

Risk Management and Insurance Coverage: What Does the Policy Say?

I: INTRODUCTION

Mid-Sized Construction Company (“Mid-Sized”) enters into an architectural services agreement and a construction contract with Big Client (“Big”) for what it hopes will be a lucrative project (“the Project”). Mid-Sized later enters into a subcontract (“the Subcontract”) with Electrical Subcontractor (“Electrical”) to provide electrical services for the Project. Hoping to cover its risks, Mid-Sized obtains errors and omissions insurance coverage from E&O Insurance Company (“E&O”) as well as commercial general liability insurance coverage from CGL Insurance Company (“CGL”) to cover any potential claims for defects in the design and construction of the Project. Mid-Sized also covers its bases by requiring, pursuant to the Subcontract, that Electrical maintain liability insurance for Mid-Sized to cover any potential claims for bodily injury arising during the Project’s construction. Pursuant to the Subcontract, then, Mid-Sized is named as an “additional insured” under Electrical’s insurance policy with American Insurance Company (“American”).

Joseph P. Passerby (“Passerby”) sustains bodily injury during the construction phase by slipping and falling on electrical wiring belonging to Electrical. Passerby sues Mid-Sized, but not Electrical. Later, Big Client determines the Project has fallen short of its expectations, and sues Mid-Sized for breach of the architectural services agreement and breach of the construction contract, alleging that Mid-Sized improperly designed and incorrectly constructed the Project’s building. Luckily, Mid-Sized has paid all of its insurance premiums, and so has Electrical, so Mid-Sized confidently mails a copy of the personal injury lawsuit to American and the other claims to CGL. Mid-Sized decides not to involve E&O in the litigation, in the hope of keeping its premiums down under that policy, which is up for renewal soon.

Matters do not proceed smoothly. Mid-Sized receives letters from American and CGL containing phrases like “reservation of rights,” “professional services exclusion” and “other insurance” that sound ominous. Now, the question that has been lurking beneath the surface rears its head: What do the policies actually *say*?

II: THE TARGETED TENDER: THE INSURED’S RIGHT TO CHOOSE ITS COVERAGE

By sending Passerby’s personal injury claim to American, Mid-Sized attempted what is known as a “targeted tender.” For reasons of its own, Mid-Sized preferred not to invoke coverage under its own policy and elected to have American pay its defense (and, if applicable, indemnity) costs. Can it do that?

A: WHEN IS COVERAGE TRIGGERED?

- *John Burns Construction Company v. Indiana Insurance Company*, 189 Ill.2d 570, 727 N.E.2d 211 (Il. 2000).

In this case, the Illinois Supreme Court upheld the insured's right to tender defense of an action to one insurer alone—or to “target” its tender. In this case, the construction company (Burns) was a “named insured” on the subcontractor's insurance policy with Indiana Insurance Company. Burns was sued for personal injury when someone slipped and fell on the parking lot that the subcontractor had paved. Burns asked Indiana to defend and indemnify it in the action. Burns stated that it looked solely to Indiana for defense and indemnification, and that although it had notified its own insurer, Royal Insurance Company, of the action, Burns did not want Royal to become involved in the suit.

Indiana initially refused to defend Burns, but later changed its position and agreed it had an obligation to do so. However, Indiana then claimed that Royal was required to share the defense and indemnity duties, for the Indiana policy contained an “other insurance” provision. This provision had language that appeared to require both insurance companies to equitably apportion coverage between them.

The question before the Illinois Supreme Court was whether an insurer to whom litigation is tendered and whose policy contains an “other insurance” clause may seek contribution from another insurer whose policy is in existence but whose coverage the insured has refused to invoke.

The Illinois Supreme Court in *Burns* upheld the principle that, in instances where an insured may have more than one policy that potentially applies, the insured's right to choose its coverage is paramount. This is true even where the targeted policy contains an “other insurance” clause that appears to place another insurer on the hook for defense and indemnity costs. The *Burns* Court held that the presence of the “other insurance” clause in the Indiana policy did not in itself overcome Burns' right to tender defense of the action to one insurer alone. The insurance provided to Burns by Royal was not “available,” in the language of the “other insurance” provision, for Burns had expressly declined to invoke that coverage. Moreover, the presence of the “other insurance” provision in the Indiana policy did not serve by itself as a trigger to the coverage afforded by Royal's policy. Therefore, this case stands for the principle that an insured may decide (for reasons of its own) not to have its own insurance company pay its defense and indemnity costs, but rather, may “target” another policy—irrespective of the “other insurance” clause in the policy. Under *Burns*, the purpose of an “other insurance” clause is not to trigger coverage, but to provide a method of apportioning coverage *that would otherwise be triggered*.

