

Coverage Analysis Considerations for Construction Defect Claims

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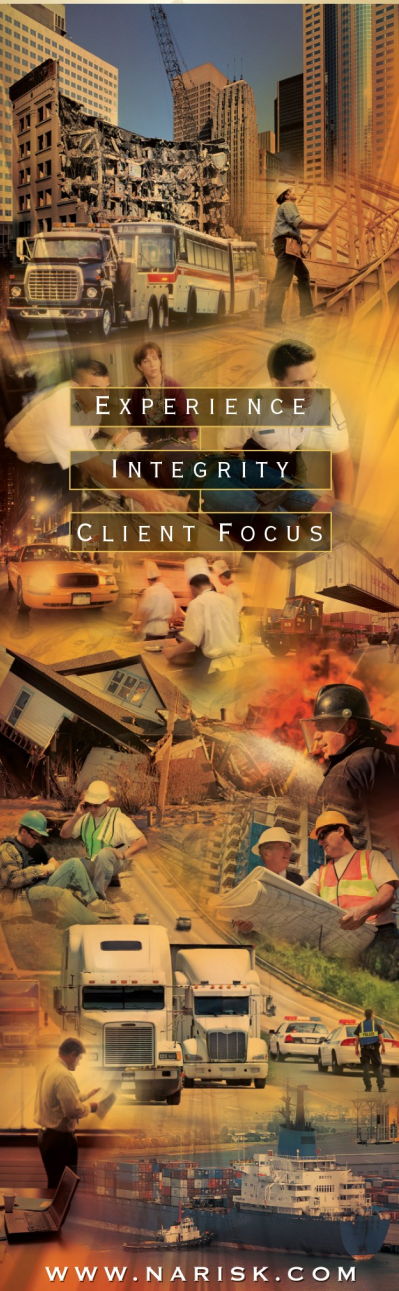
In the administration of construction risk claims, the proper analysis of coverage requires a superior level of knowledge and experience that relatively few adjusters possess. It is critical that adjusters and managers have the necessary skill and experience.

Construction claims may arise out of ongoing operations or completed operations, involving either “date certain” or continuous or progressive coverage triggers. Damages may include property damage and/or bodily injury. Coverage may be available for some damages, while being excluded for others. Further, multiple policies, often issued by different insurers and subject to differing policy limitations, may afford coverage for many of the same damages. This can create a complex tangle of interconnected coverages, obligations, duties and allocation issues.

The systematic consideration of coverage starts with an understanding of the claim facts. Since bodily injury and property damage claim fact investigation is routine for most adjusters, we turn our attention to what makes completed operations construction defects more challenging. Adjusters must determine the scope and nature of the insured’s work, whether it included inspection or supervisory control of employees of other contractor’s employees or work, when the insured’s work was started and completed, the nature and extent of the damages that are alleged to be related to the work of the insured, and whether contractual relationships exist among the parties involved in the loss. Claim facts may not be immediately apparent so consideration of coverage may be a continuing process as investigation continues. It may be proper for an insurer to issue a non-waiver of rights letter to preserve the right to assert all valid coverage defenses at a later date.

Next, the policy conditions must be considered. The standard ISO commercial general liability policy sets forth various duties owed by the insured in the event of an occurrence, offense, claim or suit. The conditions of other policies may vary, but most importantly the insured is obligated to report claims promptly and to cooperate in the investigation and defense of the claim. The conditions section of the policy will also set-forth the insurer’s obligations, particularly if other valid and collectible insurance is available.

Once the claim facts have been determined and it has been verified that policy conditions were met, the proper analysis of coverage in a construction claim moves to careful review of the policy’s insuring agreement. Even if an insurer uses common ISO policy forms, there are numerous versions that may contain different language.



Most CGL insuring agreements provide that the insurer will pay those sums that the Insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which the insurance policy applies. The insuring agreement will further require that the damages must arise out of an “occurrence” and must take place within the coverage territory and within the policy period. Often, the policy may also apply only to damages that were not known to the insured prior to the policy period.

The insuring agreement forms the foundation of the policy’s coverage grant. Generally, it is the burden of the *insured* to establish that a claim potentially falls within this coverage grant of coverage.

