INSURANCE LAW

Unfinished Business
and
Case Law Update

Drake General Practice Review
December 12-13, 2019

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I. INTRODUCTION

We left last year with a preview of coming attractions in the form of further review granted in one case and inevitable developments in bad faith and coverage law pending. Some questions have been answered. But never all. Stay tuned.

II. UNFINISHED BUSINESS

A. *City of W. Liberty v. Employers Mut. Cas. Co.*, 922 N.W.2d 876 (Iowa 2019)

A reminder of where we left off with regard to the squirrel on the power lines and a resulting fire. From last year's discussion of *City of W. Liberty v. Employers Mut. Cas. Co*., 2018 Iowa App. LEXIS 221 decided by the Iowa Court of Appeals:

> Sometimes the legal insignificance of a case is outweighed by its entertainment value – if one can successfully ignore the untimely demise of one of God's creatures. This case arises from property damages suffered in an electrical power substation owned by the City of West Liberty ("West Liberty") and insured by Employers Mut. Cas. Co. ("EMC"). The circumstances leading to the property loss was succinctly and cleverly described by the court as follows:
>
> … the squirrel was climbing on equipment when, as the district court found, 'the squirrel found itself in a rather shocking situation when it came into contact simultaneously with a cable clamp energized at 7200 volts and the grounded steel frame which supported the cable attached to the clamp.' An electrical arc was generated when the squirrel completed the circuit. The arcing lasted thirty to forty-five seconds, causing substantial damage to the City's property and short-circuiting the squirrel's life. The City and EMC agree the squirrel created the conductive path that resulted in an electrical arc that caused substantial damage to equipment at the City's electrical substation.
>
> The policy in question provided in relevant part as follows:
>
> > 2. "We" do not pay for loss or damage that is caused by or results from one or more of the following excluded causes or events:
> > . . . .
> > g. Electrical Currents — "We" do not pay for loss caused by arcing or by electrical currents other than lightning. But if arcing or electrical currents other than lightning result in fire, "we" cover the loss or damage caused by that fire.[1]
>
> EMC denied coverage as damage from "electrical currents" was excluded. EMC argued that the squirrel did not damage anything; the current did.

[1] There was no resulting fire in this case. However, the arcing caused over $200,000 in damages to the transformer and other electrical equipment.

> The Iowa Court of Appeals agreed, noting that "but for" the electrical arcing, there would have been no damage.

In a case that lends itself to tasteless puns more than most, this nutty matter made it to the Iowa Supreme Court for ultimate resolution. The Iowa Supreme Court affirmed the decisions of the district court and the Court of Appeals in denying coverage. The Court's rationale is, however, intriguing and raises a "concurrent cause" issue that has been seen with greater frequency and discusses an "anti-concurrent cause" provision that I suspect will become more frequent in property loss coverages in the future.

But first, if/when you want to find an excellent, recent cite for general principles regarding insurance policy interpretation, come to *City of West Liberty*. Note the following quotes that outline the basic principles. Although they are not new, it's always convenient to find them collected and tied with a bow.

- "Policy interpretation is always an issue for the court unless we are required to rely upon extrinsic evidence or choose between reasonable inferences from extrinsic evidence."

- "The plain meaning of the insurance contract generally prevails.

- "We will not strain the words of phrases of the policy in order to find liability that the policy did not intend and the insured did not purchase."

- "We construe exclusions strictly against the insurer."

- "…we must enforce unambiguous exclusions as written."

- "An insurance policy is not ambiguous just because the parties disagree as to the meaning of the terms."

- "…(a)mbiguity is not present merely because the provision 'could have been worded more clearly or precisely than it in fact was.'"

- "We will not interpret an insurance policy to render any part superfluous, unless doing so is reasonable and necessary to preserve the structure and format of the provision."

In its effort to obtain coverage, the City of West Liberty argues that the squirrel was the "efficient proximate cause" of the damage to the transformer and other electric equipment and since the policy contained no "anti-concurrent cause" language, coverage should be provided.

The decision contains an interesting analysis of what can be considered an "efficient proximate cause" of damage under the terms of an insurance policy. The "efficient proximate cause"

doctrine applies when "two or more causes, at least one covered by an insurance policy and at least one excluded, contribute to a loss." What would the coverage be in that case?

