

Insurance Law Section Newsletter

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Editor's Note

by Brian R. Lehrer

s in any area of the law, excess insurance has its own twists and turns. There is a great deal more to understand about the interaction between primary policies and excess policies than the simple concept that the excess policy sits above a primary policy.

This issue of the *Insurance Law Section Newsletter* is specifically devoted to excess insurance in light of the section's Nov. 17, 2015, continuing legal education (CLE) program addressing recent issues in this area. The issue contains three separate articles highlighting the law governing the interaction between primary and excess carriers. Maureen Le Pochat offers a comprehensive overview of the relative duties between the two carriers, including the primary carrier's duty to act in good faith and to give notice of potential exposure to the excess carrier. The next two articles address the recent ruling in *IMO Industries*, *Inc. v. Trans America Corp.* and its potential impact—or lack of impact—on future litigation.

While satisfactory answers and bright-line rules are always hard to come by, the second look at past decisions and these three articles provide an excellent overview of a very complex area of the law, and hopefully will whet one's appetite for what should be an excellent CLE program.

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Duties of Primary and Excess Carriers and the Role of Defense Counsel

by Maureen Le Pochat

I lying has been described as hours of boredom interrupted by moments of sheer terror. At times, the same can be said of handling claims under an excess policy. In cases where an excess carrier's first notice of a claim is after the primary policy limits are exhausted and trial is imminent, the pilot, carrier and defense attorney are kindred spirits. As will be discussed below, the insurance industry and New Jersey case law have made the above scenario the exception rather than the rule.

This article is limited to the duties of carriers who have issued excess policies. It does not address primary policies that function as excess policies or umbrella policies.

The duties owed between primary and excess carriers vary widely from state to state and are still a work in progress in New Jersey. The New Jersey courts have come to recognize that a unique relationship exists between primary and excess carriers, and have held that there are duties that arise out of that relationship.

Primary Carrier's Duty to Act in Good Faith in the Handling of Claims.

The New Jersey courts hold that a primary carrier owes a duty to an excess carrier to act in good faith in the handling of claims. In C.N.A. v. Selective,1 the court distinguished between a situation where the excess carrier is a true excess carrier and where the carrier becomes an excess carrier by operation of an "other insurance" clause. In the true excess relationship, the court held that an excess carrier had the right to rely on a primary carrier to investigate, defend, and if possible, resolve the underlying matter. The court held that a primary carrier must exercise good faith in "(1) discharging its claimshandling obligations; (2) discharging its defense obligations; (3) properly disclosing and apprising the excess carrier of events which are likely to effect that carrier's coverage; and (4) safeguarding the rights and interests of the excess carrier by not placing the primary carrier's own interests above that of the excess insurer."2

In fact, the New Jersey courts have held that the nature of the duty owed by a primary carrier to an excess carrier is the same duty of good faith and fair dealing owed to an insured. In *General Accident v. New York Marine*, 3 the court stated:

We recognize that in New Jersey it is well-established that the duty owed an excess carrier from a primary carrier is identical to that owed to the insured.⁴..., that duty exists as a result of the distinctive and unique relationship between the two carriers. It is reasonable for the excess carrier to rely on the primary carrier to act in good faith.

Duty to Settle Within the Policy Limits

The duty to act in good faith includes the duty to settle, where practical, within the primary policy limits. In other words the *Rova Farms*⁵ duty (duty to settle within limits to avoid an excess exposure) applies to excess carriers in the same way it would to an insured. In *Western World Ins Co v. Allstate Ins Co.*, the Court held:⁶

However, we are convinced that the judge erred in holding that Allstate owed no duty to Western World in the circumstances of this case. Western World, as the excess carrier has precisely the same status as the assured for purposes of this action. Recently, we expressly held that the principles enunciated in Rova Farms applied as between primary and excess carriers, and that the primary carrier owed to the excess carrier the same positive duty to take the initiative and attempt to negotiate a settlement within its policy limit as it owes to its assured. Estate of Penn v. Amalgamated General Agencies, etc., and Richard-Lewis Agency.⁷

This rule is based, in part, on the rationale that the primary carrier's failure to act in good faith would cause expenses to be incurred by the excess carrier that were not contemplated in the calculus of the premium charged. The failure of the primary carrier to investigate, defend, negotiate and, if possible, settle within its policy limits, could result in an excess verdict that could have been avoided with good faith claims handling. Premiums for excess insurance are generally substantially less than the premiums charged for primary policies. Thus, the failure to act in good faith might cause the excess carrier to incur costs that should have been absorbed by the primary carrier, and were not anticipated in the premium calculations.

Primary Carrier's Duty to Give Notice of Potential Exposure

Either by terms of the insurance agreements or by operation of law, a primary carrier has a duty to give notice of a potential claim to the excess carrier. Sufficient notice is necessary to allow an excess carrier to properly determine if the excess policy affords coverage and to allow the excess carrier to properly evaluate the matter. It is also important to give the excess carrier sufficient time to assume the handling of the matter if the primary policy exhausts. Proper notice includes keeping the excess carrier appraised of ongoing settlement discussions. This is not a duty that the primary carrier can rely on the insured to fulfill. In *American Centennial Insurance Co. v. Warner –Lambert Co*,8 the Court held:

When a primary carrier/excess carrier relationship is involved, proper notice entails the primary carrier, not the insured, advising the excess carrier of the existence of the claim. To ensure proper notice is given, the primary carrier must also notify the excess carrier on an ongoing basis of any settlement discussions or pending litigation. In this matter, ACIC was not provided with proper notice because the insured, not the primary carrier, gave inadequate notice of a pending claim. Adequate notice cannot constitute a single mailing of a form letter.

While there is a duty owed to the excess carrier to timely give notice of a loss that will potentially reach the excess layer, the failure to do so does not automatically negate coverage. As with claims against primary carriers, there must be a showing that the excess carrier was prejudiced by the failure to give timely notice in order for the excess insurer to succeed in disclaiming coverage. *Peskin v. Liberty Mutual Insurance Co.*⁹

An exception to the general rule that the primary carrier must give notice arises when the excess carrier has wrongfully declined coverage. By denying coverage, the excess carrier will forfeit the right to receive reports with respect to discovery, settlement discussions or the progress of the case in general. Or as the Appellate Division said in *Baen v. Farmers Mutual Fire Ins. Co. of Salem County*, "...where an excess carrier has denied coverage, this duty evaporates."... "When an insurer violates its contractual obligations to the insured, it forfeits its right to control settlements" 11

Duty to Defend

Primary Carrier

While an analysis of the duty to defend on the part of a primary carrier could fill volumes, for the purpose of this article the focus will be on the duty of a primary carrier where its policy limits are exhausted. It is well established that a primary carrier has a duty to defend where the allegations of the complaint may set forth a covered claim. Thus, the effect of the exhaustion will depend on the wording of the policy. As with most questions of interpretation, if the wording is ambiguous it will be interpreted in favor of the non-drafting party. In this instant, the wording would be construed against the insurer.

If the wording of the policy does not make it clear that the duty to defend ends when the policy limits are exhausted, the duty may continue past exhaustion. In *Kocse v. Liberty Mutual Insurance Co.*,¹² the court considered language in an Allstate policy that read: "Allstate will defend, at its own expense and with counsel of its choice, any lawsuit, even if groundless, false or fraudulent, against any insured for such damages which are payable under the terms of this Part, but may make such settlement of any claim or suit as it deems expedient."

Allstate paid its policy limits and sought to withdraw from the defense. The court held that unless the policy provided that the duty to defend would end with the payment of the policy limits, the duty to defend would continue. The court stated:

When construing language covering an obligation such as the duty to defend the insured, the court must look to the reasonable expectations of the insured. We are dealing with language in a long, detailed insurance policy which an insured would find difficult to understand even after painstaking study. Certainly the language in question does not clearly and plainly indicate that the insurer may withdraw from defense of the insured upon paying the policy limits. Considerations of fairness lead to the conclusion that the obligation to defend should be considered an independent obligation. The insured purchased a policy of insurance containing an undertaking by the insurer to defend actions against its insured, and the court concludes that a fair and reasonable construction of the policy language requires Allstate to continue with the defense of Kocse.

Many policies now will have limiting language that makes it clear that the duty to defend ends with the exhaustion of the policy, but what wording will suffice has not been explored in depth in this state. By way of example, if the wording of the policy is that the policy would be exhausted by payment of judgments or settlement, the payment of policy limits into court would probably not exhaust the policy, and the duty to defend would continue.

Excess Carrier

The excess carrier may also have a duty to defend if the primary carrier exhausts or wrongly refuses to defend. The duty of an excess carrier to defend a claim is generally dictated by the terms of the policy. In form follow excess policies, the duty will generally be established by the terms and conditions of the underlying policy. Other policies may include provisions that the carrier has a right but not a duty to defend, or may include a duty to defend when the underlying policy is exhausted. If the policy is silent on the duty to defend, or ambiguous, the court may impose such a duty after the exhaustion of the primary policy.

In the instances where the excess carrier does have a duty to defend pursuant to the terms of the insuring agreement, the duty will generally not arise until the primary policy is exhausted. Common excess policy language will limit the duty to defend until the underlying policy is exhausted by payment of "settlement or judgments." It is likely that the duty of an excess carrier will not be triggered either by a primary carrier tendering its policy limits or paying its policy limits into court where these actions do not settle the case. As a general rule, and dependent on the wording of the policy, the excess carrier will not have a duty to defend if the primary carrier is still under such a duty.

