Strategies and Strategems – Plots That Policyholder Counsel Are Hatching Next for You

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Defending business clients in a hostile jurisdiction is the hallmark of Kay Fuller's practice. Since joining Martin & Seibert, L.C. in 1990, Ms. Fuller has concentrated her practice on the defense of insurers in coverage and extra-contractual litigation through trial and appeal. Ms. Fuller has successfully tried a number of "bad faith" cases in Virginia and West Virginia and also provides coverage defense. She also actively litigates administrative matters and chairs the firm's litigation department.

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Ms. Popik is a co-author of the "bible" of California insurance litigation, the Rutter Group's *California Practice Guide: Insurance Litigation*. She is also a co-author of the ABA/West Group treatise, *Law and Practice of Insurance Coverage Litigation*; a contributing editor of *West's California Litigation Forms: Civil Procedure Before Trial;* a co-author of California Continuing Education of the Bar's *California Civil Writ Practice*; and a consultant to CEB's *California Civil Appellate Practice* and *California Liability Insurance Practice: Claims and Litigation*. She currently serves on the Board of the Federation of Defense and Corporate Counsel Foundation and is a former member of the Federation's Board of Directors. She is a long-time faculty member and former Dean of the Federation's Litigation Management College for claim professionals. She has served as Secretary of the American Bar Association's Tort Trial and Insurance Practice Section, as a member of the Section's governing Council, and as chair of the Section's Insurance Coverage Litigation Committee.

I. Introduction

The challenging economic climate has brought about changes in traditional positions of insurers, insureds and claimants and has carried with it renewed attempts to create, expand or resurrect previously excluded coverage. In addition, insureds are increasingly placing restrictions on information they release to insurers when making claims in spite of duty to cooperate clauses and similar contractual provisions. Heightened concerns as to privacy in this electronic age are also fueling a great deal of debate and will doubtless serve as the basis of coverage and bad faith litigation in the coming years.

The year 2009 revealed a number of scenarios by which insureds attempted to expand coverage and to "set up" insurers based upon the manner in which claims are presented, investigated or evaluated. This paper highlights some of the new and not-so-new strategies that policyholders have employed to expand questionable coverage and manufacture extra-contractual exposure.

II. Privacy Issues

Consumers are increasingly concerned about privacy issues, ranging from protecting personal financial information and medical documentation to preserving trade-secret business information. However, the release of that information is often necessary to a proper evaluation of an insurance claim, whether it be first- or third-party. Herein lies the tension between an insurer's right to know the facts of an insured's or claimant's claim, the insured's duty to cooperate, and the claimant's right to privacy. Most courts which have dealt with the issue have held that while a claimant may initially have an expectation of privacy, that expectation is either waived or diminished by the presentation of a claim for insurance benefits. The extent to which that expectation is diminished, and the extent to which the information obtained can be utilized, however, is the growing area of debate and litigation.

Many insurers utilize electronic claim files or maintain databases of information. Even when scrubbed of personally identifying information, those files and databases might still contain information to which claimants would want to limit or eliminate access.

It is beyond dispute that medical records, for example, are confidential. Despite this recognition of confidentiality, the United States Supreme Court has prohibited attempts to restrict an insurer's use of a claimant's medical records. In *Whalen v. Roe*, 429 U.S. 589 (1977), Justice Stevens, writing for a unanimous Supreme Court, upheld New York's statutory regulation which established a centralized database of individuals receiving prescriptions of Schedule II narcotic medication. Under New York's statute, public disclosure of the patient's identity was prohibited and access to the files was confined to a limited number of Health Department and investigatory personnel. Claimants' challenge to the statute,

which alleged unidentified and unspecified "fears" that privileged information would be disclosed and sought to restrict the manner in which the information was utilized, was rejected by the Supreme Court. Justice Stevens wrote:

> Even without public disclosure, it is, of course, true that private information must be disclosed to the authorized employees of the New York Department of Health. Such disclosures, however, are not significantly different from those that were required under the prior law. Nor are they meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care. Unquestionably, some individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention. Nevertheless, disclosures of private medical information to doctors, to hospital personnel, ***to insurance companies***, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient.

