Covered Events

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Covered Events

The newsletter of the Insurance Law Committee

Covered Events

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Leadership Notes

From the Editor

By Patrick B. Omilian

Warmth has finally arrived in Buffalo, but Lake Erie remains covered in icebergs. I imagine most readers are in warmer climes and many have begun turning to the air conditioners. As spring turns to summer, the Insurance Law Committee is in full swing as always. It was great catching up with everyone at ICPS in Chicago earlier this month. If you weren't there, you missed another outstanding program and great networking opportunities. But don't fret, there are more stellar programs just around the corner. From June 5–7, 2019, the Insurance Bad Faith and Extra-Contractual Liability Seminar takes place in Washington, D.C. This seminar is the preeminent program for insurance executives, claims professionals, and outside counsel who specialize in bad faith insurance litigation. You will hear from some of the nation's leading bad faith defense lawyers, who have a long history of winning these difficult cases, as well as many of the in-house professionals who manage significant bad faith litigation and industry consultants who assist with these cases across the country, and beyond. The annual Insurance Coverage and Practice Symposium in New York happens from December 5–6 at the Sheraton New York. More information on both programs can be found at dri.org.

Meanwhile, this edition of Covered Events is chock full of the usual reports on notable insurance cases across the country from a number of ILC members. No doubt there are pertinent cases here for every reader’s practice. We also have two excellent Featured Articles, both worthy of your time. Gabriel Darwick and Suzanne Whitehead offer analysis and insights on duty to defend issues that go beyond a complaint's allegations. Meanwhile, Jennifer Hamilton discusses the development in bad faith claims against individuals, an eye-opener for all. Special thanks to our authors for their contributions.

And as always, if you have interesting insight to share on an issue affecting your particular practice area, please contact our editor-in-chief, Tiffany Brown, at tbrown@meagher.com, or any of the other Covered Events editors. We are always happy to consider your article or case summary for future editions.

Patrick B. Omilian's practice focuses on complex insurance coverage, reinsurance and bad faith issues. Patrick’s practice is nationwide in scope and he advises his clients from his office in Buffalo, New York, where he is a partner at Gerber Ciano Kelly Brady LLP.

DRI ILC Young Lawyers Subcommittee

By Ashlyn M. Capote and Brandon W. Reedy

The Insurance Law Committee boasts a membership that includes many of the most accomplished insurance lawyers in the country. As a young lawyer trying to get a foot in the door, it can be a bit overwhelming. Thankfully, the Young Lawyers’ Subcommittee is here to help. Like the ILC’s substantive law subcommittees, the YL subcommittee offers exposure to talented colleagues that share your practice concerns, career aspirations, and legal interests. With a focus on issues that most prominently effect lawyers in their first ten years of practice, the YL subcommittee offers a lot more than just a way to get a foot in the door. Interested in getting published? The YL subcommittee can help. Interested in pursuing leadership roles within the ILC? The YL subcommittee can help.

The ILC's Insurance Coverage & Practice Symposium is on Thursday, December 5, 2019 this year, and the YL subcommittee always has a good showing. Between the proximity to Rockefeller Center (think ice skating) and the Christmas tree lighting, New York City is a vibrant place to be that time of year. If you have yet to take a stroll through the City's holiday market in early December, it is quite an experience. Similarly, if you are a traditional ICPS attendee and have yet to make it to the YL dinner at ICPS (likely on
December 4 this year), you have been missing out. I hope to see you there!

Ashlyn M. Capote is an associate in the Global Insurance Services Practice Group at Goldberg Segalla LLP, in Buffalo, New York.

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Featured Articles

Coverage B Conundrum: Do the Facts Alleged or the Elements of Liability Control Courts’ Duty to Defend Analysis?

By Gabriel Darwick and Suzanne Whitehead

It is well-settled that, in Wisconsin, an insurer’s duty to defend arises whenever the factual allegations in the complaint raise a reasonable possibility of coverage. Yet in West Bend Mutual Insurance Co. v. Ixthus Medical Supply, Inc., the Wisconsin Supreme Court explicitly evaluated the duty to defend based on the elements of liability to the exclusion of the factual allegations. 2019 WI 19 (Wis. 2019). The West End court’s decision represents the latest departure from a practical, deeply-rooted framework for evaluating an insurer’s duty to defend. This article examines the West Bend decision, cases in other jurisdictions reaching similar and different results, and provides the authors’ views on guiding courts away from adopting West Bend’s flawed approach.

The West Bend Court Shifts Wisconsin Law and Evaluates the Duty to Defend Based on Elements of Liability

The West Bend coverage dispute arose from a lawsuit between Abbott Laboratories, its affiliates, and West Bend Insurance Company’s named insured, Ixthus Medical Supply, Inc. In November 2015, Abbott sued Ixthus, among others, for trademark and trade dress infringement, fraud, and other common law and statutory violations. Abbott alleged that Ixthus illegally conspired to import and sell diverted international blood glucose test strips Abbott manufactured with labeling that had not been cleared by regulators for sale in the United States. This was, according to Abbott, part of a fraudulent scheme in which Ixthus knowingly participated. Abbott alleged thirteen causes of action, including Federal Trademark Dilution under Section 43(c) of the Lanham Act; 15 U.S.C. §1125(c), and claims under New York General Business Law §§360-1 and 349. Although some of the causes of action in the complaint required proof of intent, others, like those previously identified, did not.

Ixthus tendered its defense and indemnity to West Bend, its commercial general liability insurer, contending that the Abbott complaint alleges a covered “personal and advertising injury” under Coverage B. West Bend denied the tender and promptly filed suit seeking a declaration that it had no duty to defend or indemnify Ixthus. Among other things, West Bend asserted that the Knowing Violation exclusion barred coverage because the complaint alleged that Ixthus acted intentionally and with knowledge that it was defrauding Abbott by buying international test strips at a lower price and selling them domestically to increase profit. Id. at ¶25. The Knowing Violation exclusion barred coverage for “‘personal and advertising injury’ caused by or at the direction of the insured with knowledge that the act would violate the rights of another and would inflict ‘personal advertising injury.’” Id. at ¶26.

Neither Abbott nor Ixthus sought to steer the court away from the intentional acts alleged in the complaint. Rather, they relied on prior Wisconsin appellate court decisions to argue that “the inquiry is not whether the complaint alleges intentional acts, but whether the complaint alleges any nonintentional cause of action for which the insured could be liable.” It followed that since intent was not a required element of certain causes of action, the Knowing Violation exclusion did not bar coverage.

The court agreed with Abbott and Ixthus, holding that:
The knowing violation exclusion will preclude coverage at the duty-to-defend stage only when every claim alleged in the complaint requires the plaintiff to prove the insurer acted with knowledge that its actions “would violate the rights of another and would inflict ‘personal and advertising injury.’” If the complaint alleges any claims that can be proven without such a showing, the insurer will be required to provide a defense.

2019 WI at ¶29. The court continued by noting “[e]ven though the complaint generally assert[ed that] Ixthus acted wrongfully and with knowledge that it was defrauding Abbott,” the duty to defend was triggered because certain Lanham Act and GBL claims could be proven without establishing knowledge or intent to violate Abbott’s rights and inflict injury. Id. at ¶36–37.

Some Jurisdictions Take a Similar Approach


In Bridge Metal, for example, another alleged trademark infringer sought a defense under the “personal and advertising injury” coverage of a commercial general liability policy when it was sued for, among other things, violations of the Lanham Act. Like in West Bend, the insurer, Travelers Indemnity Company, sought to preclude coverage pursuant to the Knowing Violation exclusion. In the underlying complaint, the plaintiff, National, alleged that Bridge Metal, the insured, utilized confidential information to manufacture, market, and sell products apparently identical to National’s, was telling potential clientele that it could manufacture fixtures just like National’s for a less expensive price, and that Bridge Metal was trying to falsely advertise and deceptively palm off their products so as to confuse and deceive the public about the true origin of the fixtures. National further alleged that Bridge Metal’s conduct was intentional, willful, wanton, malicious, oppressive, and reckless. 812 F. Supp. 2d at 530–31. To avoid application of the Knowing Violation exclusion, Bridge Metal argued that although the complaint alleged intentional conduct, it could have been found liable for several causes of action without any finding of intentional conduct. Id. at 544. Just like the West Bend court, the district court held that the duty to defend exists “despite the allegations of intentional conduct,” because “National’s complaints asserted covered causes of action for which Plaintiffs could have been liable to National without any intentional conduct.” Id. 545. The Second Circuit affirmed.

In their efforts to shift the duty to defend analysis away from the facts and to the legal elements of a cause of action, policyholders have not focused solely on the application of the Knowing Violation exclusion in Coverage B of a commercial general liability policy. Similar efforts are sometimes made and are occasionally successful when a policyholder seeks to defeat the application of an Expected Or Intended exclusion under Coverage A of a commercial general liability policy. See Telecommns. Network Designs, Inc. v. Brethren Mut. Ins. Co., 83 Pa. D. & C. 4th 265 (C.P. 2007) (complaint alleging violations of the TCPA caused “property damage” could be proven through unintentional conduct, triggering insurer’s duty to defend).

Many Courts Resist Theoretical Circumstances and Stick to the Facts


The split over the proper duty to defend analysis is not jurisdiction-specific. As an example, take the New York
Appellate Division, First Department’s decision in Terk Techs. There, the court applied a Knowing Violation claim to bar coverage under the “personal and advertising injury” coverage section:

notwithstanding the fact that a violation of the Lanham Act can be unintentional, and that the claim in the federal action asserts that Terk acted with “reckless disregard,” we can discern no justification from the factual allegations set forth in the complaint to impose a duty to defend Terk upon Atlantic. Indeed, it is impossible to envision how Terk could have unknowingly, and unintentionally, approached a local manufacturer to produce a cheaper, low-quality knock-off of the CD 25; marketed the counterfeit product in packaging indicating it was a genuine Larsen creation manufactured in Denmark, both blatantly false; and then fraudulently misled Larsen when he inquired as to poor sales, indicating that demand was low, whereas the counterfeit product was enjoying vigorous sales. Since all of the factual allegations of the complaint are premised on intentional, “knowing” conduct, they fall squarely within the “knowledge of falsity” exclusion in the Policy.

309 A.D.2d at 32; but see Cosser v. One Beacon Ins. Grp., 15 A.D.3d 871 (N.Y. App. Div. 2005) (declining to apply Knowing Violation exclusion to complaint alleging Lanham Act and CGL causes of action that can be proven without intent).

In a recent California decision, the court held that an Umbrella Policy’s exclusion providing that there is no coverage for personal injury “when the insured acts with specific intent to cause any harm” applied to preclude coverage for false imprisonment claims by focusing on the facts alleged. See Kogler v. State Farm General Insurance Co., 291 F. Supp. 3d 1054 (N.D. Cal. 2018); see also Montrose Chem. Corp. v. Superior Court, 6 Cal. 4th 287, 291 (1993) (under California law, an insurer may deny coverage based on undisputed facts extrinsic to the complaint, concluding, “that evidence extrinsic to the underlying complaint can defeat as well as generate a defense duty...”).

