COVERAGE OPINIONS

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50 States Of Grey Claims:

The 10 Most Significant Insurance Coverage Decisions Of 2012

Randy J. Maniloff and Joshua A. Mooney White and Williams, LLP

(Cases are listed in the order decided)

Coming Soon to *Coverage Opinions*: 5th Annual *"Coverage for Dummies"*

Coverage cases demonstrate that sometimes people get in trouble by doing really dumb stuff. But they still know enough to seek insurance coverage. *"Coverage for Dummies"* is the annual look at several examples from the past year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain. Look for the 5th annual installment of "Dummies" in an upcoming issue of *Coverage Opinions*.

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50 States Of Grey Claims: The 10 Most Significant Insurance Coverage Decisions Of 2012 12th Annual "Insurance Coverage Top 10"

Randy J. Maniloff and Joshua A. Mooney White and Williams, LLP

I went into CVS the other day to buy a pack of Chiclets. I handed a dollar to the cashier and in return I received a penny -- and a receipt that was eighteen inches long. I checked with my mother and I wasn't even eighteen inches long when I was born. And why do I even need a receipt for a pack of gum anyway? It's not like chewed gum is returnable. Even Nordstrom probably draws the line there. And a foot and a half isn't even as bad as it could have been. I've been handed some receipts that clocked-in at nearly three feet.

Of course, the reason behind these Gulliver-size documents is that they often include such things as requests to take on-line surveys, your points balance in the store's savings club and coupons -- lots of them sometimes. My CVS receipt included a reminder to get a flu shot. Some stores seem to believe that their customers want to be pestered to buy more things -- before they've even left the premises.

I was complaining about all of this impertinent receipt information to my wife. She, being a lover of internet surveys, savings clubs and coupons, of course defended the stores. In fact, she concluded that my ability to take a short story, and make it very long, on account of my fascination with details (impertinent, as she calls them) somehow made me no different than CVS. Come oooon! While I wholeheartedly fail to see this comparison, I have decided to take some stock in my wife's comment and apply it to this year's annual review of the year's ten most significant insurance coverage decisions. The article is traditionally very long. While it is still long this year, I made a conscious effort to make it less so. And it is -- by a lot.

For the past four years, this annual insurance coverage best-of has included a special report – "Coverage for Dummies." Reading a lot of insurance coverage cases makes you realize that some people do really dumb stuff. Their shocking behavior causes injury and not long after a lawsuit is filed against them. The tomfool then makes an insurance claim. Somehow they still know enough to do that. "Dummies" has been a look at several examples from the past year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain. This year's Top 10 does not include a "Dummies" report. But "Dummies" is not dead. Look for 2012's "Coverage for Dummies" is an upcoming issue of *Coverage Opinions*. [Before getting started please allow me to thank my colleague Josh Mooney for his invaluable help with the writing of this article. If you have any interest in intellectual property coverage issues then I highly recommend that you subscribe to Josh's newsletter – *The Coverage Inkwell: Emerging Coverage Issues in Intellectual Property, Privacy, and Cyber Liability.*

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About The Editor

Randy Maniloff

Randy J. Maniloff is an attorney in the Philadelphia office of White and Williams, LLP. He concentrates his practice in the representation of insurers in coverage disputes over primary and excess obligations under a host of policies. Randy is the co-author of "General Liability Insurance Coverage: Key Issues In Every State" (Oxford University Press, 2nd Edition, 2012). For the past twelve years Randy has published a year-end article that addresses the ten most significant insurance coverage decisions of the year completed. Randy has been quoted on insurance coverage topics by such media as The Wall Street Journal, The New York Times, USA Today, Dow Jones Newswires and Associated Press. For more biographical information visit www.whiteandwilliams.com. Contact Randy at Maniloff@coverageopinions.info or (215) 864-6311.

