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In *Tenet Healthsystem Desert v. Blue Cross of Cal.* (no. D069057; filed 3/17/16), a California Court of Appeal held that a Hospital could state causes of action against Anthem Blue Cross for negligent misrepresentation; fraud and deceit based on suppression of facts; intentional fraud; and unfair business practices under Business and Professions Code section 17200, following the denial of coverage for healthcare services provided to an Anthem insured based on an exclusion for injuries sustained as a result of the insured's driving with a blood alcohol level in excess of the legal limit.

The Hospital alleged that the Anthem insured was severely injured in an auto accident. Acting on his insurance identification card, the Hospital's personnel contacted Anthem's claim administrators for preauthorization of treatment. Among the initial exchange of documents, was a report stating that the insured had been brought to the emergency room by ambulance after having been in a motor vehicle accident in which he was an unrestrained driver, and that he had 'tested positive for cannabis and a blood alcohol level ... of .235.'

After being forced to amend its complaint to plead fraud with specificity, the Hospital filed a 276-page third amended complaint alleging details of communications over 50 days, in which the claim administrator repeatedly authorized services which ultimately totaled $1.99 million. At no point, however, did the administrator even mention the exclusion for injuries sustained as a result of driving with an illegal blood alcohol level. And when the administrator finally did inform the Hospital, it was unable to seek reimbursement via Medi-Cal because it was too late, since claims for Medi-Cal must be submitted within 60 days from the date the services are rendered.

Notwithstanding the pages of allegations detailing the history of the claim, the trial court sustained Anthem's demurrer, finding that the complaint did not state causes of action for fraud on a theory that there was no specific allegation of any misrepresentation by the claim administrator.

The appeals court reversed. The court had no problem agreeing that the actions of the claim administrator were binding on Anthem, since the Hospital alleged that there was an administrative services contract between Anthem and the administrator for 'all communications and direct dealings with providers, such as the Hospital, including but not limited to verification of eligibility, benefits and authorization of services; negotiating with providers.'

The appeals court also agreed with the Hospital that by virtue of trade usage and custom, the authorization of services constituted an affirmative representation, based on all of the information the health plan had been provided, that the services were covered:

> “Given the specificity of these numerous alleged communications, and given the allegation that the provision of an 'authorization' has a specific meaning in this context, i.e., that an ‘authorization of services constitutes an affirmative representation that . . . the services are covered,’ Hospital has sufficiently alleged the existence of multiple affirmative misrepresentations that the care that Hospital rendered to Patient X would be covered by his insurance plan.”

The appeals court then cited authority for the proposition that fraud may also arise from conduct that is designed to mislead, and not only from verbal or written statements. That is, “a misrepresentation need not be express, but may be implied by or inferred from the circumstances.” The Hospital pointed out that Anthem's administrators had continued to request information about the treatments that not only would have been unnecessary had Anthem intended to rely on the exclusion, but that Anthem would have been barred from requesting disclosure of private patient information that was not covered.
The appeals court also said that fraud includes the suppression of facts; i.e., concealment: “In transactions which do not involve fiduciary or confidential relations, a cause of action for non-disclosure of material facts may arise in at least three instances: (1) the defendant makes representations but does not disclose facts which materially qualify the facts disclosed, or which render his disclosure likely to mislead; (2) the facts are known or accessible only to defendant, and defendant knows they are not known to or reasonably discoverable by the plaintiff; or (3) the defendant actively conceals discovery from the plaintiff.”

Finally, the court said that because negligent misrepresentation is simply fraud without scienter, the Hospital had also sufficiently alleged a claim for negligent misrepresentation as well. Thus, Anthem’s demurrer was overruled and the Hospital was permitted to pursue its claims for fraud.

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Developments Affecting Additional Insured Coverage In New York

New York courts have decided several cases interpreting additional insured endorsements that provide coverage for liability for injuries or damage “caused in whole or in part” by the named insured’s ‘acts or omissions.’ The “caused in whole or in part” language replaced the “arising out of” trigger frequently found in older additional insured endorsements which focused not upon the precise cause of the accident, but upon the general nature of the operations in the course of which the injury was sustained. While the elimination of the “arising out of” trigger was intended to limit coverage to liability caused by the named insured’s negligent conduct, New York courts have specifically ruled that there is no distinction between “caused by” and “arising out of.” The courts have found that the ‘caused in whole or in part’ by the named insured’s ‘acts or omissions’ language provides coverage for the additional insured where there is a mere nexus between the named insured’s conduct and the injury - even if the named insured is without fault. Thus, even where the named insured is not negligent, coverage will be afforded to an additional insured for an accident involving injury to an employee of the named insured or an employee of another party where a causal link exists between the named insured’s work and the accident.

