

THARPE & HOWELL, LLP

INSURANCE DEFENSE NEWSLETTER

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This informational Newsletter is brought to you by Timothy D. Lake, a Partner of Tharpe & Howell and Chair of its Insurance Coverage and Bad Faith Practice Group. Please feel free to contact "Tim" at tlake@tharpe-howell.com; or telephone number (818) 205-9955 to discuss any questions or comments you might have.

ADMINISTRATIVE PROCEEDINGS ARE SOMETIMES "SUITS" REQUIRING COVERAGE

In the case of *Ameron v. Insurance Company of Pennsylvania*, the California Supreme Court recently held that when the word "suit" is not specifically defined in a CGL form policy of insurance – an "administrative proceeding" may sometimes be equivalent to a covered "suit."

In this case, Ameron was hired to manufacture piping to be used in a project contracted by the United States Department of Interior's Bureau of Reclamation ("the Bureau"). The Bureau subsequently claimed the piping was defective and issued an order requiring Ameron (and others) to pay millions in damages to the Bureau. Ameron appealed the Bureau's order by filing a "complaint;" and the Bureau filed an "answer" which set forth a simple, concise and direct statement of each claim made. A hearing on the matter was held before a Federal Administrative Law Judge and lasted 22 days. Eventually, the Bureau and Ameron settled – with Ameron paying the Bureau a significant amount.

Ameron was insured under various policies of insurance – some of which had been issued prior to 1986. Various policies defined the word "suit" - while others did not. Although Ameron had timely tendered the matter to its insurance carriers, only one agreed to defend. The non-participating carriers claimed no coverage existed because the "administrative proceeding" did not constitute a (law) "suit."

Ameron filed an action for bad faith against non-participating insurers for their failure to defend. The Superior Court determined the administrative proceeding was not a "suit" under the terms of any of the policies and sustained the carriers' demurrers to plaintiff's complaint.

The Appellate Court reversed and remanded the case back to the Superior Court with respect to the policies which **did** define the word "suit" (or which included an obligation to indemnify for money other than "damages"). With regard to the policies that did **not** define the word "suit" – it affirmed the Trial Court's ruling. Ameron filed a Petition for Review in relation to this adverse portion of the Appellate Court's ruling. Accordingly, the only policies analyzed by the Supreme Court were those that did **not** define the word "suit."

The California Supreme Court determined that when a policy **does not** specifically define the word "suit" - a "suit" is a court proceeding initiated by the filing of a complaint. It noted that in this case, Ameron filed a "complaint" and the Bureau filed an "answer" – and the matter was heard before an Administrative Law Judge. Accordingly, it found coverage **did exist** under the policies in which the word "suit" had not been specifically defined.

Carriers and their insureds who conduct business in California should keep this extremely important ruling in mind. Essentially this decision holds that sometimes, (but not always), coverage may exist for "administrative proceeding" types of claims.

DEPENDING ON POLICY LANGUAGE, EACH HOME MAY NOT CONSTITUTE A SEPARATE CLAIM

In *Clarendon America Insurance Company (“Clarendon”) v. North American Capacity Insurance Company (“NAC”)*, Clarendon sued NAC for declaratory relief and equitable contribution in relation to a construction defect action filed against their mutual insured, Tanamera Homes and Resort Communities (“Tanamera”). Tanamera had planned to develop a residential community known as Shenandoah at Eagle Ranch, but only 8 of the homes were completed after the NAC policy went into effect. Tanamera was subsequently sued by 43 homeowners, and Clarendon picked up its defense.

NAC claimed it had no duty to participate in the action until the insured had expended a total of \$200,000 - equaling a \$25,000 self-insured retention for **each** of the 8 homes built after the its policy went into effect. Clarendon settled the claim on behalf of Tanamera and then sued NAC for contribution.

