Understanding General Liability Coverage: A Primer for Construction Lawyers

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I. Introduction

Insurance plays a critical role on every construction project of any size or complexity. Insurance is the primary third-party risk transfer mechanism used in construction. While the parties’ contract is the primary vehicle for allocating risks and defining rights and responsibilities, insurance plays a pivotal role in covering certain potential losses that no party can comfortably bear alone. Elsewhere, I attempted an assessment of the degree to which the standard insurance package covered the risks associated with the design and construction process. This was, at best, a crude attempt, but it yielded some interesting, albeit rough, conclusions.² Of the some 200 separate project risks identified, approximately one-third were amenable to management to some degree through the standard project insurance program.³

One can certainly quibble with this conclusion, but it does point out that insurance plays a vital role in today’s construction industry. Construction lawyers are well-served to understand how insurance responds to the various losses or injury that might be encountered when designing and constructing a project. Most insurance coverage controversies involve damage to property, including associated economic loss. Injuries to persons, whether workers or others, raise fewer coverage issues. As a consequence, this article focuses on coverage for injury to property rather than people. Yet the focus is more narrow than exploring insurance for

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²See Bruner & O’Connor on Construction Law, §§ 7:15 to 7:17 and 7:247 (West Group 2002).

³Bruner & O’Connor on Construction Law, § 7:15 (West Group 2002). The standard insurance program I had in mind was that called for under the American Institute of Architect’s General Conditions Document (A201), assuming coverage limits. See Bruner & O’Connor on Construction Law, § 7:16 (West Group 2002).
property loss. The main vehicle for covering property loss on most construction projects is a property policy written on a builder's risk form. Property policies, as first-party coverage, respond to losses in a much different fashion than third-party liability policies. While property coverage is perhaps the primary vehicle for insuring against property loss, it is not the focus of this article. Instead, this article analyzes third-party coverage and, in particular, general liability insurance.

Unlike property policies, the commercial general liability (CGL) policy is written on a standard form provided by Insurance Services Office, Inc. (ISO). While the CGL policy may be amended by way of endorsement, this occurs less with these policies than first-party property coverage. One might conclude that, given the relatively standardized format, court decisions interpreting CGL policies would follow a predictable pattern and display a fair degree of uniformity from jurisdiction to jurisdiction. Alas, such is not the case. Notwithstanding the fact that most CGL policies contain similar, if not identical, language, the court decisions are a scattered lot. The primary purpose of this paper is to provide some guidance to the practitioner as he or she navigates through this judicial thicket.

II. Interpretation of Policy Language

A. Analytical Conflict: Role of Extrinsic Evidence

There is conflict over interpreting insurance policies. Courts routinely state that they approach interpreting insurance policies no differently than any other contract language. It is not unusual for a court to begin its analysis with a statement to the effect that its “primary objective in construing the language of an insurance policy is to ascertain and give effect to the intentions of the parties as expressed by the language of the policy.”

Consistent with common contract interpretation analysis, courts often seek intent through one or more standard interpretation rules, including: (1) words and phrases are to be construed using their plain and ordinary meaning, unless the words have acquired a technical meaning; (2) policy language should not be interpreted in an unreasonable or strained manner to enlarge or restrict provisions beyond what is reasonably contemplated by the language;

like any contract, an insurance policy is to be construed as a whole, giving effect to every provision, if possible, because it must be assumed that every provision was intended to serve a purpose; and (4) where the language of an insurance policy is clear, courts lack the authority to change or alter its terms under the guise of interpretation.  

Insurance policies, however, are seldom individually negotiated and drafted. Instead, they are written on standard contract forms and frequently procured through the use of intermediaries, such as insurance agents or brokers. Because parties seldom have direct negotiations, if they reach mutual understanding over policy language, it is often by chance. Indeed, it is not uncommon for the insured to forego reading anything other than the declarations page and rely upon the statements of an agent or broker with respect to the extent of coverage. In this regard, the judiciary's professed aim of seeking the parties' intention is more fiction than reality.

A host of additional contract interpretation rules come into play in the event a court's analysis fails to achieve one clear and reasonable meaning. The most prevalent of these rules holds ambiguities are to be construed against the insurer and in favor of coverage. Notwithstanding a professional desire to determine intention, it is unusual for courts to go exploring for extrinsic ev-

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6See, Dimmitt Chevrolet, Inc. v. Southeastern Fidelity Ins. Corp., 636 So. 2d 700, 702, 37 Env't. Rep. Cas. (BNA) 1006 (Fla. 1993) (explaining that CGL policies are “standard insurance policies developed by insurance industry trade associations, and these policies are the primary form of commercial insurance coverage obtained by business throughout the country.”) See also, 21 Eric Mills Holmes, Holmes’ Appleman on Insurance, 2d § 129.1 at 7 (2002) (explaining that the first standard form comprehensive general liability insurance policy, now referred to as a commercial general liability insurance policy, was drafted by the industry in 1940 as a part of a voluntary effort to address misunderstanding, coverage disputes, and litigation resulting from unique language used by each liability insurer).

7But see, Rodless Properties, L.P. v. Westchester Fire Ins. Co., 40 A.D.3d 253, 835 N.Y.S.2d 154 (1st Dep't 2007), leave to appeal denied, 9 N.Y.3d 815, 849 N.Y.S.2d 31, 879 N.E.2d 171 (2007) (construed against the insurer rule would not be applied where the real party in interest is an insurance company, which was seeking contribution in the name of its insured, rather than the insured in its individual capacity).
idence to resolve ambiguities in policy language. In Continental Cas. Co. v. Employers Ins. Co. of Wausau,\(^8\) the per-occurrence coverage limit of $2,500,000 was interpreted to apply over the entire period of the three-year policy, rather than as three separate annual limits. The policy did not expressly state that the coverage limit applied on an annual basis and the court declined to entertain extrinsic evidence as to the industry’s trade and custom on such matters.\(^9\)

The normal course is for the court to simply construe the ambiguity against the insurer as the drafter of the contract. The contra proferentem rule is not triggered merely because the insured claims to have a different interpretation than the insurer. For this rule to apply, the insurance policy must be not only susceptible to two or more interpretations, but also each of the alternative interpretations must be reasonable. In McGuire v. American Southern Home Ins. Co.,\(^10\) the court was unpersuaded by the claim that a homeowner’s policy provided coverage for wind damage notwithstanding a “wind storm or hail exclusion,” because the policy conditioned the exclusion upon the receipt of a “premium credit” which was not listed on the policy’s declarations page. Nowhere did the policy expressly state that the credit had to appear on the declarations page and there was no factual dispute that the insured was not charged for wind coverage.

An insured’s argument that a policy sublimit was additional protection beyond the primary insurance limit rather than a further limitation on coverage was rejected as unreasonable in First Centrum Corp. v. Landmark Am. Ins. Co.\(^11\) The property policy provided a $3,421,000 scheduled limit for insured’s property that was destroyed by fire. The primary policy also contained

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\(^{8}\) Continental Cas. Co. v. Employers Ins. Co. of Wausau, 16 Misc. 3d 223, 839 N.Y.S.2d 403 (Sup 2007).

\(^{9}\) See also, Maryland Cas. Co. v. W.R. Grace & Co., 1996 WL 169326 (S.D. N.Y. 1996) (court declined to use evidence of alleged industry trade and custom to void the terms of the subject insurance policy, which did not specify annual aggregate limits, unlike another policy that did). But see, Parks Real Estate Purchasing Group v. St. Paul Fire and Marine Ins. Co., 472 F.3d 33 (2d Cir. 2006) (New York law requires court to consider extrinsic evidence before applying the contra proferentem rule and finding the term “contamination” in a property policy ambiguous and, therefore, reversing judgment in favor of insurer and remanding to trial court to allow parties to introduce evidence of what was intended by the use of the ambiguous term).


“ordinance or law” coverage providing $2.5 million for any undamaged portions of the insured’s properties that an ordinance or law required be demolished. The insured claimed that the ordinance or law sublimit of $2.5 million was additional insurance for its loss. The court was unpersuaded.

The logical consequence of plaintiff’s argument is to undermine the entire nature of the policies. As the district court noted, by claiming the Ordinance or Law coverage was a sub-limit of the overall policy value of $356,126,250, First Centrum essentially argues that the endorsement language “transformed the policy from a scheduled policy to a blanket policy.” As opposed to a scheduled policy, which states coverage limits for each insured property, a policy that “allocates an overall limit to the policy” is by definition a blanket policy. It is clear, however, that the policies in question are scheduled, not blanket, policies. The 2003 primary policy states that it provided coverage on a “per occurrence, scheduled limits” basis, while the 2004 binders state that they are “per occurrence/scheduled limits (NOT BLANKET).” The policies included voluminous Limit Schedules setting forth the liability limit for each property. Thus, plaintiff’s reading of the contracts is contravened by their very language and architecture. It is, as the district court stated, simply an “attempt to obfuscate the clear language of the agreement.”

B. Illusory Coverage

The doctrine of “illusory coverage” has been used to defeat otherwise clear policy language that results in a denial of coverage. This interpretation theory rests on the principle that the insurer’s argument “proves too much.” The language, if interpreted as proffered by the insurer, essentially denies the insured most if not all of a promised benefit. If, however, the insurer can demonstrate that the terms of the policy still provide a meaningful benefit to the insured, while barring coverage in the particular instance, the “illusory” argument fails. This was the case in St. Mary’s Area Water Auth. v. St. Paul Fire & Marine Ins. Co., where the insurer was able to come up with two instances where payment was made pursuant to the mechanical breakdown coverage endorsement as the corrosion and inherent defect exclusions did not otherwise apply:

In its motion for reconsideration, Defendant argues we clearly erred in concluding that mechanical breakdown could not occur in the absence of a defect or corrosion. In support, it submits the affidavit


of George Dickover, an adjuster for the Travelers Indemnity Company. For the first time in this litigation, the affidavit sets forth four examples of coverage under the mechanical breakdown endorsement which do not involve defect or corrosion. Here, we are trying to determine if the mechanical breakdown endorsement provides coverage for risks other than corrosion or defect, and the first and third risks defendant insurer has described provide evidentiary support for defeating Plaintiff’s claim of illusory coverage. As noted, we did decide that Defendant would have to show coverage for only one risk to establish that mechanical breakdown coverage was not illusory. Defendant has provided us with two of them.  

C. Reasonable Expectations Doctrine

Another device used by insureds to wrest coverage from language that otherwise suggests none exists is the “reasonable expectations” doctrine. Some jurisdictions require some hint of ambiguity before applying the doctrine. Others are more lenient. Iowa recognizes the reasonable expectations doctrine but does not expressly require an ambiguity:

An insured may utilize the doctrine of reasonable expectations to avoid an exclusion that “(1) is bizarre or oppressive, (2) eviscerates a term to which the parties have explicitly agreed, or (3) eliminates the dominant purpose of the policy. However, in order for the doctrine to apply, the insured must show “circumstances attributable to the insurer that fostered coverage expectations’ or that ‘the policy is such that an ordinary layperson would misunderstand its coverage.”

Plaintiff’s second argument, that it reasonably expected that the mechanical breakdown endorsement would cover losses caused by defects because defects are intrinsic to mechanical breakdown, lacks merit because the insured’s reasonable expectations are a separate issue from illusory coverage. The latter issue basically deals with whether exclusions take away everything that an insuring provision gives. Additionally, on the issue of reasonable expectations itself, while Pennsylvania does focus on the reasonable expectations of the insured, “an insured may not complain that [its] reasonable expectations...

14St. Mary's Area Water Auth. v. St. Paul Fire & Marine Ins. Co., 472 F. Supp.2d 630, 633 and 635 (N.D. Pa. 2007) (because policy would respond to a mechanical breakdown of a pump caused by sand ingestion due to a shallow well and mechanical breakdown of the steel shaft of a rotostrainer due to rocks and debris, neither of which involve corrosion or defect, coverage was not illusory).

15Bituminous Corp. v. Sand Livestock Sys., Inc., 728 N.W.2d 216. 222 (Iowa 2007) (remanding matter to the district court applicability of the doctrine of reasonable expectations) (citations and some internal quotations omitted).
expectations were frustrated by policy limitations which are clear and unambiguous.”

D. Reforming Policy Terms

Mistakes happen. Some mistakes involve the declarations page. Because much policy language is standard, particularly with liability policies, mistakes in core policy language are relatively rare. Yet, it is possible for the parties to use the wrong form, omit endorsements or other policy additions, or make mistakes with respect to the identity of insureds or covered property. When this occurs, may the mistake be corrected?

The remedy of reformation is equitable in nature and emanates from the maxim that equity treats that as done which ought to have been done. Where the mistake is unilateral, reformation is difficult, if not impossible, to obtain. Courts look for a showing of mutual mistake. Mere carelessness or negligence, such as failing to catch the mistake, is a common defense.\[17\]

In Caliber One Indem. Co. v. Wade Cook Financial Corp., an insured was entitled to reform its commercial property policy to change an earthquake sublimit from $500,000 to $5,000,000. Failure to catch the mistake did not preclude the insured from seeking reformation:

Importantly, Caliber One has admitted that both parties intended the original and first renewal insurance contracts to provide $5 million in earthquake coverage and that the change to $500,000 was simply a clerical error . . . . The parties’ contractual intentions were identical, and even though Cook [the insured] or Crump [the insured’s broker] may bear some responsibility for not discovering Caliber One’s error, that does not preclude reformation for mutual mistake.\[19\]

Yet, the courts are divided over whether the failure to read

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\[17\] See Washington Mut. Sav. Bank v. Hedreen, 125 Wash. 2d 521, 886 P.2d 1121, 1126 (1994) (stating that “mere carelessness, however, is not necessarily a defense to an action for reformation” and that “[i]f negligence were a defense to a reformation claim, then reformation would almost never be available as a remedy because . . . negligence generally results from the mistake.”) (internal quotation marks and alterations omitted).

\[18\] Caliber One Indem. Co. v. Wade Cook Financial Corp., 491 F.3d 1079 (9th Cir. 2007)

\[19\] Caliber One Indem. Co. v. Wade Cook Fin. Corp., 491 F.3d 1079, 1083 (9th Cir. 2007). See also, Hardcore Concrete, LLC v. Fortner Ins. Servs., Inc., 227 S.W.3d 350, 359 (Mo. Ct. App. 2007) (“Given the factual circumstances set
one's policy acts as a defense to the remedy of reformation. The Wyoming Supreme Court faced this issue in W.N. McMurry Const. Co. v. Community First Ins., Inc. Wyoming, where it concluded that, while the failure to read the policy might well act as a defense against an insured's breach of contract or tort actions against insurance brokers or carriers, the remedy of reformation was still available:

We are convinced that the majority view is the correct view—where effectuation of an antecedent agreement is thwarted by mutual mistake in reducing that agreement to writing, justice is not served by judicial enforcement of the mistaken writing, rather than the intended agreement, just because one of the parties did not read the writing. While we continue to hold that failure to read and failure to mitigate bar the legal claims [breach of contract and tort claims] . . . we conclude that they should not and do not bar the equitable remedy of contract reformation.

Out previously, Hardcore may be entitled to a reformation of its policy with Lloyd's to reflect the true intentions of both parties. To be entitled to reformation, all a party need show is that the parties intended to agree to a particular result by the instrument and that the instrument as executed was insufficient to effectuate their intention. This showing must be made by clear, cogent and convincing evidence. Once the policy is reformed to reflect the true intention of the parties, Hardcore would have all remedies of a policy holder under Missouri law."

See 2 Lee R. Russ & Thomas F. Segalla, Couch on Insurance, § 27:72, at 27–74 (3d ed. 2005 & Cum. Supp. 2006) (“The courts of the country are split over the separate question of the availability of the equitable doctrine of reformation where an insured has failed to read an insurance policy.”)


W.M. McMurry Constr. Co. v. Cmty. First Ins., Inc., 160 P.3d 71, 81 (Wyo. 2007) (citations omitted) (remanding case for determination of whether the insured could establish by clear and convincing evidence the elements of a reformation action: (1) a meeting of the minds for mutual understanding between the parties prior to the time a writing is entered into; (2) a written contract or agreement, or deed; and (3) which does not conform to the understanding by reason of mutual mistake in the drafting of the agreement).

