

Insurance

Two Thousand And Unleaven: A Flat Year For Insurance Coverage

11th Annual Review Of The Year's Ten Most Significant Coverage Decisions

4th Annual "Coverage For Dummies And Inane Observations"

by
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Commentary

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[Editor's Note: © 2012 by the Authors. Randy J. Maniloff is a Partner in the Business Insurance Practice Group at White and Williams, LLP in Philadelphia. He concentrates his practice in the representation of insurers in coverage disputes over various types of claims. He writes frequently on insurance coverage topics for a variety of industry publications (including, for the eleventh time, this review for Mealey's Litigation Report: Insurance of the year's ten most significant insurance coverage decisions). Maniloff's views on coverage issues have been quoted by numerous media including The Wall Street Journal, The New York Times, USA Today, Associated Press, Dow Jones Newswires, The Philadelphia Inquirer, The Times-Picayune and The National Law Journal. In February Maniloff will publish the 2nd Edition of "General Liability Insurance Coverage: Key Issues In Every State," a book that addresses the law in all 50 states, and the District of Columbia, on twenty-one key liability insurance coverage issues (Oxford University Press) (Co-authored with Professor Jeffrey Stempel of the University of Nevada Las Vegas Boyd School of Law). Joshua A. Mooney is Counsel in the Business Insurance Practice Group and Intellectual Property Group at White and Williams, LLP in Philadelphia. His practice primarily focuses on representing insurers in coverage litigation and bad faith matters under commercial general liability and various professional liability policies. Many of his cases involve complex and emerging issues under insurance law, including invasion of privacy rights and new

media, greenwashing, intellectual property, construction defect, additional insured coverage and contractual indemnification. All uses of the first person are references to Maniloff. The views expressed herein are solely those of the authors and not necessarily those of White and Williams or its clients. Responses are welcome.]

Everyone is entitled to an off-day once in a while. Even those who are the best at what they do put up a clunker now and then. I mean, Lloyd Webber gave us CATS, didn't he?

And that is not unlike what 2011 was for insurance coverage. In most years, with courts issuing thousands of decisions addressing insurance coverage issues, finding many that could qualify as one of the ten most significant is like putting a hot knife through butter. The pool of candidates is an embarrassment of riches. There are usually two dozen or so decisions that could all lay claim to being one of the year's ten most significant. The harder task is to scrutinize this list and, using the factors discussed below, cull it down to only the ten that qualify as the pick of the litter.

But 2011 was different. Instead of the usual abundance of decisions that could be best in show, there were barely ten in total. It was the pick of the litter box. There is little doubt that, in the eleven years of preparing this annual insurance coverage hit parade, the

eleventh year of the third millennium had the least to offer in the way of significant judicial decisions. While a list of ten standouts was capable of being created, doing so was no easy task. It was like choosing the ten best episodes of *The Love Boat*. And some of the coverage decisions that were chosen as one of the year's ten most significant would not have made the cut in a more bountiful year.

For insurance coverage, 2011 was the year that coughed up a fur ball. But at least we have our memories of the time we knew what happiness was. Look, a new day has begun.

4th Annual "Coverage For Dummies And Inane Observations"

Reading a lot of insurance coverage cases makes you realize that some people do really dumb stuff. Their shocking behavior causes injury and not long after a lawsuit is filed against them. The tomfool then makes an insurance claim. Somehow they still know enough to do that. For the past three years, this annual insurance coverage best-of has included a special report – Coverage for Dummies. "Dummies" has been a look at several examples from the past year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain.

In addition, the entertainment value of coverage cases isn't limited to this window into the world of the common-sense challenged. Coverage cases also have this way of including all sorts of interesting tidbits. While perhaps not important or relevant to anything, and sometimes just plain inane, their out of the ordinary quality makes them something that ought to be shared. The Insurance Coverage Top 10 is committed to not allowing these decisions to simply disappear into the bowels of Lexis. In no particular order, here is "Coverage for Dummies and Inane Observations" for 2011:

1. Hawaii federal court rejected the opportunity to be the first in the country to address whether dog poop on another's property is "property damage." Now *that's* a doodie to defend case. See *State Farm Fire & Cas. v. Cabatbat*, No. 09-532, 2011 U.S. Dist. LEXIS 14560 (D. Hawaii February 11, 2011).
2. A teeny weenie misunderstanding between neighbors, who speak English as a second language, as to the difference between "cutting" and "trimming" trees. Oops. See *State Farm Fire & Cas. Co. v. Kwing On Ng*, No. 64515-3-I, 2011 Wash. App. LEXIS 722 (Wash. Ct. App. Mar. 28, 2011).
3. Bad idea to light a pilot light in an oven that does not have one. See *Nationwide Mut. Fire Ins. Co. v. Parker's Propane Gas Company*, No. 299068, 2011 Mich. App. LEXIS 1694 (Mich. Ct. App. Sept. 27, 2011).
4. Also in the bad idea with matches category: Bartender poured Bacardi 151 onto the surface of a bar and lit it. The alcohol exploded and engulfed a patron in flames. *Brother Jimmy's BBQ, Inc. v. American International Group, Inc.*, No. 105077/09, 2011 NY Slip Op. 31295U (N.Y. Super. Ct. May 17, 2011).
5. Restaurant sought coverage for claims that it kept tips charged to customers' credit cards and that its managers had their fingers in the tip jar. See *New Orleans Deli & Dining, LLC v. Continental Cas. Co.*, No. 10-4642, 2011 U.S. Dist. LEXIS 111928 (E.D. La. Sept. 28, 2011).
6. Michigan federal court addressed coverage for insured for claims that he hired an underage woman to assist him with testing sex toys that he was designing for, get this. . . the military. See *Keely v. Fire Ins. Exchange*, No. 10-13707, 2011 U.S. Dist. LEXIS 69500 (E.D. Mich. June 28, 2011).
7. Insurer not liable for injuries sustained by the housekeeper when she tripped over Buddy – the family's Shitzu puppy. Buddy's other misdeed – getting underneath the blankets when the housekeeper was trying to change the beds. Court held: "[P]laintiffs could not make a showing that Buddy presented an unreasonable risk of harm to Ms. Williams." See *Williams v. Farm Bureau Ins. Cos.*, No. 2011 CA 0487, 2011 La. App. LEXIS 1340 (La. Ct. App. Nov. 9, 2011).
8. Bad idea to bring a rifle to a school board meeting – even in West Virginia. See *Taylor v. Erie Ins. Prop. & Cas. Co.*, No. 2:10-1300, 2011 U.S. Dist. LEXIS 44520 (S.D.W.Va. Apr. 25, 2011).

9. Connecticut trial court addressed coverage for woman for claims that she served a ginger cake containing marijuana. Hey, wait a minute, Martha Stewart lives in Connecticut. See *Safeco Ins. Co. v. Glass*, No. CV106007133, 2011 Conn. Super. LEXIS 874 (Conn. Super. Ct. April 8, 2011).
10. Proof that *Owens-Illinois* has no limits on its attempted use. New Jersey appellate court rejected the continuous trigger for viewing pornography in the workplace. We've come a long way since asbestos. See *General Security National Ins. Co. v. N.J. Intergovernmental Ins. Fund*, No. A-5591-08T1, 2011 N.J. Super. Unpub. LEXIS 2288 (N.J. Sup. Ct. App. Div. Aug. 25, 2011).
11. The real Travelers succeeds in shutting down insurance advertising site Travellers.com. So much for my idea to register Heartford.com. See *The Travelers Indemnity Co. v. Travellers.com*, No. 10-448, 2011 U.S. Dist. LEXIS 136447 (E.D. Va. Nov. 28, 2011).
12. Minnesota federal court addressed coverage for claims against a real estate agent that showed a house — and that's not all he showed — while its owners were out of the country. Warning: Purell required. See *Safeco Ins. Co. v. Skar*, No. 10-4789, 2011 U.S. Dist. LEXIS 82548 (D. Minn. July 27, 2011).
13. Michigan appeals court addressed coverage for thirteen year old that placed opposing basketball player in a headlock and then threw him to gym floor, causing him to suffer an acute head injury with associated seizures, two hematomas on his head, soft tissue injuries, a bruised and/or fractured iliac crest of his hip bone, photophobia and post-concussion syndrome. The same conduct by Michael Jordan would not have drawn a foul. See *Auto Club Group Ins. Assoc. v. Andrzejewski*, No. 297551, 2011 Mich. App. LEXIS 888 (Mich. Ct. App. May 17, 2011).
14. Seventh Circuit Court of Appeals, in addressing coverage for construction defects, confirmed that the Titanic's sinking was an accident. See *Continental Cas. Co. v. Sycamore Springs Homeowners Assoc.*, 652 F.3d 804 (7th Cir. 2011).
15. A fight-between-neighbors coverage case as good as any you'll find: Among lots of other unfriendly things, one neighbor shined spot lights on the other's property that were of such high intensity that they interfered with the targeted neighbors' sleeping patterns and presented a danger to the Native Hawaiian shearwater birds in the area. See *Hartford Underwriters Ins. Co. v. Masters*, Nos. 10-629 and 11-174, 2011 U.S. Dist. LEXIS 59306 (D. Hawaii June 2, 2011).
16. Elevator maintenance company performed work at a hospital and disposed of used hydraulic fluid in fifteen gallon plastic barrels that previously contained — and were still labeled for — surgical cleaning solutions. You can see where this is going. As many as 3,650 patients may have had surgical procedures using instruments that had been washed in hydraulic fluid. See *Mitsui Sumitomo Ins. Co. of Am. v. Automatic Elevator Co.*, No. 09-480, 2011 U.S. Dist. LEXIS 103165 (M.D.N.C. Sept. 13, 2011).
17. Friendly ritual between buddies of hitting each other in the groin goes just a little too far. As mom always said, it's all fun and games — until someone suffers a hematocele on the right scrotum. See *State Farm Gen. Ins. Co. v. Frake*, 197 Cal.App. 4th 568 (2011).
18. When you intentionally hit someone with your car, even if you just slowly roll forward into them, you cannot avoid the "intentional act" exclusion by maintaining that "it was nothing" and concluding that any sober person could and would have moved. Oh, did I mention, the victim was missing part of one leg and using crutches. See *Hurst v. Southern Farm Bureau Cas. Ins. Co.*, No. 11-162, 2011 Ark. App. LEXIS 701 (Ark. App. Ct. Nov. 2, 2011).
19. Court addressed coverage for injury to a patron of the Lucky Lounge who alleged

that, while being ejected from the back door, he fell down several concrete steps, landed on his head, lost consciousness and began bleeding from his ear. Lucky Lounge employees allegedly returned inside and left him bleeding and unconscious on the sidewalk. See *Indemnity Ins. Corp. v. Austin Lucky Lounge, LP*, __ N.E.2d __ (Ind. Ct. App. 2011). It should be called the Lucky To Be Alive Lounge.

