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A graduate of the University of Florida, School of Law in 1982 where he served as Executive Editor of the Law Review and on the Moot Court, he became a member of the Florida Bar in 1983. He briefly represented insurance companies in coverage litigation, and since 1985 has dedicated his career to seeking justice for insurance policyholders in claim presentation and disputes with their insurance companies.

Mr. Merlin is the founder and president of Merlin Law Group. The sixteen attorney firm maintains offices in Tampa and Coral Gables, FL, Houston, TX, and Gulfport, MS. The firm represents commercial, governmental, residential and private policyholders throughout the Gulf Region and as co-counsel nationwide.

Mr. Merlin was named a finalist and received an Honorable Mention in the LexisNexis Insurance Law Center Person of the Year 2008 -Policyholder Attorney of the Year. He is routinely invited to be a featured speaker on insurance law at some of the nation's most prestigious conferences and seminars. Because of the breadth and depth of his knowledge and experience, Mr. Merlin is frequently sought to provide comment and insight into current legal issues on the stage of the national media. He has appeared on Fox News, ABC News, CNN, and MSNBC on topics as diverse as freedom of speech, employee's and property owners' rights to privacy and slander and emotional distress.

Mr. Merlin has shared his wealth of knowledge of insurance law via articles he either authored or co-authored. Some of the titles include: *Hurricane Coverage and Litigation Issues; Florida's New Valued Policy Law and the Question of Concurrent Causation; Rules of the Road – A Different Methodology For Proving Duty and Breach; and Disaster Preparedness: A Call to Action, Establishing the Right Trial Theme for Your Bad Faith Case.* He also contributes to discussion of property insurance law on his daily blog, propertyinsurancecoveragelaw.com.

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INTRODUCTION

A business can use property insurance to limit its loss in two ways. First, it is ensuring the business obtains all necessary coverage and covering all property at a realistic cost to replace it. Obtaining the amount of coverage to truly make a business whole after a loss may require several insurance policies, a visual inspection, and the expertise of an engineer or contractor. Second, a loss can be limited by working with the insurer in the event of a catastrophe. An insurer may approve mitigation costs even before a storm if the opportunity is presented. Mitigation efforts could make a tremendous difference in the amount of damage a client sustains and in the recovery time and process. Likewise, having experienced counsel and public adjusters immediately after a catastrophe can expedite a full recovery with the insurer and even preclude further loss for the business. One of the inherent, but less obvious costs of a loss, is the emotional toll of seeing one's livelihood or life's work devastated. Consumer advocates experienced in this area can expedite full or partial payments, recommend trusted resources, and curtail negligent or bad faith actions by an insurer. As with the physical aspects for surviving a catastrophe, the key to financial survival is preparation.

This is a selection of recent property casualty coverage cases from across the country. It is intended to inform those in the hospitality industry of potential issues in obtaining property insurance and in presenting or litigating a claim. Of course, each jurisdiction is bound by its own procedures and substantive law. Companies should consult their own insurance counsel or broker with specific questions.

PROPERTY CASUALTY COVERAGE

A. Misrepresentation in the Application

1. *Illinois Casualty Company v. Toor's Inc.*[1]

A fire completely destroyed the building and contents of Toor's restaurant. Toor's filed a claim under its business owner's insurance policy issued by Illinois Casualty Company (ICC). ICC conducted a limited investigation and denied coverage.

ICC then filed a complaint for declaratory judgment, asking the Court to declare and determine that the policy provided no coverage for the loss. Toor's filed a counterclaim against ICC, requesting damages for breach of contract and punitive damages for bad faith. At issue before the Court was ICC's motion for summary judgment on its complaint and on Toor's counterclaims.

Though ICC listed several grounds when it denied the claim, the motion for summary judgment argued only Mr. Toor's alleged concealment, misrepresentation or fraud in his application for the insurance policy. ICC took issue with the discrepancies between the purchase price of the property and the insured value of the property. Mr. Toor, the sole stock owner of Toor's Inc., acquired the property for $85,000, but insured the property for $725,800. Mr. Toor

[1] *Illinois Casualty Company v. Toor's Inc*, 2009 WL 1322873 (S.D. Ind. May 12, 2009).

paid $40,000 for the contents of the building, but insured the contents of the building for $125,000. Also, Mr. Toor owned the property, not Toor's Inc.

Both ICC's and Toor's claims depended on whether Mr. Toor made misrepresentations in the application for business owner's insurance which materially affected ICC's decision to provide this insurance. The facts before the Court on the motion for summary judgment revealed that Mr. Toor enlisted the help of an insurance agent to procure the policy. This agent supplied the value of the property and its contents on the application form, and Mr. Toor seemingly relied on his expertise. The value supplied by the agent approximated the estimated replacement costs quoted by a construction firm after the fire, as well as the value ICC determined it would insure. Thus, the Court concluded that if the values asserted in Mr. Toor's application were misrepresentations, there was a genuine issue of material fact as to whether the misrepresentations would have influenced ICC's decision to issue the policy and were therefore material.[2]

ICC's claim of misrepresentation also seemed to rely upon the fact that the property was in the name of Mr. Toor, rather than Toor's Inc. The Court held that to the extent this was a misrepresentation, it was not material. An underwriter for ICC testified that she ran a title search approximately a month prior to the fire, that the search did not show that Toor's, Inc., was the title holder of the building, and that ICC intended to clear up the ownership issue when its risk inspection was conducted.[3] ICC presented no evidence to show that Mr. Toor's title ownership would have, in any way, affected its decision to accept a premium and insure the property. Accordingly, the Court denied ICC's motion for summary judgment on its claim for declaratory judgment and on Toor's counterclaim for breach of the insurance contract.[4]

Regarding Toor's counterclaim for bad faith, ICC sought summary judgment on grounds that Toor's did not present sufficient evidence of ICC's ill will. Under Indiana law, a cause of action for bad faith requires the complaining party to prove, by clear and convincing evidence, "that the insurer had knowledge that there was no legitimate basis for denying liability."[5]

In its denial and complaint, ICC alleged the fire loss was due to an intentional act of Mr. Toor or one of his agents. However, in its motion for summary judgment, ICC argued only the alleged misrepresentations discussed above. Based on those facts, the Court held Toor's raised a genuine issue of material fact on its counterclaim for bad faith and denied ICC's motion for summary judgment.[6]

This case presented two important issues every business should keep in mind when purchasing insurance. First, in every case, recovery for a loss is limited by the face value of the policy. To ensure that a policyholder can be made whole after a loss, the policy limits must accurately reflect the value of the property. Today, most properties are underinsured. This is

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[2] *Id.* at *3.
[3] The risk inspector did not go to the property until the day after the fire.
[4] *Id.* at *4.
[5] *Id.* at *4 *citing Freidline v. Shelby Ins. Co.*, 774 N.E. 2d 37, 40 (Ind. 2002).
[6] *Id.*

most often caused by inaccurate estimations of the property's insurable value. A property's value for insurance purposes should not be based on the purchase price or current market value. After a loss, the property is to be repaired or replaced, not sold, and the cost to repair or replace a structure will likely far exceed the purchase price or current market value. Debris removal, specialized work to dry out walls, new building codes, and temporarily high prices in the wake of a catastrophe can significantly increase costs.

Second, business owners and their agents should make sure that the insured party is accurately named on the application for insurance and the policy. In this case, the insurer was aware of the discrepancy and presented no evidence to suggest that it would not have issued the policy if Mr. Toor had listed himself as the owner. Another case might not have the same result. For example, an insurer may choose not to issue a policy to a person who had previously been convicted of fraud. If a mistake such as the one in *Toor's* occurred, the insurer would have grounds to deny coverage.