In the underlying complaint, the plaintiff alleged, inter alia, that the underlying defendant insured falsely imprisoned her by dragging her by the hair without her consent. The court applied the facts as alleged and held that, “[v]iewed objectively, [the insured’s] conduct supports a finding as a matter of law that he acted with the specific intent to harm Kogler when he lifted her off the ground by her hair.” Thus, the court concluded that the exclusion applied and State Farm owed no duty to defend.

Reconciling West Bend

Those courts that have departed from the Terk Techs line of reasoning, and in particular the West Bend court, do not seem to reconcile their positions with the oft-stated rule that the duty to defend should not be determined based on the theory of liability, even though that rule controls in Wisconsin and in other jurisdictions that have set aside the facts. See James Cape & Sons Co. v. Streu Constr. Co., 2009 WI App. 154, ¶16 (Wis. App. Ct. 2009) (“Our focus is on the facts alleged, the incidents giving rise to the claims, not [the claimant’s] theory of liability”); Mount Vernon Fire Ins. Co. v. Creative Hous., 88 N.Y.2d 347, 352 (N.Y. 1996) (“while the theory pleaded may be the insured’s negligent failure to maintain safe premises, the operative act giving rise to any recovery is the assault”); Amerisure Mut. Ins. Co. v. Microplastics, Inc., 622 F.3d 806, 815 (7th Cir. 2010) (“The factual allegations of the complaint, rather than the legal theory under which the action is brought, determine whether there is a duty to defend.”) (quoting Pekin Ins. Co. v. Dial, 355 Ill. App. 3d 516, 520 (2005)).

In jurisdictions that consider the theory of recovery in evaluating the duty to defend, the West Bend decision may not seem like a significant departure from the duty to defend analysis. See, e.g., Jones Boat Yard, Inc. v. St. Paul Fire & Marine Ins. Co., 2017 U.S. Dist. LEXIS 1449 (S.D. Fla. Sept. 6, 2017) (applying Florida law) (“an insurer’s duty to defend ultimately turns ‘on the facts and legal theories alleged in the pleadings and claims against the insured.’”) (citations omitted) (emphasis in original). However, while it is one thing to consider the legal theory in conjunction with the facts to evaluate the duty to defend, it is quite another to consider the legal theory to the exclusion of the facts. Engaging in the latter analysis requires a court to consider “hypothetical scenarios that could result in indemnity coverage.” Sletten & Brettin Orthodontics, LLC v. Cont’l Cas. Co., 782 F.3d 931, 939 (8th Cir. 2015). Thus, courts have declined to “imagine allegations that [the plaintiff] could have made merely because [the plaintiff’s] actual allegations went beyond the bare minimum of notice pleading.” Id. at 939 (citing Bethel v. Darwin Select Ins. Co., 735 F.3d 1035, 1040 (8th Cir. 2013)); Wackenhut Servs. v. Nat’l Union Fire Ins. Co., 15 F. Supp. 2d 1314, 1321 (S.D. Fla. 1998) (“inferences that can be made from the allegations of the complaint ‘are not sufficient’ to trigger the duty to defend.”); Hurley Constr. Co. v. State Farm Fire & Cas. Co., 10 Cal. App. 4th 533, 538 (Cal. Ct. App. 1992) (“The insured may not speculate about unpled third party claims to manufacture coverage.”)
Permitting the consideration of hypothetical scenarios not pled in the complaint to trigger the duty to defend on the premise that a claimant alleging only intentional conduct may seek at trial to prove that claim without evidence of intent is not consistent with the reality of litigation. As a preliminary matter, a complaint “must contain sufficient allegations of underlying facts to give fair notice and to enable the opposing party to defend itself effectively.” *Starr v. Baca*, 652 F.3d 1202, 1206 (9th Cir. 2011). Thus, when a plaintiff seeks to prove a trademark infringement, it must sufficiently identify the infringing conduct. *Twit, LLC v. Twitter, Inc.*, No. 18-cv-00341, 2018 U.S. Dist. LEXIS 90319 (N.D. Cal. May 30, 2018). Similarly, a plaintiff who pleads intentional infliction of emotional distress, must allege facts to support that claim. *Moncada v. W. Coast Quarty Corp.*, 221 Cal. App. 4th 768 (Cal. App. Ct. 2013). Formulaic recitations of the elements of a cause of action are insufficient to state a claim. *Harris v. Mills*, 572 F.3d 66 (2d Cir. 2009). Accordingly, where a complaint alleges detailed factual conduct to meet the notice pleading requirements, a strong argument can be made that a court should not disregard those allegations to evaluate whether it is possible the claimant may prove certain claims on different facts.

The *West Bend* court, and others applying its framework, seem to fail to consider that the allegations pled in the complaint constrict the facts and theories of liability that can be introduced at trial. *Stevens v. Helming*, 163 Conn. App. 241, 248 (Conn. App. Ct. 2016) (“Simple fairness requires that a defendant not be forced to defend against facts that are not clearly pleaded in a complaint”). Thus, a claimant who seeks to prove a cause of action based on reckless or negligent conduct for the first time at trial—when only intentional conduct is alleged in the complaint—will generally be precluded from doing so. See *White v. Mazda Motor of Am., Inc.*, 313 Conn. 610, 625 (Conn. 2014) (“the plaintiff was not required to plead a separate malfunction theory count in his complaint, but this does not relieve him of his burden of pleading facts to raise this theory in his complaint as part of his product liability claims”); *Daniels v. Bd. of Educ.*, 805 F.2d 203, 210 (6th Cir. 1986) (holding that district court did not abuse its discretion by failing to consider a new theory raised for the first time after trial). Thus, if Abbott’s case against Ixthus proceeded to trial, Abbott would be required to present its case based on Ixthus’ purported fraudulent scheme alleged in the complaint, not on some alternative basis where Ixthus perhaps negligently infringed on Abbott’s patent.

Lastly, the *West Bend* court is not necessarily correct in its view that West Bend will owe a duty to indemnify if Ixthus is held liable on a theory that does not require intent. Most jurisdictions, including Wisconsin, hold that an insurer may litigate coverage issues on which material facts were not litigated and necessary to the underlying judgment. *Nationwide Mut. Ins. Co. v. Pasiak*, 327 Conn. 225, 267–68 (2017) (collecting cases); *Valley Bancorporation v. Auto Owners Ins. Co.*, 212 Wis.2d 609, 619 (Wis. App. Ct. 1997) (insurer bears the burden of proving that the conduct not covered by the insurance policy gave rise to the damages determined by the jury). Thus, even if Ixthus was held liable under a cause of action that could be proven without intent, West Bend would still have the right to challenge its duty to indemnify based on whether the facts supported the application of the Knowing Violation exclusion. For this reason as well, the *West Bend* court’s rule is difficult to reconcile with Wisconsin jurisprudence.

**Practical Tips for Guiding Courts Away from the Liability Theory Expansion of Duty to Defend**

In the authors’ view, the *West Bend* decision upends the appropriate framework for evaluating the duty to defend without justification. But there is no turning back in Wisconsin, at least when it comes to applying a Knowing Violation exclusion. Policyholder counsel likely will rely on *West Bend* to argue for its application in other jurisdictions in similar contexts, whether it is to a Knowing Violation, an Expected Or Intended exclusion, or in some other context. To combat this approach, coverage counsel should be prepared to articulate the contradictions between the *West Bend* analysis and the rule, adopted in most jurisdictions, that requires the duty to defend to turn on the facts alleged, not the theories of liability. In our view, the theory of liability approach taken in *West Bend* is far too expansive for the duty to defend analysis.

As discussed earlier, from a practical point of view, the *West Bend* court’s decision that a cause of action built on a specific set of facts alleged in a complaint may at trial be proven on another set of facts is wrong. Further, as noted by the insurer in *West Bend*, requiring the duty to defend to turn on the elements of the cause of action would transform the duty to defend analysis into a “weighty intellectual exercise on the law, and what a cause of action minimally requires, removed from the actual facts.” This is not a reasonable or practical framework for insurers to determine their coverage obligations to insureds.
concentrates his practice in the areas of insurance and reinsurance coverage litigation. His broad coverage practice encompasses claims made under commercial general liability, commercial auto liability, excess and umbrella, lawyers and accountants professional liability, D&O, miscellaneous errors and omissions, EPL, and environmental liability policies. Gabe regularly represents insurers in additional insured and environmental coverage litigation in New York and has represented insurers in state and federal courts nationwide concerning coverage for pollution, toxic torts, and product liability under general liability policies. In addition, Gabe has counseled clients on issues under EPL, D&O, and professional liability policies. Gabe’s vigorous representation of his clients has produced favorable results at every step of the process, including pre-suit resolutions, through trial and on appeal. Gabe’s practice focuses on litigation in New York state and federal courts. He also regularly litigates cases in New Jersey and Connecticut and has represented insurers in coverage litigation in West Virginia and Pennsylvania.

Suzanne Whitehead is an Associate in Coughlin Duffy LLP’s Insurance and Reinsurance Services group. Suzanne concentrates her practice on the handling of complex insurance coverage matters principally on behalf of insurance companies. She has experience litigating coverage in both New York and Massachusetts state and federal courts. Suzanne’s practice focuses on a wide variety of coverage litigation, including commercial general liability, professional liability, directors and officers, and homeowners policies. Additionally, her practice involves advising insurers regarding pre-litigation coverage issues as well as early settlement opportunities. Suzanne has extensive experience with bad faith litigation and counseling. She also has experience with commercial disputes, including unfair business conduct, employment practices, contractual disputes, investment fraud, construction disputes, and Americans with Disabilities Act claims. Suzanne serves as an Editor for DRI Covered Events. She is also a member of the Insurance Law Steering Committee and Young Lawyers Steering Committee.

The Keodalah Conundrum: Will Washington State Actually Hold Individuals Responsible for Insurance Bad Faith?

By Jennifer Hamilton

Hard cases make bad law, as the adage goes. The clichéd legal maxim is no better exemplified than in the upcoming Washington Supreme Court decision in Keodalah v. Allstate Insurance Company, et al. The phrase most famously attributed to Oliver Wendell Holmes, Jr., refers to the utilitarian theory that exceptional facts provide a weak basis for comprehensive laws applying to all situations. Keodalah demonstrates this concept perfectly.

The case begins in April 2007, when Moun Keodalah, after bringing his truck to a complete stop at an intersection, began to cross the street and was struck by a speeding motorcyclist. The impact killed the motorcyclist and Mr. Keodalah suffered significant injury. After investigating the accident, the Seattle police department (SPD) determined the motorcyclist was traveling between 70 and 74 miles per hour in a 30 mile per hour zone. A review of Mr. Keodalah’s cell phone records showed that he was not on his phone at the time of the accident. SPD did not charge, nor cite, Mr. Keodalah.

