ANNUAL SURVEY OF DEVELOPMENTS IN INSURANCE COVERAGE LAW FOR 2013

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Connecticut courts addressed a wide range of insurance coverage and practice issues in 2013. The Supreme Court ruled on bad faith claims investigation, liability coverage for defective workmanship, the effect of a policyholder's settlement of partially-covered claims, the defense of additional insureds, and the application of the "make whole" doctrine in subrogation. The Supreme Court also touched on an issue that has received broad national attention when it held that the payment of undisclosed contingent commissions to insurance brokers did not violate Connecticut's unfair insurance and trade practices acts. Other Connecticut state and federal courts issued decisions focusing on specific exclusions and coverage issues, such as the "publication" element for personal injury coverage and exclusions for sexual molestation, vandalism, and intoxication under liability, property and life policies. The courts also addressed recurring practice issues, including reformation, the duty to cooperate, third party standing, and an injured party's right to a direct action against an insurer upon a stipulated judgment, along with several policyholder victories on statute of limitations issues.

I. CGL COVERAGE ISSUES

A. *Defective Workmanship*

In *Capstone Building Corporation v. American Motorists Ins. Co.*,[1] the Supreme Court addressed issues of first impression concerning coverage for defective workmanship claims under comprehensive general liability ("CGL") insurance policies. The decision arose from a defective building

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1 308 Conn. 760, 67 A.3d 961 (2013).

project for which the policyholder served as general contractor.[2] It involved several certified questions, including "[w]hether damage to a project contracted to be built, which was caused by defective construction or faulty workmanship associated with the construction project, may constitute 'property damage' resulting from an 'occurrence,' triggering coverage under a commercial general liability insurance policy?" The court summarized its answer as follows:

> We conclude 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. We also conclude, however, that if the property damage is the result of an insured's defective work, it is excluded from coverage by such a policy. Finally, property damage caused by a subcontractor's defective work may be covered under the exception to the "your work" exclusion.[3]

The concepts captured in this summary followed from both the standard form language of the CGL policy and the particular facts of the underlying claim in *Capstone*.

Whether defective workmanship could constitute an occurrence turned on the Supreme Court's assessment of the standard CGL policy's insuring agreement and "occurrence" definition.[4] Rejecting the insurance company's argument that defective construction lacks the necessary fortuity element to constitute an "accident" under the "occurrence" definition, the court noted the fundamental principles that the policies "are designed to cover foreseeable risk, including negligent acts," and that "'[a] deliberate act, performed negligently, is an accident if the effect is not the intended or expected result; that is, the result would have been different had the deliberate act been performed correctly.'"[5] Accordingly, "because negligent work is unintentional from

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[2] *Id*. at 763.
[3] *Id*. at 771.
[4] *See id*. at 771-75.
[5] *Id*. at 775 (quoting Lamar Homes, Inc. v. Mid-Continent Casualty Co., 242 S.W.3d 1, 8 (Tex. 2007)).

the point of view of the insured," the court found that it may constitute the basis for an "accident" or "occurrence" under the "plain terms" of the CGL policy.[6]

Turning to the "property damage" question, i.e., whether damages to the work of an insured contractor or its subcontractors constituted "property damages" under the CGL policy, the court first noted "we see no basis in the language of the policy for limiting coverage to liability for harm to third parties," finding "that physical injury to or loss of use of the insured's property is within the initial grant of coverage as described in the policy's insuring agreement."[7] However, the court also could not make a blanket ruling in favor of coverage, noting instead that the determination is "highly fact-dependent"[8] and then scrutinizing the allegations against Capstone.

It first held that "water and mold damage to portions of the insured's project, beyond the defective work itself, would qualify as 'physical injury to tangible property,'" and more generally, "[t]o the extent that the plaintiffs' claims are based on physical injury to or loss of use of nondefective property, we hold that they are within the insuring agreement's coverage."[9] On the other hand, the escape of carbon monoxide due to faulty workmanship, without more, does not qualify as property damage.[10] The court's discussion of carbon monoxide does not address coverage for bodily injury resulting from carbon monoxide exposures, and it is not clear whether the court considered the argument that the CGL policy should cover the expense of preventing or mitigating such bodily injuries.

Similar to the carbon monoxide analysis, the court concluded that building code violations, defective construction

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6 *Id*. at 776.
7 *Id*. at 777.
8 *Id*. at 778.
9 *Id*. at 782.
10 *Id*.at 782-83. The court's opinion addressed only the first prong of the policy's definition of property damage and explicitly did not address whether any of the claims might qualify as property damage based on loss of use of tangible property that was not physically injured. *Id*. at 783 n. 21.

and poor quality control do not constitute property damage, "unless they result in damage to other, nondefective property."[11] Mere diminution in value from such construction deficiencies, without causing physical injury or loss of use, does not involve "property damage," in the court's view.[12]

On the other hand, the court recognized that coverage does extend to repairs of property damaged by construction defects, stating:

> We emphasize, however, that the insuring agreement clearly does contemplate coverage for repairs to nondefective property stemming from "[p]hysical injury to tangible property" or "loss of use" caused by defective work stemming from an occurrence, including consequential costs for the necessary repairs and remediation.... Accordingly, we conclude that the commercial general liability policy covers claims for property damage caused by defective work, but not claims for repair of the defective work itself.[13]

Finally, the court considered whether any exclusions applied, noting that "[t]he various exclusions and exceptions constituted the bulk of the policy's language and are often determinative of coverage for any particular claim."[14] The policy in *Capstone* contained an exclusion for property damage to "your work," encompassing the "products-completed operations hazard," but the exclusion had an express exception for damage arising from work performed by a subcontractor.[15] Thus, the applicability of the exclusion was "a matter of fact, to be determined in each case,"[16] with the court holding "that the 'subcontractor exception' to the 'your work' exclusion would reinstate coverage if the plaintiffs ultimately prove that property damage was caused by its subcontractors' defective work," and that "[p]roperty damage resulting from the [policyholder's] own faulty

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11 *Id*. at 783.
12 *Id*. at 784.
13 *Id*. at 787 (citing Federated Mutual Ins. Co. v. Concrete Units, Inc., 363 N.W.2d 751, 757 (Minn. 1985)).
14 *Id*. at 787-88.
15 *Id*. at 789.
16 *Id*. at 790.

work … is precluded from coverage by the 'your work' exclusion."[17]

Defective workmanship issues also were the focus of *Scottsdale Ins. Co. v. R.I. Pools Inc.*[18] In this case, the insured had been sued by nineteen customers for whom it had installed pools, based on deterioration of the concrete foundation that rendered the pools unusable.[19] The insured employed subcontractors to supply and install the concrete.[20] Its commercial general liability policy with plaintiff Scottsdale: (a) required damage caused by an "occurrence," defined as "an accident"; (b) included an exclusion for "your work"; but (c) also included an exception to the exclusion where the damage was caused by work of a subcontractor.[21] The policy also included a duty to defend obligation for "a civil proceeding in which damages…to which this insurance applies are alleged."[22]

The district court granted summary judgment for Scottsdale, reasoning that defects in the insured's workmanship could not be considered "accidents" and thus were not "occurrences" as defined in the policy.[23] The district court subsequently ordered the insured to reimburse Scottsdale for the defense costs already spent based on the finding of no coverage.[24]

