GOLDBERG SEGALLA

CaseWatch: Insurance

The latest court decisions and developments | Vol.19, No. 4

CGL EXCLUSIONS

Policyholder's Defective Window Installation Not Covered Despite Agreement With Claimant

The policyholder, a subcontractor, was sued because it installed allegedly defective windows in a condominium building construction. The defective windows allegedly resulted in water damage to the building and unit owners' personal property after a 2006 rainstorm. The policy excluded contractual liability and it contained an exclusion for "your work," among other things. The policyholder assigned its rights under the policy to the condominium association and the agreement specifically stated that coverage was not to be provided for the cost of repair or replacement of the defective windows — instead, coverage was to be provided for the resulting property damage. However, at the time the agreement was reached, the only pending claim against the policyholder was breach of implied warranty of habitability. The court noted that the measure of damages for such a claim is the cost to repair the defective condition. Thus, while the agreement intended that coverage be provided for resulting damage, such was inconsistent with the damages recoverable for the pending claim against the policyholder, which were not covered. Moreover, the court also found that resulting damage would also not be recoverable because the contractual liability exclusion bars coverage for damages arising out of the agreement with the association.

No Coverage for Property Damage Where Construction Was Completed Prior to Policy's Inception

While deciding a motion for default judgment against the policyholder in a declaratory judgment action brought by the insurer, the court addressed the merits of the insurer's claim for declaratory relief. The CGL policy contained exclusions for any damages existing prior to the date of the inception of the policy, and the excess policy followed form. The underlying complaint alleged damages regarding construction of a hotel. The policyholder's work on the hotel was completed prior to the inception of the policy, but the alleged damages manifest or were discovered during the policy period. The court found the exclusion applied to bar coverage.

EDITORS

Alex J. Yastrow
Sarah J. Delaney

CaseWatch: Insurance, a collaborative effort of Goldberg Segalla's Global Insurance Services Practice Group, provides summaries of and access to important insurance law decisions and legislation.

We appreciate your interest and welcome your feedback. Please share this publication with your colleagues.

To subscribe to *CaseWatch,* or to change subscription preferences, please contact Alex J. Yastrow.

Interactive PDF
Click on case captions, headlines, and other references for full access.

Global Insurance Services

@InsureReReport

www.InsureReReport.com

Intentional Acts Exclusion Bars Coverage for Sexual Abuse of Minor

The underlying complaint alleged that protected persons under the policy sexually abused the plaintiff, a minor. The insurer denied coverage based on an intentional act exclusion. The court found that the intentional act exclusion applied to bar coverage, citing the rebuttable presumption that sexual abuse of a minor is an intentional act. The court did note that the presumption can be rebutted by evidence that the abuser suffered from mental illness, but no such showing was made here.

DUTY TO DEFEND

College Hazing Within Coverage of Policy

A college athlete sued senior members of his team for injuries he sustained during a hazing incident, including multiple claims of intentional acts and one claim of negligence. Among the facts alleged were that he was forced to drink large quantities of liquid until he vomited. This underlying case ultimately settled. The insurer for one of the underlying defendants denied coverage based on a policy exclusion for intentional and criminal acts, and because the facts alleged did not support an "occurrence" under the policy.

Holding that the facts alleged in the underlying complaint were sufficient to support an occurrence under the policy, the court held that the insurer had a duty to defend its policyholder. The court stated that even if the act that caused the injury itself was intentional, the act could still be considered negligent under the law if the actor did not intend to produce the result that ultimately occurred.

Racial Discrimination Not an Occurrence

Plaintiffs in the underlying case, African American truck drivers, brought a suit against an insured trucking company for injuries stemming from alleged racial discrimination. The plaintiffs alleged the trucking company forced African American drivers to pay kickbacks to get assigned loads to haul in their trucks, while white drivers were not made to pay. When the plaintiffs complained, the trucking company stopped assigning them loads altogether, causing substantial economic injury. In a declaratory judgment action, the court found that the insurer did not have a duty to defend, holding that the alleged discrimination was intentional by nature and therefore not a covered "occurrence."

Similarly, the court held that the alleged actions did not trigger a duty to defend under the umbrella policy due to an exclusion for knowing violation of another's rights. Because the complaint alleged that the trucking company's intentional and knowing discriminatory conduct caused plaintiffs' injuries, and that the scheme was purposely designed to discriminate on the basis of race, the court held the company was aware it was violating the plaintiffs rights and thus the umbrella policy did not provide coverage.

