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## **I. UNDERSTANDING STATUTORY LIENS**

When settling a personal injury claim liens must be satisfied, otherwise the tortfeasor (or his or her insurer) may be responsible for payment of the lien in addition to the amount paid to settle the claim. The five most common liens include: 1) Ohio Bureau of Workers' Compensation; 2) Ohio Victims of Crime; 3) U.S. Veterans and Military Personnel; 4) Medicaid; and 5) Medicare. This article discusses and provides practical advice regarding the legal obligation to satisfy statutory liens.

### **I. Ohio Bureau Of Workers' Compensation**

The Ohio Revised Code provides the Ohio Bureau of Workers' Compensation (BWC) a right of subrogation against a tortfeasor and his or her liability insurance carrier. R.C. 4121.931(A). See also *Groch v. Gen. Motors Corp.*, 2008-Ohio-546 (determining that R.C. 4121.931 is valid under Ohio's constitution). The Bureau may also pursue a subrogation claim against the claimant's automobile policy that provides underinsured/uninsured motorist coverage. R.C. 4121.931(I). However, the statute does not specifically provide subrogation rights against a claimant's medical payments coverage. This may simply be because most insurance policies exclude coverage for medical payments coverage when the claimant is eligible to receive BWC benefits.

The BWC subrogation statute also provides that the claimant has the burden of providing notice to the BWC administrator that a third party may be liable for the claimant's injuries. R.C. 4123.931(G). Even though the statute does not require a third party to notify BWC of the claim, the statute provides that the third party will be jointly and severally liable with the claimant if the claimant fails to notify the BWC.

### **II. Ohio Victims Of Crime**

If a person receives compensation under the Ohio Victims of Crime Compensation (R.C. 2743.51 to 2743.72), the state reparations fund has an independent cause of action for "reimbursement, repayment and subrogation" against 1) the offender; 2) an insurer of the offender or the victim; or 3) the victim if the victim receives additional benefits from other sources. R.C. 2743.72. See also *Montgomery v. John Doe 26*, (2000), 141 Ohio App. 3d 242. While the reparations fund has a notice provision allowing it to assert its recovery rights through correspondence from the attorney general, the statute does not require notice to be sent to a third party. R.C. 2743.72(L). Finally, the statute provides that any settlement between a victim and an insurer does not release the reparations fund's interest. R.C. 2743.72(I).

### **III. U.S. Veterans And Military Personnel**

Under the Federal Medical Care Recovery Act (FMCRA), the United States has a statutory right of recovery for compensation paid by the government to active military personnel and veterans against tortfeasors and any applicable insurance available to the injured party. 42 U.S.C. § 2651. Further, the United States also has a right of subrogation against an insurer that provides medical payments or no-fault personal injury protection (PIP) to the injured military employee or veteran. 42 U.S.C. § 2651(c).

#### IV. Medicaid

The Ohio Revised Code gives a “right of recovery” to the Ohio Department of Job and Family Services (ODJFS) against tortfeasors for collection of medical expense payments made on behalf of medicaid recipients. R.C. 5101.58(A). Because the statute provides a “right of recovery” and not a right of “subrogation,” a tortfeasor may be liable to reimburse Medicaid even if the Medicaid recipient cannot recover from the liable third party. In *Ohio Dept. of Human Serv. v. Kozar* (1995), 99 Ohio App. 3d 713, the court dismissed the state’s subrogation claim against the tortfeasor because the injured party had no cause of action against the tortfeasor. The court reasoned that the prior statute provided subrogation rights against the tortfeasor and not an independent cause of action against the tortfeasor. After this decision, the legislature amended the statute to provide the state an independent “right of recovery” from the tortfeasor. Therefore, the state may bring its own cause of action directly against the tortfeasor for recovery of benefits paid by the state.

Additionally, the statute requires the Medicaid recipient to notify ODJFS of the identity of any liable third parties. R.C. 5101.58(C). Like the BWC subrogation statute, the Medicaid statute does not require the third party to notify ODJFS. Any settlement between the tortfeasor and the Medicaid recipient will not prevent ODJFS from asserting its lien against a liable party. R.C. 5101.58(A).