Not surprisingly, it depends on the policy language. Many policies contain an "anti-concurrent cause" provision. In essence, these clauses make it clear that if there is more than one cause concurrently resulting in the loss and one cause is covered by insurance but the other is not, the fact that there is a concurrent covered loss will not serve to save or reinstate coverage.[2] Without the "anti-concurrent cause" provision, IF the squirrel caused the damage, there could be coverage.[3]

Interestingly, the EMC policy did have an "anti-concurrent cause" provision in one exclusion – but it was conspicuously absent from the exclusion for damage resulting from electrical arcing.

But, did the squirrel cause the damage? Was the squirrel an efficient proximate cause of the damage so as to offer a second, covered cause of the loss?

Not according to the district court. Or the Court of Appeals. Or the Supreme Court.

The Supreme Court reasoned as follows:

> "This is not a case of two independent causes, one of which was covered and one excluded. (citation omitted). 'The efficient proximate cause doctrine is only applicable where the causes are independent.' (citation omitted).
> ….
> The squirrel did not independently contribute to the $213,324.76 loss, *i.e.*, other than through the arcing. As the district court put it, 'The squirrel by itself did not cause any damage.' Rather, the squirrel was inextricably tied to the arcing and was the immediate reason why the arcing happened.
>
> Electrical arcing is always going to have some cause. Policy language excluding an event would be meaningless if an insured could avoid the exclusion simply by pointing out that the event itself had a cause.

No coverage. And no squirrel.

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[2] In essence, the provisions generally read something like this: "Such loss or damage is excluded regardless of other causes or events that contribute to or aggravate the loss, whether such causes or events act to produce the loss before, at the same time as, or after the excluded causes or events."

[3] "Specifically, West Liberty argues that the squirrel – not the arcing – was the efficient proximate cause of the loss. Thus it is irrelevant, according to West Liberty, that the EMC policy excludes arcing from coverage."

It is interesting to note that even before the Supreme Court's ruling in *City of West Liberty* in February, 2019, the Court of Appeals addressed a similar issue regarding concurrent causes in *Steeve v. IMT Ins. Co.*, 2018 WL 6335611.

The facts of the case are tragic by any measure. The insureds purchased a home in Council Bluffs in June, 2015, and obtained an insurance policy from IMT to protect the investment. And then it started to rain. In September 2015, the area around the Steeves' home received 6 inches of rainfall. The following morning, the insureds notice a loss of water pressure in the house and yet another 1½ inches of rain inundated the property.

Upon investigating to find an explanation for the reduced water pressure, the insureds found a broken pipe about 6½ feet below the surface. The inundation of the water had caused the soil to erode and created a large "cavern" about 6 feet in diameter below the surface.

Shortly thereafter, the insureds noticed that bricks were falling off the front of the house – and the garage door was falling off the house and would not open – and a crack in the foundation -- and an area of the roof that appeared to be separating from the house. The insureds called his insurance carrier, IMT, who hired an engineer to ascertain the cause of the settling of the house.

The engineer concluded that while "heavy rains contributed to saturating soils near the surface, oversaturation of the soils below ground surface near the building foundations occurred due to the plumbing leak at the insured's well. Oversaturation of silty soils at the insured's property led to soil movements and the recent damage . . . Damage related to the plumbing loss occurred across the front of the residence between the insured's well and the drainage ditch at west side of residence." Specifically, the policy provided that IMT did not "insure for loss caused directly or indirectly by any of the following" and such "loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss: … 2) Earth Movement." "Earth Movement" was defined to include "earth sinking, rising or shifting caused by or resulting from human or animal forces or any act of nature unless direct loss by fire or explosion ensues and then we will pay only for the ensuing loss."

IMT denied coverage based upon exclusions for earth movement and water damage. "As noted above, earth movement is specifically excluded regardless of whether the earth movement was caused by human or natural forces."

In granting summary judgment to IMT, the district court found (and the Court of Appeals agreed) that the losses due to earth movement were excluded "regardless of any other cause or event contributing concurrently or in any sequence to the loss." There it is: the anti-concurrent loss provision. It was therefore not necessary to determine the CAUSE of the earth movement, only that the earth movement caused the loss.[4]

[4] Insureds also sought to rely upon the doctrine of reasonable expectations applicable if the provision is (1) bizarre or oppressive; (2) eviscerates terms explicitly agreed to; or (3) eliminates the dominant purpose of the transaction. It is a "prerequisite" that the insured prove "circumstances attributable to the insurer that fostered coverage expectations" or that the "policy is such that an ordinary layperson would misunderstand the coverage." Insureds could not do so.

