Hot Topics in Construction Defect Litigation and Related Insurance Coverage Issues

Presented by the State Bar of Nevada's Construction Law Section

Written Materials for the Afternoon Insurance Coverage Panel

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INTRODUCTION

This article is submitted in conjunction with the afternoon session of a seminar entitled, ***Hot Topics in Construction Defect Litigation and Related Insurance Coverage Issues***, presented by the State Bar of Nevada's Construction Law Section on October 19, 2010 in Reno, Nevada and on October 20, 2010 in Las Vegas, Nevada.

The material describes various types of insurance products used in the construction industry, including a detailed discussion of the components of occurrence-based Commercial General Liability, or CGL policies. The discussion of CGL policies focuses on those provisions relating to liability coverage for third party claims alleging property damage.

In addition to outlining the case law rules regarding various CGL policy provisions, including insuring agreements, exclusions, conditions, etc., this article discusses current issues relating to an insurance carrier's duty to defend, such as the defense of pre-lawsuit proceedings, carrier claims for reimbursement of non-covered defense costs, and the right to independent counsel.

CONSTRUCTION RELATED INSURANCE PRODUCTS

This section of the article describes various types of insurance products used in the construction industry.

Performance Bond

A performance bond is a bond issued by an insurance company to guarantee that contractors will complete a project as specified under the terms of their contract. The purpose of the bond is to guarantee the value of a contractor's work and provide debt security in case an unexpected event arises.

For example, if a subcontractor agrees to pour concrete for a construction project but is unable to complete its work, a performance bond executed in favor of the general contractor would ensure timely and satisfactory completion of the work to contract specifications by another subcontractor. See Zuni Constr. Co. v. Great Am. Ins. Co., 86 Nev. 364 (1970).

THE BASIC TYPE OF INSURANCE MOST CLOSELY ASSOCIATED WITH CONSTRUCTION DEFECT LITIGATION IS COMMERCIAL GENERAL LIABILITY INSURANCE

Payment Bond

A payment bond is a type of insurance purchased by a builder that protects both the bank and the owner by providing that the insurance company will be responsible for payments due to laborers and other parties who provided services for the construction project.

Builder's Risk

Builder's risk insurance is a type of first-party property insurance usually purchased by the owner or general contractor to protect a construction project while it is under construction. Builder's risk insurance provides coverage for physical loss or damage to the insured's property during the construction period when caused by a covered event, such as fire, vandalism, wind, etc. Coverage typically extends through the construction period only and is replaced by either a commercial property policy (if the project is a commercial building) or a homeowner's policy (if the project is residential). This type of insurance generally does not provide coverage to subcontractors.

Commercial General Liability

The basic type of insurance most closely associated with construction defect litigation is commercial general liability insurance, commonly referred to as a "CGL policy." CGL policies provide insurance coverage for the legal liability of those entities and persons who qualify as insureds.

CGL policies provide two primary benefits: defense and indemnity. The defense benefit provides the insured entity or person, sometimes referred to herein as the policyholder, with a legal defense at the insurance carrier's expense. The indemnity benefit provides the policyholder with insurance protection for certain types of civil judgments and settlements to which the insurer consents. The contractual language in CGL policies place limitations on both the defense and indemnity benefits.

Owner Controlled Insurance Program

Owner Controlled Insurance Programs, also known as OCIPs or wrap-up policies, are insurance policies procured by the owner, developer or general contractor of a construction project. Instead of each individual contractor and subcontractor securing its own liability insurance, worker's compensation insurance, etc. for the project, the policyholder secures an OCIP that covers all construction and contractors on the project.

An OCIP's basic features are: (1) insurance coverage covering all contractors and subcontractors on a project; (2) an integrated owner-contractor managed safety program on the construction project; and (3) central processing of claims.

By utilizing an OCIP, owners may be able to save money on their construction projects. Because the owner pays for an insurance policy that covers the project's contractors, each contractor is expected to submit a lower bid. In essence, the owner is credited back the cost of the insurance that the contractor would normally include in the bid as overhead costs. Additionally, users of OCIP can save money on large projects through lower bulk insurance rates, improved safety management processes, and reduced disputes between contractors concerning who is responsible for a loss.

Excess and Umbrella

The terms "excess" and "umbrella" are often used to characterize insurance policies that provide additional coverage, beyond primary policies.

Generally, excess insurance provides coverage identical to an underlying primary policy, but requires the exhaustion of all primary coverage before its benefits are triggered. For example, an excess policy can provide an additional five million dollars of coverage, but only after the primary policy's limit of one million dollars is exhausted. Such policies often follow the form of the underlying primary insurance—that is, the excess policy's terms and limitations are the same as or identical to the terms and limitations in the primary policy.

Umbrella policies also provide additional coverage after all underlying primary policies have been exhausted. Depending on the policy's terms, umbrella policies may also provide coverage for losses that are not otherwise covered by the policyholder's primary policies.

Errors and Omissions

Errors and omissions insurance, also known as professional liability insurance, provides coverage to professionals, such as architects, against third-party claims arising out of the alleged mistakes of the policyholder, its employees, or independent contractors. This type of coverage is important in that many standard CGL policies exclude coverage for claims arising out of an insured's professional services.

Errors and omissions insurance may also be relevant if a policyholder's insurance broker neglected to properly procure insurance. For example, if the policyholder instructs its insurance broker to add a general contractor as an additional insured, but the broker only procures a certificate of insurance, the broker may be sued for this mistake. This type of negligence claim may be covered by the broker's errors and omissions insurance.

Fronting Policy

A fronting policy is an insurance policy where the insured pays a reduced premium for an insurance policy with a large deductible, usually equal to the policy's limits of liability. Additionally, an insured may agree to indemnify the carrier for any potential defense and indemnity costs the carrier expends because of its obligations under the insurance policy.

This type of policy is commonly used when an entity would like to insure itself, but cannot legally do so. For example, if an entity is contractually obligated to carry insurance, a fronting policy satisfies such a requirement because the insurance company is responsible for paying a loss covered by its policy. Additionally, this type of policy satisfies the policyholder's interest in self-insuring because the insurance company will recoup all its costs either through deductibles or indemnification paid by the policyholder.

Risk Retention Groups

A risk retention group is an alternative risk financing tool in which similar businesses join together to share risks. These groups are controlled by their members and usually employ a regimented loss control and claims management process.

Self-Insurance Programs

In a self-insurance program, an entity sets aside a particular amount of money each month to cover the costs of a potential claim, instead of paying premiums for insurance. These programs can either be kept in-house or through a third-party administrator. A self-insurance program enables the entity to become its own insurer: it retains control over the claims and expenses, but is also exposed to greater risk than if insured by a carrier.

INSURED QUALIFICATION

This section of the article addresses insurance policy provisions relating to who qualifies as an insured under a CGL policy. In the context of construction litigation, the most common issue involves whether the developer or general contractor qualifies as an additional insured under the policies issued to downstream subcontractors.

Additional Insured Endorsements

An additional insured endorsement generally amends Section II of a standard form CGL policy. Section II of a CGL policy describes those entities and persons who qualifies as insureds. Typically, the endorsement specifically schedules a particular entity or person, along with language that describes the extent of coverage available to that scheduled entity or person.

Additional insured endorsements, or "AIE's," usually are pre-printed forms; however, many different versions exists, and each must be separately analyzed based on its specific language.

Recently, the Nevada Supreme Court addressed various issues relating to an additional insured endorsement in the decision styled Fed. Ins. Co. v. Am. Hardware Mut. Ins. Co., 184 P.3d 390 (Nev. 2008).

In Federal Insurance, a maintenance company's employee sued a wine company for injuries sustained on the wine company's premises. Based upon an endorsement naming the wine company as an additional insured under the maintenance company's policy, the wine company sought coverage from the maintenance company's insurance carrier. The additional insured endorsement at issue provided that the wine company was an insured but only for losses "arising out of the [maintenance company's] ongoing operations performed for [the wine company]." The maintenance company's carrier refused to defend the wine company against the suit, on the grounds that the endorsement's coverage did not extend to the wine company's direct acts of negligence.

The Nevada Supreme Court rejected this argument, holding that the additional insured endorsement "includes coverage for liabilities caused by the additional insured's direct negligent acts, so long as those acts are connected to the named insured's operations performed for the additional insured." Id. at 396-397. The court based its decision on the finding that the additional insured endorsement was ambiguous. Namely, the additional insured endorsement was unclear as to whether the additional insured's fault altered the coverage provided under the endorsement. Id. at 392-393. Because there was no evidence of the insured's reasonable expectations, the court was forced to exercise its independent judgment based upon traditional rules of contract interpretation. The court therefore found that since the endorsement does not allocate fault, it does not preclude coverage for the additional insured's

own negligent acts so long as those acts are connected to the named insured's operations and causally linked to the injury. Id. at 395.

Courts in California have similarly interpreted additional insured endorsements. For example, in Acceptance Ins. Co. v. Syufy Enterprises, 69 Cal.App.4th 321 (1999), a theater hired a contractor to repair its roof. As part of the contract, the contractor agreed to name the theater as an additional insured under the contractor's liability policy. Specifically, the endorsement qualified the theater as an insured, "but only with respect to liability arising out of [the named insured's work] for that insured by or for [the named insured]." Id. at 330.

During the course of the roofing project, one of the contractor's employees sustained severe injuries while climbing through a roof-access hatch. A dispute subsequently arose as to the scope of coverage provided to the theater as an additional insured under the contractor's liability policy.

The California Court of Appeal initially determined that the language "arising out of", as found within the subject endorsement, connotes only a minimal causal or incidental relationship. Applying the facts of the case to the endorsement, the court reasoned that the relationship between the defective hatch and the roofing job was more than incidental because the injured employee could not have done the job without passing through the hatch.

The fact that the defect was attributable to the additional insured's negligence was irrelevant when applying the additional insured endorsement since the endorsement did not discuss fault. Based thereon, the court held that, "[w]hen an insurer chooses not to use such clearly limited language in an additional insured clause, but instead grants coverage for liability 'arising out of' the named insured's work, the additional insured is covered without regard to whether the injury was caused by the named insured or the additional insured." Id. at 330.

