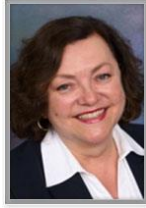


INSURANCE LAW ARTICLES 2015

| | |
|---|---|
| Ongoing Operations Additional Insured Endorsements: The Discussion Continues | 2 |
| ERISA's Diminishing Right To Direct Recovery..... | 6 |
| An Insurer's Failure To Timely Rescind A Policy <i>Ab Initio</i> Can Mean Waiver Of Its Coverage Defenses | 9 |



ONGOING OPERATIONS ADDITIONAL INSURED ENDORSEMENTS: THE DISCUSSION CONTINUES

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Ongoing operations and completed operations – when does one end and the other begin? The answer is not always clear, which means that the insurance analysis for construction defect claims is not always as straightforward as we might like.

Generally speaking, there are two types of construction defect claims. Some claims arise during the course of construction, such as when some component work must be ripped out and replaced because it is already damaging another trade's work. That is referred to as an ongoing operation claim because, even though a particular trade's work might be completed, the entire project has not been put yet to its highest and best use. Until that date, particular trades may be called back to the project, which is still ongoing.

The other type of construction defect claim is known as a completed operations claim because the project was completed before the claim is made (or suit is filed). Typically a Notice of Completion or Certificate of Occupancy is recorded to signify when construction was at least substantially completed, but that does not always happen. We then search for invoices and payment records to determine when the construction was substantially completed. As can be imagined, sometimes this analysis is more of an art than a science.

Knowing the type of construction defect is extremely important when one is analyzing an Additional Insured ("AI") tender. AI Endorsements ("AIEs") generally are of two types as well, either for completed operations claims or ongoing operations claims. The most well-known ISO forms within the insurance industry are CG 2010 (11/85) for completed operations claims and CG 2010 (109/93) for ongoing operations. Their pertinent language is as follows:

Who is An Insured (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" for that insured by or for you. [ISO Form CG 2010 (11/85)]

Who is An Insured (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured. [ISO Form CG 2010 (10/93)]

In analyzing the AI tender, we must compare the AIE with the underlying facts of the claim in order to determine whether the claim falls within the scope of coverage afforded by the AIE contained in the policy.

The Fourth District California Court of Appeal dealt with this issue in *Pardee Construction Company v. Insurance Company of the West*.¹ The case involved a large residential tract housing project built in a San Diego suburb over multiple phases in the mid-to-late 1980s. The developer's subcontracts included the

¹ *Pardee Construction Co. v. Ins. Co. of the West*, 77 Cal.App.4th 1340 (2000).

requirement that each trade contractor maintain completed operations CGL coverage, and that the developer be named as an additional insured on the policy.

The homeowners association sued the developer for construction defects in 1995, and the developer tendered its defense to the trade contractors' insurers. Some of the carriers provided the developer with a defense, but only as to claims arising out of their named insured's scope of work in this pre-*Presley*² era. Other carriers declined the developer's tender, which left the developer with an unfunded amount of defense costs which it was required to pay itself. The case eventually settled and the developer funded part of the settlement.

Shortly thereafter, the developer sued the recalcitrant carriers for breach of contract, bad faith, fraud and declaratory relief. The trial court granted dispositive motions in favor of the carriers, and the developer appealed. The Court of Appeal reversed, finding in favor of the developer because the AIEs contained comparable language found in the CG 2010 11/85 form quoted above; the Court of Appeal held that they applied to completed operations claims such as these and were not limited to project-specific claims.