The United States Court of Appeals for the Second Circuit vacated both rulings of the district court and remanded for further consideration.[25] Specifically, the Second Circuit focused on policy language dictating that in some circumstances the insured's "own work" could be covered and, as a result, defects in the insured's own work "unmistakably" are included within the policy's definition of "occurrence."[26] In this case, the court found that the question

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17 *Id.*
18 710 F.3d 488 (2d Cir. 2013).
19 *Id.* at 490.
20 *Id.*
21 *Id.*
22 *Id.*
23 *Id.* at 491.
24 *Id.*
25 *Id.* at 492.
26 *Id.* at 491-92.

of the insured's liability turned on whether the subcontractor exception to the "your work" exclusion applied, and that the district court's interpretation improperly nullified the exception.[27]

B. *"Publication" For Personal Injury Coverage*

In *Recall Total Information Management Inc. v. Federal Insurance Co.*,[28] the Appellate Court rejected an argument that the loss of computer tapes containing confidential information concerning a large number of persons triggered personal injury cover under a CGL policy because the personal information stored on the tapes had been published to the thief and potentially other unknown persons, thereby subjecting the plaintiff to potential claims and liability, including the costs of notifying the individuals whose data was lost and taking mitigating steps such as credit monitoring.[29] Recall's argument focused on the proper definition of "publication," urging the court to agree that "publication" is the communication of information "to the public" rather than "to a third party."[30] The 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."[31] Because Recall could not show that the information on the tapes was ever accessed by anyone, the Court held that there was no publication and therefore no coverage under the personal injury provision of the policy.[32]

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[27] *Id.* at 492. As to the defense obligation, the Second Circuit upheld the longstanding law that if the allegations against the insured "even *possibly*" fall within coverage, the insurance company must defend. *Id.* (emphasis in original). Because the duty to defend continues until it is definitively proven that there is no possibility of coverage under the policies, Scottsdale was not entitled to reimbursement of defense costs already paid. *Id.*

[28] 147 Conn. App. 450, 83 A.3d 664, *cert. granted*, 311 Conn. 925, 86 A.3d 469 (2014). This case is currently pending appeal before the Connecticut Supreme Court.

[29] *Id.* at 462.

[30] *Id.* at 463.

[31] *Id.*

[32] *Id.* at 463-4.

C. *Duty to Defend*

1. Negotiations Not a "Suit" Entitled to Defense

The *Recall* decision also addressed whether the defendant insurance companies had a duty to defend a claim involving the loss of tapes containing confidential personal information of several hundred thousand individuals. Recall had entered into a contract with IBM to transport and store various electronic media belonging to IBM.[33] Recall then entered into a subcontract with Ex Log to provide transportation services for the electronic media. Ex Log was required to provide various insurance coverages and name Recall Total as an additional insured.[34] In February of 2007, Ex Log was transporting computer tapes when a cart containing tapes fell out of its van near a highway exit ramp, and approximately 130 of the tapes were then taken by an unknown third person and never recovered. The tapes contained employment-related data including social security numbers, birthdates, and contact information for approximately 500,000 individuals.[35] IBM immediately acted to prevent harm from the dissemination of this personal information, claiming that it spent in excess of $6 million on mitigation expenses. IBM then negotiated a settlement with Recall for the full amount of its claimed loss.[36] Recall sought indemnification from Ex Log, and Ex Log filed claims against its CGL insurance companies, which denied coverage.[37] Ex Log then assigned to Recall all of its insurance rights, and Recall filed an action against the insurance companies alleging breach of insurance contract, among other claims.[38]

The plaintiff argued that the insurers had waived any coverage defenses because they failed to defend Recall.[39] The trial court disagreed, holding that the mere negotiations

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33 147 Conn. App. at 453.
34 *Id.*
35 *Id.* at 453-4.
36 *Id.* at 454.
37 *Id.*
38 *Id.* at 454-55.
39 *Id.*

that occurred between IBM and Recall were not a "suit" within the policy's duty to defend.[40] Recall appealed, claiming that the trial court erred when it found that the defendant insurers did not have a duty to defend with respect to Recall's negotiations with IBM.[41] The Appellate Court held that neither the term "suit" nor the phrase "other dispute resolution proceeding" was intended to encompass mere negotiations, and it reasoned that holding otherwise would obliterate the distinction between the term "suit" and the term "claim" in the policy.[42]

2. Defense of Additional Insureds

In *Misiti, LLC v. Travelers Prop. and Cas. Co of America*,[43] the Connecticut Supreme Court affirmed that the defendant Travelers did not have a duty to defend the insured where the underlying complaint for bodily injuries did not allege a sufficient causal connection between the injuries sustained and the risk insured against.[44] In this case, the plaintiff Misiti, LLC owned commercial real estate, a portion of which was leased to a tavern.[45] The tavern maintained a commercial general liability policy issued by Travelers, which named Misiti as an additional insured "but only with respect to liability arising out of the ownership, maintenance or use of that part of the premises leased to [the tavern]."[46] After a woman brought an action against Misiti for injuries she sustained from falling on Misiti's property, Misiti sought a declaratory judgment that Travelers had a duty to defend it in the personal injury action.[47] Misiti argued that in view of underlying complaint's reference to Misiti's commercial property and its description of the injured woman as a business invitee on the commercial property, it was possible that the claim arose out of the

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40 *Id*. at 455.
41 *Id*. at 456.
42 *Id*. at 459-460; *see* notes 28 – 32 for discussion of personal injury coverage.
43 308 Conn. 146, 61 A.3d 485 (2013).
44 *Id*. at 168.
45 *Id*. at 149.
46 *Id*. at 149-150.
47 *Id*. at 148-9.

woman's use of the leased premises.[48] The injured woman did not sue the tavern, nor did her complaint mention the tavern.[49]

The Supreme Court observed that its analysis was restricted to the four corners of the complaint, and that reliance on extrinsic evidence is only permitted if that evidence would support the duty to defend.[50] The Court then noted that the complaint in the underlying personal injury action must show some kind of causal connection between the injury and the risk insured against, but "our case law instructs that there is a limit to what may constitute an adequate causal connection. … [W]e will [not] 'obligate an insurer to extend coverage based … [on] a reading of the complaint that is …conceivable but tortured and unreasonable.'"[51] Ultimately the Court concluded that, even though it was undisputed that the insured premises on which the tavern operated was on Misiti's overall premises, and the underlying complaint referred to the overall premises, "we are not persuaded that this fact alone, in the absence of any alleged connection to the tavern, justifies an inference that the injuries alleged in the underlying complaint arose out of the use of the leased premises."[52]

In reaching its conclusion, the Court discussed the definition of the phrase "arising out of" and confirmed that an analysis as to whether the injuries "arose out of" the woman's use of the leased premises included a consideration as to whether her injuries originated, stemmed, or resulted from her legal or proper enjoyment of the leased premises, and whether her injuries were "incident to" or "connected with" her use of the leased premises.[53]

In contrast, in *Dominion Energy, Inc. v. Zurich Am. Ins. Co.*[54] the United States District Court for the District of

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[48] *Id.* at 161.
[49] *Id.* at 150.
[50] *Id.* at 162.
[51] *Id.* at 163.
[52] *Id.* at 165.
[53] *Id.* at 157-160.
[54] No. 3:13-CV-156(JCH), 2013 U.S. Dist. LEXIS 150569, 2013 WL 5720174 (D. Conn. Oct. 18, 2013).

