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Covered Events

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Committee Leadership

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From the Editor

By Patrick B. Omilian

Greetings friends and welcome to another edition of *Covered Events*. As usual, this edition is chock-full of legal analysis, insights and practice tips from fellow insurance practitioners across the country. Thank you to all of our contributors and especially to Karen Karabinos, Scott D. Braun, and Christopher R. Griffin for authoring this month's "feature articles." As the last days of summer wane away, enjoy!

I'd like to call everyone's attention to the ILC's Complex Coverage Forum that will be taking place at the Hartford Hilton in Hartford, Connecticut, on November 6, 2019. This event steps into the shoes of the former "Regional" insurance conference held annually in the fall and we have a fantastic program planned. Space is quite limited and complimentary registration is available on a limited basis to in-house insurance representatives. I urge you to check out the Education/Seminars page at DRI.org for additional information.

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, me at pomilian@gerberciano.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 is a partner of Gerber Ciano Kelly Brady LLP in Buffalo, New York, where he focuses his practice on bad faith and extra-contractual liability, complex insurance coverage, and reinsurance matters. He is a frequent speaker and author in these areas in addition to his interest in climate change and its effect on the insurance industry. A native of Buffalo, New York, Mr. Omilian is licensed in New York and Indiana and maintains a national practice

Professional Liability SLG

By Kurt Zitzer

The ILC's Professional Liability SLG offers a variety of exciting opportunities for its members, who include in house and outside counsel and claims professionals who focus on professional liability and claims made coverage issues. Opportunities for involvement in the past have included writing, editing and publishing updates to our Compendium, which summarizes cases dealing with professional liability and claims made coverage issues in every American jurisdiction and Canada; speaking at DRI seminars; contributing articles to *Covered Events* and other DRI publications; and presenting webcasts and webinars. Our subcommittee welcomes new members, whether you focus on professional liability coverage or just would like to learn more about this expanding area of insurance law. If you are interested in joining our subcommittee please contact me at kzitzer@meagher.com or Vice Chair William K. McVisk at WMcVisk@tresslerllp.com.

I hope to see many of you at the Insurance Coverage and Practice Symposium in New York City on December 5–6. Early December is a great time to be in New York to see the holiday decorations, enjoy the shopping, catch a sporting event or a Broadway play and go to world-class restaurants. ICP also provides a great opportunity for you to network with hundreds if coverage lawyers and claims professionals and professional liability defense lawyers, who will be attending ICP and the annual DRI Professional Liability Seminar, which will be taking place at the same time and location as ICP.

Kurt Zitzer is a litigation attorney who practices out of Meagher & Geer PLLP's Chicago, Illinois, and Phoenix, Arizona, offices, and is a leader of the firm serving on its Management Committee. He serves as the Practice Chair for the firm's Commercial Litigation and Professional Liability practice groups. He is the chair of the DRI Insurance Law Committee's Professional Liability SLG.

First Party Property SLG

By Jonathan Gross

The First Party Property SLG continues to be active in contributing articles and seminar presentations to the DRI. The SLG regularly posts blogs on the DRI Insurance Law Committee's Community discussion board. In addition, the SLG contributes to DRI's *Covered Events*. In this issue, the Subcommittee is contributing an article by Karen Karabinos regarding whether an insurer may depreciate labor in calculating the actual cash value of damaged property. Different states have different views on this issue. In addition, there will be a presentation on problems in applying the cost of making good exclusion to course of construction insurance claims that will be presented at the Complex Coverage Forum in Hartford on November 6. If you are interested in joining our SLG, we look forward to your participation. Feel free to contact me (JGross@moundcotton.com) or the SLG vice chairs, Jeremy Macklin (jmacklin@traublieberman.com) and Brandon Sipple (bsipple@chubb.com).

Jonathan Gross is a partner in the San Francisco Bay Area Office of Mound, Cotton, Wollan & Greengrass LLP. He concentrates his practice on first party and third party insurance coverage matters. Mr. Gross is the chair of the DRI Insurance Law Committee's First Party Property SLG.

Featured Articles

The Debate Involving Depreciation of Labor Costs Continues

By Karen Karabinos

The split of authority remains on whether insurance companies can depreciate labor costs in calculating the actual cash value of property damage. The Tennessee Supreme Court recently rejected an insurer's depreciation of labor costs, joining seven other states who have reached a similar decision.

The Tennessee Case

In *Lammert v. Auto-Owners (Mutual) Insurance Company*, No. M2017-2546-SC-R23-CV (Tenn. April 15, 2019), the Tennessee court addressed two different policy provisions defining actual cash value. The first policy involved a homeowners policy issued by Auto-Owners to the Lammert family providing certain coverage for a home and other structures in Nashville. The second policy involved the Reasons family and provided coverage for their home in Jackson.

Following hail storms, both the Lammerts and Reasons filed claims with Auto-Owners, who advised that the company would settle the claims on an actual cash basis, using a replacement-cost-less depreciation calculation. Auto-Owners, however, depreciated both labor and materials. The homeowners objected, arguing that Auto-Owners should not have depreciated the cost of the labor when calculating the actual cash value of the damage.

The insureds filed suit in the United States District Court for the Middle District of Tennessee Division. The federal court certified to the Tennessee Supreme Court the question of whether an insurer, in making an actual cash value payment, can withhold a portion of repair labor as depreciation when the policy provisions either:

- defined actual cash value as "the cost to replace damaged property with new property of similar quality and features reduced by the amount of depreciation applicable to the damaged property immediately prior to the loss," or
- provided that "actual cash value" includes a deduction for depreciation.

The Lammerts' policy contained the language in (1) above, and the Reasons' policy contained the language in (2) above. Neither policy provision specifically mentioned labor costs in the definitions of actual cash value.

Methods of Determining ACV

In reaching its opinion, the Tennessee Supreme Court considered the various methods courts applied in determining actual cash value, such as market value, replacement cost less depreciation and the broad evidence rule. Following an opinion from the New Jersey Supreme Court, the Tennessee court defined each method as follows:

> Market value is generally defined as the price a willing buyer would pay a willing seller, at a fair and [b]ona fide sale by private contract, neither being under any compulsion. . . . But there is a problem in that a building ordinarily has no recognized market value independent of the parcel of property in entirety, land and building together . . . .
>
> Replacement cost less depreciation has the advantage of relative definiteness. It is also easily ascertained. However, it is inflexible, and this characteristic often results in excessive recovery. Many structures today have a high replacement value because of the inflated cost of building materials even though their true commercial value represented by rentals, prospective profits, usefulness to the present owner, location and age is considerably less . . . .
>
> The problem of excessive recovery under the replacement cost less depreciation rule together with the occasional uncertainty of market value prompted development of what is now the most widely accepted rule, general denominated as the 'broad evidence rule'

Elberon Bathing Co. v. Ambassador Ins. Co., 389 A.2d 439, 443 (N.J. 1978). With regard to the broad evidence rule, the Tennessee Supreme Court also looked to the definition enunciated by the New York Court of Appeals, which allows "every fact and circumstance which would logically tend to the formation of a correct estimate of the loss." *Id.* at 443–44.

The Court's Decision

While the parties in *Lammert* agreed that the proper method of calculating actual cash value is the replacement cost less depreciation, the parties disputed whether depreciation applied to both materials *and* labor. In reaching its decision, the court applied the standard principles of interpreting insurance contracts, because Auto-Owners and its insureds presented the court with plausible interpretations of the policies. Applying those principles, the Tennessee court held that the language in both policies at issue was ambiguous, and therefore, the policies were construed in favor of the insured. Due to the ambiguity, the court ruled that labor cannot be depreciated when calculating the actual cash value using the replacement cost less depreciation method.

Calculating ACV in Future Claims

In light of the decision by the Tennessee court's decision as well as similar holdings reached by other courts, insurers should consider amending the definition of actual cash value in their polices to specifically provide that labor costs are subject to depreciation. If they decline to issue such amendments, insurers must be cognizant of each state's position when calculating actual cash value. Does the state permit the depreciation of labor costs or must the insurer exclude such depreciation when calculating actual cash value? A national search shows that 18 states have addressed the issue head on, ruling labor can or cannot be depreciated. Below is a chart of the current status of the case law, regulations or statutes of states addressing this issue.

State	Labor Can Be Depreciated	Labor Cannot Be Depreciation
Alabama		*Arnold v. State Farm Fire & Cas. Co.*, 268 F.Supp. 3d 1297 (S.D. Ala. 2017)
Arkansas		*Shelter Mut. Ins. Co. v. Goodner*, 2015 Ark. 460 (2015).
California		Cal. Code Regs. Tit. 10, §2695.9(f)(1) (2019)(the expense of labor … is not a component of physical depreciation and shall not be subject to depreciation or betterment).
Colorado	*Basham v. United Services Automobile Association*, 2017 WL 3217768.	
Kansas	*Graves v. Am. Family Mut. Ins. Co.,* 686 F. App'x 536 (10th Cir. 2017) applying Kansas Law.	

Kentucky		*Hicks v. State Farm Fire & Cas. Co.*, 751 Fed.Appx. 703 (6th Cir. 2018) applying Kentucky law.
Minnesota	*Wilcox v. State Farm Fire & Cas. Co.*, 874 N.W.2d 780 (Minn. 2016)	
Mississippi	Mississippi Insurance Dept. Bulletin 2017 (there is no statutory prohibition to labor depreciation, but "the insurer should clearly provide for the depreciation of labor in the insurance policy.")	*Titan Exteriors, Inc. v. Certain Underwriters at Lloyd's, London,* 297 F. Supp. 3d 628 (N.D. Miss. 2018)
Missouri	*In re State Farm Fire & Cas. Co.*, 872 F.3d 567 (8th Cir. 2017)	
Nebraska	*Hend v. Am. Family Mut. Ins. Co.,* 894 N.W.2d 179 (Neb. 2017)	
North Carolina	*Accardi v. Hartford Underwriters Ins. Co.*, 2018 WL 5273971. (only addressed at trial level in Superior Court)	
Ohio	*Cranfield v. State Farm Fire & Cas. Co.*, 340 F.Supp.3d 670 (N.D. Ohio 2018) (appeal filed January 2, 2019)	
Oklahoma	*Redcorn v. State Farm Fire*, 7 Cas. Co., 55 P.3d , 2012 (Okla. 2002) (using the "broad evidence" rule, "a fact-finder is entitled to consider what the life of the destroyed roof, both materials and labor, would have been, as well as any other relevant evidence presented.")	
Oregon	*Matchniff v. Great Northwest Insurance Company*, 224 F.Supp.3d 1119 (D. Ore. 2016)	
Pennsylvania	*Papurello v. State Farm Fire & Cas. Co.*, 144 F.Supp.3d 746 (W.D. Penn. Nov. 16, 2015).	
Tennessee		*Lammert v. Auto-Owners Mut. Ins. Co.*, 572 S.W.3d 170 (Tenn. 2019).
Vermont		Vermont Dept. of Financial Regulation Ins. Bulletin No. 184 (prohibits the depreciation of repair and replacement labor).
Washington		*Lains v. Am. Family Mut. Ins. Co.,* No. C14-1982-JDD, 2016 WL 4533075 (W.D. Wash. Feb. 9, 2016)

Karen Karabinos is a Partner at Drew, Eckl & Farnham, Atlanta, Georgia. Ms. Karabinos has been litigating cases for more the 32 years, with the last 21 primarily focused on the complexities of property insurance law. She has successfully handled more than 80 trials and hearings and annually conducts approximately 50 depositions and examinations under oath. She works to know her client's business strategy and goals, which allows her to partner with her clients in efficiently investigating and adjusting property claims and in defending her clients in coverage, bad faith, arson, fraud, cyber and property damage cases. She represents clients in Georgia, South Carolina, Tennessee and Alabama.

