Bad Facts Make Bad Dreams AND Bad Law:
Coverage Nightmares We Lose Sleep Over
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I. Nightmares grounded in Coverage Position Letters

Drafting and issuing a thorough and clear coverage position letter is essential for handling all types of claims where potential coverage issues are present. However, there are a number of jurisdictions that present uniquely challenging coverage concerns based on state-specific case law. Many of these issues are relevant in handling all types of claims, but herein we will discuss some state-specific issues that present particular challenges in the construction litigation context.

A. Lack of Clarity in Reservation of Rights Letters Leads to Waiver Nightmare

The South Carolina Supreme Court has set forth certain strict requirements for an insurer when issuing of reservation of rights letter it in Harleysville Group Insurance v. Heritage Communities, Inc., Appellate Case Nos. 2013-001281 and 2013-001291, 2017 WL 105021 (S.C. Jan. 11, 2017). Although the Court’s guidance on effective reservations appears to apply to all insurers and all coverage issues, the Court’s decision is particularly informative for those handling construction defect claims because the case involved a construction defect case, and accordingly addressed two common coverage issues in the construction defect context - (1) what constitutes covered “property damage” under a commercial general liability (CGL) policy; and (2) time-on-risk allocation for damages awarded under a general verdict.

By way of background, the Harleysville case involved claims for damages stemming from defective construction and resulting water intrusion at two condominium complexes. Condo owners and the condo owners’ associations sued the developer/general contractor, who then tendered the claims to its CGL carrier, Harleysville, for defense and indemnification under multiple primary and excess CGL policies. Harleysville agreed to provide a defense subject to a “full reservation of rights” in what the Court described as a “generic statements of potential non-coverage” that “(through a cut-and-paste approach) incorporated a nine- or ten-page excerpt of various policy terms, including the provisions relating to the insuring agreement, [the insurer’s] duty to defend, and numerous policy exclusions and definitions.” The Court further explained that the letters “included no discussion of [the insurer’s] position as to the various provisions or explanation of its reasons for relying thereon.”

After trials on the nature and extent of the damages (liability was stipulated), the juries returned multi-million dollar verdicts in favor of the condo owners and associations and against the insured developer. Harleysville then filed a declaratory judgment action against the developer, seeking a declaration that it had no duty to indemnify the developer or, in the alternative, an allocation of which portion of the juries’ verdicts constituted covered damages and whether those portions were subject to a time-on-risk allocation. Although the Court acknowledged that the general verdicts in the underlying actions likely included some covered and some non-covered damages (e.g., costs for removing, repairing, or replacing faulty workmanship) the Court, found that Harleysville had waived the right to contest its liability for actual damages because Harleysville’s reservations in this regard were too generic and insufficient to preserve its rights to do so. The court stated that “[i]n general, the letters didn’t state the particular grounds on which Harleysville might dispute coverage; didn’t advise the policyholder of the need to allocate between covered and non-covered losses; and didn’t reference a possible conflict of interest or Harleysville’s intent to pursue a declaratory judgment action.”
While the Court’s decision contains a number of important rulings that pertain to construction defect coverage issues, the main take-away is that a reservation of rights letter cannot serve as a mere formality upon providing a defense to an insured. Rather, a reservation of rights letter must specifically articulate the insurer’s coverage positions and to notify a policyholder of potential conflicts. Failure to do so may function as a waiver of any such coverage defenses. Therefore, as a matter of best practices in all states, coverage position letters should not be so broad as to cover all potential coverage issues under the policy, but should be limited to the potential coverage issues in the matter at hand, and should clearly articulate how those potential coverage issues pertain to the present matter.

B. Lack of Detail in Reservation of Rights Letters Leads to Waiver Nightmare

In *Western Heritage Ins. Co. v. Love*, 24 F.Supp.3d 866 (W.D. Mo. 2014) *aff’d sub nom. W. Heritage Ins. Co. v. Asphalt Wizards*, 795 F.3d 832 (8th Cir. 2015), the federal court discussed insurance coverage for a TCPA/junk fax case. The insurer agreed to defend its insured under a reservation of rights, and initially issued a letter that contained a brief description of the underlying Complaint, the name of defense counsel and the policy’s limit of liability and deductible. Then, four years later, coverage counsel for the insurer sent the insured a twelve-page reservation of rights letter that contained what the Court characterized as a lengthy, detailed explanation of the insurer’s coverage position.

However, the *Asphalt Wizards* court held that the insurer waived its coverage defenses because it undertook the insured’s defense without any reservation of rights. The Court found that the initial letter issued at the time that the insurer appointed defense counsel did not constitute a “reservation of rights letter” as it did not provide any information beyond basic claim and policy information. Further, the subsequent letter, although substantively sufficient, was untimely and, therefore, ineffective. The Court found that, because the insurer knew or should have known from the initial pleadings that there were a number of applicable coverage defenses, yet waited several years before issuing a reservation of rights letter, the insurer “waived its ability to deny coverage under the Policies.”

In ruling so, the *Asphalt Wizards* court stated that “[a] typical reservation of rights letter does most, if not all, of the following: (1) identifies the policy at issue; (2) quotes, or at least refers to, the relevant policy provisions and identify any terms, conditions, or exclusions which may bar coverage; (3) refers to specific, relevant allegations in the complaint; (4) identifies which claims may not be covered; (5) explains in detail the basis for the insurer’s coverage position; (6) sets forth the proposed arrangement for providing a defense and, depending on the law of the jurisdiction, advises the insured of its right to independent defense counsel; (7) advises the insured of any actual or potential conflicts of interest between the insurer and the insured; (8) reserves the right to withdraw from the defense; (9) contains a general reservation of rights, including the right to assert other defenses the insurer may subsequently learn to exist during further investigation; and (10) uses the words ‘reservation of rights.’” (citations omitted).