Clarendon argued the \$25,000 SIR in the NAC policy applied only one time to the construction defect action as a whole, and not to each of the eight allegedly defective homes covered by the NAC policy. NAC filed a Motion for Summary Judgment arguing that its duty to defend never arose because Tanamera never paid the \$200,000 (representing the \$25,000 “per claim” SIR for *each* of the 8 homes involved). The Trial Court ruled in favor of NAC and Clarendon appealed.

The Court of Appeal ruled in favor of Clarendon, finding that the NAC policy was ambiguous as to the term “claim,” and that varying conclusions could be reached as to whether a suit involving many homes could represent a single claim. It noted that the underlying policy had a \$2 Million limit and potentially covered 450 homes. If Tanamera was required to pay a \$25,000 SIR for each home in the event of a catastrophic loss - over \$11 million would be required; and that this was in addition to the \$400,000 in policy premiums paid.

The Court found that, based on the ambiguous language contained within the NAC policy as it relates to the definitions of “claims” and “suits,” and in light of the total, potential SIR requirement set forth above, the insured could have reasonably expected to pay only one \$25,000 SIR payment in relation to a multi-home case.

CALIFORNIA FEDERAL COURT UPHOLDS ANTI-MONTROSE LANGUAGE IN CGL POLICY

In *PMA Capital Insurance Company v. American Safety Indemnity Company*, a California District Court recently ruled on an anti-Montrose provision in a CGL policy, upholding limiting language that triggers coverage only when both the occurrence of the event that leads to the property damage **and** the property damage itself occur during the policy period.

The facts are simple. A subcontractor was issued insurance policies by PMA and ASIC over separate policy periods. Before the ASIC policy was issued, the subcontractor performed work at a construction project which was later involved in a lawsuit. The subcontractor was sued by the owners for alleged construction defects. PMA took up the defense of the subcontractor however ASIC declined coverage. Subsequently, PMA paid for the defense and paid out the indemnity on behalf of its subcontractor insured.

PMA then sued ASIC for equitable contribution for the defense and indemnity it incurred. ASIC argued an endorsement to the ASIC policy provided coverage only when both the occurrence **and** the property damage occur during the policy period. Specifically, an endorsement limited the occurrence language as follows:

“Occurrence means an accident, including continuous or repeated exposure to substantially the same general harmful conditions that happens during the term of this insurance.” (Emphasis added.)

It also noted that another exclusion provided:

*“This insurance does not apply to any occurrence, incident, or suit, whether known or unknown, to any officer of the named insured, **which first occurred prior to the inception date of the policy** or which is, or is alleged to be, in the process of occurring as of the inception date of this policy, **even if the occurrence continues during this policy period.**”* (Emphasis added.)

The Court analyzed the two above-cited policy provisions and held that any occurrence that led to property damage prior to the inception of the ASIC was effectively excluded. Accordingly, by this ruling, the California Federal Court upheld these anti-Montrose provisions - limiting triggers of coverage where both the occurrence and damage must occur during the policy period.

INTENTIONAL ACT OF ONE INSURED MAY NOT EXCLUDE COVERAGE FOR OTHER INSUREDS

In *Minkler v. Safeco Insurance Company*, the California Supreme Court recently held that where a contract for liability insurance covering multiple insureds **contains a severability clause**, an intentional acts exclusion as to one insured may **not** automatically bar coverage for another insured (who did not perform the intentional act).

In this case, “David” was sued for allegedly molesting Scott – who was then a minor. The Complaint also named David’s mother Betty as a defendant alleging that, among other things, some of the acts of molestation occurred in Betty’s home, and as a result of Betty’s negligent supervision. Betty was the named insured under a series of homeowners’ policies issued by Safeco Insurance Company of America (Safeco), and David was an additional insured.

The policies’ liability coverage provisions promised to defend and indemnify, within policy limits, “an” insured for personal injury or property damage arising from a covered “occurrence,” but **specifically excluded** coverage for injury that was “expected or intended” by “an” insured, or was the foreseeable result of “an” insured’s intentional act. [In California, it has long been held that, absent contrary evidence, in a policy with multiple insureds, exclusions from coverage described with reference to the acts of “an” or “any,” as opposed to “the,” insured are deemed to apply collectively, so that if one insured is excluded for committing an intentional act, the exclusion applies to all insureds with respect to the same occurrence.]