Often, an additional insured endorsement specifically identifies or schedules the person or entity who qualifies as an additional insured. However, insurance carriers often issue additional insured endorsements that do not schedule or identify a specific person or entity, and instead provide blanket coverage for a class of persons or entities that qualify as an "insured" under certain situations.

A typical example of such a blanket additional insured endorsement is where the endorsement extends insured status to anyone for whom the named insured has promised to procure additional insured coverage. In the construction context, this qualification is generally satisfied because most general contractors insert boilerplate language into subcontract agreements whereby the subcontractor promises to procure additional insured coverage for the general contractor. However, a general contractor's failure to properly follow through with subcontractors or maintain proper records can result in the inability to establish its status as an additional insured.

In a recent Florida case, a general contractor sought coverage pursuant to an additional insured endorsement on its subcontractor's policy. Rolyn Companies, Inc. v. R & J Sales of Texas, Inc., 671 F.Supp.2d 1314 (S.D. Fla. 2009). The policy defined additional insured as "a contractor on whose behalf you [the named insured] are performing ongoing operation, but only if coverage as an additional

insured is required by a written contract or written agreement that is an 'insured contract'..." The subcontractor's policy defined "insured contract" as "[t]hat part of any other contract or agreement pertaining to your business ... under which you assume the tort liability of another party to pay for ... 'property damage' to a third person or organization."

The court evaluated whether the provisions of the additional insured endorsement had been satisfied, but found that they had not. Specifically, the general contractor was unable to produce a written agreement reflecting the subcontractor's written promise to both procure additional-insured coverage and to assume the general contractor's tort liability. Id. at 1335-6. The court ultimately concluded the general contractor did not qualify as an insured under the subcontractor's policy.

Certificates of Insurance

Certificates of insurance are common in the insurance industry. General contractors routinely require their subcontractors to procure various types of coverage before commencing work. Additionally, general contractors often require that the subcontractor obtain an additional insured endorsement naming the general contractor. Accordingly, a subcontractor will typically obtain a certificate of insurance from their insurance broker, and then present it to the general contractor to demonstrate that the required insurance is in place.

PROBLEMS OFTEN ARISE WHEN THE GENERAL CONTRACTOR IS IDENTIFIED ON A CERTIFICATE OF INSURANCE AS AN ADDITIONAL INSURED, BUT THE ACTUAL INSURANCE POLICY ISSUED TO THE SUBCONTRACTOR DOES NOT NAME THE GENERAL CONTRACTOR AS AN ADDITIONAL INSURED.

However, after obtaining the required certificates, subcontractors often neglect to follow up with or instruct their broker to arrange for the issuance of an additional insured endorsement. Consequently, problems often arise when the general contractor is identified on a certificate of insurance as an additional insured, but the actual insurance policy issued to the subcontractor does not name the general contractor as an additional insured. This type of situation creates a serious issue as to whether the subcontractor's insurance policy provides coverage to the general contractor.

The term "certificate of insurance" refers to a standard, pre-printed form that describes one or more insurance policies in effect as of the date of the certificate. Such certificates typically set forth the name of the insurance carrier; the types of insurance coverages and policies; the policyholder's name; and the policy limits. Certificates of insurance also routinely identify the entity that issued the certificate—typically, the policyholder's insurance broker—and the entity or person for whom the certificate is issued, commonly referred to as the "certificate holder."

The certificate does not ordinarily create any contractual rights in the certificate holder under the liability policies set forth within the certificate. Rather, it is a convenient method for proving the ex-

istence of one or more insurance policies. See Empire Fire & Marine Ins. Co. v. Bell, 64 Cal.Rptr.2d 749, 757, fn. 25 (Cal. App. 1997). ("A certificate of insurance is merely evidence that a policy has been issued. It is not a contract between the insurer and the certificate holder." (citations omitted)) Thus, while a certificate of insurance is a quick and easy way to demonstrate that insurance is in place, it usually does not function to independently provide coverage where the certificate holder is not formally added as an additional insured under the insurance policy identified on the certificate.

Notwithstanding, there are situations in which a certificate of insurance has operated to provide additional insured coverage for the certificate holder. Although Nevada case law appears to be silent on the matter, in California, a certificate of insurance issued with an insurance carrier's actual or apparent authority may provide additional insured coverage, even if an additional insured endorsement was never scheduled or affixed to the subject insurance policy.

In American Casualty Company of Reading, Pennsylvania v. Krieger, 181 F.3d 1113 (9th Cir. 1999), a certificate holder alleged that he was an additional insured because the certificate was issued with the insurance carrier's authority. A district court found that the certificate holder was not an additional insured and the certificate holder appealed. Because there was no evidence indicating that the certificate was issued by an entity with actual authority from the insurance carrier, the question presented on appeal was based upon the issuing agent's ostensible, also known as apparent, authority.

The Ninth Circuit, applying California law, found that there was evidence indicating that the insurance carrier knew about the certificate of insurance naming the certificate holder as an additional insured, both before and after it was issued to the certificate holder. Therefore, the court found that there was a question of fact regarding whether the broker who issued the certificate was the insurance company's ostensible agent.

The court in MV Transportation, Inc. v. Omne Staff Leasing Inc., 378 F.Supp.2d 1200 (E.D. Cal. 2005) was presented with a similar question regarding whether a certificate of insurance was issued with the requisite authority necessary to make the certificate holder an additional insured. However, in this case, the certificate holder failed to present evidence demonstrating that the certificate of insurance scheduling it an additional insured had been issued with actual or ostensible authority. Thus, the court found in favor of the insurance carrier.

In practice, if a certificate holder is not successful in asserting that it is an additional insured based upon a certificate of insurance alone, the certificate holder's best recourse may be to sue the entity that promised to name it as an additional insured. For example, if a general contractor was supposed to be named as an additional insured under a subcontractor's policy, but was not, the general contractor's could sue the subcontractor for breach of contract.

Although an insured may be able to file an action against its broker for failing to procure the requisite insurance, the certificate holder may not have the same right. See Benjamin Shapiro Realty Company LLC v. Kemper National Insurance Companies, et al., 303 A.D.2d 245 (N.Y. App. 2003) (holding broker was not liable to certificate holder because 1) there was no contractual relationship between

the parties and 2) a certificate of insurance containing disclaimers that they are for information only cannot "be used as predicates for a claim of negligent misrepresentation") and Western Leasing, Inc. v. Acordia of Kentucky, Inc., 2010 WL 1814959 (Ky.App.) (holding broker was liable to certificate holder because 1) broker owed a duty to certificate holder to whom it delivered the certificate and 2) the certificate's disclaimer language did not foreclose the justifiable reliance of the certificate holder).

INSURING AGREEMENT

Overview

For purposes of construction defect litigation, the most important benefit under CGL policies is coverage for property damage liability.

The insuring agreement for Coverage A, Bodily Injury and Property Damage Liability provides, in pertinent part, as follows:

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result…

b. This insurance applies to "bodily injury" and "property damage" only if:

(1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory";

(2) The "bodily injury" or "property damage" occurs during the policy period...

* * *

As explained below, the insurance protection afforded under CGL policies is generally limited to those damages for which the policyholder becomes legal liable because of property damage sustained during the policy period as a result of an accident.

Property Damage

In determining whether the "property damage" requirement is met, courts look to whether a third party's claim against the policyholder seeks to impose legal liability for damages because of "property damage."

The term damages, which is not defined in CGL policies, has generally been interpreted to mean a money judgment awarded in a civil court to compensate a third party's liability claim for a past loss. The term damages does not include a monetary award intended to prevent future losses. Crystal Bay

Gen. v. AETNA Cas. & Sur. Co., No. 90-16417, 1992 WL 98269 (9th Cir. Apr. 7, 1992) (holding that construction of sewer bypass does not constitute "damages" because "there was no evidence that it would remedy damage caused by [the sewage spill]. Rather, the bypass was a prophylactic measure designed to prevent future spills.") A liability policy's coverage also does not include other forms of judicial relief, such as restitutionary relief, injunctive relief, or declaratory relief.

Thus, courts generally seek to determine whether the complaining party seeks an award of money damages because of previously-sustained "property damage." In the context of construction defect litigation, the existence or absence of "property damage" is often clear. In some instances, however, issues may arise as to whether the complaining party is seeking damages because of "property damage." CGL policies currently define "property damage" as follows:

"Property damage" means:

a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or

b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.

* * *

Most published case law interpreting the term "property damage" focuses on Part a. of the definition—namely, physical injury to tangible property.

To constitute "property damage," the damage must be to tangible property that can be seen or touched. "Property damage" does not include damage to intangible property such as goodwill, licenses, leaseholds, easements, patents, copyrights or trade secrets, and claims for economic losses or lost profits. Kazi v. State Farm Fire & Cas. Co., 24 Cal.4th 871 (2001) (neighbor sued insured to enforce an easement across the insured's real estate; held, the damages claimed were not "property damage" because an easement is not tangible property- it represents only a nonpossessory right to use another's property).

Recently, one court found that a permeating odor may constitute "property damage." In Essex Ins. Co. v. Bloomsouth Flooring Corp., 562 F.3d 399 (1st Cir. 2009), a subcontractor installed carpet in a commercial building under renovation. After the carpet's installation, an odor described as that of a locker room, playdough, or sour chemicals permeated the building. Some individuals exposed to the odor complained of headaches and other "ill effects." The First Circuit, predicting how the Massachusetts Supreme Court would rule, concluded that under Massachusetts law, odor may constitute physical injury to tangible property under certain circumstances. Id. at 406. In support of its decision, the court noted that two state court cases had found "physical loss" under property insurance policies for carbon-monoxide contamination and oil fumes.

Another court, applying the law of Vermont, found the change in the appearance of a residence may also constitute "property damage." In Fine Paints of Europe, Inc. v. Acadia Ins. Co., No. 2:08-CV-81, 2009 WL 819466 (D. Vt. Mar. 24, 2009), the insured sold defective paint that later exhibited cracking, chipping, peeling, loss of adhesion, and separation from the primer. The court held that tangible property suffers "physical injury," as used in a CGL policy's definition of "property damage," where the property is altered in appearance, shape, color, or in some other material dimension. The court therefore concluded that a "claim based on defective paint that was applied to the exterior [of a residence] and materially altered the appearance of the property by cracking, peeling and separating comes within the insuring agreement's definition of property damage." Id. at *5.