#### V. Medicare

##### A. Current Medicare Secondary Payer Act

The Medicare Secondary Payer Act provides that Medicare is the “secondary payer” for eligible Medicare beneficiaries’ medical expenses when a “primary payer” is available. Primary payers include health insurance, workers’ compensation insurance, any liability or no-fault insurance and any tortfeasor. See 42 U.S.C. § 1395(b)(2). The statute provides that if Medicare pays compensation when it is the “secondary payer,” Medicare has a right of subrogation against any “primary payer.” Even though the Medicare statute uses the word “subrogation,” Medicare’s right to recovery from “primary payers” does not depend on the recipient’s rights of recovery. *United States v. York* (C.A.6 1968), 398 F.2d 582, 584 (finding that “Congress intended to give the United States an independent right” to recover Medicare benefits from a liable third party). The Medicare Secondary Payer Act goes beyond other statutorily-imposed liens because Medicare has a right of recovery against many homeowners and automobile policies, including their “med pay” coverages. See *United Services Auto. Assoc. v. Perry* (C.A.5 1996), 102 F.3d 144, 148 (“[medical payments coverage] is a form of no-fault insurance”). Additionally, because a review of a patient’s medical records will generally put a third party on notice of the patient’s eligibility for Medicare, Medicare is not required to notify the third party of its lien. See *United States v. Bartholomew* (W.D. Okla. 1967), 266 F. Supp. 213, 215 (stating a party can easily determine through a review of the medical records that a party is eligible for Medicare benefits).

##### B. Amendments To Medicare Secondary Payer Act

On July 1, 2009, revisions to the Act will go into effect. The amendments require a primary insurer to 1) determine whether a claimant qualifies for Medicare benefits currently or in the future;

and 2) notify Medicare when a primary insurer resolves a claim with a current or future Medicare beneficiary. The amendment provides stiff penalties for primary insurers who fail to notify Medicare of a resolved claim with a current or future Medicare beneficiary.

### 1. Determine Eligibility Status Of Claimants

The eligibility status of a current Medicare beneficiary can be determined by reviewing the claimants' medical records and bills. However, a primary insurer must also determine whether a claimant is reasonably expected to qualify for Medicare eligibility when the settlement involves payment of future medical services and/or lost wages. According to the Centers for Medicare and Medicaid Services (CMS), an injured individual that is not currently receiving Medicare benefits "should ... consider Medicare's interests when the injured individual has a 'reasonable expectation' of Medicare enrollment within 30 months of the settlement date, **and** the anticipated total settlement amount for the future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000." (Emphasis in original). Thus, the primary insurer should contemplate protecting itself from not only a current but also a future Medicare "super lien."

### 2. Notify Medicare Of A Settlement

Once a primary insurer settles a claim with a Medicare beneficiary (or a person reasonably expected to receive Medicare benefits), the primary insurer must notify CMS of the resolution of the claim. The time limit for the notification is not set forth in the amendments. Therefore, a primary insurer should, to avoid the penalties, advise CMS of the potential resolution of the claim prior to entering into negotiations and/or before trial commences.

### 3. Penalties For Non-Compliance

The amendments provide that a primary insurer that fails to notify CMS of the resolution of a claim involving a Medicare beneficiary pay a fine of \$1,000.00 per day for the notification failure. This penalty is in addition to the double damages already provided under the current Medicare Secondary Payer Act. If a primary payer fails to reimburse Medicare when it knew or should have known of Medicare's lien, the United States has a private right of action against the primary insurer to recover two times the amount of Medicare benefits the beneficiary received for medical services.

## **VI. Recommendations For Settlement**

Prior to settling any bodily injury case, a claims professional should ascertain if the injured party is eligible for any benefits from any of the above mentioned agencies. Under the typical liens (BWC, Ohio Victims of Crime, Veterans Administration, and Medicaid), the insurer should

- 1) negotiate a settlement with the agency that will satisfy its lien in its entirety;
- 2) issue payment directly to the agency or issue payment jointly with the agency's name; and
- 3) require the injured party sign an indemnity clause in favor of the insurer and tortfeasor for claims by an agency seeking reimbursement of its lien.