The *Pardee* case is best known today for dictum concerning its interpretation of the CG 2010 (10/93) ongoing operations AIE form. This dictum, which did not affect the holding of the case, has fueled subsequent discussion about whether that endorsement affords additional insured coverage for completed operations claims. The Court of Appeal, in reliance on insurance industry commentaries, stated:

Moreover, in 1993, the Insurance Services Office (ISO) revised the language of the form 2010 endorsement utilized by the insurance industry to expressly restrict coverage for an additional insured to the "ongoing operations" of the named insured. This revised language effectively precludes application of the endorsement's coverage to completed operations losses. [Citation.] One insurance commentator stated regarding the 1993 revisions of the standard additional insured endorsement forms: "The restriction of coverage in the two endorsements to only ongoing operations makes it clear that additional insureds will have no coverage under the named insured's policy for liability arising out of the products-completed operations exposure. . . . The effect of this change —restricting the coverage to ongoing operations — is, however, much more profound on [form 2010]. Previous editions of [that form] contained no completed operations exclusion and, thus, could be called on to cover an additional insured for liability arising out of the products-completed operations hazard." Similarly, construction industry and underwriting spokespersons have echoed this assessment: "Completed Operations Coverage. Prior to the 1993 . . . revisions, the standard ISO additional insured endorsements provided the additional insured with coverage for liability arising out of 'your operations performed for' the additional insured, which included completed operations. More recent editions of these endorsements provide coverage only with respect to 'your ongoing operations,' which effectively eliminates coverage for completed operations." [Citation.] Although these 1993 revisions postdated the

² *Presley Homes, Inc. v. American States Insurance Co.*, 90 Cal.App.4th 571 (2001).

insurers' policies here with the exception of U.S. Fire, they evince as to Nationwide and ICW alternative express limiting language that could have been employed.³

In a post-*Pardee* world, many attorneys and claims professionals have concluded, at least in California, that a completed operations policy which includes an ongoing operations AIE should not afford additional insured coverage for a completed operations claim arising out of the named insured's work.⁴

For this reason, some insurers take the position that an AI tender for the defense of a construction defect claim which arises after the completion of construction may only trigger coverage if the policy contains a completed operations AIE. Their rationale is that the underlying claim would not have arisen unless the project was put to its highest and best use, and owned by someone other than the builder or developer. Those carriers often decline the AI tender if the policy contains an ongoing operations AIE where the underlying third-party complaint alleges damage existing from the date of substantial completion for the project, not during the course of construction. The issue becomes whether coverage should attach to a complaint which might have been drafted with the intent of avoiding a statute of limitations defense if the alleged date of damage, i.e., when the cause of action accrues, was during the course of construction and thus earlier in time than the date of substantial completion.

Many liability policies issued today for the construction industry contain only ongoing operations AIEs. This is often due to underwriting decisions which attempt to limit the scope of insurable risks. As a result, many AI tenders are declined when the policy contains an ongoing operations AIE and the claim was filed after construction was completed. Some insurers will accept AI tenders based upon ongoing operations AIEs only when the claim is made during the course of construction. The rationale is that claims should be filed timely, and so a claim which exists before the project is completed should be made before the project is completed. Thus, some insurers look to when the claim is made in relation to the construction schedule to determine whether the underlying claim is one for ongoing operations or completed operations.

However, recent Federal Court cases in California, Nevada and Arizona may give insurers reason to analyze the underlying facts more carefully when they are presented with an AI tender based upon an ongoing operations AIE and the claim was made after construction was completed.

In *Jaynes Corporation v. American Safety Indemnity Company*,⁵ an unpublished Federal Court ruling from the U.S. District Court in Nevada, the Court held that the CG 2010 (10/93) AIE form does not limit coverage to only the alleged damage which occurs during the named insured's ongoing operations, but also covers claims of alleged damage which occurs after the operation is completed but which was caused by ongoing operations.

³ *Pardee Construction Co.*, supra 77 Cal.App.4th at 1358-1359.

⁴ Few subsequent published opinions have cited *Pardee* on this issue, probably because they are factually distinguishable from *Pardee*. For a published Colorado opinion which relied on *Pardee*, see, e.g., *Weitz Co, LLC v. Mid-Century Ins. Co.*, 181 P.2d 309 (Colo. Ct. App. 2009).