Case law is relatively spares as to Part b. of the "property damage" definition—namely, loss of use of tangible property that is not physically injured.

In one duty-to-defend case, a federal district court, applying Colorado law, relied upon Part b. of the "property damage" definition where the subject property had not clearly sustained any physical injury. In American Family Mut. Ins. Co. v. Teamcorp., Inc., 659 F.Supp.2d 1115 (D. Colo. 2009), the court focused on allegations that the structure would have to be torn down due to (i) a violation of height restrictions; (ii) improper location on the lot; and (iii) improper pouring of the foundation. The court noted that the insured's alleged faulty plans and specifications caused "actual consequential damages to the entire structure that require it to be rebuilt." The court reasoned that, even if the complaint alleges no physical injury, those allegations constitute "loss of use of tangible property," and therefore satisfied the second part of the definition of "property damage." Id. at 1130.

Notably, it appears that this type of pure "loss of use" property damage is no longer a part of the definition of "property damage" in some of the policy forms being sold to developers and contractors doing business in Nevada.

Occurrence

In addition to determining whether a claim involves "property damage" sustained during the policy period, it must be established that the "property damage" or "bodily injury" resulted from an "occurrence." CGL policies define "occurrence" to mean an "accident, including continuous or repeated exposure to substantially the same general harmful conditions."

Courts have historically approached the "occurrence" requirement differently depending upon the factual context and the judicial nuances reflected in the case precedent. Some courts determine whether the cause of the "property damage," such as the original liability-producing act or omission, was accidental. Other courts also look to whether the insured expected or intended the resulting "property damage," even if the original act was deliberate, non-accidental conduct. And several jurisdictions evaluate the "occurrence" requirement in terms of the nature of the insured's liability—namely, contractual versus tort liability.

The Nevada Supreme Court has explained that an "occurrence" is a "happening that is not expected, foreseen or intended." United Nat'l Co. v. Frontier Ins. Co., Inc., 120 Nev. 678 (2004). For example, a sewage spill constitutes an "occurrence" because it is sudden and unexpected. Crystal Bay Gen., supra, 1992 WL 68269. Nevada law, as interpreted by the United States District Court, has found that water intrusion qualifies as an accident and, thus, an occurrence. Gary G. Day Constr. Co. v. Clarendon Am. Ins. Co., 459 F.Supp. 2d 1039 (D.Nev. 2006) (interpreting policy language that differs from standard CGL form's language).

The California Supreme Court has held that "the word 'accident' in the coverage clause of a liability policy refers to the conduct of the insured for which liability is sought to be imposed on the insured." Delgado v. Interinsurance Exchange of Automobile Club of Southern California, 47 Cal.4th 302, 314-315 (2009). The Delgado court explained that "an injury-producing event is not an 'accident' within the policy's coverage language when all of the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor." The Delgado court also noted that courts in a variety of contexts have "rejected the notion that an insured's mistake of fact or law transforms a knowingly and purposefully inflicted harm into an accidental injury."

Nationally, a split of authority exists as to whether or not faulty workmanship constitutes an "occurrence."

Recently, a California intermediate appellate court focused on the insured's intent to commit the liability-producing act, i.e., building a house, rather than the resulting damage caused by his unintentional encroachment. In Fire Ins. Exch. v. Sup. Ct., 104 Cal.Rptr.3d 534 (Cal. Ct. App. 2010), a homeowner built a home that encroached upon his neighbor's property, mistakenly believing he owned the subject disputed portion of the property. The court, focusing on the insured's intent to build the structure, concluded that the homeowner's actions did not constitute an "occurrence." Id. at 540-541. The court reasoned that "the insured intended all of the acts that resulted in the victim's injury," and therefore, "the event may not be deemed an 'accident' merely because the insured did not intend to cause injury." Id. at 537.

Nationally, a split of authority exists as to whether or not faulty workmanship constitutes an "occurrence." A majority of courts hold that defective workmanship, standing alone, is not an "occurrence," whereas a minority of courts find that faulty workmanship is an "occurrence." Under the majority view, faulty workmanship constitutes an "occurrence" only if something other than the insured's own work product sustains physical injury, such as a third party's personal property or non-defective work product. As recently explained by one court applying Georgia law, "while construction defects constituting a breach of contract are not covered by CGL policies, negligently performed faulty workmanship that damages other property may constitute an 'occurrence' under a CGL policy." Hathaway Dev. Co., Inc. v. American Empire Surplus Lines Ins. Co., 686 S.E.2d 855, 860 (Ga. Ct. App. 2010).

Trigger of Coverage

Even if the "property damage" and "occurrence" requirements are satisfied, courts must still determine whether the complaining party sustained "property damage" during the policy period. This requirement is often referred as the "trigger of coverage," i.e., the operative event that must occur during the policy period in order to invoke, or trigger, coverage.

Courts nationwide have generally found that a CGL policy's coverage for "property damage" liability is limited to damage sustained during the effective dates of the policy. The Nevada Supreme Court has held that "a tangible, physical injury" to property must occur during the policy period to trigger coverage under CGL policies. United Nat'l Ins. Co. v. Frontier Ins. Co., 120 Nev. 678 (2008).

In most claims for "property damage," including construction defect disputes, the timing of the damage is fairly clear. In some instances, however, the timing of "property damage" is not so clear. This is because a latent defect may cause damage that first manifests long after it occurred, or the nature of the "property damage" may implicate one or multiple policies. For example, on the one hand, a single event may result in one, immediate injury, such as a nail driven into a hidden waterline. On the other hand, a single event may result in progressively deteriorating injury, such as poorly-installed windows allowing intermittent, continual water intrusion and resulting damages. Or a continuing event may result in one or multiple injuries over a span of time, such as continual leakage of hazardous material.

A body of case law has developed to address these and related issues, especially issues pertaining to whether multiple policies are implicated. A minority of courts apply the manifestation trigger. E.g., Arnett v. Mid-Continent Cas. Co., No. 8:08-CV-2373-T-27EAJ, 2010 WL 2821981 at *7 (M.D. Fla. July 16, 2010) ("Under Florida law, the general rule is that the time of occurrence within the meaning of an 'occurrence' policy is the time at which the injury first manifests itself, that is, the date on which the damage first becomes visible.").

A majority of courts have adopted the injury-in-fact trigger, also known as the actual-injury trigger. E.g., Don's Building Supply, Inc. v. OneBeacon Ins. Co., 267 S.W.3d 20, 22 (Tex. 2008) (holding that "an insurer's duty to defend [is] triggered where damage is alleged to have occurred during the policy period but was inherently undiscoverable until after the policy expired[,]" reasoning that under Texas law, "the key date is when injury happens, not when someone happens upon it."); Montrose Chemical Corp. v. Admiral Ins. Co., 42 Cal.Rptr.2d 324 (1995) (holding that under California law, liability coverage under a CGL policy for "bodily injury" and "property damage" is established "at the time the complaining party was actually damaged.").

It appears that Nevada courts have not yet definitively determined the appropriate trigger for continuous property damage sustained during multiple policy periods. Gary G. Day Constr. Co., supra, (noting that Nevada courts have not adopted either the manifestation theory or the continuous exposure theory in a progressive loss claim).

Determining the appropriate trigger of coverage has a significant impact on construction defect litigation. Consider the following example: water intrusion occurs over the course of three years during which three different CGL policies are in effect. The water causes physical damage to the interior walls, etc., but the property damage does not manifest itself until the third year. Under a manifestation theory, the only triggered policy would be the one in effect during the third year, whereas under the continuous exposure theory, each policy would be triggered because the property sustained physical injury during each policy period.

As noted above, the Nevada Supreme Court has apparently not specifically determined which trigger applies in a progressive loss type claim. Historically, Nevada courts have looked to other states, such as California, on unsettled issues relating to insurance law. Accordingly, we discuss below the basic holding of the Montrose case and some of its implication on liability insurance coverage for construction defect lawsuits.

In 1995, the California Supreme Court issued the seminal opinion, Montrose Chemical Corp. of Cal. v. Admiral Ins. Co., 10 Cal.4th 645 (1995). The court held that CGL policies are triggered at the time the plaintiff is actually damaged, not at the time the accident (or negligent act) causing the damage occurred. More importantly, the court held that, if the damage is progressively deteriorating over multiple policy periods, the property damage may trigger coverage under each policy in effect during those periods.

The significance of Montrose to construction defect litigation is that coverage is not limited to the policy in effect at the time when the precipitating event or condition occurred, or to the policy in effect when the property damage first manifested itself. Moreover, the policy's full limit may be exposed, even if the property damage continues after the policy is terminated. As the California Supreme Court later explained in Aerojet-General Corp. v. Transport Indem. Co., 17 Cal.4th 38, 57 (1997), "[i]f specified harm is caused by an included occurrence and results, at least in part, within the policy period, it perdures to all points of time at which some such harm results thereafter."

Known Losses

The final step in analyzing the insuring agreement of a CGL policy's coverage for "property damage" liability involves determining whether the known-loss provisions apply – namely, whether any qualifying insured knew that "property damage" had occurred, in whole or in part, prior to the policy's inception.

Recent versions of the occurrence-based CGL policy incorporate the known-loss doctrine into the insuring agreement for "bodily injury" and "property damage" liability. The known-loss doctrine

developed in the common law as a "defense to coverage by which insurers are not obligated to cover losses that either are occurring when the coverage is written or already have occurred." Lewis v. Wolter Bros. Builders, Inc., No. 2009AP2037-AC, 2010 WL 1050252 at *4 (Wis. Ct. App. Mar. 24, 2010).

Only a few recent case opinions have addressed the insuring agreement's known-loss provisions. While the case law is still developing, these cases provide insight into how some courts are interpreting this relatively new, standardized language regarding the following issues: (i) the necessary extent of knowledge on the insured's part of pre-policy "property damage"; (ii) who bears the burden of proving the factual predicate for invoking the known-loss provisions; (iii) the degree of specificity to which courts will look at particular items or categories of "property damage"; and (iv) the limited application of the known-loss provisions in the duty-to-defend context.

