

RECENT DEVELOPMENTS IN INSURANCE  
COVERAGE LITIGATION

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I. INTRODUCTION

This article discusses several major insurance coverage subjects addressed by various courts during the past year, including the enforcement of insurance policy conditions, directors and officers coverage, coverage for Hurricane Katrina losses, “advertising injury” coverage, construction defects coverage, and bad faith litigation.

## II. RECENT DEVELOPMENTS IN THE ENFORCEMENT OF POLICY CONDITIONS

As this section illustrates, insurers and insureds continue to litigate over whether an insured's failure to comply with a policy condition bars coverage, particularly where the insurer was not prejudiced by the noncompliance. Some courts continue to strictly enforce policy conditions as drafted, while others rely on public policy considerations and decline to enforce policy conditions absent a showing of the insurer's prejudice (substantial or otherwise).

### A. *Recent Developments in the Enforcement of Exhaustion Clauses in Excess Policies*

Typically an insured, when purchasing a large amount of insurance, buys its insurance in layers.<sup>1</sup> For instance, a \$50 million risk might be covered by a primary policy and multiple excess policies with total limits reaching \$50 million. While each of the excess layers of coverage usually incorporates the terms, conditions, and exclusions set forth in the primary policy, excess policies also contain their own unique terms and conditions. One such condition universally contained in excess policies is an "exhaustion clause." While this clause is variously expressed in the many excess policy forms in use in the industry, such clauses typically require exhaustion (by payment) of the full limits of the primary policy (and any intervening excess policies below it) before the particular excess policy at issue is triggered.

Insureds sometimes resolve coverage disputes with their primary insurers by settling with the primary insurer for an amount less than the limits of their primary policy and then seek coverage for the remainder of the claim from one or more of their excess insurers. The recent decision in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London* calls this practice into question.<sup>2</sup>

In *Qualcomm*, the California Court of Appeals held that a below-limits settlement of a coverage dispute between an insured and its primary insurer precluded the insured from collecting insurance proceeds from its excess insurer because the insured did not comply with the "exhaustion of underlying policy limits" condition in its excess policy. While this may not seem like an extraordinary holding, there is a contradictory line of case law dating back nearly eighty years in which courts have declined to require strict compliance with exhaustion in light of public policy con-

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1. In this way, the risk of a large catastrophe is spread among several loss payors. This is beneficial to the insured, which must protect itself from the possibility one or more of its insurers may become insolvent.

2. 73 Cal. Rptr. 3d 770 (Ct. App. 2008).

siderations encouraging settlements over litigation. The *Qualcomm* decision is significant because it continues a recent trend of courts enforcing exhaustion clauses in excess policies pursuant to the ordinary meaning of the condition instead of declining to enforce exhaustion clauses based on public policy.<sup>3</sup>

### 1. History of Courts Declining to Enforce Exhaustion Clauses

Despite the fact exhaustion clauses have been included in excess policies for decades, a number of courts have refused to enforce them. The seminal case that gave rise to this trend is *Zeig v. Massachusetts Bonding & Insurance Co.*<sup>4</sup> In *Zeig*, Justice Augustus Hand declined to enforce an exhaustion clause because it was “unnecessarily stringent.”<sup>5</sup> Although the excess policy in *Zeig* required the primary policy to be “exhausted in payment of claims to the full amount of the expressed limits,” Justice Hand ruled the term “payment” could mean “satisfaction of a claim by compromise, or in other ways.”<sup>6</sup> In other words, compromise of the underlying policy could amount to “payment” triggering the excess policy, even though the underlying policy’s limits were not exhausted.<sup>7</sup> The *Zeig* court opined that to require “absolute collection” of the full underlying limits of the primary policy would “involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable,” leading to a “result harmful to the insured and of no rational advantage to the [excess] insurer.”<sup>8</sup>

While Justice Hand’s position that compromise amounted to “payment” triggering excess coverage has been largely ignored by the cases following *Zeig*, the public policy concerns raised in Justice Hand’s opinion have been widely embraced.<sup>9</sup> The common thread of the cases following *Zeig* is the

3. *Id.*

4. 23 F.2d 665 (2d Cir. 1928).

5. *Id.* at 666.

6. *Id.*

7. *Id.*

8. *Id.* Excess insurers generally reject the argument that they have no rational interest in imposing an exhaustion requirement on their insureds. The many rationales for the enforcement of exhaustion clauses include (1) restricting the risk undertaken by excess insurers; (2) assuring excess insurers only pay for covered loss; (3) forcing insureds to litigate coverage disputes with primary insurers instead of excess insurers—a factor that impacts upon the premium charged for excess coverage; (4) avoiding collusive arrangements between primary insurers and insureds; and (5) maintaining the alignment between the primary and excess insurers in the event of a coverage dispute.

9. Those cases have found that because excess insurers have no rational basis to object to a below-limits settlement between the primary insurer and the insured, the exhaustion clause simply would not be enforced. *See, e.g.,* *Pereira v. Nat’l Union Fire Ins. Co.*, No. 04-1134 LTS, 2006 WL 1982789 (S.D.N.Y. July 12, 2006); *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483 (N.D. Ohio 2006); *Kelly Co., Inc. v. Cent. Nat’l Ins. Co. of Omaha*, 662 F. Supp. 1284 (E.D. Wis. 1987); *Stargatt v. Fid. & Cas. Co. of N.Y.*, 67 F.R.D. 689 (D. Del.

courts' failure or refusal to apply the exhaustion language contained in the excess insurance policies according to its plain meaning. For example, in *Pereira v. National Union Fire Insurance Co.*, the court refused to enforce an exhaustion clause in the excess policy, finding such an interpretation would "work a [similar] hardship on the insured."<sup>10</sup> Similarly, in *Reliance Insurance Co. v. Transamerica Insurance Co.*, the Florida appellate court, while acknowledging criticisms of the *Zeig* decision, "aligned" itself with the *Zeig* holding and rejected the excess insurer's argument an exhaustion clause should be enforced as written.<sup>11</sup> Moreover, in the recent case of *HLTH Corp. v. Agricultural Excess and Surplus Insurance Co.*, the Delaware Superior Court adopted the reasoning of two cases that followed *Zeig*.<sup>12</sup> In rejecting the excess insurer's arguments, the *HLTH Corp.* court refused to require the exhaustion of the underlying policies, citing public policy in favor of settlements and the unfairness of allowing excess insurers to avoid payment.<sup>13</sup>

2. *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*

On the other hand, courts have not universally followed the holding in *Zeig*.<sup>14</sup> In *Qualcomm v. Certain Underwriters at Lloyd's, London*, the Fourth District California Court of Appeal considered whether excess insurance could be triggered when the insured settled with its primary insurer without exhausting the full limits of the primary policy.<sup>15</sup> Qualcomm acknowledged in its lawsuit against its excess insurer Certain Underwriters at Lloyd's, London (Underwriters) it had reached a below-limits settlement with its primary insurer, National Union.<sup>16</sup> Qualcomm had been sued in

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1975); *Rummel v. Lexington Ins. Co.*, 945 P.2d 970 (N.M. 1997); *Reliance Ins. Co. v. Transam. Ins. Co.*, 826 So. 2d 998 (Fla. Dist. Ct. App. 2001).

10. *Pereira*, 2006 WL 1982789, at \*7.

11. *Reliance Ins.*, 826 So. 2d at 999-1000.

12. No. 07C-09-102 RRC, 2008 WL 3413327 (Del. Super. July 31, 2008).

13. *Id.* at \*8. In reaching this conclusion, the court specifically rejected the reasoning offered in the *Qualcomm* and *Comerica* cases (discussed *infra* notes 14 and 15 and accompanying text). *Id.* at \*15.

14. See, e.g., *Comerica, Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (noting a decision that follows *Zeig* would require the court to rewrite the contract between the parties); *Wright v. Newman*, 598 F. Supp. 1178, 1197 (W.D. Mo. 1984) ("I could not very well apply *Zeig's* reasoning here, even if I personally accepted that reasoning, since to do so would appear to run headlong into the clear Colorado rule an insurance policy must generally be enforced as written"); *U.S. Fire Ins. Co. v. Lay*, 577 F.2d 421, 423 (7th Cir. 1978) (noting there exist good reasons for the excess insurer to want its exhaustion clause enforced by the courts); *Johnson v. Milgo Indus., Inc.*, 458 F. Supp. 297 (D. Minn. 1978).

15. *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 73 Cal. Rptr. 3d 770 (Ct. App. 2008).

16. *Id.* at 773. In this particular insurance tower, National Union agreed to insure the first \$20 million of Qualcomm's loss. Underwriters agreed to insure the next \$20 million of Qualcomm's loss, which was excess of the first \$20 million. *Id.*

a number of class action lawsuits arising out of the vesting of Qualcomm stock options.<sup>17</sup> Its total loss relating to the defense and settlement of these lawsuits was approximately \$29 million.<sup>18</sup>

National Union, which issued a \$20 million primary policy to Qualcomm, raised certain coverage defenses and refused to fund Qualcomm's defense of the claims. Thereafter, the parties mediated their dispute and reached an agreement whereby National Union would pay up to \$16 million of Qualcomm's settlement and defense costs in exchange for a release of any further obligation for this loss.<sup>19</sup> Qualcomm then sought coverage for the remaining liability from Underwriters and demanded they pay all of Qualcomm's loss in excess of the \$20 million primary policy. Underwriters refused to provide coverage, citing the exhaustion language in their excess policy, which required the primary insurer (i.e., National Union) to have either paid or "been held liable to pay" the *full underlying limits* of liability.<sup>20</sup> Underwriters also pointed to the maintenance clause in the excess policy, which required Qualcomm to "maintain" the full limits of liability of the underlying coverage as a condition precedent to excess coverage.<sup>21</sup> In a demurrer (motion to dismiss) Underwriters argued Qualcomm's settlement compromise with National Union had breached both the exhaustion clause and the maintenance clause.<sup>22</sup>

The trial court sustained Underwriters' demurrer, dismissing Qualcomm's lawsuit without the opportunity to replead. The trial court found Qualcomm had breached the maintenance clause in the excess policy by reaching a below-limits compromise with National Union. Qualcomm appealed.

On appeal, the appellate court declined to rule on the trial court's enforcement of the maintenance clause but instead focused on the excess policy's exhaustion clause. The clause provided, "Underwriters shall be liable *only* after the insurers under each of the Underlying policies have paid or have been held liable to pay the full amount of the Underlying limit of liability."<sup>23</sup> Qualcomm argued the appellate court should follow what it called a "majority rule" arising out of the *Zeig* decision and its progeny and decline to enforce the exhaustion clause.<sup>24</sup> Qualcomm contended it purchased the excess coverage and settled its case with National Union

17. *Id.*

18. *Id.* at 774.

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.* at 778.