The 2004 version of the CG 20 10 endorsement provides:

Section II – Who Is An Insured is amended to include the person(s) or organization(s) shown in the Schedule, but only with respect to liability for “bodily injury”, “property damage” or “personal and advertising injury” caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf;

In the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

Although the Insurance Services Office (ISO) likely included the “caused by” language in this endorsement and newer editions in an effort to provide narrower coverage than the “arising out of” trigger, perhaps even intending a proximate causation requirement, the Appellate Division, First Department disagreed. See National Union Fire Ins. Co. of Pittsburgh, Pa. v. Greenwich Ins. Co., 103 A.D.3d 473, 962 N.Y.S.2d 9 (1st Dep’t 2013) citing W&J Glass Sys., Inc. v. Admiral Ins. Co., 91 A.D.3d 530, 937 N.Y.S.2d 28 (1st Dep’t 2012) (“the phrase ‘caused by your ongoing operations performed for that insured,’ does not materially differ from the general phrase, ‘arising out of’”). New York courts will broadly construe this language in favor of coverage as long as there is a “but for” connection between the named insured’s work and the additional insured’s liability. Thus, for those accidents involving an employee of the named insured, New York courts will continue to find that a general liability insurer’s defense and indemnity...
obligations will be triggered as a matter of law even where the named insured has been found without fault.

For example, in Kel-Mar Designs, Inc. v. Harleysville Ins. Co. of New York, 127 A.D.3d 662, 8 N.Y.S.3d 304, 305 (1st Dep't 2015), Walgreens Eastern hired Kel-Mar Designs to act as a general contractor. Kel-Mar then retained subcontractor Arcadia Electrical Contractors to perform electrical work at the site. Arcadia was insured under a general liability policy issued by Harleysville Insurance Company of New York which provided additional insured coverage to Kel-Mar for "liability caused, in whole or in part, by the acts or omissions of [Arcadia]...in the performance of [Arcadia's] ongoing operations for the additional insured." During the course of construction, one of Arcadia's employees was injured when he lost his footing on a stairway at the site. The employee commenced a personal injury action against Kel-Mar which, in turn, brought a declaratory judgment action against Harleysville seeking a declaration that it was entitled to additional insured coverage with respect to the claim of the Arcadia employee. The First Department found that Harleysville was obligated to defend and indemnify Kel-Mar for an accident involving Arcadia's employee because the loss at issue resulted, at least in part, from the "acts or omissions" of the Arcadia employee while performing his work even though neither the employee nor Arcadia were found at fault for the accident.

Strauss Painting, Inc. v. Mt. Hawley Ins. Co., 105 A.D.3d 512, 963 N.Y.S.2d 197 (1st Dep't 2013), mod. on other grounds, 24 N.Y.3d 578, 2 N.Y.S.3d 390 (2014) also illustrates that a showing of negligence is not required under the "caused in whole or in part" by the named insured’s ‘acts or omissions’ language. In Strauss, the Appellate Division gave this language a very broad reading for purposes of the insurer’s indemnification obligation to the additional insured (the Met). In so doing, the court modified the lower court’s declaration that defense and indemnity would turn on an actual finding of negligence:

The wording of the court’s declaration that the Met is entitled to defense and indemnity in the underlying action must be altered, however, to exclude the necessity of a finding of negligence by plaintiff in the underlying action. The additional insured endorsement speaks in terms of ‘acts or omissions,’ not negligence. Thus, in the unlikely event that it would be found that some nonnegligent act by plaintiff caused the accident, the Met would still be entitled to coverage under the additional insured endorsement . . .

Id. at 105 A.D.3d 512, 963 N.Y.S.2d 197. The Appellate Court found that the term “acts or omissions” provides coverage for both negligent and nonnegligent conduct so long as a causal connection exists between the accident and the named insured’s acts or omissions.