In Johnson v. Plasser American Corporation¹³ the court rejected an argument that the duty was triggered when the underlying limits were "functionally exhausted" by an indication that the underlying carrier was willing to pay its policy limit. The Hartford, in this case, as excess carrier, paid \$4,000,000 in addition to the primary carrier's \$1,000,000, to settle the underlying case. After settlement, the insured, in a declaratory action, sought defense costs against The Hartford. The Hartford policy provides for a defense where: "the underlying limits of any 'underlying insurance' policy have been exhausted solely by payments of 'damages' because of 'occurrences' during the 'policy period." The underlying carrier had expressed willingness to pay its policy limit, but did not do so until the matter was completely settled. Thus, the court ruled it still had a duty to defend:

.....the obligation of an excess carrier to provide a defense is also predicated on the exhaustion of underlying coverage, and therefore, the termination of the duty to defend by the underlying carrier. "Generally, the primary insurer must pay its policy limits toward the satisfaction or settlement of the claim or judgment against the insured for an excess insurer to have any obligation to its insured. A primary insurer that properly pays its policy limits is said to have 'exhausted' its limits..."15 (stating majority view that "an excess insurer is not required to contribute to the defense of the insured" as long as "the primary insurer is required to defend"); ibid. (noting that an excess insurer's defense coverage is triggered when the "primary indemnity limits have been exhausted and the primary insurer has refused to continue the defense").

The court also went on to reject the argument that the excess carrier's duty to defend was triggered because the exhaustion of the primary policy was "inevitable." In *Kocse*, the insured argued that since the plaintiff had incurred over a million dollars in medical expenses, the primary policy exhaustion was inevitable. The court rejected the underlying carrier's reliance on out-of-state precedent offered for the proposition that the agreement to pay its limits was tantamount to exhaustion. The court noted that the offer to pay did not end the primary carrier's duty to defend, and held that where the primary carrier still had a duty to defend the excess carrier would not have an overlapping duty. The court concluded:

Significantly, NJM's policy provided that its duty to defend TGI would expire "after we have paid our applicable limit of liability under this insurance." Thus, NJM's offer to pay \$1 million—as opposed to actual payment—did not terminate its duty to defend. As a public policy matter, we discern no compelling ground to interpret the insurance provisions to require the excess carrier to provide a defense when the underlying insurer remains obliged to provide one. ¹⁶

In New Jersey, if an excess carrier does provide a defense where a primary carrier has wrongly declined to do so, the excess carrier will be able to seek reimbursement from the primary carrier. In *Rooney v. West Orange Township*, ¹⁷ the court held that an excess or secondary carrier is entitled to reimbursement for its defense expenses from the primary carrier who "has wrongfully refused to defend its assured." ¹⁸

Similarly, an excess carrier who successfully pursues a coverage action on behalf of an insured against a primary carrier that wrongfully denied coverage, may be awarded the fees and costs incurred in pursuing the declaratory action. In *Tooker v. Hartford Accident and Indemnity Company*, 19 the Appellate Division upheld the grant of attorney fees to Allstate, when it successfully pursued The Hartford for coverage on behalf of their mutual insured, stating:

We are entirely satisfied that the rule applies to all successful claimants, including an excess or secondary carrier which successfully prosecutes a coverage action against the primary carrier when the latter has wrongfully refused to defend its assured. The award of counsel fees and costs in such a case is equitable and just, and accords with the purpose of R. 4:42-9(a)(6) to discourage groundless disclaimers by carriers by assessing against them the expenses incurred in enforcing coverage for their assureds.²⁰

The Option to Defend

Some excess policies will provide that the carrier has the option, but not the duty, to defend. While the effects of such a provision have not been explored in depth in New Jersey, there is no case law to suggest the courts will do anything other than give effect to the clear meaning of the words. There is no case law that converts the option to defend into a duty to defend. In *Hatco Corp v. W.R. Grace & Co.*²¹ the United States District Court for the District of New Jersey rejected a claim by the insured that the excess carriers should be estopped from denying coverage because the carriers failed to disclaim coverage within two years after being sent notice of the suit. The court, in part, based its holding on the fact that the excess carriers did not have a duty to defend under the terms of their policy.

The court held:

Nothing in this provision could create the reasonable expectation in the insured that gave rise to a conclusive presumption of prejudice in *Griggs*. Instead, the provision makes clear that Grace should not expect *any* help from the excess insurers. That the excess insurers retained the right to participate in the defense or settlement of the claim, at their option, could create no expectation in Grace that would give rise to an estoppel.

However, if the wording is vague or unclear, the court will most likely find that such a duty exists.

As a practical matter, the carrier is likely to exercise the option to participate in the defense, as failure to do so would mean that the excess carrier would not be able to control the defense of the case. Aside from being able to control settlement discussions, a non-involved carrier would have no say with respect to theories of the defense, litigation costs or even choice of defense counsel.

Beyond the Duty to Defend

While discussed at length in other parts of this publication, the recent decision of *IMO Industries Inc. v. Transamerica Corp*²² warrants mention at this point. As a general matter, the excess insurers have no duty to participate in the defense, and may rely on the good faith of the primary insurer in settling the claims against the insured.²³ But with the holding in IMO, an excess carrier may want to be more involved in the pre-exhaustion litigation process, especially with respect to complex long-tail claims, as it could find itself on the hook for uncovered claims.

In IMO, the court considered the right of an excess carrier to "demand that their insured bear its normal burden of establishing coverage for each claim made against their policies."²⁴ The court held:

It stands to reason that accommodating a challenge to coverage in tens of thousands of individual claims would not only prove daunting, but would compromise the integrity of the framework Owens-Illinois offers for efficient and equitable allocation of losses among policies. As we have stated, policy terms and traditional principles applicable to ordinary coverage litigation must bend insofar as they conflict with application of the Owens-Illinois **1114 framework. Benjamin Moore, supra, 179 N.J. at 104, 843 A.2d 1094. The Court could thus impose a greater obligation on the part of excess insurers than specifically stated in their policies to participate in the insured's defense, or risk losing the right to challenge coverage decisions.

Nor is our conclusion inequitable. IMO put the excess insurers on notice of the thousands of claims against it, and Owens–Illinois put them on notice of the necessity of participating in order to preserve their right to challenge coverage determinations.

The trial court appropriately gave effect to a plainly stated directive of Owens–Illinois—that insurers who have declined to associate in the defense of claims against the insured may be precluded from later challenging coverage.

The Guiding Principles for Insurers of Primary and Excess Coverages

One might think that it would be desirable to have a set of rules setting forth the duties and responsible of the carriers in a primary/excess relationship. Such clear guidance is rare in the law. But in 1974, the claims executives counsel promulgated such a set of rules in *The Guiding Principles for Insurers of Primary and Excess Coverage*. These principles were voluntary, with willing carriers becoming signatories to the agreement. As such, they may be viewed now as recommendations only, though they have been cited favorably by the New Jersey courts with respect to signatory carriers. The nine rules provide: ²⁶

- 1. The primary insurer must discharge its duty of investigating promptly and diligently, even in those cases in which it is apparent that its policy limit may be consumed.
- **2.** Liability must be assessed on the basis of all relevant facts that a diligent investigation can develop, and in light of applicable legal principles. The assessment of liability must be reviewed periodically throughout the life of a claim.
- **3.** Evaluation must be realistic, and without regard to the policy limit.
- **4.** When from evaluation of all aspects of a claim, settlement is indicated, the primary insurer must proceed promptly to attempt a settlement, up to its policy limit if necessary, negotiating seriously and with an open mind.
- 5. If at any time it should reasonably appear that the insured may be exposed beyond the primary limit, the primary insurer shall give prompt written notice to the excess insurer, when known, stating the results of investigation and negotiation, and giving any other information deemed relevant to a determination of the exposure, and inviting the excess insurer to participate in a common effort to dispose of the claim.
- **6.** Where the assessment of damages, considered alone, would reasonably support payment of a demand within the primary policy limit, but the primary insurer is unwilling to pay the demand because of its opinion that liability either does not exist or is questionable, and the primary insurer recognizes the possibility of a verdict in excess of its policy limit, it shall give notice of its position to the excess insurer when known. It shall make available its file to the excess insurer for examination, if requested.

- 7. The primary insurer shall never seek a contribution to a settlement within its policy limit from the excess insurer. It may, however, accept contribution to a settlement within its policy limit from the excess insurer when such contribution is voluntarily offered.
- **8.** In the event of a judgment in excess of the primary policy limit, the primary insurer shall consult the excess insurer regarding further procedure. If the primary insurer undertakes an appeal with the concurrence of the excess insurer, the expense shall be shared by the primary and the excess insurer in such manner as they may agree upon. In the absence of such an agreement, they shall share the expense in the same proportions that their respective shares of the outstanding judgment bear to the total amount of the judgment. If the primary insurer should elect not to appeal, taking appropriate steps to pay or to guarantee payment of its policy limit, it shall not be liable for the expense of the appeal or interest on the judgment from the time it gives notice to the excess insurer of its election not to appeal and tenders its policy limit. The excess insurer may then prosecute an appeal at its own expense, being liable also for interest accruing on the entire judgment subsequent to the primary insurer's notice of its election not to appeal. If the excess insurer does not agree to an appeal, it shall not be liable to share the cost of any appeal prosecuted by the primary insurer.
- **9.** The excess insurer shall refrain from coercive or collusive conduct designed to force a settlement. It shall never make formal demand upon a primary insurer that the latter settle a claim within its policy limits. In any subsequent proceedings between the excess insurer and primary insurer, the failure of the excess insurer to make formal demand that the claim be settled shall not be considered as having any bearing on the excess insurer's claim against the primary insurer.

