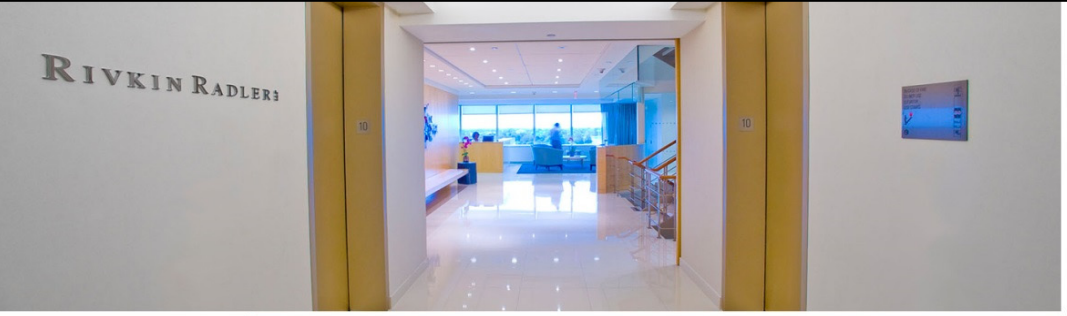

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Texas Supreme Court Advises on Incorporation of Payout Limits in Additional Insured Dispute

Disputes often arise over the extent of a party's obligation to provide insurance for another, and whether that obligation is capped at the minimum liability limit required by the parties' contract. Many times, this will affect whether an additional insured retains its status as an additional insured in excess policies written above the minimum required limits. This was the issue before the Texas Supreme Court.

Exxon hired Savage, an independent contractor, to perform work at its Baytown, Texas refinery. In the services agreement, Savage had to name Exxon as an additional insured under its commercial general liability policies at its "normal and customary" amount, or at least $2 million, whichever is greater. Savage bought primary, umbrella, and excess policies.

Two Savage employees were severely injured while working in the refinery. They settled with Exxon for $24 million. Savage's primary policy paid about $5 million toward the settlement. The umbrella insurers refused to pay because the services contract only obligated Savage to name Exxon as an additional insured up to the limits of the primary policy. They contended that Exxon was not an additional insured under their policies. Exxon paid the rest of the settlement sum and sued the umbrella insurers for reimbursement.

The dispute made its way up to the Texas Supreme Court. The court addressed whether the umbrella policies incorporated the payout limits in the services agreement. Texas law allows

extrinsic documents to be incorporated into an insurance policy where the policy clearly requires doing so. In such case, the court refers to those extrinsic documents, but only to the extent of the incorporation and no further.

The umbrella policies included as insureds those qualifying as additional insureds under the primary policy, "but not for broader coverage" than would be afforded by that policy. Thus, to determine who qualified as an insured under the umbrella policy, the court needed to look at the primary policies. The primary policy covered any person or organization to which Savage was obligated by contract or agreement to provide insurance.

Savage was required by the services contract to name Exxon as an additional insured, but the issue ultimately turned on the meaning of the phrase "broader coverage." The intermediate appellate court interpreted this to mean the payout limits of the services agreement. But the Texas Supreme Court said that was wrong.

It explained that "broader" in this sense meant the type of coverage, not the amount. Exxon sought the same coverage as the primary policy, but at the umbrella policy's higher limits. The umbrella policy said nothing about the services agreement's payout limits. And even if it did, there was no limit in it that the umbrella policy could adopt. The services agreement provided for a minimum amount of insurance, not a maximum. Whether Savage had to buy as much insurance as it did was beside the point. What mattered, the court said, is that it did buy that insurance.

Interpreting "broader coverage" to refer to payout limits, the court explained, "would give the umbrella policy a self-defeating meaning, as an umbrella policy springs into action only when the primary policy is exhausted. We could embrace such a result only if the language the parties used clearly required it. But no such language exists here…." The court noted that umbrella

policies are commonly understood to provide greater limits for the risks already covered by the primary policies.

Thus, the court held that Exxon qualified as an insured under the umbrella policies. If an umbrella insurer would like to cap additional insured coverage at the amount of the minimum limits required by the parties' contract, it must say so expressly.

The case is *ExxonMobil Corp. v. Nat'l Union Fire Ins. Co.*, No. 21-0936 (Tex. Apr. 14, 2023).

Ohio Appellate Court Upholds Criminal Acts Exclusion in Suit against Physician for Fatal Opioid Prescription

A woman overdosed on opioids prescribed by her physician. The physician was criminally prosecuted and found guilty on 187 counts, including involuntary manslaughter and unauthorized writing of prescriptions for a controlled substance other than for a legitimate medical purpose.

The woman's husband sued the physician for medical malpractice and wrongful death. The physician sought coverage under his professional liability policy, but the insurer denied coverage, citing the criminal acts exclusion. That exclusion barred coverage for "[a]ny liability resulting from any criminal or fraudulent act by the Insured."

The trial court upheld the denial, finding that the criminal conviction was conclusive proof of his civil liability arising from a criminal or fraudulent act. The physician appealed, arguing that the exclusion was vague and that it was against public policy to deny coverage for liability resulting from the negligent practice of medicine.

The Ohio Court of Appeals disagreed with the physician.

It found that the exclusion was clear and applied to any liability resulting from the insured's criminal or fraudulent acts. The physician was convicted of selling oxycodone and fentanyl

through prescriptions for other than a legitimate medical purpose. The court rejected the physician's argument that he was practicing medicine. The conviction was conclusive proof that the prescription was not for any legitimate medical purpose and operated as an estoppel in a later civil action.

The court rejected the physician's public policy argument for similar reasons. The denial of coverage was not because of negligent medical care. It was for trafficking opioids, a criminal act serving no legitimate medical purpose.