20. Quote of the year from a coverage case: "This is a difficult case. The main problem with this case is that it centers on an insurance policy that is terribly written." And, with that, the judge was just getting warmed-up in providing his thoughts about the policy. See *Unitedhealth Group, Inc. v. Columbia Cas. Co.*, No. 05-CV-1289, 2011 U.S. Dist. LEXIS 148422 (D. Minn. Dec. 27, 2011).

How The Ten Most Significant Insurance Coverage Decisions Are Chosen

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

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

selecting the year's ten most significant insurance coverage decisions, the potential to have future influence *nationally* is everything.

For example, in 2011 Maryland's highest court held that an insurer seeking to disclaim coverage on the basis of late notice under a claims-made policy must prove that it was prejudiced. See *Sherwood Brands, Inc. v. Great Am. Ins. Co.*, 13 A.3d 1268 (Md. 2011). The requirement for late notice prejudice under a claims-made policy is very unique. But because the decision is tied to a Maryland statute, it is unlikely to have any national influence. Also on the subject of late notice, Nevada's highest court held in 2011 that an insurer must show prejudice before it may properly deny coverage to an insured under an "occurrence" policy based on late notice. See *Las Vegas Metro Police Dep't v. Coregis Ins. Co.*, 256 P.3d 958 (Nev. 2011). This decision provided much needed clarification on the late notice issue in Nevada. But given that the court's conclusion is the long-held majority view, with no shortage of decisions nationally addressing the issue, *Las Vegas Metro.* is hardly the stuff of a decision that other courts around the country will run to for guidance. Thus, neither of these late notice coverage decisions was selected – or even considered – for inclusion as one of 2011's ten most significant.

Another example of an important decision in 2011 left on the Top 10 sidelines was the Supreme Court of New Jersey's decision in *Abouzaid v. Mansard Gardens Associates, LLC*, 23 A.3d 338 (N.J. 2011). *Abouzaid* may have important ramifications for the Garden State's duty to defend standard. But given that duty to defend standards are so state specific, not to mention that New Jersey's duty to defend rules are a world unto themselves, *Abouzaid* was not selected for inclusion as one of 2011's ten most significant coverage decisions.

As I remind readers every year, the process for selecting the year's ten most significant insurance coverage decisions is highly subjective, not in the least bit scientific, and in no way democratic. But just because the selection process has no accountability or checks and balances whatsoever does not mean that it wants for deliberativeness. To the contrary, the process is very deliberate. It resembles that famous picture of the baldish guy who is using a giant magnifying glass to scrutinize hanging chads on a ballot during the Florida recount in the 2000 Presidential election. That's how

much careful consideration goes into choosing the year's ten most significant insurance coverage decisions. So there is plenty of deliberation. It's just that only one person is deliberating.

The Ten Most Significant Insurance Coverage Decisions Of 2011

Below are the ten most significant insurance coverage decisions of 2011 (listed in the order that they were decided):

- *Great American E & S Ins. Co. v. Quintairos, Prieto, Wood & Boyer, P.A.* – Seven Mississippi Rush: State's appeals court allows excess insurer to get two hands on negligent defense counsel.
- *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.* – Northern District of California held that the sale of "cheap, synthetic knock-offs" — *i.e.*, counterfeits — can constitute "personal and advertising injury." For real.
- *Union Carbide Corp. v. Affiliated FM Ins. Co.* – New York's highest court applied a simple approach to a complex follow-form program. Will other courts now follow form?
- *Schmitz v. Great Amer. Assurance Co.* – Perplexcess Insurer: Supreme Court of Missouri handled drop-down in a way that will leave excess insurers' chins, err, dropped-down.
- *State Farm Fire and Cas. Co. v. Vogelgesang* – From Hawaii: macadamia nuts, coconuts and proof that coverage for construction defects has become just plain nuts. District Court demonstrated how so.
- *DeMarco v. Travelers Ins. Co.* – Rhode Island Supreme Court explained insurer's duty to settle when faced with the "Sisyphian challenge" (we had to look that up too) of having multiple claims against an insured that collectively exceed the policy limit.
- *Mosser Construction, Inc. v. The Travelers Indem. Co.* – Sixth Circuit held that the

meaning of "subcontractor," in the "subcontractor exception" to the "your work" exclusion, was ambiguous. Imagine that – something about construction defect coverage found to be ambiguous. Memo to ISO – Something to mull over.

- *AES Corp. v. Steadfast Ins. Co.* – Supreme Court of Virginia gave a chilly reception to insured seeking coverage for global warming response costs.
- *Lennar Corp. v. Transamerica Insurance Co.* – Arizona appeals court adopted a novel solution to the dispute over payment for an insured's independent counsel fees — and created the second-ever insurance coverage superhero in the process.
- *Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc.* – New England claim chatter: Massachusetts appeals court converted a CGL policy to an Employment Practices Liability policy.

Discussion Of The Ten Most Significant Insurance Coverage Decisions Of 2011

Great American E & S Ins. Co. v. Quintairos, Prieto, Wood & Boyer, P.A., __ So. 3d __, 2011 Miss. App. LEXIS 20 (Jan. 18, 2011 Miss. Ct. App. 2011)

On one hand, *Great American E&S Ins. Co. v. Quintairos, Prieto, Wood & Boyer* does not involve a "coverage" issue, in the usual sense of that term. On the other hand, it clearly involves claims handling and the amount of an insurer's liability for a covered claim. For these reasons, and because the decision addresses an issue that is without a lot of judicial guidance – and reaches a conclusion that is contrary to some of the few cases that do exist – it warranted a spot as one of the year's Top 10 coverage cases.

At issue before the Court of Appeals of Mississippi was whether an excess insurer can sue its insured's defense counsel, who had been retained by the primary insurer, alleging that, because counsel mishandled the defense, it resulted in an unnecessarily large settlement, that increased the excess insurer's liability.

It is not entirely surprising that a situation like this would arise. In general, defense counsel is chosen by the primary insurer. Unlike the primary insurer, who may have a long-standing panel relationship with defense counsel, the excess insurer may not know defense counsel from Adam. Given this lack of a personal relationship, and that counsel was hired by the primary insurer, the excess insurer may not be getting the same frequency of status reports as the primary insurer. Likewise, the excess insurer may not be as involved in the case's day-to-day activities as the primary insurer. In addition to reporting deficiencies, defense counsel also may be painting too rosy of a picture of the insured's potential to avoid liability or significant damages. Defense counsel may not be making the excess insurer aware of the true potential for an unfavorable outcome. Because of this, the excess insurer may not be monitoring the case as closely as it otherwise would, if the case were on its radar as one having a chance of impacting its policy.

For all these reasons, a higher than expected verdict or pre-trial settlement demand may come as more of a surprise to the excess insurer than the primary insurer. And, insurance companies do not like surprises (despite being in what is essentially the business of surprises). What's more, if defense counsel commits malpractice, or fails to accurately report on the problems in a case, it may be a "no harm, no foul" situation for the primary insurer. After all, the claim may have exhausted the primary policy's limits no matter what defense counsel did. Therefore, the consequences of defense counsel malpractice, overly optimistic reporting or deficient reporting, can be much greater for the excess insurer than the primary insurer. Yet, on its face, it would appear that the excess insurer has a harder road to travel if it wishes to sue defense counsel, since it was probably the primary insurer that hired counsel. In other words, the excess insurer has no privity with defense counsel. That is certainly the rationale used by some courts to preclude excess insurers from bringing malpractice actions against defense counsel.

In *Quintairos*, an excess insurer believed that defense counsel's handling of a case resulted in it having greater exposure. The excess insurer was none too pleased and sought recompense. Unlike some of the few other courts to have addressed the issue, the Court of Appeals of Mississippi cleared the way.

Shady Lawn Nursing Home was named as a defendant in nursing home liability suits. *Id.* at *1. Shady Lawn was insured by Royal under a primary policy and had an excess policy through Great American. *Id.* at *3. Royal hired the Quintairos firm to defend the cases against Shady Lawn and the firm sent Royal and Great American periodic updates regarding the status of proceedings and estimated settlement value of the cases. *Id.* However, "Great American allege[d] that the status updates consistently undervalued the underlying cases so as to intentionally avoid giving Great American notice that its excess coverage may be needed. Other concerns with the Quintairos firm were that the partners and trial counsel were not licensed to practice law in Mississippi and the attorneys had failed to designate medical experts in a timely manner. Great American contende[d] that it did not learn of these problems until Quintairos issued a litigation report valuing the expected cost of the case to be between \$3 million and \$4 million. Quintairos had previously projected the cost to be \$500,000." *Great American* at *3-4.

The Mississippi court of appeals first held that the excess insurer could not bring a direct claim for malpractice against defense counsel. The court held that, because "[n]o Mississippi case law exists abolishing the requirement of an attorney-client relationship in regard to an excess insurer," the court did "not have authority to sanction a direct action for legal malpractice. *Id.* at *10.

However, the *Quintairos* Court also held that Great American *could recover* through equitable subrogation, which would permit Great American to enforce the existing duties of defense counsel to the insured and recover damages if negligence were found. *Id.*

The *Great American* court explained its decision as follows:

It is logical that an excess-insurance carrier should be allowed to pursue a claim in the insured's place. Shady Lawn had no incentive to pursue a legal-malpractice claim against Quintairos even if it believed Quintairos to be negligent because it had insurance in place to pay the settlement. Also, Royal had no incentive to pursue a claim if it believed the settlement value to be at or near the policy limits of the primary coverage regardless of

the alleged malpractice. The only winner produced by an analysis precluding liability would be the malpracticing attorney. We recognize that a possibility exists that this may result in frivolous claims by excess-insurance carriers; but, for this Court to prohibit legitimate claims would leave the attorney who allegedly committed malpractice free from consequences if the primary insurer declined to pursue a claim. Also, we find that a conflict is not created by allowing Great American to seek equitable subrogation against Quintairos for legal malpractice. Great American and Shady Lawn have the same interest in this litigation – Shady Lawn's competent representation. Further, Quintairos has already shared attorney-client communications and work product with Great American in the underlying cases.

