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Message From the Chair

by James W. Beckley, CPCU, AIC, ARe, AIM

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"These months of town hall meetings were grueling for me and for my staff. But I am glad they took place. I believe that giving the 9/11 families direct access to me and my staff helped put a human face on the program."– Kenneth R. Feinberg

The above statement is from Kenneth R. Feinberg's book, *What Is Life Worth? The Unprecedented Effort to Compensate the Victims of 9/11* (Public Affairs of Perseus Book Group 2005). The book is now eight years old, but the ideals illustrated within it are timeless.

On September 22, 2001, President Bush signed into law the Air Transportation Safety & Systems Stabilization Act, which included the 9/11 Fund. Mr. Feinberg was appointed special master by the Bush Administration to administer the Victim Compensation Fund of 2001 ("9/11 Fund").

The Fund created tax-free compensation for families of victims killed or physically injured in the 9/11 attack. Participants had to forgo lawsuits. Eligibles included United States citizens, foreign citizens. and illegal aliens. Victims ranged from dishwashers to highly paid corporate executives. The fund had virtually an open checkbook to compensate the victims' families.

Although well-intentioned, the law was written in haste and was an unprecedented program. The 9/11 Fund administrators had to navigate technical issues such as collateral sources and interpret wrongful death statutes from different states. There were gaps in the law.

In addition to the law, they applied the following principles in their decision making: consistency (not the same as uniformity), transparency, and narrowing the gap between high and low settlements. Ultimately, claims were paid to families of 2,880 victims killed and 2,680 individuals physically injured. Total payout was approximately $7.049 billion.

Each reader can take away something different from this book. There was an economic basis for the act but the charity and compassion by the American government to create such a fund is noteworthy. I observed a common thread between the rich and poor as to matters of grieving, love, and faith.

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I was particularly struck by Mr. Feinberg's decision to be the face of the 9/11 Fund. As special master, he could have chosen an easier path. He performed this work *pro bono*. He attended hundreds of meetings with victims and survivor families. Reactions to Mr. Feinberg included gratitude, skepticism, and hostility. He thought hearing their stories and telling his story first hand would enable them to better achieve their goals. He listened, learned, and became better at the end of the process than when he started. Mr. Feinberg's actions were also examples of leading from the front to achieve organizational goals.

Not everyone can be the face of a high profile organization such as the 9/11 Fund. However, being a claims professional can put us in the position of being the face of our organization to someone. That someone can be our customer, claimant, business partner, teammate, or even a competitor.

Building on those ideas, I also offer some of my own.

- Accept responsibility for the decisions that are yours.
- Be as accessible when bearing bad news as good news.
- Try to use a means of communication that is most personal, especially for sensitive or critical matters. When possible, select an in-person session instead of a phone call. Try a phone call instead of email.

It is not a stretch to link the above actions to ethical principles such as accountability, candor, and respect.

Accepting a role of being the face of our organization is not always the easiest course. It can, however, be the most effective and rewarding. ■

50 States of Grey Claims: The 10 Most Significant Insurance Coverage Decisions of 2012

12th Annual "Insurance Coverage Top 10"

by Randy J. Maniloff and Joshua A. Mooney

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Editor's note: (1) Over the past few years, *Claims Quorum* (CQ) has had the opportunity to publish a summary of attorneys Randy J. Maniloff and Joshua A. Mooney's annual article on the top ten insurance coverage cases of the year. This CQ article is a shorter version of the original article recently published in Mr. Maniloff's insurance coverage newsletter Coverage Opinions, Vol. I, Issue 5 (Dec. 5, 2012). It has been edited and is being reprinted with the permission of Mr. Maniloff. (2) Due to space considerations, we have chosen four of the ten case discussions. The entire article can be obtained at www.CoverageOpinions.info. (3) The views expressed herein are solely those of the authors and not necessarily those of White and Williams or its clients. (4) All uses herein of the first person are references to Maniloff.

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

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

claims and whether coverage is available to an insured that must return money that it was not otherwise entitled to have in the first place.

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

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

The Top 10 Coverage Cases Selection Process

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

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

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

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

Another example of an important decision in 2012 left on the Top 10 sidelines was the Supreme Court of California's in California v. Continental Insurance Company. The court addressed allocation, an important issue in the context of continuous injury or damage claims that trigger multiple policies. But despite the importance of allocation, it is a mature issue. As it has been the subject of numerous decisions nationally, including many from state supreme courts, the potential for Continental to influence future courts is diminished.

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

The Ten Most Significant Insurance Coverage Decisions Of 2012

Editor's note: Discussion about all ten cases appear in the original article. We have chosen to include the discussion on four of the cases for our CQ readers. The entire article can be obtained at www.CoverageOpinions.info.

