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CMS, the federal agency within the Department of Health and Human Services that administers the Medicare Program, is the largest payer of medical claims in the United States. Under the mandate of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA or Act), CMS will require liability, no-fault and workers' compensation insurers to report – electronically and for the first time – the resolution of all claims involving injury to Medicare beneficiaries. CMS estimates that these insurers receive 2.9 million claims annually from Medicare beneficiaries. Anything from an automobile accident under an automobile policy, to a simple slip-and-fall under a homeowners policy, to bodily injury arising out of exposure to toxic chemicals or asbestos under a liability policy may trigger these claims, whose resolution must shortly be shared with the federal government.

The Act seeks to enforce the insurers' existing payment obligations under the Medicare Secondary Payer (MSP) statute, which establishes Medicare as the *secondary payer* to Group Health Plans (GHPs) and three types of "non-GHP" insurance coverage: liability (including self-insurance), no-fault and workers' compensation. Medicare thus has a statutory right to recover the medical payments it makes on behalf of a Medicare beneficiary from any of these *primary payers* whose policies also cover the beneficiary's medical claims. In other words, Medicare holds the "secondary" payment position to all other forms of coverage for medical claims, and Medicare's right to recover any primary payment it makes before learning of a "non-GHP" obligation takes precedence over the rights of any other party.

The new reporting arrangement – referred to as Mandatory Insurer Reporting (or MIR) by CMS – kicks off in May and June, when "non-GHP" insurers must register with CMS as *responsible reporting entities*. After a short period for system implementation and testing, they will begin submitting claims data during the last quarter of the year, or risk incurring civil money penalties of \$1,000 a day for each individual for whom they should have submitted claims information. For some insurers, this amount could be substantial, particularly if their failure to report reaches back 90 days to the last reporting period.

#### How It Will Work

For years, CMS has received claims payment information from GHPs under voluntary data-sharing agreements designed to ensure that Medicare pays the medical claims of Medicare beneficiaries secondary to GHPs. The significance of the Act for GHPs is that their data transmissions to CMS are no longer voluntary; they are mandatory. In contrast, CMS has had limited

## Featured Article

### Liability and Workers' Compensation Carriers Be Warned—Deadlines Loom for New Medicare Reporting Requirements that Carry Steep Civil Money Penalties

*Contributed by: Kathryn Bucher, Thomas W. Brunner and Lindsay L. Turner, Wiley Rein LLP*

The Centers for Medicare & Medicaid Services (CMS) will enter into a new reporting relationship with liability, no-fault and workers' compensation insurers this year as the federal government looks for new revenue streams for a financially beleaguered Medicare Program.

interaction with “non-GHP” insurers. Although they routinely pay claims involving injuries to Medicare beneficiaries, CMS has not asked “non-GHP” insurers to enter into data-sharing agreements; any coordination of benefits activity has been handled on a case-by-case basis. That relationship is about to change significantly.

### *The Data*

The Act requires “non-GHP” insurers to electronically transmit data to CMS on *all* claims involving an injury to a Medicare beneficiary that are “resolved” (or partially resolved) beginning July 1, 2009. *The date of the settlement, judgment or award, not payment, is the date that triggers the insurer’s obligation to report the resolved claim in the next calendar quarter.* These insurers also must report claims for which they have a continuing responsibility, as of July 1, 2009, to pay for medical items or services, regardless of the age of the claim. For workers’ compensation carriers in particular, this obligation may implicate claims that arose long ago but remain active today.

The claims data requested of “non-GHP” insurers is sizeable. The electronic file to be sent by the insurer captures more than 50 data elements, including information regarding the injured party (including a Social Security Number (SSN) or Medicare ID (HIC) Number); the claimant, if not the injured party (e.g., the Medicare beneficiary’s estate); the primary plan; the policy holder; and the incident (including the date of incident as defined by CMS, not the Department of Labor). Insurers also must provide information regarding the resolution of the claim, including (i) whether the claim was contested, (ii) whether there is any ongoing payment responsibility, and (iii) what the insurer’s “Total Payment Obligation” is (not simply the amount paid for medical items or services). Although there currently is no *de minimis* dollar exception for reporting purposes, CMS has stated it is gathering relevant data and will issue instructions if it adopts such a rule.

### *The Burden*

CMS has assured “non-GHP” insurers that the collection of the required data elements will not place an undue burden on them. CMS contends that the insurers already have much, if not all, of the information in their possession due to existing coordination of benefits obligations and other internal business needs. CMS acknowledges, however, in recent guidance posted on its website, that “there may be effort involved in centralizing such information for reporting purposes,” although “not a considerable burden.” We leave it to each insurer to judge this burden, but CMS has estimated that the establishment of the data exchange process alone will take, on average, a total of 375 man-hours.

