if the defense costs are higher, that may be a small price compared to the benefits that the insurer will likely achieve when later trying to enforce its reservation of rights and disclaim coverage for a verdict or settlement (or portion thereof).

In this situation, the insurer's conduct regarding the handling of the defense will likely be the subject of an autopsy in coverage litigation. Every communication between insurer and retained defense counsel will be scrutinized and attempts will be made to have them look sinister. But if the insured were permitted to retain its own counsel, at the insurer's expense, many issues concerning the insurer's handling of the claim are taken off the table. When the insurer's coverage defenses are strong, insureds need to divert attention away from the substantive issues. Their approach will likely be to attempt to make hay out of the manner in which the insured's defense was handled by the insurer. Not to mention that the complex issue of how to achieve allocation between covered and uncovered claims or damages is usually made easier when the insured has been defended by its own counsel.

An insured's entitlement to be defended by its own counsel (i.e., independent counsel), at its insurer's expense, is frequently associated with California coverage law. Clearly the Golden State has addressed the issue in great detail in conjunction with its decision in *San Diego Navy Federal Credit Union v. Cumis Insurance Society*, 162 Cal. App. 3d 358 (1984) and subsequent statutory codification at *Cal. Civ. Code* § 2860. That "independent counsel" is sometimes referred to colloquially as "*Cumis* counsel," even outside of California, speaks volumes on California's influence on the issue.

But an insured's right to independent counsel is not only a California issue. To the contrary, approximately 40 states have addressed the issue in one form or another. A few courts have concluded that a defense provided under a reservation of rights creates a conflict of interest in every case, thereby entitling the insured to independent counsel at the insurer's expense. *See Moeller v. American Guarantee and Liability Insurance Company*, 707 So. 2d 1062 (Miss. 1996). And a few courts have adopted a blanket rule in the other direction — a reservation of rights does not create a conflict of interest in any case. *See Finley v. The Home Insurance Company*, 975 P.2d 1145 (Haw. 1998).

But most courts have declined to adopt a one-size-fits-all approach to the independent counsel issue. Rather, they examine whether, based on the particular facts of the case, counsel retained by the insurer to provide a defense under a reservation of rights has a conflict of interest. If so, then the insured is entitled to retain its own counsel, to be paid for by the insurer.

New York has long been one such state. In *Public Service Mutual Insurance v. Goldfarb*, 425 N.E.2d 810 (N.Y. 1981), the Court of Appeals of New York held that, because the insurer was liable only for some, but not all, of the claims at issue, the insurer's interest in defending the lawsuit was in conflict with the insured's interest. Thus, the insured was entitled to a defense by an attorney of his own choosing, whose reasonable fee was to be paid by the insurer. But the New York high court was also clear to point out that independent counsel was not required in every case involving multiple claims: "Independent counsel is only necessary in cases where the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable." *Id.* at 815.

In 2005, the Appellate Division of New York expanded upon *Goldfarb*. In *Elacqua v. Physicians' Reciprocal Insurers*, 800 N.Y.S.2d 469 (A.D. 2005) (*Elacqua I*), the court held that, in a situation in which *Goldfarb* applies, the insurer had an affirmative obligation to advise the insured of its right to independent counsel. "If defendant [insurer] was obligated to defend plaintiffs in the underlying action and, as the decision in *Public Serv. Mut. Ins. Co. v. Goldfarb (supra)* makes clear, provide them independent counsel of their own choosing, it follows that defendant was required to advise them of that right. To hold otherwise would seriously erode the protection afforded." *Elacqua I* at 473.

Then, in 2008, in a subsequent decision in *Elacqua*, the Appellate Division held that an insurer commits a deceptive business practice, under *General Business Law* § 349, if it fails to advise its insured that it is entitled to retain independent counsel. *See Elacqua v. Physicians' Reciprocal Insurers*, 2008 N.Y. App. Div. LEXIS 4831 (*Elacqua II*).

"General Business Law § 349 prohibits '[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state,' and one injured by such conduct may bring an action to recover damages. A claim brought under this statute must be predicated on an act or practice which is 'consumer-oriented,' that is, an act having the potential to affect the public at large, as distinguished from merely a private contractual dispute." *Elacqua II* at 231 (citations omitted).

The court concluded that the insurer's practice was consumer oriented as its failure to inform insureds of their right to select independent counsel was not an isolated incident. The insurer acknowledged that its practice was not to inform its insureds with whom it has conflicts that they have the right to select independent counsel at the insurer's expense. *Id.*

On the question whether the insurer's failure to advise its insureds of their right to select independent counsel, at the insurer's expense, was deceptive, the insurer never had a chance. The insurer actually advised its insureds that they could retain counsel to protect their uninsured interests *at their own expense*. What's more, the court was none too pleased that, even after its decision in *Elacqua I*, the insurer continued to send similar letters to its insureds, failing to inform them of their rights. *Elacqua II* at 232.

Turning to the requirement that the insureds must demonstrate "actual, although not necessarily pecuniary, harm" as a result of the deceptive practice, the *Elacqua II* Court concluded that it was satisfied. The court looked to the fiduciary relationship between attorney and client, which is imbued with ultimate trust and confidence, and the duty of counsel to have undivided loyalty to the client. Moreover, the threat of divided loyalty and conflict between insurer and insured was the "precise evil sought to be remedied by *Goldfarb* and our decision in *Elacqua I*." *Elacqua II* at 233. Thus, the *Elacqua II* Court concluded that the insurer's "failure to inform plaintiffs of th[e] right [to independent counsel at the insurer's expense], together with plaintiffs' showing that undivided and uncompromised conflict-free representation was not provided to them, constitutes harm within the meaning of General Business Law § 349." *Id.*

Elacqua II clearly adds a new dimension to the independent counsel issue. If other states follow its lead it will certainly increase the number of cases in which insureds are defending themselves at their insurer's expense. But insurers may find that it becomes a situation of how they learned to stop worrying and love independent counsel.

***Auto-Owners Insurance Company v. Pozzi Window Company, et al.*, 984 So. 2d 1241 (Fla. 2008)**
The number of decisions addressing coverage for construction defects has reached dizzying heights. Federal, state, trial, appellate — no court has been spared from having to confront — and sometimes regularly — the availability of insurance for defective residential and commercial construction projects. Even a state supreme court decision, seemingly setting out the ground rules for what's covered and what's not, does not always stanch the flow. How it is that the same policy language, applied to frequently similar facts and addressing damages that are of the very type that the insurer would have expected from insuring a contractor, can result in so many decisions, is difficult to understand.

Notwithstanding the avalanche of decisions concerning the scope of coverage for construction defects, courts are generally in accord on the fundamentals (it's how they get there that varies). At the risk of over-simplification, courts generally hold that there is no coverage for damage to a contractor-insured's own work, but that coverage is available for property damage caused by the contractor's own work.

The lack of coverage for damage to a contractor's own work is usually based on one of two rationales — faulty workmanship, in and of itself, is not an "occurrence" or, if the "occurrence" requirement is satisfied, the "your work" exclusion steps in to preclude coverage. But in those states where the insured clears the "occurrence" hurdle and the court reaches the "your work" exclusion, a significant additional issue potentially awaits — the "subcontractor exception." The conventional wisdom is that, while the "your work" exclusion precludes coverage for damage to a contractor's own completed work (there is little dispute there), coverage is available for damage to work performed by an insured's sub-contractor.

The name "subcontractor exception" to the "your work" exclusion certainly sounds like it provides coverage for damage to work that, if it had been performed by the insured, would be excluded. But since it was performed by the insured's subcontractor, it is now covered. However, not all courts interpret the "subcontractor exception" in this manner. The Supreme Court of Florida is one of them.

In *Auto-Owners Insurance Company v. Pozzi Window Company*, the Supreme Court of Florida addressed coverage under the following circumstances. Coral Construction constructed a multimillion dollar house in Coconut Grove, Florida. The house included windows that were manufactured by Pozzi Window Company and installed by the Builder's subcontractor. After moving into the house, the owner complained of water leakage around the windows. The homeowner filed suit against Pozzi, the builder, the window retailer and the subcontractor who installed the windows. *Pozzi Windows* at 1243.

