Commentary

Thriller: 9th Annual Review Of The Year's Ten Most Significant Insurance Coverage Decisions

2nd Annual 'Coverage For Dummies'

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Sure Michael Jackson was as peculiar as New Jersey's duty to defend rules; as shocking as an insurer winning a bad faith case in West Virginia; as ambiguous as every word in an insurance policy (as some see it); as addicted to prescription medications as policyholders are to repeating that ambiguities in a policy must be construed against the insurer; and maybe even a walking criminal act exclusion. But despite a few oddities, Michael Jackson was also as talented as anyone who can figure out choice of law for a coverage action by applying Restatement (Second) of Conflict of Laws § 188, as modified by § 193, based on the factors set out in § 6, unless comment b to § 193 applies. And, of course, Michael's death was as tragic as the birth of the continuous trigger.

Not many people know this, but in the early 1980s Michael Jackson had grown tired of a lifetime in the music industry and was looking for a new challenge. His was a career into which he had been born. And because of that he had always wanted to chart his own course. A fire had long been burning in Michael's belly to get into the insurance claims business. By 1982 it was an inferno that he could no longer control. The time had come for him to pursue his dream. Michael broke the news to Quincy Jones that the recording sessions for *Thriller* were off. Jones, who had just had a homeowner's claim denied, and was in a foul mood toward insurance companies, convinced Michael that the insurance industry was no place for someone so sensitive.

So with a heavy heart Michael went into the studio and recorded *Thriller*. And as everyone knows, it went on to become the number one selling album of

all time. But despite *Thriller* providing Michael with unimaginable wealth and fame, he was never able to stop thinking about the career in claims that never was. All agree that Michael was a tortured soul. And there has been much speculation why. This is it.

As Michael lay awake at night during that post-*Thriller* period, thinking about concurrent causation and the pollution exclusion, it was inevitable that Beat It, his new and wildly successful song, would come on the bedside clock radio. And as he listened to himself telling a wanna-be tough guy to avoid a fight he can't win, a different set of lyrics ran through his head. But he kept them bottled-up inside. It was only after his untimely and tragic death, when his Neverland Ranch was being cleaned out, that a folded up piece of loose leaf paper was discovered deep in the back of a desk drawer. On it were scribbled the lyrics of Beat It that Michael had long dreamed to sing:

> We told you don't you ever make a claim around here
> Don't wanna see your Acord, you better not mess up our fiscal year
> There's disclaimer in our eyes and our letter's very clear
> So beat it, just beat it
>
> You better file somewhere else, better do what you can
> You ain't gonna see no money, in your lifespan
> You wanna push back, but we're the size of Hoover Dam
> We tell you beat it, but you seem to have no attention span
>
> Just beat it, beat it, don't get on our balance sheet-it
> Our bank account will not be depleted
> Showin' how funky and strong is our fight
> It doesn't matter if we're not exactly right
> We still won't pay for your dog bite
> Just beat it, beat it
> Our money's so well secreted
>
> We're out to get you, better get another quote while you can
> Don't wanna be uninsured, for your mini van
> You wanna stay covered, and not end up as broke as Ed McMahon
> So beat it, just beat it
>
> We're here to show you that we're really not scared
> If you get water in your basement that ain't no time to be unprepared
> And if we finally pay your claim you'll have an uninsured share
> So beat it, we need to stay a billionaire
>
> Just beat it, beat it
> We will not be defeated
> We'll keep you off our balance sheet-it
> Don't make us have to repeat it
> Just beat it, beat it, beat it, beat it

The 9th Annual Review of the Year's Ten Most Significant Insurance Coverage Decisions is dedicated to the memory of Michael Jackson — coverage guy at heart.

Opening Act: 2nd Annual 'Coverage For Dummies'

As anyone who reads insurance coverage cases knows — some people do really dumb stuff. For that matter, even people who do not read insurance coverage cases know that some people do really dumb stuff. *See* Balloon Boy's dad. This 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.

Last year's review of the ten most significant insurance coverage decisions included "Coverage for Dummies: The Top Ten" — a special report chronicling the year's "best of" cases in this category. Dummies was very popular based on the e-mails and other feedback that I received. Nonetheless, I wasn't sure whether to reprise it for 2009 or try to think of something even more Sophomoric. But then *Cornett Management Co. v. Fireman's Fund Insurance Co.*, 332 F. App'x 146 (4th Cir. 2009) (applying West Virginia law) was decided. And that's when I realized that Coverage for Dummies was coming back for an encore.

At issue in *Cornett* was coverage for a Hooters franchise, for sexual harassment claims by two female

employees, who alleged that they were individually called into the restaurant supervisor's office and advised that a customer had reported a stolen change purse. The women were instructed to listen to a male voice on a telephone, identifying himself as a police officer, directing them to strip naked in front of the manager. The women were threatened with arrest if they did not comply. The women complied. The telephone call was revealed to be a crank. The women filed suit. Hooters sought coverage. The Fourth Circuit concluded that the Employment-Related Practices Exclusion, contained in the restaurant's commercial general liability policy, precluded coverage for the women's claims. Amazing you say? Yes. But even more amazing — not long ago a Kansas appeals court addressed coverage for this *exact* same scheme. *LDF Food Group v. Liberty Mut. Fire Ins. Co.*, 146 P.3d 1088 (Kan. Ct. App. 2006).

In no particular order, here are the nine other decisions from 2009 that best demonstrated the frailty and imperfection of the human brain:

1. Insurer not entitled to discovery of records from insured's wife's psychologist, in an attempt to prove that no coverage was owed to insured-husband, for eye injuries sustained by his wife when he threw a carrot at her. What's up doc? *See Safeco Ins. Co. of Am. v. Vecsey*, 259 F.R.D. 23 (D. Conn. 2009) (records protected by the psychologist-patient privilege).

2. No coverage owed to a convenience store, under its commercial general liability policy, for injuries caused by a clerk that struck a customer in the head with a baseball bat, after the customer attempted to cancel a purchase. And I thought I took my job seriously. *See Essex Ins. Co. v. Quick Stop Mart, Inc.*, No. 07-CV-1909, 2009 U.S. Dist. Lexis 21268 (E.D. Pa. Mar. 16, 2009) (coverage precluded by assault and battery exclusion).

3. Consideration of coverage for insured, under homeowner's policy, for injuries caused by hitting a person with his automobile, then exiting the vehicle and striking the victim three times with a golf club, breaking three ribs — all in response to the victim entering the insured's property to retrieve a baseball accidentally hit onto the insured's property by the victim's son. When did the national pastime become the Ultimate Fighting Championship? *See Farmers Auto. Ins. Ass'n. v. Danner*, No. 4-08-0905, 2009 Ill. App. Lexis 992 (Ill. App. Ct. Sept. 3, 2009) (case remanded to trial court to consider applicability of the policy's expected or intended exclusion to an amended complaint).

4. No coverage owed to a prostitute, for injuries she caused in an accident while driving a truck loaned to her by a customer, as the truck was owned by the customer's employer and she was determined not to be a permissive user under the employer's commercial automobile policy. *See Crawford v. St. Paul Fire & Marine Ins. Co.*, No. C058676, 2009 Cal. App. Unpub. Lexis 8011 (Cal. Ct. App. Oct. 6, 2009).

5. Consideration of coverage under homeowner's policies, for serious bodily injuries sustained by motorists that drove off the road, after swerving to avoid hitting a target deer that a group of high school friends had placed 15 to 30 yards beyond the crest of a hill, at night, in the middle of an unlit two-lane roadway, with a speed limit of 55 m.p.h. *See Allstate Ins. Co. v. Campbell*, No. 09AP-306, 2009 Ohio App. Lexis 5096 (Ohio Ct. App. Nov. 17, 2009) (question of fact whether the boys intended to cause injury because they stated that their purpose was to observe the reactions of motorists suddenly confronted with an obstruction directly in front of them). Let's hope they can study their own reactions to suddenly being confronted with an obstruction directly in front of them — bars.

6. Coverage owed to insured under (presumably) homeowner's policy, for injury caused by firing a paintball at his opponent, as a post-game congratulatory gesture, and striking him in the eye after he had removed his protective eye gear. Mom was right — You won't be satisfied until you poke someone's eye out. *See Tenn. Farmers Mut. Ins. Co. v. Neill*, No. M2008-02056-COA-R3-CV, 2009 Tenn. App. Lexis 308 (Tenn. Ct. App. June 2, 2009) (intended or expected acts exclusion not applicable because the insured did not intend to cause harm).

7. No coverage owed to convenience store clerk under a Business Owner's liability policy, for injury caused by the accidental discharge of a .22 rifle that he was holding while dancing around and posing for his friends' camera phones. Mr. DeMille, I'm ready to act like an idiot. *Employers Mut. Cas. Co.*

v. Al-Mashhadi, No. 08-CV-15276, 2009 U.S. Dist. Lexis 75442 (E.D. Mich. Aug. 24, 2009) (clerk not an "insured" because he was not acting within the scope of his employment at the time of the shooting).

8. Consideration of coverage for insured, under homeowner's policy, for injuries caused by shooting his ex-wife's new husband, in a fight that started with the two men throwing each other's cellular phones. Can you hear me now? *Alfa Mut. Ins. Co. v. Bone*, 13 So. 3d 369 (Ala. 2009) (case remanded to trial court following a determination that certification of appeal had been improperly granted).

9. Coverage owed to high school student-insured, under homeowner's policy, for injuries caused to a fellow shop class student, during horseplay that followed the insured pulling a shop stool out from under the victim as a practical joke. An oldie but a goodie. *RAM Mut. Ins. Co. v. Meyer*, 768 N.W.2d 399 (Minn. Ct. App. 2009) (intentional act exclusion not applicable because the insured did not act with the requisite willfulness or egregiousness).

The Ten Most Significant Insurance Coverage Decisions Of 2009

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

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

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

Below are the ten most significant insurance coverage decisions of 2009 (listed in the order that they were decided). Some are thrillers, off the wall or just plain bad.

Addison Insurance Co. v. Fay — Land of Blago, er Lincoln, turned number of occurrences on its hair, er head.

Callahan & Sons, Inc. v. Worcester Insurance Co. — Cain and Abel of Coverage Issues: Supreme Judicial Court of Massachusetts on the seldom addressed issue of recovery of attorneys fees in an "insurer v. insurer" declaratory judgment action.