One court suggested that to apply the known-loss provisions, the insured must subjectively know about both pre-policy "property damage," as well as the probability of being held liable for damages because of that "property damage." Lewis v. Wolter Bros. Builders, Inc., No. 2009AP2037-AC, 2010 WL 1050252 (Wis. Ct. App. Mar. 24, 2010). There, a builder of five homes discovered evidence of water intrusion problems in April 2007. He was eventually sued and sought liability coverage under a policy that had incepted July 2007. The court found that under Wisconsin law,

> For the known loss doctrine to apply under a CGL policy, the insured must know more than the fact that there has been an occurrence that has caused damage to the property of a third party; the insured also must know that it is substantially probable that the insured will be liable for the damage. Id. at *4.

Based on the evidence, including a pre-suit letter from a homeowner expressing an implied threat of litigation, the court found the known-loss doctrine "applies to relieve [the insurance carrier] of the obligation to cover [the insured's] losses." Id. at *4.

An important issue not fully developed in the case law concerns the burden of proof as it relates to the known-loss provisions in a CGL policy's insuring agreement. Under the laws of many states, the policyholder bears the burden of proving a claim falls within the insuring agreement, and if the insured satisfies its burden, the burden of proving the applicability of an exclusion shifts to the insurance carrier. E.g., Aydin Corp. v. First State Ins. Co., 959 P.2d 1213 (Cal. 1998) ("The burden is on an insured to establish that the occurrence forming the basis of its claim is within the basic scope of insurance coverage. And, once an insured has made this showing, the burden is on the insurer to prove the claim is specifically excluded.").

While the known-loss provisions are akin to an exclusionary clause, they are technically part of the insuring agreement, and therefore arguably fall upon the insured to initially establish.

One court, applying Florida law, apparently placed the burden upon the insured to demonstrate he was unaware of pre-policy "property damage." In Arnett v. Mid-Continent Cas. Co., No. 8:08-CV-2373-T-27EAJ, 2010 WL 2821981 (M.D. Fla. July 16, 2010), a home built by the insured sustained multiple items of "property damage." Five different policies were in play. In evaluating the policies'

known-loss provisions, the court looked at each category of damage, as well as the evidence regarding when the insured first knew about each particular category of damage. As to two earlier policies, the court found the insured only knew about certain categories of pre-policy damage, and therefore found the known-loss provisions applied to only those items of damage. As to the third policy, however, the court found that the policy did not provide coverage for the claims alleged because the insured "has not demonstrated that it was unaware of the damage before the effective dates[]" of that policy. Id. at *4. While this opinion is somewhat unclear, and subject to differing interpretations, it appears that the district court may have required the insured to prove his lack of pre-policy knowledge regarding the construction defects.

Few state or federal courts have squarely addressed the known-loss provisions. These recent cases suggest that these provisions will likely have limited application in the duty-to-defend context. This is because, at the time of tender of a construction defect lawsuit, little or no evidence exists concerning whether the insured possessed specific, subjective knowledge of each category of "property damage" before the inception of the CGL policy at issue. Accordingly, it would appear that in most instances, insurance carriers may experience difficulties, at the time of an original tender, in disclaiming a defense obligation based solely on the known-loss provisions.

Supplementary Payments

CGL policies contain supplementary payment provisions that afford various insurance benefits that are outside policy limits. For example, the provisions promise in part that, "We will pay, with respect to any ... 'suit' ... we defend ... [t]he cost of bonds to release attachments, but only for bond amounts within the applicable limit of insurance... [and] ... [a]ll costs taxed against the insured in the 'suit'."

Recently, one court, applying Florida law, found that because an insurance carrier defended the lawsuit, it was required under the supplementary payments provisions to pay the post-trial cost bill, as well as any attachment bonds, "regardless of whether the claims are or are not ultimately covered." Arnett v. Mid-Continent Cas. Co., No. 8:08-CV-2373-T-27EAJ, 2010 WL 2821981 at *12 (M.D. Fla. July 16, 2010).

This holding appears to conflict with a recent holding by a California intermediate appellate court, which found a link between the obligation to pay certain supplementary payments and coverage for the subject claim. State Farm Gen. Ins. Co. v. Mintarsih, 95 Cal.Rptr.3d 845, 852–853 (Cal. Ct. App. 2009) (holding that "any suit we defend" language in supplementary payments provisions does not enlarge the carrier's duty to defend or obligate it to pay "costs taxed against the insured" on claims not potentially covered under the policy); but see Prichard v. Liberty Mut. Ins. Co., 101 Cal.Rptr.2d 298, 313 (Cal. Ct. App. 2000) (holding that insurance carrier's duty to pay taxed costs under supplementary payments provision was a function of carrier's defense obligation, not its indemnity obligation, and thus the carrier was obligated to pay costs whenever it owed duty of defense, independent of whether those costs would otherwise be covered by way of insurer's indemnity obligation).

EXCLUSIONS

Overview of Business Risk Exclusions

In most construction defect disputes, many items of loss will not be within the scope of a CGL policy's liability coverage.

As noted above, some items of loss in a construction defect claim will not fall within the insuring agreement because (i) the item at issue is not physically injured, and therefore does not constitute "property damage," or (ii) the pertinent jurisdiction does not consider an item of loss, such as the insured's faulty workmanship, to be "property damage" even if it has sustained physical injury.

As to those items of loss falling within the insuring agreement, various exclusions for "property damage" will often preclude coverage. These exclusions are commonly referred to as "business risk exclusions." These exclusions generally preclude coverage for risks that are the "normal, foreseeable and expected incident[s] of doing business and should be reflected in the price of the product or service rather than as a cost of insurance to be shared by others." Sterilite Corp v. Cont'l Cas. Co., 458 N.E.2d 338, 343 n.13 (Mass. Ct. App. 1983).

Thus, the risk of replacing and repairing defective materials or poor workmanship stays with the insured because it represents an ordinary cost of doing business. Liability insurance generally only provides liability coverage for damage to property other than the product or work itself. Great Am. Ins. Co. of N.Y. v. Vegas Constr. Co., No. 2:06-cv-00911-BES-PAL, 2007 WL 2375056 (D. Nev. Aug. 15, 2007).

As explained below, the work exclusions generally exclude coverage for damage to the policyholder's work. However, the scope of the pertinent exclusion depends on various factors, including when the damage occured and who performed the work.

Ongoing versus Completed Operations

In determining what items of loss are excluded, it is first important to determine when the property damage for each item occurred. Property damage during ongoing operations is potentially subject to certain exclusionary provisions, whereas property damage sustained after completion of operations is potentially subject to different exclusionary provisions. This determination is important because the exclusions for

IN DETERMINING WHAT ITEMS OF LOSS ARE EXCLUDED, IT IS FIRST IMPORTANT TO DETERMINE WHEN THE PROPERTY DAMAGE FOR EACH ITEM OCCURRED.

property damage during ongoing operations are broader than the primary exclusionary provisions for property damage after completion.

For example, the following two exclusionary provisions apply to property damage sustained during ongoing operations:

> **j. Damage To Property**
>
> "Property damage" to:
>
> …
>
> **(5)** That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or
>
> **(6)** That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.
>
> ...
>
> Paragraph (6) of this exclusion does not apply to "property damage" included in the "products-completed operations hazard".

* * *

Recent decisions have confirmed that Exclusions j(5) and j(6) operate in tandem, excluding coverage for "property damage" arising from ongoing work, but not applying to off-premises "property damage" arising from completed work. Arnett v. Mid-Continent Cas. Co., No. 8:08-CV-2373-T-27EAJ, 2010 WL 2821981 at *6 (M.D. Fla. July 16, 2010); accord, Hathaway Development Co., Inc. v. American Empire Surplus Lines Ins. Co., 686 S.E.2d 855, 863 (Ga.App. 2009) ("[T]he damages occurred after [the plumbing subcontractor] had completed its work and left the job site, and thus (j)(5), excluding coverage for property damage to property on which the insured is 'performing operations,' does not apply.").

Exclusion j(5) applies to real property on which either the named insured or its subcontractors are performing operations. Similarly, Exclusion j(6) applies to any property that must be repaired or replaced if the named insured incorrectly performed work on such property. The term "your work" is defined to include work done on behalf of the named insured.

Thus, as to "property damage" sustained during ongoing operations, coverage is excluded if the work that is damaged is the named insured's work, the work of the named insured's subcontractor, or property on which either the named insured or its subcontractor performed work.

In contrast, property damage sustained after completion of operations is subject to a different exclusion that contains an important exception— the "subcontractor exception." The exclusion for "your work" states as follows:

> l. **Damage to Your Work**
>
> "Property damage" to "your work" arising out of it or any part of it and including in the "products-completed operations hazard."
>
> This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

* * *

As reflected in the second paragraph, Exclusion l. Damage to Your Work does not apply in two situations: (1) if the damaged work was performed by the named insured's subcontractor; and (2) if a subcontractor's work caused the damage, even if the damage is to the named insured's work.

Thus, where the named insured is a general contractor or developer, the subcontractor exception essentially swallows the exclusion, because most, if not all, of the work is performed through subcontractors. Accordingly, in evaluating which work exclusion to analyze, it is necessary to determine whether the particular item of "property damage" at issue was sustained during ongoing operations or after completion of operations.

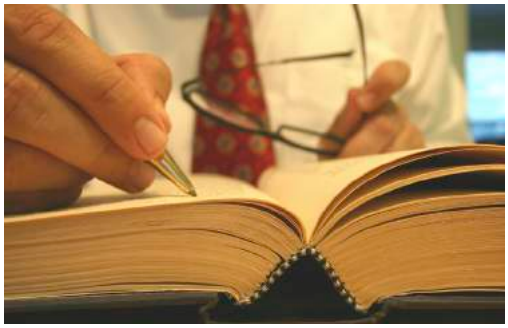
In one recent case, a project was deemed completed for purposes of evaluating liability coverage, even though some components of the project remained incomplete. In Mid-Continent Cas. Co. v. JHP Dev., Inc., 557 F.3d 207 (5th Cir. 2009), a condominium project was left partially unfinished so that the ultimate purchasers of each unit could choose and customize the finishes. During the open-ended suspension of activities by the contractor, the structure sustained water damage. The court decided that "prolonged, open-ended, and complete suspension of construction activities" did not fall within the ordinary meaning of the phrase "performing operations," as used in Exclusion j(5). Accordingly, the court found that Exclusion j(5) did not apply because the insured's operations had ceased for the foreseeable future and were no longer "ongoing." Id. at 213-4.

