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Covered Events

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In This Issue

Leadership Note

From the Editor

By Suzanne M. Whitehead

Register today for the Complex Coverage Forum on November 6, 2019, in Hartford, Connecticut! The Complex Coverage Forum will change locations next year, so this is your last chance to catch it in Hartford! Tell your clients—registration is free for all in-house attorneys and claims professionals. Registration is limited so register today.

The Complex Coverage Forum is a one day forum on the latest coverage issues. The program will feature nationally recognized industry and outside counsel speakers in a collegial setting designed to address cutting-edge developments, including the impact that new laws eliminating statute of limitations for sexual abuse claims will have on the insurance industry. A highlight of the program will be an interactive, small group luncheon discussions on a broad array of topics.

This issue of *Covered Events* includes two great featured articles: "The Tides are Turning on Special costs in Insurance Coverage Cases," by Kristal M. Low; and "An Insurer's Guide to Reserving Rights: Avoiding Traps for the Unwary," by Philip W. Savrin and Justin J. Boron.

As always, if you are interested in writing a featured article for an upcoming edition of *Covered Events*, please contact your substantive law subcommittee chair or a *Covered Events* editor. Also, to submit a case summary of a new decision, please it to one of our editors and we will include it in the next edition of *Covered Events*.

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Feature Articles

The Tides Are Turning on Special Costs in Insurance Coverage Case

By Kristal M. Low

Recently in *West Van Holdings Ltd. v. Economical Mutual Insurance Company* 2019 BCCA 110 (released April 5, 2019), the British Columbia Court of Appeal, on a three panel member, found that there was no principled legal basis to automatically award special costs to insureds who were successful in a coverage dispute. The Court of Appeal in *West Van Holdings* did a full analysis of the issue and stated clearly that all prior cases awarding special costs in the absence of misconduct were wrong; however, the comment was made in *obiter* and thus not technically binding.

A few months later, in *Blue Mountain Log Sales Ltd. v. Lloyd's Underwriters,* 2019 BCCA 240 (released June 28, 2019), the Court of Appeal affirmed the comments made in *West Van Holdings* and set aside an award of special costs based on the decision in *West Van Holdings*, as there was no reprehensible conduct on the part of the insurer.

As a result of these two cases, the landscape on awards for special costs in British Columbia specifically in insurance coverage cases has changed significantly, and insurers can breathe a little easier when defending a claim for coverage.

West Van Holdings Ltd. v. Economical Mutual Insurance Company

In *West Van Holdings,* the plaintiffs West Van and Lions Gate operated a dry cleaning business and had been sued for damages arising out of contaminants alleged to have migrated from the insureds' property to adjacent lands.

West Van and Lions Gate sought a defense under a CGL policy from Intact (their insurer from 1998 to 2002) and Economical (their insurer from 2002 to 2012). Both insurers denied coverage on the basis of exclusion clauses. Intact relied on its "Environmental Liability" exclusion, and Economical denied coverage relying on its "Pollution Liability" exclusion. Of note, there were no allegations of bad faith against the insurers in denying coverage.

West Van and Lions Gate filed a claim against Economical and Intact (2017 BCSC 2397), and in a summary judgment application successfully argued that the duty to defend had been triggered and a defense was owed to them. The insureds were also awarded special costs (solicitor and own client costs) as per the recent trend of cases that have held that "*any expenditure by the insured in enforcing that objective would, if successful, be followed by a costs award that similarly achieved that objective*." In addition, the chambers judge relied on a series of authorities that held that an award for special costs in coverage petitions did not require a finding of reprehensible conduct because of "the unique nature of the insurance contract and in terms of fulfilling the objective under that policy."

The insurers successfully appealed the decision that they owed a duty to defend and also appealed the special cost award, arguing that there was no principled basis to award solicitor-and-own-client costs against the insurers, despite the number of British Columbia Supreme Court cases that have held otherwise. In doing so, the insurers successfully argued that there was no legal basis on a matter of contractual interpretation to imply a term into the insurance contract that obliges insurers to fully indemnify an insured for expenditures arising from a proceeding to enforce coverage. They further argued that there was no uniqueness to coverage claims or any principled basis for treating coverage claims differently than any other actions arising from a contractual dispute.

The appellate court found the chambers judge had erred in finding a duty to defend and accordingly did not need to deal with the appeal of the cost award; however, Goepel, J.A. continued, in *obiter*, with a thorough discussion on the purpose of special costs (*i.e.* to deter misconduct) and the circumstances in which special costs may be awarded.

Ultimately, Goepel, J.A. stated that the lower court decisions to award special costs in coverage disputes were wrong in principle in that special costs awards were not authorized by the Rules. Given that determination, those decisions should no longer be followed.

Goepel, J.A. reaffirmed a number of the legal principles underlying what special costs were and when they were to be awarded. He also made a number of comments on the (erroneous) use of special costs awards in coverage claims. Key highlights of Goepel, J.A.'s analysis are follows:

- Costs play an important role in civil litigation. They have a purpose beyond indemnification of the successful party in the litigation (para. 64);
- Party and party costs are the default option. The purpose of party and party costs is to partially indemnify the successful litigant, deter frivolous actions and defenses, encourage both parties to deliver reasonable offers to settle, and discourage improper or unnecessary steps in the litigation (para. 66);
- The main purpose of special costs is to deter misconduct. If a losing party faces full indemnity costs irrespective of their litigation conduct, the incentive for good conduct is correspondingly diminished. (para. 108);
- Special costs are usually awarded when there has been some form of reprehensible conduct on the part of one of the parties. There are limited circumstances when special costs may be ordered where there has been no wrongdoing (paras. 68–69);
- A judge cannot impose costs sanctions that are not authorized by the Rules (paras. 64, 95);
- Special costs are not a substitute for damages or a remedy to be used for a breach of contract. They are distinct from punitive damages (para. 70);
- The law of costs in British Columbia is different from in Ontario. The *Supreme Court Civil Rules* in British Columbia do not have "full indemnity" as a level of costs that can be awarded (as opposed to the Ontario Rules). Further, an award for special costs in British Columbia does not necessarily lead to full indemnity (paras. 75–76);
- The wording of the policy governs indemnity. Where the insurance contract is limited to the cost of defending an underlying action against an insured, the language in the policy cannot be extended, or the terms implied, to cover legal fees and expenses the insured may incur in attempting to enforce its contractual right to coverage (para. 99);
- There is no legal basis to imply a term that the insurer will pay special costs if it unsuccessfully resists a claim under the policy (para. 100);

- There is no custom in the insurance industry by which insurers are expected to pay the full indemnity costs of a claimant enforcing coverage (para. 101);
- While the special nature of insurance contracts is accepted, and there is an implied term of good faith and fair dealing, this implied term does not extend or create a special costs regime to be automatically applied to all insurance claimants (paras. 104–105);
- There is no principled reason to award costs in a duty to defend case in a manner different from any other litigation (para. 109).

Ultimately, after conducting a full analysis of the matter, Goepel J.A. stated, *in obiter,* that all previous Supreme Court decisions in which special costs were awarded in coverage dispute and in the absence of misconduct were all wrongly decided and should not be followed.

Goepel, J.A.'s analysis was affirmed a few months later in *Blue Mountain.*

Blue Mountain Log Sales Ltd. v. Lloyd's Underwriters

A few months later in *Blue Mountain Log Sales Ltd. v. Lloyd's Underwriters*, 2019 BCCA 240 (released June 28, 2019), the Court of Appeal affirmed the *obiter* comments made in *West Van Holdings* on special costs. Specifically, Dickson J.A. for the court in *Blue Mountain* affirmed that costs in a duty to defend case should be awarded in the *same manner* as in other litigation. In other words, there is no exception or special circumstance that warrants a modified costs regime in insurance coverage cases.

Blue Mountain dealt with a coverage petition involving the duty to defend the insured parties in an action brought against them in Washington State for advertising liability under two CGL policies. The trial judge concluded that the insurer owed a duty to defend and awarded special costs to the insureds seeking coverage. The insurer appealed the coverage decision that it owed a duty to defend but did not appeal the award of special costs given the existing jurisprudence. Reasons in *West Van Holdings* were delivered after the oral hearing in *Blue Mountain* and while the decision was under reserve. The Court of Appeal invited written submissions on the appropriate effect, if any, on the outcome of the appeal.

The Court of Appeal in *Blue Mountain* found that it was appropriate to consider and apply the principles in *West Van Holdings* on the issue of special costs. The Court of Appeal in *Blue Mountain* was persuaded by the *obiter* comments made in *West Van Holdings* but did not do any additional analysis. Rather, the appellate court ruled to vary the award of special costs and replaced it with an award of ordinary costs, finding that "*the interests of justice favour application of the principles enunciated in West Van Holdings on special costs.*"

What Does This Mean?

A victory for insurers!

With both the *obiter* comments in *West Van Holdings* and the judgment in *Blue Mountain,* the law on special costs in a duty to defend claim in British Columbia has been significantly altered.

In effect, so long as an insurer facing a duty to defend claim does not breach its duty of good faith or conduct itself in a manner that is worthy of rebuke, it will no longer have to worry about incurring the additional costs of fully indemnifying a successful insured for legal fees and expenses in a coverage dispute. An insured will be entitled only to ordinary costs of the litigation if it succeeds in a claim for coverage, as would be the case in any contractual dispute.