Significantly, in Burlington Ins. Co. v. NYC Transit Auth., 132 A.D.2d 127, 14 N.Y.S.3d 377 (1st Dep't 2015), the Appellate Division expanded the reasoning found in Strauss to accidents involving employees of other parties. In this case, the New York Transit Authority and the Metropolitan Transit Authority retained Breaking Solutions to perform excavation work for a subway tunnel. An explosion occurred in a subway tunnel that was being excavated by Breaking Solutions’ machine after the excavator came into contact with an energized electrical cable causing NYCTA’s employee to fall from an elevator work platform. The NYCTA had the responsibility to mark such electrical hazards and to shut off the power. While it was undisputed that Breaking Solutions’ caused the explosion after striking the energized cable, there was no negligence attributable to Breaking Solutions’ employee that operated the excavator. Thus, Burlington Insurance Company, the general liability insurer for Breaking Solutions, disclaimed to the putative additional insureds NYCTA and the MTA because the injury had not been “caused, in whole or in part,” by any “act or omission” of Breaking Solutions. Although the lower court agreed with Burlington’s interpretation that the “acts or omissions,” language required a finding of fault to be triggered, the Appellate Division, reversed and found that even
though Breaking Solutions had not been negligent, the act of disturbing the energized electrical cable was a sufficient nexus to trigger the endorsement because “there [was] a causal link between the named insured’s conduct and the injury, regardless of whether the named insured was negligent or otherwise at fault for causing the accident.” Id at 132 A.D.2d 129, 14 N.Y.S.3d 378-379.

The foregoing decisions demonstrate that the fault or negligence of the named insured has no bearing on whether the accident was caused by the named insured’s “acts or omissions.” A New York court is likely to find that defense and indemnity is owed to the additional insured as long as there is a causal link that exists between the name insured’s work and the accident. Thus, if insurers wish to limit their exposure only to losses resulting from the named insured’s fault, the standard ISO additional insured endorsements need to be expressly amended to limit coverage for losses caused by the named insured’s negligent acts or omissions.

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Treatment of Wasting Policies

Insurers have increasingly adopted provisions within general liability policies that provide for ‘wasting limits’—provisions which reduce the available limits of coverage as defense costs are incurred. These types of provisions are especially prevalent where insurers add-on coverage with respect to certain types of claims. For example, where an insurer seeks to limit the scope of its obligations with regard to tort claims that would otherwise be entirely excluded under the policy.

Most liability policies provide for two main components: defense and indemnity. North American Specialty Ins. Co. v. Royal Surplus Lines Ins. Co., 541 F.3d 552, 559 (5th Cir. 2008). The policies provide for defense costs in addition to policy limits. This type of policy includes most casualty insurance policies, auto insurance policies, homeowners policies, and commercial general liability policies. Wasting policies can be characterized as ‘eroding limits’ in that payments covering the cost of defense are deducted from policy limits. These types of policies are more prevalent in the context of professional liability and directors’ and officers’ liability policies. Moreover, whether a policy is a standard policy or a ‘defense within limits’ policy (a wasting policy) is sometimes subject to interpretation.


Under the majority of liability insurance policies, the carrier bears both the duty to provide defense and the duty to indemnify the insured against liability. The policy sets forth the carrier’s guarantee that it will indemnify by paying the damages that arise out of the insured’s liability, and further provide for the defense against any suit for damages which are covered under the policy. There is typically a qualification that the carrier is not obligated to satisfy a judgment or defend against any suit after the applicable limit of the policy has been exhausted. Thus, a limit of liability bars expense beyond a certain point to satisfy a judgment or other payment of damages. However, there is no limit placed on expense required to satisfy the burden to defend in the related suit. Regularly, the costs of defense become an unpredictable and astronomical cost for the carrier.

Defense Within Limits policies reduce the available limit as defense costs are incurred, and is also referred to as a ‘wasting policy,’ ‘cannibalizing policy,’ or ‘self-liquidating policy.’ In this type of policy, the costs of defense reduce the balance of available policy limits. Some policies of this type, particularly D&O policies, entirely eliminate the duty to defend, and place the burden on the insured. This policy takes into account the unpredictable cost of defense, which can typically exhaust and far exceed the limits of the policy. See e.g., Biomass One v. Imperial Casualty and Indemnity Co., 968 F.2d 1220 (9th Cir. 1992) (wherein the policy contained a $2 million liability limit and costs of defense amounted to roughly $1.9 million). There are numerous other examples of cases where the costs of defense either exceed or substantially rivaled policy limits, prompting some insurers to limit their promises to the insured regarding the costs of defense.
An insurer who has not adopted such a “defense within limits” policy faces the problem of being “on the hook” for astronomical defense costs where the insured is unable to reach reasonable settlement and the excess carrier is not yet implicated.