Insurer Must Defend Real Estate Broker's Scheme

The policyholder's customers filed a putative class action against the policyholder, alleging a scheme in which the policyholder received secret kickback profits from the sale of reports acquired from a shell corporation that shared profits with the policyholder. The customers' allegations included breach of fiduciary duties, constructive fraud, unjust enrichment, civil conspiracy, and other state law claims.

In the declaratory judgment action, the insurer argued that each cause of action arose out of "deceptive business practices," for which the policy excluded coverage. The policyholder countered that the claims for breach of fiduciary duty and constructive fraud did not rely on a finding of deceptive business practices and accordingly were not excluded under the policy, so the insurer had a duty to defend. The court agreed that the insurer had a duty to defend, finding that the policyholder could have breached its fiduciary duties through negligence. Thus the court held the causes of action for breach of fiduciary duty and constructive fraud did not necessarily arise from the excluded deceptive business practices.

EMPLOYMENT PRACTICES/ PROFESSIONAL LINES

Professional Staffing Company's Employee Placement Constitutes "Wrongful Act"

A professional liability insurer declined to defend its policyholder after they allegedly, acting as an alter ego of a company, were sued for interfering with an employment agreement. The company and its employee at issue provided staffing services. Suit arose when the employee placed a worker with a third party company that was a client of the employee's former employer. The insurer denied coverage, asserting that the underlying claim did not allege a "wrongful act" as defined by the policy.

The Court determined that the complaint at issue did contain allegations that could constitute, possibly, "wrongful acts" as defined by the policy. The court explained that the employee's placement of a worker, while employed by the company, with a client of his former employer, along with his attempt "'to place other candidates with that customer' constitute[d] 'services provided by a staffing company to [its] client.'" The insurer argued that the complaint at issue did not allege a wrongful act because the acts at issue were not performed "in the course of providing staffing services." The court rejected the argument, looking to the plain meaning of the phrase "in the course of" and explaining that it was clear from the allegations that the employee's placement of a worker and attempt to place other candidates with the third party company occurred "during and as party of" the company's "staffing services."

ENVIRONMENTAL

Court Finds Dredging and Filling Activities Are Precluded by Pollution Exclusion

After contamination of a site, a policyholder assigned its rights to several insurance policies. The assignee thereafter sought coverage under those policies for environmental claims later brought by governmental entities. The insurers argued that since they did not consent to the assignment, and the claims had not been reduced to judgment, the assignment violated the anti-assignment clause. The court determined that anti-assignment clauses only applied to assignments prior to a loss, and did not prohibit post-loss assignments. The court further explained that since the policies were occurrence-based, and the policy periods expired prior to the assignment, the assignment of the environmental claims was effectively a post-loss assignment that did not increase or alter the risk of exposure contractually undertaken by the insurers.

Non-Cumulation Clause Equates to Anti-Stacking Provision

The insurer instituted a declaratory judgment action against the policyholder to discern whether three umbrella policies it issued to the policyholder must provide coverage for a government-ordered cleanup of state property. The policyholder filed a motion for partial summary judgment, in which it argued that the $9 million per occurrence limits of the three policies should be effectively "stacked" pursuant to the continuous trigger theory and "all-sums-with-stacking" approaches adopted by California law, to provide a total of $27 million in coverage.

Although the policies did not contain an anti-stacking provision, since the policies were issued in the 1960s and 1970s, the policies contained a non-cumulation provision. The insurer argued that this provision was the equivalent of an anti-stacking provision, which under California law precludes stacking of the respective policy limits. The court noted that other jurisdictions found that the non-cumulation provision precludes stacking, and determined that such construction gave the provision independent meaning from other language set forth in the "other insurance" clauses in the policies. As such, the court held that the non-cumulation provision was the equivalent of an anti-stacking provision, and the limits of the three separate policies could not be combined.

FRAUD

Doctors Charged in $50 Million Health Care Fraud

The U.S. Attorney's Office for the Southern District of New York recently indicted six individuals for health care fraud. These doctors defrauded Medicare, Medicaid, and several private insurance companies of over $50 million over a period of 12 years. In addition, the U.S. Attorney's Office also announced a civil lawsuit seeking damages and penalties against several clinics under the False Claims Act for fraudulent reimbursements submitted to Medicare and Medicaid over the same 12 year period.

