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Southern CD – Not so Charming

PART I – COVERAGE

I. USING EXTRINSIC EVIDENCE TO DETERMINE THE DUTY TO DEFEND

In South Carolina, Courts look primarily to the four corners of the complaint, but may also consider any facts that are known to the insurer. Courts have not expounded on whether the use of extrinsic evidence is limited only to an affirmative finding of a duty to defend or may be relied on in denying a duty to defend

Florida is a "four corners" jurisdiction with exceptions. A duty to defend is determined by comparing the allegations of the complaint to the applicable policy but may also be found by construing it in favor of the insured where factual allegations are missing. A narrow exception exists where there are *undisputed* facts that are clearly determinative of coverage, and which are not normally pled or are unnecessary to the cause of action against the insured.

Texas courts have historically followed the "eight corners" rule but the Supreme Court recently addressed whether an exception to the "eight corners" rule adopted by Texas federal courts was valid under Texas law. The Supreme Court held that courts may consider extrinsic evidence in analyzing the duty to defend under the following conditions: (1) the extrinsic evidence goes solely to the issue of coverage and does not overlap with the merits of liability; (2) the extrinsic evidence does not contradict facts alleged in the pleading; and (3) the extrinsic evidence conclusively establishes the coverage fact to be proved. This modified extrinsic evidence analysis would most likely apply to situations where the pleading itself is ambiguous on whether a duty to defend is triggered. Extrinsic evidence can be used to fill in the "gaps" in the pleading.

II. DEFENSE COST CONTRIBUTION

South Carolina generally does not allow claims for contribution of defense costs by one insurer against another. If each insurer has an independent duty to defend, they must exercise that obligation, and cannot seek reimbursement or contribution from another insurer. This does not affect an insurers' ability to challenge priority of coverage. Moreover, defense costs, unlike indemnity obligations, are not *pro-rated* based on each insurer's time on risk.

Florida historically prohibited defense cost contribution among co-insurers. This changed with the passage of Florida Statute §624.1055. In short, it applies to any "claim, suit or other action" initiated on or after January 1, 2020, and provides that a liability insurer who owes a duty to defend an insured and who defends the insured against a claim, suit, or other action, has a right of contribution for defense costs against any other liability insurer who owes a duty to defend. However, contribution may not be sought from any liability insurer for defense costs that are incurred before the liability insurer's receipt of notice of the claim, suit, or other action. The Statute provides that the court shall allocate defense costs among liability insurers in accordance with the terms of the policies and such other "equitable factors" as the Court determines to be appropriate. From the insurers' perspective, the Statute does not go far enough and there are practical issues with its application. There is no prevailing party attorney fee provision so insurers must undertake a cost/benefit analysis – it may cost more money to prosecute than any ultimate recovery. Also, both insurers must have a duty to defend. This means that the carrier against whom a contribution action is brought will defend against it by arguing that neither it *nor* the prosecuting insurer have a duty to defend. There is thus a concern for "making bad law". The Statute does not provide any guidance on exactly what is a "claim, suit or other action" *initiated* after January 1, 2020. For example, a claimant files an amended complaint after January 1, 2020, but the claim and lawsuit pre-existed it. Also, a Court's use of other "equitable factors" in determining the allocation significantly broadens the scope of the contribution action. Lastly, its application to duty to defend "right to repair" proceedings is in question.

Texas allows insurers to seek contribution for defense costs from other insurers that have a joint defense obligation to the insured

III. DUTY TO DEFEND RIGHT TO REPAIR PROCEEDINGS

South Carolina has not addressed whether there could be a defense obligation for a statutory right to repair proceeding.

Under Florida law, a statutory right to repair proceeding qualifies as an "alternative dispute resolution proceeding" under the definition of "suit". As such, the insurer's consent is required to trigger its defense obligation.

Texas has not addressed the duty to defend a right to repair proceeding but in a non-construction context has addressed whether the definition of "suit" is limited to a lawsuit. The court found that an insurer had a duty to defend its insured in EPA enforcement proceeding as it fell within the definition of "suit" in the policy.

IV. RESERVATION OF RIGHTS REQUIREMENTS AND ALLOCATED VERDICTS

South Carolina has strict guidelines that must be followed when crafting a reservation of rights ("ROR") letter. Failure to adequately inform the insured of the insurer's coverage defenses may result in a waiver of those defenses. A reservation of rights letter must clearly identify the potential grounds for a lack of coverage. A "shotgun" recitation of applicable policy language will not suffice. An explanation of how those terms potentially relates to the specific claim is required. An insurer must also inform the insured that it may intend to seek a judicial

declaration of its coverage obligations. The failure to assert any known defenses in a ROR letter may result in their waiver, so it is imperative to be as thorough as possible when drafting it.

