When "Later" is Just Too Late: Early "Issue Spotting" in Construction Claims & Litigation

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I. INTRODUCTION

Insurance issues continue to play a significant role in any construction project. Although insurance products have evolved in an effort to address policy conflict and cost concerns, issues remain that often lead to conflict between owner, contractors, subcontractors and/or their insurers on the resolution of claims. An understanding of the available products and the process of responding to a claim before and after litigation is critical to the management of these matters.

Section II of this paper provides an overview of the unique policy products that are available for construction projects, including a discussion of the considerations that are essential to the selection and management of the programs. Section II also contains a discussion of the deficiencies that have been identified by courts nationwide in the use of certain controlled insurance programs.

Section III addresses the issues that arise when a claim occurs. More specifically, Section III discusses the tender process and the defenses to coverage that may be raised by notified carriers. In Section IV, an overview of litigation considerations is provided with an in-depth discussion of the forum selection process. Finally, Section V provides an overview of evidentiary and settlement issues that often arise in the disputes involving construction insurance claims.

II. WHAT KIND OF INSURANCE IS APPROPRIATE FOR A GIVEN PROJECT?

A. Traditional Construction Risk Insurance Products and the Trend Favoring "Wrap" (OCIP and CCIP) Policies

The Owner Controlled Insurance Program ("OCIP") and the related Contractor Controlled Insurance Program ("CCIP") are programs of construction-related insurance coverage under which the owner, developer, general contractor and eligible subcontractors become named insureds under one "wrap" policy covering a particular site and/or project. The aim of such programs is to make insurance for construction risks more "equitable, uniform and efficient . . . [by] eliminat[ing] the costs of overlapping coverage and delays caused by coverage or other disputes between the parties involved in the project and, at the same time, protect[ing] all the contracting parties by bringing the risk of loss from the project within the insurance coverage of the OCIP."[1] Other stated advantages are decreased premium costs, reduced likelihood of coverage gaps arising from uninsured trades on a project, and the avoidance of coverage disputes which could otherwise arise among multiple carriers on a risk.[2]

These are optimistic goals, presumably with a firm basis in theory. However, the actual circumstances of a particular risk, loss or claim will ultimately determine whether the goals are met in practice. Wrap programs can involve multiple carriers, rather than all coverages being issued by a single company,[3] and therefore the possibility of intra-carrier disputes are not always obviated. Additionally, claims can arise among and between enrollees/participants in the OCIP/CCIP, and notwithstanding the goal of obtaining coverage for all trades that may be involved in a project, insured status is often linked to the contractual terms of the project, which may exempt certain classes of contractors or require proper paperwork for a contractor to be included as an insured under the OCIP.[4] Moreover, insurance professionals and commentators debate the extent to which wrap products actually result in lower premium costs to plan enrollees, and the answer likely varies depending upon the project, the scope of the coverage, and the cost of the policy. Finally, although not within the scope of this discussion, implementation of an OCIP may involve regulatory issues, concerns over public bidding processes and compliance with statutory insurance provisions for public projects.[5]

Whether they are or are not efficient, cost effective insurance products, commentators and the insurance industry acknowledge the increased frequency of OCIPs, CCIPs and similar wrap products as the favored mechanism for insuring construction risks large and small. Indeed, innumerable departments, divisions and agencies of federal, state and municipal entities consider the OCIP/CCIP model of insurance so superior to the traditional, multi-carrier insurance model as to mandate enrollment for contractors bidding on public projects. Wrap programs are consequently due significant consideration both in terms of project planning pre-construction, and after claims or litigation arise.

B. Typical Insurance Products Involved in Construction Risks

The risks inherent in construction activities are many, and the insurance products reasonably necessary to cover potential damages and liabilities are equally numerous. Two products that are outside the scope of the typical wrap program are **Builder's Risk**[6] insurance and surety products like the **Performance Bond** and the **Payment Bond**. With due acknowledgement for the fact that generality breeds unreliability, Builder's Risk policies typically afford first party property coverage to the builder or owner against loss of or damage respecting construction activities in progress;[7] surety products, *inter alia*, ensure the completion of the project and the payment of the involved entities. As with all insurance products, the risks covered vary significantly by the coverage forms at issue.[8]

On the other hand, the insurance products which may potentially be encompassed by wrap policies like an OCIP or CCIP include **Commercial General Liability** ("**CGL**") insurance, **Workers' Compensation** and **Employer's Liability** insurance, **Professional Liability** insurance, **Environmental Liability** insurance, and **Excess/Umbrella Insurance**. The OCIP or CCIP can delineate which coverages it provides and which types of coverage the contractors on the project must obtain on their own.[9] Whether or not the project is insured under an OCIP or CCIP, it is likely that all or most of these coverages will be obtained. A summary of each product is discussed below.

1. Commercial General Liability[10]

Commercial general liability ("CGL") policies are the most commonly available insurance in the event of a construction loss and pay "on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage . . . caused by an occurrence." The bodily injury or property damage must take place within the policy period and it does not matter when claim or suit is brought.

A general liability policy is "triggered" when "bodily injury" or "property damage" takes place during the policy period.[11] When the injury/damage "occurred" is important and may trigger coverage under older policies.

While many types of claims are limited to a two, three or six year statute of limitations, some high-exposure claims have very long tails, such as: environmental, asbestos, construction defect and intellectual property claims. It is important to critically assess the nature of the damage/loss at issue and determine whether bodily injury or property damage potentially occurred during a policy period. Depending on applicable law,[12] multiple policy periods may be triggered by a loss.

2. Professional Liability

CGL insurance is usually the first choice to cover a loss, but is not the only type of policy that may potentially apply. In addition to losses associated with bodily injury or property damage, a professional liability policy may cover non-physical, or purely economic, damages. For instance, if a project sustains cost-overruns and loss of revenue because of design errors, a policy limited to bodily injury and/or

property damage coverage would not cover these non-physical losses. In comparison, most professional liability policies cover these consequential type losses.

Professional liability insurance provides coverage for claims alleging mistakes in technical or highly-skilled areas of work. Such work is commonly defined as "professional services." In the construction context, professional services include:

- Design Work (structural, civil, soil)
- Planning
- Land surveying
- Mechanical and electrical engineering
- Construction management services (logistical work associated with the construction process, including scheduling and project site safety).

Professional liability policies are usually "claims made" policies and require: (1) that the conduct subjecting the insured to liability occur during the period of coverage, and (2) that the party allegedly aggrieved by such conduct make a "claim" against the insured during the period of coverage.[13]

A professional liability policy is intended to work in harmony with the coverage afforded under a CGL policy. In the construction context, a professional liability policy insures those risks that involve the technical design, engineering and other skilled work associated with a construction project. The CGL policy is intended to address liability for the other aspects of a construction project that concern "general negligence," falling outside the scope of professional services. Indeed, the majority of CGL policies contain exclusions for work that is considered to involve professional liability.

For a variety of reasons, a claim cannot always be neatly packaged into one particular type of coverage and may overlap between various types of policies. This professional vs. general liability debate has been an ongoing battle courts have confronted on numerous occasions. To illustrate – a construction manager may act as a general contractor and provide management services. In this scenario, classifying an error involving project oversight as either a professional or non-professional act can be difficult. This is illustrated by two cases reaching divergent conclusions.

For example, in a case from the New York Appellate Division, the court held, that a project engineer's failure regarding project safety management did not involve professional negligence: "[I]t is clear that [Engineer] Seelye's alleged failure in the underlying action to make sure that the contractor at a renovation site remained in compliance with both its contract and the relevant safety laws did not require Seelye's engineering acumen, but rather normal powers of supervision and observation."[14]

Conversely, a New York federal court concluded that the project architect's general oversight responsibilities involved "construction management", affording coverage under its professional liability policy for claims involving a construction crane that toppled over. In so holding, the court rejected the insurer's argument that the architect was not engaging in construction management because he did not perform "design work, construction means and methods, site safety, or duties assumed or required to be performed by the Construction Manager."[15]

3. Excess/Umbrella Policies

True excess insurance policies will usually "follow form," providing the same coverage as their primary counterparts and generally have no obligation to respond to a claim until the primary insurer's policy limits have been exhausted. Often times, increased limits are provided by umbrella policies, which, like excess insurance, schedule the CGL policy as "underlying", but provide coverage according to the terms and conditions of a stand alone policy. Depending upon the program, umbrella coverage may be the first layer above the CGL policy, with "follows form" excess coverage existing over the umbrella.

Moreover, for both Umbrella and Excess policies, the insured's duty to provide notice typically only arises when the insured reasonably believes that an occurrence is likely to involve the umbrella/excess coverage.[16] If there is even a possibility that the relevant damages will implicate the umbrella or excess policy, the prudent policyholder should immediately put both carriers on notice to avoid any possibility of late notice disclaimer and ensure the umbrella/excess carrier has the opportunity to timely investigate the claim as needed, or to associate in the defense of any suit being provided by the primary carrier.

4. Builders Risk

As noted, builders risk insurance is a type of first party property insurance most common in the construction context because it insures property undergoing a fundamental change during the policy period.[17] The covered risk on the date of project commencement (usually an empty plot of land) is vastly different from the risk insured on the date of project completion (a finished structure). The insured property is a work-in-progress consisting of three separate segments: (1) the part of the project that has been completed; (2) the part that is being worked-upon; and, (3) the part that is not yet begun. Consequently, builders risk insurance covers the on-site building materials and components that are being moved, assembled, and put into place.[18]

Builders risk insurance is non-standardized coverage -- policy language varies from one form to the next, often significantly. However, while there is no common policy form, the majority of builders risk policies condition coverage upon the presence of the three following criteria: (1) a "loss" to (2) "covered property" (3) caused by a "covered cause of loss".[19] While the policy is typically purchased by the owner of the project, it will usually name certain contractors as insureds, or at the very least, insure the contractors' interest in the project. Thus, a builders risk policy covering a project should be available regardless of who caused the property damage.

5. Environmental Liability Coverage

The standard CGL form contains a pollution exclusion for damage or injury "arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants", and broadly define "pollutant" as "***any*** solid, liquid, gaseous or thermal irritant or contaminant". There is a morass of case law interpreting various pollution exclusions and wording – old and new – and the extent to which a CGL policy will or will not respond to a particular liability which may or may not properly be characterized as arising from a pollutant, irritant, or contaminant is not susceptible to reliable generalities and is beyond the scope of the within discussion.

Various pollution liability products are available that are designed to specifically address an insured's potential exposure for environmental risks and pollution conditions which may be encountered as a result of the insured's operations. These products include Contractors Pollution Liability ("CPL") insurance, Premises Pollution Liability ("PPL"), which is also referred to as Pollution Legal Liability ("PLL") and Environmental Impairment Liability (EIL) insurance. The scope of coverage varies, but these forms generally cover third party liability for and the costs of defending alleged injury, clean up and property

damage arising out of pollution conditions respecting the insured site, and first party coverage for government mandated clean up costs.[20]

C. Practical Considerations in Selecting and Managing OCIP/CCIP Coverage for Construction Risks

Issues relevant to selecting the right wrap program for construction-related risks, and the challenges that can arise in managing a wrap program, are far too numerous to address individually here. Many of the considerations and problems that frequently arise, however, are addressed below.