Idaho Counties Risk Management Program Underwriters v. Northland Insurance Cos. — CSI-daho: One of the first state top courts addressed the trigger of coverage arguments made in ever-increasing DNA exoneration cases.

Essex Insurance Co. v. Bloomsouth Flooring Corp. — First Circuit sniffed out a likely Chinese drywall coverage issue — Does a permeating odor qualify as "property damage?"

Nazario v. Lobster House — Insurance Claws: New Jersey Appellate Division placed insurers in boiling water for failure to obtain their insured's consent to being defended under a reservation of rights.

QBE Insurance Corp. v. Austin Co. — Alabama Getaway, Getaway: State's high court denied an insurer's request to intervene in an underlying action

to address coverage issues. But the court provided useful guidance for insurers in the future.

Health Care Industry Liability Insurance Program v. Momence Meadows Nursing Home — *Qui Tam* Slam: Seventh Circuit shut the door on coverage under a commercial general liability policy for False Claims Act liability — just in time for the inevitable Stimulus Package fraud claims.

State Farm General Insurance Co. v. Mintarsih — Follow that Buss: California Court of Appeal addressed coverage for attorney's fees awarded to an underlying plaintiff for securing uncovered damages.

North American Capacity Insurance Co. v. Claremont Liability Insurance Co. — No Cash For Flunkers: California Court of Appeal, addressing coverage for construction defects, penalized a contractor insured that did not follow the ABCs, 123s of risk management.

Baughman v. United States Liability Ins. Co. — A Dud in the Swamps of Jersey: District Court raised the temperature on the pollution exclusion, finding that exposure to mercury, at a former thermometer manufacturing facility, was not traditional environmental pollution.

Discussion Of The Ten Most Significant Insurance Coverage Decisions Of 2009

Addison Insurance Co. v. Fay, 905 N.E.2d 747 (Ill. 2009)

Ordinarily a "number of occurrences" decision, as important as it may be, is not material for the annual insurance coverage hit parade. The decisions are legion — by my count the issue has been addressed by about 40 states. Further, the cases are extremely fact specific. The upshot of this combination is that any newly decided case addressing number of occurrences is unlikely to have much of an impact (if any) on future courts addressing the issue.

And that is just one reason why it is surprising that the Supreme Court of Illinois's number of occurrences decision in *Addison Insurance Co. v. Fay* is included as a top ten coverage decision of 2009. Another is that, when it comes to number of occurrences, Illinois's top court has been there and done that — and it wasn't even that long ago. *See Nicor Inc. v. Associated Elec. & Gas Ins. Servs., Ltd.*, 860 N.E.2d 280 (Ill. 2006).

Most number of occurrences decisions involve the court deciding whether to adopt the "cause" test (look to the cause of the damage) or the "effect" test (look to the number of claims or injuries) for purposes of making the number of occurrences calculation. The "cause" test is the majority rule nationally. *Liberty Mut. Ins. Co. v. Pella Corp.*, 631 F. Supp.2d 1125, 1135 (S.D. Iowa 2009). In general, and this is by no means a certainty, a court's adoption of the "cause" test frequently leads to a single occurrence determination.

What makes *Fay* significant is that, despite the Illinois Supreme Court's adoption of the "cause" test just three years earlier in *Nicor*, and despite *Fay* involving a paradigm set of facts that would ordinarily lead a "cause" state to find a single occurrence, the Supreme Court in *Fay* nonetheless concluded that multiple occurrences, and, hence, multiple limits, applied.

It is not unusual for coverage cases to involve tragic facts. Sadly, after a while, you can't help but become immune to them. But the facts in *Fay* are tough to take, no matter how hardened of a coverage veteran you are. On an evening in April 1997 teenage friends Everett Hodgins and Justice Carr left Hodgins's home to go fishing in a nearby lake. *Fay*, 905 N.E.2d at 749. A storm swept in, and in an attempt to get to Carr's house to escape the storm, the two boys used a shortcut through property owned by Donald Parrish. *Id.* at 750. Parish used the property to operate a business and was insured by Addison Insurance Company. *Id.* at 749. On a part of the property close to the shortcut that the boys frequently took was an excavation pit that was filled with water. *Id.* at 750. Because the sand and clay around the pit was saturated with water it created a dangerous "quick condition," meaning that the water prevented the soil from supporting a load of weight. *Id.* at 749. The two boys became trapped. *Id.* Their bodies were found three days later in the wet clay and sand surrounding the pit. *Fay*, 905 N.E.2d at 749. The doctor performing the autopsy concluded that the primary cause of the boys' deaths was hypothermia. *Id.*

Although investigators could not determine the exact manner and timing of the serious of events leading

to the boys' deaths, they did determine that when Carr reached the water-filled pit he attempted to jump across the water, but became trapped in the pit. *Id.* at 750. In an attempt to get Carr out of the pit Hodgins also became trapped. *Id.* Investigators could not conclude the amount of time that elapsed between Carr becoming trapped and Hodgins becoming trapped, or even whether Hodgins was with Carr when he became trapped. *Id.*

Addison and the boys' estates agreed to settle the claims in an amount equal to Parish's policy limits, but disagreed which policy limit applied. *Id.* The policy contained a "General Aggregate Limit" of $2 million and an "Each Occurrence" limit of $1 million. *Id.* Addison filed a declaratory judgment action seeking a determination that the boys' deaths constituted a single occurrence. *Id.* The trial court found that the boys' deaths constituted two occurrences. *Fay*, 905 N.E.2d at 750. The appellate court reversed and the issue came before the Illinois Supreme Court. *Id.*

At the outset, the Supreme Court could not escape its recent decision in *Nicor* — adopting the "cause" test, but with the caveat that "where each asserted loss is the result of a separate and intervening human act, whether negligent or intentional, or each act increased the insured's exposure to liability, Illinois law will deem each such loss to have arisen from a separate occurrence." *Id.* at 754 (quoting *Nicor,* 860 N.E.2d at 280). Based on this test, Addison maintained that, because the cause of both boys' injuries was Donald Parrish's sole negligent act of failing to properly secure and control his property, both injuries were caused by a single occurrence. *Id.* at 754.

Despite what appeared to have been classic single occurrence facts under a "cause" test, the Illinois Supreme Court concluded otherwise. *Id.* at 755. The court expressed its concern that such a decision would lead to an inadequate amount of coverage. *Id.* Indeed, the court did not even attempt to hide that it was embarking upon an outcome determinative decision:

> [I]n light of these facts, applying *Nicor* in the way Addison suggests leads to an unreasonable interpretation of Parrish's insurance policy. Focusing on the sole negligent omission of failing to secure the property would allow two injuries, days or even weeks apart, to be considered one occurrence. The defendants raised this concern in the trial court. If several injuries suffered over the course of several weeks could be bundled into a single occurrence, the likelihood that damages would exceed a per-occurrence limit is significant, as demonstrated by the damages in the instant case. Purchasers of insurance such as Parrish would be left unprotected by their insurance policy, and liable for any amount above the per-occurrence limit. In accepting a per-occurrence limit, Parrish could not have intended to expose himself to greater liability by allowing multiple injuries, sustained over an open-ended time period, to be subject to a single, per-occurrence limit. ¶ As a result, in situations where a continuous negligent omission results in insurable injuries, some limiting principle must be applied.

Fay, 905 N.E.2d at 755.

To avoid this untenable situation, the *Fay* Court introduced two new considerations to the number of occurrence equation. First, the court adopted a "time and space" test — "if cause and result are simultaneous or so closely linked in time and space as to be considered by the average person as one event, then the injuries will be deemed the result of one occurrence." *Id.* at 756 (quoting *Doria v. Ins. Co. of N. Am.*, 509 A.2d 220, 224 (N.J. Super. App. Div. 1986). "The insured's negligence consisted of an omission, the failure to maintain the property. Where negligence is the result of an ongoing omission rather than separate affirmative acts, a time and space test effectively limits what would otherwise potentially be a limitless bundling of injuries into a single occurrence." *Id.*

Next, the *Fay* Court held that, once the boys' estates provided the necessary facts to establish coverage and the value of the loss, the burden then shifted to the insurer to prove that the event or events giving rise to the damage constituted a single occurrence. *Id.* at 753. The court reached this conclusion despite acknowledging that it has long been established law in Illinois that the insured bears

the burden of proving coverage under an insurance policy. *Id.* at 752.

Examining the facts surrounding the boys' deaths, the court determined that Addison could not meet its burden of proving that their injuries were so closely linked in time and space as to be considered one event: the boys did not become trapped simultaneously and it could not be determined how closely in time the boys became trapped nor how closely in time the boys died. *Id.* at 756.

Because of Addison's failure to meet this burden the court held that the two boys' deaths constituted separate occurrences. *Fay,* 905 N.E.2d at 757. As a result, the claims were subject to the policy's $2 million general aggregate and not capped at the $1 million occurrence limit. *Id.*

As noted above, a review of number of occurrences decisions nationally demonstrates that application of the "cause" test frequently leads to a determination that a single occurrence applies. But *Fay* has provided a blueprint for courts, constrained to follow the "cause" test, but desirous of providing the additional limits that would be available if multiple occurrences applied.

***Callahan & Sons, Inc. v. Worcester Insurance Co.,* 902 N.E.2d 923 (Mass. 2009)**

Insurers sometimes confront accusations that they conspired to do some harm against the public or even their own policyholders. For example, insurers were accused of conspiring to settle Katrina claims for less than their true value. In addition, price-fixing by insurers has been alleged under various circumstances. The image that is sometimes portrayed is one of insurance company executives, holding secret meetings in cigar smoke filled back rooms, plotting ways to make even more money. Whenever I hear such allegations I shake my head in disbelief. Those leveling such charges must not be aware of the vast amount of "insurer v. insurer" coverage litigation that takes place. Based on that, it would seem that many insurers do not like each other enough to even be in the same room, yet alone conspire to do anything together.

The pros and cons of "insurer v. insurer" coverage litigation, in general, is a topic for another day. But one aspect to consider today: Given the frequency of "insurer v. insurer" litigation, it is surprising that there is so little case law addressing a prevailing insurer's right to recover its attorney's fees from the other (just a handful of states, and two of the decisions are from the 1960s, discussed *infra.*). Compare the dearth of case law in the "insurer v. insurer" context to that of an insured that prevails in coverage litigation against its insurer. Virtually every state in the country has addressed a prevailing insured's right to recover its attorney's fees. Further, the vast majority of states provide a mechanism of some sort for the recovery of such fees — which is not the same as saying that a prevailing insured will in fact recover its attorney's fees in every case.

