Ye Olde Caveat:
Rights under an insurance policy are governed by the particular language of the specific contract. Case law without identical contractual language is of limited value. Further, the law is constantly changing so it is imperative to analyze each case cited for amendments, nuances, updates and outright rejection – as always.
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I. INTRODUCTION

The number of insurance law cases decided by the Iowa Supreme Court seems to be in inverse proportion to the number of insurance law concerns voiced by our clients recently. While the Iowa Supreme Court decided few (one) insurance law cases since we last “met,” environmental catastrophes and a pandemic have generated enough stress and financial instability to cause companies and individuals to go looking for protection wherever possible and their insurance policies are a logical source. Or not.

In the interest of continuity, we will first address the continuing saga of insurance coverage for business losses from the pandemic, move on to new cases decided by the Iowa appellate courts and then run through the Top 10 (the insurance issues that are most commonly addressed in the general practice of law).

And since I can’t say this often enough: Resolution of these issues is wholly dependent on the specific language of the particular policy under consideration. Do NOT rely on these summaries based upon sample language without detailed analysis and comparison of the language of the policy you are reviewing.

II. THE PANDEMIC

In general, the weight of authority continues to crash heavily on top of the insureds to the benefit of the insurers on claims for economic losses resulting from the pandemic. There are, however, several key considerations in addressing coverage for economic loss resulting from the pandemic that require scrutiny:

- These commercial policies often provide coverage, including business interruption protection, if there is a “direct physical loss.” The case law is becoming overwhelming in support of strict enforcement of that requirement to sustain coverage for economic losses and loss of use.

- Some policies specifically protect protection resulting from "communicable or infectious diseases" – some with and some without requiring physical damage to insured property. Given the trend supporting strict enforcement of the requirement for “direct physical loss” under standard business interruption insurance policies, businesses especially concerned about the risk of disruptions occasioned by communicable or infectious disease outbreaks should consider whether to also purchase "communicable or infectious diseases" coverage.
• Check to see if there is coverage for action by civil authorities particularly if a governmental authority has limited access to or from the insured premises. Again, some require actual physical loss to trigger this coverage; others do not.

• Certainly, there are other possible ports in the storm but many policies have some form of these coverages.

• Be wary of the exclusions as well as some specifically exclude losses resulting from a virus.

Since we last “met” electronically, additional cases have come down from various courts. In general, the cases support the insurers’ denial of coverage when economic loss results solely from governmental mandates and closures. Some examples in addition to the numerous cases cited in last year’s outline:


In *Visconti*, the bus company filed a breach of contact action against its insurer based upon a denial of payment for loss of business income caused by the governor’s executive orders mandating closure to mitigate the spread of COVID-19. The policy at issue is (ironically) called an “All-Risk” policy. The policy provided protection for a “covered cause of loss” from “direct physical loss of or damage to Covered Property” unless the loss is excluded or otherwise limited. Every covered loss required that the loss “must be caused by direct physical loss of or damage to property at premises.”

As the insured didn’t even try to argue that the property was actually infected with the COVID virus, there was no coverage. Under New York law, there is no “business income/extra expense” coverage in the absence of “direct physical loss or damage” to the insured premises. “Mere” loss of use and/or functionality in the absence of direct physical loss is insufficient to trigger coverage.


The insured owned and operated a successful business selling footwear to department stores and retail establishments across the United States. It alleges that, beginning in February 2020, it started experiencing losses when state and local governments issued orders temporarily closing all non-essential businesses, the category into which Moda fell. The insured contended that it suffered immense financial injury resulting from the
government-mandated business closures and sought coverage under its policies with Hartford.

There were two policies at issue. The first is the package policy. However, that policy contained two exclusions for damage resulting from viruses. The insured contended that the damage was not caused by or resulting from the virus, but from the governmental closure mandates. The court was unimpressed. Literally “but for” the virus, there would have been no loss even if the insured could survive the requirement that there be direct physical damage to insured property.

The court next addressed the marine policy, that insured “against all risks of direct physical loss or direct physical damage to insured property from any external cause …” The court found no direct physical damage and therefore no coverage. It did, however, address the language of the policy purporting to provide coverage for “all risks.” The noted concluded that labeling “the policy as ‘all-risk’ does not relieve the insured of its initial burden of demonstrating a covered loss under the terms of the policy.”


A restaurant closed by various executive orders issued by the governor in New York for the purpose of containing the COVID-19 virus sought coverage for the economic losses resulting from the business interruption. However, as is typical (but not universal) in these commercial policies, protection for loss of income resulting from business interruption required that it result from “loss or damage to real or personal property.” There was none. Furthermore, there was an exclusion for loss caused by order of any civil authority. As if the insured’s cause weren’t dead enough, there was also an exclusion for “loss, cost or expense caused by, resulting from or relating to any virus ….” That’s three strikes and the insured is effectively out.

To the same effect, see 6593 Weightlock Drive, LLC v. Springhill SMC Corp., 147 N.Y.S.3d 386, 71 Misc.3d 1083 (N.Y. 2021).


The saga is the same. The plaintiffs/insureds were forced to limit or close their businesses because of the spread of COVID-19 and governmental orders; they sought recovery for the economic loss under the terms of their insurance policies. Again, however, the policies required that the lost income or incurred expenses be due to “physical loss of or damage to” any property. The court concluded that neither the virus itself (even if present on the
property) nor the Governor’s orders caused a physical loss of or damage to the property within the meaning of the policy. Point to the insurance company.

III. NEW CASE LAW

A. Coverage – At a Premium

In *Auto-Owners Ins. Co. v. Rosas*, No. 20-0020, 2021 WL 1904698 (Iowa May 12, 2021), an unpublished opinion from the Iowa Court of Appeals, the insurance carrier sought additional premium payments for workers’ compensation coverage provided to Mr. Rosas’ roofing business through the assigned risk pool. Before wandering our way through the facts of this case, however, let me remind you of an earlier case addressing the same issue from about a decade ago.

*Travelers Indemnity Company v. D.J. Franzen, Inc.*, No. 09-0040, decided October 29, 2010 too was purely a dispute over the amount of premium to be paid based upon a retroactive premium adjustment. The saga began with D.J. Franzen’s (“Franzen”) placement in the assigned risk pool for workers’ compensation purposes. On its application, Franzen was required to class code its employees. It listed a total payroll in class code 8810 clerical office employees of $230,000 and listed an estimate payroll of zero for code 7229 hauling employees (drivers). In previous years, the NCCI (National Council on Compensation Insurance) reported that in the three previous years, Franzen had carried workers’ compensation insurance for its code 7229 drivers in addition to its clerical employees. Franzen’s explanation was that it had sold all of its trucks and now used only owner-operators for whom they were not responsible for workers’ compensation purposes. Concern arose within Travelers, however, when it was discovered that Franzen also owned a truck leasing company.

The relationship deteriorated quickly. Travelers’ initial efforts to obtain Franzen’s cooperation in conducting a preliminary audit were ignored. On December 13, 2003, Travelers sent a letter to Franzen indicating that the policy would be placed in cancellation status if there was no cooperation with the preliminary audit. The requested information was then provided.

After reviewing the sample contract between Franzen and its drivers, Travelers determined that all drivers who signed the contract were owner-operators and independent contractors; however, Travelers also concluded that drivers who had not signed the contract were 7229 employees and subject to coverage under the workers’ compensation policy. As a result, most drivers were considered employees and a premium adjustment notice was sent to Franzen reflecting a premium of $552,436 – a noticeable increase from the initial deposit premium of $1775.