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

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

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

While nobody misunderstands a wrap-up policy to this extent, there is still plenty of misunderstanding over what a wrap-up is and what it covers. In simple terms, a wrap-up policy is a liability policy that is obtained by

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a single sponsor, such as a project owner or general contractor, that is designed to cover multiple contractors involved with a construction project. The theory is that there are various advantages, such as with respect to pricing and claims handling, to having all of the contractors insured under a single, all encompassing policy, rather than each contractor securing its own separate policy.

Except for a few differences, a wrap-up policy (a.k.a. Owner Controlled Insurance Program (OCIP) or Contractor Controlled Insurance Program (CCIP)) – even one covering a multi-million dollar project – may not look much different than a standard CGL policy issued to a mom-and-pop contractor. For example, a wrap-up policy may very well be written using a standard ISO CG 00 01 form. Further, don't look for the word "wrap-up" written anywhere in the policy – because it may not be there.

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

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

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

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

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

The insurer argued that Eustis was not covered by the wrap-up policy because the program covered only those enrolled in it. The wrap-up policy defined Insured as an enrolled contractor. Eustis admitted that it failed to complete the several steps required for enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The bad faith example that the court cited was so unique as to make it devoid of guidance on such point. These exceptions are likely to be what future disputes involving similar settlements followed by the insurer terminating its defense are all about.

Opinion-aided: Court Opens Door To Policyholder Getting Its Hands On Outside Coverage Counsel's Opinion Letter

Barton Malow Company v. Certain Underwriters at Lloyd's of London, No. 10–10681, 2012 WL 4668868 (E.D. Mich. Oct. 3, 2012)

While the insurer prevailed before the Eastern District of Michigan in Barton Malow Co., the win was not without a price – an opinion that should cause some concern for insurers when it comes to maintaining coverage opinions secured from outside counsel as privileged. The decision opens the door for policyholders to potentially obtain the opinion letters prepared by outside coverage counsel. Given that such opinion letters may contain qualifications, policyholders have a significant incentive to obtain them. Even if such qualifications are legitimate, and they

probably are, policyholder counsel would likely try to make hay out of them.

Barton Malow Company was involved in litigation with Lloyd's of London over coverage for an arbitration award arising out of the company's role as a construction manager for a University of Michigan project. Barton Malow sought to obtain certain unredacted reports prepared by a law firm that was hired by Lloyd's as coverage counsel before the litigation. Barton Malow maintained that the redacted reports were neither privileged nor subject to the work product doctrine. At the court's urging, Lloyd's produced to Barton Malow redacted portions of five reports prepared by its coverage counsel. After then producing the reports in unredacted form – again at the court's urging – Barton Malow sought to have three of the passages that Lloyd's wanted to keep redacted declared as non-privileged and not subject to the work product doctrine.

The Barton Malow court set out the following test for determining if communications by attorneys in the insurance claims process are subject to attorney-client privilege: "The communication itself must be primarily or predominantly of a legal character. The payment or rejection of claims is a part of the regular business of an insurance company. Consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business. Merely because such an investigation was undertaken by attorneys will not cloak the reports and communications with privilege because the reports, although prepared by attorneys, are prepared as part of the regular business of the insurance company."

Despite setting out a seemingly broad test, for allowing communications by attorneys, in the insurance claims process, to be outside the scope of attorney-client privilege, the Barton Malow court held that the specific communications at issue were protected by attorney-client privilege: "A review of the selected passages shows that the communications were not the work of an attorney performing a function that was part of the regular course of Underwriter's insurance business. Importantly, the passages must be read in the context of the entire report, including the text

appearing before and after the selected passages. In so doing, it is clear that the passages communicate legal advice from Underwriter's counsel regarding the extent, if any, to which Barton Malow's claim was covered. They show counsel's legal opinions regarding the scope of potential liability."

The lesson from Barton Malow is that, under its test, it is possible that the entirety of a coverage opinion from outside counsel may not be privileged. A concern for insurers in this regard should be the lack of guidance that the court provided in determining what's privileged and what's not. On one hand, the court stated that, because the payment or rejection of claims is part of the regular business of an insurance company, "reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of business" and are not privileged. On the other hand, the court concluded that the specific passages at issue were protected by privilege because it was clear that they communicated legal advice regarding the extent, if any, to which the claim was covered.

On its face, and without any detailed guidance from the court, it can be imagined that the test for what qualifies as a report which aided the insurer in the process of deciding which of the two indicated actions to pursue, and a report that communicated legal advice, regarding the extent, if any, to which the claim was covered, is not a bright line. One can imagine in camera reviews by courts to make this determination.

One take-away from the decision seems to be that insurers that employ outside coverage counsel should insist that counsel provide legal analysis to support its opinion. That seems obvious. But sometimes insurers simply seek a more cursory opinion from counsel, which could be argued to be a non-privileged report that aided the insurer in the process of deciding which of the two indicated actions to pursue.