Connecticut granted an additional insured's motion for partial summary judgment, finding that the defendant Zurich had a duty to defend Dominion in state court proceedings.[55] The dispute involved a contract between Dominion and Alstom, Inc. under which (1) Alstom was to perform work at Dominion's power generation facilities; (2) Alstom agreed to maintain insurance policies with Dominion named as an additional insured; and (3) Alstom was to indemnify and – at Dominion's sole option – to defend Dominion against all claims, loss, and damages, including attorneys' fees, and including third party claims for personal injury or death.[56] Alstom and Dominion then entered into a purchase order for Alstom to inspect a boiler. Alstom's employee, Dennis Nygaard, performed the inspection, but there was a catastrophic failure at that boiler which resulted in three deaths and several other injuries.[57] The decedents' estates then sued Dominion, Alstom, and Nygaard.

Zurich argued it had no duty to defend Dominion because the underlying facts did not trigger Dominion's status as an additional insured,[58] which depended on an "Automatic Additional Insured" endorsement stating that "any entity you [Alstom] are required in a written 'insured contract' (hereinafter called additional insured) to name as an insured is an insured but only with respect to liability arising out of your premises, 'your work' for the additional insured, or acts or omissions of the additional insured in connection with the general supervision of 'your work' to the extent set forth below.[59] Zurich argued that Dominion was not an additional insured under the policy unless Alstom was already determined to have been solely at fault.[60]

The court rejected this argument, pointing out that Zurich's interpretation would give no meaning to the contractual duty to defend provisions because Dominion would only be eligible for defense retrospectively and only if Alstom were found to be at fault.[61] The court further rejected

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[55] *Id*. at *23-24.
[56] *Id*. at *2-3.
[57] *Id*. at *4.
[58] *Id*. at *4-5, 11.
[59] *Id*. at *15.
[60] *Id*. at *18.
[61] *Id*. at *18.

Zurich's argument because its reasoning would effectively nullify the duty to defend as the law recognizes it: "Zurich construes its duty to defend to cover only Alstom's actual liability. In effect, Zurich would have no duty to defend Dominion, but only a duty to indemnify Dominion following the adjudication of any fault on Alstom's part in the state action."[62] The court concluded that Dominion was an additional insured under the policy, and that Zurich had a duty to defend, noting that "[w]hile the provisions to which Zurich points may limit Dominion's coverage, these provisions in no way nullify Zurich's duty to defend where the underlying action potentially implicates that coverage."[63]

D. *Settlement Following Insurer's Failure to Defend Partially Covered Claims*

The Supreme Court's *Capstone* decision also addressed the consequences of a policyholder's settlement of an action that its liability insurer wrongfully failed to defend where some, but not all, of the underlying claims were covered. Under *Alderman v. Hanover Ins. Group*,[64] an insurer who denies liability under a policy is liable for the amount of a settlement made by the insured before suit is brought, where the claim against the insured is found to have been covered by the policy.[65] While *Alderman* and the leading *Missionaries Co. of Mary, Inc. v. Aetna Casualty & Surety Co.* decision on which it relied[66] both involve a single claim for which the insurer wrongfully denied a defense, the certified question in *Capstone* assumed that the insurance company had an obligation to defend against at least one, but not all, of the underlying claims.[67]

The Supreme Court acknowledged that the insurer's duty to defend extends to all claims when even one falls "even possibly" within coverage, but for purposes of assessing

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62 *Id.* at *19.

63 *Id.*

64 169 Conn. 603, 363 A.2d 1102 (1975).

65 *Id.* at 611.

66 Missionaries of Co. of Mary, Inc. v. Aetna Casualty & Surety Co., 155 Conn. 104, 230 A.2d 21 (1967) (holding that liability insurance company which failed to defend under a reservation of rights a claim found to be covered was obliged to reimburse the policyholder's costs of defense and settlement).

67 *See Capstone*, 308 Conn. at 810-11.

the reasonableness of settlements under the equitable estoppel rule of *Missionaries and Alderman* reasoned that

> [T]he proper inquiry is whether the insurer would have had the duty to defend against each claim, contained in the complaint or fairly discernible from the demand for defense, when considered independently. To hold otherwise would be to expand coverage by estoppel to claims for which the insurer owes no duties under the policy. Because the duty to defend is broader than the duty to indemnify[,]… holding a breaching insurer liable for settlement amounts attributable to claims for which there was no duty to defend is unreasonable.[68]

The *Capstone* court therefore limited the breaching insurer's liability for costs of settlement "to the portion of the settlement corresponding to claims for which the insurer had a duty to defend, when considered independently."[69] The court allocated the burden of proving the reasonableness of a settlement to the insured, with the "reasonableness standard" also applicable to the allocation of settlement costs between claims.[70]

II. Policy Exclusions, Definitions And Conditions

A. *Property Damage vs. Economic Damage*

In *Homestead Country Properties, LLC v. American Modern Home Ins. Co.*,[71] the United States District Court for the District of Connecticut granted an insurer's summary judgment motion, finding that the insurer had no duty to defend or indemnify an insured former property owner in connection with an underlying action brought by a purchaser of residential property against the insured with respect to the sale of such property. The purchaser alleged the insured negligently misrepresented that the septic system at the

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68 *Id.* at 814-15.
69 *Id.* at 815.
70 *Id.* at 815-16.
71 No. 3:12-CV-1003 (JBA), 2013 WL 3716383 (D. Conn. July 12, 2013).

property functioned properly and that the property could support a septic system sufficient for a four-bedroom home.[72] The insurance policy at issue covered, generally, the insured's "legal liability for bodily injury or property damage"[73] provided such "bodily injury or property damage is caused by an occurrence[74] during the policy period." The District Court found that even if it concluded that negligent misrepresentation can constitute an "occurrence" under the policy, the damages alleged by the purchaser as "flowing from" negligent misrepresentation constitute economic damage, not property damage, and that any potential property damage (*e.g.*, the uninhabitable state of the property) "lacked any nexus" to the alleged representations.[75]

B. *Sexual Molestation Exclusion*

In *Peerless Ins. Co. v. Clemens*,[76] an insurer sought a declaratory judgment in the United States District Court for the District of Connecticut that the insurer did not have a duty to defend and indemnify its insureds under a homeowner's insurance policy in connection with an underlying action involving allegations of sexual assault of a minor. It was alleged in the underlying action, among other things, that the minor plaintiff was sexually assaulted and abused on numerous occasions by the homeowners' son while a guest in their home.[77] Liability was alleged against the homeowner parents for their failure to properly supervise

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[72] *Id*.

[73] The policy defined "property damage" as including "loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period." *Id*. at *2, n. 4.

[74] The policy defined "occurrence" as an "accident, including continuous or repeated events or exposure to conditions which results in bodily injury or property damage neither expected nor intended by the insured." *Id*. at *2, n. 5.

[75] *Id*. at *4. The District Court also noted that even if it concluded that the purchaser's allegations constituted otherwise covered "property damage," such pre-existing damage would be excluded under a provision in the policy pertaining to damage to property owned by the insured. *Id*. at 4, n. 7. The District Court also found that the insurer did not breach a duty to indemnify the insured for a separate property damage claim under the policy's first-party mold coverage, because the damage was not caused by an insured peril under the policy. *Id*. at *5.