24. *Id.* at 780.

in reliance upon the *Zeig* rule, which it argued required the courts to interpret exhaustion clauses in a manner that permitted below-limits settlements with primary insurers.<sup>25</sup>

The California Court of Appeal disagreed and refused to find *Zeig* and its progeny created an ambiguity in Underwriters' excess policy.<sup>26</sup> Instead, the court held that before Qualcomm's reasonable expectations could be considered, Qualcomm must first identify an ambiguity in the exhaustion clause.<sup>27</sup> Since there was no ambiguity in the exhaustion clause that, in turn, would support Qualcomm's argument the excess coverage could be triggered after Qualcomm had entered into a below-limits settlement with National Union, the appellate court concluded Qualcomm's subjective beliefs and/or expectations in this regard were irrelevant.<sup>28</sup>

The appellate court further rejected the *Zeig* court's interpretation of the term "payment," calling it "strained,"<sup>29</sup> and rejected the notion that Qualcomm could reasonably rely upon the rule in *Zeig* when settling with National Union, noting the numerous decisions rejecting the *Zeig* holding in favor of applying the language contained in the exhaustion clauses of excess policies pursuant to their plain meaning.<sup>30</sup>

The *Qualcomm* court also refused to rely on the *Zeig* court's public policy considerations instead of the plain meaning of the language contained in the excess policy, noting if the language in an insurance contract is unambiguous, the court will not rewrite it "for any reason."<sup>31</sup> The *Qualcomm* court stated that imposing an obligation on all excess insurers contrary to the language and intent of their respective excess policies of insurance would be contrary to California law.<sup>32</sup> Accordingly, the California court rejected Qualcomm's call to place policy considerations such as the promotion of settlements ahead of the unambiguous agreement of the parties.

The *Qualcomm* decision is one of the most recent decisions to address (and reject) *Zeig* and its progeny. Given the split in authority among jurisdictions, there can be no doubt the debate over how to construe exhaustion clauses in excess policies will continue for some time.

#### *B. Recent Developments in the Enforcement of Notice and Cooperation Clauses*

In addition to public policy arguments, like those advanced in *Qualcomm*, an additional basis upon which some insureds argue their failure to com-

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25. *Id.*

26. *Id.*

27. *Id.* at 783.

28. *Id.*

29. *Id.* at 780.

30. *Id.* at 782.

31. *Id.* at 786.

32. *Id.*

ply with a policy condition should not bar coverage is the proposition the insurer was not prejudiced by the breach of condition. Two recent developments in New York law directly address this issue. First, the New York legislature recently enacted a statute requiring an insurer, under certain circumstances, to make a showing of prejudice before it can deny coverage based upon an insured's failure to provide timely notice of a claim.<sup>33</sup> Second, the court in *Vigilant Insurance Co. v. Bear Stearns Companies, Inc.* held an insured's failure to obtain the consent of its insurer prior to settling an underlying claim barred coverage, regardless of whether the insurer was prejudiced by the insured's failure to obtain consent.<sup>34</sup>

1. New York Legislation Requiring an Insurer to Prove Prejudice to Support a Denial of Coverage Based on Late Notice

New York courts long have held an insurer may deny coverage for any claim not submitted in a timely fashion regardless of whether the insurer could show it was prejudiced by the delay.<sup>35</sup> The New York legislature recently changed this rule and on July 23, 2008, New York Governor David A. Paterson signed a bill requiring an insurer, under certain circumstances, to make a showing of prejudice before it can deny coverage based upon an insured's failure to provide the insurer with timely notice of a claim. The new statute, effective as of January 17, 2009, limits an insurer's ability to deny coverage where the insured fails to promptly notify its insurer of a claim.<sup>36</sup> In doing so, the New York legislature went where it had never gone before and prescribed the circumstances when an insured's breach of a notice provision would bar coverage.

Where applicable, the statute requires an insurer to demonstrate it was prejudiced by an insured's late notice unless, prior to providing notice of the claim, the insured (1) was deemed liable in the underlying action by a court of competent jurisdiction or in binding arbitration or (2) resolved the claim or suit by settlement or other compromise.<sup>37</sup> Under those circumstances, an insurer is entitled to the irrebuttable presumption it was, in fact,

33. N.Y. Ins. Law § 3420 (McKinney 2008).

34. 884 N.E.2d 1044 (N.Y. 2008).

35. See, e.g., *Argo Corp. v. Greater N.Y. Mut. Ins. Co.*, 4 N.Y.3d 332, 339, 794 N.Y.S.2d 704, 706 (2005) ("For years the rule in New York has been that where a contract of primary insurance requires notice 'as soon as practicable' after an occurrence, the absence of timely notice . . . , as a matter of law, vitiates the contract . . . . No showing of prejudice is required."); see also *Sec. Mut. Ins. Co. of N.Y. v. Acker-Fitzsimons Corp.*, 31 N.Y.2d 436, 440, 340 N.Y.S.2d 902, 905 (1972) ("[a]bsent a valid excuse, a failure to satisfy the notice requirement vitiates the policy . . . , and the insurer need not show prejudice before it can assert the defense of noncompliance").

36. N.Y. Ins. Law § 3420 (McKinney 2008).

37. *Id.* § 3420(c)(2)(C).

prejudiced by the insured's failure to notify it of the claim and thus there is no coverage for that matter.<sup>38</sup>

## 2. *Vigilant Insurance Co. v. Bear Stearns Cos., Inc.*

In the recent decision of *Vigilant Insurance Co. v. Bear Stearns Cos., Inc.* (*Bear Stearns*), the New York Court of Appeals held an insured was not entitled to insurance coverage for a settlement with the Securities and Exchange Commission (SEC) when the insured failed to obtain the consent of its insurers before resolving the matter.<sup>39</sup> The insured, Bear Stearns, argued, *inter alia*, notwithstanding its failure to obtain its insurers' consent, it should be entitled to coverage because its insurers were not "prejudiced" by the settlement and, to the contrary, the settlement was reasonable and even favorable to it (and, by extension, to its insurers). New York's highest court disagreed with Bear Stearns and ruled in favor of the insurers.

The facts presented in *Bear Stearns* tell a familiar story. In early 2002, the SEC, the Office of the New York Attorney General, and other regulators initiated a joint investigation into several financial institutions, including Bear Stearns, which allegedly violated a variety of rules and regulations to the detriment of certain investors.<sup>40</sup> Eager to resolve the investigation, Bear Stearns executed a "settlement-in-principle" that required (a) the SEC to file a federal court action against Bear Stearns and (b) Bear Stearns to pay \$80 million without admitting or denying the SEC's allegations.<sup>41</sup> That same day, the regulators issued a press release announcing the settlement with the financial institutions, including Bear Stearns.<sup>42</sup> Several months later, consistent with the "settlement-in-principle," Bear Stearns signed a consent agreement seeking entry of a final judgment and agreeing to pay \$80 million to the regulators.<sup>43</sup>

After the consent agreement was filed, Bear Stearns—for the first time—sought the consent of its professional liability insurers to the \$80 million settlement.<sup>44</sup> The insurers, having been denied any role in the negotiations

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38. *Id.*

39. 884 N.E.2d 1044 (N.Y. 2008).

40. *Id.* at 1046.

41. *Id.*

42. *Id.*; Consent of Def. Bear, Stearns & Co. Inc., available at <http://www.sec.gov/spotlight/globalsettlement.htm>.

43. *Bear Stearns*, 884 N.E.2d at 1046. Specifically, Bear Stearns paid \$25 million as a penalty, \$25 million as disgorgement, \$25 million to fund independent research, and \$5 million for investor education. *Id.* In addition to these monetary payments, Bear Stearns agreed to be permanently enjoined from violating *NASD Conduct Rules* 2110, 2210, and 3010, and *NYSE Rules* 342, 401, 472, and 476, which govern general standards of business conduct, communications with the public, supervision of employees, and compliance with securities laws and regulations. *Id.*; Consent of Def. Bear, Stearns & Co. Inc., available at <http://www.sec.gov/spotlight/globalsettlement.htm>.

44. *Bear Stearns*, 884 N.E.2d at 1046.

with the regulators, disclaimed coverage on numerous grounds and filed a declaratory judgment action in New York state court.<sup>45</sup> Following the federal court's approval of the settlement, the insurers moved for summary judgment. They argued, *inter alia*, there was no coverage for any part of the settlement because Bear Stearns failed to obtain the insurers' consent prior to resolving the case as required by the various policies.<sup>46</sup>

In response, Bear Stearns argued it did not breach the policies because it sought the insurers' consent for the settlement before the federal court approved the settlement.<sup>47</sup> Bear Stearns also argued it was entitled to coverage even if it failed to obtain the consent of its insurers prior to resolving the matter because the insurers were not prejudiced by the breach. Moreover, Bear Stearns contended the insurers actually benefited from the \$80 million settlement as it was "substantially reduced from the \$125 million the Regulators initially demanded."<sup>48</sup>

The trial court denied the insurers' summary judgment motion, and that position was rejected on the initial appeal, but with leave to appeal granted.<sup>49</sup> Reversing the trial and initial appellate courts, New York's highest court held Bear Stearns was not entitled to coverage for the settlement because it breached its policies when it executed the consent agreement before (a) notifying the insurers of and (b) obtaining their approval for the settlement.<sup>50</sup> The New York Court of Appeals noted Bear Stearns "did everything within its ability to settle the matter" in violation of the insurance policy even though the federal court had yet to issue the final judgment.<sup>51</sup> The court entirely ignored Bear Stearns' argument the insurers were not prejudiced by the settlement.

### C. Conclusion

These decisions illustrate the interpretation and enforcement of policy conditions can vary significantly by jurisdiction. As such, insureds must be careful to comply fully with all policy conditions or they may be found to have waived their rights to insurance recovery. Similarly, insurers must be aware of the law in each of the jurisdictions in which they issue policies to ensure a denial of coverage based upon the insured's noncompliance with a policy condition is supported by controlling law.

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45. *Id.*

46. *Id.*

47. See Brief of Defendant-Respondent at 58–59, *Vigilant Ins. Co. v. Bear Stearns Cos., Inc.*, No. 602 J60/03 (N.Y. Oct. 8, 2007).

48. *Id.* at 60.

49. *Vigilant Ins. Co. v. Bear Stearns Cos., Inc.*, 884 N.E.2d 1044, 1047 (N.Y. 2008).

50. *Id.* at 1047–48.

51. *Id.* at 1048.

III. RECENT DEVELOPMENTS IN DIRECTORS AND OFFICERS  
INSURANCE COVERAGE

Directors and officers (D&O) insurance coverage protects directors and officers of corporations and other entities against liability for claims alleging they committed wrongful acts in their capacity as company directors and officers. Corporate directors and officers face potential liability from shareholder disputes, employment litigation, and a multitude of other claims brought by creditors, competing businesses, and federal or state regulatory agencies. Given the prevalence of such claims, coverage disputes involving D&O insurance continue to be a significant source of litigation. Furthermore, considering the recent significant national economic downturn and failure of numerous financial institutions, D&O disputes likely will skyrocket in the coming years.

A. *Recent Developments Involving the Term "Loss"*

Seven years ago, in *Level 3 Communications, Inc. v. Federal Insurance Co.*, Judge Posner analyzed what constitutes a "loss" under a D&O policy and concluded an insured's settlement of a securities fraud suit did not constitute "loss" because the settlement provided restitutionary relief the court deemed to be uninsurable.<sup>52</sup> Since then, insurers and insureds alike continue to grapple with the meaning of "loss" under a D&O policy. In the past year, courts have varied in their adherence to the *Level 3* reasoning and, in doing so, further blurred the line between uninsurable restitutionary claims and insurable compensatory claims. At times, courts have also interjected a *scienter* requirement, finding a settlement or judgment involving an "innocent" insured is insurable as "loss."

1. *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Co.*

In *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Co.*, the U.S. Court of Appeals for the Eleventh Circuit held claims brought pursuant to § 11 of the Securities Act of 1933 are not insurable.<sup>53</sup> In *CNL Hotels*, the insured raised \$3.1 billion in capital between 1996 and 2004 by selling shares to the public at a cost of \$20 per share. In connection with a subsequent merger, a consulting firm issued a report suggesting the shares were worth \$12 a share. Thereafter, relying on § 11, the shareholders filed a class action seeking a refund of \$8 per share to compensate them for the difference between the purchase price and the valued price of their shares. CNL Hotels agreed to pay \$35 million to the class to settle the plaintiffs' claims and, thereafter, sought reimbursement from its insurers.<sup>54</sup>

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52. 272 F.3d 908 (7th Cir. 2001).

