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Connecticut Supreme Court Resolves Insurance Coverage for Fatal Nursing Home Fire

In 2003, a fire that destroyed Greenwood Health Center, a Hartford nursing home, also killed or injured multiple residents. This week, the Connecticut Supreme Court ruled on several insurance coverage questions arising under a liability policy Lexington Insurance Company (a unit of AIG) issued to Lexington Healthcare Group, Inc., which owned the nursing home. (There is no relation between the Insurer and the Insured.) In summary, the Court held that the term "related" is ambiguous under the circumstances of the case, that the "aggregate limit" of the policy is unambiguous and enforceable, and that the Insurer is not obligated to "drop down" and cover the insolvent Insured's self-insured retention (SIR), although the insolvency does affect a clause reducing coverage by the amount paid by the Insured. The result is that if the underlying plaintiffs prevail in their claims against the Insured, the Insurer's liability is limited to \$1 million for all thirteen claims against the Insured, despite coverage of \$500,000 per claim (on top of the Insured's SIR). The Connecticut Supreme Court reversed the trial court's finding of a \$10 million aggregate limit. *Lexington Ins. Co. v. Lexington Healthcare Group, Inc.*, SC 18681 & SC 18682, release date June 18, 2013, reported at 309 Conn. 1. The authors of this Advisory represented Lexington Insurance Company before the Connecticut Supreme Court.

Before a resident of the nursing home set the facility ablaze, the Insurer had issued

a single policy providing the Insured with professional and general liability coverage for seven nursing homes that it owned. As a result of the fire, thirteen negligence actions seeking damages for wrongful death or serious bodily injury were filed against the owners and operators of the nursing home. The Insurer filed a declaratory judgment action to determine how much coverage was available to satisfy this series of underlying claims. Because the Insured has declared bankruptcy, it is unlikely that it will be able to pay any self-insured retention or satisfy a judgment in excess of available insurance limits.

The policy at issue has a \$10 million "aggregate policy limit" for all seven nursing homes, a \$1 million "aggregate limit" per nursing home for each of the professional liability and general liability coverages, and a "per medical incident" limit under the professional liability coverage. The "per medical incident" limit is \$500,000 for each incident, which includes any claim brought by a nursing home resident (so the policy's general liability coverage was not implicated). The policy's aggregation clause defined "all claims arising from continuous, related, or repeated medical incidents" as a single medical incident.

The first issue before the Connecticut Supreme Court was whether the claims of the thirteen underlying plaintiffs are "related" medical incidents, so that a single limit of \$500,000 per incident (subject

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to the SIR provisions) would apply to all thirteen claims. The trial court had ruled that the term “related” is ambiguous because it could refer to either (a) harm from different but connected services delivered to a particular person, or (b) harm from similar or related services delivered to multiple persons. On appeal, the Insurer argued that “related” is a broad term, i.e., it encompasses both meanings, but it is not ambiguous. The state Supreme Court acknowledged that other jurisdictions agree with the Insurer’s argument – that “related” covers a broad range of connections without treating the term as ambiguous – but it nonetheless held in the context of a professional liability policy that the phrase “related medical incidents” does not clearly and unambiguously encompass incidents in which multiple losses are suffered by multiple patients or nursing home residents, when each loss has been allegedly caused by a unique set of negligent acts, errors or omissions by the insured in failing to protect a particular resident, even though there may be a common precipitating factor. The Court commented that “context is often central to the way in which policy language is applied,” and that “the same policy provision may shift between clarity and ambiguity.” Because the Court held that “related” is ambiguous under the facts presented here, the \$500,000 per medical incident limit applies individually to each underlying plaintiff, not collectively to all, if they prevail in their underlying suits against the Insured.

Next, the Court addressed whether the policy’s \$1 million “aggregate limit” applies to the underlying claims, even where there are thirteen separate medical incidents. The trial court had agreed with the underlying

plaintiffs that the policy’s professional liability coverage has an aggregate limit of \$10 million even for claims arising from a single nursing home location. Endorsements included with the policy referred to a \$10 million “aggregate policy limit” and also referred to an “aggregate limit” (which the declarations page had set at \$1 million), and the trial court ruled that the distinction between the two terms was unclear in context and it would apply the \$10 million figure when calculating the “aggregate limit.” On review, the Supreme Court said that when different terms are used in the same writing, different meanings are intended – and, when all of the policy’s provisions are given effect, there was no compelling reason to equate “aggregate limit” with “aggregate policy limit.” The Court found the language of the policy to be clear on the issue – “The Aggregate Limit is the most we will pay for the sum of all damages under this Coverage Part. The Aggregate Limit shall apply separately to each location owned or rented by you.” (Emphasis in original.) The Court held that the \$10 million “aggregate policy limit” is different from “aggregate limit” in that the former applies to all seven nursing homes listed in the policy for all claims under both the professional and general liability policy parts, but the \$1 million aggregate limit is applied to all claims from the same location under the same policy part. Because all thirteen underlying plaintiffs were injured at the same location, and all triggered coverage only under the professional liability part, the \$1 million “aggregate limit” applies to their claims. On this issue alone, the Court was divided, with three Justices agreeing with the Insurer to reverse the trial court and two Justices in dissent.

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Finally, the parties disagreed about the meaning of the \$250,000 self-insured retention. The underlying plaintiffs argued that that policy required the Insurer to pay the full \$500,000 per medical incident limit, and because the Insured was bankrupt the Insurer had to “drop down” to pay covered medical incidents starting at \$1. The Court declined to impute a term that would have the Insurer drop down because the parties had not explicitly or implicitly agreed to include such a provision in the policy. The Insurer’s coverage therefore attaches only if and when an underlying plaintiff’s claim against the Insured results in loss in excess of \$250,000. The Court nevertheless rejected the Insurer’s argument that the \$500,000 per medical incident limit, even if sitting on top of the SIR layer, is reduced to \$250,000 per incident by a term of the policy’s SIR endorsement providing: “The Limits of Liability as stated in this policy will be reduced by the payment of damages and expenses paid within the Self Insured Retentions.” Although it was the Insured’s obligation to administer and pay the first \$250,000 of loss, the Court took literally the policy language that any reduction in the per-incident limit is triggered by the “insured’s actual fulfillment of its obligation to pay the self-insured retention.” Because the policy “gives no indication as to what should occur in the event the insured cannot fulfill that obligation,” the Court

found ambiguity in whether an unpaid SIR reduced the per medical incident limit. Given that ambiguity, the Court held that the \$500,000 limit should not be reduced by the SIR in this case.

Presumably, the Insured will not be able to pay any of the SIR due to its bankruptcy, making the Insurer liable for the full \$500,000 limit per medical incident (attaching at \$250,000 per claim), up to a limit of \$1 million in the aggregate for all thirteen underlying claims. In these circumstances, the Court recognized that its decisions on the number of medical incidents and the SIR could become academic from the perspective of the Insurer, whose overall exposure is now the \$1 million aggregate limit (and not the \$10 million found by the trial court).

In response to this decision, insurers may consider reviewing their policy wording and: include a definition of “related” particularly in the context of a professional liability policy in an institutional setting; confirm the consistent use of “aggregate limit” and “aggregate policy limit” where applicable in a policy offering multiple coverage types or covering multiple locations; and clarify the effect of an insured’s inability to pay the SIR on policy attachment points and limits.

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