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Covered Events

The newsletter of the Insurance Law Committee

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Committee Leadership

In This Issue

Leadership Notes

Note from the Editor

By Tiffany Brown

I hope everyone had a wonderful Thanksgiving followed by fun and successful networking at the Insurance Coverage and Practice Symposium ("ICPS") in New York City.

If you missed ICPS (or even if you didn't) please mark your calendar and keep lookout for details about the Insurance Coverage and Claims Institute ("ICCI") which will take place April 3–5, 2019 at the Lowes Hotel in Chicago. ICCI is leading educational event for insurance executives, claims professionals, and outside counsel who specialize in insurance coverage. As an attendee you will hear from top practitioners and claims executives in the industry, be able to participate in sessions that highlight developments and trends in coverage, and gain valuable insight and the tools needed to stay at the top of the game. ICCI also promises valuable business development opportunities, with networking receptions offered throughout the program. Watch our mailbox for the brochure.

In the meantime, keep reading *Covered Events* to stay up-to-date on emerging insurance law trends and cases. And, if you learn of a new decision in your jurisdiction, or elsewhere, please consider submitting a short summary and a copy of the decision to one of our editors and we will work to get it included in the next edition of Covered Events.

Tiffany Brown is a partner of Meagher & Geer, P.L.L.P., in Minneapolis, where she focuses her practice on commercial litigation, with particular emphasis on insurance coverage disputes involving commercial, professional and personal lines of insurance, including breach of contract, declaratory judgments, and bad faith actions. Tiffany's practice also includes E&O liability defense. She has previous experience representing insurance companies in cases involving arson and other insurance fraud.

From the Chair

By Lane Finch

The Annual Meeting in San Francisco was great! The Insurance Law Committee presented "Sexual Harassment Claims in the #MeToo Era" in association with the Employment and Labor Law Committee. Our past chair, Matt Foy lead the lively panel discussion. That evening, a large ILC group met up at the Thirsty Bear Brew Pub for tapas, drinks, pool, and darts.

As I just mentioned, Matt Foy is now our *past* chair. At the end of DRI's Annual Meeting, I assumed the position of Chair of the ILC and Kathy Maus is serving as our Vice Chair. Matt provided great leadership and we hope to continue to advance the ILC as he, and many of our other great past chairs, did.

I have been involved, in a very general sense, in this committee for almost 20 years. In the early years, I mainly attended the Insurance Coverage and Practice Symposium each year because, well, it was held in New York City during the holidays! Back then, the programs were great, but I knew I was missing something. I thought of skipping ICPS, but decided to give it one more shot to see if there was something more to the ILC than great programs. At the next symposium I was lucky enough to get invited to dinner by some of the ILC's leaders who encouraged my active involvement in the committee. One of those who really gave me encouragement was Lee Craig. He started by simply asking, "What would you like to do?"

Over the years since, I have done a lot. And it has been very satisfying. Professionally. Intellectually. Socially.

Professionally, my practice has grown because of the contacts I made through active involvement in the ILC. Intellectually, I learned a tremendous amount by attending our conferences, by speaking and writing about insurance-related topics, and by interacting frequently with

other ILC members much, much smarter than I am. Socially, I made lasting friendships with numerous ILC members at firms throughout the country and with many insurance professionals at different insurance companies.

The Insurance Law Committee has a lot to offer to everyone reading this. All you have to do is answer the question "What would you like to do?" Tell us and we will do our best to help you grow professionally, intellectually, and socially.

Contract me, Kathy, or any of the dozens of ILC leaders to get involved in our committee.

Finally, after celebrating Thanksgiving recently, I am reminded that among the many things I am thankful for are my friends in the ILC and the good times we have shared over the years—and the good times I know are ahead! Happy Holidays to you and yours.

F. Lane Finch, Jr., provides insurance coverage advice, defends bad faith claims, and litigates first and third-party claims in federal and state court. He manages the Alabama office of Swift Currie, a 150-attorney firm focused solely on insurance law and litigation. Lane is the Chair of DRI's Insurance Law Committee and is very active in DRI programming and leadership. He also writes and presents frequently on insurance coverage and litigation issues to national audiences of attorneys, in-house counsel and claim executives.

Featured Articles

The Challenge of Implementing Class Waiver Agreements When There Is a Pending Class or Collective Action

By Clark Monroe and Chris Dunnells

Many industries are interested in implementing class action waivers considering the recent United States Supreme Court decision in *Epic Systems Corp. v. Lewis,* 138 S. Ct. 1612 (2018) confirming the waivers are not a violation of the National Labor Relations Act. In the transportation industry, many large motor carriers are presently under siege from class actions or collective actions filed by independent contractor drivers alleging misclassification or employee drivers under various state wage laws. Many of these cases involving motor carriers rely upon the California meal and rest break law. So, practically speaking, what does a company do that wishes to implement new arbitration agreements with class waivers or standalone class waiver agreements that do not rely on arbitration when they have current pending class litigation?

While this article addresses this issue from the perspective of a transportation lawyer, the principles for communicating with a current class or putative class members can be applied across all industries from insurance companies to manufacturers. Counsel for the employer should evaluate what class or collective litigation is pending and where it is pending before implementation of a new class waiver policy if one did not previously exist. Because the NLRB had previously taken an aggressive anti-waiver stance, many industries do not currently employ such contract provisions. *Convergys Corp. v. Nat'l Labor Relations Bd.*, 866 F.3d 635, 637-38 (5th Cir. 2017)(chastising the NLRB for persistently ignoring its prior decisions allowing class waivers and for its "disregard of our law").

Care Should Be Taken in Communicating with Putative Class Members

"Defendants are ordinarily not precluded from communications with putative class members[.]" 5 A. Conte & H. Newberg, *Newberg on Class Actions* §15.9 (4th ed.). However, district courts are empowered with relatively broad discretion to limit communications between parties and putative class members. *See Kleiner v. First Nat'l Bank of Atlanta*, 751 F.2d 1193 (11th Cir. 1985); *Jones v. Casey's General Stores*, 517 F. Supp. 2d 1080 (S.D. Iowa 2007); *Maddox v. Knowledge Learning Corp.*, 499 F. Supp. 2d 1338 (N.D. Ga. 2007); *Belt v. Emcare Inc.*, 299 F. Supp. 2d 644 (E.D. Tex. 2003); *Hoffmann-La Roche Inc. v. Sperling*, 493 U.S. 165 (1989).

In *Kerce v. West Telemarketing Corp.*, 575 F. Supp. 2d 1354 (S.D. Ga. 2008), the District Court declined to strike 16 employee declarations collected by the defendants at the pre-certification phase of a 216(b) action, reasoning

that "prior to a decision on the conditional certification question, each side has the right to communicate with potential class members" and "there is nothing improper about [an employer] gathering facts to support its defense."

The power to limit communication between an employer and putative class members should be tempered by First Amendment considerations triggered by such prior restraints on speech. The Supreme Court held that district courts "may not exercise the power [to issue a protective order prohibiting communication between an employer and putative class members] without a *specific record* showing by the moving party of the particular abuses by which it is threatened and must give explicit consideration to the narrowest possible relief which would protect the respective parties. *Gulf Oil Co. v. Bernard, 452 U.S. 89,* 102 (1981) (emphasis added).

Courts "have found a need to limit communications with absent class members where the communications were misleading, coercive, or an improper attempt to … encourag[e] class members not to join the suit." *Belt v. Emcare Inc.*, 299 F. Supp. 2d 644 (E.D. Tex. 2003). "Speech between parties with an ongoing business relationship is inherently conducive to coercive influence, and an employer-employee relationship is a salient example of this type of ongoing business relationship." *Castillo v. Hernandez*, No. EP–10–CV–247–KC, 2011 WL 1528762, at *3 (W.D.TX. Apr. 20, 2011).

It Is Possible to Obtain Provisions That Waive a Potential Class Member's Right to Join a Pending Class/Collective Action or to Compel Arbitration

In *Billingsley v. Citi Trends, Inc.,* 2012 WL 12902757 (N.D. Ala. 2012), the defendant corporation in an FLSA action approached putative class members and had them sign, among other documents, arbitration provisions which prohibited putative class members from joining the class but did not remove the arbitration route as a possible avenue of recovery. The arbitration provision, due to the up-front and necessary disclosures, was held enforceable by the District Court.

Many employers may wish to implement agreements that also contain a standalone class waiver that can be enforced in a separately filed suit in state or federal court. For the transportation industry, this is necessary considering the recent case of *Oliveira v. New Prime, Inc.,* 857 F.3d 7 (1st Cir. 2017), *cert. granted,* 138 S.Ct. 1164 (Feb. 26, 2018) in which the court found that independent contractor agreements are 'contracts of employment' within the meaning of the Federal Arbitration Act and thus the act did not apply to a dispute with New Prime's contractors. Standalone class waiver agreements without arbitration are enforceable in the Fifth Circuit, although other circuits have found otherwise. *Convergys Corporation v. N.L.R.B.*, 866 F.3d 635 (5th Cir. 2017). In California, both arbitration agreements and class waivers are difficult to enforce under state law. *Muro v. Cornerstone Staffing Solutions, Inc.,* 20 Cal. App. 5th 784 (4th Dist. 2018) (court within its discretion to find class waiver invalid).

Employers can implement provisions in new contracts that provide single plaintiff litigation or single plaintiff arbitration as the exclusive route to recovery (thereby eliminating the individual's right to join the class), if there are complete and clear disclosures. Similarly, class waivers could be collected because they do not preclude the employee or contractor from seeking a remedy either via arbitration or via an individual lawsuit.

Employers Could Face Severe Sanction if Not Properly Presented to Current Employees or Contractors

In *Longcrier v. HL-A Co., Inc.*, 595 F. Supp. 2d 1218 (S.D. Ala. 1218), the District Court found the defendant corporation had a "clear record of abus[ing] communication…to prospective opt-in plaintiffs" by "covertly concealing" the underlying class action. The Defendant corporation called each employee into a one-on-one meeting with the defendant's attorney with the employee being told the meeting was for the purpose of "conducting a survey." The Defendant candidly admitted to using this tactic on the record. However, there was no survey being conducted for academic or administrative purposes; rather, the Defendant was using the information it was gathering to solely prepare for litigation, including against the declarants themselves. The Court found that, "of critical importance," the Defendant neither informed the individuals about the class action lawsuit concerning the facts about which they were being "surveyed," or the fact that they themselves might be potential class members. The *Longcrier* Court struck the affidavits from the record and deemed them inadmissible at trial.