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To do so just send him an e-mail at Mooneyj@whiteandwilliams.com. Ordinarily I would have also mentioned that Josh's office is next door to mine. But I won't since that's the kind of information that I'm trying to eliminate this year to shorten the article. – R.J.M.].

Insurance coverage disputes often involve shades of grey – at least according to one party. In other words, claims that are viewed as black and white by both the insurer and policyholder get resolved. Claims that end up in the grey category usually do so because of a disputed interpretation of policy language as applied to a certain factual scenario. And of course, this is not surprising. After all, when it comes to insurance coverage, policy language is paramount. So disputes over the meaning of policy terms are the type that you would expect to see.

But for 2012, more than half of the ten most significant insurance coverage decisions principally involved disputes that did not center around the interpretation of specific policy language. Rather, these decisions involved situations where coverage was tied to the resolution of an issue concerning the relationship between the insurer and policyholder or an overarching or conceptual coverage issue. While the claims, at their core, may have involved policy language, the determination of coverage did not turn on the meaning of any of the specific terms of the contract between the parties. Some of these cases involved such issues as the effectiveness of a reservation of rights letter, allocation between covered and uncovered claims and whether coverage is available to an insured that must return money that it was not otherwise entitled to have in the first place.

Cases that involve these types of "macro" issues can be particularly important because these issues are more likely to recur. Of course claims that involve disputed policy language recur. A lot, sometimes. But for a coverage decision involving policy interpretation to potentially influence a future case, it requires a case with similar facts and policy language. By comparison, coverage issues that concern the relationship between the insurer and policyholder are usually not tied to any particular facts. This means that they are more likely to have across the board applicability. Translation, they can influence a great many more future decisions.

With all that we turn to the 12th annual look back at the year's ten most significant insurance coverage decisions.

The Top 10 Coverage Cases Selection Process

First a note on the selection process for the year's ten most significant insurance coverage decisions. The simple answer – it is highly subjective, not in the least bit scientific, and is in no way democratic. But just because the selection process has no accountability or checks and balances whatsoever does not mean that it wants for deliberativeness. To the contrary, the process is very deliberate and involves a lot of analysis, balancing and hand-wringing. It's just that only one person is doing any of this.

The selection process operates throughout the year to identify coverage decisions (usually, but not always, from state high courts, and this year only a few) that (i) involve a frequently occurring claim scenario that has not been the subject of many, or clear-cut, decisions; (ii) alter a previously held view on an issue; (iii) are part of a new trend; (iv) involve a burgeoning or novel issue; or (v) provide a novel policy interpretation. Admittedly, some of these criteria overlap.

In general, the most important consideration for selecting a case as one of the year's ten most significant is its potential ability to influence other courts nationally. That being said, the most common reasons why many unquestionably important decisions are not selected are because other states do not need guidance on the particular issue, or the decision is tied to something unique about the particular state. Therefore, a decision that may be hugely important for its own state – indeed, it may even be the most important decision of the year for that state – nonetheless will be passed over as one of the year's ten most significant if it has little chance of being called upon by other states confronting the issue at a later time. When it comes to selecting the year's ten most significant insurance coverage decisions, the potential to have future influence on a national scale is everything.

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The Top 10 Coverage Cases Selection Process

For example, in 2012, Ohio's highest court held in Westfield Ins. Co. v. Custom Agri Sys. that claims of defective construction/workmanship do not qualify as "property damage" caused by an "occurrence" under a commercial general liability policy. Prior to this decision, the question of whether faulty or defective workmanship qualified as an "occurrence" had been unsettled under Ohio law. Cases went both ways. So, Custom Agri Sys. clearly provided much needed resolution of this question. However, there is hardly a shortage of decisions around the country that address whether "property damage" on account of defective construction qualifies as having been caused by an "occurrence." Thus, given the vast amount of existing case law on this issue, a future court that is confronting the issue would be unlikely to turn to Custom Agri Sys. for guidance. There is no question that Custom Agri Sys. is a hugely important decision for coverage disputes in Ohio. But that does not make it one of the year's ten most significant on a national scale.