⁵ *Jaynes Corp. v. American Safety Indemnity Co.*, 925 F.Supp.1095 (D. Nev 2012).

Similar rulings were made in *Tri-Star Theme Builders, Inc. v. OneBeacon Insurance Company*,⁶ which was an unpublished decision by the Ninth U.S. Circuit Court of Appeals in Arizona, and *McMillin Construction Services, L.P. v. Arch Specialty Insurance Company*⁷ from the U.S. District Court for the Southern District of California. Both Courts had concluded that the phrase “ongoing operations” was ambiguous to a reasonable layperson, thereby rejecting insurers’ arguments that a *Pardee*-type rule should apply automatically.

The most recent Federal Court decision is a published U.S. District Court case issued by the Eastern District of California on August 14, 2014.

In *St. Paul Fire and Marine Insurance Company v. ACE American Insurance*,⁸ Beazer Homes was the developer and general contractor for a number of residential developments that were constructed in 2004 and 2005. Defendant Arch Specialty Insurance Company had issued commercial general liability policies to a number of the subcontractors on the projects. In 2011, a number of homeowners filed a collective third-party action for alleged defects in their homes, and Beazer tendered its AI defense to Arch under the trade contractors’ policies issued by Arch. Arch denied the AI tender on several grounds, including language in the AI endorsement which limited coverage to liability arising out of the insured’s “ongoing operations.”

In its decision, the Court discussed insurance policy interpretation, including definitions of “ongoing operations” and “completed operations.” Neither term is defined in the policies but the Court found that they are temporal concepts: “ongoing operations” refers to work in progress, while “completed operations” refers to work that has been completed. However, in a somewhat tortured analysis, the Court also found that neither an ongoing operations AIE nor a completed operations AIE addresses clearly when the covered property damage must manifest or be discovered in order for coverage to be triggered. Therefore, because the Court thought that Arch could have done a better job drafting its ongoing operations AIE more clearly, this was an ambiguity which must be construed against Arch. The Court concluded that a defense under an ongoing operations AIE may be triggered if the damage might have occurred during the course of construction, even if the alleged damage was discovered years later.

The case was decided on a Motion for Summary Judgment regarding whether Arch had a duty to defend. In order to prove the non-existence of coverage, the burden was on Arch to establish that the property damage did not occur during the course of construction. That is often an extremely difficult issue to prove, and Arch was unable to do so here. As a result, because there was a triable issue of material fact as to the date of damage, the Court found that Arch owed a duty to provide Beazer Homes with an AI defense, even though the policy contains an ongoing operations AIE and the claim was made after the completion of construction.

CAVEAT: THE FOREGOING DOES NOT CONSTITUTE LEGAL ADVICE. PLEASE CONSULT AN ATTORNEY FOR INDIVIDUAL ADVICE REGARDING INDIVIDUAL SITUATIONS.

⁶ *Tri-Star Theme Builders, Inc. v. OneBeacon Ins. Co.*, 426 Fed.Appx. 506 (9th Cir. 2011). The *Jaynes* Court acknowledged that *Tri-Star* has no precedential value because it is an unpublished opinion, but cited *Tri-Star* because it found the Ninth Circuit’s reasoning persuasive on construing an AIE which was comparable to the one litigated in *Jaynes*.

⁷ See *McMillin Construction Services, L.P. v. Arch Specialty Ins. Co.*, 2012 WL 243321 (S.D. Cal. 2012).

⁸ *St. Paul Fire and Marine Insurance Company v. ACE American Insurance*, 2014 WL 4078660 (E.D. Cal. 2014).