In another case, "property damage" that first appeared after completion of operations was found to be subject to Exclusion j(6). In Acadia Ins. Co. v. Peerless Ins. Co., 679 F.Supp 229 (D. Mass. 2010), the insured was hired to perform extensive renovations, including the removal, storage, and reinstallation of certain antique wood fixtures. A few months after reinstallation, the woodwork exhibited signs of cracking, shrinking, and separation. Ultimately, it was shown that the wood's damage arose out of excessive moisture during the storage and installation process. The court found that Exclusion j(6) "turns on when the insured actually inflicted the damage." Because the insured had "caused damage ... while conducting its storage and installation operations," the court found that Exclusion j(6) applied to the damaged woodwork. Id. at 244.

Interpretation of the Phrase "That Particular Part"

The most heavily litigated issue with respect to Exclusions j(5) and j(6) involves the meaning of the key phrase, "that particular part."

In Georgia, the Court of Appeals found the phrase, "that particular part," did not refer to the entire construction project. Instead, it applied only to the location and operation that the subcontractor was engaged in at the time the property sustained damage. In Transportation Ins. Co. v. Piedmont Constr. Group, LLC, 686 S.E.2d 824 (Ga. Ct. App. 2009), a plumbing subcontractor, while soldering copper pipes, negligently ignited a fire causing substantial damage to the building. In determining what constituted "that particular part," the appellate court framed the issue as whether "the payment of insurance proceeds effectively cause an insurance company to guarantee the contractor's work?" The court found that, although coverage was precluded for the damage to the room in which the subcontractor had negligently ignited the fire, Exclusions j(5) and j(6) did not operate to preclude coverage for damage to the balance of the building. Id. at 827.



In another case involving a subcontractor, a federal district court, applying the law of Florida, similarly found "that particular part" should be interpreted narrowly to include only the part of the project on which the subcontractor was working when the property sustained damage. In Amerisure Mut. Ins. Co. v. American Cutting & Drilling Co., No. 08-60967-CIV, 2009 WL 700246 (S.D. Fla. Mar. 17, 2009), a subcontractor was hired to cut plumbing access holes into the post-tensioned concrete floors of a construction project. While cutting the concrete, the subcontractor damaged a cable embedded within the concrete. Because the subcontractor was cutting areas of the concrete floor when he inadvertently damaged the embedded cable, the court found that both Exclusions j(5) and j(6) applied to preclude coverage. Id. at 6-7.

However, in cases where a general contractor is the insured, some courts interpret "that particular part" broadly. For example, a federal district court case, applying Massachusetts law, found that "any work or operations performed by [the insured], as the general contractor, necessarily encompassed the [claimant's] home in its entirety[.]" Friel Luxury Home Const., Inc. v. ProBuilders Specialty Ins. Co. RRG, No. 09-cv-11036-DPW, 2009 WL 5227893 at *7 (D. Mass. Dec. 22, 2009). Based upon this reasoning, the court determined that Exclusions j(5) and j(6) precluded coverage for any damage to the home that was caused by the insured's faulty workmanship. Id. at *8; accord, Acadia Ins. Co. v. Peerless Ins. Co., 679 F.Supp 229, 243 (D. Mass. 2010) (holding that Exclusion j(5) "delineat[es] a boundary… between any property on which the insured is in fact conducting operations and any property unrelated to the insured's project that may suffer incidental damage.").

Damage to Your Work

Exclusion l. "Damage to Your Work" precludes coverage for property damage to the named insured's defective or unsatisfactory work if the damage was caused by the named insured's defective workmanship.

For example, if the named insured defectively installs drywall, which allows water intrusion and resulting damage to interior furniture, a liability policy's coverage would extend to the cost of replacing damaged furniture, but not the cost of repairing or replacing the insured's faulty workmanship. McKellar Dev. of Nev., Inc. v. N. Ins. Co. of N.Y., 108 Nev. 729 (1992).

Where, however, the claim involves both covered property damage and non-covered damage or defects, CGL policies may provide coverage for repair and replacement of faulty workmanship in certain circumstances. Lennar Corp. vs. Great Am. Ins. Co., 200 S.W.3d 651, 678 (Tex. App. 2006).

For example, in Lennar Corp., a subcontractor negligently applied stucco to a home, thereby causing water intrusion and resulting wood rot, mold, and termite infestation. The resulting damage was covered, while the defective stucco was not. However, a court found coverage for the stucco removal, because said removal was necessary to access and repair the underlying water damage. The court reasoned that such repair costs were "damages because of property damage," and therefore within the scope of covered damages.

In contrast, the cost to access and repair or replace defective work, without resulting damage to another's property, does not constitute "damages because of property damage." N.H. Ins. Co. v. Vieira, 930 F.2d 696 (9th Cir. 1991).

In Vieira, a general contractor hired a subcontractor to install drywall into a housing project to prevent fire from spreading. The subcontractor failed to properly install the drywall, which increased the project's fire risk and decreased its market value. Other than the diminution in value, the defective drywall did not cause injury to other property. Thus, all damages claimed were to repair or replace the insured subcontractor's defective work—not damage to other property resulting from the named insured's work. The court held that, without physical injury to other tangible property, the claim was not within the scope of coverage under the CGL policy, because all damages will stem from the need to repair or replace the insured subcontractor's defective work.

The subcontractor in Vieira argued that the defective drywall caused damage to other property because holes had to be cut into the ceiling to repair his faulty workmanship. The court rejected this argument, reasoning that "diminution in value and cost of repair are not two separate harms—they are two different ways of measuring the same harm." Because the cost to repair the insured's defective work is not a covered harm, diminution in value resulting from the defective work is not covered either. "[T]he nature of the repairs cannot convert non-covered damage into covered damage." Id. at 701-02.

Contractual Liability

All CGL policies contain exclusions for contractual liability. However, the exclusionary scope does not extend to any type of contractual liability. Rather, the exclusion applies to "bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement.

Such exclusions are subject to a broad exception—namely, the exception for an "insured contract." The exception applies, thereby negating the exclusion, where the contractual assumption of liability meets the definition of an "insured contract." CGL policies define this term to mean a "contract or agreement pertaining to your [the named insured's] business ... under which you assume the tort liability of another party to pay for ... 'property damage' to a third person..."

Traditionally, most indemnity clauses in construction contracts have satisfied the definition of "insured contract," thereby invoking the exception and negating the exclusionary effect of the contractual liability exclusion. In a recent case, however, a Texas intermediate appellate court found the "insured contract" exception did not apply despite a subcontractor's written promise to indemnify the general contractor.

In Century Surety Co. v. Hardscape Constr. Specialties, Inc., 578 F.3d 262 (5th Cir. 2009), a general contractor hired a subcontractor to build a pool. When the pool sustained cracks, water leakage, etc., an issue arose as to whether the contractual liability exclusion in the subcontractor's CGL policy precluded coverage. The subcontractor had agreed to indemnify and hold the general contractor harmless. Citing Texas law regarding the duty to defend, the Fifth Circuit noted that the "insured contract" exception would apply only if the developer's petition made "specific factual contentions that ... could constitute 'a liability ... imposed by law in the absence of any contract or agreement.'" Ultimately, the court found the "insured contract" exception did not apply. The court reasoned that the developer's petition only alleged damage to the pool, i.e., the subject of the contract, and therefore sounded only in contract even though the petition alleged contract and tort theories. Id. at 270.

Thus, if a subcontractor is the named insured under a CGL policy, its liability to the general contractor under the indemnity provisions of the subcontract will generally not be excluded by the exclusion for contractual liability.

It should be noted, however, that the subcontractor's indemnity obligations must still be within the scope of coverage, i.e., damages because of "property damage" sustained during the policy period as a result of an accident. Also, the subcontractor's liability under the indemnity agreement is subject to other policy exclusions, such as the work exclusions previously discussed.

CONDITIONS

CGL policies, like all insurance policies, are subject to conditions. A condition in a contract usually refers to contractual language that imposes certain duties upon the entity or person qualifying as an insured. If the insured entity or person does not comply with the condition, such as the duty to provide prompt notice of claim, the insurance carrier's duty to defend and indemnify may be excused.

TIMELY NOTICE OF A CLAIM OR SUIT IS A CONDITION PRECEDENT TO COVERAGE.

Notice

CGL policies impose upon the named insured a duty to promptly notify the insurance carrier of a potential loss or claim. The notice condition states that "You [the named insured] must see to it that we [the insurance carrier] are notified as soon as practicable of an occurrence or an offense which may result in a claim...". The condition further provides that "If a claim is made or suit is brought against any insured, you must ... Notify us as soon as practicable."

Timely notice of a claim or suit is a condition precedent to coverage. States differ on what legal standard applies to the interpretation and application of the notice clause.

Nationally, a majority of courts require the insurance carrier to show that the policyholder's failure to promptly notify the carrier resulted in actual prejudice. The quantum of prejudice necessary to excuse the insurance carrier from its duties differs somewhat from state to state. It appears, however, that Nevada courts follow the minority approach whereby the insurer need not show actual prejudice before denying coverage: if prompt notice is a condition precedent to coverage, then failure to comply with the notice provision excuses the insurance company's performance. Las Vegas Star Taxi Inc. v. St. Paul Fire & Marine Ins. Co., 102 Nev. 11 (1986); State Farm Mutual Auto Ins. Co. v. Cassinelli, 67 Nev. 227 (1950).