III. BAD FAITH

And after a few years of drought, bad faith cases are again appearing in decisions issued by Iowa's appellate courts. And the fact scenarios are always interesting and unpredictable.

A. *De Dios v. Indem. Ins. Co. of N.Am.*, ___ N.W.2d ___ (Iowa 2019) (decided November 19, 2019).

And at last, on a certified question from the federal district court, the liability exposure of a third-party administrator to a bad faith claim is resolved!

The facts are commonplace in today's workers' compensation environment, the setting in which this claim arose. A worker was injured on the job in connection with a motor vehicle accident while employed by Brand Energy & Infrastructure Services ("Brand Energy"). The workers' compensation carrier for Brand Energy was Indemnity Insurance Company of North America ("Indemnity"). However, for purposes of adjusting the claims, Indemnity allegedly "delegated its authority of investigating, handling, manage, administering, and paying benefits under the Iowa Workers' Compensation Laws to [defendant] Broadspire Services Incorporated ("Broadspire")." Because of the manner in which the claim was handled (including non-payment of benefits and adherence to physical restrictions in the work place), the worker eventually sued both Indemnity and Broadspire for bad faith in the federal court. Having acknowledged that the Iowa law with regard to the existence of a bad faith claim against a third-party administrator was not resolved, Judge Mark Bennett certified the question to the Iowa Supreme Court for resolution.

The reported decision is largely a law review article regarding the history of bad faith actions in Iowa – from the initial recognition in third-party or excess judgment cases to establishment of the fairly-debatable standard in first party cases to extension of the principle in workers' compensation cases. It is the latter that is of particular interest in this case.

Iowa first recognized bad faith claims in the workers' compensation setting in *Boylan v. Am. Motorists Ins.*, 489 N.W.2d 742 (Iowa 1992). In so doing, the Supreme Court distinguished its holding in *Long v. McAllister*, 319, N.W.2d 256 (Iowa 1982) by reliance on the unique relationships created in the workers' compensation setting through the code and administrative rules. For example, in workers' compensation, the insurance carrier is a party to the administrative proceeding and litigation while in a third-party action, there is a prohibition against even mentioning the existence of the insurance company; in workers' compensation there are unique affirmative duties and licensure requirements placed on the insurance company that are non-existent in the general liability setting. It is the existence of these "affirmative obligations" upon which the Court relied in extending potential liability for bad faith to the insurer in the workers' compensation setting.

The Court again focused on the relationship between and among the parties in *Reedy v. White Consolidated Industries, Inc.*, 503 N.W.2d 601 (Iowa 1993). In *Reedy*, the Court was called upon to determine whether a self-insured employer could be held liable for bad faith in a civil action in spite of the exclusivity provisions of the Code insulating the employer from liability to

an injured employee for work-related injuries. Not surprisingly, the Court separated the functions of the employer and the insurer and found that when an employer takes on additional obligations as a self-insurer, it also takes on additional liability to fulfill those duties as required by law. With an employer seeks and receives the authority to act as a self-insured, it also assumes the liability of an insured and loses the protections inherent in the more limited role as employer only.

Correspondingly, an uninsured employer cannot be held liable for bad faith. *Bremer v. Wallace*, 728 N.W.2d 803 (Iowa 2007). Again, the rationale is consistent. The uninsured employer has not additionally and intentionally assumed the obligations of an insurer. The uninsured employer has neither purchased insurance nor joined a self-insured association and is therefore neither an insurer nor the substantial equivalent of an insurer. The uninsured employer cannot therefore be held liable for bad faith in handling the workers' compensation claim.

The same rationale carries forward to reject the existence of a potential bad faith liability on the part of a third-party administrator. Why?

- A third-party administrator is not in an insurer/insured relationship with anyone;

- Unlike a self-insured employer, a third-party administrator does not have to meet rigorous financial requirements and is not the subject of ongoing supervision from the workers' compensation commissioner;

- There are no "affirmative obligations" placed on third-party administrators in the code or regulations.

The Supreme Court rejected the injured workers' expressed concern that the insurer could simply delegate its obligations to a third party who would bear no risk of liability for bad faith. In so doing, the Court noted that the insurer would still be vicariously liable for the actions of the third-party administrator as its agent and the duties of the insurer in workers' compensation are non-delegable.