First, it should be noted that the insuring agreement requires that the insured must become “legally obligated” to pay damages before the insurer has an obligation to pay them. As a precondition to the insurer’s duty to pay damages on behalf of the insured, there must be a legally binding judgment or award against the insured. While this provision is included in virtually every CGL insuring agreement, adjusters should be aware that it may run afoul of various statutory, regulatory or common law requirements that a claim be settled sooner.

Second, it is important to realize that in order for damages to be covered, they must only be *because of* (emphasis added) “bodily injury” or “property damage.” They do not necessarily need to qualify as “bodily injury” or “property damage” themselves. For instance, an insured might be held liable for money damages because of “property damage” that might not otherwise not be covered. In the absence of an allegation of damages because of “bodily injury” or “property damage,” there is no coverage.

Next, the damages must arise out of an “occurrence”. Most adjusters understand that there must be an accidental component for a loss to arise out of an “occurrence,” as the term is defined by the policy but for construction claims, it can be difficult to determine, and if so, when and how many occurrences have actually happened. Adjusters must quickly determine whether the loss occurred at a discreet time and place, i.e. “date specific” occurrence subject to only one policy, or involves continuous or progressive damages that may occur over a long period of time and across multiple policy periods. Jurisdictional law varies with some jurisdictions holding that construction defects and / or defective work arise out of an occurrence, while others do not. Generally, “occurrence” cases fall into one of three categories: (1) defect construction qualifies as an “occurrence” because defective construction is not a desired result and is therefore accidental in nature; (2) defective construction does not qualify as an “occurrence;” or (3) resulting damage to other property or the work of others qualifies as an “occurrence.” While the law in this area is trending in favor of coverage, adjusters must verify the standards by jurisdiction.

At one time, the policy in effect when damages first manifested would provide coverage. The manifestation of damages was considered to be the “occurrence.” In fact, that is still the law in some jurisdictions. Similarly, the “loss in fact” standard, in which damages are held to have occurred when they actually happened, regardless of when they were discovered or manifested, is still valid law in some places. However, since the mid-1990’s, most jurisdictions have moved towards the adoption of a “continuous trigger” for coverage determination. Under this approach, first explicated in the Montrose decisions in California, the concept of an



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“occurrence” has been significantly expanded. While Montrose considered CGL coverage in the context of environmental contamination that had been ongoing for years, the decision was quickly applied to continuous loss construction defect claims as well. When applied to construction defect claims, the “continuous trigger” approach holds that damages can begin to occur as soon as the insured finishes his work and may continue right up to the present. In determining coverage, the *insurer* has the obligation to establish conclusively that no damages occurred or worsened during its policy period. The *insured* need only establish that damages *may have* started or worsened during the policy period. This is a much lower bar, and as long as the potential for coverage remains, the duty to defend remains. As a consequence, multiple successive policies, often issued by multiple insurers, may be exposed to the same loss. As discussed later, the insurance industry did develop various “anti-Montrose” exclusions in an attempt to limit coverage in continuous trigger jurisdictions.

Once it has been determined that at least one occurrence did happen during the policy period, the question becomes *how many* occurrences happened during the policy period? If a hammer hits the head of a construction worker, there is obviously just one occurrence. However, in the case of continuous construction defect claims, this determination can be difficult and Jurisdictions differ on this issue too. On one extreme, it can be argued that every carpenter’s hammer strike constitutes a separate occurrence. On the other side of the pendulum, hundreds of homes, of many different styles and completed years apart, might be considered one single occurrence. This inconsistency exists because different courts have interpreted the same policy definition of “occurrence” in very different ways. Most policies define an “occurrence” as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” The answer in a specific jurisdiction may determine whether or not there is coverage for a loss. If there is coverage, the number of occurrences will determine how deductibles, self- insured retentions and policy limits are applied to a claim. Accordingly, it is critical for adjusters to know the applicable law for the jurisdiction.

Finally, before deciding whether a claim potentially falls within the coverage grant, it may be necessary to determine whether the insured had prior knowledge of the damages. The insured may have been aware of some damages while remaining unaware of others. Depending on the policy language, there may be no coverage if the insured was aware of damages prior to the inception of the policy.

