OHIO STATE COURTS
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Duty to defend triggered when monetary damages anticipated in lawsuit for injunctive relief.

Following a landslide in a neighborhood of Cincinnati, the City brought a lawsuit against the developer of property for injunctive relief. Due to the nature of the action, the developer's CGL insurer did not provide its insured with the defense for the action, so the developer retained private counsel. Following intervention by owners of adjacent properties to the landslide, the City amended its complaint to include monetary damages. The developer's insurer provided a defense to the developer following this amendment, but did not indemnify the insured for the damages recovered by the City. In affirming the trial court's determination that the insurer had a duty to defend the lawsuit from its inception, the appellate court noted that since the City's complaint alleged damages in part due to the expenses required in stabilizing the hillside, the insurer was obligated to defend its insured. As such, the insurer was also required to reimburse the insured for the attorney's fees it incurred in defending the City's lawsuit, but not for the fees expended for advice on potential criminal liability. Finally, the appellate court agreed with the trial court that the exclusion in the policy that precluded coverage for "incorrectly performed" work on the property the insured is working on did not apply, because the insured was seeking coverage for damages caused to third parties' property, not the property it was actively developing. *Cincinnati v. Metro. Design*, 1st Dist. No. 170708, 2019-Ohio-364.

Where two overlapping insurance policies existed to cover an indemnity payment, the amount each insurance company was responsible for hinged on whether the language of one insurance policy "necessarily terminated" the nature of coverage of the other.

United Ohio Insurance Company entered into an agreement with Artisan and Truckers Casualty Company (Progressive) to split a $1.35 million dollar indemnity payment stemming from an accident involving a tractor and trailer. Both companies had $1 million dollar policies that provided overlapping coverage on the tractor and trailer. They each paid $675,000.00 with the understanding that they had a right to seek contribution from the other if they paid in excess of what their respective policies required. The Progressive policy contained an "automatic termination" provision that would terminate the Progressive policy if similar insurance on an insured auto is obtained. The Progressive policy also contained an "other insurance" provision, which noted that, for trailers, the Progressive policy will provide primary coverage only if it is attached to an insured auto that is a power unit, other than that, the Progressive policy will provide excess coverage.

The Progressive policy was issued first and provided coverage for both the tractor and the trailer. The later United policy insured the tractor only, which necessarily terminated the Progressive policy's coverage of the tractor under the "automatic termination" provision. Therefore, the power unit (the tractor) was no longer insured by Progressive. As such, the "other insurance" provision applied, noting Progressive would provide only excess coverage to the trailer. The trial court held the $1 million United policy was primary coverage, and ordered United to pay Progressive back $325,000.00 of the $675,000.00 it had paid. The court of appeals

affirmed. *Artisan & Truckers Cas. Co. v. United Ohio Ins. Co.*, 4th Dist. No. 18CA3639, 2019-Ohio-3.

An oral settlement reached a few days after an auto accident and before the medical bills have been reviewed or fault has been definitively established may not be valid.

The alleged tortfeasor's insurer called the injured third-party and orally negotiated a settlement 11 days after the accident allegedly caused by its insured. The conversation was recorded. It included express statements that the injured third-party "agreed to settle," "will give up any and all rights to file a lawsuit or make any further claim for bodily injury," agreed to "release" the insured, agreed that she was entering "full and final settlement," and that alleged tortfeasor's insurer and its insured would be indemnified and held harmless. However, the injured third-party then had second thoughts and never executed a release or cashed the settlement check. Instead, she filed suit. The trial court found the oral settlement valid and enforceable but the court of appeals reversed holding that the settlement was not valid because the alleged tortfeasor's insurer "failed to follow its own policy of obtaining the medical records and any bills associated with [the injured third-party's] damages prior to settling," the injured third-party "did not have any indication what her damages were at the time of the alleged settlement," the injured third-party "had little familiarity with the legal process of settling a claim," and portions of the telephone conversation containing the oral settlement were not recorded. The court also noted that the oral settlement occurred only 11 days after the accident and "under circumstances that evidence" "confusion about who was at fault for the accident." *Carkido v. Sweeney*, 8th Dist. No. 107383, 2019-Ohio-460.

After the estate of a deceased-insured is closed, there ceases to be a "legal representative" of the estate on the deceased-insured's homeowners policy.

When the named insured on a homeowners policy passed away, her surviving sister opened her probate estate and was appointed the commissioner of the estate. After speaking with the deceased's insurance agency, the sister was assured that no additional actions needed to be taken regarding the insurance coverage for the deceased's house, as there was still time remaining on the policy period. After the house was transferred to the sister, the deceased's probate estate was closed, and the sister's role as commissioner ended. Less than two weeks later, a fire severely damaged the home and when the sister made a claim on the homeowners policy, the insurer denied coverage on the basis that the decedent's estate no longer had an insurable interest in the property and so no coverage extended to the loss. The sister brought suit against the insurer alleging breach of contract and bad faith, and against the insurance agency alleging negligent misrepresentation.