See also, State v. Allendale Mut. Ins. Co., 154 P.3d 1233 (Mont. 2007) (insurer that failed to deliver policies to insured was still able to rely upon valid exclusions in the policies where the insured otherwise has notice of those exclusions); Empire Ins. Co. v. Ins. Corp. of N.Y., 836 N.Y.S.2d 228, 40 A.D.3d 686 (N.Y.A.D. 2 Dept. 2007) (failure to submit policy to court in seeking summary judgment was grounds for denial, as without the policy moving party failed to sustain its prima facie burden of demonstrating that it was entitled to judgment as a matter of law).
III. Disclosure and Notice

A. Duty to Provide Accurate Information

An insured is often required to fill out an application providing information about its business and past claims. If this information is incorrect, the insurer may have a basis for voiding coverage on the grounds of misrepresentation. Of course, the misrepresentation must be material to the risk undertaken by the carrier. For example, in *Marchant v. Travelers Indem. Co. of Illinois*,\(^\text{23}\) a general contractor of high-end custom homes represented that its business consisted of interior trim carpentry. This was a material misrepresentation:

There is no question that the risk associated with being a general contractor in the construction of high-end custom homes dramatically differs from those associated with carpentry and installing interior trim in new homes. Travelers' underwriter averred that the construction of high-end custom homes as a general contractor is considered a high risk activity in comparison to the operation of a carpentry-interior trim business in that the risk exposure of a general contractor is substantially higher than that of carpentry-interior trim. She further averred that because of the high risk involved in general contracting, the commercial accounts group that underwrote Marchant's policy was not authorized to offer policies to general contractors. Because Travelers carried its burden of showing that the representation of Marchant's business was false and that it was material in that it changed the nature, extent, or character of the insurance coverage risk, the trial court did not err in granting summary judgment to Travelers in its declaratory judgment action.\(^\text{24}\)

Insurance agents often play a pivotal role in completing an insured's application. As a consequence, allegations of application misrepresentation frequently implicate the agent. In *Western*


\(^{24}\)Marchant v. Travelers Indem. Co. of Illinois, 650 S.E.2d 316, 320 (Ga. Ct. App. 2007) (inner quotations omitted). See also, Sirius Am. Ins. Co. v. TGC Constr. Corp., 830 N.Y.S.2d 773, 37 A.D.3d 818 (N.Y.A.D. 2 Dept. 2007) (insurer established as a matter of law that it had no duty to defend and indemnify insured because of repeated misrepresentations regarding its role as a project manager on a construction project). But see, Schirmer v. Penkert, 840 N.Y.S.2d 796, 41 A.D.3d 688 (N.Y.A.D. 2 Dept. 2007) (to establish materiality as a matter of law, the insurer must present documentation concerning its underwriting practices, such as underwriting manuals, bulletins, or rules pertaining to similar risks that show that is would not have issued the same policy if the correct information had been disclosed in the application and, where insurer did not present such evidence, its motion was denied).
World Ins. Co. v. Majercak, the insured applied for liability insurance through its insurance agent. The agent represented that the insured performed only residential work on buildings three stories in height and did not do roofing work. Moreover, the agent claimed that the insured’s payroll was only $33,500, and that it did not use subcontractors. These representations were false, as the insured’s payroll was substantially greater than $33,500, and a good portion of its work involved shingling roofs. While there was some factual dispute over whether the insured was the source of these misrepresentations or whether the agent simply acted on its own, the court had little difficulty in dispatching of the insured’s argument as it was responsible for any alleged misrepresentations of its agent:

Pilgrim and Conrad argue, however, that there are questions of material fact as to whether Majercak caused any of the alleged misrepresentations that Plaintiff relies upon. They argue that it was Majercak’s agent, and not Majercak, who made the misrepresentations. An insurer may be estopped from asserting any misrepresentations as a defense in an action for payment under an insurance policy where the insurer’s agent is primarily responsible for the misrepresentations and the applicant has not acted in bad faith or in collusion with the insurer’s agent. However, in Majercak’s answer to Western World’s complaint, Majercak admitted that he or a duly authorized representative (his insurance agent) completed the Application.

B. Duty to Provide Timely Notice of Claim or Loss

Every year, one jurisdiction stands out from all the others in the wealth of case law committed to examining whether an insured met its obligation to provide timely notice. Without exception, New York, this year as in the past, leads the pack with numerous judicial decisions on this issue. One can speculate as to the reason for this wealth of case law. The Empire State’s jurisprudence does not require the carrier to establish prejudice and, as a consequence, an untimeliness defense has more teeth in New York than in many other jurisdictions. Moreover, relatively short periods of time can result in a finding of untimeliness and so, once again, the defense has particular potency in New York. The decision in 120 Whitehall Realty Assocs., LLC v. Hermitage

\cite{25}Western World Ins. Co. v. Majercak, 490 F. Supp. 2d 937 (N.D. Ill. 2007).
Ins. Co.,27 is illustrative. Here, the insured filed notice of claim two-and-a-half months after the incident allegedly giving rise to coverage. The court concluded that this was not reasonable and coverage was vitiated.28

New York law is equally rigid when it comes to dictating the timeliness of a carrier's disclaiming of coverage. Failure to timely disclaim coverage operates as a bar from later asserting a coverage defense.29 Timely notice of disclaimer must be given by an insurer even where the insured itself has not given timely notice.30

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28 See also, R.C. Dolner, Inc. v. My-Way Contracting Corp., 41 A.D.3d 185, 841 N.Y.S.2d 1 (1st Dep't 2007) (subcontractor's unexcused delay of more than ten months in submitting claim to its insurer barred additional insured contractor's claim under policy); Philadelphia Indem. Ins. Co. v. Genesee Valley Improvement Corp., 41 A.D.3d 44, 834 N.Y.S.2d 802 (4th Dep't 2007) (insured failed to give timely notice of potential claim where injury occurred on September 24, 2001, the insured was sued on June 4, 2002, and provided notice to the carrier on June 21, 2002); St. Nicholas Cathedral of Russian Orthodox Church in North America v. Travelers Property Cas. Ins. Co., 45 A.D.3d 411, 846 N.Y.S.2d 113 (1st Dep't 2007) (accident on sidewalk adjacent to insured's property occurred on October 14, 2003, and insured failed to establish reasonableness of its belief that no claim would be asserted against it and therefore had no excuse for untimely giving notice of the accident on May 10, 2004). But see, 105 Street Associates, LLC v. Greenwich Ins. Co., 507 F. Supp. 2d 377 (S.D. N.Y. 2007) (insured did not, as a matter of law, untimely fail to give notice, as date triggering the notice obligation was not when the insured received constructive notice of the lawsuit through service of process upon the Secretary of State, but rather when it received actual notice of the action); Klersy Bldg. Corp. v. Harleysville Worcester Ins. Co., 36 A.D.3d 1117, 828 N.Y.S.2d 661 (3d Dep't 2007) (fact issue precluded summary judgment on untimely notice defense where general contractor insured failed to give notice of injury to subcontractor's employee because it believed any potential claim would be covered by the subcontractor's workers' compensation policy); St. James Mechanical, Inc. v. Royal & Sunalliance, 44 A.D.3d 1030, 845 N.Y.S.2d 83 (2d Dep't 2007) (fact issue precluded summary judgment as to whether insured's two-year delay in giving notice of occurrence to insurer was excused based upon a claim of good-faith belief in non-liability); Wausau Underwriters Ins. Co. v. QBE Ins. Corp., 496 F. Supp. 2d 357 (S.D. N.Y. 2007), opinion clarified, 533 F. Supp. 2d 389 (S.D. N.Y. 2008) (additional insured entitled to rely upon named insured's timely notice to carrier and there was no separate notice requirement placed on additional insured).
In *Continental Cas. Co. v. Employers Ins. Co. of Wausau*, the court wrestled with the notice and disclaimer obligations in the context of a class action asbestos litigation. Class members were exposed to asbestos at numerous construction sites at numerous times, but had no way of knowing when an “injurious exposure” happened. Therefore, the individual class members had notice standards that were less rigorous than the insured general contractor. Moreover, the insured general contractor’s claim would not be denied based upon untimely notice as it appeared that the carriers failed to give timely notice of disclaiming coverage.

The question of timely notice outside the confines of New York often hinges on whether the insurer can establish it was prejudiced by the delay in notice. However, every jurisdiction looks at this question in a little different way. In North Carolina, the question of the insured’s good faith is an important consideration. The North Carolina Court of Appeals, in *Pulte Home Corp. v. Am. Southern Ins. Co.*, set forth the tenets of the defense in the course of concluding that, while a six-month delay in giving notice did not satisfy the “soon as practicable” requirements, the insurer was not entitled judgment as a matter of law as there was a question of whether the insured acted in good faith during the relevant time period:

When faced with a claim that notice was not timely given, the trier of fact must first decide whether the notice was given as soon as practicable. If not, the trier of fact must decide whether the insured has shown that he acted in good faith, e.g., that he had no actual knowledge that a claim might be filed against him. If the good faith test is met the burden then shifts to the insurer to show that its ability to investigate and defend was materially prejudiced by the delay . . . . In light of the six-month delay between Pulte’s receipt of the Mejia complaint and Pulte’s tender to American Southern, we hold that the first prong of the Great American I test has been met. Since American Southern conceded at oral argument that it was never materially prejudiced by the delay (the third prong), our focus here is confined to the second prong of the test: whether Pulte acted in good faith.

As indicated in Great American I, the burden is initially on the

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32See also, 105 Street Associates, LLC v. Greenwich Ins. Co., 507 F. Supp. 2d 377 (S.D. N.Y. 2007) (34-day delay in informing insured of decision to deny coverage was not unreasonable as a matter of law).

insured to demonstrate that it acted in good faith. In this case, Pulte furnished the trial court with an affidavit of its corporate counsel, Michael Laramie. The Laramie affidavit stated that at the time Pulte was served with the Mejia lawsuit, Pulte had the policy of investigating to determine whether Pulte could tender to a subcontractor or an insurer. The affidavit explained further: “That investigation is not simple, however, as records regarding our vendors and their insurance are kept in our local market offices. Under ordinary circumstances, it would involve inquiring of the local market to retrieve those vendor records and ascertain which vendors, and which vendor insurers, might be responsible.”

Because Pulte has presented evidence that it did not make a deliberate decision not to notify American Southern, but rather any delay was a function of its internal policies for processing claims, American Southern was not entitled to summary judgment on this argument. Moreover, because American Southern has pointed to no evidence contrary to that of Pulte, suggesting a purposeful, intentional, or deliberate decision by Pulte to delay notification, Pulte is entitled to summary judgment on the question whether Pulte’s delayed notification justified American Southern’s refusal to defend.34

IV. Deductibles vs. Self-Insured Retentions (SIRs)

Few cases directly discuss the differences between a deductible and a self-insured retention (SIR). Many insureds have only the vaguest idea of how a SIR, as opposed to a deductible, affects their coverage. As a consequence, the California Court of Appeals decision in Padilla Const. Co., Inc. v. Transportation Ins. Co.35 is worth a read. This is a construction defect case. Two homeowners filed suit against a developer in June of 2002, alleging that foundation vents blocked with stucco resulted in excessive moisture building up in the walls over the years causing decay and mold. The homes were built in 1995. During this period of time, the developer was covered under four successive primary CGL policies: (1) from 1995 to end of 1996 (Transcontinental Insurance); (2) from the beginning of 1997 to end of 1997 (Reliance Insurance); (3) from the beginning of 1998 to March 1, 2001 (Legion Indemnity); and (4) from March 1, 2001 to March 1, 2003

34Pulte Home Corp. v. Am. Southern Ins. Co., 647 S.E.2d 614, 621–622 (N.C. Ct. App. 2007). See also, Eckstein v. Cincinnati Ins. Co., 469 F. Supp.2d 455, 460–461 (W.D. Ky. 2007) (although insureds were aware of leaks in 2000 and did not make claim on property policy until 2003, claim was timely as insured’s awareness of a leak was not tantamount to an awareness of a loss and it was not until an expert report apprised them of the problem that they were fully aware of their loss).

(Steadfast Insurance). Moreover, the developer had two yearly commercial umbrella policies issued by Transportation Insurance for the period of January 1995 through the end of 1997. As a sign of the times, only two of the four primary insurers were available to defend the insured in the underlying suit—both Reliance and Legion became insolvent. Initially, the developer requested a defense only from Transcontinental. However, once defense counsel was retained, it requested a defense from Steadfast. The request never reached Steadfast, as the insured’s thirty-party claims administrator elected not to trigger the Steadfast policy because it had a $25,000 SIR. By June 2003, just a few months after the decision not to seek coverage under Steadfast’s policy, Transcontinental alerted the developer that its policy was nearing exhaustion. As a result, the insured requested defense counsel to tender to Transportation as the umbrella carrier. Transportation declined the tender on the grounds that Steadfast’s policy had not yet exhausted as required under California’s “horizontal exhaustion” rule. As a result, the developer assumed its own defense upon the exhaustion of the Transcontinental policy on December 30, 2003. In 2005, it reached a settlement with the claimants to which Steadfast contributed.

The instant case involves the developer’s coverage suit against the umbrella carrier, claiming it had a duty to “drop down” and defend once Transcontinental’s policy became exhausted. The developer lost this fight. The rationale behind the developer’s decision not to seek a defense from Steadfast lies in the difference between a deductible and a SIR. A deductible “usually relates only to the damages sustained by the insured, not to defense costs,” whereas a “SIR” is generally a specified amount of loss that is not covered by the policy but instead must be borne by the insured.”

As a consequence, an insurer has no duty to defend or indemnify where the SIR is not exceeded, even though the underlying action has the potential to exceed the limit. Therefore, where the policy has an SIR, the insured becomes responsible for defense costs until the SIR limit is exceeded.

Given the nature of the $25,000 SIR feature of the Steadfast policy, the developer chose to seek coverage under its umbrella

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policies. One can question the wisdom of this decision, as the cost of pursuing the umbrella carrier in all likelihood far exceeded the $25,000 SIR—not to mention the fact that it proved an unsuccessful pursuit. Perhaps the most interesting aspect of the decision addressed whether the Steadfast SIR was equivalent to the developer having no insurance for the first $25,000 of liability, such that the umbrella carrier was obligated to “drop down” and pick up at least this amount of defense or indemnity cost? The court concluded it did not:

The flaw in this logic is the assumption that the self-insured retention can be meaningfully separated from [Steadfast’s] policy, of which it is a creature, for purposes of [Transcontinental umbrella policy’s] “other insurance” clause. In classic insurance law terms, treating the self-insured retention as a separate entity from [Steadfast’s] policy defeats the reasonable expectations of all the parties, including the insured. It obliterates the distinction between primary and excess insurance . . . . We have already noted the great disparity in the premiums charged by [Steadfast] and [Transcontinental]. The yearly premiums charged by the former were no less than 12 to 15 times the yearly premiums charged by the latter. A primary policy imposes on an insurer a “primary duty of defense” while an excess (or “secondary” or “umbrella”) policy attaches only after primary coverage has been exhausted; hence the latter is cheaper.

But even more fundamentally bearing on the reasonable expectations of the parties, treating a self-insured retention lying “beneath” a primary policy as a period of “non-insurance” for purposes of whether an earlier excess policy is triggered in a continuing loss scenario is to ignore the terms and expectations of the “overlying” primary policy . . .

If the insured wanted to go without any insurance post-March 2001 (we will avoid the “misnomer” of “self-insure”), the insured could simply have “gone bare” and not purchased any, primary or otherwise. Such a decision, of course, would have exposed the insured’s own assets to claims that otherwise might have been insured against except in cases of continuing loss, but that would be in accord with the essential deal between it and the excess insurer (in light of the rule articulated in Montrose II): If the insured was truly bare and a claim was otherwise potentially covered by the excess policy, the excess would drop down and cover it. Then again, [Transcontinental] had essentially bet, back in 1995 and 1996, that the insured would not make any such decision precisely because it would mean exposure of the insured’s own as-
sets to *most* claims, even if the odd continuous damage claim might entail a defense obligation on its part.  

V. **Commercial General Liability Coverage**

A. **Duty to Defend**

1. **Standard Doctrine**

An insurer’s obligation to defend its insured against claims is broader than its duty to indemnify the insured against loss. While the law varies a bit from jurisdiction to jurisdiction, as a general rule an insurer owes the insured a defense if any of the claims in the complaint arguably fall within coverage. A classic expression of this rule is the following:

A liability insurer owes a broad duty to defend its insured against claims that create a potential for indemnity. The carrier must defend a suit which *potentially* seeks damages within the coverage of the policy. Implicit in this rule is the principle that the duty to defend is broader than the duty to indemnify; an insurer may owe a duty to defend its insured in an action in which no damages ultimately are awarded. To prevail . . . on the issue of duty to defend, the insured must prove the existence of a potential for coverage, while the insurer must establish the absence of any such potential. In other words, the insured need only show that the underlying claim may fall within policy coverage; the insurer must prove it *cannot*.  