Of note, however, the insurer did not waive its $1,000 per-claim deductible and the Court found that no class member involved in the suit had more than $1,000 in damages.

C. Ineffective Reservation of Rights Letter Leads to Bad Faith Nightmare

In the construction defect context, the Missouri Court of Appeals has ruled that a CGL carrier was estopped from denying coverage for a multi-million dollar construction defect suit against its insured because its coverage position letters were ineffective to preserve the insurer’s right to deny coverage because the letter were neither timely nor clear. The Court explained that the letters failed to “clearly and
unambiguously explain” how certain provisions of the applicable CGL policy triggered coverage issues with respect to the claims asserted against the insured and, in fact, did not actually explain anything or identify what coverage issues might exist. Advantage Buildings & Exteriors, Inc. v. Mid-Continent Cas. Co., 449 S.W.3rd 16 (Mo. Ct. App. 2014). Accordingly, the Court upheld the submission of a bad faith claim to the jury, even though the Court had previously found that the CGL policy at issue did not cover the claims in the underlying lawsuit.

By way of background, the insured, Advantage Buildings tendered its defense and indemnity to its CGL carrier after it was sued for property damage arising out of construction defects. The insurer sent its first coverage letter to its insured shortly after receiving notice, and stated that it “would investigate the claim and perform a coverage analysis” but “was reserving its right to assert that there may be no duty to defend or indemnify” against the claims asserted. Subsequently, the insurer sent a second purported reservation of rights letter, stating that it would conditionally defend the insured while reserving its rights.

About two years into the litigation, the insurer declined to settle the claims against its insured even though defense counsel recommended settlement. Then, only a few days before trial, the insurer sent a letter informing its insured for the first time that most of the $3M claim was not covered, and commenced declaratory judgment action on these newly-articulated coverage issues. The insured then settled with the third party plaintiff for only $500 and agreed to give it the proceeds of any award Advantage Buildings received from its Bad Faith claims against its insurer for failing to settle the underlying action within policy limits.

In a declaratory judgment action, it was determined that the insurer’s coverage position was correct in that most of the claims were not covered by the applicable policy. However, the bad faith claim proceeded to trial, and the insured obtained a judgment for $3M in actual damages and $2M in punitive damages. The insurer argued that there could be no bad faith because it defended the case and reserved its rights. The Court rejected this argument and found that the insurer’s initial coverage letter was not a "proper" reservation of rights, which must be both clear and timely, and the insured must fully understand the insurer’s position. "Defending an action with knowledge of non-coverage under a policy of liability insurance without a proper and effective reservation of rights in place will preclude the insurer from later denying liability due to non-coverage." There is a duty of good faith to settle claims against an insured. The elements to prove such a claim of bad faith failure to settle are:

1. the liability insurer has assumed control over negotiation, settlement, and legal proceedings brought against the insured;
2. the insured has demanded that the insurer settle the claim brought against the insured;
3. the insurer refuses to settle the claim within the liability limits of the policy; and
4. in so refusing, the insurer acts in bad faith, rather than negligently.

In sum, an insurer can still be found liable for bad faith for failure to settle a claim, even where coverage would not exist had the insurer properly reserved its rights under the applicable policy.

D. Reservation of Rights Letter Triggers Nightmare

Recently, an opinion issued in New Jersey set forth guidance on the issue of what is triggered when a reservation of rights letter is issued. In Northfield Insurance Company v. Ht. Hawley Insurance Company, 184 A. 3d 517 (N.J. Super. Ct. App. Div. 2018) the court issued a state-limited decision that if an insurer retains counsel and defends its insured pursuant to a reservation of rights, the insured must consent to such an arrangement. This practice is based upon the New Jersey Supreme Court’s landmark 1962 decision in
Merchants Insurance Corp. of NY v. Eggleston, 37 N.J. 114 (1962) wherein New Jersey courts opted to impose sanctions on insurers that failed to obtain their insured’s consent to being defended under a reservation of rights which was loss of the insurer’s ability to assert an otherwise applicable defense to coverage.

Eggleston has not been discussed since which left open a discussion on whether an insurer that defends its insured, under a reservation of rights, but without obtaining its insured’s consent, has automatically lost its coverage defenses -- or must the insured be prejudiced by the lack of consent.

Then, in a 2009 unpublished decision in Jose Nazario v. The Lobster House, Appellate Division Docket Nos. A-3025-07T1, A-3043-07T1, the appellate court concluded that loss of coverage defenses was automatic, with prejudice suffered by the insured not being a consideration. The court was clear: “We find nothing in Eggleston or its progeny which suggests that the insured must prove actual prejudice to create coverage, or that the carrier may prove lack of prejudice to avoid coverage by estoppel, when a fully informed written consent is lacking. The control of the litigation without proper consent equates to creating the coverage without qualification under Eggleston.”

Notwithstanding the ten-year-old precedent, the Northfield court held that an insurer who defends its insured, under a reservation of rights, but without obtaining consent, has not automatically abandoned its defenses. While Northfield v. Mt. Hawley involved a unique scenario, the opinion still concluded an insurer’s failure to follow Eggleston’s consent requirement did not automatically lead to an insurer’s loss of coverage defenses.

The underlying facts were the Empress Hotel, located near the ocean in Asbury Park, sustained roof damage as a result of Superstorm Sandy. Prior to the storm, CDA Roofing Consultants had performed roof work on the hotel. Empress and its insurer, Mt. Hawley Insurance Co., filed suit against CDA and its subcontractor, alleging CDA’s work allowed the damage to occur to roof.