In contrast, an insurance carrier cannot deny coverage under California law unless it shows that the delayed notice actually and substantially prejudiced its defense and resolution of the claim. Hall v. Travelers Ins. Co., 15 Cal.App.3d 304, 308 (1971) citing Billington v. Interinsurance Exchange, 71 Cal.2d 728, 737 (1969) ("[A]n insurer, in order to establish it was prejudiced by the failure of the insured to cooperate in his defense, must establish…if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor.")

In one recent case, a court found that late notice, which deprives an insurance carrier of the opportunity to make pre-trial decisions, constitutes a material breach of the condition, thereby excusing the

insurance carrier's contractual obligations. In Lewis v. Wolter Bros. Builders, Inc., No. 2009AP2037-AC, 2010 WL 1050252 (Wis. Ct. App. Mar. 24, 2010), the insured developer learned in April 2007 that water-intrusion problems existed in five homes. A year later, he received a letter from an aggrieved homeowner threatening litigation. The homeowner eventually filed suit in November 2008, but the developer waited until February 2009 to notify the carrier. Upon finding the April 2007 letter had triggered the insured's duty to notify its insurance carriers "as soon as practicable," the court required the insured to demonstrate the lack of prejudice to the carrier. Under Wisconsin law, prejudice means "a serious impairment of the insurer's ability to investigate, evaluate, or settle a claim, determine coverage, or present an effective defense." Ultimately, the court found that the insurance carrier had sustained prejudice, because critical litigation dates had passed; thereby depriving the carrier of the ability to file amended pleadings, file dispositive pretrial motions, complete discovery, etc. Id. at *4.

Cooperation

All liability policies require the insured to cooperate with the insurer in the investigation, defense, and settlement of a claim.

As a condition of coverage, CGL policies provide that "You [named insured] and any other involved insured must ... [a]ssist us [insurance carrier], upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply."

Case law from states that have evaluated the cooperation clause is not wholly consistent as to whether an insurance carrier must demonstrate prejudiced before its performance under the policy is excused. For example, in New York, the insurer does not have to suffer actual prejudice before disclaiming coverage for lack of cooperation. Allstate Ins. Co. v. United Intern. Ins. Co., 792 N.Y.S.2d 549 (N.Y. App. 2005) However, the Florida case of Arnett v. Mid-Continent Cas. Co., No. 8:08-CV-2373-T-27EAJ, 2010 WL 2821981 (M.D. Fla. July 16, 2010), reveals the rigorous showing some states require before a material breach of the cooperation clause is shown.

In. Arnett, a carrier claimed its insured, a general contractor, had materially breached the cooperation condition after trial by allowing the execution, levy, and public sale of its third party claims against subcontractors. Applying Florida law, the court found a carrier must prove the following to establish a material breach of the cooperation condition: (i) the insured failed to cooperate; (ii) the failure to cooperate constituted a material breach; (iii) the rights of the carrier were substantially prejudiced; and (iv) the carrier exercised diligence and good faith in seeking to bring about the cooperation of the insured. Because the carrier failed to timely reserve its right on the breach-of-condition issue, the court found it was estopped to deny coverage on this basis. Id. at *10-11.

Nevada has apparently not yet addressed the issue of whether substantial prejudice must be shown to excuse the insurance carrier's performance for lack of cooperation. However, most states in the Ninth Circuit require substantial prejudice to be shown. See Schmidt v. Allstate Ins. Co., No. CV 05-00480 DAEKSC, 2007 WL 1430341 (D. Hawai'i May 11, 2007); Clark Equip. Co. v. Ariz. Prop. and Cas. Ins. Guar. Fund, 189 Ariz. 433, 442 (Ct. App. 1997); Estes v. Alaska Ins. Guar. Ass'n., 774 P.2d 1315, 1317-19 (1989); Or. Auto. Ins. Co. v. Salzberg, 85 Wash.2d 372, 377 (1975); State Farm Fire & Casualty Co. v. Miller, 5 Cal.App.3d 837, 840 (1970); Riggs v. N.J. Fid. & Plate Glass Co. of Newark, N.J., 126 Or. 404, 410-11 (1928). For example, in California, a policyholder's lack of cooperation only bars coverage if the insurer shows that, had the policyholder cooperated, there was a "substantial likelihood the trier of fact would have found in the insured's favor." Billington v. Interinsurance Exchange of S. Cal., 71 Cal.2d 728 (1969) ("[I]n order to establish it was prejudiced by the failure of the insured to cooperate in his defense, [the insurer] must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor.")

Voluntary Payments

Generally, someone who is an insured under a CGL policy cannot expect reimbursement for payments made voluntarily and without the insurance carrier's consent. This is because CGL policies contain the following condition: "No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent."

The voluntary payment condition is "designed to ensure that responsible insurance carriers that promptly accept a defense tendered by their insureds thereby gain control over the defense and settlement of the claim." Jamestown Builders, Inc. v. Gen. Star Indem. Co., 91 Cal.Rptr.2d 514 (Cal. Ct. App. 1999). This condition has been interpreted to "protect[ ] against coverage by *fait accompli*[,]" under the rationale that an insured cannot unilaterally settle a claim and thereafter seek coverage unless and until the insured has made a claim against the insurance policy, and the insurance carrier has rejected the claim.

In one recent case, the insured general contractor repaired the interiors of certain structures that had been damaged by the faulty work of its subcontractor. Rolyn Companies, Inc. v. R & J Sales of Texas, Inc., 671 F.Supp.2d 1314 (S.D. Fla. 2009). When its insurance carrier asserted the voluntary-payment condition, the insured argued that in unilaterally making repairs, it had "tried to do the right thing;" that it was mitigating damages; and that it had been forced to make repairs because it was facing "a big lawsuit." Ultimately, the court found the insured's repair costs were "voluntary"—interpreted to mean "acting or done without compulsion or obligation"—because the insured did not show that it had tendered the claim, and that the carrier had either consented to the repairs or declined coverage. Id. at 1328.

Under the laws of some states, the voluntary payment clause does not bar coverage for involuntary payments, or payments by the insured due to circumstances beyond the insured's control. Examples

of involuntary payments are those made as a result of (i) economic necessity (the insured must act immediately to protect its interests); (ii) mistake (the insured is unaware of insurance coverage or of insurer's identity); and (iii) insurer refuses to defend (if insurer denies coverage, insurer may waive "voluntary payment" provision). Insua v. Scottsdale Ins. Co., 104 Cal.App.4th 737, 743–744 (2002) ("[I]f the insured makes no demand to defend, the no-voluntary-payments provision lawfully precludes recovery of pre-tender costs."); Jamestown Builders, Inc. v. General Star Indem. Co., 77 Cal. App.4th 341, 346 (1999); Fiorito v. Sup.Ct. (State Farm Fire & Cas. Co.), 226 Cal.App.3d 433, 440 (1990); Shell Oil Co. v. National Union Fire Ins. Co., 44 Cal.App.4th 1633, 1648 (1996).

Self-Insured Retentions

In addition to a CGL policy's standard conditions, some insurance carriers are issuing policies subject to an endorsed self-insured retention (SIR). Such provisions, which have been described as conditions precedent, set forth a "retention" or "retained limit," which is a sum of loss that is the insured's initial responsibility to satisfy before the insurance carrier's obligations are invoked. Vons Cos., Inc. v. United States Fire Ins. Co., 78 Cal.App.4th 52, 63-64 (Ct. App. 2d 2000); Gen. Star Indem. Co. v. Super. Ct., 47 Cal.App.4th 1586, 1594 (Ct. App.2d 1996).

The language of the SIR controls how it may be satisfied. Some provisions require the insured to pay the retention out of its own pocket. See Vons Cos., supra, 78 Cal.App.4th at 63 n.4 (quoting a SIR stating "[i]n the event there is any other insurance, whether or not collectible, applicable to an 'occurrence,' claim or suit within the Retention Amount, you will continue to be responsible for the full Retention Amount before the Limits of Insurance under this policy apply.").

SIR endorsements can create many practical problems. For example, if a general contractor is facing liability for a continuous loss spanning several years, multiple policies and insurance carriers may be implicated. If only one of the triggered policies is subject to a retained limit, the general contractor may not be motivated or financially able to pay the retained limit. As a result, the general contractor may not satisfy a condition precedent to one of its insurance carrier's contractual obligations. If the carrier who issued the SIR endorsement refuses to participate in the defense and settlement until the retained limit is paid or satisfied, disputes and issues may arise as to how the retained limit can be exhausted and who can do so.

Recently, the California Court of Appeal held that, if an SIR endorsement clearly requires payment only by the named insured, that condition precedent will be enforced as written. In Forecast Homes, Inc. v. Steadfast Ins. Co., 105 Cal.Rptr.3d 200 (Cal. Ct. App. 2010), a developer sought coverage, as an additional insured, under a policy issued to a subcontractor. The subcontractor's policy had an SIR endorsement that specifically required the subcontractor to pay the retained amount, and that expressly disallowed payment by others. In coverage litigation, the developer contended its payment of defense costs satisfied the retained limit. The intermediate appellate court disagreed, finding that the provisions of the SIR endorsement to be clear, conspicuous, and therefore enforceable. Id. at 203.

With respect to determining retained amounts, some retained limits are determined and applied on a "per occurrence" basis. In Liberty Mut. Ins. Co. v. Pella Corp., 631 F.Supp.2d 1125 (S.D. Iowa 2009), a window manufacturer defended multiple class action lawsuits involving defects and resulting damage, incurring over $1 million in defense costs. Its various policies contained retained limits, ranging from $100,000 to $1 million per occurrence. In determining whether the retained limits had been satisfied, a federal district court noted that Iowa had not adopted the majority or minority test for determining the number of occurrences. Id. at 1136. The court therefore adopted the majority "cause" test, holding that all the lawsuits alleged damages arising from a single "occurrence." Specifically, the court reasoned that the cause was "the design, manufacture, and ... sale of a product containing the same latent defect." Id. at 1136. Accordingly, the court found that one payment of the retained limit was sufficient. Ibid.

