INSURANCE LAW

DRAKE GENERAL PRACTICE REVIEW

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I. Introduction

As part of the never-ending effort to share the importance of insurance law, we begin this year with recent appellate cases in Iowa that demonstrate the ubiquitous nature of the industry and the law governing it.

A. *Estate of Nagel v. Nagel,* No. No. 23-1856, slip op., 2024 WL 4615749 (Iowa Ct. App. Oct. 30, 2024) (an unpublished decision)

At first glance, this would appear to be a probate/inheritance case because it is. But the conduct giving rise to the dispute arose out of an insurance issue.

Jeffery Nagel died intestate in 2020. One of his daughters filed a petition for small estate administration, requesting to be named the personal representative. She listed herself and her siblings as Mr. Nagel's heirs.

Shortly thereafter, Lori Painter filed a petition to intervene. She asserted that she was the "common law wife of the Deceased" and therefore a beneficiary of his estate. The evidence at trial reveals a very tumultuous relationship between Mr. Nagel and Ms. Painter over an extended period of time during which they were alternately together and separated. Mr. Nagel dated other women during their periods of separation.

Ms. Painter's testimony with regard to her marital status was contradictory and found not to be credible. She did have one bit of evidence, however, that the court addressed at length: a Joint Affidavit re: Common Law Marriage signed by Mr. Nagel and Ms. Painter approximately five years before his death. The affidavit represented that the parties had "agreed to live as husband and wife, and that we have so lived and cohabited since that time" under the laws of the State of Iowa. The affidavit was presented to Wellmark. Why? It was used to obtain health insurance for Ms. Painter, who was otherwise unable to find affordable coverage. That affidavit, however, was essentially the only testimony supporting her claim and the court ruled that she had failed to establish a common law marriage.

B. *Miltner Ins. Servs., LLC v. Roberts*, 2024 WL 2043087, 8 N.W.3d 191 (Iowa Ct. App. May 8, 2024) (an unpublished decision)

For reasons that do not appear obvious, many of the cases involving employees alleged misuse of confidential employment information (particularly client or customer lists) have arisen out of insurance agencies. Perhaps it is the nature of the business that relies heavily upon renewals of insurance coverage that is common and repetitive in ordinary life in the USA. For example, if you have a client who has auto insurance, the likelihood is that that policy will be timely renewed year after year, generating an annuity for the agent from the recurring premiums. That also makes the client lists valuable.

In *Miltner*, a customer services representative, Casey Roberts, and the insurance agency entered into a "non-piracy agreement" pursuant to which Ms. Roberts agreed that she would

> "at no time divulge or disclose any information regarding the business …, including but not limited to customer lists, renewal lists, information concerning customers, any other matter connected with or pertaining to the business …. It is understood and agreed by the parties hereto that all such information … shall, at all times, remain the sole and exclusive property of the Corporation. **Upon termination, (Ms. Roberts) will return to (the agency) all records or documents of any kind or character which contain, evidence or pertain to information regarding the business of (the agency)."** (Emphasis added.)

The agreement also provided for liquidated damages and attorneys' fees.

The issue? Ms. Roberts emailed the agency's client list to her private email; she subsequently resigned and took a job with a competing agency.

The agency sued Ms. Roberts and the matter proceeded to trial in 2021. The district court concluded that the agreement was enforceable but prohibited only USE of proprietary information by Ms. Roberts to solicit clients from her former employer. Mere possession of the client list was not found to be a violation of the agreement.

On appeal, the agency challenged the court's conclusions, and the decision was reversed by the Iowa Court of Appeals for a determination of "damages and other relief" to the agency. *Miltner Ins. Servs., LLC v. Roberts*, No. 21-0893, 2022 WL 2347856, at *3 (Iowa Ct. App. June 29, 2022).

The parties agreed that damages could be determined based on the record from the May 2021 trial. Evidence with regard to damages was mixed as it most often is. Ms. Roberts testified that she deleted the list from her email account as soon as she received a cease-and-desist letter from Miltner. Subsequent correspondence indicated, however, that she still had the list including a message she sent to another former Miltner employee asserting that she was "just on countdown until that non-compete is up! Ha!"