Id. at *11-12 (citation and internal quotes omitted).

The moral of the *Quintairos* story for defense counsel is obvious, as is the significance of the right that the court handed to excess insurers. Again, when a case goes south, the consequences for an excess insurer can be monumental, while the consequences for the primary insurer may be non-existent. *Quintairos* gives the party with the most at stake in this situation the right to seek compensation.

***Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.*, 761 F. Supp. 2d 904 (N.D. Cal. 2011)**

Coverage for counterfeiting actions is not contemplated under the “personal and advertising injury” section of a commercial general liability policy. However, traffickers around the country of counterfeit name brand merchandise, such as Ugg[®], The Northface[®], or Gucci[®], to name just a few, may use the Northern District of California's decision in *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.* to argue that their actions do constitute “personal and advertising injury,” under the theory that the sale of counterfeits inherently results in disparagement.

Because counterfeit merchandise is manufactured to imitate a well-known product in all details of construction and appearance, consumers may unknowingly believe they are purchasing genuine merchandise

when, in fact, they are not. Alternatively, consumers may knowingly purchase counterfeit items because the items may be had at dramatically lower prices than the real thing. Either way, intellectual property holders often claim damage through trademark dilution and loss of goodwill, materialized either because (1) when a customer has unknowingly purchased a counterfeit product of inferior quality, the customer will blame the intellectual property holder for the product's ultimate failure, or (2) even when a customer knowingly has purchased a counterfeit product of inferior quality, third-parties will not realize this fact and will blame the product's failings on the genuine product and the intellectual property holder. In both instances, the intellectual property holder will likely claim that its reputation, and the reputation of its product, have been injured.

In *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.*, the District Court for the Northern District of California held that such claims are sufficient to implicate defense and liability coverage under the definition of “personal and advertising injury,” concluding that such claims constitute ones for disparagement.

The insured, Michael Taylor Designs, Inc. (“MTD”), was a furniture retailer sued for allegedly infringing the trade dress of one of its former suppliers by offering “cheap synthetic knockoffs” of that supplier's high-end wicker furniture products. The underlying complaint alleged that MTD had a business relationship with furniture designer Ivy Rosequist in which MTD acted as the exclusive sales agent for Rosequist's high-end line of wicker furniture. *See* 761 F. Supp. 2d at 907. The relationship soured when MTD began selling synthetic wicker products that Rosequist contended were unlawful copies of her designs. *Id.*

Rosequist thereafter filed a two count complaint against MTD, alleging breach of contract and violation of the Lanham Act. *Id.* Rosequist's Lanham Act claim alleged that MTD had distributed promotional materials to its customers that contained photographs of Rosequist's distinctive and high-quality furniture, but that MTD then pulled a “bait-and-switch” by selling in its showroom “cheap synthetic knock-offs” of Rosequist's merchandise, running the risk that consumers would be confused and misled as to the origin of the knock-off items. *Id.* Rosequist claimed MTD's actions would “dilute and tarnish” her trade dress. *Id.* The complaint

later was amended to include a claim for relief entitled "Slander of Goods/Slander of Title," which repeatedly alleged that MTD had "disparaged the quality and origin" of Rosequist's goods. *Id.* at 908.

The Travelers policy at issue contained a "Web Xtend Liability" endorsement, which deleted that part of the definition for "personal and advertising injury" that would have provided coverage for trade dress infringement, and instead provided coverage only for "[o]ral, written or electronic publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." *Id.* at 907, 910-11. The primary question presented to the court, therefore, was not whether trade dress infringement was alleged, but, instead, whether "the factual allegations of the original complaint filed against MTD were sufficient to give rise to a duty to defend, despite the claims having been couched in language of trade dress infringement rather than in terms of disparagement." *Id.* at 907. Because the complaint alleged that the counterfeit merchandise would harm the reputations of both Rosequist and her products, the court held that the factual allegations were sufficient to implicate the duty to defend.

Specifically, the complaint alleged that:

- "The promotional materials widely circulated by Michael Taylor Designs, Inc. for the patrons of Westweek includes [*sic*] photographs of [Rosequist's] actual furniture (which Michael Taylor Designs, Inc. has removed from its showroom and is no longer selling), compounding the high risk that customers will visit Michael Taylor Designs, Inc. looking for [Rosequist's] furniture, *only to be unknowingly steered* instead to cheap imitation knock-offs."
- "Consumers are likely to be confused and will naturally assume that the knock-offs currently being displayed in Michael Taylor Design's showrooms are plaintiff's products."
- "Defendant's action, unless enjoined, will cause irreparable harm and injury to plaintiff and to consumers, in that it will substantially dilute and *tarnish plaintiff's established trade dress* and mislead consumers about the *true*

origins and nature of the cheap synthetic knockoffs."

Id. at 910-11 (emphasis in original).

Concluding that these allegations were sufficient to allege disparagement, the court explained that "the very essence of the injury [Rosequist was] alleging was damage to the reputation of Rosequist's products that would result from consumers encountering 'cheap synthetic knock-offs' and believing them to be products manufactured and marketed by Rosequist." *Id.* at 911. In so holding, the court rejected a common argument that the sale of knock-off merchandise cannot constitute disparagement because imitation is a form a flattery, not disparagement. Given Rosequist's claim for loss of reputation, the court held that in situations of trafficking counterfeit merchandise, there was no authority that "advertising an inferior item as if it were the product of another invariably falls outside disparagement." *Id.* at 911. That the claim was couched as a trade dress violation—and not a disparagement claim—also mattered little: "[b]ecause Rosequist was expressly alleging that the reputation of her goods was harmed by MTD's conduct, the mere fact that it was labeled as trade dress infringement does not preclude the possibility of a disparagement claim." *Id.* at 912. "The express 'disparagement' in the amended complaint arises from consumers allegedly being led to believe that Rosequist had designed and was distributing the 'cheap synthetic knock-offs' displayed in MTD's showrooms." *Id.*

The effect of this case bears watching. Because intellectual property holders almost universally claim loss of reputation and goodwill in counterfeiting actions, the reasoning of the *Michael Taylor Designs* court may have opened the door for coverage to a line of cases for which defense and liability coverage were never contemplated. Needless to say, the defense costs alone in intellectual property cases can be monumental.

***Union Carbide Corp. v. Affiliated FM Ins. Co.*, 947 N.E.2d 111 (N.Y. 2011)**

The New York Court of Appeals's 2011 decision in *Union Carbide* is poised to have influence in the world of coverage for asbestos and hazardous waste claims. The decision concerns the amount of limits of liability available under a three-year policy and the limits created (or not) by a policy's two month extension

(a so-called “stub” period). When it comes to coverage for asbestos and hazardous waste, where the damages at issue can be gargantuan, the dollar amount of coverage available, usually under long-ago expired policies, is often a paramount issue. And since such claim scenarios usually involve some three-year policies (popular back in the day), with stub issues also not entirely uncommon, *Union Carbide* is likely to be a case considered by other courts for its treatment of such issues. Not to mention that the New York Court of Appeals is no slouch when it comes to respectability.

But *Union Carbide's* inclusion as one of 2011's ten most significant is for broader reasons than just how to calculate the limits of liability available under a three-year policy and a stub period. Rather, its significance is tied to the manner, in general, in which the court addressed the relationship between primary and excess policies – a situation that, of course, has far wider ramifications than simply the worlds of asbestos and hazardous waste.

Union Carbide was hit hard by asbestos bodily injury claims, claiming that it paid over \$1.5 billion in defense costs, settlements, and judgments. *Union Carbide* at 112. It was insured under a primary policy, issued for a three-year duration, and subject to a \$5 million limit of liability. *Id.* It was not disputed that the limit of liability was an “annual aggregate,” and, as such, a separate \$5 million limit applied to each twelve months of the three-year policy. *Id.*

Union Carbide was also covered under successive layers of excess insurance. *Id.* The fifth excess layer, covering losses between \$70 million and \$100 million, was a brief subscription form policy that incorporated by reference the terms of the underlying policy pursuant to a “follow-the-form” clause. *Id.* The excess policy was issued for a three-year period and its \$30 million in coverage was described in the declarations as being for each occurrence and in the aggregate. *Id.*

At issue before New York's highest court was whether the fifth layer excess policy, by its term “\$30,000,000 . . . in the aggregate,” meant that the maximum coverage available for all three years was \$30 million or, alternatively, three times \$30 million, *i.e.*, \$30 million for each of the three years. *Union Carbide* at 113. The insurers argued that “\$30,000,000 . . . in the aggregate,” “can mean only that \$30 million is the

maximum that may be paid under the policy[.] . . . They stress that the follow-the-form clause, which incorporates the [primary] policy by reference, is expressly made ‘subject to the declarations set forth below’ and that those declarations, unlike the [primary] policy, speak of an ‘aggregate,’ not an ‘annual aggregate,’ limit of liability.” *Id.* Conversely, Union Carbide argued that “under the follow-the-form clause, the conditions in the [primary] policy are part of the subscription form policy, and that one of those conditions is that the ‘aggregate’ limit shall be annualized.” *Id.*

The court held that Union Carbide's interpretation must prevail. While noting that the insurers' interpretation of “aggregate” “might be plausible in many contexts” the court's decision was dictated by its view of the meaning of “follow-the form” clauses:

[H]ere the follow-the-form clause should prevail. Such clauses serve the important purpose of allowing an insured, like UCC, that deals with many insurers for the same risk to obtain uniform coverage, and to know, without a minute policy-by-policy analysis, the nature and extent of that coverage. It is implausible that an insured with as large and complicated an insurance program as UCC would have bargained for policies that differed, as between primary and excess layers, in the time over which policy limits were spread.

Id. Hence, the excess policy's \$30 million limit, like the primary's, was subject to a separate limit for each twelve month period – obviously making for a huge difference in the amount of coverage available under the policy.