CDA’s insurer was Northfield who advised CDA that, for a host of reasons, it was disclaiming coverage for the suit. Northfield, however, offered to provide CDA with a “courtesy defense” pursuant to a reservation of rights. Northfield later initiated a declaratory suit against CDA, seeking an ordered the insurer had no duty to defend or indemnify CDA in the Empress suit.

Mt. Hawley and Empress argued in the coverage action that Northfield was estopped from denying coverage for the claim against CDA because Northfield had violated the Eggleston rule by failing to properly seek CDA’s consent to its control of the defense. The trial court agreed with Mt. Hawley and granted its summary judgment.

The Appellate Division of New Jersey reversed in favor of Mt. Hawley. The court first addressed whether Northfield had complied with Eggleston by stating that it was “willing to provide” a courtesy defense. The court concluded for summary judgment purposes it was possible that “CDA’s failure to decline that ostensible favor justifies a finding that CDA acquiesced in Northfield’s control of the defense of the underlying action. . . . [T]he statement that a ‘courtesy defense’ would be provided might plausibly be interpreted as an offer of a defense, and not as the insurer’s insistence on controlling the defense. And, if interpreted as an offer, CDA’s following silence could be interpreted as acquiescence in Northfield’s control of the defense; such a circumstance would not offend Eggleston or its progeny.”

Other authors commenting on this case in various publications have opined the facts of the case involving a “willingness” to provide a “courtesy defense” are unique. But the New Jersey court rejected “the
argument that Eggleston permits avoidance of estoppel only if the insurer uses certain magic words in communicating with its insured.”

The more important aspect of the opinion is the court’s conclusion that, even if Northfield did not satisfy the Eggleston consent requirement, loss of its coverage defenses was not automatic. The court stated: “We reject Mt. Hawley’s argument and the motion judge’s determination that estoppel must always follow an insurer’s failure to fairly seek consent. Eggleston hardly supports such a view because waiver instead of estoppel was found implicated there. Eggleston in no way suggests that estoppel immediately attaches when an insurer, while reserving its rights or declining coverage, assumes control of the defense without first obtaining the insured’s consent.”

The court based its decision applying a summary judgment standard on two factors. First, estoppel precludes a party “from asserting rights which might perhaps have otherwise existed . . . as against another person, who has in good faith relied upon such conduct, and has been led thereby to change his position for the worse.”

Then, looking at the reliance test, the court explained: “First, it has not been shown that CDA relied on what Northfield wrote and changed its position to its detriment. The factual record suggests that CDA was defunct when Northfield declined coverage and assumed CDA’s defense. Consequently, one might ask what CDA would have otherwise done if it had rejected Northfield’s ‘courtesy defense.’ It certainly did not appear to be prepared to defend itself; no doubt CDA would have defaulted if Northfield had not provided a defense, just as CDA defaulted in this declaratory judgment action. So, it is fair to conclude — at least for summary judgment purposes — that CDA did not adjust its conduct one way or another when advised by Northfield that it would provide a ‘courtesy defense.’ In short, the evidence is inconclusive if not lacking at this time as to whether CDA detrimentally relied.”

The court also concluded there was no evidence to suggest Northfield acted with an intention or expectation that its actions would be acted upon by the other party: “The ‘other party’ — CDA — wasn’t ‘acting’ at all; it was moribund if not completely defunct at the time. Whatever Northfield did or would do in defense of the underlying action was not likely to cause injury to CDA regardless of the outcome.”

Commentary on the decision has pointed out CDA was defunct, which made it easier for the court to conclude CDA did not rely on Northfield’s actions and change its position to its detriment.

So in New Jersey, complying with Eggleston is advised for an insurer to proceed when retaining counsel and defending an insured under a reservation of rights. But for insurers that fail to do so, the Northfield case provides a different view.

II. Nightmares caused by Policy Interpretation

A. “Ongoing Operations” Deemed Ambiguous Causing Nightmares


In *Tri Star Theme Builders, Inc.*, the Ninth Circuit Court of Appeals, interpreting Arizona insurance law, held that the phrase "ongoing operations" in the context of an additional insured endorsement, was ambiguous. Tri Star, a purported additional insured under its plumbing and HVAC subcontractor’s insurance policy, sued the plumbing subcontractor’s insurer, OneBeacon, for failure to defend and indemnify Tri Star when it was sued by the owner of a project for purported design and construction defects, some of which stemmed from the HVAC and plumbing work. *Id.* at 508. The “Who Is An Insured” section of the policy included Tri-Star, but only with respect to liability arising out of the subcontractor’s ongoing operations performed for Tri-Star on the project, and only to the extent of liability resulting from occurrences arising out the subcontractor’s negligence. *Id.* OneBeacon contended that the damage alleged in the underlying lawsuit was not covered by the additional insured endorsement to the subcontractor’s policy, because it was only required to cover damages suffered while the subcontractor was performing work on the project. *Id.* The Ninth Circuit held that the key phrase, “arising out of the Named Insured’s ongoing operations,” in its plain meaning, addresses only the type of activity from which coverage may arise, not when the injury or damage must occur. *Id.* at 510. In other words, the provision did not state that injury must occur during the subcontractor’s operations, but rather must merely arise out of the subcontractor’s ongoing operations. *Id.* Because the court understood the provision to be ambiguous in that it could reasonably be construed in more than one sense, it determined the scope of coverage by considering the legislative goals, social policy, and the transaction as a whole. *Id.* at 513. It ultimately held that requiring coverage was consistent with the provision’s ordinary, plain meaning, the transaction as a whole, and the state’s policy of requiring insurers to utilize language that clearly and distinctly communicates to the insured the nature of the limitation. *Id.* at 514. Accordingly, the court concluded that OneBeacon was under a duty to defend and indemnify Tri-Star. *Id.*