For a significant decision from 2012 that also addressed the discovery of documents that one party believed were privileged, see the First Circuit's decision in Vicor Corp. v. Vigilant Ins. Co., 674 F.3d 1 (1st Cir. 2012), Here the court opened the door to an insurer potentially obtaining documents from its insured's defense counsel in underlying litigation, for the insurer's use to potentially disprove coverage in subsequent coverage litigation – and the claim was defended under a reservation of rights. ■

The Ethical Investigation of Claims

The Attorney Perspective

by Matthew J. Smith, Esq., and Frank T. Zeigon, RPA, CCLA, PLCS, CLCS, PCLA, FCLA

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In reality, there is very little material to guide an insurance law attorney specializing in fraud investigation along the correct pathway of ethical considerations. Though times have changed, insurance fraud law practitioners universally confront the same ethical dilemmas and with sparse guidance. These dilemmas manifest themselves in various contexts, including claim analysis, dealing with unrepresented parties, examinations under oath, and rendering opinions to insurance carriers. To protect the integrity and vitality of both the insurance and legal professions, it is increasingly necessary to ensure we adhere to a high standard of ethical conduct. Ethical guidelines not only promote a strong business model for our professions, but also provide crucial safeguards against liability in potential bad-faith claims.

Ethical considerations often arise in first-party claim investigations as a consequence of a lawyer's natural inclinations to advance the insurer's interests. Though attorneys often take the approach it is their job to win for clients, victory cannot come at any cost. An insurance company owes a fiduciary duty under the policy to investigate the claim fairly and impartially and to pay the claim unless there is sufficient evidence to support a denial. This is especially true as courts routinely consider insurance policies inherently unfair to the insured because the consumer cannot truly bargain for the terms and conditions of the policy outside basic parameters. Attorneys who view an investigation as an opportunity to win for the insurance company and thus primarily pursue evidence for the claim's denial, violate professional ethics because such activity compromises the carrier's duty to its insured. An attorney who analyzes claims on this basis is not serving his or her client's best interests and is likely violating his or her profession's ethical standards.

Law firms handling insurance claim investigations must remember attorneys

Get Exposed

We're always looking for quality article content for the Claims Interest Group newsletter. If you or someone you know has knowledge in a given insurance area that could be shared with other insurance professionals, we're interested in talking with you.

Don't worry about not being a journalism major. We have folks who can arrange and edit the content to publication-ready status. Here are some benefits of being a contributing writer to *Claims Quorum*:

- Sharing knowledge with other insurance professionals
- Gaining exposure as a thought leader or authority on a given subject
- Expanding your networking base
- Experiencing overall career development

To jump on this opportunity, please email either James W. Beckley, CPCU, AIC, ARe, AIM, at jbeckley@aaic.com or Donald O. Johnson, CPCU, JD, LLM, at donjohnson@dojlaw.com.

are ethically responsible for ensuring that a proper and thorough investigation occurs in a forthright manner and that all evidence is considered fairly and completely. The duty the attorney owes to the insurance carrier is to make certain a proper and thorough investigation is done so an informed and correct decision is made. This requires providing advice to the insurance carrier regarding how to proceed forward with a fair and impartial investigation. Generally, this requires an insured to be given every opportunity to document his or her claim and present that claim fully and completely under the policy terms. This practice will help avoid later allegations the attorney was not providing independent legal advice but was actually adjusting the claim as an agent of the insurer. Attorneys who are not careful in drawing this line may find themselves embroiled in a subsequent bad faith claim.

Dealing with unrepresented parties frequently creates ethics concerns for an insurance attorney, and firms should take care to properly apprise unrepresented parties of their right to counsel. Often claimants are not represented by legal counsel, especially during the early phases of the investigation. Under these circumstances, communication with the claimant presents perhaps the greatest cause for ethical concern. Attorneys should identify any duty they or the insurer has to provide the claimant status reports of the investigation process and what duties the unrepresented person may have to assist the investigation. Communication with the insured should be in writing and clearly notify the insured the attorney represents only the insurance carrier's interests. There is no privilege associated with any communications between the attorney and the claimant, and often poorly written or overly aggressive communications may be the subject of evidence of bad faith should the claim become litigated.

Ethical considerations during the EUO arise from striking a balance between simply gathering factual data and the need to confront the insured with key facts of the loss investigation. Unrepresented claimants are uniquely susceptible to later alleging they were mistreated or taken advantage of by the "insurance company lawyer." The purpose of the EUO is to gather all relevant

data for the claim's investigation and secure the truth though relevant testimony. Every claims person and attorney should be cautious to avoid jumping to a conclusion of fraud. Such responsibility is balanced by the duty an attorney has to push questioning to the acceptable limit to obtain information or even a confession from the claimant when necessary.

When the EUO is done properly, the court reporter's transcript is your best friend to combat ethical allegations provided the lawyer strikes the proper probative balance during EUO questioning. To protect both the insurer and the attorney it is vital to consider each word said in the EUO is potentially the basis for a bad faith claim against the insurance carrier.

Ethical considerations also arise when the insurer requests a final legal opinion regarding acceptance or denial of the claim. Attorneys must make certain to not allow their own thoughts and opinions regarding the claimant or the loss to cloud their ability to provide independent counsel to the carrier. Some questionable claims should be paid even when strong concern or doubt regarding the claimant or the loss remain.