The case *Blundell v. Lazzerini,* No. 2022 CA 00115 (Ohio Ct. App. Apr. 20, 2023).

6th Circuit: No Coverage for Medicare Fraud Claims Not Disclosed in Policy Application

In November 2016, a false claim *qui tam* action was filed under seal against SHH Holdings, LLC. The action alleged that SHH violated the False Claims Act by providing unreasonable and unnecessary medical services to claim the highest possible Medicare reimbursement. The action also alleged that whistleblowers were retaliated against. In January 2017, SHH learned it was the subject of an investigation by the Department of Justice.

In April 2019, SHH applied for D&O coverage from Allied World Specialty Insurance Co. The application included several questions about pending matters, including any "inquiries, investigations, administrative charges, and lawsuits" within the prior three years against "any Subsidiary, any Executive or other entity proposed for any coverage." SHH did not disclose the Medicare fraud claim. SHH ultimately obtained a claims-first made policy. The policy had an "application exclusion," which excluded from coverage any matters covered by the application's "pending matters" questions.

In August 2019, the *qui tam* action was partially unsealed and SHH received a copy of the complaint. Before the unsealing, SHH had been negotiating with the government and had reached a settlement in principle about its claims-submission practices.

SHH notified Allied World of the *qui tam* action and sought to recover its legal costs in defending against the retaliation allegations. Allied World denied coverage, citing the pending matters questions in the insurance application and the application exclusion. SHH sued Allied World in federal court. It argued the questions in the application were ambiguous and suggested that the application required disclosure only of inquiries or investigations relevant to the liability sought. The district court agreed and awarded summary judgment to SHH.

The Sixth Circuit reversed. Applying Ohio law, the court found no ambiguity. The court rejected SHH's argument that the phrase "proposed for any coverage" modified "inquiries, investigations, administrative charges, and lawsuits," noting that a qualifying phrase is ordinally read to qualify the phrase that it immediately follows. And even if the application language were ambiguous in some context, the court found it was not ambiguous when applied to the facts here. Requiring broad disclosure makes sense here, the court noted, because pending matters are relevant to an insurer's assessment of its potential underwriting risk.

The court also held that the "pending matters" questions included the retaliation allegations because one question asked SHH to identify matters that "could give rise to a claim."

For these reasons, the court reversed and entered summary judgment for the insurer.

The case is *SHH Holdings, LLC v. Allied World Specialty Ins. Co.*, No. 22-3283 (6th Cir. Apr. 21, 2023).

Montana Federal Court Rescinds Policy Based on Insured's Misrepresentations

Dual Trucking and Transport, LLC engaged in trucking operations at a site in Bainville, Montana. Dual had a pollution policy with Endurance American Specialty Insurance Co. As part of the application process for that policy, Dual represented that its operations were "100% trucking." Dual's application failed to mention its on-site treatment and waste processing operations. Dual was sued by Montana regulators for contamination and failure to obtain a permit. Endurance defended Dual in the underlying matters under a reservation of rights. Endurance filed a declaratory judgment action.

The federal court, applying Louisiana law, rescinded the policy because of Dual's material misstatements.

Rescission aside, the court found that two exclusions would bar coverage in any event. The first was the policy's off-site waste transport exclusion. That exclusion applied to "sites at which an insured has performed any contracting or site remediation services." The court rejected Dual's argument that it never engaged in contracting or site remediation services at the site. The court held that Dual's trucking of waste from the contracting site to the Bainville site was off-site waste transport under the policy.

The second exclusion was for "owned or occupied property." The exclusion barred coverage for "any property damage to any real or personal property that was owned in whole or in part, or was rented, occupied or in the care, custody or control of any insured at any time." Louisiana law applies the owned property exclusion where there is "on-site contamination with no impact to groundwater." This issue, the court observed, was resolved by the underlying

proceedings, which found that Dual occupied and controlled the Bainville site during the relevant time and that there was no evidence of off-site property damage.

For these reasons, the court granted Endurance's motion for summary judgment. The case is *Endurance Am. Specialty Ins. Co. v. Trucking*, 18-CV-134 (D.C. Mont. Mar. 23, 2023).

The Word "Any" Sinks Condo Association's Coverage Claim Over Pool Worker's Injury, New Jersey Federal Judge Finds

A condominium association retained Preferred Pool Management, Inc. (PPM) to maintain its swimming pool. In the pool maintenance contract, PPM agreed to add the condo association as an additional insured.

PPM had bought a primary general liability policy from Indian Harbor and an excess policy from Scottsdale. The Indian Harbor policy had a blanket additional insured endorsement that covered parties with whom PPM agreed in writing to add as additional insureds. The Scottsdale policy automatically included additional insureds covered by the primary policy. But the Scottdale policy also had an "Injury to Worker" exclusion. It excluded injury to "an employee … of any insured … if such injury arises out of and in the course of their employment."

PPM's employee, Visconti, was injured while performing maintenance on the pool. He fell walking up wooden steps while carrying a heavy bucket. He sued the condo association and the condo association sought coverage under PPM's primary and excess policies. The insurers denied coverage and the condo association sued.

Scottsdale moved for summary judgment, citing the "Injury to Worker" exclusion. The court found that even though Visconti worked for PPM, and not the condo association, the exclusion "plainly" applied. The exclusion applied to an employee of "any" insured if such injury

arose out of and in the course of their employment. The complaint alleged that Visconti was injured in the course of his pool maintenance work for PPM, and PPM was an insured under the policy. The court found no public policy reason for not enforcing the exclusion.

The case is *Harmon Cove IV Condo Ass'n, Inc. v. Indian Harbor Ins. Co.,* No. 22-5790 (SDW) (JRA) (D.N.J. Apr. 25, 2023).