It is not uncommon for excess policies to “follow form” to primary policies; but, at the same time, for there to also exist differences between such policies. The take-away from *Union Carbide v. Affiliated FM* is this: even if an excess insurer can show that its policy does not follow-form on all points, if it is a close call and/or if the excess insurer's argument could be viewed as technical, a court may conclude that an excess policy still follows form based on the follow-form concept. A court may conclude, like *Union Carbide*, that it is just not plausible for an insured to have bargained for policies that differed as between primary and excess layers. Of course, in a different case, an excess insurer that is

seeking to follow-form to a primary policy may benefit from Union Carbide's view of the follow-form principle.

Schmitz v. Great Amer. Assurance Co., 337 S.W.3d 700 (Mo. 2011)

It is fundamental in insurance coverage that the proceeds of an excess policy cannot be reached until the primary policy is exhausted. However, this recognized principle took an unexpected twist in *Schmitz v. Great Amer. Assurance Co.* Here the Supreme Court of Missouri differentiated between "obligation" to pay and "actual" payment language found in excess policies and held that an excess insurer was required to provide liability coverage for an underlying judgment, despite the fact that the primary policy had not been exhausted. You must be thinking – "Show Me" how they did it.

In *Schmitz*, a young woman died from injuries she sustained after falling from a portable rock climbing wall at a minor league baseball game. See 337 S.W.3d at 703-04. Her parents sued the baseball team's owner, Columbia Professional Baseball ("CPB"), which was insured under a \$1 million primary policy issued by Virginia Surety Company and a \$4 million excess policy issued by Great American Assurance Company. *Id.* at 704. The Great American excess policy provided, in part, that it did not apply until the primary insurer was obligated to the full amount of the primary policy's limits (here \$1 million), stating in its "When 'Loss' is Payable" provision:

Coverage under this policy will not apply unless and until the Insured or the Insured's "underlying insurance" is *obligated to pay the full amount* of the "Underlying Limits of Insurance."

When the amount of "loss" has finally been determined, we will promptly pay on behalf of the insured the amount of "loss" falling within the terms of the policy.

Id. at 706 (emphasis added).

When CPB tendered its defense, both insurers refused to defend, citing an amusement ride policy exclusion. *Id.* at 704. To protect itself from potential liability, CPB thereafter executed an agreement with the plaintiffs whereby the plaintiffs agreed to restrict the

collection of any judgment against CPB to the insurance policies. *Id.* A bench trial was held, and the trial court entered judgment against CPB, assessing damages in excess of \$4.5 million. *Id.*

The plaintiffs subsequently commenced an equitable garnishment action against CPB's insurance policies. Virginia Surety moved for summary judgment, arguing that the claim was not covered under the primary policy; the court denied Virginia Surety's motion and concluded that the claim was covered. *Id.* at 705. Thereafter, Virginia Surety settled with the plaintiffs in which it agreed to pay \$700,000 in exchange for a full release of the policy's \$1 million limit. *Id.* The plaintiffs then proceeded with their lawsuit against Great American, where the court later held that Great American had no obligation to pay the remaining liability because the underlying settlement with Virginia Surety had not exhausted the Virginia Surety policy. *Id.* The Supreme Court of Missouri ultimately reversed.

Examining the "When 'Loss' is Payable" provision in the Great American excess policy, the Supreme Court of Missouri stated that the provision required Great American to provide liability coverage so long as "two requirements are met: (1) the insured or the insured's underlying coverage is *obligated to pay* the full amount of its underlying limits of insurance; and (2) the amount of loss must be finally determined." *Id.* at 706 (emphasis in original). "Once those requirements are met," the court explained, "Great American [must] 'promptly pay' the amount of loss falling within the terms of the policy." *Id.* Here, the court concluded that both criteria were met because, prior to the plaintiffs' settlement with Virginia Surety, Virginia Surety had an obligation to pay its full policy limits towards the \$4.5 million verdict, despite the fact that it ultimately only paid \$700,000.

In so holding, the court distinguished between triggering language based on an obligation to pay versus language based on an actual payment of an owed loss:

The Great American policy clearly states that its coverage will apply when the underlying insurer is *obligated to pay* the full amount of the underlying limits of insurance. "Obligated to pay" has a different meaning than "has already paid." Further, contrary to Great American's arguments, there are no other

provisions in its insurance policy that require exhaustion of the underlying insurance.

Id. (emphasis in original). The Court further distinguished the matter from decisions rendered by courts in other jurisdictions, which had rejected settlements stipulating exhaustion of a primary policy without paying the full underlying limits, on the ground that the language in those excess policies required “actual payment” of the policy’s full limit, and not a mere obligation to pay. *Id.* at 707, n.6.

Finally, the court also rejected arguments that the policy provisions setting forth how the limits of the Great American excess policy apply precluded coverage. The provision in question stated:

4. Subject to Paragraphs B.2. and B.3. above, if the “Underlying Limits of Insurance” . . . are either reduced or exhausted solely by payment of “loss,” such insurance provided by this policy will apply in excess of the reduced underlying limit or, if all underlying limits are exhausted, will apply as “underlying insurance” subject to the same terms, conditions, definitions and exclusions of the “first underlying insurance,” except for the terms, conditions, definitions of exclusions of this policy.

However, we will not pay that portion of a “loss” that is within the “Underlying Limits of Insurance” which the insured has agreed to fund by self-insurance or means other than insurance.

Id. at 706-07 (emphasis added). Great American argued that the “exhausted solely by payment of ‘loss’” language mandated that the underlying limits of insurance must be fully exhausted by payment before Great American is obligated to pay.

The court disagreed, stating:

This argument ignores that the complete phrase is “if the “Underlying Limits of Insurance” . . . are either reduced or exhausted solely by payment of ‘loss.’” The portion of the policy on which Great American relies contemplates that the underlying limits of insurance may be reduced rather than exhausted.

Id. at 707 (emphasis in original). Further, the court stated that the second paragraph of the provision — referring to loss “within the ‘Underlying Limits of Insurance’ which the insured has agreed to fund by self-insurance or means other than insurance” — indicates “that the policy recognized that the underlying limits of insurance may be fulfilled by something other than insurance. Here, the underlying limits of insurance were met by a settlement that consisted of a \$700,000 payment and a \$300,000 release, totaling \$1 million. The phrase ‘means other than insurance’ expressly contemplated the situation at hand.” *Id.*

Schmitz serves as a cautionary message to excess insurers to carefully consider the language that is designed to preclude their policies from being reached until the underlying primary policy is exhausted.

***State Farm Fire and Cas. Co. v. Vogelgesang*,
No. 10–00172, 2011 U.S. Dist. LEXIS
72618 (D. Haw. July 6, 2011)**

The number of judicial decisions addressing coverage for construction defects has reached the point of disbelief. You are left to wonder if any building, anywhere – residential or commercial – completed in the past ten years has not had a construction defect. And, besides just the sheer numbers, these coverage decisions are unpredictable and reach their conclusions based on umpteen rationales. As the Supreme Court of South Carolina put it in a January 2011 decision, the state of the law in this area has become “an intellectual mess.” Of course, the Supreme Court didn’t do anything to help matters by vacating that decision just eight months later and replacing it with one that reached the opposite conclusion. [It all reminds me of that scene at the end of every *Jetsons* episode when George is going round and round on the treadmill, being chased by Astro, and screaming, “Jane, stop this crazy thing!”]

While 2011 had dozens of decisions addressing coverage for construction defects, the most significant development on the construction defect coverage landscape was the welcoming to the party of state legislatures. There are massive numbers of state laws and regulations that govern insurance. But when it comes to coverage issues under commercial general liability policies, state legislatures have generally been content to stay on the sidelines and let courts be the ones to get their hands dirty. But over the past couple of years, some state legislatures no longer have been able to hold their

tongues in the face of what they see as dissatisfaction with judicial decisions ruling that damage to an insured's defective workmanship does not qualify as having been caused by an "occurrence."

Legislative involvement in construction defect coverage kicked off in May 2010, when the Colorado General Assembly enacted "An Act Concerning Commercial Liability Insurance Policies Issued to Construction Professionals." See C.R.S.A. § 13-20-808. The Colorado Act addresses several issues relevant to coverage for construction defects, most notably declaring that: "In interpreting a liability insurance policy issued to a construction professional, a court shall presume that the work of a construction professional that results in property damage, *including damage to the work itself* or other work, is an *accident* unless the property damage is intended and expected by the insured." (emphasis added).

The Colorado legislature's decision was a direct response to the Colorado Court of Appeals's decision in *Gen. Sec. Indem. Co. of Ariz. v. Mountain States Mut. Cas. Co.*, 205 P.3d 529 (Colo. Ct. App. 2009), which held that a claim for damages arising from defective workmanship, standing alone, does not qualify as an "occurrence," regardless of the underlying legal theory pled (tort, contract, or breach of warranty). The Colorado Act specifically described the Court of Appeals's decision in *General Security* as not properly considering a construction professional's reasonable expectation that an insurer would defend the construction professional against a construction defect claim.

At the conclusion of 2010, it was possible to look at the Colorado legislation as a unique situation – nothing more than one state legislature deciding to take construction defect coverage into its own hands. But the Colorado legislature's move has not turned out to be just a one-timer that can be chalked up to some free-spirited outdoorsy types. Far from being an aberrational act and the end of the story, it appears to have been just the beginning. In 2011, three states followed Colorado's lead and adopted legislation directly in response to court decisions in their states that they believed did not provide adequate coverage to contractors for construction defects. Interestingly, while these three states, and Colorado, all set out with the same motivations, each one adopted a different approach to achieve its objective.

In June 2011, Hawaii adopted legislation that takes direct aim at *Group Builders, Inc. v. Admiral Ins. Co.*, 231 P.3d 67 (Haw. Ct. App. 2010). In *Group Builders*, the Hawaii court held that "under Hawaii law, construction defect claims do not constitute an 'occurrence' under a CGL policy. Accordingly, breach of contract claims based on allegations of shoddy performance are not covered under CGL policies. Additionally, tort-based claims, derivative of these breach of contract claims, are also not covered under CGL policies." *Id.* at 73–74. Following several pages of findings, that paint the *Group Builders* decision in very problematic terms for the state's economy, the Hawaii legislature announced that, in a policy issued to a construction professional, for liability arising from construction-related work, the meaning of the term "occurrence" "shall be construed in accordance with the law as it existed at the time that the insurance policy was issued." See HAW. REV. STAT. § 431:1(a). Thus, only policies that were issued after the May 19, 2010 decision in *Group Builders* will be subject to its holding that construction defect claims—contract and tort—do not constitute an "occurrence" under a CGL policy.

