

# Commentary

## Ten Significant Recent Insurance Decisions

By  
Robert D. Chesler

*[Editor's Note: Robert Chesler is a member of Lowenstein Sandler PC in Roseland, N.J., and chair of the firm's insurance practice group. He represents policyholders in a wide array of coverage disputes with insurers, including with respect to directors and officers, other executive liability, and mortgage insurance claims; advises companies on their insurance programs; and is actively involved in insurance broker malpractice issues. Mr. Chesler is a frequent author and speaker on insurance topics, including intellectual property and cyber insurance claims. He is Vice-Chair of the Intellectual Property Insurance Sub-Committee of the American Intellectual Property Law Association, and is listed among The Best Lawyers in America and was featured in the 2005, 2006, 2007, 2008 and 2009 editions of New Jersey Super Lawyers in the area of insurance coverage. He is also listed in the 2006, 2007 and 2008 editions of Chambers USA: America's Leading Lawyers for Business. Copyright 2009 by Robert Chesler. Response articles are welcome.]*

Each year I marvel at Randy Maniloff's 'Ten Most Significant Decisions' that appears in Mealey's. This year, he has inspired me compile my own list of recent decisions. The insurance cases that I discuss are not the most significant. Rather, each case captures and illuminates a trend that is important for professionals who, like myself, work principally in the area of liability insurance. Some of these trends are new, while others have been debated for years without resolution.

### 1. Insurer's Delay In Disclaiming Coverage

Until recently remedied by statute, New York had the worst case law in the country for policyholders on late notice. Now it may have the worst case law for insurers.

In *Continental Cas. Co. v. Stradford*, 11 N.Y. 3d 443 (N.Y. 2008), the policyholder was a dentist sued for malpractice. The insurer agreed to defend, but was shackled by the insured's failure to cooperate on numerous issues. In July 2004, the insurer sent two letters to its insured demanding cooperation; both letters were returned as unclaimed. On October 13, the insurer sent a disclaimer letter to the insured, and on October 15 filed a declaratory judgment seeking a declaration that it had no further duties because of the insured's failure to cooperate. The insured counter-claimed, and the Appellate Division held, by a 3-2 vote, that the insurer had violated N.Y. Ins. Law sec. 3420(d), which required the insurer to issue a disclaimer letter "as soon as is reasonably possible." While the Court of Appeals reversed, it did so solely on the grounds that on the circumstances of this case, a fact issue existed as to whether a two month-delay was unreasonable as a matter of law. Insurance professionals accustomed to lengthy delays by insurers now have a powerful weapon at their disposal.

*Estee Lauder, Inc. v. OneBeacon Ins. Group, LLC*, 873 N.Y. S2d 592 (N.Y. 2008) reached a similar conclusion on different facts. In that case, the insurer denied coverage because the insured did not have copies of the policies, and also issued a general reservation of rights. After litigation, the court found that Estee Lauder had proven the existence of the policies. At that point, the insurer for the first time raised late notice as a new ground for denying coverage. The court struck the defense, finding that where an insurer knew of a possible defense, the insurer had to identify it, and could not hide for months behind a general reservation of rights.

## 2. Privacy

Insurance coverage for privacy has become a key issue both for underwriters and litigators. *St. Paul Fire and Marine Ins. Co. v. Brother Intern. Corp.*, 2009 WL 865077 (3d Cir. 2009), a Solomonic decision, shows the vagaries of coverage for privacy under general liability policies. The case is one of many examining insurance coverage for 'blast-faxes,' i.e., sending unauthorized mass faxes in violation of the Telephone Consumer Protection Act ("TCPA"), 47 U.S.C. 227. The advertising injury coverage of Brother's general liability policy included coverage for "making known to any person or organization covered material that violates a person's right to privacy." The court recounted the two strands of privacy coverage: seclusion, or the right to be left alone, and secrecy, the right to keep one's confidential information out of public view. The court found that blast faxes violated the right of seclusion, while the policy term 'making known' meant that coverage only existed for violation of the right of secrecy. As a result, the court held that there was no coverage.