1. Adequacy of Limits

In the absence of an OCIP or CCIP policy with substantial per occurrence and aggregate limits (or the issuance of excess/umbrella coverage which accounts for modest primary limits), one likely outcome of the use of a wrap program is the availability of a lower aggregate limit of liability for all enrollees in the insurance program than would exist if the same enrollees obtained separate policies of liability insurance. The actual limit available to pay liability exposures is also significantly impacted by the scope of coverage afforded for defense - specifically, whether defense costs are within or outside the limit of liability.

This challenge can be addressed in a variety of ways. For example, an enrollee can participate in the OCIP/CCIP while at the same time maintaining a traditional, individual policy of liability insurance. In this case, however, the potential cost savings of participation in an OCIP/CCIP is surely lost, since the bid of an enrollee in the program is traditionally reduced to reflect the cost of the insurance the contractor would have obtained for itself were the OCIP/CCIP coverage not being provided. If that coverage is being supplemented by a separate policy purchased by the enrollee, then insurance costs are necessarily higher than they would be by a traditional insurance approach. Furthermore, such supplemental coverage can be illusory since some CGL policies expressly exclude liability arising from any project covered by a wrap policy such as an OCIP or CCIP[21]. Finally, as will be seen below, unless that policy is expressly written to be excess of OCIP or CCIP coverage, it may apply before any excess coverage afforded under the OCIP/CCIP, or could potentially apply on a pro-rate by limits or equal share basis with the primary portion of the OCIP/CCIP coverage.

Since OCIPs/CCIPs are typically multi-year policies, such programs often provide reinstated or "refreshed" aggregate limits on an annual basis, for the term of the policy. Whether an annually reinstated aggregate does anything more than traditional insurance would provide - i.e., the benefit of a new limit of liability for each year of the policy duration - depends on the circumstances of the loss and the language of the policy.

Finally, excess/umbrella coverage can be purchased over the CGL limit as a backstop against the risk of inadequate project coverage. But as a practical matter, the issue is not so much whether coverage is obtained in the form of primary coverage, supplemented by excess/umbrella, or whether a single-layer wrap program is designed with a large limit of liability. The issue is cost, which is substantial (if not prohibitive) if the aim is to obtain a policy which would afford limits equal to those which would exist under the traditional insurance model requiring each subcontractor or trade engaged in work on a project to obtain separate liability coverage.

2. Differing Premium Bases for OCIP/CCIP Programs

Retrospective rating plans in which the ultimate cost of an insurance product is variable, and determined only on the basis of the claims and payments over the period of the policy, sometimes occur in other

commercial insurance products (such as workers' compensation policies), but they are a common feature of OCIP/CCIP programs. Under this approach, where losses and claims paid determine the ultimate cost of the insurance, the total premium cost of the OCIP/CCIP product is not guaranteed, but is instead subject to adjustment. Consequently, there is an element of financial uncertainty which does not exist in the traditional CGL insurance context, where the policy premium is more typically fixed and guaranteed regardless of the claims occurring on the policy.

Fixed cost OCIP/CCIP programs are written, but the premium cost is higher due to the uncertainty on the part of the carrier of its ultimate financial exposure.

3. Control Over the Program

As the names of the products reveal, the controlling entity in the case of an OCIP program is the owner; the controlling entity in the case of a CCIP is the contractor. The cost in terms of time and expense in managing and administering an OCIP/CCIP program can be substantial. Managing the enrollment of the employees of all contractors on the project for purposes of workers' compensation coverage and subsequent claims for workers' compensation benefits alone can be daunting.

This management function of an OCIP/CCIP program can be undertaken by the named insured owner or contractor, by a third party administrator, or by the carrier issuing the OCIP/CCIP.[22] As addressed more fully below, OCIP/CCIP plan documents purporting to place obligations on parties to the OCIP/CCIP policy, and even those which merely facilitate the coverage, can create legal obligations on the part of both the parties and facilitators.

D. Issues and Conflicts Arising Under OCIP/CCIP Programs

1. Related to the Workers' Compensation Bar

Questions have arisen respecting the extent to which an owner or general contractor is the "statutory employer" of an injured employee solely by virtue of the fact that all contractors and their employees are enrollees on an OCIP. The outcome is significant: potential targets of tort liability may obtain the benefit of tort immunity to the same extent as the injured person's direct employer. Courts have reached inconsistent results on the issue, based upon differing state laws and statutory provisions respecting workers' compensation.

In Kentucky, for example, if a party secures compensation of benefits for an injured worker through insurance, that alone can trigger the workers' compensation bar in favor of that party.[23] A general contractor who purchases a wrap policy for employees subject to the Longshoremen's and Harbor Workers' Compensation Act is entitled to tort immunity for injuries to subcontractors.[24]

Similarly, in Texas, "[i]f the general contractor 'provides' workers' compensation insurance, it becomes a statutory employer of the subcontractor's employees", and is immune from suit filed by a subcontractor's employee.[25] In cases addressing the Texas workers' compensation statute, courts have found that the general contractor must do more than merely require enrollment in the OCIP to be deemed to be "providing" insurance.[26] But where OCIP enrollment is required, and where workers compensation insurance is in fact issued, covering a subcontractor pursuant to the OCIP, Texas courts have deemed the general contractor a statutory employer, even if the general contractor did not directly purchase the workers' compensation coverage.[27] In contrast, under Georgia law, simply purchasing and paying the premiums for an OCIP which provides workers compensation benefits is not the same as "providing" benefits so as to grant workers compensation immunity to the purchaser.[28]

In some jurisdictions, the fact that there is an OCIP or CCIP program in place eliminates the opportunity for the owner or general contractor to claim statutory employer status. For example, in Nebraska, courts have held that where a subcontractor is required to enroll in a workers compensation OCIP program, the subcontractor is in essence providing its own insurance, and the contractor or owner therefore cannot be deemed the statutory employer of the subcontractor's employees.[29] Michigan applies a similar rule, finding that a general contractor can only be deemed a statutory employer when the subcontractor fails to secure workers' compensation (or is not required to secure such insurance) for the injured employee. Under an OCIP, since all contractors and subcontractors are typically covered, the subcontractor is deemed to supply workers' compensation, eliminating the general contractor's opportunity to be considered a statutory employer.[30]

Other courts reach another conclusion. In those jurisdictions, the existence of an OCIP/CCIP is irrelevant to the question of whether a general contractor or owner is a statutory employer protected by immunity. In these states, relevant statutes determine the proper scope of the workers' compensation laws and employee status, and such considerations as the "right to control" and the "right to fire" are determinative¸ without regard to the presence or application of an OCIP.[31]

In Wisconsin, for example, to be considered a "statutory employer", the general contractor is required to have the typical master-servant relationship with the subcontractor's employee. In one case, the owner created an OCIP program and purchased a policy from Liberty Mutual.[32] In a dispute over workers compensation benefits, it was argued that each contractor should be deemed the employer of the injured worker and therefore be entitled to tort immunity. The court rejected the argument, noting that each contractor was considered a separate insured under the OCIP and that nothing about the OCIP program demonstrated that any other contractor should be deemed the statutory employer of the injured employee for workers' compensation purposes. The court furthermore rejected the notion that the terms of the OCIP could be determinative of an employer-employee relationship. Finally, the court stated that it would not make sense that a "less expensive insurance program would afford participants more coverage by insulating them from tort suits not just from their own employees but from employees of all other firms involved."[33]

Pennsylvania courts have reached a similar conclusion. Where an owner had a right to inspect work pursuant to the contract documents (and where, incidentally, the project was covered by an OCIP) to ensure that safety requirements were being met, this ability did not constitute "retained control" so as to make the owner the employer of a subcontractor's employee under Pennsylvania law[34].

A Maryland court held that regardless of the master/servant relationship or the fact that there is an OCIP, an entity will qualify as a statutory employer where there are "two contracts, one between the principal contractor and a third party whereby it is agreed that the principal contractor will execute certain work for the third party, and another between the principal contractor and a person as subcontractor whereby the subcontractor agrees to do the whole or part of such work for the principal contractor." [35]

2. The Resolution of Priority Disputes in the Case of Competing Insurance Policies

As noted above, a contractor/subcontractor afforded coverage under OCIP/CCIP for a particular project may have its own insurance, either because it pre-existed the OCIP/CCIP enrollment or as a means of obtaining additional coverage for future liabilities. In the workers' compensation arena, an employer may procure its own workers' compensation coverage to supplement the OCIP for injuries occurring away from the OCIP project site.[36] An OCIP and a CGL policy procured by a contractor individually may have competing "other insurance" or "excess only" endorsements which will impact the priority of coverage.[37]

In these circumstances, the intra-carrier disputes about priority of coverage which are often obviated by the issuance of an OCIP or CCIP, may arise.

In an Illinois case, Reliance issued an OCIP policy for a particular project which included workers compensation coverage. Virginia Surety had also issued a general workers' compensation policy for contractor. Reliance became insolvent, and the Illinois Insurance Guaranty Fund stepped in on behalf of Reliance, and then sought reimbursement from Virginia Surety. The contractor's bid included a credit for the cost of insurance, and was therefore covered under the OCIP. The Virginia Surety policy contained a provision indicating that coverage was provided unless there was other insurance, and Virginia Surety returned a portion of the contractor's premium as it related to the subject work site. On these facts, the court determined that the Fund was responsible for the workers' compensation benefits at issue, and that Virginia Surety had no duty to afford coverage[38].

In a California case, Aetna provided a primary commercial general liability policy, and National Union provided a commercial umbrella policy under an OCIP policy. A subcontractor enrolled in the OCIP had previously purchased CGL coverage from American & Foreign, and National Union asserted that it was excess to the primary policy issued by American & Foreign. American & Foreign argued on the other hand, that the National Union policy was purchased as part of an OCIP for the purpose of providing primary coverage for any incident at the project site, whereas American & Foreign simply afforded general coverage. Applying the competing other insurance provisions within the respective policies, the court agreed with National Union that its coverage was excess over American & Foreign.[39]

In a New York case, the workers' compensation insurer for a construction subcontractor sought a declaration that the issuer of a "wrap up" policy, covering all authorized participants in the project, was required to defend and indemnify the subcontractor, which had been brought in as third-party defendant in an employee's bodily injury action. The court held that the workers' compensation carrier failed to show that the subcontractor was an insured under the wrap-up policy; coverage under the wrap-up policy did not extend to all contractors and subcontractors but only those who enrolled in the program; the subcontractor was not a valid enrollee because written approval for hiring the subcontractor was not obtained; and therefore the subcontractor was an unknown entity who did not pay any premiums or notify the Workers' Compensation Board of the policy's issuance pursuant to New York law.[40]

In a New Jersey case, the court resolved a coverage dispute concerning which policy was primary for a bodily injury claim arising out of a construction accident. There, the owner was required by contract to maintain liability coverage during construction of a project and to designate the general contractor as a "named insured" on the policy. The general contractor also had its own general liability policy which included an exclusion for "wrap up" policies.