The agency relied upon the liquidated damages provision of the agreement which based payment upon a percentage of Ms. Roberts' salary. There was no specific evidence regarding the correlation between the liquidated damages as calculated and the actual damages suffered.

So, did the liquidated damages provision hold? Yes. The district court noted that the "overriding factor … is the immense difficulty in both proving that loss has occurred and in establishing the amount of the loss with any certainty." Under the circumstances, the district court found that calculation to be fair. The court also awarded attorneys' fees and costs to the agency.

On appeal, the Court noted that it was the obligation of the breaching party to provide that the liquidated damages were really penalties and not reasonably calculated to address damages. Ms. Roberts failed to do so, and it is not the obligation of the agency to provide that the liquidated damages provision was NOT a penalty. The matter was remanded for a determination of attorneys' fees.

C. *Gregory v. La Posada Group, LLC*, No. 23-1519, 12 N.W.3d 165 (Iowa Ct. App. August 7, 2024) (an unpublished decision)

Just an interesting case showing how insurance provisions influence other legal issues. In *Gregory*, the insured guest at a hotel sued the owner of the property based upon the language of the management agreement between the owner (La

Posada Group, LLC) and the manager (BC Lynd). The management agreement noted that BC Lynd would be "exclusively responsible for directing the day-to-day activities of the Hotel and establishing all policies and procedures relating to the management and operation of the Hotel." Under existing law, that would make BC Lynd and only BC Lynd responsible for any negligence to Mr. Gregory.

However, Mr. Gregory argues that the insurance and liability provisions of the Management Agreement confer liability on the landowner for the negligence of the manager. How? The Management Agreement provided that the landowner (La Posada) was to purchase and provide liability insurance unless BC Lynd was instructed to do so. Further, the agreement read in part:

> In the event that the insurance proceeds are insufficient or there is no insurance coverage to satisfy the demand, claim, action, loss, liability or expense and the same did not arise out of the gross negligence or willful misconduct of (BC Lynd), (La Posada) agrees, at its expense, to indemnify and hold (BC Lynd), and its subsidiaries, affiliates, officers, directors, employees, agents or independent contractors harmless to the extent of the excess liability.

Neither the district court nor the appellate court was persuaded by the argument. The appellate court noted that indemnity arrangements between the two parties do not create additional liability to the injured party from the entity that was not in fact possessing the land. In essence, the court found that the provisions governing indemnity and insurance requirements were intended to benefit only the parties to that agreement and the injured third party (Mr. Gregory) was not an intended beneficiary.

D. *State ex rel. Ommen v. City of Dubuque*, No. 23-1168, 5 N.W.2d 664 (Iowa Ct. App. March 6, 2024) (an unpublished decision)

This case is included for one and only one reason: to impress upon you the length and breath of insurance-related issues in Iowa.

The Linwood Cemetery Association was established in 1975 and for 150 years the cemetery served the City of Dubuque. Unfortunately, the condition of the

cemetery declined, and it fell into disrepair, resulting in a projected deficit of $160,000 in 2020.

Enter the Iowa Insurance Division. Why? Because the Iowa Insurance Division is charged under Iowa law with administering Iowa laws governing perpetual care cemeteries. The resolution of the relevant issues and financial woes of the Linwood Cemetery Association is complex at best but the responsibility for its handling lies with the Iowa Insurance Division. Who knew?

II. Coverage

A. *Dostart v. Columbia Ins. Group,* No. 23-1308, slip op., 2024 WL 4615623 (Iowa Ct. App. Oct. 30, 2024) (an unpublished decision)

This dispute came before the Iowa Court of Appeals on a denial of the insurance company's motion for summary judgment. The basis for the dispute was the injured party's assertion that the insurance policy issued by Columbia to the construction company (alleged tortfeasor) provided coverage to its insured. Columbia had defended its insured during the pendency of the underlying suit subject to a reservation of rights. After the Dostarts obtained a judgment for consumer fraud against the construction company, the insurer denied coverage and the Dostarts sued the construction company's insurer (Columbia) for payment.