In *Wausau Underwriters Ins. Co. v. Cincinnati Ins. Co.*, 198 Fed. Appx 148 (2nd Cir. 2006) (New York), Town Square, LLC and its insurer, Wausau Underwriters, Inc., sued Cincinnati Insurance Company, alleging that it had a duty to defend and indemnify Town Square as an additional insured under its policy with Masciarelli Construction, a construction company hired to plow and salt the Town Square’s parking lot during the winter of 2003, when it was sued by a patron that slipped and fell on ice in its parking lot. *Id.* at 149. The insurance contract provided coverage for an additional insured, such as Town Square, but only with respect to liability arising out of the construction company’s ongoing operations performed for Town Square. *Id.* Cincinnati argued that Town Square was not entitled to coverage as an additional insured under its policy with Masciarelli because the slip-and-fall did not arise out of Masciarelli’s “ongoing operations,” but rather occurred after Masciarelli had plowed and salted the lot. *Id.* at 149. The court rejected this narrow definition that “ongoing operations” only connotes actions currently in progress, such as active work. *Id.* at 150. Relying on Town Square’s contract with Masciarelli, which required Masciarelli to prevent standing water from freezing, the court concluded that the district court did not error in finding that the slip-and-fall accident qualified as a covered loss and that Town Square was an additional insured under Cincinnati’s policy with Masciarelli. *Id.* Accordingly, it held that Cincinnati was under a duty to indemnify Town Square and Wausau. *Id.*

B. “Caused in Whole or in Part” Definition Creates Nightmares

Other coverage interpretation nightmares include the interpretation of the phrase "caused in whole or in part". In *James G. Davis Const. Corp. v. Erie Ins. Exchange*, 126 A.3d 753 (Md. Ct. Sp. App. 2015), the Maryland Court of Special Appeals held that the phrase "caused in whole or in part" extended additional insured coverage beyond vicarious liability. The court explained that it was unreasonable to interpret the term "liability" as used in the 2004 version of the ISO standard form additional insured endorsement as
referring to "vicarious liability" because vicarious liability is an all or nothing proposition and thus a party could not be vicariously liable 'in part' for [the named insured's] acts.

In Burlington Ins. Co. v. NYC Transit Authority, 2017 WL 2427300 (N.Y. June 6, 2017), the New York Court of Appeals held that where an additional insured endorsement applies to bodily injury "caused, in whole or in part" by the "acts or omissions" of the named insured, the coverage applies to injury "proximately caused by the named insured." The court rejected the notion that liability "caused in whole or in part" was the equivalent to "but for" causation.

C. “Known Loss” Definition Creates Nightmares

Most primary level CGL policies contain an exclusion for coverage for known losses. The scope of this provision continues to be debated in the courts. In Arnett v. Mid-Continent Cas. Co., 2010 WL 2821981 (M.D. Fla. July 16, 2010), the policy's known loss provision barred coverage for damage known to the contractor but not damage unknown to the contractor. In Alkemade v. Quanta Indemnity Co., 2017 WL 1404708 (9th Cir. April 20, 2017), the Ninth Circuit Court of Appeals, applying Oregon law on a matter of first impression, determined the question of whether damage sustained after a repair is a continuation, change or resumption of known damage. The Court of Appeals found that where there were two possible reasons damage occurred after a repair (original construction or negligent repair), it was "plausible" to treat the new damage as distinct from – rather than a continuation, change or resumption of – the form damage.

D. “Lost Profits” as Property Damage Creates Nightmares

In Berry Plastics Corp. v. Illinois National Ins. Co., 903 F. 3d 630 (7th Cir. 2018), the Seventh Circuit addressed coverage for economic losses tied to an insured’s defective product and opened the doors for future lost profit. The court examined whether “property damage” includes lost profits associated with the insured’s customers products that were not damaged – or not even in existence. In other words, lost future profits.

The appeals court stated: “To make an obvious point first, lost profits are a form of business loss and as such are not the type of injury that the ordinary commercial general liability policy insures against. What an insurer like Illinois National undertakes to insure against in such a policy is property damage or bodily injury that results from the manufacturer’s product after it leaves the manufacturer’s hands, which represents a distinctly different form of risk from the disappointed commercial expectations of the manufacturer’s customer.”

But, in spite of this, the Seventh Circuit held coverage for lost future profits have the potential to be covered in factual scenarios that are not infrequent. The insured in Berry Plastics lost for a reason tied to the factual specifics of the case. The decision, generally speaking, is a win for policyholders.

The facts giving rise to this coverage issue are convoluted and complex. Berry manufactures plastic packaging products and produced a foil laminate product for Packgen. Packgen was developing, for its customer, CRI Catalyst Company, a container that could be used to store and ship a chemical catalyst CRI produced for use in the refining of crude oil. The foil layer of the container’s exterior surface was alleged to have failed. CRI cancelled its pending orders of containers. At the time of the failure, Packgen was selling over 1,200 containers per month. Packgen anticipated that production and sales level would continue in the future. Packgen had also made overtures to 37 petroleum refiners who had expressed interest in the containers for use in disposing of spent catalyst. Word of the product’s failure reached the oil refineries and as can be expected none of the 37 made any purchases from Packgen.
Packgen sued Berry. The jury awarded Packgen $7.2 million, which damages consisted of approximately $640,000 for unpaid invoices for containers that had already been shipped to CRI and awarded future lost profits of $6,560,000.

Berry sought coverage from its primary commercial general liability insurer, who paid its $1,000,000 limit. However, Berry’s excess insurer, Illinois National, refused. Berry filed suit.

