COVERAGE OPINIONS
Judicial Opinions Today - Impact On Counsel's Opinions Tomorrow

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The Cover-age Story

Cain Casualty Company v. Abel Indemnity Company:

Georgia Federal Court Demonstrates Frequency Of "Insurer v. Insurer" Disputes Over Montrose and First Manifestation Endorsements

Insurers have confronted accusations that they conspired to do some harm against their own policyholders. For example, they were accused of conspiring to settle Hurricane Katrina claims for less than their true value. The image that is portrayed is one of insurance company executives – think Boss Tweed types -- holding secret meetings in cigar smoke filled back rooms, plotting ways to make even more money.

Whenever I hear such an allegation I shake my head in disbelief. Those leveling such charges must not be aware of the vast amount of "Insurer v. Insurer" coverage litigation that takes place. Based on that, and what we've all seen in some situations, sometimes insurers do not like each other enough to even be in the same room -- let alone conspire to do anything together. Insurers are often-times collectively referred to as "the insurance industry." But this is a term that suggests cohesiveness that does not exist in some situations.

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Declarations: The *Coverage Opinions* Interview with Bill Passannante

Coverage Opinions finds out what's on the mind of Bill Passannante of Anderson, Kill & Olick in New York City, a member of the firm's executive committee and co-chair of its Insurance Recovery Group. Bill reflects on his involvement in some landmark coverage cases, talks about common mistakes that insurers and their counsel make when handling claims and reveals what the term "e-mail" really stands for.

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The real story is that insurance companies -- and this is the case for all industries – can have both a Coke and Pepsi-type rivalry while at the same time working together on issues about which they share a common interest. With some issues, these lines are easy to draw. When it comes to selling automobile policies, several insurers are competing tooth and nail. But if a tax or regulation were proposed that is equally detrimental to their interests, those same competitors would no doubt cooperate (individually and through trade associations) in an effort to challenge it.

But such friend or foe lines are not so easy to draw when it comes to coverage litigation. On some issues, such as the pollution exclusion and late notice, insurers are very likely aligned in their views. But when it comes to other issues, such as number of occurrences and timing-related coverage issues, insurers' positions can be fractured. Such divergence of views is a dynamic that I've been watching play out with frequency in the context of litigation over Montrose and First Manifestation Endorsements (and similarly named endorsements).

The Montrose Endorsement – an ISO creation and designed for the benefit of all insurers – was a response to a weak "known loss" standard that had been adopted by the California Supreme Court. The Montrose Endorsement (originally an endorsement and then incorporated into the insuring agreement of the ISO commercial general liability form) qualifies the requirement that "bodily injury" or "property damage" must occur during the policy period by adding that, prior to the policy period, no insured knew that the "bodily injury" or "property damage" had occurred, in whole or in part. Further, if an insured knew, prior to the policy period, that the "bodily injury" or "property damage" had occurred, then any continuation, change or resumption of such "bodily injury" or "property damage," during or after the policy period, will be deemed to have been known prior to the policy period. In essence, by operation of these provisions, the policy on the risk at the time that the insured first obtains knowledge of "bodily injury" or "property damage" becomes the last policy that can be triggered.

First Manifestation Endorsements (and similar endorsements with different names) were designed by insurers to address the adverse effect of the continuous trigger on their experience for construction defect claims.

Such endorsements were essentially designed to preclude coverage for "bodily injury" or "property damage"

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About The Editor

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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 eleven 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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that took place before the policy period, even if the insured did not know that injury or damage had taken place and even if the injury or damage was continuous or progressive. As a result, coverage is effectively limited to "bodily injury" or "property damage" that first takes place during the policy period.

While Montrose and First Manifestation Endorsements were adopted to address common concerns, the response by insurers to these policy provisions has not been one for all and all for one. A disproportionate amount of the coverage litigation over Montrose and First Manifestation Endorsements has been captioned "Insurance Company v. Insurance Company."

The reason for this seems simple. Despite all of its criticism by insurers, the continuous trigger often enables liability for a continuous injury claim to be shared by more than one insurer. But add a Montrose or First Manifestation Endorsement to the mix and a triggered insurer may now lose the ability to seek cost sharing from another triggered insurer. Saddled with sole liability for a claim, some insurers are taking to challenging the applicability of other insurers' Montrose and First Manifestation Endorsements.

That insurers sometimes do not see eye to eye when it comes to the Montrose Endorsement, even in what appears to have been a straightforward case, was on display before the Northern District of Georgia in Transportation Insurance Company v. Selective Way Insurance Company (unpublished).

In 2002, Duane West sued Lewallen Construction, alleging that Lewallen trespassed on West's property, causing damage, while Lewallen was building a biking and walking path between Marietta, Georgia and the Alabama border. During the entirety of the construction of the trail, and until October 1, 2004, Transportation insured the construction company under a commercial general liability policy. Starting on October 1, 2004, and going through October 1, 2009, Selective insured the construction company. Transportation Insurance defended and indemnified Lewallen Construction (collectively to the tune of nearly $200K) and then sued Selective for contribution to the defense and indemnity.