In *Sjoblom v. Charter Communications, LLC*, 2007 WL 5314916 (W.D. Wis. 2007), the Court, in an FLSA collective action, found the Defendant obtained numerous affidavits from potential class members in a blitz campaign and "advised potential class members that the lawsuit at issue was a class action, [but] did not notify them that they might be entitled to become a part of the lawsuit," and ruled the appropriate remedy was for the affidavits to be struck for want of full disclosure to affiants. Non-disclosure or

incomplete disclosure are not the only forms of bad faith that could warrant the affidavits being stricken. Explicitly false statements, *Byrne v. Nezhat*, 261 F.3d. 1075 (11th Cir. 2008), paying off witnesses, *Golden Door Jewelry Creations, Inc. v. Lloyds Underwriters Non-marine Ass'n*, 117 F.3d. 1328 (11th Cir. 1997), and other more overt forms of abuse would result in the same.

In the most extreme of circumstances, if the Defendant Corporation acted in clear bad faith, it is not uncommon for the Court to extend the allotted time allowed for potential plaintiffs to join the action, to force the Defendant to post a corrective notice and distribute the same to all employees, to force the Defendant to bear the cost of such a corrective notice, and to pay reasonable attorney's fees to Plaintiffs' counsel for seeking such action. *Pacheco v. Aldeeb*, 127 F. Supp. 3d 694 (W.D. Tex. 2015).

Examples of bad faith that would result in those sanctions would include: conditioning the delivery of paychecks to current employees on the employees' agreement to represent that they have no claims against Defendants; offering an employee a raise in exchange for telling Plaintiffs' counsel that he wished to dismiss his claims; writing emails on behalf of employees to Plaintiffs' counsel asking that their claims be dismissed; offering to pay an employee to persuade other plaintiffs to dismiss their claims; and/or after commencement of this suit, requiring all employees to sign an agreement representing that they had been "fully and properly compensated" for all hours worked and requiring them to bring compensation disputes to Defendants before seeking legal counsel. *Id.*

Less overt methods to dissuade potential plaintiffs from joining the lawsuit are also not permitted. For instance, in *Hampton Hardware, Inc. v. Cotter & Co., Inc.,* 156 F.R.D. 630 (N.D. Tex. 1994) the Defendant sent multiple letters out to employees, the first letter stating, "that joining the lawsuit would be at an 'enormous potential cost to your Company'" and that "[a]ll of this will cost you precious dollars and us precious time from our mission." The second letter stated: "By not participating in this suit, you will help save your Company expense in dollars and time." Finally, the third letter read, in relevant part: "By asking you to join the class, [plaintiff] is asking you to sue yourself." The court held that the letters were improper as an attempt "to reduce the class members [sic] participation in the lawsuit based on threats to their pocketbooks."

Because the intent of implementation of a new contract or other agreement is to preclude an employee or contractor from joining the collective FLSA action once signed, the Court could find such contracts were an attempt to reduce the number of class participants if proper methods are not followed in obtaining signatures on those contracts.

Methodology for Obtaining Enforceable Waivers in the Pending Litigation

Many reported cases address only new documents containing arbitration agreements. However, the same analogy can be drawn for new agreements containing standalone class waiver agreements. New employment agreements, policies, or independent contractor agreements should be enforceable assuming that there is a full disclosure of all pending actions to which a particular employee or contractor may be a putative class member. Disclosures that must be included in a full and valid disclosure to a corresponding class waiver or arbitration provision are as follows:

- The class waiver and arbitration provision must explicitly provide for an alternative method of recovery. *Billingsly,* 2012 WL 12902757 (N.D. AL 2012).
- The disclosure must list the name and style of the class action and state that, "you could potentially be a class member." *Id.*
- The disclosure should state that the individual can consult with a private attorney of his or her choosing if he or she had any questions about the process. The disclosure should acknowledge that the individual is then free, on their own, to seek the advice of outside counsel.
- Timing can be critical if a waiver is involved. The *Billingsley* court, in deferring on a motion for a corrective action, stated, "[The Defendant Corporation's] veiled attempt to discourage participation in this lawsuit by rolling out its Arbitration Agreement just as the Plaintiffs filed their motion for Conditional Certification of the Class has not gone unnoticed, and in fact, raises the concern of the court." *Id.*
- If possible, allow time for reflection before requiring an immediate signature on the new contract. Whether it is in-person or done en masse, avoiding the need for an immediate decision will allow the declarant/signer to review the documents outside of the presence of corporate representatives or counsel.
- Ideally, the disclosure and meeting should take place in an objectively non-coercive environment. Try to avoid an "in-person meeting with corporate representatives which 'may exert pressure and often demand an immediate response, without providing an opportunity for comparison or reflection.'" *Sanchez v. Bland Farms*, 600 F. Supp. 2d 1373 (S.D. GA 2014); *Rosales v. El Rancho Farms*, 2011

WL 6153212 (E.D. Cal. 2011). If a period is provided for the contractor or employee to review the contract, before being asked to sign and return it, this concern should be satisfied.

- New Policies Can Be Implemented, Just Be Cautious

At the end of the day, it is possible to obtain new and fully enforceable contracts containing an arbitration provision as well as waiving class participation, as long as such communication is coupled with explicit and complete disclosure of 1) the acknowledgement of the underlying class or collective action; 2) the possibility that the employee or contractor could be a potential class member; 3) notice to the employee or contractor that he or she is free to seek independent counsel; 4) an acknowledgment that the contract being entered into is done freely and voluntarily without the promise of reward or threat of punishment; and 5) take place in an environment conducive to a non-coerced response.

It is imperative that these steps be followed, or the Defendant runs the risk of incurring not only possible sanctions and the ire of the Court, but also loss of Defendant's ability to rely on the new class waivers or arbitration agreements.

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Christopher G. Dunnells is an associate of Dunbar Munroe in Ridgeland, Mississippi. His practice includes general insurance defense including trucking defense, premises liability, personal injury, and professional malpractice. His practice also includes commercial litigation including shareholder oppression, contract disputes, and general business law. Mr. Dunnells is admitted to practice before all state courts in Mississippi, the United States District Courts for the Northern and Southern Districts of Mississippi, and the United States Court of Appeals for the Fifth Circuit. He was admitted to the Mississippi Bar in 2015.

Special Process of Special Investigation

By Ellen Robb

Special investigation insurance claims are a bit of a niche within the world of insurance defense. Common instances are thefts and fires, basically any claim that raises suspicion. Typically, claims personnel begin the investigation of the claim by communicating with the insured, sending an adjuster to inspect the loss, requesting relevant documents, and taking a recorded statement. At that stage, for a variety of reasons, suspicion may be raised. Most companies have a special investigation unit ("SIU") and a claim is typically sent to it once suspicion is raised. The SIU claims personnel continue the company's investigation by taking an independent recorded statement, requesting documents from the insured, requesting reports (such as credit and background reports), and having an investigator conduct specific research such as canvassing the area and speaking with witnesses.

Often called cooperation clauses, most property insurance policies will contain language similar to the following:

> We may require you [the insured] to submit to examinations under oath ("EUO") as often as reasonably required and produce for copying records and documents we request . . . the policy may be void if you have willfully concealed or misrepresented a material fact or circumstance concerning this insurance

Courts typically enforce a policy's requirement for the insured to cooperate with the company's investigation of the claim, including providing truthful responses to questions. *See e.g., Watkins v. Continental Ins. Co.*, 690 F.2d 449, 451 n.2 (5th Cir. 1982), *Pacific Indem. Co. v. Golden*, 985 F.2d 51, 57 (2d Cir. 1993). *See also Stradford v. Zurich Ins. Co.*, 02 Civ. 3628 (NRB) 2002 U.S. Dist. LEXIS 24050 (S.D. NY Dec. 13, 2002) (stating insured's willful failure to appear for EUO is material breach of cooperation clause precluding recovery) and In re U.S.A. Electronics, Inc., 120 B.R. 637, 644 (E.D. NY 1990) (noting provision requiring EUO "customary cooperation clause of an insurance contract").

The SIU department may decide to hire an attorney to conduct an EUO and prepare a coverage letter after it is concluded. EUOs are similar to depositions, but they are unique. Generally, unlike depositions, they are not conducted according to any procedural rules as the claim is not in litigation. Always know the law for your state. In California, for example, statutory law allows an insured to assert any objection that could be made in state or federal law during EUOs for residential property claims. CAL. INS. CODE §790.031. As you go through the EUO process, whether you are dealing with an insured directly or with an insured's attorney can impact your approach.

Dealing Directly with an Insured

Dealing with an unrepresented insured can be challenging. When reaching out to the person for purposes of scheduling the EUO, you may be met with resistance. Often times, the person has given at least one recorded statement and does not want to sit for an EUO. Be prepared to explain that it is a requirement of the policy and send a copy of the policy to the insured for reference.

