

# Enforce

*The Insurance Policy Enforcement Journal*

## *When the Going Gets Tough: Getting Paid in Full on Your Superstorm Sandy Insurance Claim*

LARGE CLAIMS STILL UNDECIDED  
AND LITIGATION LOOMS

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*Enforce: The Insurance Policy Enforcement Journal* is the industry's premier source for information and analysis of the enforcement of insurance policy provisions.



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## From the Publishers

Dear Readers,

We are happy to share this issue of *Enforce, the Insurance Policy Enforcement Journal*, with you. This is our 12th year of publication. *Enforce* is the only journal devoted solely to issues and questions surrounding a critical issue for most businesses: the enforcement of insurance policies.



DAVID E. WOOD AND DAVID P. BENDER JR.

We always endeavor to make the content of *Enforce* timely and relevant. The biggest business-related stories on the national scene — the economic recovery and natural disasters, such as Superstorm Sandy — dominate this issue. We approach the topics of buying cyber insurance, the seemingly never-ending claims against corporate directors and officers, and the challenges to gaining additional insured coverage. In all of our articles, we seek to inform and guide you in making important decisions about protecting your business.

We keep our ear to the ground of the American economy. What we hear is an engine that was idling for a long time, but which now appears ready to roll. There will be major changes this year in health care affecting virtually all of our readers, though maybe not the changes you have been reading about in the news. *Enforce* advises companies to review their existing insurance policies and determine whether they fully protect against the new risks that could come under the Affordable Care Act.

Government regulation and investigations permeate most industries, exposing companies and their leaders to new layers of risk. And insurance companies are not always covering the losses and claims to which they contracted.

Working in the arena of risk management has never been more important to American business. We hope this issue of *Enforce* helps you to navigate through a sea that is ever changing and ever more challenging.

Sincerely,

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# When the Going Gets Tough: Getting Paid in Full on Your Superstorm Sandy Insurance Claim

By Ronald J. Papa and Marshall Gilinsky

Policyholders and insurance companies are getting down to brass tacks on complex commercial insurance claims arising out of Superstorm Sandy. Although there are many areas where policyholders have been able to reach consensus with their insurance companies on how losses are to be adjusted, a handful of legal and factual issues are creating stand-offs and holding up the resolution of large insurance claims. Because large amounts are at stake in many of these claims, these issues may result in litigation.

Policyholders should undertake a detailed analysis of the policy language and facts involved when determining what they are owed on their Sandy insurance claim and deciding whether or not their claim is being handled properly. The analysis should encompass the points below.

## Application of Sublimits (and Deductibles) for Named Storm, Windstorm, Storm Surge and Flood

Many commercial property insurance policies have deductibles and sublimits that apply to losses caused by certain perils. For example, a policy might generally provide \$20 million in limits, subject to a 5 percent deductible, but only provide \$2 million in coverage for flood losses. Is the deductible 5 percent of \$2 million, or 5 percent of the total value? Exactly

what limits are available and what sublimits apply depends on the specific terms in your insurance policy — and virtually every large commercial property policy that we have reviewed following Sandy is worded differently. Some policies define and set sublimits for things like “Named Storm,” “Windstorm” and “Flood.” Others do not. Some include “Flood” losses within the “Named Storm” sublimit when such losses happen concurrently, while others treat such losses in the reverse. Accordingly, obtaining a full and proper recovery on your Sandy claim depends on a very careful analysis of all the relevant terms in your property insurance policy.

It is especially important that policyholders realize the differences between Named Storm, Windstorm, Storm Surge, and Flood. Although Superstorm Sandy was not a “Hurricane” when it made landfall in New York and New Jersey, it still was a Named Storm, as it was a post-tropical depression at the time. Therefore, an insurance policy’s Named Storm or Windstorm deductible might apply, but the Hurricane deductibles would not.

We have recently seen several commercial property insurance policies that will cover or exclude a named storm or a flood. We have also dealt with Sandy losses where flooding occurred concurrently with the named storm, but where the insurance policy excluded only ensuing floods. In those cases, since the floodwaters either preceded or were concurrent with Sandy’s landfall, the flooding was not an *ensuing* loss and coverage was required.

We have also had cases where the insurance policy included one sublimit for “Named Storm” and a different sublimit for “Flood.” Depending on the policy wording, in situations where both types of loss occurred, the policyholder might be able to add the two sublimits together, since both types of loss occurred and they are not mutually exclusive. That said, some policies contain an “anti-stacking clause,” which often specifies that in such situations only the highest sublimit for the various covered perils applies. Others do not.

Whether a particular sublimit applies also might depend on the sequence of events that resulted in

the damage. If the windstorm preceded the flood, and it was the windstorm that caused a loss, coverage for the windstorm should be afforded, even if the policy contains an anti-concurrent causation clause (discussed in more detail below). We had one instance where a fire preceded the flooding and, therefore, the resulting loss had to be covered in full (although the additional damage caused solely by the flood was subject to the policy’s flood sublimit).

## Interpretation and Application of Anti-Concurrent Causation Clauses

Many policyholders with flood exclusions and “anti-concurrent causation” clauses in their policies are being told by their insurance companies that the clauses eliminate all or most of the coverage for their losses. Although anti-concurrent causation clauses generally are onerous and broad, in a practical sense they are not necessarily a bar to coverage. It is the adjuster’s job to separate what damage was caused by which peril, i.e., wind versus water. Where covered property damage occurred before the excluded damage, there should be coverage for the covered damage. For example, if wind damaged the insured property’s roof and allowed water to enter, such damage would be covered, whether or not the property subsequently was damaged by floodwaters.

For most large storms, the wind damage occurs first, followed by flooding. In many hurricanes (which involve wind gusts much stronger than those experienced on land during Sandy), where property was damaged or destroyed by wind prior to the flood, all of the wind loss damage generally should be covered. A building could be destroyed by wind, then be flooded. In such a situation, because the floodwaters cause no additional damage, no excluded loss occurred. As the saying goes: you can’t spoil a rotten egg.

In some states, anti-concurrent causation clauses are not enforced because they undermine a policyholder’s reasonable expectations of coverage or are contrary to state statutes. See California Insurance Code §§ 530, 532; N.D. Code Ann. §§ 26.1-32-01,

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26.1-32-03; *West National Mut. Ins. Co. v. University of North Dakota*, 643 N.W.2d 4 (N.D. 2002); *Murray v. State Farm Fire & Cas. Co.*, 509 S.E.2d 1, (W. Va. 1998); *In Vision One, LLC v. Philadelphia Indem. Ins. Co.*, 276 P.3d 300 (Wash. 2012). Although decisions in intermediate appellate courts have enforced anti-concurrent causation clauses in New York and New Jersey, neither states' highest court has ruled on the issue, and the fact patterns involved in many Sandy losses might provide a context for the establishment of pro-policyholder law on the issue in these two states. A similar result would also follow if a bill now before the New York State Legislature, prohibiting generally the use of anti-concurrent causation clauses in New York state, passes. See N.Y. Assembly Bill No. A07455A; N.Y. Senate Bill No. S5581.