One of the worst things an attorney can do from an ethical perspective is to continue to defend his or her opinion to the insurance carrier when existing or new evidence comes to light which should cause the attorney to change their opinion. Most states recognize an ongoing duty of good faith in both the claim and litigation process. The goal should be to make a proper decision regarding the claim at any phase. Sticking to a position which is wrong or incorrect will likely lead to a substantial bad faith punitive damage award, which is certainly no way to build a future attorney-client relationship.

Attorneys who handle insurance claim investigations are ethically responsible for making certain a proper and thorough investigation of the claim is conducted fairly and completely. Adhering to ethical principles is essential for keeping our professions in high regard and protecting against potential bad faith litigation. ■

2012 CPCU Society Student Program

by Lamont D. Boyd, CPCU, AIM

Lamont D. Boyd, CPCU AIM, director, insurance market, with FICO® (Fair Isaac Corporation), is responsible for client and partnership opportunities that make use of FICO's predictive analytics technology, scoring products, and consulting services. Speaking regularly to industry, regulatory, and consumer groups on behalf of FICO for the past eighteen years, he is recognized as a leading expert in predictive scoring technology. In addition to managing the CPCU Society Student Program, he is a member of the Underwriting Interest Group Committee and the Annual Meeting Task Force.

Washington, D.C., was a great experience for over two dozen risk management/insurance and actuarial studies students from universities and colleges across the nation. As director of the CPCU Society Student Program, I thank the professors and advisers who nominated our DC students, the many volunteer mentors who guided our students throughout the Annual Meeting and Seminars, the Interest Groups who opened their breakfasts and lunches to our students, and the many CPCU Society chapters who either directly sponsored a student or two or who contributed money to our general fund to assure the Student Program's ongoing success.

These 29 chapters of the CPCU Society stepped up once again this year for our 2012 Student Program:

Arizona	Hawaii
Atlanta	Kentucky
Bayou	Minnesota
Boston	New Hampshire
Brandywine Valley	New Jersey
Central Illinois	Northeastern Pennsylvania
Central Missouri	Pacific Northwest
Central Texas	Philadelphia
Charlotte	Quad City
Cincinnati	Rhode Island
Colorado	San Diego
Columbus	Santa Clara
Connecticut	Spokane
Dayton Miami Valley	Westchester
Europe	

Our sincere hope is that all chapters of the CPCU Society see the value of the Student Program in assuring that the best and brightest will find their place in the industry, throughout the world, and within CPCU Society chapters. We cannot offer this program without the significant support of chapter leaders and the contributions of our Society chapters.

Our 2012 Student Program enjoyed two very nice, new experiences while in DC—a dinner hosted by Diana L. Van Horn, CPCU, of QBE North America and a breakfast hosted by Cheryl R. Constantine, CPCU, of Travelers. These events gave our students opportunities to engage with industry leaders.

Through chapter and industry contributions, this year's students met industry leaders from around the world, learned, and networked. Here are just a few of the comments we've received from our 2012 students:

Taylor Mohr, State University of New York—Oswego:
I had an amazing time and thought the opportunity was once in a lifetime. I made a lot of connections and met some influential people. The program was well planned and extremely organized from the moment we arrived in Washington, D.C. I instantly befriended the other students nominated to participate and hope to keep those friendships, even though most of us live across the United States from each other. I loved the CPCU experience and cannot wait to become a new designee!

Grant Craigmiles, Missouri State University:
The CPCU Society Student Program has been one of the greatest experiences of my entire risk management and insurance education. The networking opportunities offered through this program were phenomenal. Beyond gaining valuable connections within the industry, I learned about the intricacies of so many different areas within the industry. I feel like I am a much more informed student of insurance and that I have an advantage in career possibilities thanks to the CPCU Society Student Program.

The CPCU Society Student Program is great in that it allows students to network on multiple levels: Students make connections with a wide variety of insurance professionals, a personal mentor, and bright students from insurance schools across the nation. When all these levels of networking opportunities are concentrated into one conference, the sky is the limit for the knowledge and connections that can be attained. I am now energized to enter such a dynamic industry!

Amy Johnson, Katie School, Illinois State University:
Il would like to sincerely thank the CPCU Society and you for everything. You did a wonderful job putting everything together for the students, and I know we all very much enjoyed the experience.

Il was also lucky to have Daniel L. Blodgett, CPCU, AIM, AIS, PMP, as a mentor. As I'm sure you're well aware, he does a great job! He

helped us with choosing sessions, introduced us to many people, brought us to the Personal Lines Interest Group Committee meeting, and was always available when we needed him.

Throughout the conference, there were several people who came up to me to ask about my being a student. It was obvious that people were aware students were there and were interested in conversing with us, which was obviously very beneficial for us!