In March 2011, Arkansas adopted legislation that a CGL policy shall contain a definition of "occurrence" that includes "[p]roperty damage or bodily injury resulting from faulty workmanship." See ARK. CODE § 23-79-155(a)(2). The statute places no restriction on exclusions in the policy. The Arkansas statute's findings and purpose make clear that it was passed in response to legislative dissatisfaction with court decisions, no doubt including its Supreme Court's decision in *Essex Ins. Co. v. Holder*, 261 S.W.3d 456, 459–60 (Ark. 2007), which held that "case law has consistently defined an 'accident' as an event that takes place without one's foresight or expectation — an event that proceeds from an unknown cause, or is an unusual effect of a known cause, and therefore not expected. Faulty workmanship is not an accident; instead, it is a foreseeable occurrence, and performance bonds exist in the marketplace to insure the contractor against claims for the cost of repair or replacement of faulty work." *Id.* at 460 (citation omitted).

In May 2011, South Carolina adopted legislation that a CGL policy shall contain or be deemed to contain a definition of "occurrence" that includes "[p]roperty damage or bodily injury resulting from faulty workmanship, exclusive of the faulty workmanship itself."

See S.C. CODE § 38–61-70. The statute places no restriction on exclusions in the policy. The South Carolina law was passed in response to legislative dissatisfaction with its Supreme Court's January 7, 2011 decision in *Crossmann Communities v. Harleysville Mutual Insurance Co.*

Then, in August 2011, the Supreme Court of South Carolina, after granting re-hearing, withdrew its January decision in *Crossmann* and replaced it with one that essentially follows § 38–61-70. In *Crossmann II*, the South Carolina high court (with the benefit of twelve *amicus* briefs) held that “the costs to replace the negligently constructed stucco did not constitute ‘property damage’ under the terms of the policy. The stucco was not ‘injured.’ However, the damage to the remainder of the project caused by water penetration due to the negligently installed stucco did constitute ‘property damage.’ Based on those allegations of property damage and construing the ambiguous occurrence definition in favor of the insured, the insuring language of the policy in *Newman* was triggered by the property damage caused by repeated water intrusion.” *Crossmann Communities v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589, 594 (S.C. 2011).

In essence, all four states that have passed laws to address the “occurrence” issue come at it in a different manner. In Colorado, damage to the insured's work itself is an occurrence. In South Carolina, damage to the insured's work itself is not an occurrence. The Arkansas statute does not specifically speak in terms of damage to the insured's work itself. In Hawaii, it depends when the policy was issued.

Those involved in coverage for construction defects – which, these days, seems to be just about everyone involved in general liability coverage – will be watching closely in 2012 to see if this pattern of legislative involvement continues. Unlike the end of 2010, when only Colorado had jumped into the legislative pool, it is more difficult, just one year later, to brush off Colorado's statute as an anomaly for addressing coverage for construction defects.

But even if more states take the legislative route, will they achieve the results sought? Can state legislatures wave a wand and, just like that, bring about the results that they desire concerning coverage for construction defects? The Hawaii District Court's July 2011

decision in *State Farm Fire and Cas. Co. v. Vogelgesang* suggests that it is more difficult than it looks to legislate coverage for construction defects.

In most ways, *Vogelgesang* is far from a significant coverage decision. Indeed, as far as construction defect coverage cases go, it is pretty much run of the mill, involving coverage for defective construction of a home. But despite its outward appearance, *Vogelgesang* earned a place as one of 2011's ten most significant coverage decisions because it demonstrates how challenging it may be for state legislatures to pass laws that determine coverage for construction defects.

To make a long story short, the *Vogelgesang* court held that no coverage was owed to a contractor under its liability policy for defective construction and failure to complete a home. In very general terms, the *Vogelgesang* court relied on the Hawaii Court of Appeals's decision in *Group Builders* to conclude that, because the various claims arose from breach of the construction contract, they were not accidents, and, hence, not “occurrences,” under the policy. *Vogelgesang* at *15-24.

The significance of *Vogelgesang* is not that the Hawaii federal court relied on *Group Builders* to conclude that no coverage was owed to the contractor for the various claims arising out of its defective construction. If that were all that *Vogelgesang* was about, it would not have even made the year's top 500 coverage cases. But the *Vogelgesang* court didn't stop after its *Group Builders* analysis. Rather, the court also addressed the recently enacted Hawaii legislation (HAW. REV. STAT. § 431:1), discussed above, which requires that the meaning of the term “occurrence” “shall be construed in accordance with the law as it existed at the time that the insurance policy was issued.”

The *Vogelgesang* court concluded that the new law did not affect its decision. To do so, the court examined the state of Hawaii law concerning coverage for construction defects as it existed in 2006 – the year that State Farm issued to the insured the first policy that could potentially provide coverage. Upon review of the relevant Hawaii decisions, the *Vogelgesang* court concluded that none of these decisions suggested that the claims against the contractor-insured, arising out of the insured's contract with the homeowners, warranted coverage.

To put this all another way, the Hawaii legislature was displeased with the Court of Appeals decision in *Group Builders* that construction defect claims – both breach of contract and tort-based, derivative of breach of contract — do not constitute an “occurrence” under a CGL policy. To solve the problem, the legislature enacted § 431:1, which states that the meaning of the term “occurrence” “shall be construed in accordance with the law as it existed at the time that the insurance policy was issued.” But, as the *Vogelgesang* court observed, and rightly so, the state of the law in Hawaii, prior to *Group Builders*, was that “contract and contract-based tort claims are not within the scope of CGL Policies.” *Id.* at *26. In other words, the state of law in Hawaii prior to *Group Builders*, concerning coverage for construction defects, was the same as it is after *Group Builders*. So tell me again how § 431:1 solved the Hawaii legislature’s problem with *Group Builders*?

On its own, *Vogelgesang* was far from being one of 2011’s ten most significant insurance coverage decisions. It merits inclusion here as a symbol of the “intellectual mess” that coverage for construction defects continues to be.

***DeMarco v. Travelers Ins. Co.*, 26 A.3d 585 (R.I. 2011)**

Generally, an insurer may face extra-contractual damages where it had an opportunity to settle an underlying claim against its insured within the policy limits, failed to do so, and the insured ultimately is held liable for damages in excess of the policy’s limits. As a matter of first impression under Rhode Island law – and a situation without much national guidance — the Supreme Court of Rhode Island addressed an insurer’s duties when the insured is faced with multiple claims, which collectively exceed the applicable policy’s limits, and one such claimant seeks to settle its claims for the policy’s limits, leaving the insured exposed as to the other claims.

In *DeMarco v. Travelers Ins. Co.*, Wayne DeMarco was seriously injured in a collision while traveling as a passenger in a motor vehicle owned by the insured, Virginia Transportation Corp. (“Virginia Transport”), and driven by the company’s owner, Leo Doire, when the vehicle veered off the road and struck two utility poles. See 26 A.3d at 587. A second passenger, Paul Woscyna, also was seriously injured; in addition, the public utility

Narragansett Electric Company (“NEC”) sustained property damage as a result of damage to its utility poles. *Id.*

At the time of the collision, the vehicle was insured by Travelers under a policy with limits of \$1 million. *Id.* DeMarco’s attorney immediately and repeatedly demanded the full limits of the Traveler’s policy in return for a full release of Doire and Virginia Transport (collectively, the “Insureds”), citing the Supreme Court of Rhode Island’s decision in *Asermely v. Allstate Ins. Co.*, 728 A.2d 461 (R.I. 1999), which imposes upon an insurer a duty to act in the best interests of its insured and those to whom the insured may assign its rights. *Id.* at 589-91. Travelers, however, refused to settle or make a counteroffer, stating that it could not settle with DeMarco and leave its insureds exposed to the Woscyna and NEC claims. *Id.* Woscyna alone had demanded \$859,000 in settlement of his claims. *Id.* at 590. In response to DeMarco’s demands, Travelers consistently maintained the position that it needed only to offer the full policy limits and have the three claimants fight over how the money was to be divided. *Id.* at 591-93. Travelers then sought to commence an impleader action. *Id.*

In the meantime, the Demarco claim went to trial, at which time Travelers offered for the first time to settle the claim for \$500,000, plus \$150,000 from the Insureds’ own funds. *Id.* at 594-95. Demarco rejected the offer and obtained a verdict for approximately \$2.8 million. *Id.* at 595. The Insureds then demanded that, under *Asermely*, Travelers pay the full amount of the verdict, plus costs for its independent counsel, on the ground that the Insureds had demanded that Travelers settle the Demarco claim for the full policy limits, and that Traveler’s refusal to negotiate on the basis that there were multiple claims merely was a pretext for delaying any potential settlement. *Id.* at 596-98. Ultimately, DeMarco and Woscyna settled their claims with the Insureds for \$550,000 and \$450,000 respectively. The Insured then assigned its extra-contractual claim against Travelers to Demarco, who commenced an action against Travelers. *Id.* at 599-600. The trial court granted summary judgment in DeMarco’s favor; the Supreme Court of Rhode Island affirmed in part and reversed in part—holding that Travelers had a fiduciary duty to negotiate, but whether it acted

reasonably was a question of fact ill-suited for summary disposition. *Id.* at 605.

Under *Asermely*, an insurer has a duty to act in the best interests of its insured. *Id.* at 606-07. Moreover, if an insurer “has been afforded reasonable notice and if a plaintiff has made a reasonable written offer to a defendant’s insurer to settle within the policy limits, the insurer is obligated to seriously consider such an offer. If the insurer declines to settle the case within the policy limits, it does so at its peril in the event that a trial results in a judgment that exceeds the policy limits, including interest.” *Id.* at 607 (quoting *Asermely*). Travelers argued that *Asermely* applies only where there is a single claimant for the policy proceeds and where that claimant offers to settle within the policy limits; Travelers contended that *Asermely* “does not apply in a situation (such as the case at bar presents) where there are multiple claimants whose combined claims exceed the policy limits.” *Id.* at 605. The *DeMarco* court disagreed.