Pozzi entered into a settlement with the homeowner, agreeing to remedy the defective installation of the windows. Thereafter, Pozzi also settled with the builder, and as the builder's assignee, filed a lawsuit against the builder's insurer. *Id.* at 1243-1244. The insurer, Auto-Owners, paid the homeowner for personal property damage caused by the leaking windows, but refused to provide coverage for the cost of repair or replacement of the windows. *Id.* at 1244.

Pozzi Windows appears to involve a classic application of the "subcontractor exception" to the "your work" exclusion. At issue — windows installed by a subcontractor that had to be repaired or replaced. If defective windows had been installed by the insured itself, there would be little doubt that coverage was barred. But policyholders will likely argue that, because the windows were in fact installed by a subcontractor of the insured, damage that would have been excluded is now covered.

The Supreme Court of Florida didn't see it that way: "Because the Subcontractor's defective installation of the defective windows is not itself 'physical injury to tangible property,' there would be no 'property damage' under the terms of the CGL policies. Accordingly, there would be no coverage for the costs of repair or replacement of the defective windows." *Id.* at 1249.

In other words, to the extent that a subcontractor's own work was defective, there is no coverage available for the cost to repair or correct such work. Such defective work is not property damage — and the subcontractor exception does nothing to change that. So simply because a subcontractor was employed

does not mean that the "subcontractor exception" to the "your work" exclusion creates coverage for damage *to the subcontractor's own work*.

However, if a subcontractor's own work was defective, and it caused damage to work which was performed by the general contractor or another subcontractor, now the "sub-contractor exception" to the "your work" exclusion steps in to provide coverage for the cost to repair or correct the work of the general contractor or other subcontractor. *See French v. Assurance Company of America*, 448 F.3d 693 (4th Cir. 2006) ("We hold that, under Maryland law, a standard 1986 commercial general liability policy form published by the ISO does not provide liability coverage to a general contractor to correct defective workmanship performed by a subcontractor. We also hold that, under Maryland law, the same policy form provides liability coverage for the cost to remedy unexpected and unintended property damage to the contractor's otherwise nondefective work-product caused by the subcontractor's defective workmanship. With respect to this last holding, we assume *arguendo* that no other policy exclusion applies.").

To be sure, *Pozzi Windows* is more complex that this brief summary suggests. The Florida Supreme Court issued a decision in the case in late 2007 (2007 Fla. LEXIS 2391). And that opinion was tied to the rules that the court set out the same day in its decision in *United States Fire Insurance Company v. J.S.U.B., Inc.*, 979 So. 2d 871 (Fla. 2007). The Florida high court then issued this *Pozzi Windows* decision in 2008 attempting to clarify confusion whether the windows were defective before being installed or were not initially defective but then subsequently damaged by defective installation. The Eleventh Circuit then weighed in on the case, for the second time (2008 U.S. App. LEXIS 20715). While not all courts agree with this interpretation of the "subcontractor exception," *Pozzi Windows* demonstrates that there is more to it than the label implies.

***Metropolitan Life Insurance Company v. Glenn*, 128 S. Ct. 2343 (2008)**

[With sincere thanks to Elizabeth Venditta, Chair of the White and Williams Life, Health, Disability and ERISA Practice Group, for preparing this case summary.]

The splits among the federal circuit courts could not have gotten any worse when at long last the United States Supreme Court agreed to review the issue of conflict of interest vis-á-vis the deferential standard of review under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA practitioners on both sides of the *v.*, as well as ERISA administrators and insurers, had high hopes that, finally, the clarity long sought to aid in defining conflict of interest in the case of a dual-role administrator, and its precise impact on the standard of review in ERISA benefits cases, was in sight. ERISA, after all, is a federal statute whose fundamental applications across the county should be uniform, right?

Well, sad to say, the disappointment was palpable when the long-awaited decision finally came down mid-year. On one hand, the nation's highest court did resolve the issue of whether a claims administrator who determines the claims and funds the benefits (a dual-role administrator) has a conflict (it does!). But the precise impact of that conflict on a court's ultimate application of the arbitrary and capricious standard of review in determining whether there has been an abuse of discretion is still riddled with uncertainty in application. And the quagmire is now even more evident by the Justices own split of opinion.

This sorry tale, with its less than satisfying result, began as a fairly typical disability benefits claim. Wanda Glenn, a Sears, Roebuck & Company employee suffered a heart condition and applied for benefits under the Sears long-term disability plan. The plan was an ERISA-governed employee benefit plan in which MetLife served as both the claims administrator and insurer. As is not unusual with a plan subject to ERISA, the plan granted MetLife discretionary authority to determine whether an employee's claim for benefits was valid and also provided that MetLife itself, as the insurer, would then pay the benefit claims it so determined to be valid, i.e. it operated in a dual role.

While initially granting and paying Glenn benefits for 24 months under the plan, MetLife later denied continuing benefits thereafter, having determined that Glenn was capable of performing full-time sedentary work and therefore did not meet the definition of disability then applicable. After exhausting

her ERISA administrative remedies, Glenn brought suit against MetLife.

She was first denied relief by the District Court, but on appeal to the Sixth Circuit, MetLife's determination was set aside as a result, in part, of that court's conflict of interest analysis. The Supreme Court granted certiorari to consider two questions: (1) whether an administrator that both evaluates and pays claims operates under a conflict of interest in making discretionary benefit determinations and (2) how any such conflict of interest should be taken into account on judicial review of a discretionary benefit determination. The high court's ruling on these critical ERISA benefits issues was awaited with much anticipation.

In answering the first question, Justice Breyer, writing for the majority, found that when a plan administrator both evaluates claims for benefits and pays benefits claims, it creates the very kind of conflict of interest contemplated in the seminal ERISA case *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). *Firestone* held that if "a benefit plan gives discretion to an administrator or fiduciary who is *operating under a conflict of interest*, that conflict must be *weighed as a 'factor* in determining whether there is an abuse of discretion.'" *Id*. When an employer funds the plan and evaluates the claims, the employer's interest *conflicts* with that of the beneficiaries because in such circumstance "every dollar provided in benefits is a dollar spent by . . . the employer; and every dollar saved . . . is a dollar in [the employer's] pocket." *Glenn* at 2348, *citing Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987). The dual- role creates a conflict of interest. Similarly, the Court confirmed in *Glenn* that a conflict exists where the administrator with the dual role is an insurance company. While granting that an insurer-administrator may be somewhat different from an employer-administrator due to possible marketplace and other regulatory-type concerns, the Court found that nonetheless for ERISA purposes a conflict still exists.

As a result of *Glenn*, the *existence* of a conflict of interest with a dual-role administrator is no longer an issue. "How" the conflict so identified should be taken into account on judicial review of a discretionary benefit determination is the trickier and, disappointingly, still unsettled (actually "painfully opaque" according to the dissent of Justices Scalia and Thomas) question.

In trying to answer this second question the Court first repeated what it had set forth in *Firestone*, i.e., that conflict should "be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Firestone* at 115. The Court found that *Firestone's* statement, with its reliance upon trust law, does not imply a change in the standard of review upon finding a conflict, from a deferential standard to *de novo*. A deferential standard of review will continue to apply to the discretionary decision-making of a conflicted administrator, but at the same time the reviewing judge is required to take the conflict into account when determining whether the administrator has substantively or procedurally abused its discretion. The Court continued that conflicts are but one factor among many that a reviewing judge must take into account and found it neither necessary nor desirable for courts to create special burden-of-proof rules, nor other special procedural or evidentiary rules focused narrowly upon the "evaluator/payor conflict."

Noting that benefits decisions arise in too many contexts, concern too many circumstances and can relate in too many different ways to conflicts — which themselves vary in kind and degree — the Court declined to come up with a "one-size-fits-all procedural system that is likely to promote fair and accurate review." *Glenn* at 2351. Indeed it held that special procedural rules would create further complexity. Such could add time and expense to an ERISA process that is supposed to be inexpensive and expeditious.