[76] No. 3:11-CV-1597 (RNC), 2013 WL 364819 (D. Conn. Jan. 22, 2013).

[77] *Id*. at *1.

their son, causing the minor plaintiff's injuries.[78] The policy at issue contained an exclusion regarding claims of bodily injury arising out of sexual molestation.[79] In granting the insurer's summary judgment motion, the District Court rejected an argument by the insureds that such exclusionary language is ambiguous, and therefore, must be construed against the insurer.[80] Moreover, the District Court specifically addressed the phrase "arising out of" finding that "causes of action sounding in negligence and recklessness fall within a sexual molestation policy exclusion if they 'have a clear causal connection to the alleged molestation and the injuries resulting therefrom.'"[81] While this matter involves a specific type of conduct, the District Court's discussion is instructive regarding the application of the phrase "arising out of" in a more general insurance context.[82]

In *Metropolitan Prop. & Cas. Ins. Co. v. Briggs*,[83] the United States District Court for the District of Connecticut refused to limit a sexual molestation exclusion to just the act of sexual molestation, holding instead that the only reasonable interpretation of the policy excludes coverage for the act itself and for injury arising from the act of sexual molestation.[84] The policyholders had purchased a homeowners insurance policy which provided coverage for "Bodily Injury" to others, but specifically provided that "Bodily Injury" does not include the actual, alleged or threatened sexual molestation

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78 *Id*.

79 *Id*.

80 *Id*. at *2 (relying on Community Action for Greater Middlesex County, Inc. v. American Alliance Ins. Co., 254 Conn. 387, 395, 757 A.2d 1074 (2000)).

81 *Id*. at *3 (quoting Electric Ins. v. Castrovinci, No. 3:02-CV-1706, 2003 WL 23109149 at *3 (D. Conn. Dec.10, 2003)).

82 "The Connecticut Supreme Court instructs that liability for accident or an injury arises out of an occurrence or offense where the accident or injury 'was connected with,' 'had its origins in,' 'grew out of,' 'flowed from,' or 'was incident to' the occurrence or offense.'" *Electric Insurance*, 2003 WL 23109149 at *3 (citing QSP, Inc. v. Aetna Cas. & Sur. Co., 256 Conn. 343, 374, 773 A.2d 906 (2001). The phrase "arising out of" ". . . is usually interpreted as indicating a causal connection" and "[a]n exclusionary clause that uses the phrase 'arising out of' precludes coverage for an entire class of risks arising out of specified conduct, and does not turn on the intent of the insured." *Id*., citing Covenant Ins. Co. v. Sloat, 2003 WL 21299384 (Conn. Super. 2003).

83 No. 3:12-cv-00389 (WWE), 2013 U.S. Dist. LEXIS 74885, 2013 WL 2358600 (D. Conn. May 29, 2013)

84 *Id*. at *7.

of a person.[85] Both of the homeowners were sued for injuries and damages resulting from one of the homeowner's sexual molestation of the victim for approximately two years.[86] The court rejected the homeowners' argument that the "sexual molestation" exclusion only applied to the act of sexual molestation, noting that such an interpretation would render the exclusionary provision of the policy meaningless.[87]

C. *Vandalism Exclusion/Ensuing Loss Coverage*

The Appellate Court addressed the vandalism exclusion in property insurance policies in *New London County Mutual Ins. Co. v. Zachem*.[88] The policyholder appealed from a declaratory judgment denying coverage, based on a trial court finding that the policy's vacancy exclusion applied because the insured premises had been vacant for more than thirty consecutive days at the time of an explosion and fire following an intrusion and theft of copper pipes from the insured house, including a propane gas line. The applicable exclusion stated: "'[W]e do not insure loss . . . caused by . . . vandalism and malicious mischief, theft or attempted theft if the dwelling has been vacant for more than [thirty] consecutive days immediately before the loss …'" The trial court also rejected the defendants' argument that the explosion and fire was covered despite the vandalism exclusion, within the general "ensuing loss" exception to policy exclusions stating "'[a]ny ensuing loss to property described in Coverages A and B not excluded or excepted in this policy is covered.'" The terms "vacant" and "ensuing loss" were undefined.[89]

The Appellate Court affirmed, rejecting the policyholder's argument that the term "vacant" was ambiguous and that even though the house was unoccupied, the vacancy exclusion should not apply because of daily visits by a relative to a garage on the premises, coupled with occasional visits to the house for maintenance. Noting that interpretation of the

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85 *Id*. at *2-3.
86 *Id*. at *1-2.
87 *Id*. at *6-7.
88 145 Conn. App. 160, 74 A.3d 525 (2013).
89 *Id*. at 162–164.

term "vacant" in this exclusion was an issue of first impression in Connecticut appellate case law,[90] the court reviewed dictionary definitions, focused on the term "dwelling," and concluded that the garage was unattached to the house and accordingly not part of the "dwelling" at issue.[91] It held that "a vacant dwelling is one that is unoccupied and does not contain items ordinarily associated with habitation, such as furniture, fixtures or personal property," and affirmed the trial court's finding that the insured house had been vacant for more than thirty consecutive days prior to the loss.[92]

The *Zachem* court also affirmed that there was no coverage under the policy's ensuing loss provision. Because the policyholders had not sought *en banc* review, the court found itself bound by the legal framework established by the Appellate Court in *Sansone v. Nationwide Mutual Fire Ins. Co.*[93] Under the *Sansone* analysis:

> In the determination [of] whether a loss is within an exception in a policy, where there is a concurrence of two causes, the efficient cause-the one that sets the other in motion-is the cause to which the loss is to be attributed, though the other cause may follow it and operate more immediately in producing the disaster. . . . [W]hat is meant by proximate cause is not that which is last in time or place, not merely that which was in activity at the consummation of the injury, but that which is the procuring, efficient, and predominant cause. . . . Proximate cause has been defined as [a]n actual cause that is a substantial factor in the resulting harm.[94]

As noted, the appeal was limited to the application of this analysis, and not the merit of this rule, which the *Zachem* court could not reach for procedural reasons. Accordingly, the court affirmed the trial court's conclusion that the "efficient cause" of the explosion was the removal of the copper propane

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[90] *Id.* at 166.
[91] *Id.* at 166-167.
[92] *Id.* at 168.
[93] 47 Conn. Supp. 35, 39-41, 770 A.2d 500 (1999), *affirmed*, 62 Conn. App. 526, 527, 771 A.2d 243 (2001); *see Zachem*, 145 Conn. App. at 169-170, 172.
[94] *Zachem*, 145 Conn. App. at 171 (quoting *Sansone*, 47 Conn. Supp. at 39).

lines, even though the subsequent spark from a water heater which ignited the escaped propane was a more immediate cause, and that the spark did not constitute a "separate and independent hazard" from which the loss ensued.[95]

The result in *Zachem* favored the insurance company's "efficient cause" analysis. However, the court clearly suggested it might reassess the *Sansone* rule, stating "we find merit in much of the [policyholders'] discussion of the issue."[96]

D. *Intoxication Exclusion*

In *Rau v. Hartford Life & Accident Ins. Co.*,[97] the United States District Court for the District of Connecticut granted summary judgment for the defendant insurance company regarding its denial of accidental death and dismemberment benefits under a group life insurance policy subject to the Employee Retirement Income Security Act ("ERISA"),[98] on the basis of an intoxication exclusion. The policy expressly granted the insurance company "full discretion and authority" to determine benefits and to construe and interpret the policy.[99] Accordingly, in contrast to *Critchlow v. First UNUM Life Insurance Company of America*,[100] where the rule of *contra proferentum* applied because the policy did not give the insurance company discretion to interpret the policy, the *Rau* court applied the "arbitrary and capricious" standard to the denial of ERISA benefits.[101] In its application of that standard, the court also considered the defendant insurance company's conflict of interest in both evaluating and paying benefits claims as a factor in determining whether there was an abuse of discretion.[102]

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95 *Id*. at 173.