This procedure, however, will not be sufficient to protect an insurance company and its insured from a Medicare lien and penalties for non-compliance. When settling a claim involving future compensation of medical or wage loss benefits to a claimant, a Medicare Set Aside trust is recommended (referred to as MSAs or WCMSAs), which is similar to a structured settlement already used in many claims. The Medicare Set Aside trust is reviewed by CMS, and upon approval from CMS, the insurer can pay the settlement, judgment or award.

Waiting for approval from CMS on Medicare Set Aside trusts may take weeks or even months. With the need to protect itself from a Medicare “super lien” and stringent penalties, insurers should insist that plaintiff’s counsel obtain CMS approval of a Medicare Set Aside trust when the settlement or judgment involves future payment of medical bills and/or lost wages.

When settling a claim involving a Medicare beneficiary without future specials, a primary insurer still has the duty to notify CMS of the resolution of a claim. It is recommended that the primary insurer advise CMS prior to payment of an award, judgment or settlement and pay Medicare directly for its lien.

## **II. SUPREME COURT OF OHIO**

### **A. Policy Changes Are Permitted Under Ohio UM/UIM Statute**

*Advent v. Allstate Ins. Co.*, 2008-Ohio-2333. The Supreme Court construed two amendments to the Ohio UM/UIM statute - S.B. 97 and S.B. 267 – and concluded that insurers essentially can amend their policies at will at the beginning of new policy periods. At issue were S.B. 97 (which makes the offering for UM/UIM coverage optional) and S.B. 267 (which allows changes in policy coverages within a two-year guarantee period). The policyholder sought \$300K in UIM limits by operation of law, but the insurer argued that only \$100K was available. Based on the facts, dates, and law, the court found in favor of the insurer. The court held that policy changes are permitted on or after October 31, 2001 (the effective date of S.B. 97) and within the policy’s two-year guarantee period on or after September 21, 2000 (the effective date of S.B. 267).

### **B. Insurer May Define Insured For Purpose Of UM/UIM Coverage As Person Not Insured For UM/UIM Coverage Under A Separate Policy**

*Wohl v. Swinney*, 2008-Ohio-2334. The Supreme Court decided that the term “insured” may unambiguously be defined as “[a]ny person occupying your covered auto who is not a named insured or insured family member for uninsured motorist’s coverage under another policy.” The plaintiff in this case sought UIM coverage from Motorists Mutual, the insurer of the auto he was driving. But the plaintiff had his own UIM coverage, so Motorists denied his claim, arguing that he did not qualify as an insured based upon the foregoing definition. The Supreme Court agreed and concluded that insurers may deny insured status to vehicle occupants who have UM coverage under another policy.



### **C. City Vehicle Is Considered “Self Insured” Under Former Ohio UM/UIM Law**

*Rogers v. City of Dayton*, 2008-Ohio-2336. The high court interpreted a prior version of the Ohio UM/UIM statute which provided that an uninsured motor vehicle is not one that is self-insured. The trial and appellate courts decided that an insured could pursue a UM claim against his own insurer after being injured by a city employee, but the Supreme Court of Ohio disagreed. The court held that because the UM/UIM statute and the policy of insurance excluded self-insured vehicles from the definition of an uninsured or underinsured vehicle, the insurer was not liable.