53. No. 07-12706, 2008 WL 3823898 (11th Cir. Aug. 18, 2008).

54. *Id.* at \*1.

Adopting the reasoning in *Level 3*, the district court held the settlement payment constituted restitution and, as such, was not covered under CNL Hotels' D&O policy. The Eleventh Circuit agreed. The Eleventh Circuit expressly rejected CNL Hotels' argument that because plaintiffs did not allege fraud, it was impossible to conclude whether the money was wrongly acquired. The Eleventh Circuit explained, "[t]he return of money received through a violation of law, even if the actions of the recipient were innocent, constitutes a restitutionary payment, not a 'loss.'"<sup>55</sup>

The Eleventh Circuit also rejected CNL Hotels' argument that § 11 damages are, by nature, compensatory. Specifically, CNL Hotels argued damages under § 11 are measured by the difference between the price the plaintiff paid for the security and its value at the time the lawsuit was filed. As such, according to CNL Hotels, the statute focuses on the plaintiff's loss. The Eleventh Circuit explained, while CNL Hotels was correct that § 11 damages are measured by the plaintiff's loss, "the loss to the plaintiff is equal to the gain of the defendant."<sup>56</sup> As such, § 11 does not preclude restitutionary relief. Because CNL Hotels benefited directly from the alleged violation of § 11, CNL Hotels' return of the benefit to plaintiffs was not insurable.

2. *National Union Fire Insurance Co. of Pittsburgh, Pa. v. U.S. Bank, N.A.*

Likewise, in *National Union Fire Insurance Co. of Pittsburgh, Pa. v. U.S. Bank*, the U.S. District Court for the Southern District of Texas held a judgment against a former chief executive officer (CEO) arising out of his termination from the company did not constitute a "loss" under a D&O policy.<sup>57</sup> In the case, the board of directors terminated the CEO in January 2002.<sup>58</sup> Despite the termination, the board agreed the CEO could remain in his position until March 2002. At that time, he would "resign," but his resignation would be treated as a "termination without cause," triggering the payment of \$3,000,000 in severance payments.<sup>59</sup> The company ultimately filed for bankruptcy relief under Chapter 11. In a later adversary proceeding, a liquidating trustee successfully argued that because the CEO resigned, he was not entitled to the severance payments.<sup>60</sup>

When the trustee sued the CEO to recover the severance payments, the CEO made a claim under the company's D&O policy. The insurer defended the action subject to a reservation of rights.<sup>61</sup> After judgment

55. *Id.* at \*3.

56. *Id.*

57. No. 4:07-CV-1958, 2008 WL 2405975, at \*5 (S.D. Tex. June 11, 2008).

58. *Id.* at \*1.

59. *Id.*

60. *Id.* at \*2.

61. *Id.*

entered against the CEO in excess of \$2 million, the insurer sought a declaration the judgment was not covered under the D&O policy. The district court agreed for two reasons: first, the judgment did not constitute “loss” under the D&O policy; and second, the “profit and advantage” exclusion barred coverage. First, relying on the “teachings” of *Level 3*, the district court concluded since the CEO was never entitled to the severance payments, the repayment of those monies did not qualify as an insurable “loss.”<sup>62</sup> Alternatively, the district court found the D&O policy’s profit and advantage exclusion—which bars coverage for an insured’s gaining of a profit and advantage to which he was not legally entitled—precluded the CEO’s claim for coverage because the judgment deprived the CEO of the benefit of his unlawful act.<sup>63</sup>

3. *Bank of America Corp. v. SR International Business Insurance Co. SE*

Other courts have held to the contrary, finding the payment of settlements or judgments does, in fact, constitute a “loss” under a D&O policy. For instance, in *Bank of America Corp. v. SR International Business Insurance Co. SE*, a North Carolina state court held the insured’s settlement of §§ 11 and 12 claims constituted an insured “loss” under a professional liability policy.<sup>64</sup> The North Carolina court rejected the insurer’s argument the settlement was restitutionary. In the underlying action, the plaintiffs alleged the insured bank (BOA) caused financial loss to the plaintiffs in connection with two bond offerings by Worldcom.<sup>65</sup>

The plaintiffs alleged BOA, in its capacity as an underwriter, not only failed to conduct a reasonable investigation into the validity of the registration statements but also negligently included misrepresentations in these statements.<sup>66</sup> Relying on the *Level 3* reasoning, the insurer maintained the court should adopt a public policy rendering § 11 claims uninsurable. In response, the insured argued that *Level 3* was not applicable because BOA was not the issuer of the securities, nor did it receive any money from the plaintiffs. In other words, the claim was not for restitution because the plaintiffs did not seek the return of money from BOA. The insurer countered that, due to BOA’s negligence, WorldCom was able to make payments to BOA on outstanding loans and, absent the negligent misrepresentations, BOA would not have received the payments from World-

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62. *Id.* at \*5.

63. *Id.* at \*6–7.

64. No. 05 CVS 5564, 2007 WL 4480057 (N.C. Super. Dec. 19, 2007).

65. *Id.* at \*2.

66. *Id.*

Com. The North Carolina court disagreed and held the payments were “loss” because they were for the repayment of legitimate debt and not the product of an ill-gotten gain.<sup>67</sup>

4. *Acacia Research Corp. v. National Union Fire Insurance Co.*

Likewise, the U.S. District Court for the Central District of California, in *Acacia Research Corp. v. National Union Fire Insurance Co.*,<sup>68</sup> found an insured’s settlement to avoid the expense of defending against a lawsuit constituted covered “loss” under the policy. In *Acacia Research*, an officer was sued for, among other things, breach of fiduciary duty and patent infringement in connection with his development of certain technology that was subsequently assigned to his employer. Given the expense of the litigation, the company settled the plaintiff’s claims. Pursuant to the settlement agreement, the company paid stock to the plaintiff, as well as royalties on three patents.<sup>69</sup> The company then sought reimbursement for the settlement under its D&O policy. The insurer took the position the payment did not constitute “loss” because the company was merely paying for property it had wrongfully acquired, i.e., the patents.<sup>70</sup>

The district court rejected the insurer’s argument finding, because the plaintiff acknowledged the company owned all rights in the patents and the disputed technology, the settlement was not for restitution. Moreover, the district court found the company’s purported innocence in the underlying litigation distinguished the case from *Level 3* because, in *Level 3*, the plaintiff made no attempt to show the suit was groundless or that the settlement was merely an effort to avoid the expense of litigation.<sup>71</sup>

B. *Recent Developments Involving Insured versus Insured Exclusions in D&O Policies*

Most D&O policies include an “insured versus insured” exclusion,<sup>72</sup> which bars coverage for claims against directors and officers brought “by the company or on behalf of the company.” As evidenced by the numerous decisions interpreting the applicability of such Insured v. Insured Exclusions, disputes continue to arise between insurers and insureds as to the scope of the exclusion in the insolvency context.

67. *Id.* at \*14.

68. No. SACV 05-501, 2008 WL 4179206 (C.D. Cal. Feb. 8, 2008).

69. *Id.* at \*4.

70. *Id.* at \*5–6.

71. *Id.* at \*14.

72. Referred to herein as an “Insured v. Insured Exclusion.”

1. *In re Laminate Kingdom, LLC*

For example, in *In re Laminate Kingdom, LLC*, a bankruptcy trustee asserted claims against a former board member for breach of fiduciary duties, constructive fraud, and aiding and abetting breach of fiduciary duties.<sup>73</sup> The former board member tendered the claim and sought coverage under a D&O policy.<sup>74</sup> The insurer argued since the claims accrued before the bankruptcy filing and because the trustee stood in the shoes of the insured debtor, the claims belonged to the insured debtor and triggered the Insured v. Insured Exclusion.<sup>75</sup> The U.S. Bankruptcy Court for the Southern District of Florida disagreed, reasoning a bankruptcy trustee prosecutes claims on behalf of the estate and for the benefit of creditors, not on behalf of the debtor.<sup>76</sup> That said, the court cautioned if the trustee's recovery were sufficient to satisfy all of the creditor's claims with a surplus for the debtor, an Insured v. Insured Exclusion could bar coverage for any surplus amount.<sup>77</sup>

2. *Oliver v. Indian Harbor Insurance Co.*

In contrast, the U.S. District Court for the Northern District of Illinois, in *Oliver v. Indian Harbor Insurance Co.*,<sup>78</sup> considered the applicability of an Insured v. Insured Exclusion in the context of a receivership. In *Oliver*, a receiver alleged a director/officer abdicated his fiduciary duties, resulting in the misappropriation of millions of dollars from the company's clients.<sup>79</sup> Refusing the director's/officer's request for coverage, the insurer argued since the claim was brought by one insured (the receiver) against another insured (the director/officer), an Insured v. Insured Exclusion barred coverage. In response, the insured argued the claims were brought on behalf of the company's investors, not the company itself, and, therefore, the Insured v. Insured Exclusion did not apply. Rejecting the insured's argument, the district court found the receiver was appointed to conserve and preserve the assets of the company, which also has the effect of benefiting investors and creditors. Although any recovery to a corporation in receivership benefits the investors, the receiver is necessarily benefiting the corporation. Given the receiver's only goal in bringing the action was to maximize the value of the company, its claims were brought on behalf of the company and were barred by an Insured v. Insured Exclusion.<sup>80</sup>

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73. No. 07-10279, 2008 WL 704396 (Bankr. S.D. Fla. Mar. 13, 2008).

74. *Id.* at \*1.

75. *Id.* at \*2.

76. *Id.* at \*5.

77. *Id.*

78. No. 07 C 5002, 2008 WL 565514 (N.D. Ill. Feb. 27, 2008).

79. *Id.* at \*1.

80. *Id.* \*3.

3. *Federal Insurance Co. v. Surujon*

Likewise, in *Federal Insurance Co. v. Surujon*, the U.S. District Court for the Southern District of Florida found an Insured v. Insured Exclusion barred coverage for claims asserted by a reorganized debtor against its former officers.<sup>81</sup> In *Surujon*, the insured debtor's confirmation plan provided for the assignment of certain litigation rights to the reorganized debtor.<sup>82</sup> Post-confirmation and pursuant to the assignment, the reorganized entity asserted claims against the former officers of the company, who, in turn, asserted claims under their D&O policy. The insurer maintained since the reorganized entity was asserting the rights of the prebankruptcy entity, an Insured v. Insured Exclusion barred coverage for the claims. The district court agreed, although it recognized other courts had reached different results in the context of a liquidating trust, receiver, or bankruptcy trust.<sup>83</sup> Given the plain language of the exclusion, however, the district court found the Insured v. Insured Exclusion applied.

4. *Strange v. Genesis Insurance Co.*

Courts continue to analyze capacity-related issues in determining the applicability of an Insured v. Insured Exclusion. For example, in *Strange v. Genesis Insurance Co.*, the U.S. District Court for the District of Massachusetts held claims asserted by a stockholder of the company were barred by an Insured v. Insured Exclusion and rejected the insured's argument that because the exclusion only barred claims brought by "security holders," stockholder claims should not fall within the scope of the exclusion.<sup>84</sup> The insured argued stockholders should not be considered "security holders" under an Insured v. Insured Exclusion because the term "security" was ambiguous.<sup>85</sup> The district court rejected the insured's argument and found an Insured v. Insured Exclusion barred coverage for actions brought by holders of security interests, as well as holders of the company's stock.<sup>86</sup>

5. *Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.*

Similarly, the New York appellate court in *Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.* suggested the Insured v. Insured Exclusion would not bar coverage where insured directors or officers asserted claims against their company in their individual capacities.<sup>87</sup>

81. No. 07-22819-CIV, 2008 WL 2949438 (S.D. Fla. July 29, 2008).

82. *Id.* at \*6.

