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Eight Years after *Bi-Economy* and *Panasia*, What is the Law of Bad Faith in New York?

By Joseph G. Grasso and Charles Platto[1]

Prior to 2008, the law of bad faith in New York seemed fairly well established. A claim for bad faith against an insurer, which might give rise to extra contractual compensatory damages, could only be maintained by demonstrating 'gross disregard' to the interests of the policy holder.[2] However, in deciding the *Bi-Economy* and *Panasia cases* on February 19, 2008,[3] the Court of Appeals appeared to abandon the 'gross disregard' standard and, instead, appeared to hold, in the context of first party claims, that a policyholder can recover consequential damages from an insurer in a coverage dispute, without a showing of bad faith at all.

It was in the immediate aftermath of these decisions that we and our colleagues wrote an article commenting on *Bi-Economy* and *Panasia,* in which we concluded that it was now a "whole new ball game and there aren't any rules" for insurance coverage disputes in New York.[4] However, in 2010, when we surveyed the ensuing jurisprudence in New York in a subsequent article, we concluded that little had changed.[5] Now, six years after that review of the legal landscape, we return to this topic and undertake another survey.

The purpose of this article is to review how New York courts have treated the law of bad faith and claims for consequential damages in insurance coverage disputes in the six years since our last article and the eight years since the Court of Appeals' decision in *Bi-Economy* and *Panasia*. Our conclusion remains that little has changed or been clarified since *Bi-Economy* and *Panasia*. The prior standard for bad faith has not been resurrected, but consequential damages are very rarely awarded. Moreover, the courts still seem to require something more than merely demonstrating that the consequential damages were foreseeable by the parties. While policyholders must now show a breach by the insurer of the implied covenant of good faith and fair dealing, the courts have had difficulty reconciling this with the prior standard for bad faith claims or articulating how a breach of the implied covenant must be demonstrated. So, we believe it is fair to say that some measure of bad faith must still be shown, and that the bad faith conduct must give rise to consequential damages, but the standard for determining bad faith remains unarticulated.

We will also address the interesting topic of the availability of attorneys' fees, since in this uncertain environment, there has been a growing tendency for

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2. *Pavia v. State Farm Mutual Auto. Ins. Co.,* 626 N.E.2d 24, 26 (N.Y 1993); *See also DiBlasi v. Aetna Life & Cas. Ins. Co.,* 147 A.D.2d 93, 98-99 (N.Y. App. Div. 2d. Dept. 1993) ("the standard is not that of a sinister motive – guilty knowledge – an intent to do harm or deprive another of his just rights and property, but rather, whether the conduct in question constituted a gross disregard of its insured's interests" (internal quotation marks omitted)).

3. *Bi-Economy Market Inc., v. Harleysville Ins. Co. of New York,* 886 N.E.2d 127 (N.Y. 2008); *Panasia Estates, Inc. v. Hudson Ins. Co.,* 886 N.E.2d 135 (N.Y. 2008).

4. Charles Platto, Rachel Lebejko-Preister, and Sujuta Gadkar Wilcox, "New York's 'Good Faith' Standard – What Does it Mean for Bad Faith?," 30-6 Ins. Litigation R. 165, 165 (Apr. 23, 2008).

5. Charles Platto, Joseph Grasso, Rachel Lebejko Priester and Alison Weir, "What is the Law of Bad Faith in New York Two Years Ago after *Bi-Economy* and *Panasia* – Have The Questions Been Answered?," 32-3 Ins. Litigation R. 69 (March 8, 2010).

policyholders to seek attorneys' fees in conjunction with bad faith/consequential damage claims. Recent decisions by the New York courts show that these attempts have been met with limited success.

The Court of Appeals has yet to revisit these issues.

Survey of Decisions Involving Bad Faith/Consequential Damages in Insurance Disputes

The New York Court of Appeals acknowledged in *Bi-Economy* that there is an implied covenant of good faith and fair dealing in every insurance contract, which encompasses the insurer's promise to investigate and pay covered claims in good faith. However, it then appeared to hold that an insured could seek consequential damages in connection with a claim for breach of insurance contract, as a breach of the implied covenant of good faith, without articulating a standard for such breach or a requirement for a showing of bad faith.

The Court in *Bi-Economy* also held that an insured's claim must satisfy certain elements in order to maintain a claim for consequential damages. First, the consequential damages must be reasonably identifiable by the plaintiff. Second, the consequential damages "must have been within the contemplation of the parties at the time the insurance contract was made."[6] To determine whether consequential damages were reasonably contemplated by the parties, courts look to the "nature, purpose and particular circumstances of the contract known by the parties" at the time of execution.[7] Recent decisions have shown that only when the insured's claim satisfies both of these elements will consequential damages be recoverable against an insurer, but they also seem to require a predicate showing of a breach of the covenant of good faith – again without articulating a standard or necessarily calling it "bad faith." Most of these decisions have arisen in the context of motion practice. These cases are summarized below.

We begin with federal court decisions which have addressed the issue, applying New York law.

In *Goldmark, Inc. v. Catlin Syndicate Ltd.,* the U.S. District Court for the Eastern District of New York granted the plaintiff leave to amend its complaint, as the plaintiff had failed to plead a claim sufficient to support recovery of consequential damages. In that case, the plaintiff sought recovery for breach of contract arising out of the defendant insurer's failure to pay a claim for theft of nearly $2 million in gold.[8] The plaintiff also brought a claim for consequential damages incurred due to the defendant's allegedly unreasonable delay in investigating that loss.[9] The court unequivocally stated that "New York law limits the availability of consequential damages for breach of an insurance contract to instances where the insurer also breached an implied duty of good faith and fair dealing."[10] The plaintiff argued that in order to recover consequential damages, it need only prove that such damages were reasonably contemplated at the time of execution.[11] The court disagreed, holding that "cases have virtually uniformly held that, after *Panasia Estates* and *Bi-Economy*, a plaintiff cannot sustain a claim for consequential damages without showing that defendants lacked good faith in processing a plaintiff's claim."[12] Therefore, the claim was insufficient as pled to support recovery of consequential damages, and the court, therefore, granted the plaintiff leave to amend its complaint.

The Eastern District reached a similar holding in *Ebrhaimian v. Nationwide Mutual Fire Insurance Company,* this time dismissing the plaintiff's claim for consequential damages against the defendant.[13] The insurance coverage dispute arose after a storm had damaged the plaintiff's home and personal property.[14] The defendant insurer refused to pay for material used in connection with repair work done on the

6. *Orient Overseas Associates v. XL Insurance America Inc.,* 2014 WL 840416, *3 (N.Y. Sup. Ct. N.Y. Co. 2014).
7. *Bi-Economy,* 886 N.E. 2d at 130.
8. *Goldmark, Inc. v. Catlin Syndicate Ltd.,* 2011 WL 743568, *1 (E.D. N.Y. 2011).
9. *Id.*
10. *Id.* at *3.
11. *Id.*
12. *Id.*
13. *Ebrahimian v. Nationwide Mut. Fire Ins. Co.,* 960 F.Supp.2d 405 (E.D. N.Y. 2013).

plaintiff's house, arguing that the work had no demonstrable connection to the storm.[15] The plaintiffs brought suit against the defendant alleging breach of contract and bad faith for failing to indemnify.[16] The court held that "the Plaintiffs do not adequately allege that they suffered any damages as a consequence of the Defendant's alleged bad faith refusal to pay their claims other than the damages associated with the alleged breach of the Policy."[17] The court stated that "at most, the Plaintiffs allege a general disapproval of [the adjuster's] investigation of their claim,"[18] as the plaintiffs admitted that the basis for their claim was that they "just felt that he wasn't doing the right thing with us."[19] The court concluded that this "general disapproval" of an insurer's actions did not support a plaintiff's claim of breach of the implied covenant of good faith and fair dealing necessary to recover consequential damages. Moreover, the plaintiff's general plea for consequential damages in the amount of $1,000,000 lacked the requisite particularity to be considered identifiable.[20] Thus, the court found that "certain issues of fact exist as to the Plaintiff's breach of contract claim," but claims for recovery of consequential damages as a result of that breach failed as a matter of law.[21]

If an insured's claim for consequential damages arising from an insurer's alleged breach of contract rests on an implied breach of the covenant of good faith, courts then apply the *Bi-Economy* tests to determine whether these damages are recoverable. In *Ripka v. Safeco Insurance,* the U.S. District Court for the Northern District of New York dismissed the plaintiff's claims for consequential damages stemming from the defendant insurer's alleged breach of the implied covenant of good faith.[22] In that case, the plumbing leak caused substantial damage to the plaintiff's home and its contents.[23] The plaintiff claimed that the defendant insurer had engaged in a series of delaying tactics "before ultimately failing to pay the claim in full or tender interest for the unsubstantiated delays in payment."[24] The plaintiff sought upwards of $200,000 in consequential damages for the defendant's failure to indemnify. The court dismissed these claims for two reasons under the *Bi-Economy* standard. First, the court held that plaintiff failed to allege that "any such damages were within the parties' contemplation at the time of contracting."[25] The court reasoned that no provision in Homeowner's Policy suggested that special damages would be available in the event of a breach, nor did the plaintiff provide evidence outside of the policy supporting their possible availability.[26] Second, the court held that "even assuming [the plaintiff's] claims for consequential damages were otherwise sufficiently pleaded," the claims lacked "sufficient particularity to identify actual losses."[27] The court reasoned that the plaintiff failed to plead any detail regarding the recovery of consequential damages beyond the dollar amount of $200,000.[28] Thus, the court held that the plaintiff's "general plea for consequential and special damages" must be dismissed as a matter of law.[29]

Courts have generally scrutinized a plaintiff's claim of alleged mutual contemplation of the claimed

14. *Id.* at 407.
15. *Id.* at 411.
16. *Id.* at 412.
17. *Id.* at 416-17.
18. *Id.* at 417.
19. *Ebrahimian,* 960 F.Supp.2d at 417.
20. *Id.* at 418.
21. *Id.*
22. *Ripka v.Safeco Ins.,* 2015 WL 3397961 (N.D. N.Y.).
23. *Id.* at *1.
24. *Id.*
25. *Id.* at *4
26. *Id.*
27. *Id.* at *5
28. *Ripka,* 2015 WL 3397961 at *5.
29. *Id.*

consequential damages through an analysis of the specific facts at play in the case. In *Jane Street Holding, LLC v. Aspen American Insurance Co.*[30], the U.S. District Court for the Southern District of New York dismissed the plaintiff's claim for consequential damages against the defendant insurer, holding that the damages were not contemplated by both parties when the policy was executed. In this case, the defendant denied the plaintiff's insurance claim for flood damage resulting from Superstorm Sandy to a generator located on the basement level of One Manhattan Plaza.[31] The plaintiff claimed consequential damages for the cost of bringing a bad faith action against the defendant.[32] After holding that the conduct of the defendant did not rise to the level of bad faith, the court also dismissed the consequential damages claim.[33] The court stated that the plaintiff's claim was predicated on damages to a generator they bought after entering into the policy with the defendant.[34] Since the plaintiff's claim of consequential damages arose as a result of the loss of the generator, the court reasoned that the parties could not have contemplated damages associated with this loss when they executed the insurance policy.[35] Therefore, the court held that the plaintiff had failed to bring a valid consequential damages claim under *Bi-Economy*, and dismissed the complaint.[36]

The U.S. District Court for the Eastern District of New York used the same analysis to reach a different result in *Sikarevich Family L.P. v. Nationwide Mutual Insurance Co.*[37] In that case, the court held that the allegations of the plaintiff's amended complaint were sufficient to support a claim for consequential damages.[38] The plaintiff alleged that it suffered "loss of business income" as a result of the defendant insurer's bad faith conduct, specifically the insurer's failure to investigate, value, and pay the plaintiff's insurance claim.[39] The plaintiff further alleged that "the damages sustained by the plaintiff as a result of [Nationwide's] wrongful conduct were within the contemplation of the parties herein as the natural and probable result of a breach of [Nationwide's] duties at the time of or prior to the parties renewing the Policy on or about October 12, 2012."[40] The nature of the commercial property insurance policy led the court to conclude that the plaintiff's loss of business income could reasonably have been contemplated by both parties at the time the policy was issued.[41] Therefore, drawing all reasonable inferences in favor of the plaintiff, the court declined to dismiss the plaintiff's request for consequential damages in connection with its breach of contract claim.

The state courts of New York have applied the *Bi-Economy* standard in a similar fashion.

