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SURVEY OF DEVELOPMENTS IN INSURANCE COVERAGE LAW FOR 2014-2016

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Connecticut courts considered numerous insurance coverage and other insurance-related issues in 2014, 2015 and 2016. The Connecticut Supreme Court addressed both coverage and non-coverage-related insurance matters, including issues pertaining to continuous injury and the duty to defend under successive insurance policies, evidence of voluntary intoxication in sexual misconduct with minor claims, subrogation, unfair trade practice claims based on labor rates used to estimate auto body repair estimates, the Connecticut Insurance Guaranty Association, and the Connecticut Insurance Department's investigation of insurance producers. Other Connecticut state courts issued a variety of insurance-related decisions, on topics ranging from the proof required to establish an unfair insurance practice to title insurance for the home of late actress Katharine Hepburn. Federal courts also issued decisions regarding a variety of insurance-related issues, including the impact of intentional or reckless acts on insurance coverage, and, most notably, one of Connecticut's most highly publicized insurance topics, the so-called "crumbling foundations" cases.

I. "Crumbling Foundations" Cases

A. *Interpretation of the Terms "Foundation," "Retaining Wall" and "Collapse"*

In *Karas v. Liberty Ins. Corp.*,[1] one of a line of "crumbling foundations" insurance coverage cases, the United States District Court for the District of Connecticut considered coverage under a homeowners policy in connection

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1 33 F. Supp.3d 110 (D. Conn. 2014).

with the substantial impairment to the structural integrity of a home's basement walls. In 2013, the insured homeowners noticed cracks in the basement walls of their home, thought to be caused by "a chemical compound found in certain basement walls constructed in the late 1980s to the early 1990s with concrete most likely from J.J. Mottes Concrete Company."[2] As summarized by the court, the insureds alleged:

> The aggregate that company used to manufacture concrete at the time contained a chemical compound which, when mixed with water, sand, and cement necessary to form the concrete, began to oxidize and expand, breaking the bonds of the concrete internally and reducing it to rubble. There is no known way to reverse the deterioration, which continues whether or not there is visible water present. At some point between the date on which the basement walls were poured and October 2013, the structural integrity of the basement walls suffered a substantial impairment. It is only a question of time until the basement walls of the [insureds'] home will fall in, and as a result the entire home will fall into the basement.[3]

The homeowners policy at issue provides coverage for "direct physical loss to covered property involving collapse of a building or any part of a building caused by only one of the following: . . . (b) Hidden decay; . . . or (f) Use of defective material or methods in construction, remodeling or renovation." The insurer relied on an exclusion which provides that "loss to [a] foundation, [or] retaining wall . . . is not included [under coverage for collapse caused by hidden decay or use of defective material or methods in construction, remodeling or renovation] unless the loss is the direct result of the collapse of a building."[4]

The parties relied on differing dictionary definitions to define the terms "foundation" and "retaining wall."[5] The insurer argued that the term "foundation" means "a usually

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2 *Id*. at 113.
3 *Id*. at 113-14.
4 *Id*. at 114, n. 3.
5 *Id*. at 115.

stone or concrete structure that supports a building from underneath; . . . *especially*: the whole masonry substructure of a building," and the term "retaining wall" means "a wall built to resist lateral pressure other than wind pressure; esp: one to prevent an earth slide."[6] The insureds argued that the term "foundation" could mean "the footing upon which the basement walls rest, which does not include the basement walls," and the term "retaining wall" means a "freestanding wall that either resists some weight on one side or prevents the erosion of an embankment."[7] The District Court found both terms to be ambiguous because both parties had reasonable interpretations, and therefore, construed the terms against the insurer, and denied the insurer's motion to dismiss the insureds' breach of contract claim.[8] The District Court also observed that the term "collapse" included the alleged substantial impairment to the basement walls.[9]

Subsequently, in *Belz v. Peerless Ins. Co.*,[10] the District Court denied another motion to dismiss the insured homeowners' breach of contract claim arising from cracked basement walls. Relying on *Karas*, and another previous case, *Bacewicz v. NGM Ins. Co.*,[11] both of which involved nearly identical facts and policy language, the District Court found that the terms "foundation" and "retaining wall" are ambiguous, and construed them against the insurer.[12]

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6 *Id*., emphasis in original.

7 *Id*.

8 *Id*. at 115-116.

9 *Id*. at 114, relying on Beach v. Middlesex Mut. Assur. Co., 205 Conn. 246, 252, 532 A.2d 1292 (1987) ("finding the term 'collapse' is sufficiently ambiguous to include coverage for any substantial impairment of the structural integrity of a building").

10 46 F. Supp.3d 157, 161 (D. Conn. 2014).

11 No. 3:08cv1530 (JCH), 2010 U.S. LEXIS 77682 (D. Conn. August 2, 2010).

12 *Id*. at 163-64. The District Court also found that the term "collapse" included the alleged substantial impairment to the basement walls. *Id*. at 163, relying on *Beach, supra*. Subsequent to the decision regarding the motion to dismiss, the District Court denied the insurer's summary judgment motion, finding that issues of fact existed as to: 1) whether the damage to the home is covered under the "collapse" provisions of the policy; 2) when the damage occurred for the purposes of whether the damage occurred during the policy period, and whether the insureds' brought the suit within a sufficient amount of time; and 3) whether the insureds used all reasonable means to prevent further damage. Belz v. Peerless Ins. Co., 204 F. Supp.3d 457, 464-66 (D. Conn. September 2, 2016).

Similarly, in *Gabriel v. Liberty Mut. Fire Ins. Co.*,[13] the District Court denied an insurer's motion to dismiss the insured homeowners' breach of contract claim. Relying on *Bacewicz*, *Karas* and *Belz*, the District Court again found the terms "foundation" and "retaining wall" to be ambiguous.[14]

In *Metsack v. Liberty Mut. Ins. Co.*,[15] the District Court again denied an insurer's motion to dismiss the insured homeowners' breach of contract claim. Similar to prior cases, the insureds argued, essentially, that the term "foundation" means the footings upon which the basement walls rest, but not the basement walls themselves.[16] The insurer argued that the prior cases should not be followed because, in part, the homeowners policy at issue uses the terms "footings" and "foundation" separately, and therefore, these terms refer to separate parts of a structure.[17] The District Court disagreed, however, reasoning that at the time the insureds' house was built, it was common for a horizontal foundation, distinct from the walls, to be constructed on top of footings.[18] The District Court also relied on the policy's language pertaining to the calculation of replacement value for the proposition that a basement wall and a foundation are not necessarily the same thing.[19] Based on that language, the court summarized:

> *[F]irst*, that a foundation can exist "below the undersurface of the lowest basement floor," which implies that a basement wall and a foundation are not *always* one and the same, and *second*, that the policy in at least some capacities differentiates between homes constructed with and without a basement by distinguishing "foundation wall . . . if there is no basement" from "foundations below the undersurface of the lowest basement floor."[20]

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[13] No. 3:14cv01435 (VAB), 2015 U.S. Dist. LEXIS 129952 (D. Conn. September 28, 2015).

[14] *Id.* at *7-10.

[15] No. 3:14cv01150 (VLB), 2015 U.S. Dist. LEXIS 131984 (D. Conn. September 30, 2015).

[16] *Id.* at *15.

[17] *Id.* at *15-16.

[18] *Id.* at *16-17.

[19] *Id.* at *18-20.

[20] *Id.* at 19, emphasis in original.

As with the other cases, the District Court found both the term "foundation" and the term "retaining wall" to be ambiguous, and construed them against the insurer.[21]

Relying on *Metsack*, the District Court in *Roberge v. Amica Mut. Ins. Co.*,[22] denied an insurer's motion to dismiss the insured homeowners' foundation claim. As in *Metsack*, the insurer argued that the separate use of the terms "footings" and "foundations" means that the policy "contemplates that footings are distinct structures from the foundation."[23] The District Court found the policy to be ambiguous on this point.[24]

B. *Extra-Contractual Claims*

In addition to breach of contract claims, the "crumbling foundations" cases have included extra-contractual claims for breach of the implied covenant of good faith and fair dealing a/k/a "bad faith," and claims under the Connecticut Unfair Trade Practices Act, General Statutes Section 38a-815, *et seq*. ("CUTPA") for violations of the Connecticut Unfair Insurance Practices Act, General Statutes Section 42-110a, *et seq*. ("CUIPA"). In *Panciera v. Kemper Independence Ins. Co.*,[25] the District Court denied an insurer's motion to dismiss the insured homeowners' bad faith and CUTPA/CUIPA claims arising out of a cracked basement walls insurance claim. The insureds alleged that the insurer acted in bad faith by "cit[ing] an inapplicable policy exclusion, while failing to disclose the collapse coverage under which [the insureds'] claim should have been covered . . . and that in doing so, [the insurer] acted with a 'design to deceive,' . . . and in violation of stated Connecticut public policy, which forbids insurers from misrepresenting the terms of insurance contracts."[26]

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[21] *Id*.

[22] Civil No. 3:15cv1262 (WWE), 2015 U.S. Dist. LEXIS 172424 (D. Conn. December 29, 2015).

[23] *Id*. at *4.

[24] *Id*. at *7.

[25] Civil No. 3:13cv1009 (JBA), 2014 U.S. Dist. LEXIS 59076 (D. Conn. April 29, 2014).

[26] *Id*. at *11, quoting De La Concha of Hartford, Inc. v. Aetna Life Ins. Co., 269 Conn. 424, 432, 849 A.2d 382 (2004).

The insureds also alleged that the insurer participated in the Insurance Services Office, Inc. ("ISO"), "a cooperative organization formed and controlled by its participants for the purpose, among others, of collecting data on claims made in defined geographic areas" and which "drafts insurance policy provisions for its participants and prepares advisory interpretations of the meanings of those provisions."[27] The insureds further alleged that the insurer "colluded with other members of ISO to uniformly deny collapse claims related to faulty concrete, despite several cases determining that such claims are covered . . . ."[28] The District Court found that these allegations were sufficient to allege that the insurer acted in bad faith.[29] As to their claim for violations of CUIPA, which requires allegations of a "general business practice," the District Court found that the insureds alleged "minimally sufficient facts to sustain their CUTPA/CUIPA claim" by alleging that the insurer "followed an industry-wide practice in denying [the insureds'] claim, and that similar claims likely had been denied by the insurer.[30]

In *Karas*, the District Court found that the insureds' sufficiently pled a bad faith claim by alleging that the insurer denied coverage "without the benefit of any inspection of the basement walls at issue in order to verify the damage or its possible causes" and the insurer "intentionally cited inapplicable policy provisions, and misled the [insureds] solely for the purpose of preserving its owns assets."[31]

Likewise, in *Belz*, the District Court found that the insureds bad faith claim was sufficiently pled where the insureds alleged that the insurer denied coverage despite knowing that a covered caused of loss existed, and knowing that similar policy language had previously been construed

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27 *Id*. at *5-6.

28 *Id*. at *12.

29 *Id*.

30 *Id*. at *13-16, referencing the pleading standard announced in Ashcroft v. Iqbal, 556 U.S. 662 (2009) and Bell Atlantic Corp. v. Twombly, 550 U.S. 544 (2007), requiring more than "bare conclusory allegations."

31 33 F. Supp.3d at 116-117, citing Capstone Bldg. Corp. v. American Motorists Ins. Co., 308 Conn. 760, 67 A.3d 961 (2013) ("An insurer's failure to conduct an adequate investigation, when accompanied by other evidence, reflecting an improper motive, properly may be considered evidence of bad faith").

in favor of coverage, and that the insurer recited irrelevant and misleading portions of the policy in its denial letter.[32] The District Court also allowed the insureds' CUTPA/CUIPA claim alleging three other instances of unfair settlement practices because of the similarity between those claims and the insureds' claim, and because the insurer had "an incentive and mechanism to avoid liability under its current policy language."[33] The District Court also stated that there is "no magic number" regarding the number of instances of misconduct an insured needs to allege in order to sufficiently allege a general business practice under CUIPA.[34]

The District Court also denied the insurer's motion to dismiss the insureds' bad faith claim in *Gabriel*, where the insureds alleged that the insurer "ignored state and federal case law concluding that the term 'foundation' is ambiguous, and intentionally cited inapplicable policy language to mislead [the insureds] in order to preserve [the insurer's assets]."[35] The District Court also found that the insureds had sufficiently pled a "general business practice" under CUIPA by alleging that the insurer denied coverage in at least four other similar cases.[36]

In *Metsack*, the District Court allowed the insureds' bad faith claim where they argued that the insurer "denied their claim without any investigation" and "misled Plaintiffs 'into believing there was no coverage by citing inapplicable policy language.'"[37] The District Court also noted that the "this is not the first 'concrete decay' claim in which the [insurer or a related insurer] has initially denied coverage on one basis – here based upon language excluding 'settling' or 'seepage' of groundwater – only to later raise arguments

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[32] The District Court also noted that the exclusions cited in the denial letter were not even raised in the motion to dismiss. 46 F.Supp.3d at 165.

[33] *Id*. at 167.

[34] *Id*. Later, in the summary judgment decision, the District Court found issues of fact existed as to the insureds' bad faith and CUTPA/CUIPA. *Belz*, 204 F. Supp.3d at 467-69. No. 3:14cv01435 (VAB), 2015 U.S. Dist. LEXIS 129952 (D. Conn. September 28, 2015).

[35] 2015 U.S. Dist. LEXIS 129952 at *13, citing *Belz* and *Karas*, *supra*.

[36] *Id*. at *15.

[37] 2015 U.S. Dist. LEXIS 131984 at *23.

that the affected structures were excluded 'foundation[s]' or 'retaining wall[s].'"[38]

In *Kim v. State Farm Fire and Cas. Co.*,[39] however, the District Court granted the insurer's motion to dismiss both the insured homeowners' bad faith and CUTPA/CUIPA claims. Like similar cases, the insureds alleged that the insurer intended to mislead them by citing "wholly inapplicable" policy exclusions.[40] The District Court found that such provisions appeared "directly applicable," and that the insurer "applied several sections of the policy in a clear and straightforward manner, while raising other apparently applicable sections which [the insurer] may choose to rely upon at a later point."[41] The District Court further found that the fact that the insureds disagreed with the applicability of the relied upon provisions "does not evince bad faith sufficient to support a breach of the implied covenant of good faith and fair dealing."[42] As to the insureds' CUTPA/CUIPA claim, the District Court found that the insureds' failed to sufficiently allege a pattern of wrongful conduct by only alleging the denial of the insureds' own claim.[43] Similarly, in *Liston-Smith v. CSAA Fire & Cas. Ins. Co.*,[44] the District Court granted the insurer's motion to dismiss the insured homeowners' bad faith claim, finding that the allegations in the complaint could only support a disagreement between the parties over the interpretation of the policy provisions at issue, but not bad faith.[45] The District Court also found that the insurer's threatened cancellation of the insurance policy due to the concrete issue did not support the insureds' bad faith claim because the complaint did not relate the threat to the breach of contract.[46] The District Court did, however, allow the insureds'

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[38] *Id.*

[39] No. 3:15cv879 (VLB), 2015 U.S. Dist. LEXIS 147823 (D. Conn. October 30, 2015).

[40] *Id.* at *9.

[41] *Id.* at *11-12.

[42] *Id.*

[43] *Id.* at *14.

[44] No. 3:16cv00510 (JCH), 2016 U.S. Dist. LEXIS 147165 (D. Conn. October 25, 2016).

[45] *Id.* at *6-7.

[46] *Id.* at *7.

CUTPA/CUIPA claim because of allegations of the insurer's involvement with ISO, as well as the fact, recognized by the District Court, that the insurer was named in multiple other similar concrete cases.[47]

C. *Contractual Limitation of Suit Provision*

Finally, in *Roberts v. Amica Mut. Ins. Co.*,[48] the District Court considered the time the insured homeowners had within which to start their suit against their insurer in connection with a "crumbling foundations" claim. The policy at issue contained a contractual limitation of suit provision which stated:

> Suits Against Us
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> No action can be brought against [the insurer] unless there has been full compliance with all the terms under Section I of the policy and the action is started within two years after the date of loss.[49]

For purposes of the insurer's motion to dismiss based on the alleged failure of the insureds to start the suit within the time set forth in the policy, the parties agreed that the relevant time period began to run from the time the insureds "learned or should have learned of the cracking in their basement walls."[50] Relying on Connecticut substantive law in this diversity suit based on a state law contract claim, the District Court reiterated that: "The Connecticut Supreme Court has long held that a contractual condition in an insurance policy requiring an action to be brought within a particular time period is . . . valid and binding upon the parties."[51] The District Court further stated: "Though the con-

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47 *Id*. at *11-13.

48 Civil No. 3:14cv1589 (SRU), 2015 U.S. Dist. LEXIS 158266 (D. Conn. November 24, 2015).

49 *Id*. at *8-9 (emphasis omitted).

50 *Id*. at *9.

51 *Id*. at *8-9, citing PHL Variable Ins. Co. v. Charter Oak Trust, No. HHDCV106012621S, 2012 Conn. Super. LEXIS 1218 (Conn. Super Ct. May 4, 2012).

tractual suit limitation is enforceable, it does not operate as a statute of limitations," and "[a]ccordingly, the interpretation of a contractual suit limitation is governed by Connecticut contract law, not statutory law."[52]

The parties agreed that the applicable date of loss was in late October or early November 2012.[53] The parties disagreed, however, as to which date the action was "started" for the purposes of the contractual limitation of suit provision in the policy. If the action was started when the complaint was filed with the District Court, October 27, 2014, the action would be timely, but if the action was started when the insurer was served, February 20, 2015, then the action would be untimely.[54]

Through a motion for reconsideration after the District Court initially granted the insurer's motion to dismiss, the insureds argued that the contractual limitation of suit provision was ambiguous as to when the action needed to be "started."[55] The District Court rejected the insureds' argument that the term "started" was governed by Rule 3 of the Federal Rules of Civil Procedure, which "defines commencement of a suit as when the complaint is filed in federal court."[56] The District Court held that the insureds' interpretation of the policy was unreasonable, and the insureds "should have reasonably contemplated such a result because the only mechanism of enforcing the insurance policy was based in Connecticut state law, under which a suit is "started" by service upon the defendant. Thus, whether filed in state or federal court, they should have reasonably understood that the action would be deemed to commence in accordance with the state law definition of commencement of a suit."[57]

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[52] *Id*. at *8, citing Monteiro v. American Home Assurance Co., 177 Conn. 281, 416 A.2d 1189 (1979).
[53] *Id*. at *7.
[54] *Id*. at *9.
[55] *Id*. at *4-5.
[56] *Id*. at *11 & 14.
[57] *Id*. at *14.