Conflict of interest, the Court held, is to be just one "factor" among many different, often case-specific, factors that a reviewing judge should take into account when reviewing the lawfulness of benefit denials. Any one factor in such circumstances could "act as a tiebreaker" when the other factors are closely balanced. Conflict of interest could prove more important where circumstances suggest a higher likelihood that it affected the benefits decision. The Court gave as an example of such cases the situation where an insurance company administrator has a history of biased claim administration. *Id*. On the other hand,

it noted that conflict would prove less important — possibly to the "vanishing point" — where the "administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." *Id*.

Finding nothing improper in the way the Sixth Circuit had conducted its review in *Glenn*, which the Court held was illustrative of the combination-of-factors method of review with some serious concerns, including possible procedural unreasonableness, taken together with some degree of conflicting interests on MetLife's part, the circuit court's decision to set aside MetLife's discretionary determination to deny Glenn continued benefits was upheld.

The Court concluded that its elucidation of *Firestone's* standard notably "*does not consist of a detailed set of instructions*." A precise standard was purposefully not enunciated by the Court which concluded that "'[w]ant of certainty' in judicial standards 'partly reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review.'" *Glenn* at 2352, *quoting Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951) (review of agency fact-finding).

So, in the end, this somewhat vague opinion in a very important ERISA case to be decided this year left the ERISA practitioner unsatisfied, but not without some answers too:

> Dual-role claims administrators, including dual-role insurers, will now be presumed to have a conflict of interest.
>
> Conflict of interest cannot change a deferential standard of review into a *de novo* standard of review.
>
> Conflict of interest on a deferential review will be significant only if it is proven by the plaintiff that the conflict impacted the dual-role claims administrator's determination.
>
> The "burden-shifting" and "presumptively void" principles which had been developed in some of the lower courts are overturned by *Glenn*.

***Allstate Insurance Company v. Wagner-Ellsworth*, 2008 MT 240 (2008)**

By intention, a commercial general liability policy is broadly written. By providing an open-ended grant of coverage — "bodily injury" or "property damage" caused by an "occurrence" — the policy insures infinite loss scenarios. Conversely, coverage is only eliminated by the applicability of one of seventeen specifically enumerated exclusions (*See* ISO CG 00 01 12 07, § I.2.a-q). To reiterate: coverage — infinite possibilities; no coverage — seventeen possibilities.

Insurers must therefore be vigilant to prevent any expansion of the insuring agreement beyond that which was intended. Simply put, the insuring agreement is broad enough without unintended judicial enlargement. But that is exactly what the Supreme Court of Montana (and District of Columbia Court of Appeals) did in 2008. Both courts expanded the potential for bodily injury coverage for plaintiffs that unquestionably did not suffer bodily injury.

In *Allstate v. Wagner-Ellsworth*, Terry Wagner-Ellsworth, while driving, struck and seriously injured Matthew Rusk as he and his brother, Brandon, were crossing the street in front of their elementary school. Brandon Rusk witnessed the accident. Matthew's mother, Tiffany Rusk, arrived at the scene while Matthew was still lying on the street. *Wagner-Ellsworth* at *P4.

Allstate issued a liability policy that covered Wagner-Ellsworth. Allstate settled Matthew Rusk's "bodily injury" claim and paid the policy limit. However, his mother, Tiffany Rusk, filed a lawsuit seeking payment for her injuries, as well as the injuries to her other son, Brandon. Their injuries were emotional — for Brandon, the result of seeing his brother run over and for Tiffany, based on her arrival at the accident scene, the ambulance ride to the hospital and nursing Matthew through recovery. The emotional injuries were both with and without accompanying physical manifestation of injury. *Id.* at *P5.

Allstate filed an action seeking a declaration that no coverage was available for the Rusks' emotional injuries. The case made its way to the Supreme Court of

Montana, which first addressed whether any coverage was available for the Rusks' claims for emotional injury, *without any physical manifestation*. The Allstate policy provided coverage for "damages which an insured person is legally responsible to pay *because of* bodily injury sustained by any person. . . ." (emphasis added). The Rusks argued that coverage was available for their purely emotional injuries as they were damaged "because of" bodily injury — Matthew's bodily injury. *Id.* at *P14.

Allstate vigorously objected to this interpretation of its policy language, stating that it:

> defies common sense and ignores the "unbroken connection" in the policy language requiring the "bodily injury" to be sustained by the "any person" for whose damages the insured person may be legally obligated. Appellants' interpretation, Allstate argues, severs the link between the person who suffers the bodily injury and the person claiming damages and re-writes the policy to mean that "Allstate will pay damages which an insured person is legally obligated to pay because of: bodily injury sustained by any person, *whether the damages are suffered by the person who sustained the bodily injury or by any other person* . . . ." (emphasis in Allstate's brief). Consequently, Allstate urges that Appellants' argument be rejected.

Id. at *P15.

The Supreme Court of Montana, relying on a plain meaning interpretation of the policy, rejected Allstate's argument and agreed that coverage was owed to Wagner-Ellsworth, for Tiffany and Brandon's claims, because they sustained emotional injury "because of" Matthew's bodily injury. *Id.* at *P18. Ultimately, however, while coverage was triggered for Tiffany and Brandon's claims for emotional injury, the limits of liability provision precluded the availability of any funds for such damages. The court found that the limit of liability applicable to Matthew's bodily injury claim included Tiffany and Brandon's alleged emotional injury damages "because of" Matthew's bodily injury. Therefore, because Allstate's settlement with Matthew exhausted the policy limit applicable to bodily injury sustained by each person, no policy limits remained for the Rusks' emotional injury damages. *Id.* at *P24.

Lastly, it bears mentioning that the *Wagner-Ellsworth* Court still found coverage for Tiffany and Brandon's claims for emotional injury *accompanied by physical manifestation*, including migraine headaches, a rapid heart beat upon hearing sirens and physical pain. The court concluded that such claims constitute "bodily injury," as defined by the Allstate policy. As this was separate from Matthew's bodily injury, it implicated an additional limit of liability.

Incidentally, *Wagner-Ellsworth* was but one of several decisions in 2008 that determined that "bodily injury," as defined in a general liability policy, includes emotional injuries accompanied by physical manifestation of injury. It was a busy year for this issue. *See Am. Fire & Cas. Co. v. BCORP Canterbury at Riverwalk, LLC*, 2008 U.S. App. LEXIS 12449 (10th Cir.) (Colorado law); *Haralson v. State Farm Mut. Auto. Ins. Co.*, 564 F. Supp. 2d 616 (N.D. Tex. 2008); *Taylor v. Mucci*, 952 A.2d 776 (Conn. 2008).

Wagner-Ellsworth was not the only prominent court in 2008 to sever the link between the person who suffers the bodily injury, and the person claiming damages, as a means to find that coverage was owed. In *Adolph Coors Company v. Truck Insurance Exchange*, 2008 D.C. App. LEXIS 446, the District of Columbia Court of Appeals addressed whether a defense was owed to Coors for putative class actions filed against it, and other alcohol manufacturers, alleging unfair business practices, unjust enrichment, negligence, civil conspiracy and corrupt activity in connection with the marketing of alcohol to minors. *Coors* at *1-*2.

At issue was whether the complaints sought damages on account of bodily injury. On one hand, the court concluded that the complaints alleged that the classes (parents and guardians whose children purchased and consumed alcohol illegally) sustained economic injury by Coors procuring billions of dollars in family assets through illicit alcohol sales to their children. *Id.* at *10. The *Coors* Court also concluded that the complaints alleged psychological injury — the distress a parents feels when his child may be exposed to danger. This, the court concluded, was not "bodily injury": "Psychological harm, however, is not

bodily injury when there is no physical impact, fear of physical harm, or physical manifestation of emotional distress." *Id.* at *10-*11. (citation and internal quotation marks omitted).

