

Policy Wording Matters[®]



Written for Underwriters, Program Managers, Claims and Legal Professionals—and Policy Drafters.

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This publication series was created by underwriters, attorneys, claim handlers and policy drafters within Gen Re in recognition of the link between good policy wording and good underwriting results. For more information, contact Mindy Pollack at 203 328 6153 or mpollac@genre.com.

The Practical Side of Policy Forms— When is it Time for New Wording?

by Doug Clark and Mindy Pollack, Gen Re, Stamford

Insurers in all lines of business often face two questions in their regular policy form work:

- > Should I adopt the new ISO, AAIS or other Bureau edition that will be effective soon?
- > When is it time to change policy wording that is not working as intended?

Every few years, ISO and AAIS come out with new commercial and personal lines policies. Some new editions contain sweeping changes; others, such as the 2007 ISO CGL, make relatively few revisions. Whenever a new form edition is available, insurers face the recurring question: *Should I adopt the new ISO or AAIS form?*

A related and no less challenging question arises for companies using the Bureaus' and their own forms. Perhaps one court has found your policy language ambiguous, but you anticipate more challenges in other states. If the highest court in your state rules against you, the answer is easy, but insurers are more likely to encounter a patchwork of court opinions and a difficult decision. *At what point in the evolving case law is it time to change the wording?* Leading insurance attorney Randy Maniloff, who has represented insurers in many coverage battles, offers his insights on this issue in "Coverage by Admission," the Outside Counsel column following this article.

The ultimate answers to both questions will be made by each company based on a variety of factors. There is no "one size fits all" answer. Gen Re and Mr. Maniloff simply provide some of the considerations on these policy change dilemmas to help you make the best decisions for your company.

For more on this topic, see Randy Maniloff's Outside Counsel Column, Coverage by Admission, on p.5.

The Practical Side of Policy Forms—When is it Time for New Wording?

(continued)



Behind Bureau Form Changes

We have observed the accelerating pace of policy form revisions and attribute the trend to the volume of coverage litigation. Prior to 1986, the average lifespan of a CGL form was seven years; since then, a new edition appears every three years. When you think of the timeline for creating a new edition, this speed takes on new meaning. Understanding the process may help you make the decision on whether to adopt a new form.

A new edition involves up to two years (or more) of research, review, drafting and filing. Let's work backwards from the new edition date of a CGL. The 2007 edition summarized in our February 2007 *Policy Wording Matters* will be effective December 1, 2007 in most states. It was actually filed in late 2006, over one year earlier. Prior to that, ISO staff spent months drafting the wording changes, following months of GL panel meetings. Prior to the meetings, ISO was collecting and researching insurance policy issues. In other words, that CGL edition, effective on December 1, 2007, may have had its beginnings in late 2005 or earlier. While this timeline may seem unduly long, policy language is too important to be rushed.

This process means that most new editions are started *right after the preceding edition was filed*, and even before it could be used. After an edition is filed with regulators, the door is closed on further changes absent an unusual event. Any cases occurring after that edition filing date will carry over for endorsements or the next policy edition. What does this mean to your decision? If you want to stay with the current edition, or do not feel it is time to address the policy defect just yet, you may have to wait three or more years before the next edition—and presumably the better edition—is available.

The Pros and Cons of Adopting the New Edition

Now that you know what goes into a new policy edition, it's time to consider your own operations and how they will influence your decision. Is your company going to stay with the 2004 CGL or the 2002 BOP, or are you going to implement the new form? We note that each pro can be turned around to a con.

Reasons for adopting the new edition include:

- > **Responding to the recent coverage decisions, changes in statutes and other developments**—If you are using the 1998 CGL edition, it won't have the new "anti-Montrose" language or the exclusion for spam and blast faxes (among others). You may be fine with giving this coverage, but if not, you could be paying more losses than you intend.
- > **Maintaining a "cutting edge" image**—Whether it's your own form or a Bureau edition, your policies are up-to-date, and that can reflect well on your company's overall image in the market and with your own staff.
- > **Fewer endorsements**—When ISO and AAIS update the edition, all interim mandatory endorsements are incorporated and insurers no longer have to issue those endorsements separately.
- > **Lower risk of underwriting errors**—By incorporating prior endorsements in the new form, there is less risk of an underwriting "error and omission" from failing to issue same, which does come up in many cases we see.
- > **Ability to use most current manual rates**—ISO rates are aligned with ISO coverage forms, so if you use the new form you can also use the new rates without having to make any special adjustments.
- > **Ability to use change notices**—See "The Catch-Up Factor" on p.3.



What Policy Changes Are You Missing?

To measure the cost of not adopting a new policy, we highlight a few of the more important wording changes made in recent editions. Some may be relevant to your book of business, others may not. In any event, if you are not using the most current Bureau form or have not updated your proprietary policy in many years, this *brief* list can point to some claims you might see now or soon.