The Wisconsin case of Southeast Wisconsin Professional Baseball Park District v. Mitsubishi Heavy Industries America, Inc., is an interesting study in how pervasive the duty to defend obligation can become in the context of an Owner-Controlled Insurance Program (OCIP). Under an OCIP, most construction participants forego securing their own insurance in favor of coverage under a single project-related policy. The theory behind OCIPs is that they save money by eliminating duplicative coverage. An inevitable consequence, however, is that one insurer ends up covering numerous participants on a construction project. In this case, the project involved the design and construction of the Miller Park baseball stadium—home of the Milwaukee
Brewers. The project had a troubled history. In the summer of 1999, a crane collapsed, killing three ironworkers. Ultimately, a $94 million verdict was rendered in favor of the families and estates of the men who died. Before the verdict in the crane-collapse case, Travelers paid its $2 million liability policy limit for the 1999/2000 policy period and declined to provide further defense of crane-collapse claims based upon a provision in its policy which allowed it to avoid further defense responsibility when it exhausted its liability limit in settlement.

The instant case, however, does not involve the crane collapse. Beginning April 1, 2001, as the stadium opened, the District (owner of the stadium) purchased three years of additional coverage from Travelers as an extension endorsement on the then-existing policy. The endorsement, called the Products and Completed Operations Extension, covered “occurrences” causing damage to “your work” during the three-year period of extended coverage. Approximately two years later, in 2003, the District sued Mitsubishi and HCH for problems with the stadium’s retractable roof. Mitsubishi, the roof manufacturer, counterclaimed against the District and cross-claimed against HCH, claiming their failures caused it to incur additional expense. HCH also counterclaimed against the District. Travelers, as the OCIP carrier, owed a defense obligation to all, which resulted in an attorney’s fee award of $27,129,373.

New York’s highest court issued an interesting ruling on the duty to defend an additional insured under an “ongoing operations” endorsement. In BP Air Conditioning Corp. v. One Beacon Ins. Group, a worker was injured when he slipped on a patch of oil while working at the World Trade Center in 2000. He sued the general contractor, who in turn brought a third-party action against BP, the subcontractor that hired the injured employee’s employer. BP, not surprisingly, sought a defense as an additional insured under the employer’s CGL carrier. While the carrier admitted that it had a duty to defend the named insured because of its potential liability to the general contractor, it contended that it had no duty to defend an additional insured until the named insured’s actual liability was established. The New York Court of Appeals rejected this reasoning:

One Beacon argues that the portion of the additional insured endorsement that states that BP is an additional insured only with

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respect to liability arising out of [Alfa’s] ongoing operations performed for that insured, requires a determination of liability for Cosentino’s injuries before BP is entitled to a defense. However, when considering this policy language in light of an insurer’s broad obligation to defend an insured, it does not affect the standard under which a duty to defend is determined. When the duty to defend is at issue, a liability alleged to arise out of Alfa’s ongoing operations is one arising out of such operations within the meaning of the policy. Here, Cosentino, in his amended complaint, alleged, among other things, that Alfa, BP’s subcontractor, was engaged in construction work at the work site where he was injured, that Alfa breached its duty to keep the work site safe and that Alfa’s breach caused his injuries. These allegations form a factual [and] legal basis on which [One Beacon] might eventually be held to be obligated to indemnify [BP] under any provision of the insurance policy and certainly bring this claim within the ambit of the protection purchased. Since there is a possibility that Cosentino’s injuries arose out of Alfa’s ongoing operations performed for BP, One Beacon’s obligation to provide BP with a defense is triggered.43

The court went on to invoke the additional insured’s reasonable expectations with respect to coverage as another reason for finding a defense obligation:

We have previously held that the reasonable expectation and purpose of the ordinary business person when making an ordinary business contract will be considered in construing a contract BP’s reasonable expectation, when it forwarded the purchase order to Alfa that required Alfa to name BP as an additional insured, was that it wanted protection from lawsuits arising out of Alfa’s work—litigation insurance. Denying BP a defense in the underlying matter would rewrite the policy without regard to BP’s reasonable expectations as expressed in the purchase order, and provide a windfall for One Beacon. Therefore, the lower courts correctly determined that One Beacon is obligated to provide BP a defense in the underlying Cosentino action, regardless of the merits of the claim.44


44BP Air Conditioning Corp. v. One Beacon Ins. Group, 8 N.Y.3d 708, 716, 840 N.Y.S.2d 302, 871 N.E.2d 1128 (N.Y. 2007) (citations and inner quotations omitted). See also, Ameron Int’l Corp. v. Ins. Co. of State of Pa., 150 Cal. App. 4th 1050, 60 Cal. Rptr. 3d 55 (Cal. Ct. App. 1 Dist. 2007) (where liability policy defines the term “suit” to include “civil proceedings” or “arbitration hearings,” the term encompasses more than civil actions and insurer has a duty to defend adjudicative administrative hearings and to indemnify the insured against liability for money awarded in those hearings; specifically, money awarded against an insured contractor by a Federal Board of Contract Appeals); Hartford Fire Ins. Co. v. Everest Indem. Ins. Co. 369 Ill. App. 3d 757, 861 N.E.2d 306 (Ill.
2. Extinguishing the Defense Obligation Through Exhausting Policy Limits

The duty to defend is grounded in contract.45 A common feature of professional liability policies is a wasting of indemnity limits based on the amount of defense costs, including attorney’s fees paid by the carrier. General liability policies, on the other hand, do not typically have this feature. Nevertheless, it is not uncommon for a general liability policy to contain language which extinguishes the duty to defend once the insurer has paid the full limits of its indemnity obligation.46 However, “exhaustion” of the primary insurer’s policy limits occurs where the insurer pays the limits either as part of a settlement or a judgment. Where the insurer sought to “exhaust” is policy limits by forwarding the limits to an excess carrier, the limits were not “exhausted” and a primary insurer still had a duty to defend.47

3. Selection of Counsel

As a general rule, the insurer, once charged with the duty of defending its insured, is permitted to control the insured’s defense. Perhaps the most significant form of control is the right

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46See Southeast Wisconsin Professional Baseball Park District v. Mitsubishi Heavy Industries America, Inc., 304 Wis. 2d 637, 2007 WI App 185, 738 N.W.2d 87, 93 (Ct. App. 2007) (crane collapse resulted in primary carrier exhausting its indemnity limits thus allowing it to avoid further defense responsibility).

47BBL-McCarthy, LLC v. Baldwin Paving Co., 285 Ga. App. 494, 646 S.E.2d 682, 686–687 (2007), cert. denied, (Sept. 10, 2007) (“The term ‘exhaust’ as it applies to policy limits means the payment either of a settlement or of a judgment, which wholly depletes the policy amount. Here, TIC concedes that it did not “exhaust” its policy limits by paying the entirety towards either a judgment or settlement. Thus, TIC’s tender of the remaining liability coverage to National Union [excess carrier] did not extinguish its duty to defend.”) (citations omitted).
to choose counsel to defend the insured. An exception to this rule occurs where a conflict of interest exists between the insurer and insured, such that the insured is entitled to choose its own counsel at the insurer’s expense. Just what constitutes a conflict sufficient to entitle the insured to retain its own counsel differs from jurisdiction to jurisdiction.48

In *American Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc.*,49 the court determined that a conflict existed such that the insured builder was entitled to retain its own counsel to defend against a homeowner’s claim that the builder failed to properly apply an exterior insulation and finish system (EIFS), causing injury to the home. In finding that a conflict existed because the insurer would benefit from a finding that the insured was liable for damage which occurred prior to the inception of the policy, the court had an occasion to expound on the conditions under which the right to choose one’s own counsel due to a conflict arise:

To determine whether there is a conflict, we must compare the allegations of the underlying complaint against the insured to the terms of the insurance policy at issue. That complaint includes exhibits, such as contracts, which are attached to it. If, after comparing the complaint to the insurance policy, it appears that factual issues will be resolved in the underlying suit that would allow insurer-retained counsel to “lay the ground work” for a later denial of coverage, then there is a conflict between the interests of the insurer and those of the insured. Put another way, if, in the underlying suit, insurer-retained counsel would have the opportunity to shift facts in a way that takes the case outside the scope of policy coverage, then the insured is not required to defend the underlying suit with insurer-retained counsel. Rather, the insured is entitled to defend the suit with counsel of its own choosing at the insurer’s expense.50

Illinois is perhaps a bit more insured-friendly on this point than other jurisdictions. It is unlikely that a California court would find a conflict exists under these circumstances sufficient to allow the insured to retain its own counsel at the insurer’s expense.51

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48 See Bruner & O’Connor on Construction Law, § 11:23 (West Group 2002).
51 See Midiman v. Farmers Ins. Exchange, 90 Cal. Rptr. 2d 85 (App. 2d Dist. 1999), ordered not to be officially published, (May 10, 2000) (distinction be-
4. Obligations of Appointed Defense Counsel

The way in which a liability insurer fulfills its defense obligation is to appoint a lawyer to defend its insured. If the insurer has reserved its rights to contest indemnity (or later contest its defense obligation), a potential conflict may arise where appointed counsel attempts to service the interests of both insured and insurer. Similar problems can arise where counsel is appointed by a number of insurers having divergent coverage interests.

The New York decision of Allianz Underwriters Ins. Co. v. Landmark Ins. Co.,52 is a cautionary tale. An excess liability insurer sued, among others, its insured’s law firm, claiming a breach of fiduciary duty. The action arose from an underlying wrongful death suit brought by the estate of a contractor’s employee mortally injured while performing work on a project for the Dunlop Tire Corporation (Dunlop). As is common in these cases, the contractor/employer contractually agreed to indemnify Dunlop and named Dunlop as an additional insured on its general liability and umbrella policies. The contractor/employer’s primary liability carrier was General Star Indemnity Corp. (which had per-occurrence limits of $1 million). The umbrella carrier for the contractor/employer was Landmark (with policy limits of $10 million). Allianz provided an excess liability policy to Dunlop in the amount of $20 million (excess of a self-insured retention of $3 million).

General Star retained defendant Underberg & Kessler to represent Dunlop in the wrongful death action. Allianz and Dunlop repeatedly demanded that its counsel commence a third-party action against the contractor/employer on the ground that it was liable under the workers’ compensation statute, and, furthermore, was contractually obligated to indemnify Dunlop. Despite

tween covered and non-covered categories of damages is irrelevant to the insured’s liability in the underlying action and, therefore, appointment of independent counsel is unjustified; Blanchard v. State Farm Fire & Casualty Co., 2 Cal. App. 4th 345, 2 Cal. Rptr. 2d 884 (2d Dist. 1991) (insurer not required to furnish independent counsel where insurer’s reservation of rights applied only to certain items of damages excluded by the policy and defense counsel had no incentive to cause liability to be found against the insured and fact that plaintiff’s total damages might exceed policy limits did not create an actual conflict of interest). See also, Insurance Co. of North America v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980), decision clarified on reh’g, 657 F.2d 814 (6th Cir. 1981) (insured’s argument that proration of coverage based on extent of plaintiff’s exposure to asbestos during policy period created conflict of interest).

Dunlop’s insistence to proceed, its counsel never commenced a third-party action against the contractor/employer. Allianz claimed the real counsel failed to commence the third-party action was that General Star also insured the contractor/employer and did not wish suit to be commenced against its insured. A jury in the wrongful death action issued a verdict in favor of the estate in the amount of $8.6 million. Allianz asserted that Dunlop’s counsel breached its fiduciary duty by manipulating the litigation process for the benefit of General Star and Landmark, without regard to the rights of Dunlop or Dunlop’s insurer, Allianz. In declining to grant the law firm’s motion for dismissal on the grounds that it owed no duty to Allianz, the court held:

Accepting plaintiff’s allegations as true, we find that, contrary to the motion court’s determination, the complaint states a cause of action based upon principles of equitable subrogation.

Underberg’s [Dunlop’s counsel] contention that Allianz is not Dunlop’s equitable subrogee because Allianz has not yet paid anything on the underlying judgment is unavailing. Contingent claims by subrogees have been recognized, especially where it would further judicial economy. Although the issue of equitable subrogation is dispositive of Allianz’s appeal, we note as well that Allianz has alleged a “near privity” relationship, sufficient to overcome a motion to dismiss. We recognize that “absent fraud, collusion, malicious acts or other special circumstances, [a party] is not liable for professional negligence to third parties not in privity”

In order for a relationship to approach “near” privity’s borders, for the purpose of maintaining a professional negligence claim, the professional must be aware that its services will be used for a specific purpose, the plaintiff must rely upon those services, and the professional must engage in some conduct evincing some understanding of the plaintiff’s reliance. Here, Allianz sufficiently pleaded that Underberg knew that the insurers and excess insurer relied on its representation of Dunlop. In addition, Allianz adequately alleged Underberg understood that reliance by virtue of its continued correspondence with Allianz, in which Allianz and Dunlop insisted that a third-party action be commenced, while Underberg declined.53

Another conflict problem arose in Flores v. Willard J. Price Associates., LLC,54 where defense counsel impleaded another party, creating an apparent conflict of interest justifying disqualification. Adrian Flores was injured in a construction accident while using a table saw at premises owned by defendant/third-party plaintiff Willard J. Price Assoc., LLC (Price) and


managed by defendant/third-party plaintiff Proto Realty Management Corp. (Proto). Mr. Flores sued Price and Proto to recover damages for his personal injuries. Price and Proto were represented jointly by Gary Cusano, as counsel appointed by their insurer, CNA Insurance Companies, under a commercial general liability policy.

Proto’s majority shareholder and president was Demetrius Moragianis. Mr. Moragianis was also the sole member of the construction manager for the project, Stateside Construction, LLC (Stateside). Mr. Cusano impled Stateside on an indemnification and contribution theory. This action led to Mr. Cusano’s disqualification:

It appears on the record to be uncontroverted that Moragianis is the one through which Proto has been acting for the purposes of this litigation. Therefore, under these circumstances and this record, he is a “party” to whom Cusano owes a fiduciary duty of undivided loyalty.

Yet, without any permission from Moragianis (nor anyone else from Proto), a third-party action was commenced against Stateside whose “alter ego” is undeniably Moragianis. There can be little doubt that the third-party suit is not in the best interest of Moragianis. Rather, such suit is for the primary benefit of the insurer, CNA, as its victory assures recoupment of any moneys CNA might pay out on behalf of its insureds . . . . Therefore, under these facts, it appears that Cusano has impermissibly placed CNA’s interests above those of Moragianis. This stratagem gives the appearance of a conflict of interest and Cusano must be disqualified. 85

Mr. Cusano’s problems ran deeper than the unauthorized commencement of a third-party action. His conflict appears to have arisen once he agreed to represent both Price and Proto. While impleading Stateside was not a benefit to Proto, it probably was to Price. Therefore, Mr. Cusano was between the proverbial “rock and a hard place.” The dissent contends that Proto and Moragianis were not the same entity. Moragianis was simply an employee of Proto. Therefore, it contends, there was no basis under the professional responsibility rules for Mr. Cusano’s disqualification. Yet, this matter really boils down to whether Moragianis was the “alter ego” of Proto and Stateside for purposes of this litigation. To the extent that Mr. Cusano had to communicate and rely upon Mr. Moragianis to defend Proto and to prosecute the third-party claim against Stateside, Mr. Cusano’s role as counsel for Proto appears untenable.

Another pitfall for defense counsel is illustrated in the Califor-

nia decision of *CalFarm Ins. Co. v. Krusiewicz*. The insured, a landscape contractor, was sued for failing to properly seal walls, allowing moisture to seep through them. To prevent further damage, the back of the walls had to be resealed, which required the removal of the backfill soil and replacement of the soil and landscaping after the walls had been resealed. The actual cost of sandblasting and repainting the walls was fairly minor (estimated to cost between $15,000 and $80,000). The cost of removing and replacing the backfill soil and landscaping, however, was another matter. It was estimated that this would cost in excess of $500,000. The insurer did not dispute that its policy responded to the costs of sandblasting and repainting the walls, but denied coverage for removing and replacing the backfill.