Franzen neither appealed the premium notice nor paid it. Travelers therefore sought recovery for the premium charged during the effective date of the policy. Franzen moved for summary judgment based upon the allegedly erroneous classification of employees as drivers. Travelers
countered with three arguments: 1) only Travelers can determine the amount of premium due; 2) the failure of Franzen to exhaust administrative remedies barred its defense; and 3) the record supports a finding that all but eight of Franzen’s drivers were employees. The Court of Appeals rejected each in turn.

**EXHAUSTION OF ADMINISTRATIVE REMEDY**

Travelers relied upon the NCCI manual which required that the insured must raise any dispute “before the appropriate administrative or regulatory body having jurisdiction over appeals on Plan matters” and argued that Franzen had waived its opportunity to object to the premium charged because it failed to dispute the premium amount before the proper administrative remedy.

The Court of Appeals rejected the argument.

In essence, the Court of Appeals held that there is a significant difference between the obligation to administratively exhaust a remedy in a defensive rather than offensive posture. The doctrine of exhaustion of administrative remedies is an affirmative defense; however, it does not prohibit a party from defending itself from a claim. The doctrine is simply inapplicable when the litigation was pursued by the insurer who is seeking to avoid defense of the claim.

**CLASSIFICATION OF EMPLOYEES**

While the Court of Appeals conceded that the insurer can classify employees, it cannot (as a matter of law) determine who are employees and who are not. That determination is made by the Iowa Code [(section 85.61(13)(c)) that establishes the appropriate criteria. In the matter before the court, it was determined that Travelers did not generate a fact question as to whether the drivers at issues were employees or independent contractors; thus, Travelers claim for money judgment was rejected and the motion for summary judgment entered in favor of Franzen was affirmed in all regards.

However, the Iowa Supreme Court granted further review and the decision was recently filed: the decision of the Court of Appeals was vacated, the judgment of the district court was reversed, and the case was remanded with instructions. *Travelers Indem. Co. v. D.J. Franzen, Inc.*, 792 N.W.2d 242 (Iowa 2010).

The Supreme Court’s decision turned on and was resolved by application of the exhaustion doctrine. The Court focused its attention on the role of NCCI as a licensed approved rating organization in Iowa. Initially, of course, it was necessary for Travelers to establish that the administrative remedies available through NCCI were incorporated into the comments of the insurer and insured. Interestingly, there was no language within Travelers’ policy that incorporated the entirety of the NCCI Basic Manual’s policies and dispute resolutions procedures and the Court found that the contract itself did not support an exhaustion argument.
However, Travelers also argued that exhaustion of NCCI’s administrative remedy was required by statute and case law. This argument fell on more fertile soil.

In a case of first impression, although the Iowa Supreme Court acknowledged that Franzen had never contractually agreed to use administrative remedies or to exhaust them prior to litigation AND although the statute itself does not specifically require exhaustion of remedies AND the statute described the appeal procedures in only permissive terms (“may”), the insured was estopped from arguing about the amount of the premium because it failed to exhaust administrative remedies.

The Court relied upon Iowa Code Chapter 515A (specifically §515A.9) and Iowa Administrative Code 191-60.4 in reaching its conclusion. The Court noted that the Code authorizes dispute resolution procedures not only for rates and rating systems but also for those “aggrieved by the application of its rating system.” However, the question is whether or not the use of the dispute resolution procedures as mandatory.

Administrative exhaustion is only imposed when two conditions are present: 1) an administrative remedy must exist for the claimed wrong; and 2) the statutes must expressly or impliedly require the remedy to be exhausted before resort to the courts. The Court had little difficulty in finding the first requirement. NCCI is a rating agency under the Iowa Code and the Commission of insurance has exercised its authority by delegating a portion of its charge regarding regulation of insurance rates to NCCI. Iowa Code section 515A.9 clearly defines a process of appeal in the event of a dispute regarding rates. The requirements are detailed and specific.

But what about the second requirement? Travelers provided no statutory language that expressly requires NCCI’s dispute resolution procedures be exhausted prior to litigation; the court found none. There is no express requirement that Franzen use the defined procedures prior to contesting the amount of the premium charge in a court of law.

However, the Court found that the comprehensive nature of the statutory scheme IMPLIEDLY required that the administrative procedures be exhausted. “The exhaustion requirement is intended to honor agency expertise by mandating that most matters be handled within the agency. . . . . Mandating that Franzen exhaust its available administrative remedies furthers these purposes.”

That leaves Franzen with the argument that Travelers cannot use the exhaustion doctrine offensively to bar it from raising its claim in defense of the collection action filed by Travelers. Again, the Court rejected the argument. While the Court acknowledged the harsh impact of its decision, it concluded that prohibiting application of the doctrine in defense of a claim essentially negated its intended effect. “Thus, we hold that Franzen was required to exhaust the remedy in section 515A.9 before asserting its defense in the courts. Franzen had the ability to contest both
the rate and the employment status of its drivers. Having failed to do so, Franzen may not now litigate that which could have been dealt with three years before this action was commenced.”

The Court directed that judgment be entered against Franzen for $552,436 less the $1,775. And there was never a claim under the policy.

I checked the statute; I checked the subsequent history of the Franzen decision. The statute remains unchanged; the Franzen decision has not been overruled and, indeed, was favorably cited in Chartis Ins. V. Iowa Ins. Com’r, 831 N.W.2d 119 (Iowa 2013). Yet none of those issues, including exhaustion of remedies, were raised in the Rosas case.

Rosas too involved an alleged employer who purchased workers’ compensation coverage through the assigned risk pool. Rosas too involved a subsequent audit to ascertain the payroll of “employees” and it also involved the insurer’s assessment of a significantly increased premium payment based upon its determination that there were significantly more “employees” than had been originally identified.

Raul Rosas was a relatively recent immigrant to the United States and did not speak, read or write English. He did, however, work. He was a self-employed roofer and ran his own residential roofing business. He and other self-employed roofers joined together to complete various jobs and split the pay. However, the payment from the customers was always made to Rosas and Blue Flame (his trade name). After Mr. Rosas received payment, he would split it with his fellow roofers based upon the work done. Each year he would issue 1099s to those with whom he had split the payments for the various jobs without withholding any taxes. And why was the payment always to Mr. Rosas and his company and not to the various other individuals? Because Mr. Rosas “had papers” and the other roofers working with him did not.

At some point in time, someone told Mr. Rosas that he needed to get workers’ compensation insurance for his business and so he did, going through the “assigned risk” market. First a note about the “assigned risk” pool. As described in the decision, the assigned risk pool is a “means for insurers to allocate the underwriting risk for a proportionate share of applicants who are unable to find coverage options in the voluntary market.” 2021 WL 1904698, at *1. Management of the assigned risk pool is provided by the National Council on Compensation Insurance (NCCI) and, once the risk is assigned by NCCI, the insurer cannot refuse to provide coverage.

On the application for workers’ compensation insurance, Mr. Rosas stated that he was a sole proprietor doing business as Blue Flame Roofing and he wanted to be excluded from coverage. He also stated on the application that he had “NO EMPLOYEES, NO HELPERS.” Mr. Rosas also stated that he used no subcontractors. The annual premium was assessed at $700 but remained subject to final determination after the policy ended and the payroll was audited.
At the end of the policy period, a supplemental information request was sent to Mr. Rosas. Mr. Rosas failed to respond. Another letter was sent. Mr. Rosas’s insurance agent responded stating the Mr. Rosas had no subcontractors, no helpers and no employees. For the second year, Mr. Rosas’s premium went up $100 to $800 to cover no one – at least based upon the information in the application and the supplemental information at the end of the first policy term.