A Recorded Statement Is Not an EUO

Courts have been clear that giving a recorded statement does not equate to sitting for an EUO. For example, in *Union Ins. Co. v. Williams*, 261 F. Supp. 2d 1150 (E.D. Mo. 2003), the insured failed to submit to an EUO. She argued that the policy language requiring an EUO was ambiguous and she was reasonable to assume that a recorded statement would count as an EUO. The Court did not agree and found in favor of the insurance. In *Watson v. Nat'l Surety Corp.*, 468 N.W.2d 448, 449 (Iowa 1991), the insureds gave multiple unsworn recorded statements to the insurance company's adjuster as well as a sworn proof of loss. The insurance company later requested they sit for an EUO, however, the insureds refused. *Id.* at 449–50. They claimed that their prior recorded statements satisfied their duties under the policy and later provided affidavits stating "each and every response [of the unsworn recorded statements] . . . is true and correct as I verily believe." *Id.* at 50. On appeal, the court found in favor of the insurance company as the policy specifically required an EUO and the unsworn statements did not suffice. *Id.*

Have Reasonable Expectations

If you are dealing directly with an insured, it is quite likely that the person is not sophisticated when it comes to insurance claims and the process that must be followed. Be prepared for pushback. It is beneficial to be as open and cooperative as possible. Ask the insured his or her general schedule and whether a particular day of the week is preferred. Be reasonable as to the location of the EUO as

well as the scheduled time as the insured's willingness to participate in an EUO—even if he or she does not agree to your suggested location/time—can be seen as substantial compliance with the policy's cooperation clause. *See e.g.* 13 Couch on Insurance §196:16 (3d ed. 2007) (citing *Abudayeh v. Fair Plan Ins. Co.*, 105 A.D. 2d 764 (N.Y. App. Div. 1984) (where insured was "at all times willing" to submit to EUO, but not at the time and place specified by insurer, insured was held to have substantially complied with the obligation to cooperate). If at all possible, make arrangements around his or her work schedule. Be prepared for an insured to cancel at the last minute or ask to reschedule. Reach out the insured a day or two before the EUO to confirm attendance. An insured, however, cannot avoid attending the EUO by stonewalling the insurance company when it comes to its scheduling. *See Hurst v. State Farm Mut. Auto. Ins. Co.*, Civil Action No. 7:05CV776 2008 U.S. Dist. LEXIS 53628 (W.D. VA July 7, 2008) (finding insured's claimed "standing offer" to sit for EUO did not fulfill his duty to cooperate). If the claim winds up in litigation, your insurance company client will be in the best position before the court if you have bent over backwards to accommodate the insured.

Details and Record Keeping Are Crucial

Be sure you keep a record of all of your interactions with the insured. Document phone calls. Document attempts to reach the insured. Send correspondence via a courier where there is a record of delivery. Insureds often do not collect certified mail returned receipt requested - instead use an express carrier with an adult signature required. Carefully explain things to the insured in easy to read and comprehend terms. Use lists or bullet points in your letters. Give the insured every opportunity to appear, but set clear deadlines in your communications with the insured. Leaving things open ended can drag things out and the your insurance company client does not want to deal with a delay issue.

Know Who Can Attend the EUO

When the insured appears for the EUO, he or she may have other people in tow. Be prepared for this and decide what you will do beforehand. Policies typically require insureds to appear for an EUO "outside the presence of another insured." If the other people are such other insureds, they cannot stay in the examination room. If they are not, you and your client will have to decide what to do. I usually will ask that just the witness stay in the room, but I have made exceptions when dealing with an elderly person or someone needed assistance. Also, if the witness happens to be a minor, allow some flexibility for an adult to accompany that person.

Use caution and always know what the policy actually requires. For example, in *United States Fidelity & Guaranty Co. v. Welch*, 854 F.2d 459, 460 (11th Cir. 1988), the insurance company requested the insureds to separately sit for EUOs. The language of the policy, however, failed to contain language similar to "outside the presence of another insured." *Id.* Looking at the actual policy and construing it most favorably to the insureds, the appellate court found that the insurance company's attempt to examine the insureds separately was an additional demand upon them that was not part of the policy. *Id.* at 461.

Keep Apprised of Safety Concerns

Dealing with an insured can become confrontational for many reasons. Be prepared to evaluate safety issues. If the insured is not represented, try to have the EUO at a public place, preferably with security. Courthouses are great if there is space available. I have conducted EUOs of a convicted murderer and a suspected serial arsonist as well as persons with a variety of criminal records (drugs, DUIs, domestic violence). Over the years my experience has taught me the importance of security. Make others present aware (court reporter or courthouse security) of known security issues.

Assist the Insured Without Crossing a Line

Remind the insured as often as necessary that you are not his or her attorney. You may find yourself—on behalf of your client—providing suggestions to the insured such as how to gather records. Frequently, requests for records supporting damaged, lost, or stolen items are part of the claim. You may conclude the EUO by giving the insured some homework as far as producing such information. Guidance can greatly assist with both the speed of receiving documents as well as dealing with the insured who may insist that attempts have been made to gather records, but the company will not provide them. Phone carriers notoriously have specific rules for obtaining records. I have provided step by step written instructions on how to get Pay Pal and eBay records. While this may seem tedious and perhaps unnecessary, if the claim ends up in court your client can show that it went above and beyond with the adjustment of the claim.

Dealing with an Insured's Attorney

Contrary to logic, an insured does not always enjoy a an actual benefit by having an attorney represent him or her at the EUO. *See, e.g., West v. State Farm*, 868 F. 2d 348 (9th Cir. 1988) (describing represented insured's refusal to answer questions and refusal of household members to sit for EUO). An attorney's involvement on behalf of an insured can either be productive or terrible. It is productive when the attorney "gets it." He or she understands the EUO process and does not posture as though it is a formal discovery procedure. He or she has control of the client and makes the client available. He or she assists the client with gathering documents and signing the EUO transcript.

The Difficult Times

It can, however, be terrible. Attorneys can be combative and obstructive. They can attempt to lay traps hoping for a delay or bad faith claim. Attorneys can also really mess things up for their client. In the Union Ins. Co. v. Williams case referenced above, according to the insured's affidavit it was her attorney who advised her not to sit for the EUO. In other words, the attorney advised her to breach her contract. Attorneys can attempt to disrupt the EUO by making objections, comments, or with other distractions. I've had an attorney take a call during an EUO without excusing himself from the room. I've had an attorney be so disruptive during the EUO, I stated on the record that he was about to cause his client to breach the terms of her insurance policy because she was not answering relevant questions. While not ideal to terminate an EUO due to failure of the insured to participate/cooperate, if it reaches that level be sure to make your record that you are there to conduct the EUO and you want to take the EUO but due to the described circumstances, you are unable to complete it.

Do Not Forget the Task at Hand

Keep yourself in check and remember you are not in litigation. Don't be the attorney who messes things up. In *Mullen v. Miss. Farm Bureau Cas. Ins. Co.*, 98 So. 3d 1082 (Miss. Ct. App. 2012), the insurer's attorney was likely understandably frustrated and did not see the forest from the trees. Basically, an appellate court determined that an insured did not refuse to sit for an EUO and that the insured prematurely denied the claim. As things progressed, the insurer did not retreat and simply schedule the EUO.

The insureds gave multiple recorded statements prior to retaining an attorney. Their attorney was misinformed that the statements previously given had been under oath and took offense to a request to schedule EUOs. Counsel for the insurer appropriately advised that the prior statements were not made under oath. The insurer's attorney then sent two separate letters requesting dates for the EUOs. The insured's counsel claimed to have never received either letter (*i.e.*, always use a delivery method that has a record of delivery—even if you are dealing with an attorney). After receiving no response from the insureds, the insurance company's attorney sent a third letter advising that the claim had been denied due to failure to cooperate. The insured's attorney responded to the third letter stating, among other things, that his clients had no intent to breach the policy's requirements.

The insured ultimately filed suit and summary judgment was granted to the insurer. On appeal, the court determined that there was insufficient evidence to support that the insured willfully refused to comply with the terms of the policy regarding EUOs. While the insured's attorney likely escaped a bad situation for him, we can all learn lessons from this case. Don't get carried away and end up having an appellate court tell your client to take the EUO.

Conclusion

When assisting an insurer with a special investigation claim, you will likely steer away from your typical litigation procedure. The suggestions made here will hopefully provide some guidance. Remember, nobody wants to sit for an EUO. Keep in mind there are many ways to tell an insured that it is part of the insurance policy and is just something he or she has to do without being a jerk. Making an enemy of the insured is a bad idea. You want them to be open during the EUO – they will tell you more if they don't hate you. Aggravation and frustration will come with special investigation; however, it is enjoyable and rewarding work.

Ellen is a solo practitioner at Robb Law Offices, PLLC, a boutique law firm specializing in insurance special investigation including coverage and claim needs such as conducting examinations under oath. Before branching out on her own, Ellen worked in the General Litigation Practice Group at a large Mississippi firm. There, she focused on civil defense for both first and third party insurance claims with an emphasis on special investigation as well as fire claims and suspected arson. She was also heavily involved in Hurricane Katrina bad faith litigation where she was the lead attorney in a multitude of mediations. Prior to practicing at the firm, Ellen served as a law clerk for Honorable Leslie Southwick at the Mississippi Court of Appeals. She was named a Rising

Star in Super Lawyers for the years 2009-2011. Ellen was selected by the Mississippi Business Journal as a Leader in Law for 2018. Ellen graduated from Ole Miss Law School with honors and was a member of the Mississippi Law Journal. Prior to law school, Ellen received her MBA from the University of Memphis and – a native Alabamian – Ellen obtained her undergraduate degree from Auburn University.

Significant Insurance Coverage Ruling Issued by New York High Court in *In the Matter of Viking Pump*

By Carri S. Leininger

In May 2016, the New York Court of Appeals issued a very significant insurance coverage decision in *In the Matter of Viking Pump, Inc.*, 27 N.Y. 3d 244 (2016). The core issues in *Viking Pump* were 1) the appropriate methods of allocation and 2) the appropriate method of exhaustion. In its decision, the high court ruled that for policies that contain "non-cumulation" clauses, "all sums" allocation with vertical exhaustion is the only appropriate method for allocating losses among policies. Under the "all sums" approach each of an insured's policies can be held liable for an entire loss. [The most recent opinion in the Viking Pump saga is out of the Supreme Court of Delaware and provides a concise summary of the tortured path of this litigation, *Viking Pump v. Century Indemnity*, 2018 WL 2331990, (May 23, 2018).

Courts across the United States have been split over the question of whether to adopt an "all sums" or "pro-rata" approach. The New York Court of Appeals decision is a game changer for insured (policyholders) facing long-tail injury claims such as the asbestos claims at issue in *Viking Pump*. Insureds can use this decision to argue for an "all sums" approach to coverage. However, as noted in the court's decision, the policy language of the specific policy must support the use of this method.