CMS most certainly will use the new data collected from the estimated 400 reporting “non-GHP” entities to augment its ability to identify situations in which Medicare has paid in the “primary” payment position but should have paid only in the

“secondary” position. Medicare, through its MSP rights of subrogation, can recover in these situations from an insurer if its efforts to collect first from the Medicare beneficiary or the provider of medical services are unsuccessful. Medicare has this right of recovery regardless of whether the insurer has already paid the beneficiary or the provider for the medical items or services at issue, but CMS must submit a request for reimbursement to the insurer within three years of the date on which the items or services were furnished.

### *The Timeline*

Although actual reporting will not go live until the fourth quarter of 2009, the first deadlines for insurers with reporting obligations are just a few months away. This May and June, insurers must register online with CMS as “responsible reporting entities” (RREs) and enroll any agents that will submit data files on their behalf. Insurers who use the services of agents nevertheless retain all liability for reporting obligations. By July, these insurers, or their agents, must have installed system software provided by the agency and have begun to send test data. After a series of successful transmissions, CMS will assign each insurer a date during the last quarter of 2009, by which it must begin its quarterly reporting. That reporting will continue indefinitely.

### *Agency Guidance*

To assist insurers with their implementation efforts, CMS is offering town-hall-style, dial-in teleconferences and computer-based training, free of charge. CMS also has promised to post a “User Guide” on its Mandatory Insurer Reporting website that will offer more details and instruction on the registration process, the acquisition and use of mandated system software, file layouts, and file submissions.

### *Penalties and Enforcement*

An insurer that fails to comply with its new reporting obligations will be subject to civil money penalties of \$1,000 *for each day* of noncompliance *for each individual* for whom it should have submitted information. CMS has advised that whether insurers are likely to experience difficulties in meeting their reporting requirements will depend, in part, upon the current format of their claims records and their ability to identify whether an individual is Medicare eligible. The agency’s recommendation for insurers is to start now to become familiar with their new reporting obligations.

Does this mean that CMS will aggressively pursue noncompliant insurers once all insurers should be routinely reporting in January 2010? Recognizing that CMS has stated publicly that it is primarily interested in facilitating insurer compliance with the Act’s reporting requirements and not in collecting penalties, we expect that CMS will take into consideration an insurer’s diligent efforts to come into regulatory compliance before pursuing any enforcement action. CMS’s initial enforcement actions more logically will focus on those insurers that fail

entirely to register, implement a reporting system or transmit data files. Whether CMS intends to audit “non-GHPs” for compliance (or has authority to do so on a routine basis when noncompliance is not suspected) is unclear. CMS guidance does make clear, however, that the agency “recommends” that insurers retain their “MSP related information” for a period of ten years, noting that certain administrative and legal actions (including administrative offsets and False Claims Act suits) can be brought against a responsible entity for ten years. In contrast, as noted above, the MSP statute only permits CMS to recover primary payments from a liability insurer for a period of three years, beginning on the date the medical item or service was furnished to the Medicare beneficiary.

Given the uncertainty over CMS enforcement activities, our recommendation for insurers is to begin now to document efforts to come into compliance with the new reporting requirements. This is particularly important for liability insurers. CMS is less familiar with “non-GHP” claims than GHP claims (CMS estimates that it is already receiving data for “some 90% of all GHP covered lives” through voluntary GHP reporting), and CMS appears still to be working out the precise details of its expectations regarding the “non-GHP” reporting process. For this reason, insurers also should monitor closely CMS’s now frequent updates to its Medicare reporting guidance.

#### *Open Questions*

- Although the new reporting obligations seem straightforward, many questions appear to go unanswered in the agency guidance. Here are some of the questions insurers are asking:
- What, if any, payments will CMS seek to recover from “non-GHP” insurers if Medicare paid primary for medical items or services covered by “non-GHP” insurance? Because insurers must report the total amount they pay on a claim, will CMS make any effort to determine how much of the insurer payment was for medical items or services? Can CMS demand the full amount of the negotiated settlement regardless of the terms of the settlement? Specifically, can CMS reach sums allocated to compensate for other damages, like pain and suffering?
- Recognizing that the reimbursement obligation of the “non-GHP” insurer under MSP law is joint and several with the Medicare beneficiary, can CMS require the insurer to pay in excess of its policy limits, or at the very least in excess of a negotiated settlement amount up to the policy limit? If policy limits are insufficient to fully compensate Medicare, can CMS reach past or future insurer payments?
- The Act only requires insurers to report once they have resolved a claim. Can a “non-GHP” insurer effectively limit its MSP exposure or reporting obligations by notifying CMS of a *pending* resolution?
- Can a “non-GHP” insurer effectively insulate or limit its MSP exposure through agreement with the claimant? Is there a way to structure insurer settlements to avoid incurring some or all reporting obligations under the Act?
- What if a claimant or an injured party refuses to provide a SSN or HIC Number? How will the insurer determine if the individual is a Medicare beneficiary? Must the insurer make this determination? MSP regulations that predate the Act do not impose an affirmative duty on “non-GHP” insurers to inquire as to Medicare eligibility; in contrast, the *MSP Manual* states that knowledge of a claimant’s Medicare status will be imputed to the liability carrier if the claimant is 65 years of age or older.
- If a Medicare beneficiary suffers no medical injury, or at least none is discovered by the time the claimant files for other damages (e.g., personal property damage), must the insurer nevertheless report the claim resolution to CMS?
- What, if any, reported “non-GHP” information does CMS intend to share with Medicare Advantage or Part D plans?