B. Contract Interpretation

1. *Lundy Enterprises LLC v. Industrial Risk Insurers*[7]

Lundy Enterprises owned numerous Pizza Hut restaurants and an office building that were damaged during Hurricane Katrina. The properties were covered under a commercial insurance policy from Wausau, which provided excess flood coverage as well as coverage for other perils. At the time the motion for summary judgment came before the Court, Wausau had paid the maximum flood coverage under the policy.

However, the same day that Wausau filed the motion for summary judgment at issue, Lundy was granted leave to supplement and amend its complaint, adding claims for property damages caused by wind, looting and vandalism. Wausau argued these claims were barred by the anticoncurrent causation clause[8] in the policy. According to Wausau, flood damages in excess of the coverage amounts provided by the policy were excluded perils, so that the anticoncurrent causation clause excluded the claims for wind, looting and vandalism. The Court disagreed. The excess flood coverage endorsement in the policy stated that flood is "added to the Policy's Covered Causes of Loss."[9] While proceeds were limited and triggered by damages in excess of the National Flood Insurance Program coverage limits, the endorsement made flood an included peril. "Once defendant paid the policy limits, flood did not become an excluded

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[7] *Lundy Enterprises LLC v. Industrial Risk Insurers*, 2009 WL 2912420 (E.D. La. September 8, 2009).

[8] Many policies contain an anticoncurrent causation clause which prohibits recovery when a covered peril and a not-covered peril (usually flood) combine to cause a loss. For example, hurricane winds may devastate the structure of a building and then a storm surge floods it. Because the covered peril (wind) combined with the not-covered peril (flood) to cause the loss, the insurer may not cover it. In the litigation following Hurricane Katrina, courts often enforced anticoncurrent causation clauses, leaving those without flood insurance devastated, with no means of recovery.

[9] *Id.* at *2.

peril, but rather a peril for which policy limits have been paid."[10] The Court distinguished *Leonard v. Nationwide Mut. Ins. Co.*, 499 F. 3d 419 (5th Cir. 2007) and *Tuepker v. State Farm Fire & Casualty Co.*, 507 F. 3d 346 (5th Cir. 2007), which barred coverage pursuant to an anticoncurrent clause in policies that specifically excluded flood coverage and which offered no flood coverage at all.

This case presents good news for policyholders with policies that contain endorsements for a peril that was excluded from the base policy. The Court held that such policies are excepted from the draconian law handed down by the Fifth Circuit in *Leonard v. Nationwide Mut. Ins. Co.*, 499 F. 3d 419 (5th Cir. 2007) and *Tuepker v. State Farm Fire & Casualty Co.*, 507 F. 3d 346 (5th Cir. 2007). Lundy's decision to purchase excess flood coverage in its commercial policy put it in a much better position than hundreds, if not thousands, of people and businesses that were denied coverage and even the right to bring their cases to court based upon the Fifth Circuit's interpretation and application of the standard anticoncurrent causation clause in the litigation following Hurricane Katrina. The practice tip to be learned from this case is to purchase endorsements for excluded perils, if at all possible. The amount Lundy paid for the excess flood coverage was wisely spent; because of it, Lundy can achieve a recovery that many Katrina victims were denied.

2. *Iroquois on the Beach, Inc. v. General Star Indemnity Company*[11]

Iroquois on the Beach is a seasonal hotel that suffered structural damage caused by water entering the building envelope due to insufficient building materials that failed to protect the building in windy and extreme climatic conditions. The damage occurred gradually over the course of several years. Iroquois' insurer, General Star, denied coverage for the loss, finding the loss came within one or more of the policy exclusions.

The issue before the Court was whether the loss was excluded under Section B.2.f. of the policy, which provided:

> B. Exclusions
>
> 2. We will not pay for loss or damage caused by or resulting from any of the following:
>
> f. Continuous or repeated seepage or leakage of water, or the presence or condensation of humidity, moisture or vapor, that occurs over a period of 14 days or more.[12]

Iroquois argued the exclusion did not apply because windstorms, a covered loss under the policy, initiated the sequence of events that resulted in the loss and the exclusion contained no

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[10] *Id.* at *2.
[11] *Iroquois on the Beach, Inc. v. General Star Indemnity Company*, 550 F. 3d 585 (6th Cir. 2008).
[12] *Id.* at 587.

"anti-concurrent, anti-sequential" clause. Citing to caselaw from another state which allowed an insured to recover when the insured risk was the last step in the chain of causation set in motion by an uninsured peril, Iroquois argued the omission of an anti-concurrent, anti-sequential clause indicated that General Star intended to provide coverage where the loss is caused by wind, if it was the first or last step leading to the seepage or leakage of water. Unfortunately for Iroquois, the Supreme Court of Michigan previously declined to adopt this "efficient-proximate-cause doctrine." In doing so, the Court explained that it found no reason "to introduce a legal theory or doctrine that departs from the literal interpretation of an unambiguous insurance contract."[13]

Pursuant to Michigan law, the insurance policy was to be interpreted according to its plain meaning, giving effect to every word, phrase, and clause.[14] The Court was also required to avoid an interpretation that would render any part of the contract surplus. As Michigan does not follow the efficient-proximate-cause doctrine, the addition of an anti-concurrent, anti-sequential clause would be surplus. Consequently, the absence of an anti-concurrent, anti-sequential clause did not support Iroquois' argument that the loss was covered because it was caused by a combination of a covered risk and an excluded risk.[15] Thus, according to the Court, "the default rule under Michigan law is that a loss is not covered when it is concurrently caused by the combination of a covered cause and an excluded cause," and the exclusion for seepage or leakage of water for at least fourteen days was dispositive.[16]

3. *Copper Mountain Inc., v. Industrial Systems, Inc.*[17]

Copper Mountain hired Amako to renovate and build an addition to the Union Creek Lodge at Copper Mountain Resort. Copper Mountain and Amako entered into a standard American Institute of Architects Owner-Contractor Agreement to govern the construction. Under the contract, Amako was obligated to procure liability insurance for and remedy damages to the non-work areas, while Copper Mountain was required to insure the construction. Accordingly, Copper Mountain added a "Newly Acquired Property and Property Under Construction" endorsement to its general Ski Areas Property Coverage (SAPC) insurance policy. The SAPC policy insured both the construction work and the Union Creek Lodge.

On November 26, 2001, while Industrial[18] was doing welding work, a fire broke out at the Union Creek Lodge, causing significant damage to the existing building and its contents. All real and personal property damaged in the fire was covered under the SAPC insurance policy, though Copper Mountain was responsible for the $1 million deductible.

Copper Mountain sued Amako and Industrial for negligence, negligent supervision, breach of contract, and indemnification, seeking approximately $1 million in damages. Copper Mountain moved for a determination that the waiver provisions in construction contract did not

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[13] *Id.* at 588.
[14] *Id.*
[15] *Id.* at 588-589.
[16] *Id.*
[17] *Copper Mountain Inc., v. Industrial Systems, Inc.*, 208 P. 3d 692 (Colo. 2009).
[18] Amako subcontracted the steel framework for the addition to Industrial.

bar its claims for damages to non-work portions of the lodge. Amako and Industrial asserted that paragraphs 11.4.7 and 11.4.5 of the construction contract barred Copper Mountain's suit.