The insurer for the owner argued that its policy did not provide "wrap up coverage" as that term is generally understood in the insurance industry because it did not provide workers' compensation coverage, did not cover any of the subcontractors, and did not provide builder's risk coverage for the premises. The Court found the term "wrap up" to be ambiguous, turning to extrinsic evidence to ascertain the intent of the insurers, which it found to require application of the exclusion to relieve the general contractor's personal insurer from any obligation to afford coverage.[41]

3. The Allocation and Collection of Premium Costs for OCIP/CCIP Coverage

As noted above, the cost of OCIP/CCIP coverage is typically accounted for (and effectively paid by each enrollee) by way of a credit against its bid for work on the project in the amount of the liability insurance the contractor would otherwise be obligated to obtain. As also noted, in policies where the premium is not fixed but is instead loss sensitive – ultimately determined only on the basis of claims paid –

adjustments to a contractor's contribution of its share of the premium cost may occur throughout and even after completion of the project. This potentiality has run afoul of at least one state's statutory provisions. Specifically, a New York court held that the terms of an OCIP program permitting post-project recalculation of an enrollee's share of the policy premium violated statutory insurance provisions, holding that the enrollee could only be required to provide a credit for insurance coverage in its initial bid.[42]

In a Massachusetts case, an OCIP program requiring the cost of insurance to be included in a bid, with deductions for the subcontractor's allocable share of OCIP insurance costs taken from the contract balances due the subcontractor was acceptable.[43] A Connecticut case pointed out the interplay of the intent of the contracting parties and the actual terms of the OCIP as it related to payment of premiums and self-insured retentions, and found a question of fact as to whether the parties' intent on the payment for these items should control to resolve arguably ambiguous policy language.[44]

4. Liability for the Control or Management Of OCIP/CCIP Responsibilities and Obligations

As noted, the cost in managing and administering an OCIP/CCIP program in terms of expenses and time can be substantial. Depending upon the plan documents, third parties may have purported obligations under the CCIP/OCIP which can create a legal duty creating liability to third parties where those duties are breached.

For example, in a South Carolina case, the OCIP plan provided that the insurance broker for the policy was an "administrator" under the plan and responsible for safety inspections. The evidence established that the broker in fact took no actual responsibility for safety inspections and was in no manner involved in ensuring safety on the project site. Based upon the provisions of the OCIP, however, the broker was held to have a legal duty to serve this function, and possessed potential liability for a workplace injury to the employee of a contractor allegedly resulting from unsafe work conditions.[45] Two California cases have addressed similar issues. In one, the insurance broker, as part of implementing an OCIP, developed a safety program for the project which identified risks attendant with the project, and then undertook to monitor compliance with that safety program. The court held that the broker could be held liable for negligently monitoring the program.[46] Another court, however, found that an owner implementing safety programs through an OCIP was not the equivalent of control over a contractor's employees, and therefore the owner would not be responsible for the independent contractor's negligence.[47]

The respective duties and obligations under a wrap program can have significant consequences. In one case, where a general contractor failed to include a subcontractor as an OCIP enrollee, requiring the owner to pay a large deductible under an OCIP to settle a tort claim by an employee of a subcontractor, the owner was deemed to have no claim for indemnity since under the construction agreement, the owner was obligated to obtain an OCIP policy and the general contractor had no insurance procurement obligation.[48]

5. Impact of Underlying Waivers of Subrogation

Contracting parties often enter into mutual "waivers of subrogation", under which the parties agree, expressly or impliedly, that they will look to insurance to cover any losses incurred on the project as opposed to seeking recovery from each other. Waivers of subrogation may expressly state that the parties will look to an OCIP or CCIP for any losses arising from the project.[49] Also, waivers of subrogation often go hand-in-hand with agreements to purchase insurance, and these interlocking provisions are read as evidencing the parties' mutual intent to waive direct claims against each other for losses arising with the project and instead turning to insurance for those losses. For example, an owner's agreement to

purchase an OCIP can be construed as evidence of an intent to waive subrogation against a contractor on the project for losses arising during the project, and to look solely to the OCIP for recovery.[50]

6. Impact of Anti-Subrogation Rules

Another potential issue raised by the implementation of OCIP and CCIP programs is the application of the anti-subrogation rule, which precludes an insurer from maintaining an action for subrogation against its own insured for a claim arising from the very risk for which the insured was covered. In a New York case, AIU Insurance Company issued a wrap-up insurance policy. Nationwide Mutual Insurance Company also insured a subcontractor-employer under a workers' compensation policy that provided coverage for damages claimed by third parties as a result of injury to the subcontractor's employees. The employee/decedent's wife obtained summary judgment against the site owner on the issue of liability. Thereafter, AIU caused the site owner to commence a third-party action against the subcontractor-employer, but AIU settled the main action after a trial on damages, and the subcontractor-employer was not involved in either the trial or the subsequent settlement. AIU argued that the subcontractor-employer was the only possible active tortfeasor, and therefore Nationwide was obligated to reimburse AIU for half of the settlement. The court noted that although the third-party action did not go forward after settlement of the main action, the anti-subrogation rule would have required its dismissal. As a result, the court held that any attempt by AIU, after having paid the settlement, to obtain reimbursement from a co-insurer must fail.[51]

Where an insurer issues policies covering separate risks under one OCIP/CCIP plan, each risk may be considered a separate and distinct policy from which the right of subrogation survives. In another New York case, Travelers Insurance issued workers' compensation and liability insurance under an OCIP. It paid under its workers' compensation policy, and the liability claims settled. Travelers asserted a statutory lien on the settlement for amounts paid out by workers' compensation, and argument was raised that the anti-subrogation rule precluded such action. The court held that the contractual relationship between defendants and subcontractor was irrelevant to right to assert statutory lien, and insurer had insured two separate risks.[52]

III. THE CLAIM OCCURS – NOW WHAT?

A. What Carriers Should the Claim be Tendered to?

Insurance policies and programs serve one fundamental purpose: to transfer the risk associated with a loss. When confronted with unexpected delays and ever-changing management concerns on the jobsite, one can easily forget that insurance is available for many losses. Policyholders must be hypersensitive to potential claims and involve available insurance as soon as possible.

Think carefully about the nature of the claim – more than one policy may be implicated.

Identifying an insurance claim can often be difficult in the construction setting. Consider, for example, a construction manager on a building construction job that is half complete. A portion of the progressing structure collapses and destroys most of the completed work. As a result of the damage and ensuing delay, a subcontractor that is already on-site cannot proceed with its work and must store materials and equipment, as well as reassign labor, until the damage is cleared and the project resumes.

The reason for the collapse is unclear, but may involve a combination of design error and contractor negligence. Once work resumes, the subcontractor submits a change order to the construction manager, indicating that the original contract price of $1 million is inadequate in light of costs caused by the collapse and must be increased to $1.2 million. The construction manager approves the change order,

assuming responsibility for the loss. In this situation, the subcontractor's cost increase resulting from the property damage is potentially covered by insurance; however, it can be overlooked as a business expense. Instead of absorbing this cost, the construction manager could potentially have transferred it to available insurance. Moreover, because of the nature of the damage, it may implicate both commercial general liability coverage and professional liability coverage.

It is important, at the onset of a loss or a potential claim, to consider all available insurance (Commercial General Liability, Professional Liability, Builders Risk, Environmental and Excess/Umbrella; *see* Section II., B., *supra*) and think critically about how the loss may require insurance to respond.

B. Other Considerations in Tendering a Claim

1. Does the Policy Respond to "Claims" or Just "Suits"?

In the CGL and Professional Liability context, the existence or non-existence of an actual lawsuit may dramatically impact the carrier's response to a claim. CGL policies pay all sums an insured becomes "legally obligated to pay" because of bodily injury or property damage, and promise to defend "suits" seeking such damages. Some insurers contend that this language requires that the policyholder's obligation to pay damages be preceded by a formal lawsuit.[53] Similarly, some carriers have taken the position that a "claim" covered by a professional liability policy requires actual litigation. Absent the initiation of such a suit, the carrier may conclude that it is not required to respond.

The insured, however, should not assume that litigation is always required and take extra precaution to put the carrier on notice. Depending on the circumstances, a claim may fall short of litigation, but still implicate available coverage.

In the professional liability setting, for instance, a "claim" generally means "a demand for specific relief owed because of alleged wrongdoing," and courts have held that it "can be some demand well short of a formal enforcement proceeding."[54] Likewise, "relief" is not a one-dimensional term and can include the requirement that a company produce documents and/or appear for a deposition: "A demand for 'relief' is a broad enough term to include a demand for something due, including a demand to produce documents or appear to testify."[55] Further, the insurer also has the right and duty to defend any "suit" alleging a claim against the insured. "Suit" is often undefined, but some courts will find a "suit" so long as the claimant has "assume[d] a coercive adversarial posture and threatens the insured with probable and imminent financial consequences."[56]

For example, in a Second Circuit case applying New York law, the insured received a demand letter from the Department of Environmental Quality commencing an administrative process to clean up environmental waste. The Second Circuit had "little trouble" viewing the administrative proceeding as a "suit" and held that the insurer was obligated to defend its insured. The court recognized that the demand letter commenced a formal proceeding against the insured, advised the insured that the agency had assumed an adversarial posture towards it, and that disregarding the demand could result in substantial loss to the insured. The court deemed these elements the "hallmarks of litigation."[57]

2. Additional Insured Carriers

If a corporation is *potentially* liable for damages, one of the first goals of risk managers and in-house lawyers is to look for sources of recovery beyond the corporation's own assets. This is also true for insurance claims. Even if a corporation has insurance coverage, it should always consider whether someone else's insurer should pay first. Having one's own insurer pay a claim is not without consequences to the policyholder. First, the limits of liability under the insurance policy are reduced.

Second, the "claims history" (a seven year look back of claims payments) is affected, causing the insured to pay higher rates for insurance in the future. Finally, and most important, tapping the insurance of another party potentially avoids the obligation to satisfy a self-insured retention ("SIR") or deductible (discussed below) carried by a corporate policyholder.

The primary mechanism by which a corporation may transfer risk to another is the contractual risk transfer scheme used in most commercial contracts, such as an indemnity agreement. Additionally, one party is usually required to add the other party as an additional insured ("AI") on its insurance policy. In construction, the owner usually requires the general contractor to name the owner as an AI and, in turn, the general contractor requires its subcontractors to name the general contractor as an AI on their policies.[58]

3. The Impact of Deductibles and Self-Insured Retentions

The existence of a deductible or SIR can also have a considerable impact on the submission of a claim. A deductible is commonly understood as that amount of a claim for which the insured is responsible. A claim will be tendered to an insurer for handling and seek reimbursement of the deductible from the insured. In contrast, an SIR requires the insured to pay a certain amount towards a loss before the insurer incurs any defense and/or indemnity obligation. Thus, the policyholder has to pay for the loss or its defense out of pocket until this threshold is met.