The Seventh Circuit had no case law on point, and, therefore, surveyed case law from other jurisdictions and ultimately held the “damages for lost profits are not covered as ‘damages because of ... Property Damage’ unless they are a measure of the actual physical injury to tangible property or for the loss of use of the property. The profits Packgen lost on future sales of its [containers] did not constitute such a measure of physical injury or loss of property. Accordingly, the court was convinced that the Indiana Supreme Court would conclude Illinois National had no duty to indemnify Berry for those lost profits.”

The Seventh Circuit affirmed and concluded coverage could be owed, to an insured, for its liability for its customer’s lost future profits. The conclusion was tied to the policy’s insuring agreement: The insurer was obligated to “pay on behalf of [Berry] those sums in excess of the Retained Limit [i.e., the $1 million covered by the (primary) policy] that [Berry] becomes legally obligated to pay as damages by reason of liability imposed by law because of ... Property Damage ... to which this Insurance applies.” In particular, the decision was tied to the phrase “because of ‘property damage.’” The court concluded:

“An ordinary understanding of the phrase ‘because of’ would include a broad array of consequential damages, not simply those that constitute a measure of the injury to the property itself. . . . And to the extent that a causal connection can be shown between property damage and lost profits, nothing in the term ‘because of property damage’ suggests that such lost profits necessarily should be excluded. If the delamination of Berry’s defective product and the disintegration of a Packgen [container] had resulted in a fire that shut down CRI’s catalyst-manufacturing facility for a substantial period of time, for example, why should the profits and market share lost to CRI as a result of this incident not be considered a measure of the injury to CRI’s property, in the sense that it addresses the entirety of a loss CRI would not have suffered but for the concrete property damage that occurred?

Given that there is no language in Illinois National’s policy that on its face excludes any category of losses that are incurred ‘because of’ property damage, we are willing to assume, consistent with Berry’s argument, that the Indiana Supreme Court might well leave the door open to coverage of future losses, including lost profits and loss of goodwill, so long as the insured can establish a causal relationship between the property damage and those losses.”

The court provided examples of the distinction between potentially covered versus uncovered lost future profits. In general, did Berry’s component, sold to Packgen, cause property damage, such as a fire to CRI’s facility – for which lost future profits could then be covered? Or was the problem with the component discovered by CRI in testing, before property damage could take place? In that case, the lost future profits would not be covered, as they would be because of the failure of the product to perform as warranted.

III. Everyone’s Nightmare Jurisdiction: Florida

A. The Anti-Contribition Rule
Under Florida law, because each primary insurer’s duty to defend is a personal contractual obligation that does not inure to the benefit of another insurer, there is no right of contribution or equitable subrogation between primary insurers to recover the costs of defending a mutual insured. *Continental Cas. Co. v. United Pacific Ins. Co.*, 637 So. 2d 270 (Fla. 5th DCA 1994).

“The rationale for [the anti-contribution rule] is rooted in public policy: if insurers could sue each other for reimbursement, they ‘would have no incentive to settle and protect the interest of the insured, since another lawsuit would be forthcoming to resolve the coverage dispute between the insurance companies.’” *Zurich American Ins. Co. v. Amerisure Ins. Co.*, 2017 WL 366232, *5* (M.D. Fla. January 19, 2017) (citing *Argonaut Ins. Co. v. Maryland Cas. Co.*, 372 So. 2d 960, 964 (Fla. 3rd DCA 1979)). The anti-contribution rule was designed to de-incentive insurers from shirking their obligations to their insureds. *Id.*, at *5*, n.9 (citing *Pennsylvania Lumbermens Mut. Ins. Co. v. Indiana Lumbermens Mut. Ins. Co.*, 43 So.3d 182 (Fla. 4th DCA 2010)).

In *Pennsylvania Lumbermens*, one co-primary insurer defended its insured and reserved its rights to reimbursement of defense costs. Once a court determined that the insurer’s policy did not provide coverage, the insurer, through an assignment from the insured, sought to collect its defense costs from the co-primary insurer. The court refused to allow the first insurer to collect because it still had an independent contractual duty to defend their mutual insured. That purpose of the anti-contribution rule “would be frustrated if carriers could reopen the door to litigation through the legal fiction of obtaining their insureds' rights.” *Zurich American* at *5*, n.9.

**B. Florida Decisional Nightmares**

1. **Rip & Tear**

*Carithers v. Mid-Continent Cas. Co.*, 782 F.3d 1240 (11th Cir. 2015) is the first decision applying Florida law to hold that the costs associated with removing and replacing purely defective work is covered under a CGL policy when doing so is required to repair covered property damage. *See also Mid-Continent Cas. Co. v. Treace*, 186 So. 3d 11 (Fla. 5th DCA 2015)(upholding damages awarded for the cost to access and repair water damage caused by faulty construction).

Some argue that *Pavarini Construction Co. (Se) Inc. v. Ace American Ins. Co.*, 161 F.Supp.3d 1227 (S.D. Fla. 2015) may have expanded the scope of an insurer’s obligation for rip and tear damages. The court relied on *Carithers* and noted that “in order to adequately repair the non-defective project components, the building had to be stabilized. Even if the predominant objective … was to fix the instability caused by the defective subcontractor work, it is undisputed that the same effort was required to put an end to ongoing damage to otherwise non-defective property; e.g. damage to stucco, penthouse enclosure, and critical concrete structural elements.” *Pavarini* at 1234. In a footnote, citing *U.S. Fire Ins. Co. v. J.S.U.B., Inc.*, 979 So. 2d 871 (Fla. 2007), the court posts that a “natural corollary” to the proposition that coverage may exist for repairing structural damage caused by the defective work of subcontractors, is that coverage may also exist for “costs to repair defective work in order to prevent further structural damage and covered loss.” *Id.* at n.6.