83. *Id.* at \*6, n.5.

84. 536 F. Supp. 2d 71 (D. Mass. 2008).

85. *Id.* at 75.

86. *Id.*

87. 859 N.Y.S.2d 174 (App. Div. 2008).

Although the state court did not analyze the issue in detail, the language suggests, where directors/officers are suing a company in their individual capacities—perhaps as shareholders—the Insured v. Insured Exclusion does not apply.<sup>88</sup>

*C. Recent Developments Involving the Term “Arising”*

The term “arising” frequently appears in D&O policy exclusions. For example, many D&O policy exclusions bar coverage for claims “arising out of” or “arising from” pollution-related events, bodily injury, and/or the insured’s professional services. As the following decisions illustrate, courts continue to interpret the term “arising” very broadly, thereby barring coverage for many D&O claims.

1. *MDL Capital Management, Inc. v. Federal Insurance Co.*

For example, in *MDL Capital Management, Inc. v. Federal Insurance Co.*,<sup>89</sup> the U.S. Court of Appeals for the Third Circuit held an exclusion barring coverage for claims “arising from” the insured’s professional services applied to claims against the company’s directors.<sup>90</sup> The insured directors argued because the complaint alleged wrongdoing arising out of their capacity as directors of the company, the D&O policy afforded coverage.<sup>91</sup> Rejecting the insured’s argument, the Third Circuit held the phrase “arising from” had a meaning similar to “but for” causation.<sup>92</sup> Because the claims would not have arisen “but for” the insured’s provision of professional services, the professional services exclusion barred coverage.<sup>93</sup>

2. *Spirtas Co. v. Federal Insurance Co.*

In *Spirtas Co. v. Federal Insurance Co.*, the U.S. Court of Appeals for the Eighth Circuit analyzed the scope of the phrase “arising from” in a breach of contract exclusion.<sup>94</sup> In the underlying lawsuit, the plaintiff alleged the insured breached its duties under a subcontract. The plaintiff also asserted equitable claims related to the contract, namely, claims for wrongful conversion, implied trust, and unjust enrichment. The insured argued the policy’s breach of contract exclusion, which contained “arising from” language, did not apply to the equitable claims. More specifically, the insured

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88. *Id.* Given the appellate court’s lack of analysis on this issue, as well as substantial contrary authority, it is difficult to determine what, if any, precedential value this decision will have.

89. No. 06-4815, 2008 WL 876406 (3d Cir. Apr. 2, 2008).

90. *Id.* at \*4.

91. *Id.*

92. *Id.*

93. *See id.*

94. 521 F.3d 833 (8th Cir. 2008).

argued because the exclusion contained “arising from” language, the exclusion did not apply.<sup>95</sup>

According to the insured, the insurer’s use of the phrase “arising from”—as opposed to the purportedly broader phrase “arising out of”—limited the scope of the exclusion. Rejecting this argument, the Eighth Circuit found all of the claims arose out of the contractual relationship between the parties and, as such, the contract exclusion barred coverage.<sup>96</sup> In so holding, the *Spartas* court relied upon a California decision that held the phrases “arising out of” and “arising from” “broadly link[] a factual situation with the event creating liability, and connote[] only a minimal casual connection or incidental relationship.”<sup>97</sup> As such, the *Spartas* court concluded it was irrelevant whether the exclusion contained the “arising out of” or “arising from” language.<sup>98</sup>

3. *Greektown Casino, LLC v. Zurich American Insurance Co.*

Lastly, in *Greektown Casino, LLC v. Zurich American Insurance Co.*, the U.S. District Court for the Eastern District of Michigan interpreted the breadth of the phrase “arising out of.”<sup>99</sup> In *Greektown Casino*, the plaintiff in the underlying action alleged breach of contract claims against the insured.<sup>100</sup> Because the insured denied he was a party to the contract, he argued the policy’s exclusion barring coverage for claims “arising out of” breaches of contract was inapplicable.<sup>101</sup> The district court reasoned that although his participation may be relevant to the merits of the underlying claim, the contract exclusion still barred coverage.<sup>102</sup> The district court expressly noted the U.S. Court of Appeals for the Sixth Circuit had held the phrase “arising out of” is ordinarily understood to mean “originating from,” “having its origin in,” “growing out of,” “flowing from,” or, in short, “incident to or having a connection with.”<sup>103</sup> Unlike in *MDL Capital Management* and *Spartas*, the plaintiff’s claims in *Greektown Casino* were limited to those for breach of contract. *Greektown Casino* is noteworthy, however, as the district court took an opportunity to set forth an expansive interpretation of the phrase.

95. *Id.* at 836.

96. *Id.*

97. *Id.* (quoting *Acceptance Ins. Co. v. Syufy Enters.*, 81 Cal. Rptr. 2d 557, 561 (Ct. App. 1999)).

98. *Id.*

99. No. 07-CV-13583, 2008 WL 597814 (E.D. Mich. Feb. 29, 2008).

100. *Id.* at \*1.

101. *Id.* at \*6.

102. *Id.*

103. *Id.* (citing *Assurance Co. of Am. v. J.P. Structures, Inc.*, 132 F.3d 32, 1997 WL 764498, at \*5 (6th Cir. 1997)).

IV. RECENT DEVELOPMENTS INVOLVING COVERAGE  
FOR LOSSES CAUSED BY HURRICANE KATRINA

In 2005, Hurricane Katrina caused widespread property damage in the City of New Orleans, where levees failed and flooded the city, and on the Louisiana and Mississippi coasts, where hurricane winds pushed a towering wall of water inland. Given Katrina's widespread destruction, it should be no surprise that years later, insurers and insureds were still embroiled in coverage disputes relating to the storm's damage.

A. *Recent Developments Involving the Term "Flood"*

Since many property insurance policies contain exclusions that bar coverage for water damage, a number of insureds sought insurance coverage for the extensive water damage caused by Hurricane Katrina on the grounds (1) the cause of their damage was the negligent design, construction, and maintenance of the levees and, therefore, their claims were covered because their policies did not expressly exclude coverage for floods resulting from human negligence; and (2) the flood exclusions in their policies were ambiguous because they did not define the term "flood" and, therefore, the exclusions must be interpreted in favor of coverage.

1. *In re Katrina Canal Breaches Consolidated Litigation*

Insureds filed most of these lawsuits in Louisiana state courts, and their insurers removed the lawsuits to federal court on diversity grounds. All of the cases were consolidated to Judge Stanwood Duval in the Eastern District of Louisiana in order to achieve a uniform result on an important issue affecting so many people.<sup>104</sup> The substantially similar policy exclusions all barred coverage for property damage caused by "water." The policies generally defined the term "water" to mean "[f]lood, surface water, waves, tides, tidal waves, overflow of any body of water, or their spray, all whether driven by wind or not." None of the policies defined the word "flood."

In a lengthy opinion, Judge Duval found the word "flood" was ambiguous because it could be reasonably interpreted to mean either (1) a flood that occurred solely due to natural causes or (2) a flood that occurred due to natural causes and/or other forces such as negligence of man.<sup>105</sup> Thus, unless the policy clearly excluded all property damage caused by a flood, regardless of whether the flood was caused by natural causes or external

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104. *In re Katrina Canal Breaches Consol. Litig.*, 466 F. Supp. 2d 729 (E.D. La. 2006), *aff'd in part, vacated in part*, 495 F.3d 191 (5th Cir. 2007), *cert. denied*, 128 S. Ct. 1230 (2008).

105. *Id.* at 756.

forces, this ambiguity rendered the exclusion inapplicable for cases where the insured could prove the New Orleans flooding was caused by negligence in the design, construction, and/or maintenance of the failed levees. On an expedited interlocutory appeal, the U.S. Court of Appeals for the Fifth Circuit reversed and held, as a matter of Louisiana law, the word “flood” was unambiguous and encompassed all floods, regardless of the cause of the flood.<sup>106</sup>

2. *Sher v. Lafayette Insurance Co.*

Nonetheless, Louisiana insureds still held out hope. Several cases addressing the interpretation of the term “flood” still were pending in the Louisiana state courts. One such case, *Sher v. Lafayette Insurance Co.*,<sup>107</sup> where the insured sought coverage for water damage to his five-unit apartment building, reached the Louisiana Supreme Court.<sup>108</sup>

On April 8, 2008, the Louisiana Supreme Court rendered its decision in *Sher*, reversing the lower courts and putting an end to the insureds’ hopes of a judicial ruling the term “flood” was ambiguous. In a brief and direct opinion, the Louisiana Supreme Court held, under settled principles of policy interpretation, the undefined term “flood” should be given its plain, ordinary, and generally prevailing meaning. As the supreme court explained, “the entire English-speaking world recognizes a flood is the overflow of a body of water causing a large amount of water to cover an area which is usually dry land.”<sup>109</sup> While the supreme court agreed with the lower courts’ position that ambiguous policy provisions should be construed against the insurer, it held the interpretation of the term “flood” proffered by the insureds—that the flood must result entirely from natural causes—was not reasonable.<sup>110</sup> The court based its holding, in part, on the fact that it found no indication within the policy the parties intended such a restrictive meaning, and, thus, the use of such an alternative definition was *per se* unreasonable.<sup>111</sup>

The Louisiana Supreme Court also found, even if the term “flood” meant only naturally occurring floods, the cause of the floods at issue was Hurricane Katrina, not the levees that failed to prevent the flood.<sup>112</sup> The

106. *In re Katrina Canal Breaches*, 495 F.3d 191.

107. 988 So. 2d 186 (La. 2008).

108. Meanwhile, proceedings in *In re Katrina Canal Breaches*, now back before Judge Duval, were stayed pending the outcome in *Sher*. Because the issue was one of state law, federal courts would be *Erie*-bound to follow any decision reached by the Louisiana Supreme Court, regardless of any conflict with the decision of the Fifth Circuit.

109. *Sher*, 988 So. 2d at 194.

110. *Id.* at 193.

111. *Id.* at 195.