ERISA'S DIMINISHING RIGHT TO DIRECT RECOVERY

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THE LETTER:

Third-party liability insurers (and other clients who actively negotiate or adjust third-party liability claims), are frequently faced with *the letter*. Yes, there are many of *those* letters, but this one is somewhat unique: it is a threatening letter from a subrogation company, claiming to represent an ERISA (Employee Retirement Income Security Act) plan insurer, seeking to recover the cost of medical benefits it paid on behalf of its insured. *The letter* states that the liability insurer must pay the subrogation company directly, or face direct liability even after settling with the third-party. *The letter* often cites a case or two in support of the claim for direct repayment, and will usually excerpt subrogation language from the plan.⁹ *The letter*, however, and the threat of direct liability for value of the lien, appears to have much less “teeth” than it did prior to a series of recent Federal court decisions.

THE LAW:

ERISA-funded insurance plans, unlike Medicare (or even state funded hospitals) do not have statutory rights to direct actions against insurers or third-parties for monies paid out for medical treatment. Up until recently, the ERISA plans would claim that their contractual assignment of benefits from their plan members entitled them to directly assert claims against third-parties for the medical treatment they paid for, claiming that the rights to recovery for the medical bills had been assigned from the plan members to the plan. The argument is that the ERISA plan claims must be settled directly, or the ERISA plan would directly pursue the monies it paid out. The ERISA plan would seek to be paid directly, and not as a part of a general settlement to a third-party. This could and would cause significant challenges when settling third-party claims, often causing delay or even potentially undoing settlements when notification of the ERISA plan's payment was brought to the attention of a carrier *after* a settlement was reached with a third-party. However, recent judicial determinations have called into question the validity of the direct action rights of the ERISA plan – to a point where it is not likely that a direct action could be maintained by the ERISA plan.

Beginning in late 2013 and continuing into 2014, several Federal Courts were presented with cases in which an ERISA qualified insurer claimed that it was entitled to directly recover monies it paid out on behalf of insureds who were also insured or provided coverage by a second insurer.¹⁰ In each case, the courts

⁹ The case often cited to is *Atteberry v. Mem'l-Hermann Healthcare Sys.*, 405 F.3d 344 (5th Cir. 2005), which allowed a plan to assert a claim on behalf of the estate of a deceased plan insured. Even *Atteberry* may no longer be considered good law. Its holding was implicitly (though not explicitly) rejected by the court in *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Health Special Risk, Inc.*, No. 3:11-CV-2910-D, 2013 WL 2656159, at *3 (N.D. Tex. 2013) *aff'd sub nom. Cent. States, Se. & Sw. Areas Health & Welfare Fund ex rel. Bunte v. Health Special Risk, Inc.*, 756 F.3d 356 (5th Cir. 2014), where the Fifth Circuit affirmed a case that held that ERISA plans were limited to equitable claims.

¹⁰ These cases were: *Central States Southeast and Southwest Areas Health and Welfare v. General Life Ins. Inc.*, 984 F.Supp.2d 246 (S.D. N.Y. 2013); *Central States Southeast and Southwest Areas Health and Welfare v. Student Assurance Services, Inc.*, 56 Employee Ben. Cas. 1897 (D.Minn. 2014); *Central States Southeast and Southwest Areas Health and Welfare v. Health Special Risk, Inc.*, 756 F.3d 356 (5th Cir. 2014); *Central States Southeast and Southwest Areas Health and Welfare v. First Agency, Inc.*

found that the ERISA insurer could not recover monies from the insurers because the ERISA statute does not permit the insurers to sue for damages.

The analysis for each of the cases varied slightly but was essentially that, based upon a 1993 U.S. Supreme Court case, the ERISA enabling statute limited the plans' right to recovery. The courts found the ERISA statute to be "carefully crafted and detailed enforcement scheme," that resulted in not only complete preemption of state claims; but also prevented the plans from exercising rights outside of the scope granted by the Congress.¹¹ The courts then looked to the statutory language: ERISA section 502(a)(3), which authorized an ERISA participant, beneficiary, or fiduciary: "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3)(emphasis added).¹²