Another example of an important decision in 2012 left on the Top 10 sidelines was the Supreme Court of California's in California v. Continental Insurance Company. The court addressed allocation, an important issue in the context of continuous injury or damage claims that trigger multiple policies.

But despite the importance of allocation, it is a mature issue. As it has been the subject of numerous decisions nationally, including many from state supreme courts, the potential for Continental to influence future courts is diminished.

Other high-profile decisions that did not make the list include Travco Insurance Company v. Ward from the Virginia Supreme Court. While it is the first supreme court decision to address whether the pollution exclusion applies to Chinese drywall (it does), Chinese drywall coverage is a significant issue in only a handful of states. Further, any state that has, as a general principle, that the absolute pollution exclusion is limited to traditional environmental pollution, is unlikely to view Chinese drywall as so qualifying. AES v. Steadfast Insurance Company, also from the Virginia Supreme Court, was the first supreme court to address the availability of coverage for damages allegedly caused by global warming. While a significant decision for the case, and a headline grabber for the media, global warming coverage cases are not exactly drowning court clerk's offices these days. While AES may have an impact in the future, that could be the distant future.

The Ten Most Significant Insurance Coverage Decisions Of 2012

Contractor Says "Oh-CIP: I'm Not Enrolled In The Wrap-up!"

Williams v. Traylor Massman Weeks, LLC, No. 10–2309, 2012 WL 1106652 (E.D. La. Apr. 2, 2012)

Who says insurance isn't cool. After all, there are wrap policies. And no self respecting risk conscious rapper would be caught without an insurance policy to protect against such things as an FCC fine for indecency, liability if any of his violent lyrics incite someone to commit a crime, injury caused by exposure to legionella in the hot tub, and the myriad of construction risks that come from building the crib. And don't forget the jewelry rider to protect against theft of the bling.

While nobody misunderstands a wrap-up policy to this extent, there is still plenty of misunderstanding over what a wrap-up is and what it covers. In simple terms, a wrap-up policy is a liability policy that is obtained by a single sponsor, such as a project owner or general contractor, that is designed to cover multiple contractors involved with a construction project. The theory is that there are various advantages, such as with respect to pricing and claims handling, to having all of the contractors insured under a single, all encompassing policy, rather than each contractor securing its own separate policy.

Except for a few differences, a wrap-up policy (a.k.a. Owner Controlled Insurance Program (OCIP) or Contractor Controlled Insurance Program (CCIP)) – even one covering a multi-million dollar project -- may not look much different than a standard CGL policy issued to a mom-and-pop contractor. For example, a wrap-up policy

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Contractor Says "Oh-CIP: I'm Not Enrolled In The Wrap-up!" - *Continued*

may very well be written using a standard ISO CG 00 01 form. Further, don't look for the word "wrap-up" written anywhere in the policy -- because it may not be there.

Then what makes a policy a "wrap-up?" Just a few key endorsements, such as an endorsement (1) stating that the policy is limited to a specific identified project; (2) amending the definition of insured to include all "enrolled" (more about this below) contractors and subcontractors (of any tier) involved on the project; and (3) extending the expiration date of the policy for several years for purposes of damage within the completed operations hazard. There are a few other possible wrap-up specific endorsements as well. But, in general, a wrap-up policy is a CGL policy with just a few enhancements required to achieve its objective of serving as an all encompassing policy for a single construction project.

Despite the theory and best intentions, the question whether claims handling is actually simpler when claims are made against multiple insureds because a wrap-up is involved, is another story. It probably depends upon who you ask and what that person's experience has been with a wrap-up policy involving multiple insured parties. While it is one thing to say that, in general, a wrap-up policy is designed to provide coverage for an entire project, the nuts and bolts of that are not so simple. Even under a wrap-up, coverage for each insured-contractor must be examined from the perspective of, well, each insured-contractor, and the damage that it allegedly caused. Therefore, putting aside some other factors, the use of a wrap-up policy may not eliminate the common and thorny problem seen in non-wrap-up construction defect situations – allocation of damage between an insured's own faulty workmanship (which is probably not covered) and damage caused by the insured's faulty workmanship (which is likely covered (our state of residence aside)).