Paragraph 11.4.7 was a waiver of legal rights:

> The Owner and Contractor waive all rights against [ ] each other and any of their subcontractors ... for damages caused by fire or other causes of loss to the extent covered by property insurance obtained pursuant to this Paragraph 11.4 or other property insurance applicable to the Work....[19]

Paragraph 11.4.5 further explained Copper Mountain's waiver of claims for damages:

> If during the Project construction period the Owner insures properties, real or personal or both, at or adjacent to the site by property insurance under policies separate from those insuring the Project, or if after final payment property insurance is to be provided on the completed Project through a policy or policies other than those insuring the Project during the construction period, the Owner shall waive all rights in accordance with the terms of Subparagraph 11.4.7 for damages caused by fire or other causes of loss covered by this separate property insurance.[20]

The builders argued paragraph 11.4.7 waived Copper Mountain's rights to the extent damages were covered by Copper Mountain's SAPC policy, and that paragraph 11.4.5 further waived claims for damages to the covered property at or near the construction site, whether it was work or non-work property.[21]

The Colorado Supreme Court rejected the builders' arguments. By agreeing to paragraph 11.4.7, Copper Mountain waived its rights for damages to the work, but it did not waive claims for damages to non-work property.[22] In reaching this conclusion, the Court applied the principle of contract construction that a contract should be interpreted "in its entirety with the end in view of seeking to harmonize and to give effect to all provisions so that none will be rendered meaningless."[23] The Court's conclusion gave effect to all provisions in the contract, while the builders' interpretation would render many provisions meaningless.[24] Further, the builders' interpretation would benefit owners who do not insure their non-work property by allowing them to pursue claims for that property, but it would deny responsible owners who insure their non-work property that same right.[25]

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[19] *Copper Mountain Inc.*, 208 P. 3d 692, 695.
[20] *Id.*
[21] *Id.* at 698.
[22] *Id.* at 699.
[23] *Id.* at 697 *citing Pepcol Mfg. Co. v. Denver Union Corp.*, 687 P. 2d 1310, 1313 (Colo. 1984).
[24] *Id.* at 700.
[25] *Id.*

In sum, the Colorado Supreme Court construed the construction contract in accordance with general principles of liability that an actor is responsible to a property owner for property damages it negligently causes, absent a clear intent otherwise in the parties' agreement.[26]

C. Venue

1. *I Santi Inc. d/b/a Luciano Ristorante Italiano v. Great American Insurance Company of New York*[27]

I Santi, Inc. is a Texas corporation whose Louisiana-based restaurant sustained damage from Hurricane Katrina. The business was insured by a policy issued by Great American Insurance Company. I Santi contested the damages Great American paid on the claim and filed suit in Louisiana state court for breach of contract and improper claims adjustment. I Santi sought to recover for the damage to its property as well as penalties, attorneys' fees, and costs provided by Louisiana Statute. On February 7, 2008, Great American removed the action to the United States District Court for the Eastern District of Louisiana based on diversity of citizenship. Great American then moved to transfer the action to the United States District Court for the Western District of Texas. I Santi opposed the transfer.

In deciding the issue of whether Great American could transfer venue, the District Court applied a clear and straightforward analysis of relevant statute and caselaw, with the controlling requirement that Great American show good cause. Under 28 U.S.C. § 1404(a), a court may transfer an action to any other district where the plaintiff could have filed suit "for the convenience of the parties and the witnesses" and "in the interest of justice." Thus, the threshold question was whether I Santi could have brought the action in the Western District of Texas.

Great American argued that the suit could have been filed in the Western District of Texas, "because that is the location of the Plaintiff's principal place of business."[28] However, 28 U.S.C. § 1391(a) provides that venue is based on the residence of the defendant, the location of the claimed events or property, or where the defendant is subject to personal jurisdiction, if no other district is available. I Santi's principal place of business did not meet any of these criteria. Accordingly, the Court concluded that Great American did not meet its burden of proving the action originally could have been brought in the Western District of Texas.[29]

Even though Great American did not meet its threshold burden, the Court conducted the second step in the analysis, whether Great American could show good cause for the transfer of venue. In deciding whether there was good cause for the transfer, the District Court addressed each of the private and public interest factors enunciated in *Gulf Oil Corp. v. Gilbert*, 330 U.S. 501, 508 (1947). The private interest factors include:

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[26] *Id.*
[27] *I Santi Inc. d/b/a Luciano Ristorante Italiano v. Great American Insurance Company of New York*, 2008 WL 4809432 (E.D.La. October 31, 2008).
[28] *Id.* at *2.
[29] *Id.* at *2.

> (1) the relative ease of access to sources of proof; (2) the availability of compulsory process to secure the attendance of witnesses; (3) the cost of attendance for willing witnesses; and (4) all other practical problems that make a trial easy, expeditious and inexpensive.[30]

The public interest factors are:

> (1) the administrative difficulties flowing from court congestion; (2) the local interest in having localized interests decided at home; (3) the familiarity of the forum with the law that will govern the case; and (4) the avoidance of unnecessary problems of conflict of laws [or in] the application of foreign law.[31]

Regarding the relative ease of access to sources of proof, the Court noted that the damaged property was located in Louisiana, the damage adjustment necessarily occurred at least in part there, and the documents supporting the claim and adjustment were split between Louisiana and Texas. As the sources of proof were split between the two forums, the Court concluded this factor was neutral.[32]

Regarding the availability of compulsory process, Federal Rule of Civil Procedure 45(b)(2) gives the district courts power to subpoena any witness within 100 miles of the trial, deposition, or hearing. Several of I Santi's witnesses lived within the subpoena power of the Louisiana District Court, so the Court found this factor did not weigh in favor of transfer.[33]

The Court also found that the cost of attendance for willing witnesses did not weigh in favor of transfer.[34] While I Santi' s two owners and the company's bookkeeper lived within the Western District of Texas, both parties planned to call expert and fact witnesses from the New Orleans area. Great American presented no evidence that witnesses would suffer a hardship in traveling to New Orleans for the trial.

The Court found that because the case was still in its early stages, a transfer would not result in delay or prejudice either party. Therefore, the other practical problems factor was neutral.[35]

Citing to caseload statistics compiled by the Administrative Office of the United States Courts for 2007, Great American argued court congestion in the Eastern District of Louisiana

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[30] *Id*. at *2 *citing In re Volkswagen AG, 371 F. 3d 201, 203 (5th Cir. 2004).*
[31] *Id.*
[32] *Id.* at *3.
[33] *Id.*
[34] *Id.*
[35] *Id.*

favored transfer. The Court cited several reasons why those statistics did not weigh in favor of transfer: they were old; in 2007, the courts were deluged with Katrina and Vioxx cases that have since been resolved or streamlined; and they did not take into account the pending criminal cases in each district, and the Western District of Texas had substantially more criminal cases on its docket.[36]

The local interest factor weighed against transfer. While I Santi has its principal place of business in Texas, the property damage occurred in the Eastern District of Louisiana. The restaurant operated in Louisiana, and its patrons were Louisiana citizens.[37]

As for the factor of forum familiarity and conflicts of law problems, because the Court's jurisdiction was based on diversity of citizenship, Louisiana's choice of law rules applied. Pursuant to Louisiana Civil Code article 3515, "an issue in a case having contacts with other states is governed by the laws of the state whose policies would be most seriously impaired if its law were not applied to that issue."[38] Great American argued that the insurance policy should be interpreted in accordance with Texas law because I Santi is from Texas. I Santi argued the policy is governed by Louisiana law because it contained policy endorsements specific to Louisiana. Great American, which bore the burden of proof, did not provide the policy to the Court, so the Court was not able to undertake the necessary analysis on this factor. However, the Court noted that it would have no problem interpreting and applying Texas law.