### Coverage for Losses Due to Service Interruption (aka What Caused the Power To Go Out?)

Many policies promise to cover the policyholder's business interruption losses due to off-premises power interruption. Obviously, many businesses suffered significant losses due to Sandy-related power outages, but policies typically only cover service interruption losses if the outage was caused by a covered peril. Furthermore, most flood exclusions have an exception for losses where the flooding leads to an "explosion" that causes loss or damage. So, for many policyholders with service interruption losses, a key question is: Why did the power go out?

For policyholders with flood coverage, the question generally is academic since an outage due to either flooding or explosion would lead to a covered service interruption loss. But for policyholders that don't have flood coverage, a lot depends upon the nature and impact of the explosions at power generation and transfer facilities that may have contributed to the widespread power outages in the Northeast region. Insurance companies have been pushing a story that the explosions reported on the news and Internet were not actually *explosions*. According to insurance companies, these explosions were simply electrical arcing occurring when many circuit breakers flipped simultaneously, without causing or contributing to the power outages. This self-serving descrip-

tion of events, however, seems questionable on several levels and will be subjected to a significant amount of scrutiny before it is accepted as a basis for the denial of what surely is millions of dollars in otherwise covered service interruption claims. Indeed, one lawsuit challenging the insurance industry's position about the ConEd "explosion" already has been filed — pitting a hotel owned by Donald Trump against one of the country's biggest property insurance companies (see *Bayrock/Sapir Organization LLC v. Affiliated FM Ins. Co. et al.*, filed in the Supreme Court of the State of New York, County of New York).

“Insurance companies [argue] these explosions were simply electrical arcing occurring when many circuit breakers flipped simultaneously, without causing or contributing to the power outages. This self-serving description of events, however, seems questionable on several levels and will be subjected to a significant amount of scrutiny...”

### Coverage for Losses Due to Closures by Order of Civil Authority

Businesses located in mandatory evacuation zones were significantly impacted by Superstorm Sandy — not just because property was damaged, but also because evacuations made it difficult or impossible



for customers to access their businesses. Other businesses outside the evacuation zones faced lesser but similar problems due to the shutdown of the mass transit system and area bridges and tunnels. Business interruption losses under such circumstances generally are covered under civil authority provisions included in most commercial property insurance policies. Nevertheless, many insurance companies are trying to limit the amounts being paid on such claims on two fronts.

“Many policyholders are facing improper pushback from their insurance companies and as a result, still have not been able to finalize their insurance claims and move forward from the disruptions caused by Superstorm Sandy.”

First, insurance companies are requiring a heightened prohibition on access to the insured premises in order to trigger the civil authority coverage. For example, insurance companies are arguing that access needs to be “prohibited” even though the policy language promises coverage based on a more liberal standard.

Second, insurance companies are limiting the duration of coverage to a period measured from the mandatory evacuation on October 28, 2013, until a subsequent executive order was issued by Mayor Bloomberg on October 31, which allowed reoccupation of buildings once New York’s Buildings Department determined they were safe.

Policyholders should be vigilant in pursuing a full recovery despite these insurance company argu-

ments. Regarding the heightened triggers urged by some insurance companies, policyholders should insist that the language in their policy be applied to fulfill the insurance company’s contractual obligation to pay. If the policy explicitly requires a total prohibition of access in order for coverage to apply, then so be it. If, however, the policy promises coverage based on a lesser impairment of access, then the claim should be adjusted on that basis.

Similarly, we have not seen any civil authority language that restricts coverage based on post-loss interim phases of reoccupation of affected areas. Rather, civil authority coverage is triggered by the mandatory evacuation (based on Executive Order 163, issued on October 28) and continues *at least* until the property at issue is allowed to be reoccupied — not when the property theoretically could have been reoccupied if only the Buildings Department had inspected it and approved such re-occupancy.

All in all, many policyholders are facing improper pushback from their insurance companies and as a result, still have not been able to finalize their insurance claims and move forward from the disruptions caused by Superstorm Sandy. Policyholders should carefully review and understand exactly what coverage their insurance policy provides and should insist on a full and fair payment on their business interruption insurance claims. ▲

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# Entanglements

## Brokers Say Rate Increases Driven by Costs of Regulations and Investigations

**P**olicyholders might not like it, but they get used to the pricing cycles of insurance markets. Current market increases, however, are being driven by a new factor — the cost of what new regulations and investigations might do to the cost of insurance, and the fear of what they might do in the future.

*Enforce* took the pulse of three major brokers who appeared at Anderson Kill's 10th annual D&O conference — and talked to one independent broker — and the consensus is clear: government regulation and the fear of dealing with extensive red tape and potential civil and criminal investigations is one of the factors that is hardening a market that has been soft for a decade.

"It is the fear of the unknown," said Fred Podolsky, executive vice president for Alliant Insurance Services. Insurance companies "want it correct for the new regulatory environment."

What's driving this new environment is shareholder and government demands that all major transactions be thoroughly scrutinized and squeaky clean. If not, any hint that something is amiss can set off an investigation by the Justice Department or the Securities and Exchange Commission or both, and, if the company is involved in a global market, might also involve law enforcement agencies in foreign lands. This is the price companies are paying for decades of Enron scandals, dot-com bubbles bursting and venerated institutions crumbling before their eyes, our panelists said.

Allison Hollern, senior vice president at Lockton Companies in London, said, "We are beginning to see regulators over here [who] either, 1) look to mimic

the U.S. regulators and how they operate, or 2) see the U.K. or European regulators work with U.S. regulators." She cited one U.K. company with operations in Malaysia and markets in the United States that potentially could be under investigation on three continents simultaneously. That would be very expensive for the company to defend and "incredibly complex" as an insurance coverage matter. "For insurers, the policy can be eroded [beginning] from dollar-one defending a multi-jurisdictional investigation," she said.

Andy Doherty, senior vice president and Atlantic region leader for Willis' FINEX North America, said that the Foreign Corrupt Practices Act has become prominent and "a lot of the time, corporate investigation expenses are not covered under the D&O policy. These investigations can be very expensive and the costs might not be covered at all depending on how the policy [is] structured."

Hollern noted that policies have been amended heavily to ensure coverage of investigations. "The policy has to be global and it needs to respond to any official regulator or body that has the authority to regulate. And you have to look closely at your retentions, depending on the class, because the policy is now triggering a lot earlier."