It is not surprising that many of these questions are the same questions that “non-GHP” insurers have been asking for years. Indeed, the body of agency guidance relating to the application of MSP law to liability insurers is not nearly as extensive or well-settled as the guidance available to other insurers. In addition, CMS has commented that the new reporting requirements do not change or eliminate any existing insurer obligations under the MSP statute or regulations. Any prior uncertainty surrounding such obligations and liabilities thus logically still exists and may be further complicated by the overlay of new reporting requirements. For all these reasons, and with some step-up in MSP enforcement activity expected in 2010, a “non-GHP” insurer would be well served to review its current MSP practices to ensure they are in line with “non-GHP” insurer obligations under MSP law.

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## Contract of Insurance

### Policy Provisions

#### Northern District of Ohio Applies De Facto Merger Doctrine in Finding Predecessor Company a Named Insured for Purposes of Exhaustion of Aggregate Policy Limits

*Bondex Int'l, Inc. v. Hartford Accident & Indemnity Co., No. 1:03-CV-1322, 2008 BL 264998 (N.D. Ohio Dec. 1, 2008)*

The U.S. District Court for the Northern District of Ohio denied insureds' motions for summary judgment and granted insurers' motions for summary judgment, ruling that one insured's predecessor was acquired through a de facto merger, making the predecessor a 'named insured' and thus subject to the aggregate limits of liability under certain insurance policies that were exhausted by payment of asbestos claims.

#### *The Corporate Acquisition*

In March 1966, Republic Powdered Metals, Inc. (Old Republic) entered into an agreement with The Reardon Company to acquire Reardon's assets (the 1966 transaction). Reardon manufactured and sold various products containing asbestos. Pursuant to agreement, Old Republic assumed liability for all products manufactured by Reardon for any bodily injuries sustained after the date of the agreement. Under the asset purchase agreement, Reardon was paid in cash rather than shares of Republic stock, but the structure of the transaction involved Reardon shareholders lending money to Republic in exchange for notes that could be converted to Republic stock.

At the same meeting where Reardon's shareholders approved the 1966 transaction, they also approved Reardon's dissolution and liquidation plan. Reardon filed articles of

liquidation in December 1966. Old Republic continued Reardon's business as a division of Old Republic, called the "Reardon Division," and maintained many of Reardon's assets, products, and facilities. Although Reardon management did not continue with Old Republic, many of Reardon's employees did continue. Old Republic continued to manufacture many of Reardon's products, and advertised such products using Reardon's trade names.

In November 1971, Old Republic changed its name to RPM, Inc., and created two wholly-owned subsidiaries called Bondex International, Inc. and Republic Powdered Metals, Inc. (New Republic). In May 1972, Old Republic transferred the assets and liabilities of Reardon to Bondex and transferred the assets and liabilities of Old Republic to New Republic. RPM thereafter became a holding company for Bondex and New Republic.

#### *The Bodily Injury Claims and Insurance Coverage*

In 1981, the first plaintiff brought suit against Bondex, claiming asbestos-related bodily injury. Thousands of additional suits were filed between the 1980's and 2000's alleging asbestos-related bodily injury caused by products manufactured by Reardon, RPM, Bondex, or New Republic.

RPM purchased liability coverage for itself and its subsidiaries from various insurers, including Century Indemnity Company, Columbia Casualty Company, Continental Casualty Company, Allstate Insurance Company and Mt. McKinley Insurance Company. The policies provided defense and indemnity coverage for the policies' 'named insured,' including RPM, Bondex, and New Republic. The named insured also included new organizations acquired by the named insured through merger. The policies contained aggregate limits of liability for 'products hazard' and 'completed operations hazard' claims, but contained no aggregate limits for claims falling outside of those coverages, including claims for bodily injury which were not caused by products manufactured by the named insured. *Bondex* at 5.

Throughout the course of the asbestos litigation, the insureds submitted claims to the insurers, categorizing such claims as products hazard claims. Ultimately, the insurers claimed that their products liability coverage aggregate limits were exhausted by payment of asbestos claims. However, plaintiffs claimed that the limits were not exhausted because the claims arose from products manufactured by Reardon, and that because Reardon was not a named insured under any of the policies, those claims were not subject to the aggregate limits. Plaintiffs brought suit against insurers in July 2003. The parties filed various cross-motions for summary judgment regarding the exhaustion issue.