Role of Defense Counsel

When one considers that the interests of the insured, the primary carrier and the excess carrier may differ, the role of defense counsel may be complex. However, counsel can play a key role in getting the three to work together and facilitating resolution of complex matters. Counsel must tread carefully to avoid becoming involved in coverage disputes, while assuring that

the three entities have sufficient information to function smoothly together:

- 1. Keep the insured informed. While defense counsel should not be concerned with the details of the insured's insurance policies, they should be aware of the amounts of any self-insured retentions and at the limits of the primary policy. As soon as it becomes apparent that a self-insured retention or primary policy limit might not be sufficient to resolve the case, counsel should discuss the possibility of excess exposure.
 - A sophisticated insured or an insured with personal counsel or an active broker may be aware of the need to put an excess carrier on notice once defense counsel makes them aware of the potential exposure.
- 2. Do not become involved with any coverage issues. While letting the insured know that the case may be worth more than the self-insured retention of primary policy limiters, counsel should not become involved in discussions with respect to the applicability of the coverages. Defense counsel will generally have been assigned and/or paid by a primary insurer, so discussion of coverage on any level could lead to a conflict of interest. Defense counsel should not be the one to issue the initial notice letters to the excess carrier, nor should they give any advice to the insured or primary carriers on the nature or extent of the excess coverage. Generally, the insured's broker or personal counsel will serve such function.
- 3. Provide such documentation as may be required. While defense counsel cannot become involved with any coverage dispute, it will be necessary to provide information and documents from the underlying case, so the excess carrier may review and evaluate the case. This should be done with the express approval of the insured. While generally the excess carrier would be entitled to this information, if there is a coverage dispute the insured and/or primary carrier might choose not to provide it until coverage issues are resolved. Again, defense counsel has to be careful to not become involved in the dispute, but only to serve as a conduit for movement of information.
- **4. Involve the excess carrier in the case.** Again with the express approval of the insured, and if the facts make it possible that excess policy involvement will be necessary to resolve the matter, counsel should

consider keeping the excess carrier in the loop in terms of discovery and settlement negotiations. Again with the approval of the insured, counsel may even go as far as to share thoughts and evaluations of the case.

To use another transportation analogy, carriers may be likened to large ships; they cannot start, stop or turn on a dime. Authorizations for settlement may have to go through several layers of management in order to get the necessary approvals. If requests for authority are made on the eve of trial or mediations, getting the necessary approvals may be next to impossible. By keeping the excess carriers in the loop and up to date on discovery and evaluations it may be easier to put together a settlement offer when needed. An informed excess carrier can be the difference between being able to make an informed evaluation or hold a productive mediation and a wasted trip.

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- 2. C.N.A. v. Selective, 354 N.J. Super. 369 (App. Div. 2002).
- 3. General Acc Ins Co v. New York Marine and General Ins Co., 320 N.J. Super. 546, 555 (App. Div. 1999).
- Baen v. Farmers Mut. Fire Ins. Co., 318 N.J. Super. 260, 267, (App. Div. 1999); Western World Ins. Co. v. Allstate Ins. Co., 150 N.J. Super. 481, 486-87 (App. Div. 1977); Estate of Louis Penn v. Amalgam. Gen. Agen., 148 N.J. Super. 419, 423 (App. Div. 1977); State Nat. Ins. Co. v. County of Camden, 2009 WL 4895245 (D.N.J. 2009).
- 5. Rova Farms Resort Inc v. Investors Ins Co of America, 65 NJ 474 (1974).
- 6. Western World Ins. Co. v. Allstate Ins. Co., 150 N.J. Super. 481, 487 (App Div. 1977).
- 7. Estate of Penn v. Richard-Lewis Agency, 148 N.J. Super. 419 (App. Div. 1977).
- 8. American Centennial Insurance Co. v. Warner-Lambert Co, 293 N.J. Super. 567 (App. Div. 1995).
- 9. Peskin v. Liberty Mutual Ins Co., 219 N.J. Super. (App. Div. 1987); Gazis v. Miller, 186 N.J. 224 (2006).
- 10. Baen v. Farmers Mut. Fire Ins. Co. of Salem County, 318 N.J. 26 (App. Div. 1999).
- 11. Baen, supra. at 71.
- 12. In Kosce v. Liberty Mutual Insurance Co., 159 N.J. Super. 340,346 (Law Div. 1978).
- 13. Johnson v. Plasser American Corporation, 2014 WL 714719 (App. Div. 2014).
- 14. Johnson, supra, at 6.
- 15. Douglas R. Richmond, *Appleman on Insurance* § 24.06 (2013). *See also* 1 Barry R. Ostrager and Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 6.03 (15th ed. 2011.
- 16. Johnson, supra. at 8.
- 17. Rooney v. West Orange Tp, 200 N.J. Super. 201,207 (App. Div. 1985).
- 18. Tooker v. Hartford Accident and Indemnity Co., 136 N.J. Super. 572, 576 (App. Div. 1975), certif. den. 70 N.J. 137, (1976); Continental Nat. American Group v. Pluda, 115 N.J. Super. 206 (Law Div. 1971), rev'd on other grounds 119 N.J. Super. 570 (App. Div. 1972); and cf. Burd v. Sussex Mutual Insurance Company, supra, 56 N.J. at 394.
- 19. Tooker v. Hartford Accident and Indemnity Company, 135 N.J. Super. 572 (App. Div. 1975).
- 20. *Cf. Felicetta v. Commercial Union Ins. Co.*, 117 N.J. Super. 524, 528, (App. Div. 1971), *certif. den.*, 60 N.J. 141, 286 A.2d 514 (1972); *577; N.J. Mfrs. Inc. Co. v. Consolidated, 124 N.J. Super. 598, 600-602 (Law Div. 1973).
- 21. Hatco Corp v. W.R. Grace & Co., 801 F. Supp. 1334, 1363 (D.N.J. 1992).
- 22. IMO Industries Inc. v. Transamerica Corp., 437 N.J. Super. 577 (App. Div. 2014).
- 23. IMO, supra, P 625.
- 24. IMO, supra, P 626.
- 25. Excess Insurance: An Overview of General Principles and Current Issues 24 *Tort & Ins Law Journal* 715, 739 (Summer 1989).
- 26. Pasker v. Harleysville Mutual Insurance Company, 192 N.J. Super. 133, 139 (App. Div. 1983).

Much (Allocation) Ado About Nothing: IMO Decision Presents Such Unique Facts the Court Resists Offering General Allocation Law Pronouncements

by Sherilyn Pastor, Nicholas Insua, and Adam Budesheim

Supreme Court declined to grant certification and review the Appellate Division's published and unpublished rulings in IMO Industries Inc. v. Transamerica Corp., it brought to a conclusion more than a decade of litigation over the responsibility for plaintiff IMO Industries Inc.'s asbestos liabilities.¹ The Court declined to disturb rulings that IMO's former parent and co-insured, Transamerica Corporation, was not obligated by its divestiture agreement with IMO or its consolidated risk management approach (purchasing insurance for itself and its then wholly owned subsidiaries, including IMO) to pay IMO's asbestos losses or to pay for gaps in insurance for IMO's asbestos liabilities.

The Court also confirmed the exhaustion of IMO's primary insurers, requiring IMO to turn to its (and Transamerica's) excess insurers for defense and indemnity of its asbestos losses. Moreover, and perhaps more importantly, the Supreme Court's ruling offered closure regarding the treatment of the unique allocation and exhaustion issues, which had been closely watched by risk managers, policyholder and insurer lawyers, and insurance companies to the extent they might bear more generally on New Jersey's allocation law regarding defense costs.

The Appellate Division recognized that aspects of this issue had not been previously addressed by New Jersey Supreme Court rulings, but it ultimately declined to make any general pronouncements. It instead limited its ruling because of the intensely factual nature of the parties' disputes.

IMO involved (among many other things) various questions relating to New Jersey's allocation law as set forth in *Owens-Illinois*, *Inc. v. United Insurance Co.*² and

Carter-Wallace, Inc. v. Admiral Insurance Co.³ But these issues arose in the context of primary insurers that had already paid their policies' full limits, and declared exhaustion, under pre-Owens-Illinois interim funding agreements with IMO. After the last primary insurer, TIG Insurance Company, had already paid more than \$30 million, IMO sought a reallocation of losses under Carter-Wallace. IMO then alleged that TIG was not exhausted, if one accepted IMO's theories relating to allocation of payments (not allocation of loss) and the impact that the timing of an insurer's prior, actual payments under the interim funding agreements should have on a later reallocation of loss.

The Appellate Division, in addressing the matter, was focused on exhaustion and the allocation of defense costs under *Carter-Wallace* to a primary insurance policy with a supplemental defense obligation (*i.e.*, the policy pays defense costs in addition to the stated indemnity limit). The trial court ruled—here, where the reallocation of loss was to an insurer that had already paid (and indeed, overpaid) its limits—that the allocation of defense costs to such policies ceases when the policy is allocated losses up to its limit.

IMO appealed this ruling, urging that defense costs should be retroactively reallocated to a policy even after that policy has been allocated its full indemnity limits, and even where indemnity costs were then being simultaneously allocated to other excess insurance policies. This allocation of 'extra' defense costs was, according to IMO, appropriate because on the reallocation of defense costs the allocation should end not on reaching indemnity limits but continue beyond it (and be based upon the actual payment of the losses). Although the Appellate Division affirmed the trial court, it neither endorsed nor rejected the trial court's ruling that payments are

irrelevant to allocating defense costs to an insurer. Instead, the Appellate Division found that the insurer's supplemental defense obligation was terminated by exhaustion through actual payment of policy limits and did not reach the question of whether the defense obligation can end based solely on an allocation of loss.

IMO's argument was not intended simply to secure some additional coverage for its indemnity losses, but rather to obtain millions of dollars in additional defense costs. IMO posited that if the policies were not exhausted by actual (prior) payment, then the policies with a supplemental defense obligation should continue to be reallocated defense costs, even long after the policies had been allocated their full limits in indemnity and the excess policies were triggered. Thereby, IMO sought to collect an additional \$48 million (and counting) in defense costs from five defense outside of limits primary policies with indemnity limits of only \$1 million each.