96 *Id*. at 170.

97 No. 3:11-CV-01772 (JCH), 2013 U.S. Dist. LEXIS 67572, 2013 WL 1985305 (D. Conn. May 13, 2013).

98 29 U.S.C. § 1001, *et seq*.

99 *Rau*, 2013 U.S. Dist. LEXIS 675572 at *4.

100 378 F.3d 246 (2d Cir. 2004).

101 2013 U.S. Dist. LEXIS at *9-10, n.2 (citing Pagan v. NYNEX Pension Plan, 52 F.3d 438, 444 (2d Cir. 1995)).

102 2013 U.S. Dist. LEXIS at *11 (citing McCauley v. First Unum Life Ins. Co., 551 F.3d 126, 132 (2d Cir. 2008)).

Under these standards, the court held that the insurer had not abused its discretion by interpreting the policy's intoxication exclusion to apply to "any injury sustained while the decedent was intoxicated, regardless of whether that injury was caused by the intoxication."[103] The decedent was legally intoxicated when she fell to her death after extending her entire torso outside the passenger-side window of a moving pickup truck, but her beneficiary argued the exclusion should not apply because the fall was caused by a defective door handle rather than her intoxication.[104] The court rejected this argument, reasoning that "[if] the drafters of the policy intended to require a causation element, they could have written the exclusion to apply to injury sustained as a result of intoxication, rather than to 'injury sustained while intoxicated,'" and contrasting the exclusion with other policy language that expressly stated a causation requirement.[105]

The court also rejected the beneficiary's argument that the insurance company had a conflict of interest because it both evaluated and paid benefits claims. The beneficiary "[had] not introduced any evidence to suggest that this conflict affected Hartford's decisionmaking," and in contrast, Hartford had introduced evidence that claims analysts and team leaders were evaluated and compensated on the "accuracy of [their] decision-making" regardless of the financial impact to the insurance company.[106]

E. *Warranty Endorsement*

In *Mt. Vernon Fire Ins. Co. v. El Rancho de Pancho, LLC*,[107] the United States District Court for the District of Connecticut held that coverage was barred under the subject insurance policy because of the policyholder's breach of the warranty endorsement provision.[108] In this case, El Rancho

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[103] *Id*. at *14.
[104] *Id*. at *5-6, 12-13.
[105] *Id*. at *14-15.
[106] *Id*. at *18-19.
[107] 985 F.Supp.2d 235 (D. Conn. 2013).
[108] *Id*. at 240.

de Pancho, which operated a bar and restaurant, entered into an insurance policy with Mount Vernon Fire Insurance Company under which Mount Vernon agreed to provide defense and indemnity for suits based on El Rancho de Pancho's contribution to the intoxication of any person.[109] The insurance policy, however, contained an exclusion for "Loss or expense, including but not limited to the cost of defense arising or resulting from a claim against any insured for 'injury' based on the selling, serving or furnishing of any alcoholic beverage, if at any time, you have breached one or more of the warranties set forth in this Warranty Endorsement attached to and made a part of this policy."[110] The Warranty Endorsement specifically stated that:

> As a condition of coverage, the insured agreed to maintain the following warranties during the term of this policy and any renewals thereof:
>
> …
>
> The establishment closes by 2:30 AM daily.
>
> Alcohol sales cease by 2:00 AM.
>
> The insured does not offer beer for less than $1.00.
>
> The insured does not offer liquor or wine for less than $1.50.[111]

One night, shortly after 2:00 a.m., Nick E. Vallas went with three friends to El Rancho de Pancho and were let in by the acting manager even though the restaurant was closed to the public.[112] Vallas and his friends were served beer, tequila and margaritas at no charge.[113] Between 3:30 a.m. and 4:47 a.m., Vallas left and drove his car off the road and into two utility poles, causing fatal injuries.[114] The court,

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109 *Id.* at 237-38.
110 *Id.* at 238.
111 *Id.* at 238.
112 *Id.*
113 *Id.*
114 *Id.*

interpreting the Warranty Endorsement as written, held that by admitting people into the restaurant after 2:00 a.m. and serving them alcohol until at least 3:00 a.m., the restaurant was not closed by 2:30 a.m. Because the policyholder had materially breached this warranty, coverage was barred.[115]

III. Litigation Issues

A. *Reformation/Parole Evidence*

In *Office Furniture Rental Alliance, LLC v. Liberty Mutual Fire Ins. Co.*,[116] the United States District Court for the District of Connecticut granted an insurance company's motion for summary judgment as to a breach of contract claim even though the policies issued contained different terms than what the plaintiff had specifically requested, while preserving negligent misrepresentation and reformation claims for trial.[117] The court found that the plaintiff policyholder had properly alleged a claim for breach of contract by asserting that it had requested coverage with the same specific terms and conditions as other policies the defendant sold to the plaintiff in the past.[118] Nevertheless, the court granted summary judgment because the request for specific terms was a prior oral negotiations that was barred by the parol evidence rule.[119] Under the rule, prior oral negotiations that contradict a written policy are only considered if there is ambiguity in the terms of the policy.[120] Here, the plaintiff did not dispute that the policy unambiguously provided insurance on a per-location basis, rather than the blanket coverage he specifically had requested. Because there was no ambiguity in the policy, the court was barred from considering evidence of the prior oral agreements.[121]

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115 *Id.* at 240.
116 981 F. Supp. 2d 111 (D. Conn. 2013).
117 *Id.* at 120.
118 *Id.* at 118-119.
119 *Id.* at 120.
120 *Id.* at 119.
121 *Id.*

B. *Contractual and Statutory Time Limitations*

Among other issues, *Known Litigation Holdings, LLC v. Navigators Ins. Co.*,[122] addressed the timeliness of suit under a fidelity policy which expressed the following contractual suit limitation: "Legal proceedings for recovery of any loss under this policy shall not be brought after the expiration of two years."[123] Because the clause did not specifically state what event would trigger the two-year period, and the paragraph preceding it discussed both the discovery of loss and the policyholder's notice to the insurance company, the court found the limitations provision ambiguous and denied the insurance company's motion to dismiss, finding a more developed record would be required.[124]

In another decision involving failure to bring suit within a contractual two-year limitations period, the United States District Court for the District of Connecticut in *VP Electric, Inc. v. Graphic Arts Mut. Ins. Co.*[125] denied the defendant's motion for summary judgment, holding that a reasonable jury could find that the defendant insurance company was estopped from asserting the suit was late based on the statements and conduct of an agent.[126] The policy required that an action be brought within two years after the policyholder first gains knowledge of the direct loss or damage.[127] The policyholder's loss arose when a shipment of copper wire went missing in May of 2008; the supplier purportedly delivered it to a VP jobsite, but VP never received it.[128] VP promptly informed its insurance agent of the disputed wire delivery, suggesting that the delivery went missing or could have been stolen.[129] In response, according to VP, the agent stated that notifying him was like notifying the insurance company, but the agent never instructed VP to submit a claim, nor did he inform VP that the missing wire delivery could be covered.[130]

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[122] 934 F. Supp.2d 409 (D. Conn. 2013).
[123] *Id*. at 418.
[124] *Id*. at 419.
[125] No. 3:12-CV-00453(JCH), 2013 U.S. Dist. LEXIS 125741, 2013 WL 4737327 (D. Conn. Aug. 30, 2013).
[126] *Id*. at *17-*18.
[127] *Id*. at *2.
[128] *Id*. at *2-*3.
[129] *Id*. at *4.
[130] *Id*. at *4.