Stick Them with the Pointy End

Examining the Use of Guilty Pleas in Subsequent Coverage Litigation

By Scott D. Braun and Christopher R. Griffin

There is an obvious overlap between the doctrine of collateral estoppel and many, if not most, insurance policies that contain coverage exclusions for intentional or criminal misconduct. It is unresolved, however, whether a guilty plea, rather than a final verdict in a criminal trial, can be a sword (or "Needle" for those of you GOT enthusiasts) for insurers and is sufficient to satisfy the intentional or criminal conduct exclusion in a subsequent coverage lawsuit. The guilty plea often carries a subtext of unstated, but commonly understood, justifications underlying the decision.

A criminal trial is arduous and uncertain, and focuses on embarrassing and shameful facts and events that many defendants prefer to keep private by not exercising the right to trial by jury if a plea agreement is an option. Accordingly, pleading down sounds reasonable when faced with those prospects, especially if it means a reduced sentence or reduction in charges. However, a guilty plea is often just the beginning of a defendant's legal journey. An aggrieved party may find solace in criminal justice, but many will pursue all available legal options, which means a civil suit soon follows criminal proceedings.

When civil suits proceed, insurers should always determine the status of any underlying criminal action if the defendant qualifies as an insured under any type of liability policy. Insurance policies contain numerous exclusions, including those for intentional or criminal acts, use of unintended force, or sexual or physical assault. What happens, then, when an insured has entered a guilty plea? On the one hand, it is logical to conclude that there would be no coverage under a policy that excludes criminal or intentional conduct, for example, since the insured tacitly admitted his intentional, criminal actions before a judge. Indeed, this line of thinking represents the approach in a majority of jurisdictions, which have embraced the position that a guilty plea establishes that an insured acted intentionally or committed an excluded offense under an applicable policy, and no further factual determination of guilt is necessary.

On the other hand, the particularities of the nature of the criminal offense, the policy language, and reasons for the guilty plea can provide opportunities for criminal defendants to argue against policy exclusions. Accordingly, a number of courts have examined the reasons behind a guilty plea, noting the desire to avoid trial or more significant charges, and found that a guilty plea has no preclusive effect in a subsequent civil trial since the criminal defendant never truly adjudicated the case on the merits. We address the two judicial philosophies on this issue by framing the matter against a recent case that represents the majority viewpoint nationally that guilty pleas are given full exclusionary effect, and nicely addresses many of the nuances that complicate this issue.

First Liberty Factual Background and Criminal Proceeding

The United States Court of Appeals, Third Circuit, applied Pennsylvania law and addressed the impact of a guilty plea on a policy exclusion in *First Liberty Ins. Corp v. MM*, 745 F. App'x 195, 196 (3d Cir. 2018) ("*First Liberty*"). As one of the most recent cases addressing the impact of guilty pleas on insurance coverage, it is an informative framework for an examination of approaches and reasoning courts around the country employ when adjudicating coverage disputes involving a criminally "guilty" insured.

BB (female) and MM (male) were students at American University (initials used in the court opinion to protect anonymity) when they met at an off campus fraternity party. After a night of drinking, MM allegedly videotaped BB performing a sexual act on him without her knowledge or consent. BB was intoxicated, disoriented, and had no recollection of the event. She became aware of the footage the following day when MM showed the video to friends and classmates who informed BB. The District of Columbia Metropolitan Police arrested MM who eventually pleaded guilty to one count of "Voyeurism – Recording."

Civil Proceeding, Declaratory Judgment Action and Holding

BB alleged in a subsequent civil lawsuit that MM "negligently, intentionally and illegally videotaped [her] performing a sexual act on him without her knowledge or consent" while at an off-campus party at American University. *First Liberty*, at 195–196. MM made a demand of First Liberty under his parents' homeowner's policy that it defend him in the lawsuit. First Liberty responded with

a declaratory judgment action that it owed MM no duty to defend based on the policy's personal liability coverage provision's definition of "occurrence" as an accident, and based on two policy exclusions precluding coverage for injuries arising out of sexual molestation, and for injuries reasonably expected to result from intentional or criminal acts of an "insured." *Id.* at 198.

The district court did not examine whether MM's actions qualified as an "accident" under the policy, since the exclusions served to preclude coverage. The court of appeals agreed with the district court's opinion and reasoning including a finding that MM's guilty plea to Voyeurism – Recording satisfied the definition of acts the criminal conduct exclusion intended to preclude. Specifically, the court noted that "by pleading guilty to the charge of "Voyeurism – Recording," D.C. Code §22-3531(c)(1)(C), MM admitted that he criminally recorded his sexual activity with BB." *Id.* at 199.

The court also held that it is unreasonable to argue that MM somehow unintentionally recorded the sexual act without consent, but even if that were a viable argument, the language of the exclusion precluded coverage for intentional *or* criminal conduct (emphasis added by the court). Thus, the guilty plea constituted a tacit admission by the insured of criminal conduct and served to preclude coverage on its own. *Id.* This specific finding by the court raises two important issues that are discussed in more detail below. First, it represents a trend by courts in a majority of jurisdictions to treat guilty pleas as conclusive admissions of criminal conduct, thereby contradicting arguments that a guilty plea does not represent a full and fair determination of a finding of criminal conduct since the criminal defendant avoids the arduous trial process of fact finding and adjudication of the issues on the merits. Second, it highlights the importance of the specific policy exclusion language, and the level of detail courts will employ when evaluating whether an exclusion is intended, by the wording in the policy, to preclude coverage. On this latter point, the court emphasized the use of the word "or" in the exclusion to demonstrate the breadth of the conduct the insurer intended to exclude.

Relatedly, the court held that the allegations contained in BB's complaint provide no reasonable interpretation of MM's conduct other than intentional conduct and sexual molestation, despite BB's inclusion of allegations of negligence. The court held that BB's negligence allegations represented artful pleading efforts and contrary assertions. It is difficult to understand, as the court pointed out, how an individual can both intentionally and unintentionally videotape a sexual act, which was, in essence, BB's argument. As discussed in more detail below, courts are on the lookout for artful pleading efforts and generally disfavor these efforts, especially when the inclusion of negligence claims creates such contradictory assertions as was seen here.

MM also contended that without a final factual determination that his conduct was intentional, a court cannot decide that First Liberty had no duty to defend. *Id.* at 198. The court disagreed, finding no precedent for the assertion that a final factual determination of an insured's conduct be rendered prior to a declination of a duty to defend. This portion of the court's opinion is important since it directly addresses lines of reasoning in jurisdictions that are less likely to give preclusive effect to guilty pleas in subsequent civil actions. By finding no support for MM's contention that a final factual determination regarding his conduct had been rendered, the court essentially contradicted arguments in other jurisdictions that a guilty plea did not represent a conclusive finding of intentional misconduct for the varying reasons people choose to plead guilty in criminal cases.

Despite being one of the most recent cases to discuss the impact of a guilty plea on insurance coverage exclusions, this case also provides a framework for the arguments courts commonly address when confronted with this issue. It also represents that majority viewpoint that guilty pleas are given preclusive effect when considering policy exclusions for criminal or intentional misconduct.

National Lay of the Land

Most courts have held that a guilty plea establishes the insured acted intentionally or committed an excluded offense and that no further factual determination of guilt is necessary. *See, e.g. Allstate Ins. Co. v. Lahoud*, 605 S.E.2d 180, 184 (N.C. App. 2004) ("[T]he guilty plea established that defendant had the intent to commit the act," and thus the intentional acts exclusion applied). Therefore, guilty pleas can be used in subsequent civil actions to justify preclusion of coverage based on intentional or criminal conduct exclusions. In *State Farm Fire & Cas. Co. v. Fullerton,* 118 F. 3d 375 (5th Cir. 1995), the United States Firth Circuit Court of Appeals reviewed opinions from jurisdictions around the country and noted that increasingly, courts tended to favor treating a guilty plea as conclusive evidence or admission of intentional or criminal conduct. A sampling of other cases further demonstrate the reasoning behind allowing guilty pleas to be used in subsequent civil trial and coverage disputes.

In *Allstate Ins. Co. v. Lahoud*, 605 S.E.2d 180 (N.C. Ct. App. 2004), an insured's guilty plea to taking indecent liberties with a child established conclusively that he committed an intentionally harmful act, and, thus, a personal umbrella liability policy exclusion for intentionally harmful acts precluded coverage. Under New Jersey law, an insured's guilty plea to assault by auto served to preclude coverage under a supplemental excess policy's felony exclusion. *Philadelphia Indem. In. Co. v. Healy*, 156 Fed. Appx. 472 (3d Cir. 2005). While the court there found that the plea did not demonstrate conclusive evidence of the underlying facts, it was sufficient to preclude coverage under the applicable exclusion for purposes of the insurer's declaratory judgment action.

Other courts, however, find that a guilty plea has no preclusive effect in a subsequent civil trial, typically employing some version of the argument that a guilty plea does not represent a full and fair opportunity for an insured to litigate the issue. *See, e.g.*, *Prudential Prop. & Cas. Ins. Co. v. Kollar*, 578 A.2d 1238, 1240 (N.J. App. 1990) (arson conspiracy guilty plea had no preclusive effect in regard to arson exclusion, because insured was not given the chance to litigate whether he actually committed arson). Courts will occasionally refer to this line of thinking as the "factual basis rule" which requires that a court must be convinced that a guilty plea founded on fact is the equivalent of a judicial determination of each of the material elements of the charged crime and satisfies the "actually litigated" requirement they employ in issue preclusion. *See Aetna Cas. & Sur. Co. v. Niziolek*, 481 N.E.2d 1356 (Mass. 1985). However, the Supreme Court of Massachusetts in that case noted that some courts find a guilty plea has no preclusive effect in subsequent litigation, but that "many more" find otherwise. *Id.*

While case law on this subject varies from jurisdiction to jurisdiction, and even within venues, some courts that apply a more stringent approach to the offensive use of the preclusive effect of a guilty plea recognize that more jurisdictions accept guilty pleas as preclusive of coverage in subsequent civil proceedings.

Lessons Learned from *First Liberty* and National Cases

While the national trend may be leaning towards viewing a guilty plea as preclusive, *First Liberty* and the sampling of cases that have addressed this issue highlight a few common themes for insurers to keep in mind when an insured has entered a guilty plea.