In conclusion, the Court held that Great American did not show that the Western District of Texas was a more convenient forum. "This is not a situation where plaintiff has selected a forum that is completely unrelated either to any of the parties or the events giving rise to the case. Accordingly, plaintiff's choice of forum deserves due deference."[39]

D. Bad Faith

1. *Mauna Kea Beach Hotel Corporation v. Affiliated FM Insurance Company*[40]

This case addressed what information an insured can request from its insurer to establish a bad faith claim. The District Court, sitting in its appellate capacity, determined the issue using two criteria: what was relevant to proving a bad faith claim under Hawaii law, and what was unduly burdensome for the insurer.

On October 15, 2006, two earthquakes struck off the coast of the island of Hawaii, damaging the Mauna Kea Beach Hotel and the Hapuna Beach Prince Hotel. The Hotels were insured by four layered policies which were triggered by the amount of loss:

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[36] *Id.*
[37] *Id.* at *4.
[38] *Id. citing La. Civ.Code Ann. art.* 3515.
[39] *Id.* at *5.
[40] *Mauna Kea Beach Hotel Corporation v. Affiliated FM Insurance Company*, 2009 WL 1227850 (D.Hawaii May 1, 2009).

(1) Mt. Hawley Insurance Company-$5 million;

(2) Westchester Surplus Lines Ins. Co.-$5 million in coverage for damages in excess of $5 million;

(3) Landmark American Ins. Co.-$20 million in coverage for damages in excess of $10 million; and

(4) Defendant Affiliate FM Ins. Co.-$20 million in coverage for damages in excess of $30 million.

Mauna Kea claimed more than $100 million in damages from the earthquakes, and submitted its claim for damages to each insurance company. The first three insurance companies paid the claim. The fourth insurance company, Affiliate FM Insurance Company, did not. Affiliate decided the damages did not meet the threshold of $30 million needed to trigger coverage.

Mauna Kea filed suit, alleging bad faith based upon Affiliate's handling of the claim and its failure to provide coverage. In discovery, Mauna Kea sought identification of all claims made within the previous ten years that contained certain forms or endorsements; identification of all law suits related to any of those forms or endorsements; and claim files for every claim that involved those forms or endorsements or involved a claim of bad faith during the five years proceeding the issuance of the policy to the present.[41] Affiliate objected, and Mauna Kea filed a motion to compel.

The magistrate judge held that a pattern of violations of Hawaii Revised Statute § 431:13-103(a)(11) [42] could be evidence of bad faith, therefore Affiliate's handling of other insurance claims was relevant to the action.[43] However, the magistrate judge also found that the discovery requests could be unduly burdensome and limited them to the identification of lawsuits and claims filed from 2006 to the present and also restricted Mauna Kea's requests for production of documents to claim files and bad faith claims made between 2003 and present.[44]

Affiliate appealed, arguing that a pattern of violations of Hawaii Revised Statute § 431:13-103(a)(11) was not relevant or discoverable evidence of bad faith and that Mauna Kea

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[41] *Id.* at *1.

[42] Hawaii Revised Statute section 431:13-103 regulates unfair competition and unfair or deceptive acts or practices in the insurance business. It lists certain conduct that can be unfair or deceptive acts, similar to the type of conduct that could establish a bad faith claim. *See Haw.Rev.Stat.* § 431:13-103(a)(11). Under the statute, a claim may be brought by the state Insurance Commissioner when an insurance company is "committing or performing" various acts "with such frequency as to indicate a general business practice ..." *Haw.Rev.Stat.* § 431:13-103(a)(11). 2009 WL 1227850 * 2 (D. Hawaii).

[43] 2009 WL 1227850 * 2 (D. Hawaii).

[44] *Id.*

could not seek discovery of claims in other states and regarding non-earthquake perils[45]. The District Court agreed in part and disagreed. Noting that Hawaii recognizes a claim for bad faith in the insurance context and that previous decisions from the Court indicated that violations of the statute could be used as evidence of insurer bad faith, the Court held a pattern of violations of the statute was relevant and discoverable.[46] The Court also rejected Affiliate's request that the discovery requests be limited to earthquake related claims, finding Affiliate failed to establish that its handling of non-earthquake claims was irrelevant to the claim at issue.[47] However, the Court agreed with Affiliate that evidence of the insurer's handling of claims in other states was not relevant or discoverable. Claims in other states would necessarily involve different statutes, different insureds, and possibly different standards.[48] Therefore, claims in other states would not be relevant to the determination of whether Affiliate acted in bad faith in denying Mauna Kea's claim or whether bad faith could be established through a pattern of violating Hawaii Revised Statute § 431:13-103(a).[49]

The Court rejected Affiliate's argument that the discovery requests, as limited by the magistrate, imposed an unreasonable and undue burden because it would still be required to review 11,707 claim files, each of which potentially contains tens of thousands of pages, including privileged attorney-client communications.[50] The Court noted the magistrate's ruling reduced the number of claim files Affiliate was required to review by at least fifty percent. Additionally, the Court noted that it further limited the document production requests to claims in Hawaii, so Affiliate's burden had been substantially reduced.[51]

2. *Cher-D, Inc., T/A Pine Knob Inn v. Great American Alliance Insurance Company*[52]

On October 1, 2004, an electrical fire damaged Cher-D's Pine Knob Inn. Cher-D promptly notified its insurer, Great American, of the loss and its intent to resume operations. In January 2005, during the adjustment process, Great American did not renew Cher-D's insurance policy, and Cher-D was unable to obtain other coverage. Vandals began entering the inn and causing additional damage, and Cher-D informed Great American. On May 23, 2005, vandals entered the inn and caused a second fire that completely destroyed the building. Great American had not paid Cher-D for the loss from the first fire.

Cher-D filed a two count complaint, alleging that Great American breached the contract to provide coverage for the second fire and that it acted in bad faith under Pennsylvania law.[53]

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[45] *Id.* at * 4.
[46] *Id.*
[47] *Id.*
[48] *Id.* at *5.
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Cher-D, Inc., T/A Pine Knob Inn v. Great American Alliance Insurance Company*, 2009 WL 1684690 (E.D.Pa. June 15, 2009)
[53] 42 *Pa. Cons.Stat. Ann*. § 8371 and "other applicable law."

The Court previously granted summary judgment in favor of Great American on the breach of contract claim, finding that the first fire was not the proximate cause of the second fire, so the policy did not cover losses from the second fire. The court denied Great American's motion for summary judgment on Count II after concluding that a reasonable jury could find by clear and convincing evidence that Great American acted in bad faith by delaying payment for the first fire. The Court based this finding on the fact that Great American waited nine months—until well after the second fire destroyed the building-- before providing its estimate[54] of the damage from the first fire, and there was no evidence in the record to suggest a reason for the delay; the contractor that provided the estimate visited the premises within two weeks of the fire.[55]

The issue before the Court was Great American's request to reconsider the denial of its motion for summary judgment on Count II. Great American argued Cher-D's complaint did not provide fair notice of a bad faith claim based on Great American's adjustment of the October 2004 fire, and, alternatively, the evidence did not support such a claim. Great American submitted two affidavits and multiple pages of deposition testimony in support of the request for reconsideration.

Great American argued that Cher-D's claim was "premised solely and exclusively on Defendant's alleged bad-faith denial of the May 2005 fire loss claim, not an alleged delay in payment of the October 2004 fire loss claim."[56] The Court disagreed. Reading the complaint as a whole, and noting that Count II specifically incorporated the preceding paragraphs, Cher-D's complaint alleged that Great American's delay in paying the amounts owed for the first fire precluded prompt repair and led to the vandalism that ultimately resulted in the second fire.[57] While Count II referenced Great American's act of "declining coverage," it also alleged Great American's "refusal ... to compensate [Plaintiff] for its losses" as constituting bad faith.[58] In sum, the Court noted that notice pleading is a modest standard, and the complaint adequately placed Great American on notice of that bad faith claim related to the first fire.