- *Cincinnati Cos. V. West American Insurance Co.*, 183 Ill.2d 317, 701 N.E.2d 499 (1998). The Illinois Supreme Court in this case considered what is necessary to trigger an insurer's duty to defend, and held that the duty arises with actual notice of a claim against an insured. The court acknowledged that an insured has the right to elect which of its insurers will defend a particular case. The court stated: “Where an insured makes such a designation, the duty to defend falls solely on the selected insurer. That insurer may not in turn seek equitable contribution from the other insurers who were not designated by the insured. This rule is intended to protect the insured's right to knowingly forgo an insurer's involvement.” The court concluded that “an insured may knowingly forgo the insurer's assistance by instructing the insurer not to involve itself in the litigation. The insurer would then be relieved of its obligation to the insured with regard to that claim.”

**B: WHEN THE INSURED HAS MULTIPLE COVERAGES: THE OPERATION AND EFFECT OF THE
“OTHER INSURANCE CLAUSE”**

- *Institute of London Underwriters v. Hartford Fire Insurance Co.*, 234 Ill.App.3d 70, 599 N.E.2d 1311 (1992).
Here, the appellate court addressed the issue whether an insured may elect which of two insurers will be required to defend and indemnify a claim when two insurance policies potentially apply. The appellate court held that an insured has the right to choose which policy will apply. The Institute of London Underwriters had provided coverage to an injured party’s employer as a named insured and to the employer’s general contractor as an additional insured. A suit was filed against the general contractor by the estate of a fatally injured employee, and Institute accepted tender of this claim from the general contractor. The contractor informed its insurer, Hartford, of the pending claim but instructed Hartford not to contribute to the defense or indemnification of the action. Institute later sued Hartford, seeking equitable contribution. Both the circuit court and the appellate court concluded that the claim for equitable contribution was defeated by the contractor’s instructions to Hartford not to defend or indemnify the action.
- *Bituminous Casualty Corp. v. Royal Insurance Co. of America*, 301 Ill.App.3d 720, 704 N.E.2d 74 (1998).
In this case, a general contractor hired a subcontractor to perform work in the construction of a grocery store. The subcontract agreement required the subcontractor to name the general contractor as an additional insured under the subcontractor’s liability insurance policy. An employee of the subcontractor was injured during the project and sued the general contractor, which tendered defense of the claim to the subcontractor’s insurer, Bituminous Casualty Corp. Bituminous asked the general contractor’s insurer, Royal Insurance Company, to participate in the defense, but Royal declined to do so.

After the underlying action was settled, Bituminous asked the court to order Royal to pay one half of the costs of the action. The Illinois Appellate Court ruled that the general contractor was entitled to select one of the insurance companies to defend the action alone. The appellate court further rejected Bituminous’ argument that, regardless of the general contractor’s election, the presence of “other insurance” provisions in the two companies’ policies entitled Bituminous to recover half the costs of the defense from the other insurer, Royal. The appellate court explained: “It is only when an insurer’s policy is triggered that the insurer becomes liable for the defense and indemnity costs of a claim and it becomes necessary to allocate the loss among co-insurers. The loss will be allocated according to the terms of the ‘other insurance’ clauses, if any, in the policies that have been triggered. However, Royal’s policy was not triggered and its obligation to defend and indemnify the general contractor with regard to the personal injury lawsuit was excused by the targeted tender to Bituminous.”
- *Alcan United, Inc. v. West Bend Mutual Insurance Co.*, 303 Ill.App.3d 72, 707 N.E.2d 687 (1999). In this case, the Illinois Appellate Court held that an “other insurance” clause in a policy will not automatically reach into coverages provided under other policies merely because such other policies are in existence. The insured still must be given the right to determine whether it wishes to invoke its rights to such other coverages before those coverages become accessible under the “other insurance” provision of a triggered policy.

**C: LIMITATIONS ON THE INSURER'S RIGHT TO OBTAIN EQUITABLE CONTRIBUTION
FROM ANOTHER INSURER IF THE INSURER EXERCISES ITS RIGHT TO CHOOSE**

- *Richard Marker Associates v. Pekin Insurance Company*, 318 Ill.App.3d 1137, 743 N.E.2d 1078 (2001). In this case, the plaintiffs sued for breach of an architectural services agreement and breach of a construction contract on the grounds that Marker improperly designed and incorrectly constructed a building which was to contain the plaintiffs' residence, dental offices and laboratory. Marker initially tendered defense of the cause of action to Pekin, which refused the tender. As a result of this refusal, Marker retained counsel to represent him in the plaintiffs' lawsuit. Marker then tendered the defense to its other insurer, Statewide. Marker later settled the lawsuit and withdrew its tender to Statewide. In the meantime, a court ordered Pekin had a duty to defend and indemnify Marker. Pekin then sued Statewide, alleging that Statewide owed Pekin equitable contribution pursuant to the "other insurance" provision of Pekin's insurance policy. Statewide denied this responsibility, pointing to the fact that Marker had deactivated its tender.

