

CLAIM DENIED

January 2005

A publication of the Lowenstein Sandler Insurance Law Practice Group

NEW DECISION CLARIFIES NEW JERSEY LAW ON INSURER'S DUTY TO DEFEND

By Robert D. Chesler, Esq.

In 1992, the New Jersey Supreme Court established that when an insurer agrees to defend its insured, the insurer has the right to allocate defense costs between covered and uncovered claims in the complaint. The court opined that such allocation should not prove difficult but it has, in fact, proven a nightmare.

Most complaints bundle together covered and uncovered allegations. In pleading a negligence claim, plaintiffs do not hesitate to add counts of intentional wrongdoing or fraud. Plaintiffs frequently allege both negligence and breach of contract. In D&O cases, some claims may be within the 'insured v. insured' exclusion, while others are not. Moreover, a request for punitive damages is made in a high percentage of cases.

The Supreme Court did not give guidance on how the parties were supposed to allocate. Insurers can often find an argument that they should pay less than 100 percent of defense costs because of uncovered allegations. Indeed, insurers sometimes simply count the number of counts, and pay the percentage of covered counts to the total number of counts: if a complaint alleges negligence, breach of contract,

intentional conduct and fraud, all arising from the same facts and seeking the same damages, the insurer may offer to pay 25 percent of defense costs.

These are difficult issues for the insured to contest. If an insurer offers to pay 40 percent of defense costs, should the insured refuse and file suit, thereby paying all of the defense costs itself until the court rules? If the insurer offers 40 percent and the insured believes that the insurer's correct share is 75 percent, can the insured cost-effectively litigate over the difference?

In *Hebela v. Healthcare Insurance Company*, Docket No. A-0417 (App. Div. June 28, 2004), the New Jersey Appellate Division has now set forth a clear allocation standard that is very favorable for insureds.

In *Hebela*, a doctor sued a hospital for employment claims, and the

Inside

**COVERAGE FOUND FOR
PRODUCT LOSS ABSENT
MATERIAL ALTERATION**

**BROKER DILIGENCE
REQUIRED TO AVERT
COVERAGE DENIALS**

**SCOPE OF COVERAGE FOR
AN "ADDITIONAL
INSURED" REMAINS
IN FLUX**

**SILICA LITIGATION
ON THE MARCH**

This document is published by Lowenstein Sandler PC to keep clients informed about current issues. It is intended to provide general information only.

hospital counterclaimed. The doctor sought coverage for the counterclaim under the hospital's D&O policy. The insurer denied coverage on an unusual public policy ground. Both the doctor and the hospital were insureds under the D&O policy, but the policy's 'insured v. insured' exclusion applied solely to claims by individuals, and not by the hospital. Nonetheless, the insurer argued that public policy prevented coverage for a claim by one insured against another. The court dismissed this defense, and next turned to the issue of allocation between the insured's uncovered costs in prosecuting its claim and the covered costs in defending against the counterclaim.

The Appellate Division stated that "the trial judge found apportionment to be difficult and unworthy of more than a cursory effort." While the Appellate Division was sympathetic to the practical difficulties of apportionment, it found that the trial court needed to make a diligent effort to reach "a fair and reasonable estimate."

The court recognized that the case before it, involving a claim and a counterclaim, was easier than cases in which the court needed to allocate between covered and uncovered claims within the same complaint. Still, the court found defense costs incurred by the insured in *Hebela* that overlapped between the claim and the counterclaim.

The court set forth the standard that the insurer had to pay all overlapping costs. The court found that the insurer had agreed to defend fully against any covered claim, and should not benefit from the fact that its defense incidentally aided the insured on uncovered claims.

While the Appellate Division was sympathetic to the practical difficulties of apportionment, it found that the trial court needed to make a diligent effort to reach "a fair and reasonable estimate."

The court next turned to the mechanics of allocation. The court recognized two distinct situations. Sometimes, the insurer agreed to defend and was seeking reimbursement of uncovered costs from the insured. Other times, as in *Hebela*, the insurer had refused to defend. In the latter case, the court placed only a slight burden on the insured to come forward with evidence of its costs. The insurer had the burden of demonstrating which costs were incurred solely with respect to uncovered claims.