II. Intentional or Reckless Acts

In *State Farm Fire and Cas. Co. v. Tully*,[58] the Connecticut Supreme Court affirmed the trial court's decision granting summary judgment in favor of an insurer under a homeowners insurance policy, finding that the insurer had no duty to defend the insured, a fifty-six year old man, in an underlying lawsuit alleging that he "'negligent[ly]' sexually assaulted [a fourteen year old girl] while he was intoxicated."[59] The insurer relied on an intentional acts exclusion, and the insured asserted that evidence of his intoxication raised an issue of fact as to whether his actions were intentional for the purposes of the exclusion.[60] In its decision, the Supreme Court analyzed the Connecticut Appellate Court's decision in *United Services Automobile Assn. v Marburg*[61] and its own decision in *Allstate Ins. Co. v. Barron*.[62] In *Marburg*, due to the nature of the sexual assault of a minor, the Appellate Court applied a presumption of intent to cause harm, for the purposes of an intentional acts exclusion, and that the insured must produce evidence of lack of intent to overcome this presumption.[63] Subsequently, in *Barron*, the Supreme Court adopted the holding in *Home Ins. Co. v. Aetna Life & Cas. Co.*,[64] which was applied in *Marburg*, that "an insured's intent to commit an act may be negated for the purposes of an intentional conduct exclusion clause when the insured did not understand the nature or wrongfulness of his conduct, or was deprived of the capacity to control his actions regardless of his understanding of the nature of the wrongfulness of his action."[65]

The insured argued that *Barron* overruled the presumption applied in *Marburg*.[66] The Supreme Court disagreed.[67]

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58 322 Conn. 566, 142 A.3d 1079 (2016).
59 *Id*. at 569.
60 *Id*. at 571.
61 46 Conn. App. 99, 698 A.2d 914 (1997).
62 269 Conn. 394, 843 A.2d 1165 (2004).
63 322 Conn. at 576-77.
64 35 Conn. App. 94, 644 A.2d 933 (1994), rev'd on other grounds, 235 Conn. 185, 663 A.2d 1001 (1995).
65 322 Conn. at 577-78, quoting *Barron*, 269 Conn. at 407.
66 *Id*. at 575.
67 *Id*. at 578.

The Supreme Court further held that evidence of voluntary intoxication may not be used to negate intent for claims arising out of sexual misconduct with a minor.[68] In reaching this conclusion, the Supreme Court analyzed approaches taken in other states,[69] and adopted an approach that does not allow an insured to use evidence of voluntarily intoxication to negate intent for insurance purposes in any case, but appeared to limit its holding to only claims involving sexual misconduct with a minor.[70] The Supreme Court also considered the reasonable expectations of an insured, and state criminal statutes regarding the inability to use intoxication as a defense.[71] Finally, the Supreme Court confirmed that an insured may still use evidence of mental disease or defect to negate intent.[72]

In *Allstate Ins. Co. v. Tandon*,[73] the defendants' insurance company sought a declaratory judgment that it owed no duty to defend or indemnify the defendants in a civil lawsuit filed in Connecticut Superior Court by Frank and Donna Genna.[74] Allstate had insured the defendants under an Allstate Deluxe Homeowners Policy and an Allstate Personal Umbrella Policy.[75] On May 28, 2010, (during the covered period), an incident allegedly occurred at Captain's Cove Marina of Bridgeport, Inc., where Frank Genna sustained personal injuries due to the actions of the defendants.[76] According to Genna's complaint, Robert Doohan (one of the defendants) and his companions assaulted Genna by beating, strangling, and holding him under water to the point of asphyxia.[77] Genna's complaint stated that due to the defendants' negligent, reckless, and intentional conduct, Genna suffered various injuries and continues to

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[68] *Id.* at 584.
[69] *Id.* at 584-86, analyzing approaches set forth in Wiley v. State Farm Fire & Cas. Co., 995 F.2d 457, 465-66 (3rd Cir. 1993).
[70] *Id.* at 586.
[71] *Id.* at 587-89.
[72] *Id.* at 590-91.
[73] No. 3:13cv585 (HBF), 2015 U.S. Dist. LEXIS 37529 (D. Conn. Mar. 25, 2015).
[74] *Id.* at *1.
[75] *Id.* at *2.
[76] *Id.*
[77] *Id.* at *6-7.

suffer from permanent brain damage.[78]

Although Allstate's policies covered damages that arose when an insured person becomes "legally obligated to pay because of bodily injury or property damage arising from an occurrence," Allstate argued against coverage because the injuries were considered by Allstate to be the result of intentional or criminal acts of the insured defendants,[79] not within the definition of an "occurrence" according to Allstate's policies.[80] Where the policy defined "occurrence" as an accident which is an "unintended and unforeseen injurious occurrence,"[81] the court observed that an "occurrence" would not include "intentional torts or other intended actions . . . [where] the intent required is the intent to commit the specific act leading to the injury, not the intent to achieve a specific result."[82]

Primarily, the District Court determined that several counts in Genna's complaint alleged that his injuries were caused by the defendants' "intentional assault and battery" of Genna, and that these counts alleging intentional behavior fell outside the realm of Allstate's duty to defend.[83] The defendants argued that the counts in the complaint alleging negligence and recklessness, by their very nature, suggested accidental or unintentional conduct.[84] The court disagreed with the defendants and held that a court of law must look past the terminology to the underlying factual allegations to determine if the complaint alleged a negligent action or an intentional act.[85] The court did not find that Allstate had a duty to defend simply because the complaint called the conduct negligent, because the actions were intentional torts and thus not an "occurrence" that

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78 *Id*. at *7-13 (stating Genna also alleged counts against defendants ranging from civil assault and battery to civil conspiracy).

79 *Id*. at *24.

80 *Id*. at *20-21.

81 *Id*. at *21 (citing Allstate Ins. Co. v. Barron, 269 Conn. 394, 408 n.10, 848 A.2d 1165 (2004) (internal quotation marks omitted)).

82 *Id*. at *22 (citing State Farm Fire & Cas. Co. v. Mesniaeff, 3:12-CV-1675 (VLB), 2014 U.S. Dist. LEXIS 37297, at *6 (D. Conn. Mar. 21, 2014) (internal quotation marks omitted)).

83 *Id*. at *23.

84 *Id*. at *23.

85 *Id*. at *24-25.

Allstate's policies insure.[86] The facts alleged in the underlying complaint showed no accident in the alleged chain of events, and thus the court looked to the motive of the acting party to determine that there was a clear intent to do harm to Genna.[87] Because the court determined that Allstate had no duty to defend the defendants and the policies did not provide coverage for Genna's bodily injuries, the court determined that there also was no duty by Allstate to cover Donna Genna's loss of consortium claims.[88] Moreover, because Connecticut law holds that the duty to defend is much broader than the duty to indemnify, where there is no duty to defend, there could be no duty to indemnify.[89] Thus, the court granted Allstate's request for a declaratory judgment that it lacked a duty to defend or indemnify the defendants.

In a case presenting similar issues, the District Court determined in *Allstate Ins. Co. v. Neleber*[90] that the facts alleged in the underlying complaint might constitute an occurrence as defined under the terms of the policy. Thus summary judgment finding that Allstate had a duty to defend entered in favor of the insured.[91] In *Neleber*, the defendant was an insured person under Allstate's Homeowners Policy, which had provisions similar to those at issue in the *Tandon* case; the policy covered "occurrences" that are accidents but does not cover any injuries or damages that were the result of intentional or criminal acts.[92] The underlying complaint named Neleber as a defendant in a civil action alleging assault and battery upon Michael Astram for allegedly negligently striking Astram in the face and head while swinging his arms when he was inattentive

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[86] *Id*. at *28.

[87] *Id*. at *27-28, agreeing with New London County Mut. Ins. Co. v. Doohan, KNL-CV-13-6017658-S, 2014 Conn. Super LEXIS 2581 (Sept. 25, 2014).

[88] *Id*. at *32-33 (finding that "loss of consortium claims are derivative of the injured spouse's cause of action" and if the injured spouse was not covered, then the consortium claims were also denied coverage).

[89] *Id*. at *35.

[90] No. 3:14cv629 (DJS), 2015 U.S. Dist. LEXIS 122563 (D. Conn. Sept. 15, 2015).

[91] *Id*. at *2.

[92] *Id*. at *3-4.

to the presence of individuals around him."[93]

The court disagreed with Allstate's arguments that Neleber's actions causing the injury were necessarily deliberate and intentional.[94] The court determined that although Count One of the complaint alleged that Neleber committed an assault and battery, there were no accompanying factual allegations to convey whether the action was intentional or accidental.[95] The court noted that under Connecticut law, an assault and battery can be committed intentionally, recklessly, or even negligently.[96] Reminding Allstate that "a duty to defend is determined by the facts in underlying complaint, not the titles assigned to various counts,"[97] the court held that Neleber's actions could fall within the definition of the term "accident" and thus under the "occurrence" definition in Allstate's policy.[98]

Allstate also argued that the incident fell within the "Intentional or Criminal Acts" exclusion of the policy, because Neleber's actions could satisfy the elements of various Connecticut criminal laws such as: assault in the third degree; breach of peace in the second degree; creating a public disturbance; or disorderly conduct.[99] The court rejected these arguments because (1) the court already had concluded that there were insufficient factual allegations to implicate intentional acts taken by Neleber, and (2) due to the limited factual allegations, the court could not conclude that Neleber's actions were reckless.[100] Because the factual allegations in the complaint might possibly fall within the policy's coverage, the court denied Allstate's motion for summary

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93 *Id*. at *5 (describing defendant's negligent conduct as "(b) In that he swung his arms while he was inattentive to the presence of individuals around him; (c) In that he failed to control his physical movements to avoid striking and injuring others; and (d) In that he behaved in an unreasonable, aggressive and threatening manner.").

94 *Id*. at *10.

95 *Id*.

96 *Id*. at *10 (citing Markey v. Santangelo, 195 Conn. 76, 78, 485 A.2d 1305 (1985)).

97 *Id*. at *11 (citing Allstate Insurance Co. v. Wilson, 18 F. Supp. 3d 156, 161 (D. Conn. 2014) (quotation marks omitted)).

98 *Id*. at *13.

99 *Id*. at *15.

100 *Id*. at *16-18.

judgment and determined that Allstate had a duty to defend Neleber in the state court civil action.[101]

In *Allstate Ins. Co. v. Jussaume*,[102] the District Court issued another ruling confirming that insurance is not meant to cover injuries resulting from intentional acts, even if those acts are cloaked in negligence allegations. The insured allegedly assaulted the underlying plaintiff by kicking him, striking him with weapons, and punching him, causing injuries.[103] While the eleventh count of the complaint alleged intentional conduct, the underlying plaintiff attempted to trigger insurance coverage by alleging, in the alternative, "negligent contact" in the seventeenth count.[104] The insurer moved for summary judgment seeking a declaration that it owed no duty to defend or indemnify the insured, based upon an exclusion in the policy for injuries expected or intended to result from the intentional or criminal acts of an insured person.[105] In granting summary judgment for the insurer, the court observed that it was immaterial that that underlying plaintiff had labeled one count as being based on an "intentional act" and another count as being based on "negligent contact"; "what matters is whether the facts alleged in the [underlying plaintiff's] Complaint could possibly establish that [the underlying plaintiff]'s injuries were caused by an occurrence."[106] It concluded that even reading the complaint in the light most favorable to the insured, the complaint failed to allege facts that could support a conclusion that the injuries were the result of an accident.[107]

In *Allstate Ins. Co. v. Wilson*,[108] the District Court similarly granted summary judgment to an insurer where the insureds' minor sons sexually assaulted an intoxicated minor female at a party, because the underlying claims

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101 *Id.* at *18-19.
102 35 F. Supp.3d 231 (D. Conn. 2014).
103 *Id.* at 233.
104 *Id.* at 234.
105 *Id.*
106 *Id.* at 237.
107 *Id.* at 237-38.
108 18 F. Supp.3d 156 (D. Conn. 2014).

labeled negligence were based on the intentional acts of the sons. In addition to allegations of sexual assault, the Complaint asserted claims for negligence, alleging that the minor sons both "[f]ailed to assist Plaintiff, who considered [them friends], when she became obviously intoxicated."[109] The victim intervened and contended that there was a plausible claim for negligence against Defendants based on their failure to assist her and prevent the sexual assault, triggering Allstate's duty to defend.[110] The intervenor conceded at oral argument that the allegation that the insureds failed to assist her is inconsistent with the claims that they were among the assailants, but maintained that because under Connecticut pleading practice she was permitted to plead in the alternative in the underlying Complaint, if there is insufficient evidence that the insureds committed intentional acts, the jury could alternatively find that they were negligent based their failure to prevent the assault by other defendants.[111]

The court rejected the alternatively pled argument, observing that while Connecticut pleading standards permit a plaintiff to plead in the alternative, the rules do "not to allow a plaintiff to engage in fantasy[.] . . . Thus, while alternative and inconsistent pleading is permitted, it would be an abuse of such permission for a plaintiff to make an assertion in a complaint that he does not reasonably believe to be the truth."[112] The court concluded that the negligence claim was "tied inextricably" to the intentional tort claims, and, as such, the underlying complaint did not allege that "an accident" arose out of an "occurrence".[113] It further concluded in the alternative that the policies' intentional and criminal acts exclusions applied because the allegations of sexual assault constituted criminal conduct and juvenile criminal charges stemmed from the incident, underscoring that the conduct alleged was both intentional and criminal.[114]

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109 *Id.* at 159.
110 *Id.* at 162.
111 *Id.* at 163.
112 *Id.*
113 *Id.*
114 *Id.* at 163-64.

In *State Farm Mut. Auto. Ins. Co. v. Simonelli*,[115] the District Court denied State Farm's motion for summary judgment seeking a declaration that it had no duty to defend its policyholder's employee based on arguments that: (1) the employee's use of a company vehicle was unauthorized at the time of the use; and (2) the employee's acts were intentional because the damage was caused while driving the company vehicle under the influence of the drug PCP.[116] Regarding the intentional acts exclusion, the court concluded that the legal characterizations of the employee's acts as negligent or reckless are not dispositive if the court finds that they do not accurately reflect the true facts of the case.[117]

In order to determine that the employee's acts were intentional, two elements are required: (1) that the individual intended to commit the act; and (2) that the individual intended to commit the resulting injuries.[118] The court acknowledged that intent to cause injury may be "inferred at law in circumstances where the alleged behavior in the underlying action is so inherently harmful that the resulting damage is unarguably foreseeable."[119] Although the court acknowledged that driving while under the influence of PCP constitutes a flagrant disregard for the safety of others, "without additional facts, it does not of itself denote an intention to harm others."[120]

State Farm further argued that the employee's subsequent guilty plea to assault charges, which included an admission of reckless behavior, was equivalent to the intentional conduct excluded under the policy.[121] The court, however, noted that "there is a longstanding distinction between

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[115] No. 3:10cv1431 (JCH), 2014 U.S. Dist. LEXIS 102807 (D. Conn. July 28, 2014).

[116] *Id*. at *2, 10-11, 15.

[117] *Id*. at *13 (citing Middlesex Ins. Co. v. Mara, 699 F. Supp. 2d 439, 456 (D. Conn. 2010) ("Connecticut courts look past the terminology in pleading to grant summary judgment for the insurer, holding that there is no duty to defend a negligence action which is actually based on intentional acts by the insured.")).

[118] *Id*. at *14.

[119] *Id*. at *15, quoting Mara, 699 F. Supp. 2d at 450.

[120] *Id*. at *18.

[121] *Id*. at *19.

intentional and reckless conduct in Connecticut statutory law and court precedent," citing General Statutes Section § 53a-3(11), (13) and the Connecticut Supreme Court's decision in *Carpenter v. Commissioner of Correction*,[122] in which the court stated that "intentional conduct and reckless conduct are 'mutually exclusive,' such that they cannot exist simultaneously with respect to the same act."[123] Thus, the court held that the employee's admission of recklessness did not establish intentional conduct barring coverage under the policy.[124]

In *Simonelli*, State Farm also relied upon the affidavit of the president of the employee's company that the employee was not authorized to use the company vehicle at the time he caused the damage (2:30 p.m.) because the employee's shift did not begin until an hour and a half later at four o'clock.[125] Defendants refuted State Farm's argument based on: (1) their position that Connecticut state law creates a statutory presumption (under General Statutes Section 52-183) that the employee while operating the company vehicle was the agent/servant of the company and therefore was operating it in the course of his employment; and (2) their argument that Connecticut courts find the vehicle owner's bald assertion that the driver was unauthorized insufficient to rebut the statutory presumption.[126] The court did not rely on defendants' arguments but still found that State Farm had failed to meet its burden of establishing the absence of any genuine issue of material fact because the record remained unclear regarding the scope of the employee's permission to use the vehicle at the time of the incident.[127] Accordingly, the court refused to grant summary judgment based on the employee's purported lack of permission to use the vehicle.[128]

In *Harleysville Worcester Ins. Co. v. Paramount Concrete,*

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122 290 Conn. 107, 125, 961 A.2d 403 (2009).
123 2014 U.S. Dist. LEXIS 102807 at **20-21.
124 *Id*. at *21.
125 *Id*. at *8-9.
126 *Id*. at *9-10.
127 *Id*. at *10-11.
128 *Id*. at *12.