Thus, the issues on appeal were whether Marker was capable of withdrawing his tender to Statewide after the plaintiffs' lawsuit was settled and whether Statewide's coverage of the plaintiffs' lawsuit was accessible for equitable contribution under the "other insurance" provision of the Pekin policy. The appellate court agreed with Statewide that Pekin was not entitled to equitable contribution from Statewide.

The court reiterated the principle that an insured's right to choose or knowingly forgo an insurer's participation in a claim is paramount, stating, "The insured may choose to forgo an insurer's assistance for various reasons, such as the insured's fear that premiums would be increased or the policy canceled in the future, and this ability to forgo assistance should be protected."

The court concluded that Marker had not relinquished his right to forgo Statewide's coverage, and rejected Pekin's position that Marker's withdrawal of his tender of defense to Statewide was of no legal consequence. Marker clearly possessed the right to forgo Statewide's coverage of the plaintiffs' lawsuit. Because his right to forgo coverage with Statewide included an ability to deactivate the coverage, Marker was not precluded from withdrawing his tender of defense simply because a tender was made.

Pekin urged the court to impose a limit on the right of an insured to choose or knowingly forgo an insurer's participation in a claim in instances where prejudice to another insurer results from such an election. Pekin argued that it was prejudiced because Marker's withdrawal of his tender to Statewide was an unfair attempt to hold Pekin solely responsible, without benefit of equitable contribution, for Marker's defense and indemnification. The court did not agree, and stated that prejudice inescapably results when an insured elects coverage for a claim with one insurer and knowingly forgoes the coverage of another insurer. In spite of this prejudice, Illinois courts continue to protect the insured's right to choose or knowingly forgo coverage.

III: THE DUTY TO DEFEND: THE INSURED'S RIGHTS WHERE COVERAGE IS DISPUTED

Mid-Sized tenders its defense of the lawsuit for breach of the architectural services agreement and the construction contract to CGL. CGL responds by pointing to certain exclusions in the policy that may prevent Mid-Sized from obtaining coverage if a judgment is entered against Mid-Sized in the Big Client litigation. CGL tells Mid-Sized that, because of these exclusions and the possibility that coverage may not be afforded under the policy, CGL is under no obligation to provide a defense in a case where it may ultimately owe no coverage in the long run. From this, Mid-Sized concludes that it must hire its own defense lawyer and pay for its own defense. Mid-Sized *thought* it had obtained insurance coverage for just this type of situation, but the exclusions that CGL points to are clearly in the policy, so it looks like CGL is right. Can CGL refuse to defend Mid-Sized?

A: COVERAGE AFFORDED UNDER A RESERVATION OF RIGHTS

- *Sims v. Illinois National Casualty Co.*, 43 Ill.App.2d 184, 193 N.E.2d 123 (1963). The Illinois Supreme Court declared in this 1963 case that an insurer taking the position that a complaint potentially alleging coverage is not covered by a policy that provides that the insurer has the right and duty to defend any claims brought against the insured cannot simply refuse to defend the insured. It must defend the suit under a reservation of rights or seek a declaratory judgment that there is no coverage. If the insurer fails to do this, it is prohibited from later raising policy defenses to coverage and is liable for the award against the insured and the costs of the suit, because the duty to defend is broader than the duty to pay.

What this means is this: there may be some allegations in the lawsuit that, if proven, would result in no coverage for the insured, due to certain exclusions to coverage contained in the policy. However, if there are at least *some* allegations that *would* end up being covered, then the insurer cannot simply refuse to defend the insured. It must do one of two things (or both): defend under a reservation of rights or file a lawsuit of its own asking a court to determine whether it is right or wrong about those exclusions to coverage. Defending under a reservation of rights simply means that the insurer will appoint defense counsel and pay the costs of defense, but reserves its right to later deny indemnification to the insured if a judgment is entered against it. The important thing is that the insurer cannot simply leave its insured hanging. If it does, then later on if and when a judgment is entered against the insured, the insurance company will have to pay for it.