As the Appellate Division acknowledged, the allocation of defense costs "ha[s] not been previously addressed in the New Jersey Supreme Court's allocation decisions."4 Owens-Illinois and Carter-Wallace adopted an allocation methodology for long-tail claims (such as asbestos) of pro rata by time, weighted by policy limits. The allocation model calculates percentages for each policy period, which determine the amount of loss allocated to those policy periods. Supreme Court allocation decisions repeatedly applied the methodology to indemnity, but never defense costs. The trial court's ruling in IMO may have tread on new ground, but the Appellate Division emphasized that it would not provide "general conclusions" regarding allocation of defense costs because "the exhaustion decision in this case is closely tied to its facts."5 Indeed, the facts of IMO are so unique they are unlikely to be replicated by any other policyholder in New Jersey. For example, the trial court found, and the Appellate Division affirmed, that IMO's own unclean hands precluded IMO from prevailing on its exhaustion and allocation of defense costs arguments.6

To understand the courts' rulings, it is necessary to understand a bit about IMO's insurance coverage. There were 10 general liability policies in dispute between IMO and the involved primary insurer, TIG. These policies provided coverage from 1977 through 1986. During this time period, IMO, a manufacturer of industrial pumps and turbines (some of which contained asbestos) was a subsidiary of defendant Transamerica Corpora-

tion. TIG, also a Transamerica subsidiary at the time, issued these policies covering Transamerica and all of its subsidiaries, including IMO. These 10 policies often were referred to as fronting policies because upon their issuance Transamerica entered into separate agreements with TIG whereby Transamerica agreed to indemnify TIG for certain losses paid under the policies. The term "fronting policies" also distinguished these 10 TIG policies from those TIG issued directly to IMO (but not Transamerica and subsidiaries) in the 1960s and 1970s (the direct policies).

The fronting policies had total limits of \$10.75 million. The first five fronting policies were defense outside of limits policies, and the latter five were ultimate net loss policies (also known as defense inside limits policies), for which payment of defense costs erodes policy limits. IMO never disputed that the five ultimate net loss policies were exhausted. Its focus was on the fronting policies with the supplemental defense obligation.

When IMO was first sued in asbestos litigation, and for 17 years after, IMO's asbestos claims were handled and paid by its primary insurers, including by TIG under the fronting policies and direct policies, until the fronting policies exhausted by the end of 2003. Through 2003, TIG had paid \$30.1 million on its policies (and Transamerica had reimbursed TIG \$15.9 million for the fronting policies under the indemnity agreements). Indeed, Transamerica's reimbursements alone were sufficient to have fully paid the \$10.75 million in limits on the fronting policies. When notified that the TIG primary policies were exhausted, IMO rejected this view and sued TIG and its former parent, Transamerica.

Throughout the course of the litigation, IMO posited a number of different theories to justify its position that the fronting policies were not exhausted, but each of those theories was either abandoned by IMO or soundly rejected by the court. For example, IMO's original theory was that Transamerica and/or TIG was liable for IMO's losses because the fronting policies had a neverending retention into which all of IMO's losses would fall, and which its former parent, Transamerica, or its primary insurer, TIG, was responsible to pay. Transamerica prevailed on summary judgment that there was no such retention. Then, at trial, IMO proposed that the fronting policies were not exhausted (and thus owed tens of millions of dollars in supplemental defense costs)

based on IMO's allocation of payment (not loss) theory, and also by the timing of TIG's payments under the interim funding agreements. The trial court, however, concluded that the fronting policies were not only exhausted, but that TIG had overpaid on those policies.

IMO had taken the position at trial that TIG's \$15.9 million in payments should be allocated among the fronting policies using Carter-Wallace-like percentages. Under IMO's theory, some policies would be allocated payments far greater than their limits, leaving other policies underpaid. The trial court, unconvinced that TIG could not apply its own payments to its own policy's limits, applied the overpayment amounts to the underpaid policies to conclude the fronting policies were exhausted (and overpaid). On appeal, IMO argued that applying overpayments to underpaid years violated Carter-Wallace's prohibition on horizontal exhaustion. The Appellate Division disagreed, explaining that horizontal exhaustion involves exhausting all primary policies before triggering excess policies, a situation simply not present here.

IMO also sought to demonstrate the TIG policies were unexhausted by urging, without success, that TIG's payments toward the fronting policies were somehow late. By way of background, in the early 1990s, IMO and its insurers entered into interim funding agreements that assigned fixed shares of IMO's defense and indemnification to the insurers and IMO. The agreements predated Owens-Illinois, and instead of using an Owens-Illinois-like allocation method, the agreements assigned equal shares to each participant, regardless of the number of policies or amount of coverage issued by each. In 1998, IMO was approached about applying the then recently decided Carter-Wallace decision to IMO's asbestos losses, but "IMO's General Counsel strongly disagreed with Carter-Wallace[,] refused to apply its methodology," and was content to remain operating under the agreements.⁷ Thus, TIG paid IMO's asbestos losses under the agreements until the exhaustion of the fronting policies by the end of 2003.

Four years into the litigation, however, IMO reversed its position and moved for an order retroactively applying a *Carter-Wallace* allocation to all of IMO's asbestos losses, even those already paid by TIG under the interim funding agreements. The retroactive application of *Carter-Wallace* in 2008 allocated *less* losses in total to the fronting policies than TIG paid under the funding agreements, but, at least initially, allocated

those losses to the fronting policies more quickly than TIG had paid under the funding agreements. The five defense outside of limits policies were retroactively allocated losses up to their full indemnity limits as early as 1999 and 2000. Although TIG's payments through 2003 were, undeniably, more than enough to exhaust the fronting policies, those payments were not made as quickly, in the early years, as the after-the-fact *Carter-Wallace* allocation would have required.

IMO relied on this alleged timing anomaly to argue the fronting policies were not exhausted, and that the five defense outside of limits policies should be assigned all defense costs allocated to those five policy periods. TIG responded that after a policy is allocated its full indemnity limits, the excess policy above is triggered and allocated all subsequently incurred indemnity costs; the defense costs should follow the allocation of indemnity to the excess policy, rather than requiring the primary policy to pay the defense costs for a claim that is covered by excess policies. The trial court rejected IMO's theory, concluding that IMO's reasonable expectations and the degree of risk transferred to the fronting policies required that defense costs be allocated to the defense outside of limits fronting policies only until they had been allocated their full indemnity limits in losses. IMO's theory, the trial court concluded, was inconsistent with the dictates of Owens-Illinois and Carter-Wallace.

The Appellate Division affirmed the trial court, finding its allocation decision allocated defense costs "in general conformity with the risks transferred to those policies."8 The court explained that "TIG made payments in good faith" under the funding agreements, and the "fact that the timing of TIG's payments failed to coincide with loss allocations as calculated later was simply an accident of the development of the pertinent law."9 Moreover, the timing discrepancy between the retroactively applied Carter-Wallace allocation and TIG's actual payments under the funding agreements "was also a product of IMO's refusal to allow a Carter-Wallace allocation at an earlier time to replace the [funding agreements]."10 This attempt by IMO to penalize TIG with \$48 million of extra defense costs as a result of IMO's own change in position prompted the trial court to rule that IMO had unclean hands, precluding it from pursuing its novel theories for additional defense costs.

Despite its general affirmance of the trial court, the Appellate Division did not explicitly address whether the supplemental defense obligation of a defense outside of limits policy could be terminated through an allocation of loss regardless of payment. Instead, it focused on the reality of TIG's payments (indeed, overpayments):

There is no dispute that TIG made payments that exceeded the aggregate of its Owens-Illinois and Carter-Wallace allocations. So we can say its policies were exhausted not just by allocation, but by allocation combined with payments that exceeded the total amount allocated to TIG.¹¹

Moreover, the court explained that because the allocation of loss to the fronting policies reached the policies' limits, TIG's payment of the allocation satisfied the policy limits as well:

Once the indemnity limits of the fronting policies were reached by allocation, and the prior aggregate payments from TIG exceeded those allocations, TIG's coverage was exhausted.¹²

Because the Appellate Division concluded TIG's actual payments exhausted the fronting policies, the court did not reach the question of whether the supplemental defense obligation can terminate based solely on the allocation of loss when payments have *not* been sufficient to exhaust the policy.

Thus, the predicate to IMO's position—that TIG's payments were insufficient to exhaust the fronting policies—was rejected by the Appellate Division, and the rest of IMO's theory collapsed. True to its word, the Appellate Division did not provide a "general conclusion" on the termination of the defense cost obligation of an outside the limits policy in a *Carter-Wallace* allocation. Rather, the court concluded: "In this case, producing a proper allocation pursuant to *Owens-Illinois* and *Carter-Wallace* requires that the fronting policies be construed to have been *exhausted by allocation and aggregate payment* by TIG that exceeded the policy limits." ¹³

The factual circumstances and novel arguments offered by IMO were unique and complex—retroactive reallocations, overpaid policies, unclean hands, etc. For that reason, the *IMO* decision offers little guidance beyond that the allocation approach set forth in *Owens-Illinois* and *Carter-Wallace* remains applicable and unchanged, and any lingering issues relating to allocation of defense costs remain to be answered (but not by *IMO*).

Sherilyn Pastor, Nicholas Insua and Adam Budesheim are partners in McCarter & English's insurance recovery group. Pastor was lead counsel to Transamerica Corp. in the IMO matter, and Insua and Budesheim also served on Transamerica's allocation, trial, and appellate team. This article is for general educational purposes, and not to provide legal advice. The views and positions offered do not necessarily reflect those of McCarter & English or its clients.