112. *Id.*

court further noted its reasoning was supported by cases from the Fifth Circuit and the Colorado Supreme Court.<sup>113</sup>

3. *Northrop Grumman Corp. v. Factory Mutual Insurance Co.*

In another Hurricane Katrina case, *Northrop Grumman Corp. v. Factory Mutual Insurance Co.*, the insured argued the flood exclusion in its excess policy did not bar coverage for damage suffered at its Mississippi shipyards as the result of the twenty-two-foot-high Hurricane Katrina storm surge.<sup>114</sup> Northrop sued its insurer, Factory Mutual, in California state court, but Factory Mutual removed the case to federal court. The U.S. District Court for the Central District of California found the flood exclusion ambiguous because it did not plainly and clearly reference hurricanes or damage caused by wind. Factory Mutual appealed and the Ninth Circuit reversed. Much like the Fifth Circuit and the Louisiana Supreme Court, the U.S. Court of Appeals for the Ninth Circuit held the ordinary, plain meaning of the word “flood” encompassed the water damage to Northrop’s shipyards.<sup>115</sup>

The Ninth Circuit then addressed Northrop’s argument the flood exclusion in its excess policy was rendered ambiguous because, while in other respects similar to the exclusions addressed in the *In re Katrina Canal Breaches* and *Sher* cases, the exclusion omitted the phrase “whether driven by wind or not.”<sup>116</sup> Northrop contended, due to this omission, the policy did not exclude wind-driven flood damage such as a storm surge. Northrop argued the omission was particularly significant because its primary policy, also written by Factory Mutual, did contain the phrase “whether driven by wind or not.”<sup>117</sup>

The Ninth Circuit was not convinced. The court of appeals concluded that a difference in definition of a term between a primary and an excess policy does not in itself create ambiguity.<sup>118</sup> The court viewed the failure to include the phrase “whether driven by wind or not” in the excess policy as “more indicative of a lack of specificity on Factory Mutual’s part than an omission evidencing its intent to narrow its exclusion.”<sup>119</sup> Further, the Ninth Circuit found Northrop had not shown it was industry custom to use the “whether driven by wind or not” phrase, and the lack of such proof

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113. *Id.* at 196 (citing *In re Katrina Canal Breaches*, 495 F.3d 191; *Kane v. Royal Ins. Co. of Am.*, 768 P.2d 678 (Colo. 1989) (a flood was caused by the failure of a dam on a man-made lake, but there was no distinction between natural and artificial floods).

114. 538 F.3d 1090 (9th Cir. 2008).

115. *Id.* at 1095.

116. *Id.* at 1096.

117. *Id.*

118. *Id.* at 1097.

119. *Id.*

weakened Northrop Grumman's argument Factory Mutual had "bucked a trend" by leaving the phrase out.<sup>120</sup> The court of appeals concluded the excess policy's flood exclusion unambiguously barred coverage for damage caused by Hurricane Katrina's storm surge.<sup>121</sup>

B. *Recent Developments in "Anti-Concurrent Cause" Provisions*

Hurricane Katrina also provided the framework for interpretation of standard "anti-concurrent cause" provisions in the context of wind and water losses. Insurers developed "anti-concurrent cause" provisions in response to numerous court decisions that used the "efficient proximate cause" doctrine to resolve coverage issues when damage is caused by two concurrent perils, one covered and one excluded. Under the "efficient proximate cause" doctrine, if the dominant and efficient cause of the loss was deemed to be a covered peril, the loss was covered, regardless of the contribution of any excluded peril to the loss.<sup>122</sup> On the other hand, "anti-concurrent cause" provisions exclude coverage when an excluded peril of whatever nature contributes to the loss, regardless of whether one peril is the efficient proximate cause.

1. *Leonard v. Nationwide Mutual Insurance Co.*

In *Leonard v. Nationwide Mutual Insurance Co.*, the U.S. Court of Appeals for the Fifth Circuit held a standard "anti-concurrent cause" provision unambiguous and enforceable under Mississippi law to contract around Mississippi's "efficient proximate cause" doctrine.<sup>123</sup> Following *Leonard*, the Fifth Circuit in *Tuepker v. State Farm Fire and Casualty Co.* held an "anti-concurrent cause" provision was unambiguous and excluded damage caused concurrently by wind (an undefined term) and water, but would not exclude damage caused exclusively by wind.<sup>124</sup>

2. *Broussard v. State Farm Fire and Casualty Co.*

In *Broussard v. State Farm Fire and Casualty Co.*, the Fifth Circuit considered a case where the Broussards, Mississippi insureds under a State Farm policy, argued their home and its contents were destroyed by Hurricane Katrina's fierce winds before the storm surge arrived.<sup>125</sup> The district court granted the Broussards judgment as a matter of law both under their named

120. *Id.*

121. *Id.* at 1098.

122. *E.g.*, *Garvey v. State Farm Fire & Cas. Co.*, 770 P.2d 704 (Cal. 1989).

123. 499 F.3d 419 (5th Cir. 2007), *cert. denied*, 128 S. Ct. 1873 (2008).

124. 507 F.3d 346, 355–56 (5th Cir. 2007).

125. 523 F.3d 618 (5th Cir. 2008).

perils personal property coverage and their "open peril" dwelling coverage. The district court submitted the case to the jury only on the question of punitive damages, which the jury then awarded.<sup>126</sup>

On appeal, the Fifth Circuit reversed and remanded. The court of appeals first held that a stipulation the hurricane caused the destruction of the Broussard's personal property was an insufficient basis for recovery under named perils personal property coverage.<sup>127</sup> Under named perils coverage, it was the insureds' burden to prove their assertion that their personal property was destroyed by wind before arrival of the storm surge.<sup>128</sup> Furthermore, while under the "open peril" dwelling coverage it was State Farm's burden to prove its contention that the loss was caused by an excluded peril, State Farm introduced sufficient expert testimony that the damage was likely caused mostly by the storm surge such that the district court should have submitted the issue to the jury for decision.<sup>129</sup>

The Fifth Circuit also vacated the punitive damages award, holding that to the extent State Farm relied upon the "anti-concurrent cause" provision in withholding payment, no punitive award was justified, given *Leonard's* holding such "anti-concurrent cause" provisions were valid and enforceable in Mississippi.<sup>130</sup>

#### V. RECENT DEVELOPMENTS IN "ADVERTISING INJURY" COVERAGE

In light of the wide array of intellectual property lawsuits filed each year, the scope of insurance coverage for such claims under the "advertising injury" provisions of standard-form commercial general liability (CGL) policies continues to generate a significant amount of insurance coverage litigation.<sup>131</sup>

##### A. *Recent Developments in Coverage for Trademark Infringement Claims*

Over the past year, a number of courts have concluded underlying trademark infringement lawsuits triggered a duty to defend pursuant to the

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126. *Id.* at 623.

127. *Id.* at 624–25.

128. *Id.* at 625.

129. *Id.* at 626–27.

130. *Id.* at 630.

131. By way of background, CGL policies provide coverage for "advertising injury," which typically is defined to include some or all of the following enumerated offenses: defamation, invasion of privacy, "misappropriation of advertising ideas or style of doing business," and "infringement of copyright, title, or slogan." In general, the insured must satisfy the following three requirements to establish coverage under a CGL policy: (1) the insured is engaged in "advertising activity;" (2) the underlying claim involves one of the enumerated "advertising injury" offenses, and (3) the "advertising injury" to the underlying plaintiff arose solely out of the insured's "advertising activities."

“advertising injury” provisions in CGL policies. Courts in the following three decisions expressly found coverage pursuant to the advertising injury offense of “infringement of title.”<sup>132</sup>

1. *Acuity v. Bagadia*

In *Acuity v. Bagadia*,<sup>133</sup> the Wisconsin Supreme Court concluded a claim alleging the insured infringed on trademarks for various software programs triggered the insurer’s duty to defend because it fell within the “infringement of title” offense.<sup>134</sup> The trademarked programs owned by Symantec® included Symantec®, Norton SystemWorks®, Norton Antivirus®, Norton Utilities®, Norton Ghost®, and Norton CleanSweep®. Each was a title employing the name brand under which the programs were sold. Courts interpreting Wisconsin case law prior to *Acuity* had held any viable business name constituted a “title” within the plain meaning of that term.<sup>135</sup> The prior Wisconsin decisions were consistent with other cases addressing the issue of whether trademark infringement is included within the “infringement of title” offense. The *Acuity* court did not reach the question of whether trademark infringement claims were also incorporated under the distinct enumerated “advertising injury” offense of “misappropriation of advertising ideas or style of doing business.”

The *Acuity* court rejected the reasoning of *Advance Watch Co. v. Kemper National Insurance Co.*,<sup>136</sup> declaring it to be an “anomaly.”<sup>137</sup> It found unpersuasive the argument that if the parties intended to insure coverage for trademark infringement, they would have expressly included the word “trademark” in the policy’s “copyright, title or slogan” provision.<sup>138</sup> Implicit in the court’s analysis was the view that it is the insurer that must delimit coverage that appears otherwise potentially available under the scope of its policy language, not the converse, as the insurers argued in *Acuity*.<sup>139</sup>

132. Such rulings may explain why a number of insurers that want to minimize the scope of coverage available under their policies for trademark infringement claims have decided to define the term “infringement of title” to include only a “literary or artistic title.” Such an approach gives rise to the argument that insurers that issued policies without such a limiting definition cannot expect them to be narrowly interpreted. *Fireman’s Fund Ins. Cos. v. Atl. Richfield Co.*, 115 Cal. Rptr. 2d 26, 33 (Ct. App. 2001) (“[A]n insurance company’s failure to use available language to exclude certain types of liability gives rise to the inference that the parties intended not to so limit coverage.”).

133. 750 N.W.2d 817 (Wis. 2008).

134. *Id.* at 826.

135. *W. Wis. Water, Inc. v. Quality Beverages of Wis., Inc.*, 738 N.W.2d 114 (Wis. Ct. App. 2007); *Charter Oak Fire Ins. Co. v. Hedeem & Cos.*, 280 F.3d 730 (7th Cir. 2002).

136. 99 F.3d 795 (6th Cir. 1996).

137. *Acuity*, 750 N.W.2d at 827 n.12.

138. *Id.* at 827.

139. See *Terra Nova Ins. Co. v. Fray-Witzer*, 869 N.E.2d 565, 574 (Mass. 2007) (“In effect, the insurers argue that the policy’s definition of injury should be read to say ‘[o]ral or written

2. *Capitol Indemnity Corp. v. Elston Self Service Wholesale Groceries, Inc.*

The U.S. District Court for the Northern District of Illinois, in *Capitol Indemnity Corp. v. Elston Self Service Wholesale Groceries, Inc.*,<sup>140</sup> found the term “title” in the phrase “infringement of title” covered falsely labeling counterfeit cigarettes under the Newport brand pursuant to a case from the U.S. Court of Appeals for the Seventh Circuit,<sup>141</sup> which held “title” could encompass any business name.<sup>142</sup>

3. *NorFab Corp. v. Travelers Indemnity Co.*

In *NorFab Corp. v. Travelers Indemnity Co.*, the U.S. District Court for the Eastern District of Pennsylvania rejected the insurer’s argument that the term “title” should be limited to “a distinctive name or designation used to identify a literary or artistic work.”<sup>143</sup> The word “title” in the phrase “infringement of title” was held ambiguous under Pennsylvania law because it had more than one contextually appropriate definition, which included “any distinctive name, appellation or epithet.”<sup>144</sup> This was in accord with the logic of an opinion from the U.S. Court of Appeals for the Third Circuit<sup>145</sup> reaching the same conclusion in interpreting the phrase “trade-marked title.”<sup>146</sup>

The district court rejected Travelers’ arguments that the pertinent phrase “PBI MATRIX®” was granted only for a design, not for a title or a name of any sort. The district court held there was no reason to read the phrase “distinctive design mark” in the complaint’s allegations as referring to the “PBI MATRIX® mark,” the ’768 mark, especially as the ’768 trademark registration gave PBI rights in the name or title of its product.<sup>147</sup>

B. *Recent Developments Involving Intellectual Property Policy Exclusions*

1. *Guaranty Bank v. Chubb Corp.*

In *Guaranty Bank v. Chubb Corp.*, Judge Posner found an intellectual property exclusion for claims involving “any intellectual property law or right . . . other

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publication of material, *the content of which* violates a person’s right of privacy.’ But . . . courts should ‘consider whether clearer draftsmanship by the insurer “would have put the matter beyond reasonable question.”’”).

140. 551 F. Supp. 2d 711 (N.D. Ill. 2008).