However, the court also addressed the more common formulation of privacy coverage, 'oral or written publication of material that violates a person's right to privacy.' The court opined that this formulation was not limited to secrecy violations but could also include an invasion of the right to seclusion, so that coverage would exist for blast-faxes under liability policies with this phrasing.

Numerous courts have addressed the issue of insurance coverage for blast-faxes, producing a welter of contradictory rulings. The insurance industry has brought this debate to a close by developing a 'blast-fax exclusion' for the general liability policy. An active market now exists for the purchase of privacy insurance, including policies that combine elements of first-party and third-party coverage.

## 3. Information And Network Technology Errors And Omissions Policy

As our society and economy shift from tangible to intangible property, the insurance industry is adjusting in its usual fashion — excluding emerging liabilities from existing policies and creating new niche policies for the new risks. Privacy coverage as discussed above is one example. In *Eyeblaster, Inc. v. Federal Ins. Co.*,

2008 WL 4539497 (D.Minn. 2008), the insured purchased both a general liability policy and a 'tech E&O' policy from the same insurer - and still failed to obtain coverage.

In the underlying case, an individual sued Eyeblaster, asserting that when he visited its website, Eyeblaster downloaded spyware on his computer. He claimed a massive amount of damage — that it changed his settings, installed pop-up advertising, redirected his web-browser, and froze his computer, resulting in the loss of tax data. He further alleged that internet transmissions 'took over' his computer, slowed computer performance, and caused the loss of massive amounts of memory.

Eyeblaster gave notice under both its general liability and tech E&O policies. As to the general liability policy, Eyeblaster asserted that the freezing of the computer constituted property damage. The court disagreed, finding that the computer was unharmed — while the software created programming difficulties, the computer hard drive was unaffected. The policy did not cover the programming difficulties because it had a software exclusion.

Eyeblaster probably believed that it was still in good shape, because it had purchased a separate policy that covered intangible property damage. The Tech E&O policy provided coverage for 'a wrongful act,' defined in pertinent part as 'an error, unintentional omission, or negligent act.' The insurer argued that since the complaint alleged that Eyeblaster intentionally placed the spyware on the computer, coverage did not lie. Eyeblaster replied with the fundamental insurance rule that coverage exists for the unintentional results of intentional acts. However, the court held that in view of the unambiguous policy definition of 'wrongful act,' Eyeblaster was out of luck. Hopefully, *Eyeblaster* is not a signal that insurers who issue new tech policies will not disclaim coverage under them on a massive scale.

## 4. Bad Faith

The insurance industry admits that with thousands of claims handlers and hundreds of thousands of claims, mistakes happen. However, the industry strenuously denies that it would actively take measures in bad faith to prevent an insured from obtaining coverage. In *City of Hollister v. Monterey Ins. Co.*, 165 Cal. App.

4th 455 (Cal. Ct. App. 2008), the court spent 69 pages recounting the insurer's 'concerted campaign of intimidation' and 'deliberate strategy of obstruction and delay'. In this case, the court found that the insurer so acted to prevent the insured from complying with a 180 day period to commence repair of a damaged building. The lesson here is that sometimes the policyholder's absolutely worst suspicions of the insurer's conduct are in fact true.

## 5. Question Disclaimers

While it is often difficult to prove bad faith, it is clear that insurers will sometimes disclaim coverage on grounds that do not pass the 'straight face' test. After all, as demonstrated by *Eyeblaster*, sometimes a marginal argument works. *Community Credit Counseling Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 2009 WL 900984 (D.N.J. 2009) concerned a claim by a non-profit under a Not-For-Profit Individual and Organization Insurance Policy. A class action was commenced against CCC, alleging that it had violated two federal statutes — each of which expressly excluded non-profits from its scope. CCC requested a defense from National Union, which replied that since CCC could not possibly have liability under these two statutes, it had no duty to defend. National Union argued that the definition of "Loss" excluded "any amount for which the Insureds are not financially liable or which are without legal recourse to the insureds." Since CCC could not be liable under the two statutes, no Loss had occurred, and it had no obligation to defend. National Union further argued that since CCC could only be liable if it was not a non-profit corporation, National Union would be entitled to rescind if CCC had liability because CCC would have made the false representation that it was a non-profit on its application. This dispute ended up in federal court, where the judge ruled that National Union had a duty to defend even if the claim was "groundless, false or fraudulent."