The motorcyclist had no insurance, and Mr. Keodalah submitted a claim to Allstate Insurance Company where he maintained underinsured motorist coverage in the amount of $25,000. Allstate’s witness interviews, as well as its third-party accident reconstruction firm, all indicated Mr. Keodalah was not at fault and the motorcyclist’s excessive speed caused the collision. Allstate, nevertheless, took the position that Mr. Keodalah was 70 percent at fault and offered $1,600 to settle the claim. (We note that 30 percent of $25,000 is $7,500). Mr. Keodalah requested the basis for Allstate’s evaluation, which Allstate refused to provide. Mr. Keodalah then sent a 20-day notice of a potential lawsuit pursuant to the Washington Insurance Fair Conduct Act (IFCA) and Allstate raised its offer to $5,000 while remaining steadfast in its refusal to explain its reasoning. Mr. Keodalah filed suit against Allstate.

During litigation, Allstate designated Tracey Smith, an Allstate employee and claim adjustor, as its 30(b)(6) deposition representative. Ms. Smith signed Allstate’s discovery responses and testified in both deposition and at trial. In its discovery responses, Allstate denied liability and alleged Keodalah failed to mitigate his damages and that
his own negligence proximately caused his injuries. In her deposition testimony, Ms. Smith claimed, in contradiction of the SPD and accident reconstruction firm, that Keodalah had been on his cellphone at the time of the accident and had run the stop sign. The jury returned a verdict for Mr. Keodalah in the amount of $108,868.20.

Keodalah then filed a second lawsuit against Allstate alleging bad-faith violation of Washington’s Consumer Protection Act (CPA) and named Allstate’s employee, Tracey Smith, personally as an additional defendant. Allstate filed a motion to dismiss the second complaint and the trial court granted the motion in part. It dismissed Keodalah’s claims against Smith and certified the case for discretionary review by the Washington State Court of Appeals.

The appellate court granted discretionary review on the following two issues: 1) whether an individual insurance adjuster may be liable for bad faith, and 2) whether an individual insurance adjuster may be liable for violation of the CPA.

With respect to bad faith, the court determined that, per RCW 48.01.030, individual insurance adjusters constitute “representatives.” Washington’s insurance bad faith statute, RCW 48.01.030, provides, in pertinent part:

The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers and their representatives rests the duty of preserving inviolate the integrity of insurance.


The appellate court similarly extended Washington’s CPA to apply to individuals, not just corporate entities. The court expanded a prior Washington Supreme Court decision that held an individual did not need to have a consumer relationship in order to file a lawsuit against a business entity. Penag v. Farmers Ins. Co. of Washington, 204 P.3d 885 (Wash. 2009). With next to no reasoning or explanation, the appellate court extended this decision to apply to individuals. Now, per Keodalah, a person can file suit against an individual under the CPA without showing a consumer relationship or privity of contract.

The shocking Keodalah decision of applying insurance bad faith liability to individual employees has caught the attention of the insurance community nationwide. Amicus briefs have been filed by the Washington Defense Trial Lawyers; the American Insurance Association, filed jointly with the American Property Casualty Insurance Association and the National Association of Mutual Insurance Companies; GEICO General Insurance Company; the Washington State Association for Justice Foundation (WSAJF); and the Coalition Against Insurance Fraud. All but one, WSAJIF (an advocacy for plaintiff’s attorneys in the Pacific Northwest), have unwaveringly argued against the appellate court’s decision.

Some have argued that pleading individual claims against Allstate bringing in the second defendant, personally, as an additional defendant. Allstate filed a motion to dismiss the second complaint, and the trial court granted the motion in part. It dismissed Keodalah’s claims against Smith and certified the case for discretionary review by the Washington State Court of Appeals.

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Other concerns involve public policy at large. As noted above, one of the advantages for pleading in an individual adjuster defendant would be to defeat removal to federal court based on diversity of citizenship. A suit brought against an in-state adjuster may prevent a foreign insurer from removing the case to federal court. Insurers may then be encouraged to hire out-of-state adjusters and/or counsel, rather than invest in its own state’s workforce. Further, the threat of litigation may very well keep many of the highly desirable millennials entering the workforce from seeking employment as an adjuster or with an insurance company in general for fear of being exposed to personal liability.

These concerns are not just conjecture as we have begun to see fallout from the appellate court’s decision. There have been two cases where the Washington District Court has relied on Keodalah in remanding them back to state courts. See Mort v. Allstate Indem. Co., No. C18-568RSL, 2018 U.S. Dist. LEXIS 153999 (W.D. Wash. Sept. 10, 2018); Tidwell v. Gov’t Employees Ins. Co., No. C18-318RSL, 2018 U.S. Dist. LEXIS 91211 (W.D. Wash. May 31, 2018).

Nevertheless, there is hope. Fortunately, the Washington Supreme Court has accepted review of Keodalah. Although this court is not exactly insurance friendly, hopefully it will be able to anticipate the torrent of consequences that could arise from imposing multi-million-dollar bad faith verdicts upon individual adjusters, even if such consequences were beyond the appellate court’s near-sighted vision.

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Recent Cases of Interest

First Circuit

**Bad Faith/TPA (MA)**

The First Circuit has sustained a lower court’s declaration that a TPA did not act in bad faith in failing to settle wrongful death claims a nursing home that went to trial and resulted in a $14 million verdict. In *Calandro v. Sedgwick Claims Mgt. Services, Inc.*, No. 18-1637 (1st Cir. Mar. 18, 2019), the court found that there were questions of fact concerning causation with respect to the death claim and that, although defense counsel had stipulated to liability with respect to the personal injuries suffered by the patient prior to her death, the TPA had made reasonable efforts to settle that aspect of claim.

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Second Circuit

**Employee Exclusion/Notice (NY/MT)**

In *Am. Trucking & Transportation Ins. Co., RRG v. Liberty Mut. Ins. Co.*, No. 18-1186-CV, 2019 WL 1324611 (2d Cir. Mar. 25, 2019), an opinion scant with facts, the Second Circuit addressed a couple of issues relative to a policy issued by carrier American Trucking and Transportation Insurance Company, RRG (ATTIC). First, with regard to the policy’s employee exclusion, that provision read that in the “trucking liability insurance provided by ATTIC, to the Named Insured(s) does not apply to ... any bodily injury to any employee of an insured arising out of and in the course of the employee’s employment by an insured or while performing any duties in furtherance of the business of an insured.” The Court determined that this unambiguously meant what it said and was triggered by injuries to employee of any insured.

Second, the insurer had claimed that its coverage was excess. However, the ATTIC policy stated that “if cargo moving equipment used by an insured during the loading or unloading process is not ... under the control of the Named Insured(s) this coverage will apply only in excess of any other available coverage.” This provision too was determined to unambiguously mean that since the claimant had “controlled” the hand truck that hurt him because he was “restraining or directing influence” over it, the coverage for it was not excess.

Third, ATTIC’s policy’s notice requirement stated that “in the event of an accident, claim, suit, or loss, the Named Insured(s) must give ATTIC prompt notice.” It also stated that “in the event of a claim or suit being made or served on any insured, the Named Insured(s) must ... immediately deliver to ATTIC a copy of such claim or suit including any demand, request, notice, order, summons or legal paper received by any insured” (emphasis added by court). This, the court found, was unambiguous in its requirement on the Named Insured to provide notice, not other insureds.

Finally, since Montana law was found to apply to this case, New York’s prejudgment interest rule was found to have been inapplicable.

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Rescission (NY)

In May 2012, US Underwriters issued a policy to Orion Plumbing, providing them with liability coverage for the following year. In September 2012, the policy was cancelled for non-payment of premiums. In June 2012, however, prior to the cancellation, a NYC Firefighter was injured at a home that was being renovated by a number of contractors, including Orion. When the case went into suit in February 2015, Orion was eventually brought into the action. Orion was subsequently dismissed from that suit but had presumably incurred defense costs.

In August 2016, US Underwriters sued Orion for a declaration of no coverage under the policy they had issued, as well as a declaration of rescission based upon Orion’s alleged misrepresentations on their insurance policy application. Orion defaulted in the DJ action. However, the magistrate hearing the case recommended that the coverage case be dismissed for lack of subject matter jurisdiction. The judge concluded that the carrier’s claims failed to present a case or controversy and that “an attenuated chain of contingencies” would have to occur before Orion could claim entitlement to coverage. US Underwriters did not contest the dismissal relative to the declaration of no coverage, but appealed the ruling as to its rescission of the policy.

On appeal, in *United States Underwriters Ins. Co. v. Orion Plumbing & Heating Corp.*, No. 18-2286-CV, 2019 WL 1253325 (2d Cir. Mar. 18, 2019), the Second Circuit held that the insurer did indeed have a justiciable claim. Citing
prior precedent, they noted that rescission claims may be justiciable even absent a pending claim. US Underwriters had pled the underlying facts, and the key for rescission – the fact that they would never have issued the policy had they known that Orion performed the work that they did. Namely, they would not have issued the policy they did had Orion informed them that they worked on residential buildings/structures. US Underwriters alleged a reasonable likelihood that they could face liability to Orion based, at a minimum, on its duty to defend under the policy. Since the misrepresentations had essentially induced the carrier to issue a policy it would not otherwise have issued, they had pled facts sufficient to raise to an actual controversy. As such, the matter was remanded back down to the lower court to address the merits of US Underwriters’ arguments.

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Fourth Circuit

Claims-Made and Reported Policy/ Untimeliness (VA)

Gateway Residences at Exchange LLC (“Gateway”) owned a building in Alexandria, Virginia. They hired a local contractor, Mechanical Design Group (“MDG”) to provide various engineering and design services. Among those, MDG was to install two “life and safety power generators” in the garage. Apparently they do so, but not very well, as when they started up them up in August 2014, they caught fire. As a result, the generators were destroyed and the opening of the 217-unit building was delayed. Gateway sued MDG and was awarded over $900,000 in damages. MDG eventually went out of business.

MDG had procured an insurance policy with Illinois Union that covered the period of February 1, 2014, to February 1, 2015. However, it was a claims-made and reported policy. While in its policy Illinois Union agreed to indemnify MDG for any legal claims that might arise out of the Gateway project, the policy also expressly stated that the coverage was provided “ON A CLAIMS-MADE AND REPORTED BASIS,” meaning that it covered “ONLY CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE INSURER, IN WRITING, DURING THE POLICY PERIOD” (emphasis in original). To further stress the point, the policy made it a “condition precedent to coverage” that any claim be reported to the insurer during the policy period.

MDG apparently never told Illinois Union about the potential claim before its policy expired in February 1, 2015. Instead, the carrier learned about it in September 2016, when Gateway notified MDG’s carriers that it intended to sue. Illinois Union thereafter disclaimed coverage on the basis of its policy provisions. In that letter, they explained that since the claim was first made outside of the policy period, there was no coverage in the first instance and there was “no coverage for this matter as no claims were made and reported during the policy period.” In the meantime, Gateway’s litigation against MDG proceeded and they ultimately received a default judgement of over $900k.

Gateway next tried to sue Illinois Union directly. From the procedural standpoint, the carrier properly removed the matter to Federal Court. While Gateway tried to remand it back down to state court, there was diversity among the parties which provided jurisdiction, and there was no valid argument to hold otherwise. As a substantive matter, however, Gateway’s only argument for coverage was that the carrier’s denial letter had been untimely sent. Thus, they asserted that the carrier had waived its coverage defenses and had to pay the claim.