And finally, the Court analyzed the holdings in other jurisdictions with regard to this issue. The analysis is somewhat complicated by the fact that about half the jurisdictions do NOT recognize the tort of bad faith against the insurer in the workers' compensation setting. Within that smaller population, however, the only jurisdiction that has extended bad faith liability to third-party administrators in the workers' compensation setting is Colorado. Analysis of the Colorado decision, however, makes it evident that the liability was extended because of the unique pattern of laws and regulations in Colorado that are not in existence elsewhere. Even beyond the workers' compensation arena, the majority of jurisdictions have rejected recognition of bad faith against third-party administrators, largely relying on the lack of privity.

For your reading pleasure, I recommend the lengthy dissent filed by Justice Appel in this case (joined by Justice Wiggins). It is nearly as long as the majority decision. Justice Appel would recognize liability of third-party administrators in workers' compensation cases. His analysis,

however, relies primarily on cases arising outside of the workers' compensation setting and without consideration for the unique circumstances inherent in the relationship between/among the parties in that instance. I submit that the unique circumstances giving rise to bad faith exposure in the workers' compensation setting that are non-existent in a tort liability situation render adoption of a different result in connection with a bad faith claim equally appropriate.

The third-party administrator managing the handling and adjustment of a workers' compensation claim cannot be held liable for bad faith in Iowa.

B. *Dunlap v. AIG, Inc*., 2019 WL 141012

The facts of this case are rather convoluted.

This case involves claims of bad faith and intentional infliction of emotional distress arising out of a workers' compensation claim. In July, 2007, Mr. Dunlap sustained a work-related injury while employed by Action Warehouse. He was awarded benefits in 2009 following hearing. In addressing the claims under Chapter 85, the deputy workers' compensation commissioner concluded that Mr. Dunlap's symptoms were caused by his 2007 injury and that he had not yet reached his maximum medical benefit, justifying a running healing period award. The deputy also found that the worker's employment was terminated because of the injury and he was therefore entitled to temporary partial disability and healing period benefits. No penalty award was made because the deputy concluded that two doctors' expert opinions made the liability for workers' compensation benefits fairly debatable.

The workers' compensation commissioner affirmed the deputy on appeal. On appeal to the district court, the agency's decision was affirmed in all regards.

Meanwhile, in September, 2009, while the agency action was pending, the worker filed a civil action against the employer and its workers' compensation insurance carrier, Commerce and Industry Insurance Company ("Commerce"), and AIG, the adjuster. The claim against the employer was later dismissed, leaving the insurer and the adjuster as defendants. The civil action was continued numerous times while the workers' compensation matter proceeded, including a 2009 request for review-reopening in which the worker sought additional benefits for bilateral arm injuries allegedly causally related to the 2007 incident. While the treating physician for the arm injury, Dr. Wolfe, who made the referral for surgery initially concluded that the arm injuries were unrelated to the 2007 incident, he subsequently clarified his first opinion to note that "it is possible (e.g., less than 51%) that [Dunlap's arm injuries] while not directly caused by the … 2007, work-related injury are a result of the natural consequences of [Dunlap's] back injury requiring him to ambulate with the use of a cane." Meanwhile, three other physicians, including the hand surgeon treating the workers' upper extremity condition, expressed the opinion that the maladies in the worker's arms were related to the 2007 injury. In November, 2014, the deputy found that the arm conditions were related to the 2007 incident or the natural consequences of it. The worker's request for alternate medical care was also granted and the deputy ultimately awarded permanent total disability benefits.

Having addressed the workers' compensation benefit issue, the civil claim for bad faith was presented for resolution. In ruling on the motion for summary judgment, the trial court addressed several issues and claims:

- Bad faith claim for the defendants' handling of the 2007 injuries;

  The district court found that the defendants were entitled to summary judgment in connection with the handling of the 2007 injuries, in large part because the deputy denied the entitlement to penalty benefits, finding that there was a reasonable basis for the defendants' positions.

  The Court of Appeals agreed. It noted that a bad faith claim for improper denial of workers' compensation benefits is essentially a first-party bad faith claim. In order to recover, the worker must establish: 1) that the insurer had no reasonable basis for denying benefits under the policy; and, 2) the insurer knew or had reason to know that its denial was without basis. The first element is objective; the second element is subjective.