As a general rule, in almost all litigation, insurance and otherwise, the losing party is not obligated to pay the prevailing party's attorney's fees. This is often referred to as the "American Rule." *See ACMAT Corp. v. Greater N.Y. Mut. Ins. Co.*, 923 A.2d 697, 702 (Conn. 2007) ("The general rule of law known as the American rule is that attorney's fees and ordinary expenses and burdens of litigation are not allowed to the successful party absent a contractual or statutory exception.") (citations and internal quotations omitted).

Therefore, the possibility of an unsuccessful insurer in coverage litigation being obligated to pay its insured's attorney's fees hinges on the existence of an exception to the American Rule in the relevant state. And such exceptions are not granted lightly. *See Monahan v. GMAC Mortgage Corp.*, 893 A.2d 298, 322 (Vt. 2005) ("We have recognized that courts may invoke their equity powers to deviate from [the American] rule, but only in exceptional cases and for dominating reasons of justice.") (citation and internal quotations omitted).

But despite this demanding standard, most states have carved out an exception of some type to the American Rule when it has been judicially determined that an insurer was obligated to provide coverage to its insured. In general, some states have enacted statutes that allow a prevailing insured to recover its attorney's fees in an action to secure coverage. Other states achieve similar results, but through judicial decisions. But whichever method is used, the most important factor is whether the insured is

automatically entitled to the recovery of attorney's fees or must it prove that the insurer's conduct was unreasonable or egregious in some way. If the latter, then look for collateral litigation concerning the insurer's conduct surrounding its (now determined to have been erroneous) denial of coverage.

While the Supreme Judicial Court of Massachusetts in *Callahan & Sons, Inc. v. Worcester Insurance Co.* addressed a prevailing insurer's right to recover its attorney's fees in an action against another insurer, the court's decision was not made without consideration of the issue in the context of a prevailing *insured's* right to such recovery.

In *Callahan,* Massachusetts's highest court confronted the issue of attorney's fees in "insurer vs. insurer" coverage litigation under the following circumstances. Callahan was hired as the general contractor for a construction project. *Callahan*, 902 N.E.2d at 924. New England Air Conditioning Service was a subcontractor on this project. *Id.* Pursuant to the terms of the subcontract between Callahan and NEAC, Callahan was named as an additional insured on NEAC's general liability policy with Worcester Insurance Company. *Id.* In January 2002, a worker employed by another subcontractor on the project brought suit in Massachusetts state court against Callahan and NEAC, for injuries allegedly sustained in a fall. *Id.* The suit alleged that the negligence of Callahan and NEAC was the cause of the fall. *Id.*

Zurich, Callahan's general liability insurer, assumed Callahan's defense. *Id.* Worcester rejected Callahan's claim for defense and indemnification. *Callahan*, 902 N.E.2d at 924. Zurich settled the underlying tort action for $75,000. *Id.* Zurich and Callahan filed a declaratory judgment action against Worcester seeking a determination that Worcester had an obligation to defend and indemnify Callahan. *Id.* The trial court concluded that Worcester was obligated to pay Zurich one-half of the settlement amount and one-half of Callahan's attorney's fees. *Id.* However, the trial court also concluded that Zurich was not entitled to an award of its attorney's fees incurred in the declaratory judgment action. *Id.* at 925.

On appeal to the Supreme Judicial Court of Massachusetts, the court noted that the Bay State makes a "limited exception" to the American Rule, allowing "an insured to recover attorney's fees associated with establishing an insurer's duty to defend under the policy." *Id.* This exception, established in *Preferred Mutual Insurance Co. v. Gamache*, 686 N.E.2d 989 (Mass. 1997), was created "because of the *special relationship* between the insured and its insurer arising out of the insurance policy, and because the assumption of responsibility for the insured's defense in litigation is one of the *core purposes* for which liability insurance is purchased; allowing recovery of attorney's fees was necessary to give the insured the full benefit of the insurance contract." *Callahan*, 902 N.E.2d at 925 (emphasis added).

The *Callahan* Court observed that it was aware of only three jurisdictions — Maryland, Illinois and Oregon — that have addressed a prevailing insurer's right to recover attorney's fees in an action brought against another insurer. *Id.* at 927, n.4. And none of these case are recent — 1987, 1966 and 1960, respectively. *Id.*

The *Callahan* Court concluded that, in an action such as this, where one insurer brings an action against another insurer, there is no special relationship between the two insurers; rather, their only connection is a common insured. *Id.* at 925. The court rejected Zurich's policy argument that the *Gamache* exception should apply in order to prevent Worcester from being rewarded for its wrongful refusal to defend its insured. *Id.* at 926. However, the *Callahan* Court stated that the policy underlying the *Gamache* exception does not seek to punish wrongdoers, but, instead, "is designed to protect the *insured's* right to receive the full benefit of its liability insurance contract." *Id.* (emphasis in original). Where, as here, the insured did not incur any cost in establishing an insurer's duty to defend, it has received the full benefit of its contract. *Id.*

Many states that allow an insured to recovery its attorney's fees, after prevailing in a coverage action, do so based on the same rationale as *Gamache* — to protect the insured's right to receive the full benefit of the policy. Therefore, it would not be surprising to see *Callahan* followed by future courts addressing a prevailing insurer's right to recover its attorney's fees in "insurer v. insurer" coverage litigation.

***Idaho Counties Risk Management Program Underwriters v. Northland Insurance Cos.*, 205 P.3d 1220 (Idaho 2009)**

It goes without saying that DNA profiling, or genetic fingerprinting, has dramatically changed the face of criminal investigation today (not to mention what it did to blow the lid off a certain White House intern investigation a few years back). DNA profiling was developed in 1984 and first used to establish a murder suspect's guilt (and another's innocence) in 1987-88 (Wikipedia — how else would I know that). In addition to its use by law enforcement, DNA profiling has also been used by individuals to prove that they were wrongfully convicted of a crime that took place at a time before such technique was available.

According to The Innocence Project, an organization that assists prisoners with proving their innocence through DNA testing, there have been 245 post-conviction DNA exonerations in the United States (34 states), with 179 exonerations coming since 2000. The average length of time served by exonerees is thirteen years and seventeen of the exonerees served time on death row. Innocence Project Fact Sheet Page, *http://www.innocenceproject.org/Content/351.php* (last viewed Dec. 5, 2009).

It is not uncommon for exonerees to file suit against various individuals and entities, such as prosecutors, police officers, police departments and municipalities, whom they blame for their wrongful conviction and imprisonment. These are very complex liability cases, not to mention possibly raising issues of governmental immunity and statutory damage caps.

But putting all of this inordinate complexity aside, there are a few things about these cases that are simple. First, upon being sued, the defendants will likely seek coverage under various insurance policies, such as Commercial General Liability, Law Enforcement Liability and Public Officials Liability. Second, and needless to say, given that the underlying plaintiff may have spent many years in prison, for a crime that has now been conclusively determined he or she did not commit, the potential damages could be (and the settlement demand will be) significant. Third, the damages or settlement demand are likely to far exceed the limits of liability available under a single policy year. As a result, it will not take long before an argument is presented by an insured, or plaintiff, that the available limits are not tied to a single year. Rather, expect an argument that a continuous trigger applies (*i.e.*, all policies on the risk from the time that the plaintiff was wrongfully arrested until the date of exoneration, or some time frame along those lines, are obligated to provide coverage).

Simply put, whether a court adopts a continuous trigger is likely the difference between a plaintiff's ability to recover significant versus minimal compensation from some defendants for having years of their lives taken from them. This point was recently made very clear by a Massachusetts federal judge, after declining to adopt a continuous trigger in a DNA exoneration case, involving a man who spent close to ten years in prison for a rape that he did not commit: "I am sympathetic to plaintiff's position and recognize that this decision may preclude him from ever being fully compensated for the losses he has suffered." *Sarsfield v. City of Malborough*, No. 07-11026-RWZ, 2007 U.S. Dist. Lexis 5445 (D. Mass. June 3, 2008), *aff'd*, 2009 U.S. App. Lexis 14304 (1st Cir. July 1, 2009).

Several state and federal courts have addressed coverage for myriad claims arising out of a wrongful conviction. For ease of reference, they are collectively referred to here as claims for malicious prosecution. But they are certainly more varied than just that and different claims may result in different outcomes. Further, not all of the cases involve DNA exoneration. Some involve other bases for overturning convictions. Lastly, the policy language at issue in the various cases, an important part of the trigger of coverage analysis, may differ.

But despite all of these variables, there is one common theme of most malicious prosecution coverage cases — the question whether a continuous trigger applies. For this reason, the Supreme Court of Idaho's decision in *Idaho Counties Risk Management Program Underwriters v. Northland Insurance Cos.*, although not involving coverage for DNA exoneration, nonetheless offers some take-aways for such claims, because of its detailed discussion of a continuous trigger in the malicious prosecution context.

In *Idaho Counties,* Idaho's high court addressed coverage for various claims brought by Donald Paradis, who was convicted in 1981 of a double murder and sentenced to death. *Idaho Counties*, 205 P.3d at

1221. In January 1996, while one of Paradis's habeas petitions was pending, his counsel obtained copies of notes that the prosecutor had made at a meeting of law enforcement officials, held two days after the bodies were discovered in 1980. *Id.* The notes revealed significant inconsistencies between the medical examiner's opinions offered the day after the autopsy and those he offered at trial. *Id.* While Paradis had been awaiting trial in 1980-81, his counsel made a routine request for disclosure, but the prosecutor did not reveal the notes or any of the potentially exculpatory evidence in them. *Id.*

The Ninth Circuit held that this nondisclosure was a violation of the prosecutor's duties. *Id.* On remand, the District Court granted the habeas petition and ordered a new trial. *Id.* Paradis plead guilty to a lesser charge and was released in 2001. *Idaho Counties*, 205 P.3d at 1221-22.