During a settlement conference, counsel hired by the insurer to defend the landscape contractor encouraged the plaintiffs to resolve their dispute through binding arbitration. The plaintiffs, however, were concerned about the insurer's refusing to pay that portion of the award representing the costs of removing and replacing the backfill. As a result, plaintiffs insisted that, if they were to go to arbitration, the insurer would have to pay any award in full within ten days. Defense counsel realized that the insurer would not agree to plaintiffs' proposal and, therefore, proffered a “solution.” The arbitrator would be instructed to award a general verdict, thereby leaving the insurer with no recourse but to pay the award. Based on this plan, plaintiffs agreed to dismiss their claims and proceed to binding arbitration.

The arbitrator made a lump-sum award of $475,000 for “remediation and compensatory damages” without providing any further specificity as to the categories of remediation costs. The insurer refused to pay the entire award and, instead, paid plaintiffs $80,000 for the cost of sandblasting and repainting the walls. Plaintiffs sued the insurer and a jury returned a special verdict finding that defense counsel was acting as the insurer's agent when he made the proposal that the insurer would have no alternative but to pay the entire award if rendered in the form of a general verdict. Therefore, the insurer was estopped from denying coverage. Nevertheless, the insurer was not liable for punitive damages as its coverage position was objectively reasonable (although the court does not go so far as to say that removing and replacing the backfill was not covered by the policy).

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B. “Property Damage”

1. Does It Matter What Property is Damaged for the Insuring Clause?

The CGL policy’s insuring clause requires the insured to establish that either “property damage” or “bodily injury” arose from the “occurrence.” The “bodily injury” element is seldom in controversy, particularly if the underlying claim involves a worksite injury. “Property damage,” however, is another matter. The CGL policy defines “property damage” as:

a. Physical injury to tangible property, including all resulting loss of use of the property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or

b. Loss of use of tangible property that is not physically injured; all such loss of use shall be deemed to occur at the time of the “occurrence” that caused it. 57

Of the two general types of property damage identified under a CGL policy, the first type (physical injury to tangible property, including loss of use of the property) is the more common. The second type of “property damage” implicates a number of policy exclusions. As a consequence, more coverage is afforded in those instances where the occurrence resulted in some “physical injury to tangible property.” Examples of this abound in construction cases. There are any number of physical deformations that can result from water infiltration or settlement, including cracking, breaking, deflecting, corroding, rusting, rotting, peeling, dissolving, and so on. Most of these type of events raise little controversy. This is particularly the case where the property damaged is not a part of the insured’s work. When the property damaged is the insured’s work, and the nature of the problem is characterized as “faulty workmanship,” some courts have a tendency to inquire whether “property damage” covers the repair and replacement of poor workmanship. While is there is nothing in the definition of “property damage” or the insuring clause that mandates such an inquiry, insurers often argue otherwise. Sometimes successfully. 58

This analysis is really nothing more than a “business risk”

57 See Swank Enter., Inc. v. All-Purpose Servs., Ltd., 154 P.3d 52, 55 (Mont. 2007) (reciting standard CGL language defining “property damage”).

58 See Travelers Indem. Co. v. Miller Bldg. Corp., 221 Fed. Appx. 265, 269 (4th Cir. 2007) (applying North Carolina law) (“The policy limited payment to those sums that the insured becomes legally obligated to pay as damages because of . . . ‘property damage,’ so long as the ‘property damage’ is caused by an ‘occurrence.’ We concluded in our prior opinion that, to the extent that
exclusion argument masquerading as a claim that the insuring clause element of “property damage” has not been met. Because the insured bears the burden of satisfying the insuring clause requirements and the insurer bears the burden of establishing the applicability of policy exclusions, this confusion can create mischief. Stripped to its basics, the contention is simply that the CGL policy was not intended to afford coverage for repairing an insured’s poor workmanship. If this is the case, and in some instances it is and others it is not, it is the work of policy exclusions rather than the insuring clause. The “property damage” element of the insuring clause simply requires the insured to establish the existence of “physical injury to tangible property” or the loss of use of tangible property—and nothing more. This conflation of business risk exclusions with the insuring clause has resulted in a tremendous amount of tortured analysis by the courts (even when eventually arriving at the correct result):

We further reject U.S. Fire’s contention that there can never be “property damage” in cases of faulty construction because the defective work rendered the entire project damaged from its inception. To the contrary, faulty workmanship or defective work that has damaged the otherwise nondefective completed project has caused “physical injury to tangible property” within the plain meaning of the definition in the policy. If there is no damage beyond the faulty workmanship or defective work, then there may be no resulting “property damage.” Other courts have also recognized that there is a difference between a claim for the costs of repairing or removing defective work, which is not a claim for “property damage,” and a claim for the costs of repairing damage caused by the defective work, which is a claim for “property damage.” . . . Like the Tennessee case, Moore & Assoc., and the Wisconsin case, American Girl, this case does not involve a claim for the cost of repairing the subcontractor’s defective work, but rather a claim for repairing the structural damage to the completed homes caused by the subcontractor’s defective work. Specifically, it was the subsequent soil settlement due to the subcontractor’s faulty workmanship that caused the structural damage to the homes. Because there was “physical injury to tangible property,” we conclude that the structural damage to the homes is “property damage” within the meaning of the policies.  

Distinguishing between the insured’s faulty work and other

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[owner] is seeking to recover from Miller the cost of correcting Miller’s faulty workmanship, the claims do not fall within the scope of the policy issued by Travelers, because faulty workmanship does not constitute ‘property damage.’ ” (some inner quotations omitted).

work is unnecessary when determining whether the “property damage” element has been satisfied. Nor does one have to employ the laborious logic found in the *J.S.U.B.* case to determine whether the “property damage” element has been satisfied in a particular case. The Texas Supreme Court got it right when it reasoned cracks in sheetrock and stone veneer met the “property damage” element:

The policy defines “property damage” as “[p]hysical injury to tangible property, including all resulting loss of use of that property.” On its face, this definition does not eliminate the general contractor’s work. The home and its component parts are clearly “tangible property.” The DiMares alleged that Lamar was negligent in designing and constructing their home’s foundation and that Lamar’s defective workmanship caused the home’s sheetrock and stone veneer to crack. These allegations of cracking sheetrock and stone veneer are allegations of “physical injury” to “tangible property.” But the district court reasons that damage to the homebuilder’s own work, the home, cannot be “property damage” because CGL insurance exists not to repair or replace the insured’s defective work and that such an interpretation transforms CGL insurance into a performance bond.

Any similarities between CGL insurance and a performance bond under these circumstances are irrelevant, however. The CGL policy covers what it covers. No rule of construction operates to eliminate coverage simply because similar protection may be available through another insurance product. Moreover, the protection afforded by a performance bond is, in fact, different from that provided by the CGL insurance policy here.

Some basis exists, however, for the district court’s assumption that CGL insurance is not for the repair or replacement of the insured’s defective work. The assumption proves true in many cases because several acts of faulty workmanship do not fall within coverage, either because they are not an “occurrence,” “accident,” or “property to faulty workmanship and does in fact allege ‘property damage.’ Moore’s subcontractor allegedly installed the windows defectively. Without more, this alleged defect is the equivalent of the mere inclusion of a defective component such as the installation of a defective tire, and no property damage has occurred. The alleged water penetration is analogous to the automobile accident that is caused by the faulty tire. Because the alleged defective installation resulted in water penetration causing further damage, Hilcom has alleged ‘property damage.’ Therefore, we conclude that Hilcom has alleged damages that constitute ‘property damage’ for purposes of the CGL.” (some inner quotations omitted); *Webster v. Acadia Ins. Co.*, 934 A.2d 567 (N.H. 2007) (“We specifically distinguish between negligent construction that resulted in property damage and merely seeking damages for the negligent construction. By alleging actual damage in the form of mildew, rot, and loss of structural integrity, the underlying writ was not simply a claim for the contractor’s defective work, but also a claim for the damage to other property suffered as a result.”) (inner quotations omitted).
damage,” or they are excluded from coverage by specific exclusions. For example, faulty workmanship that is intentional from the viewpoint of the insured is not an “accident” or “occurrence,” and faulty workmanship that merely diminishes the value of the home without causing physical injury or loss of use does not involve “property damage.” More often, however, faulty workmanship will be excluded from coverage by specific exclusions because that is the CGL’s structure.60

2. Physical Injury to Tangible Property

The industry is fond of saying economic losses do not meet the “property damage” requirement. This is sometimes, but not always, the case. Economic damages that flow from tangible property that is physically injured meet this threshold.

In Stewart Interior Contractors, L.L.C. v. Metalpro Industries, L.L.C.,61 a metal stud framing contractor purchased steel studs from a manufacturer. The steel studs failed to meet the contract specifications causing them to pull through the sheetrock, damaging wall panels, interior paint finishes, and tape and joint compound. These damages satisfied the “property damage” requirement notwithstanding the fact that, as a consequence, there was delay to the construction project resulting in consequential loss of income and profit (i.e., economic losses).62

In Swank Enterprises, Inc. v. All Purpose Services, Ltd.,63 the question was whether the selection and application of paint to pipes and tanks constituted physical injury to tangible property. The use of the improper type of paint required the pipes to be stripped and repainted requiring the treatment plant to shut down for the duration of the repair work. The Montana Supreme Court concluded that the application of improper paint did cause “physical injury” to the pipes and tanks:

Here, the application of improper paint during the 1997 policy period caused “physical injury” because it physically and materially altered the treatment center’s tanks and pipes, resulting in a detriment to the City of Libby. The detriment in fact was that the pipes and tanks had to be stripped and repainted. However, even if the


62 See also, Ferrell v. West Bend Mut. Ins. Co., 393 F.3d 786, 795 (8th Cir. 2005) (holding that measure of damages under economic loss rule “is distinct from the question of whether there was ‘property damage’ under the policy”).

City of Libby had taken no action (that is, even if the treatment plant had not been shut down and repainted), the City still would have been damaged because the paint would not have sufficiently protected the pipes and tanks . . . . Additionally, the fact that the discovery or diagnosis of the problem did not occur until after the 1997 policy period is of no consequence. A “physical injury” can occur “even though the injury is not ‘diagnosable,’ ‘compensable,’ or manifest during the policy period as long as it can be determined, even retroactively, that some injury did occur during the policy period.”

Vistas are important in Hawaii—so important that neighbors sue one another over them. In Allstate Ins. Co. v. Chesler, insured homeowners were sued by their neighbors because they built their home one foot higher than allowed by the community association. The neighbors claimed that the extra height unreasonably interfered with their light, air, and view. The coverage question reduced down to whether this allegation met the “property damage” requirement. The court found that it did not.

C. Policy Exclusions

The CGL policy contains a number of standard exclusions. Insurers also add new exclusions or restrict the scope of standard exclusions by way of endorsement. The burgeoning construction defect litigation occurring in certain parts of the country has led some insurers to add endorsements that seek to further restrict coverage for latent defects or other construction-related claims. Some exclusions are intended to carve out coverage because other common insurance policies cover such losses. For example, the employee exclusion eliminates bodily injury claims by an insured’s employees because workers’ compensation and employer’s liability coverage responds to these losses. Similarly, the auto exclusion eliminates coverage for risks otherwise covered under an automobile liability policy. Another class of exclusions are known as “business risk” exclusions.

The theory and purpose behind these exclusions is that a CGL policy is not intended to insure against common business risks.

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64 Swank Enter., Inc. v. All-Purpose Servs., Ltd., 154 P.3d 52, 56 (Mont. 2007) (some inner quotations omitted). See also, In re Silicone Implant Litigation, 667 N.W.2d 405, 415 (Minn. 2003).


66 But see, Prudential Property and Cas. Ins. Co. v. Lawrence, 45 Wash. App. 111, 724 P.2d 418 (Div. 1 1986) (where umbrella policy did not contain the term “physical” when describing the property damage element, claim against insured alleging it built its house too close to the street obstructing the neighbor’s view was sufficient to trigger the insuring clause).
such as failing to meet one’s contractual obligations. The boundaries of the “business risk” exclusions have been the subject of much debate, particularly for insureds that work in construction. It is one thing to claim that your policy does not respond to standard contract risks, such as completing a building on time, and quite another to draft policy language that is neither too broad nor too narrow, but rather, clearly eliminates this risk. Many “contract” risks fall within coverage. Failure to build a wall properly such that it collapses and injures someone’s person or property certainly falls within coverage. Yet, it is a “contract” risk. A CGL policy would not be terribly valuable to insureds engaged in commerce (after all, the “C” of the CGL policy stands for “Commercial”—it used to stand for “Comprehensive,” but the industry abandoned that meaning when courts started using it in coverage interpretation disputes) if it excluded all “contract” risks. It is this tension between carving out some coverage and yet leaving enough to make the product commercially viable that is the cause of many of the disputes over the meaning and scope of exclusionary language.

1. Employee Exclusion

The CGL’s employee exclusion is not terribly difficult to understand. Injuries to the insured’s employees are excluded. The difficulty lies in applying the exclusion to particular factual settings commonly encountered on construction projects. Unlike many sectors of commerce, employment in the construction industry can be a gray affair. Who is an “independent contractor” as opposed to “an employee” is sometimes difficult to determine. Moreover, it is not uncommon for contractors to “lease” or “borrow” workers from other construction participants on a project site. These employment permutations can give rise to coverage disputes.

For example, in *St. Paul Reinsurance Co., Ltd. v. Baldwin*, a worker was an employee, rather than an independent contractor working for himself notwithstanding that he received a 1099 tax form reflecting his compensation. The insured provided the injured worker the necessary equipment to perform the work, served as the sole source of the worker’s income, and reimbursed the worker for job-related expenses. As a consequence, the insured’s CGL policy did not provide coverage for bodily injury suffered by the worker when he was electrocuted while perform-

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ing his job. In *Yorkshire Ins. Co., Ltd. v. Diatom Drilling Co.*, an oilfield services company's CGL policy did not respond to claims of a leased employee injured on the job.  

2. **Intentional Act Exclusion**

It “goes without saying” that CGL coverage is not afforded for intentional wrongdoing. Yet, the insurance industry doesn’t take chances, hence an exclusion for intentional acts. In some jurisdictions, public policy renders intentional wrongs uninsurable. More often than not in a construction dispute, once the court gets beyond the question of whether an “occurrence” exists for purposes of the insuring clause, it seldom addresses whether the “intentional act” or sometimes known as the “intended and expected” exclusion applies.

Non-standard policy language can cause more interpretation challenges than usual. For example, in *Liebovich v. Minnesota Ins. Co.*, the insured purchased an “innovative insurance” product designed to “enhance protection and minimize threats to the personal wealth of high net worth individuals.” In this case, the policy defined the term “occurrence” as not only an “accident” but also as an “offense.” Additionally, it covered personal injury arising out of “wrongful entry or eviction.” The insured was sued by two contiguous neighbors on Geneva Lake. They claimed that he built his house in violation of a set-back restriction. When the insurer refused to defend, he retained his own counsel and eventually was ordered to pay his neighbors $10,000 in damages plus costs and disbursements. He then commenced this coverage suit. The insurer contended that it owed no defense or indemnity because of the policy exclusion for “acts or omissions or any person which are intended to result in, or would be expected by a reasonable person to cause, property damage or personal injury.” Because the set-back restriction was set forth in the insured’s deed, he had both actual and constructive knowledge of this

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69See also, Brown v. Indiana Ins. Co., 184 S.W.3d 528 (Ky. 2005) (employee exclusion is not limited to injuries for which workers’ compensation benefits are sought or payable, but applies to any injury to any employee of the insured arising out of or in the course of employment).