2. **Florida Pleading for Policyholders**

a. **Four Corners**
In Voeller Const., Inc. v. S. Owners Ins. Co., No. 8:13-CV-3169-T-30MAP, 2014 WL 1779289 (M.D. Fla. May 5, 2014), the Middle District refused to consider extrinsic evidence (an affidavit) to create a duty to defend. The Middle District reasoned that cases discussing exceptions to the four corners rule “involve uncontroverted facts outside the allegations in the underlying complaint that refer to facts that take the case outside of the policy coverage, not those that bring the case within coverage.” Id. at *5.

Composite Structures, Inc. v. Cont'l Ins. Co., 560 Fed. App’x 861 (11th Cir. 2014) exemplifies the Voeller Court’s distinction that extrinsic evidence can only be used to negate a duty to defend, not to create one. In Composite Structures, the policy contained a Pollution Buy Back Endorsement which excluded coverage but contained an exception that applied if five conditions were met, including that the occurrence be reported in writing to the insurer within 30 days after having become known to the insured. Id. at 865. The Complaint was silent as to when the occurrence was reported in writing to the insurer, however, neither the insured nor the insurer disputed that notice was untimely under the exception to the pollution exclusion. Id. at 866. Relying on Higgins v. State Farm Fire & Cas. Co., 894 So. 2d 5 (Fla. 2004), the 11th Circuit held that it was proper to consider the uncontroverted date of written notice when determining its duty to defend because the date of written notice to the insurer was not a fact that would normally be alleged in the complaint and therefore, there was no duty to defend. Id. at 866. Additionally, the 11th Circuit held that Continental was not required to file a declaratory judgment action to rely on facts outside of the underlying complaint as a basis to deny coverage because doing so is permissive not compulsory and there were no facts in dispute. Id. at 866-7.

b. Pleading “Property Damage”

In Auto-Owners Insurance Company v. Elite Homes, Inc., 160 F.Supp.3d 1307 (M.D. Fla. 2016), aff’d, 676 Fed.Appx. 951 (11th Cir. 2017), the court found that the allegations of damage pertained solely to the home built by the insured and therefore were excluded under the Damage to Your Work Exclusion and Auto-Owners had no duty to defend the insured in the underlying action. Auto-Owners insured Elite Homes, Inc., the builder of the single-family residence. After the house was completed the windows leaked and after several failed repair attempts, the homeowners filed suit. Elite Homes at 1308. Auto-Owners defended and filed a declaratory judgment action. The underlying amended complaint alleged, in relevant part, that the water intrusion due to leaky windows caused:

• “extensive damage to other property includ[ing] the frame subsurface, sheathing, insulation, drywall, and interior finishes”;
• “damage to interior portions of the home”; and
• damage to other property including, but not limited to, exterior wood framing, wood substrate, vapor barriers, insulation, drywall, and interior finishes. Id. at 1312.

Auto-Owners argued that the allegations of damage relate solely to the home, all of which was the insured’s work as the builder. The court agreed. Specifically, the court found that, while the allegations include language such as “damage to other property,” “damage to interior portions of the home,” and “damage to other property including, but not limited to,” the claims related solely to the home’s structure itself, all constructed by the insured builder. Id. The underlying amended “contains no allegations of damage to personal property or property other than the home itself. Id. A complaint seeking damages for the repair and replacement of defective materials and/or defective work does not constitute “property damage” and therefore does not fall within the insuring agreement of the CGL policy and non-defense is required. Bradfield v. Mid-Continent Cas. Co., 143 F.Supp.3d 1215, 1237 (M.D. Fla. 2015).
In addition, the allegation of “damage to the interior portions of the home” is, on its face, an allegation of damage to the home. Elite Homes at 1312 (underlining in original). Such “buzz words” and conclusory allegations are insufficient to trigger the duty to defend. Id. See also J.B.D. Const., Inc. v. Mid-Continent Cas. Co., 571 Fed. Appx. 918 (11th Cir. 2014) (concluding that absent evidence of actual damage to the building, the vague reference to water intrusion points, not water damage, in the engineering reports is insufficient to create a genuine dispute that the work caused damage to other property).

IV. And Then You Woke Up

A. Bad Dreams and Bad Faith

The term “bad faith” has become symbolic with causing trauma for in-house counsel, headaches for defense attorneys and nightmares for claims professionals. Claims for bad faith involve hindsight and the question of whether a claim could have been handled better, faster, more efficiently or differently, all decided by Monday morning quarterbacks and is not where any insurer wants to find itself. Bad faith claims can be asserted in a variety of forms ranging from codified or statutory claims to common law tort and or breach of contract claims. It is jurisdiction dependent form your nightmare will manifest itself.

B. Bad Facts Make Bad Dreams

1. Company Carrier Behavior Creates Nightmares

Recently in Moore v. GEICO, 2018 U.S. App. LEXIS 35196 (11th Cir. Dec. 14, 2018), a court analyzed a claim of bad faith based upon an irregular factual scenario. A policyholder argued its insurer had acted in bad faith by not settling a claim. In support of its position, the policyholder pointed to the manner in which another insurer had handled and settled a claim, for another insured, arising from the similar facts.

The bad faith allegations in Moore arose from a serious motor vehicle accident. Joshua Moore and Richard Waters were involved in a road rage situation on a Florida highway. Waters was drunk and on drugs. Hand gestures were exchanged. Waters swerved into Moore’s vehicle. Moore lost control, crossed the median, and hit Amy Krupp’s car head-on with her ten year-old son in the vehicle. Krupp died. Her son sustained brain injuries. Waters went to prison.