### **D. Two-Year Limitation Of Action Clause To Commence An Action Is Enforced Where The Tortfeasor Was Uninsured At The Time Of The Accident**

*Angel v. Reed*, 2008-Ohio-3193. The plaintiff was a passenger in an uninsured motor vehicle, but the negligent driver of the vehicle indicated in the police report that he had liability insurance at the time of the accident when in fact the policy of insurance was cancelled three months earlier. The plaintiff did not discover the driver’s misrepresentation until nearly three years after the accident. The policy contained a two-year limitation of action provision. The Supreme Court found that the case presented a standard uninsured motorist claim in which the tortfeasor was uninsured at the time of the accident -- that no subsequent event (*e.g.*, insolvency of the tortfeasor’s liability insurer) rendered the tortfeasor uninsured. Therefore, the high court held that consistency with precedent required the application of the unambiguous language in the two-year limitation of action provision of the plaintiff’s policy of insurance.

## **III. OHIO COURT OF APPEALS**

### **A. Policy Language, Endorsements, And Exclusions**

#### **1. Exclusion For Operating A Vehicle “For Compensation Or A Fee” Is Ambiguous When Applied To Employee Operating A Company Vehicle**

*Progressive Max Ins. Co. v. Matta*, 2008-Ohio-1112 (Seventh App. Dist.). Matta was within the course and scope of his employment by ACME Steak and Seafood Co. when he caused an accident. He had personal auto liability coverage under a policy issued by Progressive Max Insurance Company. Progressive denied liability coverage based on an exclusion for coverage arising from a vehicle being used to carry persons or property "for compensation or a fee." The court found that the "for a fee" language was ambiguous because it could be read in two very different ways: "as excluding from coverage use of a vehicle to transport property when there is any kind of payment to the insured, and second, as excluding coverage only when a fee is paid specifically for the particular act of transporting property."

**2. Insurer Has Option To Declare A Vehicle A Total Loss Over Insured's Objection**

*Miller v. Geico Indemn. Co.*, 2008-Ohio-791 (Eighth App. Dist.). Miller's vehicle was insured under a policy issued by GEICO Indemnity Company. The policy included Wells Fargo as a protected lienholder. The vehicle was stolen and, upon recovery, was found to be damaged. GEICO determined the vehicle was a total loss and paid the lienholder, Wells Fargo. Miller disputed GEICO'S determination and requested that GEICO make repairs, since she owed more on the vehicle than its fair market value. She sued GEICO for breach of contract, fraud, bad faith, theft, and violations of the Ohio Consumer Sales Practices Act. The court found that the clear language of the policy gave GEICO the option to "(a) pay for the loss; or (b) repair or replace the damaged or stolen property." The court concluded that given the discretion afforded by the terms of its policy, GEICO had acted properly. (Larry C. Greathouse and Richard C. O. Rezie of Gallagher Sharp represented GEICO).

**3. No Liability Coverage For A Child's Death Resulting From Playing In A Stationary, Unoccupied Vehicle**

*Nationwide Mut. Ins. Co. v. Guerard*, 2008-Ohio-2281 (Fifth App. Dist.). A four year old boy died when his head became stuck in a vehicle's window. The vehicle, insured by Nationwide, "was not running, being used or occupied, being loaded or unloaded and the keys were not in the ignition." The boy's mother and the administrator for the estate of the boy filed a declaratory judgment action for a determination of whether the boy's mother was entitled to liability insurance coverage under the policy. The court held that the policy did not provide coverage because "[a] stationary, unattended vehicle, that somehow became a playground for the child, does not constitute 'ownership, maintenance or use, or loading or unloading'" of the vehicle as required by the terms of the policy.

**4. No Liability Coverage For Defendant Driver For Claim Brought By Named Insured Passenger**

*Lipker v. Dosek v. American Standard Insurance Company*, 2008-Ohio-1756 (Second App. Dist.). Lipker was the holder of a policy issued by American. Dosek was driving a car owned by Lipker when he caused a collision. Lipker suffered bodily injuries. Dosek was uninsured. Lipker brought suit against Dosek and American, and American sought a declaratory judgment that it had no duty to defend or indemnify Dosek because the policy did not provide coverage for bodily injury to Lipker, the named insured. The court held that even though Dosek was an "insured person" under the policy, American had no duty to defend or indemnify Dosek because the policy exclusion stated that "coverage did not apply to bodily injury to . . . you and any person related to you and residing in your household." The policy also excluded coverage for "damage to property owned by, or in the charge of, an insured person." The court held that bodily injuries to the named insured were clearly excluded from coverage. Further, American had no duty to defend because it had no duty to indemnify for these claims.