And then there was an audit. In the audit, Mr. Rosas responded to the question concerning subcontractors as follows: “I’m subcontractor for roofing companies and I sub-contract this jobs to different people.” His tax return showed more than $100,000 in payments for contract labor. The insurer issued a bill for a total premium for the year of nearly $21,000. Mr. Rosas did not pay. The insurer brought suit to collect.

The sole issue with regard to the validity of the premium was whether or not those whom Mr. Rosas paid money to were employees or independent contractors, injury to the first giving rise to exposure to the employer and insurance carrier and impacting the premium due. Because Mr. Rosas and the other roofers worked together on jobs, splitting the labor with no one of them responsible for obtaining the work, payment was made by the job rather than by the hour, Mr. Rosas had no control over how the other roofers did their work, the other roofers used their own tools and equipment, he provided no training and the other workers were free to work for other people, the Court of Appeals concluded that the other roofers were indeed independent contractors and not employees. Because the insurer failed to provide sufficient evidence that the other roofers were indeed employees, the Court of Appeals affirmed the district court’s decision rejecting the claim for additional premiums.

In passing, it is noted that Mr. Rosas brought a bad faith claim against the insurer for pursuing the claim for an additional premium. The district court was unimpressed and the Court of Appeals simply quote the district court’s conclusions in support of its holding rejecting the claim of bad faith. Great language:

“…the actions of both parties can fairly be labeled as lazy. AOIC did not seek clarification regarding the information it received from Rosas and made assumptions it shouldn’t have without seeking more information. Rosas, on the other hand, had it within his power to nip this dispute in the bud by being forthcoming with information on his and his fellow roofers’ business practices from the beginning. …”

There is an interesting concurring opinion written by Judge Greer and joined by Judge Mullins addressing what the insurer described as issues of first impression, namely the assignment of the burden to establish the status of the workers and to investigate the facts. It is intellectual heaven for insurance geeks. Unless you have either the same issue or insomnia, however, move on.
B. The Duty to Defend – Was It On The Premises

The relevant facts of *Secura Ins. v. Black’s Heritage Farm, Inc.*, No. 19-1623 (Iowa decided January 21, 2021) are heavily dependent on geography. The Blacks owned property on both the east and west side of 530th Avenue outside of Ames. The Blacks lived at 26156 530th Avenue on the east side of the road. There were several buildings on the west side of the road including a structure leased to tenants who used it for storage of equipment, tools and other possession. Also on the west side of the road, however, was a smoldering woodpile owned or controlled by the Blacks. Ultimately the woodpile apparently decided to do more than smolder and a fire destroyed the storage building and the tenant’s property. The tenants sued the Blacks and they sought coverage under the terms of their farm insurance policy with Secura.

The policy identified the covered property as the land and buildings on the east side of the road. The Blacks did not have a policy that included the land on the west side of the road, including the building occupied by the tenant or the wood pile. The insured denied a defense to the Blacks and this litigation followed.

The outcome of this litigation was dictated by the definition of “insured premises” which, in this case, was the property described only on the east side of the road – not including the wood pile or the leased buildings on the west side of the road. The trial court noted that the insureds “have not pointed out any policy language that would expand the insured premises beyond the (forty) acres on the east side of 530th Avenue, at the address 16156 530th Avenue.”

On appeal, the insureds noted and sought protection from the liability claim under an additional provision of the policy that enlarged the definition of “insured premises” to also mean “vacant land (other than the land held for development), owned by, rented to, or used by an insured, including land where a residence or farm structure is being built by an insured; …” Unfortunately, because that provision was not relied upon by the insured at the trial court level and was not addressed by the trial court, possible coverage under that language was waived.

C. Life Insurance, Open Enrollment and “Limited Activity”

Life insurance cases and open enrollment disputes are rare. *Fisher v. Principal Life Ins. Co.*, No. 19-0672 (Iowa decided November 30, 2020) offers both.

In *Fisher*, the insured signed up through a plan offered by her employer during open enrollment to obtain life insurance for herself and her husband and paid the initial premium. The coverage was to become effective on January 1st. On that date, the employee’s husband was hospitalized and he died the following day, January 2nd. Principal denied coverage because the employee’s spouse was in a “period of limited activity” at the time the policy went into effect. The policy defined the phrase to mean any “period of time during which a person is … confined in a Hospital for any cause or confined in a Nursing Facility.” If the person is in a “period of limited activity on the
date the coverage would otherwise become effective” (in this case January 1st), the policy provided that the coverage would not be in force for that person until the Period of Limited Activity ends.

Fisher first argued that the condition governing a “period of limited activity” did not apply if the insurance was obtained during an open enrollment period. The trial court noted (and the appellate court agreed) that there was no exemption for the new policyholder if the policy was obtained during an open enrollment period and rejected the insured’s argument. Having found that the policy was unambiguous, Fisher’s breach of contract claim was denied.

Fisher also argues, however, that the doctrine of reasonable expectations should be applied to grant coverage. In addressing the applicability of the doctrine, the court first noted that it is “carefully circumscribed” and applicable only when an exclusion (1) is bizarre or oppressive; (2) eviscerates terms explicitly agreed to; or (3) eliminates a dominant purpose of the transaction. Prior to invoking the doctrine of reasonable expectations, the insured must first prove circumstances attributable to the insurer “that fostered coverage expectations or show that the policy is such that an ordinary layperson would misunderstand its coverage.” Having found that the policy is unambiguous, the insured’s argument was doomed from inception.

And finally, Fisher asserted that Principal waived the “period of limited activity” condition by keeping the initial premium payment for three months. The court noted that the waiver theory “applies where a party, knowing of an enforceable right, neglects enforcement for such a length of time that the law implies its waiver or abandonment.” Succinctly stated, the trial court found that Principal had not neglected enforcement of its rights for such as period of time as to justify imposition of a waiver.

D. Breach of Contract and Bad Faith

And all is right with the world with the Iowa Supreme Court’s analysis of bad faith in a first party bad faith case yet again. The facts of Luigi’s, Inc. v. United Fire and Cas. Co., 959 N.W.2d 401 (Iowa 2021) are not complex. In 2016, a fire broke out in the kitchen of Luigi’s restaurant, resulting in a total loss. The insurance policy with United Fire provided coverage for the building based on “actual cash value” with a limit of $550,000. Since it was a total loss, the entire limit of the policy should be paid, yes? No.

The loss is to be measured by the actual cash value and the policy provided that here are two ways to ascertain actual cash value:

1. In the event that there is a regular market for the property where the property can be bought and sold in the ordinary course of dealing, and it is possible to determine the property’s market value, then the market value of the property is the actual cash value (market approach).
2. In the event that there is no regular market for the property where the property can be bought and sold in the ordinary course of dealing, or it is not possible to determine the property’s market value, then actual cash value means the amount which it would cost to repair or replace covered property with material of like kind and quality, less allowance for physical deterioration and depreciation, including obsolescence (cost approach).

The independent appraiser assigned to this case determined that the market approach was appropriate and concluded that the actual cash value of the property immediately prior to the fire was $242,000. The insured objected and invoked the appraisal process provided by the policy under which the insured and the insurer each selected an appraiser and the appraisers in turn selected a neutral umpire. If the appraisers failed to agree, they would submit their differences to the umpire. The agreement of any two of the three would result in a decision.