- > **Homeowners—Levee Breach Issue.** The current ISO Homeowners policy excludes water damage and flooding “caused by or resulting from human or animal forces or any act of nature.” This phrase was not present in the pre-2000 forms. Similar language was enforced by a Louisiana trial court to reject coverage for water damage claims attributed to negligently built and maintained levees in New Orleans. Insurance policies without this language were held to cover the breach claims. The ruling is on appeal.
- > **CGL—Montrose and Blast Fax Claims.** The most notable addition to the 2001 ISO CGL was incorporation of the “anti-Montrose” endorsement to curtail stacking of policies after property damage is known. Without this language, some courts will allow coverage to continue until liability (as opposed to damage) becomes clear. (For contracting risks, insurers are also attuned to ISO’s revised Additional Insured endorsements—Before the 2004 revisions, many insurers manuscripted their own AI forms, and some are still deciding whether to go with the new ISO wording). More recently, ISO issued an endorsement excluding property damage as well as advertising and personal injury (AI/PI) from violations of various communications statutes. Claims seeking damages from blast faxing practices as well as computer spam are excluded. The 2007 edition available in December incorporates this change. Without it, insurers may have PD and AI/PI exposure from blast fax claims.
- > **Business Owners Liability—Aggregate Limits for AI and PI.** Before 2002, the ISO BOP aggregate limits applied to occurrences and did not specifically encompass AI and PI. The 1997 edition, in the aggregate limits provision, stated that the limit is the most the insurer will pay for all injury and damage arising from all “occurrences.” However, the policy also covered AI and PI from “offenses,” but offenses were not mentioned in the aggregate limits clause. Since 2002, the ISO BOP policy applies the aggregate limit to BI and PD and “all personal and advertising injury caused by offenses.” Insurers using the older forms without this significant change could be exposed to potentially unlimited AI and PI coverage.

Reasons for staying with the older edition include:

- > **Cost to upgrade IT systems for the new forms—**We need not say more.
- > **Cost and time to train underwriting, marketing and claim staff on what the new forms provide—**Your product is different and your staff needs to know all the changes in order to sell and service it.
- > **Agent objections to coverage constriction—**While some form changes expand coverage, most do not. Your agents may not be pleased with a product that gives less to the customer and hence may affect their relationships and sales.
- > **Inconsistent company positions—**If a Bureau offers a new coverage term that is inconsistent with your position or philosophy, you may have to take some more measurements and re-think the decision. It’s just another item to throw on the scale.
- > **Minor changes—**If the changes are minor, the benefits of a new form may not be that compelling for your book of business—but the costs still are.
- > **Updating endorsements—**Every time you adopt a new form, you face the need to review and update endorsements to align with the new form.
- > **Meshing Umbrella and Primary—**On the same theme, if your proprietary umbrella was drafted to fit over a past Bureau edition, the umbrella will need updating as well.

The Catch-Up Factor

Let’s say that you have been using the 1998 ISO CGL for the past nine years, having “sat out” the 2001 and 2004 editions. Now you are two form editions behind and see that the 2007 edition will be available by year-end. Let’s also assume that the changes in the 2007 and prior editions are important to your company, and you want to implement the latest form. What are the operational issues associated with an edition catch-up?

We alluded to some of the issues in the reasons to move or stay, but they have a different spin in a catch-up context:

- > **Change notices—**Since Bureau change notifications contemplate only the current filing, an insurer playing catch-up must develop its own change notice. That means melding all the changes notified in the interim guidance. A catch-up notice is not off the Bureau shelf, so the insurer must draft it. As some interim changes may cancel each other out, the process involves more than just “cut and paste” from previous documents.
- > **More training and explanation—**The change notification from a catch-up will be more complex simply because it is longer. The policyholder, agent and company staff have more to digest which could cause some problems for the insurer.



- > The longer you wait, the harder the catch-up tasks and the greater the impediment to making any changes. Ultimately, the forms fall further behind.

To Delay or Not To Delay—Different States

The approval process across the states is far from uniform. The vast majority of states will have approved the new edition by the effective date. A few states, and that usually includes New York, need more time. What if the edition, or any policy form you want to use, has been approved in Connecticut but not New York? Do you begin using the new form in one state or hold off until all states in your territory have approved it?

When you consider all the operational and systems costs, it is not surprising that many insurers opt to wait until all its business territories have approved the new form. New York recently approved the ISO 2004 Commercial Umbrella policy. One insurer told us that it had waited three years before adopting the policy for all states. It just did not make sense to operate IT and policy issuance systems on a split basis. This scenario is quite common for regional and national companies. Many insurers may want to keep current, but depending on where they do business, they may lag a year or two (or more) behind other carriers.