WAIT! How does the injured party proceed with a claim against the tortfeasor's insurance company. That is generally prohibited as there is no contractual relationship between the injured party and the tortfeasor's liability carrier. However, the Dostarts correctly followed the procedures set forth in Iowa Code section 516.1. That statute "lets a judgment creditor, like the Dostarts, stand in the shoes of the insured to bring a direction action against the insurer."

Columbia's defense followed predictable arguments, and it sought summary judgment in its favor on four grounds:

1) There was no "occurrence," defined as an accident. To the contrary, Columbia argued that "fraud" could not be accidental and was therefore not covered.
2) There was no "bodily injury" or "property damage" as defined in the policy because the loss was strictly economic.
3) The fraud falls within the policy's exclusion "for loss which results from an act committed by or at the direction of an insured with the intent to cause loss."
4) The statutory-damage awards fell within the policy's exclusion for "punitive or exemplary damages." (The injured parties conceded this argument.)

The injured parties resisted the first three arguments against coverage asserted by the insurer. In essence they argued that their judgment was under the consumer-fraud statute which, unlike common-law fraud, does not require an intent to deceive or even knowledge of a misrepresentation or omission. Further, they referred to an expert report documenting property damage to their home in support of the argument that there was in fact tangible evidence of property loss.

The district court denied Columbia's motion for summary judgment (with the exception of the coverage for punitive or exemplary damages conceded by the injured third party) because there were factual disputes that could not be resolved on the record made. The Court of Appeals agreed.

B. *Minnesota Lawyers Mut. Ins. Co. v. Rasmussen, Nelson & Wonio, PLC*, No. 23-1668, slip op., 2024 WL 4369947 (Iowa Ct. App. Oct. 2, 2024) (an unpublished decision)

Claims made v. occurrence policies – a significant and defining difference. As noted in previous discussions, CGL (commercial general liability), homeowners' and auto policies are generally "occurrence" policies. In other words, they provide coverage if there is an "occurrence" (accident) within the policy period. As a result, the liability under any of those policies cannot finally be determined until the statute of limitations has expired on all claims that could have arisen during the relevant policy period.

In sharp contrast, "claims made" policies cover only those claims that are actually made (as defined in the policy) during the time period in which the policy was in effect. Most professional liability policies are claims made policies.

The dispute in *Minnesota Lawyers* was based upon an alleged negligent failure by the law firm to renew a financing statement or inform the client of the need to do so. The client brought the issue to the attention of the law firm in February or March of 2021. At that time, according to the firm, the client "told (them) he would not make a claim against them." The alleged communication was verbal only. Subsequently, the debtors failed to pay and, because they lost their secured position, the clients ultimately lost more than 90% of the $2.7 million they had invested in the project.

In August of 2021, the law firm filed a renewal application for malpractice coverage with Minnesota Lawyers. No reference to a potential claim by the former clients was made. Several months thereafter, new counsel for the clients informed Rasmussen that it was time for him to "begin talks with your professional liability insurer." Because the claim was not disclosed on the renewal application, Minnesota Lawyers denied coverage and brought a declaratory judgment action to resolve the coverage issue. Based upon the record before it, the district court granted summary judgment for Minnesota Lawyers, rejecting the lawyers' assertion that they relied on the client's statement that he did not intend to pursue a claim, stating that any "experienced lawyer knows that an initial statement from someone aggrieved that they will not pursue remedies cannot be fully relied upon, there is a potential for liability in an unresolved matter so long as there are facts that *could* support a future claim."

The Iowa Court of Appeals agreed.

In reaching its decision, the court noted that the application asked if any "firm member (had) become aware of any INCIDENT which could reasonably result in a claim being made against the firm or a member of the firm." Rasmussen answered that question in the negative. When determining whether or not a claim had been made or an incident had arisen, "claim" is defined in the policy

as "any act, error or omission by any INSURED which could support or lead to a demand for such DAMAGES."

In interpreting the policy, the Court of Appeals followed its general guiding principles concerning construction and interpretation of contracts and read the policy as a whole. In particular, the appellate court noted language in the policy which required that the firm certify that "all known claims, lawsuits, incidents, and disciplinary investigations have been reported to the present and previous insurance carriers and the applicant has no knowledge of any threatened litigation **or existing facts or situations which could result in a claim being filed against the applicant**." (Emphasis added.) The applicant was also required to certify that it had no knowledge of "existing fact or situation which could result in a claim or disciplinary action …." The policy also provided that a claim is deemed made when the insured "first becomes aware of any actual or alleged act, error or omission by any INSURED which could support or lead to a CLAIM."