With the insurer’s appraiser at $242,000 and the insured’s appraiser at $1,030,000, the matter was submitted to the umpire. Ultimately the umpire and both other appraisers signed an appraisal award letter establishing the loss amount at $502,000 ($380,000 for the building and $122,000 for the furniture, fixtures, and equipment). The representative of United Fire challenged the appraisal based, in part, on the argument that the furniture, fixtures and equipment had already been paid for under a separate part of the policy and should not have been included in the value of the building. The argument was that the appraisers exceeded their authority and included items other than the real estate that they were assigned to value. Further, the appraiser for United Fire asserted that he felt “coerced” to agree to the higher number. The insured declined to permit the appraisers to reconsider the award that had been previously signed by both appraisers and the umpire.

Upon receipt of the appraisal award and the sworn proof of loss and faced with a demand for payment of the full $502,000, United Fire had thirty days from the date of the appraisal under the policy to make its payment. It did.

Eight months later, the insured sued United Fire for breach of contract and bad faith, asserting a right to the policy limit of $550,000 and punitive damages. The jury returned an award of $48,000 contractual damages (the difference between the amount of the signed appraisal which had been previously paid and the policy limit) and also returned a verdict in the insured favor on the bad faith claim in the amount of nearly $41,000 in damages for the fees the insured incurred in the appraisal process and $751.71 for legal fees incurred to write the demand letter and related work. United Fire’s post trial motions were denied and this appeal followed.

The arguments raised by United Fire were several – and persuasive:
Argument I: The appraisal process was conclusive.

Having found that United Fire had sufficiently preserved error on this issue, the court meticulously measured the performance of United Fire against the policy language and found that it met the contractual requirements. In response to the insured’s argument that it was entitled to policy limits given the totality of the loss, the court emphasized that the policy limit is just that - - a limit. It does not necessary define the payable loss. To the contrary, the policy specifically and unambiguously defines the loss to be measured by the actual cash value.

Argument II: The doctrine of reasonable expectations is inapplicable.

In support of its argument that the doctrine of reasonable expectations should be applied to find coverage, the insured used communications with the agent for United Fire. In an email exchange prior to the loss, the United Fire agent asked the insured whether or not the insured agreed to lower the “value” of the building (rather than the “limit” of the coverage) to $550,000. The court was unpersuaded by the insured’s purported reliance on the email. In spite of the insured’s argument that an insured’s reasonable expectation of payment for a total loss would be the limit of the coverage, the court concluded that the there was no evidence that an “ordinary layperson would misunderstand its coverage” or that “there are circumstances attributable to the insurer which would foster coverage expectations.”

“Construing the facts in a light most favorable to Luigi’s, Luigi’s breach of contract claim based on United Fire’s reliance on its expert still fails as a matter of law.”

Argument III: There was a reasonable basis for the positions taken by United Fire and therefore there was no bad faith as a matter of law.

And again the Supreme Court agreed. Bad faith required more than a showing that the investigation wasn’t as “thorough or all-encompassing” as Luigi’s would have liked. And the insurance company had no duty to disregard the opinion of its own expert in favor of the insured’s expert’s opinion. United Fire paid the amount of the appraisal within the contractually set 30-day period. The Supreme Court found no bad faith and that judgment too was vacated and the decision reversed.

IV. DEJA VU ALL OVER AGAIN

Consistently, the same insurance issues walk through our front door at the office. In no particular order, our recent experience has shown that these are some of the frequent:
A. Uninsured/Underinsured

In analyzing uninsured and underinsurance cases, it is important to recognize the difference between the two coverages as espoused by the Iowa Supreme Court in *Veach v. Farmers Ins. Co.*, 460 N.W.2d 845 (Iowa 1990):

The purpose of uninsured motorist coverage is to insure minimum compensation to victims of uninsured motorists. The goal of underinsured motorist coverage on the other hand is full compensation to the victims to the extent of the injuries suffered. We have adopted the "broad coverage" view of underinsured motorist coverage while taking a "narrow coverage" view of uninsured motorist coverage. This means that benefits that are duplicative in the uninsured motorist context are not necessarily so in the underinsured motorist context. 460 N.W.2d at 848.

Iowa Code Section 516A.1 mandates that uninsured/ underinsured benefits be provided unless specifically rejected in writing by the insured. The Iowa law prevails over the policy language of *Rodman v. State Farm Mutual Ins. Co.*, 208 N.W.2d 903 (Iowa 1973). Also, see *Preferred Risk v. Federal Mutual*, 611 N.W.2d 283 (Iowa 2000) (an employer’s policy that attempted to afford UM/UIM coverage for some categories of insureds, but not others, is unenforceable unless the named insured complies with Section 516A.1). Iowa Code Chapter 516A does not require umbrella policies to provide UM/UIM coverage. *Jalas v. State Farm*, 505 N.W.2d 811 (Iowa 1993).

Once UM claimant presents evidence that he or she used "all reasonable efforts" to ascertain the existence of any applicable liability insurance and was unsuccessful, then an inference may be drawn that the other vehicles were uninsured. The burden of going forward with affirmative evidence to the contrary then shifts to the insurer, although the ultimate burden of persuasion remains with the claimant. *Frunzar v. Allied Property and Casualty Ins. Co.*, 548 N.W.2d 880 (Iowa 1996).

Stacking is taking the limits of several insurance policies and essentially adding them together by staking the policies. Anti-stacking clauses are valid and enforceable unless the accident occurred before July 1, 1991, or a suit on the UIM claim was filed before September 15, 1991. Iowa Code Section 516A.2 and 1991 Iowa Acts Ch. 213, Section 30, even where the various policies involved are issued by different insurers. *Barron v. State Farm*, 540 N.W.2d 423 (Iowa 1995); *Hernandez v. Farmers Ins. Co.*, 460 N.W.2d 842 (Iowa 1990); *Mewes v. State Farm Auto Ins. Co.*, 530 N.W.2d 718, 724 (Iowa 1995).

An insured can sue insurer directly on UIM claim to recover damages the insured is "legally entitled to recover,” and is not required to sue underinsured motorist separately to determine those damages. *Leuchtenmacher v. Farm Bureau Mut. Ins. Co.*, 461 N.W.2d 291 (Iowa 1990).

An insured is entitled to make a UIM claim without fully exhausting the liability limits of the at fault party's coverage. The insured can even accept an offer of judgment for less than the
underlying liability limits and still present a UIM claim. *Hoth v. Iowa Mutual Ins. Co.*, 577 N.W.2d 390 (Iowa 1998). However, the insured would only be entitled to the difference between the total liability limits and his damages, subject to the underinsurance limits. *In re Estate of Rucker*, 442 N.W.2d 113 (Iowa 1989).

Where insureds settled for liability limits and released at-fault party, but failed to get the underinsurance carrier's consent to the settlement, the carrier can plead a breach of the "consent to settle" provisions as an affirmative defense, but must prove prejudice, i.e. that they could have successfully collected via subrogation from the underinsured driver. *Grinnell Mut. Reinsurance Co. v. Recker*, 561 N.W.2d 63 (Iowa 1997); *Kapadia v. Preferred Risk Mutual Ins. Co.*, 418 N.W.2d 848 (Iowa 1988); *Hale v. Classified Ins. Co.*, 535 N.W.2d 164 (Iowa App. 1985). Further, the insurer must prove the amount that could be realized from the tortfeasor's assets toward the satisfaction of a subrogation judgment at the time reasonably close to when the insurer's subrogation interest would have arisen if not released by the insured. *Hoth v. Iowa Mutual Ins. Co.*, 577 N.W.2d 390 (Iowa 1998).