The court held that an insurer has an “affirmative duty to engage in timely and meaningful settlement negotiations’ in spite of the sometimes Sisyphean challenge that reaching a global settlement within the policy limits represents.” *Id.* at 613. An insurer must perform “everything it reasonably could to minimize the amount of [the insured’s] direct liability,” even if such an action still will result in some exposure:

It is clear that an insurer may have to engage in a much more complex assessment of whether and how to settle claims in order to meet its duty to protect its insured’s best interests in the face of multiple claims, the aggregate of which exceeds the policy limits. However, it is also clear that such complexities do not relieve an insurer of its “affirmative duty to engage in timely and meaningful settlement negotiations” in spite of the sometimes Sisyphean challenge that reaching a global settlement within the policy limits represents. There undoubtedly will be some instances where an insured will still face direct liability even in the face of the fact that the insurer acted in the insured’s best interests; even in such a situation, however, the critical issue to be determined is whether or not the insurer did everything it reasonably

could to minimize the amount of that direct liability.

Id. at 613.

Thus, the court held that “when an insurer is faced with multiple claimants with claims that in the aggregate exceed the policy limits, the insurer has a fiduciary duty to engage in timely and meaningful settlement negotiations in a purposeful attempt to bring about settlement of as many claims as is possible, such that the insurer will thereby relieve its insured of as much of the insured’s potential liability as is reasonably possible given the policy limits and the surrounding circumstances.” *Id.* at 613-14 (citations omitted). In doing so, the court explained that the insurer must:

- “negotiate as if there were no policy limits applicable to the claims and as if the insurer alone would be liable for the entire amount of any excess judgment”; and
- “exercise its best professional judgment throughout this process, always keeping in mind the best interests of its insured and the necessity of minimizing its insured’s possible eventual direct liability[.]”

Id.

Violation of this duty, moreover, may be demonstrated at a lower threshold than that required for bad faith. The court explained that “in order to show that an insurer has violated its fiduciary duty in a multiple claimant case, the insured (or a party to whom the rights of the insured have been assigned) need not demonstrate that the insurer acted in bad faith but only that the insurer did not act reasonably and in its insured’s best interests in light of the surrounding circumstances.” *Id.* In the case before it, the court held that whether Travelers had satisfied its *Asermely* duty was best left to the trier of fact and reversed the trial court’s grant of summary judgment against Travelers. *Id.* at 615.

The critical issue to take away from *DeMarco* is that, where there is a demand to settle a claim within policy limits, the general rules that apply to this one-claim situation are not suspended because such demand, when added to the demands of other claimants, now collectively exceed the limits of the applicable policy.

***Mosser Construction, Inc. v. The Travelers Indem. Co.*, , 430 Fed. Appx. 417 (6th Cir. 2011)**

In many jurisdictions, whether a commercial general liability policy provides coverage for a construction defect matter depends upon whether the policy's "Your Work" exclusion applies. That exclusion typically states that the insurance does not apply to: "Property damage' to 'your work' arising out of it or any part of it and included in the 'products-completed operations hazard'. This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor."

A key factor for determining whether the exclusion applies, therefore, is whether the insured's work was performed by a "subcontractor." The Sixth Circuit's decision in *Mosser Construction, Inc. v. The Travelers Indemnity Company* demonstrated the consequences for an insurer on account of such an important term in the policy not being defined.

In *Mosser Construction*, the Sixth Circuit examined the meaning of the term "subcontractor" in the "Your Work" exclusion, and concluded that the term was ambiguous and meant not only those entities who perform work at a project site, but also could mean those entities that provide construction materials. As a result, a construction defect claim premised on the failure of a building material fell outside of the "Your Work" exclusion.

The insured, Mosser Construction, entered into a construction contract with the City of Port Clinton as a general contractor to perform improvements to the city's waste-water treatment facility. See 430 Fed. Appx. at 419. The contract required Mosser to "furnish all labor, materials, supplies, equipment and other facilities and things necessary or proper or incidental to complete performances of the work under [the] Contract," including placement of structural backfill beneath and around the foundation of the facility's new odor-control building. *Id.* The backfill was to meet the size and grading requirements for AASHTO # 57 coarse aggregate, an industry standard. *Id.* Mosser thereafter contracted with Gerken Materials, Inc. for the purchase of the specified structural backfill under a standard, two-page purchase order specifying that Gerken would furnish several grades of crushed limestone, including "#57 Stone," a standard inventory item

that Gerken regularly produced. *Id.* The purchase order noted that the stone was being obtained for use in the Port Clinton waste-water treatment plant, but did not otherwise refer to terms from Mosser's master contract with Port Clinton. *Id.*

After construction at the project was complete, the walls of the new odor-control building began to crack. *Id.* Port Clinton's investigation indicated that the cracking was due to failure of the structural # 57 backfill beneath and around the foundation of the building. *Id.* Port Clinton also alleged that, in addition to the odor-control building, a 42-inch effluent line and a pressurized grit line placed in the backfill also were damaged due to the defective backfill.

Mosser notified Travelers of the claim, which denied coverage under the "Your Work" exclusion. Mosser commenced a declaratory judgment action, arguing that it was entitled to defense and liability coverage because Gerken constituted a "subcontractor." Travelers argued that the "Your Work" exclusion applied because Gerken merely had supplied materials and was not a "subcontractor." *Id.* at 419-20. The parties crossed-moved for summary judgment and the district court ruled in favor of Travelers. *Id.* at 420. The Sixth Circuit reversed.

Looking to various sources, including dictionaries and case law, the Sixth Circuit held that competing definitions for the term "subcontractor" establish "multiple reasonable interpretations of the term," including those instances where an entity furnishes a specified material for a specified use. *Id.* at 424-25. Here, Gerken constituted a "subcontractor" because Mosser had contracted it to provide a specific grade of backfill for the Port Clinton project. *Id.*

Specifically, examining definitions for "subcontractor" in *Black's Law Dictionary*, *Webster's Third New International Dictionary* and the *American Heritage Dictionary*, the court observed that the term is broadly defined to mean merely an individual or business entity "that contracts to perform part or all of another's contract." *Id.* at 421-22. Here, the court concluded that the term "could be read to encompass a material supplier like Gerken because, read literally, Gerken contracted (via the backfill purchase order) to take a portion of Mosser's general contract, the obligation to provide backfill." *Id.*

The Sixth Circuit also examined federal case law interpreting the Miller Act, 40 U.S.C. § 3131, observing that the United States Supreme Court held under the Miller Act that “a subcontractor is one who performs for and takes from the prime contractor a specific part of the labor or material requirements of the original contract, thus excluding ordinary laborers and materialmen.” *Id.* at 422 (quoting *Clifford F. MacEvoy Co. v. U.S. for Use and Benefit of Calvin Tompkins*, 322 U.S. 102 (1994)). In subsequent cases, federal courts looked to multiple factors in making the determining whether an entity constituted a subcontractor, including whether “the product supplied is custom fabricated,” whether “the supplier is required to perform on site,” and whether or not the materials supplied come from existing inventory. *Id.* (citation omitted).

Under such case law, the Sixth Circuit concluded that Gerken could be a subcontractor because Gerken performed and took from Mosser “a specific part of the . . . material requirements of the original contract”; although the court also noted that Gerken might not be considered a subcontractor because Gerken had not performed any on-site work and supplied the backfill from existing inventory. *Id.* Finally, examining cases addressing the “Your Work” exclusion, the Sixth Circuit observed that “material suppliers can be subcontractors, but that some combination of fabrication to custom specifications or on-site work is required.” *Id.* at 423.

Based on the competing treatment of the term “subcontractor,” the Sixth Circuit held that the term, as used in a CGL policy, is ambiguous and could mean a supplier of construction materials: “[c]ompeting definitions of subcontractor from other contexts . . . establish that there are multiple reasonable interpretations of the term. The handful of cases defining the term in the context of the your-work exclusion also find ambiguity. Because the term is ambiguous, we must construe it strictly against Travelers and in favor of Mosser.” *Id.* at 424.

Of note, however, the Sixth Circuit imposed some restrictions upon the meaning of the term “subcontractor.” The Sixth Circuit’s definition for “subcontractor” requires that the supplier must manufacture materials that are specific to the general contractor’s requirements, and that the supply contract must specify the use of the materials supplied:

Mosser proposed that any material supplier, even a hardware store selling standard-inventory nails, would qualify as a subcontractor. Mosser’s interpretation, that *any* materials supplier is a subcontractor, is not reasonable. Although the meaning of the term is ambiguous, its meaning is not as broad as Mosser urges. For a material supplier who does not perform work at the site to be a subcontractor, the supplier must manufacture the material according to specifications supplied by the general contractor, and, its materials contract with the general contractor must explicitly incorporate terms from the master contract or otherwise explicitly indicate that the materials at issue are manufactured or supplied specifically for the master contract’s project.

Id. at 424-25 (emphasis in original). Here, the court held that Gerken was not a general supplier and had satisfied the criteria to qualify as a subcontractor in an insurance coverage context: Gerken manufactured the backfill to Mosser’s specifications (i.e., the # 57 standard) and the purchase order specified that use of the backfill would be for the Port Clinton water-treatment facility. *Id.* at 425.

Maybe ISO will look at *Mosser Construction* and conclude that the court’s differentiation between a general supplier of products, versus one that manufactures materials that are specific to the general contractor’s requirements, for purposes of the master contract, strikes the right balance for purposes of defining “subcontractor.” But with construction defect coverage seemingly knowing no bounds these days, having such an important term in that mix being declared ambiguous, is worth a look. Even if ISO is satisfied with *Mosser Construction*, insurers that would prefer a broader definition of “subcontractor” may want to consider an endorsement.

AES Corp. v. Steadfast Ins. Co., 715 S.E.2d 28 (Va. 2011)

Needless to say, the debate that centers around global warming is politically heated. However, when it comes to insurance coverage for costs associated with global warming, such as for damage that it has allegedly caused, or a company’s costs to upgrade its facilities to preclude certain atmospheric emissions, the hottest

thing so far has been the air. With few cases brought seeking damages associated with global warming, the related coverage issues have so far generally been much more talk by commentators than action.

In *AES Corp. v. Steadfast Ins. Co.*, a real dispute over the availability of insurance coverage for damages allegedly caused by global warming was resolved. On one hand, given that the global warming coverage issues have been so slow to develop, inclusion of *AES Corp.* as one of the year's ten most significant coverage cases was debatable. On the other hand, being that *AES Corp.* is from a state high court and the first to address global warming coverage, it is hard to imagine any future courts confronting the issues without at least taking a peek at the decision. For this reason, it could not be overlooked as one of the year's ten most significant.