#### *De Facto Merger*

At the outset, the district court, applying Ohio law, noted that a corporation that purchases the assets of another may be liable for a predecessor's contractual liabilities where

the transaction constitutes a de facto consolidation or merger. The court found that the indicia of a de facto merger included: (1) the continuation of the previous business activity of the predecessor and its personnel, (2) continuity of shareholders, (3) rapid dissolution of the predecessor corporation, and (4) the assumption by the purchaser of all liabilities and obligations necessary to continue the predecessor's operations.

The court determined that the issue of whether the asset purchase by Old Republic constituted a de facto merger between Old Republic and Reardon was central to determining whether the insurers' aggregate limits were exhausted by payment of claims under the products hazard coverage. The insurers argued that because the 1966 transaction was a de facto merger, Reardon would be deemed a named insured and subject to the products hazard aggregate.

The insureds argued that the court should not apply the de facto merger doctrine because the doctrine applied only in cases involving an uncompensated plaintiff or frustrated creditor, neither of which was applicable in this case.

The court found that the Ohio Supreme Court never limited the doctrine solely to cases involving uncompensated plaintiffs or frustrated creditors. Rather, the court agreed with the insureds' argument that the doctrine applied to avoid injustice to a party by obscuring what should actually be called a merger by calling it something else. However, the court disagreed that the doctrine was limited to only those cases. In addition, the insurers, the court stated, were seeking to avoid such an injustice that would result if Reardon was determined to not be a named insured. Further, the court noted that at least one other jurisdiction had applied the doctrine specifically to a case where the identity of the named insured was at issue.

Plaintiffs argued that even if the court were to find a de facto merger and that Reardon was therefore a named insured, the claims would not arise out of the 'named insured's Products' or 'Insured's Products' and would therefore not be subject to the aggregate limit. Plaintiffs cited in support drafting documents from the Insurance Services Office. The court refused to consider such extrinsic evidence, finding that the definitions in question were not ambiguous.

#### *Application of the Doctrine*

Having determined that the de facto merger doctrine was applicable, the court then analyzed whether the 1966 transaction constituted a de facto merger. The court found that the first factor, the continuation of the predecessor's business activity, was clearly present, since Old Republic maintained Reardon's assets and continued manufacturing Reardon's products under Reardon's trade names. Moreover, Old Republic continued to employ Reardon's employees. Acknowledging that Reardon's corporate personnel were not used by Republic, the court nevertheless concluded that the overall continuity of business operations supported the finding of a de facto merger.

The court recognized that the second factor, the continuity of shareholders, was not present, since the 1966 transaction was a sale of assets for cash. However, the court found that this factor was not dispositive for determining whether a de facto merger took place. The court noted that the Ohio Supreme Court had not indicated that all of the indicia for a de facto merger must be present to find such a merger, and that a rule requiring strict adherence to all indicia would be too rigid, potentially exempting certain transactions which otherwise should be considered a de facto merger. The court found that other Ohio federal courts had reached a similar conclusion. Finally, the court pointed out that because the 1966 transaction involved loans by Reardon shareholders in exchange for convertible notes, a significant nexus existed between Reardon and Old Republic after the 1966 transaction. The court concluded that the second factor was therefore met.

The court found no dispute that the third factor, namely the rapid dissolution of the predecessor corporation, was met where the 1966 transaction and Reardon's dissolution were approved by Reardon's shareholders on the same day. Similarly, the court found that the fourth factor, assumption of liabilities and obligations to continue the predecessor's business operations was also met where all parties agreed that the asset purchase agreement resulted in Old Republic's assumption of Reardon's liabilities.

Finding that the indicia of a de facto merger were satisfied, the court concluded that Reardon was a named insured under RPM's policies and that its claims were therefore subject to the aggregate limits of those policies.

#### *Exhaustion of the Mt. McKinley Policy Limits*

Mt. McKinley had paid its total policy limits of \$39 million into an attorney trust account to satisfy its obligations in connection with the asbestos claims. The plaintiffs argued that Mt. McKinley's tendering of limits to the trust account did not satisfy its duty to defend and indemnify, because an insurer may not terminate its duty to defend by unilaterally tendering its limits. Plaintiffs further argued that as the trust fund was not exhausted, Mt. McKinley's aggregate limits were not exhausted, and the insurer was therefore liable for defense costs then in excess of \$57 million.

The court rejected the plaintiffs' argument, finding that the cases disallowing exhaustion through a unilateral tender of limits were inapplicable, because Mt. McKinley deposited the funds in the trust account at the request of the plaintiffs. The court noted that, upon notification from Mt. McKinley that its limits had been exhausted, plaintiffs sought coverage from those insurers providing excess coverage above Mt. McKinley's limits. Since no evidence existed that Mt. McKinley unilaterally paid its limit to avoid defending plaintiffs, the court concluded that the payment by Mt. McKinley to the trust fund exhausted its available limits under the policies.