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An Insurer's Guide to Reserving Rights: Avoiding Traps for the Unwary

By Philip W. Savrin and Justin J. Boron


An insurer that is presented with a liability claim that might not be covered by the terms of the insurance policy can preserve its coverage defenses by entering into a reservation of rights agreement with the insured. When done properly and in a timely manner, such an agreement allows the insurer to take the necessary steps to protect the interests of the insured in defending the liability claim without sacrificing its coverage position. There are pitfalls, however, that can make preservation of coverage defenses a hazardous voyage. On one hand, because the insured is entrusting its defense to an insurer with whom it is potentially in conflict, the insurer must "fairly and fully" inform the insured of the coverage defenses, ostensibly so the insured can make an intelligent decision about accepting the qualified defense offered by the insurer. On the other hand, the consequence to the insurer of not following the sometimes-harsh rules is to indemnify a loss that was never intended to be covered in the first place. The balance between these competing interests has resulted in court rulings that can differ among the jurisdictions and that are not always intuitive. This article provides an overview of the issues presented in these circumstances to guide insurers through the process of reserving their rights while simultaneously protecting the interests of their insureds.

Content of the Reservation of Rights

In most jurisdictions, an insurer can effectively reserve its rights by sending a letter to the insured that fairly informs the insured that—irrespective of its defense of the action—it disclaims liability and does not waive defenses available. *See, e.g., Nat'l Sur. Corp. v. Immunex Corp.*, 886, 297 P.3d 688, 694 (Wash. 2013). Although a reservation of rights is technically a bilateral agreement accepted by the insured upon receipt of the letter, a formal agreement signed by the insured is generally not required. The insurer should, however, confirm that the insured has received the letter setting the terms of the reservation of rights, and in questionable cases, request that the insured acknowledge acceptance of the terms.

Substantively, the letter should do more than merely state that the claim may not be covered, without stating the grounds. Such a letter, without more, would not "fairly and fully" inform the insured whether it needed to take steps independent of the insurer to protects its own interests. On the other end of the spectrum, putting too much information about the policy can be problematic. For example, the South Carolina Supreme Court found the insurer had not adequately preserved its defenses to coverage by sending a letter that merely "incorporated a nine-or ten-page excerpt of various policy terms … [with] no discussion of Harleysville's position as to the various provisions or explanation of its reasons for potentially denying coverage." *Harleysville Group Ins. v. Heritage Cmtys., Inc.*, 803 S.E.2d 288, 299 (S.C. 2017). Other courts have similarly found that the reservation of rights letter must unambiguously explain the bases for the insurer's coverage concerns. *See, e.g., Advantage Builders & Exteriors, Inc. v. Mid-Continent Casualty Co.*, 449 S.W.3d 16 (Mo. Ct. App. 2014) (finding reservation of rights letters ineffective where the letters did not adequately explain why the defendant may not have owed coverage to its insured); *Osburn, Inc. v. Auto Owners Ins. Co.*, No. 242313, 2003 WL 22718194, at *3 (Mich. Ct. App. 2003) ("because Auto Owners' reservation of rights letter was not sufficiently specific to inform plaintiffs of the policy defenses the insurer might assert, the letter did not constitute 'reasonable notice.'")

The key to drafting an effective letter is both to specify the policy provisions at issue and to state *why* the claim might not be covered by the insurer. Because a coverage decision has not been made, the letter should stop short of stating that the claim is not covered; instead, it should provide enough information about the facts being alleged by the claimant and the particular policy provisions that could apply. A letter written in "plain English" would make its sufficiency more difficult to challenge in court. The following topics are suggested for inclusion in the letter:

- State that the allegations create coverage questions that have not been resolved and that in the meantime, the insurer is reserving its rights as explained in the letter
- Set out the factual allegations made against the insured and any additional information that may impact the coverage determination (*e.g.*, if the insured breached a notice provision in the policy)
- Identify the policy (or policies) that have been considered along with the periods of coverage and the limits of liability

- Identify the policy provisions that raise questions as to the existence of coverage, including the grants of coverage and any exclusions that may apply or policy conditions that may have been breached
- Specify the terms that are included in the reservation of rights (*e.g.*, the ability to withdraw from the defense, to file a declaratory judgment action, to seek reimbursement of costs for uncovered claims, etc.)

This list should not be considered exhaustive, as each claim is unique, but instead provides a general outline of topics to include when reserving rights under a policy.

Timing of the Reservation of Rights

The timing of the insurer's reservation of rights may be the most important consideration, as failure to timely reserve rights can result in a waiver or estoppel of the insurer's ability to resist owing coverage for the claim. The harsh result is that the insurer may end up paying a claim that it did not owe under the terms of the policy.

As a practical matter, reservations of rights letters should follow the folklore about when to vote in Chicago—"early and often." There is rarely a downside to reserving rights early and doing so at the outset of an investigation might even be necessary to preserve defenses to policy conditions (such as late notice) which are easier to waive because they are inserted for the insurer's benefit. Likewise, a reservation of rights letter should be sent (or supplemented in a timely manner) after the claim investigation has begun, upon learning of grounds that may be present a coverage concern.

The timeliness of a reservation of rights letter is particularly important when undertaking the defense of the insured to avoid waiver or estoppel of coverage or policy defenses. The premise of this rule is that the insured reasonably relies on the insurer's provision of a defense to conclude that coverage exists unless advised differently by the insurer. The prejudice to the insured's interests can include foregoing opportunities to investigate the facts or to being involved in litigation strategy decisions, to participate in settlement discussions including whether to provide funding when a settlement opportunity arises, and being left on one's own if the insurer withdraws the defense without having provided adequate notice of warning of the consequences to the insured. *See generally Pacific Indemnity Co. v. Ace Delivery Service, Inc.,* 485 F.2d 1169 (5th Cir. 1973) (applying Texas law); *Britton v. Smythe*, 743 N.E.2d 960 (Ohio Ct. App. 2000); *State Farm Lloyds, Inc. v. Williams*, 960 S.W.2d 781 (Tex. Ct. App. 1997); *City of Carter Lake v. Aetna Cas. and Surety Co.*, 604 F.2d 1052 (8th Cir. 1979); *R.A. Hanson Co., Inc. v. Aetna Cas. & Surety Co.,* 550 P.2d 701 (Wash. Ct. App. 1976). The application of the prejudice rule, however, varies from state to state. Generally, there are three categories of application: states where prejudice must be shown; states where prejudice is presumed but can be rebutted; and states where prejudice is conclusively presumed and may not be rebutted by the insurer.

First Approach: Prejudice Must Be Shown

The traditional approach has been to require the insured to show actual prejudice before the insurer is estopped from denying coverage after defending the insured without reserving rights. *See, e.g., Lextron, Inc. v. Travelers Cas. and Surety Co. of America*, 267 F.Supp.2d 1041, 1048 (D. Colo. 2003) (no prejudice shown where insurer withdrew less than four months after the litigation began); *Remodeling Dimensions, Inc. v. Integrity Mut. Ins. Co.,* 819 N.W.2d 602, 618 (Minn. 2012) (requiring insured to show prejudice caused by the conduct of the insurer); *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 782 (Tex. 2008) (requiring insured to show insurer's actions caused it prejudice); *Penn-America Garamendi v. Golden Eagle Ins. Co.*, 10 Cal. Rptr. 3d 724, 750 (Cal. Ct. App. 2004) (holding that California courts require an insured to show detrimental reliance from the insurer's provision of a defense without reserving its rights); *Fla. Mun. Ins. Tr. v. Vill. of Golf*, 850 So. 2d 544, 547 (Fla. Ct. App. 2003) ("the insured must demonstrate that the insurer's assumption of the insured's defense has prejudiced the insured"); *Westchester Fire Ins. Co. v. G. Heileman Brewing Co., Inc.*, 747 N.E.2d 955, 965 (Ill. Ct. App. 2001) (no prejudice shown where insurer withdrew defense 15 months before case settled).

The reasoning provided by these cases is that it would be inequitable to cause the insurer to cover a claim outside the terms of its policy unless the insured can show that it was actually harmed by the absence of a reservation of rights.

Second Approach: Prejudice Can Be Rebutted

The second approach is to put a burden on insurers who have not reserved their rights. It presumes the insured to have been prejudiced, but it permits the insurer to rebut the presumption with evidence. *See., e.g., Potesta v. U.S. Fid. & Guar. Co.*, 504 S.E.2d 135, 148 (W. Va. 1998) ("[W]e will presume prejudice resulted where an insured has shown that his insurer assumed the defense of an action. … The insurer may, of course, rebut this presumption by

presenting evidence to show that no prejudice actually resulted and that the insured did not relinquish his right to conduct his defense.") (internal quotation omitted); *American Home Assur. Co. v. Ozburn-Hessey Storage Co.*, 817 S.W.2d 672, 675 (Tenn. 1991) (finding the presumption of prejudice was reinforced by evidence of *actual* prejudice).

The decisions that fall in this category strike a balance between automatically finding prejudice and requiring the insured to prove actual prejudice in every instance.

Third Approach: Prejudice Is Conclusively Presumed

The third and more recent approach is to hold that prejudice is *conclusively* presumed by the absence of a reservation of rights. *See, e.g., North American Capacity Ins. Co. v. Brister's Thunder Karts, Inc.*, 287 F.3d 412, 416–17 (5th Cir. 2002) (applying Louisiana law that employs waiver theory to defense without a reservation of rights); *World Harvest Church, Inc. v. GuideOne Mut. Ins. Co.*, 695 S.E.2d 6, 12 (Ga. 2010) ("where, as here, an insurer assumes and conducts an initial defense without effectively notifying the insured that it is doing so with a reservation of rights, the insurer is deemed estopped from asserting the defense of noncoverage regardless of whether the insured can show prejudice."); *Safeco Ins. Co. v. Ellinghouse*, 725 P.2d 217 (Mont. 1986) (prejudice is conclusively presumed because "the loss of the right of the insured to control and manager the case is itself prejudicial") (internal quotation marks and citation omitted).