And then there are interesting cases regarding the statute of limitations for UM/UIM cases. The three most interesting (in my opinion) were all decided nearly a decade ago and are summarized below.


This case considered whether the two-year statute of limitations for UIM claims in an insurance policy could be applied to the claims of a third-party beneficiary of an insurance policy. In this case, the plaintiff was riding in his brother’s SUV when an accident occurred, and both were injured. The brother’s SUV was covered under a Nationwide auto policy, which included UIM coverage. The attorney for the brother and Nationwide corresponded over a number of months, and the attorney requested the policy’s declaration page and policy limits. The attorney provided medical records, and correspondence from Nationwide referenced an approaching expiration date for the claim.

Nationwide then provided a letter to the brother’s counsel indicating that the two-year statute of limitations contained in the UIM Endorsement, requiring suit to be brought within two years of the accident, had expired. The brother brought suit for UIM benefits against Nationwide and his own insurance carrier regardless, two years and thirty-one days after the accident.
The district court denied the statute of limitations defense, finding that the brother was not a party to the insurance contract between the driver and Nationwide, and not subject to the statute of limitations. The brother filed an immediate appeal. The Court of Appeals recognized recent Iowa case law in Robinson which upheld a two-year statute of limitation, but found it to be a novel issue where a third party to the contract was involved. Considering the broad scope of UIM coverage, the court held that insurance companies have a duty to inform the passenger of an insured's conditions on coverage such as a statute of limitations. As Nationwide had knowledge both of the brother’s claim and the fact he was not aware of the contractual limitations period, the court affirmed the district court and allowed the brother’s UIM claim to proceed.


The issue in this case is whether “substantial compliance” with an insurance policy’s contract can overcome the two-year contractual limitation for bringing UIM claims in the contract after the Iowa Supreme Court’s decision in *Robinson*.

This case arose from an August 16, 2009, automobile accident in which Kevin Jones alleged he was injured after being rear ended by Nathan Lockner. Kevin and Debra Jones had an automobile insurance policy through Nationwide which provided for UIM coverage. The UIM contract required the claimant to file the claim within two years from the date of the accident. A lawsuit listing only Lockner as a defendant was filed on August 11, 2011. The two-year period allowed by the policy for commencement of UIM claims against Nationwide closed on August 16, 2011. The UIM claim was not brought against Nationwide by the Joneses until November 4, 2011, well after the two-year period ended.

The court once again looked to *Robinson* for guidance and found that it was clear when it held the “two-year UIM policy deadline is enforceable as a matter of law because it matches the two-year statute of limitations in Iowa Code section 614.1(2) (2009) for personal injury actions.” The Joneses put nothing in the record to show that they complied with the two-year limitation, and in fact, admit they did not comply with it. Thus, because the lawsuit was not filed within the two-year period, the court remanded with instructions to enter summary judgment in favor the defendants.


The issue in this case is whether a two-year contractual limitation period for underinsured motorist (UIM) claims was reasonable.

On January 4, 2009, Susan Hruby and her minor daughter, Emma Hruby, sustained injuries when the car Susan was driving collided with another vehicle being driven by Christopher Fangman. The driver of a third vehicle involved in the accident, Leonardo Alvarez, was killed. At the time of the accident, the Hrubys had UIM coverage through their insurance policy provided by Allied
Property and Casualty Insurance Company (Allied), which included a two-year statute of limitations. Litigation proceeded between the Hrubys, Fangman, Steve’s Roofing Inc. (the owner of the vehicle driven by Fangman), and the estate of Alvarez—but not Allied. Two years and seven months after the accident, the Hrubys filed this UIM action against Allied. Allied moved for summary judgment on the grounds that the two-year deadline in its UIM policy had expired. The Hrubys resisted, contending the deadline was unreasonable because Susan was unable to ascertain the full extent of damages incurred within two years of the accident and because of the presence of a third party.

The court stated that a two-year limitation period for UIM claims is reasonable as a matter of law under the recently decided case of Robinson. The court also looked to the Robinson decision for guidance on the effect of a third party on the UIM claim. The court explained that “[o]ur state’s trial bar has a long-standing custom and practice of filing UIM claims together with the tort action against the driver,” thus, a “UIM claim that ‘potentially has merit’ should be filed.” Because the two-year limitation was reasonable and the third party has no effect, the court of appeals affirmed the trial court’s granting of summary judgment.

Bottom line: Do NOT rely on the general 10-year statutory limitation for bringing an action on a written contract because contractual agreements with regard to such limitations are generally enforced.

B. Duty to Defend

The duty to defend is broader than the duty to indemnity. For insureds this is very good news because the cost of defense of a claim is often equal to or greater than the indemnity value of the claim against the insured. The most-often cited case articulating the principle in Iowa is Employers Mut. Cas. Co. v. Cedar Rapids TV Co., N.W.2d 639 (Iowa 1996) wherein the Court stated:

An insurer's duty to defend is separate from its duty to indemnify; the duty to defend is broader than the duty to indemnify. The duty to defend arises ‘whenever there is potential or possible liability to indemnify the insured based on the facts appearing at the outset of the case.” (citation omitted) In other words, the duty to defend rests solely on whether the petition contains any allegations that arguably or potentially bring the action within the policy coverage. If any claim alleged against the insured can rationally be said to fall within such coverage, the insurer must defend the entire action. In case of doubt as to whether the petition alleges a claim that is covered by the policy, the doubt is resolved in favor of the insured. A.Y. McDonald Indus., Inc. v. Insurance Co. of N. Am., 475 N.W.2d 607, 627 (Iowa 1991) (en banc) (citations omitted) (emphasis added).
A plaintiff's basis of recovery is necessarily indeterminable until a case is tried. Id. So, when does the duty to defend arise if the basis for recovery on which the duty to defend is determined isn’t known until completion of the underlying litigation? The duty to defend arises whenever there is potential or possible liability to indemnify the insured based on the facts appearing at the outset of the case. In other words, the duty to defend rests solely on whether the petition contains any allegations that arguably or potentially bring the action within the policy coverage. If any claim alleged against the insured can rationally be said to fall within such coverage, the insurer must defend the entire action. In case of doubt as to whether the petition alleges a claim that is covered by the policy, the doubt is resolved in favor of the insured.


While the language is very broad and the quotations appear definitive, there are nuances to the duty to defend that have been added and/or more clearly articulated over time. Note, for example:

‘When a claim against the insured is based on facts which show that it is outside the scope of the coverage afforded by the policy, the insurer is justified in refusing to defend the action. Such refusal does not constitute a breach of the policy provisions and does not subject the insurer to any legal liability. This rule applies even though the policy provisions require the insurer to defend groundless, false, or fraudulent suits. Such provisions do not require the insurer to defend when the claim is based on facts which show it to be outside the scope of the coverage.’


As noted above, the initial cases governing the duty to defend stated that the determination was to be made based upon the allegations in the petition or complaint. That has been broadened. Noted the following from Talen v. Employers Mut. Ins. Co., 703 N.W.2d 395, 405-06 (Iowa 2005):

Talen and the Vinton bank contend that Employers may not avail itself of the employment-related-practices exclusion in the present case because the allegations of Pearson's petition setting forth his defamation claim did not identify what was said in Talen's conversations with the owner and executive officer of the Oelwein
bank. The petition only alleged that what was said was disparaging towards Pearson. Thus, Talen and the bank argue, it may not be assumed that the alleged disparagement related to Pearson's performance as an employee of the bank. We have recognized that it is permissible for a liability insurer, in determining whether to accept a tendered defense to consider facts beyond the allegations of the petition. *McAndrews v. Farm Bureau Mut. Ins. Co.*, 349 N.W.2d 117, 119 (Iowa 1984).