For example, in *Orient Overseas Associates v. XL Insurance America, Inc.,* the Supreme Court in New York County dismissed the plaintiff's claim for consequential damages against the defendant insurer because the plaintiff failed to identify and qualify the alleged harm. The insurance coverage dispute involved the defendant's alleged failure to indemnify after the plaintiff's property was damaged by Superstorm Sandy.[42] The court agreed that *Bi-Economy* and *Panasia* allowed for an insured to pursue a claim for consequential damages based upon an insurer's claimed breach of the implied covenant of good faith inherent in the policy agreement.[43] However, the court stated that "in order to recover

30. *Jane Street Holding, LLC v. Aspen American Ins. Co.,* 2014 WL 28600 (S.D. N.Y. 2014).
31. *Id.* at *3.
32. *Id.* at *11.
33. *Id.*
34. *Id.*
35. *Id.*
36. *Jane Street Holding, LLC,* 2014 WL 28600 at *12.
37. *Sikarevich Family L.P. v. Nationwide Mut. Ins. Co.,* 30 F.Supp.3d 166 (E.D. N.Y. 2014).
38. *Id.* at 173.
39. *Id.*
40. *Id.*
41. *Id.*
42. *Orient Overseas Associates v. XL Ins. America, Inc.,* 2014 WL 840416, *1 (N.Y. Sup. Ct. N.Y. Co. 2014).
43. *Id.* at *2.

consequential damages the harm that occurred beyond the breach of the contract must be proven—thus identifying the consequential damages."[44] Further, "the consequential damages must be quantified in some way."[45] The court held that the plaintiff failed to either identify or quantify the consequential damages sought in their complaint. The court concluded that "had the plaintiff alleged specific loss beyond what is contractually disputed, there may be reasons to allow for consequential damages."[46] However, that was not the case in *Orient*, and the court, therefore, dismissed the claim.

In *Yar-Lo, Inc. v. Travelers Indemnity Co.,* the insured plaintiff brought suit against the defendant insurer, seeking damages related to a sewage flood at its business premises.[47] The plaintiff, a franchise business specializing in the sale of cosmetics, alleged that it suffered $183,435 in lost business income and over $6 million in consequential damages due to the flooding.[48] The plaintiffs appealed the New York Supreme Court's decision to grant the defendant's Motion for Summary Judgment on the ground that the plaintiff's cessation of its business was not directly related to the covered loss as required by its insurance policy.[49] The Appellate Division agreed with the lower court, holding that "no issue of fact exists as to whether the parties contemplated consequential damages in the event that the plaintiff's owner decided to close the business when its operations could have continued."[50] The court reasoned that the plaintiff "failed to adduce any evidence beyond conjecture and speculation that connects its purported loss" to the flooding incident.[51] The court concluded that the plaintiff's claim for consequential damages failed to satisfy the *Bi-Economy* standard, and affirmed the lower court's decision granting the defendant's Motion for Summary Judgment.

In *Mutual Association Administrators, Inc. v. National Union Fire Ins. Co. of Pittsburgh,* the Appellate Division similarly applied the *Bi-Economy* standard to a plaintiff's claim for consequential damages caused by the defendant insurer's breach of its insurance contract.[52] In that case, however, the court found that the plaintiff's complaint satisfied the *Bi-Economy* standard and dismissed the defendant's Motion for Summary Judgment.[53] The plaintiff claimed that the defendant had breached its obligation under the insurance policy to defend and indemnify it in an action commenced in federal court pursuant to the Employee Retirement Income Security Act of 1974 (ERISA).[54] The plaintiff sought consequential damages for "the demise of [the plaintiff] as an operating business]" and "loss of income by [the plaintiff]."[55] The court held that the defendant "failed to establish, prima facie, that it acted in good faith in recommending that the plaintiff accept the settlement offer, and then discontinuing payment of defense costs once the plaintiff rejected the offer."[56] The court reasoned that although the insurance policy contained a provision excluding coverage for 'loss of earnings', "the provision plainly only applies to loss of earnings caused by a covered event under the policy, and does not preclude the recovery of consequential damages caused by [the defendant's] alleged breach of contract."[57] Therefore, the Appellate Division affirmed the lower court's decision to dismiss the defendant's Motion for Summary Judgment.

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44. *Id.* at *4.
45. *Id.*
46. *Id.*
47. *Yar-Lo v. Travelers Indemnity Co.,* 130 A.D.3d 1402 (N.Y. App. Div. 3d. Dept. 2015).
48. *Id.* at 1402.
49. *Id.*
50. *Id.* at 1403.
51. *Id.* at 1404.
52. *Mutual Ass'n Adm'rs, Inc. v. National Union Fire Ins. Co. of Pittsburgh,* 118 A.D.3d 856 (N.Y. App. Div. 2d. Dept. 2014).
53. *Id.* at 858.
54. *Id.* at 857.
55. *Id.*
56. *Id.*
57. *Id.* at 858.

Third Party Claims

Another issue that remains unsettled is how the *Bi-Economy* standard applies to actions involving claims for consequential damages claims brought by third parties. *Bi-Economy* and *Panasia* arose in the context of first party claims. Technically, they did not address the more common bad faith claims that often arise in the context of alleged bad faith refusals to defend or settle.

In *International Rehabilitative Sciences Inc. v. GEICO,* the U.S. District Court for the Western District of New York dismissed a claim by a third party against the defendant insurer, holding that the damages sought by the third party were not in contemplation of the parties at the time the no-fault policy was issued. The plaintiff, a rehabilitation facility, brought suit as the assignee of 154 individuals who had received treatment at the facility.[58] The plaintiff alleged that the defendant failed to pay for durable medical equipment provided to each of the assignors as part of their treatment for injuries sustained in various accidents.[59] Among other claims, the plaintiff sought consequential damages including damages related to loss of revenue and diminution of business value based upon the defendant's alleged failure to make timely payments of the plaintiff's claims.[60] Unlike the insurance contract at issue in *Bi-Economy*, the plaintiff could not point to any provision in GEICO's no-fault insurance policies purporting to cover consequential damages.[61]Moreover, the plaintiff was not a party to the no-fault insurance contracts at issue.[62] Therefore, the court concluded that the plaintiff did not, and could not, allege that consequential damages to third-party payees was contemplated by the parties at the time of the issuance of the policies.[63]

Similarly, in *J. Kokolakis Contracting Corp. v. Evoluation Piping Corp.,* the court dismissed the claims of an additional insured against an insurer for consequential damages, finding it implausible to believe these damages were mutually contemplated by the parties at or prior to the issuance of the policy.[64] The plaintiff, a general contractor, brought suit against a subcontractor's insurer for breach of implied covenant of good faith and fair dealing, based on the insurer's alleged bad faith denial of coverage.[65] The court held that the plaintiff contractor's alleged consequential damages, in excess of two million dollars, could not have been contemplated by the insurer when it issued the policy to the subcontractor.[66] The court reasoned that since the plaintiff did not contract with the insurer, it would be unreasonable to assume that the insurer foresaw the consequential damages allegedly suffered by the plaintiff when the policy was issued.[67]

The Civil Court for the City of New York, Queens County, also rejected the claims of a third-party claimant in *Hunter v. Hereford Insurance Company.*[68] In that case, the plaintiff brought suit against the defendant insurer for insurance bad faith and unfair claim settlement practices following an accident between the plaintiff and the defendant's insured.[69] The plaintiff sought damages for alleged injuries caused by a car accident between the plaintiff and the defendant's insured.[70] When the defendant offered $3,000 to settle the case, the plaintiff deemed the offer insufficient, and filed suit against the defendant, claiming that the insurer was negotiating in bad faith.[71] The court rejected this argument, stating that "in absence of privity, a cause of action may not be

58. *Int'l Rehabilitative Sciences, Inc. v. GEICO,* 2014 WL 6387276, *1 (W.D. N.Y. 2014).
59. *Id.*
60. *Id.* at *2.
61. *Id.* at *3.
62. *Id.* at *4.
63. *Id.*
64. *J. Kokolakis Contracting Corp. v. Evoluation Piping Corp.,* 46 Misc.3d 544 (N.Y. Sup. Ct. Suffolk Co. 2014).
65. *Id.*
66. *Id.* at 551.
67. *Id.*
68. *Hunter v. Hereford Ins. Co.,* 2015 WL 4877682 (N.Y.C. Civ. Ct. Queens Co. 2015).
69. *Id.* at *1.
70. *Id.*

maintained for breach of contract."[72] The court reasoned that "any cause of action against an insurer for 'bad faith' would sound in contract."[73] The court concluded that, as a third party, the plaintiff had no privity with the defendant, and thus would not be able to bring a bad faith claim against the insurer.[74] Therefore, the court dismissed the plaintiff's claims for failure to state a cause of action based on lack of privity.

Attorneys' Fees

Perhaps because it remains difficult for insureds to recover bad faith/ consequential damages, it has been argued that *Bi-Economy* and *Panasia* may also provide for the recovery of attorneys' fees.[75]

Although it has been suggested that *Bi-Economy* and *Panasia* provide a basis for policyholders to recover their attorneys' fees from their insurers in coverage disputes, New York courts have for the most part rejected these arguments. Unlike its English counterpart, the American judicial system has the well-established rule that both plaintiff and defendant must pay their own attorneys' fees.[76] The United States Supreme Court has recognized three specific exceptions to this rule that have also been applied in cases interpreting New York law: "(1) when a statute or enforceable contract provides for attorneys' fees; (2) where the prevailing party confers a common benefit upon a class or fund; and (3) when a losing part willfully disobeys a court order or has 'acted in bad faith, vexatiously, wantonly, or for oppressive reasons."[77] There is no right to attorneys' fees for an ordinary breach of contract claim under New York law unless the party seeking the fees can establish one of these three exceptions.[78]

Some have argued that *Bi-Economy* and *Panasia* may have added a fourth exception to the rule, i.e., a breach of the duty of good faith and fair dealing by the insurer in a coverage dispute. A handful of lower courts have allowed claims of attorneys' fees to proceed, ostensibly based upon this perceived additional exception.[79] However, these decisions run contrary to recent holdings in the both New York appellate courts and courts in other jurisdictions applying New York law, which continue to apply the traditional American rule. We summarize those cases below.

In *Stein, LLC v. Lawyers Title Insurance Corp.,* the plaintiff had originally brought a claim against the defendant to recover damages for breach of an insurance contract.[80] On appeal, plaintiff challenged the lower court's decision to dismiss the portion of their complaint that sought an award of attorney fees insofar as they were asserted against the defendant.[81] The plaintiff argued that in light of *Bi-Economy* and *Panasia,* an insured may seek consequential damages, including attorney fees, in an affirmative coverage action it brings against its insurer. The Appellate Division disagreed and instead affirmed the lower court's dismissal of the claim, holding that the plaintiff's "contention regarding the award of an attorneys' fee is without merit."[82] The court stated that "nothing in *Bi-Economy* or *Panasia* alters the common-law rule that, absent a contractual or policy

71. *Id.*

72. *Id.* at *2.

73. *Hunter v. Hereford Ins. Co.,* 2015 WL 4877682 at *2.

74. *Id.*

75. Peter A. Halprin and Bruce Strong, "NY's Evolving Acceptance of Policyholder Bad Faith Claims," June 14, 2016, http://www.law360.com/articles/806446/ny-s-evolving-acceptance-of-policyholder-bad-faith-claims.

76. *See Oscar Gruss & Son, Inc. v. Hollander,* 337 F.3d 186, 199 (2d Cir. 2003); *Hooper Assocs., Ltd. V. AGS Computers, Inc.,* 548 N.E.2d 903, 904 (N.Y. 1989).

77. *V.S. Int'l, S.A. v. Boyden World Corp.,* 1993 WL 59399, at *13 (S.D. N.Y. 1993) (quoting *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y,* 421 U.S. 240, 257-59 (1975)).

78. *In re New York Skyline, Inc.,* 471 B.R. 69, 89 (Bankr. S.D. N.Y. 2012).

79. *Richman v. Harleysville Worcester Insurance Co.,* 2010 WL 3783180 (N.Y. Sup. Ct. 2010); *Nisenbuam v. AXA/Equitable Life Insurance Co.,* 2015 WL 10478082 (N.Y. Sup. Ct. 2015); *See also* Peter A. Halprin and Bruce Strong, "NY's Evolving Acceptance of Policyholder Bad Faith Claims," Law360.com, June 14 2016 (available at: http://www.law360.com/articles/806446).

80. *Stein, LLC v. Lawyers Title Insurance,* 100 A.D.3d 622 (N.Y. App. Div. 2d. Dept. 2012).