70See Ranger Ins. Co. v. Bal Harbour Club, Inc., 549 So. 2d 1005, 1009 (Fla. 1989) (holding public policy prohibits the insured from being indemnified for a loss resulting from intentional employment discrimination).

limitation. Moreover, the neighbors’ complaint alleged that the insured’s actions were intentional and in willful disregard of their rights. The court concluded that, notwithstanding the allegations of “intentional” conduct, the insured was entitled to coverage:

Nevertheless, we agree with Liebovich that, despite the allegations in the complaint of “actual and constructive knowledge” of the setback and “willful disregard of the rights” of his neighbors, the complaint viewed as a whole suggests to the reasonable reader that Liebovich did not intentionally set out to harm his neighbors. Under Wisconsin law, an intentional act restriction only excludes coverage when the insured acts intentionally and intends that some harm follow from his or her actions. We understand that this does not necessarily require “subjective” intent to harm on the part of the insured. The law is that “objective” intent can be inferred where the insured acts intentionally and the act is substantially certain to produce injury. We also understand that the neighbors claimed they notified Liebovich of the restriction and he built his house anyway. As far as the complaint reveals, this is their basis for claiming that he willfully disregarded their rights. However, our charge—and that of insurers—is to liberally construe the allegations in the complaint in favor of the insured, and draw reasonable inferences from them, to determine whether the potential for coverage exists. Here, it is a reasonable inference that when Liebovich’s neighbors accuse him of “willful disregard” of their rights, they mean that he refused to conform his conduct to what they thought was legal and illegal; not that he knew he was building an illegal house and just did not care.\(^{72}\)

3. Contractual Liability Exclusion

With limited exceptions, CGL coverage is not intended to provide protection against an insured’s contractual commitment to be responsible for another’s liability. This makes perfectly good sense, as the insurer would need to underwrite not only the insured’s business but also those for which it becomes contractually responsible. A contractual liability exclusion, however, contains a number of exceptions. The most important exception, at least for those in the construction business, is the “insured contract” exception. An “insured contract” is an agreement under which the insured assumes the tort liability of another party to pay for “bodily injury” or “property damage” caused to a third party. A typical scenario in which this exception is triggered occurs where a subcontractor’s employee is injured on the job and sues the general contractor alleging negligent supervision or some other tort. The general contractor, in turn, claims indemni-
fication from the subcontractor under a written indemnification agreement contained in the subcontract. In most cases, the indemnity claim would be sufficient to trigger coverage under the subcontractor’s CGL policy.

The Supreme Court of Illinois, however, has concluded otherwise in Virginia Sur. Co., Inc. v. Northern Ins. Company of New York.73 The “indemnity” agreement in question was standard and read, in pertinent part:

To the fullest extent permitted by law, the Subcontractor WAIVES ANY RIGHT OF CONTRIBUTION AGAINST AND shall indemnify and hold harmless the Owner, Contractor, Architect, Architect’s consultants, and agents and employees of any of them from and against claims, damages, losses, and expenses, including but not limited to attorney’s fees, arising out of or resulting from performance of the Subcontractor’s Work under this Subcontract, provided that such claim, damage, loss or expense is attributable to bodily injury, sickness, disease or death or to injury to or destruction of tangible property (other than the Work itself) including loss of use therefrom, WHICH IS caused in whole or in part by negligent acts or omissions of the Subcontractor . . . .74

Notwithstanding the fact that this provision was a standard indemnity clause requiring the subcontractor to indemnify the general contractor for loss occasioned by the general contractor’s negligence as long as the subcontractor was jointly responsible for the harm, the Illinois Supreme Court concluded the provision did not amount to an indemnification agreement. The court read the indemnity provision as obligating the subcontractor to pay only its pro rata share of liability and, thus, was not an “indemnity” agreement. The effect of the clause under Illinois law was that the subcontractor waived its liability cap under Illinois’ workers’ compensation statute. Because the agreement was not interpreted as an “indemnity” agreement, it did not meet the “insured contract” exception of the subcontractor’s CGL policy and, therefore, no coverage was afforded. One can quibble with the court’s analysis. Although the language is not interpreted as an indemnity, it is a waiver of the workers’ compensation liability shield. Yet, a common reading of this language rules out indemnity only in instances where the general contractor is solely responsible for the injury. Illinois law expressly permits indemnity in these situations where coverage is afforded for the

obligation. The Illinois Supreme Court’s decision, however, makes a muddle out of the parties’ contractual arrangements and the legislature’s intent to permit such arrangements as long as insurance is procured.

The common requirement that the indemnity be in written form can be important. In Love v. AAA Temporaries, Inc., the “insured contract” exception of CGL policies procured by a temporary employment agency was not triggered where the “indemnity” agreement was oral rather than written. The CGL policy defined an “insured contract” as a written contract or agreement in which the insured assumes the tort liability of a third party.

4. Pollution Exclusion

Liability for pollution-related injuries began to become significant in the 1970s. The insurance industry’s first response was to eliminate coverage for pollution-related injury except in cases of “sudden and accidental” loss. The “sudden and accidental” exception proved more broad than most insurers expected. The industry, as a consequence, moved to an “absolute” pollution exclusion. Notwithstanding its moniker or the inclusive language employed to frame the exclusion, many courts have limited it to traditional environmental contamination situations.

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75 See 70 ILCS 35/3.
76 Love v. AAA Temporaries, Inc., 961 So. 2d 480 (La. Ct. App. 1st Cir. 2007).
77 See Auto-Owners Ins. Co. v. Potter, 105 Fed. Appx. 484 (4th Cir. 2004) (applying North Carolina law) (pollution exclusion does not apply to underlying claims which are more akin to an instance in which an adulterated product has been supplied to consumers); Meridian Mut. Ins. Co. v. Kellman, 197 F.3d 1178, 30 Envtl. L. Rep. 20243, 1999 FED App. 0403P (6th Cir. 1999) (applying Michigan law) (movement of fumes from toxic chemical used by construction contractor to seal floor of school was not discharge, dispersal, seepage, migration, release or escape under pollution exclusion when those fumes injured school employee working in a room immediately below where the sealer was being applied); Nautilus Ins. Co. v. Jabar, 188 F.3d 27, 30–31, 49 Env’t. Rep. Cas. (BNA) 1507, 30 Envtl. L. Rep. 20026 (1st Cir. 1999) (applying Maine law) (pollution exclusion ambiguous as applied to claim for injury arising from exposure to fumes discharge by roofing products because reasonable person would understand exclusion as applying only to environmental pollution); Bituminous Cas. Corp. v. Advanced Adhesive Technology, Inc., 73 F.3d 335, 339 (11th Cir. 1996) (applying Georgia law) (a state’s claim alleging decedent died from inhaling fumes from carpet machine in confined boat cabin space was not excluded because pollution exclusion ambiguous and the insurance company’s position that the clause excludes coverage for a consumer’s claim for damages arising out of the intended use of the insured’s product is a strained one); Stoney Run
other hand, numerous courts have applied the exclusion to traditional construction-related workplace injuries.\textsuperscript{78}

In Firemen’s Ins. Co. of Washington, D.C. v. Kline & Son Cement Repair, Inc.,\textsuperscript{79} the Federal District Court, interpreting Virginia law, concluded that the pollution exclusion was not limited to traditional environmental liability and applied it to a claim arising from inhalation of vapors following a subcontractor’s application of epoxy sealant to a concrete warehouse floor. Noting that there is a split among the jurisdictions over the breadth of the pollution exclusion, the court nonetheless found the language of the exclusion to be quite broad and not limited to traditional or outdoor pollution situations:

\begin{quote}
Co. v. Prudential-LMI Commercial Ins. Co., 47 F.3d 34 (2d Cir. 1995) (applying New York law) (death from carbon monoxide emitted from defective apartment heating system not within exclusion because it was not pollution of environment); Red Panther Chemical Co. v. Insurance Co. of State of Pa., 43 F.3d 514 (10th Cir. 1994) (applying Oklahoma law) (exclusion ambiguous and did not bar mechanic’s claim for injuries resulting from breathing fumes from pesticides which had been spilled by the insured on a car the mechanic was inspecting); Lumbermens Mut. Cas. Co. v. S-W Industries, Inc., 39 F.3d 1324, 1994 FED App. 0360A (6th Cir. 1994) (applying Ohio law) (pollution exclusion did not shield insurer from liability for injuries caused by toxic cements that were confined within area of intended use); Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 390 Md. 449, 889 A.2d 387 (2006) (pollution exclusion ambiguous in context of manganese welding fumes and not intended to bar injury by “non-environmental, localized workplace fumes”); American States Ins. Co. v. Koloms, 177 Ill. 2d 473, 227 Ill. Dec. 149, 687 N.E.2d 72 (1997) (holding that pollution exclusion did not extend beyond traditional environmental arena).


Nothing in the language of the Policy or the Pollution Exclusion clause at issue suggests that the parties intended only “traditional” or “outdoor” pollution scenarios to be excluded from coverage, and it would be impermissible for the Court to construe the clause as creating an ambiguity where none exists. The drafters of the clause could have used words of limitation to exempt indoor (i.e., non-industrial) air pollution from its application, but they did not do so. The broadness of the exclusionary language, coupled with the parties’ failure to specify that the exclusion be limited to only “traditional” or “industrial” pollution, therefore mandates the conclusion that the Pollution Exclusion clause is sweeping, excepting both environmental and indoor pollution occurrences from coverage.\(^{80}\)

5. Property Being Worked on Exclusion

A common “business risk” exclusion designated in the standard ISO policy form as 2j(5) and reads:

This insurance does not apply to:

* * *

“Property Damage” to:

* * *

(5) that particular part of real property in which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the “property damage” arises out of those operations . . . .

This is an “ongoing operations” exclusion. In other words, because the exclusion uses the language “are performing operations,” it applies when the “property damage” arises at a time that the insured or those working on its behalf are working. In Advantage Homebuilding, LLC v. Maryland Cas. Co.,\(^{81}\) the court examined the question of just what has to occur during the insured’s operations for the exclusion to apply. In this case, three homeowners secured a judgment against the insured for material


\(^{81}\)Advantage Homebuilding, LLC v. Maryland Cas. Co., 470 F.3d 1003 (10th Cir. 2006).
defects and damage to windows in their homes. The district court concluded that the masonry subcontractor was performing its work when the damage to the windows occurred. The masonry subcontractor scratched the windows or dropped mortar on them while performing its work. As a consequence, it concluded that exclusion j(5) eliminated coverage. The homebuilders claimed that j(5) did not apply because the homeowners did not have a claim against it until they acquired the property and that the exclusion did not apply as all work was completed by the time the homeowners' claims against the homebuilder arose. The Tenth Circuit rejected this argument on grounds that the language of the exclusion speaks in terms of “property damage” and not “claims.”

The Supreme Court of Kentucky found the exclusion ambiguous in *Bituminous Cas. Corp. v. Kenway Contracting, Inc.* In this case, the owners of a single-story residential structure with an attached carport wished to convert it for commercial use. They hired a contractor to remove the attached carport and perform some construction work beneath the carport. Unfortunately, a miscommunication occurred with the insured's heavy equipment operator, who had demolished most of the house by the time the project superintendent returned to the job site. The insurer claimed that exclusion j(5) applied, as the insured was performing operations on the residence when the residence occurred. The insured claimed that they had been hired only to perform work on the carport and, therefore, operations were not being performed on the residence which, in actuality, constituted the damage. The court sided with the insured on the grounds that the exclusion was subject to both interpretations and, therefore, ambiguous:

> [W]e note that the phrase “that particular part of real property” and the term “operations” are not defined in the CGL policy. The Allens [insured] suggest that from their perspective, operations should be limited to the carport. BCC [insurer] argues operations should be determined from the perspective of McComas [equipment operator], and real property should extend to any real property upon which operations are occurring. Given that the policy contains terms that are not defined, and given that each party has suggested a reasonable interpretation in light of the plain meaning of the words used, we conclude the policy is ambiguous. In keeping with the principle that “[a]n ambiguous policy is to be construed against

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82*Bituminous Cas. Corp. v. Kenway Contracting, Inc.*, 240 S.W.3d 633 (Ky. 2007), as modified, (Dec. 21, 2007) and as modified on denial of reh’g, (Jan. 24, 2008).
the drafter, and so as to effectuate the policy indemnity [.]” we conclude exclusion 2j(5) does not operate to preclude coverage.83

6. Faulty Workmanship Exclusion

This exclusion, designated as 2j(6) in the standard ISO policy form, is frequently raised in conjunction with its close relative, exclusion 2j(5). This exclusion reads:

This insurance does not apply to:

***(

“Property Damage” to:

*(

(6) that particular part of any property that must be restored, repaired or replaced because “your work” was incorrectly performed on it.

Like exclusion j(5), this exclusion does not apply to “property damage” included in the “products-completed operations hazard.” In other words, the exclusion applies to “property damage” that arises while the insured’s operations are ongoing.

The Supreme Court of Louisiana applied the exclusion to a cracking concrete problem in *Supreme Servs. and Specialty Co. v. Sonny Greer, Inc.*84 What is unusual about this opinion is that, while the court acknowledges that the exclusion applies only to property damage which arises while the insured is performing operations, it does not address when the cracks appeared in the concrete for purposes of applying the exclusion. Instead, the court got sidetracked on the issue of whether damage occurred to property that was not the insured’s work.85

7. Work Product Exclusion

The “work-product” exclusion does not play a significant role in construction disputes except in limited cases or certain jurisdictions. The exclusion eliminates coverage for “property


84 Supreme Services and Specialty Co., Inc. v. Sonny Greer, Inc., 958 So. 2d 634 (La. 2007).

85 See also, Advantage Homebuilding, LLC v. Maryland Cas. Co., 470 F.3d 1003 (10th Cir. 2006) (applying Kansas law) (exclusion j(6) applied, although “inartfully drafted”). *But see,* Bituminous Cas. Corp. v. Kenway Contracting, Inc., 240 S.W.3d 633 (Ky. 2007), as modified, (Dec. 21, 2007) and as modified on denial of reh’g, (Jan. 24, 2008) (exclusion j(6) ambiguous as it could be interpreted either as applying to work performed properly but in the wrong location, thus requiring repair or replacement, or applying only to the manner of work that was performed).
damage” to the insured’s product (“your product”) arising out of it or any part of it. The reason that the exclusion plays a minor role in construction disputes is because it is normally construed to apply only to personal property. In Dublin Bldg. Sys. v. Selective Ins. Co. of South Carolina, the insurer claimed that, although the term “product” is defined in the policy as “[a]ny goods or products, other than real property . . .”, the term “real property” meant “land” only and did not include structures affixed upon the land. The court found the insurer’s argument unpersuasive.

[T]he term “real property” is generally recognized as including both land and the structures affixed thereto. Real property is an estate or property consisting of lands and of all appurtenances to lands, as buildings, crops, or mineral rights. Real property is land and anything growing on, attached to, or erected on it. Ohio law has defined real property to include buildings attached to land. Selective fails to cite any contrary authority. Accordingly, we hold that Selective failed to meet its burden of proving that exclusion k precluded coverage, and the trial court erred in so finding.

The Fifth Circuit, applying Louisiana law, examined the “work product” exclusion in the context of additional insured coverage. In National Union Fire Ins. Co. of Pittsburgh, Penn. v. Liberty Mut. Ins. Co., an engineering contractor hired a pipe fabricator. The pipe fabricator named the contractor an additional insured under its CGL policy. The owner terminated the contractor for, among other things, supplying allegedly defective pipe. The contractor’s CGL carrier paid monies to settle the owner’s claim and then brought suit against the pipe fabricator’s insurer for contribution on the ground that they shared the contractor as an insured. The pipe fabricator’s insurer acknowledged that the contractor was an additional insured but claimed that the “your work” exclusion applied to eliminate coverage. The court agreed, finding that the terms “you” and “your work” applied only to the pipe fabricator and not the contractor as an additional insured:

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National Union seeks coverage as an additional insured, arguing the “your work” and “your product” exceptions do not apply to S&B because “you” was defined in the contract as American Pipe, not additional insureds such as S&B. We take as a given that “you” in this policy only means American Pipe, according to the policy’s definition of that word. Read with that definition, the policy excludes claims based on American Pipe’s work or product, because American Pipe is substituted for you in those exclusions. S&B’s claim as an additional insured is based on American Pipe’s work or product. S&B is correct that if S&B’s work or product had been the basis of the suit, these exclusions would not apply, but they do apply in this case because American Pipe’s work or product is the cause of the claim. Substituting “American Pipe” for “you” in the subcontractor exception similarly reveals that S&B is not entitled to relief under that exception. The policy says that the “your work” exclusion does not apply “if the damaged work or the work out of which the damages arises was performed on your behalf by a subcontractor.” Because the contract defines “you” as American Pipe, the exception applies when someone else does work as American Pipe’s subcontractor, not when American Pipe is a subcontractor. “[O]n your behalf” becomes “on American Pipe’s behalf,” so S&B cannot obtain the benefit of this exception, because no one worked on American Pipe’s behalf. S&B was excluded from coverage because American Pipe’s work or product was the basis of the claim, and American Pipe did not hire a subcontractor to work on its behalf, so the district court correctly determined that S&B’s claim was excluded.

