APPLIED SPECIALTY UNDERWRITERS

CASUALTY SPOTLIGHT™

JANUARY 2023, VOLUME 8

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ALABAMA

Seventeen Month Delay in Providing Notice of Occurrence to Insurer Deemed Late as a Matter of Law

In *Nationwide Property & Casualty Insurance Company v. Adams, et. al.,* 2022 U.S. Dist. LEXIS 210483 (N.D. Ala. November 21, 2022), a worker (Alexander) fell off a ladder while performing a job for Apple Signs Company ("Apple Signs"). Apple Signs was owned by Chris and Angela Adams ("Adams"). Alexander missed three weeks of work because of his injuries. Adams paid Alexander's medical expenses as a result of the accident. *Id*. at 1-2.

Nationwide Property & Casualty Insurance Company ("Nationwide") issued a CGL policy to Apple Signs for the relevant period. Seventeen months after the accident, Alexander sued Apple Signs to recover certain expenses. Apple Signs tendered the claim to Nationwide, which immediately filed a declaratory judgment action seeking a ruling it owed Apple Signs no defense or indemnity. It was undisputed that Nationwide's first notice of the accident was the tender of the underlying lawsuit. *Id*. at 2-3.

Nationwide moved for summary judgment on the grounds that (1) the policy included an exclusion barring coverage for injuries to employees; and (2) Apple Signs violated the conditions of the policy by waiting 17 months before providing notice of the occurrence. *Id*. at 4-5.

The Nationwide policy required that Apple Signs provide notice of an occurrence "as soon as practicable." The policy did not define "as soon as practicable", which the Alabama Supreme Court previously interpreted to mean "within a reasonable time under all of the circumstances." Adams argued he acted "reasonably" in delaying notice to Nationwide because Alexander returned to work (presumably meaning there was no reason to expect Apple Signs would be sued). *Id*. at 5, 8 (citing *Nationwide Mut. Fire Ins. Co. v. Estate of Files,* 10 So.3d 533, 535 ((Ala. 2008)).

In ruling for Nationwide, the district court focused entirely on the notice issue, inclusive of a review of other parts of the insurance policy:

> The court finds that notice after 17 months is not timely under the policy. Again, Nationwide's policy never defines "as soon as practicable" in specific terms. But other parts of the agreement are instructive. In a section describing medical payment coverage for bodily injury, the policy states: "We will pay medical expenses... for 'bodily injury' caused by an accident ... because of your operations; provided that... "the expenses are incurred and reported to us within one year of the date of the accident." This portion of the policy strongly suggests that failing to notify Nationwide of an accident within one year will terminate Nationwide's duty to pay medical expenses. Seventeen months exceeds one year, so the policy's text suggests Apple Signs' notice was untimely. *Adams*, supra. at 6-7.

Past the language of the policy, the court could not accept the insured's justification for delay in light of the circumstances surrounding the accident:

> Alabama law permits untimely notice if "acting as a reasonably prudent person, [Adams] believed that he was not liable for the accident." Chris Adams argues that his delay was justified because he "didn't think there was a need [to notify Nationwide] because [Alexander] was back to work." But Adams had to know that Alexander suffered costly injuries for two reasons: (1) Alexander's injuries caused him to miss three weeks of work; and (2) Adams was paying Alexander's medical expenses. And Adams had to know that Apple Signs was potentially liable for the costs of Alexander's injuries because Adams knew that Alexander fell off an Apple Signs' ladder while working on a job for Apple Signs. After all, Adams paid some of the bills. So, no reasonable juror could find that Adams reasonably believed he and/or Apple Signs had no potential liability. *Id.* at 8 (citations omitted).

The *Adams* decision is a curious one. First, if Alexander was an Apple Signs' employee (thus subject to the employee exclusion), one wonders why the court felt compelled to examine the inherently subjective question of "reasonable" notice. Second, one also wonders if Adams could have presented a better argument for a "justified delay" (such as a reasonable belief Alexander had fully recovered and/or that all of his bills were paid). Ultimately, the biggest takeaway from Adams is that Alabama remains among the minority of states that does not require an insurer to prove prejudice to prevail on late notice.