141. See *Charter Oak Fire Ins. Co. v. Hedeon & Cos.*, 280 F.3d 730, 736 (7th Cir. 2002).

142. *Capitol Indem. Corp.*, 551 F. Supp. 2d at 719.

143. 555 F. Supp. 2d 505, 509 (E.D. Pa. 2008).

144. *Id.* at 510.

145. See *Houbigant, Inc. v. Fed. Ins. Co.*, 374 F.3d 192, 197 (3d Cir. 2004).

146. *Id.* at 200.

147. *NorFab Corp.*, 555 F. Supp. 2d at 512.

than one described in the definition of advertising injury” barred coverage for a claim alleging the infringement of an unregistered trademark because the policy defined advertising injury to include “infringement of a registered trademark” but not the infringement of an unregistered trademark.<sup>148</sup>

2. *American Family Mutual Insurance Co. v. Roth*

Joining a multitude of decisions in which courts have narrowly construed coverage for claims alleging misappropriation of trade secrets, the Illinois appellate court in *American Family Mutual Insurance Co. v. Roth* held that an insurer had no duty to defend a claim alleging violations of the Illinois Trade Secrets Act.<sup>149</sup>

The underlying claim in *Roth* alleged the insured insurance broker improperly accessed and used American Family’s proprietary computer system software and data, which contained confidential customer lists and customer information. The Illinois court found exclusions for “any injury . . . caused by the insured, knowing . . . the act would violate the rights of another and cause such injury” or that arose from “breach of contract” or “trade secret infringement” and barred coverage for what otherwise would have been a covered claim for “invasion of privacy.”<sup>150</sup> The Illinois court based its holding on a finding there was no potential the agent’s improper acts regarding trade secret infringement were not committed without the insured “knowing” the acts would violate American Family’s rights.<sup>151</sup>

3. *Orlando Nightclub Enterprises, Inc. v. James River Insurance Co.*

Interpreting a similar exclusion, the U.S. District Court for the Middle District of Florida, in *Orlando Nightclub Enterprises, Inc. v. James River Insurance Co.*, found an exclusion for the advertising injury caused by the “knowing violation of the rights of another” did not extinguish an insurer’s duty to defend an underlying claim alleging unfair competition in violation of § 43a of the Lanham Act, the Florida Unfair Trade Practices Act, and Florida common law.<sup>152</sup> In support of its ruling, the district court found significant the insured could be found liable *without*, as the exclusion required, a finding the acts of unfair competition were caused by or at the direction of the insured with knowledge the act would violate the rights of another and would inflict “personal and advertising injury.”<sup>153</sup>

148. 538 F.3d 587, 593 (7th Cir. 2008).

149. 886 N.E.2d 1149 (Ill. App. Ct. 2008).

150. *Id.* at 1155.

151. *Id.* at 1155–56.

152. No. 6:07-cv-1121-Orl-19KRS, 2007 WL 4247875 (M.D. Fla. Nov. 30, 2007).

153. *Id.* at \*9.

The plaintiff allegedly engaged in a “bait and switch” scheme in which the beverage Rockstar was substituted for Red Bull, a name-brand energy beverage many people drink with vodka, when customers requested a Red Bull.<sup>154</sup> These allegations were mere circumstantial evidence the actions of the insured, Roxy Nightclub, were intentional, leaving a question of fact as to whether Exclusion 2(a) applied.<sup>155</sup> Finding a decision of the U.S. District Court for the Northern District of Illinois instructive,<sup>156</sup> the district court concluded Roxy Nightclub could be found liable for unfair competition even if its actions did not evidence conduct undertaken with knowledge; liability would result because the necessary elements of the cause of action did not require proof of knowing conduct.<sup>157</sup>

## VI. RECENT DEVELOPMENTS IN CONSTRUCTION DEFECT COVERAGE

A national debate continues over whether coverage is available for defective construction claims under CGL policies. As the most recent decisions demonstrate below, courts generally find coverage available when defective construction results in consequential, ancillary, and/or third-party damage. The courts’ analyses generally focus on two coverage issues: whether the damage constitutes an “occurrence” under the applicable CGL policy and, if so, whether that damage constitutes “property damage” resulting from the “occurrence.” A review of the recent case law shows a continuing and emerging trend that favors coverage for such claims.

### A. Recent Decisions Finding Coverage for Construction Defect Claims

#### 1. *U.S. Fire Insurance Co. v. J.S.U.B., Inc.*

In *U.S. Fire Insurance Co. v. J.S.U.B., Inc.*,<sup>158</sup> the Florida Supreme Court considered whether a subcontractor’s use of poor soil and improper soil compaction, which eventually caused damage to the foundation, drywall, and interior portions of a home, were covered under the contractor-insured’s post-1986 CGL policy.<sup>159</sup> After discussing how historical changes

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154. *Id.* at \*1.

155. *Id.* at \*5. Florida law on the issue remained uncertain as the Florida Supreme Court did not answer a certified question regarding the intent to injure exclusion referenced above following *Vector Prods., Inc. v. Hartford Fire Ins. Co.*, 397 F.3d 1316 (11th Cir. 2005), *voluntarily dismissed*, 933 So. 2d 1154 (Fla. 2006).

156. *Allied Ins. Co. v. Bach*, No. 05 C 5945, 2007 WL 627635, at \*2 (N.D. Ill. Feb. 27, 2007).

157. *Orlando Nightclub*, 2007 WL 4247875, at \*9–10.

158. 979 So. 2d 871 (Fla. 2007).

159. *Id.* at 874–75.

to the CGL policy broadened coverage and narrowed exclusions, the Florida court concluded a subcontractor's faulty workmanship, which unexpectedly caused damage to a completed project, constituted an "occurrence" under the policy.<sup>160</sup> In finding coverage, the Florida court focused on whether any of the damages to the home were expected from the standpoint of the insured, as opposed to basing its analysis solely on the type of property damaged (i.e., whether it was third-party property or the completed project).<sup>161</sup> Although the Florida Supreme Court acknowledged there is substantial disagreement over whether coverage exists for damage to the "work product" itself, the Florida court rejected those jurisdictions that have denied coverage for these construction defect claims.<sup>162</sup> The court reasoned such opinions erroneously emphasized "broad principles [which] categorically dismiss claims for damages" and by a misdirected focus on *what* was damaged as opposed to whether the damage was *expected*.<sup>163</sup>

The supreme court also rejected the insurer's contention that a breach of contract claim could not constitute an "occurrence," noting the CGL policy language was silent as to whether only a tort-type claim was covered.<sup>164</sup> Thus, if an insurer wished to exclude coverage for such claims, the insurer should have expressly included language excluding breach of contract claims in the CGL policy. Failure to do so, the Florida court reasoned, precluded the insurer from arguing technical legal concepts and such labels should apply to deny coverage.

Further, the court rejected the notion that to allow coverage for defective workmanship would be tantamount to converting the CGL policy into

160. *Id.* at 878–80. Several revisions through endorsements were introduced over time to narrow the policy's exclusions, including the subcontractor exception to the "your work" exclusion, which "resulted both because of the demands of the insured community (which wanted this sort of coverage) and the view of insurers that the CGL was a more attractive product that could be better sold if it contained this coverage." *Id.* at 879 (quoting 2 JEFFREY W. STEMPER, *STEMPER ON INSURANCE CONTRACTS* § 14.13[D] at 14-224.8 (3d ed. Supp. 2007)).

161. *Id.* at 883–84.

162. *Id.* at 884–86 (noting distinctions between the cases of *Travelers Indem. Co. of Am. v. Moore & Assocs., Inc.*, 216 S.W.3d 302, 309 (Tenn. 2007); *Lee Builders, Inc. v. Farm Bureau Mut. Ins. Co.*, 137 P.3d 486, 491 (Kan. 2006); *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d 65, 83 (Wis. 2004); *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 50 Tex. Sup. Ct. J. 1162, 1168 (Tex. 2007); *Wanzek Constr. Inc. v. Employers of Wausau*, 679 N.W.2d 322, 327 (Minn. 2004), which applied a broader definition of "occurrence," and the cases in *Auto-Owners Inc. Co. v. Home Pride Cos.*, 684 N.W.2d 571, 577 (Neb. 2004); *Oak Crest Constr. Co. v. Austin Mut. Ins. Co.*, 998 P.2d 1254, 1257 (Ore. 2000); *Kvaerner Metal Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co.*, 908 A.2d 888, 899 (Pa. 2006); *L-J, Inc. v. Bituminous Fire & Marine Ins. Co.*, 621 S.E.2d 33, 35–36 (S.C. 2005) (defective construction damaging the work product itself will never constitute an accident)).

163. *Id.* at 886.

164. *Id.* at 884–85.

a performance bond.<sup>165</sup> The Florida court explained a performance bond is substantively different than a CGL policy. The bond is designed to protect the *owner* of a project, whereas the CGL policy is designed to protect the *contractor*. Thus, courts that have relied on this performance bond analogy have conflated this insurance product with the CGL policy to erroneously deny coverage.

Finally, the Florida court found the CGL policy's "property damage" requirement had been satisfied because the damage to the home went beyond the faulty or defective workmanship of the subcontractor.<sup>166</sup>

## 2. *Auto-Owners Insurance Co. v. Pozzi Window Co.*

Following its decision in *J.S.U.B.*, the Florida Supreme Court in *Auto-Owners Insurance Co. v. Pozzi Window Co.*<sup>167</sup> addressed a similar coverage issue involving damaged windows under a post-1986 CGL policy.<sup>168</sup> The Florida court noted the coverage issue turned on whether the windows were damaged *before* installation or *as a result* of installation.<sup>169</sup> The supreme court, relying on *J.S.U.B.*, found a defective installation of the windows, which the builder did not intend or expect, could constitute an "occurrence" under the policy.<sup>170</sup> However, the Florida court returned the case to the Eleventh Circuit Court of Appeals for a factual determination as to whether it was the windows or their installation that caused the damage.<sup>171</sup> The court found if the windows were not defective but were damaged due to their installation, such would constitute "property damage" under the policy. However, if the windows were originally defective before installation and, thus, the claim required replacement of a defective product, that condition would not be covered as "property damage" under the policy.<sup>172</sup>

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165. *Id.* at 887–88.

166. *Id.* at 889–90. Chief Justice Lewis's concurrence agreed with the court's end result. But he warned such coverage existed primarily because of the insurance industry's haphazard changes to the CGL policy in order to appease the marketplace and make these policies more saleable. *Id.* at 891–92 (Lewis, C.J., concurring) ("However, *the insurance industry itself* created the language which has necessitated much of this at times thin and often thought-provoking interpretation by drafting CGL forms in a fashion that has pushed insureds and courts to rely on language in the exclusion to give meaning to all words in the policy and to decipher the coverage grants."). Stated otherwise, Chief Justice Lewis warned that the insurance industry could "fix" its mistakes in the future and such coverage could easily disappear.

167. 984 So. 2d 1241 (Fla. 2008).

168. *Id.* at 1243.

169. *Id.*

170. *Id.* at 1246–47.

171. *Id.* at 1248–49.