However, as is often the case, the policies at issue herein also contained a severability-of-interests or “separate insurance” clause providing that “[t]his insurance applies separately to each insured.” Accordingly, the question before the Court was whether such a clause established an exception to the rule described above, and whether Betty was barred from coverage only if her *own* conduct fell within the policies’ exclusion of intentional acts.

The California Supreme Court held that in light of the severability provisions contained in Betty’s policies, the exclusion of coverage for injuries arising from “an” insured’s intentional acts **did not** preclude coverage for Betty’s liability, if any, arising from the molestations for the sole reason that *David*, another insured under the policies, had allegedly committed intentional, and thus excludable, acts. The Court found that instead, Betty’s coverage must be analyzed on the basis of whether *she herself* committed an act or acts that fell within the intentional act exclusion. Accordingly, the California Supreme Court held that Betty was not excluded from coverage for David’s alleged intentional acts.

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DISABILITY/DISEMBLEMENT POLICY PROVISIONS UPHOLD BY U.S. COURT OF APPEALS

In *Robert Fier v. Unum Life Insurance Company of America*, plaintiff Fier appealed a District Court’s denial of benefits under two insurance policies issued by Unum. Fier had two Unum policies: a Group Long Term Disability Policy (the LTD policy) and a Group Life and Accidental Death and Dismemberment Insurance Policy (the AD&D policy).

In 1992, a drunk person shot Fier in the throat at a hunting lodge in Utah. The shot severed Fier’s spinal cord at the C6 level, leaving him permanently quadriplegic. However Fier was able to return to work at The Boyd Group in early 1993, where he earned the same salary he had received before the accident but in a new position tailored to accommodate his physical limitations. In 1997, The Boyd Group assigned Fier to a new position and reduced his salary by \$20,000. In 1998, Fier began working elsewhere where he earned a salary comparable to what he had received before the accident occurred.

In March of 1997, Fier submitted a claim for benefits under the Unum LTD policy. Between 1997 and 2004, Unum paid Fier a total of \$152,069.02. In late 2004, however, Unum informed Fier his claim had not been payable **since 1998** - when Fier’s earnings increased to his pre-injury level. Unum stated Fier was ineligible for benefits under the “Termination of Disability Benefits” provision contained within the LTD policy which provided the disability benefits “would cease on the earliest of: (1) the date the insured is no longer disabled; (2) the date the insured dies; (3) the end of the maximum benefit period; (4) the date the insured’s current earnings exceed 80% of his pre-disability earnings.”

Fier filed suit against Unum in the District of Nevada for backpay of benefits from 1993 to 1997 and for a declaratory finding that he was entitled to continuing benefit payments. He also claimed entitlement to benefits under the “dismemberment by severance” provision contained in the AD&D policy – arguing that the “severance” of his spinal cord had caused him to essentially lose function of his hands and feet.

The District Court ruled in favor of Unum and found Fier was ineligible for benefits from 1993 to 1997, and from 1998 onward, when his income exceeded 80% of his pre-injury earnings. It also rejected Fier’s claim for benefits under the AD&D policy, concluding he was ineligible because his hands and feet were not physically severed from his body. [Although Unum had counter-sued for reimbursement of appx. \$140,000 in alleged overpayments under the LTD policy, the District Court found Unum did not establish entitlement to reimbursement and Unum did not appeal that ruling.] Fier appealed.

The United States Court of Appeal upheld the District Court’s ruling by determining that the LTD’s policy provision entitled “Termination of Disability Benefits” plainly stated that the disability benefits would cease when Mr. Fier’s earnings exceeded 80% of his pre-disability earnings; and that the AD&D policy specifically held that “dismemberment by severance” means the actual detachment of limbs from the body at or above the wrist or ankle joint.

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