In addition, the contractor/sub-contractor insureds under the wrap–up policy may also be insured under their own CGL policy, purchased for their other (non-wrap-up project) work. If so, and such policy(ies) does not have a wrap-up exclusion, then these policies are likely to be brought into play for purposes of coverage for the contractor insured itself, as well as for additional insured coverage that such contractor may owe to another contractor. Thus, the idea that the use of a wrap-up policy will eliminate complex cost sharing and other disputes between multiple insurers is easier said than done.

Case law addressing coverage under a wrap-up policy is not unusual. And it often involves issues that are along the lines of typical construction defect coverage issues under a CGL policy. The issue just so happened to arise under a wrap-up policy. The Eastern District of Louisiana's decision in Williams v. Traylor Massman Weeks is different. It involves an issue, an important one at that, that is completely unique to a wrap-up policy – the enrollment process. Further, there is little law addressing the issue. For these reasons, it was selected as one of the year's ten most significant.

The issue arose as follows. Shaw Environmental & Infrastructure, Inc. was hired by the United States Corps of Engineers to build

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Coverage Opinions is a bi-weekly (or more frequently) electronic newsletter reporting and providing commentary on just-issued decisions from courts nationally addressing insurance coverage disputes. Coverage Opinions focuses on decisions that concern numerous issues under commercial general liability and professional liability insurance policies. For more information visit www.coverageopinions.info.

Contractor Says "Oh-CIP: I'm Not Enrolled In The Wrap-up!" - *Continued*

hurricane-related structures in the Inner Harbor Navigation Channel. Shaw hired Eustis Engineering as a subcontractor to perform work on the Project. A Eustis employee was injured. At some point after the work agreement was made between Shaw and Eustis, Shaw made available to its subcontractors an integrated Contractor Controlled Insurance Program ("wrap-up"). Eustis sought to require the insurer of the wrap-up policy to provide insurance and workers' compensation coverage to Eustis for the employee's claims and related defense costs.

The insurer argued that Eustis was not covered by the wrap-up policy because the program covered only those enrolled in it. The wrap-up policy defined Insured as an enrolled contractor. Eustis admitted that it failed to complete the several steps required for enrollment.
In the end, despite Eustis making various arguments in support of having insured status under the wrap-up policy, the court did not have much trouble holding that "no genuine issue of material fact exists regarding whether Eustis was an insured under the CCIP. Eustis admits that it did not complete the steps required under the CCIP Manual for enrolling in the program." In addition, the court held that it was immaterial that the agreement between Shaw and Eustis required Eustis to be covered by the wrap-up, since the insurer was not a party to such agreement.

On one hand, Williams is a simple decision. The policy required that Eustis be an "enrolled" contractor in order to be an insured under the wrap-up policy. Eustis failed to take the steps to become "enrolled." Therefore, Eustis was not an "insured." End of story.

But the case also demonstrates an important lesson for insurers: When there are steps that a contractor must take, to achieve insured status (enrollment) under a wrap-up policy, be sure that such steps have been taken. Do not assume that, simply because the policy is a wrap-up, and the party seeking coverage was a contractor or subcontractor of some tier to the general contractor, that the contractor is therefore an insured. Not every "i" gets dotted and not every "t" gets crossed when it comes to contractors and completing paperwork (yes, that's an understate ment). Williams demonstrates that real consequences that can flow from this.

At A Loss For Words: Posner Defines "Loss" Without Needing Any

Ryerson, Inc. v. Federal Insurance Co., 676 F.3d 610 (7th Cir. 2012)

Insurers sometimes maintain that a loss is not covered because, well, it's not covered. In other words, their position is that the loss is not covered because it is not a scenario that the policy was intended to cover. It is somewhat of a "we know a covered claim when we see one, and this one isn't" situation.