Know Your Policy

Insurance lawyers do not need to be reminded that coverage litigation frequently involves a deep dive into the specific language of a policy's provisions and exclusions. The *First Liberty* case provides a perfect example of a court's focus on the language of an exclusion to determine the scope of conduct an insurer intends to exclude. By noting the "or" in the intentional or criminal conduct exclusion, it can be inferred that the court interpreted the exclusion to extend to a broad range of criminal or intentional misconduct that the insurer did not intend to cover.

Know the Crime

In *First Liberty,* MM pleaded guilty to Voyeurism – Recording, which satisfied not just the "criminal" component of the policy's exclusion, but also the "intentional" component based on the statutory elements of that crime. Conversely, in *Prudential Prop. & Cas. Ins. Co. v. Kollar*, 578 A.2d 1238, 1240 (N.J. App. 1990), the insured pleaded guilty to conspiracy to commit arson, but the policy excluded actual acts of arson. The guilty plea, thus, had no preclusive effect in the insurer's coverage action, because the insured was not given the chance to litigate whether he actually committed arson. In determining the collateral estoppel effect of a prior state court criminal proceeding, courts will often look to the law of the state where the criminal proceeding took place to determine if the guilty plea addressed the conduct excluded by the policy. *See, e.g. Anela v. City of Wildwood*, 790 F.2d 1063, 1068 (3d Cir. 1986)). In the District of Columbia, for example, "a valid guilty plea acts as a conviction of the crime charged, as well as an admission of all the material facts alleged by the government." *In re Patterson*, 833 A.2d 493, 493 (D.C. App. 2003). Therefore, it is important to evaluate the specific elements of the crime the insured pleads guilty to as well as the local jurisdiction's judicial philosophy generally on whether a plea constitutes an admission of all the material facts alleged to support the criminal charge.

Be Wary of Artful Pleading

As the *First Liberty* court noted, allegations of negligent misconduct and intentional misconduct related to the same underlying action may represent an attempt by a claimant to broaden the complaint and avoid insurance coverage preclusion and ensure a solvent contributor remains involved to ultimately pay out significant claimed financial damages. Disparate allegations can lead to specious arguments, and the *First Liberty* court was not persuaded. However, in jurisdictions that are more receptive to the

mitigating circumstances that often surround guilty pleas, and more likely to hold the judicial philosophy that a guilty plea does not represent a full and fair adjudication of the defendant's conduct on the merits, artful pleading could be more successful.

Conclusion

The national judicial landscape tends to lean more towards accepting a guilty plea as sufficient to establish an insured acted intentionally or committed an excluded offense, and that no further determination of guilt is necessary. However, there are courts in jurisdictions around the country that do not subscribe to that view, and opposing cases indicate that the issue is not well-settled. It is therefore important to scrutinize the elements of the crime that led to the guilty plea, as well as the specific language of the policy exclusion or exclusions at issue to determine whether a guilty plea will be given preclusive effect. Finally, it is important to know whether your jurisdiction has a history of a more forgiving approach to the extenuating circumstances often accompanying the decision to plead guilty to a crime or whether your jurisdiction tends to treat a guilty plea as a conclusive admission of the elements of the crime.

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Recent Cases of Interest

Second Circuit

Second Circuit finds Disclaimer of Coverage Timely Where Insurer started Declaratory Judgment Action Shortly After Receiving Other Carrier's Policy, as DJ Action Constitutes Unambiguous Written Notice of Disclaimer Position *(NY)*

United Financial Cas. Co. v. Country-Wide Insurance Company (July 1, 2019)

Two insurers were potentially responsible for providing Juan Pineda with a defense and indemnification in connection with a three car accident in which he was involved while hauling goods for International Trucking Group (ITG). Either he was entitled to coverage under Country-Wide's motor carrier liability policy issued to ITS or by a non-trucking liability policy issued by UFCC to Pineda's employer and owner of the truck he was driving at the time. UFCC's policy contained an exclusion, applicable only when other insurance was available, for autos being used to carry property in any business or while such property was being loaded onto or unloaded from the insured auto. In other words, it applied when a truck was being used for business purposes.

UFCC assumed Pineda's defense and immediately tried to get in touch with Country-Wide to tender and have them pick up. While they did not have a copy of the Country-Wide policy, UFCC suspected that it should be primary over UFCC's non-trucking policy. Repeatedly, over the course of months, UFCC attempted to reach Country-Wide, to no avail. Finally, some six months after their initial attempts at contact, UFCC received a denial letter and disclaimer of coverage. About 52 days later, UFCC filed a declaratory judgment action seeking a declaration that it did not owe coverage and that Country-Wide did. Country-Wide then argued that UFCC was estopped from disclaiming because it had failed to timely serve a notice of its own disclaimer. The lower court determined that the DJ action filed 52-days after receipt of UFCC's position letter was untimely as a matter of law and pursuant to statute, and the Second Circuit took up the appeal.

New York Insurance Law Section 3420 states: "If under a liability policy issued or delivered in this state, an insurer shall disclaim liability of deny coverage for death or bodily injury arising out of a motor vehicle accident or any other type of accident occurring within this state, it shall give written notice *as soon as is reasonably possible* of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant." (emphasis added

by the court in its decision). Thus, UFCC had to disclaim once it had sufficient knowledge of the facts entitling it to disclaim. Indeed, timeliness "is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage."

The added wrinkle here was that UFCC's policy was a non-trucking policy. These policies in general exclude from coverage any accident occurring while an insured auto or attached trailer is being used to carry property in any business. There is also a state statutory requirement in New York that all insurance policies issued "to the owner of any vehicle" must contain "a provision for indemnity or security against the liability and responsibility" for "death or injuries to a person or property resulting from negligence in the use or operation of such vehicle." (NY Vehicle and Traffic Law Sect. 388(1), (4)). Gaps in coverage under this statute are not allowed. Indeed, New York courts have deemed non-trucking policies invalid unless they contain a provision making it clear that the exclusion of accidents occurring during business applies only if some other insurance plan fills in the "gap in policy coverage for any loss incurred" in the furtherance of the business.

While UFCC tendered to Country-Wide in 2016, they did not receive Country-Wide's disclaimer until January 2017. They then started a declaratory judgment action 52-days later (and a DJ action constitutes an unequivocal notice of a disclaimer, without the need for a further letter or writing). However, they did not actually even learn of or have sufficient knowledge of the facts that Country-Wide's policy actually covered Pineda until they received a complete copy of the Country-Wide policy in the discovery process in the DJ action. As such their disclaimer, *i.e.* the DJ action, was not untimely. They had already disclaimed when they learned the sufficient knowledge of the facts required. Thus, the Second Circuit overturned the district court's determination and found for UFCC.

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***1070 Park Ave. Corp. v. Fireman's Fund Ins. Co.*, --- Fed. Appx. ---, 2019 WL 2754954 (2d Cir. July 2, 2019)**

The U.S. Court of Appeals for the Second Circuit held that an insurer had no duty to reimburse the insured for costs incurred in connection with the restoration of gas service following damage to a gas line. The insured, 1070 Park Avenue Corporation (1070 Park), claimed that the building's gas line was ruptured when workers damaged a gas meter while moving a wheeled recycling bin in the building. 1070 Park alleged that it sustained damages in excess of $500,000 as a result of work performed in order to upgrade the gas system to withstand a high-pressure test required by the Administrative Code of the City of New York. 1070 Park's insurer, Fireman's Fund Insurance Company (FFIC), denied coverage for the loss based on an exclusion precluding coverage for costs associated directly or indirectly with the enforcement of any law or ordinance that requires the testing of a gas system for integrity or condition.

1070 Park sued FFIC, arguing that coverage existed for the loss based on an exception to the exclusion, namely, that coverage applied when the gas system testing was caused by "Aircraft or Vehicles." Specifically, 1070 Park argued that the exception to the exclusion applied because the recycling bin qualified as a "vehicle" since the bin was on wheels. The appellate court, however, held that the recycling bin was not a vehicle as "not everything with wheels is a vehicle." The appellate court found that the term "vehicle" as used in the policy plainly referred to objects that are reasonably expected to be used to transport people or goods that can cause massive losses. Accordingly, the appellate court held that FFIC had no duty to reimburse 1070 Park for the claimed loss.

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Third Circuit

Environmental/"Occurrences"/Excess (NJ)

The Third Circuit has revived part of a primary insurer's effort to obtain contribution from an excess insurer for sums that it paid to settle three New Jersey environmental liability claims against a waste hauler. In Penn National Ins. Co. v. North River Ins. Co., No. 18-2687 (3d Cir. July 30, 2019) (unpublished), the court affirmed the lower court's declaration that any claims with respect to the Helen Kramer Landfill were barred by the statute of limitations. The court rejected Penn National's argument that the three landfills should be treated as a single "occurrence" because they all arose out of the insured's hazardous waste hauling activities. To the contrary, the Third Circuit agreed with the District Court that these losses involved separate landfills in different areas occurring at different times resulting in separate types of environmental damage in

distinct and discreet locations, and were therefore each a separate "occurrence." While therefore affirming the entry of judgment with respect to the Helen Kramer Landfill as being time-barred, the Third Circuit ruled that Penn National might still be entitled to contribution under the excess coverage provided by North River on the grounds that the pro-rated portion of the Helen Kramer Landfill settlement allocable to its 1982–1983 policy exceeded a claimed $500,000.00 aggregate limit in that policy. As the District Court had not considered whether the sums paid to settle the Helen Kramer Landfill claim should have been subjected to Carter-Wallace allocation and would have therefore exhausted the aggregate policy limit, the case was remanded to the District Court for further findings with respect to whether such an aggregate actually existed and what effect it would have.

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Assault and Battery Exclusion (PA)

***Nautilus Ins. Co. v. Motel Mgmt. Servs. Inc.*, --- Fed. Appx. ---, 2019 WL 3283221 (3d Cir. Jul. 22, 2019)**

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

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

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Court Finds that Liquor Liability Exclusions Preclude Coverage, for Both Defense and Indemnification, in DWI Case out of Pennsylvania

***Transportation Ins. Co. v. Heathland Hospitality Group LLC* (July 26, 2019)**

Transportation Insurance Company and Continental Casualty insured Heathland Hospitality Group LLC and Heathland Hospitality Group LP (collectively "Heathland"). In 2008, a fatal car accident occurred involving a drunk driver, Whittingham, and another driver, decedent Serratore. Following the incident, the decedent's estate sued the Heathland entities for having provided Whittingham with alcohol, despite his alleged visible intoxication at their country club.

At issue in the coverage declaratory judgment action was whether Heathland's policies would provide a defense and indemnification, where they contained liquor liability exclusions. To wit, Transportation's policy included an exclusion that read that "this insurance does not apply to bodily injury for which any insured may be held liable by reason of: (1) Causing or contributing to the intoxication of any person; (2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or (3) Any statute, ordinance, or regulation relating the sale, gift, distribution or use of alcoholic beverages. *This exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages*" (internal punctuation omitted; emphasis supplied by the court). Moreover, Continental's umbrella policy included a Liquor Liability Limitation which read: "this insurance does not apply to bodily injury for which any insured may be held liable by reason of: (1) Causing or contributing to the intoxication of any person; (2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or (3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages. Unless, and then

only to the extent that coverage is provided by 'scheduled underlying insurance.'"