It has also made the policy underwriting process even more slow and tedious. According to Doherty, "We get a lot more questions on interactions with regulatory bodies . . . have all the policies and procedures been updated with respect to anti-bribery efforts?" He added that, fortunately, "most companies have thorough policies and procedures in





*“The new regulations are so complex that you can read them and still not know where you are.”*

~JAMES N. SCANLON, CEO  
SGB-NIA INSURANCE BROKERS

place. Most responsible companies will reevaluate them in light of what is happening.”

The number of microscopes on companies is “one of a number of points driving rate increases,” said Doherty, adding, “I think if the rate increases for primary coverage are in the high single digits that the regulatory landscape is contributing probably a third of that. The other two-thirds being M and A objection claims, anticipated settlements from the credit crisis claims and a low interest environment.”

Hollern suggested the long-term effect is the “gradual pushing-up of rate of the primary policy. Long term we might see a two-tiered policy in which the bottom tier is a lot more price sensitive than we’ve seen historically, and excess layers become much more of a commodity placement.”

Even mid- to small-market companies are paying the price for increased government regulation. Doherty noted the Consumer Financial Protection Bureau “obviously puts a lot of focus on how companies act in dealing with their customers. That type of oversight is not quite a direct D&O issue, but a bad customer-related issue can quickly turn into a D&O issue.”

James N. Scanlon, CEO of SGB-NIA Insurance Brokers, a large independent broker in the Los An-

geles area, deals with small- to mid-market companies feeling the weight of regulation.

Small- to mid-market business owners are dealing with increased pressure from the Labor Department over compliance with wage and hour laws and the Employee Retirement Income Security Act, known more commonly as ERISA. “It is expanding with the new health care laws and up until now, enforcement has not been a priority for the Department of Labor,” said Scanlon. He guessed that more than 50 percent of his clients are trying to comply with Labor Department regulations and wondering what happens if they fail. “Certainly, this is going to affect the cost of their EPLI [employment practices liability insurance]; the size of the retentions.”

“We are seeing some clients — especially in the construction area — who can no longer get the amount of coverage they used to.” Scanlon added that self-insured retentions are doubling and prices are increasing up to 25 percent, “sometimes doubling if you had claims activity.”

His company’s answer for its clients is to assist with a client audit to ensure compliance. “The new regulations are so complex that you can read them and still not know where you are.” But you will get hit with higher rates.

On the large-market companies, Hollern suggests, “Stress test your policy.”

In answer to the same question, Podolsky said, “Lay out a half-dozen scenarios with your brokers to determine if there is coverage.” ▲

# Allocation Clauses: Hidden Exclusions

By David E. Wood and Caroline R. Hurtado Ford

As the ripple effects of the financial crisis continue, corporate directors and officers face what seems like limitless liability exposure in the exercise of their duties. As shareholder advocates, regulators and bankruptcy trustees hunt for evidence of corporate mismanagement, their claims against unprotected directors and officers, and the entities for which they are fiduciaries, can be far more than a distraction from the company's core business: they can be a threat to its balance sheet and, as a consequence, its share price.

Officers and directors and the companies they serve depend upon D&O policies to fend off these threats. Covered "wrongful acts" usually are defined very broadly to include misrepresentations, misstatements, breaches of duty, errors and omissions. Policyholders justifiably expect broad coverage, especially their costs of defending potentially-covered claims of breach of fiduciary duty, securities fraud, and other causes of action arising out of the business of running a company.

But often a complaint against officers, directors and the entity they serve seeks redress for a mixed bag of supposed harms, including losses that would not be covered were the claimant to win a final judgment, like common law and securities fraud. In this scenario, policyholders report to their insurance company that there is no merit to plaintiff's claims, covered or non-covered, and expect their defense to be fully funded once the self-insured retention is exhausted. The D&O insurer may decline to do so, pointing to the policy's allocation provision.

Allocation provisions began to appear in D&O policies about twenty years ago, in response to D&O insurers' refusal to pay 100% of defense costs incurred by or settlements of claims against their policyholders. They contend they have a right to deny coverage for any part of defense costs allocable to non-covered persons, entities and claims. Back then, most courts addressing this kind of denial held that because a D&O

policy typically does not provide a duty to defend—meaning that a D&O insurer need not select, pay and control counsel appointed to defend the entire action alleging a single potentially-covered claim—the insurance company may deny coverage on an interim basis for the portion of defense costs attributable solely to non-covered persons, entities and claims.

Courts disagreed, however, on when and how an insurance company may refuse to pay the non-covered portion of defense costs. Some ruled that a partial allocation of defense costs to non-covered persons, entities and claims is appropriate only where that which is non-covered creates a distinct basis of liability that increases the insured's overall exposure to liability; this approach was labeled the "larger settlement rule." Others held that D&O insurers may create a ratio of covered versus non-covered persons, entities and claims based on relative exposure to liability, and fund only the part of defense costs attributable to that which is potentially-covered; this was called the "relative exposure test."

The result was chaos. Consumers of D&O insurance—companies that buy such coverage to protect their balance sheets and their senior managers and directors against personal liability—complained to underwriters that implied allocation based on unproven allegations was unfair and unpredictable. Many of these underwriters responded by adding express allocation provisions to their policies which required allocation based on the relative exposure test. In many cases, these clauses established a procedure for provisional allocation of defense costs at the outset of a claim. Despite the protests, allocation became a fact of the insurance contract that D&O insurers generally refused to waive.

Application of these allocation provisions to actual claims proved that policyholders' fears about losing big chunks of defense costs coverage in lawsuits alleging non-covered persons, entities and claims were

justified. Insurance companies offered less than 100% defense costs coverage based on allegations of non-covered conduct not because these claims had any merit, but because the claims existed. Where the non-covered conduct was a claim for fraud, policyholders pointed out that this seemed to defeat the purpose of the conduct exclusions, which excluded fraud and improper personal benefit to an insured only if the allegations were proven “in fact” or by a final adjudication. Policyholders were denied 100% defense costs coverage based on insurance companies’ predictions of their relative liability exposure, even where no discovery had been taken and no facts had been found.

Today, allocation provisions in D&O policies still can come as a nasty surprise to the entity and its directors and officers counting on full defense costs coverage. Even though Side A coverage (to protect directors and officers for claims that the company does not indemnify), Side B coverage (to reimburse the company for its indemnification of directors and officers), and Side C coverage (to protect the company when it is a named defendant) appear broad and all-encompassing, unproven claims can still dilute coverage for defense costs from the outset of litigation.

Allocation has also become a sore point in annual renewals of D&O programs. In an effort to narrow the effect of allocation provisions, brokers and risk managers propose structural changes like:

- Removing the relative exposure test from the allocation clause, giving the insureds the benefit of the larger settlement rule in jurisdictions that follow it.
- Submitting a disagreement over provisional allocation of defense costs to accelerated, binding arbitration.
- Full defense costs coverage if the insurance company and the entity cannot agree on a provisional allocation formula.