But courts set out to resolve coverage questions by, first and foremost, interpreting the words of the insurance policy. [Whether they followed through with that promise is likely tied to whether you agree with the outcome.] Based on this, the policyholder's response is likely "we also know a covered claim when we see one, and this one is because the policy language says so."

While policy language is of course king, there are some rules that dictate insurance coverage that are not based on the policy language. For example, the "known loss" doctrine. Until recently (with the introduction of the "Montrose" language in the CGL insuring agreement), "known loss" did not exist in policy language. There was no "known loss" exclusion or condition. In very general terms, it is simply a fundamental principle, adopted by courts, that insurance coverage does not exist for losses that have already taken place.

In Ryerson, the Seventh Circuit, with Judge Posner writing for the court, addressed another fundamental principle that dictates insurance coverage without regard to the language of the policy at issue: an insured cannot obtain insurance coverage for having to return money that it was never entitled to keep in the first place.This issue arises frequently. But, because there is no specific policy language to point to that says so, it can sometimes be more difficult to convince policyholders that no coverage is owed for this reason.

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At A Loss For Words: Posner Defines "Loss" Without Needing Any

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The insured, Ryerson, sold a collection of subsidiaries to the underlying Plaintiff, EMC Group, Inc., for $29 million. EMC later sued Ryerson seeking rescission of the sale and restitution of the purchase price for the subsidiaries on the ground that Ryerson had concealed an ominous impending development affecting one of the subsidiaries; namely, that the subsidiary's largest customer had declared that unless the subsidiary slashed its prices, the customer would build its own plant and stop buying from the subsidiary. When EMC purchased the subsidiary, the customer reiterated its demand for a price cut to EMC. EMC refused and the customer stopped buying from the subsidiary. In its suit against Ryerson, EMC charged that Ryerson had fraudulently concealed the customer's threat in order to induce EMC into buying the subsidiary, and also had breached the purchase contract for the subsidiaries and corresponding warranty.

Federal issued to Ryerson an "Executive Protection Policy" that covered "'all LOSS for which [the insured] becomes legally obligated to pay on account of any CLAIM ... for a WRONGFUL ACT [elsewhere defined in the policy to include a "misleading statement" or "omission"] ... allegedly committed by' the insured." Federal refused coverage on the ground that the EMC lawsuit was not a covered risk. The lawsuit later settled, with Ryerson agreeing to make "a post-closing price adjustment" of $8.5 million to "reflect[] a change in the purchase price paid by EMC to Ryerson for the purchase" of the subsidiary that had gotten into trouble with its customer. When Federal refused to indemnify Ryerson for the settlement and defense costs, Ryerson commenced a declaratory judgment action. The trial court granted Federal summary judgment and the Seventh Circuit affirmed.

Judge Posner came straight out and explained that neither EMC's claim, nor the settlement at issue, constituted a "loss" because an insured cannot obtain coverage for something it shouldn't have. "If Ryerson can obtain reimbursement of that amount from the insurance company, it will have gotten away with fraud."

In so holding, the court did not pull any punches, as to the merit (or lack thereof) of Ryerson's coverage claim. The court explained that "[i]f disgorging such proceeds is included within the policy's definition of 'loss,' thieves could buy insurance against having to return money they stole. No one writes such insurance. [A]nd no state would enforce such an insurance policy if it were written. You can't, at least for insurance purposes, sustain a "loss" of something you don't (or shouldn't) have." Furthermore, that EMC had styled its claims as one for damages, was irrelevant to the question of coverage.

In 2012, the Fourth Circuit reached a similar decision in Republican Franklin Ins. Co. v. Albermarle County School Board, 670 F.3d 563 (4th Cir. 2012). The court held that a judgment to pay wages that the school district had not paid, in violation of the Fair Labor Standards Act (being a pre-existing duty) did not constitute a "loss" under the policy.