The managers of country club (Heathland) argued that they were not in the business of selling, serving or furnishing alcoholic beverages, they just managed the club. Based upon the allegations asserted against them, the courts disagreed. The allegations of the complaint (which would trigger a defense at least) stated that they were running a business establishment that served alcohol, they managed the club's food and beverage sales/service, and they allegedly sold the alcohol that intoxicated the driver, which caused the death. Thus, the complaint unequivocally alleged that Heathland was in the business of at least selling, serving, or furnishing alcohol. Given that under Pennsylvania law, like in many other states, the four corners of the complaint determine whether there is a duty to defend, and all of the allegations fell within the exclusion, there was no duty to defend nor indemnify the DWI negligence complaint.

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

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

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

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

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

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

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

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

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

Montville acknowledged that Child M made the following allegations:

- (1) Fennes, while employed by [Montville], "engaged in various negligent, careless, reckless[,] and/or intentional conduct, including but not limited to inappropriate abusive and/or sexual conduct with his infant students" and [Montville] was "on notice of said conduct."

- (2) [Montville] was "on notice" "of said reckless and/or intentional conduct, including child abuse, both sexual and nonsexual" so as to trigger a requirement to report . . . ."
- (3) [A]s a result of the "negligence, carelessness, recklessness[,] and/or intentional conduct" of the defendants [in the Child M Action], Child M suffered "injuries."
- (4) Fennes "engaged in various acts of sexual molestation and/or child abuse against other infant students."
- (5) [Montville] was "on notice of said conduct."
- (6) Fennes "engaged in various acts of sexual molestation and/or child abuse against . . . his infant students."

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

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

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

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

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Fourth Circuit

Sexual Assaults (SC)

The Fourth Circuit has issued a short, unpublished opinion in United Property and Casualty Ins. Co. v. Roe, No. 18-2049 (4th Cir. July 10, 2019) affirming a South Carolina District Court's conclusion that a homeowner's insurer did not owe coverage for clams that a spouse negligently failed to prevent her husband's sexual abuse of a minor over a period of 10 years.

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Construction Defect (NJ)

***Schnabel Foundation Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Penn.*, --- Fed. Appx. ---, No. 18-1782 (4th Cir. July 10, 2019)**

The U.S. Court of Appeals for the Fourth Circuit held that National Union Fire Insurance Company of Pittsburgh, Pennsylvania (National Union) had no duty to defend Schnabel Foundation Company (Schnabel) in a lawsuit alleging property damage to a 17-story mixed-use building (Site). Schnabel, a subcontractor, was responsible for constructing a support of excavation system (SOE) at the Site, but did so improperly, causing property damage to neighboring properties. The neighboring buildings brought a lawsuit seeking damages for property damage and business disruption, and the building owner of the Site sought damages for construction delay. National Union denied coverage to Schnabel, in part, based on Exclusion D of the commercial general liability policy that excluded coverage for "Damage to Impaired Property or Property Not Physically Injured."

The appellate court affirmed summary judgment in favor of National Union, holding that New Jersey law was clear that commercial general liability policies "cover damages to third-party property, not costs to replace a contractor's own faulty work." The appellate court further found that Exclusion D applied as the Site constituted "Impaired Property" as it was tangible property that became less useful through the incorporation of the defective SOE. The appellate court recognized that the Site would alternatively

be "Property Not Physically Injured" under Exclusion D because it "suffered no physical injury due to the defective SOE," as "only the Site's neighboring properties suffered physical injury through floor buckling and other cognizable property damage." The appellate court also found Schnabel's work satisfied the enumerated "Property Damage" requirement in Exclusion D as the "SOE work was clearly defective, and [Schnabel's] failure to timely construct an adequate SOE … caused 'a delay or failure … to perform a contract.'" Accordingly, the appellate court held that Exclusion D barred coverage for the damage and that summary judgment in favor of National Union was proper.

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Fifth Circuit

Auto/UIM/Consent to Settle (MS)

The Fifth Circuit has ruled that consent to settle language in the auto policy's UIM section could not be enforced here where the employee was an unnamed additional insured under the policy and was unaware of the consent to settle language. In Netto v. Atlantic Specialty Ins. Co., No. 18-60588 (5th Cir. July 2, 2019), the Fifth Circuit took note of the decisions in which the Mississippi Supreme Court has distinguished between named and unnamed insureds and has expressed reluctance to give effect to notice provisions against unnamed insureds as they would place "an impossible burden on persons who are not contracting parties and who did not have possession of the insurance policy, and could not notify an insurance company of which they had no knowledge." As a result, the court ruled that consent to settle language should only apply to unnamed additional insureds if they knew or should have known of the existence of this language either because they had actual possession of the policy or the insurer had made reasonable efforts to inform them of the policy terms.

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Eighth Circuit

Property Insurance/Misrepresentations (MN)

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

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Ninth Circuit

Personal and Advertising Injury Exclusions (NV)

Cohen v. Berkley Nat'l Ins. Co., --- Fed. Appx. ---, 2019 WL 3235076 (9th Cir. Jul. 18, 2019)

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

In dismissing the lawsuit, the district court noted that the jury in the underlying defamation suit found that Berkley's insured acted with "fraud, oppression and malice" in creating the websites and publishing the material in question. The district court concluded that the exclusions were unambiguous and completely precluded coverage for the alleged defamation. The appellate court agreed that the

exclusions were unambiguous and reasoned that, based on "the underlying complaint and the verdict and judgment, which found that the conduct of [the insured] and other defendants amounted to fraud, [and thus] the 'knowledge of falsity' exclusion plainly applied."

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War Exclusions/Custom and Usage/ Contra Proferentem (CA)

In a case with significant implications for cyber-disputes and commercial property claims, a federal appellate court has ruled that a "war" exclusion did not eliminate coverage for losses that a TV production company incurred after they had to abandon production of the "Dig" show in Jerusalem due to Hamas rocket attacks during its 2014 conflict with Israel. in Universal Cable Productions LLC v. Atlantic Specialty Ins. Co., No. 17-56672 (9th Cir. July 12, 2019), the Ninth Circuit ruled that a California District erred in granting summary judgment to Atlantic Specialty based on exclusions in its television production policy for losses due to "war" or "war-like action by a military force." Rather, the court found that both parties should have understood that these attacks did not meet the customary usage of "war" in the insurance industry of a conflict between actual or de jure governments. The court found that Hamas was not the governing authority in Palestine and that these attacks were a form of terrorism that should be covered in the absence of a terrorism exclusion. The court declined to rely on the doctrine of contra proferentem in light of the fact that this exclusion was the product of negotiations between two sophisticated parties. Because the District Court had not considered whether a separate part of the exclusion for "Insurrection, rebellion, revolution," the case was remanded for further findings.

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Tenth Circuit

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

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

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

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

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

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

> Rockhill also noted Exclusion P of the professional liability policy, which states:
>
> **P. Expressed or Implied Warranties**
>
> Based upon, as a consequence of or arising out of:
>
> (1) Any expressed or implied warranties or guarantees, or
>
> (2) Any cost or other estimates for construction, renovation, removal or demolition being exceeded or inaccurate.
>
> However, this exclusion does not apply to a warranty or guaranty by you that your "professional services" are in conformity with generally accepted architectural or engineering standards.
>
> The letter states that Heirloom's "allegations relative to CFI's designs potentially implicate a 'professional services incident' that would trigger coverage" but "[t]o the extent that the damages sought arise out of . . . faulty workmanship apart from your professional services . . . the [Professional Liability] Form will not provide coverage for such damages."

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

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

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

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

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

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

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

Finally, the Court noted that the words in the body of the exclusion are more naturally read as relating to construction, rather than design. The exclusion removes coverage for the costs to "withdraw, recall, inspect, repair, replace, adjust, remove or dispose of" work, including "any

materials, parts, labor or equipment furnished." Read as a whole and in the context of the coverage agreements, the Court concluded that the parties intended the Faulty Workmanship exclusion to distinguish non-covered construction work from covered professional services.

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

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Eleventh Circuit

Notice (FL)

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

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

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

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Florida

Insurer's Decision to Seek Global Settlement Was Not Bad Faith

Montanez v. Liberty Mutual Fire Insurance Company, United States District Court, Southern District of Florida (July 23, 2019)

On January 30, 2010, Jason Brown rear-ended Nya Yanitza Montanez ("Ms. Montanez") and her two minor children, Yanely Gonzalez and Eduardo Gonzalez, Jr. Three-month-old, Yanelis Gonzalez, was killed; eight-year-old, Eduardo Gonzalez, Jr., was ejected from the vehicle, suffering head trauma; and Ms. Montanez was injured. After hitting the Gonzalez family, Brown's vehicle spun into another car occupied by Jose Ramos (38 years old) and Maria Carmona (3 years old), both of whom were also injured.

On February 1, 2010, Douglas Brown ("Mr. Brown"), Jason Brown's father, contacted Liberty Mutual to report that his son had been involved in an accident in West Palm Beach and that a child had been killed. Jason Brown was driving his father's vehicle at the time of the accident, and Mr. Brown had a Liberty Mutual automobile insurance policy, which provided liability limits of $250,000 per person and $500,000 per accident. Upon learning of the accident, Liberty Mutual assigned a claims adjuster to the case and sent the insureds "other insurance" affidavits and excess exposure letters. On February 2, 2010, Liberty obtained an "events report" from the policy department and advised Brown to obtain counsel. A potential coverage issue was identified, and a reservation of rights letter was issued.

Liberty learned that Plaintiff had retained counsel. Liberty's adjuster made multiple telephone calls over the course of a month but was unable to speak with counsel.

On March 4, 2010, Liberty Mutual sent a letter to counsel for all claimants, stating that it was making its full $250,000 per person and $500,000 per accident policy limits available to settle the claims arising from the accident. Liberty Mutual noted that it would be arranging a settlement conference to assist all claimants in reaching an apportioned settlement. That day, an attorney contacted Liberty and advised that he would be representing Plaintiff. He declined to take the contact information for defense counsel.

On March 31, 2010, Plaintiff's counsel rejected the opportunity to settle Plaintiff's wrongful death claim on grounds that Defendant should have immediately tendered the $250,000 policy limit, rather than attempt to settle all claims at a settlement conference. The letter also requested that Liberty Mutual tender $125,000 for Ms. Montanez's claims and $125,000 for Eduardo Gonzalez Jr.'s claims. On April 6, 2010, counsel for Liberty Mutual sent Plaintiff's counsel a letter, noting that Defendant had issued checks to resolve the claims of Ms. Montanez and her son in accordance with Plaintiff's March 31, 2010 letter. In addition, the letter noted that because Liberty Mutual was settling Ms. Montanez and Eduardo Gonzalez Jr.'s claims, it was able to offer the remaining available policy limit of $250,000 to settle and resolve the claim of the Estate of Yanelis Gonzalez.