Deductibles and SIRs should be analyzed carefully by insurers and policyholders because they do not always identify a specific dollar amount, but instead use a percentage of the loss or project, and can be written more broadly or narrowly than originally intended. For example, in a Second Circuit case applying Texas law, where the court addressed the application of a "wind" deductible to a loss involving rain damage. Rain was an excluded cause of loss under the subject insurance policy, except in cases where rain enters an enclosed structure through means created by a covered cause of loss. In this particular case, the rain gained access to the interior of the structure through openings caused by wind, which was a covered cause of loss under the policy. However, the policy contained a "wind" deductible equal to 1 percent of the project's total value. The insurer argued that the wind deductible applied to Turner's loss because the force of wind enabled the rain damage to occur. Turner conversely argued that the deductible did not apply because the damage itself was caused by rain, not wind. Whether or not the wind deductible applied to the loss was vital because 1 percent of the project's value exceeded the amount of the loss, which would preclude any recovery under the policy.[59]

Ultimately, the court concluded that the language of the wind deductible was unclear as to whether the deductible pertained to any loss involving wind or, instead, if it only concerned losses for which wind was the direct cause. Applying the well-recognized rule of insurance law that requires policy ambiguities to be interpreted in favor of the insured, the wind deductible was deemed not to apply. The court stated:

> The term "wind deductible" is not defined by the policy. Doubtless it applies to damage directly caused by wind; if a tornado leveled Turner's project, the wind deductible would apply. The damage in this case, however, was directly caused by rain, and only indirectly caused by wind. In other words, although wind created the opening through which the rain entered, it was the rain alone that caused the damage at issue.
>
> Nothing in the policy suggests that the wind deductible applies to damages only indirectly caused by wind . . . . Because the policy's "wind deductible" provision is ambiguous, in that it does not unambiguously

> apply to damages caused only indirectly by wind, we construe it to reach only those damages caused directly by wind.[60]

Turner, however, was not free from dissent. One judge considered it illogical to avoid the application of the wind deductible when rain would have been an excluded cause of loss, but for the fact that it gained access to the building because of wind. Thus, for the reason that coverage for rain was linked to wind, the dissent believed that it also should be linked to the wind deductible.[61] As *Turner* demonstrates, diverging interpretations of awkwardly worded deductibles are not only met with disagreement between policyholder and insurer, but may also be disagreed upon by the trier of fact.

Most importantly, the precise amount or proper interpretation of a deductible/SIR should not be assumed by either party and, for the policyholder, all insurers should be put on notice even if it initially appears the relevant damages may be within the applicable deductible or SIR.

4. Tender the Loss as Early as Possible

As discussed above, policyholders must be sensitive to potential claims and, likewise, should always take great care to tender notice of a claim or potential claim as soon as possible. Prompt notice of a claim will allow the insurer the opportunity to investigate the claim as close to its occurrence as possible[62] and avoid any possibility of a disclaimer based on late notice or a forfeiture of coverage rights by making voluntary payments.

However, what is "practicable" can vary greatly depending on applicable law and the circumstances of the particular claim. The prudent contractor should make it a practice to give notice rather than try to predict whether an incident will result in a claim under the policy.[63]

Even if notice appears to be untimely, the insured should not assume there will be no coverage. While some states hold that the failure to give timely notice results in a forfeiture of coverage,[64] other states require that the insurer prove that notice was actually late and that it suffered prejudice as a result of the late notice before it can disclaim on that basis.[65] If it can be shown that the insurer did not suffer any prejudice, the claim may still be covered in spite of late notice.

Direct communication with the insurer is critical. Policyholders seeking coverage as an additional insured, in particular, should always give separate notice to the additional insurer and not depend on the named insured to provide notice on its behalf. Likewise, policyholders should not assume that the notice obligation has been satisfied if they have given notice to a broker.

5. Voluntary Payment

Similarly, insurance policies typically contain a "no voluntary payments" provision, "which prohibits the insured from voluntarily assuming any liability [or] settling any claims . . . without the insurer's consent."[66] This policy requirement, typically found in the "Duties in the Event of Occurrence, Claim or Suit" section of a CGL policy, is geared towards preventing collusion between the claimant and the insured and to ensure insurer control over the claim.[67] In the scenario described at the onset of this section, an insurer could potentially argue that the resolution of claims between the general contractor and subcontractor violates this clause. Thus, contractors must be aware of potential issues if claims are resolved without first notifying the relevant insurers.

The application of a voluntary payments clause and the impact of a late notice will depend heavily on the facts of a particular case the applicable law, which may require a showing of prejudice.[68] Other states do not require prejudice to be shown, but make it clear that a voluntarily assumed cost (such as pretender

defense costs or repair costs undertaken by a general contractor) are not the responsibility of the insurer; however, payment by the insured does not void coverage for the claim for other, non-voluntarily assumed costs.[69] The better practice is to involve the insurer before any final resolutions are reached.

IV. WHAT TO DO WHEN AN INSURANCE DISPUTE IS LIKELY

A. Choice of Law

Choice of law can be outcome-determinative on many substantive issues in insurance coverage litigation, including litigation over coverage for construction defect claims. Sections below will highlight a number of key substantive issues on which the determination often depends on what state's law applies.

Because choice of law can be outcome-determinative on key issues, both the policyholder and insurance carrier must analyze this issue early on. The first question is: what choice-of-law rule will the court apply? Different approaches to choice of law can lead to vastly different results. Generally speaking, courts follow one of three approaches to choice of law in insurance coverage disputes: (1) the traditional *lex loci contractus* approach (First Restatement); (2) the most significant contacts approach (Second Restatement); and (3) statutory approaches.

1. *Lex Loci* Contractus. (First Restatement)

The traditional *lex loci contractus* rule applies the law of the place (state) where the insurance policy (contract) was formed. In insurance cases, the place where the contract was formed is usually considered to be the place where the policy was issued or the place where the policy was delivered to the insured.[70]

2. Most Significant Contact (Second Restatement)

Most jurisdictions have rejected the *lex loci contractus* rule as antiquated and inflexible.[71] A majority of states have adopted the *Restatement (Second)* choice-of-law rule. This approach focuses on which state has the greatest interest in the dispute.

(a) Issue-by-Issue Analysis

An introductory note to the *Restatement (Second)* explains that "the applicable law is now said to be the local law of the state which, *with respect to the particular issue*, has the most significant relationship to the transaction and the parties."[72]

(b) Principles and Factors that Guide the Restatement (Second) Analysis

Section 6 of the *Restatement (Second)* outlines seven principles designed to help a court determine which state has the most significant relationship to the dispute in a given case: (1) the needs of interstate commerce; (2) the relevant policies of the forum; (3) the relevant policies of other interested states and the relative interests of those states in the determination of the particular issue; (4) the protection of justified expectations; (5) the basic policies underlying the particular field of law; (6) certainty, predictability, and uniformity of result; and (7) ease in determining and applying the law.[73]

In applying the Section 6 principles, courts are guided by factors set forth in Section 188: (1) the place of contracting; (2) the place of negotiating the contract; (3) the place of performance; (4) the location of the subject of the contract; and (5) the domicile, residence, nationality, place of incorporation, and place of business of the parties.[74]

These five factors must be "evaluated according to their relative importance with respect to the particular issue."[75] In other words, courts do not simply add up the number of factors that point to a given state and apply the law of the jurisdiction with the most contacts.[76]

(c) Location of the Insured Risk is the Key Factor in Insurance Coverage Disputes

In insurance coverage disputes, the most significant contact is the location of the insured risk as long as the insured risk is located, at least principally, in a single state.[77] On the other hand, if the risk moves from state to state or the policy covers risks that are located in two or more states, this factor is less significant.[78]

3. Choice of Law Statutes

Several states have statutes governing choice of law in insurance coverage disputes. North Carolina and South Carolina, for example, have almost identical statutes that provide:

> All contracts of insurance on property, lives, or interests in this State shall be deemed made therein, and all contracts of insurance the application for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof.[79]

In North Carolina, courts will apply the choice-of-law statute if a "close connection" exists between the state and the interests insured by the insurance policy.[80] Similarly, in Virginia and Texas, the choice of law statutes[81] will generally not be applied in any fashion that would give "extraterritorial" effect to either state's law.

For example, Texas Courts apply a three-part test to determine whether the Texas statute requires the application of Texas law: (1) the insurance proceeds must be payable to a citizen or inhabitant of Texas; (2) the policy must be issued by a company doing business in Texas; and (3) the policy must be issued in the course of the insurance company's Texas business.[82]

B. Key Substantive Law Issues that Often Turn on Choice of Law

1. Late Notice

As described above, late notice may completely bar coverage under one state's law, such as New York law, regardless of whether the late notice prejudiced the insurer.[83] In other states the insurer has the burden of proving it was prejudiced by the late notice, failing which the late notice will not bar coverage.[84] Consequently, both the policyholder and insurance carrier should analyze the late notice issue (as well as the choice of law governing that issue) carefully before filing suit. This issue can often be outcome-determinative.

2. Trigger of Coverage for Continuous Damages

Construction disputes can raise critical "trigger of coverage" questions concerning which insurance policy or policies apply to the claim. Consider the following fact pattern:

A general contractor completes construction of a building in 2002. In 2004, water damage is discovered during an inspection. Repairs are performed in 2004, but a subsequent inspection in 2005 reveals that the water intrusion has continued. An expert concludes in 2005 that the water intrusion was caused by

improper installation of roofing and flashing materials during the original construction in 2002. The building owner sues the general contractor in 2005.

Suppose the general contractor had insurance coverage with three different insurance companies in 2002, 2004, and 2005. Which policy applies? Is it the policy in place in 2002 when the defective work was done? Is it the policy in place in 2004 when the water intrusion was discovered? Is it the policy that was in place in 2005 when the damage remains unrepaired? Is it all three policies, under a "continuous trigger" theory?

This "trigger of coverage" issue is critical to both policyholders and insurance carriers. Significant differences in policy language may mean that the resolution of this issue will determine whether any coverage exists at all and/or how much coverage exists. For example, if the only policy triggered in the above hypothetical is the 2002 policy, which has minimal limits of coverage, the policyholder may not recover enough money under the policy to cover the claim. If only the 2005 policy is triggered, a new exclusion may bar coverage. If the claim is covered under all of the policies, the policyholder may have plenty of coverage, but allocation of liability among the insurance carriers may raise significant issues.

Courts apply different approaches to this trigger of coverage issue, and knowing the trigger rule of a particular jurisdiction may guide where litigation is pursued and which law is advanced by a particular party as the controlling law.

(a) Injury-in-Fact

Under the "injury-in-fact" approach, the insurance policy in effect when the injury was actually inflicted is triggered.[85] In the fact pattern outlined above, the property damage occurred, for insurance purposes, during the installation of the roof and flashing materials in 2002.