Anna Berry, University of Houston Downtown:
What a wonderful event! I thank you from the bottom of my heart for allowing me (and all of the students) to participate in this amazing CPCU Society Annual Meeting and Seminars. I networked with so many professionals and I will be following up with each and every one of them. As for my mentor, I'm not sure how you matched us all up, but I had the *BEST ONE,* Alicja Lukaszewicz-Southall, CPCU.

Steve McElhiney, CPCU, MBA, ARe, AIAF, 2011–2012 CPCU Society president and chairman, shared his thoughts about the Student Program:

During the Washington, D.C., Annual Meeting and Seminars, I had a chance to meet virtually all of the attending students, who had varied academic backgrounds and experiences and represented various regions of the country. They were highly engaged in both the student program and in the various interactions I was able to be part of, and each of them was truly a pleasure to get to know. They asked insightful questions, and have proven they are very motivated to succeed in insurance careers in various facets of the property-casualty industry—at the carrier and broker level and as underwriters, claims professionals, and actuaries.

We have spoken much about the "pipeline challenge" confronting our industry as the "Baby Boomer" generation retires, and a new generation of knowledge workers needs to be identified, trained, and developed. The CPCU Society Student Program (now in its third year) is one of the tangible solutions we are embarking upon to meet this industry need. I am confident these students will be future leaders in the organizations they serve, as well as in the Society. A special recognition needs to be extended to Lamont Boyd, who has diligently supported the CPCU Society Student Program since its inception.

(Left to right) Hannah Dimmick, Appalachian State University; Grant Craigmiles, Missouri State University; Liz Pitts, Appalachian State University; Chase Conover, Missouri State University; Glenn Morgan, The University of Georgia; unknown–local student; Kathryn Foege, Georgia State University; Genevieve Parks, University of North Texas; Harvey Powers, University of Texas-Austin (Research Award winner—Gold); Elizabeth Saxe, St. John's University; Ali Nematpour, University of Houston Downtown; Taylor Mohr, State University of New York–Oswego; Allison Crosby, University of Colorado Denver; Anna Heliotis, St. John's University; James Heuker, Olivet College; Jay Willer, State University of New York–Oswego; Chase T. Russell, University of North Texas; Luna (Weiyue) Gu, University of Illinois at Urbana-Champaign; Christopher Watkins, Olivet College; Amy Johnson, Katie School, Illinois State University; Dan Pettie, Katie School, Illinois State University; Jill Feeney, Saint Joseph's University; LaKenya Patrice Young, Georgia State University; Kyle Guestin, Utica College (Research Award winner—Bronze); Sarah Nichols, The University of Georgia; Joe Hemminger, University of Colorado Denver; Joe Drobny, Katie School, Illinois State University (Research Award winner—Silver). [Missing from the photo: Anna Berry, University of Houston Downtown]

"A Look into the Future—Student Seminar" was a success, once again. This seminar allowed us to highlight the property-casualty insurance industry's need for the "best and brightest" now and in the future, and allowed our students to ask any questions to prepare them for their careers in the industry. The seminar is designed to help risk management/insurance and actuarial students understand more fully the variety of paths available to them in the property-casualty industry. Our students also gained a clear understanding of the value of the CPCU designation in helping them on their chosen path.

Many thanks to our 2012 student seminar speakers: Noelle Codispoti, ARM, executive director of Gamma Iota Sigma, the international risk management, insurance and actuarial sciences collegiate fraternity; Connor M. Harrison, CPCU, ARe, AU, director of custom products, The Institutes; and James R. Jones, CPCU, ARM, AIC, executive director of the Katie School of Insurance and Financial Services at Illinois State University.

Our hope is that all students and CPCUs in attendance walked away from this seminar with great ideas and a clear understanding of what is needed to grow our industry through the development of talented individuals. The CPCU Society is uniquely positioned — in large part due to the direction and support provided by chapter and interest group leaders — to offer a clear path between those who are seeking a rewarding future in the industry and those who are seeking people to contribute to that successful future.

2013 Student Program

As a direct result of the efforts of so many of you and your colleagues over the past three years, the Society has given our Student Program an enthusiastic "green light." The 2013 New Orleans program is likely to be a significant component of the collective "Engaging the Next Generation" initiative. You'll learn more about the initiative and the 2013 Student Program in the months ahead, but please plan now to support this critical program.

A final note of thanks: Once again, my sincere appreciation to all who contributed in so many ways to the success of our 2012 Student Program. As we begin working toward another successful program for 2013, please don't hesitate to contact me (lamontboyd@fico.com) with any suggestions or thoughts you may have, or assistance you're willing to offer to help us attract bright, young minds to the insurance industry and the CPCU Society! ■

Claims Quiz

Was It Really Just Rotten Eggs? (Or, Never Build Condos Next to a Chicken Farm)

by Stanley Lipshultz, JD, CPCU

Stanley L. Lipshultz, CPCU, JD, is a consultant and expert witness. He has been in the insurance industry for more than forty years, including thirty years as a defense attorney for agents and brokers. Lipshultz is a past president of the CPCU Society District of Columbia Chapter and has served the Society as chair of the Diversity Committee; chair of the Coverage, Litigators, Educators & Witnesses Interest Group; and governor. He has been a speaker at numerous CPCU Society Annual Meetings and Seminars, and frequently makes presentations to agents and brokers.