Having found the language to be clear and unambiguous, the Court of Appeals affirmed the district court's judgment in favor of Minnesota Lawyers.

C. *Heartland Co-Op v. Nationwide Agribusiness Ins. Co*., No. 23-0156, 10 N.W.3d (Iowa Ct. App. June 5, 2024) (an unpublished decision)

The insurance litigation arising in the aftermath of the derecho in 2020 continues. The basic facts giving rise to this dispute are as follows:

Heartland Co-op had an insurance policy with Nationwide that provided coverage for property damage and Nationwide agreed that the physical damage to the insured's property was covered. However, the policy limit for lost earnings and extra expenses resulting from "any one loss" was $3,000,000. While Heartland did not suffer damage in excess of $3,000,000 at any single location, it is an agricultural cooperative with many business locations throughout Iowa and other states; collectively, the damage for lost earnings and extra expenses exceeded the $3,000,000 limit. Is Heartland entitled to multiple limits of $3,000,000 or were the lost earning and extra expenses from the derecho at all of its various locations really "one loss?" In response to a motion for summary judgment by the insurer, the district court held that the $3,000,000

limit means the combined loss at all locations for one event. The Court of Appeals agreed.

Not surprisingly, the court relied upon the customary and ordinary meaning of the terms. The word "any" means "all or every." The dictionary meaning of "loss" is "destruction, ruin" or "failure to gain, win, obtain, or utilize" or, in the insurance context, "(t)he amount of financial detriment caused by … an insured property's damage, for which the insurer becomes liable."

This is helpful but not dispositive because the issue is not whether or not the loss was suffered but whether an individual loss is considered in terms of the company as a whole or in terms of the individual locations. Ah, a more complex issue. But there are other clues in the policy supporting the insurer's position. For example:

- The box for per-location coverage for "earnings-and-extra-expense loss was not checked.
- The loss limit for earnings-and-extra-expense coverage is found on the schedule for "all covered locations" as opposed to "each location."

The insured, however, raised a couple of other interesting arguments based upon the policy language:

- The relevant section of the policy refers to direct physical loss or damage to property at a "covered location" for both earnings-and-extra-expense coverage. "A" is singular. Furthermore, the policy refers to loss at "any" covered location. Again, the reference is singular. The limit must therefore be applied singularly or separately for each location.

- Secondly, the policy includes a section governing valuation that describes how an earnings loss is calculated based upon "pertinent sources of information" including "'your' accounting procedures."

The appellate court was not persuaded. In response to the arguments of the insured, the Court noted that "a covered location" simply confirms that the coverage only applies to those locations that were damaged by a covered peril. Similarly, the section regarding use of the insured's accounting practices is

useful in calculating the damage but does not address whether or not that loss is a separate loss for each location. The time differential argued by Heartland did not carry the day.

However, Judge Langholz was persuaded by Heartland's argument and filed a dissenting opinion. The judge noted that Heartland had forty-eight locations across Iowa – from Woodbine to Marengo – that suffered losses at different times to different degrees and in different amounts in different forms. The judge found that because physical damage is separated by location and the earnings-and-extra-expense damage is tied to that specific physical loss, the limit for the earnings-and-extra-expense damage must also necessarily be tied to each of the specific locations. In an ever-interesting display of the challenges of construction of insurance policies, the dissenting judge found the policy to unambiguously provide a separate policy limitation for each location while the majority found the policy to unambiguously provide a single policy limitation for all locations combined.

D. *Cincinnati Ins. Co. v. McKasson*, No. 23-0974, slip op., 2024 WL 4615898 (Iowa Ct. App. Oct. 30, 2024) (an unpublished opinion)

Charles Hartwig ran a stop light and was involved in an automobile accident while driving the truck owned by his employer, Brown's Heavy Equipment. Brown's argued that it was not responsible for the loss because Mr. Hartwig was driving the vehicle on his own time for a personal errand without its consent as the owner of the vehicle. So, did Mr. Hartwig have either expressed or implied consent to drive the truck at that time and place? Why do we care as the vehicle was insured.