To that end, on April 8, 2010, Liberty Mutual delivered the two $125,000 checks to settle Ms. Montanez and her son's claims. Similarly, on April 13, 2010, Liberty Mutual attempted to deliver a check in the amount of $250,000 to Plaintiff's counsel to settle the wrongful death claim, but Plaintiff's counsel refused to accept it.

On April 14, 2010, attorney Lewis Jack filed a lawsuit against the Browns asserting a wrongful death claim, two personal injury claims, and a loss of consortium claim. All claims were eventually dismissed except for the wrongful death claim against Jason Brown, which resulted in a consent judgment in the amount of $8,250,000. A bad faith lawsuit was then filed, and Liberty moved for summary judgment.

The Court granted the motion for summary judgment. Plaintiff argued that Liberty Mutual had an obligation to settle the most egregious claim—the wrongful death claim—before apportioning the remainder of the policy. However, this contention was unsupported by Florida law. In contrast, Florida law provides that an insurer is entitled to reasonable time to investigate a claim. In this case, approximately one month elapsed between February 1, 2010 (when Liberty Mutual first learned of the accident) and March 4, 2010 (when Defendant offered all claimants its full policy limits). In that time span, Liberty Mutual investigated a potential coverage issue, obtained a police report and "events report" from the Palm Beach County Sheriff, contacted Plaintiff's PIP adjuster, sent the insureds "other insurance" affidavits and excess exposure letters, and advised Mr. Brown to retain an attorney. In addition, Liberty's adjuster called Plaintiff's counsel five times in one month to speak about the accident and never received a response.

In response, Plaintiff's counsel waited almost one month, until March 31, 2010, to reject Liberty Mutual 's offer to settle Plaintiff's wrongful death claim. While Plaintiff argued that Liberty delayed settling the claim unreasonably, she ignored the fact that her counsel's decision not to return Liberty's calls contributed to the delay. The Court stated that "even under the most favorable construction of the facts, the Court cannot ignore Plaintiff's counsel's hand in manufacturing the delay Plaintiff now complains about. *The Court will not tolerate the use of bad faith claims as a sword for claimants in insurance litigation."*

The Court also rejected Plaintiff's argument that Liberty did not put the insured's interests on par with its own. It reasoned that this case was complex and involved multiple parties and competing claims. An infant was killed, and four people were injured, including two additional children, one of whom was ejected from the vehicle, sustaining head trauma. Under these circumstances, a reasonable juror could not find that Defendant's decision to exercise its discretion and proceed to a global settlement conference evinces bad faith. On the contrary; such a decision was properly motivated by a desire to determine the proper apportionment of policy limits and avoid indiscriminately settling selected claims, thereby extinguishing any notion that Liberty Mutual put its interests ahead of its insureds.

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Georgia

Insurer Did Not Fail to Settle Claim Against Its Insured in Bad Faith

***Kemper v. Equity Insurance Company,* United States District Court, Northern District of Georgia (July 8, 2019)**

In March 2012, Christopher Brown drove his vehicle across a road's center line into oncoming traffic and struck Ms. Kemper, who was riding her motorcycle. Mr. Brown was drunk. Ms. Kemper was injured and airlifted to a hospital.

Brown had an automobile liability insurance policy with Equity that provided $25,000 per person in bodily injury liability coverage. Equity retained Statewide Claims Service to adjust Ms. Kemper's claims against Mr. Brown.

Early in the claim process, Statewide concluded that Ms. Kemper's medical bills would exceed the policy limit. Attorney Michael Werner helped Ms. Kemper draft a demand letter. In it, Ms. Kemper offered to sign a limited release in exchange for the liability policy's limit. She stated the release must not have any language about her paying Mr. Brown's or Equity's "incurred costs" and that Equity must deliver the check to her before June 8, 2012. Ms. Kemper also wrote "PLEASE DO Not contact me, or my Friends as this Demand is very simple [sic]." Statewide received the letter, evaluated Ms. Kemper's claims, and concluded her medical bills exceeded the insurance policy's limits.

It is undisputed that Statewide (acting for Equity) had knowledge of clear liability and special damages exceeding the policy limits. Equity's agent Statewide thus had a duty to respond to Ms. Kemper's time-limited demand letter.

Ms. Kemper's demand was not Statewide's only legitimate concern, however. Statewide also worried about Equity's potential liability from liens. In Georgia, hospital liens essentially become part of an injured party's claim against an insurer.

When Statewide received Ms. Kemper's demand letter it was facing a dilemma. On the one hand, it knew the Georgia Supreme Court's decision in *Holt* required its client, Equity, to respond to that demand. It also feared Equity might face a bad faith failure to settle claim if it did not pay Ms. Kemper the full policy amount. At the very least, Equity would have faced a jury question on bad faith. On the other hand, Statewide (as Equity's administrator) feared medical liens. It knew Ms. Kemper had extensive medical bills that exceeded the policy limits. Under both Georgia's statutes and its common law, Equity had an obligation to look out for any claims or liens hospitals, physicians, or other medical service providers may have filed upon Ms. Kemper's claims against Mr. Brown, including her claim for the insurance policy limits.

Ms. Kemper's demand letter also prohibited Statewide and Equity from contacting her. This is particularly important because a lien holder would have had to give Ms. Kemper actual notice of its potential claim, while it would only have to notify an insurance company like Equity that it knew might be liable to Ms. Kemper. Ms. Kemper's instruction that Equity not contact her prevented Equity or Statewide from simply asking her whether her insurance company had paid all of her medical bills or whether any liens had been filed. It barred Statewide and Equity from an easy solution to their dilemma.

However, Georgia law has a safe harbor that protects insurance companies facing these conflicting statutory and common law duties. Georgia law protects an insurer from liability under if (1) the insurer promptly acts to settle a case involving clear liability and special damages in excess of the applicable policy limits, and (2) the *sole* reason for the parties' inability to reach a settlement is the plaintiff's unreasonable refusal to assure the satisfaction of any outstanding hospital liens from the proceeds of the settlement.

The Court concluded that Equity was entitled to the safe harbor. The undisputed evidence showed that Statewide promptly acted to settle Ms. Kemper's case, which involved clear liability and special damages above the applicable policy limits. It tried to give Ms. Kemper the $25,000 policy limits on June 5, 2012, three days before the June 8th deadline Ms. Kemper set in her demand letter. Statewide *demanded* that Kemper place settlement funds into an escrow account for the purpose of protecting the interests of any pending liens. This demand complies with Georgia case law, which suggests that an insurance company may tender its policy limits to the plaintiff, subject to a reasonably and narrowly tailored provision assuring that the plaintiff will satisfy any hospital liens from the proceeds of such settlement payment.

Here, the sole reason for the parties' inability to reach a settlement was Ms. Kemper's unreasonable refusal to assure the satisfaction of any outstanding hospital liens from the proceeds of the settlement. Ms. Kemper construed Statewide's response on Equity's behalf as a counteroffer, which she rejected because she found the demand that she place her money in an escrow account unacceptable as she needed the money to live. Ms. Kemper could have allowed Statewide or Equity to contact her to discuss any outstanding liens, informed them that there were no liens, or signed the affidavit in the limited release Statewide provided. Ms. Kemper did none of these. Instead, she disavowed her obligation to satisfy any potential outstanding liens because she had over one million dollars of medical bills and needed the money to live.

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Idaho

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

***Lete v. Travelers Casualty Insurance Company of America*, United States District Court, District of Idaho (July 30, 3019)**

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

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

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

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

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

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

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Massachusetts

Bad Faith

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

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Michigan

Long-Tail/Successor Liability

A federal district court has ruled in Magnetek, Inc. v. The Travelers Ind. Co., No. 17-3173 (N.D. Ill. July 11, 2019) that a 2004 settlement whereby Travelers paid its policy limits to Fruit of the Loom in consideration of its agreement that the policies were exhausted does not now preclude a former subsidiary that was spun off in 1999 from now seeking coverage from Travelers for demands that have been

made against it by Monsanto for PCB claims. Having found that Travelers owed a duty to defend, the court further ruled that Magnetek was entitled to use its own lawyers as a clear conflict of interest existed given the enormous potential indemnity exposure relative to the relatively small limits of coverage.

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New Jersey

Purported Additional Insured Not Insured for Its Own Negligence (Policy Provided AI Coverage "Only with Respect to" Named Insured's Work)

***Comcast v. Hanover Ins. Co. & JNET Communications,* New Jersey Superior Court, Appellate Division (July 10, 2019)**

The Hanover Insurance Company ("Hanover") issued a CGL policy to JNET. JNET had a contract with Comcast agreeing to procure insurance coverage.

Richard Endres filed a complaint alleging he sustained injuries due to the negligence of JNET and Comcast when he tripped over a temporary above-ground cable JNET installed while performing work as Comcast's contractor. Comcast tendered its defense to Hanover under the CGL policy it issued to JNET as the insured. Hanover initially accepted the defense and assigned counsel to Comcast and JNET. Comcast was dismissed from the litigation based on JNET's admission that it placed a temporary cable on the property.

The claim against Comcast was subsequently reinstated on Endres's motion after deposition testimony suggested that a Comcast technician placed or replaced the temporary cable after the JNET employee first placed the cable on the property where Endres fell. Hanover tendered the defense back to Comcast, claiming the alleged loss "did not arise out of [JNET's] work" and therefore Comcast was not owed a defense under the policy. At the trial on Endres's claim, the jury found Comcast 60 percent liable and JNET 40 percent liable and awarded damages.

Comcast sued Hanover and JNET seeking a declaratory judgment that Hanover was obligated to defend and indemnify Comcast because Comcast was an additional insured under the policy. Comcast also asserted a claim against JNET alleging that if Comcast was not covered under the policy, JNET breached its contract with Comcast by failing to obtain the insurance required by the contract.

The trial court granted Comcast's motion for summary judgment finding Comcast was an additional insured entitled to a defense and indemnification under the policy, awarded Comcast $350,000 in defense costs and fees, and denied Hanover's motion for summary judgment dismissal of the complaint. The trial court also denied Comcast's summary judgment motion on its breach of contract claim against JNET, determining JNET had, in fact, obtained the required insurance coverage.

By granting summary judgment to Comcast, the trial court ruled Comcast was an additional insured entitled to coverage under the JNET policy for its own negligence. All parties appealed. The central issue on appeal was whether Comcast is an additional insured for its own negligent acts under the policy.

The material facts were not in dispute. In the underlying personal injury trial, the jury determined JNET was 40 percent liable for Endres's injuries based on its negligence and Comcast was 60 percent liable based on its negligence. JNET is the named insured under the policy. Comcast is entitled to a defense and indemnification from Hanover under the policy only if Comcast qualifies as an additional insured for its own negligence.