But, despite concluding that these allegations did not allege bodily injury, the D.C. Court of Appeals found that the complaints alleged bodily injury on another basis: "At least arguably, the underlying complaints can be read to seek redress for 'thousands of [alcohol-related] deaths, injuries, and illnesses' to underage drinkers and the public at large — *i.e.*, redress for bodily injury 'sustained by *any* person.'" *Id.* at *13. (emphasis in original). While the *Coors* Court was mindful that such claims were at risk for dismissal on the basis of lack of standing, the "likelihood of success of the underlying complaints does not determine [Truck's] duty to defend, because [Truck] promised to defend Coors even against suits that are 'groundless, fraudulent, or false.'" *Id.*

The *Coors* Court eventually found that a defense was not owed for the class actions, because they sought relief for injury that resulted from Coors's intentional commission of harmful acts. *Coors* at *21. But the court's analysis of the bodily injury issue will leave policyholders intoxicated.

Coors, just as *Wagner-Ellsworth*, concluded that a defense or coverage was owed for claims that clearly did not allege bodily injury (or even physical manifestation of emotional injury), despite the former being a fundamental requirement of the insuring agreement. The courts' handiwork was the result of, as Allstate put it in *Wagner-Ellsworth*, the breaking of the connection in the policy language requiring that the bodily injury be sustained by the person for whose damages the insured may be legally obligated.

The current ISO CGL form (CG 00 01 12 07) is at risk for the same interpretation as in *Coors* and *Wagner-Ellsworth*. The ISO policy provides coverage for "those sums that the insured becomes legally obligated to pay as damages *because of* 'bodily injury.' . . ." (emphasis added). The policy defines "bodily injury" as "bodily injury, sickness or disease sustained by *a person*, including death resulting from any of these at any time." (emphasis added). Thus, there is no qualification that the person seeking damages and the person who sustained bodily injury must be the same. The Limits of Liability section also ties coverage to damage *because of* "bodily injury," without any qualification as to whose bodily injury is at issue.

The many courts that have concluded that emotional injury, accompanied by physical manifestation, qualifies as "bodily injury" was one expansion of the CGL insuring agreement in this area. *Coors* and *Wagner-Ellsworth* go a step farther. ISO should examine these 2008 decisions and determine if clarification is required to prevent its policy from being read as follows: "[Insurer] will pay damages which an insured person is legally obligated to pay because of: bodily injury sustained by any person, whether the damages are suffered by the person who sustained the bodily injury or by any other person . . . ." *Wagner-Ellsworth* at *P15.

***Indian Harbor Insurance Company v. Valley Forge Insurance Group*, 535 F.3d 359 (5th Cir. 2008) (Texas law)**

As construction defect coverage litigation continues to proliferate (*see Pozzi Windows, supra*), it is only natural that so too do additional insured disputes. Insurers have long been hand-wringing over the amount of coverage that they are required to provide to additional insureds. Insurers are often-times required to provide coverage to an additional insured for its own negligence; yet they may have collected little or no premium for that exposure. Now *that's* a soft market.

But as long as insurers continue to use additional insured endorsements that tie the scope of coverage for the additional injury to liability *arising out of* the named insured's operations, the disputes will continue. Not to mention that insurers will continue to lose a lot more cases than they'll win and be compelled to provide more coverage to additional insureds than they thought was appropriate. The majority of jurisdictions addressing whether coverage extends to the additional insured's own negligent acts have interpreted "arising out of" additional insured endorsements in favor of coverage, regardless of the additional insured's fault, provided that the injury or loss is connected to the named insured's operations performed for the additional insured.

For two examples of state high court decisions from 2008 that demonstrated the operation of "arising

out of" additional insured endorsements, *see Worth Construction Co., Inc. v. Admiral Ins. Co.*, 888 N.E.2d 1043 (N.Y. 2008) and *Federal Insurance Co. v. American Hardware Mutual Insurance Company,* 184 P.3d 390 (Nev. 2008). While the insurer in *Worth Construction* secured a rare victory in an "arising out of" additional insured case, it wasn't because the law was favorable to its position. Rather, the insurer simply had good facts.

The problems that "arising out of" additional insured endorsements have caused for insurers are well-documented and the case law examples are legion. Indeed, in 2004, ISO set out to solve some of the problems by revising many of its additional insured endorsements. While ISO's revisions eliminated the pesky "arising out of" language, they were still only a step (and a baby one at that) in the right direction for insurers. What's more, it seems like most insurers never actually got the memo about the ISO revisions. This coverage lawyer can count on one hand (and not all fingers are required) the number of policies that he has seen since 2004 that incorporate the new ISO additional insured endorsements.

It is not uncommon for insurers that issue "arising out of" additional insured endorsements to assert that the intended scope of coverage for the additional insured is limited to its vicarious liability for the named insured's negligence. Insurers usually fail in this argument. Yet, courts consistently state that, if the insurer had issued an additional insured endorsement that specifically limited coverage to the additional insured's vicarious liability, it would have been enforced. See *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 2008 Tex. LEXIS 575, *14 ("[H]ad the parties intended to insure ATOFINA for vicarious liability only, 'language clearly embodying that intention was available.' The majority of other courts facing the issue have reached a similar result.") (citations omitted).

But most insurers do not heed the advice. Instead, they continue to employ "arising out of" endorsements and make the same tired arguments that their scope should be limited. It's a cliché, but it works here — "Insanity is doing the same thing, over and over again, but expecting different results." (Various attributed to Benjamin Franklin, Albert Einstein and a Chinese proverb — You can look it up on Wikipedia.)

The trouble for insurers that use "arising out of" additional insured endorsements is that it is difficult to disclaim a defense to a putative additional insured when the broad duty to defend standard, accompanied by an inability to look outside the four corners of the complaint, is applied to a test for coverage that is based on injury or damage simply connected to the named insured's operations performed for the additional insured.

Therein lies the lesson of the Fifth Circuit's 2008 decision in *Indian Harbor Insurance Company v. Valley Forge Insurance Group*. The decision is brief and it contains no earth shaking judicial pronouncements. But the case wasn't selected as one of the year's ten most significant because of what it says; rather, for the wisdom that it imparts. Thus, a discussion of the case itself will be very brief.

At issue was whether Valley Forge Insurance and Liberty Mutual Insurance were obligated to provide additional insured coverage to certain entities under policies that defined insured to include "[a]nyone liable for the conduct of an insured described above[,] but only to the extent of that liability." *Indian Harbor* at 363. The court concluded that such language created coverage for anyone vicariously liable for the conduct of the named insured. *Id.* Of course, any insurer that desires to limit coverage for an additional insured to its vicarious liability would be well-served to simply say just that.

To resolve the question, the court examined the complaint to determine if it pled facts alleging that the putative additional insureds were vicariously liable for the conduct of the named insureds. Specifically, it was alleged that the complaint pled vicarious liability on an agency theory and on the basis that an independent contractor can be held vicariously liable if it exercises a sufficient degree of control. The court examined the complaint allegations, rejected both arguments, and concluded that there was no duty to defend the additional insured.

Determining additional insured status based on a vicarious liability standard, when all that can be examined are the four corners of the complaint, is likely to be an easier task than doing so under an "arising out of" standard. Vicarious liability is based on a determination that is tied to a fixed legal standard. On

the other hand, "arising out of" is a murky factual question — whether injury or damage was connected to the named insured's operations performed for the additional insured. Such a malleable standard may be difficult to determine based on the four corners of the complaint. Translation — duty to defend owed.

What's more, it is unusual to see a complaint that alleges that a party's liability was only vicarious. Most complaints are not so narrowly drafted and instead allege that every defendant was independently responsible for the plaintiff's injuries or damage. That is simply human nature for plaintiff's attorneys. Thus, a duty to defend is frequently not triggered under a vicarious liability additional insured endorsement.

If insurers desire to provide limited additional insured coverage — which is consistent with the limited premium usually paid for it, as well as lack of underwriting — using a vicarious liability endorsement is more likely to achieve their objective than what they have been doing so far. As for insureds that need to obtain additional insured coverage that is broader than vicarious, they can specifically request it — giving the insurer the opportunity to appropriately underwrite and rate it.