Inc.,[129] the District Court previously granted summary judgment in favor of the defendant, in part, but then held a trial to determine whether an exclusion applied because the defendant Paramount expected or intended its product to fail.[130]

In May 2009, R.I. Pools brought a lawsuit against Paramount, a manufacturer and supplier of a certain material called "shotcrete," after nineteen pools built by R.I. Pools incorporating Paramount's shotcrete developed significant, detrimental cracks.[131] A jury returned a verdict in favor of R.I. Pools and awarded it compensatory damages and punitive damages in the form of attorneys' fees because Paramount acted with "reckless disregard for the safety of product users, consumers and others who were injured by the product."[132]

Paramount was insured under a commercial general liability insurance policy sold by the plaintiff, which covered property damage caused by an "occurrence," defined as an accident "including continuous or repeated exposure to substantially the same harmful conditions."[133] After the unfavorable verdict, the insurer filed a declaratory judgment action asking the court to rule that the insurance policy did not provide coverage for Paramount's damages and, even if it did, that several exclusions barred coverage.[134] The court entered partial summary judgment concluding that the claims fell within the insuring agreement of the policy.[135] The court further rejected the insurer's argument that certain business risk exclusions defeated coverage.[136]

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[129] 123 F. Supp.3d 282 (D. Conn. 2015).

[130] *Id.* at 282.

[131] *Id.* at 283.

[132] *Id.*

[133] *Id.*

[134] *Id.*

[135] *Id.* at 284 (holding "[w]here an insured 'unintentionally sells a defective product that is incorporated into a third-party's finished product, the resulting impairment to the third-party's product' constitutes an 'occurrence' that causes 'property damage.'") (quoting *Chubb Ins. Co. of N.J. v. Harford Fire Ins. Co.*, No. 97-CV-6935 (LAP), 1999 U.S. Dist. LEXIS 15362 at *4 (S.D.N.Y. Sept. 27, 1999)).

[136] 123 F. Supp. 3d at 285. The court rejected application of the business risk exclusions because the underlying trial involved damage caused by the product, not the cost to remedy the product itself.

However, the court found a bench trial necessary to determine whether or not Paramount expected or intended its product to fail.

While some Connecticut Superior Court decisions have held that an insured expects or intends injury when it "knows or should know that there was a substantial probability of damage from its acts or omissions,"[137] the court noted that it "is not enough that the harm was foreseeable to a reasonable concrete manufacturer in Paramount's position."[138] Paramount's owners had no idea that the concrete was flawed in any way and had no reason to believe that the product was damaged.[139] Moreover, the man in charge of mixing the concrete believed that the concrete was reasonably safe, and even though he had concerns about the concrete's quality at times, he was just as shocked that the shotcrete caused major cracks.[140] Because the insurer's expert did not physically examine any of the materials himself nor interview any of the parties who knew anything about the concrete, the court discounted the insurer's expert and found no basis for intentional or expected production of faulty concrete.[141] Thus, the court determined that the insurer failed to prove that "individuals at Paramount actually knew, much less intended, that the shotcrete was so defective it could cause harm . . . . Without that knowledge, Paramount cannot be held to have 'expected' the nineteen pools to crack."[142]

III. Duty to Defend Under Successive Policies for Continuous Injury

In *Travelers Cas. And Sur. Co. of Am. v. The Netherlands Ins. Co.*,[143] Travelers sought a declaration that defendant

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137 *Id*. at 298 (quoting Linemaster Switch Corp. v. Aetna Life & Cas. Corp., 1995 WL 462270, at *25 (Conn. Super. Ct. July 25, 1995)).

138 *Id*. at 298. The court referred to the decisions under New York law applying the expected or intended injury exclusion narrowly to mean that an insured expects injury when it knows that the damages would flow directly and immediately from that intentional act.

139 *Id*. at 299.

140 *Id*. at 300.

141 *Id*.

142 *Id*.

143 312 Conn. 714, 95 A.3d 1031 (2014).

Netherlands owed a duty to defend certain insured contractors in connection with allegedly defective construction work at the University of Connecticut School of Law library. The trial court held that Netherlands was obligated to defend the contractor and pay a pro rata share of defense costs to Travelers.[144] Netherlands appealed and argued: (1) that Travelers lacked standing because Travelers was not a party to the Netherlands policies; (2) that the underlying allegations did not constitute an "occurrence" under the Netherlands policies because the faulty construction took place prior to their inception; (3) that the Netherlands policies' exclusion for "known injury or damage" precluded coverage; and (4) that the pro rata allocation period determined by the trial court was incorrect.[145] The Supreme Court disagreed with Netherlands on all arguments and affirmed the trial court's judgment.[146]

In 1994, the State of Connecticut hired a contractor (Lombardo) for construction of the law library, and the work was completed in January of 1996.[147] Beginning at some point after the work was completed, the law library began suffering problems with water intrusion, of which Lombardo was informed.[148] Netherlands insured Lombardo from August 31, 2000 to June 30, 2006.[149] In late 2005, Lombardo notified its insurance companies of the State's potential claim related to the law library.[150] Travelers, which insured Lombardo from 1994 to 1998, agreed to participate in Lombardo's defense; Netherlands refused to do so.[151] On February 14, 2008, the State brought an action against Lombardo and others seeking $18 million in damages allegedly needed to repair the law library.[152] In July 2009, Travelers brought an action against Netherlands seeking a declaratory judgment that Netherlands was obligated to

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144 *Id.* at 716-17.
145 *Id.* at 717.
146 *Id.*
147 *Id.*
148 *Id.* at 717-18.
149 *Id.* at 718.
150 *Id.*
151 *Id.*
152 *Id.*

pay its pro rata share of Lombardo's defense costs.[153]

Netherlands argued that Travelers lacked standing to bring the action because it alleges breach of contract between Netherlands and Lombardo and that Travelers was neither a party to, nor an intended beneficiary of, that contract.[154] Travelers responded in part by arguing that it had been "classically aggrieved," giving it the requisite standing to bring a declaratory judgment under General Statutes Section 52-29 and the implementing rule of practice, Practice Book Section 17-55.[155] Because Travelers was forced to pay all of Lombardo's defense costs due to Netherlands refusal to contribute, the Supreme Court agreed that Travelers had been aggrieved and had standing to bring the declaratory judgment against Netherlands.[156]

Specifically, the Court noted that Connecticut's declaratory judgment statute is broader in scope than the statutes in most, if not all, other jurisdictions, and is liberally construed.[157] The Court also noted that a declaratory judgment is both a common and appropriate vehicle to determine rights and liabilities under an insurance policy.[158] The Court then determined that Travelers passed the two-pronged test for demonstrating that it had been classically aggrieved: (1) Travelers had a specific, personal, and legal interest in the subject matter at issue (as opposed to a mere general interest); and (2) that such interest was injuriously affected.[159] The injurious effect to the legally protected interest need only be possible, not certain.[160] However, the Court did note that the dispute between multiple insurance companies must be ripe with respect to their defense or indemnity obligations.[161] Finally, the Court held that Connecticut would follow the line of case law from other jurisdictions holding that inclusion of the named insured in

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153 *Id*. at 718-19.
154 *Id*. at 722.
155 *Id*. at 723.
156 *Id*. at 723-24.
157 *Id*. at 727.
158 *Id*.
159 *Id*. at 729.
160 *Id*.
161 *Id*. at 730, n. 18.

such an action between insurance companies would not be required.[162]

In ruling on this issue, the Court held that Travelers had standing to bring a declaratory judgment action because "the controversy [between Travelers and Netherlands] is real and ongoing, with Travelers' claim of injury more than colorable, given . . . Netherlands' refusal to contribute to Lombardo's defense."[163]

Netherlands' first policy-based defense was that its policies were not triggered because there was no "occurrence" during the policy period.[164] Specifically, Netherlands argued that its policies did not incept until four years after construction had been completed and the water intrusion and property damage allegedly began.[165] The Court held that the Netherlands policies did not require that the "occurrence" happen during the periods they cover, but instead required that resulting "property damage" occur during those periods.[166] Because the underlying complaint alleged that the water intrusion was continuing and progressive into the 2000s, the Court held that the broadly worded allegations of property damage extended into the Netherlands' policy periods.[167]

Netherlands next argued that its policies could not cover the damage to the law library if Lombardo knew such damage had begun in whole or in part prior to Netherlands' policy period.[168] The Court first noted the distinction between the common law "known loss" doctrine, which derives from the "implicit requirement" that insurance coverage will be provided only for fortuitous losses, and the policy-based "known injury or damage" exclusion relied upon by Netherlands (although noting that there may be overlapping effects in certain cases).[169] In determining whether to

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[162] *Id.* at 731.
[163] *Id.* at 737-38.
[164] *Id.* at 743.
[165] *Id.*
[166] *Id.* at 744.
[167] *Id.* at 745.
[168] *Id.* at 747.
[169] *Id.* at 748.

apply the exclusion, the Court relied upon Connecticut law requiring that insurance policies be construed to afford coverage whenever possible and concluded that the alleged facts in the underlying complaint did not definitively preclude coverage for purposes of Netherlands' duty to defend.[170]

Specifically, the Court found that while the allegations arguably permit an inference that Lombardo knew of the property damage prior to the inception of the Netherlands policies, "they do not compel that conclusion as a matter of law."[171] Because the allegations did not specify exactly when Lombardo received notice of the damage, and similarly were vague as to when the state's forensic engineers' reports were provided to Lombardo, the complaint allowed for the possibility of coverage, requiring Netherlands to defend.[172]

Finally, Netherlands argued that the period over which the trial court had allocated defense costs was improper. Netherlands claimed that Connecticut applies the "exposure theory" to determine what policies are triggered by a loss.[173] The Court refuted Netherlands' argument and confirmed that Connecticut applies a "continuous trigger," which the trial court had properly applied by allocating the insurance companies' pro rata shares over a 144 month period.[174]

IV. Economic Loss

In *Fleming v. Government Employees. Ins. Co.*,[175] the District Court dismissed a claim under the Connecticut direct action statute by tort plaintiffs holding a judgment against policyholders for negligent failure to settle, based on the economic loss doctrine. However, the court allowed a bad faith claim to proceed on allegations that the liability insurance company failed to explain a claim denial, failed to

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[170] *Id.* at 752.
[171] *Id.* at 750-51.
[172] *Id.*
[173] *Id.* at 752.
[174] *Id.* (citing Security Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 264 Conn. 688, 826 A.2d 107 (2003)).
[175] 86 F. Supp.3d 102 (D. Conn. 2015).

fairly evaluate the claim, and failed to accept an offer to settle within policy limits.

The underlying plaintiffs had prevailed against an insured on a wrongful death claim arising out of a car crash. Prior to trial in the wrongful judgment action, there was a partial settlement in which plaintiffs released one defendant and released the auto insurance company GEICO as to two of four policies at issue. The settlement did not cover a remaining defendant, and GEICO denied coverage under the two remaining policies, allegedly with no explanation and with no objective or impartial evaluation of the claim. The underlying plaintiffs made several demands for payment of the remaining policy limits, which GEICO did not accept, and they then tried the underlying action to verdict against the remaining defendant.[176] As judgment creditors subrogated to the rights of that defendant, the plaintiffs sued GEICO under the Connecticut direct action statute[177] for negligent failure to settle within policy limits and for breach of the covenant of good faith and fair dealing. GEICO moved to dismiss both claims for failure to state a claim.

Noting that "Connecticut appellate courts have not directly addressed the application of the economic loss doctrine to negligent failure to settle claims," the District Court looked to a more general statement of the rule by the Connecticut Supreme Court in 2013, that "'the economic loss doctrine bars negligence claims that arise out of and are dependent on breach of contract claims that result only in economic loss.'"[178] Finding that the plaintiffs' claim for negligent failure to settle "arises out of, and is dependent on, the contractual relationship" between the insured and the insurance company, the District Court found it barred by the economic loss doctrine.[179]

As to the bad faith claim, however, the court found that

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[176] *Id.* at 105.

[177] CONN. GEN. STAT. § 38a-321.

[178] *Id.* at 108 (quoting Ulbrich v. Groth, 310 Conn. 375, 410, 78 A.3d 76 (2013)).

[179] *Id.*

the complaint stated a viable claim by alleging that GEICO had failed to articulate any reason for its denial of coverage under two policies, had not objectively and impartially evaluated the claim, and had unreasonably failed to accept an offer to settle within limits to avoid personal liability of the policyholders.[180] Distinguishing cases in which plaintiffs had failed to allege improper or dishonest motives, the court concluded that "[t]hese factual allegations, if proven, could support a finding that GEICO acted without a reasonable basis."[181]

The Connecticut Appellate Court addressed an apparent question of first impression in *New London County Mut. Ins. Co. v. Sielski*,[182] holding that damages resulting solely from negligent misrepresentation constituted economic or pecuniary loss, and not property damage within the liability coverage of a homeowners' insurance policy.[183] The policyholder in *Sielski* sought a defense and indemnity against an action by purchasers of his residential property alleging negligent misrepresentation through his failure to disclose water damage and mold prior to their purchase of his property.[184] The trial court allowed the insurance company's motion for summary judgment, holding that the theory of negligent misrepresentation and resulting injury alleged in the underlying action against the homeowner did not constitute property damage as defined in the policy.[185]

The Appellate Court affirmed,[186] noting that neither it nor the Supreme Court had addressed whether damages arising from negligent misrepresentation may be considered property damage or under what circumstances a negligent misrepresentation can give rise to an occurrence within the meaning of a homeowners insurance policy.[187] After noting

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[180] *Id*. at 110.
[181] *Id*.
[182] 159 Conn. App. 650, 123 A.3d 925 (2015). Although certification to further appeal was granted, 319 Conn. 956, 125 A.3d 533 (2015), the appeal was subsequently withdrawn without a decision.
[183] *Id*. at 663-64.
[184] *Id*. at 652-53.
[185] *Id*. at 653-54.
[186] *Id*. at 652.
[187] *Id*. at 657.

decisions in the Connecticut Superior Court and the District Court holding that negligent misrepresentation claims did not involve property damage, but rather economic damages,[188] the Appellate Court distinguished the Supreme Court's 2013 decision in *Capstone Building Corporation v. American Motorists Ins. Co.*,[189] which the policyholder argued was controlling.[190] *Capstone* held, inter alia, "that defective construction or faulty workmanship that causes damage to nondefective property may constitute property damage resulting from an occurrence, thus triggering coverage under the commercial general liability policy."[191] The Appellate Court found *Capstone* "readily distinguishable," because it did not address the issues in *Sielski* "whether there was any damage to the property that preexisted the asserted occurrence or a third party's damages that flowed from a purported misrepresentation of fact concerning past damage . . . that would be considered property damage" and whether there was a causal connection; "rather, the . . . question before the [Capstone] court assumed that the defective work itself was the cause of the injury suffered."[192] The Appellate Court also reviewed numerous authorities from other jurisdictions concluding that damages from misrepresentations are economic or contractual in nature and do not give rise to property damage covered by liability insurance, finding no "accident" or occurrence, even if the act alleged was a mistake, or finding no causal link between misrepresentations and property damage.[193]

Finally, the Appellate Court noted the Supreme Court's reliance in a negligent misrepresentation case on a provision in the Restatement (Second) of Torts stating that "dam-

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[188] *Id.* at 657-658 (citing Amica Mutual Ins. Co. v. Paradis, HHD-CV-13-6041224-S, 2014 Conn. Super. LEXIS 2640 (October 16, 2014); Amica Mutual Ins. Co. v. Basu, HHD-CV-12-603445-S, 2013 Conn. Super. LEXIS 2964 (December 20, 2013); Electric Ins. Co. v. Santo, UWY-CV-06-4011499-S, 2007 Conn. Super. LEXIS 2179 (August 6, 2007); Homestead Country Properties, LLC v. American Modern Home Ins. Co., 3:12cv1003 (JBA) 2013 U.S. Dist. LEXIS 97919 *4 (D. Conn. July 12, 2013)).

[189] 308 Conn. 760, 67 A.3d 961 (2013).

[190] 159 Conn. App. at 654.

[191] 308 Conn. at 771.

[192] 159 Conn. App. at 658-59.

[193] *Id.* at 659-62.

ages recoverable for a negligent misrepresentation are those necessary to compensate for . . . pecuniary loss . . . of which the misrepresentation is a legal cause."[194] Observing that the gist of the underlying plaintiffs' claim was their purchase of the policyholder's property relying on his misrepresentations regarding water seepage, rot and damage, the court found that "the alleged conditions, problems, and defects existed prior to the [policyholder's] alleged misrepresentations, and subsequent incidents causing damage after [they] purchased the property were the result of those preexisting conditions, problems, and defects.[195] It therefore concluded that "the damages claimed by the [underlying plaintiffs] as a result of the [policyholder's] alleged misrepresentations constituted economic or pecuniary losses, and not property damage within the ambit of the coverage of the policy."[196] The court also agreed that the misrepresentations could not be considered the actual or proximate cause of damages for property damage, reasoning that "[the underlying plaintiffs] may have purchased the property as a direct result of the [policyholder's] alleged misrepresentations, but the actual property damage would have existed with or without such misrepresentations or the . . . purchase."[197]

The Appellate Court also rejected the policyholder's assertion of error in the trial court's determination of the property damage issue as a question of law on summary judgment, rather than a fact question requiring trial. The policyholder again relied on Capstone, in which the Supreme Court observed that "'[W]hether an insured party makes a viable claim for property damage is a highly fact-dependent determination in each case.'"[198] Reiterating the familiar rules that an insurer's duty to defend is determined by the four corners of the insurance policy and the complaint in the underlying action, and that an insurer cannot

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[194] *Id*. at 662 (citing Updike, Kelly & Spellacy, P.C. v. Beckett, 269 Conn. 613, 645 n.25, 850 A.2d 145 (2004) (internal quotation omitted).
[195] *Id*. at 663.
[196] *Id*. at 664.
[197] *Id*. at 665.
[198] *Id*. at 667 (quoting *Capstone*, 308 Conn. at 778).

rely on extrinsic facts to avoid a defense,[199] the Appellate Court concluded "it necessarily follows that whether 'property damage' has been alleged . . . may also be addressed solely by reference to those two documents."[200] *Capstone* is not to the contrary, the court reasoned, because it merely "demonstrates that the [Supreme Court] was rejecting a per se rule for or against including all damages related to defective construction in the initial grant of coverage and requiring, instead that any damages claimed be considered individually."[201]

V. Subrogation

The Connecticut Supreme Court held in *Pacific Ins. Co. v. Champion Steel, LLC* that a workers' compensation insurer can maintain equitable subrogation claims against third-party tortfeasors to recover benefits paid on behalf of an insured employer to an injured employee.[202] The trial court had granted the tortfeasors' motions to dismiss, accepting their argument that the workers' compensation insurer had no standing to assert a claim under either General Statutes Section 31-293, which creates a statutory right on the part of an employer, not an insurer, to recover, or the common-law equitable subrogation doctrine.[203] On appeal, the Supreme Court first noted that the doctrine of equitable subrogation aims to prevent unjust enrichment of tortfeasors "by the fortuitous circumstance that the victim's loss is covered by an insurer"[204] and that it is now "'broad enough to include every instance in which one person, not acting as a mere volunteer or intruder, pays a debt for which another is primarily liable, and which in equity and good conscience should have been discharged by the latter.'"[205]

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[199] *Id.* at 668 (citing Misiti, LLC v. Travelers Prop. Cas. Co. of America, 308 Conn. 146, 61 A.3d 485 (2013); Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co., 274 Conn. 457, 464, 466-67, 876 A.2d 1139 (2005); Smedley Co. v. Employers Mut. Liability Ins. Co., 143 Conn. 510, 516-17, 123 A.2d 755 (1956)).