To Fix or Not to Fix—Coverage by Admission

When courts issue adverse interpretations of a policy, insurers start asking if a change in language is warranted. When deciding whether and when to “fix” a possible policy ambiguity, a few major questions arise. The first question is how important the issue and revision is to your business, but that is an operational issue. As to the fix itself, we see two important considerations. First, is a fix needed, and is it needed now? Second, are there downsides to revising language that could outweigh the benefits? Although we pose these separate questions, the factors and answers overlap.

Our first edition of *Policy Wording Matters* asked the “fix or not to fix” question back in January 2003. At that time, a federal appellate court was examining an insurer’s personal injury language that had been litigated in more than 100 cases and been found ambiguous in many of them—including four cases involving the insurer’s own forms. The court noted:

“In spite of this extensive history of litigation, and obvious disagreement amongst the courts and parties alike, insurance companies, and [the insurer] in particular, continue to use the phrase without any language defining its scope. Once again, we must ask, “why?” . . . A single phrase, which insurance companies have consistently refused to define, and [that] has generated literally hundreds of lawsuits, with widely varying results, cannot, under our application of common sense, be termed unambiguous.”¹

How many adverse rulings are enough to warrant a policy revision? According to the court, the existence of many legal

challenges, *by themselves*, can be evidence of ambiguity. Unfortunately, there is no clear point when policy language crosses over the ambiguity line. For most insurers, the answer will hinge on a variety of factors unique to each situation. Your sales territory, level of court, influence of the ruling court—all of these factors may play into your decision. If the highest court in your state has ruled against your wording, that is all that matters—it is time to change (the policy or underwriting guidelines). If similar language has lost in a neighboring but highly-influential state high court, it *might* be time to change. If only one lower court has spoken, it is probably best to wait for more guidance.

As to the third question, the potential downsides of revising policy language after an adverse decision, insurers have long worried that a court might interpret a policy fix as an admission that the expiring language was ambiguous. There is a catch-22 here for carriers. If you do not clarify the language and litigation grows, courts may find ambiguity *because* of the mounting coverage challenges. If you do clarify the language, another court might say that your action tacitly confirmed the ambiguity.

Randy Maniloff of White and Williams offers his perspective of revision risk in the following *Outside Counsel* column.

In Closing

Our general sense is that it is *usually* better to fix a problem than let it fester and generate more unexpected claims. The reality is that claims and claim costs will continue as long as you stay with the older wording. If you can and want to underwrite that exposure, if the exposure is minimal to your book of business, this outcome may be acceptable. If the flow of claims and claim costs is more than your company can handle, the admission risk from past policies may be outweighed by those continuing costs on future business. It all comes back to a business decision based on the pros and cons as they apply to *your business*. That means that no two insurers will have the same exact analysis and outcome. They may run through the same questions but may reach divergent answers. We hope this discussion helps you get to the best answers for your company. ■

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Endnote

¹ *New Castle County, De. v. National Union Fire Ins. Co.*, 243 F.3d 733 (3rd Cir. 2001).

Coverage By Admission

by Randy J. Maniloff,
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As discussed in this edition of *Policy Wording Matters*, a decision from a state’s highest court on a key policy provision may go a long way toward an insurer’s decision on whether or not to adopt a new version of a form. But as some court decisions reveal, even when a much-needed policy change would ordinarily have made the decision to adopt a new version of a form an easy one, insurers may still have reason to pause. There is no magic bullet for deciding whether an insurer should adopt a new version of a Bureau or company form. Rather, it is a decision that must be made by each insurer individually after weighing various pros and cons. In many instances, there is no right or wrong decision that can be made—only the best one.

One of the considerations that must be placed on the scale is whether the insurer’s decision to adopt a new version of a form will be used against it as evidence of the meaning of the old version. For example, if an insurer adopts a new version of a form that restricts coverage for a certain situation, policyholders will no doubt argue that, by definition, the old version must have been intended to grant coverage for that situation. Right or wrong, this “coverage by admission” (at least tacit admission) argument has an attractive common sense ring to it and insurers should expect to hear it from policyholders. This is a particularly important factor to consider if the policy provision being changed will continue to be subject to numerous claims still in the pipeline, notwithstanding the incorporation of the new version in policies going forward.

And just as so many of the other considerations that go into whether to adopt a new version of a form does not usually lead to a black and white answer, here too there is no certainty whether coverage by admission will be adopted—either expressly or as some evidence of the insurer’s intent—to create coverage. Several courts have been confronted with this issue and the results are mixed.

A very recent decision, from a state’s highest court, demonstrates the concern that some insurers may have about being bitten by their decision to adopt a new version of a form. In *Swank Enterprises, Inc. v. All Purposes Services, Ltd.*, the Montana Supreme Court addressed coverage for an additional insured in a construction defect-like scenario.¹ Because certain of the “business risk” exclusions addressed “you” and “your,” which the policy defined to mean the “named insured,” the additional insured argued that such exclusions did not apply to it.