LIFE, HEALTH, DISABILITY & ERISA/EMPLOYEE BENEFIT LIABILITY

Court Dismisses ERISA Claim for Benefits, Grants Leave to Assert Delay in Payment Claim

A plaintiff brought a case seeking benefits under a supplemental group life insurance policy governed by ERISA. After the case was initiated the insurer paid the policy proceeds. The insurer moved to dismiss based upon its payment of the policy proceeds. Plaintiff also claimed that the seven month-long delay in paying the life insurance benefits entitled her to prejudgment interest under ERISA. The court disagreed, finding that because the plaintiff did not recover a money judgment from a district court, no prejudgment interest is warranted. However, the court granted leave to amend stating that ERISA §502 permits awards of equitable relief and/or contractual damages under certain circumstances to compensate a beneficiary where there has been a delay in the disbursement of money owed under an ERISA plan.

Attempt to Regain Reimbursement Paid to Plan Requires Exhaustion

In a case brought by a policyholder under a state government health plan, the policyholder argued that she did not have to reimburse the plan for medical expenses it had paid on her behalf after she obtained a settlement to compensate for her injuries. The district court dismissed the case finding the plan unambiguously required the policyholder to exhaust her administrative remedies before filing suit. The reviewing court relied on cases which addressed language from ERISA (and not from New Jersey law) finding them persuasive because of similarities between ERISA and the state plan's terms.

The court held that ERISA, like the state plan at issue here, required administrative exhaustion of claims following an "adverse benefits determination," which under both ERISA and the state plan was defined as "[a] denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit." As such, the court held that since an ERISA plan member's attempt to regain money that the member reimbursed to a plan must be administratively exhausted under ERISA, a functionally identical claim under the state plan must also be administratively exhausted before the state plan member files in court.

PERSONAL AND ADVERTISING INJURY

Court Blows Series of Whistles Denying Sports Clothing Company's Bid for Coverage

The coverage dispute arose out of a complaint for trademark infringement and cybersquatting filed against the policyholder. Notably, the complaint requested that the policyholder cease and desist from using the terms "High Five," "High 5," or the associated handprint in connection with the policyholder's business. The complaint also contained a series of counts, including trademark infringement, cybersquatting, and deceptive trade practices.

The insurer denied coverage for the claim which lead to the policyholder's third-party complaint seeking a declaration regarding coverage under the policy. The court first concluded there was no initial grant of coverage since the complaint focused solely on the trademark claims alleged by the plaintiff; not the significantly different covered claims for slogan or trade dress infringement.

Even if there was an initial grant of coverage, two exclusions were applicable. First, since the injurious materials were published before the inception date of the policy, the prior publication exclusion barred coverage. Second, the plain language of intellectual property exclusion likewise precluded coverage.

Mortgage Scam Claim Deemed Uninsurable Under California Public Policy

In a motion for summary judgment, an insurer contended it did not have the duty to defend its policyholders in connection with a suit outlining a fraudulent mortgage modification scam targeting vulnerable homeowners filed by a homeowners' advocacy group. Specifically, the complaint alleged the policyholder engaged in bait and switch scheme which purportedly mimicked the services provided by the homeowners' advocacy group when it instead charged homeowners excessive and illegal fees to compile documents.

While the court concluded the complaint contained a possible disparagement claim, there was still no coverage because of a financial services exclusion that applied as it pertained to the planning, administering, managing, or advising on a mortgage plan. Moreover, California's public policy barred coverage since the actions undertaken by the policyholders were deemed to be willful and inherently harmful acts.

Picture Not Perfect: No Coverage Found in Suit Alleging Copyright Infringement of Photographs

The plaintiff, a sports photographer, alleges that a third party obtained unauthorized copies of his photos and directed the policyholder, a printing company, to print copies of the photos. The suit alleges the policyholder engaged in direct copyright infringement when it printed unlicensed copies of the plaintiff's copyrighted photos as well as indirect infringement when it provided the photos to the third party which were intended for usage in commercial products. On the insurer's motion for summary judgment, the Wisconsin federal district court concluded there was no coverage. The court reasoned that since the infringement did not occur in the policyholder's or the third party's advertisement, there could be personal and advertising injury. Notably, the court was not willing to strain the allegations in the complaint to find coverage.