  Whether or not the claim is "fairly debatable" (with a reasonable basis) can generally be decided by the court. In this case, the Court of Appeals (in keeping with the Supreme Court's earlier decision in *Gardner v. Hartford Ins. Accident & Indem. Co.*, 659 N.W.2d 198 (Iowa 2003)) decided that the denial of penalty benefits precluded a civil bad faith claim based upon the same facts and circumstances. The Court of Appeals noted that in the workers' compensation proceeding, it is even the obligation of the insurer to establish that it acted in good faith and, in this particular case, the insurer had timely medical opinions supporting its position that the injury claimed and the medical expenses sought were not related to the 2007 injury. Having proven the reasonableness of its position at least once before a tribunal, the insurer need not do so again.

- Bad faith claim for the defendant's handling of the 2012 injuries;

  After initially finding a fact issue with regard to the bad faith claim in connection with the handling of the 2012 injuries, the district court ultimately concluded that there was no fact issue and that summary judgment in favor of the defendants was appropriate in view of the two early opinions by Dr. Wolfe.

  The Court of Appeals disagreed. In essence, the court noted that the mere existence of an expert opinion denying causality is not sufficient to show the issue of liability was fairly debatable, particularly when that opinion morphed over time and was countered by the opinions of other treating physicians. The Court of Appeals did decline to extend the definition of "fairly debatable" to require "a complete consideration of all relevant facts and circumstances before concluding that any case is 'fairly debatable' as a matter of law." While noting that an opinion denying causality by itself is not enough to make an issue of liability fairly debatable, an "insurer can only rely upon a reasonable opinion denying causation to successfully defeat a claim of bad faith." Furthermore, all claims must be subject to continuing review in consideration of changing facts and

circumstances. What is "fairly debatable" at one point in time might lose that designation as opinions change or are modified.

The judges concluded that there were fact questions with regard to the existence of bad faith in connection with the 2012 arm injuries. That portion of the claim was remanded for trial.

- Bad faith for the defendant's handling of the workers' mileage claim; and,

  The district court found that it lacked jurisdiction to determine the validity of the mileage claims pursued by the injured worker. It further concluded that even if it did have subject matter jurisdiction, the claim lacked merit because the denial or delay in payment for mileage expense was indeed "fairly debatable."

  The Court of Appeals agreed with the result but not with the process or rationale. First, the appeals court noted that the claim wasn't really for mileage payment but for damages resulting from the failure to make those payments in a timely manner. Although the district court would have no jurisdiction over the first such claim, it did over the second. The Court of Appeals did agree with the trial court, however, that the insurer had a reasonable basis for the failure to make payments for mileage in view of the workers' delay in providing information and reconciliation of appointments to mileage claims.

- Intentional infliction of emotional distress.

  The district court found as a matter of law that the conduct of the insurance carrier was not sufficiently outrageous to give rise to a claim for intentional infliction of emotional distress.

  The Court of Appeals agreed.

But there is yet one more interesting nuance to this case. The injured worker also sought to amend his petition to claim abuse of process by the defendants, allegedly because of their use of the administrative procedures with the purpose of delaying payment and denying benefits. The district court concluded that administrative proceedings such as hearings before the workers' compensation commission did not constitute a "legal process" within the meaning of an abuse of process, following a previous unpublished decision, *Dobratz v. Krier*, 808 N.W.2d 756, 2011 WL 5867067.

C. *Estate of Naeve v. FBL Fin. Grp., Inc.*, 929 N.W.2d 279, 2019 WL 2679936

When must a bad faith claim be pursued?

Estate of Naeve arises from an automobile accident in which nineteen-year-old Joshua Naeve was killed. The tortfeasor's actions were subject to liability coverage with limits of $1.5 million. Unfortunately, there were many victims and ultimately, Mr. Naeve's claim was settled for half a million dollars as its portion of the coverage limit.

Mr. Naeve also, however, was protected by underinsured motorist coverage issued by Farm Bureau and his estate pursued additional funds from that source as well. As the parties were unable to agree, ultimately the case proceeded to trial and the jury awarded the underinsured policy limit which was ultimately paid by Farm Bureau.

Thereafter, however, the estate filed a petition at law against FBL Financial Group, the parent company of Farm Bureau that managed and directed the handling of the claim under the Farm Bureau policy. It included counts of bad faith, interference with contract, and conspiracy or aiding and abetting bad faith. FBL responded by asserting claim preclusion as all of the conduct at issue preceded the contract claim against the insurer, Farm Bureau, with which FBL claimed privity. Alternatively, FBL argued that it had no contract with the insured and therefore could not be charged with acting in bad faith in connection with a policy to which it was not a party. Following resistance, the matter was adjudicated by the trial court that ruled for FBL in all regards.