The trucks owned by Brown's were provided for employees to travel to customers' premises to provide service and repairs. Generally, the trucks were stored at the employer's premises overnight. However, on occasion, with specific permission, employees were authorized to keep the trucks at their homes overnight if reasonable, for example, if the first repair in the morning was closer to the employee's residence. However, in the instant case, Mr. Hartwig admitted that he "did not ask (the employer/vehicle owner) or any employee of Brown's Heavy Equipment for permission to take the Ford F-650

truck off the business premises for his own personal use before doing so" on the day of the accident.

While Brown's ownership of the truck created a rebuttable presumption that Hartwig had consent to drive the vehicle, the weight of the testimony established that Mr. Hartwig did not have permission or consent. The two key matters considered were the fact that permission was not requested and the fact that Mr. Hartwig admitted not having permission to use the vehicle when he met with Mr. Brown shortly after the accident. And then there is the recorded statement to the insurance company, the initial disclosures filed in the litigation and the admission in the defendant's answer. In fact, the lack of consent was not only supported by substantial evidence but was virtually uncontroverted.

There were two consequences to the lack of consent: the owner of the truck (Brown's Heavy Equipment) was not liable for the accident and Mr. Hartwig was not an insured under the terms of the vehicle coverage issued by Cincinnati Ins. Co. to the owner of the vehicle.

E. *Gerdts v. Donan Engineering Co., Inc*., No. 22-1861, slip op., 4 N.W.3d 464 (Iowa Ct. App. Jan. 24, 2024) (an unpublished opinion)

Mr. Gerdts owned half of a duplex in Bettendorf. There was a hailstorm in the neighborhood in April 2020. As a result of the hailstorm, many of Mr. Gerdts' neighbors, including the person owning the other half of the duplex, had their roofs repaired or replaced through other insurance carriers. However, Property and Casualty Insurance Company of Hartford (Hartford) denied the claim of damage to the shingles on Mr. Gerdts' half of the duplex although it did pay for damage to some of the softer materials on the roof such as vents and the furnace cap.

Subsequently, an engineering company was hired to inspect the damage to the roof. It concluded that the roof was not damaged by hail impact but had man-made damage, balding, age-related deterioration, and nail pops. Mr. Gerdts was less than pleased with the outcome and so sued Donan Engineering Co., Inc. (the company that performed one of the inspections and found no hail-related damage), Lance LeTellier, P.E. (who performed another inspection and found no hail-related damage) and Hartford, his insurer. The claims against the

inspectors were based upon negligence, interference with contract and conspiracy. It is instructive to take each of those claims separately.

Can the insured pursue a claim of negligence against the roof inspectors? No. Why not? In general, the parties are not in privity and a plaintiff who has suffered only economic loss due to another's negligence does not have a claim that is legally cognizable or compensable. The rule is "meant to prevent parties litigating in tort what should be litigated in contract where, presumably, the parties 'have allocated (expectations of the contractual relationship) between themselves in their contract.'" Even though some claims for professional negligence (for lawyers and accountants, for example) have been excluded from the rule regarding privity and lack of duty, the Court of Appeals relied upon an earlier case involving alleged negligence of an engineering firm decided in 2020 and reject the plaintiff's argument that a duty of care existed.

Mr. Gerdts was no more successful in his claims for tortious interference with contract. In reaching its conclusion, the court relied upon the Iowa Supreme Court's decision in *Green v. Racing Ass'n of Cent. Iowa*, 713 N.W.2d 234 , 244, (Iowa 2006) which articulated seven consideration for determination of liability for tortious interference with contract: 1) the nature of the conduct; 2) the defendant's motive; 3) the interest of the party with which the conduct interferes; 4) the interest sought to be advanced by the defendant; 5) the social interests in protecting the freedom of action of the defendant and the contractual interests of the other party; 6) the nearness or remoteness of the defendant's conduct to the interference; and 7) the relations between the parties. The courts have distinguished between those situations in which the impact on the plaintiff was merely a consequence of actions taken for a purpose other than to interfere with a contract and those in which interference was the goal.