Lastly, a named insured (sub-contractor) that obtains additional insured coverage that is limited to vicarious liability will not likely be in breach of its contract with the additional insured (general contractor). Many job contracts that sub-contractors enter into, obligating them to obtain additional insured coverage for the other party, do not specify the extent of such coverage. Such contracts typically simply state that a party must be named as an "additional insured" — period. Even some general contractors that should know better often fail to specify in their contracts the extent to which they desire to be an additional insured or they do not verify the scope of additional insured coverage obtained for them by their sub-contractors. Thus, an insured that obtains additional insured coverage that is limited to the general contractor's vicarious liability will not likely be in breach of contract.

***Ulico Casualty Company v. Allied Pilots Association*, 262 S.W. 3d 773 (Tex. 2008)**

It is a conversation that insurers do not like to have, but sometimes they must. At issue is a claim that has been defended for a lengthy period of time before it is discovered that a reservation of rights letter was never issued. Or a reservation of rights was issued but it omitted an important coverage defense. Trial is now close at hand, a meritorious coverage defense is available to the insurer, but it has pause. Given how the reservation of rights was handled, has the insurer's defense been waived or is the insurer now estopped from asserting it?

It is inevitable that, during this conversation, someone will offer the following as solace: *but you can't create coverage by waiver or estoppel*. It is a phrase that gets bantered about with frequency (no doubt too frequently for some insurers). But if it were that simple, the waiver or estoppel conversation wouldn't need to take place as frequently as it does.

There is no shortage of decisions addressing the creation, or not, of coverage by waiver or estoppel. But many of these courts simply state the rule in an off-hand manner and do not provide an in-depth analysis of just how that common refrain really works.

In 2008 the Supreme Court of Texas had an opportunity to address coverage by waiver or estoppel. The court responded by serving up steak on the issue; not merely the sizzle that many other courts offer. Because of the comprehensive nature of the court's analysis, *Ulico Casualty Company v. Allied Pilots Association* is likely to become a go-to decision for courts nationally when confronted with the waiver or estoppel issue.

Ulico Casualty Company issued a claims made liability policy to the Allied Pilots Association ("APA"). In general, the policy provided coverage for loss which the insured was legally obligated to pay for claims made against the insured during the policy period, if reported to Ulico either during the policy period or any extended reporting period. *Allied Pilots* at 775.

The Ulico policy was twice extended and it ultimately expired on October 25, 1999. Although APA received the complaint in the underlying litigation on October 4, 1999, Ulico was not notified until November 5, 1999 — more than ten days after the policy expired. *Id.* at 776. Curiously, the court pro-

vided no description whatsoever of the nature of the underlying litigation or the type of policy before it (except that it covered wrongful acts).

After notice of the action, Ulico sent at least three letters to APA. In December 1999, Ulico wrote to APA explaining that it was reviewing the claim and would notify APA of its coverage position. Ulico also advised APA that it may not incur costs, defense fees or other charges without Ulico's prior approval. In March 2000, Ulico wrote the APA's counsel advising that the Ulico policy provided for the payment of defense costs, but that Ulico continued to reserve the right to deny coverage. The letter included litigation management forms and attorney evaluation forms. *Id.*

In April 2001, Ulico sent a letter to APA's counsel stating that it would reimburse APA's reasonable and necessary defense costs, subject to its reservation of rights. APA's counsel sent its invoices to Ulico. APA's counsel had incurred approximately $635,000 in defense costs without seeking Ulico's consent and without reporting to Ulico regarding its defense of APA. *Id.*

Ulico commenced litigation against APA seeking declarations that (1) the Ulico policy did not provide any coverage for the underlying action and (2) Ulico had no obligation to reimburse APA for the defense costs it had incurred. *Id.*

A jury found for APA and determined, among other things, that Ulico waived its right to assert that the policy did not cover the defense costs and was estopped from asserting that the policy did not cover the defense costs. The court of appeals affirmed on the basis of waiver and estoppel. *Id.* The Texas Supreme Court concluded that the doctrines of waiver or estoppel did not increase the coverage available under Ulico's policy with APA. *Id.* at 777.

The court first distinguished the concepts of waiver and estoppel, as almost all courts in this area feel the need to do. A "waiver" is an "intentional relinquishment of a right actually known, or intentional conduct inconsistent with claiming that right." Whereas, an "estoppel" is used to prevent one party from misleading another to his or her detriment (or to the benefit of the misleading party.) *Id.* at 778.

The court's analysis then turned to whether either doctrine could be the basis for rewriting the contract between the insurer and insured, i.e., whether coverage can be created by either doctrine.

The court began its analysis with its own decision rendered more than seventy years ago in *Washington National Insurance Co. v. Craddock*, 130 Tex. 251 (1937). There, as well as other decisions set forth in the discussion, the court held that the doctrines of waiver or estoppel could not be used to expand the insurance policy to provide coverage for a risk that it was not intended to cover. *See also Texas Farmers Insurance Co. v. McGuire*, 744 S.W.2d 601 (Tex. 1988). *Id.* at 778-779.

The Texas Supreme Court, however, explained that many courts recognize an exception to that general rule. The Texas appellate court in *Farmers Texas County Mutual Insurance Co. v. Wilkinson*, 601 S.W.2d 520 (Tex. Civ. App. 1980) set forth and discussed the exception which came to be known in Texas as the "*Wilkinson* exception." Pursuant to the *Wilkinson* exception, waiver and estoppel cannot be used to change, re-write or enlarge the risks covered by the policy; however, if an insurer assumes control of the defense without a reservation of rights or a non-waiver agreement, with knowledge of facts indicating non-coverage, all policy defenses – including "non-coverage" are waived or the insurer may be estopped from raising them. *Id.* at 781.

On one hand, the Texas Supreme Court disagreed and found that waiver or estoppel could not overcome "non-coverage" and that an insurer cannot be compelled to pay a risk it did not contractually assume.

> We do not agree with *Wilkinson*'s statement to the effect that "noncoverage" of a risk is the type of right an insurer can waive and thereby effect coverage for a risk not contractually assumed. . . . An insurer's actions can result in it being estopped from refusing to make its insured whole for prejudice the insured suffers because the insurer assumed the insured's defense, but estoppel does not work to create a new insurance contract that covers a risk not agreed to by the contracting parties. Thus there is no "right" of noncov-

> erage that is subject to being waived by the insurer, even by assumption of the insured's defense with knowledge of facts indicating noncoverage and without obtaining a valid reservation of rights or non-waiver agreement.

Id. at 782. (citations omitted).

On the other hand, the court also examined how the rule could be impacted by the fact that a conflict of interest might arise when the insurer is defending its insured under a reservation of rights. "Under some circumstances, insurers who take control of their insured's defense without a valid reservation of rights or non-waiver agreement can and should be prevented from denying benefits that would have been payable had the claim been covered because the insured is *actually prejudiced* by the insurers actions. But the *possibility* that an apparent conflict of interest might arise under these circumstances is insufficient justification for judicially rewriting the parties' agreement." *Id.* at 785. (citation omitted and emphasis added).

The *Allied Pilots* Court concluded with the following rule:

> In sum, if an insurer defends its insured when no coverage for the risk exists, the insurer's policy is not expanded to cover the risk simply because the insurer assumes control of the lawsuit defense. But, if the insurer's actions prejudice the insured, the lack of coverage does not preclude the insured from asserting an estoppel theory to recover for any damages it sustains because of the insurers actions.

Id. at 787.

On one hand, *Allied Pilots* concluded that the general rule, at least in the technical sense, is true — coverage can not be created by waiver or estoppel. However, an insurer will be estopped to deny coverage if the insurer undertakes the insured's defense without a reservation of rights and the insured is prejudiced. Thus, the court reaches the same result as if coverage could be created by waiver or estoppel, but arrives there in a different way.

The court's answer to the waiver/estoppel issue was aptly observed by a concurring Justice: "If the insurer defends without reserving its rights, and the insured shows prejudice, the insured is entitled to recover the benefits that would have been due under the policy. To that extent, it matters little whether a court says coverage was created or that the benefits are those that would have been payable had there been coverage; a rose by any other name would smell as sweet." *Id.* at 793 (Jefferson, C.J., concurring).