[200] *Id.* at 669.

[201] *Id.* at 669-70.

[202] 323 Conn. 254, 256, 146 A.3d 975 (2016).

[203] *Id.* at 257-58.

[204] *Id.* at 262 (citing Wasko v. Manella, 269 Conn. 527, 548-49, 849 A.2d 777 (2004)).

[205] *Id.* at 262 (quoting Westchester Fire Ins. Co. v. Allstate Ins. Co., 236 Conn. 362, 371, 672 A.2d 939 (1996)).

The Supreme Court agreed with the insurer's contention that the workers' compensation statutory scheme did not abrogate its common-law right to bring a subrogation action when it has paid an insured for a loss caused by a third-party tortfeasor.[206] Noting that the equitable subrogation doctrine has "long existed at common law,"[207] the court found nothing in applicable legislation "that abrogates this long-standing doctrine in the context of workers' compensation," while "in other areas of workers' compensation, however, the legislature has expressly abrogated the common law."[208] From a public policy perspective, the court noted that allowing insurers to bring equitable subrogation claims in the workers' compensation context would "serve[] the public policy of containing the cost of workers' compensation insurance" and would "prevent the unjust enrichment of tortfeasors in situations in which the employee and employer do not bring actions to recover damages caused by the tortfeasors."[209]

Finally, the *Pacific Insurance* court rejected the tortfeasors' contention that the insurer could not assert equitable subrogation claims because at common law, personal injury claims could not be assigned, on three grounds. First, the court noted the "discernible difference between assignment and equitable subrogation, at least in the context of indemnity insurance."[210] Second, the court reasoned that "an insurer's right of equitable subrogation is distinct from an employer's right to bring an action against a third-party tortfeasor who harmed an employee," because the employer's right is statutory and was created by the workers' compensation act, while "an insurer's right of equitable subrogation arises from the common law, and it existed at the time the [workers' compensation] act was enacted."[211] Third, and related to the second point, while the court

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206 *Id*.
207 *Id*. at 263 (citing, *inter alia*, Regan v. New York & New England Railroad Co., 60 Conn. 124, 131, 22 A. 503 (1891)).
208 *Id*. at 264-65.
209 *Id*. at 266.
210 *Id*. at 267.
211 *Id*. at 269.

agreed with appellants that General Statutes Section 31-293(a) created a new statutory right of action for employers against third-party tortfeasors, it noted that "[t]he *insurer's* right to be subrogated to the employer's rights under § 31-293 (a) … is derived from the common law."[212]

VI. Title Insurance

First American Title Ins. Co. v. 273 Water Street, LLC[213] concerned a declaratory judgment action filed by a title insurer. In 2004, a developer purchased the summer home of the late actress Katharine Hepburn for $6 million.[214] The developer then subdivided the property into 3 lots and put the property on the market for a total asking price of $30 million.[215] In 2005, the developer learned of the town's claim to ownership of a discontinued road that ran over part of the property and ended at the waterfront.[216] Litigation commenced after the title company's offer of $17,000 was rejected by the developer, which claimed its loss was $5 million.[217] The title insurer sought a declaration that a payment of $40,000 would satisfy its obligations under the policy and the developer countered alleging breach of contract and bad faith.[218] Following a jury verdict of $2 million, the title company appealed to the Connecticut Appellate Court. On appeal, the title insurance company argued that the developer lacked standing to bring its counterclaim because in 2011, it had transferred a portion of the property which contained the title defect to a third party. The insurer argued that that transfer terminated the policy as to that portion of the property.[219] The Appellate Court disagreed and held that the owner's coverage was deemed to survive the conveyance of a portion of the insured property.[220]

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[212] *Id.* at 270 (emphasis in original).
[213] 157 Conn. App. 23, 117 A.3d 857 (2015).
[214] *Id.* at 26.
[215] *Id.*
[216] *Id.*
[217] *Id.* at 27.
[218] *Id.*
[219] *Id.* at 29.
[220] *Id.* at 36.

In *Chorches v. Stewart Title Guaranty Co.*,[221] an individual purchased property in Greenwich, Connecticut in 1996 that was subject to an easement that was unknown to the purchaser and was not discovered by the attorney who performed the title search prior to purchase. Following a demand by the purchaser under his title policy, he accepted a $15,000 payment, signed a release from future liability related to the easement, and agreed to a policy endorsement specifically providing an exception to coverage for the easement.[222] The title company also filed suit on the purchaser's behalf against the prior owner/seller and the attorney who had performed the title search, but the purchaser was denied any relief based on his failure to prove any damages.[223]

The plaintiff purchaser then brought an action against the title company alleging breach of contract and bad faith denial of coverage with respect to another action brought by the purchaser against his neighbors for trespass based on their ongoing use of the easement.[224] The District Court granted defendants' motions to dismiss and for summary judgment on three separate grounds: (1) the endorsement agreed to by plaintiff discontinued any continuing obligation of defendant with respect to the easement claims at issue; (2) the release signed by plaintiff foreclosed his breach of contract claim; and (3) even if the endorsement and release did not preclude plaintiff's claim, it still would fail because the trespass claims at issue in his action against his neighbors were outside the scope of his title insurance policy.[225]

The court further found that the trespass action could not have implicated the easement issue because the Connecticut Supreme Court already had determined that the plaintiff suffered no damages related to the easement.[226] Finally, the court dismissed plaintiff's bad faith claims, hold-

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[221] 48 F. Supp.3d 151, 153 (D. Conn. 2014).
[222] *Id.* at 153.
[223] *Id.* at 153-54.
[224] *Id.* at 154.
[225] *Id.* at 155-56.
[226] *Id.* at 156.

ing that the failure of the breach of contract claim was fatal to a corresponding claim for bad faith denial of coverage.[227]

VII. Unfair Practices

In *Artie's Auto Body, Inc. v. Hartford Fire Ins. Co.*,[228] the plaintiffs, three Connecticut auto body repair shops and an association of Connecticut auto body repair shops, brought a class action suit against the defendant insurance company.[229] The plaintiffs alleged that the insurer had violated CUTPA by requiring its appraisers to use artificially low hourly labor rates set by the insurer when estimating the cost of auto body damage sustained by the insurer's customers, instead of rates that "more accurately reflect the actual value of those services, when appraising auto body damage sustained by insureds."[230] The jury rendered its verdict for the plaintiffs, determining that the insurer's labor rate practices "offended the public policy embodied in § 38a-790-8" of the Regulations of Connecticut State Agencies.[231] The trial court awarded the plaintiffs compensatory and punitive damages, but on appeal, the Connecticut Supreme Court held that the trial court incorrectly concluded that Section 38a-790-8 supported the plaintiffs' CUTPA claim alleging unfair labor rate practices. Because Section 38a-790-8 did not prohibit or regulate the negotiation of hourly labor rates dealing with auto body repair services, the insurer's labor rate practices could not offend the public policy embedded in Section 38a-790-8.[232] The Supreme Court reversed and remanded, directing judgment as a matter of law for the defendant.

While the hourly labor rate that the insurer's appraisers were using was significantly lower than the hourly labor rates that were posted in the plaintiff auto body shops, the insurer's rates were approximately equal to the rates that other insurance companies in Connecticut paid for their

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227 *Id.* at 157-58.
228 317 Conn. 602, 119 A.3d 1139 (2015).
229 *Id.* at 604.
230 *Id.* at 605.
231 *Id.* at 614.
232 *Id.* at 605.

auto body repair services.[233] Even the plaintiff auto body shops conceded at trial that because almost all of their business is insurance related, it is "exceedingly rare for them to be paid their posted hourly labor rates."[234] At the close of evidence, the trial court instructed the jury that for the plaintiffs to prevail on their CUTPA claim, they must have proved that the insurer's practices violated at least one prong of the "cigarette rule," which is a test that Connecticut courts have adopted for determining liability under CUTPA.[235] Thus, the plaintiffs were required to establish that one or more of the insurer's practices meet at least one of the following three criteria: "(1) it offends public policy, as it has been established by statutes, the common law or other established concept of unfairness; or (2) it is immoral, unethical, oppressive or unscrupulous; or (3) it causes substantial injury to consumers, competitors or other business persons."[236]

The policy set out in Section 38a-790-8 is the code of ethics for motor vehicle physical damage appraisers, which requires an appraiser to "approach the appraisal of damaged property without prejudice against, or favoritism toward, any party involved in order to make fair and impartial appraisals, to disregard any efforts on the part of others to influence his judgment in the interest of the parties involved, and to prepare an independent appraisal of damage."[237] However, the court determined that Section 38a-790-8 does not serve to regulate the conduct of appraisers in the development of labor rates but rather serves to regulate the appraiser's conduct when estimating the cost to insurers of auto body repairs.[238] Moreover, the court determined that appraisers who negotiate for the cost of auto repairs on behalf of their employers would never owe a duty of impartiality to the auto repair shops with whom they are dealing.[239] Therefore, the plaintiff's CUTPA

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[233] *Id*. at 607.
[234] *Id*.
[235] *Id*. at 609.
[236] *Id*. at 609-10.
[237] *Id*. at 610 (internal citation and quotation marks omitted).
[238] *Id*. at 625.
[239] *Id*. at 627.

claim alleging unfair labor rate practices has nothing to do with the conduct regulated by the statute, and based on the court's determination that the insurer's labor rate did not violate public policy, judgment was directed in favor of the insurer.[240]

In *Hartford Roman Catholic Diocesan Corp. v. Interstate Fire & Cas. Co.*,[241] the insured plaintiff alleged breach of contract, breach of the covenant of good faith and fair dealing, and violations of the CUIPA and CUTPA, claiming that the insurer wrongfully failed to pay it for losses related to several abuse claims covered by excess liability insurance policies. The insured alleged that Interstate had made a general business practice of avoiding its obligations to its insureds in at least two other states.[242] In ruling on the insured's motion to compel, the Magistrate Judge ordered production of documents evidencing other policyholder's claims.[243] The insurer objected to the ruling, arguing that the Magistrate Judge erred in requiring the production of documents evidencing other policyholders' claims by erroneously concluding that CUIPA includes unfair insurance practices occurring outside the state of Connecticut.[244]

The District Court disagreed with the insurer, and affirmed the Magistrate Judge's ruling.[245] The District Court observed that while Section 38a-815 requires that the alleged unfair claim settlement practice occur in Connecticut, nothing in Section 38a-816(6) requires that evidence relevant to whether a plaintiff's injury was part of a general business practice be confined to Connecticut only. "Rather, instances of alleged unfair trade practices from outside the State are relevant to proving that an in-State plaintiff was the victim of the culpable conduct that CUIPA was intended to combat instead of an isolated instance of misconduct exempted from CUIPA . . . . That a general

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[240] *Id.* at 627-28, n.16.
[241] No. 3:12cv1641 (JBA), 2015 U.S. Dist. LEXIS 3542 (D. Conn. January 13, 2015).
[242] *Id.* at *2.
[243] *Id.* at *4-5.
[244] *Id.* at *11-12.
[245] *Id.* at *14.

insurance practice includes manifestations from outside of Connecticut does not lessen the culpability of a defendant's in-State conduct."[246]

Subsequently, the District Court held a 3 week bench trial on the plaintiff's claims of breach of contract, breach of the implied covenant of good faith and fair dealing, and violations of CUTPA/CUIPA arising out of Interstate's failure to reimburse the plaintiff for settlements of negligent supervision claims involving sexual abuse by clergy.[247]

The District Court found in favor of the plaintiff for its breach of contract claims, awarding damages in the amount of the settlement payments plus interest running from the date that Interstate should have made payment. As to the plaintiff's common law claim for breach of the implied covenant of good faith and fair dealing, the district court held that while Interstate's conduct "was certainly negligent, perhaps even reckless," the Court found no inference of a "dishonest purpose" or "sinister motive," as was required.[248]

As to the CUTPA/CUIPA claim, the District Court held that Interstate engaged in unfair insurance practices with the plaintiff (violating 3 prongs of CUIPA), and that Interstate engaged in the same misconduct with other policyholders. Notwithstanding those findings, the District Court concluded that the amount evidence offered by the plaintiff of the insurer's misconduct with its other policyholders (10-12%) did not rise to the level of a "general business practice", as required under the statute to prove a CUIPA violation.[249]

In *Tucker v. American International Group, Inc.*,[250] after the dismissal of substantive coverage claims on a claims-made employment practices liability ("EPL") insurance policy because the policyholder had failed to provide timely notice of a demand letter received prior to inception of the

246 *Id.* at *13-14.
247 199 F. Supp.3d 559 (D. Conn. July 2016).
248 *Id.* at 601.
249 *Id.* at 613-14.
250 179 F. Supp.3d 224 (2016).

policy,[251] the sole remaining claim alleged violations of the "unfair settlement practices" provision of CUIPA,[252] asserted through CUTPA.[253] The plaintiff, who had obtained a judgment against the policyholders and an assignment of their claims under the EPL insurance policy,[254] alleged that the defendant insurance companies failed to properly investigate the claim, failed to conduct a timely or thorough investigation of the facts, failed to make any coverage determination for more than four years, and did so only after an adverse jury verdict, and refused to participate in the ADR procedures specified in the policy itself.[255]

After a thorough review of CUTPA and CUIPA law, including the private right of action through CUTPA's enforcement provisions, the proximate cause requirement, and the requirement of proof of multiple instances of misconduct to show a "general business practice,"[256] the court turned to the insurance companies' summary judgment motion. They argued that there was no evidence that the policyholders "wanted a settlement," which was necessary to prove "unfair settlement practices," nor of repeated unfair conduct constituting a general business practice.[257] The plaintiff responded that the insurers mishandled the claim by closing the file while her claim was still pending, without a prompt or "any" investigation of the claim and by failing to provide a coverage determination for four years, until after a judgment was entered against the policyholder.[258] As to the general business practice requirement, the plaintiff identified several cases litigated in federal court in which the defendant insurance companies or their AIG affiliates were found or alleged to have engaged in similar unfair settlement practices,[259] as well as a report published

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[251] Tucker v. American International Group, Inc., 3:09cv1499 (CSH) 2015 U.S. Dist. LEXIS 9874 (D. Conn. Jan. 28, 2015).
[252] CONN. GEN. STAT. § 38a-816(6).
[253] CONN. GEN. STAT. § 42-110a.
[254] 179 F. Supp.3d at 235, n.19.
[255] *Id*.
[256] *Id*. at 229-30.
[257] *Id*. at 231-33.
[258] *Id*. at 233.
[259] *Id*. at 234.

by a trial attorneys' association and an expert opinion report.[260]

The District Court denied as to the insurance companies' motion in part and granted it in part, finding genuine disputes as to whether they had engaged in unfair business practices in investigating and processing the claim under subsections (C) and (D) of General Statutes Section 38a-816(6) and reasoning that "[e]ven if [plaintiff] ultimately had no contractual rights [under the policy] due to the claims-first-made provision, CUIPA requires insurance companies to process claims without the use of unfair business practices."[261] In other words:

> [E]ven if, as it turned out, [plaintiff's] claim was not properly covered by the claims-first-made policy, and thus Defendants were correct in ultimately denying coverage …, the question remains whether Defendants' investigation of the claim prior to that determination was reasonable — sufficient and/or properly conducted — so that a CUIPA violation did not occur. Specifically, did Defendants "adopt and implement reasonable standards for the prompt investigation of claims arising under [the] insurance polic[y] at issue?" Exactly how and when did Defendants investigate [plaintiff's] claims and were the steps they took, if any, "reasonable" and/or "based upon all available information"?[262]

As to proof of the defendants' "general business practices," the court found that "at least four" of the cases cited by plaintiff from jurisdictions across the country offered proof of "similar unfair business practices … that resemble[d] the allegedly wrongful practices in the present case."[263] While the facts in those cases were "similar, rather than identical" to the facts in *Tucker*, the court found that