During the course of the underlying litigation defense counsel provided status reports to Transportation and the owner of Lewallen. Included in these reports was information about the damage to West's property that was allegedly caused by Lewallen.
In June 2006 West's suit was dismissed without prejudice and re-filed in November 2006.

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Insurance Company Mascots That Actually Make Sense

I enjoy all of the characters that some insurance companies have developed over the past few years to promote their brands. But what I find curious about them is that they often times have no connection to insurance. I love the Gecko as much as the next guy. But what does a talking lizard have to do with auto insurance? The same with Aflac's talking duck and Progressive's Flo. Clever as they may be, these characters just seem out of place selling insurance. Look, Snoopy is the Fonz of dogs, but I don't think about life insurance when I see him on the Met Life blimp.

Surely there are some characters that insurers could be using to sell their policies that make more sense. Wouldn't it make more sense to use characters whose appearance actually have a connection to the insurance policy that they are trying to sell. Take an insurer trying to sell high level excess policies. If I saw the Jolly Green Giant I would definitely think to myself – You know, maybe I should buy coverage

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The claims and causes of action asserted in the 2006 suit were virtually identical to those asserted in the 2002 suit. In early 2007 Transportation notified Selective for the first time about West's suit against Lewallen. Selective maintained that it had no obligation to provide coverage to Lewallen on the basis of its policy provisions that no coverage was owed if, prior to the policy period, Lewallen knew that property damage had occurred, in whole or in part. Further, if Lewallen knew, prior to the policy period, that the property damage had occurred, then any continuation, change or resumption of such "property damage," during or after the policy period, would be deemed to have been known prior to the policy period. While the court referred to this language as the "known loss" exclusion, it is that of the Montrose Endorsement, and not an exclusion.

To make a long story short, the court had little trouble concluding that the Montrose Endorsement precluded any obligation on Selective's part to contribute to the amount paid by Transportation to defend and indemnify Lewallen for the West suit. "[T]he substantive allegations of the second complaint demonstrate that Lewallen knew of the property damage underlying Mr. West's claims prior to the Selective Policy period. In the second complaint, Mr. West raised claims against Lewallen for trespass and negligence per se. In support of these claims, Mr. West alleged that '[o]n or about May 22, 2002, [Lewallen] ... cut Plaintiff's fences, entered the Subject Property, graded such property, and poured concrete upon such property.'" Further, the court concluded that any trespass occurring after Selective's policy period began was a continuation of the alleged ongoing property damage that began in May 2002. As such, it was deemed to have been known prior to the policy period and, therefore, subject to the Montrose Endorsement.

Transportation Insurance Company v. Selective Way Insurance Company, No. 11-1383 (N.D. Ga. Nov. 14, 2012) is available on the PACER system.

New York Insurance Law § 3420(d)(2)-torial: Dan Kohane Provides A Superb Explanation Of New York's "30 Day" Disclaimer Statute

It is widely known that New York insurance law includes a statute to the effect that, generally speaking, for purposes of a bodily injury claim under a liability policy, an insurer that seeks to disclaim coverage must do so by way of "written notice as soon as is reasonably possible" to the insured and the claimant. This statute is codified at New York Insurance Law § 3420(d)(2). The "as soon as is reasonably possible" requirement is often considered to be, but could be fewer, 30 days.

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excess of $50 million. And who better to sell the $1 million primary policy in that new $100 million tower? The Oomph Loompahs of course. And what about a mascot for car insurance that actually has something to do with cars? Kitt from Night Rider probably isn't too busy these days. Give him something more to do than just sitting around Hoff's driveway. Pet insurance? So obvious. Scooby Doo. And you could get him for practically nothing. He would take payment in Scooby Snacks. Fire insurance policies? I can see Smokey the Bear telling you not to play with matches. But, if your house should still happen to burn down, be safe and have a policy from Fire Mutual. If Goofy can't sell professional liability policies, who can? And if you are trying to sell pollution liability policies there could be no better spokesperson than a guy who has spent his entire life in a trash can. Get me Oscar the Grouch on the line.

That's my time.

I'm Randy Spencer.

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New York Insurance Law § 3420(d)(2)-torial: - *Continued*

The amount of case law that 3420(d)(2) has generated is tremendous and there is no shortage of decisions in which insurers have been compelled to pay claims, that were otherwise excluded, because of a failure to comply with it. In general, 3420(d)(2) has a reputation for being very harsh on insurers. While such a reputation is deserved, the statute is not without some opportunities for insurers to be relieved of its burdens.

That 3420(d)(2) is not always a doomsday scenario for insurers was recently demonstrated by the New York Appellate Division, Second Department's decision in State Farm Fire and Casualty Company v. Raabe. State Farm sought a judicial determination that it was not obligated to defend or indemnify an insured in an underlying action involving personal injuries sustained in a parking lot altercation. At issue was whether the underlying incident was an accident or an intentional act. In other words, was there a covered "occurrence."

State Farm acknowledged that it did not provide written notice of disclaimer, to all interested parties, pursuant to 3420(d)(2). However, State Farm argued that it had no obligation to do so, on the basis that the claim did not fall within the coverage terms of the policy. In other words, while not spelled out by the court, State Farm's argument was that its denial was based on the failure of the claim to satisfy the insuring agreement, being the "occurrence" requirement. State Farm was not relying on an exclusion or breach of a policy condition to disclaim coverage.