Other courts have conclusively presumed prejudice but only after the passage of significant time that has materially affected the insured's interests. *See e.g., American Handling Equipment, Inc., v. T.C. Moffatt & Co.*, 184 N.J. Super. 131, 140 (N.J. Super. App. Div. 1982) (finding the insurer precluded the insured from exercising any control over "important phases of preparation and presentation of the defense of the case") (citation omitted); *O'Neill Investigations, Inc. v. Illinois Employers Ins. of Wausau*, 636 P.2d 1170, 1178 (Alaska 1981) ("it would be futile to attempt to prove or disprove that the insured could have better investigated, negotiated or defended").

The decisions that fall within this category present the harshest rules to insurers. Conclusively presuming prejudice means that coverage will be owed even if the insured was not harmed at all by the absence (or delay) in receiving a reservation of rights letter from the insurer. As one court explained,

> the insured has surrendered innumerable rights associated with the control of the defense including choice of counsel, the ability to negotiate a settlement, along with determining the timing of such negotiations, and the ability to decide when and if certain defenses or claims will be asserted.

World Harvest, 695 S.E.2d at 12. *See also Braun v. Annesley*, 936 F.2d 1105, 1111 (10th Cir. 1991) (construing Oklahoma law) ("We think our result today creates a better rule, one that encourages an insurer to thoroughly investigate its policy and notify persons before assuming their defense that it is reserving its right to later contest coverage.") (Emphasis in original).

Insurers in these jurisdictions are cautioned to be especially vigilant about reserving rights before taking action on behalf of the insured.

The *Hoover* Anomaly

Any discussion of the law surrounding an insurance company's reservation of rights would be incomplete without mention of *Hoover v. Maxum Indemnity Company*, 730 S.E.2d 413 (Ga. 2012), decided by the Supreme Court of Georgia. In *Maxum*, the insured waited until it was sued two years after a serious injury before providing notice to the insurer. In reviewing the complaint, the insurer advised the insured that it would not be defending the lawsuit because the injury fell within an exclusion in the policy, but it also reserved its rights on other grounds explicitly stating that the two-year delay in notice may have breached conditions in the policy. Both the trial court and the intermediate appeals court found that the two-year delay voided coverage, but the Supreme Court of Georgia reversed, reasoning that the reservation of rights was ineffective to preserve the late notice defense.

According to *Hoover*, "a reservation of rights is a term of art in insurance vernacular and is designed to allow an insurer to provide a defense to its insured while still preserving the option of litigating and ultimately denying coverage." *Id.* at 416. The insurer could have defended the insured under a reservation of rights and brought a declaratory judgment action to have the extent of its coverage obligations resolved. But because the insurer had not provided a defense, its attempt to reserve rights was deemed a nullity.

The *Hoover* decision contained a strong dissent attacking the reasoning, which it termed "illogical:"

> [A] reservation of rights … is a standard and acceptable means of determining one's rights, often through litigation and discovery, when facts become evident. Under the majority's reasoning, an insurance company could deny

> a claim based on one defense, discover during litigation that, but for the fraud of the insured, it could have raised another defense, and be unable to raise the new defense simply because it was not explicitly asserted the moment that the claim was denied. The mere assertion of one defense cannot be considered the waiver of other defenses, absent some statement or conduct *showing an intent to waive*.

730 S.E.2d at 421 (Melton, J., dissenting) (emphasis in original).

Hoover remains the law in Georgia, but it does not appear to have been adopted by other states. Further, its reach has been limited in certain respects, such as to third-party liability lawsuits where a defense was tendered and to preservation of policy conditions (such as late notice) as opposed to substantive coverage terms. *See Langdale Co. v. Nat'l Union Fire Ins. Co.*, 110 F. Supp. 3d 1285 (N.D. Ga. 2014) (*aff'd on other grounds* 609 F. App'x. 578 (11th Cir. 2015)); *Bank of Camilla v. St. Paul Mercury Ins. Co.*, 939 F. Supp. 2d 1299 (M.D. Ga. 2013). Its holding remains an anomaly in barring insurers from reserving rights without providing a defense even in the limited circumstances presented in that case.

Conclusion

As the above discussion demonstrates, there are pitfalls in the law that may prevent insurers from enforcing coverage limitations. In some cases, even without any prejudice having been shown, an insurer can be compelled to cover a claim that lies clearly outside the scope of the policy. And even if the insurer has advised its insured that it is reserving its rights, the coverage defenses may not have been preserved if the court determines that the communication was not clear or came too late in the process to be effective. The bottom line is that insurers must be vigilant in both identifying coverage defenses and in communicating with their insureds to effectively preserve their defenses to coverage. Failure to do so in a clear and timely manner can have harsh consequences despite the best of intentions.

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Recent Cases of Interest

First Circuit

Declaratory Relief/Diversity Jurisdiction (Massachusetts law)

In *Bearbones, Inc. v. Peerless Ind. Ins. Co.,* No. 18-1139 (1st Cir. Aug, 21, 2019), a federal court of appeal ruled that it cannot address the substantive question of whether a Massachusetts District Court properly granted summary judgment to Peerless where questions of fact exist concerning whether diversity jurisdiction exists. Although there was complete diversity between the two insured Massachusetts corporations and Peerless (an Illinois corporation), the court took note of the fact that there must also be diversity as to whether the parties have their principal place of business and that Peerless had alleged in its Answer that it had its principal place of business in Massachusetts. The appeal was therefore put on pause for 90 days during which time the District Court would clarify the actual facts as to jurisdiction.

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Third Circuit

Sexual Abuse/Prior Known Acts Exclusion

Montville Township Board of Education v. Zürich Am. Ins. Co. **(3d Cir. July 26, 2019)**

Third Circuit Court of Appeals Rules Prior Known Acts Exclusion Bars Coverage to School for Sexual Abuse Allegations

Montville Township Board of Education ("Montville") hired Jason Fennes ("Fennes") as a first-grade teacher and track

coach in 1998. After several reports and investigations of his alleged sexual abuse against students, Fennes resigned in 2010. Months later, Cedar Hill Prep School ("Cedar Hill") hired him as a teacher. While still employed by Cedar Hill, Fennes was arrested and indicted on charges of sexually abusing a number of Montville students and a Cedar Hill student.

A student at Cedar Hill ("Child M") sued Fennes and Cedar Hill for injuries resulting from Fennes's sexually abusing her in February 2012. In an amended complaint, Child M added Montville as a defendant, specifically alleging that the school district knew about Fennes's sexual abuse, failed to notify the authorities, and agreed to withhold Fennes's history of sexual abuse from his prospective employers. The lawsuit ("Child M Action") thus claimed that Montville enabled and facilitated Fennes's sexual abuse at Cedar Hill.

During the relevant time, Montville held an insurance policy ("Policy") with Zurich American Insurance Co. ("Zurich"). The Child M Action potentially implicates two coverage parts of the Policy. The first ("Commercial General Liability Part") generally excludes coverage for "bodily injury . . . arising out of or relating in any way to an abusive act." The second ("Abusive Acts Part")—the only part at issue in this appeal—obligates Zurich to defend Montville against any lawsuit for "loss because of injury resulting from an abusive act to which th[e] [Policy] applies."

The Abusive Acts Part also includes a "Prior Known Acts Exclusion." Under that exclusion, there is no coverage under the Abusive Acts Part for "[a]ny claim or suit based upon, arising out of[,] or attributable, in whole or in part, to any abusive act of which any insured, other than any insured actually committing the abusive act, has knowledge prior to the effective date" of the Policy. As pertinent here, the Policy took effect in July 2011.

Approximately a week after Child M filed the Complaint, Zurich sent Montville a letter disclaiming coverage and reserving its rights under the Policy. According to Zurich, it had no obligation to defend Montville under either part of the Policy. As to the Commercial General Liability Part, Zurich determined that Child M's bodily injury arose from Fennes's abusive acts, thereby excluding coverage. As to the Abusive Acts Part, Zurich concluded that the allegations in the Complaint brought the Child M Action within the Prior Known Acts Exclusion, therefore also barring coverage.

Montville sued Zurich seeking a declaration that Zurich owed Montville a duty to defend it in the Child M Action. The parties filed summary judgment cross-motions for summary judgment. The trial judge granted summary judgment to Zurich and declared it had no duty to defend Montville.

Montville conceded there was no coverage under the Commercial General Liability Part. The sole issue on appeal is whether a duty to defend was owed under the Abusive Acts Part. Montville contends that the Complaint is rife with ambiguity, precluding its allegations from definitively falling within the ambit of the Prior Known Acts Exclusion.

Montville acknowledged that Child M made the following allegations:

- (1) Fennes, while employed by [Montville], "engaged in various negligent, careless, reckless[,] and/or intentional conduct, including but not limited to inappropriate abusive and/or sexual conduct with his infant students" and [Montville] was "on notice of said conduct."
- (2) [Montville] was "on notice" "of said reckless and/or intentional conduct, including child abuse, both sexual and nonsexual" so as to trigger a requirement to report . . . ."
- (3) [A]s a result of the "negligence, carelessness, recklessness[,] and/or intentional conduct" of the defendants [in the Child M Action], Child M suffered "injuries."
- (4) Fennes "engaged in various acts of sexual molestation and/or child abuse against other infant students."
- (5) [Montville] was "on notice of said conduct."
- (6) Fennes "engaged in various acts of sexual molestation and/or child abuse against . . . his infant students."

Montville's only argument attempting to elude operation of the Prior Known Acts Exclusion is that Child M's use terms like "abusive" is "vague, undefined, and subject to multiple interpretations," as Complaint lacks an "enumeration of specific abusive acts." For example, Montville posited that the Complaint could be read as simply alleging that Montville only knew Fennes had students sit on his lap in a "platonic manner," presumably outside the ambit of the Prior Known Acts Exclusion. Montville claimed that this "ambiguity" demands interpretation in its favor.