## Excess Insurers’ Perspectives

Wasting policies carry implications for excess insurers in addition to primary insurers. Where a primary insurer, through the terms of the issued policy, can deduct the defense expenses it incurs from the balance of policy limits, it is more likely that the excess carrier’s coverage will be triggered by the claim. That is, the primary policy will be exhausted more quickly, exposing the excess carrier to financial obligation it may not otherwise have been exposed to.

Excess carriers are thus motivated to litigate this issue of whether or not defense costs can be deducted from the balance of available limits in wasting policies. Particularly where the terms of the underlying policy are ambiguous with regard to whether or not the policy is a ‘wasting’ policy, or where the primary and excess policies contradict each other on that issue, the ensuing litigation can be contentious.

In some regards, however, wasting policies provide predictability for excess insurers. In that wasting policies make more certain the likelihood that certain types of claims will or will not exhaust primary policies, they make the reinsurers' task of pricing more reliable. Wasting policies also eliminate insureds’ reliance on so-called ‘unlimited defense.’ The effect is that insureds must be more reasonable when predicting the amount of coverage they actually require, and the likelihood of triggering an excess policy may be reduced.

### Defense Under Wasting Policies and Exposure to Bad Faith

Insurers must recognize the potential for misrepresentation of the terms of a wasting policy at the inception of the policy. An insurer would be wise to market the policy in a way that explicitly sets out the fact that policy limits are subject to deduction for defense costs. Without this type of explicit notice, a statement that the policy carries particular indemnity limits could be patently misrepresentative. The layout and design of the policy should reasonably lead the reader to conclude that the insurer intends to deduct the costs of defense from the limits of indemnity.

Defending under a wasting policy presents a conflict for the insurer: where defense costs and indemnification may exceed the limits of liability, defense costs continue to erode the portions of policy limits which are available for settlement or to satisfy a judgment. As a result, the insured has an interest in ensuring that the full limit of liability is available for settlement or to satisfy a judgment, while the insurer may seek to defend the case on the merits. While it may be in the financial risk of the insured to offer the policy limits, the insurer could seek to establish that there is no liability, and, as a matter of reputation, that the insurer does not easily tender policy limits.

Insurers should candidly provide information about the costs and risk associated with defense to insureds. Where a policy contains defense within limits provisions, an insurer may need to defend under a reservation of the right to withdraw when the policy limits are exceeded. Under a wasting policy where the cost of defense may exceed policy limits, there is a clear conflict with regard to the carrying out of the defense of the claim. That is, aggressive defense directed by the insurer might rapidly exhaust the policy, exposing the insured to additional liability. Under a standard policy, there is no conflict where the insurer has issued a reservation of rights letter warning that the claim may exceed the policy limit. Under a wasting policy, the insurer should allow the insured to select counsel if the likelihood that the limit will be met or exceeded is very high. A carrier who fails to involve the insured in the directing of defense in this situation risks acting wrongfully and failing to satisfy the duty to defend, or being estopped from denying coverage beyond policy limits.

If the insurer chooses not to settle the claim, and the verdict falls within the policy limits, the insurer is typically required to indemnify the insured by satisfying the judgment. However, where a verdict is returned in excess of policy limits, the insurer may
be exposed both to the excess liability and to bad faith liability for failure to settle. Factors for evaluating whether or not the insurer acted in bad faith typically revolve around the communication between insurer and insured, the manner in which the insurer evaluated the claim, and the manner in which the insurer responded to settlement offers. Under a wasting policy, each of these types of factors are implicated.

Consider what constitutes a demand within policy limits under a wasting policy. Do ‘policy limits’ refer to (1) the stated indemnification limit in the policy, (2) the balance available after subtracting defense costs incurred so far, or (3) the predicted balance available after defense concludes and settlement is reached?

Florida Treatment of Wasting Policies

Even under a standard policy, an insurer’s duty to defend may terminate when the policy limits are exhausted. See Underwriters Guarantee Ins. Co. v. Nationwide Fire Ins. Co., 578 So. 2d 34 (Fla. 4th DCA 1991). An insurer may not simply tender the policy limits and withdraw its defense. See Aetna Ins. Co. v. Borrell-Bigby Electric Co., 541 So. 2d 139 (Fla. 2d DCA 1989). However, where the policy clearly and unambiguously notifies the insured that the insurer will withdraw its defense after limits are exhausted, and the insured consents, the insurer may tender its limits into court and withdraw the defense.