Following his release, Paradis filed an action against various law enforcement officials involved in his case and alleged violations of civil rights, negligence, false arrest, malicious prosecution, false imprisonment, negligent and intentional infliction of emotional distress, defamation, false light and invasion of privacy. *Id.* at 1222. Certain claims were dismissed but others were allowed to proceed on the basis that Paradis had alleged some continuing torts that were not barred by the statute of limitations. *Id.*

The various law enforcement defendants were insureds, as part of the Idaho Counties Risk Management Program, under policies issued by Northland Insurance Company from 1986 to 2001. *Id.* ICRMP defended the insureds, providing separate counsel for several defendants. *Id.* The *Paradis* action was eventually settled and Northland disclaimed coverage for both reimbursement of defense costs and the settlement. *Id.* ICRMP filed a complaint against Northland for breach of contract on account of its refusal to reimburse it. *Idaho Counties*, 205 P.3d at 1222. The trial court granted Northland's motion for summary judgment that it had no obligation to reimburse ICRMP. *Id.*

Putting aside certain collateral considerations, the Supreme Court of Idaho affirmed, holding that the Northland policies (providing general liability and law enforcement liability) were not triggered. *Id.* at 1224. The policies provided coverage for, among other things, bodily injury and personal injury during the policy period. *Id.* However, the court characterized the policies as providing coverage for an *occurrence* that took place during the policy period. *Id.* In any event, the court ultimately concluded that, because the policies' definition of occurrence made clear that continuing torts are considered to be a single occurrence, and an occurrence requires a resulting injury, the time of an occurrence is when the injurious effect first manifests itself. *Id.* at 1226.

The supreme court agreed with the trial court's conclusion that:

> the Kootenai County insureds' alleged failure to disclose exculpatory evidence and to properly train their employees regarding such disclosure was the sole proximate cause of all the damage alleged by Paradis in his complaints. The district court held that, in accordance with both *Appalachian* [*Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3rd Cir. 1982)] and *Kootenai County v. Western Cas. and Sur. Co.,* 113 Idaho 908, 750 P.2d 87 (1988), the occurrence took place when the resulting injury first manifested itself, which occurred in 1980 when proceedings against Paradis first began in Idaho.

Id. at 1225-26.

ICRMP argued that this conclusion was illogical in light of the fact that the federal district court found that Paradis had alleged continuing torts. *Id.* at 1226. The supreme court was not persuaded: "Reliance on the commencement of the statute of limitation is not dispositive in determining when a tort occurs for insurance purposes. Statutes of limitation and triggering dates for insurance purposes serve distinct functions and reflect different policy concerns." *Id.*

The supreme court reviewed the various causes of action asserted by Paradis and concluded that, for each one, the occurrence took place before the inception of the Northland policies issued to ICRMP. *Id.* at 1226-27. Although the court examine each cause of action separately, its conclusion can be summarized as follows:

> Paradis' first claim alleged that Kootenai County and then Kootenai County Prosecutor Walker failed to train their staff regarding *Brady* disclosure requirements by the time when, in 1981, Paradis became the subject of a criminal investigation and then prosecution by Kootenai County in violation of his constitutional civil rights. The injury from this alleged failure to train manifested itself when Paradis was initially prosecuted in 1980-1981, which occurred prior to the Northland policy period. Allegedly, the initial failure led to the continued withholding of exculpatory evidence and thus continued injury; however, such continued action and ongoing injury arose out of a single occurrence. Thus, under the policy, this claim alleged a single occurrence that took place prior to the policy period, and Northland is not liable for it.

Id. at 1226.

Again, with the caveat that a variety of claims are asserted in underlying actions for wrongful conviction, and that the policy language at issue in the resulting coverage cases may differ, the Idaho Supreme Court's decision in *Idaho Counties* — one of the first supreme courts to address trigger of coverage for malicious prosecution — is consistent with the majority of courts around the country. For a survey of this trigger issue nationally, see *Town of Newfane v. General Star National Insurance Co.*, 784 N.Y.S.2d 787 (2004), *appeal granted* 789 N.Y.S.2d 454 (2005), *appeal withdrawn* 835 N.E.2d 664 (N.Y. 2005).

***Essex Insurance Co. v. Bloomsouth Flooring Corp.*, 562 F.3d 399 (1st Cir. 2009)**

Chinese drywall is no flash in the wok. While it is certainly not the proverbial *next asbestos*, neither is it the next Y2K. Claims are mounting and the Multi-District Litigation pending in New Orleans is proceeding at a rapid clip. The litigation has placed a host of legal issues on the table. Recent issues of *Mealey's Litigation Reports: Construction Defects* have reported on some settlements, as well as defendants invoking the economic loss rule to prevent tort recovery; builders allegedly tricking homeowners into settling without providing all of the facts; a default judgment entered against a Chinese-based drywall manufacturer; debate over application of a state's right to repair law to Chinese drywall claims; and class certification issues.

In addition, studies are underway (and some results are in) to determine if the presence of Chinese drywall in homes causes property damage and bodily injury. The Consumer Product Safety Commission recently concluded that there is a "strong association" between chemicals emitted by Chinese drywall and corrosion of metals. The CPSC also concluded that, while the hydrogen sulfide and formaldehyde levels detected in 51 studied homes containing Chinese drywall were at concentrations below irritant levels, the additive or synergistic effects of these and other compounds in the subject homes could cause irritant effects. The Formaldehyde Council, a trade group, begged to differ. Melanie Trottman & M.P. McQueen, *CPSC Ties Drywall, Corrosion*, The Wall Street Journal, Nov. 24, 2009.

Given that so many defendants in Chinese drywall cases are smallish size contractors, it is very likely that the ability of homeowners to recover some of their losses, even if they establish liability, will be tied to the availability of insurance for such defendants. On this subject there has been more sizzle than steak. While lots of commentators have identified and hypothesized about the likely coverage issues, judicial decisions setting out the actual parameters of coverage for Chinese drywall claims have been elusive. And it may remain that way for some time — until coverage actions are filed (of which there have only been a few so far) and work their way through the system.

Some of the most critical issues surrounding coverage for Chinese drywall will be trigger, the pollution exclusion and "business risk" exclusions. Given that the treatment of all three of these issues varies widely between states, it is natural to expect that the extent of coverage for Chinese drywall will likewise run the gamut. But this much is certain — even if courts are ultimately generous in providing coverage for Chinese drywall, the amount available will be a drop in the bucket compared to Towers-Perrin's oft-cited projection of $15 billion to $25 billion for the total Chinese drywall bill. The simple fact remains that, because many of the defendants in the litigation are small size contractors, those that even have insurance

likely have minimal limits, such as $1 million per occurrence, with such limit probably subject to a general or products-completed operations aggregate limit of the same amount or perhaps $2,000,000 (and multiple occurrences may not apply anyway). In other words, many homeowners are likely to be disappointed when comparing their damages to their recoveries.

It is still too early for any concrete judicial guidance on Chinese dry wall coverage issues. However, given how much has been made of the so-called rotten egg smell allegedly given off by Chinese drywall, the First Circuit's decision in *Essex Insurance Co. v. BloomSouth Flooring Corp*. — addressing whether odor can constitute a physical injury to property — may prove relevant in future coverage disputes.

The case arose as follows. In 2000, Suffolk Construction Corporation subcontracted with BloomSouth Flooring Corporation to install carpet tile and related materials in the offices of Boston Financial Data Services. *Essex*, 562 F.3d at 401. BloomSouth subsequently subcontracted out the supply and installation of the carpet to two other companies. *Id.*

The carpet was installed in Spring 2001. *Id.* Sometime thereafter BFDS employees moved into the building and noticed an odor that they described as a "locker room" smell, a "sour chemical" smell, or a "playdough" smell. *Id.* Some employees complained that the odor caused ill effects, including headaches. *Id.* BFDS notified Suffolk of the problem. *Id.* One of BloomSouth's subcontractors scraped up the original carpet adhesive in an effort to eliminate the odor. *Id.* Such effort failed and the odor spread to other areas of the building. *Essex*, 562 F.3d at 401. Tests on the flooring to determine the cause of the odor were inconclusive. *Id.* at 402.

BloomSouth was insured under commercial general liability policies issued by Essex Insurance Company, naming Suffolk as an additional insured. *Id.* BFDS demanded that Suffolk remove the carpet and eliminate the smell. *Id.* Suffolk demanded that BloomSouth respond to BFDS and BloomSouth refused. *Id.*

As a result, Suffolk paid BFDS nearly $1.5 million for remediation efforts. *Id.* Suffolk then notified Essex of BFDS's claim and demanded that, as an additional insured under the BloomSouth policies, Essex defend and indemnify it. *Essex*, 562 F.3d at 402. Essex denied Suffolk's claim. *Id.*

Suffolk filed an action against BloomSouth for negligence, breach of contract, indemnity and related claims and Essex filed a declaratory judgment action against BloomSouth and Suffolk. *Id.* Essex sought a declaration that it was not required to defend or indemnify Suffolk for the BFDS claims nor BloomSouth for the Suffolk action. *Id.* The trial court granted Essex's motion for summary judgment, holding that certain business risk exclusions relieved Essex of its policy obligations. *Id.*

The First Circuit reviewed the trial court's decision de novo. Although the parties did not address directly whether odor constituted "physical damage to tangible property," instead focusing on whether one of the exclusions applied, the court noted that the odor, as physical damage, was a threshold issue that required analysis prior to making any decision regarding the applicability of the exclusions. *Id.* at 404.

Because the Massachusetts Supreme Judicial Court had not yet decided whether an odor could constitute a physical injury, the First Circuit noted that its decision would be "an informed prophecy of what the court would do." *Essex*, 562 F.3d at 404 (internal quotation omitted). The insureds identified unpublished Massachusetts decisions that they argued stood for the proposition that odor could constitute physical injury under Massachusetts law. *Id.*

First, *Matzner v. Seaco Insurance Co.*, No. 96-0498-B, 1998 Mass. Super. Lexis 407, at *13 (Mass. Super. Ct. Aug. 12, 1998) held that "carbon monoxide contamination constitute[d] a 'direct physical loss of or damage to' property." *Id.* at 405. Second, *Arbeiter v. Cambridge Mutual Fire Insurance Co.*, No. 94-00837, 1996 Mass. Super. Lexis 661, at *3 (Mass. Super. Ct. Mar. 15, 1996) found "that fumes are physical loss which attach to the property." *Id.*

Essex responded to the insureds' reliance on these cases by making three arguments. *Id.* First, the odor could not constitute physical injury because the underlying claims referenced injury to the "air," not injury to "tangible" property. *Id.* The First Circuit

quickly dismissed this contention, noting that Suffolk alleged that the odor "permeated the *building*." *Essex*, 562 F.3d at 405.