Although there is no requirement that the insurer pay for independent counsel when reserving its rights, as a "best practice" it should inform the insured that it may elect to do so "at its own expense." Additionally, a ROR letter must inform the insured that the underlying jury verdict should be allocated between covered an un-covered damages to preserve the right to secure coverage later. Until very recently, insurers were not certain whether they also had to intervene in the underlying matter to seek such an allocation. The South Carolina Supreme Court recently has more recently held, however, that insurers need not seek intervention. An insurer's right to contest a general verdict in a subsequent declaratory judgment action will be preserved if it notifies the insured of the right to seek allocation in the ROR letter.

Florida law is similar but not identical. Except in limited circumstances, there is no definitive case-law articulating what must be specifically stated in a ROR are letter[1]. While coverage cannot be "created" through the doctrines of waiver or estoppel, an insurer can be precluded from relying on a particular defense if an insured relied to its detriment on the insurer's failure to raise it. In addition, under Florida law a ROR letter is viewed as a separate agreement between the insured and its insurer and the right to recover defense expenditures must be included in it.

In addition, unlike South Carolina law, an insured under Florida law can reject a defense under a ROR, take control of its own defense (including selection of counsel) and resolve the case in its best interest without insurer participation.

In terms of notifying the insured of its need to obtain an allocated verdict, Florida law (at least in Federal Court) is generally the same as in South Carolina. It must be pointed out, however, that the ROR letter itself is not alone sufficient for this purpose.

The timing of an allocated verdict notification is important. It must not be so late in the underlying proceeding whereby the insured is unable to conduct the necessary discovery or secure expert opinion to segregate covered from uncovered damages.

Under Texas law, an insurer is required to provide a timely notice of its reservation of rights which fairly informs the insured of the insurer's position. An insurer that assumes the insured's defense without a reservation of rights or non-waiver agreement, but is otherwise armed with facts indicating non-coverage, will be deemed to have waived or otherwise be estopped from asserting its coverage defenses. Also, an insurer must comply with Texas's Prompt Payment Statute. If a conflict of interest arises, an insured is entitled to select independent counsel at the insurer's expense. A conflict of interest arises when the facts to be adjudicated in the underlying lawsuit are the same on which the reservation of rights is predicated. Texas courts have not

[1] The exception is Florida Statute §627.426 which applies to Admitted insurers but not Surplus Lines insurers. Under it, "Conditions" defenses are waived unless specific criteria for reserving rights is followed in terms of timing and content. This Statute *may* also require an insurer to appoint mutually agreeable counsel to defend an insured.

specifically addressed whether an insurer has an obligation to inform its insured about the need for an allocated verdict.

V. “OCCURRENCE” and “PROPERTY DAMAGE”

Under South Carolina, Florida and Texas law, an insured’s faulty workmanship which damages other property, including the work of other trades, is considered an “occurrence” under the “standard” insuring agreement in a CGL policy. South Carolina has statutorily incorporated this interpretation into all CGL policies governed by SC law. Further, damage to other property or work (including work of other trades) qualifies as “property damage” under the commonly applied definition in a CGL Policy. The cost to repair or replace the insured’s own defective work, however, is not considered “property damage” caused by an “occurrence.”

A. Coverage for “Rip & Tear” Costs

Under South Carolina law, the issue of whether “rip and tear” (*i.e*., access) costs are covered is not settled. But, federal court decisions, including courts from other jurisdictions interpreting South Carolina law, have concluded that “rip and tear” costs are not covered.

Florida law is completely different. Under Florida law, costs to access and repair otherwise covered “property damage” are covered. For example, a contractor defectively constructs a balcony. As a result, water infiltrates and damages the garage which was outside the balcony contractor’s scope of the work. Costs to replace the balcony would be covered if necessary to repair the garage damage. Going further, there is law that suggests costs to mitigate damage are also covered. For example, a window contractor defectively installs windows. Water intrusion occurs and damages carpeting and drywall. There is case law that supports the argument that the windows must nevertheless be repaired by the window contractor for the simple fact of preventing additional damage.

Texas considers costs to access, and repair covered property damage as damages “because of” “property damage” and are therefore covered under a CGL policy.