In Virginia, like in many other states, there is a statutory provision relative to a carrier’s responsibilities when disclaiming coverage. Virginia Code Section 38.2-2226 states, in pertinent part: “Whenever any insurer on a policy of liability insurance discovers a breach of the terms or conditions of the insurance contract by the insured, the insurer shall notify the claimant or the claimant’s counsel of the breach. Notification shall be given within forty-five days after discovery by the insurer of the breach or of the claim, whichever is later.” Thus, a carrier is required to provide notice or risk waiver.

Here, however, the Circuit Court correctly pointed out that the statute “makes two things clear: it covers denials based on the insured’s ‘breach’ of the terms and conditions of the policy and applies to arguments properly characterized as waivable ‘defenses’.” Yet in this case, the crux of the matter did not have to do with breaches or defenses, but rather scope of coverage. Since the claim was outside of the scope of coverage in the first instance, there clearly was no legal duty to incur uncovered claims and the 45-day rule did not apply.


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Fifth Circuit

Misrepresentation (MS)

The Fifth Circuit has ruled in Imperium Ins. Co. v. Shelton & Associates, No. 16-60730 (5th Cir. Mar. 6, 2019) that while it would grant panel rehearing of its August 30, 2018 opinion, it continued to believe that the underlying claims satisfied the court’s “amount in controversy” requirement and that the court had correctly ruled that the claims in question were not covered. Applying Mississippi law, two of the judges ruled that the insured’s failure to disclose its knowledge of circumstances that were likely to lead to a claim against the firm was a material misrepresentation that voided any malpractice coverage that would otherwise have applied. Writing in dissent, Judge Haynes disputed that any reasonably attorney would have known that a claim was likely to be made against it based upon these circumstances.

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Eighth Circuit

Auto/UIM/Stacking/”Illusory” Coverage (MO)

The Eighth Circuit has rejected an insured’s argument that his auto insurer committed fraud and was unjustly enriched by charging premium for three separate policies for which the insurer subsequently refused to pay UIM benefits in light of anti-stacking language contained therein. In a brief opinion, the Eighth Circuit declared in Country Preferred Insurance Company v. Lee, No. 18-2096 (8th Cir. Mar. 14, 2019) that the insurer’s UIM coverage was not illusory since it extended coverage for non-named, non-family passengers and drivers of the insured’s other vehicles.

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Ninth Circuit

Procedure/Removal (WA)

The Ninth Circuit has ruled that an auto insurer’s removal to federal court was timely. In Anderson v. State Farm Mut. Automobile Ins. Co., No. 15-35981 (9th Cir. Mar. 8, 2019), the Ninth Circuit joined the Fourth Circuit in holding that receipt of an initial pleading by a statutorily designated agent does not begin the thirty-day removal clock under 28 U.S.C. §1446(b)(1), and that it was instead actual receipt by State Farm that started the removal clock.

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Connecticut

Bad Faith

The Moura family is experiencing a Connecticut epidemic, crumbling concrete foundations. They bought, in 2009, a home that was constructed in 1998. By March 2017, they noticed cracks in their basement walls. The Mouras concluded that it was likely due to a form of concrete that oxidizes, expands, and breaks the bonds of the concrete, speculating that the concrete was produced by notorious Connecticut concrete manufacturer J.J. Mottes Concrete Company. Asserting that it is “only a question of time until the basement walls collapse,” the Mouras filed a homeowner’s claim with their carriers. When Liberty denied the claim and Harleysville did not issue a coverage decision, the Mouras brought suit in Connecticut Superior Court, claiming breach of contract and violation of the Connecticut Unfair Insurance Practices Act (CUIPA) and the Connecticut Unfair Trade Practices Act (CUTPA). The carriers removed.

Post-removal, but pre-answer, Harleysville denied coverage and the Mouras sought leave to amend their complaint to address the denial and to add causes of action for bad faith. Under the Erie doctrine, the courts look to state court opinions to determine the contours of the implied covenant of good faith and fair dealing. In Connecticut, the implied covenant of good faith and fair dealing arises entirely from common law. The district court noted, and the parties agreed, that most Connecticut state courts “would typically reject the Plaintiffs’ claims” because the state courts have not found the insurers’ conduct in concrete decay claims sufficient to state a claim for bad faith. But, some federal district courts have held otherwise. The case is Moura v. Harleysville Preferred Ins. Co., 2019 WL 936590, Case No. 3:18-cv-422 (D. Conn. Feb. 26, 2019).

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Georgia

**Bad Faith/Failure to Settle**

In *First Acceptance Ins. Co. of Georgia, Inc. v. Hughes*, --- S.E.2d ---, 2019 WL 1103831 (Ga. Mar. 11, 2019), the Georgia Supreme Court held that an insurer’s duty to settle arises only when it is presented with a valid offer to settle within policy limits. Ronald Jackson (Jackson) was involved in a multi-vehicle accident that resulted in his own death and serious injuries to other drivers and passengers. Jackson’s auto insurer, First Acceptance Insurance Company of Georgia, Inc. (First Acceptance), agreed that Jackson’s liability was clear and that the damages exceeded the $50,000 per accident policy limit. Two of the accident claimants sent a series of letters to First Acceptance, offering to settle their claims at the available policy limits. The letters did not impose a deadline for First Acceptance’s response to the settlement offer, and before First Acceptance responded, the claimants revoked their settlement offer. First Acceptance subsequently offered to pay the policy limits to settle the claims, but its offers were rejected.

Following a jury trial, the claimants obtained a $5 million judgment against Jackson’s estate. The estate sued First Acceptance for the entire judgment and punitive damages and attorney’s fees, alleging that First Acceptance acted in bad faith by failing to accept the settlement offer before it was withdrawn. The Georgia Supreme Court rejected the argument that an insurer’s duty to settle arises when it knows or reasonably should know that settlement of a claim within policy limits is possible. The Supreme Court instead held that First Acceptance’s response to the settlement offer, and before First Acceptance responded, the claimants revoked their settlement offer. First Acceptance subsequently offered to pay the policy limits to settle the claims, but its offers were rejected.

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Illinois

**Construction Defect/Occurrence**

In *Acuity Ins. Co. v. 950 West Huron Condo. Ass’n*, --- N.E.3d ---, 2019 WL 1416820 (Ill. App. Ct. Mar. 29, 2019), the Appellate Court of Illinois, First District ruled that Acuity Insurance Company (Acuity) had a duty to defend its subcontractor insured, Denk & Roche Builders Inc. (Denk) against allegations of faulty workmanship because the same constituted an occurrence. The appellate court’s ruling reversed the decision of the trial court, which found Acuity had no duty to defend.

Acuity issued a commercial general liability policy to Denk. Denk was a subcontractor on a condominium building in Chicago that was constructed during the late 1990s and early 2000s. Several years later, the homeowners’ association noted several construction defects that allegedly led to water intrusion in the building. The association filed a lawsuit against the general contractor, who in turn sued Denk for faulty workmanship.

The appellate court rejected Acuity’s argument and the decision of the trial court, saying that Acuity’s argument that the defects were the natural and ordinary consequence of Denk’s faulty work was at odds with existing Illinois law. Instead, the appellate court held that because Denk’s faulty workmanship was alleged to have caused damage to a part of the construction that was not a part of Denk’s scope of work, the same constituted an occurrence under the Acuity policy, “notwithstanding that it would not be an occurrence from a general contractor or developer’s perspective.” Instead, “[f]rom the eyes of the subcontractor, the ‘project’ is limited to the scope of its own work, and the precise nature of any damage that might occur to something outside of that scope is as unknown or unforeseeable as damage to something entirely outside of the construction project.”

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**Umbrella Coverage/Additional Insureds/Permissive Drivers**

The Illinois Appellate Court has ruled that a permissive user was not entitled to claim coverage under a vehicle owner’s umbrella policy. In *State Farm Mutual Automobile Ins. Co. v. Murphy*, 2019 IL App (2nd) 180154 (Ill. App. Ct. Mar. 29, 2019), the Second District declared that the permissive
user was not some other “person or organization to the extent they are liable for the use of an automobile, recreational motor vehicle or watercraft by a person included” in the other insured provisions of the umbrella policy. The court rejected the claimant’s argument that this language was ambiguous or that the “last antecedent rule” limited the application of the “person included” language to watercraft and not also to automobiles. Because the named insured in this case was not liable for the permissive user’s operation of this vehicle, the court declined to find that the permissive user was entitled to coverage as an insured.

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Massachusetts

Business Risk Exclusions

The Massachusetts Appeals Court has ruled in All America Ins. Co. v. Lampasona Concrete Corp., No. 18-P-247 (Mass. Ct. App. Mar. 19, 2019) that a trial court erred in ruling that Exclusion J(6) precluded coverage for the cost of removing and replacing a hospital’s flooring structure when the insured subcontractor had only worked on the concrete slab underlying the floor. Under the circumstances, the Appeals Court ruled that the judge had erred in making a factual finding that the flooring was one integrated structure and, furthermore, that the carpeting and vapor barrier over the negligently installed flooring slab were not “that particular property” on which the insured was performing operations at the time.

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Bad Faith

Despite having previously ruled that that a liability insurer did not owe CGL coverage beyond the $300,000 liquor liability sublimit that it had already paid, a federal district court has ruled that a liability insurer is subject to treble damages under the Massachusetts Consumer Protection Act for its claimed willful failure to conduct a full pre-suit investigation of an accident in which an inebriated stripper fatally collided with a car being driven by an off-duty police officer. In Capitol Specialty Ins. Co. v. Higgins, No. 14-40086 (D. Mass. Mar. 25, 2019), Judge Hillman ruled that the liability insurer had willfully failed to interview key witnesses and had not followed up leads that would have contradicted its insured manager’s self-serving claim that the bar had not served any drinks to its employee. He observed that “had Capitol used minimal effort and expense and allowed Norfield & Associates to track down and interview witnesses, and collect the relevant facts immediately following the accident this case would have followed a far different path.” Having found that the insured’s liability for serving alcohol to the 20 year-old dancer that contributed to her car crash was reasonably clear, the District Court ruled that Capitol Specialty’s delay in settling had diminished the available limits because of defense costs in the interim and had obliged the claimant to incur legal expense to obtain a settlement. The court therefore concluded that Higgins had suffered $1.8 million in damages, which he trebled based upon a finding of willful misconduct. Judge Hillman did not explain how he concluded that $1.8 million was the amount of damages, although he did ruled that he was not bound by a $7.5 million consent judgment that the insured had previously entered into with the bar.

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Failure to Settle

Great American Insurance Company (Great American) sued Granite State Insurance Company (Granite State) for allegedly failing to settle a lawsuit brought by Amadeo Gallotto (Gallotto) against Parkview Condominium Trust (Parkview) for Gallotto’s worksite injuries. Granite State provided $1 million of primary coverage and Great American issued $5 million of excess coverage to Parkview. Granite State defended Parkview in the underlying action. During a mediation shortly before trial, the smallest dollar amount Gallotto would accept from Granite State was $2.15 million. During trial, further settlement negotiations ensued. Granite State rejected an approximate $900,000 demand but countered with a high-low suggestion within the policy limits, which Gallotto rejected. A jury ultimately entered a $7.5 million verdict against Parkview, requiring Great American to pay its policy limits.