8. Completed Operations Exclusion

This exclusion, which goes by a number of different names, including the “Your Work” exclusion, can play a significant role in limiting coverage for construction deficiencies in a completed operations context. The exclusion is particularly problematic for insureds that perform their own work. Insureds that employ others, such as a general contractor that uses subcontractors to construct the project, are less affected by the exclusion due to an express exception for subcontractor work. As the Texas Supreme Court explained:

Lamar submits that this exclusion would have eliminated coverage here but for the subcontractor exception. According to Lamar, this exception was added to protect the insured from the consequences of a subcontractor’s faulty workmanship causing “property damage.” Thus, when a general contractor becomes liable for damage to work performed by a subcontractor—or for damage to the general contractor’s own work arising out of a subcontractor’s work—the subcontractor exception preserves coverage that the “your-work”

exclusion would otherwise negate. Lamar’s understanding of the subcontractor exception is consistent with other authorities who have commented on its effect.\footnote{Lamar Homes, Inc. v. Mid-Continent Cas. Co., 2007 WL 2459193 *7 (Tex. 2007). See also, 2 Stempel on Insurance Contracts, § 14[13][D] at 14-224.8–14-224.9; 2 Alan D. Windt, Insurance Claims and Disputes, § 11.3 at 73–74 (4th ed. 2006 Supp.).}

The exclusion has been cited in support of the theory that the insuring clause requirement of an “occurrence” must admit of instances of “faulty workmanship.” As the Florida Supreme Court in \textit{U.S. Fire Ins. Co. v. J.S.U.B., Inc.},\footnote{U.S. Fire Ins. Co. v. J.S.U.B., Inc., 979 So. 2d 871 (Fla. 2007).} reasoned, if the faulty workmanship never rose to the level of an “occurrence” then there would be no need for work-related exclusions. Moreover, the subcontractor exception to the exclusion would be rendered meaningless.

\section{Impaired Property Exclusion}

This exclusion requires one to juggle a number of different concepts. On the one hand, the exclusion speaks in terms of “property” that has not been physically injured. On the other hand, the exclusion also incorporates the concept of “impaired property,” which is a defined term—the definition of which is more lengthy than the exclusion. The exclusion also has an exception for loss of use of other property arising out of “sudden and accidental physical injury to the insured’s work or product after it has been put to its intended use.” In essence, the exclusion eliminates coverage for property damage to impaired property or property that has not been physically injured arising out of:

(1) a defect, deficiency, inadequacy, or dangerous condition in “your product” or “your-work”; or (2) a delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

This can be a difficult exclusion to interpret and apply. The Louisiana Court of Appeals in \textit{Stewart Interior Contractors, L.L.C. v. Metalpro Industries, L.L.C.},\footnote{Stewart Interior Contractors, L.L.C. v. Metalpro Industries, L.L.C., 969 So. 2d 653 (La. Ct. App. 4th Cir. 2007)} characterized the exclusion as eliminating coverage for damage to property that has not been physically injured or for which only loss of use is sought. The exclusion does not apply where there is physical damage to property other than the insured’s work or product after the product has been put to its intended use. While the exclusion focuses on “loss-of-use” property damage, it does not eliminate all such
injury from coverage in instances where there is no physical injury to tangible property.

10. Prior Injury Exclusion

Because of concerns over numerous policies responding to latent and long-festering property damage, the industry has begun to craft policies with manuscript exclusions intended to affect traditional coverage triggers. In *Williams Consol. I, Ltd. v. TIG Ins. Co.*, the problem was an improperly installed vapor barrier that caused moisture to condense which led to mold growth. The house was constructed in 1991, but it was not until 2000 that the homeowners became aware of the problem. They claimed the mold contamination made them ill and forced them to leave their home. They sued their builder. The builder sought coverage and defense under its CGL policy with a coverage period of August 1, 1999, to May 1, 2001. The insurer denied any obligation to the insured on the grounds that the policy contained an exclusion that read:

No insurance coverage is provided under this policy to defend or indemnify any insured for “bodily injury,” “property damage,” “personal injury,” or “advertising injury” which has first occurred or begun prior to the effective date of this policy, regardless of whether repeated or continued exposure to conditions which were a cause of such for [sic] “bodily injury,” “property damage,” “personal injury” or “advertising injury” occurs during the period of this policy and cause [sic] additional, progressive or further “bodily injury,” “property damage,” “personal injury,” or “advertising injury” all of which is excluded from coverage.

This exclusion shall apply whether or not the Insured’s legal obligation to pay damages has been established as of the inception date of this policy.

The court interpreted the exclusion to apply notwithstanding the fact that the injury or damage had not manifested itself until after the effective date of the policy as long as injury occurred prior to the inception date. Nonetheless, the court concluded that the insurer had not established entitlement to summary judgment, implicitly drawing a distinction between mold growth and property damage:

Even presuming that there was some degree of mold growth beginning within the first two years of occupancy and continuing until the vapor barrier was removed, the summary-judgment evidence

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does not address when the Mokrys’ alleged property damage or bodily injury first occurred or began. Evidence that some mold grew in the first two years of occupancy does not prove that the mold caused property damage or bodily injury in the first two years of occupancy. The summary-judgment evidence did not conclusively prove that the Mokrys’ alleged property damage or bodily injury first occurred or began before August 1, 1999.95

11. Professional Services Exclusion

The general liability policy, as the name implies, is not intended to cover specialized risks arising out of the provision of professional services. Professional risks are covered by professional liability insurance. Professional liability insurance, a form of “errors and omissions” coverage, is written through policies that are structured much differently than the CGL policy. Professional liability policies are written on a “claims made” basis rather than an “occurrence” based approach. Under an occurrence policy, coverage is triggered based largely on the timing of the injury. Under a claims-made policy, coverage is triggered when a claim is asserted against the insured. Claims-made policies have much shorter half-lives than occurrence policies. An occurrence policy issued in the late 1960s might well respond to a 21st century claim, depending upon the trigger approach used in the relevant jurisdiction. Claims-made policies, on the other hand, cannot be resurrected (without purchasing tail coverage) once they expire without a claim having been asserted. From this perspective, financial exposure to an insurer under a claims-made policy is more predictable than with an occurrence policy. The medical insurance crisis of the 1970s caused the industry to first move medical malpractice policies from an occurrence-based product to a claims-made approach—with other professional policies following suit.

This exclusion is often added by way of a restrictive endorsement to the CGL policies of insureds who regularly perform professional services. The intent of the exclusion is to carve out professional risk that is subject to transfer to an insurer under a professional liability policy.

Some courts focus on the nature of the insured and broadly apply the exclusion to almost any act undertaken by a licensed professional. Other courts focus more on the nature of the act and apply the exclusion only where the act is properly characterized as one requiring the training, education, skill, and experi-
ence of a professional. The West Virginia Supreme Court, in Webster County Solid Waste Authority v. Brackenrich & Associates, Inc., appeared to adopt the broad approach when applying the exclusion to a municipal solid waste authority's claims against an engineering firm hired to design and supervise the construction of certain upgrades to a landfill. In rejecting the municipality's arguments that its claims against the engineer for improper supervision did not trigger the exclusion, the court reasoned:

While the Authority suggests that the negligence averments contained in the complaint are both professional and non-professional in nature, the only averments that it suggests qualify as non-professional are the inspection-related allegations. Given the clear obligation to provide such inspection services as part of the duties delineated in the “Agreement for Engineering Services,” we do not find the Authority’s position on this issue to be persuasive.

According to the court’s logic, if the act falls within the scope of a professional's contract, it is deemed “professional” for purposes of the exclusion.

The majority trend focusing on the nature of the service was aptly expressed in Camp Dresser & McKee, Inc. v. Home Ins. Co.:

In determining whether an omission or activity falls within the

98But see, U.S. Fidelity and Guar. Co. v. Armstrong, 479 So. 2d 1164, 1168–1169 (Ala. 1985) (on appeal from trial court ruling in favor of coverage, but, containing no findings of fact, coverage was found where engineer testified that he performed both professional services and non-professional services, such as acting as a liaison between the owner and contractor); Cochran v. B.J. Services Co. USA, 302 F.3d 499 (5th Cir. 2002) (applying Louisiana law, CGL policy’s “professional services” exclusion did not apply to supervision of oil-drilling operations, where neither the supervision nor the activity being supervised at the time of the accident, involved technical or specialized expertise); Aetna Fire Underwriters Ins. Co. v. Southwestern Engineering Co., 626 S.W.2d 99 (Tex. App. Beaumont 1981), writ refused n.r.e. (where design agreement did not expressly require engineer to locate underground pipelines and the court could not, as a matter of law, determine that such work required engineering education, the exclusion did not apply). But see, Womack v. Travelers Ins. Co., 251 So. 2d 463 (La. Ct. App. 1st Cir. 1971) (inclusion of underground pipelines in plans is an engineering service).
scope of a professional services exclusion, courts generally look to
the nature of the conduct under scrutiny rather than to the title or
the position of those involved . . . Accordingly, the fact that [the
insured’s] contracts with the city of Detroit may have been
performed by engineers or other professionals does not compel the
conclusion that the contracts, in all respects, called for professional
services. Such an interpretation would have the exclusion swallow
the policy.

Yet, even under an “act” rather than an “actor” analysis, supervi-
sion activities are usually considered to be professional services.¹⁰⁰

This exclusion was examined in N. Am. Treatment Sys., Inc. v.
Scottsdale Ins. Co.,¹⁰¹ where a California water district sought to
build a new wastewater treatment plant. It wished to incorporate
a relatively new treatment process that produces recycled water
through a more efficient manner by employing an “extended air”
approach. The new technology was called a “BOAT system”—the
equipment was shaped somewhat like a boat, with the wastewater
flowing from the stern to the bow. To accomplish this work, the
district retained North American Treatment Systems, Inc.
(NATS), to act as project manager. NATS was a limited-purpose
corporation, having been formed solely for the purpose of this
project. It did not possess a California license to perform either
professional engineering or contracting services. Most of NATS
corporate officers and representatives were principals or employ-

Super. 241, 302 A.2d 177 (Law Div. 1973) (supervision by engineer of trenching
operation was a professional service); Sheppard, Morgan & Schwaab, Inc. v. U.
S. Fidelity & Guaranty Co., 44 Ill. App. 3d 481, 3 Ill. Dec. 138, 358 N.E.2d 305
(5th Dist. 1976) (exclusion applies to trench collapse, where the engineer agreed
to supervise the project); U.S. Fidelity & Guar. Co. v. Continental Cas. Co., 153
applied to architect’s liability under Illinois Structural Work Act, where worker
injured when he fell through an unguarded skylight); Utica Lloyd’s of Texas v.
applied to liability for trench collapse, where insured had non-engineering
personnel perform inspection services). But see, Reliance Ins. Co. v. National
Union Fire Ins. Co. of Pittsburgh, Pa., 262 A.D. 2d 64, 691 N.Y.S.2d 458
(N.Y.A.D. 1 Dept. 1999) (engineering firm’s obligation to inspect contractor’s
ongoing work to insure compliance with contract and applicable safety laws
required only normal powers of supervision and observation and not engineer-
to contribution from architect’s CGL carrier, where worker injured by wall col-
lapse alleged that architect’s negligence was not restricted to negligence in the
design of the plans and specifications of the wall).

ees of United Industries, Inc. (United), which manufactured and supplied the BOAT clarifier. While the court does not explain just how a California corporation doing work on a wastewater treatment plant in California ended up having a coverage dispute in Louisiana after a California arbitration, it appears that the role of United might have played a part in the situs of the case (although the court says precious little about who or what United is).

NATS’s contract was for nearly $33 million. It was designated as a “professional services” contract and required NATS to perform “the professional services required for the design, engineering, construction management, and operations management required for the construction and operation of the treatment plant . . . .” How NATS intended to perform this work without the appropriate licenses is not discussed. It is not surprising that NATS had difficulty securing coverage under a CGL policy for problems that arose with this contract. Many of these problems were the result of the court’s application of the policy’s professional services exclusion:

Coverage for professional liability is usually excluded under CGL or other commercial liability policies, being usually provided under special policies, which, depending upon the profession or business, may be referred to as malpractice, errors and omissions (E&O), or professional liability policies. Even though the District did not specifically require NATS to maintain professional liability insurance in place, as opposed to CGL coverage, this fact is not determinative of the nature of those services it independently provided . . . .

It must be noted that NATS agreed to provide those “professional services” required for “construction management,” in turn required for “construction”; it did not agree to provide any professional services required for the actual physical construction of the RP-4 plant . . . . The evidence is undisputed that the parties do not consider the Contract to be a construction contract and that the District considered APC/T&K to be the “contractor” in that respect . . . . Scottsdale’s policy provides no definition of the term “professional services.” “Professional services,” in its usual connotation, means services performed by one in the ordinary course of the practice of his profession, on behalf of another, pursuant to some agreement, express or implied, and for which it could reasonably be expected some compensation would be due. In determining whether a particular act is professional in nature, a court should examine the character of the act itself, rather than the title or character of the party performing the act. Factors that should be considered are whether the act involved the exercise of professional judgment or required the exercise of a particular skill or discretion acquired by special training, or whether the act could have been done by an unskilled or untrained person . . . .

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As to actual coverage under the policy, however, the uncontradicted evidence before us demonstrates that the property damage from the collapse of the BOAT clarifier were caused by NATS’s failure to render professional services required of it as a “Project Manager” under the Contract. It is undisputed that the District retained NATS’s services as a consultant for the RP-4 plant project because of its expertise and familiarity with the particular process involved. It is worthy of note that the Contract did not limit the use of the term “professional services” to the professional engineering services NATS provided through its sub-consultant, NBS Lowry . . . . NATS’s corporate representative admitted in his deposition taken in this action that NATS was aware of when the channel leak testing was being conducted by APC/T&K, was aware that a subcontractor or supplier was present installing chain wheels on water valves, and that NATS “should have done a better job” of coordinating the activities of the various personnel of the District, APC/T&K, NBS Lowry, and the subcontractor or supplier at the time of the BOAT clarifier collapse. The latter duties fell squarely within NATS’s admitted contractual responsibility for “professional services” as overall project liaison, thus rendering the “professional services exclusion” applicable to it.102

12. Auto Exclusion

CGL policies do not respond to losses arising out of the operation of motor vehicles for the simple reason that the automobile liability insurance policy responds to these losses. For the most part, the auto exclusion gives rise to few interpretation disputes.

Once in a while, however, factual circumstances are such that a question arises as to whether the exclusion applies. In Employers Mut. Cas. Co. v. St. Paul Ins. Co.,103 an issue arose as to whether the auto exclusion applied where the motor vehicle involved in a crash was used as a “stationary steel barricade” as opposed to a mobile vehicle. The accident occurred on a highway striping project where the vehicle in question was a “crash truck” that trailed the work crew providing a safety barrier for the movable worksite. The court found the exclusion applied:

Employers first argues the accident did not arise out of the inherent nature of the truck as such and that the use of the truck had terminated because the truck was stopped on the freeway when the Hudmans drove into it. Employers argues the truck was being used as a barrier, not a vehicle. We disagree. The truck was being used to transport the driver, the crash barrier, and the flashing arrow sign when the Hudmans drove into it. Although the truck was not


moving and was not in gear when the Hudmans drove into it, the
tuck was still being used to transport the driver, crash barrier,
and sign at the time of the accident. 104

13. Employee Exclusion

As with the auto exclusion, the employee exclusion is intended
to carve out coverage for liability covered under another
policy—in this case, the workers’ compensation/employer’s li-
ability policy. Questions can and do arise with respect to the
scope and operation of this exclusion when the party seeking
coverage is an additional insured.