Second, Essex argued that odor simply cannot constitute physical injury to property, but failed to cite any authority in support of this position. *Id.* As a result the First Circuit rejected Essex's argument given the authority of *Matzner* and *Arbeiter*. *Id.* at 405-06.

Third, Essex argued that, even if it were incorrect on the first two points, case law suggests that, at the very least, in order for odor to constitute physical injury, the odor must have persisted even after the source of the odor was removed. *Id.* at 405. According to Essex, there was no persistent odor because it did not remain once the carpet was removed. *Id.* The First Circuit found that, although Essex may be correct that the odor must be permeating, the "underlying complaint explicitly assert[ed] that the odor 'permeated the building.'" *Id.* at 406.

The First Circuit ultimately held "that odor can constitute physical injury to property under Massachusetts law, and also that allegations that an unwanted odor permeated the building and resulted in a loss of use of the building are reasonably susceptible to an interpretation that physical injury to property has been claimed." *Essex*, 562 F.3d at 406.

***Nazario v. Lobster House*, Nos. A-3025-07T1, A-3043-07T1, 2009 N.J. Super. Unpub. Lexis 1069 (N.J. Super. App. Div. May 5, 2009)**

New Jersey's duty to defend seems to suffer from schizophrenia. On one hand, it could be argued that it is the most restrictive in the country for insureds. After all, *Burd v. Sussex Mutual Insurance Co.*, 267 A.2d 7 (N.J. 1970) affords insurers the right, in many cases, to decline to provide a defense and instead convert its defense obligation to one of reimbursement of defense costs at the conclusion of the case. "[T]he practical effect of *Burd* is that an insured must initially assume the costs of defense itself, subject to reimbursement by the insurer if it prevails on the coverage question." *Trustees of Princeton University v. Aetna Cas. & Sur. Co.*, 680 A.2d 783, 787 (N.J. Super. App. Div. 1996) (quoting *Hartford Accident Indem. Co. v. Aetna Life & Cas. Ins. Co.*, 483 A.2d 402, 407 n.3 (N.J. 1984)). Further, such reimbursement obligation can then be limited, admittedly when feasible, solely to those costs that were incurred to defend covered claims. *See SL Indus. Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266 (N.J. 1992). Based on these principles, insureds frequently view the Garden State's duty to defend as standing in contrast to the rule, applied just about everywhere else in the nation, that the duty to defend is broader than the duty to indemnify.

On the other hand, it could just as easily be argued that New Jersey's duty to defend is the most expansive in the country for insureds. Even before *Burd* was hatched, the Supreme Court of New Jersey held in *Merchants Indemnity Corp. v. Eggleston*, 179 A.2d 505 (N.J. 1962) that an insurer that wishes to defend its insured, under a reservation of rights, can do so only if it obtains its insured's consent. In other words, an insurer that wishes to take the common course of action of appointing panel counsel to defend its insured, while at the same time sending its insured a reservation of rights letter, setting out reasons why, notwithstanding providing a defense, the insurer may not have an obligation to pay some or all of any damages awarded, must advise the insured of its right to object to being defended in such a matter.

New Jersey courts have imposed a simple sanction on insurers that fail to obtain their insured's consent to being defended under a reservation of rights — loss of the insurer's ability to assert an otherwise applicable defense to coverage. *See Certain Underwriters at Lloyd's, London v. Fredericick*, No. A-3234-04T2, 2006 N.J. Super. Unpub. Lexis 2763 (N.J. Super. Ct. App. Div. Apr. 4, 2006); *Selective Ins. Co. v. Allstate Ins. Co.*, No. A-6061-02T2, 2006 N.J. Super. Unpub. Lexis 238 (N.J. Super. Ct. App. Div. Mar. 10, 2006); *Pa. Nat'l Mut. Cas. Ins. Co. v. South State, Inc.*, No. 07-2989, 2008 U.S. Dist. Lexis 98456 (D.N.J. Dec. 3, 2008).

Despite the fact that *Eggleston* has been on the books since the same year as the Cuban Missile Crisis, not to mention imposing an obligation on insurers with the most serious of all consequences for their failure to comply, some insurers have not been aware of the decision. Consequently, they have not obtained their insured's consent to being defended under a reservation of rights and paid dearly for it. One insurer's failure to be aware of such a long-standing decision recently left a New Jersey appellate court incredulous. It had the following to say — just before concluding

that the insurer was estopped from denying coverage because its reservation of rights did not comport with *Eggleston*, "Borrowing from my own experience, every once in a while you see something and you scratch your head and you wonder why a carrier that's in the business of doing this type of thing would not know how to do it appropriately. It's not particularly difficult, but those things happen I guess. *Allstate Ins. Co.,* 2006 N.J. Super. Unpub. Lexis 238, at *19.

How it is that a decision as significant as *Eggleston* managed to fly under the radar for so long is a mystery. But *Eggleston's* days as a stealth coverage issue appear over, as evidenced by the spate of decisions over the past four years that have applied it to preclude an insurer from asserting an otherwise applicable coverage defense. In 2009 the New Jersey Appellate Division added one more decision to that list. But what makes this most recent entry particularly noteworthy is the court's rejection of the specific arguments presented by insurers in an effort to avoid the consequences of *Eggleston*.

Nazario v. Lobster House involved coverage for bodily injury sustained by an employee of a door company when he fell from a ladder while installing overhead garage doors at the Cape May, New Jersey warehouse facility of Cold Spring Fish and Supply Company. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *6. Cold Spring sought coverage from its two primary liability insurers — Essex Insurance Company and Sirius America Insurance Company. *Id.* at *2. Essex and Sirius both appointed counsel to defend Cold Spring under a reservation of rights and each insurer filed declaratory judgment actions against Cold Spring seeking a judicial determination that it was not entitled to coverage. *Id.* at *2-3.

The trial court ruled that the terms and conditions of the Essex and Sirius policies did not provide coverage to Cold Spring for the underlying tort action. *Id.* at *4. Coverage was precluded under the Sirius policy because it did not extend to Cold Spring's wholesale warehouse operations. Coverage was precluded under the Essex policy on account of an exclusion for negligent hiring and independent contractors and subcontractors. *Id.* at *15-16.

But despite the trial court's decisions concerning the lack of coverage — at least under the provisions of the Essex and Sirius policies — the court also concluded that both insurers' reservation of rights letters were ineffective because they failed to inform Cold Spring that their offers to defend could be accepted or rejected. *Id.* at *4. As a result, the policy provisions were tossed aside and the insurers were estopped to disclaim coverage. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *4. Appeals were taken to the Appellate Division. *Id.* at *6.

The New Jersey Appellate Division was just as unsympathetic to the insurers' position as the trial court. The appellate court began its analysis by setting out several quotations from *Eggleston*. Most notably: "If an insurer 'wishes to control the defense and simultaneously reserve a right to dispute liability, it can do so only with the consent of the insured.' Agreements may be 'inferred from an insured's failure to reject an offer to defend upon those terms, but to spell out acquiescence by silence, *the letter must fairly inform the insured that the offer may be accepted or rejected.*'" *Id.* at *12 (emphasis added and citation omitted) (quoting *Eggleston*, 179 A.2d at 512).

Seeing the writing on the wall, that the appellate court had every intention to follow *Eggleston*, the insurers focused on the trial court's statement that "prejudice is presumed by the absence of control of the litigation." *Id.* at *19. The insurers argued that it could be demonstrated that Cold Spring suffered no prejudice as a result of being represented by counsel chosen by the insurers. *Id.* They pointed out that Cold Spring retained personal counsel to serve as defense counsel and to monitor the action on its behalf, with such personal counsel also filing third party pleadings and attending depositions. *Id.* As such, the insurers argued that a *rebuttable* presumption of prejudice should have been applied. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *19. Further, Sirius pointed out that its defense was not based on a policy exclusion, but, rather, a complete lack of coverage — the Sirius policy did not extend to Cold Spring's wholesale warehouse operations. *Id.* at *19-20.

However, the Appellate Division was not persuaded that prejudice was even a consideration under *Eggleston*:

> Because Essex and Sirius actively assumed defense of the claim but did not disclaim

> liability or reserve its rights through "appropriate measures" as set forth in *Eggleston,* we affirm the trial judge's finding that both insurers are estopped from denying coverage. *** ¶ We find nothing in *Eggleston* or its progeny which suggests that the insured must prove actual prejudice to create coverage, or that the carrier may prove lack of prejudice to avoid coverage by estoppel, when a fully informed written consent is lacking. The control of the litigation without proper consent equates to creating the coverage without qualification under *Eggleston.*

Id. at *20-21.

The significance of *Lobster House* is this. The insured was represented by personal counsel, who apparently cooperated with the insurers' retained counsel. In addition, there was a complete lack of coverage under the Sirius policy. Nonetheless, the insurers' were still estopped from denying coverage. By applying *Eggleston,* even under these facts, and rejecting a prejudice consideration, the court seemingly adopted strict liability for insurers that fail to obtain their insured's consent to being defended under a reservation of rights. The moral of the story for insurers is simple. The safest way to stay out of boiling water is to follow *Eggleston* when undertaking an insured's defense. If *Lobster House* is the law, this appears to be easier than attempting to prove *Eggleston's* inapplicability.

***QBE Insurance Corp. v. Austin Co.*, No. 1071144, 2009 Ala. Lexis 128 (Ala. May 15, 2009)**

It should be so much easier than this. Many suits involve claims or damages that are in all likelihood covered in part and not covered in part. When this happens insurers take the proper course of action, as mandated by courts almost unanimously, and defend the entire claim under a reservation of rights. The case then proceeds to trial. And, of course, neither plaintiff nor defendant-insured have any interest in a verdict being rendered, in such a format, to enable a post-trial determination between covered and uncovered claims to be made. The litigants would much prefer a general verdict, allowing for an opportunity to argue that, because there is now no way to allocate the claims or damages between covered and uncovered, everything must be considered covered.

The litigants can also be expected to maintain that the insurer coulda, woulda, shoulda filed a declaratory judgment action in an attempt to avoid the problem. Of course they say that now. If the insurer had in fact filed a declaratory judgment action, the insured would have likely bemoaned the expense and perhaps even sought to have the declaratory judgment stayed while the underlying litigation proceeded.