**B: COVERAGE WHERE THERE IS A CONFLICT OF INTEREST BETWEEN INSURED AND INSURER:
PEPPERS COUNSEL**

Having informed itself of its right to a defense under the policy, Mid-Sized turns again to CGL and points out that at least some of the allegations in the lawsuit would fall within the policy's coverage, so Mid-Sized requests that CGL hire a defense lawyer to represent it in the Big Client lawsuit. CGL again declines, telling Mid-Sized that while that is true, if some of the other allegations were to end up being proven against Mid-Sized, that would result in a finding of no coverage. Since it is in CGL's interest to have those allegations proven, there is obviously a conflict of interest. CGL cannot direct or participate in Mid-Sized's defense because it has a direct interest in seeing some of the allegations against Mid-Sized proven. Therefore, CGL again declines to provide a defense, based upon the conflict of interest. Is CGL right?

- *Maryland Casualty Co. v. Peppers*, 64 Ill.2d 187, 355 N.E.2d 24 (Il. 1976); *Thornton v. Paul*, 74 Ill.2d 132, 384 N.E.2d 335 (Il. 1978). The situation described above presents an exception to the general rule stated above. The Illinois Supreme Court held that an insurer must decline to defend where there is a conflict of interest between it and the insured. However, the insured's rights and the insurer's obligations do not end there. The Illinois Supreme Court held that, because of the serious ethical problems that might be involved, the insurer facing a conflict of interest with its insured in the conduct of the insured's defense is not obligated or permitted to participate in the defense. However, the insurer must pay the costs of independent counsel for the insured. The insured has the right to be defended by counsel of his own choosing. Counsel retained under these circumstances has come to be known as "Peppers counsel."

Peppers counsel ensures that the insured has the right to control the defense.

IV: THE PROFESSIONAL SERVICES EXCLUSION

When CGL initially refused to defend Mid-Sized by pointing to certain exclusions in the policy, it was primarily focused on the professional services exclusion. This is a major hurdle for an engineer or other professional seeking coverage under a commercial general liability policy (CGL). Most design or analytical services performed by an engineer will fall within the definition of professional services. However, some services may fall within a gray area, requiring the CGL insurer, at a minimum, to defend the claim (as discussed above). If a court later finds the professional services exclusion is ambiguous as applied to a particular fact situation, then the ambiguity will be construed in favor of coverage for the insured.

For the most part, if the allegations in the lawsuit stem from wrongful or negligent conduct arising from the professional's breach of the standard of care, then the defense should be tendered to the errors and omissions carrier (E&O).

V: ECONOMIC LOSS

Returning to Big Client's lawsuit against Mid-Sized, we were told it was for breach of an architectural services agreement and a construction contract. Mid-Sized tendered the defense to CGL, not wanting to involve its E&O policy. While an insured does have the right to choose its coverage, it needs to make sure the policy affords coverage for the type of damages being sought. Commercial general liability policies cover bodily injury or property damage. They do not provide coverage for pure economic loss such as lost profits, diminution in value of property, damages caused by delays in construction or other damages which are not the consequence of harm to tangible property. CGL policies cover negligence actions, but not breach of contract actions. Courts generally refuse to allow recovery for contract actions seeking pure economic loss under CGL policies. Thus, if the only damages sought are for economic loss, no coverage will be available under the standard CGL policy.

Here again, Mid-Sized may have been better suited to tender its defense to its errors and omissions (E&O) carrier. An errors and omissions policy is a professional liability policy providing coverage for all demands for money or services alleging a "wrongful act," which is defined as a negligent act, error or omission in the performance of professional services. This is a better prospect for coverage for economic loss.

VI: OCCURRENCE VERSUS CLAIMS MADE POLICIES

CGL coverage is offered on either an “occurrence” or “claims made” basis. Professional liability policies are generally written on a claims made basis.

Under occurrence based policies, coverage is triggered at the time damage occurs, if there is a policy in effect at that time. Under a claims made policy, coverage is triggered only if a claim is “first made” against the insured during the term of the policy.

Once a risk is written on a claims made basis, it is necessary to continue to purchase claims made coverage or make other adjustments in coverages. For example, if an engineer is alleged to have made a design error in 2002 that resulted in damage in 2003 and a claim was first made against the insured in 2004, but the insured had a claims made policy in 2003 which it changed to an occurrence based policy in 2004, a gap in coverage would occur. The 2003 claims made policy would not be triggered because no claim was made against the insured in that year. The 2004 occurrence based policy would not respond because the damage occurred in 2003 (assuming no continuing damage).

Thus, the method by which coverage is triggered (on an occurrence versus a claims made basis) is an important consideration when designing an insurance program and when changing from one type of insurance to another.