Id. at 602 (emphasis added).

The Supreme Court deemed it appropriate that claimants disclose private medical information to insurance companies in the normal course of activities and further upheld the right to collect and use such data so long as accompanied by a concomitant statutory or regulatory duty to avoid unwarranted disclosure. Additionally, the *Whalen* Court held the New York program did not, on its face, pose a sufficiently grievous threat to individual privacy interests to establish a Constitutional violation. Moreover, these unarticulated "fears" were insufficient to restrict the use of medical information. The *Whalen* Court held there was no support in the record or in the experience of the State of New York in administering the program to even support an assumption that security provisions would be administered improperly.

Finally, the *Whalen* Court considered the collection of data and held:

> We are not unaware of the threat to privacy implicit in the accumulation of vast amounts of personal information in computerized databanks or other massive government files . . . . The rights to collect and use such data for public purposes is typically accompanied by a concomitant statutory or regulatory duty to avoid unwarranted disclosures . . . . We therefore need not, and do not, decide any question which might be presented by the unwarranted disclosure of accumulated private data, whether intentional or unintentional, or by a system that did not contain comparable security provisions. We simply hold that this record does not establish an invasion of any right or liberty protected by the Fourteenth Amendment.

Id. at 605-606.

Despite the Supreme Court's apparent grant of authority nearly three decades ago to obtain, utilize and retain confidential information, claimants are attacking, and courts are eroding, insurers' ability to obtain, utilize and maintain such information beyond the adjustment of a specific claim – and in some cases are limiting that ability to the life of that specific claim. This obviously erodes an insurer's ability to engage in trend analysis or utilize information for underwriting or other purposes. It may also compromise an insurer's ability to do business electronically, since some courts have gone so far as to prohibit the electronic maintenance of claimant information.

Insurers must be on guard for such attacks, particularly since they usually come in underlying claims against insureds which may require intervention by the insurer to protect its business interests. This is also prime ground for "set ups" against insurers. Although this information is obviously necessary to the proper adjustment of a claim, claimants now attempt to attach conditions to the disclosure or release of such information and then allege delay when an insurer cannot accept those terms. When it is the insured that is refusing to provide the requested information, insurers should consider the duty to cooperate clause, since the attempt to impose such conditions may be contrary to the insured's contractual duty to provide the information without restriction.

Obvious business interests as well as potential bad faith and discovery issues are implicated in this tactic. An insurer faced with this scenario must be prepared to demonstrate how it maintains and utilizes the information it obtains, including the aggregation of information which is devoid of personally identifying information. In the absence of such a showing, courts are more inclined to err on the side of protecting the purported privacy interest without fully realizing the legitimate business needs for the requested information.

III. Intentional Acts Exclusion

In 2009, the intentional acts exclusion has come under attack, and courts have adopted a variety of theories to find coverage despite the exclusion.

A. Separate Acts of Negligence Independently Considered an "Occurrence"

The intentional acts exclusion was effectively nullified by the Supreme Court of Ohio in *Safeco Insurance Co. of America v. White*, 122 Ohio St. 3d 562, 913 N.E.2d 426 (Ohio 2009), when the son of an insured couple attacked and stabbed a neighbor. While the Court found the *son's* actions to be intentional and thus excluded by the family's four homeowners and umbrella policies, the Court

held that the claims of negligent supervision against the *parents* were independent claims that were covered as an "occurrence."

In *White*, 17-year-old Benjamin White attacked and repeatedly stabbed Casey Hilmer, the 13-year-old daughter of Steve and Megen Hilmer, as she was jogging in their neighborhood in 2003. Her injuries were not fatal. Benjamin, who lived with his parents at the time of the attack, pleaded guilty to attempted murder and felonious assault and was convicted and sentenced to an aggregate term of 10 years in prison.