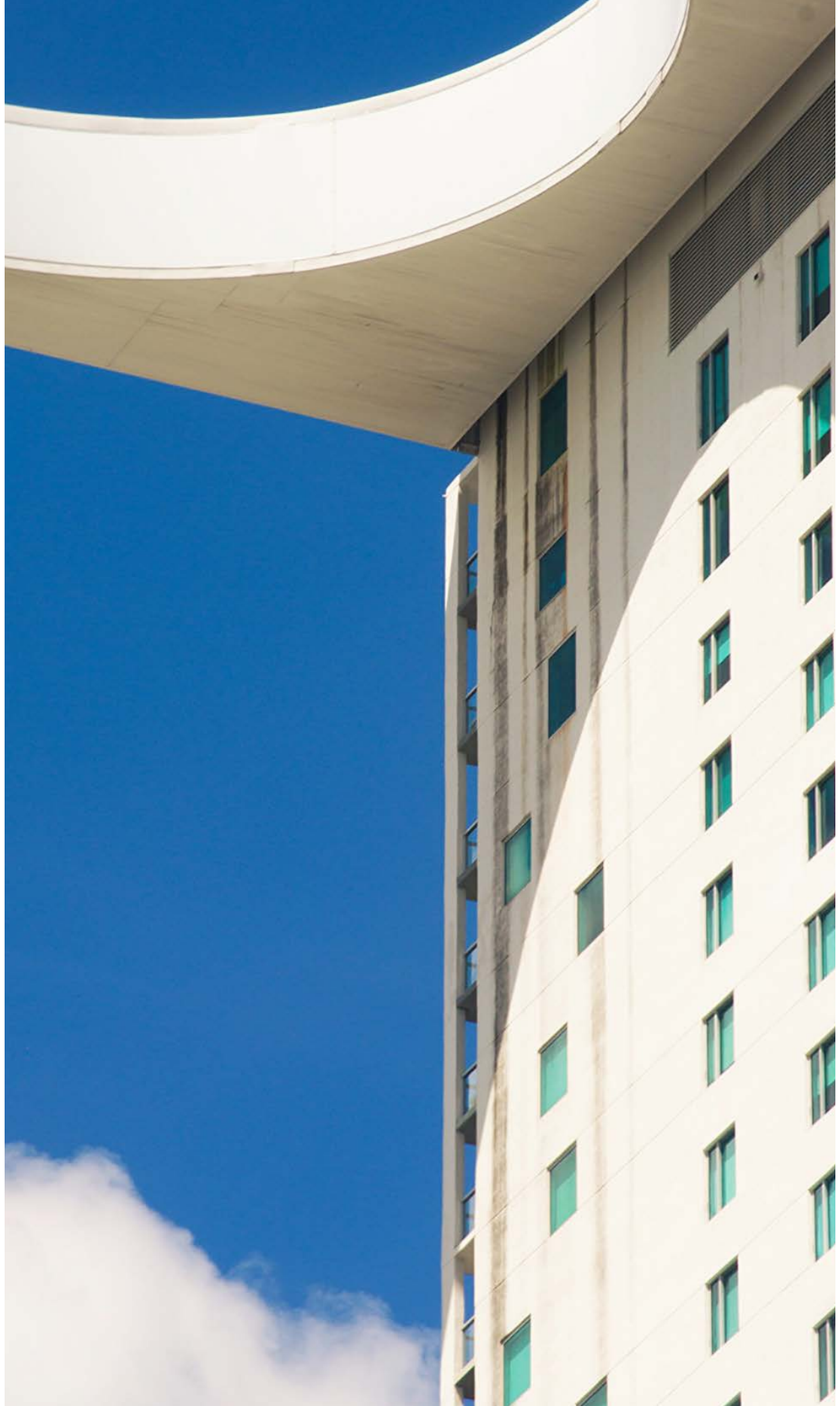
FLORIDA

Insurer Not Required to Prove Policyholder "Irrefutably" Knew of Property Damage Prior to Policy Period to Eliminate Duty to Defend

In *United Specialty Ins. Co. v. Jockey Club Condo Apartments, Inc.*, 2022 U.S. Dist. 216745 (S.D. Fla. December 1, 2022) the Jockey Club Condominium Apartments, Inc. ("Jockey Club") operated a condominium and leased apartment complex in Miami, Florida. Christopher Brumder owned several condominium units at the property. In March of 2020, Brumder filed a lawsuit against Jockey Club alleging it was responsible for water damage to several units owned by Brumder. Brumder's case was consolidated with an action Jockey Club had filed against Brumder on related issues in November 2019. *Id*. at 1-2.

United Specialty Insurance Company ("USIC") issued a general liability policy to Jockey Club for the period February 15, 2020 to February 15, 2021. It received notice of Brumder's claims against Jockey Club in April 2020. USIC defended Jockey Club pursuant to a reservation of rights, but filed a declaration judgment action seeking a ruling it owed no obligations to Jockey Club under its CGL policy. *Id*. at 2-3.