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[260] *Id*. 245-47.
[261] *Id*. at 241.
[262] *Id*.
[263] *Id*. at 246 (citing Acacia Research Corp. v. Nat'l Union Fire Ins. Co., No. SACV 05-501 (PSC), 2008 U.S. Dist. LEXIS 96955, 2008 WL 4179206, at *16 (C.D. Ca. Feb. 8, 2008); Anderson v. Amer. Int'l Group, Inc., No. 2003-01212-B, 2014 Mass. Super. LEXIS 48 (Mass. Super. Ct. April 8, 2014); United Technologies Corp. v. Am. Home Assur. Co., 118 F.Supp. 2d 181, 184 (D. Conn. 2000); Victaulic Co. v. American Home Assur. Co., No. RG12642929 (Alameda County Superior Court, California)).

each provides examples of the defendant insurer's general failure to properly and/or timely investigate a claim."[264] However, the court rejected a report compiled by the American Association for Justice which included the AIG defendants among "The Ten Worst Insurance Companies in America" and which "discussed AIG's claims handling practices in a negative light,"[265] finding insufficient support for the plaintiff's contention that it came within the hearsay rule exception for "market reports and similar commercial publications."[266] The court further refrained from ruling on the admissibility of an expert report submitted by the plaintiff that criticized the defendants' claim investigation, finding "numerous factors to be evaluated before [admitting] such evidence"[267] and concluding that such an evaluation was not needed because the cases presented by the plaintiff were sufficient to create fact issues regarding the general business practice question.[268]

Finally, as to damages, while the court reiterated that the plaintiff had no right to recover policy proceeds in light of the prior substantive coverage decision, it found that she nevertheless could recover statutory damages on her CUTPA/CUIPA claim.[269] The court cautioned that proving damages from the insurance companies' investigation would "present a considerable challenge" because the plaintiff knew her demand letter preceded the EPL policy at issue and because, as the policyholders' subrogee, she is presumed to have read the terms of the policy.[270]

Williams v. Safeco Ins. Co. of Am.[271] addressed the legal standard for proof of unfair settlement practices that are part of a "general business practice" in violation of CUIPA in the context of a motion in limine. The insureds' complaint alleged that although Safeco acknowledged coverage for

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[264] *Id.* at 247.
[265] *Id.* at 245.
[266] *Id.* at 247 (citing Fed. R. Evid. 803(17)).
[267] *Id.*
[268] *Id.* at 248.
[269] *Id.* at 248-49.
[270] *Id.* at 249.
[271] FST-CV-12-6016414-S, 2015 Conn. Super. LEXIS 2727 (Super. Ct. Oct. 28, 2015).

damage to their home caused by a faulty valve in the municipal sewer system, it unreasonably delayed payment through unfair settlement practices that kept them from their home for several years.[272] A week before trial, Safeco moved in limine to bar the insureds' evidence or argument regarding unsubstantiated allegations or complaints of bad faith against it to prove that Safeco's alleged unfair settlement practices in their claim were part of a "general business practice" as required by General Statutes Section 38a-816(6). Safeco argued that unsubstantiated allegations or complaints are not relevant evidence and would unduly prejudice and confuse the jury.[273] The Superior Court entered an order permitting four categories of evidence to prove a "general business practice," provided that such evidence was directly relevant to the unfair settlement practices alleged in the complaint:

> (1) live testimony of similar practices involving other insureds of Safeco; (2) evidence of similar practices in complaints before the insurance commissioner that have been ruled upon as valid, or comparable testimony from Insurance Department personnel; (3) written evidence of similar practices in complaints before courts that have been adjudicated against Safeco; and (4) evidence provided by the insurer's internal sources as to its practices.[274]

In the memorandum supporting this order, the court first noted that the issue of how to allege a "general business practice" had been extensively considered by the courts,[275] yet the problem of proof, once a general business practice was properly alleged, remained "far less considered."[276] In *Lees v. Middlesex Ins. Co.*,[277] the Connecticut Supreme

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[272] *Id.* at *1.
[273] *Id.* at *2.
[274] *Id.*
[275] *Id.* at *6 ("'[F]or a plaintiff to allege CUIPA and CUTPA violations successfully, the plaintiff must allege more than a singular failure to settle a plaintiff's claim fairly. The plaintiff must allege that the defendant has committed the alleged wrongful acts with such frequency as to indicate a general business practice.'") (quoting Quimby v. Kimberly Clark Corp., 28 Conn. App. 660, 672, 613 A.2d 838 (1992)).
[276] *Id.*
[277] 229 Conn. 842, 643 A.2d 1282 (1994).

Court had approved a trial court's refusal to consider evidence of other suits filed against an insurance company and complaints lodged with the insurance commissioner where the plaintiff had adduced no additional facts or information regarding those other matters. The *Williams* court reasoned that the *Lees* decision "sets a threshold, requiring that such suits and claims have evidentiary value before they may be considered in support of a CUIPA/CUTPA claim:[278]

> In other words, (1) they must involve the same or very similar practices as alleged in the complaint, and (2) they must involve other claimants. Evidence of suits and claims may be relevant only if it proves "that there has been a general business practice as to the precise type of unfair claims practice alleged." . . . In particular, "judicial findings concluding that an insurer had mishandled claims against its insureds would similarly be admissible to establish a general practice if they were sufficient in other respects, namely number, frequency and similarity."[279]

The court stated as a third requirement that the proffered evidence must comply with the rules of evidence, including those relating to relevance and inadmissible hearsay.[280] As to the concerns arising when a judicial or quasi-judicial record of one case is offered as evidence in another, the court found "guidance" in the "principles that underlie judicial notice," i.e. that generally, "'[c]ourt records may be judicially noticed for their existence, content, and legal effect,'" but not as a "'general hearsay exception.'"[281]

Applying these principles, the court noted that each of the other complaints against Safeco that were alleged as support for the policyholders' CUIPA claim involved conduct that was either unspecified or dissimilar to the conduct in *Williams*.[282] Accordingly, the court found none of them

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[278] 2015 Conn. Super. LEXIS 2727 at *8-9.

[279] *Id*. at *9 (citations omitted)(quoting Thomas v. Biller Associates Tri-State, Inc., NNH-CV-05-4010695-S, 2009 Conn. Super. LEXIS 2383, *5 (August 31, 2009); Edible Arrangements, Inc. v. Brenner, NNH-CV-08-5019463-S, 2010 Conn. Super. LEXIS 43, *12 (January 7, 2010)).

[280] *Id*. at *10.

[281] *Id*. at *11 (quoting C. Tait & E. Prescott, Connecticut Evidence (4th Ed. 2008) §2.3.4(d), at 97).

[282] *Id*. at *13.

"admissible as evidence in support of a general business practice because they do not constitute findings of a relevant unfair claim settlement practice entitled to collateral estoppel effect."[283]

VIII. Reinstatement, Misrepresentation and Conditions Precedent

In *Brown v. State Farm Fire and Cas. Co.*,[284] the plaintiff suffered a fire loss at his home on April 21, 2006. The plaintiff had purchased a homeowner's insurance policy from State Farm, which had sent a bill for the policy to the plaintiff in February of 2006.[285] On March 22, 2006, State Farm sent plaintiff a cancellation notice stating that the policy would be canceled on April 6, 2006 if payment was not received by that date.[286] After the fire, plaintiff discovered the cancellation notice and immediately sent payment for the February bill, which State Farm credited to the plaintiff's account on April 22, 2006 – the day after the fire.[287] The trial court found that the plaintiff's payment reinstated the policy, effective April 22, 2006, and rendered judgment for State Farm following a bench trial, from which the plaintiff appealed.[288]

The Connecticut Appellate Court affirmed the trial court's judgment that late premium payments, such as that made by the plaintiff here, merely reinstate coverage on a prospective basis and do not apply to retroactively reinstate coverage.[289] Noting that Connecticut appellate courts had not previously considered this issue, the court found that reinstating coverage prospectively "effectuates an important principle of insurance law: the concept of fortuity . . . . This principle explains why a person cannot suffer a loss and then subsequently purchase insurance to cover that loss."[290]

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[283] *Id.*
[284] 150 Conn. App. 405, 90 A.3d 1054, *cert. denied*, 315 Conn. 901, 104 A.3d 106 (2014).
[285] *Id.* at 408.
[286] *Id.*
[287] *Id.* at 408-09.
[288] *Id.* at 409.
[289] *Id.* at 414.
[290] *Id.* at 413-14.

The court also cited authority that an insurance company accepting a late premium to reinstate coverage only prospectively must clearly convey that limitation to the policyholder prior to accepting the late premium payment.[291] In *Brown*, the court found that the cancellation notice sent to plaintiff explicitly provided this information by stating that there would be no coverage between the dates of cancellation and reinstatement.[292] Accordingly, based on the language of the policy and the cancellation notice, and based on public policy requiring fortuitous losses, the court rejected the plaintiff's argument that State Farm had waived its right to deny coverage by accepting plaintiff's late premium payment.[293]

In *Vasily v. MONY Life Ins. Co. of America*,[294] the District Court granted in part and denied in part the insurer's motion for summary judgment on the insured's claims for breach of contract, equitable estoppel, "disproportionate forfeiture/unfair penalty," and breach of the duty of good faith and fair dealing.[295] The policyholder failed to pay his premium by the end of the grace period on thirty-four occasions between 2001 and 2010. For each occasion he would receive a "restoration letter" from the insurer indicating that it would restore his policy if he paid the overdue premium within twenty days. If he did so, the letter indicated that his policies would continue in force.[296] On each occasion, he paid the overdue premium and his policies would continue to be in force.[297]

The policyholder's health declined and his son was granted power of attorney on May 11, 2010.[298] The 31-day grace period on two of the policies expired on June 2, 2010.[299] On June 2, 2010, the insurer issued restoration letters for these policies as it had done in the past.[300] The money was wired

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[291] *Id.* at 414.
[292] *Id.*
[293] *Id.* at 415.
[294] 104 F. Supp.3d 207 (D. Conn. 2015).
[295] *Id.* at 210.
[296] *Id.* at 212.
[297] *Id.*
[298] *Id.*
[299] *Id.*
[300] *Id.*

to the insurer on June 14, 2010, one week after the policyholder had died on June 7, 2010.[301] The insurer returned the wired payments on July 6, 2010, and denied the claim for death proceeds. The insurer argued on summary judgment that the grace period had expired; reinstatement requires payment of the overdue premium with interest plus evidence of continued insurability; evidence of insurability during the twenty-day restoration period allowed by the insurer's letter includes the condition that the insured be alive; and, because at the time the insurer received the overdue premiums on the policies the insured had died, plaintiffs could not provide satisfactory evidence of insurability and therefore could not reinstate the lapsed policies.[302] In response, plaintiffs argued that the restoration letters modified the life insurance policies because the insurer consistently allowed the policyholder to cure any lapse caused by non-payment of the premiums within the policies' grace periods, so long as payment of such overdue premiums was made within 20 days from the date of the restoration letters.[303]

The court held that, while the policies were never modified, the insurer was equitably estopped from rejecting the payments made after the grace period because "the course of dealings established by [the insurer]'s restoration procedure could have led [the insured to form a reasonable belief that payment within the twenty day restoration period would be treated by [the insurer] in the same way as payment within the previous 31 day grace period."[304] It further held that because the previous reinstatements were never conditioned on the insured being alive, the insured's death cannot act to end the reinstatement period.[305]

The District Court found a question of fact requiring trial of the materiality element of a life insurance company's rescission claim in *Principal Nat'l Life Ins. Co. v.*

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301 *Id.*
302 *Id.* at 213.
303 *Id.* at 214.
304 *Id.* at 218.
305 *Id.* at 219.

Coassin.[306] The insurance company issued the policy after receiving an application and supplemental statement of health which disclosed a visit to an internist for dizziness and vertigo complaints several months earlier and stated that the issues were "[r]esolved completely without recurrence" with "[n]o further MD visits needed."[307] In fact, in the roughly two-week gap between submission of the application and the supplemental health statement, the insured had seen a cardiologist and an ear, nose and throat specialist who ordered subsequent testing, which led to an MRI and consultation with a neurologist who concluded, several weeks after submission of the supplemental health form, that the insured had a "common" and "benign" condition, for which "no further investigation was necessary or appropriate."[308] Several months later, a second MRI revealed a brain tumor, which led to the insured's untimely death within the policy's two-year contestability period.[309]

On the insurance company's motion for summary judgment, the District Court applied Connecticut law allowing an insurance company to void a policy upon proof of "(1) a misrepresentation (or untrue statement) by the plaintiff which was (2) knowingly made and (3) material to [the insurer's] decision whether to insure."[310] The court found no dispute on the knowing misrepresentation elements, because the insured continued suffering symptoms that led him to see two doctors, one of whom ordered further testing, in the two weeks prior to submitting his supplemental health statement, and because he attested that he had not seen any doctors in that time frame and that his symptoms had resolved.

The court found a question of fact as to materiality, i.e., "the effect which the knowledge of the fact in question would have on the making of the contract."[311] Following Second

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306 No. 3:13cv1520 (JBA), 2015 U.S. Dist. LEXIS 128840 (D. Conn. Sep. 25, 2015).

307 *Id*. at *3-4.

308 *Id*. at *5-7.

309 *Id*. at *7-8.

310 *Id*. at *12 (quoting Pinette v. Assurance Co. of Am., 52 F.3d 407, 409 (2d Cir. 1995)).

311 *Id*. at *18 (internal quote and citation omitted).

Circuit authority finding that "[a]n answer to a question on an insurance application is presumptively material,"[312] the court noted the competing assessments of the insurance company's underwriter, who stated that the company would have declined to issue the policy, and the claimants' expert, who stated that the company would have postponed its underwriting decision but ultimately would have issued the policy after learning that the neurologist who read the first MRI concluded the insured had a benign condition requiring no further investigation.[313] While the insurance company argued to the contrary, the court noted underwriting guidelines which allowed covering persons with benign vertigo if the cause was fully investigated, and therefore found a dispute of material fact precluding summary judgment.[314]

In *Zurich Am. Ins. Co. v. Expedient Title, Inc.*,[315] the District Court granted summary judgment rescinding a title insurance company's professional liability insurance policy, finding no question of material fact regarding the knowing falsity of a policyholder's response to an application question whether any of its officers was the subject of a governmental investigation.[316] The policyholder, Expedient, interpreted the question to concern only actions as a title agent and answered "no," despite knowing that an attorney who was one of its shareholders and an officer in its title insurance business was being investigated by a New York state court grievance committee. The District Court concluded that the application question "easily embraced the professional disciplinary investigation of Expedient's officer," and reasoned that "an insured may not escape a finding of knowing falsity by misinterpreting the plain language of a policy application."[317]

Applying Connecticut law, the court reasoned that Zurich had to prove three elements to prevail on rescission:

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312 *Id.* at *20 (quoting Pinette, 52 F.3d at 411).
313 *Id.* at *23-24.
314 *Id.* at *26-27.
315 No. 3:11cv1633 (MPS), 2015 U.S. Dist. LEXIS 167998 (D. Conn. Dec. 6, 2015).
316 *Id.* at *1-2.
317 *Id.*

"(1) a misrepresentation (or untrue statement) by the plaintiff which was (2) knowingly made and (3) material to defendant's decision whether to insure."[318] As noted above, as to the first element, the court found that a reasonable lay person could not interpret the question about government investigations to be limited to the operation of the applicant's business as a title agent, because it asked about "any" inquiry from "any" authority regarding the applicant or any proposed insured, and that accordingly the policyholder's answer was false.[319] As to the second element, the court found the misrepresentation was knowingly made because both the individual who was the target of the attorney grievance investigation and another officer of the insured were aware of the investigation.[320] Rejecting their contention that they misunderstood the question, the court stated "allowing an insured to stave off rescission by asserting that he or she was laboring under an erroneous interpretation of the question would be tantamount to excusing the insured for not reading the application at all—something that Connecticut courts have refused to do."[321] The court found the misrepresentation to be material because of a presumption that application responses are material, because the application stated the policy would be issued in reliance upon responses, because the policy expressly incorporated responses to the application, and because in the court's view, an affirmative response to the question about pending investigations would have substantially influenced issuance of the policy or the premium rate.[322]

The court alternatively granted summary judgment based on the policy's claims-made-and-reported insuring agreement and notice provisions, because the policyholder had received several letters prior to inception of the policy which came within its "claim" definition.[323] Like many professional liability policies, Zurich's policy defined "claim" to

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318 *Id*. at *25 (quoting Pinette, 52 F.3d at 409).
319 *Id*. at *28-29.
320 *Id*. at *29-32.
321 *Id*. at *34 (citing *Pinette, supra*, 52 F.3d at 410).
322 *Id*. at *35-37.
323 *Id*. at *40-42.

include "a demand for money or Professional Services," and prior to the period in which the policyholder was formally served with a lawsuit, it had received letters outlining the facts of the claim and making clear that the claimant demanded money.[324] Further, if there was any doubt that the correspondence involved an actual claim, the policy stated a condition precedent of notice of potential claims if any insured "has any basis to believe that any Insured has breached a professional duty or to foresee that any such act or omission might reasonably be expected to be the basis of a Claim."[325] The court found this condition was not met, because the correspondence in a prior policy period setting out the claimants' complaints and demand for damages gave the policyholder a basis to foresee its conduct "might reasonably be expected" to give rise to a claim.

In *Great Lakes Reinsurance (UK), PLC v. JDCA, LLC*,[326] the District Court denied a commercial property insurer's motion for summary judgment against its insured premised on the insured's alleged failure to satisfy a condition precedent to coverage, where the insurer had not waived that condition.[327] During the negotiation of the property policy in question, it was represented to the insurer that the subject property had sprinklers,[328] however, the property, in fact, had no sprinklers.[329] Several months after the policy was issued, the property sustained severe fire damage.[330] After determining that the existence of sprinklers was a condition precedent to coverage, the District Court attempted to reconcile inconsistencies between two Connecticut Supreme Court decisions to determine whether the insurer had waived its right to rely on the sprinkler issue to deny

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[324] *Id*. at *42-44.

[325] *Id*. at *44-45 (emphasis in original).

[326] No. 11-00001(WGY), 2014 U.S. Dist. LEXIS 163863 (D.Conn. Nov. 21, 2014).

[327] This matter also involved claims by the insured against its insurance broker, and an insurance premium financing company, and related summary judgment motions. *Id*., *9-11.