After Benjamin was convicted, the Hilmers sued Benjamin and his parents on multiple claims, including battery claims against Benjamin and negligent supervision, negligent entrustment, and negligent infliction of emotional distress claims against Benjamin's parents. At trial, a jury found that Benjamin committed a battery, an intentional tort, and that his intentional acts caused the victim's father to suffer emotional distress. The jury also found that the Whites were negligent in their supervision of Benjamin and that this negligence also injured the victim and caused her father to suffer emotional distress. Based on these findings, the jury awarded the Hilmers $6,500,000 in compensatory damages against Benjamin and his parents and $3,500,000 in punitive damages against Benjamin. According to the jury, Benjamin was 30 percent responsible for the Hilmers' injuries and the Whites 70 percent responsible.

In a subsequent declaratory judgment action, Safeco, which issued one homeowners and one umbrella policy, argued it had no duty to indemnify or defend against negligence claims arising from intentional criminal conduct. The Ohio Supreme Court disagreed, finding that liability coverage hinges on whether the act is intentional *from the perspective of the person seeking coverage*. Because neither parent intentionally harmed the victim, the injury was accidental from their perspective, and the act which caused the injury therefore constituted an "occurrence."

The *Safeco* Court next considered the intentional acts exclusion and concluded that the intentions of the party who committed the intentional tort – in this case, the son – were immaterial in determining whether the allegedly negligent parents had coverage. The Court held that torts such as negligent supervision and negligent entrustment are "separate and distinct" from the related intentional torts committed by another. The Court therefore examined the injuries arising from the negligent acts of the parents independently, rather than as a part of the intentional act committed by their son. In so doing, the Court concluded that the intentional acts exclusion did not apply to the negligent supervision, negligent entrustment and negligent infliction of emotional distress claims pled against the parents.

A Colorado court performed a similar exercise – but to opposite effect – in *Mountain States Mutual Casualty Co. v. Hauser*, 2009 WL 2182600 (Colo. App.

July 23, 2009), in which the Court was called upon to determine whether a sexual assault by a restaurant manager against an employee constituted an "occurrence" in the context of a commercial general liability policy. The Court held it was not and, thus, that the insurer had no duty to defend or indemnify the restaurant.

The Court also considered other tangential allegations raised by the victim and concluded that the restaurant's alleged negligence in hiring and supervision of the manager were neither an "occurrence" nor an "accident." Even if these acts were considered to be an "occurrence" or "accident," the Court found that they would nonetheless be excluded from coverage by the policy's "expected or intended injury" exclusion. "Rather than resort to 'head-spinning judicial efforts at definition,' we conclude that the common understanding of an 'accident' does not include the assault that occurred here," the Court held.

B. Intent

Intent and the standard to be applied in determining "intent" has also been considered by courts and has resulted in findings of coverage.

In *American Family Mutual Insurance Co. v. Nunley*, 2009 WL 775424 (D. Ariz. March 2,3, 2009) (slip copy), an employee of the insured got into an argument with an independent contractor in the office, at one point grabbing her and pinning her against a wall. The alleged assailant argued he never consciously *intended* to touch the claimant and did not intend to harm her.

The employer of the alleged assailant filed a declaratory judgment action arguing that the expected or intended injury exclusion precluded coverage and that there was thus no duty to defend the employee under its business owners policy. The District Court considered the affidavit of the alleged assailant which stated he did not consciously intend to touch the claimant and determined there were factual questions in dispute as to whether the contact was intentional and concluded summary judgment was inappropriate. The Court also refused to apply the abuse or molestation exclusion, finding the victim was not in the "care, custody or control" of the insured at the time of the incident.

In cases of self-defense, the exclusion was again nullified and coverage afforded in *Vermont Mutual Insurance Co. v. Walukiewicz*, 290 Conn. 582, 966 A.2d 672 (2009), where the Supreme Court of Connecticut reversed a jury finding of no coverage in a dispute between an insured and his wife's ex-husband.

Here, the Court held that injuries suffered by an assailant at the hands of an insured acting in self-defense amounted to an "accident" under a homeowners policy. The Court considered whether the subjective intent of the insured was relevant to the determination of coverage. Ultimately, the Court concluded that actions taken in self-defense "by their very nature, are spontaneous and unplanned. Moreover, by definition, they are prompted by unforeseen, dangerous

circumstances warranting an immediate response. Because acts of self-defense are unplanned and unintentional, it follows that they are accidental within the meaning of the policy." When a person legitimately acts in self-defense, the Court held, his primary intent is not to cause injury, but to prevent harm to himself. Accordingly, the intentional injury exclusion did not preclude coverage because the injuries were neither expected nor intended by the insured.