- 1. IMO Industries Inc. v. Transamerica Corp., 437 N.J. Super. 577 (App. Div. 2014) certif. denied 222 N.J. 16 (2015).
- 2. Owens-Illinois, Inc. v. United Insurance Co., 138 N.J. 437 (1994).
- 3. Carter-Wallace, Inc. v. Admiral Insurance Co., 154 N.J. 312 (1998).
- 4. IMO, 437 N.J. Super. at 588.
- 5. Id. at 609.
- 6. *Id.* at 612-13.
- 7. Id. at 596.
- 8. Id. at 611.
- 9. *Id.* at 612.
- 10. Id.
- 11. Id. at 610 (emphasis added).
- 12. Id. at 611.
- 13. Id. at 612 (emphasis added).

Commentary:

Is IMO Predictive of New Jersey Law on Below-Limits Settlements?

by Julia Talarick and Jonathan Messier

s the limits of liability of older primary commercial general liability policies have been **L** depleted in responding to massive tort and environmental claims, insureds increasingly look to excess insurance programs—once considered available only for truly catastrophic losses—as a means of reducing exposure to uninsured losses. The key issue in many insurance coverage disputes has, therefore, shifted to whether the limits of liability in primary and umbrella liability policies were properly exhausted, such that the insured may access the limits of liability in excess liability policies. That inquiry, in turn, gives rise to at least two threshold inquiries: 1) whether the underlying insurance must actually pay the claims to be deemed exhausted, and 2) whether there are any circumstances where exhaustion will be deemed in the absence of an actual payment by the underlying insurer or a complete resolution of the claims.

Excess liability policies generally 'attach' only after a finite, defined sum of the limits of the underlying liability insurance becomes exhausted.¹ Exhaustion of the underlying insurance—whether in a primary or umbrella layer—generally is a condition precedent to an excess insurer's duties under the excess policy, most notably the duty to indemnify the insured.² Generally, courts have held that the insured bears the burden to show that all applicable underlying insurance has become exhausted given the insured's knowledge of its insurance program.³ This approach makes sense because generally the insured is in a better position than the excess insurer to know if and when underlying primary insurance has been exhausted.

There are essentially two competing viewpoints on whether complete exhaustion of underlying insurance is required before liability can attach to an excess liability policy. A majority of jurisdictions follow the holding of Zeig v. Massachusetts Bonding & Insurance Co., and do not require actual payment of the limits of liability by

the underlying insurer.⁴ These jurisdictions hold that a settlement between an insured and an underlying insurer for less than policy limits does not prevent the insured from seeking coverage from its excess insurers, provided, however, the insured is treated as self-insured for the delta between the settlement amount and the underlying policy limits, and excess insurance attaches only after the insured "fills the gap." The *Zeig* line of cases declines to enforce such clauses based on: 1) the absence of language in the excess policy specifically stating that all applicable underlying insurance must be exhausted, and 2) a public policy favoring the settlement of insurance claims.

Many jurisdictions (including a recent decision by the Second Circuit) reject the public policy approach of *Zeig* and enforce policy language regarding exhaustion as written. These jurisdictions require an actual payment of the underlying limit of liability by the underlying insurer, and will not permit an insured to fill the gap in a below-limits settlement situation.⁶ These courts often support their holdings by citing to the statement in *Zeig* that "[i]t is doubtless true that the parties could impose such a condition precedent to liability upon the policy, if they chose to do so."⁷

The Leading Cases in New Jersey

The Supreme Court of New Jersey has not ruled on whether the *Zeig* approach or the modern approach is the law of New Jersey. The Supreme Court has, however, provided some indication about how it might rule if the issue were presented. In *Werner Industries, Inc. v. First State Insurance Co.*, the Supreme Court agreed with a trial court ruling that an umbrella liability insurance policy did not "drop down" because of the primary insurer's insolvency, thereby providing coverage for risks before actual payment of the underlying limit of liability.⁸ The Court held that the language of the excess policy did not require the excess insurance to

drop down and assume a risk before the excess attachment point. Some practitioners argue *Werner* suggests New Jersey law would adopt the modern approach and adhere to policy language in the excess policy to determine whether an excess liability policy will attach before the complete exhaustion of the primary policy.

Nonetheless, other practitioners argue New Jersey would follow the *Zeig* approach, thereby permitting an insured to access excess insurance in a below-limits settlement situation so long as the excess insurer is provided with a credit for costs incurred by the insured falling within the delta created between the settlement amount with the insurer and the limit of liability for the underlying policy or policies.¹⁰

Is IMO Predictive of New Jersey Law?

Practitioners recently have turned to the Appellate Division case of IMO Industries, Inc. v. Transamerica Corporation, in an attempt to predict how the Supreme Court of New Jersey might rule on the issue of below-limits settlements.11 In IMO, the insured, IMO Industries, Inc.; its former parent company, Transamerica Corporation; Transamerica's former subsidiaries, which included TIG Insurance Company; and more than a dozen insurers disputed liability insurance coverage for thousands of underlying asbestos bodily injury claims under a \$1.85 billion liability insurance program spanning decades. TIG issued a series of fronting policies, as well as other liability policies, to IMO and made defense and indemnity payments under the fronting policies for asbestos-related claims asserted against IMO. TIG made its payments under the fronting policies under two interim agreements entered into with IMO, whereby the parties agreed upon an allocation of costs. TIG eventually took the position that the fronting policies were exhausted because the aggregate payments made by TIG equaled the total policy limits available under the fronting policies. IMO disputed this contention based on the relevant policy language, which stated that TIG would "not be obligated to pay any claim or judgment or defend any suit after the applicable limit of the [insurer's] liability has been exhausted by payment of judgments or settlements." IMO initiated a declaratory judgment lawsuit to resolve the dispute, and the trial court ruled in favor of TIG.

The Appellate Division addressed a number of issues on appeal. On the exhaustion issue, the Appellate Division framed the issue on appeal as "whether TIG must cover defense costs for an endless or indefi-

nite time until it has actually paid the indemnification limits of its policies, or whether those policies were exhausted and TIG has no further obligations to IMO." The Appellate Division affirmed the trial court judgment and adopted retroactive application of an *Owens-Illinois* allocation, whereby payments by a single insurer may be shifted from one policy year to another to determine exhaustion such that the total amount paid by the insurer—as opposed to the total amount paid, or required to be paid, under each policy—determines whether an insurer's defense and indemnity obligations have been fully satisfied. In so doing, the court found the parties' characterization of the costs paid, as memorialized in the interim agreement, as well as the relevant policy language relating to exhaustion, to be immaterial.

IMO held, under the facts of the case, that liability policies may be deemed exhausted, and a defense obligation terminated, based on a reallocation of losses where the total payments made, regardless of whether those payments were originally characterized as defense or indemnity, equal the total limits of liability under the insurers' policies. Notably absent from the decision was a discussion of Zeig or the more modern approach of considering policy language relating to exhaustion. The reasons for this may be that IMO dealt with an uncommon fact pattern and, further, had to address New Jersey precedent disregarding certain policy language in the context of allocating costs for long-tail insurance claims. Importantly, the Appellate Division limited its holding to the facts of that case.12 IMO does not provide guidance on the more common scenario where an underlying insurer and insured resolve a coverage dispute using a below-limits settlement. For this reason, IMO may not be instructive about exhaustion in the context of belowlimits settlements.

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- 1. *See, e.g., Couch on Insurance* 2d, p. 62.91 ("Excess insurance does not come into operation until the damage exceeds the maximum limitation of the primary policy.") (collecting cases).
- 2. See, e.g., Comerica Inc. v. Zurich Am. Ins. Co., 498 F. Supp.2d 1019, 1028 (E.D. Mich. 2007); Aerojet-Gen. Corp. v. Commercial Union Ins. Co., 155 Cal. App. 4th 132, 137 (3d App. Dist. 2007) (equating the attachment of liability clause to a condition precedent).
- 3. See, e.g., Consolidated Edison Co. of N.Y. v. Fyn Paint & Lacquer Co., Inc., 2005 U.S. Dist. LEXIS 899, at *16 (E.D.N.Y. 2005) (holding that an excess insurer's duty to defend is triggered "only when there is a showing that 'the potential liability of the insured is so great' that the primary insurers' coverage will be exhausted."); Sherwin-Williams Co., supra, 105 F.3d at 263 (6th Cir. 1997) (holding that the insured "must first show that there is no other insurance coverage available to it beyond mere denial by [the primary insurer].").
- 4. 23 F.2d 663 (2d Cir. 1928).
- 5. See, e.g., Fed. Ins. Co. v. Srivastava, 2 F.3d 98 (5th Cir. 1993); Stargatt v. Fid. & Cas. Co. of N.Y., 67 F.R.D. 689 (D. Del. 1975), aff'd, 578 F.2d 1375 (3d Cir. 1978); Siligato v. Welch, 607 F. Supp. 743 (D. Conn. 1985); Reliance Ins. Co. v. Transam. Ins. Co., 826 So. 2d 998 (Fla. Ct. App. 2001).
- 6. See, e.g., Mehdi Ali, et al. v. Fed. Ins. Co., Docket No. 11-5000-cv, No. 11-5000 (2d Cir. 4 June 2013); Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 161 Cal. App. 4th 184 (Cal. App. 4th Dist. 2008); Intel Corp. v. Am. Guar. & Liab. Ins. Co., 2012 Del. LEXIS 480, Case No. 692, 2011 (Sept. 7, 2012); JP Morgan Chase & Co. v. Indian Harbor Ins. Co., 2012 N.Y. App. Div. LEXIS 4627 (June 12, 2012).
- 7. Zeig, 23 F.2d at 666.
- 8. See 112 N.J. 30, 36 (1988).
- 9. *Id.* at 36.
- 10. See Chem. Leaman Tank Lines v. Aetna Cas. & Sur. Co., 177 F.3d 210, 214 (3d Cir. 1999) (in a case of statutory construction involving an insurer insolvency, holding that "the excess liability carrier was entitled to a credit equal to the full amount of the policy limits"); see also Carpenter Tech. Corp. v. Admiral Ins. Co., 172 N.J. 504, 517 (2002) (holding that an excess insurer is entitled to a credit "for the limits of the primary insurers' policies") (citing UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co., 276 N.J. Super. 52 (Law Div. 1994)).
- 11. 437 N.J. Super. 577 (App. Div. 2014).
- 12. *Id.* at 609 ("To allay some of the fears expressed by *amicus curiae*, the exhaustion decision in this case is closely tied to its facts.").