A few states expressly estop insurers from litigating allocation issues if they made no effort to solve such problem during the course of the underlying action. *See Herrera v. C.A. Seguros Catatumbo*, 844 So. 2d 664, 668 (Fla. Dist. Ct. App. 2003) ("In the instant case, Catatumbo [the insurer], aware of the terms of its own policy, made no effort to have the final disposition result in a verdict that would provide a basis for consideration of the exclusionary clause. The Herreras are, therefore, entitled to recover the unsegregated damage awards on all three of it claims [general verdict]."); *see also U.S. Concrete Pipe Co. v. Bould*, 437 So.2d 1061, 1065 (Fla. 1983).

Given how common this problem is, it is surprising that not more guidance exists on how to solve it. It would seem that the ideal solution is to allow the insurer to intervene in the underlying action, solely for purposes of seeking special jury interrogatories, the answers to which would enable the claims or damages to be allocated between covered and uncovered. Procedurally, since the insurer can not ask its retained defense counsel to request these coverage-based special jury interrogatories, the insurer would file a motion to intervene as a party in the underlying action.

Under the Federal Rules of Civil Procedure, a party is entitled to intervene as of right, upon timely application, when the applicant "claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties." Fed. R. Civ. P. 24(a)(2). It is likely that a similar right exists under most state rules of civil procedure.

It is hard to imagine a party more worthy of the right to intervene than an insurer, who has done the right thing and defended under a reservation of rights, and

may now lose its entitlement to enforce its coverage defenses in the event of a general verdict. After all, the insurer has an interest relating to the subject of the action (it is paying for its defense and may be obligated to pay for any damages); the disposition of the action may certainly impair or impede the insurer's ability to protect that interest (if the insurer can not seek post-trial apportionment of a general verdict); and the insurer's interest is far from adequately represented by the existing parties (to the contrary, the existing parties stand to benefit by keeping the insurer as far away as possible from the courthouse).

But despite this, insurers do not have a great track record for having motions to intervene granted. Unfortunately for insurers, the need to intervene is often-times not addressed until late in the game, as the case is getting close to trial. At that point, insurers may have trouble overcoming the requirement that the intervention request must have been made timely. The insurer is frequently painted by the litigants, in their opposition to the motion to intervene, as a Johnny-come-lately, whose presence will throw a money wrench into the trial and cause all kinds of prejudice. In reality, the insurer is not asking to delay the trial, is not seeking to take discovery, has no interest in disturbing any aspect of the case and nobody on the jury will have any knowledge of its presence. The insurer simply wants a seat at the charging conference, so that the jury's verdict can reflect the various claims and damages for which evidence had just been presented by the parties. This would prevent the need for collateral coverage litigation. And isn't judicial economy a significant goal of the system?

Despite all this, things did not go well for the insurer in *QBE Ins. Co. v. Austin,* which sought to intervene in an underlying action to request special jury interrogatories, to determine the basis for the jury's verdict, so that an allocation could be made between covered and uncovered damages.

In *Austin*, an insurer sought to intervene in an underlying action, to request special jury interrogatories, to determine the amount of damage caused by defective construction (covered) and the cost to repair or replace defective construction (uncovered). *Austin*, 2009 Ala. Lexis at *3. There were also issues concerning when damage took place. *Id.* at *4. The insurer expressed its concern that, in the event of a general verdict, it would not be able to make such determinations. *Id.* at *4. The trial court denied the insurer's motion for permissive intervention and the Supreme Court of Alabama affirmed. The court's opinion is methodical — setting forth each requirement for permissive intervention followed by an analysis whether it was satisfied by the insurer.

The court held that the first requirement, that the request to intervene be timely, was not satisfied because the insurer was aware of the coverage issue sixteen months before it sought to intervene. *Id.* at *12-13. The court next turned to the second requirement — prejudice to the existing parties because of the would-be intervenor's failure to make a timely application. *Id.* at *13. The court held that, because the insurer sought to participate in discovery, in addition to submitting special jury interrogatories, and because the seventeen parties had substantially completed written discovery, the insurer's intervention would necessarily complicate and further delay the action, thereby prejudicing the existing parties. *Id.* at *14.

The third factor, prejudice to the would-be intervenor if its petition were denied, was not satisfied because the insurer could file a separate declaratory judgment action to resolve the coverage issue. *Austin*, 2009 Ala. Lexis at *14-15. In essence, even though the insurer was not adequately represented by an existing party, a final judgment in the case would not bind the insurer. *Id.* at *14.

Lastly, the court concluded that the fourth factor was not satisfied because "Nothing in QBE's motion to intervene shows any unusual or compelling circumstances that prevented it from seeking intervention earlier for the purposes of participating in discovery rather than after written discovery was substantially completed and depositions had begun." *Id.* at *15.

In summary, in denying the insurer's motion to intervene, the Alabama high court concluded that "[t]here are 17 parties to this litigation, which involves alleged defects in constructing a building, and the controversy is already sufficiently complex because of the nature of the action." *Id.* at *16.

While the Supreme Court of Alabama closed the door on the insurer (and perhaps because Alabama has an alternate procedure that the insurer did not

pursue), the court's opinion provides useful guidance for future insurers confronting the same problem. In other words, by seeing why the motion to intervene was denied, insurers can act accordingly. Decisions as detailed as *Austin*, and from a state supreme court no less, addressing the intervention issue, under such paradigm facts, are few and far between. For this reason, *Austin* may become a go-to case for other states confronting the issue.

***Health Care Industry Liability Insurance Program v. Momence Meadows Nursing Home*, 566 F.3d 689 (7th Cir. 2009)**

On February 18, 2009, the Fifth Circuit issued its opinion in *Branch v. Allstate Insurance Co.*, 560 F.3d 371 (5th Cir. 2009), addressing potential fraud in the adjustment of Hurricane Katrina claims under federally backed flood insurance policies. In doing so the court observed that the potential for fraud in government programs is inherent, especially in those programs involving the emergency spending of mass amounts of federal funds. Coincidentally, eerily so, on that very same day, President Barack Obama signed into law the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5), better known as the Stimulus Package.

It is hard to imagine a greater example of the emergency spending of mass amounts of federal funds than the $787 billion Stimulus Package. That being so, it is clear that some fraud, and, more likely, a significant amount, will come out of it. Indeed, the President himself has comes to terms with the inevitable, stating: "No plan is perfect. And I can't stand here and promise you that not one dollar will slip through the cracks. But what I can promise you is that we will do everything in our power to prevent that from happening." Liz Sidoti, *Obama Urges States to Use Recovery Money Carefully*, Associated Press, Mar. 20, 2009.

Of course, not everyone who detects fraud is going to be content to merely report it to the appropriate authority and move on. Opportunities will likely exist for some fraud detectors to share in the financial benefit of their efforts by pursuing claims under the False Claims Act's *qui tam* provisions. 31 U.S.C. §§ 3729-3733.

The False Claims Act is a federal statute, originally enacted in 1863, that provides for civil penalties against any person who, among other things, knowingly presents a false or fraudulent claim for payment to a contractor, grantee, or other recipient if the United States government provided any portion of the money or property which is requested or demanded. 31 U.S.C. § 3729(a)(1), (c).

The False Claims Act also contains *qui tam* provisions that, in certain circumstances, permit suits by private parties, on behalf of the United States, against anyone who violates the Act." *United States v. Lockheed Martin Eng'g & Sci. Serv. Co.*, 336 F.3d 346, 351 (5th Cir. 2003); 31 U.S.C. § 3730. The Act allows for a successful plaintiff, called a relator, to receive a percentage of any recovery based on the relative role of the relator and government in the case. 31 U.S.C. § 3730(d).

Needless to say, that was a vast oversimplification of a complex area of the law. The False Claims Act has centuries old underpinnings, a labyrinth of procedural requirements, a body of case law interpreting it that is legion and has been the subject of significant scholarly attention — much of it devoted to its general use and Constitutional issues. Even the name *qui tam* (pronounced kwe-tam) is complex. It is short for the Latin phrase *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, which means "who pursues this action on our Lord the King's behalf as well as his own." *Vt. Agency of Natural Res. v. United States*, 529 U.S. 765, 769 n.1 (2000).

If massive federal spending under the Stimulus Package is going to lead to *qui tam* suits, then, just as day follows night, claims will be made by parties seeking coverage, under their general liability policies, for a defense and any potential damages arising out of such suits. Enter *Health Care Industry Liability Insurance Program v. Momence Meadows Nursing Home*, in which the Seventh Circuit provided a primer on such issues.

At issue before the Seventh Circuit was the availability of coverage for a False Claims Act suit, filed by two former employees of Momence Meadows Nursing Home, who alleged that the nursing home violated Medicare and Medicaid requirements by submitting claims that failed to meet professionally recognized standards of healthcare. *Momence Meadows*, 566 F.3d at 691.

Momence Meadows sought a defense for the FCA suit (which also included whistleblower claims) under a policy issued to it by The Health Care Industry Liability Insurance Program ("Healthcap") that contained Commercial General Liability and Professional Liability coverage parts. *Id.* at 691-92. Healthcap filed an action seeking a declaration that it had no duty to defend or indemnify Momence Meadows for the underlying FCA suit. *Id.* at 691. The District Court held that Healthcap had no duty to defend Momence Meadows. *Id.* at 692.

On appeal, the Seventh Circuit examined the availability of coverage by focusing on the following policy language. The Professional Liability coverage part obligated Healthcap "to defend any suit seeking damages 'because of' an 'injury' that is caused by a 'medical incident' arising out of the providing or withholding of various professional services, including medical or nursing treatment. *Id.* at 694. The Commercial General Liability coverage part obligated Healthcap "to pay those sums Momence becomes legally obligated to pay as damages *because of* 'bodily injury' and to defend Momence against any 'suit' seeking those damages." *Id.* (emphasis added).

In an effort to trigger coverage, under both coverage parts, Momence Meadows pointed to the allegations in the FCA complaint of physical harm to the residents:

> That physical harm to the residents arose out of a medical incident, Momence asserts, because (according to the underlying complaint) it resulted from the provision of shoddy medical and nursing treatment. Momence therefore concludes that the underlying complaint seeks damages "because of" the physical harm to the residents. As Momence puts it, "[b]ut for the inadequate care and resulting bodily injury, there would have been no lost services and no false claim[s]."

Momence Meadows, 566 F.3d at 694.