PRIORITY OF COVERAGE/ ALLOCATION

Incorporation Clause Renders Policy Excess to Two Others

A dispute amongst three insurers concerned the allocation of settlement payment for an underlying motor vehicle accident with bodily injuries. As the underlying action neared resolution, all implicated insurers were released through settlements except for Insurers #1, #2, and #3, which agreed to fund the remaining settlement balance, but only upon a determination of the priority of coverage among their three policies.

In the coverage action, the three insurers agreed that the priority of coverage turned on an interpretation of the "other insurance" clauses of their three respective policies. The "other insurance" clauses for Insurer #1 and #2 were substantially the same, as they used common ISO form language. Insurer #3's policy, however, was quite different as it did not contain an "other insurance" clause, but incorporated one by reference from an underlying scheduled policy. Insurers #1 and #2 argued that their policies' language contained "true excess" clauses, while Insurer #3's policy contained a pro-rata provision.

But, Insurer #3 argued that its policy was actually written to be excess of other insurance and that language in Insurer #1 and #2's policies recognizes this. Alternatively, Insurer #3 argued that, at most, it should only be held to apportion its coverage with Insurers #1 and #2. Ultimately, the court found that Insurer #3's policy was "written to be excess of all other insurance coverage," and, therefore, the "other insurance" provisions of Insurer #1 and #2's policies did not apply.

REGULATORY

NAIC Appeals Covered Agreement to Treasury Secretary

On March 15, 2017, the NAIC submitted a letter to the U.S. Treasury Secretary Steven Mnuchin expressing concerns about the recently negotiated Covered Agreement between the U.S. and EU. One of the NAIC's central concerns centers on the "significant confusion among current and former government officials, insurance regulators and the industry regarding the nature of the obligations to be undertaken, the purported benefits that were gained, and the concessions that were made."

The NAIC requested that the Treasury Department "seek written clarification regarding the interpretation and application of . . . the Agreement's terms" given that state insurance regulators will be "responsible for implementing most aspects of the Agreement." This clarification would also help to determine "whether the Agreement is in the best interest of the United States insurance sector" and "ensure any implementation is consistent with the intent of those that negotiated it."

ELANY Publishes Practical Tips on Applying New York's New Cybersecurity Regulation to "Unique Situations"

March 16, 2017

On March 16, 2017, The Excess Line Association of New York (ELANY) released *Bulletin 2017-12* which contains some practical guidance for insurance producers that will face some "unique situations" not addressed in the other commentary. Specifically, the bulletin refers to insurance producers that "may not meet the technical definition of a 'Third Party Service Provider.'" However, if that producer

exchanges "nonpublic information" with a New York licensed insurer, "it is probable" that those insurers "will treat them as 'Third Party Service Providers.'" Producers treated as Third Party Service Providers may be required to "implement separate and various cybersecurity requirements adopted by each insurer subject to the regulation." A complete copy of the bulletin is located here.

Insurance Regulator Testifies at House Hearing on Cyber Insurance

The House Homeland Security Subcommittee on Cybersecurity, Infrastructure Protection and Security Technologies recently held a hearing entitled "The Role of Cyber Insurance in Risk Management." One of the four witnesses who testified at the hearing was North Dakota Insurance Commissioner and former NAIC President Adam Hamm.

Commissioner Hamm currently chairs the NAIC Cybersecurity Task Force. Among other things, he testified, "The expansion of cyber risks and the growth of the cybersecurity insurance are a tremendous opportunity for the insurance sector to lead the development of risk-reducing best practices and cyber-hygiene across our national infrastructure. Insurance has a long history of driving best practices and standardization by creating economic incentives through the pricing of products, and the underwriting process can test the risk management techniques and efficacy of a policyholder making a broader range of businesses secure." A video of the hearing is located here.

House Passes Law Repealing Anti-Trust Exemptions for Health Insurance Companies

On March 22, 2017, the House of Representatives passed H.R. 372 – Competitive Health Insurance Reform Act. If ultimately passed and signed, this bill would amend the McCarran-Ferguson Act by removing the anti-trust exemptions for "business of health insurance (including the business of dental insurance and limited-scope dental benefits)." The House passed this bill on a bipartisan basis by a vote of 416-7. The bill has now been sent to the Senate for its consideration.