VI. TRIGGER OF COVERAGE and “TIME ON RISK”

South Carolina has a “hybrid” trigger test for determining when coverage should apply. It employs an “injury-in-fact” trigger to determine when “property damage” first occurs then applies a “continuous trigger” for policies beginning with the “injury-in-fact” until the claim becomes a “known loss.” In practice, insured’s counsel typically allege that “property damage” has been occurring “since construction” or “since completion,” which is interpreted to mean since the project’s completion, through the filing of the underlying lawsuit. However, an insurer is only obligated to indemnify an insured for the “property damage” which occurs during its policy period. In circumstances where “property damage” is deemed to be occurring continuously, possibly over many years, an insurer is only responsible for its “*pro rata*” time on the risk. An insurer’s percentage of exposure will be directly proportional to the number of years it provided coverage. For periods where the insured “goes bare” or otherwise failed to carry coverage, the burden for that share of the damages falls on the insured.

While Florida also employs an injury-in-fact trigger, there is no comparable “time on risk” analysis. Rather, the burden of proof remains on the insured to prove when covered “property damage” occurred. If this burden is not met, an individual insurer will not face coverage liability even if it is within a string of consecutive policies issued by a variety of different insurers.

Texas has adopted an injury-in-fact trigger for construction defect claims. Like Florida, there is no clear time on risk analysis. Texas’s intermediate appellate courts generally have followed the “all sums” allocation approach, where the insured may elect which policy period to pursue coverage. Targeted insurers, however, do retain a right of contribution from other potentially triggered policies.

PART II – RESOLUTION

I. THE ROLE OF THE INSURED

An insured must provide notice to its insurer as soon as it has reason to believe that a claim *may* be made against it. An insured should not wait until it receives a statutory Notice of Defect or even worse, a lawsuit. Notice should certainly be given before any inspections or destructive testing occurs. Without timely notice an insurer may lose access to crucial claim information. Ultimately, a failure to provide notice or to cooperate with the insurer jeopardizes coverage.

When a claim is first presented, the insurance representative’s initial source of information is the insured. The representative will review the information provided and request additional information as necessary. To facilitate this process, the insured must gather its job file and all available insurance information at the beginning of the claim. Any response from an insurer should be circulated to the other insurers. At that point the insurers can communicate amongst themselves, share information, and plan their respective investigations. The speed and efficiency of this initial step is largely dependent on the insured. Presuming that the insured maintained its records, this initial exchange of information should not be a protracted process.

As a matter of good business practice an insured should have a document retention policy for at least basic project documents. Oftentimes, an insured does not obtain or maintain such basic things as contracts or certificates of insurance. Payroll and accounts payable records are also an important resource for identifying who worked on the project and how long it lasted. This information is critical to an insurer's claim investigation.

The bottom line is that if an insurer does not have information, it can't make a claim determination. If an insurer must repeatedly follow-up with an insured to get information or go to other sources because an insured isn't cooperating, the claim will stall. This is often a source of frustration for both the claim professional and the insured. On the one hand, the claim professional can't advance the claim and on the other, the insured becomes increasingly impatient over the length of time the claim is taking. Sometimes an insured will reflexively retain counsel unnecessarily creating an antagonistic relationship. While experienced insurance counsel can be an invaluable resource in the claim resolution process, inexperienced counsel can hinder the process. The point here is that if an insured believes that legal counsel is necessary, it should select one with the necessary insurance background.

II. THE ROLE OF DEFENSE COUNSEL

Once a lawsuit is filed and an insurer appoints counsel for the insured, he or she becomes the primary source of information. A lawsuit against an insured does not end the insurer's duty to investigate the claim. Efforts to settle can and should continue throughout the proceeding. It could very well be that information needed by an insurer can be obtained quickly and without formal discovery. Especially at the early stages of litigation it is in everyone's best interest to share information and try to settle the dispute. Far too often, though, the parties get embroiled in "boiler plate" discovery without having any settlement discussions. The lawsuit then drags on for years.

If litigation proceeds, defense counsel should still make every effort to streamline the discovery process. He/she must keep both the insurer and the insured abreast of the facts as they develop. He/she can also develop other insurance information and facilitate discussions between all insurers. Again, having a dispute languish in court for years does not serve anyone's best interests.

III. THE ROLE OF COINSURERS

All potentially implicated insurers should be involved early in the claim process to gather facts and discuss coverage issues and allocation. However, each involved insurer may be experiencing its own cooperation and lack of documentation issues. It is imperative that the insurers work cooperatively from the beginning. Experienced claim representatives know the coverage issues and should begin addressing them at the outset. Nothing prevents insurers from exchanging information about the claim. In practice, there is much more communication and cooperation between insurers who share a common insured than there is between insurers of different insureds. That does not have to be the case. All insurers share the common goal of gathering facts and having a complete coverage picture to advance the process.