The Court further considered public policy and reasonable expectations claims, concluding that because acts of self-defense are not wrongful, it does not offend public policy to afford insurance coverage. Additionally, because acts of self-defense enjoy societal approval and are legally sanctioned, a policyholder reasonably would expect to be afforded liability insurance coverage, the Court held.

In a case otherwise decided on procedural grounds, the Superior Court of Connecticut also considered whether an individual with diminished mental capacity could form the intent necessary to trigger the intentional acts exclusion. See *Doe v. Stamford Marriott Hotel & Spa*, 2009 WL 1334577 (Conn. Super. April 16, 2009) (unpublished).

C. Ambiguity in Policy Language

The intentional acts exclusion was also nullified by the U.S. District Court for the Western District of Washington on the theory that an ambiguity exists in a policy that affords coverage for certain acts that are intentional in nature but then excludes coverage under the intentional acts exclusion.

In *Western Protectors Insurance Co. v. Shaffer*, 624 F. Supp. 2d 1292 (W.D. Wash. 2009), the Court found coverage under a homeowners policy for allegations of invasion of privacy but not for claims of battery, intentional infliction of emotional distress or childhood sexual abuse filed against a grandmother/babysitter who knew or should have known such acts were being committed in her home by another to which she was complicit. The Court specifically found that the homeowners policies in question specifically provided coverage for personal injury resulting from an invasion of privacy yet they "do not apply to liability which results directly or indirectly from . . . an intentional act by or at the direction of any person." This, the Court concluded, created an ambiguity which, at a minimum, triggered the duty to defend.

The Court criticized the insurer for failing to provide a reasonable interpretation of these policy provisions and determined it failed to meet its burden that the personal injury claimed was excluded by specific policy language. The District Court readily acknowledged that its rationale would seem to mandate a duty to defend whenever a claim for invasion of privacy is alleged, but held it is the drafter of the insurance contract which bears the burden of proving application of its own policy language.

After issuing this opinion in January, the Court in February refused the insurer's Motion for Certification of Order on Summary Judgment in order to permit an interlocutory appeal to the Ninth Circuit. *Id.* 2009 WL 484526 (W.D. Wash.).

The holding in *Western Protectors* is opposite that reached by the New Hampshire Supreme Court in *State Farm Insurance Co. v. Bru*ns, 156 N.H. 708, 942 A.2d 1275 (2008), which also arose from the insured's alleged sexual assault of a minor. In *Bruns*, the Court held that the invasion of privacy claim was merely a "rebranding" of the claims for sexual assault which were excluded from coverage. In reaching its decision, however, the *Bruns* Court was careful to limit its holding to the facts before it:

> We do not hold that the policy at issue could never cover claims for invasion of privacy or false imprisonment; nor do we hold that there is no set of facts upon which State Farm would become liable to defend and/or indemnify [the alleged sexual abuser]. Instead, we hold only that on the facts *as they are alleged*, the claims for false imprisonment and invasion of privacy are inextricably intertwined with and dependent upon the uncovered sexual assault claims and are, therefore, outside the policy's coverage.

IV. Attempts to Resurrect Coverage for Faulty Workmanship Claims

CGL policies generally provide coverage for "bodily injury," typically defined as "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time." (Specific policies should be consulted for any deviations in the definition.) Such policies also generally exclude coverage for loss arising out of "faulty workmanship," "defective construction," and the like. Insureds are seeking to circumvent these exclusions by expanding the scope of "bodily injury" coverage to nontraditional injuries such as injuries to one's psyche, loss of sleep or other tangential ailments resulting from otherwise excluded faulty workmanship.

Such an attempt, however, was rejected by the U.S. District Court for the District of Colorado in *Admiral Insurance Co. v. Hosler*, 626 F. Supp. 2d 1105 (D. Colo. 2009). In *Hosler*, the homeowners, as assignees of the insured developer, sought indemnification for a state court judgment against the insured developer for claims of faulty construction which they claim caused them "bodily injury" in the context of loss of sleep.