[328] *Id*. at *14.

[329] *Id*. at *17.

[330] *Id*. at *25. The fire occurred just one day after the insurer cancelled the policy for non-payment of premium, but this issue was withdrawn from consideration by the insurer. *Id*. at *10.

coverage.[331] Analyzing the "more permissive waiver standard" with respect to insurance in *MacKay v. Aetna Life Ins. Co.*,[332] which is that by delivering an insurance policy to, and accepting payment from, an insured, an insurer may waive defenses based on facts already known to it, the District Court found that the facts could not establish that the insurer knew about the non-existence of sprinklers prior to issuing the policy.[333] Analyzing the more conservative, and more recent, waiver standard with respect to insurance in *Heyman Associates. No. 1 v. Ins. Co. of the State of Pa.*,[334] which is that waiver, in most cases, cannot create coverage under a policy for something that is expressly excluded, the District Court found that the insurer did not did not waive its ability to rely on the non-existence of sprinklers as a defense to coverage, regardless of whether the insurer had knowledge after the policy was issued.[335]

In *Palkimas v. State Farm Fire & Cas. Co.*,[336] the Connecticut Appellate Court affirmed summary judgment in favor of a homeowners insurance company, holding that it had no duty to cover damage to the policyholder's home, on the ground that the policyholder failed to submit a proof of loss as required under the applicable policy.[337] The policyholder notified the insurance company of losses from a sanitary pipe rupture and subsequent damage resulting from attempted repair in freezing temperatures.[338] However, the policyholder never filed a formal proof of loss, and the policy required submission of a signed and sworn

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[331] *Id.* at *37.

[332] 118 Conn. 538, 173 A. 783 (1934).

[333] 2014 U.S. Dist. LEXIS 16383 at *45. The District Court also discussed "general waiver standards." *Id.* More specifically, the District Court discussed how waiver can be either express or implied, but that implied waiver should be evidenced by some affirmative conduct of the alleged waiving party. *Id.* at *46-48.

[334] 231 Conn. 756, 653 A.2d 122 (1995).

[335] *Id.* at *50-51. The District Court also found that the insurer was not estopped from denying coverage based on the sprinkler issue because there was no evidence that the insurer, or its agents, did anything intended to induce the insured's reliance with respect to whether there would be coverage regardless of the sprinkler issue. *Id.* at *51-53.

[336] 150 Conn. App. 655, 91 A.3d 532, *cert. denied*, 314 Conn. 904, 99 A.3d 1169 (2014).

[337] *Id.* at 656.

[338] *Id.*

proof of loss within 60 days of loss.[339] On the insurance company's motion for summary judgment, the trial court determined that the policyholder had failed to satisfy a condition precedent of the policy, stating that "'an insured must file a proof of loss prior to making a claim . . . and bringing suit . . . but if the insured belatedly submits a proof of loss and the policy does not specifically state that doing so is grounds for denial, the insurer must prove that the late submission caused some prejudice.'"[340]

On appeal, the policyholder in *Palkimas* argued that the insurance company has the burden of proving prejudice when it denies coverage on the ground of failure to submit a sworn proof of loss.[341] The Appellate Court rejected that argument and affirmed, in a decision which "turns on the distinction between a *delayed* filing of a proof of loss and a *failure* to file a proof of loss."[342] The Appellate Court affirmed, finding no case law that required an insurer to prove prejudice following an insured's failure to submit proof of loss under an insurance policy, rejecting the policyholder's reliance on *Arrowhood Indemnity Co. v. King*[343] and other late notice cases which pertained to delayed filing of a notice of claim or proof of loss, and not the failure to give notice or file a proof.[344]

IX. Choice of Law and Jurisdiction

In *General Accident Ins. Co. v. Mortara*,[345] the Connecticut Supreme Court held that Connecticut law applied to the interpretation of an automobile insurance policy issued to a Connecticut resident for a vehicle garaged in Connecticut, affirming lower court decisions which had vacated an arbitration award that erroneously applied New Jersey law to an underinsured motorist claim arising from a New Jersey accident.[346] The policyholder had sought application of New

339 *Id*. at 656, n. 1.
340 *Id*. at 658 (quoting trial court).
341 *Id*.
342 *Id*. at 659 (emphasis in original).
343 304 Conn. 179, 39 A.3d 712 (2012).
344 150 Conn. App. at 659-60.
345 314 Conn. 339, 101 A.3d 942 (2014).
346 *Id*. at 341-43.

Jersey law under tort-based choice of law rules, in light of a stipulation that her failure to exhaust the tortfeasor's insurance policy precluded recovery of underinsured motorist benefits under Connecticut law.[347] The court summarized the issue, and its conclusion, as follows:

> This appeal presents a choice of law question: when a dispute between an insurance carrier and its insured regarding the insurance carrier's obligation to pay underinsured motorist benefits requires a determination of whether the relevant policy provisions provide coverage for the claim, is the issue properly resolved under the choice of law rules governing claims sounding in tort or claims sounding in insurance and contract? Our existing precedent already has conclusively answered this question . . . . [i]t is well established that in such an instance, the choice of law determination is made by applying the insurance and contract choice of law rules set forth in §§ 6, 188, and 193 of 1 Restatement (Second), Conflict of Laws (1971).[348]

Reviewing the arbitration award de novo because the substantive issue concerned a question of law subject to compulsory arbitration,[349] the *Mortara* court quoted extensively from the court's decision in *American States Ins. Co. v. Allstate Ins. Co.*,[350] which in turn explained Connecticut's adoption of the "most significant relationship" approach of the Restatement 2d, Conflict of Laws in *Reichhold Chems. v. Hartford Accident & Indem. Co.*[351]

The analysis begins with Section 193 of the Restatement (2d), which provides that the substantive rights of a contract of fire, surety or casualty insurance "are determined by the local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy, unless with respect to the particular issue, some other state has a more significant relationship . . . to the transaction and the parties, in which event the local law of

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[347] *Id.* at 342.
[348] *Id.* at 340-341.
[349] *Id.* at 344 (citing Kinsey v. Pacific Employers Ins. Co., 277 Conn. 398, 404 n.5, 891 A.2d 959 (2006)).
[350] 282 Conn. 454, 461-63, 922 A.2d 1043 (2007).
[351] 243 Conn. 401, 703 A.2d 1132 (1997); *see generally* 314 Conn. at 345 - 349.

the other state will be applied," such that there is a "presumption in favor of application, in liability insurance coverage cases, of the law of the jurisdiction that is the principal location of the insured risk."[352] That presumption may be overcome under Section 6 of the Restatement (2d) only if another state's interests outweigh the interest of the state where the insured risk is located, considering the five contacts specified in Section 188(2): "(a) the place of contracting, (b) the place of negotiation of the contract, (c) the place of performance, (d) the location of the subject matter of the contract, and (e) the domicile, residence, nationality, place of incorporation and place of business of the parties."[353]

The *Mortara* court concluded the principal location of the insured risk was in Connecticut not only because of the obvious factors in an automobile insurance policy, i.e., that the policy was issued to a Connecticut resident for a vehicle garaged in the state, but also because it was amended with provisions specifically referring to Connecticut law, "thus demonstrating that the principal location of the insured risk was a factor in formulating the terms of the policy."[354] Absent other factors, *Mortara* supports the conclusion that endorsements conforming a policy to local law, which are frequently found in many types of policies, may function as a de facto choice of law provision.

As to the counterweighing interests of other jurisdictions, the court noted that the policyholder had failed to offer any evidence to suggest that New Jersey, rather than Connecticut, was the place of performance of the contract.[355] While the policy listed a Pennsylvania address for the insurance company, the court also observed that the insurer was doing business in Connecticut and had multiple places of business in various states, such that the needs of interstate systems should not accorded significant weight. It further observed that the protection of justified expectations, the basic policies underlying uninsured motorist law, and cer-

[352] *Id*. at 346 (internal citations and quotation marks omitted).
[353] *Id*. at 348 (internal citations and quotation marks omitted).
[354] *Id*. at 349.
[355] *Id*. at 349-50.

tainty, predictability and uniformity of result all supported application of Connecticut law as the principal location of the insured risk.[356] Finally, the court noted that the relevant policy of Connecticut in requiring full exhaustion of the tortfeasor's liability coverage before recovering underinsured motorist benefits is "absolute," and Connecticut law is easy to determine and apply.[357]

In *Webster Bank, N.A. v. Travelers Cas. & Sur. Co.*, the District Court granted Webster's motion to remand to state court its action against Travelers alleging breach of the forgery provisions of a financial institution bond rejecting the insurance company's removal to federal court under 28 United States Code Section 1352.[358] When Webster sued Travelers in Connecticut state court claiming coverage under a financial institution bond required under federal law for a loss resulting from a customer's alteration of documents, Travelers removed the action to federal court, arguing that the bond was required under federal banking regulations.[359] Under that statute, federal district courts "have original jurisdiction, concurrent with State courts, of any action on a bond executed under any law of the United States."[360]

The court found that the statute required security only for employee dishonesty. Because the claim arose from the wrongdoing of a non-employee, the applicable portion of the bond was not required by the statute, and the action was therefore not removable.[361]

X. Application of Insurance-Related Statutes

In *Connecticut Insurance Guaranty Association v. Drown*,[362] the Connecticut Supreme Court affirmed the Appellate Court's finding that the Connecticut Insurance

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356 *Id.* at 350-51.
357 *Id.* at 351-52.
358 No. 3:15-cv-00385 (VAB), 2015 U.S. Dist. LEXIS 156903 at *1, 7. (D.Conn. November 20, 2015).
359 *Id.* at *6-7.
360 28 U.S.C. § 1352.
361 2015 U.S. Dist. LEXIS 156903 at *11-13.
362 314 Conn. 161, 101 A.3d 200 (2014).

Guaranty Association was not estopped from challenging coverage under a professional liability insurance policy because of an insolvent insurer's pre-insolvency conduct. The Supreme Court further affirmed the Appellate Court's finding that a certain policy exclusion barred coverage in connection with an underlying medical malpractice action.[363] The Association is a nonprofit entity created by statute for the purpose of providing limited protection for policyholders and claimants if an insurer becomes insolvent.[364] In the underlying action, the insolvent insurer defended an insured obstetrical medical group for approximately six years, pre-insolvency, and without reserving its rights to deny coverage, in connection with a claim of vicarious liability for certain co-defendant physicians' negligence in relation to the delivery of a child.[365] The insolvent insurer failed to appear at a court-ordered mediation, and then sent the professional corporation a letter raising an exclusion in the policy, for the first time, pertaining to vicarious liability.[366] The insolvent insurer again failed to appear at the continued mediation, and a default judgment was entered against the insured as a result.[367] Subsequently, the insured settled with the claimants for the policy's full limit, and assigned the claimants its rights against the insolvent insurer.[368] After the insurer was declared insolvent, the Association sought a declaration that it had no obligations under the policy because of the vicarious liability exclusion.[369]

The Supreme Court reasoned that, by statute, the Association is only authorized to pay claims covered under the policy,[370] and the purpose of the Association is limited in that it does not assume all of the obligations of the

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[363] *Id*. at 165.
[364] *Id*. at 172, citing CONN. GEN. STAT. §§ 38a-838 and 38a-839.
[365] *Id*. at 166.
[366] *Id*.
[367] *Id*.
[368] *Id*. at 166-67.
[369] *Id*. at 167-68.
[370] *Id*. at 172-73, citing CONN. GEN. STAT. § 38a-841.

insolvent insurer.[371] Accordingly, the Association is not estopped from challenging the existence of a covered claim under a policy issued by an insolvent insurer, regardless of the acts of the insolvent insurer.[372] As to the applicability of the vicarious liability exclusion, the Supreme Court rejected an argument that such exclusion is ambiguous, and therefore, under the rule of contra proferentem, should be construed in favor of coverage.[373] The physician in question was not included on the declarations page, and therefore, the argument was, essentially, that had the qualifying phrase also applied to "physicians," the exclusion would not apply to the negligence of the physician in question.[374] In rejecting this argument, the Supreme Court applied the last antecedent rule of contractual and statutory construction, whereby "qualifying phrases, absent a contrary intention, refer only to the last antecedent in a sentence."[375] In this matter, the phrase "for whom a premium charge is shown on the declarations page" was found only to refer to the directly preceding term "any paramedical", not also to the otherwise preceding terms "individual physicians or nurse anesthetists."[376] The Supreme Court further rejected an argument that the exclusion renders coverage under the policy illusory because "it does not make sense for an obstetrical medical group to buy a policy with no coverage for doctor malpractice."[377] The Supreme Court reasoned that the policy, in fact, affords coverage, albeit limited, for vicarious liability in connection with the negligence of certain unscheduled paramedical personnel, and therefore, the coverage is not illusory.[378]

In *Financial Consulting, LLC v. Commissioner of*

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[371] *Id.* at 176-77, relying on Potvin v. Lincoln Service & Equipment Co., 298 Conn. 620, 6 A.3d 60 (2010). The Supreme Court also discussed the negative impact of payments by the Association on premiums charged to Connecticut policyholders. *Id.* at 177.

[372] *Id.* at 178.

[373] *Id.* at 189-90.

[374] *Id.* at 184.

[375] *Id.* at 189.

[376] *Id.* at 189-90.

[377] *Id.* at 185.

[378] *Id.* at 192. Justices McDonald and Eveleigh dissented and would have found the policy ambiguous.

Insurance,[379] the Connecticut Supreme Court reversed the trial court's decision dismissing a declaratory judgment action brought pursuant to the Uniform Administrative Procedure Act[380] against the Connecticut Insurance Commissioner by certain licensed insurance producers, finding that while there is a requirement to exhaust available administrative remedies prior to pursing declaratory relief under General Statutes Section 4-175 once an administrative proceeding has been commenced, no such proceeding had been commenced against the producers in this matter. The Connecticut Insurance Department had commenced an investigation of the producers in connection with their sale of life insurance policies to military personnel, had issued certain "second chance" notices to the producers pursuant to General Statutes Section 4-182, informing the producers of the allegations and allowing them the opportunity to show their compliance with the law.[381] The Supreme Court found the statutory scheme to be ambiguous as to whether relief under Section 4-175 can be pursued while an administrative proceeding is pending, but ultimately concluded that allowing the pursuit of a judicial remedy during the pendency of an administrative proceeding would undermine the purpose of the exhaustion doctrine.[382] As to whether the "second chance" letters triggered the exhaustion requirement, the Supreme Court found that, in this matter, only formal license revocation proceedings, with notice provided pursuant to General Statutes Section 4-177, not Section 4-182(c), would have triggered such requirement.[383] The Supreme Court further found that the producers had standing to bring the declaratory action because the producers sufficiently plead that their rights or privi-

[379] 315 Conn. 196, 105 A.3d 210 (2014).
[380] *Id*. at 198, citing CONN. GEN. STAT. § 4-175.
[381] *Id*. at 201.
[382] *Id*. at 212-15, discussing the concerns of the exhaustion doctrine, namely, offering the reviewing court the benefit of an agency's findings and conclusions, relieving the reviewing court of having to unnecessarily decide an issue to the extent a party would have received a satisfactory administrative disposition, and the notion that agencies, not courts, should have primary responsibility for the programs they are charged with administering.
[383] *Id*. at 218-21.

leges had been threatened or impaired by the investigation.[384]

In *Ferraro v. Ridgefield European Motors, Inc.*, the Connecticut Supreme Court upheld an interest award against a workers compensation carrier as falling within the statutory authority for such an award.[385] The issue in the case turned on whether it was appropriate for the workers' compensation commissioner to issue an interest award against a prior insurance company where that prior company agreed to its apportionment amount after formal proceedings concluded but before the commissioner issued his final findings and order.[386]

Essentially, the prior insurance company argued that only when a commissioner actually determines apportionment liability is he or she authorized to award interest.[387] Because the company accepted its apportionment share in this case, and the commissioner never had to make an apportionment determination, it argued that the award of interest was impermissible.[388] The Court disagreed, finding that the plain and unambiguous language of Section 31-299b specifically authorizes the commissioner to make such awards based on the record of the proceedings.[389]

In particular, the Court held that the legislature intended the statute "to allow for an ultimate distribution of liability that would not place an undue burden on the last insurer on the risk."[390] Because the formal proceedings were completed in this case, the commissioner properly made findings, even if those findings were to accept the apportionment agreed upon by the insurance companies.[391] Accordingly, the Court concluded that "the existence of the agreement did not deprive the commissioner of the authority to make a determination as to apportionment liability

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384 *Id.* at 226-29.
385 313 Conn. 735, 739, 99 A.3d 1114 (2014).
386 *Id.* at 737.
387 *Id.* at 744.
388 *Id.*
389 *Id.* at 749-50.
390 *Id.* at 752.
391 *Id.* at 753.

and to award interest."[392]

In *Compassionate Care, Inc. v. Travelers Indemn. Co.*,[393] the Connecticut Appellate Court reversed that portion of the trial court's judgment in favor of a workers' compensation insurer, holding that certain health care professionals were not the insured health care referral business's employees, but were instead, independent contractors, and General Statutes Section 31-292, relating to the lending of employees to others, did not require the insured to provide workers' compensation benefits to the health care professionals. The Appellate Court affirmed, however, the other aspects of the trial court's judgment in favor of the insurer, finding that regardless of the determination that the health care professionals were not the insured's employees, the insurer had a contractual right to charge the insured a higher premium than originally estimated, based on a final audit of the insured's operations.[394] The Appellate Court reasoned that the workers' compensation policy in question required the insurer to defend the insured in response to any claim, even if the insured never intended to cover the claimant under the policy, and the premium could be based on this exposure.[395] The Appellate Court also rejected the insured's argument that it was not contractually obligated to pay the higher premium because the insured only signed an insurance application;[396] the insured was bound by the provisions regarding audits and potential increased premiums found in the very policy under which the insured sought coverage.