The Seventh Circuit did not buy it. The court rejected Momence Meadows's argument by concluding that the statutory damages sought by the plaintiffs resulted from the allegedly false Medicare and Medicaid filings, and not from any alleged bodily injury to the residents. *Id.* at 694-95. "Although the allegations in the underlying complaint detailing the injuries suffered by Momence residents put a human touch on the otherwise administrative act of false billing, they need not be proven by the plaintiffs to prevail." *Id.* at 695.

The federal appeals court also noted that other courts around the country have recognized the distinction between the proof required for the FCA claim and the conduct underlying the false claims. *Id.* "They uniformly hold that an insurer is not obligated to defend a qui tam suit merely because the insurer would have to defend the insured against a suit for damages resulting from the insured's conduct underlying the qui tam action." *Id.*

***State Farm General Insurance Co. v. Mintarsih*, 175 Cal. App. 4th 274 (Cal. Ct. App. 2009)**

In *State Farm General Insurance Co. v. Mintarsih*, the Court of Appeal of California addressed the availability of coverage for attorney's fees awarded to an underlying plaintiff for securing damages that were themselves not covered. While this issue arises with some regularity, case law addressing it is sparse. For that reason alone, *Mintarsih* could have been selected as one of the year's ten most significant insurance coverage decisions. But there was another reason — which first requires some background.

Because of the sanctity of the duty to defend being broader than the duty to indemnify, insureds — not surprisingly — do not take it lightly anytime they perceive an insurer straying from this principle. One such circumstance is when an insurer, following a judicial determination that its duty to defend did not in fact exist, then attempts to recover defense costs from an insured to whom it nonetheless provided a defense.

Insureds typically respond that reimbursement of defense costs can not be allowed because it would amount to the insurer achieving, at the conclusion of the case, that which it was not permitted to do at the inception of the case, namely, treating the duty to defend as other than broader than the duty to indemnify. *See Perdue Farms v. Travelers Cas. & Sur. Co.*, 448 F.3d 252, 258 (4th Cir. 2006) ("[A] partial right of reimbursement [of defense costs] would thus serve

only as a backdoor narrowing of the duty to defend, and would appreciably erode Maryland's long-held view that the duty to defend is broader than the duty to indemnify.").

Nonetheless, despite this perceived challenge, litigation surrounding an insurer's right to reimbursement of defense costs has been active for the past fifteen years, with a significant spike in the past five. In general, insurers have been winning a few more of these cases than they've been losing. But the score is close.

The best known case on the subject of reimbursement of defense costs is *Buss v. Superior Court of L.A. County,* 939 P.2d 766 (Cal. 1997), holding that, in a so-called "mixed" action, in which some claims are potentially covered and others are not — thereby triggering a duty to defend the action in its entirety — an insurer may thereafter seek reimbursement of defense costs for claims that are not potentially covered. *Buss*, 939 P.2d at 776.

The Supreme Court of California rested its decision on the rationale that an insurer has not been paid premium to defend the insured against claims that are not even potentially covered. *Id.* Because the insurer did not bargain to bear these costs, it has a right of reimbursement that is implied in law as quasi-contractual. *Id.* Under the law of restitution such a right runs against the person who benefits from unjust enrichment and in favor of the person who suffers loss thereby. *Id.* at 777.

Now back to *Mintarsih*, where the Court of Appeal of California held that no coverage was owed for attorney's fees awarded to an underlying plaintiff for securing damages that were themselves not covered. In reaching this decision the court looked to *Buss* for guidance — and then some. *Mintarsih* cited to and quoted from *Buss* repeatedly.

In *Mintarsih* the Court of Appeal of California addressed the availability of coverage for attorney's fees awarded to a prevailing party in a wage and hour claim under the state's Labor Code. Specifically, Mimin Mintarsih brought an action against Dennis and Dina Lam alleging that from 1997 to 2004 she was falsely imprisoned in the Lams home and forced to work as a domestic servant. *Mintarsih*, 175 Cal. App. 4th at 280. The Lams sought coverage from State Farm under a homeowners and umbrella policy. *Id.* State Farm undertook the Lams defense subject to a reservation of rights, including to seek reimbursement of defense costs. *Id.*

A jury ultimately awarded Mintarsih $87,000 for false imprisonment and other tort claims, $2,500 in punitive damages against each defendant and close to $750,000 for the wage and hour violations. Id. The court subsequently granted Mintarsih's motion for attorney's fees and costs as the prevailing party on the wage and hour claims, awarding her $733,000 in attorney's fees and $161,000 in other costs. *Id.*

State Farm filed a declaratory judgment action against the Lams and Mintarsih seeking a determination of the parties' rights under the homeowners and umbrella policy. *Mintarsih*, 175 Cal. App. 4th at 280-81. Putting aside other issues, the Lams conceded that State Farm had no duty to indemnify the amount awarded for the wage and hour violations. *Id.* at 281. However, the Lams argued that State Farm was nonetheless obligated to pay the attorney's fees and costs for the wage and hour claims, even if they arose from a claim for which there was no coverage under the policies. *Id.*

The trial court held that State Farm had a duty to indemnify to Lams for the cost award of $161,000, but no duty to indemnify with respect to the attorney's fee award of $733,000. *Id.*

The case proceeded to the Court of Appeal of California, where State Farm did not challenge the lower court's finding that it was liable for the $161,000 cost award. *Id.* at 282, n.5. However, Mintarsih argued that the policies' supplemental payments provisions required State Farm to pay costs awarded against the Lams in suits it defends, *including attorney fees as costs*, even if the attorney's fees arise from claims that are not covered under the policies. *Id.* at 282.

Turning to the language of the State Farm policies, the company agreed in the homeowner's policy to pay "expenses we incur and costs taxed against an Insured in suits we defend." *Id.* at 284. Under the terms of the umbrella policy, State Farm agreed to pay "the expenses we incur and costs taxed against you in suits we defend." *Mintarsih*, 175 Cal. App. 4th at 284.

The court characterized these provisions as making the insurer's obligation to pay an award of costs against the insured dependent on the defense duty. *Id*. Once the court reached that conclusion, it's determination of coverage was inextricably tied to *Buss* and its rational as followed in *Golden Eagle Insurance Corp. v. Cen-Fed, Ltd.*, 148 Cal. App. 4th 976 (Cal. Ct. App. 2007). Based on *Buss*, the *Mintarsih* Court had no trouble concluding that State Farm was not obligated to pay attorney's fees as costs that can be allocated solely to claims that are not even potentially covered. *Id.* at 855.

The *Mintarsih* Court described the rationale for its decision as follows:

> [T]he duty to defend claims in a "mixed" action that are not potentially covered is not a contractual duty, and the reference in the supplemental payments provision to "suits we defend" encompasses only those claims that the insurer agreed to defend under the terms of the policy. Just as an insured could not reasonably expect to retain the benefit of an insurer's payment of defense costs that can be allocated solely to claims that were not even potentially covered (*Buss, supra,* 16 Cal.4th at pp. 51, 53, 65 Cal.Rptr.2d 366, 939 P.2d 766), an insured could not reasonably expect an insurer to pay costs that can be allocated solely to claims that were not even potentially covered.

Id.

Despite the *Mintarshi* Court's allegiance to *Buss*, the decision could nonetheless be followed by courts that reject *Buss* as completely incompatible with the breadth of the duty to defend. As the *Mintarshi* Court's decision did nothing to prevent the insured from obtaining a complete defense, courts that have been hostile toward *Buss* may not be troubled by the decision.

***North American Capacity Insurance Co. v. Claremont Liability Insurance Co.*, 177 Cal. App. 4th 272 (Cal. Ct. App. 2009)**

There are a couple of reasons why construction defect claims have been so expensive for insurers — in addition to their exposure for the claims themselves. First, the litigation frequently leads to enormous defense costs. A case may start out simple enough — property owner sues builder for defective construction. But then the builder files a third-party action against a dozen or more subcontractors. Each of the third-party defendant subcontractors then file a fourth-party action against their own subcontractors. It does not take long before there are twenty-five contractors in the case — regardless of whether they have any relationship to the defective work. And each one of the defendant-contractors — even the one that installed the doorbell — will need to be vigorously defended in the litigation. This means that their counsel will need to become familiar with dozens of boxes of documents, attend fifty-seven depositions and deal with umpteen experts. Under such circumstances, the defense costs can not help but become significant, especially compared to some defendants' ultimate exposure. [And, incidentally, considering that each contractor-defendant may have two or three involved insurers, plus their coverage counsel, the inevitable mediation that is held, in an effort to help settle the case, needs to be at Madison Square Garden.]

The second reason why construction defect claims have been such a drain on insurers is that a general liability policy, issued to a contractor, may have been priced on the basis that the insurer's exposure will be minimized by the insured's entitlement to (1) contractual indemnity from its subcontractors; and (2) additional insured rights from its subcontractors' insurers. Of course, while this may be the case on paper, the reality is sometimes much different.

Unfortunately for insurers, unless they are issuing policies to the Felix Unger's of contractors, or contractors that have in-house legal departments, it is not infrequently the case that their insureds did not do everything, or sometimes anything, to effect any risk transfer to their sub-contractors. The insureds, perhaps relying on personal relationships and past positive experiences when choosing their subcontractors, or because the job is small, may operate simply based on a handshake or loosely written agreement.

As a result, risk transfer techniques — even basic ones — are not always employed by insureds. And who pays the price for such sloppy business practices? Not the one at fault. Rather, the contractor's insurer, who has now lost the opportunity that it should have had,

to transfer its insured's exposure to a down-chain subcontractor, is left holding the bag. This is likely one reason why some insureds come up so short in securing effective contractual indemnity agreements from their subcontractors, and actually being named as additional insureds, for purposes that matter, on their subcontractors' policies.

In other words, the reason why some insureds are poor at employing basic risk transfer techniques is likely because there is no penalty imposed on them for being so. After all, as far as the insured may be concerned, it employed a risk transfer technique — it bought insurance, didn't it? Thus, unless an insurer can prospectively review every contract that its insureds enter into, the insurer is at its insureds' mercy to protect the insurer's interests — something that the insureds may not be qualified nor incentified to do. This is the hand that the claims department is often dealt — and it is not the idyllic picture that the underwriter may see when prospectively evaluating and pricing the risk.