During construction of a condominium complex in Littleton, Colorado, the contractor omitted sound- and fire-proofing implements. The unit owners alleged this faulty construction caused loud noises in their units. One unit owner testified he had to move his bed out of his bedroom and into the living room to avoid the

noise and alleged that this construction defect caused him to feel frustrated, embarrassed, dissatisfied and to lose sleep. Attempts to repair the problem caused more damage. At trial, a jury awarded each unit owner damages for loss of use, noneconomic damages, various economic damages and the cost of repairs. When the contractor filed for bankruptcy, the homeowners instituted a declaratory judgment action against Admiral, the contractor's insurer.

The District Court rejected the homeowners' attempt to predicate coverage on this theory, holding that claims for "purely non-physical or emotional harm" do not constitute "bodily injury" under an insurance policy. An insured must demonstrate a "physical manifestation" in order to trigger coverage. As a case of first impression, the District Court predicted that the Colorado Supreme Court would likewise reject the claim, concluding that the term "bodily injury" in an insurance policy connotes *physical* harm. Sleeplessness, the Court held, is an aspect of mental suffering and is not considered a physical injury to or a sickness of the body.

Another attempt to create coverage for faulty workmanship was rejected by the U.S. District Court for the Western District of Arkansas in *Cincinnati Insurance Co. v. Collier Landholdings, LLC*, 614 F. Supp. 2d 960 (W.D. Ark. 2009), which centered on the issue of faulty workmanship by a subcontractor and whether faulty workmanship, standing alone, constituted an "occurrence." The Court concluded it did not. The Court likewise rejected the contractor's attempt to create another theory of recovery based on breach of contract because Arkansas law does not permit breach of contract damages for liability imposed "on account of" or "because of" property damage. Accordingly, the insured contractor could not recover damages under its CGL policy. Rather, the Court held, a performance bond would have been the proper instrument to protect the contractor from loss arising from repair and/or remediation of defective construction.

In *Essex Insurance Co. v. Bloomsouth Flooring Corp.*, 562 F.3d 399 (1st Cir. 2009), the First Circuit analyzed a faulty workmanship claim under the "physical injury" to property damage provision of a CGL policy and held that that odor allegedly caused by defective carpeting could constitute "physical injury" to property.

The insured, Bloomsouth, was a subcontractor on a construction project to install flooring materials. Tenants of the building alleged the carpeting had an odor described as "a "locker room" smell, a 'playdough' smell, or a 'sour chemical' smell. Some further complained that the odor caused headaches or other ill effects. Following an unsuccessful $1 million plus remediation effort, coverage litigation ensued. The contractor alleged the odor permeated the building.

Essex's policies with Bloomsouth provided coverage for "property damage," defined to include "[p]hysical injury to tangible property, including all

resulting loss of use of that property," and "[l]oss of use of tangible property that is not physically injured." The policies also contained "business risk exclusions" that related directly to the insured's faulty workmanship, as opposed to damage caused to a third party.

At trial, the magistrate judge granted summary judgment to Essex. The First Circuit reversed, rejecting Essex's contention that the business risk exclusions in its policies relieved it of the duty to defend or indemnify. According to the court, odor can constitute physical injury to property under Massachusetts law. The Court further concluded that the odor may have resulted in a loss of use of the building – both of which are susceptible to an interpretation that physical injury to property was present. This, the Court held, was sufficient at least to trigger the duty to defend. The Court thereafter overruled the application of the all business risk exclusions as a matter of law.

It is anticipated that claims such as those presented in *Bloomsouth* will continue as an attempt to avoid direct faulty workmanship claims for damages allegedly caused by airborne contaminants or similar causes.

V. Use of Endorsements to Create Coverage

Insureds and insurers alike are increasingly turning to endorsements to bolster their coverage positions as well. Many exclusions are industry or insured-specific and no specific trend is yet identified. Those cases which may be of assistance generally to practitioners, however, are summarized below.

In *Auto-Owners Insurance Co. v. Ferwerda Enterprises, Inc.,* 283 Mich. App. 243, 771 N.W.2d 434 (2009), the Court of Appeals of Michigan turned to the Building Heating Equipment endorsement to a CGL policy and held the endorsement was a carve-out to the total pollution exclusion in the policy.