District Court Makes Illi-noise Whether Policy Language Can Alter A Long-Standing Duty To Defend Rule

Philadelphia Indemnity Insurance Company v. Chicago Title Insurance Company, No. 09-7063, 2012 WL 1658291 (N.D. Ill. May 11, 2012)

Anyone who reads a lot of coverage cases will tell you that it is unusual to pick up a new decision and see an issue that is completely novel. Seeing a new take on an issue, sure. Unique policy language, of course. But coming across an entirely new issue is not typical. However, that's what happened when we read the Northern District of Illinois's decision in Philadelphia Indem. Ins. Co. v. Chicago Title Ins. Co.

Chicago Title is complicated and involves lots of issues. But for purposes of discussing the one that matters here, we can skip over most of that, including even the facts. At issue was this – Chicago Title had a duty to defend an insured in an underlying action. It is well-settled under Illinois law – and the law in most places – that if an insurer has a duty to defend one count of a complaint, it has a duty to defend all counts of the complaint. The court referred to this as Illinois's default rule for purposes of duty to defend. So far, nothing controversial.

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District Court Makes Illi-noise Whether Policy Language Can Alter A Long-Standing Duty To Defend Rule

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But here's the rub – the Chicago Title policy contained a provision that discussed certain duty to defend issues, and then went on to state: "[Chicago Title] will not pay any fees, costs or expenses incurred by the insured in the defense of those causes of action which allege matters not insured under the policy."

In other words, at issue was this – Did Chicago Title's policy language, which limits the duty to defend to solely potentially covered claims, trump Illinois's long-standing rule that if an insurer has a duty to defend one count of a complaint, it has a duty to defend all counts of the complaint?

The court held that it did not, stating that Chicago Title could not "contract around" its duty to provide a complete defense, so long as one count of a complaint is potentially covered. Put another way, a policy cannot "undo a default rule imposed by law." As such, Chicago Title had a duty to provide its insured with a complete defense.

The rationale for the Chicago Title court's decision was this. In Maryland Casualty v. Peppers (1976), the Illinois Supreme Court adopted these duty to defend rules: (1) "If the complaint alleges facts within the coverage of the policy or potentially within the coverage of the policy the duty to defend has been established;" and (2) "This duty to defend extends to cases where the complaint alleges several causes of action or theories of recovery against an insured, one of which is within the coverage of a policy while the others may not be." What's more, the Chicago Title court noted, other Illinois cases have used this same 2-step process for determining if an insurer has a duty to defend.

The Chicago Title court concluded that "[f]or both of these propositions, the court made no reference to the policy language, instead citing a large number of Illinois cases and secondary sources. This strongly indicates that, like courts in Ohio, Illinois courts impose the complete defense rule as a matter of law, turning to the policy language only to determine whether any facts in a complaint bring a case within the scope of coverage." "No case that Chicago Title has cited or that the Court has found suggests that the duty to provide a complete defense arises based on the terms of an insurance policy rather than as a matter of law. The Court therefore concludes that Chicago Title may not contract around this duty."

As a federal district court opinion, with not exactly a crowded field addressing the issue, Chicago Title is certainly not the last word on the ability of insurers to draft and uphold policy language that conflicts with case law. Further, a review of PACER indicates that the case is now en route to the Seventh Circuit. But with more and more manuscript forms and endorsements in use, insurers may face challenges – freedom of contract be damned – in upholding such policy provisions if they conflict with coverage rules that are deemed to exist as a matter of law or fundamental principle, as opposed to having been created based on policy language.

Putting The End In Defend: Insurer Can Settle The Only Covered Claim And Then Withdraw From The Defense

Society Ins. v. Bodart, 819 N.W.2d 298 (Wis. Ct. App. 2012)

Consider this - an insurer is defending its insured in a case that has both covered and uncovered claims. The insurer settles the covered claims. So with only uncovered claims remaining, the insurer now withdraws its defense. After all, the duty to defend only attaches if there is the potential for coverage. And because of the settlement, there is no longer any potential for coverage. This seems simple enough.