In *Electrical Contractors, Inc. v. Ins. Co. of the State of Pa.*,[397] the Connecticut Supreme Court, in response to a certified question presented from a federal district court, held that the ninety day response requirement contained in General Statutes Section 49-42(a) is directory, rather than mandatory, and that the Connecticut legislature did not

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[392] *Id.* at 754.
[393] 147 Conn. App. 380, 83 A.3d 647 (2013).
[394] *Id.* at 405.
[395] *Id.* at 401-03.
[396] *Id.* at 403-04.
[397] 314 Conn. 749, 104 A.3d at 713 (2014).

intend that a surety that fails to pay or to deny a claim by the statutory deadline thereby waives any substantive defenses and forfeits its right to contest the merits of the claim. The plaintiff, Electrical Contractors, Inc., provided labor, equipment and materials under a subcontract with The Morganti Group Inc. for Newtown High School's renovation.[398] Morganti obtained a labor and materials payment surety bond on the project from the defendant insurance company.[399] The plaintiff thereafter sought an equitable adjustment to the subcontract price to recover additional costs from Morganti resulting from its alleged deficient performance, but Morganti did not respond substantively to those claims.[400] The plaintiff then, pursuant to General Statutes Section 49-42(a), sent notice of its claim for the additional costs to the defendant, as surety.[401]

The surety requested and obtained additional information from Electrical Contractors,[402] and the surety then indicated that it needed to ascertain Morganti's position on the claim.[403] After 90 days had passed from submission of the claim without a coverage determination, Electrical Contractors then commenced an action against the surety, and the parties filed cross motions for summary judgment.[404] The District Court certified questions of law to the Connecticut Supreme Court.[405] The Supreme Court held that a surety's failure to make payment or serve notice denying liability on a claim under General Statutes Section 49-42(a) within that 90-day deadline is tantamount to a denial of the claim and does not constitute a waiver of the surety's right to defend the claim on the merits.[406] The court reasoned that the statute's use of the word "shall" was not mandatory.[407] Further, Section 49-42(a) includes

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398 *Id.* at 752.
399 *Id.*
400 *Id.* at 753.
401 *Id.*
402 *Id.*
403 *Id.*
404 *Id.*
405 *Id.* at 754.
406 *Id.* at 755.
407 *Id.* at 764.

express penalty provisions that award costs to the prevailing party in a legal action, allow interest on the amount recovered and permit attorney fees if it appears any claim, denial or defense was without substantial basis in fact or law but does not expressly penalize an insurer for failing to respond within 90 days.[408] The court observed that "the equities favored treating the response requirement as directory," as prompt compliance may not be within the surety's complete control: ". . . [T]he surety is caught in the middle between the claimant and the principal; it cannot compel either party to provide the information and documentation it needs to determine the relevant facts, resolve the dispute, and evaluate the validity of the claim. Moreover, the surety may need to solicit additional information from third parties such as the project owner, the architect, or other contractors and vendors associated with a project. Their cooperation also may not be timely forthcoming."[409]

In *Martinez v. Empire Fire & Marine Ins. Co.*,[410] the Connecticut Appellate Court held that the MCS-90 endorsement to a motor carrier's liability insurance policy, required to meet the financial responsibility by the Motor Carrier Act of 1980 (the "MCA"),[411] did not extend coverage to a truck that had been removed from the policies' schedule of covered vehicles, when the vehicle from which the policyholder's liability arose was not being operated for hire at the time of the accident that injured the underlying plaintiff.[412] The issue was not previously decided in Connecticut courts and was resolved under federal law,[413] because the endorsement is issued to comply with the federal MCA and regulations thereunder requiring commercial motor carriers transporting goods for hire in interstate commerce to meet financial responsibility requirements to protect the public.[414]

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[408] *Id*. at 760.
[409] *Id*. at 766.
[410] 151 Conn. App. 213, 94 A.3d 711 (2014), *aff'd on other grounds*, 322 Conn. 47, 139 A.3d 611 (2016).
[411] 49 U.S.C. §§ 10101 *et seq*.
[412] 151 Conn. at 225.
[413] *Id*. at 219.
[414] *Id*. at 220 (citing 49 U.S.C. § 13902 (a)(1)(A) and Carolina Cas. Ins. Co. v. Yeates, 584 F.3d 868, 875 (10th Cir. 2009)).

The MCS-90 endorsement provides in relevant part:

> "[The [insurance company]] . . . agrees to pay, within the limits of liability described herein, any final judgment recovered against the insured for public liability resulting from negligence in the operation, maintenance or use of motor vehicles subject to the financial responsibility requirements of Sections 29 and 30 of the Motor Carrier Act of 1980 *regardless of whether or not each motor vehicle is specifically described in the policy* . . . . It is further understood and agreed that, upon failure of the [defendant] to pay any final judgment recovered against the insured as provided herein, the judgment creditor may maintain an action in any court of competent jurisdiction against the [defendant] to compel such payment."[415]

The *Martinez* court followed the "great weight of authority throughout the country" which considers whether the vehicle was "*presently* engaged in the transportation of property in interstate commerce" to assess whether it is subject to the financial responsibility requirements of the MCA and therefore within coverage.[416] The court observed that the majority of other courts had taken a "trip-specific" approach to the analysis, "finding the relevant question in these cases to be whether the accident occurred while the vehicle was transporting property, for-hire, in interstate commerce."[417]

The trial court in *Martinez* had granted summary judgment for the insurance company on the ground that the vehicle involved in the accident while traveling within state lines was not engaged in "interstate commerce."[418] The Appellate Court affirmed on an alternate ground, finding no dispute that at the time of the accident involving the vehicle that had been removed from scheduled coverage, "the insured, through its employee, was transporting its own

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[415] *Id*. at 217 (emphasis in original); *see also* 49 C.F.R. § 387.15 (regulation pursuant to MCA prescribing form of endorsement).

[416] *Id*. at 222 (citing Canal Ins. Co. v. Coleman, 625 F.3d 244 (5th Cir. 2010)).

[417] *Id*. (citing Canal Ins. Co. v. Coleman, 625 F.3d at 253-54; Brunson v. Canal Ins. Co., 602 F. Supp. 2d 711, 715-16 (D.S.C. 2007); Newman v. State Farm Mut. Auto Ins. Co., 62 So. 3d 808, 811-12 (La. App. 2011).

[418] *Id*. at 219.

property, for its own benefit, without being compensated by any third party."[419] Accordingly, "where the insured effectively was undertaking a personal errand, we cannot construe [the policyholder] to have been operating its vehicle 'for-hire' at the time the collision occurred," which supported summary judgment for the insurance company.[420]

In *Ragusa Corporation v. Standard Fire Ins. Co.*,[421] the District Court denied a flood insurer's motion to dismiss the insureds' entire complaint, including causes of action for breach of contract, and certain extra-contractual causes of action, including negligent misrepresentation, breach of the implied covenant of good faith and fair dealing, and violation of CUIPA,[422] arising out of the insureds' claim for coverage for flood damage sustained to a house during Hurricane Irene. The policy in question was issued pursuant to the National Flood Insurance Program.[423] The District Court rejected, among other things, the insurer's argument that the insured's extra-contractual state law claims were preempted by federal law, and violate the Appropriations Clause of the United States Constitution, which bars monetary claims against the federal government that are not authorized by statute.[424] The District Court found that the insureds' could bring such state law claims because they were seeking recovery from the insurer, not the government, for the alleged actions of the insurer.[425]

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419 *Id.* at 224.

420 *Id.* at 224-25. While the Appellate Court affirmed on the alternate ground that the vehicle was not being operated "for hire," the Supreme Court based its subsequent affirmance on the interstate commerce issue addressed by the trial court, i.e., "that the MCS-90 endorsement does not apply to the accident at issue because it applies only to liability arising from the transportation of property in interstate commerce, and the accident at issue occurred while [the policyholder's] truck was on an intrastate trip entirely within Connecticut." Martinez v. Empire Fire & Marine Ins. Co., 322 Conn. 47, 50, 139 A.3d 611 (2016).

421 Civil No. 3:12cv1069 (WWE), 2014 U.S. Dist. LEXIS 40812 (D.Conn. March 27, 2014).

422 CONN. GEN. STAT. § 38a-815 *et seq.*

423 *Id.* at *8.

424 *Id.* at **11-12.

425 *Id.*

XI. Other Notable Insurance Decisions

A. *Relatedness of Claims*

In *Lexington Ins. Co. v. Lexington Healthcare Group, Inc.*,[426] the Connecticut Supreme Court construed the phrase "related medical incidents" to maximize coverage under the professional liability coverage part of a nursing home's liability insurance policy, in the context of multiple negligence actions seeking damages for wrongful death or bodily injury resulting from a single fire at the nursing home.[427] In thirteen separate underlying actions against the policyholder Lexington Healthcare Group, Inc. and others, the victims' personal representatives alleged "multiple and varying specifications of negligence."[428] Among other things, they alleged negligence in admitting the individual who set the fire; failing to treat her properly and prevent her access to cigarette lighters; failing in general to provide sufficient staffing, sprinklers, fire extinguishers and smoke detectors; inadequate training in fire response and evacuation; and specific failures on the night of the fire to respond properly by closing doors and using fire extinguishers.[429]

The applicable liability policy issued by Lexington Insurance Company[430] was subject to a limit of $500,000 "per medical incident."[431] On cross-motions for summary judgment in the insurance company's action for declaratory relief, the trial court held that the acts, errors or omissions underlying each underlying plaintiff's injuries or death constituted separate medical incidents and were not "related medical incidents" that would be subject to a single $500,000 limit.[432] The policy's "limits of insurance" provi-

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[426] 311 Conn. 29, 84 A.3d 1167 (2014), *superseding on reconsideration* Lexington Ins. Co. v. Lexington Healthcare Group, Inc., 309 Conn. 1, 68 A.3d 1121 (2013).

[427] *Id.* at 32-33.

[428] *Id.* at 33, 36.

[429] *Id.* at 36.

[430] There was no corporate affiliation between the Lexington Healthcare parties and their insurance company Lexington Insurance Company, despite the similarity in names. *Id.* at 33, n. 2.

[431] *Id.* at 36.

[432] *Id.* at 36.

sion stated that "[a]ll claims arising from continuous, related, or repeated medical incidents shall be treated as arising out of one medical incident."[433]

The trial court also held that the total amount of coverage for all of the individual claims was the policy's $10 million "[a]ggregate [p]olicy [l]imit" provided via an endorsement to the policy, rather than the $1 million "[a]ggregate [l]imit" for professional liability coverage stated in the policy declarations, but held that that language pertaining to a $250,000 self-insured retention per occurrence reduced the $500,000 per medical incident coverage to $250,000 per medical incident.[434]

On cross-appeals, which the Supreme Court transferred directly to itself,[435] the insurance company argued that the underlying victims' claims arose from "related medical incidents," because "all of their injuries or deaths stemmed from the same root cause, namely, the admission of the individual who started the fire to Greenwood and the failure to supervise her properly," and that as a result a single policy limit applied to all of the individual claims collectively rather than to each claim individually.[436] In particular, the insurance company assigned error to the trial court's finding that the term "related" is ambiguous and argued that the term unambiguously has a broad meaning requiring aggregation of all claims having a "causal or logical connection" to the same source.[437]

The Supreme Court disagreed and affirmed that the acts, errors and omissions alleged in the underlying actions were not "related" within the meaning of the policy.[438] The court was not persuaded by other decisions finding the term "related" to be unambiguous, because "[c]ontext is often central to the way in which policy language is applied; the same language may be found both ambiguous and unambiguous

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433 *Id*. at 39.
434 *Id*. at 36-37.
435 *Id*. at 34, n.6.
436 *Id*. at 39-40.
437 *Id*. at 40-41 (internal quotations omitted).
438 *Id*. at 41.

as applied to different facts."[439] In the Supreme Court's words, "one court's determination that the term related was unambiguous, in the specific context of the case that was before it, is not dispositive of whether the term is clear in the context of a wholly different matter."[440]

Although the Supreme Court applied the term "related medical incidents" in a manner which would otherwise maximize coverage, it disagreed with the trial court that a $10 million aggregate limit was available for all claims.[441] Instead, the Supreme Court found that the maximum aggregate limit available under the policy for the subject claims was, clearly and unambiguously, $1 million, and that the endorsement to the policy which provided for a $10 million "aggregate policy limit" did not alter the $1 million "aggregate limit" for professional liability claims provided for in the policy's declarations.[442] The Supreme Court also disagreed with the trial court and found that the policy was ambiguous as to whether coverage was reduced from $500,000 to $250,000 per medical incident in connection with the self-insured retention.[443] The Supreme Court agreed with the trial court that the policy did not "drop down" to cover amounts below the self-insured retention not satisfied by the insured.[444] In sum, even though there is $500,000 available for each separate "incident," the insurance company's liability is capped at $1 million.

B. *Business Pursuits Exclusion*

In *Nationwide Mut. Ins. Co. v. Pasiak*,[445] the plaintiff insurance companies brought an action seeking a declaratory judgment to determine whether they were obligated to defend or indemnify the defendant in connection with a per-

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[439] *Id*. at 42 (quoting Highwoods Properties, Inc. v. Executive Risk Indemnity, Inc., 407 F.3d 917, 923 (8th Cir. 2005)).

[440] *Id*.

[441] *Id*. at 54.

[442] *Id*. at 54, 56. Justices Eveleigh, McDonald and Espinosa dissented from this portion of the opinion.

[443] *Id*. at 66-67.

[444] *Id*. at 64.

[445] 161 Conn. App. 86, 127 A.3d 346 (2015), *cert. granted*, 320 Conn. 913, 130 A.3d 266 (2016) (decision pending).

sonal injury action brought against him by Mrs. Socci, a former employee of defendant, and her husband.[446] The defendant had a homeowner's insurance policy and umbrella policy that he claimed mandated that the insurers defend him in the personal injury action because while the incident occurred at his "business," the construction company office he owned was located in his home.[447] The trial court held that the umbrella policy's business pursuits exclusion, which excluded from coverage occurrences "arising out of" an insured's business pursuits, did not apply here and therefore the insurers had a duty to indemnify and defend defendant.[448] The Connecticut Appellate Court reversed and remanded with direction to render judgment in favor of the insurers, because the trial court incorrectly ruled that the "business pursuits" exclusion did not apply.[449]

The trial court had concluded that while it is undisputed that the insured owns and operates a business that employed Ms. Socci, the complaint did not expressly allege that she was harmed as a result of her employment, but rather as a result of his treatment of her after the "attempted robbery of his home."[450] The lower court had agreed with the insurer that the homeowner's policy did not cover the emotional distress, but further concluded that the umbrella policy "contained broader coverage than the homeowner's policy with respect to emotional distress and that none of the exclusions relied on by the insurers precluded indemnification as a matter of law."[451]

The Appellate Court disagreed with the lower court, finding that the "language of the business pursuits exclusion in the umbrella policy establishes an expansive standard of causation between the incident giving rise to a claim for coverage and the insured's business pursuits."[452] Examining the facts, the Appellate Court determined that insured was

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446 *Id*. at 88.
447 *Id*. at 90.
448 *Id*.
449 *Id*. at 89.
450 *Id*. at 93.
451 *Id*. at 93-94.
452 *Id*. at 95.

indeed running a business out of his home and that the injuries arose out of the insured's business pursuits.[453] Had Mrs. Socci not been at the insured's home, fulfilling her duties as an employee in his office, she would not have been assaulted by the masked robber and then detained by the insured.[454] Thus, the business pursuits exclusion exempted the insurers from indemnification and a duty to defend the insured.

C. *Contract Exclusion*

In *Town of Monroe v. Discover Prop. and Cas. Ins. Co.*,[455] the Connecticut Appellate Court reversed the trial court's summary judgment ruling in favor of the insurer, holding instead that the insurer breached its duty to defend the Town in the underlying action. The policy excluded coverage for any claim based upon construction, architectural or engineering contracts or any other procurement contract, and for claims for which the insured had assumed the liability in a contract or agreement. The exclusion also stated that it did not apply to damages the insured would have incurred absent a contract or agreement.[456] The Town argued on appeal that the court erred in determining that the allegations of negligent misrepresentation in the underlying complaint fell within the policy's contract exclusion. Specifically, the Town contended that the allegations of the complaint could not support the finding of an enforceable contract, or of a procurement contract of any kind, and, therefore, it could not be proved that the negligent misrepresentation cause of action arose out of that contract. The Town also argued that even if the allegations supported the existence of a contract, the underlying negligent misrepresentation claim was a tort claim "separate and independent from" the underlying contractual claims, and coverage was not necessarily precluded by the policy's contract exclusion. Thus, because the claims were not necessarily excluded by

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[453] *Id.* at 99.
[454] *Id.* at 100.
[455] 169 Conn. App. 644, 151 A.3d 848 (2016), *cert. denied*, 324 Conn. 911, 153 A.3d 653 (2017).
[456] *Id.* at 648.

the policy language, the Town argued that the defendant had a duty to defend.[457]

In response, Discover argued that the underlying negligent misrepresentation claim did arise out of its breach of contract claim because count three incorporated all of the facts alleged in count one without including any additional facts. Discover also argued that because the allegedly breached contract is the sole basis alleged in the underlying complaint for the misrepresentation, the negligent misrepresentation claim did not trigger the defendant's duty to defend.[458]

The Appellate Court rejected Discover's argument, holding that an exclusion defeats a duty to defend only when the allegations in the complaint "clearly and unambiguously establish the applicability of a policy exclusion."[459] The only evidence in the underlying complaint that a contract existed was the developer's allegation that "it was promised that if the underlying plaintiff received the necessary approvals for the construction of a tower, the town would locate its police communications system on that tower." There is no further description of the alleged "contract."[460] Furthermore, when the underlying action reached the Appellate Court on appeal it treated the underlying plaintiff's breach of contract and negligent misrepresentation claims as separate and distinct. The Appellate Court found that its prior decision illustrated that a trier of fact could have found the Town liable for negligent misrepresentation but not breach of contract.[461]

D. *Theft Coverage*

In *Mercedes Zee Corp., LLC v. Seneca Ins. Co.*,[462] the plaintiff, which owned an empty commercial building in

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457 *Id*. at 648-49.
458 *Id*. at 649.
459 *Id*. at 649-50.
460 *Id*. at 650.
461 *Id*. at 651. The court also rejected the insurer's arguments (1) that a "personal profit" exclusion applied, and (2) that the claim for restitution and compensation did not suggest "damages" under the policy.
462 151 F. Supp.3d 255 (D. Conn. 2015).