The court agreed with State Farm: "[T]o the extent that any injuries sustained by the plaintiff in the underlying personal injury action arose from intentional acts, the policy here affords no coverage, and compliance with the disclaimer requirement of Insurance Law 3420(d) was unnecessary."

The Raabe decision, as is often the case with the New York Appellate Division, is brief and provides minimal discussion of 3420(d)(2). As the decision is one in which the statute did not result in a harsh outcome for the insurer, as is the statute's reputation, it warrants further discussion. Since such further discussion is not found in the decision, *Coverage Opinions* reached out to Dan Kohane, of Hurwitz & Fine in Buffalo, an authority on many things coverage, including New York Insurance Law 3420(d)(2). Not surprisingly, Dan provided the best explanation of 3420(d)(2) that I've ever seen. All comments from this point forward are Dan's.

New York Insurance Law's Section 3420 can prove fatal to liability insurers that are unfamiliar with its traps. A "deeming statute," it imposes requirements on casualty policies that are grafted onto policies issued in New York and requires strict compliance to avoid dire consequence. Unlike most jurisdictions where insurers protect themselves by sending out Reservation of Rights letters, New York generally finds such letters ineffective to protect carriers against a failure to comply with statutory requirements for prompt disclaimer.

Under 3420(d)(2), in the case of a bodily injury or wrongful death claim arising out of an accident, occurrence or lawsuit, where there is a New York issued or delivered policy and a New York accident,

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New York Insurance Law § 3420(d)(2)-torial: - *Continued*

the statute requires that the insurer must "give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage to not only the insured, but the injured person or any other claimant." Liability insurance carriers that fail to comply will lose their rights to rely on exclusions and breaches of policy conditions. Reservation of rights letters do not provide solace.

Section 3420 has become known, colloquially, as the "Thirty-Day" rule but it is often misunderstood and misapplied. The section is clear. It applies to "disclaimers of liability or denials of coverage" in certain types of cases only. By its terms, and by application, the statute only applies to: liability policies issued or delivered in New York State; accidents within New York State; and bodily injury and wrongful death claims. The requirements do not apply to property damage claims. Likewise, they do not apply to "personal or advertising injury" claims (e.g. libel, slander, defamation) unless there is a bodily injury component alleged. Under New York law, "emotional distress," even without physical injury, is considered bodily injury so the statute may apply where such a claim in made.

What the statute doesn't instruct, but the case law clearly teaches, is that a failure to strictly comply with these requirements renders a disclaimer invalid and ineffective and results in a loss of most coverage defenses if the policy applies in the first place. The statute does not speak of "reservation of rights" and the courts have held that a reservation of right letter is not a substitute for a disclaimer letter.

For the statute to apply, the claim must fall within the grant of coverage, for the statute does not create coverage where none existed. For example, if an insurer is placed on notice of an accident or claim but there was no policy in force for the purported insured at the time, or there was no occurrence, the failure to disclaim will not create coverage. However, if the claim falls within the grant of coverage and the basis for disclaimer is an exclusion or breach of policy condition (notice or cooperation, for example), a failure to deny coverage "as soon as reasonably possible," by sending out a letter to the insured, the injured person and those who may be "other claimants" (e.g. potential cross-claimants), may enable those, who did not receive proper notice of a coverage denial, to successfully challenge and overturn that denial.

Under § 3420(d)(2), "written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage" generally means within 30 days of the time when the insurer had knowledge of the grounds to deny. Although the timeliness of such a disclaimer generally presents a question of fact, where the basis for the disclaimer was, or should have been, readily apparent before the onset of the delay, any explanation by the insurer for its delay will be insufficient as a matter of law. If an investigation is necessary before a denial of coverage is concluded, insurers have a duty to "expedite" the disclaimer process and the courts will look to see whether the insurer acted promptly.

Thank you Dan for taking such a complex area of New York insurance law and summarizing it in such a brief and clear manner.

To learn more about § 3420(d)(2), and lots more about coverage, I highly recommend that you subscribe to *Coverage Pointers*. For over 13 years Dan has published this bi-weekly electronic coverage newsletter that focuses primarily on New York State decisions. If interested in subscribing, just drop him an e-mail at ddk@hurwitzfine.com

State Farm Fire and Casualty Company v. Raabe, No. 2011-09134 (N.Y.A.D. 2 Dept. Nov. 14, 2012) is available on the New York Appellate Division website.

Is This Heaven? No, It's The Iowa Supreme Court Addressing The "Any Insured" Issue

It is routine for a court, setting out to resolve an insurance coverage dispute, to begin its opinion by laying out the rules that will determine its decision. And it is likely that somewhere in the court's recitation will be a statement that its most

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important consideration is to be the language of the policy.

For as stark an example as any of the mandate that policy language is at the heart of insurance coverage, look to the coverage disputes that turn on the difference between "any" or "an" and "the," often appearing in exclusions. The use of one versus another of these teeny tiny and seemingly innocuous words can be the difference between significant coverage, or no coverage, for a claim. If that doesn't tell you that policy language is at the heart of insurance coverage, nothing will.