Summary of *Viking Pump*

Viking Pump involved a lawsuit by Viking Pump and Warren Pump, two manufacturing companies, against their excess insurers for coverage for asbestos liability claims with exposure spanning from anywhere from 1972–1985. Both Viking and Warren sought coverage under primary policies issued by Liberty Mutual. As Liberty Mutual's coverage neared exhaustion, litigation arose as to whether Viking and Warren were entitled to coverage under excess policies, and if so, how indemnity should be allocated across the triggered policy periods.

The Liberty Mutual umbrella policies provided that the insurer:

> will pay on behalf of the insured *all sums* in excess of the retained limit which the insured shall become legally obligated to pay, or with the consent of the [insurer], agrees to pay, as damages, direct or consequential, because of "(a) personal injury . . . with respect to which this policy applies and caused by an occurrence." (emphasis added).

"Occurrence" is defined, in relevant part, as "injurious exposure to conditions, which results in personal injury" which, in turn, is defined as "personal injury or bodily injury which occurs *during the policy period*." (emphasis added). The policies also state that, "[f]or the purpose of determining the limits of the [insured's] liability: (1) all personal injury . . . arising out of continuous or repeated exposure to substantially the same general conditions . . . shall be considered as the result of one and the same occurrence."

The excess policies issued by the Excess Insurers either follow form to (*i.e.*, incorporate) these provisions, or provide for substantively identical coverage. The excess policies that did not follow form to the Liberty Mutual "non-cumulation" provision contained a similar two-part "Prior Insurance and Non-Cumulation of Liability" provision.

The parties cross-moved for summary judgment with respect to the availability of coverage and allocation of liability under the excess policies. Viking and Warren advocated for an "all sums" allocation. Given that the exposure spanned such a large number of years, if pro-rata were applied, Viking and Warren faced potential exposure for uninsured years, before the policies were in place, and for periods of time after the polices expired. The "all sums" method would essentially allow the insureds to increase their losses in a single policy year that they select. Under the "all sums" allocation method, each policy triggered by a

claim is independently liable for the full claim. The insured can recover the full amount of its liability for the claim from one or more triggered policies selected by the insured. The insurer may then attempt to pursue contribution from other policies which were triggered by that same claim.

Under a "pro rata" approach, each policy triggered by a claim is only liable for a portion of the loss "typically based on the time no the risk relative to the time that other triggered policies were on the risk. Thus, if the "pro-rata" method were applied, it would essentially require spreading of the losses across multiple policy periods, dipping into periods of time where the policies were not in place.

The Delaware Court of Chancery granted summary judgment to Viking and Warren. On appeal, the Delaware Supreme Court concluded that resolution of the allocation and exhaustion disputes depended on significant and unsettled questions of New York law. Therefore, it certified two questions to the New York Court of Appeals.

The two questions certified from the Delaware Supreme Court were as follows:

- Whether under New York law, "the proper method of allocation to be used is all sums or pro rata when there are non-cumulation and prior insurance provisions." and
- Whether "vertical or horizontal exhaustion applies to determine when a policyholder may access its excess insurance . . . when the underlying primary and umbrella insurance in the same policy has been exhausted."

Based upon the facts of the case and the policy language of the relevant policies, the court in *Viking Pump* held that all sums allocation and vertical exhaustion applied to the asbestos claims at issue.

The court's ruling, holding that "all sums" allocation applied, was based upon the presence of the "non-cumulation" and "prior insurance" provisions of the policies at issue. A prior insurance provision reduces policy limits by the amount of coverage available to a policyholder under other, earlier insurance policies. A "non-cumulation clause" provides that only a single policy limit is available for a loss covered under multiple policy periods. The court explained that the existence of a "non-cumulation" provision, conflicts with the basic assumption favoring "pro rata" allocation because a "pro rata" approach is based upon the idea that no two policies can cover the same loss, whereas a "non-cumulation provision" contemplates two policies covering the same loss. "In a "pro-rata" allocation, the "non-cumulation" clause would, therefore, be rendered surplusage "a construction that cannot be countenanced under our principles of contract interpretation and as a result that would conflict with our previous recognition that such clauses are enforceable." *Viking Pump* at 261. Thus, the court held that these provisions are incompatible with a pro rata allocation scheme. Interestingly, the court admitted that a "pro-rata" allocation method is a "legal fiction" that should be dispensed with in the face of "non-cumulation" clauses.

In determining that the "pro-rata" method did not apply, the court distinguished its prior decision in *Consolidated Edison Co. v. Allstate Insurance Co.*, 98 N.Y.2d 208, 222 (2002), in which it applied the "pro rata" allocation method to losses on account of long tail environmental liabilities. The court noted that its decision in *Consolidated Edison* held that "pro rata" was appropriate for the policy language before it, however, it made clear that "pro rata" allocation was not mandated and, instead, the appropriate allocation would depend on the policy language and other facts specific to each particular case. After *Consolidated Edison*, many people interpreted the decision to provide that New York law required "pro rata" allocation for long-tail injury claims. The court's decision in *Viking Pump* clarified that *Consolidated Edison* did not create a "blanket rule" that "pro rata" allocation should automatically be applied to long-tail injury claims. Furthermore, the court's decision makes it clear that general rules of contract interpretation will dictate the meaning of a policy, and which method should be applied.

Additionally, the *Viking Pump* court determined that vertical, rather than horizontal exhaustion, was the appropriate method for exhaustion under the facts and policy language of the case. The court concluded that based upon the policy language, "vertical exhaustion is more consistent than horizontal exhaustion with this language tying attachment of the excess policies specifically to identified policies that span the same policy period" and furthermore, "vertical exhaustion is conceptually consistent with an all sums allocation, permitting the insured to seek coverage through the layers of insurance available for a specific year." *Viking Pump* at 1156. With vertical exhaustion the insureds can reach excess coverage for certain years even if their primary policies for other years have not been exhausted.

Impact of Viking Pump

The decision in *Viking Pump* is favorable to insured (policyholders). It allows insureds with long tail injury exposure a more straightforward path to obtaining coverage for costly losses, spanning multiple years. The insured can simply select a single triggered policy year and go up vertically to

each level of coverage under their insurance. This allows an insured to potentially recover a higher amount.

However, while the court in *Viking Pump* did find the "all sums" and "vertical exhaustion" approaches appropriate under the facts of that case, this does not mean that these methods are now the *required* methods under New York law. The court in *Viking Pump* pointed out that its decision is not inconsistent with its prior decision in *Consolidated Edison*. As the court stated in *Consolidated Edison*, the decision of whether to apply an "all sums" or "pro rata" allocation method will depend on the specific policy language at issue applied to the specific facts of the case.

This opinion is also favorable for primary carriers. Excess carriers are quick to argue "Horizontal Exhaustion! Horizontal Exhaustion!" This opinion can be used as shield against such broad based attacks.

Additionally, this decision may increase litigation regarding when an accident "occurred." Indeed, we may see less resolution at mediation and more "fights to the finish" on the date of "occurrence" issue. The common refrain "TOR, TOR," may not help coverage counsel settle the case at mediation.

Recent Cases of Interest

Second Circuit (NY)

Sandy/Windstorm Coverage

The Second Circuit has revived a Superstorm Sandy claim, declaring in *Madelaine Chocolate Novelties, Inc. v. Great Northern Insurance Company*, No. 17 3396 (2d Cir. Oct 23, 2018) that a New York District Court erred in refusing to find coverage for storm-surge damage to the insured's property owing to its possible conflict with the policy's windstorm endorsement. Whereas the New York District Court had ruled that the flood exclusion unambiguously precluded coverage, the Second Circuit concluded that factual questions needed to be resolved with respect to ACC language in the windstorm endorsement conflicted with the flood exclusion. The Second Circuit declared that the district court may consider permitting discovery into interpretive materials relating to the windstorm endorsement and its relationship with the policy's coverage provisions.

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Recoupment of Defense Costs

***SPARTA Insurance Co. v. Technology Insurance Company,* September 21, 2018**

Second Circuit holds Carrier is Estopped by Seeking Reimbursement of Past and Accruing Defense Costs, Where It Undertook the Defense Without Asserting Policy Defenses or Reserving Rights to Do So

South Nassau Communities Hospital hired Stasi Brothers Asphalt Corp. for a parking lot repaving job, with a general contractor Roadwork Ahead, Inc. on the project. During the process, a worker was injured falling into a drywell. Two carriers, SPARTA Insurance Company (Sparta) and Technology (Technology) Insurance Company disputed their respective responsibility for liability and defense of the ensuing tort suit. In short, at issue was the fact that the agreement between the property owner and general contractor stated that Sparta would undertake their defense and indemnify them.

In their initial coverage correspondence, Sparta adopted the position that its undertaking of the defense would be subject to a reservation of rights limiting coverage to the terms and conditions of the policy issued to the subcontractor. However, it did not spell out what terms and conditions might bear out that obligation. They then ultimately argued that they would not indemnify the owner due to its own negligence, and that Technology should pay for half of the defense of the claim, in light of the other insurance clause. The parties objected in that Sparta had undertaken the defense without any express and explicit reservation of its rights.

In New York, an insurer "who undertakes the defense of an insured, may be estopped from asserting a defense to coverage, no matter how valid, if the insurer unreasonably delays in disclaiming coverage and the insured suffers prejudice as a result of that delay." Moreover, prejudice is presumed when a carrier undertakes a defense and the insured loses the right to control that defense. There, even if there is no coverage, any defenses have been waived. These principles apply to both claims made by insureds, and those made as between insurers.

Here, Sparta undertook the defense and indemnification without an express assertion of policy defenses or reservation of the privilege to do so. Indeed, in an email to the attorney for the general contractor, they merely said that they agreed to "pick up the defense and indemnification … pursuant to the contract and policy." Their later letter read similarly. The court found that these "communications did not suggest that Sparta planned to assert policy defenses to its coverage of the defense and indemnification, or that it was reserving the right to do so later." Indeed, in another later email they stated that they were picking up the defense "without reservation" and gave counsel notice to close their file for Technology and open one for Sparta. As such, its later attempt to assert policy defenses had been waived and they were estopped from doing so.