Several years prior to the economic downturn in 2007, FBN Design Build and Omitian Properties entered into an agreement to build a cluster of luxury condominium townhomes on the eastern shore of Maryland. The grand project was to include a golf course and a man-made lake named Boondoggle. The project was to be built on property listed for sale by Fowl Field Farms. Omitian secured several preliminary bids, but FBN Design Build made the lowest.

The farm of over 50,000 acres was to be subdivided, with a percentage sold to Omitian and the remaining portions retained by Fowl Field Farms and used for raising chickens and for egg production. Although the chicken and egg property was downwind from the new project, the developer and the builder gave that little thought. Omitian bought the land, secured the necessary zoning and permits, and negotiated a contract with FBN and its president, Dewey Rader. Rader advised Omitian that he had access to a considerable amount of building materials at a fraction of wholesale cost because his brother-in-law had unused building materials from various unfinished projects around the state of Florida. As a result, FBN could design and build the townhomes for less than half of what other builders would charge, and the structures could still be sold at market value. Impressed, Omitian did not ask any questions about the materials.

The written agreement between Omitian and FBN contained the following language:

BUILDING MATERIALS: All Building Materials shall be supplied and incorporated into project by [Builder] at Builder's cost. Omitian acknowledges that it has been advised that a fractional portion of the materials to be used in construction have been discarded by other builders as unusable but remain unused. Omitian warrants that its representative(s) has inspected the Building Materials and found them to be satisfactory for the project.

*DAMAGES: * **** FBN shall not be responsible for damages to person or property occasioned by Omitian, its agents, third parties, acts of God, or other causes beyond FBN's control. Omitian shall hold FBN harmless from and shall indemnify FBN for all costs, damages, losses, and expenses, including judgments and attorneys' fees, resulting from claims arising from causes set forth herein. Neither party shall be responsible for any extracontractual damages beyond those enumerated in this agreement.

A certificate of insurance and an additional insured endorsement were issued by Shifting Sands Mutual Insurance Company, FBN's insurer on behalf of Omitian.

The project, aptly marketed, was completely sold out before the first shovel of dirt was moved. Omitian could not have been more pleased. However, problems began when some of the first homeowners began to complain about water damage to the fronts of their homes and about a strange "rotten egg" smell coming from the interiors. Omitian did not know about exterior insulation and finish systems (EIFS). Nor was Omitian aware that almost all of the drywall used in the interiors of the homes came from Ira Ekans' warehouses in Florida, which were filled with Chinese drywall and fire retardant treated (FRT) plywood. As the problems were reported by the owners to FBN and Omitian, they attempted to handle each one until they became overwhelmed by the sheer numbers. EIFS and FRT problems were minor compared to the Chinese drywall troubles. Omitian's staff was convinced that the rotten egg smell was originating from Fowl Field Farms and that there were no problems with the homes, aside from the EIFS and FRT, which they characterized as trivial matters.

The entire mess was wrapped up in a nice bundle and submitted as a claim to Shifting Sands Mutual for handling as well as to Omitian's insurer, Perdue Insurance Company which notified Shifting Sands Mutual that its policy, assuming coverage, would be excess due to the additional insured endorsement. Both FBN and Omitian had standard commercial general liability (CGL) policies.

E. Scrooge was not one to shy away from making bold decisions on questionable claims. In her case, the big "D" was denial! She became vice-president, claims, of Shifting Sands by being courageous and thinking outside the box. She was aware of the potential for bad-faith problems created by knee jerk denials, so she dutifully had the claim investigated by a well-respected outside adjusting firm Blue Crab Property and Casualty Adjustors.

Statements were taken from Omitian and Rader. Omitian claimed no knowledge of the origin of the building materials other than what it was told by Rader. Rader was evasive in his statement, especially when it came to his knowledge of the materials in the warehouses. Scrooge also retained an architect with a degree in mechanical engineering, Dr. D. Ziner, to address the Chinese drywall complaints. Ziner's conclusion, after conducting field and laboratory tests on the drywall, was that the homeowners, especially those who had abandoned their homes, were simply oversensitive to the smells. His report further concluded that the claims were the result of "mass hysteria" brought on by the wafting unpleasant smell from Fowl Field Farms. None of the homeowners had engaged any experts to challenge the Ziner findings.

Scrooge was aware of the tens of millions of dollars in claims pending against FBN and Omitian. She considered pollution and the usual battery of construction defect exclusions, but she was concerned with Omitian's apparent unawareness of the fact that Chinese drywall had been used in the construction of the homes. Scrooge now seeks the assistance of the CPCU Society Claims Interest Group for an analysis of the claims and advice on whether to pay or deny them. If you were in her shoes, what would you do?