On appeal, the Court of Appeals first noted that all parties in privity are entitled to the same benefit of the claim preclusion argument. Having found privity (a topic more appropriately addressed by other speakers) between Farm Bureau and FBL, the question is whether or not the estate should have brought any bad faith action at the same time that it filed the suit for breach of contract. The conclusion? Yes. Speak now or forever hold your peace. In reaching that conclusion, the court noted as follows:

> First-party bad-faith claim based on denial of insurance benefits without a reasonable basis ordinarily arises out of the same transaction as a breach-of-contract claim for denial of those same benefits. This means a final judgment in the breach-of-contact case would bar the bringing of a subsequent, separate bad-faith lawsuit. (quoting *Villarreal v. United Fire and Casualty Company*, 873 N.W.2d 714 (Iowa 2016).

Resolution of the issue is always, however, tied to the timing of the events and conduct giving rise to the claim. It is possible for the conduct of the insurer to give rise to a claim of bad faith AFTER the filing of the initial law suit. Under such circumstances, there is necessarily no requirement that the claims be filed simultaneously. In this case, however, the conduct giving rise to the bad faith claim pre-dated the filing of the breach of contract count and should have been filed simultaneously with that action – or lost. And the fact that the same conduct (denial of benefits, for example) continued during the underlying breach of contract claim will not support a later separate action for bad faith if the conduct is continuing in nature.

Although the district court did not reach the issue, the Court of Appeals further considered FBL's argument that it was not a party to the insurance contract and could not therefore be held liable for breach of good faith obligations arising from it. That answer is found in *De Dios v. Indem. Ins. Co. of N. Am.*, ____ N.W.2d ____ (Iowa 2019) and I refer you to that section of the outline just to heighten the mystery.

IV. COVERAGE AND POLICY INTERPRETATION AND CONSTRUCTION

A. *Addison Ins. Co. v. MEP Co.*, 2019 WL 5790866

What is an "occurrence" under the terms of a commercial general liability ("CGL") policy?

In this case, the insured ("MEP") was hired to reshape a levee. The insured was taken to several sites from which it was told dirt could be moved to complete the work. Unfortunately, MEP moved dirt from individual owners' private property. It was then sued. At the time of the claims, MEP had a CGL policy issued by Addison Insurance Company ("Addison"). MEP presented a claim for expenses it incurred in the federal litigation under the terms of the policy. Addison denied coverage.

The Court of Appeals largely quoted – and adopted – the language of the district court. In essence, the district court found that in order to be covered under the terms of the CGL, the loss must have resulted from an "occurrence" – an "accident, including continuous or repeated exposure to substantially the same general harmful conditions." In taking that language and applying it to the facts of the case, it was concluded that there was no "accident", but rather intentional conduct. MEP had been shown the sites from which he was to remove dirt but went elsewhere; the insured had related inconsistent (at best) information that caused the court to find that the testimony on behalf of the insured was only retroactive justification. Such is not sufficient to rise to the level of an "occurrence."

B. *Sleister v. State Farm Fire & Cas. Co.*, 2019 WL 371390

Every insurance policy of which I am aware places duties on the insured as well as the insurer. Occasionally, those provisions are dispositive of the dispute and *Sleister v. State Farm Fire & Cas. Co.*, 2019 WL 371390 is such an example.

In *Sleister*, the insured, Georgios Symeonidis, was involved in a "house flipping" business pursuant to which he owned and served as the general contractor for property in need of repair while Mr. Sleister advanced the funds necessary for repairs and became entitled to the proceeds of sale. Mr. Symeonidis obtained an insurance policy on the home. Unfortunately, the house was in very poor condition at the time as verified by the photographs taken by the underwriting department of State Farm upon issuance of the policy. How poor was the condition of the house? There was a sign on the front door posted by the city declaring the property to be a public nuisance unsafe or unfit for public habitation.