### Other Issues

Because Reardon was determined to be a named insured and the claims were properly categorized as products hazards, the court held that the Century, Columbia, Continental, and Allstate policies were exhausted and granted those insurers' motions for summary judgment. As to the remaining counts in plaintiffs' complaint, the court granted summary judgment in favor of Mt. McKinley on plaintiffs' claims that the insurer breached its duties to defend and good faith and fair dealing by failing to pay remaining defense costs. The court found additional counts based on Reardon's status being that of a non named insured were moot and granted plaintiffs' motions for summary judgment on Mt. McKinley's fraud and misrepresentation counterclaims and dismissed McKinley's third party complaint against plaintiffs' attorney alleging breach of fiduciary duty.

Based on its finding that Reardon was a named insured under the applicable policies, the court granted insurers' motions for summary judgment and determined that their respective limits of liability were exhausted by virtue of payments for the asbestos claims.

## Health & Disability Insurance

### Subrogation

#### Western District of Kentucky Holds Health Plan Barred from Seeking Reimbursement Due to Failure to Intervene in Underlying Personal Injury Suit

*Humana Health Plans, Inc. v. Powell*, No. 3:07CV-385-H, 2008 BL 265976 (W.D. Ky. Dec. 01, 2008)

The U.S. District Court for the Western District of Kentucky granted summary judgment in favor of a member of a health benefit plan, holding that the plan's failure to intervene in an underlying personal injury action barred it from seeking reimbursement from the plan member out of amounts recovered from a tortfeasor.

#### *The Accident and Claim for Reimbursement*

Patti Powell obtained health coverage through her husband's business with Humana Health Plans, Inc. In October 2002, Powell was injured in an automobile accident. Powell received medical care for her injuries, and Humana paid medical benefits of \$24,518 under the plan.

Thereafter, Powell sued the driver of the other vehicle involved in the accident and made a claim against her own insurer for underinsured motorist coverage. Powell ultimately settled

the lawsuit for \$100,000 and settled with her insurer for \$450,000. Humana was in contact with Powell's counsel during the lawsuit, but did not intervene in the suit. Powell's counsel failed to notify Humana of its subrogation rights pursuant to KRS 411.188(2). The settlement funds were paid directly to Powell.

In July 2007, Humana filed suit against Powell, seeking the imposition of a constructive trust or an equitable lien over funds from the state court settlement. Under the employee benefit plan of which Powell was an insured, beneficiaries were required to reimburse the plan for medical benefits if they receive a recovery from another source. Powell claimed that Humana never notified her that it would seek reimbursement of the medical benefit. The parties cross-moved for summary judgment before the district court.

#### *Right to Equitable Relief under ERISA*

Humana argued that it was entitled to assert a claim for equitable relief pursuant to ERISA, 29 U.S.C. 1001-1461. Specifically, Humana sought an equitable lien or constructive trust upon funds in Powell's possession, pursuant to the U.S. Supreme Court's decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). Powell argued that such relief was precluded by the Supreme Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002).

The court noted that under Section 1132(a)(3) of ERISA, a fiduciary may bring an action to obtain equitable relief where a claimant has violated the terms of a plan. The court identified the key issue as whether the relief sought by Humana was a permissible equitable action or an impermissible legal action.

The court explained that in *Knudson*, the Supreme Court held that where, in a personal injury action, monies were deposited into court pending resolution of reimbursement issues and the funds were out of the beneficiary's control, the insurer in seeking injunctive relief was actually attempting to impose personal liability upon the insured, a legal remedy not available under ERISA. The court noted that in *Sereboff*, the Supreme Court determined that where the insurer sought "specifically identifiable" funds within the possession and control of the claimant, the relief sought by way of a constructive trust was equitable in nature and therefore permissible under ERISA. The Supreme Court in *Sereboff* distinguished *Knudson* by pointing out that in *Knudson* the funds at issue were not in the claimant's possession.

The district court determined that insofar as Powell had personal possession of the funds at issue, *Sereboff* would be controlling, and Humana would have the right to seek a constructive trust under ERISA. However, the court reasoned that without appropriate discovery, it could not determine the status of the funds to ascertain whether the funds in Powell's account were funds to which Humana was entitled.

### *The Make-Whole Doctrine*

Powell also argued that the “make-whole doctrine” barred Humana’s recovery of medical benefits. The court noted that the doctrine prohibits an insurer from asserting subrogation rights where the insured’s loss exceeds the recovery from the tortfeasor and its insurer, citing *Copeland Oaks v. Haupt*, 209 F. 3d 811 (6th Cir. 2000). The court found that an exception to the doctrine applies where the contract at issue calls for reimbursement and identifies a priority to the funds recovered, regardless of whether the claimant is made whole by way of recovery.

The court cited to the language of the Humana Plan, which provided “We will automatically have a lien to the full extent of benefits advanced upon any recovery . . . that you receive . . . and we shall have a first priority lien, regardless whether you have been fully compensated for your whole loss.” *Humana* at 7.