Please email your claims analysis to Denise Brown at dbrown@iwins.com, and we will publish the best analyses in the next issue of the CQ. ■

The Growing Significance of Coverage "B"

by Catherine L. Heise, *Amerisure Insurance* and Adam Kutinsky, *Kitch Law Firm*

About the Authors

Catherine Heise, JD, is a corporate claims consultant at Amerisure Insurance Company and has completed five out of eight CPCU exams.

Adam Kutinsky, JD, CPCU, is an attorney with the Midwest-based Kitch Law Firm, where he co-chairs the firm's insurance practice group.

They are both council members of the State Bar of Michigan Insurance and Indemnity Section.

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The Commercial General Liability Policy (the "CGL") forms the basis for insurance coverage across the United States. The CGL basic form (the CG 001) has undergone numerous revisions over the years, the latest occurring in 2007[1]. The CGL policy is split into multiple coverage sections, including Coverage A (insuring for "bodily injury" and "property damage" arising out of an "occurrence"), Coverage B (insuring for damages because of "personal and advertising injury"), and Coverage C (medical expenses for "bodily injury"). Of the three, Coverages A and C have been referred to as the "snap, crackle and pop" coverages – a reference to the bodily injury and property damage claims which they cover. On the other hand, while Coverage B extends to some "consequential" flesh and bone damages, it is primarily designed to cover economic injury arising out of losses that do not or may not manifest in physical injury to persons or property.

Coverage A, which insures against third party liability for losses to persons and property, provides the liability coverage that, historically, businesses have sought when purchasing insurance. Coverage B, on the other hand, can be analogized to a younger sibling of the more well known Coverage A. Indeed, prior to 1986, "personal" or "advertising" injury coverage was not part of the standard CGL policy, and had to be added by way of an optional endorsement. Now, however, organizations that do not need or desire coverage for "personal and advertising injury" claims must obtain an endorsement to exclude it.

Like a younger sibling, Coverage B has grown in significance to CGL policyholders since it was first added to the standard coverage in 1986. And as the United States economy moves from a manufacturing base, to service and web-based industries, Coverage B will become increasingly important. The proliferation of "personal and advertising injury" claims is noticeably significant because of the broader coverage for resulting injuries when triggered. The expansive coverage for "personal and advertising injuries" may not be appreciated by a manufacturer with limited exposure to the internet or other forms of mass media, but it becomes substantially more important to companies that rely heavily upon web-based media and advertising whose end-users of the information may be unknown, and in some cases virtually unidentifiable. Even more noteworthy is the simplicity of publishing information to hundreds – or thousands – or millions – of people without much effort.

For example, consider the many social media websites whose membership consists mainly of professional service providers. "Posting" a message on such a website is easy and free. Once the message is sent into cyberspace, it can be viewed by every person who visits the page. Occasionally, those websites will also send an email to its members, announcing the posting and providing a link with an opportunity to respond.

It would be nearly impossible for the "poster" to know every single person who becomes an end-user of the published information, especially because membership is "organic" – meaning it can grow and shrink without the control of its individual members. In this respect, any person who posts on a professional website is likely engaging in a personal and advertising injury risk that is potentially covered by Coverage B of the CGL. For these reasons, the social media boom portends a growing risk assumed insurers that provide CGL coverage.

So, what protection does Coverage B provide to a 21st century, information-based business? The analysis of whether a claim triggers either the duty to defend and/or the duty to indemnify the insured involves a four part analysis: the language of the insuring agreement, the predicate offenses that give rise to a "personal and advertising injury" claim, the set of specific exclusions and – somewhat collaterally – whether the insurer's duty to defend the policyholder is triggered.

In examining the standard ISO form, Coverage B's "insuring agreement" – the basic grant of coverage – states that the insurer will pay those sums the insured is legally obligated to pay because of "personal and advertising injury" to which the insurance applies. Significantly, the insurer also has the right and duty to defend the insured in any suit seeking "personal and advertising injury" damages. The insurer's assumption of the duty to defend the policyholder – even under a reservation of rights – is of significant economic value to the insured.

The "Definitions" section of the CGL policy defines "personal and advertising injury" as one or a combination of seven specific acts or "predicate offenses":

1. False arrest, detention or imprisonment;
2. Malicious prosecution;
3. Wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord, or lessor;
4. Oral or written publication of material that slanders or libels a person or organization's goods, products, or services;

5. Oral or written publication of materials that violate a person's right of privacy;
6. The use of another's advertising idea in your "advertisement"; or
7. Infringing upon another's copyright, trade dress or slogan in your "advertisement".