In *McAndrews* we stated this principle as follows: "The scope of inquiry, however, must sometimes be expanded beyond the petition, especially under 'notice pleading' petitions which often give few facts upon which to assess an insurer's duty to defend." *Id*. Quoting from an earlier case, we stated that an insurer has no duty to defend "if after construing both the policy in question, the pleadings of the injured party and any other admissible and relevant facts in the record, it appears the claim made is not covered by the indemnity insurance contract." *Id.* (quoting *Cent. Bearings Co. v. Wolverine Ins. Co.*, 179 N.W.2d 443, 445 (Iowa 1970)). We find this principle to be especially relevant when the basis for withholding coverage is a policy exclusion the application of which is not readily ascertainable from the allegations of the petition and will not necessarily be determined in the tort litigation. (citation omitted).

Because the obligation to defend can fluctuate with development of new facts, continuing analysis is required.

C. Standards of Construction and Interpretation


An insurance policy is to be construed as a whole, giving the words used their ordinary, not technical meaning to achieve a practical and fair interpretation. The court will not give a strained

When interpreting insurance policies, a court must "seek to ascertain from its words the intent of the insurer and insured at the time the policy was sold." *Jensen v. Jefferson County Mutual Insurance Association*, 510 N.W.2d 870, 871 (quoting *Grinnell Mut. Reinsurance Co. v. Voeltz*, 431 N.W.2d 783, 785 (Iowa 1988)).


Because insurance policies are in the nature of adhesive contracts, their provisions are to be construed in a light most favorable to the insured. *Krause v. Krause*, 589 N.W.2d 721, 726 (Iowa 1999). Due to the nature of an insurance policy, the benefit of the doubt in the drafting is interpreted against the insurance company. *Westfield Ins. v. Economy Fire & Cas.*, 623 N.W.2d 871, 875-76 (Iowa 2001).

### D. Occurrence and Intentional Acts

As a matter of public policy, insurance policies generally provide liability protection only for an “occurrence.” “Occurrence” is almost always a defined term in the policy and, in general, means an accident, something unexpected. As if to emphasize the issue, most insurance policies also include exclusions for intentional harm. While the distinction appears clear superficially, application is complex.

The Iowa Supreme Court noted that the “common definition” of the term “accident” is “an unexpected and unintended event.” *National Surety Corp. v. Westlake Investments, LLC*, 880 N.W.2d 724, 735 (Iowa 2016) (citing *United Fire & Cas. Co. v. Shelly Funeral Home, Inc.*, 642
N.W.2d 648, 652 (Iowa 2002) (quoting Weber v. IMT Ins. Co., 462 N.W.2d 382, 287 (Iowa 1990)). Significantly, however, the Court holds that determination of whether or not the occurrence is an “accident” must be measured from “the viewpoint of the insureds and what they intended or should reasonably have expected.” Id. at 734 (quoting the jury instruction that it approved). The Court noted that it has “previously concluded an intentional act resulting in unexpected and unintended property damage qualifies as an accident that amounts to an occurrence covered by a CGL policy so long as the insured did not expect and intend both the act itself and the resulting harm . . .” Id. at 735 (Emphasis added) (citing West Bend Mutual Insurance Co. v. Iowa Iron Works, Inc., 503 N.W.2d 596, 600–01 (Iowa 1993)).

Perhaps the best way to describe the dichotomy is by case example.

In Addison Ins. Co. v. MEP Co., 2019 WL 5790866, 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.”

And finally, Liberty Mut. Ins. Co. v. Pella Corp., 650 F.3d 1161 (8th Cir. 2011) offers a clear analysis of the interrelationship between the requirement of an “occurrence” and the exclusion for “intentional acts.” In Liberty Mut., the Eighth Circuit Court of Appeals applied the definition of “occurrence” but specifically found that the insured knew of the defect in its product and knew that it would permit water leakage and inevitably resulting damage to the surrounding area. Id. at 1175-76. There was no surprise. There was no accident. Damage to surrounding property from the insured’s conduct was not only expected but inevitable in Liberty Mutual.1

1 “Specifically, the Pappas complaint alleged that Pella knew that its windows had a defect that allowed water to leak through the window frame. Similarly, all of the claims in the Saltzman complaint derived from the allegation that Pella knew “that its windows contained an inherent defect that permitted [water] leakage.” In both cases, the property damage—whether to the windows themselves or the structure of the building near the windows—was caused by a defect that Pella was alleged to have known about. Under Iowa law, such defective workmanship, as alleged in the
While the requirement of an “occurrence” is most closely associated with liability policies, the exclusion for intentional acts causing harm is found in most insurance policies, including property loss coverages. One of the most interesting examples of the ramifications of the exclusion is found in *Postell v. Am. Family Mut. Ins. Co.*, 823 N.W.2d 35 (Iowa 2012). The issue in this case was whether an intentional loss exclusion policy could apply to deny coverage to an innocent coinsured who had no part in the intentional act.

In *Postell*, a married couple, Michelle and David, owned a home together. Michelle eventually filed for divorce after years of abuse and marital difficulties. David became depressed and threatened to harm Michelle and himself. He unsuccessfully attempted to kill himself with a gun, but police intervened. Later, he told Michelle that he had poured gasoline throughout the house, turned on the stove, lit candles, and was waiting for the house to blow up. Some close friends and family observed the carpet doused in gasoline and smelled fumes. David then lit two fires in the home, and died three days later from his burn injuries. Michelle sought coverage from her residential fire insurance policy with American Family Mutual Insurance Company. The policy excluded policy for intentional losses caused by “any” insured, and also contained a “severability” clause stating coverage applied separately to “each insured.”

The court first considered the applicability of the intentional loss exclusion. The court agreed that when a policy refers to “a” or “any” insured, it refers to the act of either insured, so that David’s acts could trigger the intentional loss exclusion. The court rejected Michelle’s argument that David’s acts were unintentional as “uncontrollable impulses to commit suicide by fire.” Instead, the court found substantial evidence that David did not have a mental defect, knew the consequences of his acts, and intended to damage the house in his suicide.

Next, the court considered Michelle’s argument that she was an “innocent spouse,” and could still recover because she was not involved in David’s acts. The court held that “[i]t is well-settled law in this state that the use of the words, ‘any insured,’ is an unambiguous phrase that precludes coverage for all insureds, including an innocent coinsured spouse.” Then, the court considered whether the “severability” clause providing coverage to “each” insured gave Michelle coverage separate from David’s act. The court reiterated prior precedent that these severability clauses do not have this substantive effect, and the exclusion applied to all insureds’ coverage. Finally, the court considered the “reasonable expectations” doctrine, and found the phrase “any” insured to be unambiguous and Michelle knew of the scope of the exclusion.

Finally, the court recognized that Iowa Code § 515.109 had been recently amended by the legislature to narrow the minimum protections for insureds in fire policies. These amendments

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_**Pappas and Saltzman Suits,** cannot be considered an occurrence, i.e., “an undesigned, sudden, and unexpected event.”* Pursell, 596 N.W.2d at 70 (quotation and citation omitted).”* _Liberty Mut. Ins. Co. v. Pella Corp.*, 650 F.3d 1161, 1176 (8th Cir. 2011).
made a prior decision of the court, which gave coverage to an “innocent” spouse, moot. As a result, the Court held that there was no basis to find coverage for Michelle.