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Tenth Circuit (UT)

E&O/Inter-Related Claims Exclusion

The Tenth Circuit has ruled in *Morden v. XL Specialty Ins. Co.*, No. 17-4029 (10th Cir. Sept. 10, 2018) that claims that were asserted against a registered investment advisor during the term of XL's financial-services-liability policy were excluded from coverage as involving "inter-related wrongful acts" arising out of similar claims brought by the SEC prior to the issuance of the policy. The court ruled that the claims brought against the insureds by various clients all shared common characteristics wherein the clients were promised too much, not warned of risks and not informed of conflicts of interest of their advisors who had undisclosed stakes in the ventures. In finding that the claims by the insured's clients were "inter-related" with the earlier SEC claim, the Tenth Circuit observed that the acts were committed by the same entity against the same victims using the same techniques during the same timeframe.

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California

Auto/Limits/"Loss of Consortium" Claims

The Court of Appeal has ruled that a wife's claim for loss of consortium is subject to the same "per person" limit as the injuries suffered by her husband in an auto accident. In keeping with earlier precedents interpreting similar language, the Third District ruled in *Jones v. IDS Ins. Co.,* C084065 (Cal. App. Sept. 25, 2018) that this conclusion was mandated by the policy's coverage for "damages for bodily injury, including damages for care and loss of services" even though the policy did not expressly refer to the aggregation of consortium claims as such.

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Pollution Insurance

A federal district court has ruled in *Essex Walnut Owner L.P. v. Aspen Specialty Ins. Co.*, 2018 U.S. Dist. LEXIS 138276 (N.D. Cal. Aug. 15, 2018) did not pay for the redesign of a structural support system even though the work was necessitated by soil contamination. As the court observed, "Although the redesign of the shoring system addressed the instability in the soil that was purportedly due to the debris, the revised shoring system neutralized instability, not contamination of the soil."

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Bad Faith

***Yahoo! Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA,* October 12, 2018**

Issue of Fact as to whether Insurer Committed Bad Faith by Denying Coverage based upon an Exclusion that was not in the Relevant Policy

This insurance coverage dispute stems from several class action lawsuits filed against Plaintiff Yahoo! Inc. over its practice of scanning the content of e-mails. Yahoo tendered the lawsuits to its insurer, Defendant National Union First Insurance Company of Pittsburgh, PA, who denied coverage. Though National Union eventually retracted the denial for some claims, Yahoo had by then put on its own defense and had settled the e-mail scanning claims, paying over $4 million in the process. Yahoo sought to establish that National Union breached its duty to defend, its duty to indemnify, and committed bad faith when it denied and delayed coverage.

Yahoo argued that National Union's decisions to deny coverage of the E-mail Scanning Lawsuits were breaches of the covenant of good faith and fair dealing and demonstrates bad faith. In support, Yahoo argued that (1)

National Union cited an exclusion for "Insureds in Media and Internet Type Businesses" that was not retained in the relevant policy; (2) National Union cited this same deleted exclusion in the initial denial of coverage for the Holland lawsuit; (3) National Union used an incomplete copy of the 2011 Policy to determine whether the Holland lawsuit was a covered claim; and (4) National Union insinuated that Yahoo's inaction and failure to submit "information easily at hand" was the reason it denied coverage for the Holland lawsuit.

The court denied Yahoo's motion for summary judgment on the bad faith claim. Though the above facts were not subject to a material dispute, there was more than one inference that can be drawn from this evidence. A reasonable jury could find, as National Union argues, that there was no bad faith because its errors were simply mistaken coverage decisions and that it otherwise acted reasonably under the circumstances. Conversely, a reasonable jury could find that National Union committed bad faith by failing to investigate Yahoo's claims thoroughly. To that end, the evidence could support the finding that National Union undertook an incomplete review of its own claims file when it declined coverage for the Holland lawsuit because, had it done so, it would have discovered its response to the Sutton and Penkava lawsuits, which accurately cited the coverage grant of the policy. In addition, the evidence could support a finding that National Union committed bad faith by conducting a negligent review of its own policies, relying on standards known to be improper when denying coverage, and attempting to shift the blame for its erroneous coverage decision to its insured. To that end, the record contained at least two instances in which National Union cited policy exclusions that were not actually part of the policy, and one instance where it made a coverage decision with incomplete information.

Because the court was unable to draw inferences from the evidence and resolve the claim as a matter of law, it was up to a jury to decide whether National Union's claims-handling with respect to the E-mail Scanning Lawsuits constitutes bad faith.

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"Property Damage"/Loss of Use

The Fourth District has ruled that a liability insurer owes coverage for a law suit in which a property owner claimed that the insured tenant's negligence in failing to prevent a shooting on the premises that resulted in local authorities revoking the owner's ability to operate is as a nightclub. In *Thee Sombrero, Inc. v. Scottsdale Ins. Co.*, E067505 (Cal. App. Oct. 25, 2018), the Court of Appeal declared that the owner's inability to use the premises profitably was a "loss of use of tangible property" within the policy's grant of coverage for "property damage." The court ruled that the focus should not be on the loss of entitlement but on the loss of use of property damage that results from the loss of the entitlement.

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Connecticut

Asbestos/Limits of Coverage/Stub Policies/Statutes of Limitations

In a complex case concerning the claimed coverage obligations of various primary and excess liability insurers for asbestos claims against a pipe manufacturer, Judge Bolden has ruled in *First State Ins. Co. v. Ferguson Enterprises, Inc.*, No. 16-1822 (D. Conn. Sept. 28, 2018) that a sixteen month period issued by Swiss Re and an eleven month umbrella policy issued by American Home only owed a single aggregate limit, rejecting First State's argument that both insurers an additional limit of coverage for the stub period. In any event, the District Court ruled that First State's claims for equitable contribution were untimely whether the applicable statute of limitations was that of California (two years) or Connecticut (one year).

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Fraud and Misrepresentations

A federal district court has ruled in *Vermont Mut. Ins. Co. v. Natiello*, No. 17-2050 (D. Conn. Sept. 27, 2018) that the "fraud and false swearing" clause in a homeowner's policy, which provides that coverage is voided if the insured makes material misrepresentations concerning a claim under the policy, was not limited to issues of coverage and could be asserted by an insurer to eliminate coverage in a case where the insured gave false testimony at trial to help the plaintiff.

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Yacht Policy/Electrical Arcing

A federal district court has ruled in *National Liability and Fire Ins. Co. v. Jablonowski*, 2018 WL 4623027(D. Conn. Sept. 26 2018) that a supposed "slow burn" that caused damage and mold to the insured's yacht was not a "fire" within the scope of the policy's first-party coverage. In light of the uncontroverted testimony of the insurer's expert that the loss was actually due to electrical arcing, Judge Eginton declared that the cause of loss had never evolved to the point of combustion and therefore did not trigger coverage. Further, the District Court refused to find that the alleged sanding of an interior cabin had not amounted to "vandalism" since there was no evidence of willful or malicious destruction.

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First Party/"Collapse"

The putative class action that a few Connecticut homeowners filed nearly three years ago against over a hundred insurers alleging that property insurers conspired to eliminate coverage for crumbling foundation claims got a bit smaller last week when Judge Bolden ordered the dismissal of several insurers who had only issued policies with newer language requiring abrupt "collapses." In *Halloran v. Harleysville Preferred Mut. Ins. Co.*, No. 16-133 (D. Conn. Oct. 19, 2018), Judge Bolden declared that older "collapse" forms were ambiguous with respect to timing and rejected any suggestion that Connecticut would imply an "imminent" requirement of collapse as the Washington Supreme Court recently did in Queen Anne Park. The District Court also declined to dismiss claims based on the insured's failure to bring suit with the policy's two year limitation period, declaring that this is an affirmative defense better suited to a motion for summary judgment based upon a fully developed factual record. The court also declined to strike the plaintiffs' class allegations, declaring that these arguments could be addressed when the plaintiffs eventually moved to certify the Rule 23 class. Judge Bolden did rule, however, that no further amendments to the pleadings would be permitted and that the case, having "languished" for nearly three years as the plaintiffs constantly amended and revised their theory of the case, must now go forward with discovery limited to the class claims and a hearing on the issue of class certification.

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Florida

Liability Insurance/"Prior Knowledge" Exclusion

A Florida judge has ruled in *Berkley Assurance Co. v. Expert Group Int'l, Inc.* No. 16-3466 (M.D. Fla. Sept. 27, 2018) a 2015 liability policy did not cover a 2014 Colorado class action suit alleging that the insured had illegally conspired to suppress au pair wages around the country in light of language in the policy confirming that "[a]s of the inception date of this policy, no insured, had any knowledge of any circumstance likely to result in or give rise to a "claim" nor could have reasonably foreseen that a "claim" might likely be made." Judge Jung declined to find that the filing of an Amended Complaint during the policy period adding a new claimant was sufficient to avoid this exclusion.

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Duty to Defend/Construction Defect

***Nat'l. Builders Ins. Co. v. RQ Bldg. Prods.*, S.D. Fla., October 5, 2018**

Court Affirms Finding of a Duty to Defend Where Underlying Complaint Alleges Facts Which Fairly and Potentially Bring the Suit Within Policy Coverage

This decision relates to a United States Magistrate Judge's Report and Recommendation on the plaintiff's motion for summary judgment. The US District Court agreed with the Magistrate Judge's finding that the allegations in the underlying construction defect complaint gave rise to a duty to defend. The Court noted that under Florida law, an insurer has a duty to defend "when the complaint alleges facts which fairly and potentially bring the suit within policy coverage." Such a duty "depends solely on the allegations in the complaint filed against the insured."