**5. Breach Of An Agreement Is Not An Occurrence Under A Homeowner's Insurance Policy**

*Erie Ins. Group v. Grange Mut. Cas. Co.*, 2008-Ohio-1295 (Sixth App. Dist.). Besozzi co-signed a lease for property, but was not a tenant of the property. Besozzi agreed to be liable for any damages to the rental property caused by the tenants. Due to the tenants' negligence, a fire damaged the property. Erie Insurance Group, the property owner's insurance carrier, paid for the damages and filed suit against Besozzi. Grange Mutual Casualty Company issued a homeowner's policy to Besozzi, but did not list the property as an insured location. The court held that the Grange policy did not provide coverage, because the damages were not caused by an occurrence. The court reasoned that Besozzi's liability resulted from her agreement to pay for the damages on behalf of the tenants and not from the fire itself.

**6. Court Upholds One-Year Time Limitation On Claims For Interior Mold And Water Damages, And Denies Coverage For Exterior Mold, As There Was No "Physical Loss To Property"**

*Mastellone v. Lightning Rod Mut. Ins. Co.*, 2008-Ohio-311 (Eighth App. Dist.). Following a jury verdict, the appellate court vacated the judgment for mold damage on the exterior siding of the insured's house. The insuring agreement provided insurance against direct loss to property, "only if that loss is a physical loss to property." The court found that plaintiff failed to provide any evidence of actual damage to the wood siding. Rather, the testimony showed that the mold did not compromise the structural integrity of the wood, and could be cleaned from the wood surface. The court upheld the granting of a directed verdict relative to the claims of water damage and mold to the interior of the house, as a one-year time limitation barred those claims. The evidence showed that the insureds were aware of water intrusion and mold years prior to filing suit. Further, the court found that the insurance company had a reasonable justification for denial of the claim on the bifurcated claim for bad faith.

**B. UM/UIM**

**1. A Specific Policy Exclusion For Motorcycles Controls Over General Policy Language Regarding Covering A Motorcycle When It Qualifies As A Temporary Substitute Auto**

*Miller v. Erie Ins. Co.*, 2008-Ohio-515 (Third App. Dist.). Miller was employed by Miller Rigging. Miller Rigging had UM/UIM coverage with Erie Insurance Company. Within the scope of his employment, Miller traveled to release a vehicle from the impound lot. Normally, he used a pickup owned by Miller Rigging, but that day the pickup was out of service. As a result, Miller drove his own motorcycle to release the vehicle from impound. While en route, Miller was struck by a vehicle operated by Tiel. Tiel's insurance carrier paid his policy limit. Miller then pursued UM/UIM coverage under the policy issued by Erie. The Erie policy excluded UM/UIM coverage for a "miscellaneous vehicle unless the miscellaneous vehicle is listed on the Declarations and a premium is shown for this coverage." It defined "miscellaneous vehicles" to include motorcycles,

but Miller's motorcycle was not listed on the Declarations page of the Erie policy. Miller asserted that his motorcycle qualified as a temporary substitute motor vehicle and that, accordingly, he was entitled to coverage. The court agreed that Miller's motorcycle fell within the policy definition of a temporary substitute motor vehicle but found that the specific clause prohibiting UM/UIM coverage for miscellaneous vehicles prevailed over the general definitions that qualify Miller's motorcycle as a temporary substitute auto in certain situations.