Other retained limits are applied on a "per claim" basis. As illustrated in a recent case, however, an SIR endorsement may not be enforceable if the term "claim" is deemed ambiguous. In Clarendon America Ins. Co. v. North American Capacity Ins. Co., No. E048176, 2010 WL 2377835 (Cal. Ct. App. June 15, 2010), two insurance carriers embroiled in contribution litigation disputed the meaning of a $25,000 per-claim retained limit that was endorsed on one carrier's policy. The underlying construction defect litigation involved multiple homes in a large residential project. Ultimately, the California Court of Appeal held the insured was only liable to make a single payment of $25,000 for the entire lawsuit. Although the SIR endorsement distinguished between "claim" and "suit," the court found the undefined term, "claim," to be ambiguous, because other policy provisions used "claim" and "suit" synonymously. Id. at 9.

Contractor Warranties

Increasingly, some insurance carriers are issuing policies that impose strict conditions upon building contractors who hire downstream subcontractors. These endorsed conditions—often referred to as contractor warranties or special contractor conditions—are intended to excuse the carrier's contractual obligations unless the insured complies with the terms and conditions therein. Contractor warranties usually require the insured to obtain from each downstream contractor one or more of the following: a hold harmless agreement; a certificate of insurance; or an additional insured endorsement.

Increasingly, some insurance carriers are issuing policies that impose strict conditions upon building contractors who hire downstream subcontractors.

The intent of such endorsed conditions is to shift damages caused by the named insured's subcontractor to that contractor and its insurance carrier. Complying with these procedures affords the named insured and its carrier with additional layers of protection, thereby preserving the named insured's policy limits. However, as a practical matter, some developers, general contractors, and their construction supervisors fail to obtain one or more of these risk-shifting documents from each subcontractor. This may be due to the rush to complete the project on time, sloppy administrative practices and procedures, etc.

In any event, the California Court of Appeal has enforced such conditions where they are conspicuous and clear—at least in the context of contribution litigation between insurance carriers. For example, in North American Capacity Ins. Co. v. Claremont Liab. Ins. Co., 99 Cal.Rptr.3d 225 (Cal. Ct. App. 2009), two carriers sought to allocate a settlement they paid to settle a construction defect suit against their mutual insured. One carrier's policy was subject to a contractor warranty endorsement requiring hold harmless agreements and certificates of insurance. Id. at 229-230. Evidence revealed that the insured failed to obtain the required hold harmless agreements and certificates of insurance from several subcontractors. The court found the contractor warranty endorsement constituted a condition precedent, not an exclusion, because it "impose[d] certain duties on the insured to obtain the coverage provided by the policy." Id. at 290. The court, observing the endorsement was "clear and explicit," held that it "establishes a precondition of coverage as to work done by subcontractors for whom [the insured] failed to secure both a written hold harmless agreement and a certificate of insurance." Id. at 290-291.

POLICY LIMITS

One of the most important issues to evaluate in analyzing an insurance policy is its limits on insurance. Often, this basic step is overlooked at the initial stages of a construction defect lawsuit. It is important to understand the nature of each policy limit, as well as the extent to which one type of policy limit functions in relation to another type of policy limit. In order to understand policy limits, it is also important to understand the function of deductibles and self-insured retentions.

General Aggregate Limit

The General Aggregate Limit is the maximum amount the insurer will pay in a single policy period for all damages because of bodily injury or property damage, except damages paid for bodily injury or property damage sustained after completion of operations. The general aggregate is a separate source of funds. However, the general aggregate may not apply to many construction defect lawsuits because most such lawsuits concern only property damage sustained after completion of operation.

Completed Operations Aggregate Limit

The Completed Operations Aggregate Limit, which is also a separate source of insurance funds, is the maximum amount the insurer will pay under a CGL policy for property damage sustained after completion of operations. In order to determine if this limit applies, one must analyze whether the claim for property damage falls within the "products-completed operations hazard." Generally, a claim will fall within this hazard, which is specially defined in CGL policies, if the property damage occurs away from the named insured's property and arises from the named insured's completed work.

Each Occurrence Limit

The Each Occurrence Limit is the maximum amount the insurer must pay for each separate "occurrence" of "property damage." Notably, this limit is not a separate source of insurance funds. Rather, it functions as a ceiling for damages resulting from one "occurrence." Thus, the Each Occurrence Limit places a cap on the amount of funds available under a policy's other sources of funding, such as the General Aggregate Limit and the Completed Operations Aggregate Limit.

For example, if the Each Occurrence Limit under a CGL policy is one million dollars, and the Completed Operations Aggregate Limit is two million dollars, an insurance carrier's liability for damages will be limited to one million dollars where the damages stem from one "occurrence." If the carrier pays one million dollars to settle a claim or satisfy a judgment, one million dollars will remain available under the Completed Operations Aggregate Limit for future claims.

Disputes often arise as to whether a particular claim or related claims result from one or multiple occurrences. If a policyholder can successfully argue that the lawsuit involves multiple occurrences, it may be entitled to amounts in excess of the Each Occurrence Limit. In a construction defect lawsuit involving multiple homes, plaintiffs, and items of property damage, an insured contractor or developer may be able to fashion arguments that the claim involves multiple occurrences. Chu v. Canadian Indemnity Co., 224 Cal. App. 3d 86, 274 Cal. Rptr. 20 (4th Dist. 1990), opinion modified, (Oct. 5, 1990) (insured contractor sought liability coverage for certain specific construction defects discovered after condominium units were sold, despite having knowledge of numerous and pervasive defects in the property when the property was sold; held, knowledge of one construction defect is not the equivalent of knowledge of other distinct defects, thereby implying that each category of defect or damage constitutes a separate "occurrence" triggering per occurrence policy limits and deductibles); Gary G. Day Construction Company, Inc. vs. Clarendon America Ins. Co., 459 F.Supp.2d 1039 (D.Nev. 2006) (framing contractor named in lawsuit involving defects in 53 homes sought coverage under non-standard policy containing "deemer" clause and requiring both the "occurrence" and the first instance of "property damage" be within the policy period; held, "[T]he Court must determine whether both the 'occurrence' and the first instance of 'property damage' in each individual home took place during the relevant dates of the Policy.").

In evaluating the multiple occurrence issue, Nevada follows the "cause theory" to determine how many occurrences there are for purposes of the Each Occurrence Limit. The "cause theory" focuses on the number of acts producing the injuries or damage rather than the number of injuries actually resulting. In performing the legal analysis, courts determine whether there is "but one proximate, uninterrupted and continuing cause which resulted in all the injuries and damage." If a series of injuries all "flow from a single cause," then there is only one "occurrence." If each injury is caused by a different, independent act, then there is a series of occurrences. Ins. Co. of Am. v. Weston, 107 Nev. 610 (1991).

Deductible

A deductible is a portion of an insured loss for which the policyholder is responsible. It generally is a specific sum that the insured must pay before the insurer owes a duty to indemnify the policyholder for a covered loss. A deductible relates only to the damages for which the policyholder is indemnified, not to defense costs. The insurer is fully responsible for defense costs regardless of the amount of the deductible so long as there is a potential for coverage under the policy. Forecast Homes, Inc. v. Steadfast Ins. Co., 181 Cal.App.4th 1466 (2010) citing Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2008) ¶ 7:378, p. 7A-121.

DUTY TO DEFEND

Construction defect lawsuits are expensive to litigate. The right to an adequately-funded legal defense is an important insurance benefit to insured builders and subcontractors. And the cost of defending builders and subcontractors is a serious exposure to insurance carriers. In fact, the cost of a defense often exceeds a carrier's exposure for potentially-covered damages. As a practical matter, it is often the ongoing cost of a legal defense that drives the settlement of many construction defect disputes, even where the carrier possesses significant coverage defenses.

Accordingly, insured builders should ordinarily tender their defense to their insurance carrier as soon as possible, as well as to any downstream subcontractors and their carriers. Under Nevada law, an insurance carrier owes a duty to defend a qualifying insured if the pleadings raise the potential for coverage for any single claim or item of damage. This is true even if the pleadings allege many non-covered claims or items of damage.

As explained below, issues may arise as to whether the insurance carrier must "defend" even though no lawsuit has been filed against the qualifying insured. Issues may also arise if the insurance carrier agrees to defend but seeks reimbursement for defense costs incurred in the defense of non-covered claims. Finally, issues may arise as to whether the insurance carrier, who agrees to defend under a reservation of rights, must furnish "independent counsel" and surrender control of the defense to the qualifying insured.

Pre-Lawsuit Proceedings

Under CGL policies, an insurance policy is generally not triggered unless the policyholder faces potential liability for covered damages in a "suit." CGL policies define a "suit" as "a civil proceeding in which damages to which this insurance applies are alleged." A "suit" also includes an arbitration proceeding to which the named insured must submit. Moreover, the "suit" requirement will attach under certain circumstances if the policyholder and insurance carrier consent to another form of dispute resolution, such as a mediation.

Generally, however, pre-lawsuit proceedings as well as administrative proceedings are generally not considered a "suit." In anticipation of this position, which is widely taken by liability insurance carriers in the United States, the Nevada Legislature codified a rule requiring an insurer to treat Chapter 40 claims "as if a civil action has been brought against the contractor, subcontractor, supplier or design professional..." NRS 40.649(2).

The California Court of Appeal addressed the issue as to whether an insurance carrier's duty to defend a "suit" includes pre-litigation proceedings required under California law. In Clarendon America

Ins. Co. v. Starnet Ins. Co., 2010 WL 2904995 (Cal.App. 4 Dist., July 27, 2010), two insurers disputed whether a CGL policy's definition of "suit"—i.e., "a civil proceeding in which damages ... to which this insurance applies are alleged"—includes pre-litigation procedures under California law, commonly known as the Calderon Process. Id. *at* *1. The Calderon Act requires a common interest development association to satisfy certain dispute-resolution requirements with respect to the builder, developer, or general contractor before the association may file a complaint in court for construction or design defects. Idbd. Observing that the Calderon Process is mandatory, the court found it satisfied the definition of "suit," reasoning that it is "part and parcel of construction or design defect litigation initiated by an association and, as such, cannot be divorced from a subsequent complaint." Id. at *7.