After reviewing the insuring agreement, consideration must be given to the various exclusions contained within the policy. The ISO commercial general liability coverage form contains seventeen (17) exclusions applicable to coverage for bodily injury and property damage claims. Some of these exclusions will rarely apply to construction risk claims, but others will often apply to limit or preclude coverage. In addition to the exclusions contained in the commercial general liability coverage form, other endorsements are often added to the policy that may further reduce coverage. Adjusters must remember that the *insurer* has the affirmative obligation to conclusively establish the absolute applicability of an exclusion before it is a reliable basis to disclaim coverage.



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As previously mentioned, in response to Montrose and its progeny, the insurance industry developed numerous exclusions designed to limit coverage to a single policy. The most common are (1) anti-stacking exclusions; (2) known loss exclusions; (3) progressive or continuous damages exclusions; and (4) prior work exclusions. These exclusions must be read carefully as the language can differ. In some cases, the insurer must establish when damages actually began. This can be extremely difficult if different damages started at different times. Some of these exclusions may contain a “deemer provision” that may establish when damages are deemed to have occurred. It may contain exceptions for certain circumstances. Other common exclusions may include condo / townhouse exclusions, large project exclusions, roofing limitations, wrap exclusions, scheduled projects exclusions, classification exclusions, various special conditions exclusions, asbestos, silica, or sulfates exclusions, foreign products exclusions, land movement or subsidence exclusions, EFIS, open roof or hot tar use, and mold or living organism exclusions. Each exclusion must be carefully considered and applied to the specific claim facts.

Many construction claims involve litigation or arbitration. It is well established that the duty to defend is predicated on the mere potential for coverage. If after careful analysis of the claim facts and policy provisions the claim presents a potential for covered damages, the insurer has a duty to defend any “suit” seeking those damages. However, in that the suit may allege both covered and uncovered damages, the defending insurer must decide if the legal defense should be provided subject to a reservation of the insurer’s right to assert coverage defense at a later time. The consequences of issuing a reservation of rights letter vary by jurisdiction, so the decision to issue a reservation of rights letter must be considered carefully.


Finally, additional insured endorsements may present further complex coverage questions. It is common for an insured to be required by contract to name the general contractor or developer as an additional insured on the subcontractor’s general liability policy. Additional insured endorsement coverage analysis is worthy of its own separate discussion. It is important to note here that an additional insured claim may present a significant exposure. In litigated matters, a different adjuster is usually assigned to analyze coverage that may be afforded to the additional insured to avoid conflicts or jeopardizing privilege.

If a potential for coverage exists, the adjuster must repeat the coverage analysis for all other policies that may afford coverage to the insured. If other insurance is potentially triggered, careful consideration of the “other insurance” provisions in all potentially implicated policies is necessary. When considering the duties that may be owed by multiple insurers to defend the same insured, it is worth remembering that each insurer owes joint and several duties to defend the entire suit. As such, it may be necessary to allocate the cost of indemnity or defense among multiple insurers.

Some allocation funding agreements are subject to reallocation at the end of the case, but again adjusters must be careful. The insurer may be able to recover a portion of its cost of defense from another insurer, or even from the insured, however these rights vary by jurisdiction. Some jurisdictions do not recognize equitable contribution or recovery claims between insurers. Many jurisdictions do not recognize an insurer’s right to seek recovery from its insurer for the cost of defending uncovered claims.



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For these reasons it is important to secure an allocation agreement upfront, if possible. Common allocation methods may include: (1) time on the risk; (2) equal shares; (3) premium paid; (4) available limits; and (5) any other equitable method.

Proper analysis of coverage for a construction defect claim requires superior experience and knowledge. An experienced adjuster must consider the claims facts and all the provisions of every policy (and state law) that may afford coverage to the insured. In many jurisdictions, a coverage defense that is not timely raised may be waived. Even an experienced auditor may not recognize a coverage defense that was overlooked. For these reasons, it is critical that adjusters and managers are experienced, knowledgeable, and able to properly analyze coverage for these complex claims.

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