One situation where this issue arises with regularity is the applicability of an exclusion for the conduct of "any insured" or "an insured." Consider a suit filed by the victim of an attack at the hands of a teenager neighbor living in his parents' home. The teenager, as an "insured" under his parents' homeowners policy, will likely seek coverage for the suit under the liability section of such policy. In some instances, the policy will contain an exclusion for, among other things, bodily injury which results from "the criminal acts of any [or an] insured." And not surprisingly, because the teenage perpetrator insured committed a crime, the criminal act exclusion will usually preclude coverage for him.

But what about the claim against the parents for failing to prevent the attack? After all, the parents themselves did not commit a criminal act. However, insurers frequently argue that coverage nonetheless remains unavailable to them. The insurer's expected argument will be that the exclusion at issue applies to injury that results from the "criminal acts of any insured" -- and "any insured" (the parents' son) in fact committed a criminal act. In other words, in such a situation, expect insurers to maintain that the applicability of the criminal act exclusion is not limited solely to the insured that actually committed the criminal act. Rather, so the argument goes, it applies to all insureds, including so-called "innocent co-insureds."

Insurers frequently make this argument for good reason – because many courts accept it. But despite concluding that no coverage is owed to the innocent co-insured, courts sometimes point out that their decision would have been different if the exclusion at issue had applied to "criminal acts of the insured." If so, the exclusion's applicability would have been limited solely to the insured that committed the criminal act (the teenage son) and coverage for his parents would have remained available.

It would appear that, when a court concludes that "any" means any, thereby precluding coverage for an innocent co-insured, it is being completely faithful to the policy language. But policyholders often say not so fast. Even if forced to concede that, at least on its face, "any" does mean any, policyholders are likely to argue that coverage nonetheless remains available for innocent co-insureds, because any other outcome would be inconsistent with the policy's "Separation of Insureds" provision. The intent of such provision is to provide each insured with separate coverage, as if each were separately insured with its own policy, subject to the limits of liability.

Not surprisingly, innocent co-insureds, facing the prospect of no coverage because of an exclusion that applies to the conduct of "any insured," point to the Separation of Insureds clause in an effort to prevent such outcome. Their argument is that, to determine the availability of coverage for one insured, based on the conduct of another insured, would be violating the Separation of Insureds clause, as it would not be treating each insured as if they were separately insured with a distinct policy. While it is not the majority rule nationally, no shortage of courts have agreed with this position.

The Supreme Court of Iowa set forth an excellent discussion of the "any insured" versus "the insured" issue in Postell v. American Family Mutual Insurance Co. (published). While there is nothing unusual about the decision, it provides a thorough discussion of both sides of the argument. The case arises in the context of a fire policy, but when it comes to the "any insured" versus "the insured" issue, first-party property and liability policies are interchangeable.

The case is a tragic one involving suicide committed by David Postell by lighting his house on fire.

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Michelle, his wife of 31 years, and joint-owner in the house with David, sought coverage under a fire insurance policy issued by American Family. The claim was for approximately $250,000 for buildings, personal property and loss of use.

American Family disclaimed coverage on the basis of a policy exclusion for "any loss or damage arising out of any act committed: a. by or at the direction of any insured; and b. with the intent to cause a loss." The policy also included a Separation of Insureds clause that provided that the "insurance applies separately to each insured. This condition will not increase our limit for any one occurrence." So the insurer's argument went, even though Michelle was an innocent co-insured (and all agreed that she had nothing to do with the fire), the exclusion for loss or damage arising out of any act committed by or at the direction of any insured (David was also an insured), precluded coverage to her.

The South Carolina court upheld American Family's position. After concluding that David had the requisite intent to cause a loss, the court turned to the "any insured" and Separation of Insureds issues. The Supreme Court had no problem concluding that "any insured" meant "an unspecified insured." Thus, American Family properly denied coverage to Michelle. This was not a surprising decision.

Even courts that ultimately find for the innocent co-insured usually initially conclude that "any insured" applies to all insureds.

After concluding that the intentional act exclusion applied to Michelle, even though she was an innocent co-insured, the next question was whether the Separation of Insureds clause could serve to alter that initial determination. The court concluded that it did not. "[T]he purpose of severability clauses [another term for Separation of Insureds] is to spread protection, to the limits of coverage, among all of the named insureds. The purpose is not to negate bargained-for exclusions which are plainly worded. Here, the policy illustrates this fact because after the severability clause, it states, 'This does not increase our limit.' … [T]he severability clause serves to reinforce the language differentiating between joint obligations ('any' or 'an' insured) and separate obligations ('the' insured)."

Postell v. American Family Mutual Insurance Co., No. 12-0098 (Iowa Nov. 16, 2012) is available on the Supreme Court of Iowa website.

Washington Federal Court: Easy Button For "Expected Or Intended" Exclusion

Insurers have traditionally had a rough go at precluding coverage on the basis of an exclusion for bodily injury or property damage damage that was expected or intended by the insured. While it is not difficult to prove that an insured's action was intentional, the insurer is sometimes also required to establish that the insured intended the injury or damage that in fact occurred. When a court uses this standard, the expected or intended exclusion will sometimes not apply to unintended consequences of the insured's actions. Thus, the insured tries to get around application of the expected or intended exclusion by arguing that, even if it acted intentionally, it just didn't see the injury or damage coming. [Certain exceptions apply when conduct is of such a nature that the court infers that the insured had the requisite intent to cause the injury. But that's a different story.]