(b) Manifestation

Under the "manifestation" approach, the policy in place at the time the damage is first manifest or discovered is triggered.[86] In the hypothetical fact pattern outlined above, the policy in place in 2004 would be triggered under this theory, because the water damage was first discovered in 2004.

(c) Continuous Trigger

Under the "continuous trigger" approach, all insurance policies in effect during the continuing or progressive damage are triggered.[87] In the hypothetical fact pattern above, all of the policies in place between 2002 and 2005 would be triggered under a "continuous trigger" theory, because the damage continued throughout that timeframe.

(d) Exposure

Under the "exposure" approach, the policy in place at the time that the property was exposed to the harm is triggered.[88] Depending on the facts, this theory could point to the same policies as the "injury-in-fact" trigger of coverage theory. The "exposure" theory could also trigger multiple policies if continuing exposure to progressive or additional damage occurs during multiple policy periods.[89] In the hypothetical fact pattern outlined above, an "exposure" trigger of coverage theory could trigger all of the policies in place between 2002 and 2005, because the building was exposed to water intrusion throughout that timeframe.

3. Do Construction Defects Constitute an "Occurrence"?

One of the most critical issues in litigation over insurance coverage for construction defects is whether a construction defect constitutes an "occurrence" for insurance policy purposes. Some courts find that construction defects constitute an "occurrence," because the defects were unexpected and/or unintended by the policyholder and therefore constitute an "accident, including continuous or repeated exposure to substantially the same harmful conditions."[90]

Other courts have reached the opposite conclusion. These courts have concluded that no "accident" has occurred. Rather, the construction defects are the natural and foreseeable consequence of a failure to perform under a contract.[91]

Again, knowing the rule in a particular jurisdiction respecting the existence of an "occurrence" in the construction defect context may have a significant impact on the selection of a forum for coverage litigation and the law which is advanced in that litigation as controlling.

4. Allocation: May the Policyholder Seek Full Coverage from Any Covering Policy?

If multiple policy years are triggered, a critical issue arises over whether the policyholder is entitled to full coverage under any single policy among all of the covering policies, or whether the coverage be allocated, by some method, among all of the policies that are triggered. Policyholders, of course, prefer a theory that allows them to select one policy and hold the carrier issuing that policy liable for the entire loss (up to the limits of that policy and any excess policies in place for that policy period). The insurer then has the burden of pursuing contribution from all other policies triggered by the claim. Approaches that allow the policyholder to select one policy (or vertical exhaustion through one policy period) are typically referred to as the "pick and choose," "all sums," or "joint and several" approach.[92] Courts adopting this approach reason that because a policy is triggered, it is triggered in full. The policy obligates the carrier to pay "all sums for which the insured is liable."

Other courts have ruled that coverage obligations must be allocated among all policies triggered by the claim. This approach requires horizontal exhaustion across all primary polices that are triggered before reaching any excess policies. Insurers prefer this approach because it spreads the liability across multiple policies without requiring the insurers to litigate against each other to recover contribution.

Allocation methods may vary. Courts sometimes allocate the coverage based on "time on the risk," apportioning liability among insurers in proportion to the length of time for which their policies covered the claim.[93] Other courts allocate liability among insurance carriers according to their policy limits.[94] Other courts have considered factors other than time on the risk or policy limits. For example, if the facts demonstrate that more injuries or damage occurred during a particular policy year or years, the allocation method could proportion the liability among insurance carriers accordingly.[95]

5. Potential Obligation to Pay Multiple Deductibles or Self-Insured Retentions

If multiple insurance policies are triggered, the policyholder's obligation to pay a deductible or self-insured retention becomes an issue. Must the policyholder pay multiple deductibles/self-insured retentions, or is the policyholder entitled to coverage after paying a single deductible/self-insured retention? Generally speaking, if a court allocates liability for coverage among multiple insurance policies, then the policyholder must typically pay multiple deductibles, satisfying the deductible for each policy that is triggered.[96] If the policyholder is allowed to "pick and choose" among all triggered policies,

the policyholder typically must pay only one deductible or self-insured retention, satisfying the deductible/self-insured retention for the policy year chosen.[97]

Forcing the policyholder to pay multiple deductibles could result in the policyholder paying more than its appropriate share of the loss. For example, suppose five consecutive polices are triggered by a continuous damage claim. Each policy has a $100,000 deductible and a $1 million policy limit. If the policyholder is forced to pay $500,000 in deductibles before any insurance coverage is reached, the policyholder is arguably paying considerably more than its fair share of the loss. By the same token, each insurance carrier is getting the benefit of a much higher deductible than the policy premium likely reflects.[98] To avoid this unfair result, some courts apply prorated allocation of the deductible to be paid by the policyholder.[99]

Needless to say, if the policyholder has a large deductible or large self-insured-retention, the policyholder will not want to pay more than one deductible. A policyholder considering litigation must carefully consider what state's law will apply to the allocation/multiple deductible issue to evaluate the potential outcome in the forum chosen for litigation.

C. Procedural Concerns

1. Parties' Respective Burdens of Proof in the Coverage Litigation

Generally speaking, the policyholder has the burden of proving that a claim falls within the coverage provisions of the policy. Under a general liability policy, this typically means proving an "occurrence" took place during the policy period, resulting in sums the insured is legally obligated to pay as damages because of "bodily injury" or "property damage." The terms "occurrence," "property damage," and "bodily injury" are defined terms in the policy and are often the subject of litigation. As noted, in construction defect claims, the policyholder has the burden of proving that the construction defect is a covered "occurrence."

Once the insured proves that a claim falls within the coverage grant of the insurance policy, the insurance company has the burden of proving that an exclusion precludes coverage for the claim. In construction defect claims, insurance carriers will look to the "business risk" exclusions, such as the "your work" and "impaired property" exclusions.

These respective burdens of proof for the policyholder and the insurance carrier are standard in most jurisdictions. The approach to specific coverage provisions or exclusions, however, varies widely in different jurisdictions.

2. Will Insurance Litigation be Stayed Pending the Underlying Litigation?

Insurance coverage disputes frequently relate to underlying claims that are being litigated against the policyholder. The insurance coverage dispute may raise issues that could prejudice the insured in the underlying litigation. For example, the insurance carrier may want to prove that the policyholder expected or intended the injury or damages at issue, in order to deny coverage on the basis of the "expected or intended" policy exclusion. The insurance carrier's efforts to prove such an expectation or intention of the policyholder in the coverage litigation could significantly increase the policyholder's risk in the underlying litigation. Both the insurance carrier and the policyholder have an interest in limiting the policyholder's exposure in the underlying litigation. Consequently, it may benefit both the insurance carrier and the policyholder to stay the insurance coverage litigation pending the outcome of the underlying litigation.

The insurance carrier, however, may want to resolve the insurance coverage issues as quickly as possible, in order to avoid the costs of defending the policyholder in the underlying litigation. The duty to defend is broader than the duty to indemnify, and the insurance carrier may face a bad faith claim if it refuses to defend the policyholder in the underlying litigation. Consequently, the insurance carrier is often eager to litigate the insurance coverage dispute, in hopes of obtaining a quick ruling that it owes no duty to defend or indemnify the policyholder.

Many courts will stay litigation of an insurance coverage dispute if the insurance coverage litigation could prejudice the policyholder in the underlying litigation. Courts are particularly inclined to stay insurance litigation if issues in the insurance coverage disputes overlap with issues in the underlying litigation.[100] Courts will also consider (a) whether discovery in the insurance coverage action could prejudice the policyholder in the underlying litigation, (b) the burden of requiring the policyholder to fight a "two-front war," and (c) the burden on judicial resources.[101] Another approach is to request a stay of the underlying liability litigation until the coverage dispute is resolved.[102]

V. INSURANCE ISSUES ARISING DURING THE PENDING CLAIM OR SUIT

A. Overview/Introduction

Once the parties' positions have been staked out, the case against the insured develops. Three exposures develop simultaneously as evidence is gathered and the liability brought into focus: (1) the insured's exposure to the plaintiff in the underlying or liability case; (2) the insurer's exposure on the policy; and (3) the insured's exposure for uncovered damages. In theory, the insured and the insurer each seek to minimize the collective exposure to the plaintiff, then sort out the coverage arguments later. In practice, how and what discovery is conducted, what litigation positions are taken, and how exposure and case status is reported to the carrier and the policyholder drive settlement decisions and evaluation. If a global settlement of the liability and coverage issues is feasible, the discovery and evidence from the liability case become the foundation for later insurance litigation.

1. Traps to Avoid Respecting Evidence in Insurance Litigation When the Liability Case Settles

It is no surprise that in insurance litigation, the rules of evidence apply. However, many clients and lawyers fall into one of two common traps. The first one is to not develop facts necessary to litigate the coverage case later, such as where a case settles because of off-the-record and/or protected communications. The second, related, trap is to assume that a coverage determination against a non-participating carrier will be favorable simply because the settlement seemed favorable. An insurance case is, quite simply, a new lawsuit; the liability case is the earth where the evidentiary seeds are planted.

2. The Case Within a Case and Problems Created by Settlement

Follow-on insurance litigation after settlement is, in many respects, similar to professional liability matters where the issues are tried as a "case within a case." In a professional liability case, the foundational fact is whether there is an injury to the plaintiff, measured by a settlement or judgment that would not have been necessary but for the negligence of the defendant; similarly, in insurance coverage litigation, the fundamental question is whether the settlement by the insured or unsatisfied judgment against it would not have occurred had the carrier recognized coverage under the policy. If the insured receives a defense verdict or pays nothing, there are no damages aside from defense costs; if there is a settlement or judgment on an uncovered claim against the insured, there are no damages for an action against the carrier.

The concept of litigating a "case within a case" is less difficult where the underlying case proceeds to trial, because the basis for the insured's liability is documented. While insurance coverage must be kept in mind when considering settlement with certain parties or the form of the verdict (discussed below), a settlement raises several difficult questions regarding evidence in a subsequent case, including:

- Where defense counsel in the liability case opines that liability is likely and that a settlement can be obtained on more favorable terms, what is the admissibility and weight of counsel's opinion in the insurance case?

- Are the discovery responses by the insured, or letters sent to other parties by the insured or its lawyer, admissible in subsequent insurance litigation, and for what purpose?

- Are discovery responses and letters sent by other parties in the liability case (not insureds or parties to the insurance litigation) admissible under any circumstances?

- If the liability case settles at mediation, what effect does that have on admissible evidence in the subsequent insurance litigation?

Jurisdictions differ as to whether the issues may be handled in a single lawsuit. For example, under California law, common issues between the liability and coverage case are tried and determined in the liability case. Thus, for example, if an insured is sued for bodily injuries arising out of an assault, and the matter proceeds to trial and judgment, the insurer may not later force the insured to prove its liability to the plaintiff and the amount of damages. Rather, in subsequent insurance litigation, the issue is limited to whether that liability is covered by the insurance policy under an estoppel theory.[103]

However, what if the liability case settles, and the insurer has denied coverage, or refused to contribute to the settlement? In that case, there is no adjudication of the insured's liability or the amount thereof. Since most cases settle, early recognition of coverage issues – and handling them – are critical.