The Third Circuit found that a plain reading of the allegations in the Complaint unequivocally brings them within the ambit of the Prior Known Acts Exclusion. That exclusion relieves Zurich of the duty to defend only if the Child M Action (1) is attributable, even in part, (2) to abusive acts (3) about which Montville had knowledge (4) prior to July 2011. Montville did not contest first, third, and fourth elements of the exclusion. The only question therefore was

whether Child M's allegations of "abuse," rise to the level of "abusive act[s]" as defined in the Policy. The Third Circuit ruled they did.

The Abusive Acts Part defines an "abusive act" as being, as relevant here, "any act . . . of actual . . . abuse or molestation done to any person, resulting in 'injury' to that person, including any act . . . of actual . . . sexual abuse or molestation . . ., by anyone who causes or attempts to cause the person to engage in a sexual act . . . if that person is incapable of appraising the nature of the conduct or is physically incapable of declining participation in or communicating unwillingness to engage in the sexual act." The Third Circuit held that the allegations squarely fell within the ambit of the Prior Known Acts Exclusion. Accordingly, the Court ruled that the insurer had no duty to defend the school.

Disclaimer: This decision is labeled as a "not precedential" opinion and does not constitute binding precedent.

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Assault and Battery Exclusion (Pennsylvania Law)

***Nautilus Ins. Co. v. Motel Mgmt. Servs. Inc.*, --- F. App'x ---, 2019 WL 3283221 (3d Cir. Jul. 22, 2019)**

The U.S. Court of Appeals for the Third Circuit affirmed the U.S. District Court for the Eastern District of Pennsylvania's grant of judgment on the pleadings to Nautilus Insurance Company (Nautilus), finding that there was no coverage for allegations of sexual assault occurring at a motel operated by Nautilus's insured, Motel Management Services Inc. (MMS). MMS sought coverage from Nautilus for a lawsuit brought by a minor female, who alleged that she was forcibly required to engage in sexual acts and the commercial sex trade, including at a motel owned and operated by MMS. Specifically, she alleged that "MMS facilitated her exploitation by knowingly renting rooms at its motel to the traffickers … failed to intervene or to report the traffickers' illegal conduct; and … financially profited from (the minor's) exploitation."

MMS sought coverage for the lawsuit from Nautilus, which brought an action seeking a declaration that there was no coverage under its policy. The district court granted judgment on the pleadings and declared that Nautilus had no duty to defend or indemnify MMS for the minor's lawsuit. The appellate court agreed, noting that the assault and battery exclusion in the Nautilus policy provided that Nautilus "'will have no duty to defend or indemnify any insured in any action or proceeding alleging damages arising out of any assault or battery,' regardless of culpability, intent, or relationship of the perpetrator of the assault or battery to the insured, or whether the damages occurred at premises owned or operated by the insured." The minor's lawsuit did not allege negligence on the part of MMS, but rather alleged that MMS failed to report the assaults and financially profited from them. Therefore, the assault and battery exclusion applied to preclude coverage.

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Environmental/"Occurrences"/ Excess (New Jersey law)

The Third Circuit revived part of a primary insurer's effort to obtain contribution from an excess insurer for sums that it paid to settle three New Jersey environmental liability claims against a waste hauler. In [https://t.e2ma.net/click/s22c2c/4nzlf2/sif1xs]*Penn National Ins. Co. v. North River Ins. Co.*, No. 18-2687 (3d Cir. July 30, 2019) (unpublished), the court affirmed the lower court's declaration that any claims with respect to the Helen Kramer Landfill were barred by the statute of limitations. The court rejected Penn National's argument that the three landfills should be treated as a single "occurrence" because they all arose out of the insured's hazardous waste hauling activities. To the contrary, the Third Circuit agreed with the District Court that these losses involved separate landfills in different areas occurring at different times resulting in separate types of environmental damage in distinct and discreet locations, and were therefore each a separate "occurrence." While therefore affirming the entry of judgment with respect to the Helen Kramer Landfill as being time-barred, the Third Circuit ruled that Penn National might still be entitled to contribution under the excess coverage provided by North River on the grounds that the pro-rated portion of the Helen Kramer Landfill settlement allocable to its 1982–1983 policy exceeded a claimed $500,000.00 aggregate limit in that policy. As the District Court had not considered whether the sums paid to settle the Helen Kramer Landfill claim should have been subjected to Carter-Wallace allocation and would have therefore exhausted the aggregate policy limit, the case was remanded to the District Court for further findings with respect to whether

such an aggregate actually existed and what effect it would have.

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Fourth Circuit

Prior Publication Exclusion (North Carolina law)

***Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Beach Mart, Inc.*, --- F.3d ---, 2019 WL 3483167 (4th Cir. Aug. 1, 2019)**

The U.S. Court of Appeals for the Fourth Circuit held that an insurer must continue defending a beach apparel company in a trademark infringement suit brought by another retailer. In the underlying case, Beach Mart Inc. (Beach Mart) was sued by L&L Wings Inc. (L&L) for improperly using L&L's trademarked name in displays and advertisements in its apparel shops. Beach Mart sought coverage for the suit from its liability insurer, Pennsylvania National Mutual Casualty Insurance Company (Penn National). Penn National agreed to defend Beach Mart under a reservation of rights and thereafter filed a declaratory judgment action in the U.S. District Court for the Eastern District of North Carolina, seeking a ruling that the prior publication exclusion in Beach Mart's policies applied to preclude coverage.

The trial court agreed with Penn National and held that the prior publication exclusion applied to relieve Penn National of its duty to defend Beach Mart. Specifically, the trial court found that the exclusion applied because Beach Mart's alleged violations began before the effective date of the first Penn National policy. However, the appellate court reversed the decision and held that the prior publication exclusion did not apply. The appellate court noted that L&L alleged that Beach Mart misused L&L's trademark in new ways after the first policy took effect. Accordingly, the appellate court held that "a prior publication exclusion will not bar coverage for offensive publications [1] made during the policy period [2] which differ in substance from those published before commencement of coverage." Therefore, Penn National was not relieved of its duty to defend Beach Mart in the underlying suit.

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Fifth Circuit

Economic Loss (Alabama Law)

***Greenwich Ins. Co. v. Capsco Indus., Inc.* --- F.3d ---, 2019 WL 3773450 (5th Cir. Aug. 12, 2019)**

The U.S. Court of Appeals for the Fifth Circuit held that an insurer had no duty to indemnify an insured construction contractor for a lawsuit brought by one of its subcontractors seeking, as damages, the value of the work it performed under the theory of *quantum meruit*. In the underlying case, the aggrieved subcontractor, Ground Control, sought damages against Greenwich Insurance Company's (Greenwich) insured, Capsco Industries, Inc. (Capsco), after Capsco fired it from a construction project at the Margaritaville Spa and Hotel in Biloxi, Mississippi, and then refused to pay for Ground Control's work on the project. The trial court ultimately voided the contract between Ground Control and Capsco, and held that Ground Control could only proceed against Capsco under the theory of *quantum meruit* to recover for the value of the services it provided to Capsco for which it was not paid. Ground Control ultimately accepted a judgment against Capsco in the amount of $199,096.

While the underlying case was pending, Capsco's insurers, including Greenwich, filed a declaratory judgment action in federal court, seeking a finding that they had no duty to defend or indemnify Capsco for the underlying case on the basis that the *quantum meruit* claim was for purely economic loss, rather than for "property damage" caused by an "occurrence." Ground Control, in turn, argued that Capsco was covered because the amounts that it was seeking in the underling case were related to its repair and replacement of damaged property on the construction project.

The district court agreed with Greenwich and found that any connection between the property damage and Ground Control's quantum meruit claim was too tenuous to create a duty to defend, and it was simply a claim for economic loss. The appellate court agreed, reasoning that the *quantum meruit* claim was not a claim for damage to property or loss of use, but rather it was a claim for "payment of work." The appellate court held that a claim for "[p]ayment for work is a step removed from paying for property damage that necessitated the work," and was, therefore, a claim for purely economic loss. Accordingly,

Greenwich owed no duty to indemnify Capsco for the *quantum meruit* judgment.

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Construction Litigation/Waiver of Subrogation (Mississippi law)

The Fifth Circuit has asked the Mississippi Supreme Court to clarify whether a contractor's waiver of subrogation claims against subcontractors as set forth in Article 11.3.7 in the AIA standard form agreement applies to the full extent of property insurance that covered the loss or whether, as a Mississippi District Court ruled in this case, the waiver only extends to the insured's own work. In *Liberty Mut. Fire Ins. Co. v. Fowlkes Plumbing, LLC,* No. 18-60608 (5th Cir. Aug. 12, 2019), the court therefore asked whether "the waiver of subrogation between the school district and Sullivan limited to damages to the Work or does it also apply to damages to non-Work property?"

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D&O/"Claims Made"/Related Claims (Texas law)

The U.S. Court of Appeals for the Fifth Circuit ruled in *ADI Worldlink v. RSUI Indemnity Co.,* No. 17-41050 (5th Cir. Aug. 2, 2019) that a D&O insurer was not obliged to provide coverage for various claims that were timely reported to RSUI during its policy term as they were related to claims in earlier years that were not timely reported.

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Property Insurance/Limitations Period (TX)

The Fifth Circuit affirmed a Texas District Court's ruling that a homeowner's suit against her property insurer was time-barred where she waited more than two years after the claim was denied. In Smith v. Travelers Cas. Ins. Co. of America, No. 18-20645 (5th Cir. July 26, 2019), the Court of Appeals ruled that the statute of limitations for first party claims runs from the date of the insurer's denial and rejected the insured's contention that the "discovery rule" should toll the insured's claims until it obtained information establishing that the insurer had wrongly denied its claim. Similarly, the court ruled that the two year limitations period for filing suit was not tolled by discussions between the parties after Travelers had denied the claim.