The court found that the Humana Plan’s language was clearer than that addressed in *Copeland Oaks*, and that there was no case law requiring Humana to use the term “make whole” in the provision in order for it to be effective. The court concluded that the plan language satisfied both of the requirements set forth in *Copeland Oaks* regarding priority of the lien and recovery in circumstances where the claimant has not been made whole, and therefore held that the make whole doctrine did not bar recovery by Humana.

#### *Failure to Assert Subrogation Rights Pursuant to KRS 411.188*

Powell argued that Humana was barred from seeking equitable relief because it failed to assert subrogation rights in the personal injury action as required by KRS 411.188. Humana argued that Powell was estopped from relying on the statute based on Powell’s failure to comply with KRS 411.188(2), which states,

At the commencement of an action seeking to recover damages, it shall be the duty of the plaintiff or his attorney to notify . . . those parties believed by him to hold subrogation rights to any award received by the plaintiff . . . . The notification shall state that a failure to assert subrogation rights by intervention . . . will result in a loss of those rights with respect to any final award received by the plaintiff[.]

*Humana* at 10.

The court found that KRS 411.188 clearly requires an insurer to intervene in the underlying action to preserve its subrogation rights, and that failure to do so results in a loss of such rights, citing *McCormack Baron & Associates v. Trudeauux*, 885 S.W. 2d 708 (Ky. App. 1994). Finding no dispute that Humana failed to intervene in Powell’s suit, the court determined that the remaining issue was whether Powell’s failure to comply with KRS 411.188(2) estopped Powell from relying upon the statute.

The court found that Kentucky law requires an insurer to intervene even where notice is not provided under 411.188(2) where the insurer is otherwise aware of its subrogation rights and the existence of the personal injury suit, citing *Lampton v. Boley*, 870 S.W. 2d 428 (Ky. App. 1993). The court noted that in both *Lampton* and *McCormack*, the courts determined that strict compliance with 411.188(2) was not required to bar the insurer’s subrogation rights where the insurer is aware of the suit and its rights, as evidence of such awareness satisfies the purpose of 411.188(2).

The court determined that Humana was clearly aware of the suit through its discussions with counsel for Powell, and that Humana and Powell’s counsel had specifically discussed subrogation rights. The court accordingly concluded that Humana could not rely on 411.188(2) to estop Powell from relying on the statute, and that Humana was barred from seeking subrogation pursuant to KRS 411.188.

Accordingly, the court granted Powell’s motion for summary judgment.

## Insurance Litigation

### Insured Duties to Insurer

#### District of New Jersey Denies Summary Judgment on Late Notice Issue but Grants Motion for Judgment on the Pleadings for Claim Falling Outside Insurer’s Coverage Period

*Langan Engineering & Environmental Services, Inc. v. Greenwich Insurance Co.*, No. 07-2983, 2008 BL 271472 (D.N.J. Dec. 5, 2008)

The U.S. District Court for the District of New Jersey denied one insurer’s motion for summary judgment on the basis that issues of material fact precluded summary judgment on a late notice defense, but granted another insurer’s motion for judgment on the pleadings on the basis that the occurrence took place after expiration of that insurer’s coverage.

#### *The Wall Collapse*

In January 2002 Castle Village Owners Corporation retained Langan Engineering and Environmental Services, Inc. to perform engineering and related services in connection with inspection and evaluation of a retaining wall on Castle Village’s property. Castle Village and Langan entered into various agreements between January 2002 and September 2004.

On May 12, 2005, a large section of the wall collapsed, causing property damage, blocking the road and sidewalk, and causing additional damage to third-party personal property, including automobiles. Castle Village brought suit against several entities

in New York state court. In its Third Amended Complaint, dated March 22, 2007, for the first time, Castle Village named and Langan and Morris Park Contracting Corporation, whom Castle Village hired at the recommendation of Langan, and whose work Langan was to supervise, monitor, inspect, and approve. Langan also certified that Morris Park's work was properly completed. The allegations against Langan included professional negligence and breach of contract. The allegations further sought to hold Langan responsible for the defective construction work performed by Morris Park during 2004.

Langan then brought suit in New Jersey state court against several insurers, including Virginia Surety Insurance Company, Inc. and United States Fidelity & Guaranty Company (USF&G). USF&G and other insurers issued commercial general liability (CGL) and excess liability policies to Langan. Virginia Surety sold CGL policies to Morris Park under which Langan was named as an additional insured. Langan sought a declaration that the insurers were obligated to defend and indemnify Langan for the Castle Village litigation. In June 2007, the matter was removed to federal court.

#### *Virginia Surety's Motion for Summary Judgment*

Virginia Surety moved for summary judgment on the basis that Langan failed to timely notify it of the wall collapse, in breach of the policy. The court, applying New York law, noted that compliance with a notice provision is a condition precedent to coverage, and that the insurer need not show prejudice resulting from the failure to provide timely notice. The court found that a notice provision requiring notice "as soon as practicable" is interpreted to require notice "within a reasonable time after the duty to give notice has arisen." *Langan* at 9 (quoting *Christiana General Insurance Co. v. Great American Insurance Co.*, 979 F.2d 268 (2d Cir. 1992)). The court further found that a failure to give timely notice may be excused where the insured either lacked knowledge of the occurrence or had a reasonable belief it would not be liable, and that the question of reasonableness is ordinarily a fact question inappropriate for summary judgment. The court did note, however, that a delay may be unreasonable as a matter of law, warranting the granting of summary judgment in favor of the insurer.