Because the plans were limited to seeking *equitable relief*, the courts found that the plans could not sue for payment or reimbursement of monies from other insurers because the suits or claims would not be claims for equity – they would be claims for recovery of money. Because the ERISA statute only provided equitable relief, the suits were dismissed.¹³

The plans sought to creatively argue that at the very least there should be a "constructive trust" against monies held by third-parties for the plan beneficiaries. In essence, the third-party liability carrier was essentially holding the monies for the ERISA insurer. However, this argument was generally rejected. The reasons provided from the courts have been varied, including that there is no statutory right for a constructive trust or lien: "ERISA-plan provisions do not create constructive trusts and equitable liens by the mere fact of their existence; the liens and trusts are created by the agreement between the parties to deliver assets."¹⁴ Courts have also found that they cannot impose a constructive trust where there is: (1) no contract between the plan and the recipient; or (2) no identified location of funds – such as account or specified location.

THE TAKEAWAY:

The holdings of the cases appear to severely limit a plan's options for recovery of medical benefits paid – essentially to suit against its insured once payment is recovered. There is a question, however, as to whether plans could conceivably be able to file suit for the imposition of constructive trusts against monies held by third-parties for the benefit of their plan members. This issue is not as clear cut. This area of law is developing and may be subject to modification, although this would most likely require Congressional changes to the ERISA statutes. As noted by the Second Circuit Court of Appeals: "the Supreme Court has made its reading of section 502(a)(3) clear: "[i]t is ... not our job to find reasons for what Congress has plainly

756 F.3d 954 (6th Cir. 2014); *Central States Southeast and Southwest Areas Health and Welfare v. Bollinger*, 2014 WL 3427199 (3rd Cir. 2014); and *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Gerber Life Ins. Co.*, 771 F.3d 150, 159 (2d Cir. 2014).

¹¹ *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993).

¹² "[O]ther appropriate equitable relief" had previously been defined to mean only "those categories of relief that were typically available in equity (not suits for money damages)." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002).

¹³ It deserves stating that ERISA recovery rights are not the same as Medicare reimbursement, which is governed under 45 USC. § 1395y(b)(2)(B)(ii), and does have the right to recover money when a "conditional payment" has been made.

¹⁴ *Gerber supra*, 771 F.3d at 157.

done.” . . . [W]e are bound to apply the law as interpreted by the Supreme Court, hoping that it (and that Congress) will revisit this tangled web sooner rather than later.”¹⁵

In the end, the takeaway is that (in most cases) subrogation for ERISA plans may not be a stumbling block to settlement with third-party claimants. At the very least, based upon these recent Federal cases, there is a good faith basis for liability carriers to resolve claims with the third-parties and direct the ERISA plans to look for recovery from their plan members.

Each and every claim, including ERISA subrogation claims, carries with it a unique set of circumstances and issues. For that reason, it is recommended that liability carriers faced with ERISA plan subrogation strongly consider retention of legal counsel for evaluation of the legal effect of both Federal and state statutes upon the claims being asserted therein.

CAVEAT: THE FOREGOING DOES NOT CONSTITUTE LEGAL ADVICE. PLEASE CONSULT AN ATTORNEY FOR INDIVIDUAL ADVICE REGARDING INDIVIDUAL SITUATIONS.

¹⁵ *Id.*, 771 F.3d at 159.



AN INSURER'S FAILURE TO TIMELY RESCIND A POLICY *AB INITIO* CAN MEAN WAIVER OF ITS COVERAGE DEFENSES

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Query: When does acting correctly result in a big mistake?

Answer: When other correct actions are not done timely, or not done at all, and the resulting prejudice results in a waiver of one's legal rights.

That was the ruling in *DuBeck v. California Physicians Service*,¹⁶ a March 2015 published opinion by the California Court of Appeal. Therein lies a warning for the tardy, non-diligent insurer.