The supplier sued to recover payment, and VP promptly informed the agent of the lawsuit.[131] The agent again did not advise VP to notify the insurer, advising instead that VP should defend the action with its own attorneys and explaining that he considered it a business dispute.[132] After judgment entered against VP in the lawsuit for the missing wire, it informed the agent, who then submitted a claim for stolen property to the insurance company.[133]

The *VP Electric* court denied summary judgment on these facts, because even if the agent was not affirmatively misleading, the policyholder might still be entitled to estoppel if the agent's statements were so grossly negligent as to amount to constructive fraud.[134] Notably, the court also found that a reasonable jury could conclude that VP's principal was not in a position to determine himself from the policy whether the missing shipment would have been covered, because the policy was 203 pages in length and contained various forms setting forth various types of coverage.[135]

In *Fradianni v. Protective Life Ins. Co.*,[136] the Connecticut Appellate Court reversed the trial court's grant of summary judgment in favor of an insurer in an action brought by the insured for breach of contract in connection with a life insurance policy. Most relevantly, the insured alleged that the insurer breached the policy when it annually charged rates in excess of those allowed under the policy.[137] The trial court found that the six year statute of limitations under General Statutes Section 52-576(a) barred the insured's claims, concluding that the continuing course of conduct doctrine did not toll the statute of limitations, and that each alleged annual breach of the policy by the insurer did not constitute a separate breach for purposes of the statute of limitations.[138] The Appellate Court agreed that the continuing course of

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131 *Id.* at *5.
132 *Id.* at *5-*6.
133 *Id.* at *6.
134 *Id.* at *16.
135 *Id.* at *17-*18.
136 145 Conn. App. 90, 73 A.3d 896 (2013).
137 *Id.* at 95.
138 *Id.* at 95-96.

conduct doctrine[139] did not toll the statute of limitations because at the time of each alleged annual breach, damages "were readily calculable and actionable at the time of each breach, unlike those cases where it is the cumulative effect of the defendant's behavior that gives rise to the injury."[140] Accordingly, however, the Appellate Court found that the separate alleged breaches occurring within the statute of limitations period were not barred.[141]

C. *Third Party Standing/Indispensable Parties*

The *Known Litigation Holding* decision also addressed the standing of a loss payee to sue for insurance policy benefits and the related question of the policyholder's status as an indispensable party in such a suit. The plaintiff was successor to a bank that had been named as a loss payee under several policies issued to an ATM servicer and affiliated courier who were responsible for transferring the bank's cash. The policies stated that a designated loss payee "has no rights under the contract of insurance," and that "the only right conferred is the right to receive direct payment."[142] Finding no support for the insurance company's contention that the outcome of the third-party beneficiary test depends on the type of insurance policy being interpreted, the court looked to the terms of the policy to determine whether the loss payee was an intended third-party beneficiary with standing to sue.[143] Noting that under Connecticut law, "'the ultimate test to be applied in determining whether a person has a right of action as a third party beneficiary is whether the intent of the parties to the contract was that the promisor should assume a direct obligation to the third

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[139] Generally, "[T]o support a finding of a continuing course of conduct that may toll the statute of limitations there must be a breach of a duty that remained in existence after commission of the original wrong related thereto." *Id*. at 97-99 (quoting Watts v. Chittenden, 301 Conn. 575, 583-85, 22 A.3d 1214 (2011)). The Appellate Court did not address whether the continuing course of conduct doctrine applies in breach of contract actions, in addition to tort actions. *Id*. at 100, n. 9.

[140] *Id*. at 100.

[141] *Id*. at 102.

[142] 934 F.Supp.2d at 413.

[143] *Id*. at 417.

party beneficiary,'"[144] the court found standing, because the unambiguous provision granting the loss payee "the right to receive direct payment" showed an intent to create a direct obligation from the insurance company to the loss payee.[145]

On a related note, because the insurance company's liability to the policyholders in *Known Litigation Holdings* might not be fully discharged by paying the loss payee plaintiff, and because they had not designated the bank as the sole loss payee entitled to one hundred percent of any payment, the court directed that the policyholders be joined.

In *O&G Industries v. Aon Risk Services, Northeast*,[146] the United States District Court for the District of Connecticut held that plaintiffs Kleen Energy Systems, LLC, Keystone Construction and Maintenance Services and Bluewater Energy Solutions, Inc. had standing to sue the defendant, Aon Risk Services, as third party beneficiaries to a brokerage services agreement between the plaintiff O&G and Aon, even though Kleen, Keystone and Bluewater were not parties to O&G and Aon's agreement.[147] Pursuant to that agreement, Aon was to procure insurance for a construction project under a contractor controlled insurance program ("CCIP").[148] O&G requested that Aon procure the required insurance coverage under O&G's engineering, procurement and construction contract with Kleen, the project owner.[149] The construction contract contained specific requirements with respect to the insurance to be obtained, and further required O&G to indemnify and defend Kleen against liability and losses resulting from the negligence of O&G or its subcontractors, including Keystone and Bluewater.[150] Aon procured the CCIP insurance and prepared a manual which it provided to each CCIP participant,

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144 *Id.* at 418 (quoting Grigerik v. Sharpe, 247 Conn. 293, 311-12, 721 A.2d 526 (1998)).

145 *Id.*

146 922 F. Supp. 2d 257 (D. Conn. 2013).

147 *Id.* at 265-267.

148 *Id.* at 263.

149 *Id.* at 264.

150 *Id.* at 263.

including plaintiffs.[151] After an explosion at the construction site, several lawsuits were brought against the plaintiffs, at which point O&G and the other plaintiffs discovered that the defense costs coverage provided under the CCIP excess liability policies was less than what the construction contract required.[152]

While the court held that plaintiffs Kleen, Bluewater and Keystone had standing to sue Aon for breach of contract and tort liability, it ultimately dismissed the breach of contract claim, noting the lack of allegations that the plaintiffs contracted with Aon for a specific result.[153] Without such allegations, the court concluded, the breach of contract claim was "merely a professional malpractice claim couched as a contract claim."[154]

D. *Failure to Cooperate/Produce Evidence*

In *Chicago Title Ins. Co. v. Bristol Heights Associates, LLC*,[155] the Connecticut Appellate Court upheld the trial court in a declaratory judgment action brought by an insurer seeking a determination regarding its obligations under a title insurance policy to an insured property owner in connection with property tax liens on the subject property. The insured failed to respond to certain requests for information and documents from the insurer prior to paying the tax liens.[156] The insured argued that it had no obligation to respond to such requests because they exceeded the scope of what was required under the policy and were intended by the insurer to find support for the insurer's coverage defenses.[157] The Appellate Court found that the policy required the insured to provide the requested information and documents, even if such information and documents were requested to