This is exactly what the insurer did in Society Ins. v. Bodart. And the Court of Appeals of Wisconsin had no trouble concluding that the insurer's conduct was appropriate. While policyholders often have a lot of trouble when only covered counts are dismissed by a court, and the insurer subsequently withdraws from the defense, the issue is likely to cause even more angst when the insurer settles the only covered claim. Screams of bad faith, and a few other choice words that are not suitable for a family insurance publication, are likely to come in response.

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Putting The End In Defend: Insurer Can Settle The Only Covered Claim And Then Withdraw From The Defense - *Continued*

The case is as straightforward as they come. Bodart Landscaping was named in a civil action in Michigan alleging five claims. The Wisconsin appellate court didn't even say a single thing about the underlying claims -- as if they were not relevant to the coverage dispute. All that mattered was this: Society Insurance filed an action in Wisconsin seeking a declaration regarding its duty to defend Bodart in the Michigan action. The trial court concluded that Bodart's policy with Society provided at least arguable coverage for one of the five claims in the Michigan action and that Society therefore had a duty to defend. So Society assumed the defense. It then settled three of the five claims, including the only claim that the trial court had concluded was at least arguably covered.

Society sent Bodart a letter stating "Since, according to the [duty-to-defend order], Society has now settled the only covered claim against you, together with two other claims which were not covered, Society will no longer be furnishing a defense to you in the Michigan action." Bodart responded by filing a motion for contempt, asserting that Society's unilateral decision to withdraw its defense violated the duty-to-defend order.

There you have it. That's the entire factual scenario. The Wisconsin appellate court then set out to answer this single question: "[W]hether Society had a continuing duty to defend Bodart after the only arguably covered claim against Bodart was settled and dismissed, leaving only non-covered claims." The court held that the insurer did not.

In answering this question the court noted that it needed to consider two sources of authority: any relevant policy terms and any rules which, while not stated in the policy, are well established in case law.

Turning to the terms of the Society policy, the court focused on the provision that "gives the insurer discretion to settle claims and provides notice to the insured that the insurer 'will have no duty to defend the insured against any 'suit' ... to which this insurance does not apply.'"

The court's conclusion with respect to the policy language was this: "It is true that this provision does not expressly address the particular question of whether Society's duty might continue when the only arguably covered claim has been settled and dismissed. In this respect, the policy language could be said to be silent on that question. We conclude, however, that a reasonable insured would understand this language as Society does, to mean that Society has no duty to defend an insured in a suit once it has become clear that the suit no longer involves any claim that is even arguably covered. Stated another way, once all at least arguably covered claims are settled and dismissed, those claims are no longer part of the suit, and the insurance no longer involves any claim that is even arguably covered. Stated another way, once all at least arguably covered claims are settled and dismissed, those claims are no longer part of the suit, and the insurance no longer applies to that suit."

Now turning to case law for guidance, the parties agreed that no Wisconsin case had decided whether an insurer has a continuing duty to defend remaining claims after all at least arguably covered claims are settled and dismissed. However, the court concluded from the parties' briefing and its own research [case law and secondary sources that the court addressed] "that the general rule consistently reflected in persuasive authority is this: An insurer's duty to defend ends after all at least arguably covered claims are settled and dismissed."

Lastly, the Bodart court "hastened to add:" "[T]he persuasive authority on which we rely includes exceptions to that rule. At a minimum, these sources suggest that the rule may not apply when the insurer's withdrawal from the action would prejudice the insured's defense of the remaining, non-covered claims, (citation omitted) or when the insurer has purported to 'settle' claims out of a case but has done so in bad faith[.] Prejudice may come from withdrawal at a time or under circumstances that undermine the ability of the insured to produce a material witness or to otherwise adequately prepare his or her defense to the remaining claims.