Reimbursement Claims

In the past decade, many insurance carriers are reserving their rights to seek reimbursement for attorney fees incurred in defending claims for which no potential coverage exists. In a mixed action—a lawsuit involving some claims that are potentially within the scope of coverage and other claims that are not potentially covered—the insurer must provide a complete defense.

However, some states such as California may permit the insurance carrier to seek reimbursement of some of the fees it incurs in defending claims that were not potentially covered. To do so, the carrier must reserve its right to seek reimbursement; prove that as to certain claims, no potential for coverage ever existed; and that the fees and expenses for which reimbursement is sought were incurred solely in the defense of those claims for which no potential coverage ever existed. The carrier bears the burden of proof, and the standard of proof is a preponderance of the evidence. Buss, et al. v. Superior Court, 16 Cal.4th 35, 48-49 (1997).

The Nevada Supreme Court has apparently not addressed directly the reimbursement issue as the California Supreme Court did in Buss. However, it appears the Ninth Circuit Court of Appeals has addressed a similar issue and permitted an insurer to seek reimbursement under Nevada law. See Crystal Bay Gen., 1992 WL 68269. It should be noted, however, that a federal court's interpretation of Nevada law is not binding upon state courts. Moreover, Crystal Bay may be limited to its unique facts and not a recognition, such as in Buss, of a generally applicable right of a liability insurance carrier to seek reimbursement under Nevada law.

Independent Counsel

When a liability insurance carrier agrees to defend an insured developer, builder, or contractor in a construction defect lawsuit, it usually reserves its rights to deny coverage for claims and items of damage that are not within the policy's scope of coverage.

Ordinarily, the carrier then retains a defense attorney on the carrier's panel to defend the policyholder. Generally, an insurer owing a duty to defend an insured has the right to control the defense and settlement of the underlying action, and to otherwise directly participate in the action. To that end, the carrier has the right to select the attorney to prosecute the policyholder's defense.

If, however, state law recognizes that both the carrier and the policyholder are clients of the attorney, issues may arise as to whether the insurer-appointed counsel possesses a conflict of interest, such as the type of conflict found in the seminal California case of San Diego Navy Federal Credit Union v. Cumis Insurance Society, Inc., 162 Cal.App.3d 358 (1985).

In Cumis, the California Court of Appeal recognized that in some instances, an insurance company must surrender its contractual right to select defense counsel and control litigation decisions. The court was primarily concerned with the common situation in which an insurer retains panel counsel to defend its policyholder, while reserving its right to later deny payment of the policy's indemnity benefit.

The Cumis court felt that when a coverage dispute exists, the insurer's defense counsel cannot effectively represent the interests of both the insurer and policyholder. The Cumis court ruled that under such circumstances, the insurer must pay the reasonable legal fees charged by the attorney whom the policyholder selects and controls, commonly referred to as "Cumis counsel" or "in-dependent counsel."

In reaching its conclusion, the Cumis court assumed that the insurer's defense counsel would favor the interest of one client (the insurer). This assumption rest upon the fact that panel counsel typically have an ongoing economic relationship with the insurer, who is paying for legal services rendered to the policyholder. More specifically, the rationale is that, since panel counsel wishes to continue receiving new files from the insurer, he or she will be naturally motivated to favor the insurer.

It appears that Nevada law is not entirely settled as to whether a policyholder, who is being defended by an insurance carrier, is entitled to independent counsel if the carrier's agreement to defend is under a reservation of rights.

In light of recent case law, however, it appears that Nevada courts may adopt an approach similar to California's, which permits a policyholder to demand independent counsel in certain situations. In the June 2007 edition of Nevada Lawyer, Jeffrey W. Stempel, Esq., a professor at the William S. Boyd School of Law, wrote that "it would appear that Nevada will follow California's lead" with respect to a policyholder's right to independent counsel. Jeffrey W. Stempel, *The Relationship Between Defense Counsel, Policyholders, and Insurers: Nevada Rides Yellow Cab Toward "Two-Client" Model of Tripartite Relationship. Are Cumis Counsel and Malpractice Claims by Insurer's Next?*, Nevada Lawyer, June 2007, at 20.

Under Nevada law, both the insurance carrier and insured are the clients of the insurer-appointed defense counsel.

Professor Stempel's article is based in large part on the holding in Nevada Yellow Cab Corp. v. Dist. Ct., 152 P.3d 737 (Nev. 2007), in which the Nevada Supreme Court found that under Nevada law, both the insurance carrier and insured are the clients of the insurer-appointed defense counsel. Rule 1.7 of the Nevada Rule of Professional

Conduct provides that, subject to certain exceptions, "a lawyer shall not represent a client if the representation involves a concurrent conflict of interest." A concurrent conflict of interest exists if: (1) The representation of one client will be directly adverse to another client or (2) There is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer." Nev. Rule Prof. Resp. 1.7; see also, Nev. Rule Prof. Resp., Rule 1.4, subd. (a)(5) ("A lawyer shall: ... Consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law."); Nev. Rule Prof. Resp. 1.3, subd. (a) (subject to certain exceptions, "A lawyer shall not reveal information relating to representation of a client unless the client gives informed consent [or] the disclosure is impliedly authorized in order to carry out the representation...").

In 1987, the California Legislature codified the essential holding of the Cumis case, but clarified and limited the holding in several respects. See Cal. Civ. Code § 2860. Interpretive case law has not clearly identified the circumstances under which an insurer-appointed defense counsel will be disqualified under Section 2860. More specifically, courts have not uniformly agreed on what constitutes a "conflict" under the statutory standard. Despite this lack of uniformity, the case law generally shows that a disqualifying conflict of interest may exist under Section 2860 if: the policyholder's liability turns upon either the nature of its liability-product conduct (i.e., accidental versus intentional) or the cause of the claimant's losses and the circumstances of the litigation, including the nature of the evidence, provides the insurer-appointed defense counsel with the means of steering the resolution of conduct or causation issues into non-coverage.

In the context of construction litigation, California courts have not uniformly found that an insurer's agreement to defend builders and contractors under a reservation of rights triggers the right of insured builders to demand independent counsel.

For example, in Blanchard v. State Farm Fire & Casualty Co. [2 Cal.Rptr.2d 884 (Cal.App. 1991), the underlying claim involved a lawsuit by homeowners against a general contractor alleging various construction defects. The insurance carrier agreed to defend the contractor under a reservation of rights. Under the terms of the insurance policy, the contractor retained the risk of repairing or replacing faulty workmanship, while the insurance carrier had agreed to insure the risk of damage to the property of others. Litigation ensued as to whether the contractor was entitled to independent counsel. The California Court of Appeal found the carrier's reservations did not trigger the contractor's right to demand independent counsel. The Blanchard court reasoned that the contractor had produced no evidence to show in what specific way the insurer-appointed defense attorney could have controlled the outcome of the damage issue to appellant's detriment, or had incentive to do so. Observing the contractor referred only to "an unspecified possibility of a conflict[,]" which is insufficient under Section 2860, the court reasoned that because, "[t]he coverage issue involved only damages" and "[i]nsurance counsel had no incentive to attach liability to [the policyholder]," the contractor was not entitled to independent counsel.

In contrast, a federal district court declined to follow Blanchard where the insurance carrier reserved its rights on a policy provision limiting coverage for property damage caused by earth movement. Scottsdale Ins. Co. vs. The Housing Group, 1995 U.S. Dist. Lexis 8791. The district court framed the issues as: will the defense attorney's representation of the insured developer be rendered less effective by reason of its retention by the insurer, i.e., will the manner in which the defense is prosecuted affect the outcome of the underlying coverage dispute? The court found a disqualifying conflict of interest, thereby entitling the developer to independent counsel. In reaching its decision, the court focused upon the potential causes of the property damage at issue in the underlying lawsuit against the developer. The court reasoned that, if the damage was caused by earth movement, coverage would be limited to $100,000, whereas if the damage resulted from another cause, the sublimit would not apply and the developer would be entitled to the full policy limit of $1,000,000.

Viewed nationally, the case law involving entitlement to independent counsel is far from uniform or fully developed. Even in states that have codified specific rules—such as California, Alaska, and Florida—many issues remain unresolved including the following:

1. Whether an insurance carriers owes a legal duty to advise and disclose to the policyholder any potential or actual conflicts of interest created by the carrier's reservation of rights?

2. What is the pertinent legal standard for determining the hourly rate to which independent counsel is entitled?

3. Does the insurance carrier possess the right to reject independent counsel who cannot demonstrate his or her professional competence in the subject matter of the lawsuit or that he or she is covered by malpractice insurance?

4. Must the insurance carrier offer independent counsel, and if so, choose independent counsel, or may the carrier await the policyholder's demand for independent counsel?

5. Whether or not the insurance carrier's failure to provide independent counsel functions to either waive or estop the carrier's right to assert coverage defenses?

6. If the insurance carrier reserves rights to seek reimbursement of attorney fees incurred in defense of claims for which no potential coverage exists, must independent counsel provide detailed legal invoices that permits the carrier to allocate covered versus non-covered attorney fees?

7. If the subject insurance policy is issued in State A, but the lawsuit at issue is venued in State B, which state's laws govern whether or not the policyholder is entitled to independent counsel?

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Jeffrey Bolender's professional background includes both large and small law firm experience, including his own firm which he formed in 2001. He began his legal career in 1988 as a paralegal at the national law firm Latham and Watkins. His legal experience and expertise in insurance law commenced in 1992, while employed as a law clerk during law school. Since first becoming a lawyer in 1994, Mr. Bolender has litigated over one hundred insurance lawsuits in seven states. He also litigates complex matters in state, federal, and appellate courts, including lawsuits involving insurance agent malpractice, subrogation, trademark and copyright disputes, unfair competition, wrongful death, and products liability. He has also advised underwriters in the creation of new insurance products.

Mr. Bolender's prior experience as an insurance coverage lawyer includes employment at Selman Breitman and Ropers, Majeski, Kohn & Bentley. He is an active member of the Los Angeles Bar Association, the South Bay Bar Association, and the Defense Research Institute. He is licensed to practice law in California, Hawaii, Washington DC, as well as Nevada, where he is a member of the Construction Law and Insurance & Health Law sections of the Nevada State Bar.

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