The court thus held that all defense costs, presumptively, are covered. The insurer has the burden of demonstrating which defense costs were incurred solely with respect to uncovered claims. The insurer must

pay mixed costs incurred with respect to both covered and uncovered claims. Thus, if a complaint asserts clearly unrelated claims of negligence and breach of contract seeking separate damages, the insurer may only need to pay for the negligence claim. However, if the complaint alleges negligence, breach of contract, intentional wrongdoing, and fraud, seeking the same damages arising from the same operative facts, the insurer must pay all of the defense costs.

COVERAGE FOUND FOR PRODUCT LOSS ABSENT MATERIAL ALTERATION

By Lynda A. Bennett, Esq.

In a favorable ruling for policyholders, the Appellate Division recently found coverage for a product loss even though the "material or chemical composition" of the product was not altered. The decision is important for two reasons. First, it construes the requirements of "direct, physical loss" and "risk of physical loss" broadly. Second, it reinforces the canons of insurance policy interpretation requiring insurance companies to use clear and direct language in their policies so that coverage fulfills the insured's reasonable expectations.

In *Customized Distribution Services v. Zurich Ins. Co.*, No. A-1586-03T1 (Dec. 16, 2004), Customized Distribution Services ("CDS") was

sued by Campbell Soup Company (“Campbell”) for failure to rotate and ship a beverage product that CDS was storing in its warehouse. Campbell claimed that, as a result of CDS’s failure to rotate and ship product before its expiration date, Campbell was forced to sell the product to secondary markets as a lower grade product and at less than 50 percent of its original value.

CDS sought coverage for the loss under a Warehousemen’s Liability policy that it had purchased from Zurich Insurance Company (“Zurich”). The policy promised coverage for “‘loss’ caused by a ‘covered cause of loss’ to ‘covered property.’” The policy defined “covered causes of loss” to mean “risk of direct, physical ‘loss’ to ‘covered property’...” unless excluded. The policy excluded coverage for loss resulting from a “delay, loss of use, loss of market, or any other consequential loss.”

Zurich denied the claim on primarily two grounds. First, Zurich argued that there was no “direct, physical” loss because there was no material change in the product; rather, there was merely a reduction in the value of the product. Second, Zurich contended that Campbell’s claim arose from the failure to rotate and ship the product in advance of the expiration date and, as such, the loss resulted from a delay and/or loss

of use of the product, which was excluded from coverage. The trial court agreed with Zurich’s coverage position.

In reversing the trial court, the Appellate Division held that there was no express requirement in the policy that, for coverage to apply, the product’s material or chemical composition must be altered. To the contrary, the court noted, coverage undeniably would be available if the loss arose from the bottles containing the product being broken where the beverage itself would remain undamaged and unaltered. Moreover, the court held that the inclusion of the term “risk” within the definition of “covered causes of loss” further supported the finding that the policy did not require any actual physical damage to or alteration of the material composition of the product before coverage was available. The court held that Campbell’s product changed based on its customers’ negative perception of the beverage after the expiration date and that change was the “functional equivalent” of damage of a material nature or an alteration in physical composition. If Zurich intended to provide a narrower scope of coverage, the court concluded, it was “incumbent” on Zurich to “clearly and specifically rule out coverage in the circumstances where it was not to be provided.”

Turning to the exclusion relied on by Zurich, the Appellate Division focused its analysis on the parties’ reasonable expectations. In so doing, the court assumed that both CDS and Zurich understood the “delay, loss of use” exclusion to bar coverage for losses that CDS may incur as a result of delay or loss of use, not losses of use suffered by its customers. Moreover, the court concluded that CDS’s liability did not arise from a delay or loss of use because the market for Campbell’s beverage was not lost. Rather, the value of the product was diminished because of customer perception when the beverage reached a certain age. Finally, the court agreed with CDS that to adopt Zurich’s interpretation that “loss of use” should be construed to mean the product’s diminished utility would render the coverage illusory.

**DILIGENCE REQUIRED TO
AVERT COVERAGE DENIALS
BASED ON BROAD
INTERPRETATION OF
EXCLUSIONS IN
D&O POLICIES**

By Phillip Kaczor, Esq.

The New Jersey Appellate Division recently affirmed a denial of coverage based on a broadly worded exclusion contained in a D&O policy. The case underscores the need for broker diligence and careful risk assessment during policy negotiations.