As for the two affidavits and deposition testimony Great American submitted with its motion for reconsideration, they were not submitted with the motion for summary judgment. Therefore, the Court disregarded them as a basis for reconsideration.[59]

3. *General Electric Credit Union v. National Fire Insurance of Hartford*[60]

General Electric sought to recover insurance proceeds for a fire loss that occurred at a restaurant it financed. The restaurant was insured under a commercial fire insurance policy

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[54] Great American's estimate of approximately $1 million did not differ significantly from Cher-D's earlier estimate of $1,250,745.11.
[55] 2009 WL 1684690 at * 1.
[56] *Id.* at *3.
[57] *Id.*
[58] *Id.*
[59] *Id.* at *4.
[60] *General Electric Credit Union v. National Fire Insurance of Hartford*, 2009 WL 3210348 (S.D. Ohio September 30, 2009)

issued by National Fire to Leadership Group of Ohio, LLC. General Electric provided financing to Leadership for the restaurant, and its interest was secured by UCC financing statements. National Fire claimed that the policy named General Electric as a simple "loss payee," so it had no standing to bring suit for coverage issues or bad faith.

General Electric argued it was entitled to payment for the loss and asserted extra-contractual claims for bad faith and punitive damages because National Fire allegedly failed to complete its investigation promptly and disposed of damaged property without advising General Electric.

National Fire moved for bifurcation of the proceedings, arguing that General Electric's standing and the coverage issues should be resolved before the extra-contractual claims for bad faith and punitive damages. According to National Fire, bifurcation would avoid unnecessary and protracted litigation. National Fire also sought a protective order based on General Electric's request for "the identities, roles and activities of any other person or entity ... including ... *attorneys, paralegals, clerks or other personnel of any law firm* or other entity, with respect to evaluating, managing, handling, processing and/or investigating of any claim under the Policy."[61] National Fire objected to requests that sought information and materials protected by the attorney/client privilege or the attorney work product doctrine.

As to National Fire's request for bifurcation, the Court explained that bifurcation should occur only if it serves judicial economy and does not unfairly prejudice any party.[62] The court rejected National Fire's argument that the facts underlying the coverage and bad faith claims were separate and distinct. While there is a distinction between the claims, the factual allegations underlying General electric's bad faith claim (improper investigation of the fire) also form the basis of the contractual claim (if the fire was improperly investigated, coverage may have been improperly denied).[63] The Court also rejected National Fire's argument that the contract claim did not require discovery of its procedures, practices, manuals or other claims processing materials, finding that the way National Fire processes claims may directly impact the "correctness" of the claim denial.[64] In this case, the claims were so interrelated that bifurcation would not further judicial economy

The Court also rejected National Fire's argument that the claims should be bifurcated to determine General Electric's standing to pursue a bad faith claim. According to National Fire, if General Electric was a simple "loss payee," National Fire did not owe it a duty of good faith, and without a duty of good faith, there can be no bad faith claim. National Fire submitted no law to support its argument.[65] Therefore, National Fire failed to meet its burden of showing that bifurcation was necessary.

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[61] *Id.* at *1.
[62] *Id.* at *2.
[63] *Id.* at *3.
[64] *Id.*
[65] *Id.* at *4.

Regarding National Fire's argument that that it would be prejudiced if discovery regarding the bad faith allegations proceeded before the coverage claim was resolved, the Court noted that National Fire presented nothing more than speculation that the information requested by General Electric would impact National Fire's ability to defend the coverage claim.[66] General Electric's statement that it was not seeking information subject to the attorney/client privilege or attorney work product also indicated that National Fire would not be prejudiced by the discovery requests. Further, the mere possibility that resolution of the coverage issues might preclude General Electric's bad faith claim was not sufficient grounds to delay discovery and further extend litigation and would not conserve the resources of the parties or the Court.[67]

CONCLUSION

This summary of recent property casualty coverage litigation is intended merely as an overview. It is important to remember that each jurisdiction may have its own procedure, that federal and state issues of pleading and proof may be different, and that the substantive law of each jurisdiction must be accounted for. Thus, a ruling or law applied in these example cases may not apply across the board. Experienced insurance counsel should be consulted for any specific questions.

[66] *Id.* at *5.
[67] *Id.*

HOSPITALITY INDUSTRY INSURANCE LITIGATION UPDATE - 2009

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David E. Wood specializes in insurance policy enforcement under business insurance programs, devoting his practice to evaluating business insurance claims and prosecuting insurance recovery litigation. He graduated from Williams College in 1979 with an A.B. degree *cum laude*, and received his Juris Doctor degree from the University of California, Hastings College of Law in 1985.

Practice Summary

The policyholders Mr. Wood typically serves include *Fortune 1000* corporations and corporate directors and officers, with special emphasis on construction, financial services and technology risks. Representative clients include Turner Construction Company, Ford Motor Credit, Granite Construction Incorporated, Insight Enterprises, Inc., East-West Bank and Computer Sciences Corporation in the United States, and Aecon Group, Inc. in Canada.

Professional Honors

Mr. Wood holds the "AV" rating for professional skill and ethics conferred by *Martindale-Hubbell*. Chosen by 60,000 of his peers, and based on the independent research of *Law and Politics* magazine, he was named one of the top Southern California lawyers in 2007.

Professional Activities

Mr. Wood is quoted frequently in national media on significant insurance matters including *CNBC* Television (November 5, 2005, insurance broker liability), *Bloomberg* Radio (September 27, 2002, World Trade Center coverage litigation), *USA Today* (June 15, 2002, insurance recovery*), Financial Week* (October 26, 2008, federal regulation of the insurance industry), *Forbes* (November 15, 2004, contingent commission scandal at Marsh), and *Forbes.com* (June 14, 2007, insurance recovery trends). Mr. Wood is a frequent speaker before professional organizations like the Association of Corporate Counsel, the Society of Corporate Secretaries and Governance Professionals, Mealey's, the International Risk Management Institute, the Risk & Insurance Management Society, and the Center for International Legal Studies.

Professional Publications

Mr. Wood has published articles for trade and legal publications including *D&O Advisor, The John Liner Review, The National Law Journal, Risk Management Magazine, California Lawyer,* San Francisco *Recorder,* and *Risk & Insurance Magazine,* to name but a few.

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I. SCOPE OF ARTICLE

A year ago, this author noted in a paper prepared for this conference that:

> [a]s the insurance market floats in uncertainty, the operating environment for hospitality companies is unequivocally challenging. Competition is up, restaurant sales are down, occupancy rates are declining and lenders are withdrawing credit from the market. Scaled back development, store closures, stock declines and general downsizing are resulting in a spate of hospitality company disputes with lenders, builders, landlords, tenants, employees and shareholders. As margins tighten across the board, careful buying of new insurance and utilization of existing insurance can mean the difference between remaining profitable or succumbing to the unprecedented challenges of today's market.[1]

The caution urged one year ago is all the more necessary today. Markets continue to be uncertain, and the operating environment for this industry continues to be volatile. Careful selection of policies and attendant endorsements is now more important than ever. As illustrated below, the deletion or insertion of just one term can mean the difference between a fully insurance-funded defense and having to fend off expensive and complex litigation without assistance. Furthermore, even with carefully crafted policies, without a coherent and company-wide risk management strategy, even the best policies can be underutilized or end up void.