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[151] *Id*. at 264.
[152] *Id*. at 265.
[153] *Id*. at 269-270.
[154] *Id*. at 270. *Compare Office Furniture Rental*, 981 F.Supp.2d at 117-18 (agreement to procure same-as-existing coverage supported breach of contract action).
[155] 142 Conn. App. 390, 70 A.3d 74 (2013).
[156] *Id*. at 409.
[157] *Id*. at 404-5.

further the insurer's coverage investigation.[158] The Appellate Court further found that the trial court did not err in finding that the insured failed to cooperate with the insurer and that such failure prejudiced the insurer.[159] The Appellate Court reasoned that the insured provided no excuse for its failure to cooperate, and that it was reasonable to infer from the evidence that the insurer's ability to investigate and defend the claim was prejudiced by the insured's failure to cooperate.[160]

In *Mali v. Federal Ins. Co.*,[161] the Second Circuit drew a critical distinction between an adverse inference jury instruction issued as punishment for misconduct, which requires that the court make specific factual findings justifying the sanction, and an instruction that simply explains to the jury the inferences the jury is free to draw depending on their own findings with respect to the evidence presented, which requires no predicate factual findings by the court.[162] The case involved denial of a claim for a fire that destroyed the plaintiffs' barn, and the failure to produce photographs of the interior of the barn prior to its destruction.[163] The court held that the instruction given regarding the failure to produce the photographs merely explained to the jury that it was free (but not required) to draw an adverse inference, which was not a sanction but just an explanation of the jury's fact-finding powers.[164]

Although the jury ultimately found that the plaintiffs had violated the fraud and misrepresentation clause of the policy,[165] the *Mali* court held that Federal was not entitled to equitable relief seeking to recover payments made to plaintiffs because those payments were not alleged to have been procured through fraud.[166] Moreover, Federal had not

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158 *Id.* at 406.
159 *Id.* at 407-10.
160 *Id.* at 409-410.
161 720 F.3d 387 (2d Cir. 2013).
162 *Id.* at 393.
163 *Id.* at 389-91.
164 *Id.* at 393.
165 *Id.* at 391.
166 *Id.* at 394.

asserted counterclaims for restitution, and the court held that Federal's failure to so plead constituted a waiver of any such claims.[167]

E. *Direct Action*

In *Tucker v. Am. Int'l Group, Inc.*,[168] the United States District Court for the District of Connecticut held that a stipulated judgment and partial payment is not a satisfied judgment for purposes of Connecticut's direct action statute, Conn. Gen. Stat. Section 38a-321. In this case, the policyholder was the plaintiff's former employer. After the plaintiff brought an employment-related lawsuit against the policyholder, the plaintiff and the policyholder entered into a stipulated judgment in which a small percentage of the overall judgment was paid to the plaintiff, and the policyholder assigned to the plaintiff all of its rights against the defendant insurance companies. The plaintiff then brought an action against the defendant insurance companies to recover the rest of the judgment as a subrogee of the policyholder under Connecticut's direct action statute.[169] The defendant insurance companies sought dismissal, arguing that the plaintiff could not bring an action under the direct action statute because the stipulated judgment should be considered a satisfied judgment. Rejecting that argument, the District Court held that a stipulated judgment may form the basis of an action under Connecticut's direct action statute.[170] The court noted, however, that the injured party has no superior rights to those of the insured, so the insurance company under such circumstances may still raise all appropriate defenses and be heard on the question of policy coverage or the possibility of fraud.[171]

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167 *Id*. at 395.
168 936 F. Supp. 2d 1 (D. Conn. 2013).
169 *Id*. at 3-5.
170 *Id*. at 13.
171 *Id*. at 13-14.

IV. Broker/Agent Liability

A. *Contingent Commissions*

The long-running nationwide controversy over "contingent commission" agreements between insurance brokers and insurance companies reached the Connecticut Supreme Court in *State v. Acordia Inc.*[172] The court concluded that the defendant insurance broker's contingent commission agreements had not violated the Connecticut Unfair Insurance Practices Act ("CUIPA")[173] or the Connecticut Unfair Trade Practices Act ("CUTPA"),[174] and accordingly reversed a trial judgment finding violations"[175]

The defendant in *Acordia* was an independent broker that offered clients a choice of policies from multiple insurance companies.[176] It had entered contingent commission programs with a number of insurance companies who agreed to pay on a quarterly basis an additional 1 percent of the total premiums placed with that company, in addition to any commission already paid to the broker. In exchange for that payment, the defendant represented that the participating insurers would be given "priority status" and "more business."[177] Five insurance companies agreed to participate, and management of the broker was directed to give them "preferential consideration" on new and renewal business.[178] The broker's policyholder clients were never informed, and at trial, several clients testified they relied on the broker to provide "independent and unbiased advice."[179] The trial court found that the clients had not suffered monetary harm from the failure to disclose the program and paid the same premiums as they would have paid absent the program, but nevertheless found that the broker had breached a fiduciary duty, violating both CUTPA and CUIPA, and ordered that the broker

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[172] 310 Conn. 1, 73 A.3d 711 (2013).
[173] General Statutes § 38a-815 *et seq*.
[174] General Statutes § 42-110a *et seq*.
[175] *Acordia*, 310 Conn. at 10.
[176] *Id*. at 11.
[177] *Id*. at 12.
[178] *Id*.
[179] *Id*.

account for undisclosed commissions for products purchased by consumers in Connecticut.[180]

The Supreme Court found that the trial court erred by resting its conclusion on a determination that the broker had breached a fiduciary duty owed to its clients.[181] Reviewing the structure of CUIPA, it noted that CUIPA Section 38a-815 "identifies two different ways in which a practice may be determined to be an unfair insurance practice in violation of CUIPA: the practice may fall under one of the defined unfair insurance practices in § 38a-816, or the Insurance Commissioner … may determine, pursuant to General Statutes §§ 38a-817 and 38a-818, that the practice constitutes 'an unfair method of competition or an unfair or deceptive act or practice in the business of insurance . . . .'"[182] The court observed that in addition to setting forth a broad array of unfair practices, the statute defined each listed practice in specific detail,[183] and that the legislature intended to provide a "comprehensive list of insurance practices that are unfair or deceptive in violation of CUIPA," but also recognized the need for the state insurance commissioner to determine whether additional conduct was unfair or deceptive.[184] Because the concealed contingent commission practice was neither enumerated in the statute nor addressed by the insurance commissioner following a hearing, the Supreme Court addressed whether the legislature intended its enumeration of unfair practices "to preclude the courts from determining that a party engaged in an unfair insurance practice in violation of CUIPA based on legal authority other than §38a-816, specifically, the common law."[185] Reviewing the legislative history and many amendments of CUIPA adding new unfair practices, the court concluded "that the legislature intended to occupy the field of defining unfair

[180] *Id*. at 13-14.
[181] *Id*. at 15.
[182] *Id*. at 19.
[183] *Id*. at 20.
[184] *Id*. at 23.
[185] *Id*. at 24.

insurance practices, thereby precluding courts from incorporating common-law principles as a basis for finding an unfair insurance practice," and accordingly, it held that "the common-law principle of fiduciary duty cannot provide the foundation for a CUIPA violation."[186]