Waters had a policy of insurance with Peak Insurance that offered only $10,000 in property damage coverage. Moore had coverage pursuant to his parents’ GEICO policy, which provided bodily injury coverage of $10,000 per person/$20,000 per occurrence and $10,000 in property damage coverage.

The Krupps hired counsel who made “essentially identical settlement offers to both Waters’ and Moore’s insurers: If, among other things, the insurer, within twenty-one days, paid claimants the full amount of available coverage, submitted a document for claimants to sign releasing only the insureds and provided affidavits from the insureds or their insurance agents swearing that there was no other available insurance, claimants would fully release the insureds from any further liability stemming from the accident.”

Waters’ insurer, Peak, complied with these conditions and the Krupps settled their claims against Waters.

GEICO proceeded on a different course. GEICO attempted settle, but the Krupps felt GEICO’s efforts inadequate, “primarily because (1) GEICO provided a form document that released, not only its insureds, but also ‘all officers, directors, agents or employees of the foregoing [named insureds], their heirs, executors,
administrators, agents, or assigns’, and (2) GEICO provided vague and incomprehensible affidavits from its insureds, the Moores, regarding the possible availability of additional insurance.”

The Krupps rejected GEICO’s efforts to settle their bodily injury claims and sued Moore. A jury returned a verdict of approximately $45 million in the Krupps’ favor and held Moore 10% responsible. As a result, the court entered judgment against Moore for over $4 million.

Moore initiated suit in federal court against GEICO wherein he asserted that, under Florida law, GEICO had acted in bad faith by its failure to settle with the Krupps within his coverage limits.

GEICO filed a motion in limine, which was denied. GEICO argued that, under Fed. R. Evid. 403, the district court prohibit Moore from “(1) ‘presenting evidence, testimony, or argument that the underlying claim ‘could’ have been settled, that [claimants were] willing to settle, or that GEICO had an opportunity to settle the underlying claim because [claimants] settled with PEAK’; and (2) ‘presenting evidence, testimony, or argument relating to PEAK’s handling of a claim against Waters.’”

During trial, “Moore frequently put on evidence and made argument that Peak was able to settle claimants’ property damage claim against its client for the property limits of that policy.” The jury found that GEICO had acted in bad faith.

Afterwards, during post-trial proceedings, the court ruled it had erred in allowing the jury to hear evidence of claimants’ settlement with Peak and the manner in which Peak’s carrier had handled its claim. A new trial ensued in which GEICO prevailed. Moore appealed on the issue of the admissibility of Peak’s handling of the claim.

The Eleventh Circuit affirmed the decision that the Peak settlement and facts related to same were inadmissible. The court explained Rule 403 provides “[t]he court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.”

The court further explained: “Evidence of claimants’ settlement with Peak certainly had some probative value. The manner in which Peak handled the claims against its insured was probative, at a minimum, to counter GEICO’s evidence that it could not understand claimants’ settlement conditions, which were the same for both insurers. Evidence of Peak’s claims handling also bolstered Moore’s expert’s testimony as to the insurance industry’s custom and practice in handling claims of catastrophic injuries. Moreover, the fact that claimants settled with Peak was relevant to counter GEICO’s argument that claimants never intended to settle their claims for the minimal insurance coverage available.

The probative value of this evidence was diminished because the claim Peak settled was not identical nor even substantially similar to the claim GEICO was handling. Peak’s insured had only property damage coverage and, between that coverage and the property damage coverage that GEICO provided its insured Moore, there was no likelihood that claimants’ property damage claims would exceed that available coverage. GEICO, on the other hand, provided its insured, Moore, not only property damage coverage, but also bodily injury coverage. The amount of that bodily injury coverage, however, was minimal. Faced with catastrophic bodily injury claims, there was a clear possibility of a bodily injury judgment
against Moore that would far exceed his coverage. The claims Peak settled, then, were significantly different from the claims GEICO was handling.

2. Even Without Bad Faith, Excess Judgments May be Covered

In Century Insurance Company v. Dana Andrew, 134 Nev. Adv. Op 100 (December 12, 2018), the Supreme Court of Nevada held that although the insurer breached its duty to defend, it had not done so in bad faith. Regardless, the court still concluded the insurer could be liable for a judgment in excess of its policy limit.

The Andrew case grew out of a motor vehicle accident. Michael Vasquez used his truck for personal use and for his mobile auto detailing business, Blue Streak Auto Detailing, LLC. Vasquez struck Ryan Pretner, causing significant brain injuries. Blue Streak was insured pursuant to a commercial liability policy issued by Century Surety Company with a limit of $1 million.

Century Surety investigated and concluded that Vasquez was not driving in the course and scope of his employment with Blue Streak when the accident occurred. On that basis, Century rejected a demand to settle the claim within the policy limit. Pretner filed suit, alleging Vasquez was in fact driving in the course and scope of his employment. Interestingly, Century refused to defend Blue Streak. Vasquez and Blue Streak defaulted. Century, while aware of the default, continued to maintain the reinsurer’s coverage.

Vasquez and Blue Streak entered into an agreement with Pretner not to execute a judgment against them. Blue Streak assigned its rights against Century to Pretner. The court entered a default judgment against Vasquez and Blue Streak for $18,050,183. The court’s findings of fact stated that “Vasquez negligently injured Pretner, that Vasquez was working in the course and scope of his employment with Blue Streak at the time, and that consequently Blue Streak was also liable.”

As an assignee of Blue Streak, Pretner filed suit against Century for breach of contract, breach of the implied covenant of good faith and fair dealing and unfair claims practices.

The federal court concluded Century breached its duty to defend Blue Steak, but such breach was not in bad faith. The court went back and forth on whether Century’s liability was capped at its $1,000,000 limit plus the defense costs incurred by Blue Streak (of which there were none). The court concluded that bad faith was not a requirement to hold Century liable in excess of the policy limit. However, the court stayed its decision in order to certify the question to the Supreme Court of Nevada.