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Sixth Circuit

Guns/Assault and Battery Exclusions (Kentucky law)

The Sixth Circuit ruled that six claims brought against a nightclub for failing to protect patrons from an "active shooter" were subject to an assault and battery exclusion in the club's general liability policy. In *United Specialty Ins. Co. v. Cole's Place, Inc.* No. 18-5445 (6th Cir. Aug. 22, 2019), a divided appellate panel found that the U.S. District Court judge in Kentucky had properly exercised jurisdiction, despite competing claims in state court. Further, the Sixth Circuit ruled that the District Court has correctly ruled that these attacks were a "battery" and that the alleged liability of the club for failing to prevent the assaults "arose out of" excluded acts.

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Seventh Circuit

Direct Physical Loss to Covered Property (Illinois Law)

***Windridge of Naperville Condo. Ass'n v. Philadelphia Indem. Ins. Co.*, --- F.3d. ---, 2019 WL 3720876 (7th Cir. Aug. 7, 2019)**

The U.S. Court of Appeals for the Seventh Circuit affirmed the decision of the U.S. District Court for the Northern District of Illinois, which held that Philadelphia Indemnity Insurance Company (Philadelphia) was required to cover the replacement of all siding at a development owned by Windridge of Naperville Condominium Association (Windridge), even though only portions of the buildings' siding were damaged.

During a wind and hail storm in May 2014, several buildings at Windridge's development experienced damage

to the aluminum siding on their south and west sides. Philadelphia, which issued a property policy to Windridge, agreed to cover replacement of the damaged siding, but not the undamaged siding on the north and east sides of the buildings. However, Windridge could not find replacement siding to match the undamaged panels, meaning that the siding would not be uniform. Windridge requested that Philadelphia cover the cost to replace all four sides of the buildings, but Philadelphia refused. In the ensuing lawsuit, the district court granted summary judgment in favor of Windridge.

The appellate court agreed with the district court's ruling that Philadelphia was required to cover replacement of siding for all four sides of the buildings. The appellate court reasoned that, as a replacement-cost policy, the end result should be that the insured is made whole, as if the covered loss had never happened. The appellate court held that the phrases "direct physical loss" and "covered property" were potentially ambiguous, because their definitions did not answer the question of whether the undamaged portions must be replaced. The appellate court held that "[t]he district court's conclusion that the buildings as a whole were damaged — and that all of the siding must be replaced to ensure matching — is a sensible construction of the policy language as applied to these facts. Philadelphia Indemnity's interpretation — pay to replace only the specific panels of siding that were directly hit by hail, leading to two-tone buildings — is less reasonable."

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Late Notice/Excess (Illinois law)

The Seventh Circuit has ruled that an excess insurer was not obliged to provide coverage for a large verdict arising out of the trial of its automobile liability claims against insured in light of the fact that it was only notified of the loss on the eve of trial, seven years after the original accident had occurred. In *Landmark American Ins. Co. v. Deerfield Construction, Inc.,* No. 18-2206 (7th Cir. Aug. 12, 2019), the Seventh Circuit declared that notice seven years late was neither "prompt" or "as soon as practicable." The court rejected the insured's argument that its latest notice was excused because it had been advised that the underlying suit was "frivolous" and that it therefore had no reason to believe that Landmark's excess coverage would be triggered. The court refused to find that Landmark was equitably estopped since it had not controlled the insured's defense or made statements upon which the insured had relied to its detriment. The court also refused to impose liability on the broker, Arthur J. Gallagher.

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Eighth Circuit

First Party/Employee Theft (Minnesota law)

The U.S. Court of Appeals for the Eighth Circuit ruled in *C.S McCrossan, Inc. v. Federal Ins. Co.*, No. 18-1949 (8th Cir. Aug. 6, 2019) that a Minnesota District Court was correct in declaring that the "employee theft" and "forgery" sections of Federal's policy did not provide coverage because the embezzler was an "authorized representative" of the insured.

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D&O/Allocation (Minnesota law)

The Eighth Circuit has ruled in Brand v. National Union Fire Insurance Company of Pittsburgh, *P.A.* No. 18-1372 (8th Cir. Aug. 16, 2019) that a Minnesota District Court did not err in granting summary judgment to a directors and officers insurer on the issue of allocating defense costs between insured and uninsured parties. The Eighth Circuit emphasized that the directors have taken a "all or nothing" approach asserted that they were entitled to be reimbursed for 100 percent of the defense costs and could not now make an intermediate demand alleging that they should be reimbursed for 40 percent or 82 percent based upon alternative theories of allocation.

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Excess/Undifferentiated Verdicts (MN)

The Eighth Circuit has ruled that a Minnesota judge erred in ruling that an excess insurer had failed to show that a sexual molestation exclusion in an excess policy did not preclude coverage for a $7 million verdict against the insured day care center. Whereas the District Court has

ruled that RSUI had failed to show what portion of the verdict was for injuries due to sexual assault (as opposed to claims of physical assault that would have been covered), the Eight Circuit ruled in *RSUI Ind. Co. v. New Horizon Kids Quest, Inc.,* No. 17-3567(8th Cir. Aug. 12, 2019) that as RSUI had not been a party to the underlying trial and as the jury had not categorized the damages awarded, RSUI was entitled to litigate whether the damages for physical assault were $3 million or less and therefore fully within the limits of the underlying Travelers policy.

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Property Insurance/Misrepresentations (Minnesota law)

The Eighth Circuit ruled in Borchardt v. State Farm Fire & Cas. Co., No. 18-2610 (8th Cir. July 29, 2019 that a Minnesota District Court did not err in barring coverage for an insured's fire loss on the basis of material misrepresentations by the insured. The court rejected the insured's argument that, "being inaccurate on their proof-of-loss statement does not necessarily equate to being untruthful with an intent to deceive or defraud their insurer." The court found that there was ample evidence to support the jury's finding that the insured's misrepresentations in this case were material and "substantial enough to matter to a reasonable insurer."

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Ninth Circuit

Personal and Advertising Injury Exclusions (Nevada Law)

***Cohen v. Berkley Nat'l Ins. Co.*, --- F. App'x ---, 2019 WL 3235076 (9th Cir. Jul. 18, 2019)**

The U.S. Court of Appeals for the Ninth Circuit affirmed the District of Nevada's dismissal of a claim by Bradley S. Cohen and his company (Cohen) against Berkley National Insurance Company (Berkley), finding that coverage was excluded under the policy issued by Berkley for a defamation claim made by Cohen against Berkley's insured, which was a commercial tenant in a building owned by Cohen. The insured allegedly created multiple websites that contained disparaging remarks against Cohen, including comparing him to the infamous New York Ponzi scheme perpetrator Bernie Madoff. The suit resulted in a verdict against Berkley's insured for $38 million. Cohen then sought to recover the judgment from Berkley, which refused to pay the judgment because coverage was excluded under the exclusions for knowing violation of the rights of another and material published with knowledge of falsity.

In dismissing the lawsuit, the district court noted that the jury in the underlying defamation suit found that Berkley's insured acted with "fraud, oppression and malice" in creating the websites and publishing the material in question. The district court concluded that the exclusions were unambiguous and completely precluded coverage for the alleged defamation. The appellate court agreed that the exclusions were unambiguous and reasoned that, based on "the underlying complaint and the verdict and judgment, which found that the conduct of [the insured] and other defendants amounted to fraud, [and thus] the 'knowledge of falsity' exclusion plainly applied."

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Bad Faith/Genuine Dispute Doctrine

***Genesis Insurance Company v. National Union Fire Insurance Company of Pittsburgh, PA* (9th Cir. Aug. 12, 2019)**

Genuine Dispute Doctrine Barred Bad Faith Claim

The court below granted National Union summary judgment on Magma's claims for breach of contract and breach of the covenant of good faith and fair dealing. The Ninth Circuit affirmed.

Previously, the court had concluded that National Union was liable to Magma on a theory of equitable subrogation. It had not concluded that National Union breached its contract. Magma had incurred liability in the underlying litigation, and Genesis made a $5 million payment to Magma. Subsequent litigation determined that National Union was ultimately legally responsible to the insured for the loss. Therefore, National Union was liable under a theory of equitable subrogation. That court had not determined that National Union had breached its contractual obligations.

The court below also correctly held that Magma could not prove damages. First, Magma was not responsible for any portion of the settlement. Genesis contributed $5 million to the settlement of the claims and National Union repaid Genesis $5 million plus interest. Second, Magma's damages claim fails because the asserted damages could not have been proximately caused by National Union's alleged breach.

Summary judgment was also appropriately granted on the claim of breach of the covenant of good faith and fair dealing. Magma argued that National Union violated the covenant by litigating coverage. National Union's dispute over its coverage liability, however, is protected under the "genuine dispute" doctrine, which holds that an insurer does not act in bad faith when it mistakenly withholds policy benefits, if the mistake is reasonable or is based on a legitimate dispute as to the insurer's liability.

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D&O/Consent to Settle (Arizona law)

In its latest request for help from a state court, the Ninth Circuit certified a D&O insurance coverage question to the Arizona Supreme Court in *Apollo Education Group v. National Union Fire Ins. Co. of Pittsburgh, PA*, No. 17-17293 (9th Cir. Aug. 15, 2019) asking how it should determine "whether National Union unreasonably withheld consent to Apollo's settlement with shareholders in breach of contract under a policy where the insurer has no duty to defend." At issue is a D&O policy which does not contain duty to defend language and requires the insurer's consent to any settlement, said consent not to be "unreasonably withheld."