In Country Mutual Insurance Company v. Spencer (unpublished), the Washington federal court demonstrated that insurers can avoid this challenging expected or intended standard by simply using different policy language. At issue in Spencer was coverage for Shirley Spencer, for an underlying suit brought against her by her husband, who was convicted and incarcerated for sexual abuse of his two children and step child. While the sex abuser is usually not the one bringing suit, here it was alleged that Mrs. Spencer was engaged in a conspiracy to frame Mr. Spencer. The opinion does not set out a lot of facts, but it was alleged that Mrs. Spencer had an affair with the detective on Mr. Spencer's case.

Mrs. Spencer sought coverage for the underlying suit under a homeowner's policy.

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The policy contained an exclusion, in pertinent part, for bodily injury "which may reasonably be expected or intended to result from the intentional acts of an 'insured' even if the resulting 'bodily injury' … [i]s of a different kind, quality or degree than initially expected or intended."

Mrs. Spencer sought to avoid the application of the expected or intended exclusion by arguing that the allegations against her could involve consequences that were unforeseeable to her. In other words, she could have simply had an affair with the detective without expecting that he would frame her husband. Mrs. Spencer's argument, that her conduct led to unintended consequences, and, therefore, fell outside the exclusion, would have likely had support under Washington law – if the policy at issue had contained a different version of the expected or intended exclusion. More specifically, under Washington law, in the well-known Woo case, involving a dentist that fitted a patient with boar's fangs and photographed her, the dentist avoided application of the expected or intended exclusion because he had to expect or intend the negative reaction of the patient to his prank.

But the language of the expected or intended exclusion contained in Mrs. Spencer's policy differed from that which was at issue in Woo. In Mrs. Spencer's Country Mutual policy, the expected or intended exclusion applied to bodily injury that resulted from intentional acts, even if such injury "was of a different kind, quality or degree than initially expected or intended."

By using such language, County Mutual avoided the outcome that often befalls insurers seeking to enforce an expected or intended exclusion -- they cannot do so because they cannot prove that the insured intended the injury or damage that occurred. Country Mutual used an exclusion that was designed to avoid this difficult expected or intended standard. Well that was easy.

Country Mutual Insurance Company v. Spencer, No. C12-5044 (W.D. Wash. Nov. 8, 2012) is available on the PACER system.

South Carolina Supreme Court: New Construction Defect Statute Is Unconstitutional In Part

Over the past couple of years, news about coverage for construction defects, under South Carolina law, has reached the point of Law and Order reruns. Everywhere you turn there it is. And now the latest development – a constitutional law issue. I looked at thousands upon thousands of coverage cases in the course of writing two editions of my Insurance "Key Issues" book and I do not recall ever seeing one that addressed an issue of constitutional law. Con law and coverage just don't have any reason to dance.

To best understand this latest development in the South Carolina CD drama, you need to start at the first episode. Here is the brief version.

In January 2011, in Crossmann Communities v. Harleysville Mut. Ins. Co., the Supreme Court of South Carolina held that "where the damage to the insured's property is no more than the natural and probable consequences of faulty workmanship such that the two cannot be distinguished, this does not constitute an occurrence."

In May 2011, in direct response to legislative dissatisfaction with the Crossmann decision, South Carolina adopted legislation that a CGL policy shall contain or be deemed to contain a definition of "occurrence" that includes "[p]roperty damage or bodily injury resulting from faulty workmanship, exclusive of the faulty workmanship itself."

Then, in August 2011, the Supreme Court of South Carolina, after granting re-hearing, withdrew its January decision in Crossmann and replaced it with one that essentially follows the new statute. The Crossmann II court held that, while no coverage was owed to an insured for defective construction, coverage was owed for the consequential damages of defective construction.

Now to the latest episode. The South Carolina construction defect statute contained a provision stating that it applies "to any pending or

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South Carolina :

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or future dispute over coverage that would otherwise be affected by this section as to all commercial general liability insurance policies issued in the past, currently in existence, or issued in the future."

In Harleysville Mut. Ins. Co. v. State of South Carolina (published), the Supreme Court addressed certain constitutional challenges to the statute. The court held that the statute does not violate the separation of powers doctrine, is not unconstitutional special legislation and does not deprive Harleysville of equal protection. However, the high court also held that the statute's retroactivity provision is unconstitutional, in violation of the state and federal Contract Clauses. Therefore, the statute may only apply prospectively to policies executed on or after its effective date of May 17, 2011. Now the question for next season is presumably how this decision fits within Crossmann II.

Harleysville Mut. Ins. Co. v. State of South Carolina, No. 27189 (S.C. Nov. 21, 2012) is available on the South Carolina Supreme Court website.