Revisions like these can ease the insureds’ feeling that the allocation provision is really an exclusion in disguise, crafted to suppress directors’, officers’ and entities’ expectations of coverage.

## Allocation In Action

The U.S. government’s recent whistleblower suit against Bank of America can be viewed as a case study for analysis of allocation under a D&O policy. The government alleges that Bank of America fraudulently sold loans to



Fannie Mae and Freddie Mac that did not conform to the requisite underwriting standards or representations and warranties in the parties’ contracts. Assuming for the sake of analysis that Bank of America has a typical D&O policy with a “relative exposure” allocation provision, we can use this case as a hypothetical for considering how allocation might be dealt with by D&O insurers under these circumstances.

In arguing for dismissal of the government’s complaint, Bank of America asserted that there were no allegations of deception and that all claims arose out of an alleged breach of a contract—the underwriting standards governing the sale of loans. Under these circumstances, a D&O insurer might argue that none of the government’s claims are covered because of the breach of contract exclusion. This exclusion typically would be subject to an exception reinstating coverage where the same damages are recoverable under a non-contract theory of liability. In response to an insurer argument that this exclusion justifies allocation of a portion of defense costs to a non-covered contract-based claim, the insureds would point out that the government’s claims are based not just on breach of contract, but also upon an alleged failure to conduct adequate due diligence and quality control. These facts trigger the exception to

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the exclusion because they articulate a negligence claim—precisely what is insured by a D&O policy.

The insurance company might also assert that a conduct exclusion precluding coverage for dishonest, fraudulent or criminal acts might also apply, justifying allocation. In its challenge to the government's complaint, Bank of America argued that inadequate diligence is not fraud. It is well-settled that a fraud claim must be based on more than a breach of contract, subject to narrow exceptions. In the face of a fraud claim that is surrounded by facts that show negligent conduct, the policyholder must argue that all claims—covered and non-covered—are inextricably linked, and that the insurance company must fund the insured's defense until there is a final adjudication that actual fraud occurred. Ultimately, the way to protect against allocation based on a conduct exclusion is to demand that the exclusion state expressly that it will not apply to defense costs except to support a claim for reimbursement in the event of a final adjudication that excluded conduct occurred.

But suppose that the bank's D&O policy was issued in California where Insurance Code § 533 acts as an implied exclusion for "wilful acts." This statute is a conduct exclusion that can apply—and be considered in allocating covered from non-covered liability exposure—without a final adjudication of fraud. The policyholder must argue that the insurance company's reliance upon § 533 directly contravenes the purpose of the "final adjudication" language in the typical conduct exclusion: to preclude its effect unless and until an insured is determined by a court or jury, after appeals, to have committed excluded acts. Here, the bank might also contend that findings of massive, systemic failures in due diligence can never rise to the level of actionable fraud, and therefore cannot trigger § 533 before a final adjudication is made. In other words, the government's allegations of fraud against Bank of America should never be part of a conversation with the D&O insurers about allocation.

We cannot know the exact language of Bank of America's D&O program, and analysis of how allocation might be treated by the policyholder and its D&O insurers is illustrative only. Apportioning defense expenses under a relative exposure allocation clause should be provisional, and should be driven by the argument that the policyholder has no real exposure to liability for non-covered acts. It should be noted that where a D&O policy provision requires allocation, rules of law disallowing appor-

tionment (for example, where defense costs are reasonably related to defense of both covered and non-covered persons, entities and claims, in some jurisdictions all defense costs are covered) may be trumped by the policy language mandating allocation between covered and non-covered matters. The insured's careful examination of the complaint and the factual basis for liability, and assertive presentation to the insurance companies of real and potentially-dispositive defenses to liability, are critical to moderating or overcoming the exclusionary effect of an allocation clause.

## Higher Scrutiny?

Uncertain profits, increased regulations and the complexities of today's financial markets mean higher scrutiny of corporate decisions—and more complex and expensive liability exposure for directors, officers and entities. Corporate management, boards and their counsel should expect D&O insurers to evaluate recently-filed litigation and parse claims in a way that allocates away part of defense costs coverage, and have strategies in mind ahead of time to resist allocation as much as possible. Forewarned is forearmed. Anticipating an insurance company's game plan at the outset of a claim, and finding ways to win the best allocation of defense costs available—preferably, no allocation at all—is the way to get the most defense costs coverage out of D&O policies. ▲

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# Maximizing Additional Insured Coverage

By Scott C. Turner

Most businesses — with the requisite bargaining power — require that they be added as additional insureds under the liability coverage of other businesses they work with, such as contractors, tenants, suppliers, vendors or consultants. This is within the context of an overall risk-management requirements package that includes maintaining specified liability coverage, and full indemnification for claims arising out of the affiliated businesses' products and services.

Obtaining additional insured coverage yields a long list of very important risk management benefits. A short list of examples include:

- protecting the additional insured's loss record under its own policy, thereby keeping its future premiums lower (particularly important in highly cost-competitive industries);
- transferring the additional insured's sole fault negligence to the other party's insurer (particularly in those states that bar such risk transfers by indemnity agreement between the parties); and
- substantially increasing the total policy limits available for liabilities.

“Obtaining additional insured coverage yields a long list of very important risk management benefits.”

## Different Additional Insured Endorsement Forms Provide Very Different Coverage

The Insurance Services Office currently offers 29 standard additional insured forms, and the American Association of Insurance Services offers eight. Additionally, individual insurers often write their own additional insured endorsements using non-standard language, often providing highly restricted coverage. Worse yet, most of the standard forms have been significantly altered from year to year, such that coverage under a pre-2004 edition of a particular ISO form differs greatly from coverage under the current post-2004 edition of the same numbered form.

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“If an additional insured is in an industry that faces fairly frequent claims, it is particularly important to establish a reputation among insurance companies and their lawyers for vigorously enforcing its negotiated additional insured rights.”

Let's take the construction industry as an example. Given the broad range of possible additional insured coverage theoretically available on the market, a general contractor looking to maximize its coverage under its subcontractors' commercial general liability policies should consider these questions:

- Coverage for its vicarious liability for subcontractor-caused injury or damage is probably a given, but is there coverage for direct liability for injury or damage the general contractor itself causes? Does this include situations in which the general contractor was solely at fault? For example, the ISO form additional insured endorsement most often used for the construction industry is form CG 20 10. The pre-2004 editions of that form generally covered a general contractor's sole fault, whereas the current 2004 edition limits coverage to liability "caused in whole or in part by [the named insured's] acts or omissions."
- Does the "other insurance" provision in the subcontractor's policy provide that its coverage is primary and non-contributory — or excess to any other insurance available to an insured? If the latter, much of the benefit of additional insured coverage is lost. Is there anything in the language that would support an insurance company's argu-

ment that coverage should be allocated between it and the general contractor's own insurer?