The Montana Supreme Court agreed with this interpretation advanced by the additional insured—at least it concluded that the policy was ambiguous. The court noted that, on one hand, when strictly construed based on its plain language, the exclusions did not exclude claims made by the additional insured. On the other hand, the exclusions were prefaced by the language: “this insurance does not apply to,” which the court concluded could be read to exclude coverage to *any* insured. However, not content to stop there, the *Swank Enterprises* court was also guided by the insurer’s decision to amend the policy language at issue:

“As further evidence of ambiguity, we need only consider the amended endorsement to the 1998 policy, entitled “Additional Insureds,” which expressly provides, unlike the 1997 policy, that “all exclusions” apply to “additional insureds.” Logic dictates one of two reasons for the change. Continental changed the policy so that the exclusions referring to “you” and “your” would also apply to additional insureds, which implies that the exclusions did not apply to additional insureds under the 1997 policy, or Continental sought to clarify that the exclusions apply to additional insureds, which indicates that the 1997 policy was ambiguous.”²

Swank Enterprises demonstrates why some insurers may be gun-shy about changing policy wording, even when it would appear that it is necessary. Once again, the decision is a balancing act. The adverse impact of coverage by admission may be a short-term consequence that gives way to long-term benefits.

But not all courts agree with *Swank Enterprises*. See *Penton Media, Inc. v. Affiliated FM Insurance Co.*, citing court’s prior order (“The mere fact that Affiliated FM decided to



clarify future policies when faced with a lawsuit is not proof that the previous language meant what Penton asserts it does, or is even ambiguous.”³ But see *Fortunato v. Highlands Ins. Group*, (“If an insurance company changes language in a policy in order to clarify language in the prior policy, this implies that the earlier policy needed clarification. Language which needs clarification is ambiguous and must be construed against the insurer.”)⁴

Courts also disagree over what impact *Federal Rule of Evidence* 407 has on the issue. In general, for purposes of proving negligence, this rule renders inadmissible any evidence of a subsequent remedial repair. The rationale for the rule is simple. It is good social policy to encourage people to make repairs in furtherance of safety. It would discourage people from doing so if it could be used against them as evidence of negligence for a pre-repair accident. Even though the rule states that its purpose is for proving such things as negligence, product defect or the need for a warning, it is easy to see how it could be addressed in the analogous context of an insurer’s decision to revise a policy form.

In *Gilliam v. American Casualty Company*, the court held: “Under *Federal Rule of Evidence* 407, evidence of subsequent remedial measures is not admissible to prove culpable conduct by the party taking those measures.”⁵ Accordingly, the Court may not consider American’s subsequent modification of its D & O policy in deciding this summary judgment motion.” But the court in *American Casualty Company v. Continisio* disagreed: “The insurers argue that subsequent revisions of the policy language should be excluded under *Fed. R. Evid.* 407, which excludes evidence of subsequent repairs offered for the purpose of showing negligence or

culpable conduct. Since the subsequent revisions are offered by the FDIC for the purpose of showing the ambiguity of the earlier contractual language, this objection is without merit.”⁶

Just as so many of the factors surrounding the decision whether to adopt a new version of an insurance policy form comes with no right or wrong answers, it is likewise difficult to predict if an insurer will be penalized for its decision to do so by a court that uses it as the basis for finding “coverage by admission.” ■



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Endnotes

- ¹ 336 Mont. 197 (2007).
- ² *Swank Enterprises* at 203-04.
- ³ 2006 U.S. Dist. LEXIS 64387, *11 (N.D. Ohio).
- ⁴ 345 N.J. Super. 529, 535 (App. Div. 2001).
- ⁵ 735 F. Supp. 345, 351, n.9 (N.D. Ca. 1990).
- ⁶ 819 F. Supp. 385, 399, n.8 (D.N.J. 1993).

Big News



New Wisconsin UM/UIM Disclosure Requirement—Umbrella and GL Policies

Wisconsin regulators have adopted a permanent rule clarifying the UIM notice obligations of Personal and Commercial Umbrella as well as GL insurers providing any auto coverage in their policies. Under the new rule, the insurer must disclose on the application, or in a separate notice, whether the insured has the ability to purchase UIM coverage on the policy. The rule does not require an offer of UIM. This action follows two adverse court decisions and many months of

industry drafting and lobbying efforts. The disclosure requirements are set forth in Rule 6.77 and took effect on June 1, 2007.

If you would like more information on the rule and compliance obligations, please refer to Gen Re’s electronic *NewsBrief* report on June 4, or contact the editors of this publication.

Editors Note: A similar issue arose in Georgia where an appellate court held that the personal umbrella insurer must offer UM/UIM. ISO has just announced the availability of a new PU endorsement for UM/UIM, DL 98 07 10 07. The Georgia Insurance Department has approved the filing.