New York State Of Bind For Policyholder: Federal District Court Does Not Allow General Contractor To Reach The "Subcontractor Exception"

I've always found it curious that, while New York is the real estate capital of the country, the state does not have a large body of case law addressing coverage for construction defects. That is not to say that there is none. There certainly is. But the state's highest court has never addressed the issues. As a result, the law is based on a few Appellate Division cases (with the most frequently cited one being nearly 20 years old) and a hodge-podge of trial court and federal court decisions.

I would have expected a different situation when it comes to New York law and CD coverage. But then again, maybe it makes sense. Given how expensive construction is in New York, those who can afford to build something there can also seemingly afford to make sure that it is done right. They probably don't use popsicle sticks to build houses in New York like they do in some states.

Despite it being unpublished and from a federal court, the Southern District of New York's decision in Illinois National Insurance Company v. Tutor Perini Corporation is worthy of note. Tutor Perini contains paradigm construction defect coverage facts -- a general contractor seeking coverage for property damage caused by the work of subcontractors.

While the decision addresses the issue that is at the heart of the national battle over coverage for construction defects – whether faulty workmanship is an "occurrence" – it does so, much more importantly, in the context of how the "occurrence" issue impacts the "subcontractor exception" to the "your work" exclusion.

That's the real issue when it comes to coverage for CD. The Tutor Perini opinion also contains a good discussion of New York law to date concerning coverage for construction defects. It summarizes the law and provides the cites to some of the main cases in the area. It will be a good place to start when confronted with a New York CD case.

Tutor Perini served as the general contractor for the construction of a bus terminal. An area of masonry on the façade of the bus terminal collapsed. A company retained by the Metropolitan Transportation Authority investigated and identified numerous construction defects. Tutor Perini conceded that the work was not performed in conformity with the construction contract. Tutor Perini sought coverage from various insurers.

While the case addressed lots of issues, the important one for purposes of CD coverage is that the court held that no coverage was owed because the only damage based upon the facade failure was to the depot itself. Thus, the facade failure did not constitute an "occurrence." The court also rejected Tutor Perini's argument that it avoids the "occurrence" issue because the façade failure was

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caused by work performed by subcontractors. "As an initial matter, if the insured is unable to meet its burden of proving coverage, a court need not determine whether any of the exclusions from coverage would apply. Further, it is well-settled under New York law that even damage to a property resulting from work performed by contractors does not transform a non—'occurrence' into an 'occurrence.' This is so because a general contractor is responsible for the entire project and all work done by subcontractors is done on the general contractor's behalf."

The moral of the Tutor Perini story is simple and one that many courts follow, to the consternation of policyholders. The court's determination, at the outset, that damage solely to an insured's work product was not caused by an "occurrence" ended the discussion right there. By concluding that coverage was not owed, because the "occurrence" requirement of the insuring agreement had not been satisfied, the exclusions did not need to be reached. In particular, there was no need for the court to reach the "Your Work" exclusion, which really means that there was no need for the court to reach the "Subcontractor Exception" to the "Your Work" exclusion. As a result, despite the fact that Tutor Perini used subcontractors, coverage nonetheless remained unavailable for damage caused by its subcontractors' work.

Illinois National Insurance Company v. Tutor Perini Corporation, No. 11-431 (S.D.N.Y. Nov. 15, 2012) is available on the PACER system.

Declarations:

The *Coverage Opinions* Interview With Bill Passannante

Coverage Opinions finds out what's on the mind of Bill Passannante of Anderson, Kill & Olick in New York City, a member of the firm's executive committee and co-chair of its Insurance Recovery Group. Bill reflects on his involvement in some landmark coverage cases, talks about common mistakes that insurers and their counsel make when handling claims and reveals what the term "e-mail" really stands for.

When you told me that you grew up in Greenwich Village my immediate reaction was -- nobody grows up in Greenwich Village! What was that like? Can you give me a little more about your background and what led you to law school and then insurance coverage.

I grew up in lower Manhattan. My mother worked three jobs while finishing college (with a 4.0 average!) at night, and raising three boys. She raised three professionals: a medical doctor; an MBA accountant; and me, the lawyer. Greenwich Village in the sixties was very different from the Village of today. Yes, it was the Woodstock generation, but lower Manhattan was a family neighborhood. Remember, this is before the enormous run-up in real estate values which priced most families with children out of the area.

We did have quite a connection to the area as my Uncle (after whom I was named) was the New York State Assembly Member for lower Manhattan for almost 4 decades.

I have wanted to be a lawyer from when I was old enough to speak, though since I have always had a good grasp of numbers, I took a detour as an Econometrician (a mathematical economist) for a few years to fund law school tuition. I met Gene Anderson by happenstance, and at that first late night meeting he (literally) threw a client file at me and told me to talk to him about solving the client's problem in the morning. That was my first step on the path to a practice as an insurance recovery lawyer.

You have been involved in some landmark coverage cases and have represented some of the country's biggest companies in their pursuit of coverage. What are some of the highlights of your career?

Well, we are just getting started, and look forward to hopefully many more to come.

On the non-insurance front, one highlight was working on several white collar criminal matters with Rudy Giuliani when he was my law partner at Anderson Kill prior to his becoming Mayor of New York City. Those were very interesting matters and working with Rudy on white collar cases was a memorable experience.