## **2. Ohio's UM/UIM Statute Places No Limit On Available UM/UIM Coverage Exclusions**

*Bousquet v. State Auto Ins. Co.*, 2008-Ohio-922 (Eighth App. Dist.). Bousquet was a passenger in a pickup truck owned and driven by her husband, who caused an accident in which Mrs. Bousquet was seriously injured. The pickup truck was insured by State Auto Insurance. Both Mr. and Mrs. Bousquet were insureds under the policy. She sought UM/UIM coverage under the State Auto policy. State Auto denied coverage because a UM/UIM vehicle in the policy was limited to a vehicle "not owned by or furnished or available for the regular use of you or any family member." Mrs. Bousquet asserted that the exclusion was invalid under Ohio's UM/UIM statute, R.C. 3937.18. The court found, however, that under the statute's plain language the exclusion was permitted. The court reasoned that insurers are free not to offer UM/UIM coverage at all and, if insurers opt to offer UM/UIM coverage, they are free to include exclusions or limitations on that coverage.

## **3. Three-Year Suit Limitation Bars UIM Claim**

*Lynch v. Hawkins*, 2008-Ohio-1300 (Sixth App. Dist.). On June 4, 2003, Keith Lynch was in an automobile accident. Lynch advised State Auto, her automobile insurance carrier, of the accident and obtained a rental vehicle through State Auto. State Auto, however, did not receive any notice of an underinsured motorist claim until April 17, 2006 when Lynch's attorney sent State Auto notice of his representation of Lynch and notice of the claim. On June 20, 2006, Lynch filed suit against State Auto to recover underinsured motorist benefits. State Auto denied that it owed coverage, because the policy requires the insured to file suit within three years of the date of loss. Lynch argued that State Auto's failure to advise Lynch of the contractual limitation within sixty days of the expiration of time to file suit, prevented it from applying the three-year contractual limitation. The court held that because State Auto did not have notice of Lynch's intent to file an underinsured motorist claim until it advised that Lynch had legal representation for the claim, State Auto was not required to advise Lynch of the contractual limitation under the Ohio Administrative Code. The court also determined the three-year contractual limitation to bring an underinsured motorist claim against State Auto was not unreasonable.

## **4. Policy Definition Precludes UIM Coverage Where Claimant Has Other UIM Coverage Though Not Available**

*Ashcraft v. Grange Mut. Cas. Co.*, 2008-Ohio-1519 (Tenth App. Dist.). Plaintiff was a passenger in a vehicle operated by Paynter, when they were involved in an accident caused by Pittinger. Pittinger was insured by Progressive, which paid plaintiff the bodily injury liability limits

of \$12,500 per person. Because plaintiff's UIM coverage under his policy with Personal Service Insurance Company had UIM limits of \$12,500 per person/\$25,000 per accident, plaintiff was not able to recover from his own UIM policy. Plaintiff then sought UIM coverage through Paynter's policy with Grange, which contained UIM coverage in the amount of \$100,000 per person/\$300,000 per accident. The Grange policy defined an "insured" as including "Any other person while **occupying your covered auto** with a reasonable belief that that person is entitled to do so, if that person is not insured for Uninsured Motorists Coverage under another policy." The court upheld the policy language, denied UIM coverage to plaintiff, and rejected the argument that he was not "insured" under the Personal Service policy. The court also rejected plaintiff's argument that the Grange definition is equivalent to an "escape" clause, as the "other insurance" clause was not at issue. Moreover, the definition language did not amount to an "escape clause."

### **C. Workmanship/Construction Claims**

#### **1. Contractor's Policy Exclusions For Defects In 'Your Work' Unambiguously Excludes Coverage For Poor Workmanship And Failure To Perform Under Contract**

*Stiggers v. Erie Ins. Co.*, 2008-Ohio-1702 (Eighth App. Dist.). Stiggers hired Elie to complete an addition to Stiggers' home. Elie was insured under a contractor's policy issued by Erie Insurance. Stiggers filed suit against Elie in connection with the construction of the addition alleging that Elie did not complete the project and that the work performed was defective. Elie did not appear and Stiggers obtained a default judgment in his favor. Stiggers then filed a declaratory judgment action against Erie Insurance seeking to satisfy the judgment against Elie. The court found that while poor workmanship could constitute an occurrence under the Erie policy, coverage was excluded. Specifically, the court found that poor workmanship and failure to complete performance under a contract was excluded because Erie does "not cover . . . property damage to . . . that particular part of real property upon which operations are being performed by you . . . [or] that particular part of any property that must be restored, repaired or replaced because your work was faulty . . . [or property damage] resulting from . . . delay in or lack of performance on a contract or agreement by or for you or a defect, deficiency, inadequacy or dangerous condition in your product, your work, or work performed for you." The court found these exclusions to unambiguously bar coverage for Stiggers' claims against Elie.