The court also found that the CUTPA claim was barred "because conduct by an insurance broker or insurance company that is related to the business of providing insurance can violate CUTPA only if it violates CUIPA, and a CUTPA claim in this context cannot be based on breach of a common-law duty."[187] It stated that CUIPA "provides the exclusive and comprehensive source of public policy with respect to general insurance practices," and therefore violation of CUIPA or arguably another statue regulating a specific type of insurance was necessary to find a violation of public policy and support a CUTPA claim.[188] The court concluded that "a common-law breach of fiduciary duty arising in the insurance context that does not violate CUIPA or some other statute regulating the insurance industry cannot provide the basis for a valid CUTPA claim."[189]

B. *Negligent Misrepresentation*

In *Azoulay v Allstate Ins. Co.*,[190] the United States District Court for the District of Connecticut denied a plaintiff policyholder's motion to amend his complaint to add an insurance agent as a defendant in a dispute concerning a Standard Flood Insurance Policy.[191] When the policyholder received only partial reimbursement from damages caused to his home by Hurricane Irene, he discovered that the extent of coverage under his policy was lower than what he expected.[192] The policyholder sought to add the insurance agent as a defendant in his action against the defendant

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[186] *Id.* at 26-27.
[187] *Id.* at 27.
[188] *Id.* at 37.
[189] *Id.* at 37-38.
[190] No. 3:12 cv 1693 (JBA), 2013 U.S. Dist. LEXIS 147277; 2013 WL 5596017 (D. Conn. Oct. 11, 2013).
[191] *Id.* at *14.
[192] *Id.* at *3.

insurance company, asserting that the agent misrepresented the extent of coverage.[193]

The court briefly described the history of the National Flood Insurance Program and noted that because flood risk policies issued by private insurers under the program are supported by the federal treasury, a person seeking to use those funds is obligated to familiarize him- or herself with the legal requirements for receiving federal funds.[194] The court also noted that the details of the policies issued under this program are codified in federal law, and therefore available to everybody, so policyholders have constructive notice of policy terms.[195] The court concluded that because the participants in this federal insurance program have constructive knowledge of policy terms and are charged with the knowledge of the terms and conditions of the program, the plaintiff would not have been able to establish that he reasonably relied on the agent's representations.[196] Further, the structure of the National Flood Insurance Program precludes imputation of any claims against an agent to an insurance company. [197]

The court did note, however, that "to the extent that plaintiff intends to assert a state law claim for negligent misrepresentation by [the agent] in connection with procuring the flood insurance policy, then such a claim would not be preempted by federal law.[198]

V. BAD FAITH

In *Capstone Building Corporation v. American Motorists Insurance Company*,[199] the Supreme Court also resolved the certified question: "Can an insurer's bad faith conduct in investigating an insurance claim provide a basis for a cause of action under Connecticut law."[200] Construing the question

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193 *Id*.
194 *Id*. at *6-8.
195 *Id*. at *9.
196 *Id*. at *11, *13.
197 *Id*. at *12.
198 *Id*. at *13.
199 *Capstone Building Corporation*, 308 Conn. 760.
200 *Id*. at 793.

to refer solely to a bad faith in investigating the claim, as opposed to breaching the duties to defend or indemnify, and noting that a bad faith action under Connecticut law "must allege denial of the receipt of an express benefit under the policy," the court answered in the negative. More to the point "under the facts of the present case," the Court did not recognize a cause of action based solely on the insurer's failure to investigate, "because the insurance policy at issue provides that the decision of whether and how to investigate lies exclusively with the insurer."[201] However, the court also cautioned that:

> [A]n insurer's "failure to conduct an adequate investigation of a claim … when accompanied by other evidence, reflecting an improper motive, properly *may* be considered as evidence of … bad faith." …. Consequently, although not actionable separate from the bad faith denial of a substantive benefit, an insurer's investigation will often be key evidence in a bad faith cause of action.[202]

The court also cautioned that "[i]nsurers disclaiming their duty to defend or indemnify under the policy, subsequent to a failure to investigate, risk extracontractual liability for consequential economic and noneconomic losses," along with the risk of CUTPA and CUIPA liability for insurers with a "general business practice" of inadequate investigations.[203]

VI. SUBROGATION

In Fireman's *Fund Insurance Company v. TD Banknorth Insurance Agency, Inc.*,[204] the Supreme Court held that the "make whole" doctrine in subrogation is the default rule in under Connecticut law, but does not apply to insurance policy deductibles, on certification of the deductible question by

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[201] *Id*. at 794.

[202] *Id*. at 801 (quoting PSE Consulting, Inc. v. Frank Mercede & Sons, Inc., 267 Conn. 279, 310, 838 A.2d 135 (2004)(italics in original)).

[203] *Id*. at 801-02 (citing Connecticut Unfair Insurance Policies Act (CUIPA), General Statutes § 38a-815 *et seq*., and Connecticut Unfair Trade Practices Act (CUTPA), General Statutes § 42-110a *et seq*.).

[204] 309 Conn. 449, 72 A.3d 36 (2013).

the United States Court of Appeals for the Second Circuit.[205] Analyzing the question of first impression whether the make whole doctrine applies in Connecticut, the Supreme Court framed the issue by noting the potential inequitable result in a subrogation claim when the amount recovered by a subrogated insurance company from the responsible third party is insufficient to satisfy both the total loss sustained by the insured and the amount the insurance company paid on the claim, to which the make whole doctrine responds "by restricting the enforcement of an insurer's subrogation rights until after 'the insured has been fully compensated for her injuries, that is . . . made whole.'"[206] The court was persuaded the doctrine is "sound policy" because of the equitable principle that "'the burden of loss should rest on the party paid to assume the risk, and not on an inadequately compensated insured, who is the least able to shoulder the loss.'"[207] Reviewing the few cases and conflicting commentators addressing whether the make whole doctrine applies to deductibles along as well as otherwise uninsured loss,[208] the Supreme Court noted that a deductible "represents the level of risk that the insured has agreed to assume, ordinarily in exchange for a lower premium cost for the insurance policy."[209] It concluded that "the equitable considerations supporting the make whole doctrine are inapplicable to deductibles,"[210] noted that holding otherwise "would effectively disturb the contractual agreement…thereby creating a windfall for [the policyholder] for a loss that it did not see fit to insure against in the first instance when it contracted for lower premium payments in exchange for a deductible."

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[205] *See* Fireman's Fund Ins. Co. v. TD Banknorth Insurance Agency Inc., 644 F.3d 166 (2d Cir. 2011).

[206] 309 Conn. at 456-57 (quoting In re DeLucia, 261 B.R. 561, 567 (Bankr. D. Conn. 2001)).

[207] *Id*. at 457 (quoting 16 L. RUSS & T. SEGALLA, COUCH ON INSURANCE (3d Ed. 2005) § 223:136, pp. 223-152 through 223-153).

[208] *Id*. at 458-66.

[209] *Id*. at 466.

[210] *Id*. at 468-69.

VII. Conclusion

Taken together, these 2013 decisions reflect the Connecticut courts' careful attention to the particular policy language, facts, and common law or statutory framework of each case. The broad rules and precedents of insurance law may seem simple to seasoned practitioners, but the parade of procedural and factual permutations continues to challenge the bar and bench alike.