To Prevent Stacking, Get All the Right Pieces

We see many cases where insurers tried to fit one loss into one policy. The insurer might have wanted several actions to be considered one claim. Good “series of acts” language usually takes care of this issue. However, the insurer may also have wanted that claim to fall within a single policy, perhaps a policy before its own coverage began. Good deemer language can take care of this challenge.

Related acts and deemer clauses are not standardized or off-the-shelf. Most carriers develop their own language. While we see some company forms in early stages, we more often see them in court cases where they are applied to construction defect or sexual molestation claim scenarios. Here we get to see what worked and what did not, and why. Two recent court decisions reinforce the importance of using the right related acts and deemer wording, together. Using half the solution may leave you with double the loss you bargained for.

Winning Language—One Claim, One Policy Period'

The insured was an automobile financing company. Two class actions had been filed, both based on discriminatory interest rate practices. The claims-made policy included the following provisions:

“Claims based upon or arising out of the same Wrongful Act or Interrelated Wrongful Acts committed by one or more of the Insured Persons shall be considered a single Claim, and only one Retention and Limit of Liability shall be applicable. However, each single Claim shall be deemed to be first made on the date the earliest of such Claims was first made, regardless of whether such date is before or during the Policy Period.

Interrelated Wrongful Acts are defined as:

Wrongful acts which have as a common nexus any fact, circumstance, situation, event, transaction or series of related facts, circumstances, situations, events or transactions.”

The Federal appellate court had little trouble finding that there was only one claim and that coverage was available only from the policy in effect when the first claim was made. Although the suits were filed by two different sets of plaintiffs under two different legal theories, the common basis for those suits was a *single business practice*.

Why did this language work? First, the interrelated wrongful acts language tied the two class actions together into one claim. The suits shared a “common nexus”—a single business practice—and were a single claim. Second, the deemer language took care of which policy covered the claim. The policy in effect when the first claim was first made, and only that policy, provided coverage. The deemer language is similar to ISO’s claims-made CGL, but with an additional phrase confirming that the triggered policy may precede the policy in question.

We have seen similar language succeed in occurrence forms. In our February 2007 *Policy Wording Matters*, we discussed a contractor policy with winning deemer language.² In particular, the occurrence form stated:

“The . . . property damage resulting from such occurrence first takes place during the policy period. . . All property damage . . . in consequence of an occurrence shall be deemed to take place at the time of the first such damage, even though the nature and extent of such damage or injury may change . . .”

The California federal court enforced the deemer provision, finding that the policy language linked all continuing damage from an occurrence to the first instance of damage. The first instance of damage from that occurrence had to take place during the policy period in order to find coverage, and the court upheld that requirement.





Losing Language—One Claim, Two Policy Periods³

This case involved an occurrence policy with an exclusion, and then a buyback, of molestation coverage. The company had issued successive policies to a foster care agency. In the underlying tort claim, a child alleged numerous acts of sexual abuse by one person that spanned two policies. The policies provided coverage only if:

“The molestation first occurs during the policy period.”

There was no related acts language in the endorsement, and also no deemer language directing coverage into a single policy. With both elements lacking, the court found coverage under two policy periods. The reference to molestation in the singular also seemed important to the court. Since an act of molestation first occurred under each policy, there was coverage available under each policy. However, the court would not go so far as to consider each incident of molestation as warranting its own claim limit. An incident is not a claim, which is defined as a suit for damages. Thus, the insurer paid out two claim limits instead of one under the first policy.

What went wrong for the insurer? If the insurer had incorporated “related acts” language binding multiple acts of

abuse by one perpetrator into one claim, the court might have found only one claim under one policy. As to which policy covered the claim, a different approach should have worked. If the insurer had deemed *all* of the “related acts” of molestation to first occur during the policy when molestation “first occurs,” the court would probably have found one limit in the earlier policy period. The single sentence covering molestation acts that first occur in the policy period failed on both counts. It *sounds* like it is getting at the issue, but it does not quite get there. The related acts and deemer are missing.

One of the biggest challenges to drafting policies is that close is usually not enough. All the parts have to be present and fit with each other or you are providing more coverage than you charged for. ■

Endnotes

- ¹ *WFS Financial, Inc. v. Progressive Casualty Ins. Co., Inc.*, 2007 U.S. App. LEXIS 8973.
- ² *USF Ins. Co. v. Clarendon America Ins. Co.*, 2006 U.S. Dist. LEXIS 20924.
- ³ *Western World Ins. Co. v. Lula Belle Stewart Center, Inc.*, 2007 U.S. Dist. LEXIS 12006.

Pollution Exclusion Applied to Scrap Metal

Judd Ranch, Inc. v. Glaser Trucking Service, Inc., 2007 U.S. Dist. LEXIS 37628

Many claims test the reach of the pollution exclusion, and here a lower court has found that it applies to scrap metal that inadvertently mixed with and hence contaminated animal feed. The insured, a small trucking company, was hired to deliver feed pellets to a nearby cattle ranch. The trailer had previously been used to haul scrap metal, but the truck was not properly cleaned before picking up the feed pellets. The cattle consumed the metal fragments, and this suit followed.