#### **2. No Coverage Under CGL Policy For Negligent Workmanship/Construction Claims Or Breach Of Contract Claim**

*Paramount Parks, Inc. v. Admiral Ins. Co.*, 2008-Ohio-1351 (Twelfth App. Dist.). Paramount Parks entered into a contract with Roller Coaster Co. of Ohio ("RCCO") to provide engineering services and materials for the construction of the Son of Beast roller coaster at Kings Island Amusement Park. RCCO is now defunct and was insured under a CGL policy issued by Admiral Insurance Co. Paramount sued RCCO for breach of contract, express warranty, implied warranty, breach of contract/professional malpractice, promissory estoppel, unjust enrichment and negligence. RCCO notified Admiral, which denied coverage. The case was removed to federal

court and Paramount obtained a judgment against RCCO for over \$20 million. After Admiral refused to pay any of the judgment against RCCO, Paramount filed a declaratory judgment action against Admiral. The court of appeals affirmed the granting of summary judgment and held that the defective or negligent workmanship or construction claims were not “occurrences” under the policy and, therefore, did not trigger coverage.

#### **D. Coverage For Intentional Acts**

##### **1. Intentional Acts Exclusion For Injury That Was “Expected Or Intended From The Standpoint Of The Insured” Applies Only If The Injury Itself Was Expected Or Intended**

*Owner Operators Independent Drivers Risk Retention Group v. Natasha T.J.D. Stafford*, 2008-Ohio-1347, (Third App. Dist.). Pielack and Stafford were involved in a motor vehicle collision. At the time of the collision Pielack was employed by White & Red Transportation Services, Inc., which was insured by Owner Operators. Pielack pled no contest to aggravated vehicular assault charges related to the collision, which is a felony of the fourth degree. Stafford filed suit against White & Red, amongst others, for his injuries, and Owner Operators filed suit for a declaration that it had no duty to defend or indemnify the defendants in the underlying personal injury action. The policy contained an intentional acts exclusion which excluded coverage for bodily injury or property damage that was “expected or intended from the standpoint of the ‘insured’.” Owner Operators argued that Stafford’s injuries were “intended” because they were of the intentional and reckless type that resulted in a felony conviction for aggravated vehicular assault. However, the court held that the definitions of “intentional” and “reckless” were not interchangeable, and the policy only excluded coverage for injuries or damage that were actually expected by the insured. The court, therefore, found a duty to defend and indemnify White & Red and its employees.

#### **E. Bad Faith**

##### **1. Violation Of Ohio’s Unfair Claims Practices Act Cannot Serve As Basis For A Bad Faith Claim**

*Price v. Dillon*, 2008-Ohio-1178 (Seventh App. Dist.). Price was injured in an automobile accident while insured under an automobile policy issued by Grange Indemnity Insurance Company which provided \$5,000 in med-pay coverage. Price was also insured under an individual health insurance policy issued by American Community Mutual Insurance Company. Price asserted that the seven month delay by Grange in paying his med-pay claim amounted to bad faith. He relied on the ten day payment period set forth in the regulation implementing Ohio's unfair claims practices act. The Court found that because Ohio Admin. Code 3901-1-54(B) specifically states that “nothing in this rule shall be construed to create or imply a private cause of action” violation of the rule could not serve as basis for a claim of bad faith. The court further found that although Grange had breached its contract by directly reimbursing American rather than making the med-pay directly to Price, Price had suffered no damages because American had a subrogation interest under the terms of its policy.