In essence, *Allied Pilots* is a win for insurers. While the Texas Supreme Court concluded that coverage not expressed in the policy can nonetheless still be owed, the insured must prove that it was *actually prejudiced* by the insurer's actions. Other states have concluded that prejudice is deemed to exist by the mere act of the insurer defending without a reservation of rights. But in Texas, insurers will be afforded the opportunity to established that the defense they provided, notwithstanding that it was without a reservation of rights, was appropriate. On this basis, the insured was not prejudiced by the defense and the absence of a reservation of rights is not a bar to asserting a coverage defense.

***Don's Building Supply, Inc. v. OneBeacon Insurance Company,* 2008 Tex. LEXIS 753**

When it comes to latent injury and damage, such as asbestos and hazardous waste, the continuous trigger is king. Even in states that have adopted trigger theories with different names, such as injury-in-fact or actual injury, the end result often looks very similar to a continuous trigger. Policyholders are smitten with the continuous trigger and insurers fought it for yours (even though it provides cost sharing opportunities for insurers in many cases). Whatever you think of the continuous trigger, it is here to stay for claims involving latent injury and damage.

But when the question is trigger of coverage for construction defect claims, insurers have had success beating back the continuous trigger. Some courts have examined the rationale for the continuous trigger and concluded that it just does not apply in the construction defect context. As a result, some courts have been adopting a manifestation trigger for construction defect — only the policy (singular) on the risk when the property damage was first discovered (putting aside — discovered by whom) is obligated

to provide coverage. It goes without saying that the insurance dollars available between a continuous and manifestation trigger can be staggering.

Many insurers are also choosing not to take their chances with the courts when it comes to trigger of coverage for construction defect. Instead, they are endorsing their policies with an assortment of trigger provisions that, in one form or another, are designed to limit coverage to only a single policy.

But insurers that are still issuing policies that use the traditional trigger test — property damage during the policy period — will likely continue to face arguments in favor of a continuous trigger in response to any asserted manifestation position.

Litigation over trigger of coverage for latent injury and damage resulted in many lengthy and detailed decisions explaining the courts' rationale for their adoption of the continuous approach. But many decisions addressing trigger of coverage for construction defect have not been as thorough. The Supreme Court of Texas changed that with its decision in *Don's Building Supply, Inc. v. OneBeacon Insurance Company*, issuing what may be the most detailed decision to date on the construction defect trigger issue. The Texas high court put the kibosh on the manifestation trigger and adopted an actual injury or injury-in-fact trigger. But whatever label is placed on it, the Texas approach will resemble a continuous trigger when put into practice in most cases.

Don's Building Supply, Inc. manufactured and distributed a synthetic stucco finishing for the exterior of buildings (EIFS). Between 2003 and 2005, various homeowners filed suit against Don's alleging that the EIFS was defective and not weather-tight. Instead the EIFS allegedly allowed water to penetrate the building and caused the wood to rot. Water seeping into the structures over a period of time allegedly caused significant damage and reduced property values. As a result, the EIFS had to be refitted and/or replaced. *Don's Building* at *2.

The homeowners alleged that the damage began with the first water infiltration — approximately six months to a year after installation. However, the homeowners did not discover the damage to the structures at that time. *Id.; see OneBeacon Ins. Co. v. Don's Bldg. Supply, Inc.*, 496 F.3d 361, 362 (5th Cir. Tex. 2007) ("the damage . . . remained undiscovered until some point within two years of the filing of the suit").

OneBeacon Insurance Company issued commercial general liability policies to Don's Building from December 1, 1993 through December 1, 1996. During that period of time, the homes were fitted with EIFS, but no damage was discovered. Don's tendered the homeowners litigation to OneBeacon and OneBeacon initially agreed to defend. Thereafter, OneBeacon filed a declaratory judgment action in the United States District Court for the Northern District of Texas seeking a determination that it had no duty to defend or indemnify under its commercial general liability policies. OneBeacon asserted that no coverage was available for the homeowners litigation because the "duty to defend does not arise until the damage becomes identifiable." *Id.* at *3. Because the damage was not discovered until approximately 2001, OneBeacon maintained that its policies, in place from 1993 to 1996, were not implicated.

The district court agreed with OneBeacon. Don's appealed to the Fifth Circuit, which certified two related questions to the Texas Supreme Court: "When not specified by the relevant policy, what is the proper rule under Texas law for determining the time at which property damage occurs for purposes of an occurrence-based commercial general liability insurance policy? *Don's Building* at *3. Summarizing question two — applying the rule from question one, does a lawsuit against an insured allege that property damage occurred within the policy period of an occurrence-based insurance policy if it alleges that the actual damage was continuing and progressing during the policy period, but undiscoverable until after the policy period?" *Don's Building* at *28.

Addressing the first question, the Supreme Court of Texas stated that it was bound by the rules of contract interpretation — applying the policy as written and affording the words in the policy their plain meaning. The OneBeacon policies covered "property damage" which occurs during the policy period. Applying the plain meaning of these provisions, the Supreme Court of Texas rejected the district court's

holding that property damage does not occur until it is identifiable. Instead, the Texas high court found that the "property damage" occurs when "actual physical damage to the property occurred." *Don's Building* at *7.

To reach this decision, the Texas Supreme Court set forth a comprehensive review of the numerous tests adopted by courts nationally addressing when "property damage" occurs. Although ultimately adopting the "injury-in-fact" rule, the court also discussed the manifestation, exposure and multiple trigger tests. The Texas appellate courts had, prior to the decision in *Don's Building*, adopted both a manifestation rule and an exposure rule.

According to *Don's Building*, the key to coverage is "damage, not damage detection." *Id.* at *23. "The policy asks when damage happened, not whether it was manifest, patent, visible, apparent, obvious, perceptible, discovered, discoverable, capable of detection, or anything similar." *Id.* at *26.

The court recognized that it is admittedly difficult to determine when the damage actually occurred, versus when it was discovered; however that is the rule required by the policy language. "[W]e cannot exalt ease of proof or administrative convenience over faithfulness to the policy language[.]" *Don's Building* at *25. Applying this test to the matter before it, the court explained: "So in this case, property damage occurred when a home that is the subject of an underlying suit suffered wood rot or other physical damage. The date that the physical damage is or could have been discovered is irrelevant under the policy." *Id.* at *7-8. The Texas Supreme Court had significant support for its decision and cited more than thirteen decisions from other jurisdictions which have also adopted the "injury-in-fact" rule.

According to the Texas Supreme Court, if insurers want a test other than "injury in fact" to apply, that rule must be written into the policy. However, when a policy provides coverage for "property damage" which occurs during the policy period — the question is when the damage occurs, not when it manifests. Therefore, without policy language stating that a manifestation test should apply, the "injury-in-fact" test is applicable to an occurrence-based commercial general liability policy.

Addressing the second question, the Texas Supreme Court, having adopted the "injury in fact" trigger, found that an insurer's duty to defend and indemnify under an occurrence-based policy is triggered by allegations that the actual damage was continuing and progressing during the policy period, even if such damages were not discoverable until after the policy period ended. Therefore, to the extent the plaintiffs alleged any "property damage" during any policy period, due to Don's allegedly defective product, at least a duty to defend was implicated.

The supreme court's decision was a Texas Two-step for Don's. Nearly a month after the supreme court's decision was issued, Don's was granted summary judgment in a similar case. *See Union Ins. Co. v. Don's Bldg. Supply, L.P.*, 2008 Tex. App. LEXIS 7027.

Because of its breadth — addressing various competing trigger theories and examining case law nationally — *Don's Building* is not likely to go unnoticed by future courts, whatever the jurisdiction, confronted with the construction defect trigger issue.

***Collins Holding Corporation v. Wausau Underwriters Insurance Company,* 666 S.E.2d 897 (S.C. 2008), 2008 S.C. LEXIS 280, *rehearing denied by* 2008 S.C. LEXIS 303**

It is a conundrum that every insurer-side coverage professional confronts: A complaint is filed against an insured that pleads conduct that could have only been committed intentionally. It belies common sense and all reason that the conduct alleged could have been committed in any manner other than intentionally. But despite all that, the complaint invariably alleges that the insured acted negligently in causing injury or damage (in addition to the various counts alleging intentional conduct).