USIC sought summary judgment on the duty to defend by asserting Jockey Club allegedly knew about water damage in Brumder's units prior to the inception of its policy. Specifically, Brumder's operative (amended) pleading alleged, starting in April 2019, that he "repeatedly" informed Jockey Club about water damage in his units for which Jockey Club was responsible. Jockey Club argued USIC could only end its duty to defend by "irrefutably establishing" that Jockey Club had knowledge of the property damage prior to its policy period. *Id*. at 3, 5.

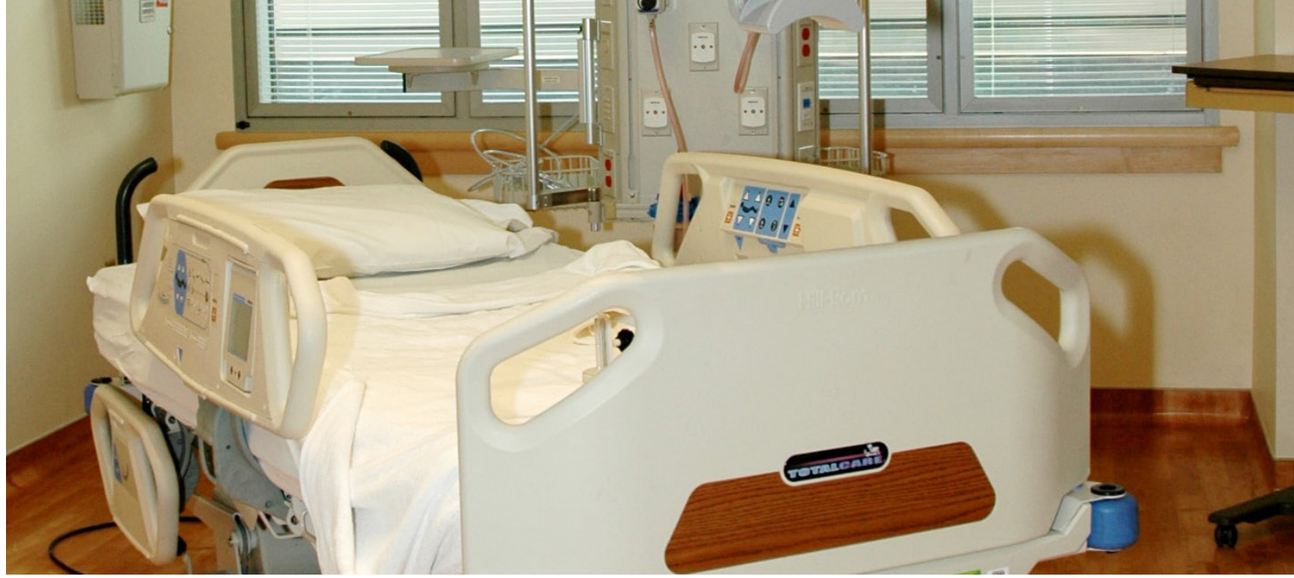


The court began its analysis by reciting general principles of Florida insurance law speaking to (1) a party not being able to insure a loss it knows has already occurred; and (2) an insurer's duty to defend being determined solely by reviewing the allegations in the underlying complaint. In forcefully ruling for USIC, the court noted how Jockey Club had no credible answers when applying the law to the facts at issue:

> Applying these foundational principles to this case, Jockey Club's opposition fails to make it out of the gate.
>
> First, Jockey Club's refusal to apply the facts Brumder alleges in his complaint to the duty-to-defend analysis finds no legal support, nor does Jockey Club's contention that United must establish its prior knowledge of Brumder's claims as "undisputed fact." Next, Jockey Club does not deny that its prior knowledge of the damage, as alleged in Brumder's underlying pleading, would exclude coverage under Florida law. Furthermore, it is not even necessary in this case to read fortuity and known-loss principles into the policy here as the policy itself explicitly restricts coverage for property damage "only if" no insured knew that the damage had occurred, in whole or in part, prior to the policy's inception. Jockey Club also does not dispute that this language excludes coverage for known losses.
>
> There is no dispute here that (1) the facts set forth in the underlying pleading

allege Jockey Club's knowledge of the damages at issue, prior to the inception of the policy; and (2) prior knowledge of the damages precludes coverage under Florida law and the terms of the policy. Accordingly, United is entitled to summary judgment. As such, the Court concludes that the policy at issue in this case does not obligate United to defend or indemnify Jockey Club against Brumder's claims in the underlying lawsuit. *Id*. at 5-8 (citing *Nourachi v. First American Title Ins. Co.*, 44 So.2d 602 (Fla. 5th DCA 2010) and Princeton Excess & Surplus Lines Ins. Co. v. Hub City Enterprises, Inc., 808 F. App'x. 705 (11th Cir. 2020).