Pursuant to that plan, Mr. Symeonidis hired a roofing contractor whom Mr. Sleister thought was going to just remove and replace shingles and sheeting. Instead, the contractor removed the entire roof, including some of the trusses - - just before the rainstorm hit that afternoon, with predictable resulting interior damage. A claim was made on the insurance policy. Two weeks later a claim specialist inspected the property. But by that time, most of the interior walls and flooring of the structure had been removed. The insured claimed that it was necessary to proceed

in view of the insurer's delay and the deteriorated condition of the property. The insurer was unimpressed with that argument and denied coverage because the insured violated his " duty under the policy to allow (the insurer) to inspect the damage prior to the demolition or commencement of repairs."

The case was tried on a single breach of contract count. The jury returned a verdict in favor of the insured. However, upon motion, the trial court granted judgment in favor of State Farm notwithstanding the verdict. Appeal followed.

In analyzing the case, the Court of Appeals noted that under Iowa law, "a party claiming entitlement to coverage under an insurance policy must prove compliance with the policy's terms." The insured can do so by showing: 1) substantial compliance with the condition precedent; 2) that the failure to comply was excused or waived; or, 3) the failure to comply was not prejudicial to the insurer. However, prejudice to the insurer is presumed unless substantial compliance is shown.

After reviewing the record, the Court of Appeals concluded that none of the three conditions applied and the insured had failed to meet the condition precedent necessary to establish coverage.

C. *33 Carpenters Constr., Inc. v. Cincinnati Ins. Co.*, 2019 WL 478254

The facts of this case are consistent with a growing trend in property damage claims. A hail and wind storm damaged the insured's home. The insured entered into an agreement with a construction company, 33 Carpenters Constr., Inc., (hereinafter "Carpenters") that appeared to also serve as an adjuster in the case, stepping in to attend meetings with the insurance company and participating in inspections. The insured and Carpenters apparently entered into an agreement under which Carpenters would repair the house in exchange for any proceeds paid by Cincinnati under the terms of the insurance policy. The original agreement was apparently not part of the record; however, on October 10, 2016, the insured and Carpenters executed an "Assignment of Claim and Benefits" pursuant to which Carpenters essentially claimed ownership of the claim. When the insurance company refused to deal with Carpenters but communicated with its insured, Carpenter filed suit.

Cincinnati defended the suit, in part by contending that in the process of obtaining the assignment of the claim from the insured, Carpenters acted as a public adjuster without a license in violation of Iowa Code chapter 522C. In essence, the insurance company asserted that because Carpenters acted as an "unauthorized public adjuster" and its "actions of obtaining and enforcing the assignment of" the insured's claim was without authority, rendering the assignment of the claim void. Carpenters countered by asserting that the assignment of the claim in October was a valid post-loss assignment, rendering any allegedly wrongful conduct prior to that date moot. Besides, says Carpenters, only the Insurance Commissioner can enforce Chapter 522.

The Court of Appeals (Judge Mullins) first addressed the general law regarding the necessity of having an insurable interest in the property, noting that insurance policies "are not assignable prior to loss without the insurer's consent." In fact, the Cincinnati policy specifically included a

provision holding any assignment of the policy invalid without Cincinnati's written consent. That changes, however, with the occurrence of the loss. At that point, the assignment is not of the insurance policy but of a change in action under the policy.

The trial court ruled, however, that the assignment remained invalid because it violated the licensure requirement for public adjusters under Iowa Code Chapter 522C. Carpenters' web site included and advertised services such as advocating on an insured's behalf with their insurance company and working directly with the carrier to ensure that all damaged areas of the property are included in the claim. In this case, Carpenters also interjected itself into negotiations between the insurer and the insured.

In an effort to address the issue, Carpenters admitted that neither it nor its representatives were licensed public adjusters. The Court of Appeals found that that omission was fatal to Carpenters' claim, stating, "if 33 Carpenters was operating as an unlicensed public adjuster when it entered into a contract with (the insured), such contract would be unenforceable," applying the general rule that a contract made in the course of a business for which a license is required but not obtained is unenforceable. Having concluded that Carpenters was indeed acting as a public adjuster without a license, its claim failed.

D. *Metro. Prop. & Cas. Ins. Co. v. Auto Owners Mut. Ins. Co.*, 924 N.W.2d 533 (2019)

A husband and his wife formed an LLC, Parker House, to hold title to investment companies, including a farmhouse where the facts giving rise to this claim developed. The farmhouse was purchased for investment purposes. It was furnished, although no one lived there. The farmhouse was used for recreation, including hunting, fishing, target shooting, riding all-terrain vehicles and dirt bikes, running the dogs, and swimming.