In many jurisdictions, once an insurance carrier denies coverage, any later settlement reasonably entered by the insured in good faith becomes presumptive evidence that (1) the insured would have been held liable at trial, and (2) the settlement amount was less than any judgment against the insured had the case proceeded to trial. The insurance carrier bears the burden of proof on both issues to overcome the presumption. As stated by a California Appellate Court:

> Where there is no trial and no judgment establishing the liability of the insured, but a settlement of the litigation has been made, the question whether liability of the insured was one which the contract of insurance covered is still open, as is also the question as to the fact of liability and the extent thereof, and these questions may be litigated and determined in the action brought by the insured to recover the amount so paid in settlement. The settlement, or a judgment rendered upon a stipulation of such a settlement, becomes ***presumptive evidence only of the liability of the insured and the amount thereof, which presumption is subject to being overcome by proof on the part of the insurer."*** [104]

The carrier can introduce evidence to rebut the presumption as to any of the following: (1) whether the insured is liable at all, (2) the reasonable settlement value, or (3) on what theory the insured was liable. These complexities can occur in long tail exposures with multiple theories of liability asserted against an insured. Examples are everywhere, but, would include in a construction defect matter whether the principal damages relate to both earth movement and defective construction of improvements, or whether

damages are the result of defective construction or the failure to disclose them at the time of sale to the purchasers.

A developer and/or contractor can be liable for negligently performing construction improvements, or for failing to disclose the condition of those improvements at the time of sale. Most would agree that, in a vacuum, an insured's liability for failing to disclose the condition of property during a sale would not be covered as an economic loss under a general liability policy[105], whereas, if the insured was a real estate developer, damage caused by defects in construction during the improvement phase may very well be[106]. Under California law, however, if insurance litigation resulted after settlement, an issue would be whether the claim settled was "failure to disclose" or "negligent construction". The carrier and the insured will introduce evidence as to what claim was settled.

Whether carrier or policyholder, it is critical to spot liability issues that will likely become insurance issues while the theories and damages are being discovered and documented. Remembering that why a case settled may have to be proven, the practitioner needs to keep in mind:

- What are the different theories of liability, and where are they documented?
- What is the liability exposure on the different theories of liability?
- What is the likelihood of liability on each?
- What is the easiest for the plaintiff to prove, and what are the "home runs" for plaintiff?
- What is the amount paid by others on the same claims, and are the liability theories different against them?
- Did defense counsel recommend a settlement, and why?
- Was there agreement between the insured and carrier at the time of settlement as to why the case settled, how much was to be paid, and that settlement was the proper course?

3. Particular Problems Where Liability Case Settles in Mediation

An entirely separate set of traps is involved in mediation. Many complex construction disputes (and for that matter, asbestos or environmental disputes) are managed and mediated outside of the court confines. In California, the mediation privilege in Evidence Code §*1119, et seq.,* renders documents, charts and statements made in the context of the mediation inadmissible in any subsequent proceeding without a signed agreement from all parties to the mediation. [107] Query whether any of the following may be used as evidence by the insured or the insurer in any subsequent insurance litigation:

- Cost of repair (construction defect or property damage claim);
- Mediation brief and settlement demand by the plaintiff to the insured(to show the claims that would be made if the case did not settle, and arguments against the insured);
- Documentation of the amounts paid in settlement by parties to the litigation other than the insured (to show the insured's settlement was reasonable and/or that settlement for the amount contemplated was in the insured's best interest);

- Statements by the mediator or other parties regarding settlement negotiations—to show other parties' positions.[108]

- Settlement demands, counsel's recommendation re: settlement and a carrier's offers that might influence the insured to settle the lawsuit (to show that a carrier's offers were unreasonable in light of the evidence that would be presented).

B. Litigation Decisions and Communications with the Carrier

An insurance company likely has "the right and duty" to defend an insured against allegations which are potentially covered by the policy. For purposes of this section, it is assumed that the carrier has a duty to defend, and the focus turns instead to the role of defense counsel in creating evidence for use in insurance litigation later.

1. The Right to Independent Counsel

A defense lawyer has an ethical duty to both the insurer and the insured. However, should there be any conflict between them, in most cases the insured is placed above the insurer for purposes of the duty of loyalty. In states that recognize the tripartite relationship, the insured and insurer are within the attorney-client relationship. Most defense counsel hired by the insurer are well aware of their ethical obligations to the insured, and scrupulously abide by them. They understand that their client is best served, normally, by a settlement of the matter minimizing amount paid by their client, the insured. Most will try to steer their efforts impartially to limit liability and damage, and will avoid blatant coverage issues.

In California, the insured's right to independent counsel is governed by statute. The Civil Code prescribes when a conflict of interest exists: when the outcome of a coverage issue can be affected by counsel first retained by the insurer.[109] Succinctly, the insurer may reserve its right to deny coverage (i.e. there may or may not be coverage depending on how the facts are ultimately determined) based upon an issue (a specific reservation of rights) that can be affected by the manner in which the defense is handled. In those circumstances, the insured can choose counsel at the insurer's expense. Other states have similar rules by statute or case law. As a rule of thumb, however, if the carrier simply denies coverage outright for some of the damages, but not others, it is less likely that a conflict of interest exists.

However, even being careful, defense counsel can affect coverage issues by the discovery they undertake, the litigation positions they advance, and the evaluations they give the carrier and the insured. If independent counsel is allowed, then the policyholder has far greater control over opinions and facts supporting likely liability on different theories.

The decision to provide independent counsel can influence the ultimate coverage situation for the client/insured. However, what happens when the carrier refuses to provide independent counsel? On the one hand, arguments can be made by policyholders that the carrier has not provided a conflict-free defense and thus has waived its coverage defenses. On the other hand, the carrier will argue that the statute itself is silent as to any remedy and that, at most, the insured would be entitled to the cost of independent counsel.[110] Clearly, depending on the jurisdiction, identifying whether the insured is entitled to independent counsel and insisting on those rights, may influence a carrier's willingness to settle.

2. Communications with Defense Counsel Affecting Coverage Issues

The next question is how defense counsel can influence the outcome of insurance litigation. First, the opinions of defense counsel concerning liability and damages are certainly relevant and admissible when the case involves settlement rather than trial. Assuming the carrier is unwilling to fund a settlement, but

willing to allow the insured to settle and seek coverage, one of the threshold questions is "what claim was settled," or "was the settlement reasonable"? In many cases, the answer will be obvious. In others, however, it will not be.

For example, in an environmental case, the pleadings alleged that a pollution condition was not promptly rectified when it was discovered in 1984, although the insured was under close supervision by the State's agencies and was cooperating and taking direction regarding monitoring and testing. As a matter of insurance coverage, since California follows the continuous injury trigger, any groundwater damage had been done by the time it was discovered. The insured's operation that was allegedly causing damage was unchanged for decades, and early policies (pre-1972) had no pollution exclusion. Defense counsel was extremely experienced, with extensive background in coverage and environmental liability matters. However, given that the "failure to rectify claim" seemed defensible even under CERCLA, and the "damage during normal operations for decades" was less so, defense counsel's litigation strategy was to argue publicly in pleadings and discovery that the only liability theory that had any validity was the failure to rectify.[111]

In most states, if the insured could be liable for the same damages based on concurrent causes, it is entitled to coverage if any of them would be covered under the policy. Stated differently, if there is a single item of damage caused by a covered and an uncovered cause concurrently, or in sequence, in most circumstances the insured is entitled to coverage.[112] Therefore, whether defense counsel is "independent" or "carrier-appointed," communications with the insured and the carrier must document clearly the different theories and the evidence supporting each, and even the reasons for the settlement.

C. Trial

Assuming an insurer has agreed to defend, and the liability case is proceeding to trial, the trial itself will affect the insurance coverage issues. Most importantly, the insured (or the plaintiff in a direct action) will have to prove that the judgment is within the scope of coverage provided.[113] A corollary to this rule is that the insured and the insurer are "in privity" for purposes of matters that are adjudicated in the liability trial. Therefore, those matters may not be re-litigated, and operate as collateral estoppel in the second coverage trial.[114] In theory, only those matters that were not litigated in the liability trial may be litigated in the second trial. The client must consider what issues are "actually litigated" in the first trial. Thus, the strategic use of special verdict forms (to ask the jury specific questions about the evidence), the decision certain causes of action, and the decision whether to settle at all with certain of the parties (to include or exclude evidence relating to a particular party) are part of the strategic decisions that can have a huge impact on insurance coverage.

An example will illustrate how a simple liability issue - deciding whether to settle with a subcontractor - can directly influence coverage. In a construction defect case, there were water intrusion issues relating to communal bathrooms in a hotel, and separate issues relating to the elevator construction and maintenance, which led to leaking oil into the soil. Maintaining the cross-complaint against the elevator subcontractor assures that there will be a verdict separating the elevator/pollution-related issues from the shower/water damage-related issues. Figuratively speaking, without raising a finger to assert a coverage defense, not settling with one of the subcontractors resulted in a verdict that separated out the pollution related damages from the verdict as a whole.[115]

Similarly, in a California construction defect action, a plaintiff was required to show "damage to other property" caused by a construction defect in order to collect under a tort theory of liability against the developer.[116] In that case, insurance coverage was problematic, and the plaintiff knew there would be a subsequent direct action to collect insurance for any verdict. Recognizing that in California, construction defects are an "occurrence" but covered "property damage" must be shown by demonstrating that a defect

in construction caused damage to other property[117], the plaintiff dismissed the breach of contract claims prior to trial, and took the case to verdict on the negligence claims only. This tactical decision allowed the plaintiff to argue in the subsequent insurance action that the jury's award must have been based upon covered "property damage" because the jury's finding that the defendant was liable in negligence meant that it had determined that the defects in construction had in fact caused damage to other property. That argument proved very persuasive in the subsequent case, even though it was not clear from the evidence that the jury understood the subtlety.[118]

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[1] *Pride v. Liberty Mut. Ins. Co.*, No. 04-C-703, slip p. at 2, 2007 WL 1655111 (E.D. Wis. June 5, 2007), *citing* J. Loveless, "Construction Insurance: Do you Only Get What You Pay For?" 78 N.Y. St. B.A.J. 10 (March-April 2006).

[2] J. R. Evans and J. S. Berry, "Construction Defect Coverage Law: Past, Present and Future", New Appleman on Insurance, Current Critical issues in Insurance Law (December 2008).

[3] *See Southeast Wisconsin Professional Baseball Park District v. Mitsubishi Heavy Industries America*, 738 N.W. 2d 87 (Wis. App. 2007)(four companies issued five policies, "layered" under an OCIP covering the construction of a stadium).

[4] *See Waco Scaffolding Co. v. National Union Fire Ins. Co. of Pittsburgh, PA.*, 1999 WL 980629 (Ohio App., October 28, 1999).