**F. Subrogation****1. Insurer Providing Med-Pay Benefits May Obtain Reimbursement From Its Insured After A Settlement By The Insured**

*Macejko v. Ortiz*, 2008-Ohio-1188 (Seventh App. Dist.). Macejko was insured by an automobile policy issued by Nationwide Insurance Company. She was injured in an accident caused by Ortiz and received \$10,000 pursuant to the med-pay section of the Nationwide policy. She signed a subrogation assignment in order to receive the med-pay from Nationwide. She later settled with the tortfeasor for \$100,000. Nationwide sought reimbursement for its \$10,000 payment. The court found Nationwide was entitled to reimbursement, because the plain language of the Nationwide Policy and the assignment provisions provided that Macejko agreed to reimburse Nationwide out of any settlement proceeds. Further, Macejko had breached the notice and cooperation clauses of the Nationwide policy by failing to notify Nationwide of the settlement before impairing Nationwide's subrogation rights.

**G. Reservation Of Rights****1. Insurer That Provides A Defense For Two Years Under A Reservation Of Rights Is Not Barred By Laches From Challenging Coverage**

*Am. Family Ins. Co. v. Chamunda, Inc.*, 2008-Ohio-1910 (Ninth App. Dist.). MJ Food Mart sold alcohol to a minor who later caused an automobile collision that killed two people and injured several others. The injured parties filed suit against MJ Food Mart. American Family Insurance Company insured MJ Food Mart under a business liability policy. American Family defended MJ Food Market under a reservation of rights for two years. American Family then filed suit seeking a declaration that it had no duty to defend or indemnify MJ Food Mart. There was no dispute that: 1) the policy excluded coverage to any insured that sells alcoholic beverages for "bodily injury or property damage for which any insured may be held liable by reason of . . . the furnishing of alcoholic beverages to a person under the legal drinking age"; or 2) that the only claims against the MJ Food Mart arise from the alleged sale of alcohol to a minor driver. Rather, MJ Food Mart asserted that laches applied to bar the insurance company's coverage defense because American Family lead MJ Food Mart to believe that there was coverage by defending for two years. The court, however, found American Family's initial reservation of rights sufficient to overcome laches. MJ Food Mart further asserted that American Family had breached its contract by failing to provide an "adequate" defense. The court reasoned that because American Family was not contractually obligated to provide any defense to its insured it "cannot be held liable for breach of contract for failure to provide an adequate defense."

## **H. Pollution Exclusion**

### **1. “Sudden And Accidental” Pollution Has A Temporal Component And Does Not Include Pollution That Occurs Gradually Over Time**

*M&M Metals Int’l v. Continental Ins. Co., et al.* 2008-Ohio-1114, (First App. Dist.). M&M Metals is a scrap-metal dealer that sent scrap material to several third-party dump sites, some of which were subject to EPA investigation and cleanup. M&M sought primary and excess coverage for its liabilities from three carriers. Each policy excluded coverage related to pollution, unless the pollution is sudden and accidental: “*this [pollution] exclusion does not apply if such discharge, disbursal, release, or escape is sudden and accidental.*” The trial court granted summary judgment for the insurers based on this policy language. The appellate court rejected plaintiff’s argument that the “sudden and accidental” exclusion applied. M&M argued that a fire in 1964 and a hurricane in 1972 were material facts that would defeat summary judgment on whether M&M’s claims fell within the exclusion. The court disagreed, holding that these incidents fell outside of the time period encompassing M&M’s liabilities, so the incidents were immaterial to whether M&M was entitled to coverage. M&M also argued that periodic rainstorms and corresponding soil erosion could have caused “sudden and accidental” pollution, but the court disagreed because erosion is gradual by definition, and rain should have been expected. Finally, M&M argued that the insurer’s interpretation of the word “sudden” is barred by regulatory estoppel because the insurance industry told insurance regulators that the pollution exclusion would bar coverage for intentional pollution, not accidental pollution, and M&M is entitled to coverage because “sudden” means “unexpected.” The court rejected this argument because Ohio courts have consistently given a temporal component to the term “sudden” and barred coverage for gradual pollution, such as in M&M’s case.