It is important to recognize that a defending insurer is under no *obligation* to share information that is developed by defense counsel. It is far more beneficial for co-insurers to jointly defend and learn the facts rather than having one or more insurers remain "ignorant". Settlement cannot occur without common knowledge of the facts.

IV. THE MEDIATOR’S PERSPECTIVE

Mediation provides an opportunity for the parties to eliminate the uncertainty of a future jury award and to therefore control their exposure. The insurers obviously play a crucial role in whether the matter gets resolved. From a mediator’s perspective, construction defect conflicts are among the most difficult matters to resolve. There are numerous parties and insurers all with antagonistic interests. Insurers frequently get claims for the same project by different parties. Insurers also get claims by multiple parties claiming to be insured under the same policy. There may be primary insurance, different levels of excess insurance and different types of insurance. The one and only constant, however, is that prompt and efficient resolution of these cases is contingent on an awareness of the insurance issues and a plan to address them. The lack of preparation and the failure to timely and adequately address insurance coverage and allocation issues will needlessly frustrate the mediation process.

While the parties will typically submit mediation briefs that address the liability and damages issues of the underlying litigation, they often do not address coverage issues or allocation disputes even if known to exist. Too often, the mediator is not advised of an insurance issue until well into the mediation and is then faced with a “mediation within the mediation.” At that point, there may be no way to resolve the undeveloped coverage or allocation issues and the mediation fails.

It is the shared responsibility of the parties and the mediator to prepare for maximum success at mediation. Advance preparation and coordination between all involved parties is crucial. Experience has shown that pre-mediation preparation is the key to a prompt, efficient and successful mediation. This “seven step program” will greatly enhance the process:

1. All potentially involved insurers must have been placed on notice. This must happen at the earliest possible opportunity. Many claims trigger more than one policy. Consecutive and excess policies may be implicated; different types of coverage may be implicated such as general liability, professional liability, and builder’s risk; different parties may be making claim under the same policy as an Additional Insured or as a Named Insured. The parties and their insurers must have the complete insurance “picture” as early as possible.

2. Know which insurers are participating and which are not. It is important to reach an agreement with the implicated insurers, particularly those who are defending, that all insurers who should participate will participate. If some insurers will not participate, agreement must be reached among the participating insurers on if and how settlement can be achieved without the recalcitrant insurers and what can be done to secure their participation.

3. Everybody must be educated and committed to the process. Insurers are increasingly unwilling to “pay and chase,” that is, pay the entire settlement themselves and then pursue other insurers for recovery. A defending insurer may attend a mediation and be well-informed regarding the case, but nevertheless refuse to contribute because a coinsurer is either not present, not prepared or is simply unwilling to cooperate. An insurer’s primary source of information is its retained defense counsel. To evaluate settlement, the insurer needs to understand the risks associated with a trial loss and the potential magnitude of a damages award. If a representative is poorly informed, he or she will likely not have sufficient authority at the mediation to effectively contribute to a global resolution. Accordingly, defense counsel should review prior requests from the insurer and ensure that all requested and necessary information has been provided well in advance of the mediation.

4. Provide written demands in advance of the mediation. Mediation should not occur until the claimant has a realistic picture of its damages claim as well as the availability of coverage and outstanding coverage issues. Neither the parties nor their insurers can adequately analyze exposure without an understanding of their respective expectations. This process takes time. Claimants should not wait until the day before or even the week before mediation to set forth their demands.

5. Resolve insurer allocation issues in advance. While it is sometimes possible for insurers to resolve these issues among themselves, that is uncommon. More often, the mediator facilitates the dialogue and sometimes the insurers participate in a "pre-mediation" insurance mediation. Counsel should not hesitate to get the mediator involved in the insurance aspect of the case prior to the formal mediation session in the liability case.

6. Educate the mediator on the insurance issues before the mediation. Often there will be insufficient time for the mediator to become fully versed on insurance issues if they have not already been explained in prior submissions. Provide this information sufficiently in advance of the mediation so that the mediator can map a strategy and perhaps begin discussing the issues with the participating insurers.

7. Insurance representative availability. The proper representative or representatives must attend or at least be available by telephone. If there are unresolved coverage issues, it is not uncommon for a separate insurer representative to address only those issues with or without coverage counsel. If representatives are not physically present, counsel should make sure that they have after-hours access, accounting for any difference in time zones.

CONCLUSION

There are a variety of coverage issues under South Carolina, Florida and Texas law which must be appreciated in-order-for a claim to be promptly and efficiently handled and resolved. All implicated parties must be prepared and committed to the process. With adequate preparation, coverage and liability obstacles can be overcome and the matter concluded in the most efficient manner possible.