[5] *See Liberty Mut. Ins. Co. v. Louisiana Ins. Rating Comm.*, 696 So.2d 1021 (La. App. 1997) (dispute over rule-making and rating process for OCIP); *Independent Ins. Agents of Oklahoma, Inc. v. Oklahoma Turnpike Auth.*, 876 P.2d 675 (Okla. 1994) (approval process for OCIP under statutory provisions regulating insurance for public projects).

[6] Discussed Below in further detail

[7] Couch on Insurance 3d, §§1:53, 155:43.

[8] *Id.*, §1:53.

[9] *See USF and G v. Employers Cas. Co.*, 672 F. Supp. 939 (E.D. La. 1987) (OCIP did not provide automobile coverage and contractors had to obtain automobile coverage on their own).

[10] Increasingly, CGL insurance for a project will be included in the project wrap-up program, either an owner controlled insurance program ("OCIP") or contractor controlled insurance program ("CCIP"), discussed in more detail in Section II.

[11] *See, e.g., Smith v. Hughes Aircraft Co.*, 22 F.3d 1432, 1440-41 (9th Cir. 1993); *American Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 565 F.Supp. 1485 (S.D.N.Y. 1983); *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1040 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982).

[12] As described in more detail in Section IV, the method for analyzing "trigger" varies from state to state and can lead to different outcomes.

[13] A third condition required under a more-stringent form of a "claims made" policy, known as a "claims made and reported policy" is that the insured must provide notice of the claim to the insurer within the policy period.

[14] *Reliance Ins. Co. v. National Union Fire and Ins. Co. of Pittsburgh* 262 A.D.2d 64 (N.Y. App. Div. 1999). at 65.

[15] *Continental Cas. Co. v. JBS Constr. Mgmt.*, No. 09 CV CIV. 6697, 2010 WL 2834898 (S.D.N.Y. July 1, 2010). at *5.

[16] *See, e.g., Trustees of Univ. of Pa. v. Lexington Ins. Co.*, 815 F.2d 890, 896 (3d Cir. 1987) (the policy "unambiguously sets out an objective standard for the time at which notice was required. The policy required notice whenever the Insured had information from which it might 'reasonably conclude' that an occurrence was 'likely to involve' the policy.").

[17] Property insurance operates on a first-party basis and compensates the insured for damage to its own property (whereas CGL and professional liability insurance reimburses the insured for its liability to a third party).

[18] *See Village of Kiryas Joel Local Dev. Corp. v. Ins. Co. of N. Am.*, 996 F.2d 1390, 1392 (2d Cir. N.Y. 1993) and *Fireman's Fund v. Structural Sys. Tech., Inc.*, 426 F. Supp. 2d 1009 (D. Neb. 2006):

> "Builders risk" insurance is a unique form of property insurance that typically covers only projects under construction, renovation, or repair....The purpose of builder's risk insurance is to compensate for loss due to physical damage or destruction caused to the construction project itself. A policy of insurance containing a "builder's risk' clause or clauses should be construed reasonably

> and if uncertain in meaning, in favor of the contention of the insured so as to cover if possible a risk obviously sought to be insured.

[19] *See, e.g., Harbor Communities, LLC v. Landmark Am. Ins. Co.,* No. 07-14336, 2008 WL 2986424. At *2 (S.D. Fla. Aug. 4, 2008) (quoting Landmark Amer. Ins. Policy Coverage Form, # LHQ334573); *Oceanside Pier View, L.P. v. Travelers Prop. Cas. Co. of Am.,* No. 07 CV 1174, 2008 WL 7822214, at *3 (S.D. Cal. May 6, 2008) (quoting Traveler's Ins. Co.'s builder's risk provisions); *Turner Constr. Co. v. Ace Prop. & Cas. Ins. Co.*, 2004 U.S. Dist. LEXIS 24142 (S.D.N.Y. Dec. 1, 2004); *Phillips Home Builders v. Travelers Ins. Co.,* 700 A.2d 127, 128 (Del. 1997).
[20] New Appleman Insurance Law Practice Guide, V. 4, 42.11[2] (2010).
[21] *Colony National Ins. Co. v. The Teaford Co., Inc.*, 2010 WL 45339369 (N.D. Ga. Oct. 26, 2010)(OCIP exclusion in enrollee's separate CGL policy precluded any supplemental coverage under the CGL policy over the OCIP).
[22] *Liberty Mut. Ins. Co. v. Massachusetts Water Resource Authority,* 2007 WL 1977940 (Mass. Super. 2007)(Carrier issuing OCIP policy identified as program administrator pursuant to a written contract with the Owner).
[23] *Casey v. Vanderlande Indus., Inc.*, 2002 WL 1496815 (W.D. Ky., June 28, 2002).
[24] *Washington Metropolitan Area Transit Authority v. Johnson*, 467 U.S. 925, 104 S. Ct. 2827 (1984).
[25] *HCBeck, Ltd v. Rice*, 284 S.W.3d 349, 353 (Tex 2009); *Hunt Const. Group, Inc. v. Konecny,* 290 S.W.3d 238 (Tex. App. 2008); *See also Lazo v. Exxon Mobil Corp*, 2009 WL 1311801 (Tex. App. May 7, 2009).
[26] *See Rice*, 284 S.W.3d at 355; *Hunt Const. Group, Inc. v. Konecny,* 290 S.W.3d 238 (Tex. App. 2008); *Funes v. Eldridge Elec. Co.*, 270 S.W.3d 666 (Tex. App. 2008).
[27] *HCBeck, Ltd v. Rice*, 284 S.W.3d 349, 353, 358-359 (Tex 2009). *See also Funes v. Eldridge Elec. Co.*, 270 S.W.3d 666 (Tex. App. 2008).
[28] *Pogue v. Oglethorpe Power Corp.*, 267 Ga. 332, 477 S.E.2d 107 (1996).
[29] *Culp v. Archer-Daniels-Midland Co*., 2009 WL 2003301 (D.Neb. July 2, 2009).
[30] *Burger v. Midland Cogeneration Venture*, 202 Mich. App. 310, 507 N.W.2d 827 (1993).
[31] *See e.g. Schmidt v. Intel Corp.*, 112 P. 3d 428 (Or. App. 2005); *Chase v. Terra Nova Indus.*, 728 N.W.2d 895 (Mich. App. 2007) (discussing statutory provisions for implementation of OCIP); *Lambert v. Tennessee Valley Auth.*, 2002 WL 32059747 (E.D. Tenn., Sept. 17, 2002).
[32] *Pride v. Liberty Mutual Ins. Co*., 2007 WL 1655111 (E.D. Wis. 2007).
[33] *Id.*
[34] *Zuno v. Wal-Mart Stores, Inc.*, 200 WL 1545258 (E.D. Pa. 2009).
[35] *Rodrigues-Novo v. Recchi America, Inc.*, 381 Md. 49, 846 A.2d 1048 (2004).
[36] *American Protection Ins. Co. v. Acadia Ins. Co.*, 814 A.2d 989 (Me. 2003) (if contractor was covered under terms of OCIP, then OCIP carrier was responsible for workers' compensation benefits to contractor's employee, notwithstanding that contractor secured coverage for workers' compensation injuries occurring away from OCIP project site).
[37] *Royal Ins. Co. Wausau Ins. Cos.*, 1994 WL 879846 (Sup. Ct. Mass., July 1, 1994) ("excess only" endorsement in contractor's individual policy controlled and resulted in OCIP as primary coverage).
[38] *Virginia Sur. Co. v. Adjustable Forms Inc*., 888 N.E. 2d 733 (Ill. App. 2008).
[39] *National Union Fire Ins. Co. of Pittsburgh, Pa. v. American and Foreign Ins. Co*. 2006 WL 4757339 (C.D. Cal. 2006).
[40] *Hartford Underwriters Ins. Co. v. American International Group, Inc., et al.,* 751 N.Y.S.2d 175, 300 A.D.2d 24 (2002).
[41] *Welcome v. Just Apartments, LLC,* 2008 WL 2696252 (N.J. Super. A.D.).
[42] *East Hills Metro, Inc. v. Jeffrey M. Brown Associates, Inc.*, 74 A.D.3d 730, 907 N.Y.S.2d 16 (2010).
[43] *Dowd Plumbing Corp. v. Travelers Casualty & Surety Company of America*, 73 Mass. App. Ct. 1120 (2009).
[44] *Mohegan Tribal Gaming Auth. v. Kohn Pedersen Fox Assoc.*, 2003 WL 23177993 (Sup. Ct. Conn., Dec. 23, 2003).
[45] *Houston Casualty Co. v. St. Paul Fire & Marine Ins. Co*., 2010 WL 1430097 (D.S.C. April 7, 2010).
[46] *Velazques v. Metropolitan Water Dist.*, 2002 WL 31820222, Case No. E025952 (Cal. Ct. App., 4th Dist., Dec. 17, 2002).
[47]*Alvarado v. Metropolitan Water Dist.*, 2002 WL 53701, Case No. E028778 (Cal. Ct. App., 4th Dist., Jan. 15, 2002).
[48] *Knutson Construction Services Mid-West, Inc. v. Board of Rege*nts, 767 N.W.2d 420 (Iowa App. 2009).