The Nevada Court concluded that, even in the absence of bad faith, an insurer may be liable for a judgment that exceeds the policy limits—“if the judgment is consequential to the insurer’s breach.” In coming to this conclusion, the court observed it was adopting the minority view, with the majority rule being that an insurer’s liability, for a non-faith breach of the duty to defend, is capped at its policy limit plus the insured’s defense costs.

The court’s rationale for adopting the minority rule, was that “[u]nlike the minority view, the majority view places an artificial limit to the insurer’s liability within the policy limits for a breach of its duty to defend. That limit is based on the insurer’s duty to indemnify but a duty to defend limited to and coextensive with the duty to indemnify would be essentially meaningless; insureds pay a premium for what is partly litigation insurance designed to protect . . . the insured from the expense of defending suits brought against him.”
The *Andrew* court was quick to point out the insurer’s excess liability was not automatic: “However, we are not saying that an entire judgment is automatically a consequence of an insurer’s breach of its duty to defend; rather, the insured is tasked with showing that the breach caused the excess judgment and is obligated to take all reasonable means to protect himself and mitigate his damages.”

The court’s opinion suggests an insurer is more likely to be faced with an excess judgment when its insured is faced with defending a lawsuit, on its own, but cannot afford a lawyer. Here, any default judgment, and consequent settlement over the limits, would be more likely to have been caused by the breach of the duty to defend. As the court further explained, compare this to an insured that can afford to mount a defense -- and it is as good as one that the insurer would have provided. In such case, the entire judgment would not be consequential to the insurer’s breach of the duty to defend. Thus, the insurer’s liability should be capped at the policy limit.

3. **Even When Pay Can Be Found in Bad Faith**

In *Higginbotham v. Liberty Ins. Corp.*., No. 18-747 (W.E. Pa. Nov. 27, 2018), the insurer defended its insured under a reservation of rights, litigated coverage and then settled the claim. The Pennsylvania federal court concluded the insurer could still be in bad faith.

At issue was coverage for Erica Higginbotham, pursuant to a homeowner’s policy, for claims arising out of sexual abuse by her father-in-law of children whom Higginbotham was babysitting. In particular, Higginbotham was sued for negligent supervision of the children and failing to recognize the risk that her father-in-law posed.

The homeowner’s insurer, Liberty Insurance, undertook Higginbotham’s defense pursuant to a reservation of rights and cited several exclusions. Liberty and Higginbotham both filed a declaratory judgment action on the issue of whether coverage was owed for defense and any liability. Liberty filed in federal court while Higginbotham filed in state court. The federal court declined jurisdiction because of state action so Liberty filed a counterclaim in the state action. Liberty’s motion for judgment on the pleadings was denied. An appeal to the Pennsylvania Superior Court was quashed. The underlying action was settled by Liberty and the state court declaratory judgment action was then over.

Higginbotham filed a complaint against Liberty, in Pennsylvania state court, asserting a claim for statutory bad faith and contractual bad faith. Liberty removed the bad faith action to federal court and filed a motion for judgment on the pleadings. The court denied the motion with respect to both the contractual bad faith claim and statutory bad faith claim.

Liberty argued “that it was entitled to judgment on the pleadings because it did not act in bad faith (1) by filing the federal action and a counterclaim in the state action while providing Higginbotham with a defense in the underlying lawsuit, or (2) in its handling of the issues surrounding the underlying litigation. In her response, Higginbotham argues that Liberty’s issuance of a ‘manipulative’ reservation of rights and use of the courts to delay resolution of the underlying litigation in order to ‘improve its negotiating position,’ was done in bad faith, and caused her to suffer emotional distress and bodily harm and to incur legal expenses to defend herself against Liberty’s unfounded declaratory judgment actions.”

On the contractual bad faith claim, the court noted “Pennsylvania Supreme Court precedent allows the insurer to defend subject to a reservation of rights [and] . . . applicable case law encourages insurers to file declaratory judgment actions.” While Liberty did both of these things, the Court refused to hold it was insulated from the possibility of bad faith: “It is undisputed that Liberty investigated the underlying lawsuit.
once the complaint was brought to its attention; that Liberty provided Higginbotham with counsel, subject to reservation of rights; that Higginbotham chose to hire private counsel to litigate Liberty’s declaratory judgment motions; and that the underlying lawsuit was ultimately settled. However, the thoroughness of that investigation, applicability of the exclusions relied upon by Liberty, and propriety of delaying settlement for two years to actively pursue declaratory relief against its insured present unsettled questions of fact. Viewing the evidence in the light most favorable to Higginbotham, a reasonable jury could find that Liberty’s actions, in the aggregate, constituted a bad faith breach of its contractual duties to Higginbotham, and could lead that jury to return a verdict in her favor.”

On the statutory bad faith claim -- 42 Pa.C.S. § 8371 – the court concluded that the “focus in section 8371 claims cannot be on whether the insurer ultimately fulfilled its policy obligations, since if that were the case then insurers could act in bad faith throughout the entire pendency of the claim process, but avoid any liability under section 8371 by paying the claim at the end.... [T]he issue in connection with section 8371 claims is the manner in which insurers discharge their duties of good faith and fair dealing during the pendency of an insurance claim, not whether the claim is eventually paid.”

Clearly, the court was unwilling to rule there was no possibility of bad faith: “The allegations in the pleadings demonstrate that there are outstanding material issues of fact which could lead a reasonable jury to conclude that Liberty’s investigation and claim-handling was motivated by its own self-interest, and in bad faith, regardless of the fact that the claim was ultimately paid.”