East Hampton, Connecticut that was broken into and damaged by intruders, sought payment to cover its losses under the terms of an insurance policy sold by the defendant insurance company.[463] The insurer argued that it did not cover the losses because copper pipe had been stolen from the building, thus rendering the incident outside the scope of the policy, which covered damages from "vandalism" but excluded damages from "theft."[464] The District Court denied both parties' motions for summary judgment because it determined that both parties had "overlooked in some respects the guiding principles that should govern interpretation of the policy."[465]

The policy stated in relevant part that it would cover "willful and malicious damage to, or destruction of, the described property" but that it would not cover "loss or damage caused by or resulting from theft, except for building damage caused by the breaking in or exiting of burglars."[466] The insured argued that it was limiting its claim to the damages sustained to the interior of the building, not the stolen pipe, and thus it was entitled to almost $2 million in damages.[467] The insurer, on the other hand, interpreted the vandalism/theft clause to cover graffiti damage and damage done to the building as the intruders broke into the premises, but not the rest of the damages inflicted on the interior of the building because they were "caused by or resulting from theft" and thus were not covered.[468]

Rejecting both parties' interpretations of the vandalism/theft clause, the court interpreted the clause using three principles.[469] First, the policy "inherently requires consideration of the intent and purpose of the wrongdoer to determine the scope of coverage"[470] – whether it be to van-

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[463] *Id.* at 257.
[464] *Id.*
[465] *Id.*
[466] *Id.*
[467] *Id.* at 258.
[468] *Id.* (noting that the damages resulting from theft were still not covered by the policy, even if the "damage resulted from the malicious or willful destruction of property").
[469] *Id.* at 259-60.
[470] *Id.* at 259.

dalize or steal – with respect to each item of claimed damage.[471] As a result, the court decided to use an item-by-item approach to determine which damages would be considered to have arisen from vandalism and which would be considered to have arisen from theft.[472] Second, the court followed the principle that the exception for theft extends to more than just the loss of stolen property itself but also includes damage to property that was "necessary to or in furtherance of an act of theft."[473] Finally, the court determined that property damage stemming from an attempted theft that did not result in an actual theft is covered as an act of vandalism under the policy.[474]

Because a wrongdoer still would be a vandal whether he destroyed property for no purpose, for revenge, or in the pursuit of something to steal, the court determined that the policy should cover damages due to acts of attempted (but not actual) theft. Thus, the insured's interpretation was incorrect because it wrongly limited the theft exception to include only the value of the property stolen rather than including damages done to the building while in furtherance of an actual theft.[475] Likewise, the insurer was incorrect in seeking to exclude coverage for "damages to building components that were not in furtherance of an act of actual theft."[476] Accordingly, the court denied both parties' motions for summary judgment.

In *Accounting Resources, Inc. v. Hiscox, Inc.*,[477] the District Court dismissed a policyholder's complaint, holding that the theft exclusion in a professional liability insurance policy barred coverage.[478] The policyholder, a bookkeeping and accounting services provider, sent a client's funds to hackers who had breached the client's email account and provided fraudulent instructions for fictitious vendor pay-

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[471] *Id.* at 260.
[472] *Id.*
[473] *Id.* at 260-61.
[474] *Id.* at 261.
[475] *Id.* at 262-63.
[476] *Id.* at 263.
[477] No. 3:15-cv-01764 (JAM), 2016 U.S. Dist. LEXIS 135450 (D. Conn. Sep. 30, 2016).
[478] *Id.* at *2.

ments to bank accounts controlled by the hackers.[479] The client sought to recover its lost funds from the policyholder, which in turn made a claim under its professional liability insurance policy. In the ensuing litigation, the insurance company moved to dismiss for failure to state a claim based upon a "misappropriation of funds" exclusion stating:

> We will have no obligation to pay any sums under this Coverage Part, including any damages or claim expenses, for any claim … based upon or arising out of the actual or alleged theft, misappropriation, commingling, or conversion of any funds, monies, assets, or property.[480]

Predicting what appeared to be an undecided issue under Connecticut law,[481] the District Court rejected the policyholder's principal argument that the exclusion applied only to theft or misappropriation committed by the policyholder or an employee, but not to acts committed by third parties like the hackers responsible for the disputed loss.[482] The court recognized the logic of distinguishing between theft by the policyholder and by a third party, but it found neither express language nor ambiguous language supporting that result.[483] To the contrary, it noted "[t]he policy's wording says nothing about who must engage in the theft or misappropriation of funds," and reasoned that "[t]he absence of limitation bespeaks breadth."[484] Noting another exclusion that clearly identified the class of persons whose excluded acts would fall outside coverage, the court reasoned further that "[t]he parties could plausibly have drafted the policy to exclude only claims of theft or misappropriation by plaintiff or its employees, but this they did not do."[485]

E. *"Publication" of Confidential Information*

In *Recall Total Information Management Inc. v. Federal Ins. Co.*,[486] the Connecticut Supreme Court affirmed the

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[479] *Id.*
[480] *Id.* at *3.
[481] *Id.* at *7.
[482] *Id.* at *5.
[483] *Id.* at *6.
[484] *Id.* (emphasis in original).
[485] *Id.* at *7.
[486] 317 Conn. 46, 115 A.3d 458 (2015).

Appellate Court's decision which held that that there was no publication and therefore no coverage under the personal injury provision of a liability insurance policy for the costs of notifying individuals whose data was lost and for credit monitoring after the policyholder lost computer tapes containing confidential information concerning a large number of persons.[487] In *Recall*, an additional insured had agreed to transport and store computer tapes containing personal information of IBM employees, and during transport, the tapes fell off a truck operated by a subcontractor, the named insured, onto the roadside. There was no evidence that anyone ever accessed the information, but IBM provided identity theft services to potentially affected persons and claimed reimbursement of that expense from the insureds, which in turn sought coverage under the personal injury provisions of their general liability and umbrella liability policies.[488] The trial court granted summary judgment for the insurance companies and the Appellate Court affirmed, finding that the loss of the tapes did not constitute a "personal injury" as defined by the policies because there had been no "publication" of information that violated any person's right to privacy.[489] The Supreme Court affirmed, adopting the Appellate Court's opinion as the proper statement of the issue and applicable law.[490] As previously noted,[491] while the insureds had argued that "publication" is the communication of information "to the public" rather than "to a third party," the Appellate Court disagreed, holding that "[r]egardless of the precise definition of publication, we believe that access is a necessary prerequisite to the communication or disclosure of personal information."[492]

F. *Application of Settlements to Uninsured/Underinsured Motorist Coverage*

In *Guarino v. Allstate Prop. Cas. Ins. Co.*,[493] the

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[487] *See* Recall Total Info. Mgmt. v. Fed. Ins. Co., 147 Conn. App. 450, 462, 83 A.3d 664 (2014).
[488] *Recall Total*, 317 Conn. at 49.
[489] *Id*. at 50-51.
[490] *Id*. at 51.
[491] *See* Stein, Malone, Spaide & Suerth, *Annual Survey of Developments in Insurance Coverage Law for 2013*, 88 CONN. B. J. 150, 155 (2015).
[492] 147 Conn. App. at 463.
[493] 315 Conn. 249, 105 A.3d 878 (2015).

Connecticut Supreme Court affirmed the trial court's grant of summary judgment to the insurer, holding that settlements with two alleged tortfeasors for an amount in excess of the Uninsured/Underinsured Motorist (UIM) coverage limits reduced UIM benefits to zero even without a determination by a trier of fact apportioning fault and damages. The policy at issue had a UIM limit of $100,000 and provided: "The limits of this coverage will be reduced by . . . all amounts paid by or on behalf of the owner or operator of the uninsured auto or underinsured auto or anyone else responsible."[494] The plaintiff settled with both tortfeasors, one for $20,000 and one for $225,000.[495] Both settlement agreements disclaimed liability.[496]

After the plaintiff settled with the first tortfeasor for $20,000, she filed a UIM claim against Allstate which was consolidated with her action against the second tortfeasor.[497] She alleged that she was entitled to recover UIM benefits because the first tortfeasor's negligence had caused the injury and because she had exhausted the first tortfeasor's policy for less than her policy coverage.[498] After the second tortfeasor settled, Allstate moved for summary judgment, arguing that the combined settlements exceeded the $100,000 UIM policy.[499] The plaintiff opposed the motion, contending that there would have to be a finding of fault and an apportionment of damages before there could be any reduction in UIM coverage.[500] The court agreed with the defendant, granted its motion and rendered judgment in its favor.[501] The Appellate Court affirmed and the plaintiff was granted permission to further appeal. On appeal, plaintiff argued that the lower courts failed to apply binding precedent under which a fact finder must apportion fault and damages before an insurer's liability may be reduced by set-

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494 *Id.* at 252.
495 *Id.*
496 *Id.* at 252-53.
497 *Id.* at 252.
498 *Id.*
499 *Id.* at 253.
500 *Id.*
501 *Id.*

tlement payments.[502] The Supreme Court rejected this argument, concluding that an underinsured motorist carrier is entitled to judgment as a matter of law when multiple alleged tortfeasors settle the insured's claims in an aggregate sum in excess of the policy limits.

G. *Breadth of Additional Insured Coverage*

In *First Mercury Ins. Co. v. Shawmut Woodworking & Supply, Inc.*,[503] the District Court granted summary judgment, finding that an insurer had a duty to defend a general contractor and a subcontractor as additional insureds under a commercial general liability policy issued to the general contractor's sub-subcontractor in suits seeking damages for the death and injuries to certain employees of the sub-subcontractor. The District Court found that the particular additional insured endorsement at issue did not require a direct contractual relationship between the general contractor and the sub-subcontractor for there to be a duty on the part of the insurer to defend the general contractor.[504] The District Court reasoned that, among other things, the agreement between the general contractor's subcontractor, which hired the sub-subcontractor, and the sub-subcontractor included a provision whereby the sub-subcontractor agreed to name the general contractor as an additional insured under its policy.[505] The District Court further refused to "read into the Additional Insured Endorsement terms such as 'direct' or 'between' in contravention of the rule that courts will not read terms into a contract."[506] The District Court also looked beyond the four corners of the underlying complaints to determine that there was at least a possibility that the underlying actions fell within the coverage under the policy, such that the

[502] *Id.* at 253-254.
[503] 48 F. Supp.3d 158 (2014), *aff'd*, 660 Fed. Appx. 30 (2nd Cir. 2016).
[504] *Id.* at 167. The additional insured endorsement provided coverage to: "any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy . . . ." *Id.* at 163.
[505] *Id.* at 166-67.
[506] *Id.* at 167.

insurer had a duty to defend the general contractor and the subcontractor.[507] The District Court rejected the insurer's argument that the additional insured endorsement limited coverage to the vicarious liability of the additional insured despite the fact that the endorsement did not include the term "vicarious liability," instead finding that the endorsement applied more broadly to any liability caused, at least in part, by the sub-subcontractor.[508]

H. *Residence at an Insured Premises*

In *McCants v. State Farm Fire & Cas. Co.*,[509] the Connecticut Appellate Court affirmed the trial court's judgment in favor of the plaintiff on her claim that the defendant breached the parties' contract of insurance after the insurer denied coverage for her fire loss claim. The insurer claimed on appeal that the trial court erred in rejecting its special defenses regarding residency and misrepresentation.[510] It argued that the court erred in (1) finding that the plaintiff resided at the insured premises at the time of the fire and (2) concluding that the plaintiff made a misrepresentation to the defendant during its investigation of her claim, but that the misrepresentation was not material.[511]

The insurer's investigation focused on the issue of the plaintiff's residency at the time of the fire, after the plaintiff reported that 6 months before the fire she had moved into the home of a niece to babysit her children at night, had not slept at her property for several months, and kept no personal property there and even though she used her niece's address on tax returns.[512] Because the policy did not cover losses at premises other than "residence premises" of the insured, the defendant denied the plaintiff's claim.[513] At

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[507] *Id.* at 170.

[508] *Id.* at 174. The District Court also found that an exclusion pertaining to professional services did not bar coverage because not all of the allegations in the underlying complaints involved professional services. *Id.* at 175.

[509] 157 Conn. App. 509, 116 A.3d 844, *cert. denied*, 317 Conn. 923, 118 A.3d 549 (2015).

[510] *Id.* at 511.

[511] *Id.*

[512] *Id.* at 512, 516-17.

[513] *Id.* at 517.

trial, the plaintiff testified that she lived at the insured property at the time of the fire. She testified that she was unemployed and volunteered to help her niece with child care by staying at her home three or four nights a week.[514] When not babysitting for her niece, she stayed at the insured premises.[515] In its memorandum of decision, the court found that the insurer had not proved its special defenses contesting the plaintiff's residency and alleging concealment or fraud.[516]

The Appellate Court concluded that the determination of whether the plaintiff "resided" at the premises was a factual issue that was reviewable on appeal subject to the clearly erroneous standard.[517] Evidence including the plaintiff's testimony that she resided with her mother on the first floor when she was not babysitting four nights per week and the fact that the plaintiff did not pay rent to her niece were deemed sufficient to support the conclusion that the plaintiff resided at the insured premises.[518] The Appellate Court rejected the insurer's second claim of error. Following the fire, the insurer requested copies of lease agreements for the premises in connection with the plaintiff's claim for lost rents.[519] The insurer alleged that the plaintiff violated the fraud provision of the policy when she did not provide either the original leases or copies of the original leases, but rather provided newly recreated versions of the lease agreements without disclosing that they were recreations.[520] The Appellate Court agreed with the trial court that the misrepresentation was not material because the plaintiff did not ultimately make a claim for lost rents.[521]

I. *Coverage for Negligent Supervision*

In *Pacific Employers Ins. Co. v. Travelers Cas. and Sur. Co.*,[522] a hospital's excess blanket catastrophic liability

514 *Id.* at 513.
515 *Id.*
516 *Id.*
517 *Id.* at 515.
518 *Id.* at 521-22.
519 *Id.* at 523.
520 *Id.*
521 *Id.* at 525.
522 136 F. Supp.3d 211 (D. Conn. 2015).

insurer filed a declaratory judgment action against the primary insurers and hospital seeking a declaration that the underlying claims against the hospital concerning a former endocrinologist's sexual abuse of children over several decades fell under the hospital's primary general liability (GL) coverage rather than its hospital professional liability (HPL) coverage. In 2012, the District Court had previously granted the excess insurer partial summary judgment that the underlying claims fell under the hospital's GL coverage, triggering the primary GL insurers' duty to defend. It also denied the parties' cross-motions for summary judgment but subsequently granted a motion for reconsideration and ordered briefing on, among other things, the questions of whether sexual misconduct allegations are beyond the scope of HPL coverage, and whether a claim of negligent supervision was beyond the scope of an HPL policy. The District Court held that the excess policy was triggered by exhaustion of *either* the GL or HPL policy limits for that claim,[523] and that negligent failure to supervise claims against hospital were not beyond the scope of the HPL policy.[524]

J. *Exclusion Not Raised by Insurer in Denial Letter*

In *Sonson v. United Services Automobile Association*,[525] the defendant ultimately denied coverage on rescission grounds based on alleged material misrepresentations by the plaintiff. However, an earlier reservation of rights letter reserved defendant's right to raise additional defenses, including a specifically enumerated exclusion for losses caused by racing activities.[526] The trial court found for defendant on the dual grounds that rescission was appropriate and that the policy's racing exclusion applied.[527] The insured appealed and argued that: (1) the insurer waived its right to raise the racing exclusion by not specifically citing it as the basis for ultimate denial of coverage; and (2) even if the exclusion were raised properly, it should not apply.[528]

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[523] *Id*. at 219-220.
[524] *Id*. at 221.
[525] 152 Conn. App. 832, 835; 100 A.3d 1 (2014) (decided under Virginia law).
[526] *Id*. 835, 837, n. 2.
[527] *Id*. at 836.
[528] *Id*.

The Connecticut Appellate Court affirmed the trial court and refuted both of the insured's arguments.[529] Specifically, the court found that insured failed to account for the insurer's reservation of rights letter that expressly informed the insured of the potential applicability of the racing exclusion.[530] The court held that there is no authority supporting the insured's "contention that an insurer that denies coverage on one basis is precluded from asserting another basis of denial in later legal proceedings, when proper notice has been issued to the policy holder."[531]

The court noted several Connecticut rules of insurance policy interpretation, including that insurance policies are "prime examples of contracts of adhesion," and as such, "courts sometimes have allowed policyholders to obtain coverage despite their failure to comply strictly with the terms of their policy."[532] Further, the court adopted the rule of contra proferentem, that courts will interpret ambiguous policy terms in favor of granting coverage to the policyholder, and the rules that exclusionary language will be strongly construed against the insurance company, who also bears the burden of proving that an exclusion applies.[533] In this case, however, it was clear that the plaintiff's activities fell within the terms of the racing exclusion (he was racing his car on a racetrack when it was damaged), and thus the court affirmed the trial court's determination that the racing exclusion applied.[534]

XII. CONCLUSION

As seen from the broad range of issues addressed by Connecticut courts in 2014, 2015 and 2016, insurance cases often involve many different aspects of Connecticut jurisprudence, and many different types of insurances. While in many instances, insurance cases focus on the canons of insurance coverage law and the proper interpre-

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[529] *Id*.
[530] *Id*. at 837.
[531] *Id*. at 837-38.
[532] *Id*. at 833.
[533] *Id*. at 838-39.
[534] *Id*. at 840.

tation of the terms of an insurance policy, issues often arise regarding the practices of insurance companies, procedural issues and statutory construction.