Comcast's claim it was an additional insured rested upon the following policy provisions:

> 1. Additional Insured by Contract, Agreement or Permit
>
> . . . .
>
> 5.a. Any person or organization with whom you agreed, because of a written contract, written agreement or permit to provide insurance, *is an insured, but only with respect to*:
>
> (1) *"Your work"* for the additional insured(s) at the location designated in the contract, agreement or permit
>
> ***

The policy defines "Your Work" as:

> *(1) Work or operations performed by you or on your behalf; and*
>
> *(2) Materials, parts or equipment furnished in connection with such work or operations.*
>
> ***

Hanover argued that under the circumstances presented here Comcast is not an additional insured for its own negligent acts under the plain language of the policy. More particularly, Hanover noted the policy provides

Comcast is an additional insured but "only with respect to" JNET's work. Hanover contended Comcast is not an additional insured for its own negligence because the jury based its finding of Comcast's liability on Comcast's direct negligence unrelated to JNET's work and not vicarious liability based on JNET work. Hanover contended that Comcast is not an additional insured "with respect to" the work for which the jury found it directly liable, and that Comcast's contentions to the contrary ignore the policy's plain and unambiguous language and the jury's verdict. The Appellate Division agreed.

In the first instance, to qualify as an additional insured under the policy, Comcast must be a party for whom JNET, as the named insured, agreed to provide insurance. That condition was satisfied here; JNET agreed to provide insurance under its contract with Comcast. However, Comcast's status as a party to whom JNET contractually agreed to provide insurance does not, by itself, render Comcast an additional insured entitled to coverage.

The policy expressly and unambiguously limits those who satisfy the first requirement for qualification as an additional insured. Thus, those parties to whom JNET agreed to provide insurance are additional insureds but "only with respect to . . . Your Work." The policy defines "Your Work" as JNET's "[w]ork or operations" or "[m]aterials, parts or equipment furnished in connection with such work or operations." Thus, under the policy's plain language, Comcast is an additional insured solely and exclusively in reference and relation to JNET's work.

Comcast made no showing that its liability for Endres's injuries was based on JNET's work or that the jury found it vicariously liable for JNET's negligence in the performance of JNET's work. Instead, the jury apportioned liability based on JNET's and Comcast's separate and distinct negligence. The Appellate Division determined that the policy provides that Comcast is an additional insured "only with respect to" JNET's work; it does not provide that Comcast is an additional insured with respect to its own work or negligence.

Since the jury found Comcast separately liable based on its own negligence and with reference and relation to its own work, the Appellate Division ruled that Comcast was not an additional insured for its own negligence under the circumstances presented.

The Appellate Division reversed the order granting Comcast summary judgment on its claim for coverage under the policy and denying Hanover's summary judgment motion dismissing Comcast's coverage claim.

Since Comcast was not entitled to coverage under the policy, the factual premise underlying the trial court's dismissal of Comcast's breach of contract claim against JNET was no longer extant. The record on appeal did not otherwise permit a disposition of the motion because the record was incomplete. The Appellate Division vacated the order denying Comcast's motion for summary judgment on its breach of contract claim against JNET and remanded for the trial court to address the motion on the merits.

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

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New York

Court Denies the Parties' Cross-Motions for Summary Judgment Because Applying the Windstorm Definition to the Policy's Coverage-Granting Clauses Creates an Ambiguity with Respect to the Policy's Flood Exclusion

***Madelaine Chocolate Novelties v. Great Northern Ins. Co.*, District Court, Eastern District of New York (July 19, 2019)**

This decision stems from Plaintiff's breach of contract claim against defendant Great Northern Insurance Company. Plaintiff's manufacturing facility sustained damage resulting in substantial inventory and business income losses. Subsequently, Plaintiff submitted an itemized proof of loss to Defendant. In turn, Defendant paid under $4 million and disclaimed coverage for the remaining losses pursuant to the Policy's Flood Exclusion.

The Policy at issue contained several exclusions including a "Flood Exclusion" which eliminates coverage for "loss or damage caused by or resulting from: waves, tidal water or tidal waves; or rising, overflowing or breaking of any boundary, of any. . .oceans or any other body of water or watercourse, whether driven by wind or not, regardless of any other cause or event that directly or indirectly contributes concurrently to: or contributes in any sequence to, the loss or damage, even if such other cause or event would otherwise be covered." Importantly, the Policy's at issue "Flood Exclusion" contained an Anti-concurrent causation ("ACC") clause. The Policy contained several endorsements including a "Windstorm Endorsement."

On September 26, 2017, the Second Circuit on appeal concluded that the "Windstorm Endorsement adds an ACC

clause to the definition of a covered peril for the entire Policy." The Second Circuit also noted that "it is undisputed that, for purposes of the Policy, a 'windstorm' is a covered peril." Based upon its decision, the Second Circuit directed the Eastern District on remand to "(i) assess whether the Windstorm Endorsement's ACC clause conflicts with other provisions and otherwise creates an ambiguity is-à-vis the Policy's Flood Exclusion," and (ii) to the extent this Court concludes an ambiguity exists, to consider "interpretive materials relating to the Windstorm Endorsement and its relationship with the Policy's coverage provisions."

Now on the current motion for summary judgment before the Court, Plaintiff contends that the Windstorm Definition's ACC clause creates an ambiguity that cannot be resolved in Defendant's favor because (i) the Windstorm Definition's ACC clause supersedes the Flood Exclusion's ACC clause as an "added or attached" change to the "basic insurance contract" and (ii) the record is otherwise devoid of any relevant extrinsic evidence supporting an interpretation that would foreclose coverage.

In contrast, Defendant argued that that (i) the Flood Exclusion unambiguously precludes coverage because "applying the definition of 'windstorm' throughout the policy has no impact on the scope of coverage afforded under the Policy," and (ii) even if the Windstorm Definition creates an ambiguity vis-à-vis the Flood Exclusion, extrinsic evidence favors Great Northern because it reveals that Madelaine had no reasonable expectation of receiving flood coverage, under any circumstances, when it purchased its Great Northern insurance policy.

The Court began its analysis on whether the Windstorm definition's ACC Clause creates an ambiguity vis-à-vis the "Flood Exclusion." The court found that the Windstorm Definition applied to where the term "windstorm appeared through the Policy in bold and to the definition of a "covered peril," and to the stand-alone term "peril" in the Policy at issue. As such, the Court concluded that based upon the Windstorm definition as applied to the Policy's coverage granting clauses, the Policy at issue covered (i) Applying the Windstorm Definition to the Policy's coverage-granting clauses, which encompasses damage caused by "covered perils" and "perils," the Policy covers (ii) "direct physical loss or damage to: building; or personal property, caused by or resulting from a *windstorm…regardless of any other cause or event that directly or indirectly: contributes concurrently to; or contributes in any sequence to, the loss or damage, even if such other cause or event would otherwise be covered* not otherwise excluded" *and* (iii) "actual or potential impairment of operations…caused by or resulting from direct physical loss or damage by a *windstorm… regardless of any other cause or event that directly or indirectly: contributes concurrently to; or contributes in any sequence to, the loss or damage, even if such other cause or event would otherwise be covered* to property, unless otherwise stated."

Next, the Court considered whether there is ambiguity when viewing the coverage-granting clauses in their entirety, including the Windstorm Definition, and the Flood Exclusion side-by-side. In its analysis, the Court noted that when it applies the Windstorm Definition to the Policy's coverage grants for damage caused by a "peril not otherwise excluded" it cannot ignore the exclusionary clauses. To do so the Court determined that it would result in ignoring the Policy's coverage grants and leave them without force and effect. As such, the Court found to reconcile the coverage-granting clauses with the Windstorm Definition, it would need to add language. Therefore, the Court determined that the "need to supply a missing term" established that applying the Windstorm Definition to the Policy as a whole, creates an ambiguity vis-à-vis the "Flood Exclusion."

Thereafter, the Court considered whether the ambiguity in the Policy could be resolved as a matter of law. On this point, Plaintiff argued that the Policy's ambiguity must be resolved as a matter of law because "when an endorsement potentially conflicts with other provisions of the policy, the plain language of the endorsement is controlling." While the Court generally agreed with Plaintiff's statement of the law, the Court nonetheless disagreed with Plaintiff's application of the rule of law to the facts of the matter at hand. In its reasoning, the Court noted that "where one provision is executed simultaneously with a conflicting provision, the former does not supersede the latter just because it is styled as an "endorsement."

In sum, the Court found that the extrinsic evidence revealed triable issues of fact and therefore the Court need not resort to the doctrine of *contra proferentem* to resolve the Policy's ambiguity as a matter of law.

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Duty to Defend Landlord as Additional Insured for Accident in Common Area Where Broad Lease Provisions Require Coverage for Use of Those Areas Even Though Not Leased Premises

Pixley Development Corp. v. Erie Insurance Company, **Appellate Division, Fourth Department (July 31, 2019)**

Pixley commenced this action seeking a declaration that defendant Erie Insurance Company ("Erie") is obligated to provide a defense and indemnification for Pixley, as an additional insured, in an underlying personal injury action. Pixley also demanded judgment against defendant Candy Apple Café (Café) for contractual. The plaintiff in the underlying action (tort plaintiff) alleged that he sustained injuries when he slipped and fell on ice in the delivery driveway behind a plaza owned by Pixley while delivering supplies to the Café, a tenant of the plaza.

An insurer's duty to defend is exceedingly broad and an insurer will be called upon to provide a defense whenever the allegations of the complaint suggest a reasonable possibility of coverage. The duty to defend is derived from the allegations of the complaint and the terms of the policy. Here, the court found, allegations of the personal injury complaint and the terms of the policy created a reasonable possibility that the tort plaintiff's claims are covered under the terms of the policy.

Pursuant to the provisions of the lease, the premises leased to the Café was defined as "a ground floor store approximately 5600 square feet, (the Premises'), together with . . . the right to use the driveway designated for delivery purposes in common with other tenants." Although the delivery driveway was deemed a common area under the terms of the lease, the Café was required to pay its proportionate share of common area maintenance charges and was further obligated to provide "for the benefit of Pixley, a comprehensive liability policy of insurance protecting Pixley against any liability whatsoever, occasioned by accident, on or about the Premises, or any appurtenances thereto."

The Café obtained the requisite insurance policy, which named Pixley as an additional insured, but that additional insured endorsement insured Pixley "only with respect to liability arising out of the ownership, maintenance or use of that part of the premises leased to the Café and shown in the Schedule." The supplemental declarations to the policy identified the leased premises only by its address.

The court concluded that the allegations in the complaint suggest a reasonable possibility of coverage inasmuch as the tort plaintiff's claims arguably "arise out of" the Café's maintenance or use of that part of the premises leased to it."

Pixley established on its motion that the use of the delivery driveway was included in the scope of the demised premises and there are triable issues of fact whether the Café " assumed some responsibility for maintenance of that area, including snow removal.

Other factors relevant to our determination that the claims arguably arise out of that part of the premises leased to the Café are that the lease required the Café to procure insurance against any liabilities "on or about the demised premises or *any appurtenances thereto* and required the Café "to pay its proportional share of the common area costs' incurred in operating and maintaining the subject property"

However, the court found premature any ruling on the obligation to indemnify.