The coverage professional must now decide if a defense is owed to the insured. On one hand, the allegations clearly do not allege an "occurrence" or allege that the injury or damage was expected or intended. Thus, there are grounds to disclaim a defense to the insured. On the other hand, the determination whether a duty to defend is owed is tied to the four corners of the complaint, including if the allegations are groundless. So based on that test, the negligence cause of action may trigger a defense (and a complete one at that, including for the intentional conduct).

Courts are mixed in their responses to insurers that deny a defense under these circumstances. Some courts apply common sense, see the negligence cause of action for just what it is — artful drafting designed to trigger a defense and bring insurance dollars to the table — and conclude that a defense is not owed. Other courts follow the four corners rule to the letter and conclude that the existence of the negligence cause of action is sufficient to obligate the insurer to defend its insured.

This is a sticky wicket for insurers. Any decision by the insurer to disclaim a defense will no doubt be met with a mountain of case law stating that the duty to defend is based on the four corners of the complaint. In addition, the question whether a "negligence" cause of action has been legitimately plead, or is simply a device designed to trigger a defense, can be a subjective one, making it hard to predict how a trial judge will react.

In 2008 the Supreme Court of South Carolina was confronted with this dilemma and it resolved the issue in a manner that satisfied both schools of thought. In *Collins Holding Corporation v. Wausau Underwriters Insurance Company*, the Supreme Court of South Carolina addressed coverage for Collins Holding, an owner, operator or distributor of amusement devices and gambling machines, for an underlying action alleging that the company systematically violated South Carolina laws specifically enacted to protect the public from excessive gambling losses. *Collins Holding* at *1, *5.

The supreme court held that the insurer did not breach its duty to defend Collins Holding in the underlying action because the plaintiff's complaint did not allege the possibility of an "occurrence." The policy at issue was general liability and it provided coverage for bodily injury caused by an "occurrence," defined as an accident. *Id.* at *5.

The court reached its decision that there had been no breach of the duty to defend on the basis that the underlying plaintiffs asserted that Collins Holding exceeded the maximum daily payout limit of $125 and engaged in advertising schemes which fraudulently induced the plaintiffs to believe that they could win "jackpots" in excess of the $125 limit. The court also looked to the fact that the plaintiffs employed words and phrases such as: "unlawfully and fraudulently seek to induce and entice;" "engaged in advertising about and offering inducements . . . that are clearly and expressly prohibited by South Carolina law;" "racketeering activity;" "conspiring;" "knowingly engaging;" and "knowingly conducting." *Id.* at *5-*6. The court concluded that "[t]hese allegations constitute intentional, deliberate, and illegal acts executed with the purpose of addicting patrons to gambling machines, and in our view, such alleged conduct cannot be construed as accidental in nature." *Id.* at *6.

The significance of *Collins Holding* was its rejection of the lower court decision that a defense was owed on the basis of a negligent misrepresentation cause of action. The supreme court acknowledged that, while the underlying action did include a cause of action for negligent misrepresentation, "we must look beyond the label of negligence to determine if Insurance Company had a duty to defend Collins." *Id.* at *7.

In rejecting the view that the negligent misrepresentation cause of action triggered a defense, the *Collins Holding* Court was persuaded by the fact that such cause of action incorporated the allegations in the complaint that were clearly not accidental:

> To support their negligent misrepresentation claim, the Plaintiffs incorporated the previous facts and alleged Collins sold, leased, and distributed machines that were equipped in a manner "as to permit manipulation" and that were configured to be used in a manner that violated laws expressly designed to protect the public from the lure of excessive gambling. In our view, these allegations do not support a claim for negligent conduct. . . . Therefore, because the negligent misrepresentation claim incorporates the same facts and does not allege an "occurrence," we hold that this cause of action did not trigger Insurance Company's duty to defend.

Id. at *8 (citation omitted).

Justice Pleicones filed a dissenting opinion. His Honor would have affirmed the decision of the trial court that a defense was owed. Putting aside the dis-

senting Justice's thoughtful reasons why the negligent misrepresentation cause of action had a legitimate factual and legal basis, the crux of his decision was based on obedience to the four corners of the complaint: "I recognize that based solely on the assertions in the Plaintiffs' third amended complaint, it is unlikely that Collins, as owner/lessor of the machines, could ultimately be liable for negligent misrepresentation. However, when determining whether an insurer has a duty to defend, the obligation is determined by the allegations in the complaint." *Id.* at *11.

Collins Holding solved the faux-negligence problem in a way that satisfies both factions — those who believe that common sense and reality trump the four corners of the complaint and four-corners strict constructionists. The majority knew that the negligent misrepresentation cause of action was a ruse. But because that cause of action incorporated the allegations contained in the intentional-based causes of action, the majority was able to reach what it knew to be the right decision — denial of a defense — while remaining faithful to the four corners of the complaint. The decision is very brief and the court's solution was simple. But brief and simple can still be significant.

There is some prior case law demonstrating the South Carolina Supreme Court's "incorporation" method for handling the tension between a faux-negligence cause of action and the strict four corners rule for determining a defense obligation. However, the existence of a state high court decision on the issue, and especially one containing competing majority and dissenting opinions on the specific point, may be a shot in the arm for using this solution to this common duty to defend conundrum.

***Whole Enchilada, Inc. v. Travelers Property Casualty Company of America*, 2008 U.S. Dist. LEXIS 77186 (W.D. Pa.)**

The following is an article that Maniloff published on the Manhattan Institute's Point of Law website in October. *See http://www.pointoflaw.com/columns/archives/2008/10/whole-enchilada-inc-v-traveler.php*.

FACTA litigation and all its abusiveness have been chronicled in the legal press. Here's the elevator pitch. Identity theft is a serious problem. So Congress set out to reduce the amount of financially sensitive paper floating around by prohibiting merchants from printing identifying credit and debit card information on receipts. But the Fair and Accurate Credit Transaction Act went awry.

When it comes to identity theft, the receipts to worry about are those that contain more than the last five digits of a customer's card number. However, the law was drafted in such a manner that it is violated if a merchant prints a receipt containing nothing more than a card's expiration date — *even if the card numbers were properly truncated*. It turned out that many merchants assumed that they were in compliance with FACTA by simply truncating their customers' card numbers on receipts, and didn't realize they needed to omit the expiration date as well. That seems like an honest mistake, and one without likely consequences most of the time: after all, knowing the card's expiration date will not enable identity theft if the would-be thief lacks access to sufficient accompanying card numbers. But the statute says what it says. As a result, many thought-to-be-complaint merchants found themselves being sued for issuing non-compliant receipts.

The question here was not whether stores would pay for someone's actual experience of identity theft. FACTA eliminates the need to prove actual injury by allowing for an award of statutory damages in an amount between $100 and $1,000 for a willful violation. That doesn't sound like much. But the law also allows for the recovery of attorney's fees — the magic provision that can turn lawyers into social activists. Not to mention that where there is one FACTA violation there are sure to be many (many, many). Enter the class action lawyers, coupon settlements and six-figure attorney's fees awards. See, for example, *Palamara v. Kings Family Restaurants*, 2008 U.S. Dist. LEXIS 33087 (W.D. P.A. April 22, 2008) (court approves FACTA settlement that awards each class member their choice of ice cream, soup, salad or homemade pie from the defendant's restaurant, with a value of up to $4.68. As for the plaintiffs' attorney's fees: an amount not to exceed $75,000).

There is nothing new in itself about this type of litigation business model. But most of the time the laws invoked in attorney's-fee-driven suits at least address some genuine wrong to be righted or injury to be recompensed, and the exploitation is (one hopes) just an unfortunate and unintended consequence.

FACTA is different. It has been the Olympics of gaming the system. In many instances it serves no purpose whatsoever. Federal judges have said so; but they have also said that they are powerless to do anything about it.

FACTA is unique for another reason. Avoiding the political divisiveness that so often accompanies any effort at tort reform, Congress stepped in relatively quickly to close the loophole that allowed for basing liability on nothing more than an expiration date violation. That it did so with virtually no attempts at opposition — the House voting 407-0 and the Senate by unanimous consent — speaks volumes about just how abusive the litigation was.