This article addresses some recent insurance litigation in the context of the hospitality industry. It is intended as a summary to allow companies and their outside lawyers to identify new and emerging issues for implementing appropriate insurance-related practices and procedures. Insurance is a highly specialized area and companies should consult their experienced commercial insurance broker or outside insurance counsel with specific questions.

II. COVERAGE GAPS & CARRIER POSITIONS

A. Assault & Battery

1. *Acceptance Indemnity Insurance Company v. Yuddin*

In the early morning hours of January 20, 2007, Jerry White entered Kimberly Walker's home with a gun. He abducted Walker and her four children at gunpoint. He brought them to the Sleepy Hollow Motel in Elkhart, Indiana where he had stayed at least two times that same month. This time, to the surprise of the clerk, he checked in under a false name. Despite the discrepancy, and in disregard of motel policy, the hotel clerk neither asked for identification nor asked for information about White's car.

[1] Wood, WHAT HOSPITALITY LAWYERS NEED TO KNOW ABOUT INSURANCE 1-2, Hospitality Law Conference, February 2009

For the next three days, White held Walker and her children captive in the motel, using the children as leverage to force Walker's compliance. He had her disguise herself and pay for the room each night under the assumed name he chose on January 20th. Throughout this time, the motel employees did nothing to investigate the situation or confirm the identity of the "guests." After these three horrific days, police successfully rescued Walker and her children, and White was eventually convicted of attempted murder and eight counts of criminal confinement. [2]

Later, Walker and her children sued the hotel for negligence. They alleged that by failing to follow hotel procedures regarding identification of guests, and by failing to pay attention to news reports of the abduction, the hotel lengthened their confinement and increased the number of injuries they suffered.[3] The hotel tendered the claim to its CGL insurance carrier, Acceptance, which denied coverage under the assault and battery exclusion in the policy and sought declaratory relief that there was no coverage.[4]

On cross-motions for summary judgment the district court for the Northern District of Indiana agreed with the insurance carrier on the coverage issue.[5] The court characterized the entire four day event as an ongoing assault and thus excluded from coverage by the policy.[6] The court gave little credence to the argument that the negligence of hotel employees contributed to the Walkers' harm, saying "Walker can not escape the fact that her captivity at her home and at the motel was the result, at least in part, of an ongoing and violent assault."

This case presents a compelling argument for buying back assault and battery coverage. The carrier in this case avoided coverage by convincing the court that the entire injury suffered by the Walkers was the result of an “ongoing assault” and thus wholly excluded under the assault and battery provision of the policy. Perhaps because the language of the exclusion is so stark, the court gave little credence to the hotel employees’ failure to follow their own internal procedures.

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[2] *Acceptance Indemnity Insurance Company v. Yuddin*, 2009 WL 3756926 *1-*3 (N.D. Ind.)

[3] *Id.* at *3

[4] *Id.* The typical assault and battery exclusions reads:

This Insurance does not apply to:
A. Any claims arising out of Assault and/or Battery or;
B. Any act or omission in connection with the prevention of suppression of such acts, whether caused by or at the instigation or direction of you, your employees or volunteers, patrons or any other persons, or
C. Claims, accusations or charges of negligent hiring, placement, training or supervision arising from any of the foregoing are not covered.
We shall have no obligation to defend you, or any other insured, for any such loss, claim or suit.

[5] *Id* at *6

[6] *Id.*

2. Clarendon American Insurance Company v. Jai Thai Enterprises

In *Clarendon,*[7] two restaurant patrons were assaulted at a restaurant event. The restaurant had hired a promoter for the event, and the promoter had in turn hired two men to act as security guards.[8] When the patrons sued the restaurant for negligently failing to protect the restaurant patrons, the restaurant tendered the claim to its insurer. The insurer defended under a reservation of rights and simultaneously sued for a declaration that it had no duty to defend or indemnify. The insurer then sought summary judgment in the declaratory relief action.

Rather than relying on any assault and battery exclusion, the insurer claimed that the restaurant breached a representation or warranty by failing to make sure that the security guards carried proper insurance.[9] According to the carrier, this breach completely voided the policy, thus relieving it of any obligation to defend or indemnify.[10]

The restaurant did not argue that it somehow complied with the security guard insurance requirement. In fact, it failed to even oppose the insurer's motion for summary judgment.[11] Nevertheless, the court found that the insurer was not correct as a matter of law that the insured's breach of the security guard provision was sufficient to void the entire policy.[12]

Relying on Washington precedent that required courts to consider an insurance clause "holistically to determine if a beach of [a] clause is intended to void a policy,"[13] the court found that the restaurant's breach of the security guard insurance clause did not cause a total forfeiture of coverage. Though the section of the policy containing the security guard clause stated that "breach of any of the following representations and warranties will result in this policy not applying to any 'claim' or 'suit' brought hereunder," the court noted that another provisions in that section included an agreement not to serve raw seafood. The court rhetorically inquired whether the insurer could deny all coverage if the assault had occurred on "Sushi Night."[14] Characterizing an affirmative answer as absurd, the court concluded that the failure of the restaurant to make sure the security guards were insured could not operate to void the policy.

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[7] 625 F. Supp. 2d 1099 (W.D. Wash. 2009)

[8] *Id.* at 1101

[9] The "Breach of Representations and Warranties Endorsement" of the restaurant's policy required that all security guards employed by the restaurant maintain CGL insurance at least as broad as the restaurant's, among other requirements.

[10] *Id.*

[11] *Id.* at 1102

[12] *Id.* at 1109

[13] *Id.* at 1105 *citing Port Blakely Mill Co. v. Springfield Fire & Mar. Ins. Co.*, 59 Wash. 501 (1910)

[14] *Id.* at 1105-06

Nevertheless, the fact that the restaurant had breached the policy was not seriously in doubt and so the court ruled that the insurer was entitled to damages flowing from that breach. However, because the record was incomplete about what the extent of those damages would be, the court granted the insurer's motion only to the extent that the insured violated the policy terms.[15]

In this case the court did not say whether Jai Thai's policy contained an assault and battery exclusion. Nevertheless it serves as a warning that insurance carriers may not always attack coverage at the most obvious weak point. It also serves as strong encouragement to make sure that all terms of the policy are complied with when engaging independent contractors and outside help. While the restaurant did not lose coverage entirely in this case, the court left open the possibility that its failure to comply with the security guard insurance provision could be the sole cause of the damages suffered. Under such a result, the policyholder would be entitled to no indemnification under its policy.

B. Advertising & Personal Injury

1. *Creative Hospitality Ventures v. United States Liability Insurance*

Creative Hospitality Ventures v. U.S. Liability Insurance Co.[16] considered the complexities of insurance coverage for a claimed violation of FACTA.[17] In the underlying suits, certain customers of a restaurant sued the restaurant claiming that their receipts for debit card purchases at the restaurant bore the expiration date of the debit card and/or more than the last five numbers of the card in either negligent or willful violation of FACTA. [18] The restaurant sought a declaration that its carrier was required to defend and indemnify the suit, and the insurance carrier moved to dismiss.

The restaurant sought coverage under the advertising injury portion of its CGL policy.[19] The insurer contested advertising injury coverage for several reasons: (1) that handing a receipt to a customer does not constitute "publication" (2) violation of the FACTA does not constitute an "injury" for the purpose of the policy (3) statutory damages under FACTA amount to punitive damages and are thus not insurable (4) "willful violation" under FACTA is an intentional act and thus not insured under the policy.[20]

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[15] *Id.* at 1109

[16] 2009 WL 2993739 (S.D. Fla)

[17] The "Fair and Accurate Transaction Act" (15 U.S.C. §1681) requires that all credit card receipts show no more than the last 5 digits of the card number and forbids the printing of the expiration date. The act provides penalties for both negligent and willful violations of the act.