Porter v. American International Cos., No. A-5213-02T2 (App. Div. Nov. 1, 2004) involved claims of conversion, unfair practices, and misrepresentation related to an Asset Purchase Agreement. Pursuant to the Agreement, the policyholder-purchaser acquired all but one business unit of the seller's business and also assumed control of a "lock box" account into which all payments related to the seller's businesses were made. The Agreement required the policyholder-purchaser to remit to the seller those payments that were attributable to the carved out business unit. The seller sued when the necessary payments allegedly were not made.

The policyholder's demand for a defense from its D&O insurer was denied based on a broad exclusion barring coverage for claims "alleging, arising out of, based upon or attributable to any actual or alleged contractual liability of the Company or any other Insured under any express contract or agreement." The insurer argued that the policyholder's alleged liability for the tendered claim "arose out of" the Purchase Agreement and the obligations assumed by the policyholder in connection with that Agreement.

The Appellate Division affirmed the insurer's interpretation of the exclusion, notwithstanding the canon of construction applicable to

the interpretation of insurance contracts that requires courts to construe exclusionary language narrowly. In so holding, the court noted that the phrase "arising out of" historically has been given a broad definition, whether it was used to

Policyholders should view these decisions as cautionary tales of the need for diligence in insurance policy negotiations.

define or exclude coverage. The court further held that there was an "interdependence" between the claims brought in the underlying action and the Asset Purchase Agreement such that "the claims could not have existed had there not been a contractual obligation" assumed by the policyholder.

The Fifth Circuit reached a similar result in *National Union Fire Ins. Co. v. U.S. Liquids, Inc.* No. 03-20542, 2004 WL 304084 (5th Cir. Feb. 17, 2004). There, the underlying claim involved a consolidated securities fraud action and a shareholders' derivative suit brought against the insured waste management company for its alleged failure to disclose illegal waste disposal practices. Here too, the policyholder's demand for a defense from its D&O insurer was denied. The policy's pollution exclusion barred coverage for claims:

alleging, arising out of, based upon, attributable to, or in any way involving, directly or indirectly: (1) the actual, alleged, or threatened discharge, dispersal, release or escape of pollutants; or (2) any direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants, including but not limited to a Claim alleging damage to the Company or its securities holders.

As in *Porter*, the coverage denial was upheld based on a broad interpretation of the "arising out of" language in the exclusion. The *US Liquids* court held that because the losses described in the complaint "bore more than an incidental relationship to the broad polluting conduct excluded in the policy and that 'but for' such illegal activities those underlying claims would not exist," the claim was barred by the exclusion.

Policyholders should view these decisions as cautionary tales of the need for diligence during underwriting and renewal policy negotiations. They both highlight the need to: (a) guard against broad "arising out of" language in exclusions; and (b) establish reasonable expectations for coverage based on your company's risk exposures. In *Porter*, an exclusion limited to "breach of contract claims" may have allowed for coverage. In

U.S. Liquids, the policyholder may have had coverage if the exclusion was limited to “pollution claims.” Moreover, there may have been alternative risk transfer mechanisms available in either case to provide the protection the policyholder expected. The best practice to avoid surprises like *Porter* and *U.S. Liquids* is to work cooperatively with your broker and coverage counsel to evaluate risk exposures before coverage is bound and claims are made.

SCOPE OF COVERAGE FOR AN “ADDITIONAL INSURED” REMAINS IN FLUX

By Lynda A. Bennett, Esq. and Kristina D. Pasko, Esq.

Additional insured status is crucial for many companies. While the construction industry springs to mind, other examples are numerous: landlords are additional insureds on tenants’ policies (or vice versa), and distributors and retailers are additional insureds on manufacturers policies. The “standard” ISO additional insured endorsement states: “Section II -- Who Is An Insured is amended to include the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured.” The scope of coverage available to an “additional insured” has become an increasingly common subject of coverage litigation.

The disputes typically center on the meaning of the phrase “arising out of” in the endorsement. The additional insured argues for the broadest possible interpretation *i.e.*, it is covered for any and all injury that is causally connected to the business between the additional insured and the named insured. Conversely, the named insured and its insurer, seeking to minimize the coverage obligation, argue that the additional insured is covered only to the extent that it is vicariously liable for the acts or omissions of the named insured. The New Jersey Appellate Division has issued opinions that support both sides’ arguments.