- Does it cover both the named insured's ongoing and completed operations, as some forms attempt to eliminate coverage for the latter? Many courts have held that the editions of the CG 20 10 endorsement issued since 1993 have eliminated or excluded coverage for the subcontractor's completed operations and cover only its ongoing operations. Use of the pre-1993 form is sometimes available, and a new CG 20 37 form is sometimes available to add completed operations coverage back into the additional insured coverage.
- Does the additional insured endorsement require that the pertinent jobsite be listed by name for coverage to apply, or are all the subcontractor's jobsites automatically covered?
- Are any unexpected and unwanted exclusions included?
- Is coverage provided both as the commercial general liability policy's Coverage A (bodily injury and property damage), and Coverage B (personal and advertising injury coverage)?

Unfortunately, there may be practical limitations on the nature and amount of additional insured coverage available to the subcontractor or subcontractors involved. Depending on market conditions, and the industry and nature of the named insured, insurance companies may be unwilling to provide the desired level of additional insured coverage, at any price. Asking for the impossible or impractical only creates problems and frustration. Knowing the maximal additional insured coverage currently available on the insurance market requires a sophisticated administrator with considerable insight into market conditions.

### Confirming the Required Additional Insured Coverage Was Actually Obtained and Remains in Force

Because the insurance policy purchase transaction is between the named insured subcontractor and its insurance company, it isn't procedurally easy for a general contractor to confirm whether the subcontractor has complied, and continues to comply,



with the general contractor's requirements for additional insured coverage.

Typically, a certificate of insurance issued by the subcontractor's insurance broker confirms coverage. Unfortunately, there are many large problems and inadequacies with this reporting system. Generally, the best that can be done is for the general contractor's subcontract to 1) require that a specific additional insured endorsement (by form number and edition date) be used, 2) require that the general contractor receive a certificate of insurance explicitly confirming that the subcontractor's policy was in fact endorsed with that specific form, and 3) require that a copy of the actual endorsement used be attached with the certificate to further confirm that the endorsement was properly prepared. Nevertheless, do not expect easy confirmation here. Because of the problems with the certificates of insurance procedure, additional insureds, such as general contractors, need an administrator to closely monitor and vigorously enforce both their subcontractors' initial compliance and their continuing compliance with these requirements. Given the number and nuanced nature of the problems here, and a great deal of foot-dragging by insurance brokers and insurance companies, that administrative task is a significant and sophisticated undertaking.

## Obtaining the Additional Insured Coverage Benefits on Actual Claims

It's not over yet. Even after actually being named as an additional insured, there is still more work to be done when a liability claim is made. Insurance companies resist their additional insured obligations, usually by pressing the additional insured to look to its own insurance for defense and the payment of any settlement or judgment, because (so they claim) their coverage is excess to the additional insured's own coverage — or, at worst, contributory with the general contractor's own insurance. Even when the primacy of their coverage obligations is clearly spelled out in their own policy, they will often simply ignore all protests to the contrary. If hauled before a court or mediator, they raise a variety of arguments, such as it was inequitable and unenforceable to force the poor subcontractor to shoulder the general contractor's

entire coverage burden when the general contractor is partially or solely at fault. For example, in *Cosimini v. Atkinson-Kiewit Joint Venture*, 877 F.Supp. 68, 71-73 (D. R.I. 1995), in response to technical arguments tying the scope of additional insured coverage to esoteric problems with the indemnity agreement in the subcontract, the court held that both the indemnity agreement and the additional insured coverage were limited to only that percentage of the damages awarded that were attributable to the subcontractor's fault.

Additional insureds must know and anticipate these arguments and be prepared to rebut them. If an additional insured is in an industry that faces fairly frequent claims, it is particularly important to establish a reputation among insurance companies and their lawyers for vigorously enforcing its negotiated additional insured rights.

Is additional insured coverage ultimately worth all this work? Almost everyone thinks so. ▲

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# Beyond Health Insurance

## What Your Company Should be Doing Today to Protect Against New Risks Created by the Affordable Care Act

By Rhonda D. Orin and Daniel J. Healy



The enactment of the Patient Protection and Affordable Care Act brings new insurance exposures for risk managers to consider, far beyond the obvious issue of health insurance.

Areas worthy of consideration are liability insurance, directors and officers insurance, errors & omissions insurance, stop-loss insurance and more specific policies covering employment practices, employee benefits and crime. All corporations would be well advised to review their existing insurance policies and assess whether they provide full protection for the new risks that may come with this entirely new set of regulations.

### Liability Insurance

Liability insurance provides defense and indemnification against lawsuits filed by third parties. This type of insurance is relevant because the Affordable Care Act has the potential to produce third-party lawsuits against corporations, such as private lawsuits by employees against employers for alleged violations.

Although the law is still in its infancy, one private action already has been filed and resolved. In 2011, a convenience store employee in Iowa sued her employer in federal court on grounds of noncompliance.

The employee, a nursing mother, alleged that the store had failed to provide her with a private location during which she could express breast milk during her workday. She alleged that her employer had violated the Affordable Care Act, which amended the Fair Labor Standards Act by requiring employers to provide employees with “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public” to express breast milk.

In July, the Northern District of Iowa rejected the argument that the employee had a private right of action under the health care law. The court ruled that any alleged interference with this new right must be addressed solely by filing a complaint with the Department of Labor.

The court also ruled, however, that a private cause of action is available to employees who assert that they were terminated or otherwise subjected to retaliation for complaining about an employer’s noncompliant practices.

Like the first raindrop, this lawsuit is destined to be the first of many that are filed by employees against their employers, arising from alleged violations of the Affordable Care Act and the various statutes that it amends. Corporations and their risk managers would be well advised to make sure that they have appropriate insurance protection before the downpour gets underway.

## Directors & Officers Insurance

D&O insurance provides defense and indemnification to directors and officers who are individually named in lawsuits against their corporations. An example would be shareholder class actions, which often are filed when large corporations suffer losses on grounds of alleged corporate mismanagement. Such derivative lawsuits are commonplace following alleged violations of Sarbanes-Oxley antifraud law and securities laws, so there is reason to believe they will follow alleged Affordable Care Act violations as well.

The federal agencies overseeing compliance — the IRS, Department of Labor and Department of Health and Human Services — have the power to impose monetary penalties or taxes on companies that violate the Affordable Care Act. These enforcement proceedings, whether by audit or otherwise, may be lengthy and complex. They may be expensive to defend in terms of legal fees and costs, and may lead to large losses in penalties, taxes and interest.

D&O policies should be scrutinized carefully to assess whether they cover shareholder actions alleging mismanagement of the health care law. On the one hand, D&O policies often exclude coverage for violations of the Employee Retirement Income Security Act of 1974, known as ERISA, and other statutes regarding employee benefits, such as workers’ compensation laws. On the other hand, shareholder class actions alleging Affordable Care Act losses may be more comparable to securities class actions than to ERISA litigation.