The policy’s pollution exclusion defined pollutant as “any solid, liquid, gaseous or thermal irritant or contaminant,” and the arguments focused on whether scrap metal (in this case recycled aluminum) could be a pollutant, and whether other conditions of the exclusion were met.

The court rejected coverage on both counts. First, scrap metal became a “contaminant because once it mixed with another substance, the feed pellets, it became harmful.” Although the recycled material satisfied the definition of waste, it is clear that the metal was a “solid contaminant” without having to go further. Second, the metal dispersed when it mixed with the feed. The exclusion was satisfied, and there was no coverage.

Point: Kansas law is favorable on pollution exclusions, and the courts have applied it in a variety of scenarios. We think this case is important because of the unusual facts, and how similar scenarios could arise. The court

focused on contamination rather than the naturally hazardous properties of the substances. If the truck had carried wood chips (for example) that were mixed with cattle feed, we think the exclusion would be applied by this court. A contaminant is something that should not be there and, as a result, causes harm. This outcome should not be expected in many and perhaps most states. Roughly half the states apply the pollution exclusion only when hazardous material or industrial operations are involved, but Kansas and courts like this one are reading the words of the policy and not adding their own. If the decision is appealed to a different outcome, we will let you know.

Brief Case



Cut and Paste



Per Location Aggregates and the Umbrella

If you are an umbrella carrier considering per location aggregate coverage, caution and care are advised! Aside from the obvious financial exposures from a significant expansion of aggregate policy limits, we call your attention to a forms issue. The umbrella and underlying policies may not be a good fit.

The reason has to do with the separate products aggregate in the primary but not in (generally) umbrella forms, and that most per location aggregate endorsements in the primary do *not* apply to products. The ISO primary CGL contains a general aggregate for premises operation losses and then another products/completed operations aggregate. The ISO umbrella does not provide a separate products/completed operations aggregate, nor is it written to apply on a per location basis (although you can add CU 24 36 to achieve this result). In addition, the ISO per location aggregate endorsement for primary business does not encompass products exposures.

Lets look at how a per location aggregate endorsement on the umbrella might work, given these differences. We assume that the primary policy does have per location coverage using ISO forms and the umbrella limit was endorsed to apply on a per location basis. For a products loss (lets say contaminated food that is ultimately served at a local chain of restaurants insured under the same policy), as we noted previously, the primary policy products aggregate limit is exhausted from losses from all locations. The insurer could exhaust that limit quickly once

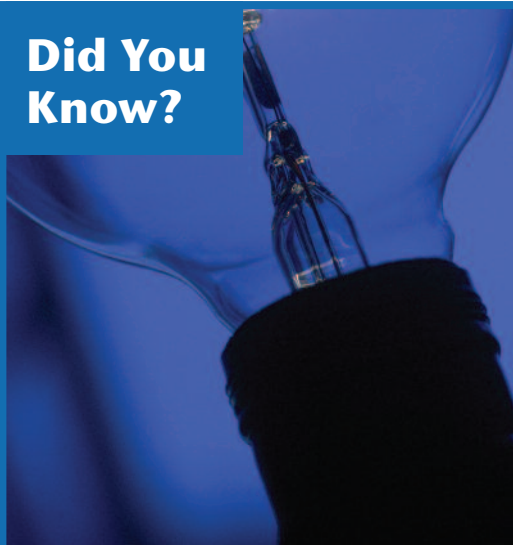
claims involving multiple restaurants come in. But what happens in the umbrella? Based on the way the umbrella policy was written and endorsed, products are part of the overall aggregate limit in the umbrella. That means if you have issued a per location aggregate limit without separating products for different aggregate coverage treatment, you may be paying the umbrella aggregate limit for products for *each affected location* over a primary aggregate for all locations.

Was this your intended result? Did your pricing contemplate this extension of cover, and is this aggregate limit expansion within your risk appetite? Based on the fact pattern and policy construction, you may pay more than expected on these types of losses without realizing the expansion of coverage from non-concurrent treatment.

The policy drafting danger (over and above the underwriting danger from multiple aggregates) is “cutting and pasting” the per location aggregate language from the primary form into the umbrella policy. The same endorsement will have very different coverage implications for primary and umbrella beyond the significant financial exposure from per location aggregates. There is no current ISO endorsement resolving this problem. If you choose to consider these extensions, you may want to start drafting your endorsement from the ISO primary form (CG 25 04 03 97), but there is more work to do—you may be surprised by a very large unexpected umbrella claim. Providing per location aggregates takes caution and care without policy language pitfalls, but it takes even more care to get the wording right.