The appellate decision noted that the seven factors were not analyzed or applied by the district court. Instead, the district court created a new criterion: establishing improper professional conduct through an expert witness (which Mr. Gerdts did not have). Since the existence of hail damage is routinely determined by persons who are not engineers, the court found that the trial court's requirement of expert testimony was not proper. The trial court granted summary judgment to the engineers on an improper basis. That does not, however, end the inquiry. If the trial court was right for the wrong reason, as

long as the argument was preserved, the decision can be affirmed. And it was. After extensive analysis of the seven criteria, the Cout of Appeals found that Doran was entitled to summary judgment on the claim of intentional interference with contract.

And finally, the Court of Appeals rejected Mr. Gerdts' argument that he was a third-party beneficiary of the contract between Donan and Hartford.

The partial dissent filed by Judge Tabor is interesting and worth your time. In essence, she pointed out several additional facts that could give rise to an implication of an improper motive and asserted that the issue should be submitted to a jury rather than resolved in summary judgment. She also urged the Supreme Court to clarify whether or not engineering negligence is exempt from the economic loss rule. Note that an application for further review was filed.

F. *Schmidt v. Farmers Mut. Hail Ins. Co. of Iowa*, No. 23-0894, slip op., WL 4369617 (Iowa Ct. App. Oct. 2, 2024) (an unpublished decision)

And here we have yet another bit of litigation stemming from the derecho in 2020. The insureds, Joseph and Bambi Schmidt, disagreed with the insurance company's assessment of damages to their insured property. They contended that they were entitled to more than the nearly $50,000 paid by Farmers. The matter was submitted to arbitration. The Schmidts chose one arbitrator; Farmers chose one arbitrator; and the designees of the Schmidts and Farmers then chose an umpire, the third member of the arbitration panel. The panel concluded that no further payments were due to the insureds (by a two to three majority) and this breach of contract claim against Farmers followed.

This case is a testament to the power of the arbitration panel and the heavy obligation on any party seeking to challenge it. Although the Schmidts argued that the "appraisal did not account for 'certain substantive damages,'" the argument was unavailing. In order to overturn an arbitration decision, there must be allegations and evidence of fraud, mistake or malfeasance in the appraisal process. Mere disagreement with the result is insufficient.

In an effort to avoid the conceded lack of fraud, mistake or malfeasance, the Schmidts argues that the problem with the arbitration process was simply that the process did not include every damaged property item. However, the court found that the disagreement was really as to the valuation and that, in and of itself, is inadequate to challenge the arbitration decision.

G. *Grinnell Mut. Reinsur. Co. v. Weber*, 2024 WL 3879551, No. LACV017612 (Iowa Dist. July 10, 2024)

While this is not an appellate court decision, it demonstrates common arguments involving coverage disputes and is therefore worth discussing. The facts are tragic. Shirley Weber operated a day care in her home. In fact, she had done so from 1976 to 2022, 45 years. On June 28, 2022, one of the children in her care was strapped into a car seat and then left unattended while Ms. Weber cared for other children. The child slid down in the car seat, suffocated and died. At the time of the child's death, Ms. Weber was caring for ten children. Her liability insurance policy with Grinnell Mutual provided protection for Weber IF she was not caring for more than six children on the day of the loss.

As the coverage afforded was unambiguous, Ms. Weber claimed that she was entitled to coverage based on the doctrine of reasonable expectations. In order to recover on that basis, she needed to establish that an ordinary layperson would misunderstand the policy's coverage, that circumstances attributable to the insurer fostered coverage expectations, that the exclusion relied upon was bizarre or oppressive, that the exclusion eviscerates a term which the parties explicitly agree to, or that the exclusion relied upon eliminated the dominant purpose of the policy. The trial court systematically reviewed the record applicable to each of these claims and found that there was no evidence to support a claim that coverage should be provided under the doctrine of reasonable expectations. The court concluded that a reasonable person should be able to understand the limitation in the number of children and that the risks inherent in a home day care compared to a commercial day care supported the numeric limitation and did not eviscerate the dominant purpose of the policy. No coverage was afforded.