REINSURANCE

Court Punts on Reinsurance Coverage Due to Missing Underlying Policies

This case involves a large-scale, ongoing dispute regarding coverage for a number of asbestos claims. The plaintiff insurer wrote the relevant policies in 1966 through 1972. The insurer could not locate those underlying policies, however, which led to a dispute over whether the policies had aggregate limits of coverage for bodily injury or not. The insurer also issued umbrella policies to its policyholder for those same years, and ceded $5 million in excess of $5 million of the umbrella layer to several reinsurers, including the defendant.

The underlying policies were not reinsured. The policyholder was subject to many thousands of asbestos claims, and filed a declaratory judgment suit against the insurer in 2003. As a result, the ceding insurer settled with the insurer in 2007. As part of the settlement, the ceding insurer required that the policyholder agree to stipulate that all of the primary policies had aggregate limits for bodily injury of $300,000 and that all such limits had been exhausted. Crucially, if the primary policies did not have aggregate limits, the reinsured umbrella layer would not be reached. Finding an ambiguity regarding whether aggregate limits were provided, the court ultimately found that the evidentiary proof was too lacking to make a dispositive ruling because complete copies of the policies were not provided.

OUR GLOBAL INSURANCE SERVICES TEAM:

Chairs

David L. Brown
Jeffrey L. Kingsley

Partners

Richard J. Ahn
Sharon Angelino
Kevin M. Apollo, Special Counsel
Troy A. Bataille
Brian R. Biggie
Peter J. Biging
Dennis J. Brady
Pamela T. Broache
Marc W. Brown
Christian A. Cavallo
Richard J. Cohen
Paul S. Danner
Sarah J. Delaney
William J. Edwins
Jennifer H. Feldscher
Brendan T. Fitzpatrick
Daniel W. Gerber
Michael T. Glascott
Anthony J. Golowski II
Michael A. Hamilton
Todd R. Harris
David G. Harris II
Michael P. Kandler
Edward K. Kitt
Paul L. Knobbe
Louis H. Kozloff
Todd D. Kremin
Jonathan M. Kuller
Michael J. Leegan
Michael F. Lettiero
John I. Malone, Jr.
Matthew S. Marrone
Paul D. McCormick
Michael McQuaide
Joshua L. Milrad
Colleen M. Murphy
Joseph A. Oliva
Patrick B. Omilian
James M. Paulino II
Frederick J. Pomerantz
Kurits B. Reeg
Joanna M. Roberto
Michael S. Saltzman
Jonathan Schapp
Jonathan L. Schwartz
Thomas F. Segalla
Paul C. Steck
Theodore W. Ucinski III
Joseph J. Welter
Brady A. Yntema
Jonathan S. Ziss

Associates

Aaron J. Aisen
Andrew P. Carroll
Fallyn B. Cavalieri
Court Cousins
Jason L. Ederer
David M. Frohlichstein
Laura J. Irk
Megan Kosovich
Jennifer M. Mannion
Nicholas J. Pontzer
Joanne J. Romero
Thomas J. Seery
Leigh R. Trigilio
Clayton D. Waterman
Christopher R. Weiss
Colin B. Willmott
Alex J. Yastrow
Brandon D. Zeller

Goldberg Segalla is one of the premier firms serving the international insurance and reinsurance community. Our Global Insurance Services Practice Group is a transatlantic team known for its abilities to bridge international gaps, to handle any challenge facing clients in the insurance and reinsurance space, and to perform cutting-edge work that profoundly impacts the market. As recognitions like *Reactions* Law Firm of the Year demonstrate, Goldberg Segalla is a go-to firm globally for high-risk litigation, complex and innovative transactions, and challenging regulatory concerns. For more information on our Global Insurance Services team, please contact David L. Brown or Jeffrey L. Kingsley.

NEW YORK | CHICAGO | PHILADELPHIA | ORLANDO | MIAMI
WEST PALM BEACH | BALTIMORE | ST. LOUIS | GREENSBORO | HARTFORD | PRINCETON
NEWARK | BUFFALO | ROCHESTER | SYRACUSE | ALBANY | WHITE PLAINS | GARDEN CITY

GOLDBERG SEGALLA

CALL | FAX
646.292.8700 | 646.292.8701

INQUIRIES
INFO@GOLDBERGSEGALLA.COM

GOLDBERGSEGALLA.COM

711 3RD AVENUE, SUITE 1900
NEW YORK, NY 10017