Either way, employers and risk managers should review those exclusions carefully, both in their existing D&O policies and in future policies, to assess their applicability to potential litigation. They also should undertake to acquire as much insurance protection as possible.

The possibility of antitrust lawsuits is an additional consideration for corporations engaged in the business of health care, such as hospitals, health care systems and organizations of service providers. Experts agree that the Affordable Care Act is likely to lead to consolidation of health care operations, and that transition, in turn, is likely to generate a wave of antitrust allegations and litigation. In fact, the Justice Department and the Federal Trade Commission have pledged to intervene in mergers and collaborations that appear to have a dampening effect on competition in a given market.

Some D&O policies provide coverage for antitrust litigation, at least with regard to defense costs, while others exclude it. For corporations in the business of health care, it would be wise to make every effort to secure D&O coverage for Affordable Care Act antitrust actions, at least until the dust settles from the law’s full effect.

## Errors & Omissions Insurance

E&O insurance provides defense and indemnification for corporations accused of professional malpractice. Claims of professional malpractice are anticipated to increase in upcoming years, especially for corporations engaged in health-related occupations.

One reason for the anticipated increase is that the individual mandate will lead to many more consumers of health care. With more people receiving health care, there will be more opportunities for mistakes to be made — or at least alleged.

Overburden on the medical establishment is another reason for the anticipated increase. Based

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on experience with health care reform in Massachusetts, the demand for medical care is expected to overwhelm the current supply of medical professionals and hospital beds.

An aggravating factor is the concurrent aging of baby boomers. Waves of retirements can be expected in upcoming years among the current stock of medical providers. Doctors and nurses, along with a large chunk of the working population, will slowly turn into elderly retirees — consumers of the very services they used to provide.

Even if insurance companies sharply increase the cost of professional liability premiums, the message for corporations in the business of health care is clear. Professional liability insurance is a necessity for survival in the years ahead.

## Stop-Loss Insurance

Stop-loss insurance indemnifies self-insured employers and group health plans when medical losses exceed predetermined levels. The levels can be set on a per-employee basis, a plan-wide basis or both.

The use of stop-loss insurance usually corresponds to the size of the employer or group plan. The largest plans — 5,000 covered lives or more — typically do not purchase stop-loss insurance. But the vast majority of self-insured plans do. An estimated 60 percent of self-insured plans rely on stop-loss insurance, which translates to approximately 50 million covered lives.

The existence of stop-loss insurance does not have a direct impact on the covered individuals in a plan. Plans are bound to honor their contractual obligations to their members regardless of whether the plans have stop-loss indemnification. But stop-loss insurance can have a substantial impact indirectly. In a year of high losses, the existence of stop-loss insurance can spell the difference for a plan between solvency and insolvency.

The Affordable Care Act increases the value of stop-loss insurance for all plans, even massive ones with 5,000 members or more. One reason is that the law eliminates annual and lifetime financial limits on benefits. Because plan members will have the potential for unlimited coverage, the plans will have the corresponding potential for unlimited risk. Many plans are expected to view stop-loss insurance as the best, if not the only, solution.

## Other Types of Insurance

Other insurance policies that may provide coverage for Affordable Care Act–related risks include employment practices liability insurance, employee benefits liability insurance and crime insurance. Such insurance can fill the coverage gaps left by the exclusions in liability, D&O and E&O policies.

Employment practices liability insurance provides defense and indemnification to corporations named in lawsuits based on employment decisions and actions. Many of these policies are manuscript and contain a variety of exclusions, often for losses from the violation of certain federal laws. The Affordable Care Act is relatively new, amends other laws and may not be contemplated by employment practices policies. Moreover, even if the health care law is found not to provide a right of recovery for certain employee benefit decisions, these employees may allege claims under the various statutes that the law amends, which then may fall under the policies.

Employee benefits liability insurance, which provides coverage for employee benefit plans, can be available when employment practices and D&O coverage are excluded. Employee benefits liability insurance typically covers alleged violations of ERISA, the Fair Labor Standards Act and comparable statutes. It provides defense and indemnification for mistakes in administering employee benefits offered to employees.

The Affordable Care Act requires corporations to make various decisions about employee benefits, which leads to increased liabilities for those decisions. Thus, this fairly specialized type of insurance may become more prevalent as the full effects of the law unfold.

Finally, crime insurance and fidelity bonds provide indemnification for losses suffered by a corporation due to fraud and other crimes. The insurance is “first party” in that it covers the losses suffered by the company. The health care law potentially expands corporate exposure to allegations of fraud and criminal activity, as corporations (particularly health care providers) may face alleged violations of the False Claims Act, as well as whistleblower claims. Thus, in doing an overview of existing insurance policies, crime insurance and fidelity bonds should be considered as well.

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# Data Security

## Tips and Red Flags When Buying Cyber Insurance

By Joshua Gold and Cort T. Malone

**T**he Department of Homeland Security and lawmakers have issued warnings recently regarding the need for businesses to do a better job of minding the store when it comes to data security. Companies themselves are aware of this need: a recent survey indicated that about 30 percent of corporate general counsels believe that their companies are unprepared for a serious data breach. That's a sobering figure that should cause in-house lawyers, risk managers and IT departments to stop and think about their own company's ability to protect its customers and itself from this risk. A smart blend of careful contracting, the right purchases of insurance, due diligence and follow-up with employees can assist greatly in reducing the risks associated with data security breaches.

### Risk Management for Data Security Breaches Through Insurance

Data security breaches can lead to a slew of different losses. In the wake of a cyber incident, significant expenses can be incurred in defending class-action litigation, indemnifying those who have a

stake in disclosed information, and responding to state attorneys general, the Federal Trade Commission and the Securities and Exchange Commission. The costs of investigating cyber breaches and complying with notification laws can be significant. Cyber incidents can also affect profitability when an incident interrupts business and systems need to be taken offline or security needs to be redeveloped.

The good news is that the insurance market for policyholders shopping for specialty cyber policies is more competitive than ever before. This means more flexibility and coverage options than were available five years ago. As always, however, it is essential to mind the fine print. Below are a few issues to work out with underwriters at the point of sale — not the point of claim.

### Exclusions for Terrorism, Hostilities

Many cyber insurance policies contain exclusions for terrorism, "hostilities (whether war is declared or not)" and claims arising from "acts of foreign en-

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emies.” Given that many cyber attacks and breaches are believed to originate in foreign countries and some of those are further believed to be at the direction of foreign governments, policyholders must decide whether such exclusions make the cyber coverage unsuitable for their needs. This question may be especially germane if the policyholder is in a key infrastructure industry, defense industry or technology sector.