Florida and the courts which exercise jurisdiction over it have yet to decide issues of bad faith in the context of wasting policies. Nevertheless, the principles underlying bad faith litigation are predictive of how a court would decide the issue. Generally speaking, an insurer has a duty to protect its insured from a judgment exceeding the limits of the insurance policy by settling within those limits. See, e.g., Berges v. Infinity Ins. Co., 896 So. 2d 665, 668-69 (Fla. 2004). This issue can become particularly tory when the limits are eroded by payment of defense costs. Although there is a surprising dearth of case law on this particular issue, it has nonetheless been well-documented by both practitioners and academics. See Shaun McPartland Baldwin, Legal and Ethical Considerations for ‘Defense Within Limits’ Policies, 61 DEF. COUNS. J. 89 (1994); Gregory S. Munro, Defense Within Limits: The Conflicts of ‘Wasting’ or ‘Cannibalizing’ Insurance Policies, 62 MONT. L. REV. 131 (2001). In short, insurers who issue wasting policies must be extremely careful to settle potentially meritous claims quickly.

Of course, the insurer can always exercise its right to defend under a reservation of rights, appoint counsel, and investigate the claim prior to making an offer. See, e.g., Liberty Mut. Ins. Co. v. Lone Star Indus., Inc., 661 So. 2d 1218, 1220 (Fla. 3d DCA 1995). Nevertheless, willingness to offer policy limits to settle a claim serves to protect the insured from an excess judgment and protect the insurer from potential bad faith liability.

Special Considerations

In Florida, judicial treatment of wasting policies is especially important for insurers carrying risk for nursing homes. Traditional measures of damage, like lost income, were considered in the context of damages in claims made by the elderly, and it was logical for insurers to eagerly carry the relatively minimal risk. Subsequently, the pervasiveness of elderly-abuse litigation drove verdicts and altered the nature of the risk significantly. While carriers continue to insure the industry, there have been substantial changes to the nature of the policies.

The newer policies are wasting policies. Nursing home insureds are typically defended under a reservation of rights, and the insured may be entitled to hire independent counsel at the insurer’s expense. Risk managers for nursing homes and carrier representatives equally must have knowledge of the way in which defense costs will be deducted from the indemnity limits of wasting policies, and to consider the impact that this will have a potential aggregate limit covering all claims in a policy year.

Conclusion

Wasting policies present significant implications for insurers and their counsel with regard to handling defense. Though such policies provide certainty for insurers with regard to how much will be spent on defense, the policies may expose the insurer to bad faith liability. Further, where such policies seem
The trial court denied Travelers’ motion for summary judgment, holding that the no-voluntary-payment provision was analogous to a notice provision and, therefore, required a showing of prejudice by Travelers. The trial court also rejected Travelers’ argument that it was necessarily prejudiced because it was deprived of the ability to litigate the claim. On appeal, the Colorado Court of Appeals affirmed the trial court’s ruling, imposing a prejudice standard.

Notably, the Court also distinguished Stresscon’s agreement from those approved in Nunn v. Mid-Century Insurance Co., 244 P.3d 116 (Colo. 2010). Nunn agreements, as they are known, allow insureds to enter into an agreement with third-party claimants in which the insured confesses liability and assigns all claims against the carrier in exchange for entry of judgment and a covenant not to execute.

The underlying case involved a claim between the general contractor and its subcontractor, Stresscon. The general contractor sought damages for construction delays resulting from an accident which caused serious bodily injury. Prior to any suit or arbitration being filed, and without informing its insurer, Travelers, Stresscon entered into an agreement with the general contractor, agreeing to pay various damages. Stresscon then sought indemnity under the liability policy issued by Travelers; Travelers denied coverage pursuant to a no-voluntary-payment provision.

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No-Voluntary-Payments Clauses in Colorado

In April, the Colorado Supreme Court rejected an attempt to impose a prejudice standard for no-voluntary-payments clauses in liability policies. Travelers Property Cas. Co. of America v. Stresscon Corp., 2016 CO 22. In this same case, the Court also took the opportunity to stress the narrow application of so-called Nunn agreements in Colorado (whereby insureds enter into pretrial agreements with third-party claimants, assigning all claims against the carrier in exchange for entry of judgment and a covenant not to execute).

The underlying case involved a claim between the general contractor and its subcontractor, Stresscon. The general contractor sought damages for construction delays resulting from an accident which caused serious bodily injury. Prior to any suit or arbitration being filed, and without informing its insurer, Travelers, Stresscon entered into an agreement with the general contractor, agreeing to pay various damages. Stresscon then sought indemnity under the liability policy issued by Travelers; Travelers denied coverage pursuant to a no-voluntary-payment provision.

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