On the date of the accident, the son of the owners of the LLC ("Nick") and a friend and girlfriend went to the farmhouse to ride dirt bikes. The husband/father, Jay, had been there earlier in the day as well and, before he left, he told his son to be sure to lock up and secure the farmhouse. When Nick was locking up, he noticed that one of the family's firearms had been left on a bed in one of the bedrooms. Nick picked up the firearm to put it away when it discharged, killing his friend.

The friend's family brought suit seeking to recover for the death of their son. The property owners turned to two policies for protection. The first was a policy issued through Metropolitan Property and Casualty Insurance Company ("Metropolitan") that covered the husband and wife and their sons. It specifically insured the primary home, personal vehicles and the farm house.

The LLC that owned the farmhouse, Park House, was also separately covered by a "Tailored Protection" insurance policy from Auto-Owners Mutual Insurance Company ("Auto-Owners") that included a CGL with a million dollar limit. The Auto-Owners policy had earlier been amended with an endorsement insuring the farmhouse and farmland. After inspection by the insurance agent, the property added was described as a "Storage Building" and "Vacant Land."

Metropolitan reached a settlement agreement with the deceased's family to pay $900,000 in exchange for a full release of the individuals and the LLC. Auto-Owners denied coverage, stating that its policy only covered individuals with respect to the "conduct of a business" and that the death was not business related.

Metropolitan filed suit for contribution from Auto-Owners and the matter was submitted to the court on a bench trial. Expert witnesses were called to testify as to the reasonableness of the settlement and allocation of fault among the various potential parties. Ultimately, the trial court entered judgment against Auto-Owners for $450,000. The district court found that Parker House was insured under the Auto-Owners' policy. The court also found that the son, Nick, could be covered under the Auto-Owners' policies as either an employee or volunteer worker when he was securing the rifle. Because the court found the settlement to be reasonable, judgment was entered in favor of Metropolitan for half of the settlement paid.

For the record, the general principles governing construction and interpretation of insurance policies not enumerated in *City of West Liberty*, *supra*, are found in this case. Take note.

Auto-Owners appealed asserting that: 1) Nick was not acting for Parker House at the time of the accident; and that, 2) there was no premises liability. The Supreme Court rejected both arguments.

With regard to Nick, the Court concluded that his conduct in securing the property at the direction of the manager of the LLC could create an agency and, by extension, coverage under the policy. Since the conclusion of the district court was supported by substantial evidence, the Supreme Court affirmed that portion of the decision.

Similarly, with regard to the issue of premises liability, the Supreme Court found that the district court's decision was supported by the language of the policy and the facts. Significantly, the policy did not limit coverage for the named insured, the LLC, to acts taken "in the conduct of (its) business" as it was for the individuals and employees. Of equal significance, the Court found premises liability on the part of Parker House as the owner of the property. Interestingly, the trial court allowed expert testimony with regard to the interpretation of the policy and the ultimate coverage issue – an unusual development in my experience. In any event, the Supreme Court concluded that the loaded gun left on the bed constituted a dangerous condition triggering premises liability and Nick's negligence would have been imputed to Parker House. Auto-Owners was therefore obligated to contribute half of the reasonable damages paid.

V. MISCELLANEOUS, BUT INTERESTING

A. ***Clark v. Ins. Co. Pa.*, 927 N.W.2d 180 (Iowa 2019)**

Well, this is interesting. Have you come across advertisements or promotions by insurance companies touting their safety inspections and selling their expertise to prevent injuries on site? What happens when the inspection is allegedly inadequate and purportedly fails to protect those on site, particularly the workers? Suit was brought against Insurance Company State of Pennsylvania by workers injured on the premises resulting from exposure to hazardous

chemicals allegedly because of negligent or inadequate inspections. Is the insurance company liable?

The insurance company moved to dismiss the claim, citing Iowa Code section 517.5 which provides in relevant part as follows:

> No inspection of any place of employment made by insurance company inspectors or other inspections inspecting for group self-insurance purposes shall be the basis for the imposition of civil liability upon the inspector or upon the insurance company employing the inspector ….

The injured workers resisted the claim of immunity on several grounds, largely constitutional, that are probably more appropriate for a different speaker. It is, however, a fascinating trip down law school lane and the Court ultimately rejected all claims of unconstitutionality, ruling against the injured workers.