The plaintiff argued that the Magistrate Judge's recommendation ignored Florida law which precludes courts from drawing even reasonable inferences to create a duty to defend where there are no allegations of any property damage during construction. The starting point of plaintiff's objections was its claim that the underlying complaint did not allege "when the allegedly defective work resulted in water intrusion and when that water intrusion damaged the property." The plaintiff objected to the Magistrate Judge's conclusion that the underlying complaint clearly stated that water intrusion occurred as a result of RQ's negligent workmanship in designing and installing windows, which led to toxic fungi and/or dust mites and that

"the defects and conditions were latent and in existence at the time [the underlying plaintiffs] took occupancy of the residence." . . . . The Magistrate Judge held that, for purposes of determining whether a duty to defend exists, it was not unreasonable to conclude that the water intrusion and fungi growth . . . occurred during the period between the time in which the windows were installed and the underlying plaintiffs moved into the property.

The plaintiff argued that "[i]mplicit in this conclusion" is the "improper inference that the damage either had to occur during construction or during the two days after the underlying plaintiffs took occupancy and the last Builders policy ended." In support, the plaintiff cited cases that forbid inferring causes of action that would have established a duty to defend from unpled allegations or from a party's statements or conduct.

The US District Court noted that the Magistrate Judge's conclusion did not find a duty to defend by inferring an unpled cause of action, nor did it rely on a party's statements or conduct. As such, the Court overruled the plaintiff's objection. Furthermore, the Court agreed with the Magistrate Judge that the allegations in the underlying complaint were "not conclusory or without factual support" because the home was completed at the time of sale and possession by the underlying plaintiffs and the windows were necessarily installed before the underlying plaintiffs moved into the home (while the Policies were in effect). The Court concluded that the underlying complaint alleged facts that *fairly and potentially* brought the suit within the policy coverage.

Specifically, the underlying complaint alleged in paragraph 223 that:

> [D]efective, negligent and/or inadequate construction, design, and/or installation of windows and window components. . . *resulted in chronic water intrusion* into the walls, columns, ceilings, interstitial cavities and/or drywall and baseboard. . . *which caused microbiological contamination in the form of the growth of toxic and/or allergenic fungi*
>
> *and dust mites* which posed a serious health hazard to the occupants of the home, have *caused personal injury* to the occupants of the home, and *required evacuation of the occupants. . . for the repair and remediation . . . .*

In Paragraph 224, the underlying complaint alleged that the defects and conditions were *latent* and *in existence at the time the underlying plaintiffs took occupancy* of the residence and that the damages were *"continuous and progressive over time."*

Paragraphs 223 and 224 alleged that RQ Building Products, Inc.'s negligent conduct caused water intrusion, that in turn caused the growth of toxic and/or allergenic fungi and dust mites, and that these defects and conditions were "latent" and "in existence at the time" the underlying plaintiffs took occupancy of the residence—at which point the insurance policy was in effect. Paragraphs 223 and 224 thus refuted the plaintiff's argument that the complaint failed to allege the existence of resulting property damage during the policy period.

The Court rejected the plaintiff's argument that the underlying complaint deficiently alleged when the damage occurred as such a position has been repudiated by controlling case law. The Court cited case law holding that an insurer had a duty to defend where underlying complaint *"suggested that the damage occurred at some point"* during the time the "policies were in effect.

Furthermore, the Court acknowledged that the question of when precisely the damage occurred "may be answered at trial, [but] at this point [the] only concern is with the pleadings, not the proof at trial, and it matters not that there ultimately may be no coverage under the policy," because the law establishes that "the insurer may be required to defend a suit even if the later true facts show there is no coverage.

The Court noted that even assuming that the allegations in the underlying complaint leave some doubt as to precisely when the damage occurred, it is settled law that "any doubt as to the duty to defend. . . must be resolved in favor of the insured."

Accordingly, the Court found that the allegations in the underlying complaint gave rise to the plaintiff's duty to defend the property damage claims.

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Ripeness

Mid-Continent argued that the matter was ripe because its duty to indemnify was based "only on when Delacruz performed [its] work" and it was not based on a final adjudication in the underlying state case. The Court disagreed.

The Court noted that "the ripeness doctrine involves both jurisdictional limitations imposed by Article III's requirement of a case of controversy and prudential considerations arising from problems of prematurity and abstractness that may present insurmountable obstacles to

the exercise of the court's jurisdiction, even though jurisdiction is technically present." It "protects federal courts from engaging in speculation or wasting their resources through the review of potential or abstract disputes." Ripeness ultimately "goes to whether [a] district court had subject matter to hear the case."

To determine a claim's ripeness, courts consider two matters: (1) "the fitness of the issues for judicial decision, and (2) the hardship to the parties of withholding court consideration." For an insurer's duty to indemnify, many district courts in the Eleventh Circuit have held "that an insurer's duty to indemnify is not ripe for adjudication unless and until the insured or putative insured has been held liable in the underlying action." The Court noted that it had previously held that an insurer's duty to indemnify is not ripe without a determination of the insured's liability.

The Court held that Mid-Continent failed to provide any compelling reason to cut against the courts' prior decisions. Although Mid-Continent's argument that its duty to indemnify depended solely on when Delacruz performed its work may be accurate, it missed the point on ripeness. If Delacruz is not liable, it does not matter when Delacruz performed its work because indemnification is not required. The Court stated that only time will tell how the ongoing state court case plays out. Mid-Continent also failed to identify any hardship it would suffer if the Court withheld consideration on this issue. Nor was it clear if Delacruz would even seek indemnification from Mid-Continent if Delacruz was found liable. Consequently, the Court determined that Mid-Continent's duty to indemnify was not ripe, and its claims requesting a declaration on its duty to indemnify were dismissed without prejudice.

As a result, the Court held that Mid-Continent's argument on its duty to defend Delacruz also failed because they hinged on the Court first deciding Mid-Continent's duty to indemnify. Although Mid-Continent argued that it had no duty to defend Delacruz in its motions, it never affirmatively sought this relief in its Second Amended Complaint.

Instead, the Second Amended Complaint only sought a declaration on its duty to indemnify Delacruz. Therefore, as there were no remaining claims, the case was dismissed in its entirety without prejudice. Accordingly, Mid-Continent's motions were denied.

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Illinois

First Party/"Water Below the Surface of the Ground"

The Appellate Court has ruled in *Central Illinois Compounding, Inc. v. Pharmacists Mutual Ins. Co.*, 2018 IL. App. (3d) 170809 (Ill. App. Ct. Sept. 6, 2018) that a first party exclusion for loss to the insured premises caused by "water below the surface of the ground" precluded coverage for a flood that resulted from nearby boring operations by a contractor that damaged the water service line a few feet from the insured premises. The Third District rejected the insured's argument that this exclusion only applied to water damage that occurred below ground. The Appellate Court ruled that this construction of the policy was contrary to its grammatical structure, as its text made clear that the exclusion applied to the area where the release of water had originated and was not restricted to loss or damage below the surface of the ground. The court also rejected the insured's argument that water that seeped up through the foundation of the insured's property was no longer "water below the surface of the ground."

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E&O/"Claim"/"Related Acts"

A federal judge has ruled that ten separate lawsuits alleging that the insured mishandled human remains all involved similar allegations of wrongdoing and therefore constituted a single $2 million "claim" under a professional liability insurance policy underwritten by Hiscox. In *Lloyd's Syndicate 3624 v. Biological Research Center of Illinois, LLC*, 2018 U.S. Dist. LEXIS 160263 (N.D. Ill. Sept. 19, 2018), the District Court found that the claims were sufficiently similar as to fall within the policies aggregating language for a "continuous, repeated or related wrongful acts."

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Sexual Abuse/"Any Insured"

The Appellate Court has ruled that a trial judge erred in refusing to find coverage for allegations that day care operator failed to prevent her spouse from abusing a child in her care. While agreeing that the policy's exclusion for injuries "intended by, or which may reasonably be expected to result from intentional or criminal acts or omissions of any insured person" would have barred coverage for any claim against the perpetrator, the Second District declared

in *Allstate Indemnity Company v. Contreras*, 2018 IL App. (2d) 170964 (Ill. App. Ct. Sept. 25, 2018) that the intent of one insured could not be imputed to the other. Further, even though the exclusion applied to "any insured person," the court declined to give it broader effect that similar exclusions for "the insured" in keeping with cases such as Westfield National.

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Kansas

Tripartite/Negligent Selection of Counsel/Restatement

The Chief Justice of the U.S. District Court in Kansas has rejected the ALI Restatement's conclusion that insurers may be liable if they appoint defense counsel even after learning that the lawyer has a "problem." In *Progressive Northwestern Insurance Company v. Gant*, 2018 WL 4600716 (D. Kan. Sept 24, 2018), declaring that Restatement was still unpublished and, furthermore, that this aspect of Section 12 did not reflect Kansas law and that the insurer in this case was not liable for hiring an attorney who had a reputation for being obstreperous and for "thwarting settlements." The District Court also predicted that the Kansas Supreme Court would not require an insurer to evaluate future potential conflicts of interest that had not come to pass at the time that it appointed defense counsel.

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Michigan

Bad Faith

***Wausau Underwriters Ins. Co. v. Reliable Transport. Specialists,* D. Mich., October 17, 2018**

Court Granted Insurer's Motion to Dismiss Its Own Declaratory Judgment Action So It Could Litigate the Insureds' Bad Faith Claim as a Defendant.

The case stems from an underlying lawsuit filed by Holt against Reliable Transportation Specialists, Ushe, and Containerport Group after Holt was struck by a tractor trailer operated by Ushe. At trial, Holt obtained a verdict against Reliable and Ushe in the amount of $8,735,142.35. Reliable and Ushe took the position that Wausau was responsible to pay the entire amount of the judgment because of its bad faith failure to settle within the $1,000,000 policy limits.

In the Fall of 2017, Wausau, Reliable, Ushe and Holt reached an agreement pursuant to which: (1) Wausau paid its $1,000,000 policy limit plus supplementary payments owed pursuant to policy terms; (2) the application for leave to appeal to the Michigan Supreme Court would be withdrawn; and (3) Holt agreed to forego further collection on the judgment against Reliable and Ushe until the action pending before this court is resolved, including all appeals. Wausau paid Holt $1,545,462.55 on behalf of Reliable and Ushe. A partial satisfaction of judgment as to Reliable and Ushe was entered by the trial court on November 29, 2017.