The obvious conclusion in *Jockey Club* begs the question of why litigation was necessary in the first place. One can presume Brumder's "older" pleadings did not allege Jockey Club knew of the water damage prior to the policy period because USIC defended its insured for a year before seeking a declaratory judgment. *Jockey Club* highlights the caution insurers often exhibit in detangling themselves from what becomes an uncovered claim.



MINNESOTA

Defective Design and Manufacture of Product is a Single Occurrence for Purpose of Applying "Per Occurrence" Deductible

In *Federal Insurance Company v. 3M Corporation*, 2022 U.S. Dist. LEXIS 212230 (Dist. Minn. November 23, 2022), 3M was the defendant in more than 5000 product liability lawsuits arising from the defective design and manufacture of the Bair Hugger Patient Warming System (designed to manage patient temperature during surgery). The cases were centralized for pretrial proceedings in multidistrict litigation ("MDL") in the District of Minnesota. *Id*. at 1.

Federal Insurance Company ("Federal") issued insurance policies to Arizant Healthcare ("Arizant"), which designed and manufactured the Bair Hugger from 2003 to 2010. 3M acquired Arizant in 2010 and became the successor in interest to Arizant's policies. Approximately 20 percent of the MDL claims alleged a bodily injury that occurred during surgeries conducted between 2003 and 2010. *Id*. at 3-5.

Each of the Federal policies between 2003 and 2008 included a "per occurrence" deductible, which was defined as follows:

> Per Occurrence Basis – the deductible amount applies to all damages, defense costs, and other Supplementary Payments because of:
>
> - All bodily injury or property damage as the result of any one occurrence, regardless of the number of persons or organizations who sustain damages because of that occurrence.

Each policy defines an "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The 2008 to 2010 polices included a "per event" deductible, which was defined as "an occurrence, offense, wrongful act or other cause of loss as described in the applicable coverage." Federal agreed there was no substantive difference between the two deductibles. *Id*. at 5-7.

Federal filed a declaratory judgment action against 3M seeking various rulings on cover-

age, including (1) 3M must satisfy a separate deductible for each injury; and (2) defense costs must be apportioned based upon the proportion of cases that Federal's policies cover. On a cross motion for summary judgment, 3M argued (1) it need only satisfy a single deductible amount per policy period; and (2) Federal was liable for the full costs of the MDL defense. *Id*. at 2.

In addressing the deductible issue, the district court methodically reviewed Minnesota law on the issue and concluded the "cause test" was the appropriate vehicle through which to determine the number of occurrences:

> Although courts applying Minnesota law have not wholesale adopted a "cause test" to be blindly applied when construing "occurrence", it has been applied at least where the damages are continuous and repetitive in nature. While the "cause test" is not applicable in every case, "occurrence" and "injury are not the same under Minnesota law, even when the injury is more discrete than chemical discharge…
>
> In *H.B. Fuller*, the Court found that there was a single occurrence because "Fuller's manufacture of asbestos-containing products is the same kind of singular, continuous, and repetitive cause as chemical discharge. This was so because the manufacture "was based on the same formulas at each of the approximately nine plants where it was performed" and so the manufacturing process was the ultimate cause and occurrence…
>
> The court remains convinced that *H.B. Fuller* accurately predicted how the Minnesota Supreme Court would have resolved the case. And it remains convinced of its vitality today. First, neither the Minnesota Supreme Court nor the Eight Circuit has reached an inconsistent result. Second, as the Minnesota Supreme Court has held and Federal does not challenge, continuous events can merge into one continuing occurrence even when it causes discrete injuries later. *Id*. at 16-17 (citing *H.B. Fuller Co. v. U.S. Fire Ins. Co.*, 2012 WL 12894484 (D. Minn. March 2, 2012).

While noting the application of the "cause test" can prove difficult from case to case, the district court held 3M need only satisfy a single deductible per policy period. Specifically, the court focused on (1) the allegations against 3M; and (2) the circumstances surrounding the manufacturing of the product itself:

> [T]he court finds its reasoning in *H.B. Fuller* applicable here. The facts of *H.B. Fuller* and here are sufficiently analogous for two reasons. First, the policy definitions (i.e. an "occurrence") are very similar…Second, the underlying circumstances are similar. In *H.B. Fuller*, the manufacturer produced a product that did not cause injury with every use, nor did it cause immediate injury but only did so in certain circumstances. So too here: the Bair Hugger does not cause immediate injury or do so with every use but only in some circumstances. In both cases, the underlying claims were predicated on the manufacturers design and production of the products. It is thus irrelevant if they were manufactured at different times and in different places. Here, and in *H.B. Fuller*, there is no allegation that there was a meaningful difference in the manufacturer's activities or the causes of harm…
>
> Second, although Federal contends "occurrence"/"each event" should be interpreted to mean individual injuries from the individual surgeries, in the underlying actions against 3M, the claims are based not on whether some Bair Hugger devices were defective, but rather that all Bair Huggers were defective in their design and manufacture. Therefore, the alleged "occurrence" in the MDL cases is not each individual exposure during surgery. *3M*, supra at 20-23 (further citations omitted).