172. *Id.*

3. *Auto Owners Insurance Co. v. Newman*

In *Auto Owners Insurance Co. v. Newman*,<sup>173</sup> the South Carolina Supreme Court refined its earlier opinion in *L-7, Inc. v. Bituminous Fire & Marine Insurance Co.*<sup>174</sup> to find the alleged defective construction and installation of stucco siding that caused severe water damage to a homeowner's property was covered under the general contractor's CGL policy.<sup>175</sup> The South Carolina court relied principally on the New Hampshire Supreme Court's decision in *High Country Assoc. v. New Hampshire Insurance Co.*<sup>176</sup> In *High Country*, the New Hampshire court found coverage existed for a subcontractor's defective installation of siding that resulted in moisture seeping into a homeowner's property and that caused widespread decay of the interior and exterior walls and loss of structural integrity over a nine-year period.<sup>177</sup> The South Carolina Supreme Court in *Newman* likewise found the "continuous water intrusion into the home resulting from the subcontractor's negligence qualifie[d] as an 'accident.'"<sup>178</sup>

The *Newman* court analyzed the historical changes in the CGL policy regarding coverage for a subcontractor's work and how the exception to the "your work" exclusion actually extended coverage for a subcontractor's negligence that causes property damage.<sup>179</sup> The South Carolina court rejected the insurer's claim the insured should have expected these types of damages, finding "in the absence of any evidence otherwise, it is unreasonable to believe [the contractor] expected or intended its subcontractor to perform negligently."<sup>180</sup> The court further found that because the underlying moisture damage could not be assessed or repaired without first removing the stucco exterior, an allowance for the replacement of the defective stucco also was covered by the CGL policy as "a cost associated

173. No. 26450, 2008 WL 648546 (S.C. Mar. 10, 2008), *rehearing granted* (Aug. 22, 2008).

174. 621 S.E.2d 33 (S.C. 2005). In *L-7*, the South Carolina Supreme Court found a subcontractor's negligent road design, preparation, and construction, while potentially causing "property damage," did not warrant coverage because the damage claim did not constitute an "occurrence" under the CGL policy. *Id.* at 36. The damage was only to the work product itself and caused by faulty workmanship, which the court determined did not constitute an "accident" and, as such, the claims for the faulty work did not constitute an "occurrence" under the policy. *Id.*

175. *Newman*, 2008 WL 648546, at \*4.

176. *Id.* at \*3 (citing *High Country Assoc. v. New Hampshire Ins. Co.*, 648 A.2d 474, 476 (N.H. 1994)).

177. *High Country*, 648 A.2d 474.

178. *Newman*, 2008 WL 648546, at \*3.

179. *Id.* at \*4 (citing *French v. Assurance Co. of Am.*, 448 F.3d 693, 701 (4th Cir. 2006) (discussing evolution of the standard CGL policy and the "your work" exclusions)).

180. *Id.* at \*5.

with remedying the other property damage that resulted from an ‘occurrence.’”<sup>181</sup>

4. *Wausau Underwriters Insurance Co. v. State Automobile Mutual Insurance Co.*

The U.S. District Court for the District of New Jersey in *Wausau Underwriters Insurance Co. v. State Automobile Mutual Insurance Co.*,<sup>182</sup> applying Pennsylvania law, concluded coverage existed for damages caused by stone fascia improperly installed on the exterior of the homeowner’s property.<sup>183</sup> After analyzing Pennsylvania Supreme Court precedent, which described how fortuity affects whether there was an “occurrence,” the district court held the faulty work constituted an unexpected event and, therefore, was an “occurrence” under the CGL policy.<sup>184</sup> The district court further concluded the damage to unspecified property, the decreased value of the home, and the damage to other property in repairing or replacing the defective stone fascia constituted “property damage” under the policy.<sup>185</sup>

B. *Recent Decisions Denying Coverage for Construction Defect Claims*

1. *Essex Insurance Co. v. Holder*

The Arkansas Supreme Court, in *Essex Insurance Co. v. Holder*,<sup>186</sup> found “defective workmanship standing alone—resulting in damages only to the work product itself—is not an ‘occurrence’ under a CGL policy.”<sup>187</sup> There, homeowners brought an action against their contractor prior to the

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181. *Id.*

182. 557 F. Supp. 2d 502 (D.N.J. 2008).

183. *Id.* at 519.

184. *Id.* at 515–16 (citing Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co., 908 A.2d 888 (Pa. 2006) (finding no accident, and therefore no coverage existed, for breach of contract claims for defective work done in designing and constructing a coke oven battery); Donegal Mut. Ins. Co. v. Baumhammers, 938 A.2d 286 (Pa. 2007) (finding a coverable accident occurred in negligence suit against parents for damages resulting from their adult son’s killing of five people)).

185. *Id.* at 516–17. Although the court determined that none of the policy’s exclusions applied because damage to property other than the work product was alleged, the court explained that it could not determine which CGL policy covered the “occurrence” because the complaint failed to specify when the “property damage” occurred. Thus, the court denied the parties’ dispositive motions, noting that it did not want to encourage future plaintiffs to provide purposefully vague complaints regarding when property damage occurred. *Id.* at 518–19.

186. 261 S.W.3d 456 (Ark. 2008).

187. *Id.* at 459. The court also noted that there was a split in jurisdictions over whether defective workmanship constituted an accident under the terms of the CGL policy. *Id.* at 458 (citing United States Fid. & Guar. Co. v. Cont’l Cas. Co., 120 S.W.3d 556, 563 n.4 (Ark. 2003)).

building's completion, alleging they suffered damages resulting from the contractor's delays, employment of incompetent subcontractors, and defective or incomplete construction.<sup>188</sup> The Arkansas court noted the term "accident" under Arkansas law has been interpreted to mean "an event that takes place without one's foresight or expectation—an event that proceeds from an unknown cause, and therefore not expected."<sup>189</sup> Relying on federal precedent, the court concluded a contractor's obligation to repair its subcontractor's defective workmanship should not be deemed unexpected and, as such, any damage to the work product itself could not be considered an "accidental occurrence under the policy."<sup>190</sup> As the Arkansas court observed: "[f]aulty workmanship is not an accident; instead, it is a foreseeable occurrence, and performance bonds exist in the market place to insure the contractor against claims for the cost of repair or replacement of faulty work."<sup>191</sup>

## 2. *Stuart v. Weisflog's Showroom Gallery, Inc.*

In *Stuart v. Weisflog's Showroom Gallery, Inc.*,<sup>192</sup> a homeowner who contracted to have an addition to his home sued the contractor, claiming the latter had misrepresented its remodeling work in violation of Wisconsin's Home Improvement Trade Practices Act.<sup>193</sup> The contractor's insurer disclaimed coverage based on the "economic loss" doctrine and the fact a misrepresentation, by definition, could not constitute an "occurrence."<sup>194</sup> The Wisconsin Supreme Court agreed with the insurer, observing that a misrepresentation could not constitute an "occurrence" under the CGL policy because such conduct inherently contained an intent to induce, which could never be considered "accidental."<sup>195</sup> The Wisconsin court

188. *Id.* at 457.

189. *Id.* at 458 (citing *Cont'l Ins. Co. v. Hodges*, 534 S.W.2d 764, 765 (Ark. 1976), for definition of "accident").

190. *Id.* at 459. The court distinguished the CGL policy from a performance bond to provide a rationale for not finding coverage for a subcontractor's faulty workmanship. "[The CGL policy] is not intended to substitute for a contractor's performance bond, the purpose of which is to insure the contractor against claims for the cost of repair or replacement of faulty work. [Contractor] might have elected to purchase a performance bond to protect it from a known business risk that its subcontractor would not perform its contractual duties." *Id.* (quoting *Nabholz Constr. Corp. v. St. Paul Fire & Marine Ins. Co.*, 354 F. Supp. 2d 917, 923 (E.D. Ark. 2005)).

191. *Id.* at 460.

192. 753 N.W.2d 448, 450 (Wis. 2008).

193. *Id.*

194. *Id.* at 455–56.

195. *Id.* at 457. The U.S. District Court for the District of New Jersey in *Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Parkshore Dev. Corp.*, No. Civ. 07-1331 (D.N.J. Sept. 10, 2008), applied New Jersey law to find improperly caulked stucco and leaking windows installed by a subcontractor did not constitute an "occurrence" under a CGL policy where the faulty work

further rejected the contractor's contention a statutory violation did not meet the required level of *mens rea* to deny coverage: "To determine whether an act is accidental within the meaning of the CGL policy . . . , we need only determine whether the occurrence giving rise to the claims was an unintentional act in the sense . . . it was not volitional."<sup>196</sup>

### 3. *Lyerla v. AMCO Insurance Co.*

The U.S. Court of Appeals for the Seventh Circuit in *Lyerla v. AMCO Insurance Co.*,<sup>197</sup> applying Illinois law, held an insurer did not have to defend its insured for contractual damages arising from the insured's failure to timely complete construction of a residential property.<sup>198</sup> The Seventh Circuit noted Illinois courts, generally, "have reasoned that damage to a construction project resulting from construction defects is not an 'accident' or 'occurrence' because it represents the natural and ordinary consequence of faulty construction."<sup>199</sup> But the Seventh Circuit also recognized the national split in authority over whether defective work can constitute an "occurrence" under a CGL policy.<sup>200</sup> Indeed, the district court cited the Illinois appellate court's decisions in *Country Mutual Insurance Co. v. Carr*<sup>201</sup> and *Stoneridge Development Co. v. Essex Insurance Co.*<sup>202</sup> to show a split of authority even existed within the Illinois state courts.<sup>203</sup> Ultimately, how-

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led to damage to the work product of the insured. Although the complaint alleged misrepresentations relating to the quality of the insured's work were in violation of New Jersey's Consumer Fraud Act, similar to the case in *Weisflog*, the district court did not address whether those misrepresentations constituted an "occurrence" under the CGL policy, focusing rather on the unanswered question of what "property damage" those representations caused to find summary judgment inappropriate.

196. *Stuart*, 753 N.W.2d at 459. The district court also rejected the contractor's argument a CGL policy's property damage coverage clause must include coverage for "misrepresentation claims" because the policy's risk exclusions specifically referred to "warranties or representations." *Id.* at 460. The district court concluded a "misrepresentation" is "but a subset of 'representations'" and, further, "the representation is not required under the exclusion to be false." *Id.* at 460-61. Additionally, the district court did find the alleged mold and rot damage to the home constituted "property damage" under the policy. Nonetheless, the court concluded, despite allegations of negligence, the "your work" exclusion coupled with the products-completed operations hazard clause applied to bar coverage. *Id.* at 464.

197. 536 F.3d 684 (7th Cir. 2008).

198. *Id.* at 694.

199. *Id.* at 689.

200. *Id.*

201. *Id.* at 690 (citing *Country Mut. Ins. Co. v. Carr*, 867 N.E.2d 1157 (Ill. App. Ct. 2007) (holding damage to basement walls unexpectedly caused by contractor's backfilling constituted an "occurrence" resulting in "property damage")).

202. *Id.* (citing *Stoneridge Dev. Co. v. Essex Ins. Co.*, 888 N.E.2d 633, 654 (Ill. App. Ct. 2008) (finding that cracks that developed in home "were not an unforeseen occurrence that would qualify as an 'accident,' because they were the natural and ordinary consequences of defective workmanship")).

203. *Id.*

ever, because the underlying complaint only alleged monetary damages resulting from faulty workmanship—as opposed to faulty workmanship *that damaged actual property*—the district court reasoned whether any “occurrence” existed was irrelevant because no “property damage” was alleged to have resulted from such an “occurrence.”<sup>204</sup> Consequently, coverage was denied.

The above cases simply reinforce the obvious; the coverage issue of whether faulty or defective workmanship is covered under a CGL policy will continue to be litigated with varying results. Indeed, the results may vary not only from one jurisdiction to another but, in some instances, within the same jurisdiction. The emerging trend, however, appears to favor a finding of coverage.