81. *Id.*

82. *Id.*

provision permitting the recovery of an attorneys' fee, "an insured may not recover the expenses incurred in bringing an affirmative action against an insurer to settle its rights under the policy."[83] Since the documentary evidence proved that no such provision existed in the insurance policy, the court held that the plaintiff's claim was correctly dismissed.[84]

The Appellate Division again rejected the argument that *Bi-Economy* and *Panasia* had altered the traditional common law rule with respect to recovery of attorney fees in *Santoro v. GEICO.*[85] In that case, the defendant appealed from the lower court's decision to deny its motion for summary judgment, which sought to limit the plaintiff's alleged damages to the policy limit of $275,000.[86] The Appellate Division agreed and reversed, thereby granting the defendant's motion.[87] The Court reasoned that:

> "While 'consequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted in an insurance contract context, so long as the damages were within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting' (*Panasia Estates, Inc. v. Hudson Ins. Co.,* 886 N.E.2d 135 (N.Y. 2008), *the only consequential damages asserted by the plaintiff are an attorneys' fee and costs and disbursements resulting from this affirmative litigation, which are not recoverable.*"

Santoro, 117 A.D.3d at 1028 (emphasis added). Thus, the court emphasized that while *Bi-Economy* and *Panasia* may have changed the rules with respect to consequential damages generally, those two cases have had no effect on the common-law rule concerning attorneys' fees.

Courts in other jurisdictions have similarly held that, under New York law, attorneys' fees generally remain unrecoverable as consequential damages in cases where the insured affirmatively brings an action against its insurer for coverage. For example, in *Wausau Underwriters Insurance Co. v. Danfoss, LLC,* the defendant insured brought counterclaims against the plaintiff insurer, including a claim for attorneys' fees expended in defending against the insurer's breach of contract claims.[88] The defendant premised this counterclaim on three separate legal theories.[89] The U.S. District Court of the Southern District for Florida applied New York state law in this diversity action, and dismissed all three theories in turn.

First, the defendant argued that his claim met one of the exceptions to the general common-law rule with respect to recovery of attorney fees recognized by the U.S. Supreme Court, i.e. that attorneys' fees are only recoverable when the opposing party "has acted in bad faith, vexatiously, wantonly, or for oppressive reasons."[90] The court, however, held that the bad faith exception to the "American Rule" with respect to attorneys' fees did not apply in this case. The court reasoned that in applying the bad faith exception, the "appropriate focus for the court is the conduct of the party in instigating or maintaining the litigation," not the party's business conduct.[91] In *Wassau*, the defendant's counterclaim concerned the plaintiff's alleged breach of contract. Therefore, because the counterclaim was based on the plaintiff's business conduct rather than the plaintiff's conduct in the litigation, the bad faith exception did not apply. Therefore, the defendant "could not recover attorneys' fees under this theory."[92]

Second, the defendant argued that it could

83. *Id.* at 623, quoting *New York Univ. v. Continental Ins. Co.,* 662 N.E.2d 763, 772 (N.Y. 1995).
84. *Id.*
85. *Santoro v. Geico,* 117 A.D.3d 1026 (N.Y. App. Div. 2d. Dept. 2014).
86. *Id.* at 1027.
87. *Id.* at 1028.
88. *Wausau Underwriters Ins. Co. v. Danfoss, LLC,* 2015 WL 9094201 (S.D. Fla. 2015).
89. *Id.* at *13.
90. *Id.* (*quoting Alyeska Pipeline Serv. Co. v. Wilderness Soc'y,* 421 U.S. at 257-59 (1975)).
91. *Id.*
92. *Id.*

recover attorneys' fees as consequential damages in the context of a first-party insurance coverage dispute. In making that argument, the defendant cited *Bi-Economy* and *Panasia* in support of his theory, claiming that the opinions had expanded the damages recoverable in first-party bad faith insurance claims under New York law.[93] The court disagreed, holding that New York courts "largely have not interpreted *Bi-Economy* and *Panasia* as allowing the recovery of attorneys' fees as consequential damages."[94] In support of this holding, the court cited a number of recent New York cases, including: *Goodfellow v. Allstate Indem. Co.* (finding plaintiff could not recover attorneys' fees, costs, and litigation expenses as a form of consequential damages),[95] *Quick Response Comm. Div. v. Aon Risk Services of Illinois, Inc.,* ("there is abundant authority from New York courts that the general rule is that 'an insured may not recover the expenses incurred in bringing an affirmative action against an insurer to settle its rights under the policy' . . . the Court agrees that this is the current state of the law),[96] *Woodworth v. Erie Ins. Co.* ("nothing in *Bi-Economy* or any post-*Bi-Economy* authority cited by the parties suggests that the New York Court of Appeals intended through its *Bi-Economy* decision to alter in the insurance context the traditional American rule that each party should bear its own attorneys' fees"),[97] and *Santoro v. GEICO* (discussed above). By invoking this line of authority, the *Wassau* court confirmed that in its view, *Bi-Economy* and *Panasia* have not changed the general rule with respect to attorneys' fees in New York.

The third theory put forth by the defendant was that, under *Sukup v. State,*[98] *it could recover attorneys' fees because the dispute involved "more than an arguable difference of opinion between carrier and insured over coverage."*[99] *In Sukup,* the New York Court of Appeals articulated a possible exception to the American Rule with respect to attorneys' fees in cases where an insured makes "a showing of such bad faith in denying coverage that no reasonable carrier would, under the given facts, be expected to assert it."[100] Although *Bi-Economy* and *Panasia* implicitly overruled *Sukup,* an insured may still allege a separate independent tort claim against an insurer, provided that the insurer's conduct rises to the level of egregious bad faith. Here, the court held that the defendant's complaint had inadequately plead the necessary elements of the *Sukup* standard, and therefore dismissed the claim under this theory as well.[101]

It was also the *Sukup* standard, rather than some new exception articulated in *Bi-Economy* or *Panasia,* that drove the court's holding on the issue of recover of attorneys' fees in *Nat'l R.R. Passenger Corp. v. Arch Specialty Ins. Co.*[102] *T*hat case concerned an insurance coverage dispute between Amtrak ("plaintiff") and various insurance companies ("defendants") that arose in the aftermath of Superstorm Sandy.[103] The plaintiff had purchased a number of all-risk property insurance policies from the defendants with a policy period spanning December 2011 to December 2012.[104] While the policies were in effect, Superstorm Sandy made landfall near New York City on October 29, 2012.[105] The storm caused waters of the East and Hudson Rivers to rise and "inundate" the plaintiff's tunnels, damaging various types of equipment.[106] *T*he coverage dispute centered on

93. *Id.*
94. *Wausau Underwriters Ins. Co*., 2015 WL 9094201 at *14.
95. *Goodfellow v. Allstate Indem. Co.,* 2014 WL 7384239, *4 (W.D. N.Y. 2014).
96. *Quick Response Comm. Div. v. Aon Risk Services of Illinois, Inc.,* 2012 WL 6021438, *2 (N.D. N.Y. 2012).
97. *Woodworth v. Erie Ins. Co.,* 2009 WL 1652258, *5 (W.D. N.Y. 2012).
98. *Sukup v. State,* 227 N.E.2d 842 (N.Y. 1967).
99. *Wassau,* 2015 WL 9094201 at *14.
100. *Sukup,* 227 N.E.2d at 844.
101. *Wassau,* 2015 WL 9094201 at *14.
102. *Nat'l R.R. Passenger Corp. v. Arch Specialty Ins. Co.,* 124 F.Supp.3d 264 (S.D. N.Y. 2015).
103. *Id.* at 266.
104. *Id.*
105. *Id.* at 267.
106. *Id.*

"whether the definitions of "flood" in the policies here at issue encompass inundation caused by storm surge."[107] However, the court also took up the defendants' motion to dismiss the plaintiff's demand for consequential damages, which included attorneys' fees.[108]

The court stated that "New York courts have since rejected the argument" that *Bi-Economy* and *Panasia* created a new exception to the common-law rule with respect to attorneys' fees.[109] Nevertheless, the *Amtrak* court allowed the plaintiff's claim for attorneys' fees to go forward, "albeit in a more limited manner," under the exception articulated in *Sukup*.[110] The court reasoned that the plaintiff had alleged that the defendants declined to make interim payments required under the policies for amounts that are "not the subject of reasonable dispute."[111] Therefore, the court allowed the plaintiff's claims for attorneys' fees to go forward, concluding that the insurer's conduct in that case did indeed rise to the level of egregious bad faith. Thus, the case does not signal a shift in New York law, nor does it showcase a new exception to the general rule as to recovery of attorneys' fees. Instead, the decision is based on entirely separate factual grounds, and New York law remains settled in this area.

Conclusion

Although the legal landscape continues to evolve in the wake of *Bi-Economy* and *Panasia,* the changes wrought by these decisions are not nearly as drastic as many predicted in 2008. However, a few general points can be made. First, it appears that New York, like many other jurisdictions,[112] now has provided a remedy to policyholders for breach of the covenant of good faith and fair dealing in first party coverage disputes. Second, it also appears that instances where insureds recover consequential damages in these disputes remain limited. Lastly, despite a small number of lower court decisions, New York courts and federal courts applying New York law, by and large continue to apply the traditional American rule with respect to attorneys' fees. The anticipated sea change in the wake of *Bi-Economy* and *Panasia* has simply not materialized.

107. *Id.* at 269.

108. *Nat'l R.R. Passenger Corp.,* 124 F.Supp.3d at 280.

109. *Id.*

110. *Id.*

111. *Id.*

112. *See* William T. Barker and Paul E.B. Glad, "Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance," 30 Tort & Ins. L.J. 49-102 (1994).

Bad Faith/Duty to Settle

Insurer's Failure to Reevaluate Case after Trial Court Eliminates Key Affirmative Defense Justifies Bad Faith Failure to Settle Verdict

Eighth Circuit Upholds District Court's Denial of Insurer's Post-Verdict Motions

Bamford v. Regent Insurance Co., 822 F.3d 403 (8th Cir. 2016)

Case at a Glance

In this fact intensive decision, the Eighth Circuit Court of Appeals held that the district court properly denied an insurer's post-verdict motions challenging the jury's verdict in a bad faith failure to settle case. Evidence that the insurer failed to reevaluate its settlement position after a trial court ruling in the underlying case eliminated a key affirmative defense was sufficient to support the jury's finding that the insurer's refusal to settle breached the duty of good faith and fair dealing. Evidence that the insurance company made multiple efforts to settle based on its evaluation of the case, continuously increased its reserves and offers in the settlement process, followed the advice and valuations of outside counsel and two mediators, discussed the claim value in roundtable meetings with senior management, and reasonably relied on Nebraska's reputation as a conservative jury verdict jurisdiction was insufficient to establish that the insurer acted in good faith as a matter of law or to justify granting a new trial. While interesting on the facts, the case is so fact intensive it provides little precedential value in terms of black letter law.

Summary of Decision

This case arose out of an automobile accident. The insured, Bamford, Inc., purchased a commercial auto liability policy from Regent Insurance Company (Regent). The policy limits were $6 million. Michael Packer (Packer), an employee of Bamford, was involved in a two-vehicle collision with another vehicle driven by Bobby Davis (Bobby). During the accident event, a steel pipe stored on the roof of Packer's vehicle became dislodged and impaled Bobby. He suffered a number of serious injuries and underwent extensive medical treatment. On the day of the accident, Regent opened a claim file establishing a $1 million reserve. As part of the reserve, $700,000 was designated for Bobby's injuries. Bobby and his wife retained attorney Tom Fee (Fee) to represent them. In May 2010, Fee's communications regarding the nature and extent of Bobby's injuries prompted Regent to have the case reviewed by the major case unit. The major case unit retained attorney Brian Nolan (Nolan) to provide a valuation of Bobby and his wife's claims (hereinafter referred to as the Davis claim).

On August 5, 2010, Fee sent Regent a settlement package offering to settle the Davises' claims for Bamford policy limit of $6 million. Fee asserted that the claims had a verdict potential between $7.5 and $10 million. The demand further indicated that if the offer was not accepted by September 13, the settlement amount would increase to $10.6 million. The settlement package provided by Fee included videotaped interviews of an accident witness and Bobby's emergency room physician, together with an additional 1,000 pages of attachments, such as the police report, photographs, medical records, an economist's report, tax returns, and a life care plan. Later in the latter part of August, Regent hired Nolan to defend Bamford against the Davises' claims. Bamford independently hired another attorney, Daniel Placzek (Placzek), to represent its interests in the matter. On August 23, Placzek sent Regent a letter asserting that the Davises' claims presented an exposure risk above Bamford's $6 million policy limit and demanded that Regent settle the claims within the policy limits. In September 2010, Nolan informed Regent that he did not think the value of the Davises' claims was close to the policy limits. He valued their claims at less than $1 million. Nolan also advised that he was investigating a possible loss-of-consciousness defense on the theory that Packer, suddenly and unforeseeably, lost consciousness before the accident. Nolan told Regent that such a defense would be a complete bar to liability, but that he needed more information.