Secondarily, the court agreed with Federal that is was only obligated to pay the portion of defense costs associated with those actions alleging bodily injury during its policy periods – not the MDL litigation as a whole. Where the multi-district litigation statute speaks to the coordination or consolidation of separate actions, "the law treats the individual cases in an MDL as distinct:"

> In view of the Policies' language and how the MDL statute and courts handle MDLs and their constituent cases, the Policies' defense duty language is reasonably susceptible to only one meaning which does not require Federal to pay the full cost of the MDL….Minnesota law requires defense of all claims within a case to which a defense duty attaches but it does not require defense of a case in which a defense duty does not attach to any part of any claim even if the case is related to one the insurer has a duty to defend. *Id*. at 30-31 (citing 28 U.S.C. §1407 (a)) (further citations omitted).

While Federal made all of the arguments one would expect of an insurer under these circumstances, the outcome in *3M* was largely predictable. Insurers generally struggle under a "cause test" in a products liability setting and the allegations in the underlying cases (defective design and manufacture) fell neatly within the precedent relied upon by the court.

NEW YORK

"Use" of Contaminated Equipment During Performance of Cosmetic Pedicure Triggered Application of Professional Liability Exclusion

In *Walker v. Erie Ins. Co.*, 2022 N.Y. App. Div. LEXIS 6253 (N.Y. App. 4th Div. November 10, 2022), the underlying plaintiff ("plaintiff") contracted a bacterial (MRSA) infection during a pedicure performed at the insured's nail salon in New York City. She sued the insured alleging its negligence caused her injuries. The insured tendered the lawsuit to its general liability insurer, Erie Insurance Company ("Erie"). Erie disclaimed coverage on

the basis that a professional liability exclusion barred coverage for the claim. *Id*. at 1-2.

Plaintiff obtained a judgment against the insured and thereafter filed an action against Erie seeking recovery under New York Insurance Law §3420. Erie sought to dismiss the action on the grounds that the professional liability exclusion within its policy barred coverage. The exclusion, in relevant part, stated, that the insured's policy "does not apply to 'bodily injury'…due to …[t]he rendering of or failure to render cosmetic…services or treatments." The trial court denied Erie's motion on the pleadings, while also denying plaintiff's motion for summary judgment. Both parties appealed. *Id*. at 2.

Plaintiff asserted that the professional services exclusion only bars "injuries due to the *manner* in which the cosmetic service was performed", which would not include the preparatory tasks undertaken before a customer arrives for treatment (i.e. cleaning the equipment). While recognizing the burden was on Erie to prove the exclusion applied, the court (1) rejected the plaintiff's narrow interpretation of the exclusion; and (2) found it squarely applied to the allegations included in plaintiff's own complaint:

> Nowhere does the exclusion limit its reach to "the manner" of performance, which, under plaintiff's view, means only those precise physical acts undertaken contemporaneous with the cosmetic service upon the customer's person, but does not include any tasks taken in the preparation for the service. Rather, as our analysis of the exclusion language makes clear, the policy excludes coverage for injuries caused by the performance of acts that constitute part of the pedicure service. …
>
> We conclude that defendant's submissions established that the exclusion applies to the facts here because the bodily injury (MRSA infection) was due to (caused by) the rendering (the performance) of a cosmetic service and treatment (the professional pedicure) with the unsanitary pedicure equipment and materials. As is clear from the allegations of negligence for which the insured was found liable, plaintiff's injury was not caused by the insured's mere failure to sanitize the pedicure equipment – i.e. plaintiff was not simply infected by her presence among unsanitary instruments at the nail salon – but rather was caused by the insured's ***use*** of that contaminated equipment while performing the professional pedicure on plaintiff's feet and toenails. We have considered the plaintiff's contentions seeking to classify the insured's culpable conduct as ordinary negligence in maintaining the premises that is distinct from the rendering of a professional pedicure and conclude that those contentions lack merit. *Id*. at 6-7, 10-11 (emphasis added).