VII. RECENT DEVELOPMENTS INVOLVING EVIDENTIARY  
ISSUES IN BAD FAITH LITIGATION — *RINEHART V.*  
*SHELTER GENERAL INSURANCE CO.*

Bad faith litigation, with its proclivity to generate unique factual scenarios and atypical alliances between insureds and third parties, frequently presents evidentiary challenges for both courts and attorneys. The Missouri Court of Appeals’ recent decision in *Rinehart v. Shelter General Insurance Co.* is emblematic of the type of evidentiary issues that arise in this ever-evolving area of insurance litigation.<sup>205</sup>

The *Rinehart* case arises from a 1998 automobile accident where Michael Rinehart and his passenger, Charles Adkins, collided with another vehicle, containing Renee Ingram and Kelly Krohn. Ingram, Krohn, and Adkins were all seriously injured. Shelter General Insurance Co. insured Rinehart’s vehicle under a policy with liability limits of \$50,000 per person and \$100,000 per occurrence.<sup>206</sup>

After the accident, Ingram and Krohn (Ingram/Krohn) retained an attorney. In early 1999, the attorney sent letters to Shelter General demanding \$50,000 each for Ingram and Krohn. Shelter General responded by stating it was willing to exhaust its \$100,000 per occurrence limit, but Ingram/Krohn would need to come to an agreement with Adkins regarding how the money would be divided between the three injured individuals.<sup>207</sup> Ingram/Krohn rejected this proposal.

204. *Id.* at 692–93.

205. 261 S.W.3d 583 (Mo. Ct. App. 2008).

206. *Id.* at 588.

207. *Id.* Shelter General spoke with Adkins three times during 1998 and once in the spring of 1999. Adkins, a longtime friend of Rinehart, did not retain an attorney. During those

In mid-June 1999, Ingram/Krohn's lawyer sent another letter to Shelter General demanding the \$50,000 per person policy limits be paid to Ingram/Krohn. The demand was good until August 16, 1999. Ingram/Krohn advised they would interpret a rejection of the demand as bad faith by Shelter General for refusing to settle the claims.<sup>208</sup>

Shelter General did not advise Rinehart of any of the settlement demands but, in July 1999, sent a letter to Rinehart advising that Shelter General intended to settle the Ingram/Krohn claims for two-thirds of the \$100,000 per occurrence policy limit. Although Rinehart was given twenty days to object, he never did so. In early August 1999, Shelter General extended the two-thirds offer. Ingram/Krohn rejected the offer.<sup>209</sup>

Ingram/Krohn later sued Rinehart and obtained judgments against him.<sup>210</sup> After the judgments were rendered, Rinehart entered into an agreement with Ingram/Krohn requiring Rinehart to pursue a bad faith action against Shelter General and remit all proceeds from the lawsuit, if any, to Ingram/Krohn to satisfy the outstanding judgments.<sup>211</sup>

Rinehart sued Shelter General claiming he had incurred "financial loss, damage to his credit, attorneys' fees[,] and emotional distress" due to Shelter General's bad faith refusal to settle Ingram's and Krohn's claims within the policy limit. Rinehart ultimately obtained a jury verdict against Shelter General for \$6,285,001 in compensatory damages and \$3,000,000 in punitive damages. Shelter General appealed.<sup>212</sup>

#### A. *Testimony Regarding the Underlying Settlement*

Among the evidentiary issues on appeal was the trial court's decision to allow Rinehart to testify about the settlement he reached with Ingram/Krohn, and, specifically, the emotional impact the agreement had on him.<sup>213</sup> Although the settlement agreement was made known to the jury,

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conversations, Shelter General led Adkins to believe he would not receive any payment from Shelter General in connection with the accident. As a result, Adkins never submitted a claim to Shelter General. *Id.*

208. *Id.* at 589.

209. *Id.*

210. *Id.* Ingram was awarded \$2,961,192 in damages and \$630,735 in prejudgment interest. Krohn was awarded \$874,468 in damages and \$186,690 in prejudgment interest. *Id.*

211. *Id.*

212. *Id.* In order to support a claim of bad faith, Missouri law required Rinehart to show Shelter's *mental state* in refusing to settle the accident claim. See *Zumwalt v. Utilities Ins. Co.*, 228 S.W.2d 750, 754 (Mo. 1950). The evidence must demonstrate that the insurer had "intentional disregard of the financial interests of the plaintiff in the hope of escaping the full responsibility imposed by its policy." *Id.* Circumstantial evidence is sufficient to satisfy this state of mind. *Id.*

213. *Rinehart v. Shelter Gen. Ins. Co.*, 261 S.W.3d 583, 589-90 (Mo. Ct. App. 2008).

Shelter General's counsel argued Rinehart's testimony was unfairly prejudicial since it injected issues of poverty and invoked sympathy for Rinehart as well as Ingram/Krohn, who were not parties to the lawsuit. The appellate court rejected Shelter General's argument, noting the testimony was largely cumulative of other evidence, including the settlement agreement itself, which had been admitted over Shelter General's objection.<sup>214</sup> The *Rinehart* court also concluded the testimony regarding the settlement agreement was relevant to prove the emotional distress Rinehart was claiming as part of his damages.<sup>215</sup>

*B. Evidence of Insurer's Conduct with Respect to Other Insureds*

As in many bad faith cases, Rinehart's counsel sought to establish Shelter General's bad faith by offering evidence of an unrelated instance where Shelter General had failed to make a settlement offer, thereby resulting in a sizeable judgment against an insured. Rinehart argued this evidence was relevant to establishing Shelter General's "pattern and practice" of misconduct. Conversely, Shelter General contended the evidence was unfairly prejudicial and irrelevant.

The appellate court, in affirming admission of the evidence, noted the evidence was pertinent to the issue of Shelter General's "mental state" and to Rinehart's claim for punitive damages. The *Rinehart* court noted, "Punitive damages require clear and convincing proof of a culpable mental state . . . 'by . . . 'reckless disregard for an act's consequences."<sup>216</sup> Therefore, when intent is the focus, a party's actions toward another are relevant to the inquiry.<sup>217</sup>

*C. Expert Testimony Regarding Insurer's Claims-Handling Procedures*

Shelter General also challenged the admissibility of Rinehart's expert's testimony as to Shelter General's claims-handling procedures. The ex-

214. *Id.* at 590. The Missouri court also rejected Shelter General's argument it had been prejudiced by Rinehart's testimony highlighting his destitution since the settlement agreement—the admission of which Shelter General did not appeal—allowed the jury to infer Rinehart did not have sufficient personal assets to pay the judgment. *Id.*

215. *Id.* According to the Missouri court, "Rinehart's testimony about the financial pressure he felt from the judgment, the need to pay Ingram and Krohn, and the need to provide for his family—was necessary to explain the factors causing him emotional distress as a direct result of Shelter's failure to pay the claims of the accident victims." *Id.*

216. *Id.* at 591.

217. Central to the appellate court's decision was the fact Rinehart had shown a number of similarities between the handling of his claim and the handling of the unrelated claim,

per opined Shelter General was negligent, unreasonable, and/or reckless for (a) failing to advise Rinehart of Ingram/Krohn's settlement demand; (b) not accepting what Shelter General at one point believed was an offer from Ingram/Krohn to settle for two-thirds of the \$100,000 per occurrence limit;<sup>218</sup> (c) giving Rinehart only twenty days to reject Shelter General's offer of two-thirds of the limit to settle Ingram's and Krohn's claims; and (d) only offering to settle with Ingram/Krohn for two-thirds of the limit rather than agreeing to Ingram/Krohn's limit demand. The expert concluded, "Shelter [General] intentionally disregarded Rinehart's financial interest in an attempt to escape full responsibility on his policy."<sup>219</sup>

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including, *inter alia*, the involvement of the same Shelter General claims representative in both claims. *Id.* Such an inquiry is frequently determinative of whether unrelated conduct of the insured is found to be relevant or admissible. *See Kentucky Farm Bureau Mut. Ins. Co. v. Troxell*, 959 S.W.2d 82, 85–86 (Ky. 1997) (affirming admissibility of evidence regarding insurer's handling of other claims as establishing insurer's awareness the same adjuster engaged in a pattern of using unacceptable methods in handling claims); *Moore v. Am. United Life Ins. Co.*, 150 Cal. App. 3d 610, 626, 197 Cal. Rptr. 878 (1984) (holding evidence of insurer's handling of similar claims was "relevant to the issues of whether defendant engaged in unreasonable practices. . . [.]"). *But see Nat'l Sec. Fire & Cas. Co. v. Coshatt*, 690 So. 2d 391 (Ala. 1996) (affirming trial court's decision *not* to allow evidence regarding insurer's handling of other claims). *See also Allstate Ins. Co. v. McGee*, 276 S.E.2d 108, 111 (Ga. Ct. App. 1981) (testimony regarding action of *another* insurance company in paying a similar claim admissible as pertinent to the issue of defendant insurer's bad faith).

218. The facts set forth in *Rinehart* do not address any belief on Shelter General's part that Krohn and Ingram had made an offer to settle for two-thirds of the policy limit. Presumably, this was evidence elicited through discovery and not relied on by the court in reaching its decision.

219. *Rinehart v. Shelter Gen. Ins. Co.*, 261 S.W.3d 583, 592 (Mo. Ct. App. 2008). Shelter General offered two unsuccessful arguments in response to the expert's testimony. First, Shelter General argued the expert's opinion did not comply with § 490.065 of the Revised Missouri Statutes—Missouri's evidentiary standard for the admissibility of expert testimony—because he did not testify his opinion was based on the type of information reasonably relied upon by others in the field and was otherwise reasonably reliable. Essentially, Shelter General argued the expert's testimony lacked the statutory foundation. The court rejected this argument because Shelter General had not made this objection at trial, stating, "[c]laims of inadequate foundation will not be considered for the first time on appeal." *Id.*

Shelter General's second argument focused on the expert's admission he was unfamiliar with the legal definition of bad faith in Missouri. *Id.* at 593. The court disagreed and found, regardless of whether the expert understood the legal standard to be applied, the expert confirmed there was "circumstantial evidence to support a finding the insurer intentionally disregarded Rinehart's financial interest in the hope of escaping full responsibility on his policy." *Id.* Specifically, the Missouri court held, "[t]estimony by an expert is almost always useful as to what facts are critical in the assessment of whether or not the insurer acted in bad faith." *Id.* And, relying on *Zunrath*, the Missouri court held the expert's testimony "was admissible because it addressed the factual circumstances necessary to support the mental element of Rinehart's bad faith claim." *Id.*

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The decision of the *Rinehart* appellate court to allow testimony from Rinehart's expert with respect to claims-handling issues is not anomalous, and is consistent with decisions from other jurisdictions.<sup>220</sup>

*D. Conclusion*

*Rinehart* addresses three critical categories of evidence in a bad faith case. The opinion provides a roadmap for evidence that can be admitted and gives insight into how a practitioner should go about getting that evidence in front of a court or jury.

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220. See *Safeco Ins. Co. v. Ellinghouse*, 725 P.2d 217, 225 (Mont. 1986) (the court found "no abuse of discretion in allowing attorneys to appear as expert witnesses for the purpose of stating their opinion on an insurer's duty to evaluate the facts, on what constitutes a reasonable evaluation of the facts, or on and how an insurer should have approached the negotiations with the plaintiff"); see also *Klein v. State Farm Mut. Auto Ins. Co.*, 948 P.2d 43 (Colo. Ct. App. 1997) (attorneys and former employees of the insurance industry may offer opinions regarding insurance industry standards in a bad faith case).

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