In *AES Corp. v. Steadfast Ins. Co.*, the Supreme Court of Virginia held that a lawsuit against an insured, for allegedly contributing towards global warming, did not allege an "occurrence" to implicate coverage. The court reached this decision even where such allegations were tinged with negligence, because, according to the complaint, global warming was the natural and foreseeable result of the insured's use of fossil fuels in its energy-generating operations.

The Native Village of Kivalina and City of Kivalina ("Kivalina"), a native community located approximately seventy miles north of the Arctic Circle on the tip of a small Alaskan barrier reef (man that's gotta be a cold place), commenced a lawsuit against the insured, AES Corporation, and numerous other defendants, for damages allegedly caused by global warming stemming from emissions of greenhouse gases. *See* 715 S.E.2d at 30. In the lawsuit, Kivalina alleged that AES engaged in energy-generating activities through the use of fossil fuels that emit carbon dioxide and other greenhouse gases, and that such emissions contributed to global warming, "causing land-fast sea ice protecting the village's shoreline to form later or melt earlier in the annual cycle." *Id.* The melting ice allegedly exposed the shoreline to storm surges, resulting in erosion of the shoreline and rendering the village uninhabitable. *Id.*

Kivalina's complaint alleged that AES acted intentionally and "knew or should have known" the consequences of its greenhouse gas-emitting actions. The complaint specifically alleged that AES "*intentionally*

emits millions of tons of carbon dioxide and other greenhouse gases into the atmosphere annually." *Id.* (emphasis in original). The complaint further alleged that AES "*knew or should have known* of the impacts of [its] emissions' of carbon dioxide, but that '[d]espite this knowledge' of the 'impacts of [its] emissions on global warming and on particularly vulnerable communities such as coastal Alaskan villages,' AES 'continued [its] substantial contributions to global warming.'" *Id.* (emphasis in original).

Kivalina then dedicated sixteen pages and sixty-six paragraphs to explain global warming, including the claim that there is "a clear scientific consensus that global warming is caused by emissions of greenhouse gases, primarily carbon dioxide from fossil fuel combustion and methane releases from fossil fuel harvesting." *Id.* at 30-31. The complaint stated three causes of action: two for nuisance and one for concert of action. *Id.* at 31. One of the nuisance claims alleged that AES and others "have engaged and continue to engage in intentional or negligent acts or omissions that unreasonably interfere with the use and enjoyment of Plaintiffs' properties." *Id.*

AES sought defense and indemnity coverage from its insurer, Steadfast Insurance Company. In the ensuing coverage action, Steadfast argued that it did not owe defense or indemnity coverage based on three grounds: (1) the complaint did not allege "property damage" caused by an "occurrence"; (2) any alleged injury arose prior to the inception of the Steadfast policy; and (3) the claims alleged in the complaint fell within the scope of the pollution exclusion. *Id.* at 30. AES and Steadfast cross-moved for summary judgment. The Virginia Circuit court ruled in favor of Steadfast, holding that the complaint did not allege an "occurrence." *Id.* The Supreme Court of Virginia affirmed.

The Supreme Court of Virginia commenced its analysis with the observation that the terms "occurrence" and "accident" are "synonymous and . . . refer to an incident that was unexpected from the viewpoint of the insured." *Id.* at 32 (quoting *Utica Mut. Ins. Co. v. Travelers Indem. Co.*, 286 S.E.2d 225, 225 (Va. 1982)). "We have held that an 'accident' is commonly understood to mean 'an event which creates an effect which is not the natural or probable consequence of the means employed and is not intended, designed, or reasonably anticipated.'" *Id.* (quoting *Lynchburg Foundry Co. v. Irvin*, 16 S.E.2d 646, 648 (Va. 1941)). "An accidental

injury is one that 'happen[s] by chance, or unexpectedly; taking place not according to the usual course of things; casual; fortuitous.'" *Id.* (citing cases).

Here, the court observed that Kivalina alleged that AES intentionally released carbon dioxide and greenhouse gases as part of its electricity-generating operations. *Id.* An intentional act cannot be deemed an accident or "occurrence"; nor can "the natural and probable consequences of an insured's intentional act." *Id.* Because global warming is alleged to be a natural and probable consequence of AES's intentional actions, the alleged global warming and its damaging consequence cannot be deemed to result from an "occurrence." *Id.* at 33-34.

Nevertheless, AES argued it was entitled to coverage because the complaint alleged negligence, namely that because "AES 'knew or should know' that its activities in generating electricity would result in the environmental harm suffered by Kivalina, Kivalina alleges, at least in the alternative, that the consequences of AES's intentional carbon dioxide and greenhouse gas emissions were unintended." *Id.* at 33 (emphasis in original). According to the court, "[i]n essence, AES argues that the damage to the village resulting from global warming caused by AES's electricity-generating activities was accidental because such damage may have been unintentional." *Id.*

The Supreme Court of Virginia rejected the argument. Whether or not AES was negligent in understanding the consequences of its intentional actions did not change the fact that global warming was the natural and foreseeable result of its actions. Therefore, the damages lacked the necessary fortuity to constitute an "occurrence":

In the Complaint, Kivalina plainly alleges that AES intentionally released carbon dioxide into the atmosphere as a regular part of its energy-producing activities. Kivalina also alleges that there is a clear scientific consensus that the natural and probable consequence of such emissions is global warming and damages such as Kivalina suffered. Whether or not AES's intentional act constitutes negligence, the natural and probable consequence of that intentional act is not an accident under Virginia law.

Id.

In other words, whether or not AES was negligent in not knowing that the damages would be a natural and probable cause of its intentional actions did not change the nature of the damages and, therefore, was irrelevant:

Even if AES were actually ignorant of the effect of its actions and/or did not intend for such damages to occur, Kivalina alleges its damages were the natural and probable consequence of AES's intentional actions. Therefore, Kivalina does not allege that its property damage was the result of a fortuitous event or accident, and such loss is not covered under the relevant CGL policies.

Id. at 34. "If an insured knew or should have known that certain results would follow from his acts or omissions, there is no 'occurrence' within the meaning of a comprehensive general liability policy." *Id.* at 33 (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* § 8.03[c]).

While global warming coverage claims have been slow to develop, it seems unlikely that AES will be the last word of the issue. And given that so much about global warming is the subject of debate, it is likely that some future courts will see the coverage issues differently.

***Lennar Corp. v. Transamerica Ins. Co.*, 2011 Ariz. App. Unpub. LEXIS 1386 (Ariz. Ct. App. Nov. 8, 2011)**

When confronted with a defense subject to a reservation of rights, an insured will sometimes demand the right to retain "independent counsel," to be paid for by the insurer. When that right is afforded, it is then sometimes accompanied by a dispute, between the insured and insurer, over the hourly rate to be paid to the insured's selected counsel. The insured's chosen counsel sometimes has an hourly rate that is higher, and sometimes significantly so (like, double or even triple), than that of the insurer's panel counsel. In these situations, courts usually resolve the issue by examining several factors (counsel's experience, complexity of the case, the venue, other market considerations, etc.) to determine what is the appropriate hourly rate to be paid by the insurer to independent counsel.

In *Lennar Corp. v. Transamerica Ins. Co.*, the Court of Appeals of Arizona confronted a dispute over the payment of independent counsel fees and suggested a

different approach to resolve it — not simply the default route of attempting to determine the appropriate rate to be paid to independent counsel to defend the insured in the case.

In *Lennar*, the insureds, collectively known as “Lennar,” were homebuilders sued in construction defect litigation. 2011 Ariz. App. Unpub. LEXIS 1386, at *2. Lennar tendered its defense to certain insurers, and subsequently retained John Balitis of the law firm Fennemore Craig (“Fennemore”) to serve as defense counsel. *Id.* at *3. In January 2001, Gerling American accepted the defense subject to a reservation of rights. In April 2001, Gerling sought to retain Jill Herman of the law firm Lorber, Greenfield & Polito (“Lorber”) to represent Lennar in the underlying litigation and to terminate payment of any subsequent fees charged by Fennemore in Lennar’s defense. *Id.*

Lennar objected, asserting that Gerling was obliged to continue to pay Fennemore’s fees, because Balitis served as a necessary “independent counsel,” in view of a conflict of interest created by Gerling’s reservation of rights. *Id.* Lennar proposed that Herman participate as its “co-counsel-of-record,” such that both Balitis and Herman would assume “a significant and active role in Lennar’s defense,” with Gerling paying the fees for both lawyers at each law firm’s respective rates. *Id.* at *3-4. Gerling declined, informing Lennar that the Fennemore firm could remain involved, but at Lennar’s own expense. *Id.* at *4. In a subsequent coverage action, the Superior Court of Arizona held, on summary judgment, that Gerling was not obligated to pay for both sets of lawyers.

The issue before the Court of Appeals was whether Lennar was entitled to independent counsel, on Gerling’s dime, because Gerling had assumed Lennar’s defense subject to a reservation of its rights. Lennar argued that it was, and that Gerling was obligated to pay Fennemore’s bills at Fennemore’s rates. The Court of Appeals disagreed.

Citing a 1970s Court of Appeals of Arizona decision, the *Lennar* Court acknowledged that a reservation of rights could create a conflict of interest, but the Court of Appeals held that such a conflict did *not* entitle an insured to a defense from multiple law firms:

Lennar starts down the correct path to understanding when it might be permissible to

have counsel-of-choice in a conflict of interest situation, but its argument takes an unwarranted step beyond the holding of that case. *Fulton* acknowledged that a conflict of interest “obviously” exists when, as here, an attorney employed by an insurer to defend an insured does so under a reservation of rights, but the court went on to hold that the insured can give informed consent to the continued representation by the attorney that the insurer provides. [Citation omitted.] The case does not stand for the proposition that the availability of representation with informed consent implies an entitlement to *multiple* defense firms at the insurer’s expense.

Id. at *10 (emphasis in original) (citing *Fulton v. Woodford*, 26 Ariz. App. 17, 20, 545 P.2d 979, 982 (1976)). The court further noted that Gerling had offered to retain the Fennemore law firm, but at the same rates as those charged by the Lorber firm it had selected; yet, Lennar had refused. *Id.* at *13. Having taken the “‘all or nothing’ approach”, the court rendered its “decision accordingly” and gave the insured nothing. *Id.* Because Lennar had insisted on retaining Fennemore, at Fennemore’s rates, Lennar was responsible for paying Fennemore for the work invoiced. *Id.*

While *Lennar* may involve some unique facts, its takeaway may have more across-the-board application. The court seemed to reject the idea that the only way to resolve a conflict created by a reservation of rights is to have the insured defended entirely by independent counsel, followed by a possible dispute over the counsel’s hourly rates. Rather, the *Lennar* Court recognized that the insured’s personal counsel could have a more limited role in the case, while still protecting the insured vis-à-vis coverage issues created by the reservation of rights. The court concluded that any danger inherent in a reservation of rights—created conflict could be remedied by having the insured’s personal counsel serve as an “independent guardian” to watch over an insured’s coverage rights.