Great American filed suit against Granite State, alleging that Granite State failed to settle the underlying action within the limits of the Granite State policy. The U.S. District Court for the District of Massachusetts found that Granite State did nothing wrong. The district court noted that Gallotto’s only “demand that fell within the policy limits was the demand for something in the $900,000 range, made early in the trial. It was not unreasonable for Granite State to reject that demand. …” The district court
reasoned that, in light of the defense counsel’s repeated assessments of Parkview’s likelihood of success at trial, “Great American has not shown that ‘no reasonable insurer would have refused [that] settlement offer’ at the time it was made.” Accordingly, judgment was entered in favor of Granite State.


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Consent Judgments/Res Judicata

A federal district court has rejected a third-party claimant’s effort to resurrect a consent judgment that the First Circuit had earlier ruled was invalid because it failed to impose a legal obligation on the part of the insured to pay a judgment that would be covered by an excess policy. In Salvati v. Fireman’s Fund Insurance Company 18-11289 (D. Mass. Mar. 1, 2019) Judge Saylor ruled that the disposition of the original lawsuit against the excess insurer was res judicata with respect to this second suit, rejecting the plaintiff’s argument that a new clause that the parties subsequently added in an effort to avoid the effect of the First Circuit’s ruling created “new facts” that would avoid issue preclusion in this case.

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Mississippi

Homeowners’ Policy/Earth Movement Exclusion

The background facts can be summarized as follows. After learning her home’s foundation was defective, Ms. Smith filed a claim under her homeowner’s insurance policy for the repair of the foundation, but her insurer Mississippi Farm Bureau Casualty Insurance Company (“Farm Bureau”) denied the claim. In Mississippi Farm Bureau Cas. Ins. Co. v. Smith, 264 So. 3d 737 (Miss. Mar. 7, 2019), Ms. Smith alleged that Farm Bureau’s refusal to pay for her foundation repairs not only breached the insurance contract, but constituted bad faith and a tortious breach of contract.

Ms. Smith filed suit against both her home builder, and, as pertinent here, Farm Bureau, demanding an award of damages to repair the foundation, and further, an award of damages for inconvenience, anxiety, emotional distress, plus, extra contractual damages, punitive damages, and attorneys’ fees. Whew.

Farm Bureau’s motion for summary judgment, arguing Ms. Smith’s claim was properly denied because her home’s foundation defects were not covered because of the policy’s earth movement exclusion, was denied by the Circuit Court. Farm Bureau’s petition for interlocutory appeal was granted by the Supreme Court of Mississippi.

Per Supreme Court’s opinion, the earth movement exclusion from Ms. Smith’s homeowner’s insurance policy states:

A. We do not insure for loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss. These exclusions apply whether or not the loss event results in widespread damage or affects a substantial area.

...
2. Earth Movement

Earth Movement means:

a. Earthquake, including land shock waves or tremors before, during or after a volcanic eruption;

b. Landslide, mudslide or mudflow;

c. Subsidence or sinkhole; or

d. Any other earth movement including earth sinking, rising or shifting; caused by or resulting from human or animal forces or any act of nature unless direct loss by fire or explosion ensues and then we will pay only for the ensuing loss.

The Mississippi Supreme Court’s opinion recited its analysis and consideration of four cases decided in various Mississippi courts between 1977 and 2018 which had wrestled with the applicability of various earth movement exclusions to various property damage claims. None of those four cases had the same exclusionary language as the Farm Bureau case, however.

It was noted by the Mississippi Supreme Court that the earth movement exclusion contained in the Farm Bureau policy at issue did not limit application of the exclusion to only those losses or damage caused by “natural” forces. Because the Farm Bureau policy also excluded coverage for loss or damage arising from earth movement caused by non-natural/external forces (i.e., “human” forces), the Farm Bureau exclusion was read broadly to exclude coverage for Ms. Smith’s loss or damage, which Ms. Smith asserted in her papers was or could have been caused by at least three different events: faulty design of her builder for the foundation of her house; poor compaction on the fill dirt by her builder when her house was first built; or, a busted water line that could have leaked water under the house to the extent that voids developed beneath the foundation of the house. Ms. Smith also argued the policy nonetheless expressly covered “water damage,” and leaked water was or could have been the cause of her foundation problems, and as such, the earth movement exclusion could not be applied, due to asserted ambiguity in the policy.

The Mississippi Supreme Court rejected Ms. Smith’s arguments. The Court noted the Farm Bureau policy stated the earth movement exclusion applied “regardless of any other cause or event contributing concurrently or in any sequence to the loss.” Ms. Smith’s policy was found to contain an unambiguous earth movement exclusion providing that loss or damage caused by earth movement is excluded from coverage, whether the earth movement was caused by natural forces or external forces. The Court held that even under Ms. Smith’s variously asserted sets of facts/hypothetical causes, the earth movement exclusion would apply, because even Ms. Smith’s expert had opined that whether one of Ms. Smith’s hypothetical causes of the foundation damage or another was a cause, a contributing factor in any event to the loss was in fact earth movement.

Friends, this case reminds us that, regardless of case law which may be cited in support of applicability or inapplicability of any exclusion, a court will in any event look to the actual wording of the particular exclusion at issue. If the wording of such exclusion is clear and unambiguous, the court will apply it. Here, regardless of other court decisions interpreting similar, but different earth movement exclusions, the Supreme Court of Mississippi ultimately looked to the specific exclusionary language at issue and applied it, in order to provide, in my humble opinion, the true meaning and intent of its terms, as this Court correctly decided this case.

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Montana

Stacking

_U.S. Specialty Ins. Co. v. Estate of Ward, 2019 MT 72, ¶_1 (Mont. Mar. 26, 2019) reached the Supreme Court of Montana, in as a result of the United States District Court for the District of Montana certifying a question asking the Montana Supreme Court to address the Estate of Darrell L. Ward’s third-party claim to stacked liability limits in an aircraft insurance policy that covered multiple aircraft. The Supreme Court of Montana concluded that the answer to the reformulated question is no.

The background facts are as follows. Mark Melotz was piloting his aircraft, FAA Number N9936T, with Darrell Ward as a passenger. The plane crashed. Both Melotz and Ward were killed. Melotz had insured N9936T and two other aircraft under one insurance policy issued by U.S. Specialty Insurance Company (“USSIC”). Melotz paid a separate premium for each aircraft.

The aircraft insurance policy’s applicable coverage provision provides as follows:
1. What We Cover

We will pay damages you, and anyone we protect, are legally required to pay for bodily injury or property damage caused by an occurrence during the policy period.

...  
e. Coverage DL covers bodily injury to passengers and others and property damage in a combined limit of liability for each occurrence which includes a lower limit for each person.

The most we will pay for bodily injury to each person is shown in item 6DL opposite “each person.” The most we will pay for all bodily injury and property damage is shown in item 6DL opposite “each occurrence.”

The policy describes each aircraft, with a stated $100,000 limit for “each person,” and a stated $1,000,000 limit for “each occurrence.” The policy defines an “occurrence” as “a sudden event ... involving the aircraft during the policy period, neither expected nor intended by you, that causes bodily injury.”

Following Ward’s death, USSIC paid Ward’s Estate $100,000—the per-passenger limit for bodily injury claims involving N9936T. Ward’s Estate argued that it was entitled to stack the coverage of each aircraft’s per-passenger limit, for a total of $300,000.

The Montana Supreme Court found no ambiguity in the pertinent policy provisions. The Court recognized an “occurrence” in the context of this policy is a “sudden event ... involving the aircraft during the policy period, neither expected nor intended by you, that causes bodily injury.”

The policy does not define the word “involved,” the Court determined that a common-sense reading of that term made plain that it refers to the aircraft that is a part of the sudden event that caused bodily injury.

The Estate’s argument that public policy requires the stacking of the liability coverages applicable to each plane was rejected by the Court, which noted that Montana does not statutorily regulate aviation insurance in any manner. Montana statutory law regulating motor vehicle liability insurance was not applicable to this aircraft liability insurance coverage issue, in the Court’s view.

The Court then analyzed the “reasonable expectations doctrine.” The Court noted that doctrine’s requirement that the Court apply a liberal construction of the insurance contract in favor of coverage when the policy language is such that an ordinary, objectively reasonable person would fail to understand that the policy technically does not provide the coverage at issue or where circumstances attributable to the insurer would cause an ordinary, objectively reason-

able person to believe that the coverage exists. The Court also noted that in applying the doctrine the terms of the insurance policy must be construed in their plain, ordinary, and popular sense. Here, the Court found:

The plain language of the USSIC policy and the Estate’s status do not entitle it to a reasonable expectation of stacked liability coverage. The policy defines passenger as “any person who is in the aircraft or getting in or out of it.” Coverage is limited to the aircraft involved in the crash. As a passenger in N9936T, Ward was an insured under that policy only. Ward did not have a connection to the other two aircraft because he was not a passenger in either of those aircraft and he was not an insured. The policy states that “the most” USSIC will pay per passenger is $100,000 for each occurrence.

Citing prior decisions of Montana courts, the Court continued:

[t]he plain language of the policy makes clear that the aircraft not involved in an accident are not part of the occurrence and coverage for those aircraft is not available for that accident. Ward was not an insured and did not have a reasonable expectation of benefits for additional aircraft owned by Melotz that were not “involved” in the crash.

Finally, the Estate of Melotz does not have a reasonable expectation under the plain language of the policy that Ward is entitled to stack the coverages...although Melotz paid premiums for three separate policies, Ward was not an “insured” under Melotz’s policies for the uninvolved aircraft. And Melotz did not seek benefits under the policy’s “liability to others” coverage. Melotz did not have a reasonable expectation that a third party would be entitled to stack coverages for which that party was not an insured. Melotz paid for coverage that would pay liability damages for bodily injury caused by an occurrence with a separate coverage limit for each aircraft. Any expectation that a passenger would recover more than the $100,000 limit for that aircraft in a crash is not objectively reasonable under a common-sense reading of the policy.

The takeaway a folk is that although aircraft liability insurance may be something most of us rarely if ever deal with in our day-to-day work, the analysis of the Court here mirrors how courts most often consider and determine more regularly encountered liability insurance coverage issues. What does the policy at issue say is always the starting point for such analysis.

So, please feel free to call us with your coverage questions. We’re here to help you consider, understand and
interpret the relevant policy language at issue in the claims you are handing. Until then, be well, and think spring!

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New Jersey

**PIP Limits/Medical Expenses**

In *Haines v. Taft*, No. 079600, 2019 WL 1339479 (N.J. Mar. 26, 2019), each plaintiff was injured in a car accident. Each was insured under a standard policy with insurance that provided for $15,000 in PIP coverage instead of the default amount of $250,000. Neither plaintiff was able to sustain a claim noneconomic loss (pain and suffering) due to each policy’s limitation-on-lawsuit option. Each plaintiff filed a personal injury claim suing the other driver for medical expenses in excess of their elected PIP coverage ($28,000 and $10,000, respectively).