Recent Cases

by Brian R. Lehrer

n a case involving an oil spill, the New Jersey Supreme Court recently held that plaintiffs could not assert a bad faith claim against insurers who provided homeowner's coverage to the former owners of a neighboring property.¹

Plaintiffs John and Pamela Ross alleged their residence was damaged by the migration of home heating oil from a leaking underground oil storage tank located at a neighboring residence. As part of their claim, they sued the insurer who provided homeowner's coverage to the former owners of the neighboring property, asserting a claim of bad faith.

An underground tank intended for the storage of home heating oil was installed on the property designated as 72 Leighton Avenue in Red Bank. The property was owned from 1988 to 1999 by defendant Susan Elman, and her insurance carrier was High Point Insurance Company. In 1999, she sold the property to the Lowitz defendants who owned it until 2003. The Lowitz defendants were insured by State Farm until Feb. 2003 and by New Jersey Manufacturers (NJM) until Oct. 2003.

In Aug. 2003, the Lowitz defendants entered into a contract to sell the property. Prior to the closing, a leak in the storage tank was identified. It was cleaned up by State Farm and NJM. In 2004, the plaintiff bought the residential property located at 66 Leighton Avenue, and in 2006 allegedly first learned the oil had contaminated Lowitz's property and an adjoining property at 70 Leighton Avenue. In late 2006, plaintiff Ross put his property up for sale, and in 2007 it was discovered the oil had migrated onto his property, causing the sale of his property to be cancelled. State Farm and NJM agreed to pay monies toward the replacement of the plaintiff's deck, pool and retaining wall in the event remediation on the property necessitated the destruction of those structures.

However, the plaintiffs claimed they were not responsive to a request that they commence remediation and pay the plaintiffs' expenses, and ultimately the plaintiffs filed suit against numerous parties, including State Farm and NJM.

The plaintiffs alleged they were third-party beneficiaries of the insurance contract between the insurers and their insureds, and that they insurers violated the covenant of good faith and fair dealing. Ultimately, State Farm and NJM entered into an agreement regarding the terms of the remediation of the plaintiff's property. The remediation was completed in Oct. 2009, and in Aug. 2010 the New Jersey Department of Environmental Protection issued a no further action letter.

State Farm and NJM moved for summary judgment, and the trial court held the plaintiffs were not parties to the insurance contracts at issue, and therefore had no standing to recover the policy proceeds, and that public policy did not mandate a third-party be deemed the intended beneficiary of the insurance company's contractual duty to its insured to act in good faith with respect to a settlement. The Appellate Division affirmed. The Supreme Court then affirmed the Appellate Division.

Generally, an individual or entity that is a stranger to an insurance policy has no right to recover the proceeds. By virtue of an assignment of rights, a third party may assert a bad faith claim against an insurer. When a court determines the existence of third-party beneficiary status, the inquiry focuses on whether the parties to the contract intended others to benefit from the existence of the contract or whether the benefits so derived arise merely as an unintended incident of the agreement.

The court recognized an insurance company's duty of good faith and fair dealing to its insured in the processing of insurance claims. However, an insurer's duty of good faith and fair dealing has never been applied in New Jersey to recognize a bad faith claim by an individual or entity that is not the insured or an assignee of the insured's contract rights.

It is a fundamental premise of contract law that a third-party is deemed to be a beneficiary of a contract only if the contracting parties so intended when they entered into their agreement. Here, there is no suggestion in the record that the parties to the insurance contracts at issue had any intention to make plaintiffs, then the neighbors of the insured, a third-party beneficiary of their agreements. Nor does the migration of oil from the Lowitz's property to plaintiffs' residence retroactively confer third-party beneficiary status on plaintiffs. The insurers' duty of good faith and fair dealing in this case extended to their insured, not to plaintiffs.²

In sum, the Supreme Court upheld the dismissal of the bad faith claims against State Farm and NJM.

Auto Insurance—Voided Basic Policy Provides Only Basic Limits

In a case involving a basic automobile policy voided for fraud, the Supreme Court recently held that the innocent third party was only entitled to \$10,000 of liability coverage, not \$15,000.³

In March 2010, defendant Sabrina Perez applied for an auto insurance policy with Citizens United Reciprocal Exchange (CURE). She chose a 'basic' coverage policy with an optional \$10,000 coverage limit for third-party bodily injury liability. She lied on the application by failing to disclose that defendant Luis Machuca was a resident of her household.

In April 2010, Machuca was operating Perez's auto when he was involved in an accident. The accident victim, Dexter Green, filed a claim for personal injuries. Machuca also filed a claim for injuries against Perez's policy with CURE. CURE then filed a complaint against Perez alleging she had violated the Insurance Fraud Protection Act at N.J.S.A. 17:33A-1 et. seq., and sought to void the policy for fraud regarding the innocent third party, Green.

The trial court determined Perez's policy with CURE could be rescinded and voided, and awarded CURE court costs and attorney's fees because Perez had violated the Insurance Fraud Protection Act. The trial court denied all claims asserted by Machuca against CURE because Machuca was part of the fraudulent misrepresentations to CURE. However, the trial court held that in situations where an insurance policy is voided as a result of misrepresentations made by the insured, innocent third parties such as Green were entitled to coverage, and found that Green was entitled to \$15,000 of coverage under N.J.S.A. 39:6A-3 and N.J.S.A. 39:6B-1, because that was the minimum liability coverage mandated by New Jersey law. The Appellate Division

affirmed, but the Supreme Court reversed, holding that Green was only entitled to \$10,000 of liability coverage from the CURE policy.

Pursuant to N.J.S.A. 39:6A-3 and 39:6B-1, the minimum mandatory liability limits for an automobile insurance policy are \$15,000/\$30,000. However, pursuant to N.J.S.A. 39:6A-3.1, the mandatory minimum liability coverage limit for a 'basic' automobile liability policy is \$0, with an option for the insured to purchase \$10,000 worth of liability coverage.

Generally, a material factual misrepresentation made in an application for insurance may justify a rescission if the insurer relied upon it to determine whether or not to issue the policy. There was no question in this case that had CURE known Machuca would have been using the Perez vehicle, the policy would not have been issued because of Machuca's driving record. However, in New Jersey where a policy is voided as a result of a misrepresentation made by the insured, innocent third-party victims of automobile accidents such as Green are nonetheless entitled to coverage. The question in this case was how much coverage.

The court held that CURE was liable to Green for \$10,000 worth of liability coverage, not \$15,000. The court held that an insured's fraud should not enhance recovery by a third party and refused to obligate CURE to provide the statutory minimum of \$15,000 of liability coverage under a standard policy where it had issued a basic policy. Crucially, the court concluded that had Perez not opted for the \$10,000 liability limits, CURE's liability to Green would have been \$0.

Accordingly, we conclude that where an insured elects to add the basic policy's optional \$10,000.00 coverage for third-party bodily injury in their original contract, the insurer shall be liable to innocent third parties for the contracted \$10,000 amount as the minimal amount available under our compulsory system of automobile insurance coverage, even when that basic policy is later voided. Thus, evaluating the amount of recovery to which Green would have been entitled had Perez not fraudulently completed her insurance application, we hold that CURE is liable to Green in the amount of \$10,000.00. We further hold that when an insured elects not to add the basic policy's optional \$10,000.00 coverage in

their original contract, the insurer shall not be held liable to any injured, innocent third-party claimants under that contract.⁴

Policy Assignments—Valid After Claim Made

In a case involving the assignment of an insurance policy, the Appellate Division recently held that the assignment of insurance policies by a predecessor corporation to a successor corporation was valid where a claim under the policy had already been made.⁵

The case involved an enormously complex factual history involving the issuance of policies to predecessor corporations, replete with mergers and reformations. However, stripped to its essentials, Aetna Casualty and various other insurers issued policies during the 1960s and 1980s to the Givaudan Fragrances Corporation. Ultimately, Givaudan was found by the New Jersey Department of Environmental Protection (DEP) to have contaminated soil and groundwater at its Clifton site with hazardous materials.

In the 1990s, after a series of complex corporate mergers and reformations, the Givaudan Flavors Corporation was formed. There was no dispute that the plaintiff Givaudan Fragrances Corporation was an affiliated company with the Givaudan Flavors Corporation.

In Aug. 2004, the Environmental Protection Agency (EPA) notified Fragrances that it was potentially liable under federal law for hazardous discharges that had emanated from the Clifton site. In 2006, the DEP also filed suit against Fragrances for damages caused by discharges from the Clifton site. A year earlier, in 2005, the DEP had commenced an action against several companies that had operated sites within a contaminated area known as the Newark Bay Complex, and ultimately Fragrances was named as a third-party defendant in that action.

Ultimately, plaintiff Givaudan Fragrances Corporation claimed it was insured under the insurance policies the defendants had issued to the Givaudan Corporation between 1964 and 1986. In March 2010, Givaudan Flavors Corporation assigned Fragrances all of Flavors' insurance rights under various policies the defendants had issued to the Givaudan Corporation from Nov. 1964 to Jan. 1986.