Later, Nolan informed Regent that he had learned that Packer had a history of seizures which were

controlled with medication. Nolan expressed his belief that the loss-of-consciousness defense had a 25% chance of success. At the same time, Nolan increased his value of the Davises' claims to a settlement value between $1.5 and $1.75 million.

Bamford and the Davises participated in a mediation in December 2010 with Regent authorizing Nolan to commit as much as $1 million to settle the claims. Nolan's opening offer was $500,000, and Fee's opening demand was $6 million. Nolan ultimately came up to $775,000 while Fee ultimately came down to $4,995,000. At that point Regent instructed Nolan to offer $1 million indicating that he would be given additional authority if he thought the case would settle. The mediator's valuation of the case ranged between $2.5 and $3 million. The mediator instructed Nolan not to offer $1 million because the mediator believed that such an offer would not make significant headway in advancing the mediation. A lawsuit followed.

As the defense progressed, Nolan advised Regent that he continued to believe the facts of the case warranted asserting the loss-of-consciousness defense although he advised Regent that it would also need to continue reassessing the defense's applicability throughout discovery.

Regent sought a second valuation opinion from a different attorney, Steve Ahl (Ahl). Ahl valued the claims between $1.75 and $2.25 million. Thereafter the Davises reinstated their policy limits settlement demand citing improvements in their case. Placzek again demanded, on Bamford's behalf, that Regent settle within the policy limits. The adjuster worked on preparing a report to increase the posted reserve for Bobby's claims from $700,000. However, the adjuster was warned by a supervisor that any large increase in the reserve would be a "big red flag" to senior management. The reserve was increased to $1.75 million.

Nolan increased his valuation to $2 million. The adjuster noted to senior management that determining a settlement range was challenging given the unique nature of Bobby's injuries. One executive opined that, based on his perception of Nebraska as a conservative state, "nothing is worth more than $2M in Nebraska." The same executive noted that the loss-of-consciousness defense was problematic in any venue and that the nature of the injuries would be sympathetic. This executive suggested a settlement range between $1.75 and $2 million based on both Nolan and Ahl's recommendations. A second executive suggested that $1.75 million sounded optimistic and warned that the case could get worse. After this, the adjuster prepared a third reserve increase to just under $2 million. At that point the adjuster conveyed to his supervisors that he estimated a 75% chance the case would settle for $2 million. There were several other instances where the adjuster, Nolan and Ahl articulated their perception that Nebraska was a conservative jurisdiction in terms of its verdicts.

A second mediation occurred. On the same day as the mediation, the Davises filed a motion for summary judgment on the loss-of-consciousness defense. At the mediation, Nolan's highest offer was $1.6 million and Fee's lowest settlement offer was $5.4 million. During the mediation, the mediator informed Nolan and the adjuster that the Davises would not settle for less than somewhere in the $3 million range. The mediator made a comment that the adjuster interpreted as indicating that, were the mediator representing Bamford, he would not settle for more than $2.5 million. The day following the mediation, the Davises offered to settle for $5.45 million. For a third time, Placzek demanded that Regent settle within its policy limits.

Because trial was approaching, Nolan prepared a pretrial report which increased his anticipated verdict range to between $2 and $3 million. Nolan also decreased his estimate of the success of the loss-of-consciousness defense from 25% (as expressed in December 2010) to 10%. He reported that a jury might be troubled by the potential merits of the loss-of-consciousness defense.

The adjuster, Nolan and several Regent executives and adjusters participated in a telephonic roundtable where Nolan informed the group that Fee had advised him that he would recommend to his clients a settlement between $3.8 to $3.9 million. The roundtable group decided to increase the reserve for the Davises' claims by $250,000 to $2.25 million.

Placzek sent a fourth letter demanding that Regent settle within its policy limits. This letter provided a detailed analysis of the evidence developed in discovery which Placzek believed would support an excess verdict. He also specified how he believed the evidence would combat Nolan's planned arguments.

The district court granted the Davises' motion for partial summary judgment striking the loss-of-consciousness defense and finding Bamford liable for the accident as a matter of law. Therefore, the only issue at trial was the amount of damages to which the Davises were entitled. As a result of this development, Nolan and the adjuster requested authorization to make a $3 million settlement offer. Neither the adjuster nor Nolan believed that the Davises would accept $3 million.

The week before trial, the parties' settlement negotiations intensified. Fee offered to settle for $5.3 million. Nolan made a counteroffer of $1.75 million. Thereafter, Fee offered to settle for $5.2 million or, in the alternative, he proposed a bracket in which the Davises would move to $4.2 million if Bamford would move to $3.2 million, with the Davises having the next move. Fee made it clear that the Davises would not settle in the $2 million range. Nevertheless, Nolan offered $1.85 million. The day before trial, Fee offered to settle for $3.9 million with Nolan countering with an offer of $2.05 million.

Once trial commenced, Fee refused to continue settlement discussions. Regent did not make another offer under the belief that its last offer of $2.05 was still pending because it had not been explicitly rejected. The jury returned its verdict for $10.6 million. Bamford appealed. During the pendency of the appeal, the parties settled the case for $8 million. Bamford was responsible for the amount in excess of the policy limits.

Bamford then sued Regent alleging that Regent breached its fiduciary duty and acted in bad faith in refusing to settle the Davises' claims. Following a five-day trial, a jury returned a verdict for Bamford, awarding its requested damages of $2,037,754.33. Following the verdict, Regent renewed its motion for judgment as a matter of law or for a new trial, which the district court denied. The Eighth Circuit affirmed, finding that "Bamford presented sufficient evidence from which a reasonable jury could conclude that Regent acted in bad faith in failing to settle the Davises' claims within the policy limits."

On appeal, Regent argued that there was no evidence that was presented at trial from which a reasonable jury could find that Regent had refused to settle the Davises' claims in bad faith. The trial evidence demonstrated that the failure to settle was an honest mistake in judgment. In that regard, Regent contended that its conclusion that it ultimately had to pay over $2 million more than the Davises' last demand of $3.9 million and that its alleged bad faith was not supported by the record because it made multiple efforts to settle; it continuously increased its reserves and offers; it followed the advice and valuations of Ahl, Nolan, and the two mediators; it discussed the claims in a roundtable meeting with senior management; it reasonably relied on Nebraska's reputation as a conservative jury verdict jurisdiction; Fee himself opined that the verdict would be at least in the $3.5 to $4.5 million range; and Regent believed that settlement negotiations would continue during the trial.

In reviewing these arguments, the court noted that if accepted, they could perhaps be adequate to support the conclusion that Regent acted in good faith. However, with a pending motion for summary judgment, the question was, drawing all reasonable inferences in Bamford's favor, whether a reasonable jury could find that Regent acted in bad faith. In that regard, the court held that there was sufficient evidence in the record to support such a conclusion. The court found that while the jury could have concluded that Regent, by relying on valuations received from mediators, counsel, and internal adjusters, reasonably embraced a low value for the Davises' claims early in the case, the jury could also find that Regent ultimately acted in bad faith in failing to reassess the value of the claims in light of case developments and advice from its own players that the low value was inaccurate. The court observed that the trial court did not merely grant the Davises request to strike the loss-of-consciousness defense, but also found Bamford liable as a matter of law. During the pretrial period, Nolan and the adjuster had counted on a tempering of damages when the jury heard the purportedly sympathetic facts that would be introduced to support the loss-of-consciousness defense such as Packer's history of seizures and use of seizure medication. The trial court's ruling meant that the jury neither heard the purported sympathetic facts supporting a medical emergency nor would the jury hear other evidence that could moderate its view of Bamford's culpability. The court found that a reasonable jury could view Regent's stark inaction in the face of the seismic and unforeseen developments in the case and, contrary to the advice from its counsel and primary adjuster, as a complete and total refusal

to consider the fiduciary duty it owed Bamford.

The court held that Bamford had presented sufficient evidence from which a reasonable jury could conclude that Regent acted in bad faith by failing to settle.

Brief Statement

Insurance companies must continuously re-evaluate a case value when there is a substantial likelihood of an excess verdict. // Plitt

No Settlement Duty Without Clear Liability in Florida

Insurer Absolved of Excess Liability

Welford v. Liberty Ins. Corp., __ F. Supp. 3d __, 2016 WL 3360431 (N.D. Fla. June 24, 2016)

Case at a Glance

A federal court applying Florida law has granted summary judgment for a liability insurer on a "failure to settle" claim. Because the insured's liability was not clear, the insurer had no duty to initiate settlement discussions.

Summary of Decision

Late at night in 2009, on a rural Florida highway, Matthew Zisa made two attempts to pass a Mercury Sable driven by John Middleton. The first attempt was unsuccessful. The second was disastrous.

During the first attempt, Middleton allegedly sped up while Zisa tried to pass. On his second try, Zisa was traveling in the path of oncoming traffic when he struck three friends who were walking in that lane, wearing dark clothes and without a flashlight. Two of them died, and the third was injured.

The Sable was insured by Liberty under an auto policy issued to Lisa Mottsey. Mottsey's daughter Cassie Mayhair used the car, and had entrusted it to Middleton, her boyfriend, before the accident. The liability limits for bodily injury were $10,000 per person and $20,000 per accident.

What happened after that is complicated and disputed, but the main point is that no one initially felt Mayhair was liable for the accident. The police report blamed the pedestrians for the accident, Mayhair denied liability, and even the investigator for the plaintiffs' attorney found no grounds to pursue Mayhair. In fact, Mottsey was so incensed at the possibility of a claim that she falsely told the plaintiffs' investigator that she was uninsured. Eventually, two of the victims filed suit against Mottsey, who forwarded the complaint to Liberty. Within two days, Liberty tendered its policy limits, which were initially rejected. The Welford claim went to trial and resulted in a judgment against Middleton (the Sable's driver) of $501,600. Mottsey and Mayhair were each assessed $100,000, which was subsumed within Middleton's liability.

In the obligatory "failure to settle" case, the plaintiffs argued that Liberty was liable under *Powell v. Prudential Prop. & Cas. Ins. Co.*, 584 So. 2d 12 (Fla. 3d DCA 1991). In *Powell*, the Court of Appeal had imposed an affirmative duty on a liability insurer to initiate settlement discussions when liability was clear and damages would likely exceed the policy limits. The plaintiff in Welford argued that, although Liberty had tendered its limits within two days of receiving the lawsuit, it had failed to promptly tender the limits earlier, when Mottsey first notified it of the accident. Granting summary judgment for Liberty, however, the court held no reasonable trier of fact could have found liability was "clear" when Mottsey reported the claim. Indeed, she had initially suggested her daughter was only a witness to an accident, not that she (or anyone else) was responsible for the accident. Moreover, the highway patrol officer had placed no blame on Middleton, all of the insureds vehemently disputed liability, the Sable never touched the plaintiffs or Zisa's car, and plaintiffs' investigator even concluded there was no basis to pursue the Sable driver. As if that were not enough, even plaintiffs' bad faith expert conceded in deposition that "[n]o, there was no clear liability" on the part of Middleton, Mayhair, or Mottsey.

In reaching that determination, the court rejected plaintiffs' proffered interpretation of the word "clear" as meaning the insured had "some potential" liability. If that were the case, the court reasoned, an insurer would have to settle every claim, "as it is almost always possible that an insured may be found at least *partially* liable for an injury." Rather than defining

precisely what "clear" means, the court found it sufficient that the insureds' liability was not "clear" under *any* objective measure of the term. Because there was no basis to contend Liberty put its own interests ahead of its insureds', especially where it tendered its limits within two days of seeing the complaint, summary judgment was proper.

Comment

Florida is "ground zero" for the movement to set up insurers on creative failure-to-settle claims, and *Welford* is not unique by any means. What is rare, however, is the court's refusal to countenance the attorneys' attempt to create a failure-to-settle claim. For now, the buck has stopped at the District Court. Time will tell whether the Eleventh Circuit, which has recently undercut another Florida judge's efforts to block such tactics, will likewise reverse this one. // Barnes

Bad Faith/Excess Insurance

Litigated Judgment Is Not Prerequisite to Excess Insurer's Equitable Subrogation Claim against Primary Insurer for Bad Faith Failure to Settle

Excess Insurer Paid Portion of Settlement within Its Policy Limits

RSUI Indemnity Co. v. Discover P & C Insurance Co., __ Fed.Appx. __, 2016 WL 1745119 (9th Cir. May 3, 2016)

Case at a Glance

Under California law, an excess insurer, when faced with a primary insurer's unreasonable refusal to pay a settlement demand within policy limits, may contribute to the settlement on behalf of the insured, and then sue the primary insurer to recover the amount of the settlement under an equitable subrogation theory. The absence of a litigated judgment does not preclude an equitable subrogation action for bad faith failure to settle where the excess insurer actually contributes to the settlement.