E. **Own Work**

Commercial General Liability policies almost always contain and exclusion for loss or damage to “your work.” But again, the nature of the damage must be articulated and clearly defined. In *National Surety Corp. v. Westlake Investments, LLC*, 880 N.W.2d 724 (Iowa 2016), the insureds were the developer and general contractor of an apartment complex in West Des Moines. As described by the Iowa Supreme Court, the case arose out of the following factual background:

During construction, numerous problems surfaced within the complex, including visible water penetration issues in several buildings. These problems did not hamper the sale to Westlake because the parties believed them to be aesthetic. However, that turned out not to be true. After the sale closed in November 2003, the construction defects throughout the complex continued to cause widespread water penetration issues.

*Id.* at 727. The purchaser, Westlake, sued the insured to “recover lost profits, repair costs and other damages” resulting from the water damage. *Id.* Ultimately the case was settled with the entry of a consent judgment for $15,600,000. *Id.* Litigation was then filed to resolve the issue of available insurance coverage for the loss sustained.

In ascertaining the extent of coverage available, after *Westlake*, previous decisions addressing coverage for property damage for faulty workmanship should be read narrowly and with a clear eye toward delineation of the type of damage. For example:

*In Pursell Construction, Inc. v. Hawkeye-Security Ins. Co.*, 596 N.W.2d 67 (Iowa 1999), unlike many subsequent circumstances in which the authority was sought to be applied, the insured was seeking coverage for repair of its own defective work. The Court in *Westlake* emphasized the significance of that fact, stating:

Relatedly, *Pursell* is factually distinguishable from the present case. In *Pursell*, the contractor who performed the defective work was the insured. *Id.* at 68. The only damage alleged to have resulted from the defective work was the cost of repairing the insured’s own defective work product. *Id.* at 68, 70–71. In contrast, *Westlake* proved defective installation of the building wrap and flashings resulted in water penetration that caused widespread consequential damage to interior building components that were not defective, including the wood framing, drywall,

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2 Furthermore, there is an unaddressed issue in *Pursell* with regard to the existence of “property damage” as the house itself suffered no physical damage. It was simply not in compliance with the safety codes and therefore had to be raised. That is an economic loss, not “property damage” that requires physical damage.
insulation, carpet, nails, staples, and other metal fasteners inside the walls. (Emphasis added).

_Id._ at 737.

And, contrary to some interpretations, in my opinion, _W.C. Stewart Constr. Inc. v. Cincinnati Ins. Co._, 2009 WL 928871 (Iowa Ct. App.) is equally unsupportive of the proposition that faulty workmanship cannot constitute an occurrence. First, it is noted that _Stewart_ is an unpublished decision of the Iowa Court of Appeals. An unpublished opinion of the Iowa appellate courts “may be cited in a brief if the opinion or decision can be readily accessed electronically” but “shall not constitute controlling legal authority.” Iowa R. Civ. P. 6.904 (2) (c). (Emphasis added)

Secondly, the Iowa Supreme Court has confirmed that the factual analysis of _Pursell_ upon which the Court of Appeals relied in _Stewart_ is in error. In reaching its decision in _Stewart_, the Court of Appeals stated as follows:

The _Pursell_ court . . . held that “defective workmanship standing alone, that is, resulting in damages only to the work product itself, is not an occurrence under a CGL policy.” _Id._. Stewart argues that because Rubloff’s counterclaim (the basis for the claim in _Stewart_) asserted damages to property other than Stewart’s work product, _Pursell_ is not controlling. Stewart reads _Pursell_ too narrowly. The faulty workmanship in _Pursell_ required re-installation of plumbing and duct work with which _Pursell_ had not been involved, just as the faulty workmanship by Stewart required reconstruction of walls Stewart had not built.

_Id._ at *3. (Emphasis added). However, the Iowa Supreme Court has now confirmed that Stewart’s argument is valid. _Pursell_ was not read too narrowly by the appellant in _Stewart_; it was read too broadly by the Court of Appeals. The plumbing and duct work were not damaged by faulty workmanship but required work in the repair process. The distinction defines the result.

The holding in _Pursell_ is limited by its plain language to situations in which the insured performed defective work and sought coverage for the cost of repairing the defective work product.” _Westlake_, 880 N.W. 2d at 738. (Emphasis added). In _Westlake_, the Supreme Court emphasize the distinction and the importance of the difference as the only damage alleged to have resulted from the defective work (in _Pursell_) was the cost of repairing the insured’s own defective work product. (citation omitted). In contrast, _Westlake_ proved defective installation of the building wrap and flashings resulted in water penetration that caused widespread consequential damage to interior building components that were not defective, including the wood framing, drywall, insulation, carpet, nails, staples, and other metal fasteners inside the walls.”
It is a distinction emphasized by the Iowa Supreme Court in Pursell and consistent with the Supreme Court’s recent pronouncement: “We agree with the majority rule and now join those jurisdictions that hold that defective workmanship standing alone, that is, resulting in damages only to the work product itself, is not an occurrence under a CGL policy.” Pursell, 596 N.W.2d at 71. (Emphasis added). The Iowa Court of Appeals in Stewart was simply in error.

Editorial Comment: In my opinion, Westlake overruled Stewart by implication if not by declaration. Even if it weren’t overruled, however, the Supreme Court has now confirmed that Pursell is limited to circumstances existent in that case and that the Court of Appeals in Stewart improperly interpreted the Pursell case upon which it relied.

So, how broadly can/should Westlake be read? The Supreme Court noted that it “need not consider whether property damage arising due to the insured’s own defective workmanship may constitute an occurrence in the context of a modern standard-form CGL policy.” Westlake, 880 N.W. 2d at fn. 8. However, arguably the requirement to establish an “occurrence” is not changed by the existence or absence of a subcontractor. In either circumstance, it requires an accident, “an unexpected and unintended event.” If the event were other than an accident, then the insured must have intended the act and intended or reasonably expected the resultant damage.

Furthermore, if faulty workmanship is not even an occurrence, why would it be necessary to for the insurer to exclude damage to “your work” later in the policy? It wouldn’t. Since the policy is read as a whole, there must be circumstances in which faulty workmanship can constitute an occurrence as defined in the standard CGL policy.

Having no desire to rephrase what has already been articulately stated, the Supreme Court explains the relationship between the exclusion for “your work” and the recognition of an “occurrence”:

Thus, although exceptions and exclusions cannot “create coverage that otherwise is lacking” under an insuring agreement, they offer insight into whether coverage exists under an insuring agreement by shedding light on what the terms it contains mean. (Citations omitted).

.....

It would be illogical for an insurance policy to contain an exclusion negating coverage its insuring agreement did not actually provide or an exception to an exclusion restoring it. (citations omitted). Just as we will not strain to interpret an

3 Unless one of the parties specifically asked to have Stewart overruled, the Iowa Supreme Court would not do so on its own. (“Normally we do not overrule our precedent sua sponte.” Westlake,*24, fn. 15.)
insurance policy to impose liability on an insurer, we will not strain to interpret an insurance policy to deprive an insured of coverage the policy clearly contemplates. (Citation omitted). Nor will we interpret an insurance policy in a manner that renders an exception or exclusion it contains to be superfluous unless it is evident interpreting the policy to give meaning to a particular exception or exclusion would be unreasonable in the context of the structure and format of the policy as a whole. (Citation omitted).

*Westlake*, 880 N.W.2d at 739-40.