[49] *Reed & Reed, Inc. v. Weeks Marine, Inc.*, 2004 WL 256335 (D. Me., Jan. 9, 2004).
[50] *Affiliated FM Ins. Co. v. Patriot Fire Protection, Inc.*, 120 Wash. App. 1039 (2004).
[51] *AIU Ins. Co. v. Nationwide Mutual Ins. Co.*, 878 N.Y.S.2d 52, 62 A.D.3d 421 (2009).
[52] *Romano v. Whitehall Properties*, LLC, 852 N.Y.S. 2d 645 (N.Y. Sup. 2007).
[53] *See e.g., Ameron International Corp. v. Ins. Co. of the State of Pennsylvania* 50 Cal.4th 1370 (Cal. 2010) – a federal administrative adjudicative proceeding was a "suit" under the CGL, retreating somewhat from the previous rule that a "suit" was limited to a lawsuit in a court of law.
[54] *Windham Solid Waste Mgmt. v. Nat'l Cas. Co.*, 146 F.3d 131, 134-135 (2d Cir. 1998).
[55] *Minuteman Int'l, Inc. v. Great American Ins. Co.*, No. 03 CV 6067, 2004 WL 603482, at *1 (E.D. Ill. March 22, 2004) (SEC investigation constituted a "claim" under an errors and omissions policy); *Richardson Elecs, Ltd. v. Fed. Ins. Co.*, 120 F.Supp. 2d 698, 701 (E.D. Ill. 2000) ("[C]haracterizing a [Justice Department] investigation as involving a 'request' for information understates the seriousness of what such investigation involves.").
[56] *Hartog Rahal P'ship v. Am. Motorists Ins. Co.*, 359 F.Supp.2d 331, 332 (S.D.N.Y. 2005); *Ryan v. Royal Ins. Co. of Am.*, 916 F.2d 731, 735 (1st Cir. 1990) ("To argue that the word 'suit' is to be accorded talismanic significance brings to the language of the policy a precision that the drafter omitted and that the parties were not bound to anticipate.").
[57] *Avondale Industries, Inc. v. Travelers Indemnity Co.*, 887 F.2d 1200 (2d. Cir. 1989). at 1206.
[58] Again, many projects are now employing OCIPs or CCIP, which replaces this standard model and provides one insurance program for all tiers of contractors.
[59] *Turner Constr. Co. v. ACE Prop. & Cas. Ins. Co.*, 429 F.3d 52 (2d Cir. 2005)
[60] *Id*. at 54.
[61] *Id*. at 56 (Staub, C.J. dissenting).
[62] *See Aetna Cas. & Sur. Co. v. Murphy*, 206 Conn. 409, 417 (1988) ("The purpose of a policy provision requiring the insured to give the company prompt notice of an accident or claim is to give the insurer an opportunity to make a timely and adequate investigation of all the circumstances. . . .").
[63] Under the traditional claims-made policy, for example, notice must be provided "as soon as practicable." Other notice provisions require the insured to inform the insurer "immediately" or "promptly" or "within a reasonable time". These inexact terms allow for a certain degree of subjectivity as to when notice must be given to the insurer. One court has described these terms as "roomy words," meaning "a reasonable time under all the circumstances." *See Young v. Travelers Ins. Co.*, 119 F.2d 877, 880 (5th Cir. 1941).
[64] *See, e.g., Flick v. Liberty Mut. Fire Ins. Co.*, 205 F.3d 386 (9th Cir.), *cert. denied*, 531 U.S. 927 (2000) in a first party context. *State Farm Mut Auto Ins. Co. v. Cassinelli* 216 P.2d 606 (Nev. 1950)
[65] *See, e.g., PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 360, 634 (Tex. 2008), and *Belz v Clarendon America Ins Co.* 159 Cal.App.4th 615 (Cal.App. 2007); .
[66] BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES 357 (14th ed. 2008).
[67] *See Id.; Onder v. Allstate Ins. Co.*, No. 02-213-IEG, 2002 WL 1354826, at *15 (S.D. Cal. June 12, 2002).
[68] *See* MD. CODE ANN., Ins. § 19-110 (2010) (Maryland's statute requiring an insurer to establish actual prejudice to succeed on a disclaimer based on lack of cooperation).
[69] *See e.g., Low v. Golden Eagle Insurance Co*. 110 Cal. App. 4th 1532, 1546 (Cal App. 2003)
[70] *See, e.g., Roomy v. Allstate Ins. Co.*, 123 S.E.2d 817, 820 (N.C. 1962).
[71] *O'Connor v. O'Connor*, 519 A.2d 13, 18 (Conn. 1986).
[72] RESTATEMENT (SECOND) OF CONFLICT OF LAWS, ch. 8, intro. note (emphasis added).
[73] *Id.* § 6(2)(a)-(g).
[74] *Id.* § 188(2)(a)-(e).
[75] *Id.* § 188(2).
[76] *See, e.g., Emerson Elec. Co. v. Aetna Cas. & Sur. Co.*, 743 N.E.2d 629, 640 (Ill. App. Ct. 2001) (noting that not all of the factors are of equal significance).
[77] *See* RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 193 & cmts. b-e.
[78] *Id.*
[79] N.C. GEN STAT. § 58-3-1 (2010); S.C. CODE ANN. § 38-61-10 (2010).
[80] *See, e.g., Fortune Ins. Co v. Owens*, 526 S.E.2d 463, 466 (N.C. 2000); *Collins & Aikman Corp. v. Hartford Acc. & Indem. Co.*, 436 S.E.2d 243, 246 (N.C. 1993).
[81] VA. CODE ANN. § 38.2-313 (2010); TEX. INS. CODE ART. 21.42 (2010).

[82] *Hefner v. Republic Indem. Co. of Am.*, 773 F.Supp. 11, 13 (S.D. Tex. 1991).
[83] *See, e.g., Argo Corp. v. Greater N.Y. Mut. Ins. Co.*, 827 N.E.2d 762, 764 (N.Y. 2005).
[84] *See, e.g., Great Am. Ins. Co. v. C. G. Tate Constr. Co.*, 279 S.E.2d 769, 775 (N.C. 1981).
[85] *See, e.g., Harleysville Mut. Ins. Co. v. Berkley Ins. Co. of the Carolinas*, 610 S.E.2d 215 (N.C. Ct. App. 2005).
[86] *See, e.g., Wrecking Corp. of Am., Virginia, Inc. v. Ins. Co. of N. Am.*, 574 A.2d 1348 (D.C. Cir. 1990); *Mraz v. Canadian Universal Ins. Co., Ltd.*, 804 F.2d 1325 (4th Cir. 1986).
[87] *See, e.g., Joe Harden Builders, Inc. v. Aetna Cas. and Sur. Co.*, 486 S.E.2d 89 (S.C. 1997), and *Montrose Chem. Corp. v. Admiral Ins.* 10 Cal.4th 645 (Cal. 1995).
[88] *See, e.g., TBG, Inc. v. Commercial Union Ins. Co.*, 806 F.Supp. 1444 (N.D. Cal. 1990).
[89] *Id.*
[90] *See, e.g., Anthem Elec., Inc. v. Pacific Employers Ins. Co.*, 302 F.3d 1049 (9th Cir. 2002); *Auto Owners Ins. Co. v. Newman*, 684 S.E.2d 541 (S.C. 2009).
[91] *See, e.g., Lexicon Inc. v. Ace Am. Ins. Co.*, 2010 WL 79479 (E.D. Ark. Jan. 7, 2010); *Penn. Nat'l Mut. Cas. Ins. Co. v. Parkshore Dev. Corp.*, 2009 WL 1737032 (D. N.J. June 17, 2009); *CMK Dev. Corp. v. West Bend Mut. Ins. Co.*, 917 N.E.2d 1155 (Ill. App. Ct. 2009).
[92] One of the seminal cases applying the joint and several approach is *J.H. France Refractories Co. v. Allstate Insurance Co.*, 626 A.2d 502 (Pa. 1993). *See also, Goodyear Tire and Rubber Co. v. Aetna Cas. and Sur. Co.*, 769 N.E.2d 835 (Ohio 2002); *Armstrong World Ind., Inc. v. Aetna Cas. and Sur. Co.*, 52 Cal. Rptr. 2d 690 (1st Dist. 1996).
[93] *See, e.g., City of Sterling Heights v. United Nat'l. Ins. Co.*, 2007 WL 172529 (E.D. Mich. Jan. 19, 2007); *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App. 4th 1279 (Cal. Ct. App. 1998).
[94] *See, e.g., AMHS Ins. Co. v. Mut. Ins. Co. of Ariz.*, 258 F.3d 1090 (9th Cir. 2001) (Arizona law).
[95] *See, e.g., Olin Corp. v. Certain Underwriters at Lloyds London*, 468 F.3d 120 (2d Cir. 2006) (New York law).
[96] *See, e.g., Atchison, Topeka & Santa Fe Railway Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003) (Kansas and Illinois law); *Public Service Co. of Colo. v. Wallis and Companies*, 986 P.2d 924 (Colo. 1999); *E.I. duPont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929 (Del. Super. Ct. 2004).
[97] *See, e.g., Cal. Pacific Homes, Inc. v. Scottsdale Ins. Co.*, 83 Cal. Rptr. 2d 328 (1999). *See also*, J. Stephen Berry & Jerry B. McNally, *Allocation of Insurance Coverage: Prevailing Theories and Practical Applications*, 42 TORT TRIAL & INS. PRAC. L.J. 999, 1012 ("By pushing all liability into one policy period, the insured can avoid the effect of deductibles of multiple policies by paying only one.").
[98] Marc S. Mayerson, *Settlement of Complex Liability Coverage Disputes*, 33 TORT & INS. L.J. 783, 798 (Spring 1998).
[99] *See, e.g., PECO Energy Co. v. Boden*, 64 F.3d 852, 857 (3d Cir. 1995); *LaFarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389 (5th Cir. 1995).
[100] *See, e.g., Great Am. Ins. Co. v. Superior Court of L.A. County*, 100 Cal. Rptr. 3d 258, 270 (Cal. Ct. App. 2009); *Allianz Ins. Co. v. Guidant Corp.*, 839 N.E.2d 113, 133 (Ill. App. Ct. 2005) ("[A]s a general matter, a declaratory judgment action to determine an insurer's duty to indemnify its insured should not be decided prior to the adjudication of the underlying action where the issues to be decided in both actions are substantially similar.")
[101] *See, e.g., McCullough v. Minnesota Lawyers Mut. Ins. Co.*, 2010 WL 441533 (D. Mont. Feb. 3, 2010); *Great Am. Ins. Co. v. Superior Court of L.A. County*, 100 Cal.Rptr.3d 258 (Cal. Ct. App. 2009).
[102] *See, e.g., Newhouse by Skow v. Citizens Sec. Mut. Ins. Co.*, 501 N.W.2d 1 (Wis. 1993).
[103] *See, e.g., Clemmer v. Hartford Ins. Co.* 22 Cal.3d 865 (Cal. 1978)
[104] *Lamb v. Belt Casualty Co.* (1935) 3 Cal. App. 2d 624, at 631-362; see also *Isaacson v. California Ins. Guarantee Assn.* (1988) 44 Cal. 3d 775, 791-794
[105] *See, e.g., Allstate Ins. Co. v. Miller* 743 F.Supp. 723 (N.D. Cal. 1990)
[106] *See, e.g., Maryland Cas. Co. v. Reeder* 221 Cal.App.3d 961 (Cal.App. 1990)
[107] *See, e.g., Simmons v Ghaderi* 44 Cal. 4th 570 (Cal. 2008).
[108] New scenarios, and more, were analyzed pursuant to California law in *New Evidentiary Rules Applied to Insurance Litigation,* John H. Podesta, New Developments in Evidentiary Law in California, ©2010 Thompson Reuters-Aspatore.
[109] Cal. Civil Code §2860
[110] Much has been written on the subject of independent counsel throughout the United States and the remedies provided for failure to provide it. *See, e.g.*, materials provided in last year's seminar: Independent Defense

Counsel: When Can The Policyholder Select Its Own Defense Lawyer and How Much Does the Insurer Have to Pay? A 50-State Survey.

[111] *Employers Ins. of Wausau v. California Water Service Company (N.D.Cal.)* 2008 U.S. Dist. LEXIS 65433

[112] *State of California v Allstate Ins. Co.* 45 Cal. 4th 1008, 1028-1029 (Cal. 2009)

[113] *Rafeiro v. American Employers Ins. Co.* 5 Cal.App.3d 799 (Cal.App. 1970)

[114] *Clemmer v Hartford Ins.*(1978) 22 Cal.3d 865

[115] As this insurance case was ultimately settled there is no case citation for this anecdote

[116] *Aas v. Superior Court* (2000) 24 Cal.4th 627.

[117] *F&H Constuction v. ITT Hartford Ins. Co of the Midwest* (2004) 118 Cal. App. 4th 364.

[118] Similarly, this insurance case was ultimately resolved by settlement in the San Diego Superior Court, so there is no case citation.