## Exclusions for Contractual Liability

Some cyber insurance policies purport to exclude coverage for “any guarantee, warranty, contractual term or liability assumed or accepted by an Insured under any contract or agreement.” Exclusions of this type are often misused by certain insurance companies to contest valid claims. “Contractual liability” exclusions are particularly problematic in the cyber insurance realm because many policyholders will have contractual relationships with merchant banks, credit card companies, clients, vendors, investors and other business partners. In the case of a cyber breach impacting a policyholder’s relationship with these entities, insurance companies may try to argue that such exclusions bar coverage otherwise available under the cyber policy. Some insurance companies will also argue that breach of contract damages do not constitute a covered “loss.”

Even if the cyber insurance policy provides a carve-out from the exclusion for scenarios in which the policyholder may have liability absent the contract relationship, policyholders still are regularly forced to refute creative arguments about legal doctrines that are not supposed to apply to the insurance coverage realm, such as the so-called economic loss doctrine. These types of exclusions therefore need to be eliminated or greatly narrowed in scope to avoid their potential application to cyber losses.

## Unauthorized Collection of Data Exclusions

Some cyber insurance policies contain exclusions for the “unauthorized” collection or gathering of information. For policyholders engaged in some forms of online business activity, such an exclusion can be problematic. For instance, it was reported recently that the FTC had warned several data brokerage firms that their practices of gathering and selling consumer information potentially violate the Fair Credit Reporting Act. Other companies have been accused of keep-

ing consumer credit card transaction data for too long a time after the credit card transaction was complete. Policyholders that gather information for consumer transactions, marketing purposes or as part of their core business model, must gauge how an exclusion for unauthorized collection might be used by an insurance company to evade insurance coverage for a data security breach claim.

## Pollution Exclusions

Cyber insurance policies may also contain exclusions for “pollutants.” Again, depending upon the policyholder’s industry, such an exclusion may be problematic or lead to an unnecessary dispute over the scope of coverage for a claim. Given that cyber attacks are increasingly aimed at key infrastructure, it is possible that a cyber attack could implicate “pollutants.” Insurance companies have been very aggressive over the years in urging a broad application of pollution exclusions to go far beyond industrial polluters, such as arguments that indoor air quality claims implicate pollution exclusions. Accordingly, depending on the policyholder’s industry, imposition of an exclusion for pollutants may require a conversation at your underwriting meetings.

## Violation of Statute, Rule, Law or Consumer Protection Law

Some cyber policies have exclusions that seek to restrict or void coverage where the policyholder has violated a statute, rule, law or order of a regulatory agency. There are many variations of such exclusions and it is important that the insurance broker either eliminate such exclusions, or find a policy that has the most palatable one available. In the wake of a serious data breach or cyber attack, it is not uncommon for regulators and others to assert that the policyholder’s data-handling and conduct violated state or federal law as noted under “Unauthorized Collection of Data Exclusions” above.

## Untested Policy Language

A great many of the cyber insurance policy terms and forms now on the market are untested in court. That is likely to change in the future as more of this insurance is purchased and insurance companies start staking out “the limits” of coverage in response to claims. Policyholders should anticipate this inevitability by looking hard at these terms and forms before buying them. Poli-



cyholders also should steer clear of foreign law and foreign mandatory arbitration clauses that sometimes creep into cyber insurance policies, almost always favoring the interests of the insurance companies.

## Cyber Insurance is Just One Piece of the Puzzle

There are now more options than ever to protect against cyber losses via dedicated specialty insurance for a data security breach. Before purchasing such insurance, however, it is important to examine what coverage the business has under its traditional insurance policies and identify where potential coverage gaps might exist. Make sure as well that coverage will be available — whether under cyber policies, business package policies, E&O policies or crime bonds/policies — when cloud computing services are used. Most insurance coverage can readily be adapted to expressly cover cloud computing risks.

The bottom line is that the insurance policy should match the cyber exposure of the policyholder so that coverage for a data security breach is as comprehensive and protective as possible. After all, this is the point of insurance. ▲

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## Conclusion

In the years since the passage of the Affordable Care Act, many employers have taken important actions to avoid problems with compliance and implementation. There has been less conversation, however, about what new risks will be created by these new regulations, and how they should be managed. This critical year before 2014, when the health care law becomes fully effective, is the right time for employers to turn their attention to assessing what new liabilities may arise under the law, whether their existing insurance policies will cover those liabilities and whether new insurance products may prove to be necessary. ▲

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# RISK RADAR

HOT TOPICS TO WATCH IN THE COMING MONTHS

## Texas

***Intermodal Equip. Logistics, LLC. v. Hartford Acc. & Indem. Co.*, CIV.A. G-10-458, 2013 WL 140090 (S.D. Tex. Jan. 10, 2013)**

Breach of contract claims often go hand-in-hand with bad faith claims. But can a bad faith claim exist without a breach of the insurance contract? According to this recent decision from the Southern District of Texas, the answer is yes.

*Intermodal* involved a first-party insurance dispute in which Intermodal sought coverage for \$700,000 in business interruption losses due to Hurricane Ike. Property insurance company Hartford valued Intermodal's loss at only \$208,000. Intermodal sued, seeking damages for statutory violations, fraud, breach of contract and bad faith.

In response, Hartford moved to compel an appraisal to determine the extent of Intermodal's business interruption loss. The appraisal process set forth in the policy resulted in an award of \$705,539. Hartford promptly paid the amount due, then moved to dismiss Intermodal's claims, arguing its payment constituted compliance with its obligations under the policy.

The judge dismissed all of Intermodal's claims except the bad faith claim. The court noted that "in most circumstances, the policyholder may not prevail on a bad faith claim without first showing that the insurance company breached the contract." However, the court concluded that Texas law recognizes three exceptions to this general rule. First, in Texas, the duty of an insurance company to timely investigate its policyholders' claims is an independent tort that can be pursued even in the absence of a showing that the insurance company breached the policy. Second, the Texas Insurance Code and its Deceptive Trade Practices Act are additional to any other remedies. Under the court's logic, this meant that if Intermodal could prove Hartford unduly delayed payment after its liability became reasonably clear, then it could state a claim under these

statutes. Third, Texas courts have recognized that in the absence of a breach of contract, a policyholder may still recover tort damages if it is shown that the insurance company committed some extreme act causing injury.

This decision is good news for policyholders in Texas, providing important leverage over insurance companies unwilling to pay claims once it is clear a payment is due.

## Washington

***Vision One, LLC v. Philadelphia Indem. Ins. Co.*, 174 Wash.2d 501 (2012) and *Sprague v. Safeco Ins. Co. of America*, 174 Wash.2d 524 (2012)**

In rulings handed down the same day, the Washington State Supreme Court interpreted similar policy language concerning similar "ensuing loss" or "resulting loss" clauses in similar factual settings — but reached very different results.