For example, in *Myers v. New Jersey Sports & Exposition Authority*, No. A-3750-00T5 (Dec. 12, 2002), a subcontractor’s employee was injured while working on a renovation project for the New Jersey Sports & Exposition Authority (“NJSEA”). NJSEA was an additional insured under a liability policy issued to an architect who was working on, and in fact supervising, the renovation project. Following the accident, NJSEA made a demand under the architect’s policy. The insurer denied coverage, claiming that the injury was not caused by negligence on the part of the architect, but rather the general contractor. The Appellate Division rejected the insurer’s denial, holding that the alleged injury “grew

out of” the architect’s work and therefore NJSEA was entitled to coverage.

A similar result was reached in *Garibaldi v. Rainbow Landscaping*, No. BER-L-7062-02 (N.J. Super. Law Div., Mar. 22, 2004), where the court broadly interpreted the scope of coverage available for a condo association that was an additional insured under its landscaping company’s liability policy. There, the underlying plaintiff tripped on a pile of leaves in the condominium parking lot. The plaintiff sued the association and the landscaper for negligence. Per the contract requirements, the association was an “additional insured” subject to the limitation that it was covered “only with respect to operations performed by [the landscaper].” The insurer declined to defend the association on the theory that the landscaper was not performing “operations” on the condominium grounds at the time plaintiff was hurt.

The Appellate Division rejected the insurer’s argument, noting that the contract required the landscaper to “inspect the . . . grounds” and maintain the parking lot and sidewalks clear of leaves and other debris. Since the landscaper had an obligation to inspect and clean up the premises as needed, the allegedly “dangerous condition may have been created as a result of [the

landscaper]’s breach in its ‘operations.’” Accordingly, the court gave the additional insured the benefit of coverage by broadly construing the nexus between the underlying claim and the business between the named insured and the additional insured.

More recently, however, the Appellate Division adopted a much narrower scope of coverage for an additional insured, as advocated by a named insured’s insurer. In *Vornado Realty Trust v. Travelers Indemnity Co.*, No. A-6208-02T3 (Oct. 14, 2004), Produce Connection leased space in a building owned by Vornado. Produce was required to name Vornado as an additional insured under its general liability policy but, pursuant to the additional insured endorsement, only with respect to “liability arising out of the ownership, maintenance, or use of the Premises leased to” Produce. During the leasehold, an arson fire in the building damaged property of other tenants, who sued Vornado for failing to maintain a sprinkler system in the building. Vornado sought coverage from Produce’s insurer.

The Appellate Division upheld the insurer’s denial of coverage on two grounds. First, the additional insured endorsement expressly required a nexus between the fire and the premises occupied by Produce and there was no evidence of such a

nexus: Produce had no responsibility for the sprinkler system, the failure of which allegedly caused the fire; the fire did not originate on the Produce premises; and there was no evidence that Produce started the fire. Second, the court held that the “obvious intent” of the license agreement was to protect Vornado from vicarious liability on the Produce premises, not to cover all claims that may arise at the building where Produce happened to lease space. The court concluded that additional insureds are not guaranteed coverage better than the coverage actually issued.

To avoid the risks associated with conflicting judicial interpretation like those discussed above, the insurance industry has begun using a new ISO additional insured endorsement that eliminates reference to liability “arising out of” the named insured-additional insured relationship. The new endorsement states that coverage for an additional insured applies only to injury or damage “caused in whole or in part” by the acts or omissions of the named insured. The explicit purpose of the endorsement is to limit the insurer’s responsibility to the additional insured to its vicarious liability based, in whole or in part, on the named insured’s acts or omissions.

Every company that expects protection because of its additional

insured status must have its broker or coverage counsel review each additional insured endorsement and advise as to the scope of protection that it provides.

SILICA LITIGATION ON THE MARCH

By: Robert D. Chesler, Esq.

On November 2, 2004, Robert D. Chesler chaired the New Jersey Institute for Continuing Legal Education seminar entitled “Is Silica the Next Asbestos?” Speakers included: Robert Adams of Environ, Bill Jones of Navigant Consulting, Adrienne Cronas of Arthur J. Gallagher, Marc Gaffrey of Hoagland, Longo, Moran, Dunst & Doukas, Thomas Quinn of Wilson, Elser, Moskowitz, Edelman & Dicker, and Greg Noble of Wilentz, Goldman & Spitzer.