Summary of Decision

RSUI Indemnity Company (RSUI) provided excess liability insurance and Discover P & C Insurance (Discover) provided primary to an insured. Presumably while defending the insured (the opinion's facts are sketchy), Discover rejected several offers to settle within policy limits. Without Discover's permission, the insured and the excess insurer settled with the claimant for an amount in excess of Discover's primary limits, and RSUI paid the excess on behalf of its insured.

RSUI then sued Discover for bad faith failure to settle under an equitable subrogation theory. Because the personal injury action had resolved through settlement, there was no litigated excess judgment. The district court concluded that California law required the entry of a litigated excess judgment as prerequisite to an equitable subordination action.

The Ninth Circuit disagreed with the district court's prediction of how the California Supreme Court would rule when presented with the question of whether a litigated excess judgment is a prerequisite to an equitable subrogation action by an excess insurer against a primary insurer. In *Hamilton v. Maryland Casualty Co.,* 27 Cal.4th 718, 117 Cal.Rptr.2d 318, 41 P.3d 128 (Cal.2002), the supreme court had made a litigated excess judgment an element of a *policyholder's* assigned cause of action against a primary insurer for bad faith failure to settle. The *Hamilton* opinion did not, however, address whether a litigated judgment is an element of an excess insurer's equitable subrogation claim against a primary insurer, and the intermediate California appellate courts have reached conflicting results on the question. *Compare Fortman v. Safeco Ins. Co.,* 221 Cal.App.3d 1394, 271 Cal.Rptr. 117 (Cal.Ct.App.1990) (holding that an excess insurer's equitable subrogation claim does not depend on the entry of an excess judgment to prove damages to the insured), *with RLI Ins. Co. v. CNA Cas. of Cal.,* 141 Cal.App.4th 75, 45 Cal.Rptr.3d 667 (Cal.Ct.App.2006) (expressly rejecting *Fortman*).

The Ninth Circuit predicted that the California Supreme Court would adopt the rule announced in *Fortman.* In distinguishing *Hamilton,* the court emphasized the *Hamilton* court's concern with the risk of a collusive settlement between the insured and the claimant in which the insured and the claimant

agree to inflate a stipulated judgment beyond the actual value of the case, absolving the insured of financial liability and artificially increasing the value of the claimant's subsequent suit against the insurer—a concern not present when an excess insurer funds a portion of a settlement. If the *Hamilton* court had intended its decision to apply to equitable subrogation actions by excess insurers, the Ninth Circuit reasoned, it would have overruled *Isaacson v. California Insurance Guarantee Ass'n,* 44 Cal.3d 775, 244 Cal.Rptr. 655, 750 P.2d 297, 308-09 (1988), in which the supreme court had previously allowed an action for breach of the duty to settle without a litigated excess judgment where the insured had expended its own funds to settle the underlying claim in excess of the insurance policy limits. Instead, the *Hamilton* opinion distinguished *Isaacson. Fortman,* in the Ninth Circuit's view, recognizes the critical distinction in *Hamilton* and *Isaacson* between settlements that are potentially collusive and settlements that are not.

The Ninth Circuit added that the *Fortman* rule is "consistent with public policy interests identified by California courts in the insurance context: it promotes the settlement of claims, promotes excess insurers' contribution to settlement, and is favorable both to the insured and to claimants." As the Ninth Circuit had previously observed, under California law, "policy considerations pertinent to both the courts and the insurance industry favor allowing an excess insurer to enforce a primary insurer's duties to the insured." *Valentine v. Aetna Ins. Co.,* 564 F.2d 292, 297 (9th Cir.1977). // DiMugno

Bad Faith/ Genuine Dispute Defense

"Genuine Dispute" over Coverage Relieves Property Insurer of Liability for Insurance Bad Faith Where Insured's Lack of Cooperation Impeded Insurer's Investigation

Insurer Entitled to Summary Judgment on Bad Faith Claim

Paslay v. State Farm General Insurance Co., 248 Cal.App.4th 639, 203 Cal.Rptr.3d 785 (2d Dist. 2016)

Case at a Glance

Although triable issues of fact existed regarding whether the insurer breached the insurance contract by refusing to pay for repairs, a genuine dispute about coverage entitled the insurer to summary judgment on the insured's bad faith and elder abuse claims where the insureds prematurely commenced repairs precluding the insurer from adequately investigating the nature and cause of the loss.

Summary of Decision

The insureds, Clayton and Traute Paslay, sought coverage under their homeowners property insurance policy for water infiltration damage resulting from the failure of a roof drain during a rain storm. The insurer, State Farm, did not contest coverage for water infiltration damage, but for damage to the master bathroom and ceiling drywall that the insurer contended did not result from water infiltration related to the storm. The Paslays sued State Farm for breach of contract, insurance bad faith, and, since Traute Paslay was 80-years-old, elder abuse under the California Elder Abuse Act, Welfare & Institutions Code, §§ 15610.07, 15610.30.

Summary Judgment Evidence on Existence of "Genuine Dispute" Regarding Coverage

The issue examined in the published portion of

the Second Appellate District's opinion was whether the trial court properly granted summary judgment in favor of State Farm on the insureds bad faith and elder abuse claims on the ground that a "genuine dispute" existed regarding coverage for the disputed portion of the loss. The summary judgment evidence showed that the insured's policy contained a $5,000 limit on mold damage and covered building code upgrades only if the increased costs of complying with current building codes enforcement is "directly caused" by an insured loss. Consequently, the policy covered the full cost of mold abatement (amounts in excess of the $5,000 sublimit) and the cost of asbestos removal to comply with current building codes only in areas of the Paslays' home that suffered water infiltration damage.

After an initial inspection, State Farm gave the Paslays a $25,000 check as an advance on repairs and approved an additional $85,000 advance to cover the cost of securing alternative living arrangements while the Paslays' home was being repaired. During a second inspection ten days later, Clayton Paslay expressed concerns about mold damage and stated that wanted his contractor to remove drywall ceilings throughout the house in order to abate asbestos. In response, State Farm's adjuster advised Clayton of the policy's $5,000 mold limit, which included the cost of drywall removal for mold testing and remediation. In a letter following the second inspection, the adjuster reiterated his advice about the mold sublimit and stated that State Farm was "awaiting an estimate from your contractor regarding the asbestos abatement for the ceiling damaged as a result of the water loss." Before submitting the estimate or any proposal regarding the scope of work, the Paslays' contractor removed drywall ceilings throughout the house. The contractor did so without informing State Farm in advance.

Over the next several months, the Paslays obtained a building permit for a complete remodel of the master bathroom and submitted a $262,234.70 repair estimate to State Farm. After receiving the repair estimate, State Farm's adjuster and a contractor hired by State Farm reinspected the property to determine the scope of water damage. They discovered that the Paslay's master bathroom had been reduced to studs, and the shower entry reframed. State Farm maintained the contractor's commencement of work before the insurer completed its investigation precluded the insurer from determining whether the costs of demolishing and reconstructing the master bathroom, a new electrical panel, and replacing undamaged ceiling drywall were related to water infiltration.

When the initial six-month lease for the rented premises expired, State Farm authorized payment of their rent on a monthly basis. However, the landlord rented the residence to a different tenant and the Paslays had to move back into their home before repairs were completed.

The Paslays' final repair estimate totaled $349,589.27. State Farm ultimately paid the Paslays more than $248,000 under the policy, but refused to pay for the demolition and reconstruction of the master bathroom, a proposed new electrical panel, and the replacement of undamaged ceiling drywall on the ground that such costs were unrelated to water infiltration.

The Paslays contended that State Farm's refusal to pay the disputed portions of the claim constituted bad faith and elder abuse. In opposition to State Farm's motion, the Paslays focused on State Farm's failure to investigate whether rain water infiltrated the master bathroom. According to Clayton Paslay, he and his contractor examined the master bathroom for water damage shortly before the Paslay's were to leave on an overseas trip. After removing portions of the bathroom's wall, they discovered substantial water damage. In exploring the extent of the damage, they removed cabinets, fixtures, and other parts of the bathroom. Clayton stated that he phoned the State Farm adjuster, discovered that he was unavailable, and left a message requesting an immediate investigation of the water damage. Two days later, the adjuster arrived at the house. By then, the wet debris had been removed from the master bathroom and discarded, although Clayton claimed to have sent pictures of the wet debris to the adjuster.

The Paslays' contractor testified that the work he performed in the bathroom "was done to repair the damage done by the water intrusion" and that the only way to determine the extent of water intrusion was to remove portions of the drywall ceilings throughout the house. Regarding the replacement of the electrical panel, the contractor testified that the existing panel was overloaded and posed a safety hazard.

Bad Faith

Based on this evidence, the court of appeal upheld summary judgment for State Farm on the bad faith claim even though triable issues of fact remained with respect to the breach of contract claim. In so ruling, the court cited numerous authorities for the proposition that "an insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not liable in bad faith, even though it might be liable for breach of contract." *Quoting Chateau Chamberay Homeowners Assn. v. Associated International Insurance Co.,* 90 Cal.App.4th 335, 347, 108 Cal.Rptr.2d 776 (2001). The court determined a genuine dispute existed over whether water infiltration damage necessitated repair of the master bathroom, removal of the drywall ceilings, and replacement of the electrical box. The substantial disparity in the scope and cost of repairs did not, in the court's view, suggest that State Farm acted in bad faith.

The court acknowledged that an insurer invoking the genuine dispute defense must have conducted a thorough and unbiased investigation of its insured's claim. The court, however, found that State Farm's investigation was reasonable as a matter of law because the Paslays had prevented the insurer from investigating the damage in the master bathroom and to the ceilings. The court explained: "Generally, the reasonableness of an insurer's conduct 'must be evaluated in light of the totality of the circumstances surrounding its actions.' [] Thus, the adequacy of the insurer's claims handling is properly assessed in light of conduct limiting the insurer's investigation by parties with an interest in policy benefits." Here, "the Paslays removed the damaged property before State Farm had an opportunity to conduct a full assessment of the Paslays' proposals and contentions. The record shows only that State Farm did what it could to assess the claimed losses before denying them. In our view, even if those denials were mistaken, nothing suggests that State Farm acted in bad faith. Summary adjudication was therefore proper on the bad faith claim."

Elder Abuse

The court held its dismissal of the bad faith claim was also dispositive of the elder abuse claim. The Elder Abuse Act applies only when a person or entity "[t]akes, secretes, appropriates, obtains, or retains real or personal property of an elder" for "a wrongful use or with intent to defraud, or both," as well as "by undue influence...." (Welfare & Institutions Code, §§ 15610.30(a)(1); (a)(3).) Here, State Farm's liability for elder abuse turned on whether its withholding of disputed funds constituted a "wrongful use" of those funds. Answering the question in the negative, the court concluded that a wrongful use "occurs only when the party who violates the contract actually knows that it is engaging in a harmful breach, or reasonably should be aware of the harmful breach." Having already determined that State Farm had a reasonable basis for contesting coverage, the court found "no evidence that State Farm acted in subjective bad faith or unreasonably in denying additional benefits."

The court distinguished *Negrete v. Fidelity and Guar. Life Ins. Co.,* 444 F.Supp.2d 998 (C.D.Cal.2006). There, a federal court held that the plaintiff's allegations that the insurer employed deceptive and fraudulent practices in selling annuities to senior citizens supported a cause of action for elder abuse. The federal court concluded that the fraud allegations were sufficient to state an elder abuse claim. Here, by contrast, Traute raised no triable issues regarding the existence of bad faith or unreasonable conduct by State Farm.