On the insurance side, one advantage in practicing at Anderson Kill is that the insurance recovery practice is not just "cases," it is a mission for each client. Our insurance recovery practice, in concert with its focus on representing solely policyholders, has a theme: Understanding the 'lore' and history of insurance is as important as the 'law' and gives life to many arguments. These qualities lead many of our lawyers to specialize and work extraordinarily hard to build better arguments and better ideas in coverage matters. I have been privileged to represent many clients in matters that were resolved before ever being filed in court. A select few of my cases, which did end up in court with public filings include the following.

Bill Passannante

Just a couple of weeks ago we prevailed for a client in the Appellate Division here in New York in a matter for Alfa Laval regarding obligation under law to pay to defend asbestos claims. (Travelers Cas. & Sur. Co. v. Alfa Laval Inc., Index No. 650667/09 (App. Div. 1st Dep't, Nov. 13, 2012)).

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In a different area of insurance, D&O liability insurance, we prevailed in a matter for Princeton University involving the advancement of defense costs. (Trustees of Princeton University v. National Union Fire Ins. Co. of Pittsburgh, PA., 83 N.Y.S.2d 437, appeal dismissed, 11 N.Y.3d 847 (Nov. 24, 2008)).

For Weyerhaeuser Company we won a ruling that no overt legal threat is required to activate environmental liability insurance. (Weyerhaeuser v. Aetna, 123 Wash.2d 891 (1994)), which resolved the case involving 34 insurance companies as to *all but one* company against whom we conducted several jury trials.

Similarly, we prevailed for a client in a case in Delaware involving summary judgment to advance defense costs in a white collar D&O case. (HLTH Corp. v. Agricultural Exc. & Sur. Ins. Co., 2008 WL 3413327 (2008), appeal as to certain insurance companies, Axis Reinsurance Co. v. HLTH Corp., No. 565, 2009 (2010)).

Years ago, in a case in front of then Judge Michael Mukasey (subsequently U.S. Attorney General), our client won summary judgment that insurance company duty to defend was triggered by lead paint claim. (Lefrak Organization, Inc. v. Chubb Custom Ins. Co., 942 F. Supp. 949 (1996)).

In a case involving a liability insurance dispute related to a corporate merger we won summary judgment for Quest Diagnostics. (St. Paul Fire Ins. Co. v. MetPath, Inc., 38 F. Supp.2d 1087 (1998)).

Our representation of the non-profit United Policyholders in many *amicus curiae* briefs on cutting-edge insurance questions in courts around the county has helped by making sure that the perspective of policyholders is heard by courts making the law.

Even this short list of reported cases shows that there is a need for the solutions we provide.

I saw your presentation in December 2011 in NYC at the DRI Insurance Coverage and Practice Symposium, in which you described fifteen common mistakes that you believe insurers and their counsel make. It was one of the best seminar presentations I've ever seen. What are some of the most important of those mistakes?

Thanks. We have seen quite a few. Here's two mistakes from that list:

Assert "Prejudice" On Account of Late Notice Without Basis

In order to rely upon the defense of "late notice" most states require that there be a showing of prejudice to the insurance company on account of the delay in providing notice. In one case involving long-term historical environmental damage the insurance company asserted that: (1) it lost the opportunity to interview employees; (2) it never was provided the names of certain witnesses; (3) it was denied access to the premises; and (4) certain witnesses were dead.

At trial, the policyholder presented evidence that: (1) the insurance company did not seek to interview any employees as part of its claims investigation; (2) the policyholder provided information containing the names of certain witnesses; (3) the policyholder did not deny the insurance company access to the premises; and (4) some of the witnesses whom the insurance company asserted were deceased actually were not, and in fact testified at trial.

Deny A Claim That Your Client is Advertising as A Covered Claim at the Same Time.

Anderson Kill maintains a database of insurance company advertising materials, which includes advertisements spanning over a century. Claims and underwriting do not communicate perfectly with each other, or with marketing. One of our policyholder clients saw advertisements depicting *their very claim* as an example of a *covered* claim, while at the same time the insurance company was denying coverage for that claim. Marketing, underwriting and claims don't com municate perfectly.

During your DRI presentation you told the audience what the term "e-mail" stands for in your practice. Can you share that here.

'E-mail' stands for EVIDENCE-mail. Or, if one prefers it may stand for EXHIBIT-mail.

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This is something we repeat to young lawyers, and to clients not familiar with the trial process. Lawyers usually appreciate the importance of words, particularly of the words they write. For a number of reasons, mostly revolving around the supposedly informal 'chatty' nature of email, texting and social media communications, many people seem to believe incorrectly that such communications disappear the way an informal *and unrecorded* conversation 'disappears' after being spoken. Trial lawyers know that they do not. 'E-mail' stands for EVIDENCE mail.

I'm sure that you have many fond memories of Gene Anderson (who passed away in 2010). Can you share some things that he taught you.

Gene was a partner, mentor and friend, and an inspiration to many at Anderson Kill. He was one of those leaders who was interested more in the personal and professional advancement of those he worked with than some of the other measuring sticks. Two of the many things Gene taught: (1) work hard; and (2) do the right thing. Working hard was clear from the outset when he "caught" me leaving the office at 7:30 p.m. and asked if I was "working half-a-day". Work hard.