Wording Note: See Products/Completed Operations Hazard Redefined Endorsement CG 24 07 for restaurant classes. Coverage applies to bodily injury or property damage arising out of the products hazard whether such bodily injury or property damage occurs on the insured’s premises or elsewhere.

Did You Know?



AAIS is getting more state approvals of its new Homeowners package, HO 01 06 and endorsements. The new edition makes *many* improvements to the preceding form. Most of the revisions clarify coverage or improve the structure of the policy. For example, mold (bacteria, fungi, wet rot or dry rot) was removed from the “Wear and Tear” exclusion and now appears in its own exclusion. However, mold coverage is provided when it is the direct result of a covered peril, e.g., covered water leaks. Another change on the liability side is to the definition of bodily injury (BI). The preceding edition said that BI did not

include bodily harm arising out of communicable disease, molestation, physical abuse or emotional distress. Now most of these carve-outs are exclusions. The new BI definition excepts bodily harm arising out of emotional distress that does not result from physical injury to a person. In a few cases, the AAIS forms recognize changing consumer demand and exposures—limited coverage for miniature motorized vehicles is one example. Most recently, Minnesota, Georgia and Kentucky approved the filing, which has an effective date of July 1, 2007.

A Summary of New Laws and Rulings Affecting Insurance Policies and Coverage



In this Round-up, we close by harking back to the theme of our first article in this *Policy Wording Matters*. Both cases concern the interpretation of policy language that has been revised in Bureau or many company forms.

Packaging Seal Was Not Advertising in General Liability and Umbrella

An insured's use of a competitor's packaging material for sending products to existing customers did not constitute "advertising" in a CGL and CU policy, according to the Michigan Supreme Court.

The underlying claim involved the insured's repair of two products originally sold by the competitor. After making the repairs, the insured simply placed the products in the original package, added its own seal, and sent it off. Upon discovering these two mailings, the competitor claimed a variety of intellectual property law violations. Ultimately, the two parties settled the claim for \$1,800 but the insured sought defense coverage under the CGL and umbrella (issued by same company).

The issue was whether the conduct amounted to an advertisement which would determine whether the claim qualified for advertising injury. The CGL defined advertisement (and the CU policy followed underlying) as a notice that is "broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers." The Michigan Supreme Court held that the act of shipping a product in a competitor's packaging with your own name affixed is not sufficient to satisfy the definition of advertisement. There was *no public dissemination* of information about goods and services for the purpose of attracting customers. In fact, the insured mailed the products to existing customers. The court distinguished opposing case law where the policies involved did not define advertisement. Here, the policy clearly required publication to the general public to attract customers, and none of these requirements were met. As a result, there was no defense coverage for any of the advertising injury claims. *Citizens Ins. Co. v. Pro-Seal Service Group, Inc.*, 2007 Mich. LEXIS 928.

Point: The definition of advertisement was crucial to the favorable outcome, yet this language was only added to ISO policies back in 1998. The language in the *Citizens* policy is identical to that in the 1998 edition. In 2001, ISO added further language addressing Internet and website advertisements. These changes go a long way to aligning intent with coverage and avoiding many of the AI coverage suits and claims we saw a decade ago. It also adds to the many reasons for keeping current with industry forms.



Unlawful Marketing of Alcohol Is Not Liquor Liability

A New York state court has held that claims of unlawful marketing of alcohol to minors does not fall within the scope of liquor liability in a commercial liability policy. Many such suits have been filed by the parents of minors against alcohol manufacturers and sellers nationwide, and similar claims could well arise with regard to other products. The CGL covered "all damages" from "injury" by reason of selling alcohol. The New York appellate court ruled that there was no damage, and that marketing did not amount to the sale of alcohol under the endorsement. In the court's words, "The paucity of case law does not overcome the clear language of the words employed (nor the fact of a premium of only \$184 for the Liquor Liability Coverage) to expose this carrier to liability for the mere consumption of an alcoholic product without resultant injury and damages." In sum, there was no duty to defend because damages based on marketing were not covered. *Great Northern Ins. Co. v. Kobrand Corp.*, 2007 N.Y. App. Div. LEXIS 6350.

Point: The 2007 ISO CGL, filed for use after December 1, 2007, also addresses these marketing suits in liquor liability endorsements. The new wording clarifies the requirement that bodily injury or property damage be present. To date, most courts have dismissed the underlying liability claims (see note 1 in the dissenting opinion of this case), but many insurance coverage suits are still pending. The issue is one of defense costs, which can (and often do, as we see in the advertising case above) exceed indemnity.

Brief Case



Umbrella Dropdown Denied in Louisiana

Huggins v. Gerry Lane Enterprises, 2007 La. LEXIS 1240.

In rejecting state appellate precedent on dropdown obligations, the Louisiana Supreme Court has restored some certainty to the umbrella insurance world in that state. The court held that a typical Commercial Umbrella policy did *not* drop down after the insolvency of the underlying carrier.