Each defendant made pre-trial motions to preclude plaintiff from presenting evidence of medical expenses that exceeded their $15,000 PIP limits. Defendants relied on N.J.S.A. 39:6A-12 (“Section 12”), which addresses the inadmissibility of evidence of losses collectible under personal injury protection, and *Roig v. Kelsey*, 135 N.J. 500 (1994). In *Roig*, the New Jersey Supreme Court held that the public policies underlying the no-fault system required that Section 12 be construed to prohibit injured parties from recovering medical deductibles and copayments from a tortfeasor.

In opposition to the motion, plaintiff Joshua Haines maintained that medical bills exceeding PIP coverage constitute “economic loss” as that term presently is defined in N.J.S.A. 39:6A-2(k) and that evidence of such medical bills should thus be admissible. Similarly, plaintiff Tuwona Little distinguished the present case from *Roig*, stating that, in amending the definition of economic loss to include “medical expenses” after *Roig*, the Legislature “clearly evinced its intention to allow recovery [in tort] for medical expenses.”

The trial courts ruled against plaintiffs in each matter and prohibited plaintiffs from admitting evidence of their medical expenses that exceeded their $15,000 PIP limits. The Appellate Division consolidated the cases on appeal, and, in a published opinion, reversed both trial court orders. The Supreme Court granted certification.

The Court began its analysis by reviewing Section 12. Section 12 addresses evidence that is admissible or not in a claim for bodily injury. Despite the provision’s narrow focus on evidentiary matters in trials for noneconomic losses, plaintiffs construed the third paragraph’s language—“Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss sustained by the injured party”—in concert with the present definition of “economic loss” in N.J.S.A. 39:6A-2(k), to give rise to a stand-alone right to pursue a third-party liability claim against a tortfeasor exclusively for uncompensated economic loss of medical benefits not covered due to having a lesser amount of PIP coverage.

After reviewing the pertinent statutory provisions, the Court stated, “Section 12 does not unmistakably compel plaintiffs’ interpretation. Indeed, one can envision an equally plausible construction that such uncompensated economic losses may be recovered from the tortfeasor within the context of a viable suit for bodily injury.”

Given the difference in interpretations between Plaintiffs and Defendants, the Court reviewed the historical development of New Jersey’s No-Fault law looking for legislative intent.

The Court discussed at length the history of no-fault insurance, and emphasized that the New Jersey no-fault system is one of changing priorities, shifting from full coverage to cost containment.

In 1998, the Legislative enacted Automobile Insurance Cost Reduction Act (“AICRA”). AICRA is the most significant and most recent amendment to the no-fault law.

In AICRA’s opening section, the Legislature declared that its goals were “to preserve the no-fault system, while at the same time reducing unnecessary costs which drive premiums higher.” AICRA changed the arbitration process used for benefit disputes, established bases for determining whether treatments and diagnostic tests are medically necessary, revised the threshold for suits for noneconomic loss, and created insurance options with decreased coverage in exchange for lower premiums. AICRA’s regulatory scheme ensured that benefits were paid according to their medical necessity, keeping premiums at a manageable level, while preventing such claims from inundating the court system.

The Court found that some provisions of AICRA indicate that the Legislature was concerned that people might be subject to the lower PIP coverage limits without making the conscious decision to do so. The Court found that this concern would seem “overblown” “if a private cause of action remained to recover any medical costs above the selected PIP ceiling.”
The Court determined that AICRA’s legislative history demonstrates that there was a legislative awareness of the possibility of creating a gap in medical coverage should PIP coverage be lowered, which presumes the absence of other forms of reimbursement, such as suits in tort, to fill that gap.

Based upon the legislative intent in enacting AICRA and numerous other cost containment amendments to New Jersey’s no-fault law, the Supreme Court held that:

… [I]nterpreting Section 12 to allow the admission of evidence of medical expenses falling between the insured’s PIP policy limit and the [presumptive PIP amount of $250,000] … transgresses the overall legislative design of the No-Fault Law to “reduce court congestion, . . . lower the cost of automobile insurance,” and most importantly, avoid fault-based suits in a no-fault system.

Based on the strong evidence of a legislative effort to avoid fault-based suits in the realm of medical expenses in the No-Fault Law, we cannot conclude that the Legislature clearly intended Section 12 to allow fault-based suits consisting solely of economic damages claims for medical expenses in excess of an elected lesser amount of available PIP coverage. …

[T]o do so would be to “lose sight of the overwhelming goals of reducing court congestion and lowering the cost of automobile insurance.”

The Court further found that efforts to subject medical costs to careful review and control through AICRA’s extensive regulatory programs would be undercut by the ability of a third party to sue for medical expenses above their PIP policy coverage limit but below the presumptive amount of $250,000. The Court reasoned that such suits would commandeer the judicial resources that the arbitration system was enacted to preserve.

The Court rejected Plaintiffs’ argument entirely:

The result of plaintiffs’ reading of AICRA could allow the unintended – and, one could assert, absurd – consequence whereby someone who chooses a lower PIP coverage option could receive a higher overall reimbursement. ...We cannot envision that the Legislature countenanced such results. ...

Under the No-Fault Law, the ability to sue is the exception, not the rule. The Legislature has determined that the benefits of creating limited but automatic medical reimbursement for injured motor-vehicle-accident victims outweigh the ability of a minority of injured parties to recover larger amounts in tort.

Accordingly, the Court concluded that the Appellate Division judgment must be reversed, and ordered that the cases be remanded to the trial court for entry of dismissal.

The Supreme Court closed its decision by stating that if the Legislature disagrees with the Court’s analysis and ruling, it is free to amend the law.

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**Permissive Driver**

On May 2, 2017, Plaintiff Alicia Ortiz was in an auto accident while operating a vehicle borrowed from her boyfriend’s brother. Defendant Personal Service Insurance Company issued an auto insurance policy to Lourdes Naba, plaintiff’s daughter. Asserting she was a resident of Lourdes’s home, plaintiff claimed she was entitled to personal injury protection (PIP) benefits under Lourdes’s policy with defendant. Plaintiff submitted a PIP application to defendant. Defendant took a recorded statement from plaintiff about the accident. During the course of that statement, plaintiff acknowledged she did not have a valid driver’s license at the time of the accident. Defendant declined the request for PIP benefits, advising plaintiff it was “not possible” for her to obtain permission to operate the vehicle because she was “not legally eligible to drive” in this State.

In *Ortiz v. Pers. Serv. Ins. Co.*, No. A-4190-17T2, 2019 WL 1294198, at *1 (N.J. Super. Ct. App. Div. Mar. 20, 2019), Plaintiff sued Personal Service Insurance seeking a declaration that she was eligible for PIP benefits under Lourdes’s policy with defendant. There was no dispute that plaintiff was not a licensed driver. The motion judge granted summary judgment, ruling plaintiff she was excluded from receiving PIP benefits under the policy because she was an unlicensed driver at the time of the accident.

N.J.S.A. 39:6A-7(b) permits an insurer to exclude PIP coverage to “any person having incurred injuries . . ., who, at the time of the accident . . . (2) was occupying or operating an automobile without the permission of the owner or other named insured.”

The Appellate Division ruled that a vehicle owner cannot grant permissive user status to an unlicensed driver, and therefore, an unlicensed driver is not entitled to PIP benefits when operating a vehicle without permission. The Appellate Division further found that plaintiff – knowing she was unlicensed – must also be assumed to know she was not entitled to drive the vehicle and that a vehicle...
The owner could not permit her to drive the vehicle within the meaning of N.J.S.A. 39:6A-7(b).

The Appellate Division affirmed the grant of summary judgment to the carrier.

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

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Admiralty Law/Yacht Coverage

Plaintiff Chartis Property Casualty Company (“Chartis”) issued a Yacht policy to John and Joan Inganamort (the “Defendants”). The policy insured Defendants’ 65-foot, 1996 Sportfish vessel, *Three Times A Lady*, which was berthed in Boca Raton, Florida. On September 5 or 6, 2011, the Inganamorts’ yacht suffered a partial sinking while docked in Florida. Chartis claimed the boat partially sank due to a hole in Defendants’ boat brought about by years of lack of upkeep. Defendants claimed “heavy rainstorms” overwhelmed the vessel, causing it to sink. Chartis commenced a declaratory judgment action against Defendants in the District of New Jersey, seeking a declaration there was no coverage for the yacht as there was no fortuitous loss.

In *Chartis Prop. Cas. Co. v. Inganamort*, No. CV1204075WHWCLW, 2019 WL 1277518, at *1 (D.N.J. Mar. 20, 2019), the Court determined that federal maritime law applied. The fortuity rule states that “all-risk policies in marine insurance contracts only cover losses caused by fortuitous events.” Under the rule, “[a] loss is not fortuitous if it results from an inherent defect, ordinary wear and tear, or the insured's intentional misconduct. On the other hand, losses that arise from acts of nature or the insured's negligence are covered.” In admiralty law, “[t]he burden of proof generally is on the insured to show that a loss arose from a covered peril.”

Chartis argued that the policy at hand did not cover the damage sustained by Defendants’ boat because it is an “all-risk” policy that only covers losses that the policyholders can prove were “fortuitous.”

Defendants contend that the partial sinking of their boat stemmed from heavy rainfall, and cite two reports written by their expert, Charles Stevens, a Marine Surveyor and Licensed Insurance Adjuster. Mr. Stephens stated that there were “5 to 15 inches of rain” in South Florida in September of 2011 based on “talking to other people,” including “people at the marina” and “the captain.” The only other evidence that the Inganamorts submitted was the testimony of a security guard employed by the Inganamorts’ homeowners’ association who said there was “heavy rain.”

Chartis argued that heavy rain could not have been the proximate cause of the yacht’s partial sinking. Chartis submitted a historical weather chart that showed there was only 3 inches that week. Likewise, no other boats in the marina where the vessel was docked were found to have been damaged by any heavy rainfalls during the same time period.

The Court found that there was not enough evidence for a rational juror to find that the amount of rainfall was sufficiently fortuitous to have caused the partial sinking of the boat. Defendants did not submit sufficient evidence, such as meteorological data or publicly available reports, as to the rain’s severity. (read: security guard not qualified to render meteorology reports). The Court ruled that Defendants had no evidence to demonstrate a fortuitous loss, and the insurer was entitled to a declaration that there was no coverage for the yacht.

Note: This decision is not for publication.

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New York

DJ Action - Discovery

In *Am. Med. Alert Corp. v. Evanston Ins. Co.*, 170 A.D.3d 456, 93 N.Y.S.3d 837, 838 (N.Y. App. Div. Mar. 7, 2019), Evanston sought to compel the deposition of an employee who was previously deposed in a related action to which Evanston was not a party. The appellate court affirmed the finding of the motion court. The motion court denied the motion on the ground that because the employee had been deposed in the related action, an examination by Evanston would be redundant.

We cannot tell from the decision what different questions the insurer would have asked in the DJ deposition.

Author’s Note: Sometimes, the way to resolve this problem before it occurs is to join the underlying case and the declaratory judgment action for discovery purposes so that everyone gets a shot at the witness.