This summer President Bush signed into law the Credit and Debit Card Receipt Clarification Act (Public Law No. 110-241). The Act states that any person who printed an expiration date on a receipt that was provided to a consumer between December 4, 2004 and June 3, 2008, but which otherwise complied with the card number truncation requirement, shall not be deemed in willful noncompliance with FACTA.

The Act does not do away with the basing of FACTA violation solely on expiration dates. Rather, by deeming that an expiration date violation taking place during this window will not be considered "willful," it does away with the customer's ability to recover statutory damages (which, of course, are the only damages that matter since actual damages can't be sustained). The Act went into effect, and poof, a boatload of FACTA cases disappeared.

The Receipt Clarification Act served to retroactively eliminate the potential for damages in likely hundreds of FACTA cases. But any merchant that commits an expiration date violation after the Act's effective date of June 3rd is back in the soup, subject to statutory damages if "willfulness" can be proven.

So despite Congress's efforts, FACTA lives on and the possibility of a second wave of litigation looms. At this point, however, it seems likely that those retailers that are still printing expiration dates on receipts are the proverbial mom and pops, such as — to cite personal experience — the kids' shoe store and deli in my neighborhood. The national franchise retailers and restaurants have already been put through the drill. If the remaining FACTA malefactors are small retailers and restaurants (which, small though they may be, might have printed thousands of non-compliant receipts at $100 to $1,000 a pop), then the availability of insurance to fund the litigation will likely become a crucial factor in determining how FACTA litigation evolves from here.

Because this litigation is driven by attorneys' economic self-interest, there will be far less enthusiasm for pursuing it if insurance proceeds are not available for FACTA damages and in particular for the attorney's fees needed to settle. If insurance money is available, FACTA will remain, as it has been, low-hanging litigation fruit. Plaintiffs will file suit and seek to settle, using as leverage the insurers' exposure to defense costs as well as the always-present risk of a runaway verdict. But it is much more difficult to reach a settlement with or collect a judgment from a small business when there is no insurer to deal with. Therefore, resolution of the insurance coverage questions will likely go a long way toward determining FACTA's future.

That process has now begun. When FACTA litigation first proliferated, many insurers faced the question of whether it posed a kind of liability included within the scope of commercial general liability coverage, especially as to the costs of defense. That assessment had to be undertaken without the benefit of case law on the subject. Now, at last, a FACTA coverage case has caught up to the litigation, with a Pennsylvania federal court issuing what is apparently the first decision to address insurance coverage for a FACTA action.

In *Whole Enchilada, Inc. v. Travelers Property and Casualty*, the Western District of Pennsylvania found that no coverage was available to a policyholder under a commercial general liability policy for an alleged violation of FACTA. The business in question, a restaurant in Pittsburgh, had provided the plaintiff in the underlying putative class action with an electronically printed receipt that included the expiration date of his credit or debit card. The question addressed by the court was whether coverage was available under the "Personal Injury" section of a CGL policy issued by Travelers Insurance to Big Burrito Holding Company.

Of note for insurance coverage mavens, the Travelers policy at issue initially contained a standard Insurance Services Office definition of "personal injury," which defined the term as "injury, including consequential 'bodily injury,' arising out of one or more of the following offenses: . . .e. Oral or written publication, in any manner, of material that violates a person's right of privacy.

However, the Travelers policy was amended by endorsement to define "personal injury" as "injury, other than 'bodily injury' arising out of one or more of the following offenses: . . .e. Oral, written or electronic *publication of material that* appropriates a person's likeness, unreasonably places a person in a false light or *gives unreasonable publicity to a person's private life*." (emphasis added).

The *Whole Enchilada* decision is lengthy (50 pages). In general, the court concluded that, based on the nature of a FACTA violation — stemming for a one-on-one transaction between customer and merchant — it does not involve the kind of public communication to which the terms "publication" and "publicity" refer. The money paragraphs are as follows:

> Here, however, the *Reed* Complaint does not allege publication that gives unreasonable publicity to a person's private life. It does not allege that Whole Enchilada displayed the plaintiff's information to the public or took any action designed to disseminate the information to the public at large. Rather, the Complaint alleges factual allegations stating that the Reed plaintiffs' credit or debit card information was printed on a receipt that was handed back to them, in violation of FACTA. While the Complaint alleges that Whole Enchilada printed information, this Court finds it does not allege the kind of public communication to which the term "publicity" refers, thereby triggering coverage.
>
> * * *
>
> In the context of the factual scenario surrounding Whole Enchilada's alleged violation of this provision of FACTA, the Court's reasoning becomes clear. At the point of sale transaction, a cardholder gives his or her credit or debit card to the individual at the cash register. The credit information is exchanged between the cardholder, Whole Enchilada and the cardholder's bank. There is no violation of a privacy right, insofar as the cardholder willfully gives over his or her credit information to Whole Enchilada so that the information can be used to process the sale. This factual scenario does not meet the requirement of publicity under the policies.

Whole Enchilada at *54-*56.

The *Whole Enchilada* court addressed coverage under a non-standard definition of "personal injury," namely, *publication* of material that gives unreasonable *publicity* to a person's private life. But most FACTA claims will test whether coverage is available for "personal injury" that is defined as oral or written *publication*, in any manner, of material that violates a person's *right of privacy*. However, while it addressed "publicity," the *Whole Enchilada* court also concluded that FACTA does not violate a person's "privacy right," when such policy language was not even before it.

Given the court's additional conclusion that a FACTA violation does not involve "publication" and its determination that the "statutory damages" being sought for a FACTA violation are not compensatory, and, therefore, do not satisfy the policy's "damages" requirement, *Whole Enchilada* is broad enough to encompass those claims that are brought under the standard ISO definition of "personal injury." That is the take-away point from the case. Also of great practical importance for the future, insurers have been adding specific FACTA exclusions to their policies and ISO has such an exclusion in the pipeline. So plaintiffs' lawyers are on notice that likely wellsprings of insurance money are drying up.

On one hand, *Whole Enchilada* was a defeat for policyholders. Even those defendants that had their FACTA claims extinguished by the Receipt Clarification Act likely still have claims for defense costs and would have benefited from a finding of coverage. For such companies, there is no way to put a positive spin on the decision. On the other

hand, if a second wave of FACTA claims is on the horizon aimed at small companies that have done no real injury to consumers, then the lack of insurance availability may help to prevent the claims from being brought in the first place. When it comes to collecting a settlement or judgment, plaintiffs seek the path of least resistance, most commonly via the insurance route. But if that road is blocked, plaintiffs may simply decide that the risk of being unable to settle a FACTA case or collect a judgment is too great and turn back. That would be an ultimate outcome much to be desired for insurance buyers, for insurers, and for our society as a whole.

Endnotes

1. With credit to David Letterman for one of my all-time favorite jokes.

2. I had never heard of a potato gun. I must need to get out more. Google it and you'll learn that a potato gun (or spud gun) is just as the name says: "A potato gun sometimes called a spudzooka or spud gun is weapon that can launch spuds at over 200 ft/s. It is a propellant based gun that uses any propane based aerosol as a propellant (most experiments use hair spray, for it is inexpensive and easy to use). The way it works is propellant is injected into the combustion chamber and ignited with a BBQ sparker, as the gas expands it pushes the potato up the barrel and out of the gun." *http://www.mshamash.com/spud/spudgun1.html.* Not surprisingly, Amazon.com reports that people who bought their potato gun also bought the marshmallow shooter. I'm not making that up.

3. The *Webb* Court rejected the argument that assignment of claims against insurance agents will result in "collusive" stipulated judgments which will bind insurance agents which had no chance to contest them. The court concluded that, unlike a stipulated judgment involving an insurer — which may be contractually obligated to defend or indemnify the insured — no such contract exists between the insured and the agent. Thus, the agent is not bound by the prior judgment in an action in which the agent was not a party. This is likely a complexity in any case against both an insurer (who is bound by the stipulated judgment) and insurance agent who is not so bound. ■