In the *Ferwerda* case, patrons of a Holiday Inn were injured by noxious gas released into the pool area following a repair to a pipe. The system that filtered and heated the pool also heated the pool building and thus the Court applied the endorsement. The endorsement held that the absolute pollution exclusion did not apply "to 'bodily injury' if sustained within a building at such premises, site or location and caused by smoke, fumes, vapor or soot from equipment used to heat a building at such premises, site or location." This endorsement, the Court held, rendered the total pollution exclusion "less than absolute." This rendered the policy ambiguous thus requiring remand for a factual determination.

The Court of Appeals also considered an argument by the insured hotel that in denying coverage, the insurer waived any potential reliance on any pollution exclusions and any right to challenge the applicability of the building

heating equipment endorsement. The denial letter reserved all other applicable grounds for denial of coverage, thus the waiver claim was rejected.

Claimants and insureds alike are also seeking restriction of the Designated Work exclusion, with mixed results.

In *Hawaiian Isle Adventures, Inc. v. North American Capacity Insurance Co.*, 623 F. Supp. 2d 1189 (D. Hawaii 2009), the District Court of Hawaii found the Designated Work exclusion was ambiguous. The issue arose following the drowning during snorkeling of a customer of the insured. The CGL policy listed the following activities in the Designated Work exclusion: waterfall hiking, snorkeling, boogie boarding, and surfing. The insured argued this applied to employees not customers because the definitions section of the policy defined "your work" as "work or operations performed by you or on your behalf" and thus arguably did not apply to customers. The Court agreed finding the insurer's interpretation of the policy "would exclude almost all situations in which a customer might sustain an injury, rendering the contract either illusory or close to illusory."

VI. Attempts to Expand Coverage

Not only are the lines of coverage being stretched, but those who are seeking coverage also continues to grow. Individuals are attempting to posit themselves as third-party beneficiaries to another's insurance contract or allege facts that fall outside exclusionary language. Both have met with mixed success.

A. Third-Party Beneficiaries

A chiropractor who treated an injured worker filed a class action against the patient's employer's workers' compensation insurer asserting claims for breach of contract and unjust enrichment arguing he was a third-party beneficiary to the policy in *Martis v. Grinnell Mutual Reinsurance Co.*, 388 Ill. App. 2d 1017, 905 N.E.2d 920 (2009).

Applicable policy language in the workers' compensation policy stated:

> We [Grinnell] are directly and primarily liable to any person entitled to benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you [employer] and us.

The Appellate Court of Illinois, however, held that the chiropractor was not a third-party beneficiary and therefore had no right to enforce the policy and thus dismissed the breach of contract allegations. Specifically, the Court held that medical providers are generally not third party beneficiaries of insurance policies, particularly workers' compensation policies. The only exceptions to this rule are

when (1) the policy expressly identifies medical providers as third party beneficiaries or (2) the policy provides for payment directly to medical providers. Looking at policy language, the Court also concluded the chiropractor was not a third-party beneficiary because there was no provision in the policy identifying medical providers as persons entitled to benefits.

A lessee of an insured also attempted to garner coverage under the insured's CGL, commercial auto and umbrella policies in *Employers Mutual Casualty Co. v. Bonilla*, 612 F. Supp. 2d 734 (N.D. Tex. 2009). Here, the insured, Jolly Chef, leased mobile catering trucks. Bonilla leased one of Jolly Chef's trucks. Two of Bonilla employees drove the truck and cooked inside the truck. While cleaning the truck after a day's route, the driver poured gasoline on the indoor floor of the truck to "cut the grease." The cook, however, turned on a pilot light which caused a flash fire and severely injured her. She thereafter sued Bonilla and Jolly Chef. After judgment was entered, Bonilla sought indemnification from Jolly Chef's various policies.

Jolly Chef's insurer, Employers Mutual, argued Bonilla was not a named insured and thus would not be entitled to coverage. Thereafter, the case revolved around whether Bonilla was operating, using or maintaining a covered auto. The District Court found that the activities which led to the fire were not necessary to enable the truck to transport food and thus fell outside the operation, maintenance or use clause of all applicable policies.