The Limits of Liability in the umbrella policy stated that the company “shall only be liable for the ultimate net loss in excess of:

1. the applicable limits of scheduled underlying insurance stated in Item 5. of the Declarations, for occurrences covered by scheduled underlying insurance . . . ; or . . .

3. the retained limit, for occurrences covered by this policy only.

The policy also contained a financial impairment condition specifically referring to the insolvency of the underlying insurer.

The Louisiana Supreme Court held that subsections 1 and 3 above unambiguously applied in different situations and should not be read together. Only the first one (scheduled underlying) applied in the case, and the language was clear that the Umbrella was available above that underlying limit. The additional condition on financial impairment only confirmed the reading and the court’s ultimate conclusion.

Point: Although most states would prohibit dropdown with this policy language, a Louisiana appellate court had previously required the umbrella carrier to attach at the primary level. Similar policy language was involved. This high court provides insurers with strong guidance on what policy language will work in the state.

Tools of the Trade



Policy Checklists—Revised Massachusetts Guidance

In previous editions we reported on state statutes and regulations mandating coverage

summaries and checklists. Florida and Maryland are two notable examples. Recently, the Massachusetts Department of Insurance revised its checklists for casualty, homeowners and inland marine policies. Unlike the other laws, the Massachusetts checklists are a *filing tool* to help insurers prepare policies that comply with existing law. They are not part of a policyholder disclosure statement. These checklists provide insurers with clear guidance on what types of provisions are not permissible or that must be filed for approval. For example, guaranteed replacement cost on HO policies may be capped at *no less than* 125% of the dwelling value/limit, and blanket dog bite exclusions are not permitted. The updated checklists can be found in Filing Guidance Notice 2007—A (May 25, 2007).

Closing Quotes

“The last thing we want to do is go into a claim situation without a policy.”

—John Lupica, President and Chief Executive Officer of ACE USA, in *Business Insurance on NewsEdge* (May 18, 2007)

“Merely being able to conjure up a remotely possible second interpretation is not sufficient to invoke the ambiguity rule...If it were, no contract would be safe from modification by construction . . . Thus, we will not rewrite State Farm’s policy by interpretation to bind it to covering a greater risk than that for which it has received premiums.”

—*Petras v. State Farm Mutual Auto Ins. Co.*, 2007 Wisc. App. LEXIS 405

“Have a great summer!”

—Editors of *Policy Wording Matters*

Cover articles from previous *Policy Wording Matters* publications

- > The 2007 ISO CGL—Keeping Up With the Changes, February 2007
- > Drafting Abuse Exclusions That Won't Be Abused, November 2006
- > The 2006 ISO BOP Policy—What's New for Property and Casualty Insurers?, August 2006
- > Personal Injury Coverage—What Does the HO Endorsement Cover?, March 2006
- > Drafting Abuse Exclusions That Won't Be Abused, November 2005
- > Claims-Made Policy Wording—Keeping Up with the Law, July 2005
- > Does Your Policy Meet the Haynes Test?—The Need for Conspicuous Coverage Restrictions, April 2005
- > ISO's 12-2004 Liability Form Changes, November 2004
- > Policy Language, April 2004
- > Business Interruption—Suspension and Access Issues after September 11, January 2004

Here are some other recent Gen Re research publications:

- > Auto Conference Highlights: Advertising, Claims and Technology—*Driving Lessons*, May 2007
- > Underwriting “Art vs. Science”—May 2007
- > Concurrent Causation and Property Insurance—Will Exclusions Ever Apply?—*Property Matters*, May 2007
- > Underwriting to New Liability Exposures—*Casualty Matters*, April 2007
- > Does Illegal Immigration Have Implications for Standard Lines Carriers?—*Insurance Issues*, March 2007
- > Underwriting Contractors—From the Midwest to All States—*Insurance Issues*, March 2007
- > Uninsured and Underinsured Motorist Liability Survey—February 2007
- > Family Medical Leave Act—*E-News EPLI*, February 2007*
- > New EEOC Endorsement Data—*E-News EPLI*, February 2007*
- > MCS-90 Territory Change Proposed—*E-News Auto*, January 2007*
- > Insureds Wintering In Florida—New Ruling—*E-News Auto*, December 2006*
- > Common Coverages, Uncommon Exposures—*Casualty Matters*, December 2006
- > Property Insurance and Pandemics—*Policy Wording Matters*, November 2006
- > Georgia and Wisconsin Developments on UM/UIM and Umbrella Policies—*E-News Umbrella*, October 2006*
- > Enterprise Risk Management—Its Implications, Benefits and Process, October 2006
- > For Increasing EPLI Sales, Agents Could Lead the Way—*EPLI Monitor*, October 2006
- > Catastrophic Injury Management and Early Intervention—*Insurance Issues*, September 2006
- > Leveraging Your Brand—*Regarding Risk*, September 2006

* *Electronic only*

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