Comment

Presley is unusual in that the insured's conduct precluded the insurer from investigating whether the disputed portion of the loss was covered. In the absence of such evidence, insurers are less likely to obtain summary judgment based on the existence of a genuine dispute about coverage. In *Wilson* v. 21st Century Ins. Co., 42 Cal. 4th 713, 68 Cal. Rptr. 3d 746, 171 P.3d 1082 (2007), the California Supreme Court held that whether a "genuine" or "legitimate" coverage dispute exists, relieving a first party insurer of extracontractual liability for contesting of coverage, depends on the "totality of the circumstances." The totality of circumstances test adopted by the supreme

court in *Wilson* arguably limits the effectiveness of the genuine dispute rule as a defense to bad faith cases. Under *Wilson,* insurers may no longer rely on the fact that evidence points in both directions on coverage to establish the existence of a genuine dispute and obtain summary judgment on bad faith. A dispute is now genuine, and an insurer's erroneous denial of coverage is reasonable, only if the insurer properly weighed and evaluated the evidence favoring coverage and searched for facts supporting coverage in its investigation. In the absence of evidence that the insured interfered with the insurer's investigation, the quality of an insurer's investigation and evaluation of a claim will almost always be a factual question precluding summary judgment. *See, e.g., Blake v. Aetna Life Ins. Co.,* 99 Cal.App.3d 901, 905-906 (1979) (failure to supply critical information negates bad faith). // DiMugno

Builder's Risk Insurance

Issuance of Homeowners Policy Does Not Terminate Contractor's Builder's Coverage for Home Still under Construction

Builder's Risk Policy Must Cover Fire Damage

Fontana Builders, Inc. v. Assurance Company of America, __ N.W.2d __, 2016 WL 3526408 (Wis. June 29, 2016)

Case at a Glance

A contractor's builder's risk policy did not terminate upon the issuance of a homeowners policy held by the occupant/prospective purchaser of a house under construction. According to the court, the contractor had a reasonable expectation that coverage would remain in effect under the builders risk policy while construction continued and while the contractor remained the owner of the house. Thus, the builders risk insurer could not deny coverage for fire damage to the property on the basis that the policy had terminated.

Summary of Decision

Fontana Builders involved a 2007 fire that destroyed a home that was still under construction. At the time of the loss, the property was insured under an Assurance builder's risk policy that provided coverage to building contractor, Fontana Builders. The home was also insured under a homeowner's policy issued by Chubb, which covered the occupants/presumptive purchasers, the Arcolas. Notably, Mr. Arcola was also the sole shareholder of Fontana Builders. After the fire, Chubb settled with the Arcolas. Assurance, meanwhile, denied coverage, based on a "permanent property insurance" condition in the builder's risk policy. The clause fell under a section of the policy specifying "WHEN COVERAGE BEGINS AND ENDS," and provided that "coverage will end at the earliest of" a number of circumstances including "when permanent property insurance applies."

After coverage was denied, Fontana initiated suit. Initially, the trial court granted summary judgment that the Assurance policy provided coverage to Fontana as a matter of law. In the subsequent jury trial, the jury determined the amount Assurance owed Fontana under the policy, and also awarded bad faith damages. The court of appeals reversed the decision, holding that the trial court erred when it found that the Assurance policy provided coverage as a matter of law; instead, the jury should have made this determination. The court of appeals reasoned that, under Wisconsin law, when words or terms in a contract must be construed using extrinsic evidence, the question is one for the trier of fact. On remand, the jury determined that the policy did not provide coverage for Fontana's fire loss.

On appeal, the Supreme Court of Wisconsin answered the following questions: (1) was the interpretation of the "when permanent property insurance applies" clause a question of fact for a jury or a question of law for the court? (2) if interpretation of the "permanent property insurance" condition was a question of law, did the condition terminate Fontana's coverage under the policy? The court held (1) interpretation of the clause was a question of law for the court; (2) the condition did not terminate Fontana's coverage.

As to its first holding, the court examined prior case law and explained that the interpretation of a

contract, insurance or otherwise, creates a question of fact for the jury only when the extrinsic evidence helps demonstrate or illuminate the parties' understandings of the clause at issue at the time they entered the contract: "interpretation of an insurance contract becomes a question for the jury only when necessary to resolve factual disputes about the parties' understandings at the time they entered into the contract." Since neither party argued that extrinsic evidence explained their respective understanding of the "permanent property insurance applies" clause, it was improper for a jury to determine its meaning.

In interpreting the clause, the court found the phrase to be ambiguous when read in isolation. However, when it considered the phrase in the context, i.e., "when coverage begins and ends," it found that the phrase related to termination of the builder's interest in the property. The court therefore examined the interests covered by the Assurance and Chubb policies to determine whether the existence of the Chubb policy terminated Fontana's coverage with Assurance. The court focused on the fact that Fontana was a closely held corporation, separate and distinct from the Arcolas. Further, Fontana obtained builder's risk coverage to protect its interest in the product it was building, while the Arcolas obtained homeowner's insurance "to guard against the risk of loss to their belongings on the property." The court thus reasoned that because the Arcolas obtained the Chubb policy for their interest as occupants and prospective purchasers, this did not trigger the termination of Assurance's policy since the Chubb policy did not apply to the same interest as the Assurance policy. The court further reasoned that if this were not the case, it would be possible for any third party to terminate a builder's risk policy by buying, e.g., insurance near the end of construction while preparing for closing. // Troy

Directors & Officers Insurance

D & O Insurance Policy's "Personal Profit Exclusion" May Apply To Suit Alleging Misrepresentations That Induced Consultant To Continue Working Without Pay

Misrepresentations May Have Provided Insured with Opportunity to Obtain Economic Benefits

Winbrook Communication Services, Inc. v. United States Liability Insurance Company, 89 Mass. App. Ct. 550, 52 N.E.3d 195 (2016)

Case at a Glance

Under Massachusetts law, the "personal profit exclusion" in a directors and officers insurance policy may preclude coverage of a suit alleging that the insureds made negligent misrepresentations to induce a consultant to continue working without pay.

Summary of Decision

DeSales Group, LLC retained Winbrook Communication Services, Inc. to help develop and promote a children's' storybook series. The series never went to market. Winbrook sued DeSales and William York (collectively, DSG), alleging that York negligently misrepresented DSG's financial condition in order to induce Winbrook to continue its work without pay. Winbrook sought to recover compensation for its work.

DSG was insured under a directors and officers policy. The insurer denied coverage, contending that Winbrook's claims were for failure to pay a contractual debt, which did not constitute a "Wrongful Act" within the meaning of the policy. The insurer also contended that exclusion C, a "personal profit exclusion," applied. The insurer did not defend under a reservation of rights, and did not seek a declaratory judgment.

A default judgment was entered against DSG. Winbrook then brought a declaratory judgment action against the insurer. A trial court ruled that the underlying case established that Winbrook alleged

that DSG was liable for negligent misrepresentation, which was a covered claim. The trial court ruled that there was a factual dispute as to whether exclusion C applied. The trial court denied the insurer's request to conduct discovery on the issue of whether there had been a negligent misrepresentation. Neither party, however, requested discovery as to whether exclusion C applied. A different trial court judge then granted summary judgment in favor of the insurer on its claim that exclusion C precluded coverage. The trial judge ruled that the exclusion applied because DSG gained an advantage or an opportunity to profit based on Winbrook's work without payment. The trial judge entered summary judgment in favor of the insurer. The appellate court reversed and remanded.

The appellate court determined that the default judgment against DSG established that DSG had been sued for negligent misrepresentation. The default judgment bound the insurer, because it had notice of the claim and refused to defend. The insurance policy expressly covered negligent misrepresentation claims. The underlying suit did not allege a breach of contract, but instead alleged that DSG made false promises to induce Winbrook to continue to work. The damages Winbrook sought to recover arose from the alleged misrepresentations. Coverage was not precluded by the fact that Winbrook's damages may have been similar to or equivalent to contract damages.

The court held that there were factual issues as to whether coverage was precluded by Exclusion C, which stated,

> "[the insurer] shall not be liable to make payment for Loss in connection with any Claim made against any Insured arising out of, directly or indirectly resulting from or in consequence of, or in any way involving: ...
>
> "C. any of the Insureds gaining in fact any profit, benefit, remuneration or advantage to which such Insured was not legally entitled."

The court held that the exclusion may apply to the extension of trade credit, because this may create an advantage by providing an opportunity to attract capital or customers.

The court held that there were factual issues as to whether DSG gained such an advantage. Discovery had not been conducted on this issue. The insurer did not show that, following the alleged misrepresentations, DSG obtained money, goods, or services to which it was not entitled. On the other hand, there was evidence that, following the misrepresentations, Winbrook, as well as an artist, continued to provide services, and goods were produced for trade shows. // Jordan

Discovery/Privilege

New York High Court Restores Litigation Requirement to Common Interest Doctrine

Disclosure to Third Parties with Common Interest Results in Waiver of Attorney-Client Privilege unless Litigation Is Pending or Anticipated

Ambac Assurance Corp. v. Countrywide Home Loans, Inc., __ N.E.3d __, 2016 WL 3188989 (N.Y. June 9, 2016)

Case at a Glance

The Court of Appeals of New York declined to expand the scope of the common interest doctrine as it related to the protection of privileged communications by eliminating the requirement that the communication be related to litigation. Instead, it reaffirmed the state's long-standing requirement that, in addition to the other elements of the common interest privilege, litigation must be anticipated for the privilege to exist.

Summary of Decision

Ambac, an monoline insurer that guaranteed payments on certain residential-backed loans, sued Countrywide. The lawsuit alleged that Countrywide breached contractual obligations, fraudulently misrepresented the quality of their loans and fraudulently induced Ambac to guarantee them. Ambac also named Bank of America (BOA) as a defendant. BOA and Countrywide were in merger negotiations in 2007, announced a merger plan on January 11, 2008, and closed the merger on July 1, 2008. During

discovery, BOA withheld certain communications between BOA and Countrywide that occurred after the signing of the merger plan but before the merger closed. BOA claimed that the communications were protected by the attorney-client privilege since they pertained to a number of legal issues the companies had to resolve jointly in anticipation of the merger closing.

Ambac moved to compel production of these documents. A referee issued a report that stated that if a common legal interest exists, and litigation is anticipated, then the common interest privilege comes into play; if not, then the doctrine does not afford protection and the disclosure to third party results in waiver of the privilege. The referee ordered the parties to review the withheld documents, update the privilege logs and submit any documents still in dispute. BOA moved to vacate the ruling; the Supreme Court denied the motion. BOA appealed. The Appellate Division ruled in its favor, deciding to follow the federal courts that have "overwhelmingly rejected" a litigation requirement.

In reversing this decision, the Court of Appeals reviewed the scope of the attorney-client privilege in New York, which is "narrowly constructed"; the party asserting the privilege bears the burden of establishing entitlement to the protection, i.e., that the communication is primarily for legal services, in the course of a professional relationship, and that the communication was confidential and not waived. Normally, the presence of a third party waives the privilege, but there are exceptions, including the common interest exception. The court reviewed the history of the privilege, which stems from criminal trials in which sharing information between represented parties was for the limited purpose of assisting common claims. After reviewing this history, the court declined to modify the existing requirement that shared communications must be in furtherance of a common legal interest in pending or reasonably anticipated litigation in order to be privileged from disclosure and expand the doctrine to protect shared communications in furtherance of any common legal interest.

The court accepted as reasonable the idea that privileged, shared communications must be limited to situations where the benefit and necessity of sharing communications is at its highest—i.e., during litigation. The court rejected BOA's view that banks constantly face the threat of litigation and that an expanded common privilege would promote better legal representation, ensure compliance with the law and help avoid litigation. The court saw no evidence that mergers and acquisitions would *not* go forward within the state if the privilege were not extended, or that corporate clients would stop complying with the law. Rather, the court perceived the greater difficulty to be defining when the "common interest privilege" would exist outside the litigation context; the danger would be the elimination of evidence and that the underlying communication would really be for a commercial purpose, rather than for securing legal advice. The requirement of litigation serves as a "valuable safeguard against separately-represented parties who seek to shield exchanged information from disclosure based on an alleged commonality of legal interests but who have only commercial or business interests to protect." // Troy

Duty to Defend

Wisconsin High Court Rejects Use of Extrinsic Evidence to Create Duty to Defend

Court Reaffirms "Four Corners" Rule with a Vengeance

Water Well Solutions Service Group, Inc. v. Consolidated Ins. Co., __ N.W.2d __, 2016 WL 3545838 (Wis. June 30, 2016)

Case at a Glance

In a split decision, the Wisconsin Supreme Court has unambiguously reaffirmed the "four corners" rule governing a liability insurer's duty to defend. Despite a vigorous dissent, the court confirmed there are no exceptions to the rule that extrinsic evidence cannot create a duty to defend, and disapproved of contrary authority from the state's intermediate court of appeal.

Summary of Decision

In 2009, the water district for Waukesha,

Wisconsin, hired Water Well Solutions Service Group to replace a pump on its well. After the new pump was installed, it came loose from the pipe column and fell to the bottom of the well, requiring further repairs. Argonaut Insurance Company paid for the repairs under the district's property policy, and brought a subrogation action against Water Well, which tendered its defense to Consolidated under a CGL policy. Consolidated denied coverage on the ground the only damage was to Water Well's own product, an excluded CGL risk.