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Auto/UM/"Permissive User" (Hawaii law)

The Ninth Circuit certified a question to the Hawaii Supreme Court, asking in *State Farm Mut. Auto Ins. Co. v. Mizzuno*, No. 17-15497 (9th Cir. Aug. 5, 2019) "is a permissive user of an insured vehicle, whose connection to the insured vehicle is permission to use the vehicle to run errands and drive to work, entitled to uninsured motorist (UM) benefits under the chain-of-events test because he was injured by an uninsured motorist?"

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Tenth Circuit

Uber/"Mend the Hold" Doctrine (Oklahoma law)

Although the so-called "mend the hold" doctrine prohibits an insurer that has asserted one basis for denying coverage from adopting a different rationale after the dispute goes into suit, the Tenth Circuit ruled in *Genzer v. James River Ins. Co.,* No. 18-1605 (10th Cir. Aug. 20, 2019) that an auto insurer's bases for disputing a UIM claim by an Uber driver had changed as the result of shifting legal arguments presented by the claimant and were therefore not subject to the "mend the hold" doctrine. In any event, the Tenth Circuit noted that Oklahoma courts had yet to clearly adopt the "mend the whole" doctrine and questioned whether they would ever do so. As a result, the Court of Appeals affirmed the Oklahoma District Court's ruling that the James River policy was not ambiguous with respect to the scope of coverage for when covered transportation services ended.

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Faulty Workmanship Exclusion

Rockhill Ins. Co. v. CFI-Global Fisheries Mgmt. **(10th Cir. July 24, 2019)**

US Court of Appeals Holds that the Faulty Workmanship Exclusion Does Not Apply to Damages Caused by Negligent Design Work

This declaratory-judgment action arises out of an underlying construction defects and negligent design action related to the construction of a river enhancement project. In 2012, Heirloom I, LLC., ("Heirloom") owned property in Colorado and contracted with CFI-Global Fisheries Management ("CFI") to design and construct a fisheries enhancement project on the property. CFI completed the project, but its work was defective and the project was destroyed by natural processes four times in three years.

In July of 2015, Heirloom initiated arbitration proceedings against CFI for breach of contract and negligence related to the design and execution of the project. CFI requested that Rockhill Insurance Company ("Rockhill"), its professional and general liability insurer, defend it in the arbitration. Rockhill issued an insurance policy to CFI, which included three coverage parts: commercial general liability coverage; contractor's pollution liability coverage; and professional liability coverage. The professional liability coverage form applies to damages arising from a "[p]rofessional services incident," defined as "any negligent act, error or omission" in "your rendering, or your failing to render, 'professional services'" that "results in injury or damage." It also states that "your work" means: "(1) Work or operations performed by you or on your behalf; and (2) Materials, parts or equipment furnished in connection with such work or operations."

On August 21, 2015, Rockhill sent CFI a letter agreeing to defend the arbitration but reserving its right to deny coverage. In outlining Rockhill's coverage position, the insurer implied some of the damages could fall within the policy, but discussed several exclusions that might apply. Rockhill identified Exclusion M of the professional liability policy, which reads in full:

> **M. Faulty Workmanship**
>
> Based upon, arising out of or for any loss, cost or expense incurred to withdraw, recall, inspect, repair, replace, adjust, remove or dispose of "your work." This includes, but is not limited to, the cost to investigate "your work," or the cost of any materials, parts, labor or equipment furnished in connection with such withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal.

Rockhill also noted Exclusion P of the professional liability policy, which states:

> **P. Expressed or Implied Warranties**
>
> Based upon, as a consequence of or arising out of:
>
> (1) Any expressed or implied warranties or guarantees, or
>
> (2) Any cost or other estimates for construction, renovation, removal or demolition being exceeded or inaccurate.
>
> However, this exclusion does not apply to a warranty or guaranty by you that your "professional services" are in conformity with generally accepted architectural or engineering standards.

The letter states that Heirloom's "allegations relative to CFI's designs potentially implicate a 'professional services incident' that would trigger coverage" but "[t]o the extent that the damages sought arise out of . . . faulty workmanship apart from your professional services . . . the [Professional Liability] Form will not provide coverage for such damages."

The arbitrators awarded Heirloom $609,994.91 plus prejudgment interest. The parties subsequently stipulated to an additional $265,000 award of attorney's fees and costs. Neither party requested the arbitrators' decision be accompanied by an explanation of reasoning. However, attached to the final award is a spreadsheet identifying invoices paid to third party contractors who worked on the river enhancement project following CFI's failures, and a line item for remaining construction.

Rockhill filed a declaratory-judgment action against CFI and Heirloom prior to the issuance of the arbitration award. It sought a declaration that it had no duty to defend and indemnify CFI in connection with the arbitration. CFI and Heirloom asserted counterclaims for declaratory judgment and breach of contract. The district court granted summary judgment for Rockhill, holding the entirety of the damages awarded to Heirloom were excluded under the policy's Faulty Workmanship exclusion, along with the attorneys' fees and costs. Thereafter, CFI and Heirloom filed appeals.

In reviewing the district court's decision, the US Court of Appeals agreed with the district court that the damages awarded by the arbitrators resulted from a "professional services incident." As such, the only issue to be determined by the Court was whether an exclusion places the damages award outside of otherwise available coverage. The Court noted, that exclusions must be clear and specific to be enforceable.

In determining whether the Faulty Workmanship exclusion barred coverage, the district court focused on a broad definition of "work" as an "activity involving mental or physical effort done in order to achieve a purpose or result." It thus held that the Faulty Workmanship exclusion's references to "your work" applied to both design and construction.

The Court of Appeals disagreed with the district court and concluded that the district court failed to assess the context in which the term work is used. The Court relied on three contextual guideposts and held that the Faulty Workmanship exclusion was not intended to cover design failings.

First, the clause appears in a professional liability policy. As a general matter, such policies cover damages arising

from professional services rendered, in the matter at bar, CFI's professional design service in providing a plan for the stream modification. Professional services are those "arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual. Thus, the Court determined that the overall purpose of the professional liability coverage was for CFI to obtain insurance for its "mental or intellectual" undertakings rather than its "physical or manual" work. Accordingly, the Court found the cases construing similar exclusions in commercial general liability policies to be inapplicable to their interpretation of a professional liability policy.

Second, the Court found that the heading "Faulty Workmanship" clearly evinced the narrower scope of the exclusion. The Court noted that Rockhill itself stated to CFI: "To the extent that the damages sought arise out of . . . faulty workmanship apart from your professional services . . . the [Professional Liability] Form will not provide coverage for such damages." The term "workmanship" typically refers to "the art or skill of a workman," which is an individual "employed or skilled in some form of manual, mechanical or industrial work." Consistent with the general purpose of professional liability coverage, the term distinguishes manual and physical work from professional undertakings.

Finally, the Court noted that the words in the body of the exclusion are more naturally read as relating to construction, rather than design. The exclusion removes coverage for the costs to "withdraw, recall, inspect, repair, replace, adjust, remove or dispose of" work, including "any materials, parts, labor or equipment furnished." Read as a whole and in the context of the coverage agreements, the Court concluded that the parties intended the Faulty Workmanship exclusion to distinguish non-covered construction work from covered professional services.

Accordingly, the Court held that the district court should not have granted summary judgment to Rockhill as to the design components of CFI's work for Heirloom. Because the district court concluded otherwise, it did not consider whether the entire arbitration award (including attorney's fees and costs) was covered under a correct reading of the exclusion or whether the damages should or could be apportioned between design and construction. As such, the Court left that issue for the district court to consider in the first instance.

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Eleventh Circuit

Notice (Florida Law)

***Crowley Mar. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, --- F. App'x ---, 2019 WL 3294003 (11th Cir. July 23, 2019)**

The U.S. Court of Appeals for the Eleventh Circuit held that an insurer was not obligated to cover approximately $2.5 million in costs that its insured paid to defend a subsidiary's vice president against antitrust allegations. In the underlying matter, the U.S. Department of Justice (DOJ) commenced an investigation against Thomas Farmer and several other individuals accused of setting artificially high prices for shipping between Puerto Rico and the United States. Crowley Maritime Corporation (Crowley), the parent company of Farmer's employer, sought to recover the defense costs it had paid on Farmer's behalf from its insurer, National Union Fire Insurance Company of Pittsburgh, PA (National Union). National Union initially denied Crowley's request for coverage in 2008 on the grounds that none of the warrants or subpoenas issued by DOJ mentioned Farmer by name. However, a 2008 affidavit mentioning Farmer was uncovered in 2015, two years after an arbitration panel had initially ruled in favor of National Union.

After discovery of the affidavit, Crowley again sought coverage from National Union for Farmer's defense costs. However, the trial court dismissed Crowley's complaint on the basis that Crowley's claim for coverage was untimely. The appellate court agreed with the trial court's determination on the issue of timeliness and stated that "[e]ven assuming that the Claim based on the Affidavit was 'first made against' Farmer during the Policy Period or the Discovery Period, Crowley failed to timely report that Claim to National Union as required by section 7(a) of the Policy." On that basis, the appellate court concluded that National Union was not required to reimburse Crowley for the defense costs incurred on Farmer's behalf.

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Delaware

Bad Faith/Punitive Damages (Michigan Law)

Buhl Building, L.L.C. v. Commonwealth Land Title Insurance Company **(Del. Sup. Ct. Aug. 19, 2019)**

Bad Faith and Punitive Damage Claims Dismissed under Michigan Law

Buhl sued Commonwealth, its title insurer, after the failed $43 million sale of a skyscraper located in downtown Detroit. The Complaint had three counts: (1) breach of insurance contract seeking money damages; (2) declaratory relief; and (3) bad faith. Buhl asserted that the Defendants breached the implied covenant of good faith and fair dealing by refusing Buhl's request for indemnification without a reasonable justification. In addition, Buhl contended that the Defendants acted in bad faith because the Defendants delayed in addressing a discrepancy in title and refused to indemnify Buhl. Buhl also sought punitive damages on its bad faith claim.