The defendants refused to recognize the assignment on the ground that their respective policies prohibited policy assignments without the insurer's consent, and none of the insurers had consented to the assignment. Fragrances countered that the assignments were valid and bonding upon the defendants.

The trial court found the assignments invalid, but the Appellate Division reversed.

The policies at issue were 'occurrence' policies. In those kinds of policies, the peril insured is the occurrence itself. Generally, once the occurrence takes place, coverage attaches even though the claim may not have been made for some time thereafter. It was not disputed that the subject policies required the insurer's consent in order for the insured to assign the policy to a third person.

However, once a loss occurs, an insured's claim under a policy may be assigned without the insurer's consent.6 The Appellate Division noted that the purpose behind a no assignment clause is to protect the insurer from having to provide coverage for a risk different from what the insurer had intended. A no assignment clause guards an insurer against any unforeseen exposure that may result from the unauthorized assignment of a policy before a loss. However, if there has been an assignment of the right to collect or to enforce the right to proceed under a policy after a loss has occurred, the insurer's risk is the same because the liability of the insurer becomes fixed at the time of the loss. Thereafter, the court noted, the insurer's risk is not increased merely because there has been a change in the identity of the party to whom a claim is to be paid. The court rejected the defendant's argument that an insurer's contractual duty to honor its obligations under a policy cannot be triggered until a judgment has been recovered against an insured. The defendants' policies were liabilities policies, not indemnity policies. While indemnity policies require proof of payment by the insured as a condition precedent to recovering from the insurer, liability policies do not, and thus the post-loss assignments of the policies were valid.

Employer Liability/Separate Trial for Coverage

In a relatively complicated tort case that involved ancillary insurance coverage issues, the Appellate Division recently held that in a personal injury action where the plaintiff cannot proceed against his employer due to the worker's compensation bar, but tortfeasors have potential indemnification claims against the employer, the negligence and contractual indemnification issues should be tried simultaneously before a jury with the

employer going on the verdict sheet.⁷ However, the Appellate Division held that to the extent there are insurance coverage issues, those issues should be decided by either the court, or where a jury demand has been made by the insurers or the insureds, by a separate jury.⁸

The case involved an enormously complex fact pattern. Essentially, Jack D'Avila was seriously injured in a workplace accident and subsequently received negligent medical treatment causing his death three years later. A suit was filed against numerous parties, which could not include the plaintiff's employer because his claim was barred by the exclusive remedy provision within the worker's compensation statute at N.J.S.A. 34:15-8. However, the plaintiff decedent's employer was sued for contractual indemnification and therefore brought into the case.

The matter was tried to verdict. The trial court permitted the decedent's employer to participate in the jury trial, but disallowed the jury from ascertaining the employer's percentage of fault on the verdict form.

Pursuant to N.J.S.A. 34:15, an employer may not be sued by an employee for negligence that causes him or her injury. However, although worker's compensation is the exclusive remedy absent proof of an intentional wrong, the act does not preclude an injured employee from pursuing claims against third-party tortfeasors. While third-party tortfeasors cannot seek contribution from an employer under the Joint Tortfeasors Contribution Law at N.J.S.A. 2A:53A-1 et. seq., indemnification of a third party by an employer pursuant to an express contract is not barred by the act.

The Appellate Division noted that an earlier holding had precluded an employer from participating in the trial of the employee's case. That court had held that the trial of the third-party indemnification claim should be severed. The court held that it was to consider whether the impetus for a unitary proceeding was stronger here than it was in *Kane*, and concluded the sheer number of defendants and claims mandated that judicial efficiency should take precedence and warrant an exception to *Kane*.

Given the scope and complexity and number of parties in the case, the Appellate Division departed from *Kane* and held that

the sounder practice... is to try the negligence and contractual indemnification issues simultaneously before the jury. After the evidence has been presented at such a

trial, the court should issue carefully-crafted jury instructions, addressing the pivotal factual issues that the jury must decide. The verdict form will likewise need to be carefully designed, so as to only have the juror address the question of the employer's potential fault when it is absolutely necessary to do so.¹⁰

The Appellate Division held that the jury must be instructed that it should only consider the employer's negligence if it is first determined that the conduct of the defendant seeking indemnity is not the sole cause of the accident. Additionally, the jury should be given appropriate instructions about the presence of the employer's counsel in the trial, explaining he is participating solely with respect to certain factual issues the jury might need to address, and the jury should not be given an "ultimate outcome" instruction divulging that the plaintiff cannot recover any damages from the employer.

The court then discussed the insurance coverage issues and held it was not appropriate to submit coverage issues to the single jury. The presence of an insurance counsel in the case would be confusing. Further, it would undoubtedly risk speculation by a jury regarding the amounts of insurance coverage and could easily taint the jury's findings on negligence and the amount of any damages awarded—pointing out that Evidence Rule 411 generally excludes proof of liability insurance in cases involving negligence or other wrongful conduct. The court held the coverage issues must instead be decided by the court, or where a jury demand has been made by the insurers or the insureds, a separate jury.

ERISA—Statute of Limitations

In a case involving the Employment Retirement Income Security Act of 1974 (ERISA), the Third Circuit recently held that a six-year statute of limitations applied to the plaintiff's ERISA claim where the benefits denial letter did not advise the plaintiff that the plan provided for a one-year statute of limitations.¹¹

Dr. Nevil Mirza treated an employee of the Challenge Printing Company. He performed back surgery and submitted a claim to Insurance Administrator of America, the company charged with processing claims under Challenge's ERISA plan.

Insurance Administrator denied the claim on June 2, 2010, seeking more documents. After submitting more documents and working his way through the

internal review process, Mirza received a denial letter in Aug. 2010 indicating he had a right to bring a civil action under ERISA. None of the denial letters mention that under the plan Mirza had one year from the date of the final benefits denial to seek judicial review.

In March 2012, roughly 19 months after he received the final denial, Mirza filed suit. The case was dismissed on summary judgment because he had failed to file within the one-year statute of limitations outlined in the plan. The Third Circuit reversed.

Pursuant to 29 U.S.C. § 1001 et. seq., ERISA governs most employee welfare benefit plans. Regulations pursuant to 29 C.F.R. § 2560.503-1(g)(1)(IV), when a plan administrator denies a request for benefits, it must set forth a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action. ERISA provides that a participant or beneficiary may bring a civil action to recover benefits due to him or her under the terms of the plan.¹² The statute, however, does not prescribe any limitations period for filing such an action. When a statute does not provide a limitations period for filing a claim, the court borrows the statute of limitations from the most analogous state law claim, which in this particular case was a breach of contract. That statute of limitation is six years pursuant to N.J.S.A. 2A:14-1.

However, because an ERISA plan is nothing more than a contract, parties may agree to a shorter limitations period so long as the contractual period is not unreasonable.

The Third Circuit noted that the case was governed by 29 C.F.R. § 2560.503-1(g)(1)(IV), which provides that the plan administrator must set forth "a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of the act following an adverse benefit determination." The court held that a plain reading of this section obligated the defendants to advise of the one-year plan deadline in the letter denying Mirza's benefits. Thus, the Third Circuit reversed the district court.

ERISA—Assignment of Benefits

In a case involving an assignment of benefits clause under ERISA, the Third Circuit recently held that a patient's assignments to his or her healthcare provider of the right to receive payment of insurance benefits that did not directly refer to the right to file suit was sufficient to give the provider derivative standing under ERISA.¹³

The plaintiff, North Jersey Brain & Spine Center, treated three patients who were members of an ERISA-governed healthcare plan administered by defendant Aetna, Inc. Prior to surgery, each patient executed an assignment that read as follows: "I authorize NJBSC to appeal to my insurance company on my behalf...I hereby assign to NJBSC all payments for medical services rendered to myself or my dependents."

Following treatment, Aetna refused to pay. NJBSC filed suit against Aetna and the district court dismissed the complaint, holding that the assigned rights to payment did not give NJBSC standing to sue under ERISA. The Third Circuit reversed.

The issue in the case was what type of assignment is necessary to confer derivative standing to sue under ERISA. NJBSC argued that an assignment of the right to payment is sufficient. Aetna argued that an assignment must explicitly include not just the right to payment, but also the patient's legal claim to that payment if a provider is to file suit.

The court noted that ERISA itself is silent on the issue of derivative standing and assignments. The court then held that as a matter of federal common law, when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA. An assignment of the right to payment logically entails the right to sue for non-payment. Thus, the Third Circuit reversed the district court.

CGL Policies—Consequential Damages Covered

In a case involving a comprehensive general liability policy (CGL), the Appellate Division recently held that the unintended and unexpected consequential damages caused by a subcontractor's defective work constituted "property damage" and an "occurrence" under the insurance policy. In *Cypress Point*, the plaintiff was a condominium association. It brought claims against its developer, Adria Towers; the developer's insurers; and various subcontractors. The developer had served as the general contractor on the condominium project and hired subcontractors who performed all of the construction work.

The subcontractors performed faulty work. They failed to properly install the roof, flashing, gutters and leaders, among other things. As a result, the plaintiffs

alleged the faulty workmanship caused consequential damages to the common areas and unit owner's property, including damages to steel supports, exterior sheathing and interior sheathing, as well as various leaks.

The trial court granted summary judgment to the insurers, holding that there was no property damage or occurrence as required by the policy to trigger coverage. The Appellate Division reversed. It noted that the sole question was whether consequential damages to the common areas of the condominium complex and to the unit owner's property caused by subcontractors' defective work constituted property damage and an occurrence under the policy. It held that the answer was yes.