Note: A trend seems to be developing which is broadening additional insurer's obligations to defend with respect to common-area claims. Carriers that want to narrow that obligation need to carefully script policies. The courts seems to be separating, as they should, decisions AI defense and indemnity.

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In a Direct Action Against Insurer to Secure Liability Insurance Coverage Complaint Alleges Sufficient Facts to Survive Motion to Dismiss

S.P v. Dongbu Insurance Company, **Appellate Division, Second Department (July 31, 2019)**

This was a direct action claim.

Dongbu Insurance Company ("insurer") issued to Kosher Food Depot, Inc. (hereinafter KFD or the insured), a "Businessowners Policy" covering the period from March 11, 2013, to March 11, 2014. The defendant York Risk Services Group (hereinafter York) is the claims administrator for the policy.

The policy includes an endorsement entitled "Limitation of Coverage to Designated Premises or Project" (hereinafter the endorsement), which added the following provision to "Section II - Liability": "This insurance applies only to bodily injury,' property damage,' personal and advertising injury' and medical expenses arising out of: 1. The ownership, maintenance or use of the premises shown in the

Schedule and operations necessary or incidental to those premises; or 2. The project shown in the Schedule." The endorsement's schedule and the "Businessowners Policy Declarations" identified the premises as 1279 42nd Street in Brooklyn, and the declarations described the insured's business as "Grocery."

On March 6, 2014, the underlying "plaintiff" allegedly was injured in front of 1215 44th Street in Brooklyn, when he was struck by a flatbed pushcart or hand truck operated by an employee of KFD during the course of employment. The plaintiff subsequently commenced a personal injury action against KFD, and the insurer disclaimed coverage on the principal ground that the accident site was not a covered location under the policy. The plaintiff later moved for leave to enter a default judgment against KFD. The motion was granted, and a judgment]was entered in favor of the plaintiff and against KFD. A copy of the judgment with notice of entry was served upon KFD, as well as the insurer and York.

Subsequently, the plaintiff commenced this direct action against the insurer and York pursuant to Insurance Law §3420(a)(2) to recover the amount of the unsatisfied judgment entered in the personal injury action.

Pursuant to Insurance Law §3420(a)(2), an injured person who has obtained an unsatisfied judgment against a tortfeasor may commence an action against the tortfeasor's insurer to recover the amount of the unsatisfied judgment, up to the policy limit.

Contrary to the defendants' contention, the complaint sufficiently stated a cause of action pursuant to Insurance Law §3420(a)(2) against the insurer to recover the amount of the unsatisfied judgment in favor of the plaintiff and against the insured. The evidence submitted by the defendants did not demonstrate that a fact alleged in the complaint insofar as asserted against the insurer was undisputedly not a fact at all. The complaint against the insurer stands.

However, the complaint against the TPA, York, is dismissed. The evidence submitted by the defendants conclusively established that York did not have independent authority to issue the disclaimer and only did so at the direction of the insurer; that York is not an insurance company and did not participate in any way in the underwriting, issuance, or binding of the policy; and that York has no contractual privity with KFD or the plaintiff.

Coverage has not yet been conclusively established. If it is, the insurer will not be able to contest the findings of liability or the amount of damages established in the default under the authority of *Lang v. Hanover*, 3 NY3d 350 (2004). That is the danger inherent in not defending and allowing a default to be entered.

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Failure to Copy Additional Insured's on Policy Disclaimer Based on Policy Exclusions Renders Disclaimer Ineffective as to Those Parties

***AVR-Powell C Development Corp. v. Utica First Insurance Co.*, Appellate Division, Second Department (July 24, 2019)**

AVR-Powell was the owner of and general contractor at a construction site and entered into a written agreement with Vinny Construction Corp. ("Vinny") for masonry work. Vinny was required to procure and maintain a commercial general liability insurance policy naming AVR-Powell and the Powell Cove as additional insureds. Vinny was insured by Utica First and the policy included a "Blanket Additional Insured" endorsement specifying that an "insured also includes . . . a Ny person or organization whom you are required to name as an additional insured on this policy under a written contract or written agreement." AVR-Powell and Powell Cove were also named as insureds under a general liability insurance policy issued to AVR-Powell and Powell Cove by nonparty Mt. Hawley Insurance Company ("Mt. Hawley").

An employee of Vinny Construction allegedly was injured while working at the construction site. In March 2009, Mt. Hawley wrote to Utica tendering a claim on behalf of the plaintiff AVR Realty Company, LLC ("AVR Realty"), and Powell Cove for defense and indemnification in connection with any claim by the injured employee. The following day, Utica sent a letter to Vinny disclaiming coverage based on the policy exclusion for bodily injuries sustained by an employee of the insured in the course of his or her employment ("employee exclusion"). The claim was retendered to Utica and again, the employee exclusion formed the basis for denial

In February 2015, Powell Cove and AVR Realty, through counsel, advised Utica that its disclaimer of coverage was ineffective inasmuch as it was not sent directly to the additional insureds, and they renewed their demand for coverage. Utica rejected the position that its disclaimer was invalid, and, after receiving a copy of the contract between AVR-Powell and Vinny Construction, it sent

a letter dated March 20, 2015, directly to the plaintiffs, disclaiming coverage.

Pursuant to Insurance Law §3420 (d), an insurer is required to provide its insured and any other claimant with timely written notice of its disclaimer or denial of coverage on the basis of a policy exclusion and will be estopped from disclaiming liability or denying coverage if it fails to do so.

On their motion for summary judgment, the plaintiffs established their prima facie entitlement to judgment as a matter of law by demonstrating that Utica did not give timely written notice of its disclaimer directly to its additional insureds.

In opposition, Utica failed to raise a triable issue of fact. There is no merit to Utica's contention that its obligation to comply with Insurance Law §3420(d) did not begin until it received the contract documents in March 2015. Utica did not need to receive those documents in order to provide a disclaimer directly to the additional insureds based on the employee exclusion. An insurer may not delay issuance of a disclaimer on a ground that the insurer knows to be valid while investigating other possible grounds for disclaiming.

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Even Voluntary Reformation of Auto Liability Policy Limits Was Unenforceable as to Injured Party

***McGuckin v. Privilege Underwriters Reciprocal Exchange,* Appellate Division, Second Department (July 17, 2019)**

In December 2011, the McGuckin allegedly was injured when a vehicle in which he was a passenger was involved in a collision. At the time of the collision, the vehicle was driven by Douglas Gambon and owned by Carol Giambrone (hereinafter together the Giambrones) and was insured by the defendant under a liability policy providing for bodily injury coverage up to $250,000 per person/$500,000 per occurrence. In May 2012, the plaintiff commenced an action against the Giambrones to recover damages for personal injuries he sustained in the accident.

When PURE, the insurer, investigated the accident, it concluded that the Giambrones had made substantial misrepresentations in securing the policy. Recognizing that there was case law that prohibited retroactive rescission of the auto policy, PURE and the Giambrone 's, represented by counsel negotiated a modification and reformation of the policy, reducing the bodily injury coverage to a single $80,000 limit.

Thereafter, the Giambrones notified the plaintiff that the coverage limit applicable to the accident was $80,000. The plaintiff subsequently obtained a judgment against the Giambrones in the amount of $300,000 in the underlying personal injury action and assigned the judgment to McGuckin.

McGuckin then then commenced the instant action seeking a determination that the purported reformation of the subject insurance policy was invalid and unenforceable, that the PURE was bound by the full bodily injury coverage limits stated in the original policy, and that PURE was obligated to satisfy the full amount of the judgment obtained in the personal injury action. McGuckin also a sought to recover his attorneys' fees and expenses incurred in connection with this action.

The lower court ruled that the reformation was lawful and binding and McGuckin appealed. The Second Department reversed, holding that an auto insurer may not retroactively reform a policy to reduce the stated bodily injury coverage limits after a loss caused by its insured occurs, even if the reduced limits still meet or exceed the statutory minimum As such, by demonstrating that the policy in effect at the time of the accident provided for a bodily injury coverage limit of $250,000 per person, and submitting the $300,000 judgment he obtained against the defendant's insureds in the underlying personal injury action, the plaintiff demonstrated his prima facie entitlement to judgment as a matter of law on his causes of action for a judgment declaring that the purported reformation of the policy was invalid and unenforceable and that the defendant is bound by the full bodily injury coverage limits stated in the original policy.

However, the plaintiff failed to demonstrate his prima facie entitlement to judgment as a matter of law declaring that the defendant is obligated to satisfy the full amount of the judgment, he obtained against the Giambrones. Contrary to his contention, the plaintiff failed to identify any basis on which the defendant was obligated to pay the additional $50,000 beyond the original policy's bodily injury coverage limit. As such, the plaintiff was entitled to summary judgment on that cause of action, but only to the extent of declaring that the defendant is obligated to satisfy the first $250,000 of the judgment.

McGuckin did not justify a claim for any damages in excess of $250,000 nor does he recover legal fees.

Note: I represented PURE in this matter. The difference between this case and the precedent cited by the court is that in this case, the policyholder and the carrier agreed to the reformation and that agreement was assigned to the injured party. He stood in the shoes of the policyholder. The policyholder AGREED to the reformation and the McGuckin should have no greater rights than PURE's policyholder. We will see about an application for leave to appeal.

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No Contractual Indemnity for Owner, nor Tenant, Where Neither Were Expressly Referenced in the Indemnity Agreement

***Huang v. 57-63 Greene Realty, LLC,* Appellate Division, Second Department (July 24, 2019)**

Plaintiff sustained injury when he fell from a scaffold while employed with LTI. In turn, he sued the owner and tenant of the premises seeking to recovery for injuries sustained in the fall.

The owner/tenant then commenced a third-party action against Fahey (as general contractor) and LTI seeking contractual indemnification. LTI moved for summary judgment arguing that its contract with Fahey did not require it to indemnify the owner/tenant. The argument was based upon a plain reading of the provision which did not unambiguously and expressly extend to owner/tenant. Citing the lack of any direct connection to the contract, the Court agreed that LTI did not have an obligation to either owner or tenant.

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Pennsylvania

Business Pursuits/Qui Tam Claims

A lawsuit that a contractor brought against a whistleblower who had unsuccessfully brought a qui tam claim accusing the plaintiff of defrauding the Pennsylvania Department of Transportation has been held not to be subject to a business pursuit's exclusion in the whistleblower's personal umbrella policy. In Nationwide Mutual Insurance Company v. Arnold, 2019 Pa 213 (Pa. Super. July 11, 2019), the Superior Court declared that even though these statements were made in the context of the insured's former employment with the State Department of Transportation, they lacked the elements of continuity and a profit motive required under Pennsylvania law. The court emphasized that the law suit against the insured was based on statements and actions undertaken by the insured outside of his job. Since the suit was based on the insured's personal conduct rather than the performance of his official duties as an employee of PA DOT, the court ruled that the business pursuits exclusion did not apply.