In Roundtree v. New Orleans Aviation Bd., 105 an employee of
an asbestos abatement subcontractor was injured during abate-
ment operations. He sued the general contractor, who was named
an additional insured under the asbestos abatement subcontractor’s CGL policy. The policy’s employee exclusion eliminated
coverage for bodily injury to an employee or principal of a
subcontractor of the insured if they are or were in an “asbestos
abatement area” where “asbestos abatement operations” are or
were being performed. The policy also contained a “separation” or
“severability” provision which provided that the insurance ap-
plies “as if each Named Insured were the only Named Insured
and separately to each Insured against whom claim is made or
‘suit’ is brought.” Such severability provisions, in effect, require
the policy to be construed as providing separate coverage for each insured, i.e., “as if each was separately insured with a distinct
policy.” 106 Moreover, such severability provisions have “the e-
cfect of rendering the employee exclusion inapplicable where an em-
ployee of one insured is injured by the other insured.” 107 The
confluence of the severability provision with the specific language
of the employee exclusion rendered the policy inapplicable to the
additional insured general contractor, as its subcontractor’s (the

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(Tex. Ct. App. 2005) (also finding the “specialized equipment” and “mobile
equipment” exceptions did not apply). See also BP America, Inc. v. State Auto
“any insured” in an “Auto Exclusion” clause of a commercial general liability
policy excludes from coverage all automotive occurrences attributable to any of
the insureds).

4th Cir. 2005).

2002).

asbestos abatement subcontractor) employee was injured and, under the express language of the exclusion, bodily injury to an employee of one of the insured’s subcontractors is not covered. The policy, however, did respond to a claim against another additional insured—the owner. Because the owner did not hire the asbestos abatement contractor, it was not a subcontractor of the owner’s and therefore the exclusion did not apply to claims against the owner.

D. Additional Insured Coverage

1. Creation of Coverage

Insurance, like most risk allocation in the construction industry, runs down hill. Owners request their contractors to provide them coverage. Contractors, in turn, request their subcontractors to do the same. The vehicle by which insurance flows down hill is the additional insured endorsement. A common requirement of these endorsements is that the commitment to procure such coverage be in writing.  

In a similar vein, an Illinois Court of Appeals has determined that no additional insured coverage was afforded an owner under circumstances where the named insured’s contract, which did not contain an obligation to purchase additional insured coverage for anyone, did not reference the general contractor’s agreement with the owner, which did. As a consequence, the general contractor’s obligation to procure additional insured coverage did not “flow down” to the subcontractor.  

108See Cincinnati Ins. Co. v. Gateway Const. Co., Inc., 372 Ill. App. 3d 148, 310 Ill. Dec. 71, 865 N.E.2d 395 (1st Dist. 2007) (oral agreement to add general contractor and others as an additional insured under subcontractor’s policy was insufficient to create coverage where additional insured endorsement required commitment to be in writing). Moreover, a subcontractor’s agreement to indemnify the general contractor and secure general liability coverage for itself is not equivalent to agreeing to make the contractor an additional insured under the subcontractor’s liability policy. See Lennar Corp. v. Auto-Owners Ins. Co., 214 Ariz. 255, 151 P.3d 538, 550 (Ct. App. Div. 1 2007), review denied, (Sept. 25, 2007).

109See Clarendon America Ins. Co. v. 69 West Washington Management LLC, 374 Ill. App. 3d 580, 312 Ill. Dec. 534, 870 N.E.2d 978 (1st Dist. 2007). See also, Clarendon America Ins. Co. v. Aargus Sec. Systems, Inc., 374 Ill. App. 3d 591, 312 Ill. Dec. 544, 870 N.E.2d 988 (1st Dist. 2007) (paragraph in named insured's contract simply requiring the purchase of insurance does not require securing additional insured coverage and even if certificate of insurance could be interpreted to suggest otherwise, it did not create a contract obligation and was insufficient to prove named insured had an obligation under a valid written contract to provide such coverage).
In Penn National Ins. v. HNI Corp.,\textsuperscript{110} a fireplace manufacturer
sought additional insured coverage under an installer's policy for
losses incurred to a model home due to fire. Yet, the policy did
not list the fireplace manufacturer as an additional insured and
the certificate of insurance did not suggest otherwise. As a conse-
quence, the court could not find that the fireplace manufacturer
was an additional insured under the installer's policy.

The Eighth Circuit's decision in Ohio Cas. Ins. Co. v. Union
Pacific Railroad Co.,\textsuperscript{111} presents an interesting question of the
timing of the writing in which the named insured agrees to
provide additional insured coverage. Union Pacific hired Tri-
State to provide traffic control services at its construction sites.
Tri-State was to name Union Pacific as an additional insured
under its general liability policy. The blanket additional insured
endorsement contained in Tri-State's policy rendered additional
insured coverage to all persons to whom Tri-State was obligated
to provide additional insured coverage under a written agreement.
The written agreement had to be currently in effect or becoming
effective during the term of the policy and executed prior to the
injury. The Tri-State contract with Union Pacific became effective
on June 1, 1998, and expired on June 1, 2000. Ohio Casualty's
policy, under which additional insured coverage was sought, ran
from January 22, 2000, to January 22, 2001. After June 1, 2000,
Tri-State continued to provide traffic control services for Union
Pacific, notwithstanding the fact that its contract had expired.
On August 7, 2000, a Union Pacific train collided with a vehicle
at a railroad crossing at which Tri-State was providing flagging
services. Tri-State's insurer denied Union Pacific additional
insured coverage on the grounds that there was no written
contract in effect on August 7, 2000, when the injury occurred,
obligating Tri-State to procure additional insured coverage for
Union Pacific. Union Pacific countered that the additional insured
endorsement simply required a written commitment be in place
at the time Ohio Casualty's policy commenced instead of at the
time of injury. The court agreed with Union Pacific:

\[\text{Any ambiguity on this point is resolved by the endorsement's}\]
\[\text{express requirement that the written contract or agreement be}\]
\[\text{"currently in effect or become[e] effective during the term of [the]}\]
\[\text{policy." The plain, ordinary and popular definition of "currently" is}\]
\[\text{"at present." "Currently" is not reasonably susceptible to an inter-}\]
\[\text{pretation that it refers to the unknown date of a future occurrence}\]

\textsuperscript{111}Ohio Cas. Ins. Co. v. Union Pacific Railroad Co., 469 F.3d 1158 (8th Cir.
2006).

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that triggers coverage. To interpret “currently” as referring to a
time other than the date the policy issued would neutralize the
phrase “or becoming effective during the term of [the] policy.” In
other words, to give meaning to the phrase “or becoming effective,”
“currently” can only reasonably refer to the date of issuance.
Therefore, “currently in effect,” as used in the Additional Insured
endorsement, unambiguously means in effect on the date the policy
issued.

There are no words or terms of the Additional Insured endorsement
that require a written contract or agreement be in effect on the
date of the occurrence triggering coverage when the occurrence
happens within the policy period. If Ohio Casualty intended the Ad-
tional Insured endorsement to require that the written contract
or agreement be in effect on the date of such occurrence, it could
have expressly stated that prerequisite and limited additional
insured status to the duration of the underlying written contract,
as opposed to the policy period. It did not. As written, the Additional
Insured endorsement unambiguously includes as an insured an or-
ganization that is required to be insured under the policy pursuant
to a written contract that is in effect on the date the policy issued
and executed prior to the bodily injury. The Tri-State contract met
each of these requirements. Therefore, Union Pacific is an additional
insured under the primary policy, and its status as an additional
insured for work performed by Tri-State on its behalf during the
policy period did not automatically terminate on the expiration date
of the written contract.\textsuperscript{112}

On occasion the issue is not whether a written agreement ex-
ists sufficient to trigger additional insured coverage, but whether
the claimant falls under the “blanket” endorsement. In \textit{Six Flags,
Inc. v. Steadfast Ins. Co.},\textsuperscript{113} a water ride designer’s additional
insured endorsement conferred coverage on all vendors, but only
with respect to the distribution or sale in the regular course of
the vendor’s business of the named insured’s products. Six Flags,
an amusement park owner, claimed it fell within the definition of
a “vendor,” and therefore was afforded coverage as an additional
insured for a claim brought by patrons alleged to have nearly
drowned on the ride The insurer denied coverage on the grounds
that Six Flags neither distributed or sold the designer’s products
but, instead, charged patrons to ride the named insured’s
products. The court agreed with the insurer. Nevertheless, Six
Flags secured additional insured status under another policy
endorsement which required a written agreement obligating the
named insured to provide such coverage. While the insurer

\textsuperscript{112}Ohio Cas. Ins. Co. v. Union Pacific R.R. Co., 469 F.3d 1158, 1163–1164
(8th Cir. 2006) (applying Arkansas law) (citations omitted).

claimed that no such agreement existed between its insured and Six Flags, the court disagreed, finding that the parties’ partial writings together with their subsequent actions demonstrated the existence of a binding preliminary agreement for the construction of the water ride. Moreover, the parties’ negotiations established that one of the terms of this preliminary agreement was a requirement to provide additional insured coverage.

While most additional insured coverage in the construction industry is secured through blanket endorsements, on occasion the policy will contain a scheduled endorsement. Under a scheduled endorsement, the additional insured must be identified by name in the endorsement or elsewhere in the policy. Scheduled endorsements require more administration. This is particularly so where the named insured does business with numerous entities seeking additional insured coverage. The named insured must take care to insure that additional insured endorsement is kept current by deleting entities that no longer are entitled to coverage and adding new ones that are. A subcontractor that performs a lot of jobs over the course of a year is better off with a blanket endorsement as opposed to trying to administer a scheduled endorsement.

Some of the administrative problems encountered with scheduled endorsements were on view in Travelers Indem. Co. v. Commerce & Industry Ins. Co. of Canada,114 where no organization was identified as an additional insured in the space provided for this purpose under the subcontractor’s policy. Yet the policy’s “declarations extension” specifically listed plaintiff as an additional insured. The insurer contended, however, that the declarations extension related to endorsements unrelated to the one providing additional insured coverage. Moreover, the “declarations extension” afforded coverage to plaintiff without the necessity of that entity being specifically listed in the policy. Therefore, additional insured coverage was afforded a mill owner for the injuries incurred to an employee of the named insured during the installation of a caustic washer in the mill.115

115See also, Rodless Properties, L.P. v. Westchester Fire Ins. Co., 40 A.D.3d 253, 835 N.Y.S.2d 154 (1st Dep’t 2007), leave to appeal denied, 9 N.Y.3d 815, 849 N.Y.S.2d 31, 879 N.E.2d 171 (2007) (additional insured coverage properly denied where scheduled endorsement required contract to be executed prior to loss and where contract was never reduced to a writing, execution required full performance which had not occurred prior to loss).
2. Scope of Coverage

Risk allocation in the construction industry is heavily influenced by OPI—Other Peoples’ Insurance. Owners seek coverage under general contractors’ policies, who, in turn, seek coverage under their subcontractors’ general liability policies. Basically, the named insured—often the lower-tiered contractor—grants the additional insured cover under its CGL policy for liability arising out of the acts or omissions of the named insured. While the insurance industry believed that this coverage would extend no further than instances where the additional insured is vicariously liable for the wrongs of the named insured, many courts have interpreted the language as providing a broader coverage grant.\textsuperscript{116}

The broad coverage grant under additional insured endorsements using the language “arising out of,” has led the industry to craft endorsements employing different language. One such attempt was to draft an endorsement that provides coverage only with respect to liability arising out of the named insured’s ongoing operations performed for the additional insured and then only as respects any claim, loss, or liability arising out of the named insured’s operations if such claim, loss, or liability is determined to be solely the negligence or responsibility of the named insured. Under this language, the coverage grant is closer to a vicarious liability standard. Yet, in keeping with the common practice of interpreting ambiguous language against the insurer, the “solely negligent” endorsement has been broadened to negate coverage only where the additional insured actually contributed to the loss.

\textsuperscript{116}See Longwood Cent. School Dist. v. American Employers Ins. Co., 35 A.D.3d 550, 827 N.Y.S.2d 194 (2d Dep’t 2006) (school district entitled to additional insured coverage under policies of the plumbing contractor and construction manager where accident, which occurred as employee was traversing parking lot to inspect frozen pipe, arose out of contractor’s work on school project and where injured employee was led to the construction area by construction manager’s employee, the accident arose out of the construction manager’s work so as to fall within the scope of its additional insured endorsement); Sandy Creek Cent. School Dist. v. United Nat. Ins. Co., 37 A.D.3d 812, 831 N.Y.S.2d 465, 217 Ed. Law Rep. 906 (2d Dep’t 2007) (contractor’s worker’s fall on ice in owner’s parking lot, while on his way to lunch, entitles the owner to coverage as an additional insured under the contractor’s liability policy); Ohio Cas. Ins. Co. v. Union Pacific Railroad Co., 469 F.3d 1158 (8th Cir. 2006) (scope of “arising out of” additional insured endorsement broader than the concept of proximate cause and where railroad crossing accident occurred at site where named insured was providing flagging services was sufficient nexus for coverage).
In *City of New York v. Evanston Ins. Co.*,\(^{17}\) the named insured contracted with the City of New York to perform sidewalk repair work. It named the City an additional insured under a “solely negligent” endorsement. An employee of the contractor was injured while working at the site when he was struck by two motorcyclists. He sued the City, claiming that it had failed to provide him with a safe workplace. The City sought coverage under the sidewalk contractor’s policy. The carrier denied coverage on grounds that, until there was a determination that the sidewalk contractor was 100% responsible for its employee’s injuries, there was no duty under the additional insured endorsement. The City, on the other hand, claimed that the term “solely” referred only to an apportionment of fault as between the sidewalk contractor and the City, without regard to the potential liability of third parties—in this case the motorcyclists. Thus, the City maintained that it would be an additional insured under the policy if the sidewalk contractor bore some responsibility for the accident and the City itself was faultless. The court agreed with the City:

Here, we find that, as used in the policy’s blanket additional-insured endorsement, the word “solely” is ambiguous, and neither party suggests that extrinsic evidence will aid in ascertaining its intended meaning. Thus, the question is one of law for the court to determine. Under such circumstances, “[c]ourts have consistently construed ambiguous policy provisions in favor of coverage and against the insurer who drafted the policy.” Indeed, “[i]n order for the insurer to prevail, it must demonstrate not only that its interpretation is reasonable but also that it is the only fair interpretation.” Although, arguably, both of the proposed interpretations of the word “solely” are reasonable, Evanston’s interpretation is hardly the only fair one. Insurance contracts are to be interpreted according to the reasonable expectations and purposes of ordinary businesspeople when making ordinary business contracts. In our view, the City’s interpretation best comports with such reasonable expectations and purposes here because it would exclude coverage only in those cases in which the putative additional insured is found to be partially at fault for the happening of the accident.\(^ {18}\)

3. **Completed Operations v. Ongoing Operations**

More recent additional insured endorsements have been


drafted to eliminate completed operations coverage. The purpose behind this change was to eliminate additional insured coverage for lengthy latent property damage claims.\textsuperscript{119}

The “ongoing operations” language can influence the coverage afforded in situations beyond latent property damage. In New York City Housing Authority v. Merchants Mut. Ins. Co.,\textsuperscript{120} a tenant sued the City Housing Authority for injuries he sustained when he was shot on Housing Authority’s property, allegedly as a result of a faulty electromagnetic locking system. The Housing Authority sought coverage as an additional insured under the security system installer’s policy. No coverage was afforded, as the shooting occurred after the installer’s work was complete and the additional insured endorsement provided coverage only for liability arising out of the installer’s ongoing operations.

4. Effect of Policy Exclusions on the Additional Insured

In some cases, the additional insured endorsement will contain specific exclusionary language. In this case, there is little debate over whether the language directly applies to the additional insured—although there may be debate over just what the effect is. There is less unanimity over the application of standard policy exclusions on the additional insured (\textit{i.e.}, those contained in the body of the policy but not the endorsement). For example, in Guachichulca v. Laszlo N. Tauber & Associates, LLC,\textsuperscript{121} the “employee” exclusion contained in a subcontractor’s general liability policy operated to exclude coverage for the additional insured general contractor when an employee of the subcontractor was hurt on the project site and sued the general contractor. Given that this is a common scenario for triggering additional insured coverage in a contractor/subcontractor relationship, it is a curious holding.\textsuperscript{122} By contrast, in \textit{State Auto. Ins. Co. v. Habitat Constr.}

\textsuperscript{119}See Weitz Co., LLC v. Mid-Century Ins. Co., 181 P.3d 309 (Colo. Ct. App. 2007), cert. denied, 2008 WL 921278 (Colo. 2008) (general contractor was not entitled to additional insured coverage under plumbing subcontractor’s policy for water intrusion damage that occurred after the subcontractor’s work was complete).

\textsuperscript{120}New York City Housing Authority v. Merchants Mut. Ins. Co., 44 A.D.3d 540, 844 N.Y.S.2d 23 (1st Dep’t 2007).