Prior to that agreement, Wausau had commenced a declaratory judgment action seeking a declaration that it was only responsible for paying the policy limit and not the entire verdict. Wausau initiated its declaratory judgment action against Reliable, Ushe and Holt while the underlying verdict was being appealed by Reliable and Ushe. Despite naming Holt in the action, Wausau took the position that he was not entitled to proceed and that it only named him to protect its insured from immediate collection efforts. Reliable and Ushe filed counterclaims for breach of contract and tort, alleging that Wausau acted in bad faith against its insured by refusing to negotiate a settlement of the Holt Litigation within the policy limits.

Wausau moved to dismiss its own declaratory judgment complaint without prejudice. Wausau argued that it initiated the declaratory judgment action when it was unclear if the verdict would survive post-judgment motions and appeal. With the underlying action resolved, it argued that the counterclaims for breach of contract and bad faith should control.

The court noted that Wausau's declaratory judgment action had been pending for three years. depositions had been conducted and there was extensive discovery conducted. Holt expended hundreds of hours of attorney's fees defending the declaratory judgment action. The defendants accused Wausau of engaging in an about-face trial strategy. They argued that it did not want the jury to know it had sued its insured and Holt, and it did not want the burden of proving its case.

While the court did not opine that it believed Wausau was acting nefariously, it did agree to dismiss the case. However, the court noted that Wausau's declaratory judgment action required the defendants to expend a great deal of time and effort engaging in discovery. Accordingly, while the court agreed to the dismissal, it ordered Wausau

to pay all of Holt's attorney's fees incurred in the declaratory judgment action.

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First Party/Business Interruption

A federal district court has ruled in *Milk Indus. Mgmt. Corp. v. Travelers Indemnity Company of America*, 2018 U.S. Dist. LEXIS 147743 (D.N.J. Aug. 30, 2018) that a milk distributor's claim for business interruption coverage after a fire destroyed its distributor's dairy production facility was limited to the time that it should have taken for the distributor to rebuild its plant. The court noted that "[b]ecause [the insured] never resumed operations at a new permanent location, the [period of restoration] is based on when the 'property at the described premises'—[the Subcontractor's] facility—'should be' rebuilt." Further, the court refused to require the insurer to provide "extended business interruption coverage" in these circumstances. Emphasizing the difference between "would have" in the ordinary business income provision and "actually did" for Extended Business Interruption coverage, the court observed that this coverage "does not rely upon estimations, but rather when the property is actually repaired, rebuilt or replaced, and when operations are resumed." Because the milk supplier plant was never rebuilt and the insured's operations never resumed, the insured was not entitled to extended business interruption coverage.

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Bad Faith

***Orban v. Liberty Mutual Fire Ins. Co.,* D. N.J., October 9, 2018**

District Judge Dismisses Claim of Bad Faith Denial Because Question of Coverage Was Fairly Debatable

Liberty Mutual ("Liberty") issued an insurance policy (the "Policy") to Plaintiffs, Natalie and David Orban ("Plaintiffs"). The Policy excludes coverage for various types of loss, including "loss caused directly or indirectly by . . . [w]ater [d]amage, meaning . . . [w]ater below the surface of the ground, including water which exerts pressure on or seeps or leaks through a building, sidewalk, driveway, foundation, swimming pool or other structure" (the "Water Damage Exclusion"). The Water Damage Exclusion applies "regardless of any other cause or event contributing concurrently or in any sequence to the loss."

The Policy also includes a Sinkhole Collapse Endorsement, providing insurance for "direct physical loss to property . . . caused by Sinkhole Collapse." It defines "Sinkhole Collapse" as "actual physical damage arising out of, or caused by, sudden settlement or collapse of the earth supporting such property and only when such settlement or collapse results from subterranean voids created by the action of water on limestone or similar rock formations."

Plaintiffs commissioned five parties to determine whether this damage was the result of a sinkhole collapse, including Frey Engineering. Frey Engineering concluded that the damage was caused by a sinkhole.

In 2015, Liberty was notified of cracks in the basement floor and foundation wall of Plaintiffs' house. Liberty investigated the claim. Specifically, Liberty hired two engineers—Chris Reith and Peter Svaboda—to inspect the building at the premises and determine the cause of loss. Based upon the engineers' reports, Liberty denied the claim. Prior to disclaimer, Liberty's adjuster received a copy of the Frey report. The adjuster concluded that the Frey report was wrong because it conflicted with Reith's and Svaboda's conclusions.

Plaintiffs sued Liberty alleging, among others, breach of contract and bad faith denial of insurance claim. Liberty moved for summary judgment on all claims.

The Court found an issue of fact on the breach of contract claim. The Sinkhole Collapse Endorsement included in the Policy covers "actual physical damage arising out of, or caused by, sudden settlement or collapse of the earth supporting such property and only when such settlement or collapse results from subterranean voids created by the action of water on limestone or similar rock formations." Plaintiff's expert, Frey, concluded that the damage was caused by a sinkhole.

Liberty argued that, even if the damage was caused by sinkhole collapse, Plaintiffs cannot recover because of the Policy's Water Damage Exclusion. The Water Damage Exclusion, by its terms, excludes coverage for "loss caused directly or indirectly by [water damage,] regardless of any other cause or event contributing concurrently or in any sequence to the loss." According to Liberty, "if Plaintiffs' loss was caused even in part by Water Damage, . . . there is no coverage for Plaintiffs' claims."

The Court found that, even if Liberty's interpretation of the Policy is correct, there was a genuine dispute of fact as to whether Plaintiffs can claim any loss that was not caused in part by water damage. Liberty's two experts concluded that the loss *was caused* in part by water damage and one of Plaintiff's experts concluded that the loss *was not caused* in part by water damage. Summary judgment was denied on the breach of contract claim.

The Court granted summary judgment to Liberty on the bad faith denial claim. In New Jersey, a claim of bad faith requires a showing that the insurer knowingly or recklessly lacked a reasonable basis to deny the claim. A bad faith claim must fail where the insurer's denial of the claim was fairly debatable. The Court found that Liberty refused to pay Plaintiffs' claim on the basis of reports written by two engineers, Reith and Svaboda. No facts had been put forth to show that these reports were wholly fraudulent, or were crafted without any investigation or expertise.

The Court held that fact that these two engineers arrived at conclusions consistent with Liberty's decision to deny Plaintiffs' claim demonstrates that that decision was fairly debatable. Therefore, on the bad faith denial claim summary judgment was granted to Liberty.

Disclaimer: This is an unpublished decision which has precedential value in only limited circumstances.

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Property/Condition Precedent to Coverage

***Vineland 820 N. Main Road, LLC v. U.S. Liability Ins. Co., D.* N.J., September 29, 2018**

New Jersey Federal Court Rules that Protective Safeguards Condition Was Clear and Unambiguous, Upholds Denial of Fire Loss Where Insured Failed to Comply

Vineland 820 N. Main Road, LLC ("Plaintiff") owns premises located at 820 N. Main Road, Vineland, New Jersey. Plaintiff obtained property insurance with United States Liability Insurance Company ("USLIC").

Part of the policy contained a form titled "Protective Devices Or Services Provisions" (Protective Safeguard condition"). The policy required, as a condition of insuring the building, that Plaintiff "have and maintain the Protective Devices or Services listed" in an incorporated schedule. The schedule required that "[a]ll electric is on functioning and operational circuit breakers." The policy stated: [USLIC] will not pay for loss or damage caused by or resulting from fire if, prior to the fire, [Plaintiff]: (1) Knew of any suspension or impairment in any protective safeguard listed in the Schedule . . . and failed to notify [USLIC] of that fact; or (2) Failed to maintain any protective safeguard listed in the Schedule . . ., and over which you had control, in complete working order.

On May 7, 2015, a fire started in the wiring on the second floor of 820 N. Main Road. Following an investigation, USLIC denied coverage for the claim based upon Plaintiff's failure to comply with the Protective Safeguard condition.

Plaintiff sued USLIC alleging wrongful denial of claims, bad faith, failure to conduct a reasonable investigation, breach of contract, breach of implied covenant of good faith and fair dealing, breach of fiduciary duty, and requested punitive damages. USLIC moved for summary judgment.

USLIC's expert opined that the "main electrical panel" for the second-floor apartment that caught fire was actually a "fuse panel box." Undisputed pictures reveal that, in fact, this was a fuse panel box with four fuses. Plaintiff's own expert admits the existence of the fuse box. Plaintiff, however, suggested that the "fused subpanel was protected by a circuit breaker." This was inconsistent with his expert's testimony. His expert testified that, it was unknown whether the circuit breakers function, but the fact that a tenant switched the breakers off before the fire department arrived, "suggests they *did not*."

USLIC's motion for summary judgment focused on one point. As a condition of providing insurance, Plaintiff was required to maintain operational circuit breakers for all electric at the premises; Plaintiff failed to meet this condition. Because Plaintiff failed to meet this condition, USLIC argued that it has no obligation under the insurance policy to pay for any damage caused by the fire.

Plaintiff resisted summary judgment. First, Plaintiff argued that because the use of a fuse (or a non-functioning circuit breaker) was not the cause of the fire, it was "unfair" for USLIC to deny coverage. Second, Plaintiff argued that it did not know of the "Protective Devices Or Services Provisions" and that it was an "obscure" provision of the contract. Third, Plaintiff argued that because the fuses were on a circuit breaker, denial of coverage was incorrect.

The Court began its analysis by reviewing the Protective Safeguard condition. The court found that the endorsement was unambiguous. The Court explained that: The contract required "[a]ll electric" to be "on functioning and operational circuit breakers." That means that all electric used in the building must only run through a circuit

breaker. If, prior to a loss, these circuit breakers were not maintained "in complete working order" USLIC had no obligation to "pay for loss or damage caused by or resulting from fire."

Upon reviewing the language of the endorsement, the Court immediately rejected Plaintiff's argument that "the loss had to be connected to the exclusion condition in order for it to be even considered." The Court ruled that nothing in the endorsement required that the fire be caused by or resulting from use of fuses or an inoperative circuit breaker.