B. Attempts to Avoid Exclusions

A Massachusetts court held that a homeowners policy does not provide coverage to the estate of an overnight guest of the insured who died of an apparent suicide by overdosing on medication that was accessible to the guest. In *Massachusetts Property Insurance Underwriting Ass'n v. Gallagher*, 75 Mass. App. Ct. 58, 911 N.E.2d 808 (2009), the Court considered the controlled substance exclusion of the homeowners policy which excluded claims for bodily injury:

> [a]rising out of the use, sale, manufacture, delivery, transfer or possession by any person of a Controlled Substance(s) [*sic*] as defined by the Federal Food and Drug Law at 21 U.S.C.A. Sections 811 and 812. Controlled Substances include but are not limited to cocaine, LSD, marijuana and all narcotic drugs. However, this exclusion does not apply to the legitimate use of prescription drugs by a person following the orders of a licensed physician.

The insured seized upon the "arising out of" language in the exception to the exclusion, arguing that it is analogous to a "but for" test and asserting that "but for" his use of the medication on which the houseguest overdosed, the

medication would not have been available to the decedent. The court found this argument "entirely without persuasive force."

An insured under a CGL policy also attempted to skirt an exclusion, specifically a burglary exclusion, in *Certain Underwriters at Lloyds, London v. Law*, 570 F.3d 574 (5th Cir. 2009), when air conditioning units were damaged in a burglary. The Court held that damage to the units was within the theft exclusion and outside the burglary exception to the policy's vandalism coverage since the damage was inflicted solely in furtherance of a theft of copper tubing. The policy at issue expressly provided coverage for loss caused by vandalism, but excluded coverage for damage resulting from theft. The theft exclusion contained an exception for any damage resulting from burglars breaking into or exiting from the insured building.

Underwriters denied coverage based on the policy's theft exclusion and sought a declaratory judgment in district court that it had no duty to indemnify. The insured counterclaimed, seeking a declaration that the claim was covered. The Fifth Circuit held that the vandalism coverage, the theft exclusion and the ingress/egress exception indisputably turned on the purpose for which the damage was done. According to the Court, damage done for no purpose other than to destroy property is "vandalism"; incidental damage done in furtherance of thievery is considered damage resulting from theft; and damage to the insured building done by the burglar entering or leaving the building falls within the ingress/egress exception. To hold otherwise, the Court held, would nullify the exclusion and its narrow exception. Finding the damage was solely in furtherance of stealing copper, the Court concluded that the damage was due solely to further a theft and was not vandalism. Moreover, because the damage did not result from breaking into the insured building, the ingress/egress exception was inapplicable.

Insureds also attempted to increase or expand coverage in the application of definitions. In *Mortgage Express, Inc. v. Tudor Insurance Co.*, 278 Neb. 449, 771 N.W.2d 137 (2009), the Supreme Court of Nebraska rejected an insured's claim that slander of title was an insured event.

In *Mortgage Express*, the insured filed suit against its liability insurers, Tudor and Cincinnati, seeking a declaration that the insurers were obligated to defend an underlying suit filed by a third party arising from disputes over a promissory note which led to a slander of title claim. The Nebraska Court held that an errors and omissions policy does not provide coverage for slander of title because it is not a "good," "product," or "service" within the meaning of personal injury coverage in a CGL policy. A "good" or "product," the Court held, refers to tangible property, not title to real estate.

VII. Conclusion

It appears that a number of claims that were filed and/or decided in 2009 are claims that might not have been brought but for the difficult economic times, which are forcing both insureds and claimants to seek coverage in unorthodox ways. Insurers should expect such claims to continue. Moreover, difficult economic times affect insurers as well, making it difficult for insurers to conduct investigations of certain claims without incurring substantial costs. Claimants are equally aware of the cost-benefit analysis insurers and all businesses must conduct. Insurers must be vigilant, however, not to fall short of their contractual and statutory duties to insureds when claims are presented, as doing so could lead to bad faith actions and/or institutional attacks as to the manner in which claims are investigated or coverage decisions are made.