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**Additional Insured**

L & M Restoration ("Restoration") was hired by defendant M & M Realty ("Realty") to perform work at Realty's. Restoration's insurance policy, issued by Burlington Insurance Company, provided additional insured coverage for loss caused, in whole or in part, by Restoration's acts or omissions to any entity that L & M agreed in writing to name as an additional insured. Tower Insurance Company, Realty's insurer, Realty's defense of an action brought against it by an Restoration employee injured on the job, after Burlington refused Realty's tender, and now seeks, in *M & M Realty of New York, LLC v. Burlington Ins. Co.*, 170 A.D.3d 407, 95 N.Y.S.3d 178 (N.Y. App. Div. Mar. 5, 2019), reimbursement from Burlington for costs it incurred defending and settling the underlying action.

The contract between Realty and Restoration is ambiguous was to whether L & M was required to name M & M as an additional insured under the Burlington policy. The extrinsic evidence properly considered by the motion court did not conclusively demonstrate the parties' intent in this regard but presented an issue of credibility to be determined by a factfinder.

If it is determined that Restoration intended to name Realty as an additional insured under the Burlington policy, then Burlington will be obligated to reimburse Tower for its defense costs, because the allegations of the underlying complaint and the known facts suggest a reasonable possibility of coverage, i.e., a reasonable possibility that the underlying injury was caused, in whole or in part, by L & M's acts or omissions. Moreover, Tower submitted evidence that demonstrates that the acts or omissions of L & M, which directed and controlled the underlying plaintiff’s work, were a proximate cause of the plaintiff's injuries. The policy issued to Realty by Tower is excess over the Burlington policy.

This decision is consistent with *Burlington Ins. Co. v NYC Tr. Auth.*, 29 N.Y.3d 313, 321–22 (2017). Look to the allegations in the complaint (not the third-party complaint – and the proof).

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**Intellectual Property Exclusion**

A Federal District Court has ruled in *Lepore v. Hartford Fire Insurance Company*, No. 16-689 (S.D.N.Y. Mar. 12, 2019) that an intellectual property exclusion in a liability insurance policy precluded any obligation to provide a defense to a competitor's allegations that a fashion designer through allegation violated the terms of a licensing agreement by which Lepore had agreed to permit NL Brand Holdings to use her designs. In granting summary judgment for The Hartford, Judge Failla declared that the IP exclusion extended to other types of claims, including unfair competition, nor was it restricted to claims for "personal and advertising injury." In any event, the District Court concluded that the claims were separately excluded as “arising out of a breach of contract” since they could not have been made “but for” the insured's breach of its licensing agreement with NL.

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**Notice**


On May 10, 1979, Hanover issued a general liability insurance policy to Plaintiff covering damage or accident arising out of the ownership, operation and maintenance of the Insured Location between May 10, 1979 and May 10, 1982 (the “Hanover Policy”). The Hanover Policy contained a notice requirement, which required the insured to provide written notice if a claim is made or suit is brought against the insured.

On October 6, 2003, the DEC issued a notice of claim (the “Notice of Claim”) to the Plaintiff. The Notice of Claim provided that the DEC had “included the [Insured Location] in the Registry of Inactive Hazardous Waste Disposal Sites in New York State.” Following the Notice of Claim, the DEC sent Plaintiff its Record of Decision in March 2012. The Record of Decision identified Plaintiff as one of the Potentially Responsible Parties and who may be legally liable for the contamination at the site. The Record of Decision also stated Plaintiff declined to implement a remedial program when requested by the DEC.

On May 4, 2016, Plaintiff served a notice of claim under the Hanover Policy. Plaintiff contended that it failed to submit a claim before because it had not been aware of the Hanover Policy until early 2016 due to the deteriorating health of its President. In response to the notice of claim,
Hanover denied Plaintiff’s claim under the Hanover Policy citing Plaintiff’s late notice.

Thereafter, Plaintiff commenced this action. Now Hanover has moved to dismiss pursuant to 12(b)(6).

The Court considered whether the Plaintiff stated a viable claim under the Policy. First, the Court noted that “[u] nder New York law compliance with the notice provisions of an insurance contract is a condition precedent to an insurer’s liability under policies with effective dates prior to January 17, 2009.” Further, the Court noted that no-prejudice rule governs such policies and therefore if an insured fails to provide timely notice as required by the particular policy, then, absent a valid reason for the delay, the insurer is under no obligation to defend or indemnify the insured.

Applying this rule of law as the Hanover policy was issued well before January 17, 2009, the Court turned to when Plaintiff’s obligation to provide notice arose. Plaintiff conceded that it had to provide notice pursuant to the “occurrence” provision under the Hanover Policy. However, Plaintiff argued that a “claim” occurred by the time the Plaintiff submitted its demand letter in 2016 because no suit or other litigation against the Plaintiff had yet commenced. Nevertheless, the Court rejected Plaintiff’s argument. In its reasoning, the Court noted that while the Second Circuit has not explicitly held that a receipt of a Potentially Responsible Party (“PRP”) designation constitutes a “claim” under notice-of-claim provisions, the Second Circuit has recognized that a powerful argument can... be made to that effect, because an insurance company would want the opportunity to play a role in whatever proceedings might follow. As such, the Court held that Plaintiff’s obligation to provide notice to Hanover was triggered when the DEC’s Record of Decision designated Plaintiff as a PRP.

Next, the Court considered the timeliness of Plaintiff’s notice. The Court began its discussion by acknowledging that “where a policy has an immediate notice of suit requirement, even a relatively short delay in providing notice violates that requirement. The Court also acknowledged that it will forgive the absence of “immediate” action by the claimant, so long as the claimant carries the burden of offering a reasonable excuse for the delay.

Here, the Court held Plaintiff’s delay of four years since it first received the DEC’s Record of Decision and thirteen years in the case of the Notice of Claim was inordinately long. In addition, the Court found that there was no reasonable excuse for the delay. While the Court noted that it had great sympathy for Plaintiff’s president hardship, Plaintiff could not justifiably blame a delay of such great length entirely on his illness. The Court also noted that a medical ailment might justify a minor delay, in order for an emergency but not a delay of four years. Further, the Court noted that accepting the factual allegations in the Complaint as true, the President’s family of Plaintiff had assumed control and apparently failed to even look for an insurance policy for over a decade. Moreover, the Court reasoned “it would be profoundly unfair to permit the Plaintiff to avoid one of the most basic obligations of its agreement with [Hanover] simply because the Plaintiff failed to exercise the minimal diligence necessary to discover the [Hanover Policy].

In sum, the Court granted Hanover’s motion to dismiss the Complaint in its entirety because Plaintiff breached the Hanover Policy’s notice provision.

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Repudiation of Policy/Non-Cumulation Clause

The insured defendant entered into a settlement to pay for remediation of a former manufactured gas plant. The issue in Century Indem. Co. v. Brooklyn Union Gas Co., 170 A.D.3d 632 (N.Y. App. Div. Mar. 28, 2019) is the insurer Century’s motion for summary judgment as to whether it was obligated to reimburse the insured for amounts it agreed in a settlement to pay for remediation of the manufactured gas plant, whether certain insurance policies issued by Century and its predecessors require a pro rata allocation of losses, and whether the per-occurrence limits in certain of the policies are limits for the respective policies’ entire terms, rather than annual per-occurrence limits.

In modifying the trial court, the Appellate Division held that Century’s commencement of this litigation constituted a repudiation of liability under the policies for the remediation claims against the insured, relieving the insured of its obligation under the policies to obtain Century’s consent before agreeing to pay for remediation costs for the manufactured gas plant.

The appellate court also held that the trial court correctly determined that the “other insurance” clauses in four of the policies do not contain “non-cumulation” or “anti-stacking” clauses and therefore occurrences or losses spanning successive policies must be allocated pro rata across the successive policies. However, the policies that had multi-year terms or contained a multi-year renewal were determined to be ambiguous as to whether the per-occurrence limits...
were limits for the respective policies’ entire terms or were annual per-occurrence limits.

The appellate court lastly affirmed that trial court’s finding that the insured was not on notice at the time the minutes of executive conference meetings in 1951–1952 and 1988–1989 were lost or destroyed and that the minutes may have been needed for future litigation. Thus, the trial court properly concluded that sanctions were not necessary as a matter of elementary fairness.

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Pennsylvania

Bad Faith

State Farm issued a rental dwelling policy to Plaintiff covering Plaintiff’s property located in Philadelphia. Plaintiff suffered a loss on January 18, 2018, which it alleged was covered under the policy. Plaintiff alleged further that State Farm refused to pay benefits under the policy without justification. Plaintiff initiated a lawsuit alleging breach of contract and bad faith. The case is 1009 Clinton Properties, LLC v. State Farm Fire & Cas. Co., No. CV 18-5286, 2019 WL 1023889 (E.D. Pa. Mar. 4, 2019).

Plaintiff made the following bad faith allegations against State Farm:

- a. Sending correspondence falsely representing that Plaintiff’s loss caused by a peril insured against under the Policy was not entitled to benefits due and owing under the Policy;
- b. In failing to complete a prompt and thorough investigation of Plaintiff’s claim before representing that such claim is not covered under the Policy;
- c. In failing to pay Plaintiff’s covered loss in a prompt and timely manner;
- d. In failing to objectively and fairly evaluate Plaintiff’s claim;
- e. In conducting an unfair and unreasonable investigation of Plaintiff’s claim;
- f. In asserting Policy defenses without a reasonable basis in fact;
- g. In flatly misrepresenting pertinent facts or policy provisions relating to coverages at issue and placing unduly restrictive interpretations on the Policy and/or claim forms;
- h. In failing to keep Plaintiff or their representatives fairly and adequately advised as to the status of the claim;
- i. In unreasonably valuing the loss and failing to fairly negotiate the amount of the loss with Plaintiff and their representatives;
- j. In failing to promptly provide a reasonable factual explanation of the basis for the denial of Plaintiff’s claim;
- k. In unreasonably withholding policy benefits;
- l. In acting unreasonably and unfairly in response to Plaintiff’s claim;
- m. In unnecessarily and unreasonably compelling Plaintiff to institute this lawsuit to obtain policy benefits for a covered loss, that Defendant should have paid promptly and without the necessity of litigation.

State Farm moved to dismiss arguing that the Complaint was devoid of factual allegations to support a bad faith claim and only contained boiler-plate allegations. To succeed on a bad faith claim in Pennsylvania, a plaintiff must demonstrate that 1) the insurer did not have a reasonable basis for denying benefits under the policy and 2) the insurer knew or recklessly disregarded its lack of reasonable basis in denying the claim.

The court concluded that Plaintiff’s allegations were sufficient to survive the motion to dismiss. The court stated that in a bad faith claim it must “do away with a robotic reading of Twombly and Iqbal and instead use its common sense when addressing whether a bad faith claim can survive a motion to dismiss.” Using that common sense analysis, the court concluded that a claim had been stated.

The court also reasoned that if a bad faith claim survives a motion to dismiss there would be no greater burden on the parties because the discovery needed to flesh out the breach of insurance contract claim is the same discovery
needed to investigate the bad faith claim. According to the court, the bad faith claim does not change the facts or issues of the case; normally the facts alleging the breach of insurance contract supports a plaintiff’s allegation that the defendant acted in bad faith.