First, the court determined that Michigan law applied because the contract involved a commercial property located in Michigan and much of the performance of the contract at issue took place in Michigan.

Having concluded that Michigan law applied, the court dismissed the claims for bad faith and punitive damages. Michigan does not recognize claims for bad faith breach of insurance contracts and punitive damages. Thus, those claims were dismissed.

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Idaho

Bad Faith/UIM

Lete v. Travelers Casualty Insurance Company of America **(D. Idaho July 30, 2019)**

Failure to Respond to UIM Claim within 60 Days as Was not Unreasonably and Intentional Delay Required for Bad Faith

In October 2015, Simon Lete was driving his dump truck when it was struck by an uninsured motorist. Lete suffered injuries to his right shoulder and his dump truck was damaged. On June 20, 2018, Lete filed a claim under his UIM insurance policy for the injuries and damages he suffered. Lete claimed total damages of $385,336.27. His claim demanded a response from Travelers within sixty days.

Travelers agent Juli Morrow evaluated Lete's claim. On September 13, 2018 Morrow called Lete's phone and left a voicemail offering to settle the claim for $20,938.47. At the time she left the voicemail, Lete had already initiated this lawsuit against Travelers. Travelers had not yet received notice or service of the suit.

On October 25, 2018,Lete's counsel demanded that the $20,938.47 settlement offer be paid as the "undisputed" portion of Lete's claim. Travelers agreed to pay the amount but maintained the position that the payment represented a fair and appropriate resolution on Lete's UIM claim.

Lete alleged that Travelers handled his UIM claim in bad faith. He argued that Travelers did not respond until 85 days after the claim was submitted and did not tender the $20,938.47 payment until five months after claim submission. Since the $20,938.47 offer represented the "undisputed portion" of his claim, Lete argued that Travelers acted in bad faith by delaying payment.

Travelers' motion for summary judgment dismissing the bad faith claim was granted. Travelers did not intentionally and unreasonably deny or delay payment to Lete. Ms. Morrow evaluated Lete's claims and requested additional information about Lete's medical insurance payments so that she could properly assess damages. The settlement offer of $20,938.47 was made to Lete before Travelers was aware that a lawsuit had been initiated, within 90 days of the claim submission.

Lete also argued that Travelers violated Idaho Code §41-1839, which states that an insurer of a UIM policy who fails to pay an amount "justly due" within 60 days of a claim must also pay the insured's attorney's fees in a legal action to recover the insurance payment. The court concluded that there was no basis to conclude that an insurer who exceeds 60 days in responding to a UIM claim has unreasonably and intentionally delayed payment – as is required in a claim for bad faith.

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Illinois

Environmental/Duty to Defend/"Suit"

The Appellate Court has ruled that ITW's liability insurers were not obligated to pay defense costs for a mediations that the insured entered into with the federal government to avoid litigation over its responsibility to clean up a hazardous waste site notwithstanding the insured's contention that the mediation was linked to a law suit involving the original source of the contamination. Not only was the mediation clearly not a "suit," the First District further ruled in Illinois Tool Works v. ACE Specialty Ins. Co., 2019 IL App (1st) 181945 (Ill. App. Ct. Aug. 23, 2019) that the subject of the mediation was separate from the claims that were in litigation and that imposing "a duty to defend ITW in the AUS-OU mediation merely because it involves claims related to the Site 36 lawsuit would lead to an absurd result."

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Auto/Excess/Intoxication Exclusion

The Appellate Court ruled that a trial judge erred in refusing to give effect to an "intoxication" exclusion in an excess auto policy issued to a rental car customer. In Crowley v. Empire Fire & Marine Ins. Co., 2019 IL App (2d) 180752 (Ill. App. Ct. Aug. 2, 2019), the Second District ruled that the supplementary insurance was not mandated by Illinois law and that any exclusions contained in it were therefore not void as being contrary to the public policy underlying the state's minimum insurance regime for motorists.
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Massachusetts

Bad Faith

A federal district court refused to dismiss a liability insurer's claim that Quincy Mutual acted in bad faith in directing its insured to file a frivolous and ultimately unsuccessful lawsuit against another insurer seeking coverage as an additional insured. In *Quincy Mut. Ins. Co. v. Atlantic Specialty Ins. Co., No. 18-11868* (D. Mass. July 29, 2019), Judge Burroughs ruled that summary judgment should not be granted as Quincy Mutual had not yet been able to obtain discovery from Atlantic Specialty with respect to whether and to what it extent it knew that these claims were baseless. The court rejected Atlantic Specialty's alternative arguments that litigation conduct cannot form the basis for a 93A claim. Finally, Judge Burroughs granted Quincy Mutual's motion to compel production of Atlantic Specialty's claim file, including privileged communications and work product that would have been protected from discovery had Atlantic Specialty not pleaded "advice of counsel" as an affirmative defense to these 93A claims. The court left the door open to limit production of certain privileged communications by submitting a privilege log explaining why this legal advice was unrelated to the 176D claims and had not been relied on it in the underlying matter.

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Mississippi

First Party/Katrina/Procedure/Special Master

The Mississippi Supreme Court ruled that a state trial judge erred in transferring to herself one of the State's HAP Katrina suits against property insurers while at the same time stating that these cases were overburdening the judiciary and should be referred to a special master for disposition. While declaring that a judge might, under appropriate circumstances circumvent the arbitrary assignment of cases to trial judges where doing so would be more efficient, the Supreme Court ruled in *Safeco Ins. Co. of America v. Hood,* No. 2017-IA-01554 (Miss. Aug. 22, 2019) that these stated goals were clearly inconsistent with Judge Green's ruling that she did not have time for these cases and wanted to assign them to a Special Master whose fees would be borne by the parties. Further, the court ruled that assigning these cases to a Special Master over the insurers' objection, together with the extraordinary range of powers conferred on the Master to exercise jurisdiction "concurrently" with the judge, was an abuse of discretion.

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New Jersey

Prior Claims/Materiality

Pokhan v. State Farm **(N.J. App. Div. July 30, 2019)**

Despite Insured Admitting She Fibbed About Prior Claims on Insurance Application, New Jersey Appellate Division Re-Instates Insured's Lawsuit Ruling Insurer Failed to Show Materiality

Following a fire that severely damaged her home in Newark, Pokhan made a claim under her homeowners' policy issued by State Farm. State Farm investigated and ultimately denied the claim based on Pokhan's "[v]iolation of the fraud provisions of the policy." Pokhan sued State Farm alleging breach of contract. State Farm answered and raised affirmative defenses including Pokhan's misrepresentations on her insurance application and during the claims investigation.

Pokhan testified at trial that in 2012, Hurricane Sandy ripped shingles from the roof. Pokhan made a claim under her policy for which she received payment of $5000 or $6000. In early 2013, a frozen pipe burst on the second floor causing extensive water damage throughout the residence. According to Pokhan's trial testimony, she received $90,000 from insurance on that claim. After the second claim, Pokhan started shopping around for new insurance because her premium was going up. Pokhan applied for coverage with State Farm and was approved for coverage after speaking with an agent by telephone.

In January 2015, a fire caused extensive damage to plaintiff's home, rendering it uninhabitable. State Farm sent an investigator to take a recorded statement. Although recorded, the statement was not under oath and the investigator explained at the outset it was being taken "strictly to gain information about [Pokhan] and about [her] loss." When the investigator asked about prior losses at the property, Pokhan acknowledged a "frozen pipe" but denied she sustained any damage, and said she did not "believe any payments were made." Pokhan further told the investigator she had not had any other losses at the property, omitting the roof damage from Sandy. In an examination under oath in April, however, Pokhan corrected her misstatements, detailing the flood loss and the prior insurer's payments.

Asked on cross-examination why she initially told the investigator she had not made a claim for the flood loss, Pokhan replied "[b]ecause I didn't feel like she needed to know that." Pokhan continued, "she's not telling me what's going on. So I'm new to this. I mean, being recorded by an agent that's not telling me anything." Pokhan's response prompted State Farm's counsel to ask: "So you gave her the wrong information?" prompting Pokhan to reply: "If that's what you want to call it."

After plaintiff rested, State Farm moved for involuntary dismissal pursuant to Rule 4:37-2(b), arguing Pokhan admitted there was a $90,000 flood loss "prior to taking out insurance with State Farm," and acknowledged she had not been truthful to State Farm's investigator when asked about it directly.

Pokhan's counsel claimed that Pokhan was misled by the investigator telling her the inquiry was limited to the fire loss. Pokhan contended that she did not think the investigator had any business asking her about questions that touched on the accuracy of her insurance application. The trial court judge ruled that the investigator was entitled to explore whether there were material misrepresentations on the application, calling it a "legitimate concern." The trial court then dismissed the complaint. Pokhan appealed.

The Appellate Division agreed that Pokhan's admissions at trial satisfied State Farm's burden to prove her misstatements were willful. The Appellate Division framed the issue on appeal as whether State Farm had shown the materiality of those misstatements.

Under New Jersey law, "[a]n insured's misstatement is material if when made a reasonable insurer would have considered the misrepresented fact relevant to its concerns and important in determining its course of action." The Appellate Division ruled: "There was absolutely no evidence in this record that would permit a fact-finder to judge the materiality of Pokhan's misstatements to State Farm under that test." The Court noted the insurance application was not part of the record and that the investigator deposition did not address how Pokhan's statements were relevant to State Farm's concerns or important in determining a course of action. In addition, the Appellate Division deemed the trial judge's discussion on materiality to be "only speculation."