[18] *Id.* at *2-*3

[19] The policy provided coverage for injury arising out of "oral or written publication, in any manner, of material that violates a person's right of privacy;"

[20] *Id.* at *9

On the first point, the insurer argued that "publication" required some form of *public* dissemination of the information. Because the credit card receipts were handed only to the holders of the cards, the disclosure could not be public. The court rejected this argument noting that the policy covered "publication, *in any manner*." Because at least one court had held that publication did not require that the recipient of the publication have "previous ignorance" of the matter published, the court found that the debit card receipts at issue satisfied the policy's broad definition of "published in any manner" and that the insured had presented a reasonable interpretation of the policy language at issue.[21]

The insurance company next contended that the plaintiffs in the underlying suit had failed to allege facts that constituted an injury. Specifically, the insurer pointed out that a violation of FACTA was neither a bodily injury, property damage, an advertising injury, nor a personal injury. The court, however, pointed out that by the language of the policy any violation of a "right of privacy" constituted a covered injury. Because the policy did not define the phrase, the court first had to determine what constituted a "right of privacy." Turning to the legislative history of FACTA, the court acknowledged that one of the primary purposes of FACTA was to prevent identity theft by preventing the disclosure of private financial information. More specifically, to prevent the disclosure of complete account numbers on electronically printed receipts.[22]

Having determined that some right of privacy existed, the court next considered whether plaintiffs in the underlying suit had actually alleged such a violation. The court found that because the plaintiffs had alleged a failure to truncate account information on electronically generated receipts, they had alleged the violation of a privacy right created under FACTA and thus a covered advertising injury.[23]

Next, the insurer argued that to the extent the underlying suits alleged a willful FACTA violation, they were excluded from coverage by the policy exclusion for the "knowing" violation of the rights of another. However, US Supreme Court precedent established that "willful" non-compliance with FACTA could arise out of reckless behavior, thus falling short of the standard for "knowing" violations. Accordingly, the complaints alleged covered conduct even where they alleged willful violations of FACTA.[24]

This case serves as an illustration of the complexity of arguments a carrier will marshal to avoid novel and potentially costly claims. Note the four different levels at which the carrier attempted to avoid coverage: first, that the action complained of (the handing over of the receipt) failed to meet the definition of the covered act; next, that the act complained of was not actually any sort

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[21] *Id.* at *10 - *13

[22] *Id.* at *14 - *16

[23] *Id.*

[24] *Id.* at *18-*21

of injury; next, that the type of damages sought, even admitting liability for a FACTA violation, was not the sort of damages covered by the policy; and finally, that a certain subset of damages under FACTA was not covered due to the "knowing" acts exclusion in the policy. While the insured here was able to convince the court that coverage did exist, this was largely due to the expansive drafting of the policy. As is apparent in the next case, a slight change in policy language can cause a court to find that a virtually identical claim is not covered under the policy.

2. *Whole Enchilada Inc. v. Travelers Property Casualty Co.*

Whole Enchilada[25] arose out of facts similar to *Creative Hospitality*, but turned on different policy language. The language of the policy in *Whole Enchilada* insured against advertising or personal injury arising out of "publication of material that appropriates a person's likeness, unreasonably places a person in a false light or gives unreasonable publicity to a person's private life."

Working with this policy language, the court first considered whether a FACTA violation could be a "publication" for the purposes of the policy. The court found that it could not. Specifically, the court found that "publication" required some sort of dissemination to the public, and not just to the individual cardholder.[26]

Next, the court considered and rejected the insured's argument that the financial material protected by FACTA constituted a "person's likeness" as used in the insurance policy. The court rejected this argument as stretching "beyond any reasonable expectation of coverage." First, because no one seriously considered financial information to be a person's "likeness" and second, because, even if such information was equivalent to a likeness, the complaint in the underlying action did not allege any appropriation of the likeness, but merely failure to truncate account umbers in accord with FACTA.[27]

Furthermore, the court rejected the insured's argument that a violation of FACTA gave "unreasonable publicity to a person's private life." The court's conclusion here was dictated by its earlier consideration of the term "publication" in the policy. Because there was no public disclosure of the information, there could be no unreasonable publicity.[28]

In this case, because the insurance policy essentially enumerated the elements required for personal and advertising injury, the insured was unable to argue its way into coverage. This underscores the importance of carefully selecting the language of both the general policy and its endorsements to make sure potential claims are covered. Do not accept one insurer's restrictive definition of injury if a policy with a more expansive definition is available.

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[25] 581 F. Supp. 2d 677 (W.D. Penn. 2008)

[26] *Id.* at 696

[27] *Id.* at 698

[28] *Id.* at 699-701

C. Bacteria, Use of Premises, & Consumable Products

1. *Lancer Insurance v. Perez*

On April 30, 2004, a tour bus driver, unknowingly suffering from active tuberculosis, transported a high school class to an amusement park.[29] Several of the passengers became infected and sued the driver and the tour bus company. The company tendered the claim to its business automobile insurer, Lancer, which denied any duty to defend. The tour company defended the trial without Lancer's assistance and judgment was rendered against them in the amount of $5.25 million and the company sued for declaratory relief that Lancer was obligated to indemnify them for the full amount. The passengers intervened in the declaratory action and the trial court granted summary judgment in favor of the passengers and against Lancer.[30] However, the appellate court reversed after determining that there were material, factual disputes over whether the passengers' injury resulted from the "use" of the bus as defined in the Lancer insurance policy.[31]

Before making its determination on the meaning of "use," the court first turned to, and rejected, Lancer's assertion that an accident consisting of an infection with a contagious disease could never trigger coverage under the business automobile policy as written. Lancer's argument rested on a line of cases that held certain accidents that happened to occur inside vehicles did not arise out of the "use" of the vehicle.[32] However, because there were other cases that held the opposite, Lancer's broad argument, that coverage was impossible, failed. Both lines of conflicting cases utilized the three-factor test articulated in *Mid-Century Ins. Co. of Tex. v. Lindsey*.[33] The three factors are: (1) the accident must have arisen out of the inherent nature of the automobile, as such (2) the accident must have arisen within the natural territorial limits of an automobile, and the actual use must not have terminated, (3) the automobile must not merely contribute to cause the condition which produces the injury, but must itself produce the injury.[34]

Next the court turned to whether the injuries suffered by the infected passengers qualified as arising out of the use of the vehicle, based on the *Lindsey* factors. The two main points of contention were (1) whether the passengers were only exposed to tuberculosis in the bus, or whether exposure occurred outside the bus during interactions with the driver and (2) whether the bus's air circulation system allowed in outside air, or merely re-circulated air inside the bus. The first issue addressed the second *Lindsey* factor and the second addressed the third *Lindsey*

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[29] *Lancer Insurance Co. v. Perez*, 2009 WL 3644018 (Tex. App. – San Antonio)

[30] *Id.* at *1

[31] The relevant clause in the policy stated that Lancer would pay "all sums an 'insured' legally must pay as damages[. . .]resulting from the ownership, maintenance, or use of a covered 'auto.'"