One reason why the proliferation of "personal and advertising injury" claims must be treated seriously is Coverage B's use of two significant, but undefined terms in the coverage grant: "injury" and "advertising". As discussed in one authoritative text:

> It is noteworthy that the definition is phrased in terms of injury, not bodily injury. The CGL coverage form does not define injury. However, injury has a much broader meaning than bodily injury. Black's Law Dictionary (8th ed. 2004) defines injury as "[t]he violation of another's legal right, for which the law provides a remedy; a wrong or injustice," or simply as "[a]ny harm or damage". So, for example, injury includes mental anguish or injury, fright, shock, humiliation, and loss of reputation, but it is not limited to these things.[2]

"Injury", as used in Coverage B, also includes "consequential" bodily injury. "Consequential" bodily injury may accompany the commission of a "personal and advertising injury", such as where a tenant is evicted from a house, or when a customer scuffles with a security guard in an false arrest situation.[3]

Although the CGL policy defines "advertisement", it does not define "advertising." Michigan has adopted a broad definition of "advertising", holding that it means, "to advise, to announce, to apprise, to command, to give notice of, to inform".[4] If the alleged wrongful act or acts is one of the "seven deadly sins" listed above, the second step in the analysis is determining whether coverage under B is precluded under one or more of the 15 specific exclusions. Some of the exclusions are identical to those found in Coverage A (breach of contract, war, contractual liability, criminal acts, etc.). Although not all of the exclusions specific to Coverage B will be listed here, the practitioner will frequently encounter "knowing violation of the rights of another" (exclusion [a]), "material published with knowledge of falsity" (exclusion [b]), and "infringement of copyright, patent, trademark, or trade secret" (exclusion [i]).

A cursory reading of the triggering offenses, followed by the exclusions, could lead an insured or its counsel to believe that the coverage provided under B is illusory – the predicate offenses seem to naturally trigger the exclusions. How can slander be anything other than a "knowing violation" of another's rights? How can "libel" not be "knowingly false"? How can infringement on a copyright or trade dress not implicate the "infringement" exclusion?

The key to understanding the triggers for the duty to defend and indemnify in a Coverage B situation depends in significant part on the elements of the particular cause of action alleged. Michigan law has long been clear that the duty to defend is broader than the duty to indemnify, and that the insurer has the duty to look behind the allegations in the complaint to analyze whether coverage is possible.[5] If there is any doubt whether a complaint alleges liability covered under the policy, the doubt must be resolved in the insured's favor.[6] If any theory falls within the policy, the insurer owes a duty to defend the suit.[7]

For example, the elements of a defamation claim are a false and defamatory statement, of and concerning the plaintiff, an unprivileged communication to a third party, and fault amounting to "at least negligence" on the part of the publisher.[8] An insured sued for "defamation", therefore, would be entitled to a defense under Coverage B, since the tort of defamation does not require "knowledge" of the allegedly false statement or writing. Similarly, if the complaint leaves open the possibility that the insured acted without "knowledge" of the alleged falsity, the exclusion cannot be applied to the complaint in its entirety.[9] Finally, if the terms used – such as "wrongful invasion" or "false arrest" – are undefined, the court must give the words their plain and ordinary meaning, apply the definitions set forth in the contract,[10] with any ambiguities being construed against the insurer in favor of the insured.[11]

As noted earlier, as America transitions to a knowledge and information-based economy, the protection provided under Coverage B of the CGL policy will play an important role in risk management for insureds, and in defense and indemnity exposures for insurers. An understanding of the predicate offenses, applicable exclusions, definitions, and existing case law will continue to be a necessary and valuable skill for both insureds and carriers.

Endnotes

1 ISO/Commercial General Liability form 12/01/2007

2 Commercial Liability Risk Management and Insurance, (6th ed.) American Institute for Chartered Property Casualty Underwriters/ Insurance Institute of America

3 The 1998 ISO revisions to the CGL policy provided coverage for "consequential" bodily injury under Coverage B, and precluded it in exclusion (o) to Coverage A. Malecki, Donald S. & Flitner, Arthur L., Commercial General Liability, 50 (8th ed. 2005)

4 GAF Sales & Service, Inc. v Hastings Mut Ins Co., 224 Mich. App. 259, 264, 568 N.W.2D 165, 168 (1997), citing, People v Montague, 280 Mich. 610, 274 N.W. 347 (1937).

5 Shefman v Auto-Owners Ins Co, 262 Mich App 631, 687 NW2d 300 (2004); Radenbaugh v Farm Bureau Gen Ins Co of Michigan, 240 Mich App 134, 610 NW2d 272 (2000).

6 Radenbaugh at 138, 610 NW2d 272.

7 Reurink Bros., Star Silo, Inc. v Maryland Cas Co., 131 Mich App 139, 345 NW2d 659 (1983).

8 Mitan v Campbell, 474 Mich 21, 706 NW2d 420 (2005).

9 Bay Electric Supply, Inc v Travelers Lloyds Ins Co., 61 F. Supp.2d 611, 619 (S.D. Tex. 1999)

10 GAF Sales at 261, 568 NW2d at 167.

11 Powers v DAIIE, 427 Mich. 602, 622, 398 NW2d 411, 419 (1986). ■

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Claims Interest Group

Claims Quorum

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