Some insurers have grown tired of paying the price for their insureds' *laissez faire* approach to risk transfer and risk management. They have begun to include endorsements in their policies that essentially preclude coverage to the insured, for a loss arising out of a subcontractor's operations, if the insured did not obtain an indemnity agreement from the subcontractor and proof that the subcontractor is insured (and sometimes also proof that the insured was named as an additional insured on the subcontractor's policy). In other words, some insurers are making their insureds real partners in the insurance relationship — by requiring them to have some skin in the game when it comes to prudent risk management. You can try to educate insureds about doing business prudently as a contractor, but that may be slow going. The fastest way to teach them will be if there are financial consequences for failure to do their lessons. Losing money has a way of making people fast learners.

In *North American Capacity Insurance Co. v. Claremont Liability Insurance Co.,* the Court of Appeal of California addressed an insurer's endorsement that was designed to minimize the consequences to the insurer for its insured's failure to employ basic risk transfer measures. At issue was a cost sharing dispute between two insurers that collectively paid to settle a construction defect claim against their mutual insured. *North American Capacity Ins. Co.*, 177 Cal. App. 4th at 276. North American Capacity challenged the trial court's determination of its allocable share. *Id.* The trial court based its decision on the existence of a Contractors Warranty Endorsement contained in the Claremont policy that provided as follows:

> In consideration of the premium charged, it is hereby understood and agreed that such coverage as is afforded by this policy shall not apply to operations performed by independent contractors unless: [¶] 1. The insured has received a written agreement from each and every independent contractor holding the insured harmless for all liabilities incurred by the independent contractor. [¶] 2. The insured has obtained certificates of insurance from each and every independent contractor indicating that the independent contractor will maintain similar coverage as provided by this policy and with limits as shown in the above schedule, unless otherwise agreed to in writing by the company. Failure of the independent contractor to maintain similar coverage as provided by this policy and with limits as shown in the above schedule shall not invalidate this policy but in the event of such failure, the company shall only be liable to the same extent as we would have been had the independent contractor maintained such coverage and limits of insurance.

Id. at 280, n.5.

Putting aside a plethora of other issues, the Court of Appeal examined the Contractors Warranty Endorsement contained in the Claremont policy and enforced it against an insured that failed to comply with its terms for eight of thirteen sub-contractors that it had retained for a project. The court, concluding that the endorsement was a condition of coverage and was conspicuous, plain and clear, held as follows:

> JDG [general contractor] knew, or is presumed to have known, of this precondi-

> tion prior to acceptance of the Claremont policies. JDG could have protected itself by obtaining from its independent contractors agreements for indemnity and certificates of insurance before entering into the policy or by seeking modification of this policy term, e.g., by paying a larger premium. Indeed, JDG's president testified, and the trial court found, that it was JDG's normal practice to obtain hold harmless agreements and certificates of insurance for projects on which JDG worked. Merely requiring that JDG continue its normal business practice of obtaining hold harmless agreements and certificates of insurance as a precondition to coverage did not render either the Claremont primary or umbrella insurance contractors warranty endorsements impossible of performance.
>
> We find the "clear and explicit" meaning of the contractors warranty endorsements, as used in their "ordinary and popular sense" by a layperson establishes a precondition of coverage as to work done by subcontractors for whom JDG failed to secure both a written hold harmless agreement and a certificate of insurance. The trial court therefore did not err in finding the contractors warranty endorsement enforceable under the facts of this case.

Id. at 290.

By enforcing the Contractors Warranty Endorsement contained in the Claremont policy, Claremont was entitled to disclaim coverage for damages caused by contractors for whom the insured general contractor failed to comply with its requirements. This enabled the appellate court to uphold an allocation that placed, what should have been some of Claremont's liability, on NAC.

North American Capacity is not the first court to address, and uphold, a Contractors Warranty Endorsement. *See Scottsdale Ins. Co. v. Essex Ins. Co.*, 98 Cal. App. 4th 86 (Cal. Ct. App. 2002) (addressed in detail in *North American Capacity*). Granted, while the court in *North American Capacity* upheld the Contractors Warranty Endorsement, the insured at issue, under these particular circumstances, was not penalized for it. Nonetheless, for insurers that are using Contractors Warranty Endorsements, or something similar, and perhaps not aggressively enforcing them, or for insurers considering their use for the first time, *North American Capacity* may be a push that they need in that direction.

***Baughman v. United States Liability Ins. Co.*, 08-2901, 2009 U.S. Dist. Lexis 106400 (D.N.J. Nov. 12, 2009)**

The debate over the applicability of the pollution exclusion is well-known by anyone in the claims business. No doubt you don't want to hear it again any more than I want to write about it. To make a long story short, in general, and without regard to specific policy language, some states apply the pollution exclusion broadly, based on its plain meaning, and hold that it precludes coverage for injury and damage caused by irritants or contaminants of every type. Other states apply the pollution exclusion narrowly, and hold that it precludes coverage solely for injury and damage caused by so-called "traditional environmental pollution," which is generally held to mean industrial pollution. So if the injury or damage was caused by non-traditional environmental pollution, say, carpet fumes, then the pollution exclusion will not serve to preclude coverage.

When pollution claims arise in states that are in the latter camp, such as New Jersey (*see Nav-Its, Inc. v. Selective Ins. Co.*, 869 A.2d 929 (N.J. 2005)), the court's task is to decide whether the irritant or contaminant at issue qualifies as traditional environmental pollution. If it does not, then the pollution exclusion will not serve as a basis to preclude coverage.

In *Baughman v. United States Liability Insurance Co.*, the District Court of New Jersey was required to answer the question whether mercury qualified as traditional or non-traditional environmental pollution. The coverage issue arose as follows.

In 2005, Becky and Stephen Baughman purchased Kiddie Kollege Daycare & Preschool, an existing daycare center. *Baughman* at *2. In 2006, Becky was informed by the New Jersey Department of Environmental Protection that the daycare building was uninhabitable due to mercury contamination. *Id.* at *3. It was undisputed that the alleged mercury

contamination was on account of a thermometer manufacturing company that operated in the building twenty years earlier. *Id.*

Lawsuits were filed by children that attended the daycare center and employees, against the Baughmans, the daycare center's prior owner, the property owner, the thermometer manufacturer and several governmental entities, alleging that the mercury contamination in the building was well known for a long period of time. *Id.* at *4-5. The suits alleged that, despite this knowledge, the unremediated property was permitted to be converted to a daycare center. *Id.* at *6. Among other things, the plaintiffs sought the creation of a trust for the purposes of funding medical monitoring. *Id.* at *8-10.

Becky Baughman was the named insured under a commercial general liability policy issued by USLIC. *Id.* at *1-2. USLIC disclaimed coverage to the Baughmans for defense an indemnity for the underlying action. *Id.* at *1.

The New Jersey District Court first concluded, following a lengthy analysis, that the demands in the underlying actions for medical monitoring qualified as damages for bodily injury, and, hence, fell within the CGL policy's coverage grant. *Id.* at 25.

The *Baughman* Court next addressed the applicability of the pollution exclusion – which appears to be a "total" pollution exclusion, despite it being referred to in the opinion as the "absolute" variety. *Id.* at *10-11. Not surprisingly, the court turned first to the New Jersey Supreme Court's decision in *Nav-Its* for resolution of the issue. *Id.* at *26. In *Nav-Its*, the supreme court interpreted a similar pollution exclusion and concluded that its scope "should be limited to injury or property damage arising from activity commonly thought of as traditional environmental pollution." *Id.* at *26-27 (quoting *Nav-Its* at 937). Consequently, the *Nav-Its* Court concluded that the pollution exclusion did not preclude coverage for a suit by a physician exposed to fumes as a result of painting, coating and floor sealing work in his office. *Id.* at *27.

The *Baughman* Court observed that *Nav-Its* "does not provide much specific guidance on the meaning of 'traditional environmental pollution,' beyond the observation that the exclusion was intended to avoid liability for 'environmental catastrophe related to intentional industrial pollution.'" *Id.* at *27 (quoting *Nav-Its* at 937). Faced with this limitation, the *Baughman* Court sought guidance from the cases from other jurisdictions on which the *Nav-Its* Court relied, as well as the cases on which those cases relied. *Id.* at *27, *29-30. Taking this approach, the court determined that an examination of such cases led to the conclusion that [even if such cases did not say so specifically] "traditional environmental pollution does not include exposure to toxic materials released indoors and thus does not include mercury contamination in Kiddie Kollege." *Id.* at *28. Further, the court stated that "[w]hile the mere presence of contaminant outdoors is not necessarily sufficient, exposure to indoor contaminants is not traditional environmental pollution as defined by the New Jersey Supreme Court." *Id.* at *31 (citation omitted).

The flaw in *Baughman* is this. *Nav-Its* supposedly did not provide specific guidance on the meaning of "traditional environmental pollution," beyond the observation that it is "environmental catastrophe related to intentional industrial pollution." This left the *Baughman* Court to have to look for additional guidance. But what additional guidance did it need? How else would you describe injury sustained by numerous people, on account of exposure to a highly hazardous substance such as mercury, which was caused by the failure to remediate waste from the operations of a thermometer manufacturing company, as anything other than an environmental catastrophe related to intentional industrial pollution. Based on the explicit test in *Nav-Its*, there was no need for the *Baughman* Court to adopt an indoor-outdoor distinction for purposes of determining if the mercury at issue qualified as traditional environmental pollution.

Baughman is not the first court to resolve the traditional versus non-traditional environmental pollution issue by specifically adopting the indoor-outdoor distinction. *See Connecticut Specialty Ins. Co. v. Loop Paper Recycling, Inc.*, 824 N.E.2d 1125 (Ill. App. Ct. 2005). Nor is *Baughman* the first court to avoid applicability of an otherwise applicable pollution exclusion when the underlying claims involved injuries sustained by children. *See Porterfield v.*

Audubon Indemnity Co., 856 So. 2d 789 (Ala. 2002) *rehearing denied,* 2003 Ala. Lexis 291 (holding that lead-based paint is a pollutant, but that the pollution exclusion nonetheless did not bar coverage because lead-paint flakes, chips, and/or dust did not qualify as a discharge, dispersal, release, or escape of a pollutant); *see also Lititz Mutual Ins. Co. v. Steeley*, 785 A.2d 975 (Pa. 2001) (same).

Baughman's legacy may be that, when it comes to the pollution exclusion, New Jersey courts have shown themselves to be influential on others around the country. And that's not surprising. After all, if I had a claim involving damage caused by pineapples, I'd want to know how courts in Hawaii have treated the issue. In any event, Becky Baughman is now policyholders' favorite Jersey Girl. ■