In October 2004, Bonnie DuBeck accidentally injured her left breast and developed a lump. In February 2005, she visited a medical center where she underwent a biopsy and scheduled further testing. The lump was determined to be cancerous. Ms. Dubeck underwent months of surgical and other medical procedures for breast cancer and leukemia.

Five days after Ms. Dubeck's first visit to the medical center, she applied for health insurance through Blue Shield. The application contained a series of detailed questions about whether she had ever treated for, or had any symptoms, pertaining to breast problems. She checked "no" to all the questions. She stated her last medical visit occurred in September 2004 and described her present status as "great." Above her signature was the following statement:

I alone am responsible for the accuracy and completeness of the information provided on this application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be canceled or rescinded upon such a finding.

Blue Shield issued the policy effective April 1, 2005. It contained cancellation and termination provisions. Approximately 17 months later, Blue Shield sent Ms. DuBeck a cancellation notice based upon a determination that she had committed material misrepresentations in the insurance application. The notice stated further that the policy was not being rescinded, and that it was being cancelled only prospectively, so that any claims incurred prior to the date of cancellation would be honored.

Ms. Dubeck initiated coverage litigation against Blue Shield because, prior to issuance of the cancellation notice, it had rejected some claims she had submitted based upon her pre-existing medical condition. She therefore reasoned that Blue Shield had continued to collect premium payments from her despite its actual or constructive knowledge about her breast cancer condition more than a year before cancelling the policy. The operative complaint asserted causes of action for Breach of Contract, Violation of the Covenant of Good Faith and Fair Dealing, and Intentional Infliction of Emotional Distress.

¹⁶ *DuBeck v. California Physicians' Service*, 234 Cal.App.4th 1254 (2015).

Blue Shield's answer asserted an affirmative defense that the policy was subject to rescission based on the material misrepresentations in her insurance application, which rendered the policy void *ab initio*. Blue Shield moved for summary judgment on that defense. The trial court ruled in favor of Blue Shield, and Ms. DuBeck appealed.

The Court of Appeal agreed with Ms. DuBeck. By waiting a year to cancel the policy and not electing to rescind the policy instead, Blue Shield's actions were deemed inconsistent with the right to rescind. Accordingly, Blue Cross was found to have waived its rescission rights by not acting more quickly.

California law entitles an insurer to rescind a policy when the insured has misrepresented or cancelled material information in the policy application. Such a rescission acts retroactively to cancel the policy back to Day One. However, California Civil Code Sections 1691 and 1693 mandate that a party must effect a rescission promptly upon discovering facts which entitle that party to rescission. A delay in seeking the right to rescind may result in forfeiture of that right where the delay results in prejudice to the other party, including the insurance context.¹⁷

Had Blue Shield asserted a right to rescind in 2006, Mrs. DuBeck would not have been forced to pay more premiums or incurred the effort and expense to enforce claims which the cancellation letter said would have been honored. Furthermore, Blue Shield should have initiated its coverage investigation sooner, once it first knew about her medical condition. As the Court explained:

[A]n insurer could not rely on misrepresentations in an insurance application to avoid liability where the misrepresentations were contradicted by other information known to the insurer when it issued a policy. [Citation.] . . . "The [facts known to the insurer] should have put the underwriter on notice that the application form was incomplete and inaccurate in material respects. By failing to request additional information from [the doctors who examined the applicant] the insurance company waived any misstatements or concealments which subsequently appeared to exist in the application." [Citations.]¹⁸

Hence, the insurer did the correct thing by seeking to cancel the policy, according to the cancellation and termination provisions in the policy. However, the insurer erred by not investigating the underlying facts more diligently, by denying claims despite promising to honor them, and by not rescinding the policy timely. All these actions caused prejudice to the insured, something that the Court of Appeal refused to condone.

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¹⁷ *DuBeck*, supra 234 Cal.App.4th 1254, 184 Cal.Rptr.3d 743, 750-751 [and cases cited therein].

¹⁸ *Id.*, 184 Cal.Rptr.3d at 762-753.