Generally, it has been held that there is no insurance coverage for faulty workmanship where the damages claimed are solely the cost of correcting the work itself. This is considered a "business risk," and is considered uninsurable.¹⁵

When interpreting insurance contracts, courts look to the plain language of the policy. If the terms are clear, then the terms are given their plain and ordinary meaning. Basically, the insurance policy provided that it provided coverage where the insured became legally obligated to pay damages because of property damage caused by an occurrence. The policy defined occurrence as an accident, including continuous or repeated exposure to substantially the same general harmful conditions; and defined property damage as physical injury to tangible property or loss of use of tangible property that is not physically injured.

The court concluded that the consequential damages alleged amounted to property damage and an occurrence. The consequential damages clearly constituted "physical injury to tangible property," as the faulty workmanship damaged the common areas and the unit owner's property.

The court then addressed the misapplication of *Weedo* and other prior holdings. The *Weedo* court had interpreted a 1973 Insurance Services Office, Inc. (ISO) form, and held that there was no insurance coverage for faulty workmanship where the damages claimed were solely the cost of correcting the work itself. However, this case involved consequential damages, which were not defective work damages, but rather were distinct from the cost of correcting the work itself.

We emphasize that the consequential damages here are not the cost of replacing

the defective work—that is the improperly installed roof, flashing, gutters and leaders, brick and EIFS façade, windows, doors and ceilings. Those costs are considered a business risk associated with faulty workmanship. Rather, the consequential damages are those additional damages to the common areas of the condominium building and the unit owner's property.¹⁶

The court also noted two critical differences between the 1973 ISO form and the 1986 ISO form. The word "occurrence" is defined differently in the 1973 ISO form, which defines it as an accident that results in property damage neither expected nor intended from the standpoint of the insured. The 1986 policy defines occurrence as an accident, including continuous or repeated exposure to substantially the same general harmful conditions, and does not directly include property damage in the policy's definition of an occurrence. Secondly, the 1986 form includes a significant exception to an exclusion not contained in the 1973 form. The policies contain exclusions for property damage to "your work" arising out of it or any part of it, but the 1986 policy contains an exclusion that the exception does not apply if the damage work or the work out of which the damage arises was performed on "your behalf by a subcontractor." Thus, the court concluded that for insurance risk purposes, consequential damages caused by a subcontractor's faulty workmanship are considered differently than property damage caused by a general contractor's work.

If the parties to the insurance contract did not intend the subcontractor's faulty workmanship causing consequential damages to constitute 'property damage' and an 'occurrence,' as those terms are defined in the policy, then it begs the question as to why there is a subcontractor's exception. The absence of such an exception in 1973 ISO form is important because in defining 'property damage' to effectuate insurance coverage, we previously rejected any attempt to separate a subcontractor's faulty workmanship from that of a general contractor...Thus, as a matter of an insurance underwriting risk, the exception treats consequential damages caused from faulty workmanship by

subcontractors differently than damage caused by the work of general contractors.¹⁷

The court concluded that the developer/general contractor would reasonably expect that consequential damages caused by the subcontractor's faulty workmanship constituted property damage and an occurrence under the policy. The court found persuasive the majority rule that construction defects causing consequential damages constitute occurrences under insurance policies. The court pointed to federal case law holding that under the same policy language, liability coverage existed for the cost to remedy unexpected and unintended consequential property damage to the contractor's otherwise non-defective work product caused by the subcontractor's defective workmanship.¹⁸

Finally, the court concluded that the plaintiff had met the definitions of property damage and occurrence under the policy, but that did not mean that insurance coverage existed. The court did not reach the question of whether the plaintiff was entitled to insurance coverage under the policy because there were exclusions, and those had not been addressed by the lower court. The case was remanded to the Law Division for further proceedings.

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- 1. Ross v. Lowitz, et al., __ N.J. __ (2015).
- 2. Slip Opinion at page 28.
- 3. CURE v. Perez, __ N.J. __ (2015).
- 4. Slip Opinion at 18-19.
- 5. Givaudan Fragrances Corp. v. Aetna Casualty, et al., __ N.J. Super. __ (App. Div. 2015).
- 6. See generally, Elat, Inc. v. Aetna Cas. & Sur., 280 N.J. Super. 62 (App. Div. 1995).
- 7. Estate of D'Avila v. Hugo Neu Schnitzer, et al., __ N.J. Super. __ (App. Div. 2015).
- 8. Id.
- 9. Kane v. Hartz Mountain, 278 N.J. Super. 129 (App. Div. 1994), aff'd ob., 143 N.J. 141 (1996).
- 10. Slip Opinion at page 44.
- 11. Mirza v. Insurance Administrator of America, et al., __ F. 3d __ (3d Cir. 2015).
- 12. See generally, 29 U.S.C. § 1132(a)(1)(B).
- 13. North Jersey Brain & Spine Center v. Aetna, Inc., __ F. 3d __ (3d Cir. 2015).
- 14. Cypress Point v. Adria Towers, 441 N.J. Super. 369 (App. Div. 2015).
- 15. Weedo v. Stone-E-Brick, Inc., 81 N.J. 233 (1979).
- 16. Cypress Point, 441 N.J. Super. at 379 (App. Div. 2015).
- 17. Cypress Point, 441 N.J. Super. at 381 (App. Div. 2015).
- 18. French v. Assurance Co. of Am., 448 F. 3d 693 (4th Cir. 2006).

Recent Cases Retrospective

by Brian R. Lehrer

ince 1998, I have edited the *Insurance Law Section Newsletter*. Over those years, I have digested a few hundred cases. As the old issues collect dust, I thought it might be worthwhile to do a retrospective of the digested cases to provide a handy reference.

This issue's subject is excess insurance policies.

Primary and Excess Carriers—Fiduciary Duty

The Appellate Division held that where an excess carrier denies coverage, the primary carrier's fiduciary duty to the excess carrier is extinguished.¹

Bad Faith—Second- and Third-Tier Excess Carriers

The Appellate Division held that a second-tier excess carrier owed no duty to a third-tier excess carrier to negotiate and settle in good faith an insured's first-party property loss claim in accordance with the principals enunciated in *Rova Farms*, but rather that the third-tier excess carrier had to demonstrate the absence of a reasonable basis for this second-tier carrier's refusal to settle.²

Policy Construction—Reform by Statute Excess Clauses

The Appellate Division held that an excess policy was required to provide the same coverage as an underlying policy, which had been reformed by statute.³

UIM—Notice/Prejudice/Excess and Primary Carriers

The Appellate Division held that an underinsured motorist (UIM) carrier was not prejudiced by an insured's failure to give a *Longworth* notice, and held that while the host vehicle's policy was primary, it did not provide coverage because the excess UIM insurer failed to give the primary UIM insurer a *Longworth* notice.⁴

Umbrella Policies—Insured Covered for Judgment on Behalf of Spouse

Recognizing the unique nature of umbrella policies, a trial court held that an umbrella policy covered the plaintiff for a judgment entered against him on behalf of his wife.⁵

Primary v. Excess Insurance—True Excess v. Other Insurance Excess

The Appellate Division examined the difference between insurance policies that are truly excess policies, and those that are excess merely by virtue of other insurance clauses for the purposes of determining the potential duty owed by one carrier to another. The court held that where one carrier is excess solely by virtue of another insurance clause, it is not a true excess carrier, and thus the primary carrier does not owe it a duty.⁶

Liability Policies—Umbrella Carrier Not Advised of Residency Change

In a case involving an umbrella liability policy, the Appellate Division held that the umbrella carrier was not obligated to extend coverage to the son of the named insured for an accident that occurred after the son moved out of the household and failed to advise the carrier.⁷

Excess Insurance—Notice

The Supreme Court held that an excess carrier did not suffer appreciable prejudice due to a lack of timely notice, and thus could not deny coverage for an accident involving the insured.⁸

Primary and Excess Insurance—Primary Carrier's Duty

In a case involving a primary carrier and an excess carrier, the Appellate Division held that a hearing was necessary to determine whether the primary carrier violated its fiduciary duty to the excess carrier to engage in good faith efforts to settle claims within its policy limits, so that it could not be liable for pre-judgment interest above its primary limits.⁹

Primary v. Excess Insurance—Evidentiary Hearings

In a case involving a dispute between a primary carrier and an excess carrier, the Appellate Division held that an evidentiary hearing was required to determine whether the excess carrier's conduct in settlement negotiations was relevant to its claim that the primary carrier was liable for the entire amount of pre-judgment interest from a jury verdict that was in excess of the primary carrier's liability limits.¹⁰

Insurance Coverage—Excess/Allocation/Choice of Law

In a case involving comprehensive general liability policies, the Appellate Division held that New Jersey law applied to the allocation of coverage among triggered insurance policies for personal injury claims from multiple states in determining whether the liquidator of the insolvent excess insurers had breached its contract in denying claims for payment.¹¹

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- 1. Baen v. Farmer's Mut. Fire Ins. Co., 318 N.J. Super. 260 (App. Div. 1999).
- 2. M&B Apartments v. Telster, 328 N.J. Super. 265 (App. Div. 2000).
- 3. Sunoco Products v. Fire & Cas. Ins., 337 N.J. Super. 568 (App. Div. 2001).
- 4. Hallion v. Liberty Mut. Ins., 337 N.J. Super. 360 (App. Div. 2001).
- 5. Fortunato v. Highlands Ins. Group, 345 N.J. Super. 529 (Law Div. 2001).
- 6. CNA Ins. Co. v. Selective Ins. Co., 354 N.J. Super. 369 (App. Div. 2002).
- 7. Greer v. Naklicki, 379 N.J. Super. 153 (App. Div. 2005).
- 8. Gazis v. Miller, 186 N.J. 224 (2006).
- 9. NJM v. NCC, 393 N.J. Super. 340 (App. Div. 2007).
- 10. NJM v. NCC, 413 N.J. Super. 94 (App. Div. 2010).
- 11. In re Liquidation of Integ. Ins., 427 N.J. Super. 521 (App. Div. 2012).