The policy at issue in the *Vision One* case was an "all risk policy with a resulting loss clause." The court explained that all risk policies provide coverage for all risks unless the specific risk is excluded. Resulting (or ensuing) loss clauses, however, "operate to carve out an exception to the policy exclusion." As such, the important question in analyzing ensuing or resulting loss clauses is "whether the loss that ensues from the excluded event is covered or excluded."

The loss in the *Vision One* case arose from the construction of a condominium project in Tacoma. A subcontractor installed shoring so that the construction company could pour the concrete for the first floor of the building. The shoring gave way, and the newly poured concrete along with rebar and framing came crashing down on the parking area beneath the first floor. Philadelphia Indemnity denied insurance coverage to Vision One based on two exclusions: 1) a deficient design exclusion, and 2) a faulty workmanship exclusion. Vision One disputed Philadelphia's position, arguing that the

cause of the loss was a “collapse,” and that a collapse was covered by way of the resulting loss clause in the faulty workmanship exclusion.

After a thorough analysis of Vision One’s policy and the relevant exclusions, the court agreed with Vision One’s interpretation. In a unanimous decision, the court determined that the collapse of the first floor was a loss resulting from the faulty workmanship. Since the risk of collapse was covered under the policy, Vision One had insurance coverage for its loss.

If the discussion of ensuing or resulting losses was not complicated enough, it got more complicated with the *Sprague* case (as indicated above, decided the same day as *Vision One*).

*Sprague* involved very similar facts and similar policy language. At issue in *Sprague* was whether a homeowner was entitled to insurance coverage for damage to decks that had been constructed improperly, which led to rot that compounded the loss. On discovery of this defect, engineers from the homeowners’ insurance company Safeco warned the homeowners not to use the decks. Safeco engineers also installed shoring to keep the decks from collapsing.

Like *Vision One*, the homeowners in *Sprague* had an “all risk” policy. They sought coverage from Safeco on the theory that the decks were in a state of “collapse.” Safeco denied coverage based on exclusions for construction defects and rot damage.

In response, consistent with *Vision One*, the homeowners argued that the policy’s “resulting loss” clause provided coverage because “collapse” was a covered risk. They claimed that while the decks did not physically fall down and collapse, Washington law has defined “collapse” liberally to mean “substantial impairment of structural integrity.”

In a sharply divided opinion, the majority ruled in favor of Safeco, finding that the decks’ “condition was the result of the excluded perils of defective workmanship and rot and did not constitute a separate loss apart from those perils.” The court further noted that “the only loss was to the deck system itself. That loss resulted from rot caused by construction defects.”

The dissent took issue with the majority, noting that the *Sprague* case “is in all material respects the same as *Vision One*. ...”

The dissent has a point. These cases are tough to distinguish considering the similarity in facts and similarity in policy language. As a possible explanation for the divergent holding, the dissent noted that “the ensuing loss is easier to see in *Vision One*.” In short, it was easier for the justices to “visualize” the ensuing loss in *Vision One* because it involved an actual physical collapse rather than an internal impairment to structural integrity.

For policyholders, these cases demonstrate an important lesson: insurance coverage decisions can often turn on the smallest of facts.

## Colorado

***D.R. Horton, Inc.-Denver v. Mountain States Mut. Cas. Co.*, 2013 WL 674032 (D. Colorado 2013)**

In *D.R. Horton*, the U.S. District Court for Colorado had to decide a problematic question: is an insured a “first-party claimant” in relation to its liability insurer for purposes of Colorado Revised Statute § 10-3-1116(1) and § 10-3-1115?

C.R.S. § 10-3-1116(1) allows a “first-party claimant” to sue its insurance company for unreasonable delay or denial of payment of insurance benefits. C.R.S. § 10-3-1115 defines “first-party claimant” as “an individual, corporation, association, partnership or any other legal entity asserting an entitlement to benefits owed directly to or on behalf of an insured under an insurance policy.”

In a victory for Colorado policyholders, the judge held that D.R. Horton met the definition of “first-party claimant,” allowing it to sue its liability insurance company under C.R.S. § 10-3-1116(1). This ruling opened the door for D.R. Horton to seek the statutory remedies of attorney’s fees and double damages based on the insurance company’s unreasonable treatment of the policyholder in a third-party claim.

In making this ruling, the court followed the plain language of the statute, noting that C.R.S. § 10-3-1115(b)(I) defines “first party claimant” as an insured seeking benefits owed “directly to or on behalf of” the insured.



## 7th Circuit

***West Bend Mut. Ins. Co. v. Arbor Homes LLC*, 703 F.3d 1092 (7th Cir. 2013)**

If there was ever any doubt about the truth of the old adage “no good deed goes unpunished,” *West Bend* settles it.

The dispute between Arbor and West Bend stemmed from faulty construction of a single-family home. As the court put it, “A plumber [hired by Arbor] made one of the biggest mistakes a plumber can make: he forgot to connect the home’s drainage system to the city’s sewer.” As a result, raw sewage was discharged into the crawl space of the home over a period of months. Predictably, the homeowners began feeling ill and contended that they could no longer occupy the house.

On discovery of the error, Arbor made every effort to fix the problem. It hired a specialty cleaning company that assessed and cleaned up the damage. The cleanup efforts included excavating the crawl space and decontaminating the homeowner’s furniture, insulation and ductwork. The homeowners were not satisfied, asserting they were “unwilling to accept a brand new home that had been filled with sewage and then cleaned.” The homeowners demanded that Arbor purchase the home and build them a new one.

As an additional insured on the plumber’s general liability insurance, Arbor directed the plumber in writing to put insurance company West Bend on notice of the homeowners’ claims. The plumber never did so. Negotiations continued among Arbor, the homeowners and the plumbing contractor, with-

out the insurance company at the bargaining table. When Arbor eventually settled with the homeowners, it again wrote to the plumber. Arbor confirmed the terms of settlement with the homeowners, again without writing directly to the insurer, and advised that the plumber or West Bend could contact the builder if they needed any additional information. Having heard no objections from either the plumber or West Bend, Arbor signed a settlement with the homeowners, and agreed to buy their tainted home and build them a new home.

In a declaratory relief action, West Bend denied insurance coverage under a mold exclusion and the voluntary payments provision. The District Court granted summary judgment for the insurance company on these grounds.

On appeal, the 7th Circuit began and ended its analysis with the voluntary payments provision. While the court praised Arbor’s conduct in resolving the homeowners’ claims, it nevertheless concluded that the builder’s actions violated the policy’s prohibition against incurring any expense without the insurance company’s consent. The court pointed out that West Bend had no knowledge of the settlement until months after the deal was concluded. The court explained that in reaching the settlement without West Bend’s consent, Arbor deprived the insurance company of its rights under the policy, as well as the “opportunity to participate in the investigation or settlement.”

For policyholders — especially those that take quality control seriously — this case serves as a stark reminder that involving a liability insurance company early in any claim and obtaining consent to any settlement, are important steps in preserving insurance coverage. ▲

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