\textsuperscript{121}Guachichulca v. Laszlo N. Tauber & Associates, LLC, 37 A.D.3d 760, 831 N.Y.S.2d 234 (2nd Dep’t 2007).

\textsuperscript{122}See also, Penn National Ins. v. HNI Corp., 482 F. Supp. 2d 568, 611–613 (M.D. Pa. 2007) (completed operations exclusion in policy applied to coverage af-
Co., a subcontractor’s insurer brought a declaratory judgment action against the additional insured general contractor seeking to apply the policy’s professional services exclusion in an instance where an employee of the subcontractor was injured on the jobsite. The insurer did not raise the “employee” exclusion contained in the policy. And the court found that the professional services exclusion did not bar coverage as there were no allegations in the complaint that the general contractor was providing such services. Under this reasoning, the employee exclusion also would not apply as the injured worker was not an employee of the additional insured general contractor.

The Supreme Court of Montana, in Swank Enterprises, Inc. v. All Purpose Services, Ltd., found the policy ambiguous on whether policy exclusions applied to the additional insured. Swank, as general contractor, entered into a contract for the construction of a water treatment plant with the City of Libby. Swank hired All-Purpose Services to paint the filter tanks and pipes at the treatment plant. All Purpose used an improper type paint which caused damage to the tanks. The City of Libby sued Swank, which sought coverage under All Purpose’s policy as an additional insured. The carrier denied coverage on the grounds that a variety of “business risk” exclusions, including the “faulty workmanship” and “work-performed” exclusions applied to eliminate coverage. The general contractor countered by arguing that the policy’s “severability of interests” clause entitled “separation of insureds,” and entitled the additional insured to coverage notwithstanding the application of policy exclusions to the subcontractor as the named insured. The court agreed with the general contractor:

Swank [general contractor] contends, and the District Court agreed, that the “severability of interests” clause acts to provide All Purpose [subcontractor], as the named insured, and Swank, as the additional insured, with separate coverage as if each were separately insured with a distinct policy. As the exclusions only reference the “named insured,” they do not apply to Swank as an “additional insured.” The only restriction on Swank’s coverage, Swank claims, is that the liability “arise out of” All Purpose’s operations for Swank.

Continental counters that, while the exclusions do refer to All Purpose and All Purpose’s work, they also exclude Swank’s claims for a fire loss which occurred after the project was complete).


that arise from All Purpose's word because the exclusions apply to all claims alleging the described “property damage” regardless of who was seeking coverage. Continental would have no reason to include exclusions relating to Swank's own work, because Swank's own work is outside the scope of coverage. According to Continental, Swank is entitled to full coverage as a separate insured, but not to extra coverage excluded under the policy.

* * *

The exclusions at issue, therefore, can be read two says: Either the exclusions only apply to All Purpose, since they specifically referenced the named insured, or the exclusions arise from the actions of the named insured but apply to any insured seeking coverage. In other words, the language of the exclusions is ambiguous. An ambiguity exists when the contract taken as a whole in its wording or phraseology is reasonably subject to two difference interpretations. Ambiguities in the language of the contract will be construed the insurer.125

5. Allocation of Loss Between Primary and Additional Insured Coverage

On occasion after an insurer has paid out monies on behalf of an additional insured, it will seek recovery from the additional insured's primary carrier. This was the situation in Harleysville Ins. Co. v. Travelers Ins. Co.126 How these disputes are resolved depends, in part, upon the language of the policies and the terms of the agreement between the named and additional insureds. In this case, the New York Supreme Court, Appellate Division, ruled that the additional insured carrier was the sole primary insurer and, thus, responsible for all costs incurred in defense and settlement of the underlying action, but that the additional insured's primary carrier was obligated to provide excess coverage to its insured:

Here, plaintiff does not dispute that Savarino [general contractor], an additional insured under its policy, is entitled to primary coverage. Rather, the dispute is whether, pursuant to the terms of the policies, Travelers' [general contractor's primary carrier] coverage of Savarino is primary along with plaintiff's primary coverage of Savarino as an additional insured or whether Travelers' coverage

125Swank Enter., Inc. v. All Purpose Servs., Ltd., 154 P.3d 52, 56–57 (Mont. 2007). See also Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Liberty Mut. Ins. Co., 234 Fed. Appx. 190 (5th Cir. 2007) (business risk exclusions applied only to named insured and not additional insured, as the terms “you” and “your work” referenced only to the named insured).

of Savarino is excess to plaintiff’s coverage. We have therefore examined “the purpose each policy was intended to serve as evidenced by both its stated coverage and the premium paid for it . . . , as well as . . . the wording of its provision concerning excess insurance [the “other insurance” clause] . . . . Pursuant to the “other insurance” clauses in both policies, the policies provide primary coverage except that the coverage is excess where any other primary insurance is available to the insured for which the insured has been added as an additional insured by attachment of an endorsement. Savarino is added as an additional insured on plaintiff’s primary policy, and thus the excess clause is triggered in the Travelers policy but not in plaintiff’s policy. We therefore conclude that the excess coverage clauses are not “deemed to cancel each other out” and thus do not result in coinsurance. Rather, pursuant to the terms of the policies, Travelers’ coverage is excess to plaintiff’s coverage, and we therefore conclude that coverage under plaintiff’s primary policy must be exhausted before Travelers is required to contribute under its policy\(^{127}\)

6. Effect of Additional Insured Status on Insurer’s Subrogation Rights

A carrier that pays out benefits on behalf of an insured has a right to “step into the shoes” of its insured and pursue recovery against third parties responsible for the loss. What happens when one of those third parties is also an additional insured under the insurer’s policy? That was the issue addressed in *Liberty Mut. Fire & Ins. Co. v. E.E. Cruz & Co.*\(^{128}\) Liberty Mutual provided primary coverage to an electrical contractor known as TAP. TAP was working on a project in Flushing, Queens, that called for the underground installation of 15 concrete sewage retention tanks. TAP was the prime electrical contractor and responsible for providing and installing electrical systems and components for the project. As part of its contract with the project’s general contractor, Cruz, TAP provided additional insured coverage under its policy to Cruz and the City of New York. During the course of the project, millions of gallons of sewage flooded the construction site causing damage to TAP’s equipment and uninstalled electrical components stored at the project site. The sewage flood was allegedly caused when Cruz and the City prematurely connected the existing sewage system to the project. Liberty Mutual, under


its contractor’s equipment and installation floater policies, reimbursed TAP more than $2.5 million for its loss. Liberty Mutual also provided additional insured coverage to Cruz and the City under the CGL policy issued to TAP. When Liberty Mutual sought recovery for payments it made to TAP under its contractor’s equipment and installation floater policies, the defendants resisted on grounds that an insurer could not recover from its own insured for the very risk for which the insured was covered—this is known as the anti-subrogation rule. This caused the court to explore the scope of additional insured coverage afforded under the Liberty Mutual policy. The court determined that the “arising out of” language used in the additional insured endorsement provided broad coverage to the City and, as a consequence, Liberty Mutual had no subrogation rights against it:

In the insurance context, courts in New York have deemed the words “arising out of” to be broad, general, comprehensive terms ordinarily understood to mean originating from, incident to, or having connection with the subject of the exclusion. . . . In light of the foregoing, to the extent plaintiff presses a narrow reading of “arising out of” for the purposes of understanding what type of causal connection is required between the occurrence and the “ongoing operations performed” by TAP in determining the scope of coverage for the City under the endorsement, its argument is not compelling . . . . Furthermore, the fact that the cause of the occurrence was allegedly unrelated to TAP’s work under the Contract does not preclude the claim from arising out of” its “ongoing operations.” The New York Appellate Division has held that when a named insured’s employee was injured as the result of additional insured’s negligent placement of a barricade—where the placement of that barricade had “nothing to do with the named insured’s work for the additional insured”—that personal injury claim “arose out of named insured’s work.” Therefore, this Court finds that plaintiff’s claim for property damage, allegedly resulting from the negligence of defendants [City and general contractor], arises out of TAP’s ongoing operations for the City, despite the fact that TAP was not actively working at the time of the injury and that the cause of the injury was allegedly unrelated to TAP’s work. As such, the claim brought here by plaintiff-subrogee as alleged against the City seeks recovery from its own insured for the very risk for which the insured is covered, and is therefore barred by the antisubrogation rule.129

E. Settlement and Release

A great deal of law has developed over the procedures governing settlement of disputes in instances where insurance coverage is resolved. A common process, but one that varies from state to state, involves the insured settling the underlying lawsuit brought against it by, among other things, transferring its rights against its carrier to the injured claimant in exchange for a release of liability. The injured claimant is then responsible for prosecuting the insurance coverage dispute against the insurer. In a case where the assigned claims were against the assignor's insurance agent, one of first impression, the Supreme Court of New Hampshire determined that this arrangement was valid and enforceable.

The majority of jurisdictions have found such assignments valid. Jurisdictions have used different approaches to find such assignments valid. Many jurisdictions distinguish between a release and covenant not to execute on a judgment. In these jurisdictions, an assignment is valid if it is coupled with a covenant not to execute because the insured remains liable for the excess judgment; an assignment coupled with a release is void because the release extinguishes the insured's liability. . . . A minority of jurisdictions have ruled that even a covenant not to execute extinguishes an insured's liability for an excess judgment. . . . For the most part, these conflicting decisions reflect a balancing of policy considerations. Chief among these considerations is concern about the risk of collusion, when an insured is protected from liability by a covenant not to execute or a release before entry of judgment. In our view, the benefits of such settlement agreements outweigh the risks. We believe it is preferable to uphold assignments under these circumstances than to allow a negligent party to escape liability. . . . Like other courts, we believe that the risk of collusion can be eliminated by requiring the contractors [assignees] to bear the burden of proof on the assigned claims and by recognizing that the defendants [insurance agents], who are not parties to the settlement agreement, cannot be bound by its terms. The defendants remain free to raise collusion or fraud as a defense.130


“arose out of” contractor’s work on a renovation project for which construction manager was sued due to a fire loss).
In *Howard v. Royal Specialty Underwriting, Inc.*,
\(^{131}\) a subcontractor’s employee was severely injured when a steel pipe weighing over 1,000 pounds fell on her. She sued the general contractor, which sought a defense from her employer pursuant to a contractual indemnity provision. The employer’s insurer refused to defend the general contractor. As a result, the general contractor entered into a settlement agreement with the injured worker, which included a $17.4 million judgment coupled with a covenant not to execute and an assignment of the general contractor’s rights against the subcontractor’s insurer. The insurer intervened to contest the reasonableness of the settlement. The trial court held a reasonableness hearing, at which it found the settlement to be reasonable. The Washington Court of Appeals agreed:

The evidence showed that Howard’s injuries included both paralysis and brain damage and that the injuries were permanent. The trial court questioned the parties about the need for 24-hour care. Royal also had the opportunity to present evidence suggesting that Howard’s injuries were not as significant as Howard claimed, and that the 24-hour care may not be necessary for the duration of Howard’s life . . . . The trial court also questioned Howard’s treating physician and adjusted the reasonable amount of settlement based on different life expectancy figures given during that testimony. The trial court had sufficient information before it to make a reasonableness determination. Given the extent of Howard’s injuries, Ania’s clear liability, Ania’s financial situation, and the anticipated cost of future litigation, the trial court did not abuse its discretion in determining that $17.4 million was a reasonable settlement.\(^ {132}\)

**F. Attorney’s Fees**

It is not unusual for insureds to seek recovery of attorney’s fees incurred in pursuing an insurer for defense or indemnity. The

covenant not to execute on excess judgment is valid); Kobbeman v. Oleson, 574 N.W.2d 633 (S.D. 1998) (assignment coupled with release from liability of excess judgment valid); Tip’s Package Store v. Commer Ins. Manag., 86 S.W.3d 543 (Tenn. Ct. App. 2001) (same). See also Note, Judicial Approaches to Stipulated Judgments, Assignments of Rights, and Covenants Not to Execute in Insurance Litigation, 47 Drake L. Rev. 853, 856–860 (1999) (trend “seems to lean overwhelmingly toward the majority rule” that upholds assignment of insurance claim accompanied by covenant not to execute on judgment); but see, Oregon Mut. Ins. Co. v. Gibson, 746 P.2d 245 (Or. Ct. App. 1987).


outcome differs from jurisdiction to jurisdiction. For example, in New York, an insured is hard-pressed to recover its attorney's fees unless the insurer compels the insured to incur fees in defending against a declaratory action. In *Buck v. Horseheads Industrial Capital Management, II LLC,* the court noted:

[T]he New York Court of Appeals enunciated the rule in New York that such a recovery [of attorney's fees or other expenses] may not be had in an affirmative action brought by an assured to settle its rights [as against the insurer], but only when he has been cast in a defensive posture by the legal steps an insurer takes in an effort to free itself from its policy obligations. The court added that unlike the circumstances presented when an insurer compels its assured to defend against its attempts to obtain a declaration of its right to disclaim, here it is the insured itself that has taken the offensive. Furthermore, it is not inherently unfair to disallow recovery for litigation fees to a prevailing party when these would not be assessed against an unsuccessful one.

Insureds are more successful in Florida, as the recovery of attorney's fees in suits against insurers is permitted by statute. Thus, in *Ryan Inc. Eastern v. Continental Cas. Co.,* a subrogated surety was entitled to recover the fees expended in pursuing coverage under CGL policies issued to its principal. As the court reasoned:

Where, as in this case, a surety properly makes payment to correct defective construction or to complete a construction project undertaken by its principal, the surety becomes subrogated to the rights and remedies of its principal. It follows that the Surety is subrogated to any rights which the Contractor may have against its CGL carriers. For this reason, we conclude that the Surety stands in the shoes of the Contractor as a first party claimant under the CGL policies. As a first party claimant standing in the shoes of the


134 See Fla. Stat. § 627.428.

Contractor, the Surety is entitled to an award of fees under the statute. Moreover, the Contractor executed a general indemnity agreement in favor of the Surety, which required it to indemnify the Surety for its court costs and attorney’s fees. Thus a denial of fees to the Surety would lead to the Contractor’s responsibility to indemnify the Surety for payment of its fees without the possibility of reimbursement from the Primary Insurer and the Excess Insurer. Such a result would be contrary to the goals of section 627.428. Besides, the opposing view exalts form over substance. The Surety could have achieved the same outcome by arranging for the Contractor’s attorney to carry the ball in the litigation.\(^{136}\)

Pennsylvania, on the other hand, permits the recovery of fees in a coverage action only upon the insured’s showing that the insurer acted in bad faith.\(^ {137}\)

Indiana has joined those jurisdictions which permit the recovery of attorney’s fees against an insurer where the fees were incurred as a result of the insurer’s breach of contract. In Masonic Temple Ass’n of Crawfordsville v. Indiana Farmers Mutual Ins. Co.,\(^ {138}\) the Masonic Temple was compelled to sue its contractors, engineers, and architects because its property insurer declined to cover its losses. In this sense, the recovery of attorney’s fees was really more in the nature of another consequential loss caused by the defendant’s conduct. This is sometimes referred to as the “third-party litigation exception” to the American rule that each party bears its own litigation costs.\(^ {139}\)


\(^{137}\)See Precision Door Co., Inc. v. Meridian Mut. Ins. Co., 353 F.Supp. 2d 543, 558 (E.D. Pa. 2005) (“Some jurisdictions have an established exception [to the general rule that attorneys’ fees are not recoverable in a breach of contract action] regarding the enforcement of insurance policies. These jurisdictions hold that legal fees incurred in a declaratory judgment action to determine insurance coverage constitute a direct loss incident to the breach of contract and are recoverable by the injured party. Pennsylvania has no such exception unless there is bad faith and the Declaratory Judgment Act applies.”).


\(^{139}\)See also, Nalivaika v. Murphy, 120 Ill. App. 3d 773, 76 Ill. Dec. 341, 458 N.E.2d 995 (1st Dist. 1983) (finding that, because third-party litigation was necessary to protect plaintiffs’ interest, litigation expenses reasonably incurred in suit were recoverable); First Fiduciary Corp. v. Blanco, 276 N.W.2d 30 (Minn. 1979) (stating that, when the wrongful act of the defendant thrust the plaintiff into litigation with a third person, the plaintiff may recover from the defendant the expenses incurred in conducting the litigation against the third party, including attorney’s fees); Dorofee v. Planning Bd. of Pennsauken Tp., 187 N.J. Super. 141, 453 A.2d 1341 (App. Div. 1982) (stating that the state’s cases allow