Langan admitted that it was aware of the wall collapse in 2005. However, Langan contended it was not aware that Castle Village would bring suit against Langan based on the alleged actions of Morris Park. Langan alleged that it was not notified of the Castle Village action until March 27, 2007, when it received a copy of Castle Village's Third Amended Complaint, which sought damages against Langan for the defective work performed by Morris Park. Langan asserted that it provided notice on the same date to Virginia Surety and that, accordingly, notice was timely under the policy.

Virginia Surety argued that the two-year delay in notice after the wall collapse was unreasonable as a matter of law, notwithstanding Langan's alleged belief in its non-liability.

Virginia Surety cited to a number of cases wherein delays in notice of less than two years were deemed unreasonable as a matter of law.

The court was unpersuaded that the cases cited by Virginia Surety supported its claim that Langan's notice was unreasonable as a matter of law, finding that each of the cases looked at the reasonableness of the specific excuse for the delayed notification. The court found that Langan's excuse regarding notice created a genuine issue of material fact which precluded summary judgment. The court noted that while Langan admitted knowledge of the wall collapse, it claimed lack of awareness until March of 2007 of any liability in connection therewith, and that its argument in that regard was sufficient to survive Virginia Surety's motion for summary judgment. The court accordingly denied Virginia Surety's motion for summary judgment.

#### *USF&G's Motion for Judgment on the Pleadings*

USF&G moved for judgment on the pleadings pursuant to Fed. R. Civ. P. 12(c), on the basis that the occurrence causing property damage occurred outside of USF&G's policy period. The USF&G policy was in effect from May 20, 2003 to September 1, 2004. The policy covered "'property damage' . . . caused by an 'occurrence' . . . that occurs during the policy period." *Langan* at 13.

The court initially noted that the standard for a motion for judgment on the pleadings under Fed. R. Civ. P. 12(c) was the same as that for a motion to dismiss under Fed. R. Civ. P. 12(b)(6), namely that the plaintiff cannot establish sufficient facts to state a claim for relief that is legally plausible.

Langan argued that USF&G's motion should be denied because the Castle Village complaint alleged property damage occurring during the USF&G policy period. Langan argued in the alternative that the complaint, at a minimum, suggested that property damage was continuous, including during the USF&G policy period.

The court found that Langan's argument confused allegations of negligence with property damage. Specifically, the court noted that the allegations of the Castle Village complaint were that Langan negligently supervised Morris Park and negligently failed to inform Castle Village of the deteriorating condition of the wall. The court reasoned that while Langan might be correct that damage to the wall existed during the USF&G policy period, there was no allegation that Langan caused property damage during the policy period. The court further noted that the property damage forming the basis for Castle Village's complaint was solely attributed to the wall collapse on May 12, 2005. This occurred well after the expiration of the USF&G policy.

The court also rejected Langan's attempt to import a 'continuous trigger' theory of coverage to construction cases. Langan argued that, under this theory, property damage

occurred during the USF&G policy period, as evidenced by the allegations in the Castle Village complaint, specifically that “property damage consisting of the continuous movement, deterioration, increasing cracks, and developing bulges in the wall, was apparent when Langan first entered the site years before the collapse of the wall.” *Langan* at 15.

The court noted the general rule that the timing of an occurrence is not when the wrongful act is committed but rather when resulting property damage actually takes place. The court acknowledged that New Jersey had adopted a refinement of this rule. In New Jersey, where progressive injury or damage takes place over many years, damage in each year is treated as a separate occurrence. However, the court found that cases in the Third Circuit utilizing the continuous trigger theory have been limited to property damage due to environmental pollution and injury resulting from exposure to asbestos. The court, however, declined to extend the continuous trigger theory beyond its application to environmental, toxic tort, asbestos, and related cases, stating that it would be “inappropriate to do so.” *Langan* at 17 (quoting *Prolerized Schiabo Neu Co. v. Hartford Accident & Indemnity Co.*, 990 F. Supp. 356 (D.N.J. 1997)). Accordingly, the court concluded that because the property damage at issue did not occur until after the expiration of the USF&G policy period, USF&G was entitled to judgment on the pleadings.

## Property & Casualty Insurance

### All Risk Insurance

#### District of New Jersey Holds ‘Ensuing Loss’ Provision in an All Risk Policy Provides Coverage for Damage Caused by Defective Materials to Other Covered Property

*Spiniello Cos. v. Hartford Fire Insurance Co.*, No. 07-CV-2689 (DMC), 2008 BL 260654 (D.N.J. Nov. 21, 2008)

The U.S. District Court for the District of New Jersey granted partial summary judgment to an insured, finding that a ‘faulty materials’ exclusion in the policy was modified by an ‘ensuing loss’ provision, which provided coverage for damage to property other than the faulty material itself.