The bad faith example that the court cited was so unique as to make it devoid of guidance on such point.

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Putting The End In Defend: Insurer Can Settle The Only Covered Claim And Then Withdraw From The Defense - *Continued*

These exceptions are likely to be what future disputes involving similar settlements followed by the insurer terminating its defense are all about.

Peach Clobber: Georgia Supreme Court Hits Insurer For An Ineffective Reservation of Rights Letter

Hoover v. Maxum Indem. Co., 730 S.E.2d 413 (Ga. 2012)

"What's in a name? That which we call a rose by any other name would smell as sweet." William Shakespeare, "Romeo and Juliet," Act II, Scene 2. But the same cannot be said of reservation of rights letters. In fact, just the opposite. A letter that is called a reservation of rights may be nothing of the sort.

What makes a letter a "reservation of rights" letter? Is it enough to call it a reservation of rights letter? It is enough to say, sometimes multiple times, that the insurer is reserving its rights to deny coverage? In some cases, the answer is no.

Despite how commonplace reservation of rights letters are for insurers in the claims context, some courts have taken issue with the content of such letters – concluding that, while a letter with the words "reservation of rights" may have been issued, the notice provided to the insured in such letter, of the reasons why coverage may not be owed for some claims or damages, was not sufficiently specific to be adequate.

One court described the situation as follows: "In this case, the Court finds that Safeco's reservation of rights letter did not 'fairly inform' Liss of the reasons it was reserving its rights and that the letter was inadequate as a matter of law to preclude application of the estoppels doctrine. The only factual reference contained within the policy is: 'As you are aware, this lawsuit arises out of a gunshot incident on July 10, 1997.' More importantly, the letter sets forth pages of policy provisions but does not explain why Safeco believed the insurance policy would possibly not cover Liss for the shooting incident. In other words, Safeco did not 'apply' the sole fact stated to the policy's legal terms." Safeco Ins. Co. of Am. v. Liss, No. DV 29-99-12, 2005 Mont. Dist. LEXIS 1073, at *41 (Mont. Dist. Ct. Mar. 11, 2005); see also Osburn, Inc. v. Auto Owners Ins. Co., No. 242313, 2003 WL 22718194, at *3 (Mich. Ct. App. Nov. 18, 2003) ("[W]e conclude that, because Auto Owners' reservation of rights letter was not sufficiently specific to inform plaintiffs of the policy defenses the insurer might assert, the letter did not constitute 'reasonable notice.'") (comparing an example of sufficiently specific reservation of rights language to that which was not).

Such was the issue before the Georgia Supreme Court in Hoover. The underlying plaintiff, Hoover, sustained serious injuries when he fell from a roof while working for his employer, the insured, Emergency Water Extraction Services. EWES held a commercial general liability insurance policy issued by Maxum. Maxum denied defense and liability coverage under the policy, citing the policy's Employer Liability Exclusion. After Hoover obtained a $16.4 million judgment against EWES, he filed suit against Maxum pursuant to an assignment of claims from EWES. In the coverage action, Maxum disregarded the Employer Liability Exclusion and instead defended its coverage denial based on EWES's failure to provide timely notice. An ultimate issue became whether that coverage defense had been waived.

Notably, when denying coverage based on the Employer Liability Exclusion, Maxum's declination letter "purport[ed] to reserve Maxum's right to claim a number of other defenses, including that 'coverage for this matter may be barred or limited to the extent the insured has not complied with the notice provisions under the policy.'" The denial letter further stated as follows: "Maxum's specific enumeration of the above policy defenses is not intended as a waiver of any other policy defenses that Maxum may have or that may arise from facts discovered in the future[,] nor should Maxum be estopped from raising additional coverage defenses. Maxum also continues to reserve the right to raise any other coverage defenses, including the right to disclaim coverage on any other basis that may become apparent as this matter progresses and as Maxum obtains additional information."

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