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South Carolina

Late Notice/Auto

In a complex opinion that traces the evolution of late notice law in South Carolina, the state Supreme Court has ruled that recent legislative enactments mandating basic levels of auto insurance did not entirely negate the effect of untimely notice. In Neumayer v. Philadelphia Ind. Co., No. 27902 (S.C. July 24, 2019), the court ruled that although Section 38-77-142 (C) voids any language that would defeat coverage for the mandated $25,000 limits for auto insurance, it did not eviscerate the consequences of an insured's untimely notice. As a result, the court ruled that Philadelphia Indemnity was only obliged to pay $25,000 on behalf of its insured and not the full amount of a $622,500 default judgment against the insured.

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Texas

Insured's Bad Faith Claims Dismissed After Insurer Paid Appraisal Award

***Ortiz v. State Farm Lloyds,* Supreme Court of Texas (June 28, 2019)**

Oscar Ortiz had a homeowner's policy with State Farm Lloyds and submitted a policy claim to State Farm for wind and hail damage to his home. State Farm sent an adjuster to inspect the property, and the adjuster estimated the amount of the damage caused by wind or hail to be $732.53, which was below the policy's $1,000 deductible. The adjuster observed additional damage that he concluded was not caused by hail and thus was not

covered by the policy. In response to State Farm's request that Ortiz forward any estimates related to this loss that exceed your deductible, Ortiz sent State Farm an estimate he received from a public adjuster valuing the loss at $23,525.99. State Farm conducted a second inspection with the public adjuster present and revised the damage estimate to $973.94, again concluding the damage amount did not exceed the deductible.

Approximately six weeks after being notified of the results of the second inspection, Ortiz sued State Farm for breach of contract, violations of the Prompt Payment Act, and statutory and common law bad faith insurance practices. State Farm answered and, approximately two months later, demanded an appraisal pursuant to the insurance policy.

Ortiz objected, arguing that State Farm had waived its right to appraisal by waiting too long to demand it. State Farm filed a motion to compel appraisal, which the trial court granted. The appraisal award set the replacement cost of the loss at $9,447.52 and the actual cash value at $5,243.93. State Farm paid the award, minus the deductible, approximately seven business days after receiving it. State Farm then moved for summary judgment, arguing that its payment of the appraisal award resolved and disposed of all claims in the lawsuit.

First, the court concluded that State Farm was entitled to dismissal of a breach of contract claim. An insurer does not breach a policy simply because an appraisal award is higher than the amount an insurer offered. Here, State Farm invoked the agreed procedure for determining the amount of loss and paid the binding amount. In doing so it complied with its policy obligations, and the insured failed to identify any other breach.

The insured's bad faith claim was also dismissed. Other than the amount that has already been paid, Ortiz did not seek to recover any actual damages he claims were caused by State Farm's Insurance Code violations. For example, he did not claim the delay in payment resulting from State Farm's allegedly unreasonable investigation caused additional property damage to his home, nor did he seek either appraisal costs or sums related to pre-appraisal damage assessments. Because Ortiz sought no actual damages other than the policy benefits paid in accordance with the policy's appraisal provision, he could not maintain a bad faith claim under either the common law or chapter 541.

However, the court held that the insurer's payment of the appraisal award did not, as a matter of law, bar the insured's claim under the Texas Prompt Payment of Claims Act.

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Vermont

Post-Trial Judgment for Insurer as a Matter of Law Reversed – Collision Insurance Coverage – Insurer May Not Unilaterally Determine the Value of an Insured's Collision Damage Claim

***Parker's Classic Auto Works v. Nationwide Mutual Ins. Co.,* Supreme Court of Vermont (June 28, 2019)**

Background: The plaintiff collision repair shop Parker's Classic Auto Works, Ltd., of Rutland, Vermont ("Parker's"), sued Nationwide Mutual Insurance Company ("Nationwide") for breach of contract in Vermont state court. Parker's sued as assignee of approximately 70 different Nationwide policyholders, alleging Parker's had repaired approximately 70 different collision-damaged policyholder vehicles to pre-accident condition between 2009 and 2014, but that in each instance Nationwide paid out less on the associated collision damage claims made by those policyholders than what Parker's final bills had charged those policyholders for the completed repairs under the separate repair contract the policyholders had entered into with Parker's for the repairs. Parker's as assignee of the policyholders refers to the difference between what Nationwide paid on the claims and what Parker's charged for the repairs as "short pays." A jury trial of Parker's breach of contract claims was conducted in the Vermont Superior Court, Rutland Unit, Civil Division. The evidence presented to the jury included the fact that Parker's repair contracts with the policyholders were completely independent of the insurance contracts between the policyholders and Nationwide, and moreover, that Nationwide was under no contractual obligation of any kind to pay anything directly to Parker's. However, Parker's, through the assignments provided to it by the policyholders, asserted it therefore stood in the shoes of the policyholders to be paid the fair value of the damage/loss suffered by the collision-damaged, insured policyholder vehicles. (The policyholders also signed directions to pay the claim proceeds directly to Parker's, rather than the policyholders.) The jury returned a verdict finding Nationwide liable to Parker's for breach of the assigned collision damage claim rights of the policyholders, in the "short pay" amounts asserted by Parker's, awarding Parker's $41,737.89 in total on the

approximately 70 short pay claims. Nationwide moved post-trial for judgment as a matter of law, and the Superior Court judge who presided over the trial, the Hon. Helen M. Toor, granted Nationwide's post-trial motion, awarding Nationwide judgment as a matter of law. Parker's then appealed the post-trial judgment for Nationwide to the Vermont Supreme Court. Parker's appeal was heard and considered by the entire Vermont Supreme Court *en banc*.

The decision is curious in numerous respects. This is a breach of contract case. The Vermont Supreme Court's decision reverses the lower court's order which had granted defendant Nationwide post-trial judgment as a matter of law. Yet, nowhere in the decision does the Vermont Supreme Court recite any Vermont case law describing what exactly a plaintiff's burden of proof is in a breach of contract case being tried in Vermont.

In addition, rather than explaining through its decision why the plaintiff-appellant Parker's arguments and position on this appeal won the day, Supreme Court instead devotes virtually the entirety of its decision to rebutting and/or discounting the defendant-appellee Nationwide's arguments presented in response to Parker's appeal. Supreme Court's decision oddly refrains from advising the reader exactly what plaintiff Parker's arguments were in support of its appeal.

The decision makes vague reference to a so-called "standard collision-insurance policy" without elucidating what the pertinent terms of this hypothetical "standard" policy are. Further, the decision opts to merely summarize portions of the pertinent provisions of the Nationwide "Century II" auto insurance policies at issue, rather than set forth for the reader's benefit the complete extent of the collision coverage provisions and the limit of liability provisions of the Nationwide policies at issue.

There is no specific reference in the decision to any specific testimony heard by the jury during the trial. Rather, generalized summations of portions of testimony are merely alluded to [1].

At one point in the decision, Supreme Court references that "the actual issue" in this case is "whether plaintiff's bills here were covered." This telling reference is indicative of Supreme Court's flawed analysis of the plaintiff Parker's appeal of Superior Court's post-trial judgment as a matter of law in favor of Nationwide. The testimony at trial coupled with the documentary evidence at trial indisputably established that nowhere in the policies at issue does it say Nationwide is obligated to pay invoices or bills generated by a collision repair shop or anyone else repairing a policyholder's vehicle which is afforded collision damage coverage.

Rather, the *actual issue* in this case is whether plaintiff Parker's met its burden under Vermont law at trial to prove all the elements of its breach of contract claims against defendant Nationwide. A closely related issue in this case is whether the jury's verdict for Parker's is in conformity with the trial judge's jury instruction that Parker's had the burden of proving through the evidence presented that the assignors/policyholders had suffered some financial loss, a component of proving a breach of contract claim in Vermont.

If you have read this far, you've read the footnote indicating that yours truly tried this case to verdict and thereafter obtained post-trial judgment for Nationwide as a matter of law. Here's some information about the trial not set forth in the Vermont Supreme Court's decision. There was uncontroverted testimony from Parker's representative that he had no knowledge of any policyholder having suffered any out-of-pocket financial loss, and all policyholder vehicles were repaired to pre-accident condition and returned to the policyholders/assignees without Parker's ever asking the policyholders/assignees to pay Parker's the short pay amounts. With Supreme Court having opted not to indicate what the elements of a breach of contract claim are in Vermont, the reader is left to surmise for herself and himself what exactly the legal grounds for reversing the Superior Court's post-trial ruling in favor of Nationwide are.

This author can attest to the following additional notable facts about the trial which the Supreme Court either ignored or in any event failed to reference in its decision:

- The trial testimony of Material Damage Claims Adjuster Alan Douse of Nationwide was uncontroverted as to the fact that he met with each insured at the time he prepared Nationwide's repair estimate, reviewed his repair estimate line-by-line with the insureds, and got agreement from the insureds after doing so as to the amounts of his repair estimates. After getting agreement from the insureds as to the value of the claim Mr. Douse then issued claim payment checks directly to the insureds. As such, the decision's assertion that Nationwide "unilaterally" determined the value of the insured's claims is simply mistaken. The value of the claims was agreed to by each of the policyholders during their meetings with Mr. Douse.
- Parker's lone witness at trial conceded on cross-examination that policyholders making a claim under the collision coverage of their auto insurance policies with

Nationwide were under no obligation to actually get the collision-damaged vehicles repaired, but rather, could simply pocket the amounts of the claim check proceeds for themselves.

- On all claims, Parker's was clearly informed in writing by Nationwide of the extent Nationwide was willing to pay on the claims.
- Not a single assignor/policyholder testified at the trial.

Considering item #3 above, the Vermont Supreme Court's supposed basis for distinguishing the *Cascade Auto* case discussed in the decision [*Cascade Auto Glass, Inc. v Idaho Farm Bureau, Ins.*, 141 Idaho 660, 115 P.3d 751 (2005)] from the instant matter was supported by neither the trial transcript nor the documentary evidence making up the record on appeal. The Nationwide policies in evidence at the trial reserved to Nationwide the right to inspect the collision-damaged vehicles, and then pay the insureds directly on the claim, and that is what in fact occurred according to the uncontroverted testimony of Mr. Douse at trial. It is indisputable that the policies at issue create no obligation for anyone, including the policyholder, to repair the collision-damaged vehicles which the claims concerned. The insured policyholder can simply pocket the claim proceeds. As such, there is no legitimate basis for Supreme Court to have determined, for the purpose of attempting to distinguish the *Cascade Auto* case from the instant matter, that "no policy language viewed 'from the perspective of… a reasonably prudent person applying for insurance' suggests that defendant [Nationwide] may unilaterally determine the value of a claim." Rather, the policy language in evidence coupled with the trial testimony and common-sense experience "suggests" people who purchase collision insurance coverage do so accepting the fact that it is the insurer—and not some third-party to the contract—that determines the value of the collision damage claim.

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Washington

Auto/Subrogation/"Made Whole" Doctrine

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

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