In Water Well's subsequent bad faith suit, the trial court granted summary judgment for Consolidated, and the intermediate appellate court affirmed. The Wisconsin Supreme Court accepted review to consider whether to create an exception to the "four corners" rule, under which an insurer's duty to defend is measured solely by the allegations of the underlying complaint, to the exclusion of all other evidence. After considering the proposal, the high court rejected it.

The starting place was the court's 1967 decision that established the "four corners" rule in the first place. Since then, all appellate decisions in Wisconsin, save one, had steadfastly adhered to the rule. Despite that, Water Well invited the court to create a limited exception where (1) the underlying suit fell within the insuring clause, (2) the insurer denied coverage based on an exclusion without first seeking declaratory relief, and (3) the factual allegations were incomplete or ambiguous. After reviewing authority from Wisconsin and elsewhere, the court rejected the proposed exception, reasoning that it lacked both precedent and a compelling rationale. In the majority's view, the "four corners" rule promoted certainty and avoided speculation over the underlying plaintiff's "true" allegations. The court emphasized, however, that its decision would not immunize insurers that *incorrectly* analyzed their obligations: such insurers remained liable for the insured's actual defense costs, risked being estopped to deny coverage, and faced extra-contractual liability (including punitive damages) for improperly denying coverage. Moreover, the court noted, it continued to recommend that insurers seek declaratory relief prior to denying an insured's defense to make sure no coverage was available. That said, on the facts before it, Consolidated had correctly denied coverage because the only damages sought in the underlying complaint were for repair of the insured's faulty product.

A vigorous dissent by two justices disagreed with the majority opinion, both in principle and in its application to the case before it. According to the dissent, Wisconsin was in a shrinking minority of jurisdictions clinging to a strict application of the "four corners" rule, and Wisconsinites would be better served by a rule that recognized substance over form in allowing extrinsic evidence to inform the duty to defend.

Moreover, even applying the "four corners" rule, the dissent would have found a duty to defend because Argonaut's subrogation suit was not clearly limited to damage to Water Well's product. To the contrary, the complaint mentioned damage to "pipes" without saying who owned them, and evidence in the summary judgment record showed there was resulting damage to Waukesha's well and associated apparatus.

Comment

In *Water Well*, the Supreme Court achieved its goal of making its position clear: "We now unequivocally hold that there is no exception to the four-corners rule in duty to defend cases in Wisconsin." Those are not weasel words. What is less clear is what the court was trying to accomplish with its decision. If only one case in the past 49 years had deviated from the rule, there was no urgent need to accept review and restate what had been the law since L.B.J.'s presidency. Moreover, the inability of the justices to agree on whether the "your product" exclusion applied is rather unsettling, perhaps underscoring the court's admonition that declaratory relief is the safest course for an insurer uncertain of its defense obligation. // Barnes

Excess Insurance/ Duty to Defend

Insured v. Insured Exclusion Does Not Preclude Duty to Defend Third-Party Contribution Claims

Excess Insurer's Duty to Defend Does Not Depend on Exhaustion of Primary Policy

Cincinnati Insurance Co. v. Estate of Chee, __ F.3d __, 2016 WL 3248181 (7th Cir. June 13, 2016)

Case at a Glance

A 16-month delay in notifying an excess insurer did not prejudice the insurer and thus did not relieve the insurer of its duty to defend.

An excess insurer's duty to defend does not depend on the primary insurer paying its full policy limits in the absence of unambiguous policy language conditioning the excess insurer's duty to defend on the exhaustion of primary limits.

If an insured's spouse sues the insured for negligence and her treating physicians for medical malpractice, and the physicians then seek contribution from the insured, the insured v. insured exclusion in the insured's policy precludes a duty to defend the spouse's lawsuit but not the physicians' contribution action.

Summary of Decision

The insured was driving and his wife was a passenger when their car slammed into a tree. His wife died as a result of injuries suffered in the accident. Her estate filed two lawsuits: one against the insured accusing him of negligent driving, and another against the physicians who treated her at the hospital following the accident for professional malpractice. The physician defendants, in turn, filed third-party actions against the insured for contribution should they be held liable to the wife's estate.

The insured had two liability policies: a $250,000/$500,000 primary policy with State Farm Mutual Automobile Insurance Company, and a $5 million excess policy with Cincinnati Insurance Company. State Farm defended the insured against both the estate's lawsuit and the physicians contribution actions.

After denying the insured's request for a defense and indemnity, Cincinnati sought a declaratory judgment that its policy did not apply to either the wife's estate's lawsuit or the physicians' contribution actions. Cincinnati based its denial of coverage on three provisions in its policy: the requirement that the insured provide notice of a claim "as soon as practicable," the duty to defend provision, and the insured v. insured exclusion. The district court ruled against Cincinnati, and the Seventh Circuit, applying Illinois law, affirmed in part and reversed in part. Judge Easterbrook wrote for the Seventh Circuit panel.

Notice

The insured did not notify Cincinnati until 26 months after the accident, although his wife's estate did so 16 months after the accident. The circuit court agreed that notice 16 months after the accident does not "remotely" satisfy the insured's contractual requirement to provide notice "as soon as practicable," but pointed out that the policy allows Cincinnati to deny coverage only if the insured's breach of the notice provision "is prejudicial to us." The court explained that to satisfy the prejudice requirement, Cincinnati must show "concrete prejudice." Cincinnati's assertion that evidence "might have been lost" was not, in the court's view, sufficiently concrete to justify the insurer's refusal to defend.

Duty to Defend

When Cincinnati filed suit, the primary insurer had offered to pay its policy limits, but the offer had not been accepted due to a dispute over the terms of the release. Cincinnati maintained that it was entitled to sit on the sidelines until the primary insurer wrote a check exhausting the primary policy limits. The court disagreed, finding nothing in the defense clause in Cincinnati's policy that conditions the duty to defend on the exhaustion of underlying limits. The defense clause provided:

We will have the right and duty to defend the insured against any suit seeking damages because of bodily injury, personal injury or property damage to which this insurance applies. We will have no duty to defend the insured against any suit seeking damages for bodily injury, personal injury or property damage to which this insurance does not apply. We may, at our discretion, investigate any occurrence and settle any claim or suit that may result when:

a. The applicable limit of the underlying insurance and any other insurance have been exhausted by payment of claims; or

b. Damages are sought for bodily injury, property damage or personal injury to which no underlying insurance or other insurance applies.

As Judge Easterbrook explained,

This is straightforward. If the policy applies to the claim, Cincinnati must defend. Once the applicable limit of underlying insurance has been paid out (by the Chees or the primary insurer), Cincinnati obtains the right to settle the claim or suit. But neither the duty to defend nor the duty to indemnify depends on disbursal of the applicable limit. And for good reason. If another insurer's payment were essential to Cincinnati's duties, then the bankruptcy—or just the unreasonable conduct—of the primary insurer would leave the insured bereft of coverage. Who would buy such a policy? No matter; Cincinnati did not *write* such a policy.

Insured v. Insured Exclusion

Cincinnati's policy excluded coverage for "[b]odily injury or personal injury to any insured." But the exclusion had a statutorily mandated exception "[w]hen a third party acquires a right of contribution against you or any relative." The parties agreed that both the insured's wife and her estate qualified as insured's under the policy and thus the exclusion sans the exception would have precluded coverage for the estate's suit against the insured. The parties also agreed that the exception created coverage for the physicians' contribution action. The issue was whether the exception overrode the exclusion and reinstated coverage not just for the physicians' contribution action, but for the estate's action as well. The district court believed that it did, at least in this case where the various lawsuits were consolidated, and thus ruled that Cincinnati was obligated to defend both the estate's lawsuit and the physicians' contribution action. The circuit court, however, thought otherwise, and, accordingly, reversed the district court's ruling that Cincinnati had a duty to defend the estate's lawsuit.

In reversing the district court, Judge Easterbrook pointed out that no Illinois appellate court has ruled that language similar to the exception to the insured v. insured exclusion in Cincinnati's policy renders the exclusion inapplicable for all purposes once any third party requests contribution, and for good reason. Allowing coverage intra-family suits any time a third party seeks contribution would undermine the exclusion's purpose of discouraging collusive lawsuits and encourage frivolous claims against third parties in order to provoke contribution actions against the insured.

The fact that the lawsuits were consolidated in one action did not change Judge Easterbrook's analysis. Since "the contribution exception for third-party claims applies only to claims *by* the third parties," he explained, "it doesn't matter how many suits are pending, or in how many courts." // DiMugno

Health Insurance

Health Plan Was Not Liable for Providers' Acts under Enterprise Liability Theory

Treating Health Plan and Providers as Separate Entities Would Not Have Inequitable Result

Gopal v. Kaiser Foundation Health Plan, Inc., __ Cal.App.4th __, __ Cal.Rptr.3d __, 2016 WL 3524389 (2nd Dist. May 26, 2016)

Case at a Glance

Summary judgment was properly granted to a health plan on wrongful death and negligence claims arising from different treatment of a nonmember patient by providers contracted with the plan. California law barred vicarious liability claims against the health plan for acts of providers. Joint enterprise liability did not apply when treating the health plan and its medical group and hospitals would not have an inequitable result. Application of liability limits to the providers, but not to the hospital, was not an inequitable result but a policy determination of the legislature.

Summary of Decision

Plaintiff's wife was admitted to the emergency room at a Kaiser Foundation hospital and died after she was transferred to another hospital. She was not a member of the Kaiser Foundation Health Plan. A CT scan revealed that the decedent had a large brain hemorrhage that constituted a neurological emergency. The emergency room did not have neurological services and the decedent therefore needed to be transferred to a facility that could treat her.

The hospital had different transfer protocols and procedures for member and nonmember patients. Members with a neurological emergency were transferred to a Kaiser facility with an available neurosurgeon. In the case of nonmembers, the hospital case manager contacted the patient's insurance provider and asked permission to transfer the patient. Once permission was granted, the nonmember's insurer was responsible for transfer and further care. Decedent waited multiple hours before being transferred, and before receiving surgery almost 15 hours after her CT results. She died two days after surgery. Plaintiff's expert testified that she would not have died had she received prompt appropriate treatment.

Plaintiff sued for wrongful death and negligence, alleging that the hospital, medical group and health plan treated the patient differently than they would have treated a member, in violation of California law, and that the different treatment caused her death. The health plan moved for summary judgment arguing that it did not direct or require providers at the hospital to deal with patients in any particular way, and that the providers exercised their own medical judgment in the course of their employment by the hospital or medical group, not the health plan. Plaintiff argued that the health plan, hospital and medical group comprised a singled integrated joint enterprise completely controlled by the health plan, and that the health plan was liable for the providers' acts and omissions. The trial court granted summary judgment for the health plan, rejecting plaintiff's theory of enterprise liability.

The court of appeal affirmed, concluding that the enterprise liability theory did not apply to the health plan. The Knox-Keene Act governing California health care service plans provided that health plans were not "providers," while the hospital and medical group were. The Act, Health and Safety Code section 1371.5, barred claims against a health plan for vicarious liability, stating that the plan and providers were each responsible for their own acts or omissions. Under California law, however, if the three entities were a single enterprise, they were each liable for all the acts and omissions of each other.

Two conditions were required for application of joint enterprise liability. The first condition was such a unity of interest and ownership that the separate corporate personalities were merged. The second condition was an inequitable result if the acts in question were treated as those of one corporation alone. As to the first condition, the court determined that the unity of interest or ownership between the health plan and providers was authorized by the Knox-Keene Act, which explicitly allowed the health plan to directly own and operate hospitals and to contract with physicians to provide health care to its

members. As to the second condition, however, the court concluded that there was nothing inequitable in requiring plaintiff to look to the providers for compensation for their claims, and that plaintiff was not without recourse or remedy. The court noted that plaintiff sought to hold the health plan liable because it was not subject to the Medical Injury Compensation Reform Act (MICRA) limitation of damages. The fact that providers, but not health plans, were subject to MICRA was not an inequitable result, but a public policy determination made by the legislature. Accordingly, plaintiff's reliance on the enterprise theory was unavailing. // Holt

Policy Interpretation

Colorado Supreme Court Rejects Use of Extrinsic Evidence to Create Ambiguity in Insurance Contract

Insurer's Reliance on the Unambiguous Policy Terms Was Reasonable, Despite Extrinsic Evidence Supporting Contrary Position

American Family Mutual Ins. Co. v. Hansen, __ P.3d __, 2016 WL 3398507 (Colo., June 20, 2016)

Case at a Glance

When a discrepancy exists between the policy declarations page and an extrinsic lienholder statement regarding who was an insured, the Colorado Supreme Court held that the discrepancy did not create an ambiguity because the ambiguity doctrine can only be used to determine whether an ambiguity exists within the four corners of the insurance contract itself and cannot be created by an extrinsic document which is not part of that contract.