Doing the right thing was something he always did. One client shared a story (of many similar anecdotes): *"The September 11 attacks made our offices (near the Trade Center site) completely unusable. I called various partners at Midtown firms, hoping someone would have space for our insurance team. Only Gene Anderson agreed. He did it with these exact words which I remember well – 'Whatever you want, the answer is yes.' Our team moved into offices at Anderson Kill. We were accepted by Gene and everyone and Anderson Kill provided all services free of charge. We stayed until we could move back into our offices, a full six months later. Gene would visit with the assistants telling others in the area 'You'd better treat them nice.' And when we finally returned to our offices Gene sent my assistant a big bouquet of flowers."* Do the right thing.

What are your thoughts on possible coverage disputes involving Hurricane (or not a Hurricane) Sandy?

I predict that what we call the "invisible seven-digit exclusion" will be apparent in abundance. Because so much damage and loss was sustained – and so much money is at stake -- the motivation on the part of insurance companies to deal sharply on claims will be immense. Some areas in which we can predict disputes are: (1) so-called "flood" exclusions, particularly where damage is sustained on account of other causes of loss such as wind or fire; (2) valuation of lost business income and contingent business income; (3) civil authority coverage; (4) application of "hurricane deductibles" to this "superstorm"; and (5) concurrent causation issues.

You are a prolific speaker and writer on coverage issues, including being an editor of The Policyholder Advisor from Juris Publishing. Can you describe the book and the process for putting it together?

The Policyholder Advisor newsletter is our regular newsletter on insurance recovery topics. Many of our lawyers write for the newsletter and the topics can be very diverse within the area of insurance recovery. Such as: captive insurance, property losses, business income calculations, product liability losses, professional liability issues, D&O issues, and many more.

When we had been publishing for just about a decade, we were approached by an independent legal publishing house – Juris Publishing – who asked if we had considered putting the newsletter together in book form. I along with Bob Horkovich edited and revised the articles for content and style. We gathered and rearranged them into subjects for chapters, and actually put together a reorganized and updated several-hundred-page book. As you know from your personal experience with *General Liability Insurance Coverage – Key Issues in Every State* it takes a tremendous amount of very time-consuming work to go from manuscript to finished bound

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published a second edition shows that you must enjoy self-inflicted punishment!

What keeps you busy when you are not in the office?

I have three wonderful children, so high school and college theater productions, academics and sports events keep my wife and I quite involved. I also try to do some distance running pretty regularly, although travel and trial schedules do make it difficult!

I am privileged to be involved in the alumni association of a highly academically competitive Jesuit High School – Regis High School -- the only tuition-free private all-scholarship school in the United States. The school has a remarkable history of which I am a beneficiary. It was founded in 1914 by the generosity of an anonymous benefactor and initially supported solely by the generosity of her family, later also by its alumni and friends. My involvement is my way of doing my part to maintain that generous tuition-free legacy. The graduates of the school are extraordinarily generous.

Where can I get the best slice of pizza in New York?

This is one of those statements that will cause more violent disagreements than an insurance claim, but clearly John's Pizza on Bleecker Street (278 Bleecker Street, between 6th Avenue & 7th Avenue) has the best extra-thin-crust coal-oven pizza in New York City. The lines can be long and they don't take reservations. If live jazz music and a cheesy calzone (a folded-over stuffed pizza) is your style, then the best is Arturo's (106 West Houston Street (pronounced 'How-ston' by New Yorkers, not 'You-ston' as out-of towners pronounce it) on the corner of Thompson Street).

Late-r Notice:
A Look At Decisions To Come

Pennsylvania Supreme Court to Address Proving Late Notice Prejudice

The Pennsylvania Supreme Court has agreed to hear an appeal in Vanderhoff v. Harleysville Insurance Company to answer what circumstances constitute prejudice to an insurer arising from an insured's failure to timely inform the insurer of the involvement of a phantom vehicle in an uninsured motorist claim. Much of the insurer's argument goes to the loss of its ability to undertake certain types of investigations that are done in phantom vehicle cases.

Under Pennsylvania law, for purposes of an occurrence based third-party liability policy, an insurer seeking to deny coverage, for late notice of a claim, must prove that it suffered prejudice. This is the Brakeman rule, which also applies to uninsured motorists claims involving phantom vehicles.

The Pennsylvania Supreme Court agreed to answer the following questions: "(1) What constitutes 'actual prejudice' to relieve an insurance company of its obligation to pay insurance benefits to an insured? (2) Should 'actual prejudice' involve proof by an insurance carrier that it suffered a real material impairment of its ability to investigate and defend an uninsured claim? (3) What constitutes a reasonable basis for a trial court finding that prejudice exists in a late report of a phantom vehicle?"

While Vanderhoff is an uninsured motorist case, it seems quite likely that the court's pronouncements will also apply to proving prejudice in the context of late notified claims under occurrence based third-party liability policies, especially if the insurer's prejudice argument is based on the impairment of its ability to investigate.

Vanderhoff v. Harleysville Insurance Company, No. 375 MAL 2012 (Pa. Nov. 14, 2012) is available on the Supreme Court of Pennsylvania website.