While the appellate court denied plaintiff's appeal and agreed the exclusion applied to the plaintiff's injuries, it denied Erie's appeal because it had not offered sufficient proof the insured had notice of the exclusion (a requirement to be able to rely upon an exclusion pursuant to §3420). Erie submitted a certified copy of the policy to the trial court, but that (by itself) did not establish that policy was actually mailed to the insured. *Id*. at 13-14.

The *Walker* court's decision is sound, in that it refused to parse the professional services exclusion in a "manner" as to render it meaningless. Injury resulting from a pedicure was exactly what the GL policy intended to exclude. The decision also cautions any insurer relying upon an exclusion to make sure it can offer proof of notice of the exclusion to the insured.

PENNSYLVANIA

Insurer with Unambiguous Policy Exclusion Denied Judgment on Pleadings Where Insured Pled It Held "Reasonable Expectation" of Coverage

In *Atain Ins. Co. v. V2Props.*, LLC, 2022 U.S. Dist. LEXIS 199265 (E.D. Pa. November 2, 2022), the insured, V2 Props, LLC ("V2"), was the general contractor on a construction project in Philadelphia, Pennsylvania. On April 12, 2019, a worker measuring siding while standing on a scaffold suffered a head injury and died. The worker's family filed suit against V2 alleging it was responsible for the control and safety of the site and that its negligence caused the worker's death. Plaintiffs alleged the decedent was a "business invitee" and "construction worker" performing work on the project at the time he was injured. *Id*. at 2.

Atain Insurance Company ("Atain") issued a general liability policy to V2 in effect at the time of the accident. V2 tendered the lawsuit to Atain for defense and indemnity, to which Atain responded by declining coverage. Specifically, Atain relied upon the Employer's Liability Exclusion within its policy, which (in relevant part) stated as follows:

> This insurance does not apply to:
>
> e. Employer's Liability
>
> 1. "bodily injury" to an "employee," subcontractor, employee of ***any*** subcontractor, "independent contractor", employee of ***any*** "independent contractor", "temporary worker", "leased worker", "volunteer worker" of any insured or ***any*** person performing work or services for any insured arising out of and in the course of employment by or service to any insured for which any insured may be held liable as an employer or in any other capacity; *Id*. at 8 (emphasis added).

Atain's disclaimer noted that the decedent fell under "one or more of the several types of workers identified in the Employer's Liability Exclusion." Atain thereafter filed a declaratory judgment action seeking a ruling it owed no defense or indemnity for the subject claim. In answering Atain's complaint, V2 filed an affirmative defense asserting that "the policy at issue does not reflect the reasonable expectations of the insured and the policy should be reformed to meet those reasonable expectations." *Id*. at 3-4.

V2 opposed Atain's motion for judgment on the pleadings by arguing the exclusion was ambiguous. Specifically, V2 asserted it was unclear if it applied only to injury sustained by direct employees of V2, which was "more compatible with common law notions of legal liability in this context." The court rejected this argument as contrary to the language governing coverage:

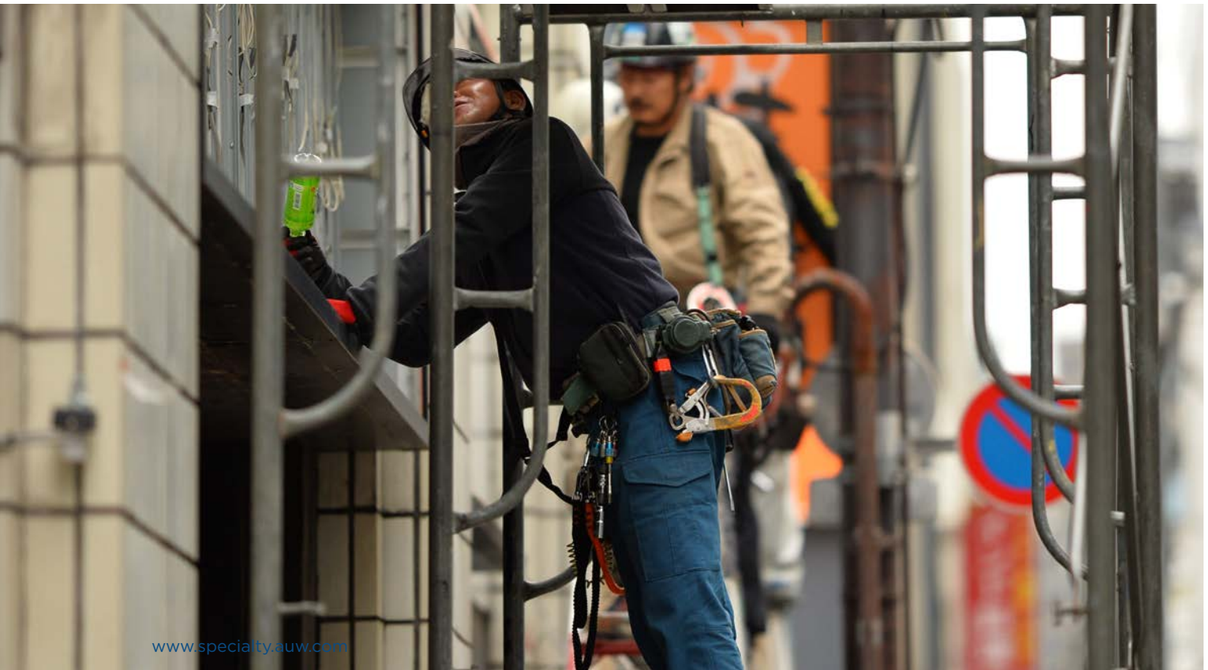
> [I]n making these arguments, V2 does not point to any actual textual ambiguity in the Employers Liability Exclusion that could affect its coverage here. Indeed, as applied here, there is nothing ambiguous in the language of the exclusion, which provided that there is no coverage for bodily injury to an "employee', subcontractor, employee of a subcontractor, ' independent contractor', employee of any 'independent contractor'... or any person performing work or services for any insured arising out of and in the course of employment by or service to any insured for which ay insured may be held liable as an employer or in any other capacity." While V2 apparently argues that the language does not comport with its reasonable expectations regarding coverage, "generally courts cannot invoke the reasonable expectations doctrine to create an ambiguity where the policy itself is unambiguous." Accordingly, we have no basis on which to conclude that the Employer's Liability Exclusion is ambiguous as applied to V2's claim." *Id*. at 10-11 (citing *Malcon Diamond v. Penn Nat'l Ins. Co.*, 815 A.2d 1109, 1114 (Pa. Super. Ct. 2003).

V2 then asserted that it held a reasonable expectation it would be covered for injuries to workers that are not its employees and, therefore, the court should reform the policy to meet this expectation. While Pennsylvania law provides that courts are to look at the reasonable expectations of the insured when considering coverage, (1) "in most cases, the language of the insurance policy will provide the best indication of the content of the parties' reasonable expectations"; and (2) a court must (nonetheless) examine the "totality of the insurance transaction involved to ascertain the reasonable expectations of the insured." *V2Props*, supra. at 12 (citing *Humans & Res. LLC, v. Firstline Nat'l Ins. Co.*, 512 F. Supp. 3d 588, 603 (E.D. Pa. 2021).

Atain argued it was entitled to a judgment on the pleadings regardless of V2's representation, given (1) V2 was a commercial insured; (2) V2 presented no evidence Atain engaged in any deceptive conduct; and (3) V2 was represented by a broker in placing such coverage. While the court noted the doctrine was available even to what would be considered a sophisticated insured, the court denied Atain's motion on procedural grounds:

While it does appear that V2 was represented by a broker because V2 states as much in its Motion to Dismiss or Stay this action, this fact is not established by the limited document that we may consider in connection with Atain's Motion. Moreover, Atain's argument that V2 has not alleged sufficient facts to support its affirmative defense is unpersuasive when "an affirmative defense need not be plausible to survive; it must merely provide fair notice of the issue involved." This is because "[p]roviding knowledge that the issue exists, not precisely how the issue is implicated under the facts of a given case, is the purpose of requiring averments of affirmative defenses." ...Under all of these circumstances, and in light of our obligations to draw all inference in favor of V2 and to "examine the totality of the insurance transaction involve to ascertain the reasonable expectations of the insured," we will not summarily reject V2's reasonable expectations defense on the limited record before us. Rather, we conclude that the question of whether the reasonable expectations doctrine applies in this case should be resolved on a full factual record. *Id*. at 15-16 (citations omitted).

V2 Props presents a harsh and unnecessary application of the "reasonable expectations" doctrine. Any insured facing a disclaimer may claim it held a "reasonable expectation" of coverage. That, by itself, should not be allowed to force discovery in a declaratory judgment action. Here, V2 was a commercial insured that, by its own admission, was represented by a broker in placing insurance. While Atain should obtain summary judgment after discovery is complete, the time and expense associated with this exercise appears wasteful.



TEXAS

Excess Insurer Did Not Clearly and Unambiguously Exclude Coverage for Defense Costs in "Follow Form" Excess Policy

In *Ohio Casualty Ins. Co. v. Patterson-Uti Energy, Inc., et al.*, 2022 Tex. App. LEXIS 8578 (Tex. App. 14th Dist. November 22, 2022), Ohio Casualty Insurance Company ("Ohio Casualty") issued a third-layer "follow form" excess policy to Patterson-Uti, Inc. and related entities (collectively "Patterson"). Ohio Casualty's policy included no duty to defend. *Id*. at 1-2, 15.