The court focused on several key provisions of the insurance policy regarding who the policy covers when probate is initiated, particularly the following language: "We insure the **legal representative** of the deceased but only with respect to the premises and property of the deceased covered under the policy at the time of death." The parties agreed that while the sister was the commissioner of the decedent's estate, she qualified as a "legal representative" of the deceased under the policy and Ohio probate law. However, the court, citing a factually similar Georgia appellate court decision, held that since the deceased's property had been transferred,

the Estate closed, and the sister's duties as commissioner discharged, the sister ceased being a "legal representative" of the deceased-insured. As such, the policy's coverage of the insured's interest in her real and personal property was extinguished by the time that the fire occurred. *Walker v. Albers Ins. Agency*, 1st Dist. No. C-180207, 2019-Ohio-1316.

Where an insured assigns payment of benefits to a hospital, the insured becomes liable to reimburse whatever amount in damages the insurance company paid to the hospital, if the insured recovers from another.

Christopher Steinborn had health insurance through Anthem and auto insurance through Farmers when he incurred $5,803.89 at Akron General as a result of an auto accident for which he was not at fault. At the hospital, Steinborn assigned insurance benefits owed to him to Akron General. Anthem adjusted the charges down to $1,585.00, the amount presented to Steinborn. However, Farmers paid the $5,000 from Steinborn's medical payments policy directly to Akron General. Akron General accepted Farmers' payment, removed the contractual adjustment, and submitted a bill of $803.89 to Steinborn, which he paid. Farmers put Steinborn on notice of its $5,000 right of subrogation. Steinborn settled the case with Cincinnati Insurance Company (CIC), the tortfeasor insurance company, for $93,000. CIC issued two checks to Steinborn, one for $5,000 to reimburse Farmers, and the other for the remainder of the settlement. Once Steinborn refused to reimburse Farmers, CIC stopped payment on the $5,000 check and paid Farmers directly as required by arbitration. Steinborn bought suit against both insurance companies, seeking the $5,000 CIC paid to Farmers. The trial court granted the insurance companies' motions for summary judgment, specifically noting that Farmers did not act in bad faith by not obtaining Steinborn's approval to pay Akron General since: (1) the policy was silent on the issue of prior approval; and (2) Farmers had Steinborn's assignment of rights to the hospital. The trial court also considered payment of medical bills as "damages," giving rise to Farmers right of subrogation. The court of appeals agreed and affirmed. *Steinborn v. Farmers Insurance of Columbus, Inc., et al.*, 5th Dist. No. 2018CA00128, 2019-Ohio-1745.

Where a jury award of punitive damages for a bad faith claim was partially based on inclusion of the Unfair Claims Settlement Practices Act as the standard for defining bad faith, it is reversible error since the UCSPA is regulatory in nature and does not create a private cause of action.

In September 2010, Bobby Brummitt and his wife were among several injured in an auto accident when Dylan Seeholzer ran a stop sign. Seeholzer had only $50,000 in bodily injury coverage. The Brummitts had $500,000 in UM/UIM coverage under their policy with Ohio Mutual Insurance Group. The Brummitts were not pleased with how Ohio Mutual handled the claim. Bobby Brummitt filed a bad faith claim. In Ohio, "an insurer acts in bad faith where it fails to exercise good faith in the processing of a claim of its insured where its refusal to pay the claim is not predicated upon circumstances that furnish reasonable justification therefore." Over Ohio Mutual's objection, the trial court allowed Brummitt's expert to testify that alleged violations of the UCSPA are evidence of bad faith. Also over Ohio Mutual's Objection, the trial court instructed the jury that it could consider alleged violations of the UCSPA in its deliberation as to if Ohio Mutual acted without reasonable justification. The jury awarded Brummitt $250,000 in punitive damages. Ohio Mutual appealed. The court of appeals noted that the trial

court abused its discretion when it overruled Ohio Mutual's objection of Brummitt's expert's UCSPA testimony. The court of appeals further ruled that including the UCSPA in the jury instructions confused the jury as to the definition of bad faith. The court of appeals held that alleged violations of the UCSPA do not constitute evidence of bad faith because the rules are regulatory in nature and do not create a private cause of action. Partially because of this, the court of appeals reversed the $250,000 punitive damage award. *Brummitt v. Seeholzer*, 6th Dist. No. E-16-020, 2019-Ohio-1555.