The seminar was inspired in part by the filing of about 15 silica complaints in Middlesex County by Wilentz, Goldman & Spitzer. The defendants in those cases, and potential future defendants, have been in suspense over whether these cases were only the first of many. Greg Noble of Wilentz confirmed that his firm intended to file many more silica claims. He mentioned a number of industry targets including foundries, ceramics, glass making and construction, along with manufacturers of respirators and

other health and safety equipment. Further, as with asbestos, plaintiffs may bring claims of conspiracy by companies and their insurers alleging that they suppressed knowledge of the danger of silica. Noble expected that silica claims would be granted mass tort status by Judge McCormick in Middlesex County within a year. While Noble spoke passionately of the need to protect the injured claimants, other speakers were more cynical. They attributed the rise of silica claims to fears that legislators would place limits on asbestos litigation, and that the pool of asbestos plaintiffs was running dry.

While asbestos and silica are often grouped together, the seminar highlighted the important differences between them. Because of improved health and safety procedures, the number of silica-related deaths has declined sharply over the past two decades to the current total of about 200 deaths a year. While federal agencies have labeled silica a carcinogen, it does not cause mesothelioma. Moreover, defense attorneys question whether the tests that found silica to be a carcinogen properly screened for other environmental factors, such as cigarettes. A single silica particle will not cause injury; rather, a critical mass resulting from long term exposure is necessary. These factors indicate that the number of silica claimants will not approach the huge number of asbestos plaintiffs.

Also, the dangers of silica exposure have been known since the sixteenth century. As a result of the widespread knowledge of silica's dangers, defendants have the advantage of defenses like the sophisticated user doctrine. This doctrine dictates there is no duty to warn a user of a particular hazard when such a hazard is generally known by ordinary users of the product. The state supreme courts of Minnesota and Texas have recently discussed these defenses. *Gray v. Badger Mining Corp.*, 676 N.W.2d 268 (Minn. 2004) (genuine issues of material fact existed as to whether worker was a sophisticated end user, whether his employer was a sophisticated intermediary, and whether silica sand supplier's warning to employer was adequate); *Humble Sand & Gravel, Inc. v. Gomez*, No. 01-0652, 2004 WL 2090592 (Tex. Sept. 17, 2004) (splitting on whether the sophisticated user doctrine shielded silica supplier from liability; majority reversing and remanding for new trial). *See also Haase v. Badger Mining Corp.*, 682 N.W.2d 389 (Wis. 2004) (not addressing the sophisticated user defense, but evaluating the material and substantial change that the silica sand underwent after leaving the possession of the supplier.)

The seminar concluded with a discussion of insurance coverage. Like environmental and asbestos

liability, silica cases involve the "continuous trigger" so that, under New Jersey law, all insurance policies from first exposure to silica to manifestation of the alleged injury are severally implicated. This places a premium on the identification of old general liability policies by the policyholder. Silica claims may also be subject to exclusions. In recent years, insurers have added specific silica exclusions to some policies. Also, some insurers contend that the absolute pollution exclusion clause precludes coverage for silica. The New Jersey Supreme Court has not yet addressed this issue. Unfortunately, companies with silica liability may also find themselves in conflict with their insurance carriers.

LOWENSTEIN SANDLER PC
Attorneys at Law



INSURANCE OUTPOST

Publications

- “Insurance is Available for Blast Fax Lawsuits,” *New Jersey State Bar Association Newsletter, Insurance Law Section*, Vol.1, No. 2, Lynda A. Bennett, Esq. and Veronica Castro, Esq., November 2004
- “Practical Insurance Tips For Risk Managers And In-House Lawyers,” *riskVue*, Robert D. Chesler, Esq. and Lynda A. Bennett, Esq., October 2004

- Insurance Law and Mass Tort Alert: “Protecting Against Silica Claims,” Robert D. Chesler, Esq., November 2004

Upcoming Events

- The National Business Institute’s Bad Faith Litigation in New Jersey Seminar, April 7 & 8, 2005
Lynda A. Bennett

Recent Outpost Legal Highlights

- New York Court Limits Scope of the Pollution Exclusion
- *U.S. Underwriters Ins. Co. v. City Club Hotel, LLC*
- Statute of Limitations Tolled for Policyholder ‘Lulled’ Into Complacency

LOWENSTEIN SANDLER PC
Insurance Coverage Practice Group
65 Livingston Avenue
Roseland, New Jersey 07068

Presorted
First Class Mail
US Postage
PAID
Permit #73
West Caldwell, NJ