Additionally, although the Court in *Westlake* did not have proper facts before it to address the recognition of an “occurrence” if there were no subcontractor, it commented as follows in Footnote 9:

We need not decide whether to overrule *Pursell* to decide the case before us, as the damages Westlake claims arose because defective work performed by the insureds’ subcontractors caused extensive property damage to the complex. We note many courts that have concluded defective workmanship does not constitute an occurrence under circumstances similar to those we considered in *Pursell* have subsequently concluded defective workmanship performed by an insured’s subcontractor may constitute an occurrence covered by the insuring agreement in a modern standard-form CGL policy. (citations omitted)

*Id.* fn. 9. The Court clearly appreciates the trend to acknowledge defective workmanship as an occurrence if there is damage to property other than the actual work product of the insured.

And finally, the overwhelming majority of jurisdictions in the United States that have addressed the issue have now recognized that collateral damage resulting from defective workmanship can be an occurrence under the language of the post-1986 ISO policy.

Since *Westlake* was decided, other cases have addressed this and similar issues with amazing rapidity.

Shortly after *Westlake* was decided, but without mentioning it in the opinion, the Eighth Circuit decided *Decker Plastics v. W. Bend Mut. Ins. Co.*, 833 F.3d 986 (8th Cir. 2016). In *Decker Plastics*, the federal Court of Appeals was called upon to decide whether or not collateral damage resulting from a defectively manufactured product to property other than the insured’s would be covered under the language of a standard CGL policy. In a *per curium* decision, the three-judge panel decided as follows:

West Bend argued, and the district court agreed, “that A1’s claimed losses against Decker Plastics, as foreseeable and expected consequences of Decker Plastics’
defective workmanship …, did not result from an ‘accident,’ and were not an ‘occurrence’ under” West Bend’s policy.

We disagree with this analysis because it disregards the Supreme Court of Iowa’s narrow holding in Pursell—that a claim of “defective workmanship standing alone, that is, resulting in damages only to the work product itself,” is not an occurrence. 596 N.W.2d at 71. Here, Decker’s defective bags were sold to its customer, A1’s, which then used the bags to store its own property, landscaping materials. The defective bags unexpectedly deteriorated, causing damage to A1’s other property. The deterioration of the bags was the covered occurrence. To rephrase Pursell’s definition of “accident,” the occurrence was “a misfortune with concomitant damage to a victim [A1’s], and not the negligence [of Decker] which eventually result[ed] in that misfortune.” The covered property damage (if any) was to A1’s property other than the bags.

Result: Coverage!

_Pella Corp. v. Liberty Mut. Ins. Co., 2016 WL 6514171 (S.D. Iowa, November 1, 2016)_

Shortly thereafter, Senior Judge Gritzner issued his opinion in _Pella Corp_. The court stated as follows, relying heavily on _Decker Plastics_:

In that case, Decker Plastics, a manufacturer of plastic bags, sold its product to A1, a vendor of landscaping materials. Id. at 987. Because Decker Plastics failed to manufacture the bags with an ultraviolet inhibitor, the bags deteriorated in the sunlight, causing small shreds of plastic to mix with A1’s landscaping materials. Id. A1 sued Decker Plastics to recover its losses, and Decker Plastic’s insurer denied coverage. Id. Reversing the district court’s ruling, the Eighth Circuit determined that the deterioration of Decker Plastics’ bags was a covered occurrence, and predicted that the Supreme Court of Iowa would follow the reasoning of similar cases to limit the holding of Pursell to cases where the alleged occurrence is defective workmanship causing damage only to the work product itself. Id. at 988. The Court finds the facts of _Decker Plastics_ to be substantially analogous to the facts of this case, and its reasoning is sound. _Decker Plastics_ and the Iowa case law on which it is based command the conclusion that defective workmanship resulting in third party property damage can give rise to an occurrence under Iowa law. (footnote omitted)

Moreover, _Decker Plastics_ clarifies how an “accident” may arise in the context of a claim based on defective workmanship. _Decker Plastics_ acknowledges that the defective workmanship itself is not an accident according to Iowa law. Id. at 987. Rather, the accident in _Decker Plastics_ was the deterioration of the bags that was
made possible due to defective workmanship. The deterioration, not the defective workmanship that caused it, was an unintended misfortune that resulted ultimately in damage to the claimant’s property (including property other than the bags themselves). Id. at 988. Similarly, here, the Sample Claims generally allege that water leaked through windows because of defective workmanship, causing various damage and injuries. *Decker Plastics* suggests that the accident in such a case would be the leaking of the windows—not the defective workmanship itself. The question remains whether such an event indeed qualifies as an accident.

Liberty Mutual argues that Pella’s defective workmanship at issue in the Sample Claims cannot be an accident because the natural, expected consequences of faulty workmanship are not sufficiently fortuitous to be considered accidental. Liberty Mutual’s argument suggests that claims based on negligence, which necessarily require that the injury be the foreseeable consequence (even if unintended) of the alleged tortious conduct as opposed to a separate intervening cause, do not give rise to an occurrence. To the extent that defective workmanship can give rise to an occurrence, under this approach, it can only be the case where the damage-causing event is *not* foreseeable. This is what Liberty Mutual says distinguishes the Padovano and Morse claims from the remaining Sample Claims. Only events that are not “the natural, expected consequence of a leaking window,” such as personal injuries sustained by a fall, or the collapse of an entire ceiling, qualify as accidents under this approach. Liberty Mut. Br. in Supp. of MSJ 21 n.13, ECF No. 168-1. Liberty also argues that the inclusion of the term “sudden” in the standard Iowa definition of accident, see, e.g., *Pursell*, 596 N.W.2d at 70, supports this view; gradual property damage due to water leakage is not “sudden” and thus would not be an accident.

But the term “accident,” as used in this context, encompasses more than what might be best understood as freak accidents. This should be clear from the definition of “occurrence,” which specifically *includes* “continuous or repeated exposure to substantially the same general harmful conditions.” *Pella* App. 566. Nor is the standard Iowa definition of an “accident” incompatible with negligence. *Norwalk*, 246 F.3d at 1137 (citing *Pursell*, 596 N.W.2d at 70).

Result: Coverage!

And the Court of Appeals of Iowa has also issued a decision governing classification of faulty workmanship as an occurrence. In *Hudson Hardware Plumbing & Heating v. AMCO Ins. Co.*, 2016 WL 5930779 (Iowa Ct. App., October 12, 2016), the contractor and subcontractor sought coverage from their insurer when they were sued as the result of mold, excess humidity and excess
odor in the building allegedly result from fault in the “design and installation of the HVAC system.”

In keeping with *Westlake*, the Court of Appeals first looked to see if there was, in fact, damage other than the cost of repairing or replacing the insured’s own work. Noting that there were references to damage resulting from mold and humidity beyond the HVAC system itself, it was concluded that there was an occurrence. Next, the panel addressed the existence of tangible personal property. Since the case came on appeal from a ruling granting summary judgment but without a complete trial record, the Court of Appeals concluded that there was at least a question as to whether or not there was property damage *other than* to the insured’s own product in view of the references to required repair of such property as the roof and windows. Given the issues existing, the Court of Appeals concluded that a defense was owed because of the possibility of coverage.

Result: Coverage!

**F. Obligations of the Insured Upon Loss**

In general, the first and foremost duty of an insured is notification of the loss to the insurance company PROMPTLY. If possible, take photos; keep records; monitor changes; AND review the insurance policy for conditions precedent and obligations. 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 the insured had failed to establish any of these options and coverage was denied.