In fact, the court went so far as to state that “an insurance bad faith claim is in the category of claims that require less factual explanation” to state a plausible cause of action.

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Utah

Prior Notice Exclusion/Reimbursement

A federal district court has ruled in Starr Indemnity and Liability Company v. MonaVie, Inc., 14-395 (D. Utah Mar. 15, 2019), that a liability insurer was not obliged to provide coverage for allegations that the insured falsely promoted the health benefit of its fruit juices. The court declared that these claims were subject to a “prior notice” exclusion as involving losses that were based upon or attributable to “the same or essentially the same facts alleged ... in any claim which has been reported or in any circumstances at which notice has been given ... “ Further, the court ruled that MonaVie was required to reimburse Starr for defense costs that had been paid in the interim in light of language in the policy stated “in the event and to the extent that the insured shall not be entitled to a payment of Defense Costs under the terms and conditions of this policy such payments by the insured shall be repaid to the insurer by the insured ... “

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Virginia

Additional Insureds

A federal district court has ruled in Waste Management, Inc. v. Great Divide Ins. Co., 3:17 (E.D. Va. Mar. 12, 2019) that injuries suffered by a truck driver in the course of attempting to fix problems with a “tipper” at a waste disposal facility did not trigger coverage for the suit against the landfill operator because the claims against the landfill operator were not based upon any act or omission on the part of the named insured.

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West Virginia

Ambiguity/Reasonable Expectations

The West Virginia Supreme Court has ruled that an umbrella policy that a Zurich affiliate issued to an auto dealership unambiguously restricted coverage to the dealership and the dealership’s owner and therefore did not cover a permissive use claim involving a vehicle operated by the owner’s son. In State of West Virginia ex rel Universal Underwriters Ins. Co. v. Wilson, No. 18-0509 (W. Va. Mar. 9, 2019), the court ruled that the scope of umbrella coverage was limited to the “Designated Persons” and was not affected by a separate endorsement to the primary policy that extended coverage to persons in the insured’s household. Further, the court declined to find coverage based upon the doctrine of reasonable expectations, which the court sought to clarify: “In order to bring clarity to the bench and bar, we now expressly hold that as a general rule, in order for the doctrine of reasonable expectations to be applicable to an insurance contract, there must be an ambiguity regarding the terms of that contract. However, an exception to this general rule occurs when reliable and relevant evidence, extrinsic to the insurance contract, casts a reasonable doubt as to whether coverage was provided by an otherwise unambiguous policy.” The court declined to apply the exception in this case, as the dealership’s claim that it was assured by its insurance agent that the son would be covered was inconsistent with testimony by a 30(b)(6) witness that no such assurances were ever given. The court also justified its ruling on the basis of judicial estoppel, declaring that even though the conventional contours of this doctrine did not apply to these facts, “we now hold that for summary judgment purposes, judicial estoppel may be applied against a litigant to prevent the litigant from using deposition testimony of a nonparty that is not consistent with a position taken by the deponent in a previous case, or with a position taken earlier in the same case.”

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Covered Events | 2019 Issue 4 24 Insurance Law Committee
Wisconsin

Duty to Defend

The background facts can be summarized as follows. Ixthus, a medical supply company operating in Wisconsin, was insured under a commercial general liability insurance (“CGL”) policy with West Bend, which provided coverage for “personal and advertising injury.” Specifically, the CGL policy provided:

2. COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of “personal and advertising injury” to which this insurance applies. We will have the right and duty to defend the insured against any “suit” seeking those damages. However, we will have no duty to defend the insured against any “suit” seeking damages for “personal and advertising injury” to which this insurance does not apply....

b. This insurance applies to “personal and advertising injury” caused by an offense arising out of your business but only if the offense was committed in the “coverage territory” during the policy period.

“SECTION V—DEFINITIONS” of the CGL policy defines “advertisement” and “personal and advertising injury” as:

1. “Advertisement” means a notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters. For the purposes of this definition:

   a. Notices that are published include material placed on the Internet or on similar electronic means of communication; and

   b. Regarding web-sites, only that part of a website that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement.

   ....

14. “Personal and advertising injury” means injury, including consequential “bodily injury,” arising out of one or more of the following offenses:

   ....

   f. The use of another’s advertising idea in your advertisement,” or

   g. Infringing upon another’s copyright, trade dress or slogan in your “advertisement.”

Under “COVERAGE B,” the CGL policy contains exclusions for both “Knowing Violation of Rights of Another” and “Criminal Acts”:

2. Exclusions

This insurance does not apply to:

a. Knowing Violation of Rights of Another

“Personal and advertising injury” caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict “personal and advertising injury.”

....

d. Criminal Acts

“Personal and advertising injury” arising out of a criminal act committed by or at the direction of the insured.

....

In a lawsuit filed in New York federal court in 2015, Abbott, a health care company that manufactures and sells blood glucose test strips in both the domestic and international markets, sued Ixthus along with over 100 other defendants, asserting thirteen federal statutory and common law claims for relief arising from Abbott’s belief that the “defendants” were “import[ing], advertis[ing] and subsequent[ly] distribut[ing]” boxes of Abbott’s international test strips in the United States. The thirteen claims alleged against Ixthus and the other defendants were: (1) Federal Trademark Infringement under Section 32 of the Lanham Act; 15 U.S.C. §1114(1); (2) Federal Unfair Competition under Section 43(a) of the Lanham Act, 15 U.S.C. §1125(a)(1); (3) Common Law Unfair Competition (New York law); (4) Federal Trademark Dilution under Section 43(c) of the Lanham Act, 15 U.S.C. §1125(c); (5) State Law (New York) Trademark Dilution; (6) State Law (New York) Deceptive Business Practices; (7) Unjust Enrichment; (8) Violation of Federal RICO, 18 U.S.C. §1962(c); (9) Conspiracy to Violate Federal RICO, 18 U.S.C. §1962(d); (10) Importation of Goods Bearing Infringing Marks under 15 U.S.C. §1124; (11) Fraud and Fraudulent Inducement; (12) Aiding and Abetting Fraud; and (13) Contributory Trademark Infringement.

Upon being served with Abbott’s 2015 federal court complaint, Ixthus tendered its defense to its CGL insurer West Bend. In a March 2016 letter to Ixthus, West Bend denied Ixthus’s tender, and explained why it took the position that the Abbott lawsuit was not covered by the CGL policy. In August 2016, West Bend filed a complaint in the circuit court seeking a declaratory judgment that West Bend had no duty to defend or indemnify Ixthus in
Abbott’s lawsuit. In March 2017, West Bend filed a motion for summary judgment. The circuit court granted West Bend’s motion, concluding that although the allegations in Abbott’s complaint fell within the initial grant of coverage, the knowing violation exclusion applied, thereby eliminating any duty West Bend had to defend Ixthus in Abbott’s federal court action.

The Court of Appeals reversed the Circuit Court’s grant of summary judgment to West Bend. The Court of Appeals agreed with the Circuit Court that the allegations in Abbott’s complaint fell within the initial grant of coverage, but disagreed with the Circuit Court as to the applicability of the knowing violation exclusion. See West Bend Mut. Ins. Co. v. Ixthus Med. Supply, Inc., No. 2017AP909, unpublished slip op., ¶ 10, 12–14, 381 Wis.2d 472, 2018 WL 1583124 (Wis. Ct. App. Mar. 28, 2018) (per curiam). The Court of Appeals concluded the knowing violation exclusion did not apply because several of the claims alleged in the complaint could be established without having to prove Ixthus’s actions were intentional. As such, the Court of Appeals held that Abbott’s complaint asserted potentially covered claims not consumed by the knowing violation exclusion, and concluded West Bend had a duty to defend Ixthus. Id.

The sole issue preserved for consideration of the Supreme Court of Wisconsin was the duty to defend issue. Supreme Court set forth the three-step process it utilizes when analyzing duty-to-defend cases:

- “First, a reviewing court determines whether the policy language grants initial coverage for the allegations set forth in the complaint. If the allegations set forth in the complaint do not fall within an initial grant of coverage, the inquiry ends.”

- Second, “if the allegations fall within an initial grant of coverage, the court next considers whether any coverage exclusions in the policy apply.”

- Third, “[i]f any exclusion applies, the court next considers whether an exception to the exclusion applies to restore coverage.”

The Wisconsin Supreme Court’s decision stated it had determined the allegations in Abbott’s complaint very plainly alleged that Ixthus, as a “Defendant,” engaged in advertising that caused substantial injury to Abbott. Supreme Court went on to note that fleshing out the factual allegations at trial may affect indemnification under the policy, but at the duty-to-defend stage, the court liberally construes the allegations in the complaint, and makes all reasonable inferences from the allegations.

Having concluded the allegations in the complaint fell within the initial grant of coverage under the personal and advertising provision of the CGL policy, Supreme Court next applied the second step in the duty-to-defend analysis to determine whether any of the exclusions in the CGL policy applied to eliminate West Bend’s duty to defend Ixthus.

Supreme Court stated the knowing violation exclusion will preclude coverage at the duty-to-defend stage only when every claim alleged in the complaint requires the plaintiff to prove the insured acted with knowledge that its actions “would violate the rights of another and would inflict ‘personal and advertising injury.’” If the complaint alleges any claims that can be proven without such a showing, the insurer will be required to provide a defense. The Supreme Court rejected West Bend’s argument that the knowing exclusion should be applied to bar any duty to defend because the “story” told by Abbott’s 156-page complaint told the reader that Ixthus “deliberately and willfully” participated in a “fraudulent scheme,” saying, “[W]e do not base insurance coverage decisions on stories or themes. We apply the law, and applicable law in this case requires us to compare the allegations in the complaint to the words of the exclusion to ascertain whether Abbott makes any claims that do not base liability on a showing of a knowing violation of another’s rights and infliction of advertising injury.” The Supreme Court went on to reiterate that unless an exclusion knocks out every pleaded claim, leaving no potentially covered advertising-injury claim for which the insured could be liable, the duty to defend remains.

Here, according to the Supreme Court, Abbott’s voluminous claims in the complaint include multiple claims that fall within West Bend’s personal and advertising injury coverage provision and do not require proof that Ixthus acted with knowledge or with intent to violate Abbott’s rights and inflict injury, citing as examples Abbott’s claims of violations of federal and state trademark statutes. Abbott’s federal and state law causes of action for trademark dilution included allegations that Ixthus infringed upon Abbott’s trade dress in Ixthus’ advertisements, thereby alleging covered claims for personal and advertising injury which do not require proof of knowing or intentional action on the part of Ixthus. Supreme Court emphasized that in this 156-page complaint when “even one covered offense is alleged in the underlying complaint, the insurance company has a duty to defend,” in affirming the Court of Appeals, and confirming West Bend has a duty to defend its insured in Abbott’s federal action.
The Supreme Court of Wisconsin’s decision was presumably a rather bitter pill for West Bend to swallow given the insurer had won summary judgment at the Circuit Court level. Not to mention that the magnitude of Abbott’s federal court litigation potentially may involve conducting or even sitting through depositions of over a hundred named defendants located all around the world, something likely to result in a substantial defense counsel legal bill being generated just for discovery in the case.


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