Patterson was sued for personal injury/negligence which resulted in a large settlement that triggered coverage under the primary policy and multiple excess policies. Patterson made a claim against Ohio Casualty' to recover damages awarded against it, as well as defense costs. Ohio Casualty funded its portion of the settlement, but refused to reimburse Patterson for any portion of defense costs. *Id*. at 3.

The primary policy was issued by Liberty Mutual Insurance Europe ("Liberty"), which provided coverage for "ultimate net loss," defined to include:

> the amount the "Insured" is obligated to pay, by judgement or settlement, as damages resulting from an "Occurrence" to which this Policy applies, including the services of suit, institution of arbitration proceedings, and all "Defense Expenses" in respect of such "Occurrence."

"Defense expenses" was defined to mean:

> Investigation, adjustment, appraisal, defense and appeal costs and expenses and re and post judgment interested, paid or incurred by or on behalf of the 'Insured." *Id*. at 8-9.

The Ohio Casualty policy included a "following form" provision which provided that it "follows the 'first underlying insurance' '[e]xcept for the terms, conditions, definitions and exclusions of this policy." The Ohio Casualty policy states it will pay the amount of "loss" covered by the

policy, where "loss" is defined as:

> Those sums actually paid in the settlement of satisfaction of a claim which you are legally obligated to pay as damages after making proper deductions for all recoveries and salvage. *Id*. at 11.

Ohio Casualty argued its definition of "loss" superseded Liberty's definition of "ultimate net loss" and limited its obligation to a common and ordinary meaning of "damages." Patterson filed a declaration judgment action seeking a ruling that defense costs were covered by the Ohio Casualty policy. On competing motions for summary judgment, the trial court determined Ohio Casualty's policy did not "clearly and unambiguously" exclude covered defense costs and granted Patterson's motion. Ohio Casualty appealed. *Id*. at 3-4.

On appeal, the court focused on what was and (more importantly) what was not in the Ohio Casualty policy:

> [T]he excess policy contains no definition of damages. Because the excess policy contains no independent definition of damages or disavowal of the definitions in the primary policy, we look to the primary policy to determine if there is an applicable definition or scope for "damage" that is followed by the excess policy. The primary policy does not use "damages" as a defined term but in the definition of "ultimate net loss" explains that the damages covered by the policy include "the service of suit, institution of arbitration proceedings and all 'Defense Expense" in respect of such "Occurrence." *Id.* at 11-12.

In affirming the trial court's ruling, the court of appeals determined it would not substitute any "ordinary" meaning of "damages" for that included in "first underlying insurance" to which Ohio Casualty followed form:

> Ohio Casualty argues the term "damages" should be understood using its ordinary meaning and that the commonly accepted meaning does not include attorney's fees or litigation expenses. However, while courts generally do give words and phrases in insurance policies their ordinary and accepted meaning unless otherwise defined in the policy, Ohio Casualty offers little explanation of why this court should look to the ordinary meaning of "damages" when the primary policy, which the excess policy follows, already defines the scope and meaning of damages...
>
> Ohio Casualty further argues it was not required to exclude coverage of defense expenses because the policy never provided any coverage of defense expenses. However, this argument requires acceptance of Ohio Casualty's premise that the definition of "loss" implicitly deleted and superseded the definition of "ultimate net loss" and scope of damages covered by the primary policy. However, we find no support in the excess policy for Ohio Casualty's argument. The excess policy specifically states that it will "follow" the primary policy and provide the same coverage as in the primary policy, unless excluded or specifically conditioned in the excess policy. There is no language in the excess policy, let alone clear and unambiguous language, excluding defense costs from coverage under the excess policy. We are also troubled by the public-policy ramifications of accepting Ohio Casualty's argument as it could conceivably could open the door for vague language in excess policies to implicitly diverge from primary policies in "follow form" excess policies with far-reaching financial consequences for insureds. Because the intent to exclude coverage for defense expenses was not expressed in clear and unambiguous language in the excess policy, we conclude that the Patterson Companies' interpretation of coverage is reasonable. *Id*. at 12-14 (citations omitted).

The *Patterson* decision highlights the care an insurer must use in altering critical terms within a "follow form" excess policy. The definition of "ultimate net loss" in the Liberty policy was certainly unusual for a CGL policy. One can only speculate as to whether Ohio Casualty noted that distinction prior to issuing its policy.

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