## 6. Counting Occurrences

There have been dozens of decisions in the past few years holding, mostly in the context of asbestos and other mass torts, that each separate claim is a separate occurrence. However, insurance brokers have largely failed to protect their clients from this risk by adding either aggregate deductibles, or an aggregating provision to the policy.

*Mid-Continent Casualty Co. v. Clean Seas Co.*, 2009 WL 812072 (M.D.Fla. 2009) is a standard product liability claim that underscores the importance of this issue. The insured sold paint for boats; the paint proved defective and damaged the boats. The first part of the court's decision was a significant victory for the insured — the court found coverage for damages and repairs to the boats and the cost of removing the paint. The second part of the decision, though, clawed back much of this victory. The court held that each damaged boat was a separate occurrence, so that each boat was subject to the deductible of \$1,000. Query: if the broker had not explained the issue to the insured and provided it with a choice of a per claim deductible or an aggregate deductible, did the broker commit malpractice?

## 7. Notice! Notice! Notice!

Numerous cases deny coverage to the insured on a claims-made policy for failing to provide notice of a claim to the insurer. The chief problem is that the policy definition of 'claim' is usually so broad and uncertain that while the average insured knows to provide notice when it receives a complaint, it may not realize that it must also provide notice even of letters.

*MedPointe Healthcare, Inc. v. Axis Reinsurance Co.*, 2009 WL 901959 (D.N.J. 2009) underscores this dilemma. The case concerned an employment practices liability policy which defined claim, in pertinent part, as 'a written demand against any Insured for monetary damages or other relief' and 'a formal administrative, investigative or regulatory proceeding' before the EEOC 'commenced by a notice of charges, formal investigative order or similar document. . . .' Axis issued two consecutive policies to MedPointe, covering September 28, 2003 to September 28, 2004, and September 28, 2004 through September 28, 2005. The policy provided that all claims must be reported 'as soon as practicable after any of the Policyholder's Executive Officers first becomes aware of such Claim, but in no event later than sixty (60) days after the expiration of the Policy Period. . . .'

In the underlying case, MedPointe terminated an employee on October 13, 2003. On October 17, an attorney acting on her behalf sent a letter to MedPointe requesting reinstatement. On August 16,

2004, MedPointe received notice from the EEOC of the employee's EEOC Charge, and on September 24, 2004, it received notice from the EEOC that it was 'closing its file on this charge.'

On April 21, 2005, MedPointe was served with the employee's complaint, and promptly provided notice to Axis, which denied coverage. Coverage litigation ensued, and Axis brought a motion for summary judgment, asserting that the employee's letter and the EEOC charge from 2004 were 'claims' under the policy that MedPointe needed to report, and that as a result the notice under the 2004-5 policy was untimely.

The court denied the insurer's motion on the basis that disputed facts existed. As to the letter, the court found that it did not 'request damages or insinuate that a claim for discrimination is being made. As a result, the insured could reasonably have believed that the letter was not a demand, but rather a request to return to work.'

The court found that the EEOC charge was a claim. However, the court reasoned that a fact issue existed as to whether the failure to provide notice was reasonable since the company could have concluded that the EEOC had decided the claim against the employee. Axis has filed a motion for re-consideration of this part of the holding, asserting that the duty to give notice attached as soon as the insured received the claim, regardless of ensuing developments.

## 8. Beware Of Exclusions

In *Delta Financial Corp. v. Westchester Surplus Lines*, 398 B.R. 382 (Bankr. D. Del. 2008), the insured company engaged in a transaction with its noteholders in which the noteholders were to receive cash flow certificates with a value of \$153,000,000. However, the certificates turned out to have a value of only about \$43,000,000, resulting in litigation. When the company turned to its Director's and Officer's Liability policy, the insurer denied coverage on the basis of an 'inadequate consideration' exclusion which stated, in pertinent part that there was no coverage for claims 'based on . . . actual or proposed payment of the Company of allegedly inadequate or excessive consideration in connection with the purchase of securities issued by any company.' The court upheld the insurer's disclaimer.