##### *The Property Damage and Coverage*

Spiniello Companies was in the pipeline rehabilitation and repair business. Spiniello was hired in 2006 to recondition an underground sewer pipe at a wastewater treatment plant in Memphis, Tennessee. The project required Spiniello to create a pipe liner through the use of a curing process, which involved the mixing of chemicals and polymer to form a resin which was then used to coat a fabric material liner. The liner

was then installed within an existing pipe, and hydrostatic pressure was used to keep the liner in place until the resin cures, or hardens.

In August 2006 Spiniello purchased an ‘all risk’ insurance policy from Hartford Fire Insurance Co. to cover the project. The policy contained a ‘faulty materials’ provision, which excluded from coverage “loss caused by or resulting from . . . [d]efective, deficient, inadequate or flawed . . . materials.” *Spiniello* at 2. The exclusion was modified by an ‘ensuing loss’ provision, which stated, “[b]ut we will pay for resulting direct physical ‘loss’ to other Covered Property, except as otherwise excluded or limited.” *Id.*

In November 2006 Spiniello incurred a loss in connection with the project when a defective catalyst it used to hasten the hardening of the liner caused the resin to harden prematurely, which in turn caused collapse and destruction of the liner to be installed in the pipe. Spiniello submitted a claim to Hartford for the loss, and Hartford denied the claim based on the faulty materials exclusion. Thereafter, Spiniello sued Hartford for breach of contract and bad faith. Both parties moved for summary judgment.

##### *The Ensuing Loss Provision Provides Coverage*

Spiniello argued that the loss due to the collapse of the liner was covered under the ‘ensuing loss’ provision as damage to ‘other covered property.’ Hartford argued that the claim was excluded by the faulty materials exclusion because the loss was caused by the defective catalyst.

The district court found that there was no factual dispute between the parties as to the cause of the damage to the liner. The court noted that the crux of the dispute was the interaction between the faulty materials exclusion and the ‘ensuing loss’ provision. The court acknowledged that, on its face, the faulty materials exclusion excluded losses resulting from defective materials. However, the court found that the exclusion was modified by the ‘ensuing loss’ provision, wherein Hartford agreed to pay for “resulting direct physical loss to other Covered Property.” *Spiniello* at 5. The court acknowledged that the ‘ensuing loss’ provision arguably conflicted with the faulty materials exclusion, insofar as it provided coverage to other covered property even where the loss resulted from the use of defective materials.

The court ultimately agreed with Spiniello’s interpretation of the ‘ensuing loss’ provision. The court determined that the defective catalyst was an external agent used to harden the resin, and that the defective nature of the catalyst caused the resin to harden prematurely, thus causing the liner’s collapse. Citing *GTE Corp. v. Allendale Mutual Insurance Co.*, 372 F.3d 598 (3d Cir. 2004), the court found that construing the ‘ensuing loss’ provision consistent with the insured’s reasonable expectations led to the conclusion that the liner constituted “other Covered Property,” and that damage caused by the defective material was therefore covered.

The court rejected Hartford's argument that the 'ensuing loss' provision applies only when a separate and independent covered event causes the loss, finding that nowhere in the provision is there a stated requirement of an intervening event. The court reasoned that if Hartford had intended such a requirement, it should have explicitly set forth the requirement in the policy. The court found the fact that Hartford had required an intervening cause in other sections of the policy as evidence that Hartford did not intend an intervening cause requirement as part of the 'ensuing loss' provision.

The court disagreed with Hartford that the decision in *GTE Corp.* supported the position that an 'ensuing loss' provision requires an intervening event. Instead, the court found that the Third Circuit never ruled on the issue. The court found *GTE Corp.* distinguishable in any event, because the insured in that case failed to establish damage to property other than the defective property itself.

The court concluded that a reasonable construction of the 'ensuing loss' provision was that it covered the collapse and required removal and replacement of the liner. Acknowledging its earlier comment regarding the conflict between the 'ensuing loss' provision and faulty materials exclusion, the court noted that while arguably an ambiguity was created by the conflicting provisions, such ambiguity would nevertheless require the court to construe the language in Spiniello's favor, citing *Cooper Labs, Inc. v. International Surplus Lines Insurance Co.*, 802 F. 2d 667 (3d Cir. 1986). The court therefore held that the 'ensuing loss' clause provided coverage for the loss at issue, and accordingly granted Spiniello's motion for partial summary judgment.

The court denied Hartford's motion for summary judgment with regard to the bad faith claim. Pointing out that bad faith is inappropriate where coverage for a claim is 'fairly debatable,' the court found that factual issues remained regarding Hartford's reasons for denying the claim.

# Insurance Law Cheat Sheet

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