Plaintiff also argued that because the company's owner did not read the insurance policy, Plaintiff should not bound by it. Under New Jersey law, a policyholder is obliged to read the policy he receives and is bound by the policy's clear terms. An insured cannot escape the clear terms of an insurance policy just because he has not read them.

Finally, the Court addressed the factual argument that Plaintiff's fuses were on a circuit breaker. The Court stated that:

> the fact that the fuses exist means that less than all of the electricity at the premises was on a circuit breaker. Because electricity was running through the fuse, the electricity going through those fuses was not on a circuit breaker.
>
> In addition, Plaintiff's own expert admitted that the circuit breaker likely did not work. Therefore, the Court also found that Plaintiff "[f]ailed to maintain [the circuit breaker] . . . in complete working order" in violation of the policy.

Accordingly, the District Judge ruled that the denial of insurance coverage was proper. As a result, the Court granted summary judgment in full to the insurer and dismissed Plaintiff's claims for wrongful claim denial, bad faith, failure to conduct a reasonable investigation, breach of contract, breach of implied covenant of good faith and fair dealing, breach of fiduciary duty, and punitive damages.

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New York

Additional Insured/"Proximate Cause"

***Pioneer Central School District v. Preferred Mutual Ins. Co.*,**
Appellate Division, Fourth Department, October 5, 2018

Fourth Department Embraces Burlington. Where Named Insured Employer Was Not Responsible for Snow and Ice Removal, Employee Injury Caused by Ice Does Not Trigger Additional Insured Coverage Under Employer's GL Policy's AI Clause

Pioneer CSD ("Pioneer") commenced this action against defendant Preferred Mutual Insurance Company ("Preferred Mutual") seeking a declaration that Preferred Mutual is obligated to defend and indemnify Pioneer in an underlying personal injury action.

Kleanerz provided janitorial services to Pioneer pursuant to a contract containing an indemnification provision through which Kleanerz agreed to indemnify Pioneer in actions for bodily injury "arising or resulting from any act, omission, neglect or misconduct of [Kleanerz]." Kleanerz was insured by Preferred under a policy containing an additional insured endorsement listing Pioneer as an additional insured for bodily injury "caused, in whole or in part, by" the "acts or omissions" of Kleanerz or of those acting on Kleanerz's behalf.

Dawn Ayers, a Kleanerz employee, commenced the underlying personal injury action against Pioneer, alleging that she was injured when she slipped on snow or ice in the parking lot of Pioneer Middle School after completing her shift. Pioneer filed a third-party summons and complaint against Kleanerz and thereafter commenced this action against defendants, seeking a declaration that Preferred was obligated to indemnify Pioneer either as an additional insured under Kleanerz's policy with Preferred Mutual or pursuant to the indemnification provision in the janitorial services contract between Pioneer and Kleanerz.

Preferred contended that Pioneer did not qualify as an additional insured under the policy and that the indemnification provision in the janitorial services contract did not create coverage for Pioneer.

The Fourth Department concluded that Pioneer was not an additional insured under the policy inasmuch as Ayers' injuries were not proximately caused by Kleanerz. This is one of the first post-*Burlington* cases that demonstrate its impact on diminishing the breadth of additional insured clauses.

The policy's additional insured endorsement provided that the injury must have been "caused, in whole or in part, by" Kleanerz's conduct, and thus it required that the insured must have been a proximate cause of the injury, not merely a "but for" cause (see Burlington Ins. Co. v NYC Tr. Auth., 29 NY3d 313, 321 [2017]). Here, it was undisputed that Kleanerz was not responsible for clearing ice and snow from the parking lot and that Ayers' fall resulted from her slipping on the ice or snow.

Although Pioneer contended that Kleanerz caused the accident by instructing Ayers to exit Pioneer Middle School through a door located near the area where Ayers subsequently slipped, Kleanerz's instructions to Ayers "merely furnished the occasion for the injury" by "fortuitously placing Ayers in a location or position in which . . . [an alleged] separate instance of negligence acted independently upon [her] to produce harm" and were not a cause of the accident triggering the additional insured clause of the policy.

The court further concluded that the indemnification provision in the janitorial services contract did not create coverage under the insurance policy. The insurance policy covers liability assumed in an "insured contract" between Kleanerz and a third party. An "insured contract" is defined in the policy as "[t]hat part of any other contract or agreement pertaining to [Kleanerz's] business . . under which [Kleanerz] assume[s] the tort liability of another party to pay for bodily injury' . . . to a third person or organization, provided the bodily injury' . . . is caused, in whole or in part, by [Kleanerz] or by those acting on [Kleanerz's] behalf." Here, the injuries were not "caused, in whole or in part, by" Kleanerz's acts, and thus the indemnification provision of the janitorial services contract did not fall within the "insured contract" coverage provided by the insurance policy.

Preferred Mutual had no duty to indemnify Pioneer and consequently no duty to defend [Pioneer] in the pending Ayers action. Moreover, because the policy did not provide coverage to Pioneer, Preferred Mutual was not required to timely disclaim coverage.

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E&O/Qui Tam/Fraud Exclusion

A federal district court has ruled in *Affinity Living Grp., LLC v. Starstone Specialty Ins. Co.*, 2018 U.S. Dist. LEXIS 163655 (M.D.N.C. Sept. 25, 2018) that the professional liability insurer of a nursing home operator did not owe coverage for qui tam claims based on the insured's claimed Medicaid fraud in the operation of various adult care homes. As the predicate for these claims was dishonest conduct on the part of the insured, the court ruled that coverage was excluded as involving "dishonest, fraudulent, criminal or intentionally malicious act, error or omission by an Insured...." Further, the court ruled that the claims were subject to an exclusion for any "Claim made by or on behalf of any federal, state or local governmental or regulatory agency or entity, including but not limited to any Claim alleging health care fraud . . . ."

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Additional Insureds

The Supreme Court of North Dakota has ruled in *Borsheim Builders Supply, Inc. v. Manger Insurance, Inc.*, 2018 ND 18 (N.D. Aug. 25, 2018) that a lower court erred in ruling that a contractor was not entitled to coverage as an additional insured or that coverage was precluded by the CGL policy's "contractual liability" exclusion.

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Ohio

"Occurrence"/Construction Litigation

***Ohio N. Univ. v. Charles Constr. Servs., Inc.*, --- N.E.3d ---, Slip Op. No. 2018-Ohio-4057 (Ohio Oct. 9, 2018)**

The Ohio Supreme Court ruled yesterday that Cincinnati Insurance Company (CIC) had no duty to defend its general contractor insured, Charles Construction Services Inc. (Charles), finding that a subcontractor's faulty work on a hotel and conference center at Ohio Northern University (ONU) was not an "accident."

ONU contracted with Charles in 2008 to build The University Inn and Conference Center. Charles obtained a CGL policy from CIC that included a Products Completed Operations Hazard clause and terms specifically related to work performed by subcontractors. In September 2011, after work was completed, ONU discovered extensive water infiltration and other damage to the building and estimated repairs at $6 million. ONU sued Charles for breach of contract, and Charles lodged third-party complaints against several subcontractors. CIC agreed to defend Charles under a reservation of rights and later obtained a declaratory judgment, freeing it from any duty to defend Charles.

In its ruling, the trial court relied upon the Ohio Supreme Court's opinion in *Westfield Ins. Co. v. Custom Agri Sys., Inc.*, 979 N.E.2d 269 (Ohio 2012), which found that property damage stemming from a policyholder's own defective work is not an accidental "occurrence," giving rise to an insurer's duty to defend. An appellate panel reversed, acknowledging that *Custom Agri* remained "good law" as applied to property damage claims resulting from the policyholder's own work, but reasoning that *Custom Agri* failed to address policy provisions dealing with subcontractors.

The Ohio Supreme Court reviewed the decision by the Ohio Court of Appeals to determine whether *Custom Agri* applies to claims regarding a subcontractor's faulty work. Despite a nationwide trend favoring coverage for such claims, the Supreme Court held that *Custom Agri* applies in equal force to damages tied to the work of a policyholder's subcontractors, so Charles was not covered for the ONU construction defect litigation: "We hold that property damage caused by a subcontractor's faulty work is not fortuitous and does not meet the definition of an 'occurrence' under a CGL policy."

The Supreme Court also noted that a ruling in favor of Charles would contravene the purpose of CGL coverage by effectively granting insurance coverage for a foreseeable risk: "As we explained in *Custom Agri*, CGL policies are not intended to protect owners from ordinary 'business risks' that are normal, frequent or predictable consequences of doing business that the insured can manage." The Ohio high court specifically rejected arguments by Charles, ONU and construction trade groups in favor of coverage for subcontractors' work based on recent holdings in various other jurisdictions, stating that "[r]egardless of any trend in the law, we must look to the plain and ordinary meaning of the language used in the CGL policy before us. … When the language of a written contract is clear, we may look no further than the writing itself to find the intent of the parties."

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Definition of Property

***Kimmelman v. Wayne Ins. Group,* No. 18CV001041 (C.P. Sept. 25, 2018)**

The Court of Common Pleas in Franklin County, Ohio ruled that BitCoin qualifies as property rather than money for insurance purposes.

Plaintiff James Kimmelman (Kimmelman) submitted a claim to the defendant Wayne Insurance Group (Wayne), reporting approximately $16,000 in stolen BitCoin. Wayne investigated the claim and awarded Kimmelman $200 after determining that BitCoin was "money" and governed by a sublimit within the insurance contract.

Kimmelman then filed an action for breach of contract and bad faith against Wayne. Wayne moved for judgment on the pleadings, arguing that its classification of BitCoin as "money" was proper such that there was no breach of contract or bad faith. In support of its argument, Wayne cited to various news articles and an Internal Revenue Service (IRS) document which states that BitCoin is "virtual currency."

Examining the same document, the court noted that the IRS stated "'[f]or federal tax purposes, virtual currency is treated as property.'" Thus, the court held that BitCoin, "although termed 'virtual currency,' is recognized as property by the IRS and shall be recognized as such by this Court." Accordingly, the court denied Wayne's motion for judgment on the pleadings.

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