Summary of Decision

This case involved a dispute regarding who was the insured under an American Family UIM policy. The case arose out of an automobile accident in which Jennifer Hansen was injured. After the accident she presented a UIM claim to American Family asserting coverage under an American Family auto insurance policy on her 1998 Ford Escort. As proof of insurance, she offered lienholder statements issued by her American Family local agent that identified her as the named insured at the time of the accident. However, American Family's own records, including a November 2007 declarations page (one month before the accident) indicated that the named insureds on the policy at the time of the accident were Hansen's stepfather and mother. In reliance upon the policy, as reflected by its own records, American Family determined that Hansen was not insured under the policy and denied coverage. Hansen then filed a lawsuit against American Family alleging breach of contract, bad faith and statutory bad faith. Prior to trial, American Family reformed the contract to name Hansen as the insured, and the parties settled the breach of contract claim, leaving only the common law and statutory bad faith claims for trial.

The trial court ruled that the deviation in the records issued by American Family's agent and those produced by American Family's underwriting department created an ambiguity in the insurance policy regarding the identity of the named insured and, therefore, the trial court instructed the jury that an ambiguous contract must be construed against the insurance company. The jury found in favor of American Family on the common law bad faith claim but in Hansen's favor on the statutory bad faith claim. On appeal, the Appellate Court found that the lienholder statements created an ambiguity and that even if American Family's legal position was a reasonable one regarding who was the insured, American Family could still be held liable for statutory bad faith. The Colorado Supreme granted certiorari and then reversed.

The Colorado Supreme Court held that because the insurance contract itself unambiguously named William and Joyce Davis as the insureds at the time the policy was issued, the trial court and Court of Appeals erred in relying on extrinsic evidence to find an ambiguity in the insurance contract. The Court held that the ambiguity must appear in the four corners of the document before extrinsic evidence can be considered. In other words, the trial court and the Court of Appeals impermissibly allowed extrinsic evidence to create the ambiguity. Extrinsic evidence can only be used as an aide in ascertaining the intent of the parties once an ambiguity is found.

On appeal, Hansen argued that the agent's issuance of the 2007 lienholder statement created an ambiguity because insurance agents have the authority to bind insurance companies. However, the Court did not consider whether agents have authority generally to bind the insurance company or if the agent had such authority in the case at bar because Hansen did not claim that the 2007 lienholder statement constituted a contract of insurance standing on its own. Moreover, Hansen did not explain how the lienholder statement could modify the November 2007 declarations page naming her mother and stepfather as the insureds.

Next, Hansen argued that even if the insurance contract itself was unambiguous, an ambiguity existed under the doctrine of reasonable expectations. Hansen argued that by issuing to her a document identical to a declarations page in every respect except for the notation "for lienholder use" created a reasonable expectation of coverage. However, the Court found that Hansen could not rely on her reasonable expectations to establish her identity as the named insured when the November 2007 declarations page unambiguously identified her mother and stepfather as the insureds. The Court did find that Hansen was not remediless. According to the Court, she could have sought reformation of the contract to accurately reflect the intention of the parties. In fact, after receiving documentation from Hansen verifying that she was the owner of the vehicle, American Family did elect to reform the policy to substitute Hansen for her mother and stepfather as the named insured and provide coverage for her injuries.

Because American Family had a reasonable belief for denying coverage, the statutory bad faith claim failed. // Plitt

Professional Liability Insurance

For Purposes Insurance Coverage under Professional Liability Policy, Claim Occurred When Elements of Malpractice Action Existed, Notwithstanding Law Firm's Fraudulent Concealment

Elements of Legal Malpractice Claim Did Depend on Fraudulent Concealment of Claim

Minnesota Lawyers Mutual, Insurance Co. v. Protostorm, LLC, __ F.Supp.3d __, 2016 WL 3447892 (E.D. Va. June 22, 2016)

Case at a Glance

Under Virginia law, for purposes of determining coverage under a professional liability insurance policy for a legal malpractice judgment based on a law firm's failure to file a patent application, a claim occurred when all of the elements of the malpractice cause of action came into existence, notwithstanding the law firm's fraudulent concealment of its malpractice.

Summary of Decision

In 2000, Protostorm, LLC retained a law firm to prepare and prosecute patent applications for an internet game. The law firm filed a provisional patent application with the U.S. Patent and Trademark Office ("PTO") in June 2000. The final application was due one year later. On June 25, 2001, the firm timely submitted a Patent Cooperation Treaty filling ("PCT Application"), which allowed the applicant to establish a priority date among all the countries designated in the application. To obtain a patent from a designated country, the applicant had to make country-specific filings. In the PTC Application, the firm designated 86 countries, but failed to designate the United States.

The failure to designate the United States could have been corrected by September 2001. The firm failed to correct the omission. Nonetheless, the firm

could have preserved Protostorm's ability to seek a U.S. patent by filing a new application by February 2003, but the firm failed to do so.

Unbeknownst to Protostorm, the firm abandoned the patent application. The firm did not withdraw as counsel of record at the PTO or the World Intellectual Property Organization. The firm told Protostorm in December 2001 that the PCT Application had been submitted and was proceeding.

From December 2001 until early 2006, there were no communications between the firm and Protostorm. In 2006, Protostorm unsuccessfully attempted to contact the firm. In June 2007, the firm told Protostorm there were problems with the patent application. On January 25, 2008, the firm informed Protostorm of the failure to designate the United States in the application.

In March 2008, Protostorm filed a legal malpractice action. A jury found in favor of Protostorm and awarded $6,975,000 in compensatory damages. The jury found that the statute of limitations was tolled by the firm's concealment of its malpractice.

The firm was insured under a professional liability policy providing $5 million in coverage for any claim arising out of any act, error, or omission occurring before October 25, 2006, and $10 million in coverage any claim arising out of any act, error, or omission occurring after that date. The insurer filed a declaratory judgment action, seeking a ruling that its liability was limited to $5 million. Applying Virginia law, the court granted summary judgment in favor of the insurer.

The policy provided $5 million in coverage "[w]ith respect to any CLAIM...arising out of any act, error or omission which occurred on or before: 10/25/06," and $10 million in coverage "[w]ith respect to any Claim ... arising out of any act, error or omission which occurred subsequent to: 10/25/06." The policy defined CLAIM as a "lawsuit...seeking DAMAGES." Coverage, however, was limited to claims resulting from "the rendering or failing to render PROFESSIONAL SERVICES." Thus, the court determined, a "CLAIM" referred to a covered cause of action.

The policy did not define "arising out of." In *The Doctors Co. v. Women's Healthcare Associates, Inc.*, 740 S.E.2d 523 (Va. 2013), the Virginia Supreme Court considered the meaning of "arising out of" when used in a professional liability insurance policy. The Virginia Supreme Court ruled that this phrase has a broader meaning than "resulting from." The Virginia Supreme Court ruled that "arising out of" requires the elements of the cause of action to be causally connected to the alleged acts, errors, or omissions.

Applying this rule, the federal district court held that the judgment in the malpractice case did not arise out of any act, error, or omission occurring after October 25, 2006. The court determined that the acts, errors and omissions occurring before October 25, 2006 established all of the elements of the malpractice cause of action. The law firm's breach of duty in failing to prosecute the patent applications became irremediable in February 2003, at the latest. Damages were based on loss of royalties from 2001 through 2012. Although the law firm's subsequent concealment of its malpractice tolled the statute of limitations, this misconduct was not necessary to establish the elements of the malpractice cause of action.

The court held that the claim did not arise out of the acts tolling the statute of limitations. As a factual matter, for the malpractice suit to be timely, the statute of limitations had to be tolled only until March 4, 2005. As a legal matter, under New York law, the cause of action accrued on the date of the malpractice. // Jordan

Property Insurance

Washington Supreme Court: Insurance Policy Bars Coverage for Water Damage from First Day of Vacancy

Endorsement Unambiguously Replaces Policy Vacancy Exclusion

Kut Suen Lui v. Essex Insurance Company, __ P.3d __, 2016 WL 3320769 (Wash. June 9, 2016)

Case at a Glance

A "Change of Conditions Endorsement" to the insured's property insurance policy unambiguously changed the scope of coverage for losses that occur

while the insured property is vacant. While the main policy excluded coverage for water damage only after the property has been vacant for 60 days, the endorsement precluded all coverage for water damage the moment the property became vacant. Since the insured's last tenant had left the property before the water damage occurred, the policy did not cover the damage and the insurer was entitled to summary judgment.

Summary of Decision

The insureds owned a commercial office. A few weeks after the last tenant moved out of the building, a frozen sprinkler pipe broke in the building and caused substantial water damage to the building. Upon discovering the water damage, the insureds notified their property insurer, Essex Insurance Company, and filed a claim.

Coverage for the water damage turned on the effect of a "Change in Conditions Endorsement" on the policy's vacancy exclusion in the policy issued to the insureds. The vacancy exclusion in the underlying policy provided that after the building has been vacant after more than 60 consecutive days, the policy would no longer cover water damage. The Endorsement read as follows:

> CHANGE IN CONDITIONS ENDORSEMENT
>
> *Please read carefully as this changes coverage under your policy.*
>
> VACANCY OR UNOCCUPANCY
>
> Coverage under this policy is suspended while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days, unless permission for such vacancy or unoccupancy is granted hereon in writing and an additional premium is paid for such vacancy or unoccupancy.
>
> Effective at the inception of any vacancy or unoccupancy, the Causes of Loss provided by this policy are limited to Fire, Lightning, Explosion, Windstorm or Hail, Smoke, Aircraft or Vehicles, Riot or Civil Commotion, unless prior approval has been obtained from the Company.

The underlying policy's definitions section provided that a building is vacant if less than 31 percent of the building is being rented or used for its customary operations, unless it is under construction or renovation.

In denying coverage, the insurer took the position that the endorsement immediately suspends coverage at the inception of any vacancy for all but specifically named causes of loss. Because the property was vacant and water damage was not one of the named causes of loss, Essex maintained that the policy provided no coverage.

Arguing that the policy's coverage restrictions applicable to vacant properties become effective only after the property has been vacant for 60 days, the insured sued the insurer. Both parties filed summary judgment, and the trial court ruled in favor of the insureds. The trial court found ambiguity in the policy with respect to whether it excluded coverage for water damage during the first 60 days of vacancy. The Washington Court of Appeals reversed, ruling that the plain language of the endorsement unambiguously limited coverage to only the enumerated causes of loss at the moment the building became vacant, not after 60 days as the trial court held.

The Washington Supreme Court granted review and unanimously affirmed the Court of Appeals. Given the unambiguous language and structure of the policy, the supreme court found that an average insured would understand that "(1) the endorsement's terms supersede the terms of the underlying policy, (2) the endorsement's first paragraph excluded all coverage after 60 days of vacancy, and (3) the endorsement's second paragraph provided only limited coverage from when the building first became vacant up until 60 days of that vacancy." The court rejected the insured's characterization of the endorsement's first paragraph as the "dominant concept" that controls the second paragraph and the insured's attempts to harmonize the endorsement with the vacancy exclusion in the underlying policy in order to make the endorsement's coverage restrictions apply only after 60 days. The insureds' arguments, the court observed, ignored the "controlling nature of the endorsement" and rendered superfluous the endorsement's entire

second paragraph making certain coverage restrictions "effective at the inception of any vacancy."

The supreme court made short work of the insureds' argument that the underlying policy's definition of vacancy did not apply to the endorsement. The insureds urged the high court to ignore the policy's definition and adopt a definition of "vacancy" that precludes a finding of vacancy if the building's owners maintain "a continuous physical presence at the property." The court refused to do so, observing that "[w]hen an insurance policy defines a term, that definition applies throughout the policy . . . The [insureds] offer no conflicting language from within the insurance policy to demonstrate that this definition is ambiguous."

Comment

The supreme court refused to consider the insureds' contention that the building was under renovation at the time of the loss and thus not "vacant" because the question was not raised in the trial court. Consistent with the vacancy exclusion's purpose of avoiding the greater risk and expense associated with losses that cannot be mitigated because nobody is present in the insured building, courts have construed the "under construction" exception to the vacancy exclusion to apply to all building endeavors, whether new construction or renovation, that require "substantial and continuing presence" of workers at the premises. *TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 40 Cal.4th 19, 50 Cal.Rptr. 3d 597, 145 P.3d 472 (2006). // DiMugno

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