[32] *Id.* at *5

[33] 997 S.W.2d 153 (Tex. 1999)

[34] *Id.*

factor.[35] The court found that the evidence presented with the summary judgment motions was conflicting, and thus the passengers had not proved as a matter of law that their injury arose out of the use of the bus. More specifically, the court found that it was possible the passengers became infected by interacting with the driver outside the bus, thus negating the second *Lindsey* factor. Furthermore, if the air conditioning system allowed in outside air rather than just re-circulating interior air, then it was not clear that the automobile "itself produce [d] the injury," thus negating the third Lindsay factor.[36]

While this case admittedly concerns the "use" of an automobile, the lack of certainty and the inability of the insured to win coverage on summary judgment is disturbing for property owners in the hospitality industry as well. While the locus of the injury in this case is a bus with an infected driver, it could just as easily be a hotel lobby and an infected guest. The fact that coverage for a claim arising out of such a scenario could turn on whether or not the HVAC system of the lobby is self-contained should give risk managers pause. Again, careful selection of policy language is crucial to achieving efficient and decisive results should litigation against the carrier prove necessary.

2. *Nationwide Mutual Fire Ins. Co. v. Dillard House, Inc.*

In *Nationwide Mutual Fire Insurance Co. v. Dillard House, Inc.*,[37] the insurer sought declaratory relief from both its defense and indemnity obligations in an underlying wrongful death suit brought against a hotel defendant. The decedent in the underlying lawsuit contracted Legionnaire's disease, allegedly from use of the hotel hot tub.[38]

As a preliminary matter, the court held that a declaration as regards indemnity was premature when the underlying suit remained unresolved. Next, the court turned to the defense obligation on the insurer's motion for summary judgment.[39] The insurer initially took the position that the death failed to qualify as an occurrence because it was not an "accident" under the policy. The position is extreme.[40] According to the insurer, the death resulted from a "conscious and voluntary failure" to maintain sanitary conditions in the insured's swimming facilities. The court rejected the position explaining that it "immunize [d] [the insurer] from liability in nearly every case where a plaintiff alleges that an insured acted negligently." The court pointed out that, should the insurer's position prevail, the classic banana peel slip and fall in a grocery store would not be covered under a CGL policy because the grocery store could be characterized as having

[35] *Lancer at *7*

[36] *Id.* at 7-9.

[37] 2009 WL 2835203 (N.D. Ga.)

[38] *Id.* at *1

[39] *Id.* at *3

[40] *Id.* at *4

"consciously and voluntarily" failed to adopt a practice of frequently monitoring its floors for banana peels.[41]

Next, the court considered the less extreme contention that, even if the death was an occurrence, it was excluded under the bacteria exclusion of the policy. This analysis hinged on an exploration of an exception to that exclusion, the "consumption" exception.[42] While almost any injury arising from exposure to bacteria was excluded from coverage under the policy, there was an exception for bacteria contained in "a good or product intended for (bodily) consumption." The parties principally debated over the meaning of "consumption." Relying principally on dictionary definitions, the court found the matter easily resolved because the exception was ambiguous. In the face of that ambiguity, the insured offered a reasonable interpretation that triggered the exception and thus coverage. Accordingly, because Georgia law requires policies to be construed in favor of coverage, the insurer was required to provide a defense.[43]

This case in particular is a stunning example of the extreme position a carrier will take to avoid coverage. Nationwide's contention that the death in this case arose from a "conscious and voluntary failure" to maintain swimming facilities is tantamount to trying to write out the very existence of negligence. As the court rightly points out, Nationwide's argument, if believed, operates to relieve a carrier of liability in almost any imaginable scenario. On the more particular issue of coverage for bacterial harm, this case and the next illustrate how careful consideration of exclusions can assist a policyholder in establishing coverage. While death from Legionnaire's would seem to be clearly excluded under the bacteria exclusion, the "good or product" exception saved coverage for the policyholder.

3. *Union Insurance Company v. Soleil Group*

Though the carrier took a less extreme position in *Union Insurance Company v. Soleil Group,*[44] the battle for coverage was still hard-fought. The parties in this case first differed over whether or not hot tub water was a "product". Though the carrier asserted that the cause of the harm was the swimming pool and hot tub, the court disagreed and found, instead, that the source was the hotel's water.[45] Next the court discussed whether the water was a good or product intended for consumption. The court had no trouble finding that water in a hotel is a product, and next turned to the meaning of "intended for consumption" and, more specifically, "consumption." The court acknowledged that consumption is traditionally defined as "the using up of consumer goods and services." The insurer thus argued that pool and hot tub water failed to meet this definition because they were not "used up in the process of being used".[46] The court disagreed, noting that,

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[41] *Id.* at *4

[42] *Id.* at *5

[43] *Id.* at *6

[44] 2:07-CV3995-PMD (2009 D. SC)

[45] *Id.* at 6-9

[46] *Id.* at 10

while the quantity of the water may not have been diminished with use, the quality of the water certainly was.

Next, the court dispensed with the insurer's argument that, because the guests had not themselves consumed the water, but merely been exposed to it, the exception did not trigger coverage. The court quickly dismissed this argument noting that the exception was for products *intended* for consumption, not products actually consumed.[47]

Finally, the court addressed the insurance company's contention that the court's interpretation effectively read the bacteria exclusion out of the policy. The court disagreed. It pointed out that, had water somehow invaded the walls of the hotel, and mold formed there, causing disease, then the bacterial exclusion would apply and the exception would not trigger coverage. Accordingly, the insurer was required to provide a defense to the hotel defendant in the underlying suit.[48]

Here again we see that insurers are capable and willing to fight over nearly every word of the policy to avoid coverage – words they themselves selected. Just like the previous case, a careful parsing of language that triggers coverage, compared with a favorable presentation of the facts, can turn a potentially costly claim into one completely financed by the insurer.

D. EPLI And The Administrative Claim

1. *National Waste Associates, LLC v. Travelers*

In *National Waste*,[49] an insurer denied coverage under an employment practices claims-made policy purchased in 2007, and the insured sought a declaration that coverage existed under that policy. The insurer claimed that the plaintiff in the underlying case had previously been involved in an unemployment benefits action with the insured that was heard in 2005 before the Connecticut Department of Labor.[50] Furthermore, the insurer contended that the insured failed to disclose this prior action on its application for the insurance policy. The policy excluded coverage for claims related to prior administrative proceedings and voided coverage if there was a knowing misrepresentation on the application. The application asserted that there had been no employment-related proceedings involving the insured for the previous three years. Relying on precedent from several jurisdictions, the trial court had no trouble finding that the unemployment benefits hearing constituted a prior proceeding for the purpose of the policy exclusion. Accordingly, there was no coverage under the EPLI policy.[51]

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[47] *Id.* at 10-11

[48] *Id.* at 11-12

[49] 2008 WL 2746021 (Conn. Super.)

[50] *Id.* at *4

[51] *Id.* at *6

Last year, this author explained the inherent dangers in EPLI claims-made policies, warning in particular of the troubling situation in which consecutive insurers could deny a claim, one because it was not reported during the relevant policy period, and the other because it was not made during the subsequent period.[52] While such a situation has not recently been litigated, *National Waste* serves as a cautionary tale for strictly complying with the requirements of the claims made and reported EPLI policy. There is no indication that the insured in the case was trying to hide anything from the insurer. Indeed, in all likelihood the insured thought that an unemployment benefits hearing was probably not the sort of thing it needed to disclose, nor the sort of thing that, several years later, would ripen into a lawsuit. Nevertheless, by failing to disclose the action, the insured was denied coverage for this claim. A scrupulous investigation into any prior administrative hearing should be conducted before signing applications for EPLI policies.

[52] [52] Wood, WHAT HOSPITALITY LAWYERS NEED TO KNOW ABOUT INSURANCE 7, Hospitality Law Conference, February 2009