The only ground for the argument that a conflict existed was Gerling’s reservation of rights upon agreeing to defend Lennar. But even if the reservation of rights gave rise to a conflict between Gerling and Lennar, such a

conflict would not justify the role that Fennemore actually played in Lennar's defense.

Given the potential for conflict that existed between Gerling and Lennar because of the reservation of rights, Lennar could reasonably have reshaped Fennemore's role to that of *an independent guardian of its rights concerning coverage*. But Lennar chose instead to have two lead defense attorneys equally participating in the decision-making and workload. Because such an arrangement was not justified by a conflict of interest—actual or potential—we find no legal authority upon which Lennar was entitled to reimbursement for Fennemore's continued service as co-counsel after it accepted Lorber's representation.

Id. at *10-11 (emphasis added).

Will the *Lennar* idea take off in the coverage arena—spreading from Phoenix, Arizona, all the way to Tacoma, Philadelphia, Atlanta and L.A.? Don't get superstitious [and] don't be suspicious. If so, we will have another term to describe the types of insured counsel involved in reservation of rights—created conflict situations: *Cumis* counsel, meet Independent Guardian Counsel. [While Independent Guardian Counsel may sound like the first insurance coverage superhero, it is really the second one to come along. The original insurance coverage superhero is Ace Insura, Claims Detective, the coverage mystery solving gum shoe who was the brainchild of a former editor of Independent Agent magazine and is brought to life by Bill Wilson and Jonathan Hermann of the Independent Insurance Agents & Brokers of America].

***Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc.*, __ N.E.2d __, 2011 Mass. App. LEXIS 1561 (Mass. Ct. App. Dec. 16, 2011)**

When it comes to coverage for “bodily injury” to an employee of the insured, ISO's CG 00 01 commercial general liability form leaves little doubt that none is available. For many reasons, this is an exposure that has long been precluded from the scope of coverage available under a CGL policy. Yet, despite the obvious desire for insurers to exclude employee “bodily injury” coverage, Part B of the ISO CGL form does not contain an exclusion for “personal and advertising injury” to an

employee of the insured. I have long found this differential treatment between the two coverage parts to be curious. And I'm obviously not the only one – since many insurers frequently endorse Part B of their CGL policies with exclusions for “personal and advertising injury” to: “(1) A person arising out of any: (a) Refusal to employ that person; (b) Termination of that person's employment; or (c) Employment-related practices, policies, acts or omissions, such as coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination or malicious prosecution directed at that person.” *E.g.*, see Form CG 21 47 12 07.

So, if insurers have little appetite for Part B “employee” exposure in the first place, and given the availability of such coverage under an Employment Practices Liability policy – where the exposure can be more specifically underwritten and priced – why has ISO not simply incorporated the CG 21 47 exclusions into its Form CG 00 01 terms and conditions?

Maybe the answer is that the potentially covered “employee” Personal Injury scenarios are viewed as limited. In other words, perhaps the potential for Part B “employee” coverage is seen by some insurers as a tolerable risk. If that's the case, then the end-of-year decision from the Massachusetts Court of Appeals in *Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc.* should give those insurers that have, for now, been willing to take on Part B “employee” risk, something to ponder. *Cleary Consultants* demonstrates the breadth of employment practices liability coverage that could be provided by insurers that fail – intentionally or inadvertently — to endorse their CGL policies with an exclusion for employment-related practices. Even the court made this observation.

At issue in *Cleary Consultants* was coverage for an employer for employee-on-employee sexual harassment. In other words, the case involved the type of claim for which an employer would ordinarily purchase an Employment Practices Liability policy.

Rebecca Towers, a recruiter, filed a claim against her employer, Cleary Consultants, and her immediate supervisor, Jonah Adelman, with the Massachusetts Commission Against Discrimination. *Cleary Consultants* at *3. The court summarized Towers's complaint as follows:

From the start of and throughout her employment, Adelman made sexually explicit, inappropriate, and unwelcome comments to Towers, over her protestations. Adelman inquired about her divorce and expressed amazement that her ex-husband would have let "such a beautiful girl" go. Adelman told her about his sex life and asked about hers; and he brushed off her expressed desire not to discuss her personal life with him by saying that if she stayed close to him, he would make sure she was a success and would be able to take care of her children.

Id. at *3-4.

This is actually the G-rated version of the facts. The court went on to describe Adelman's communications with Towers in much more graphic terms, as well as the fact that Adelman caused Towers to be exposed to sexually explicit material. *Id.* at *4-5.

Mary Cleary's response to Towers's complaints is unlikely to win any awards in the category of how to appropriately respond to a sexual harassment situation:

Towers complained to Cleary about Adelman's behavior. Towers's first complaint was made after one week or so of employment, during the final week of May, 2006. Towers told Cleary that Adelman made her feel uncomfortable and described the inappropriate comments made by him. Cleary's response was to laugh and to instruct Towers to ignore Adelman's behavior, stating that he made Cleary money, and that was why she kept him. She also stated that Towers was "a very attractive girl and, in this business, [she] should use that to [her] advantage." Later, in June, 2006, Towers asked if she could work from home in order "to avoid the discomfort caused by [Adelman's] inappropriate conduct." Cleary denied her request, saying in so many words, "Jonah may be rough around the edges, but he's harmless. He will teach you a lot. Just try to ignore the other stuff." When Towers again complained in September, 2006—this time stating that she was being exposed to pornographic material—Cleary downplayed Adelman's conduct

as simply being "immature" and emphasized his skills as a recruiter.

Id. at *5-6. Finally, after Towers complained to Adelman that his conduct caused her significant distress, he responded that she could not give one hundred percent to the job because she was a single parent. Adelman told Towers, who had been working from home because her daughter was ill, not to bother coming back. Towers considered herself terminated and did not return to work. *Id.* at *6.

After some back-and-forth between Cleary and its CGL insurer, Norfolk & Dedham Mutual Fire Ins. Co., Norfolk agreed to defend Cleary, against the Massachusetts Commission Against Discrimination claim, under a reservation of rights. Norfolk's main issue was that "the complaint stated a claim for discrimination and could not reasonably be construed to 'adumbrate' a claim for invasion of privacy because it contained no allegation that Adelman had published his offensive comments about Towers to others, as required under the terms of the personal and advertising injury coverage of the policy." *Id.* at *8.

Towers then filed an amended complaint, which was obviously drafted for purposes of triggering coverage under the Norfolk policy. Towers added allegations that, among other things, Adelman speculated about her sex life, which was witnessed and overheard by her co-workers; Adelman's inappropriate conduct deeply embarrassed her; Adelman invaded her right to privacy and slandered her reputation by circulating his humiliating, vulgar, false, and demeaning statements among co-workers. *Id.* at *11.

The trial court concluded that the facts alleged by Towers qualified as invasion of privacy and defamation to satisfy the definition of "personal and advertising injury" in the policy. However, the trial court also concluded that the actions of the Cleary defendants fell within the exclusions for injury caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict "personal and advertising injury" and injury arising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity. *Id.* at *11-12.

The Massachusetts appeals court reversed summary judgment in favor of Norfolk. Putting aside how it

concluded that the exclusions were not applicable, which is not the point for purposes of this discussion, the court held that the complaint alleged an invasion of privacy. The court looked to the Massachusetts Invasion of Privacy statute, which requires that a person allege an unreasonable, substantial and serious interference with his or her privacy. *Id.* at *18-19. Using this as the test, the *Cleary* court held:

From the inception of the case, Towers alleged that Adelman repeatedly made offensive sexual comments about her appearance and her relationships. He questioned her about her sex life during her marriage and after her divorce, and ridiculed her choice of boyfriend by using an offensive, derogatory term to question the boyfriend's sexuality and Towers's attraction to him. These allegations should have been understood by Norfolk as raising a claim for invasion of privacy.

We reject any suggestion that, for the most part, Adelman's comments were not published to others, as required for coverage to attach, and that any remaining comments were too benign to form a basis for a claim of invasion of privacy. The amended complaint specifically alleges that Adelman's speculations about Towers's sex life were witnessed and overheard by her coworkers, and that he circulated humiliating, vulgar, false, and demeaning statements among her coworkers. Indeed, even prior to amendment, Towers's allegations created the distinct possibility that her claims involved *public* humiliation, and any conceivable doubt on that score soon was dispelled by

the Schlemann affidavit. Schlemann averred that he had witnessed Adelman harassing Towers "on many occasions," and then gave "[e]xamples," which, by definition, should have been understood by Norfolk to be illustrative and not exclusive.

Id. at *20-21 (emphasis in original).

In general, the facts of *Cleary* – a male employee making comments of a sexual nature to a female subordinate or co-worker — are hardly unusual. To the contrary, while Adelman's conduct may have been worse than some other office Casanovas, *Cleary* involves a fairly typical sexual harassment claim. What makes this case remarkable is that, for purposes of insurance coverage, the Massachusetts Court of Appeals equated a sexual harassment claim with a right of privacy claim to impute coverage under Coverage Part B of the policy.

In doing so, the Massachusetts appeals court in *Cleary* may have provided a road map for underlying plaintiffs to secure coverage for garden-variety sexual harassment claims from insureds that have a garden-variety CGL policy — but not an EPL policy. And this is hardly an unusual inventory of many company's insurance assets. Indeed, the *Cleary* Court itself noted that "unlike other commercial liability insurance policies, [the Norfolk policy] made no attempt to exclude personal and advertising injury associated with discrimination against or harassment of an employee." *Id.* at *16-17 (several citations to examples omitted).

Insurers that have heretofore eschewed endorsing Coverage Part B with Form CG 21 47 – which serves to preclude coverage for, among other things, employee harassment claims – may want to study *Cleary* and be certain that they are comfortable with the employment-practices exposure that they may be providing in their CGL policies. ■

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