Since the insurer had not sufficiently shown the materiality of the misrepresentation, the Appellate Division ruled the involuntary dismissal of plaintiff's complaint was in error and remanded the case for a new trial.

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

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New York

SUM/Claims Professional's Testimony

McCullouch v. New York Central Mutual **(N.Y. App. Div. 4th Dep't Aug. 23, 2019)**

Insurance Claims Professional's Evaluation of Serious Injury IRRELEVANT and Should Not Be Allowed by Fact Finder. Thousands Cheer.

A truly wonderful decision from the Fourth Department. Save this one!

Plaintiff commenced this action seeking to recover supplementary uninsured/underinsured motorist (SUM) benefits from New York Central Mutual ("NYCM"). The jury returned a verdict finding that the accident was not "a substantial factor in causing an injury to [plaintiff]." Thereafter, the Supreme Court denied plaintiff's motion to set aside the verdict as against the weight of the evidence.

The Fourth Department upheld the lower court's decision which prohibited the plaintiff from calling, as a witness, any claims representatives employed by NYCM or from entering into evidence any proof of insurance. It was undisputed at trial that plaintiff carried SUM coverage pursuant to a policy issued by defendant and that the SUM coverage was applicable to plaintiff's motor vehicle accident, and thus there was no need for plaintiff to offer further evidence establishing the existence of the policy. Similarly, there was no indication in plaintiff's pleadings or elsewhere in the record that she was alleging that defendant denied her claim for SUM benefits in bad faith and thus the investigation regarding plaintiff's claim was not relevant to the issues at trial. The court held:

> Here, we agree with defendant that its representatives were not witnesses to the accident, have no personal knowledge of the facts of the accident, and are not medical doctors qualified to testify regarding plaintiff's alleged injuries. Thus, NYCM's investigation and evaluation of plaintiff's claim is therefore irrelevant to the issue whether plaintiff sustained a serious injury, which, along with the issue whether any such injury was causally related to the accident, were the primary issues before the jury.

The court upheld the verdict as supported by the evidence.

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South Carolina

Auto/Notice Clause

Neumayer v. Philadelphia Indemnity Ins. Co. **(S.C. July 24, 2019)**

Reversal of Circuit Court Decision Finding the Notice Clause in an Auto Liability Policy Void Under South Carolina Statutory Law

A bus driven by Defendant Partman struck Neumayer, a pedestrian, injuring Neumayer. Partman worked for Defendant Primary Colors Child Care Center. Neumayer sued both defendants. Neither defendant answered or responded in any fashion. A default judgment was entered, and after a damages hearing, Neumayer was awarded $622,500.

Over eighteen months after the entry of default, Philadelphia Indemnity Insurance Co. (Philadelphia), Primary Colors' insurance carrier, received notice that its insured was involved in a lawsuit that culminated in a default judgment. Neumayer's counsel sought to collect $622,500 from Philadelphia, which declined to pay that amount, instead asserting its indemnification obligation was limited to $25,000 under South Carolina jurisprudence requiring an insurer to pay only the minimum limits when it is substantially prejudiced by its insured's failure to provide notice of a lawsuit. Philadelphia also argued its failure to receive notice of the underlying lawsuit prevented an opportunity to investigate and defend.

Neumayer filed a declaratory judgment action asking the court to require Philadelphia to pay the judgment in full. Philadelphia answered with a counterclaim against Neumayer, and cross-claimed against officials at Primary Colors, arguing that its indemnity obligation was limited to $25,000. Both parties moved for summary judgment, and after a hearing, the circuit court found in favor of Neumayer. The circuit court framed the issue as "whether or not Philadelphia can properly reduce the available coverage to the statutory minimum through a cooperation provision in the Policy."

The notice and cooperation provision at issue in this case is located under the "Business Auto Conditions" section and states:

> 2. Duties In The Event Of Accident, Claim, Suit Or Loss
>
> We have no duty to provide coverage under this policy unless there has been full compliance with the following duties:

> 1) In the event of "accident," claim, "suit" or "loss," you must give us or our authorized representative prompt notice of the "accident" or "loss."
>
> * * *
>
> 1) Additionally, you and any other involved "insured" must:
>
> * * *
>
> (2) Immediately send us copies of any request, demand, order, notice, summons or legal paper received concerning the claim or "suit."

The South Carolina Code cited to by the circuit court's decision is Section 38-77-142(C), stating: "Any endorsement, provision, or rider attached to or included in any policy of insurance which purports or seeks to limit or reduce the coverage afforded by the provisions required by this section is void."

The South Carolina Supreme Court's decision recaps and analyzes the history and use of notice clauses in liability insurance policies in South Carolina. There's also discussion of the notice-prejudice rule and South Carolina's adoption of the same after the state extensively amended its laws governing automobile insurance in 1974.

In reversing the circuit court, South Carolina's Supreme Court determined the circuit court erred in ruling that Section 38-77-142(C) invalidates the standard notice clause contained in the insurance policy issued to Primary Colors by Philadelphia. Supreme Court held that while an insurer must provide the statutorily mandated minimum coverage, an insurer may continue to invoke notice clauses to deny coverage above the statutory limits, providing the insurer can prove that it was substantially prejudiced by its insured's failure to comply with the provision.

No sea change in South Carolina automobile liability insurance law.

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Auto/UIM

On a certified question from a federal district court in South Carolina, the state Supreme Court ruled in *Progressive Direct Ins. Co. v. Reeves,* No. 27909 (S.C. July 24, 2019) that the obligation of auto insurers to offer UIM coverage set forth in Section 38-77-350 (C) was satisfied at the time that the policy was originally issued and did not require the insurer to make new offers every time that the policy was amended to add insureds or change the scope of coverage. As a result, the court ruled that Progressive was not required to provide UIM benefits to its insured's son who was added to the policy after it was issued.

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Vermont

Auto Insurance/Damage/"Short Pay" Claims

The Vermont Supreme Court ruled in *Parker's Classic Auto Works, LTD. v. Nationwide Mut. Ins. Co.,* 2019 VT 46 (Vt. July 12, 2019) that an auto insurer cannot "short pay" claims by an auto repair company to recover the full amounts that it paid to repair insured vehicles. As the term "damage" was not defined in the policy, the court construed it as meaning "the amount of money needed to repair an insured vehicle to pre-accident condition not to exceed the value of the vehicle before the accident." The court was not persuaded by Nationwide's argument that the insureds themselves had not suffered any loss since it was only the repair shop that had not been fully reimbursed for its costs and observed that an assignee such as the repair shop may seek to collect an unpaid debt on behalf of its assignor. Finally, the court rejected Nationwide's argument that it was not obliged to pay "repair and labor costs" because labor costs are only covered under the towing clause of the policy and not the collision-coverage insuring clause.

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Virginia

Equitable Contribution

Nationwide Mutual Fire Ins. Co. v Erie Ins. Exch. **(Va. July 13, 2019)**

Circuit Court Erred in Dismissing Insurer's Complaint Against Another Insurer in Equitable Contribution Action - Vacated and Remanded – Liability Insurance Coverage – Equitable Contribution to be Awarded Insurer Consistent With Prior Allocation of Coverage Liability

Nationwide paid $2.9 million to settle a wrongful death claim in full. This occurred shortly after a ruling of the Cir-

cuit Court in "Nationwide I," an insurance coverage action, holding Nationwide was going to be liable for the first $3 million of coverage on the wrongful death claim, and that Erie's coverage kicked in only after that. After the $2.9 million settlement payment was made by Nationwide, an appeal to the Virginia Supreme Court (still in "Nationwide I" here folks), resulted in Nationwide getting reversal of the trial court's allocation of coverage. Supreme Court ruled in "Nationwide I" in 2017 that one of three Nationwide policies making up the aforementioned "first $3 million of coverage" didn't apply. Supreme Court's ruling as to the insurance coverage disputes was that each insurer (Nationwide and Erie) had primary coverage of $1 million, with the companies sharing excess liability over that figure on a pro rata basis.

Despite Nationwide's victory in 2017 at the Virginia Supreme Court in "Nationwide I," Erie refused to reimburse Nationwide any of the $2.9 million Nationwide had paid to settle the underlying wrongful death action. Erie's position was that Nationwide settled the underlying claim voluntarily, without Erie's consent, and Erie was protected by a consent-to-settle provision in its policies.

So, Nationwide commenced the instant equitable contribution action. The Circuit Court bought into Erie's argument on the equitable contribution issue, and held Nationwide is fully liable for its voluntary settlement payment. Nationwide appealed, bringing us to the second time around for these parties at the Virginia Supreme Court. And a second-straight reversal of the ruling of the Circuit Court. The majority opinion which is but a mere click away holds that Erie, by denying coverage, waived its right to fall back upon its consent-to-settle provision in its policy.

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Washington

Auto/Subrogation/"Made Whole" Doctrine

The Supreme Court of Washington has ruled in *Daniels v. State Farm Mutual Automobile Ins. Co.,* No. 9618-9 (Wash. July 3, 2019) that lower courts erred in holding that an auto insurer that was only able to recover 70 percent in a subrogation act was not required to reimburse its insured for 100 percent of the policy deductible. The court ruled that the "made whole" doctrine required a first party insurer to reimburse the full amount of the insured's deductible before it could retain any portion of the subrogation proceeds for itself. The court declared that "whether in the context of a reimbursement request, off set or direct subrogation action, a false-free insured must be made whole for their entire loss before an insurer may offset or recovery its own payments." Furthermore, the Supreme Court found that State Farm's policy violated WAC 284-30-393, a regulation promulgated by the Washington Insurance Department that require insurer's to include deductible in its subrogation demands. The court appears to have been persuaded by an amicus brief that the Insurance Department filed asserting that State Farm's policy was inconsistent with the purpose underlying this regulation.

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