The 'inadequate consideration exclusion' is one of numerous new exclusions that the insurance industry is adding that sharply reduce coverage, and which often pass unnoticed by insurance brokers and consultants. ISO has developed extremely broad exclusions for 'Electronic Data' and for 'Microorganisms, Biological Organisms, Bioaerosols or Organic Contaminants.' Two of the cases discussed above, *Brother* and *Eyeblaster*, both hinged on new exclusions. One insurer uses a nano-technology exclusion. Most of the new exclusions do not appear as part of the body of the policy but as endorsements that are often overlooked.

The policyholder does have two remedies for new exclusions. In most states, the insurer on a renewal must advise the policyholder of any reductions in coverage. The broker has a similar duty to advise its client of any changes to the policy. Both insurers and brokers often fail in these duties.

## 9. No Second Bite

In *Executive Risk Indem., Inc. v. Jones*, 171 Cal. App. 4th 319 (Cal. Ct. App. 2009), Reese Jones sued STARS, an investment company, for bad advice. STARS noticed the claim to its D&O insurer, which refused to participate in the proceedings or defend STARS, which it knew was insolvent. The insurer apparently took this position because the policy had a retention of \$250,000. STARS could not adequately defend itself, and Jones recovered an arbitration award of \$22,000,000, plus an assignment of STARS' policy rights. In the *Jones* case, the insurer initially prevailed in the trial court on its argument that it was not collaterally estopped by the arbitration award because it was not a party to the arbitration. The appellate court reversed. It found that 'Despite the entreaties of its insured, [the insurer] refused to intervene or otherwise protect its own interests. . . . Assuming [the insurer] made a calculated decision not to intervene or otherwise protect its interest in these proceedings, it is not unfair to preclude [the insurer] from re-litigating the court-approved judgment's determination of STARS' liability and damages.' As a result, the insurer retained its coverage-based defenses, but could not re-litigate STARS' liability to Jones or the damages. In *Mutual of Enumclaw Ins. Co. v. T&G Const., Inc.*, 165 Wash. 2d 255 (Wash. 2008), the Supreme Court of Washington reached a similar conclusion.

## 10. Additional Insured

Additional insured status is critical in many different settings, particularly with construction and vendor's liability. However, almost no one knows precisely what protection additional insured status provides, and the case law is all over the place. Many insurance professionals believe that additional insured status provides coverage when the additional insured is sued vicariously for liability resulting from the named insured's acts. However, as discussed in *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008), many courts have interpreted additional insured status more broadly.

In *Evanston*, the contractor named the landowner, ATOFINA, as an additional insured pursuant to a general liability policy that stated that an 'insured' included 'A person or organization for whom you have agreed to provide insurance as is afforded by this policy; but that person or organization is an insured only with respect to operations performed by you or on your behalf, or facilities owned or used by you.' An employee of the contractor drowned on the site, due solely to the negligence of ATOFINA. The court found that the employee was on the site because of the contractor's operations. While Evanston argued that the insurance policy did not state that it covered liability resulting from the owner's sole negligence, the court noted that Evanston could have clarified

the issue by writing the policy so that Evanston was only responsible for the additional insured's vicarious liability. As a result, the court found Evanston liable to ATOFINA. Practitioners should note that other insurance policies can contain different additional insured provisions, including ones that do limit the insurer's exposure to vicarious liability.

## Conclusion

This list does not include a number of major topics, such as trigger and allocation, broker liability, and construction defects. Not only do new issues arise, such as privacy. Old issues never seem to become resolved, rather, they mutate into new formulations and often become more complex. I have litigated choice of law since 1983. At that time, the basic rule was locus contractus. This evolved into a multi-factor test of weighing different interests that provides little predictability and is constantly re-litigated. Trigger and allocation have been litigated for thirty years, yet major new decisions still proliferated in the past year, in some cases upsetting seemingly accepted legal principles. Prior to about 1980, insurers and their corporate policyholders shared a common worldview that usually resulted in agreement on claims without litigation. That paradigm was first shattered by asbestos and environmental liability, and has proven impossible to re-create. Insurance coverage litigation is here to stay. ■