H. *Rath v. Arch Ins. Co.,* No. 23-0157, 6 N.W.3d 342 (Iowa Ct. App. April 10, 2024) (an unpublished decision)

And again, the aftermath of the derecho that hit in 2020 is a "gift" that just keeps on giving for insurance law nerds although not for those who felt the impact of the powerful storm.

Keith Rath had a dispute with the insurer of his home over losses sustained as a result of the windstorm. The dispute arose because Mr. Rath did not purchase the insurance directly. Instead, the bank holding a security interest in his home contracted with Arch Insurance to protect the asset – a "force-placed" policy after Rath's homeowners' insurance lapsed. Arch Insurance argued that it owed no duty to Rath because it had no contract with him directly and he was not an intended third-party beneficiary.

The district court agreed with the insurer and granted its motion for summary judgment dismissing the breach of contract and related claims brought by Rath against Arch Insurance. However, the Court of Appeals disagreed. According to the majority of the appellate court, the parties chose to replace text in the policy stating that Rath, as the "Borrower," "has no interest in this policy" with an endorsement expressly giving Rath a benefit. That endorsement provides that while Rath "is neither a Named Insured nor an additional named insured under the policy,' he "shall be considered an additional loss payee only as respects amounts of insurance over and above the interests to whatever amount the parties set on the notice of insurance for the property. We see no possible purpose for the endorsement besides providing a benefit to Rath."

Judge Schumacher disagreed. The judge noted that the policy "does not name the borrower as an additional insured, delineate that the policy covers the borrower's interest in the insured property, or otherwise state that the borrower is a beneficiary of the lender's coverage, including that of a third-party beneficiary. To the contrary, the policy indicates that no direct or indirect coverage is provided to the borrower." The Notice of Insurance received by Mr. Rath annually specifically listed the residence in question but noted that "This is not a Homeowner's Policy." It also stated in bold: "This Notice of Insurance is for information only. It neither amends, extends nor alters the coverage afforded by the lender's master policy which it described."

The dissent also focused on the language of the Declarations page which specifically stated that the policy "does not provide coverage for …. The Interest or equity of the Borrower as it is collateral protection Insurance, protecting Your Interest, subject to the Policy terms and conditions." The policy stated that it does not "provide coverage for the Interest or equity of the Borrower" and that the "Borrower is not a Named Insured under this policy and no coverage is provided, either directly or indirectly, to the Borrower."

With regard to the endorsement relied upon by the majority, the dissent emphasized that the endorsement specifically states that it does not change any of the definitions of the insurance policy itself. And so, this "unambiguous" policy leads to diametrically opposing opinions based upon readings of the "clear" language.

III. Miscellaneous

Each of the following decisions, while interesting, has a rather narrow impact or focus. We therefore draw them to your attention without extended analysis.

A. *Berman v. Minnesota Lawyers Mut. Ins. Co.*, slip opinion, No. 23-1050, 2024 WL 4760531 (Iowa Ct. App. Nov. 13, 2024) (an unpublished decision)

In *Berman*, the plaintiff, a self-represented resident of California, filed suit for civil extortion against Minnesota Mutual. The case arose ostensibly because Minnesota Mutual filed a subrogation claim against the trust in which the plaintiff was the remainder beneficiary. The claim delayed distribution of the trust assets until the subrogation claim could be resolved.

Mr. Berman filed suit asserting civil extortion because of the delay in distribution pending resolution of Minnesota Mutual's claim. And he chose to file the suit in Iowa. Why? Because Minnesota Mutual does business here. The case was dismissed by the district court in Polk County, finding that it lacked authority to hear the case in Iowa because none of the alleged conduct occurred in Iowa and the court therefore lacked territorial jurisdiction. Over four years later, Mr. Berman filed a motion to reopen the extortion case in Iowa. The district court declined to reopen the case and Mr. Berman appealed. In a

short option, the Iowa Court of Appeals adopted the district court's rationale for dismissal and affirmed the decision.

B. *Iowa Individual Health Benefit Reins. Assoc. v. State University of Iowa*, 999 N.W.2d 656 (Iowa 2023)

If you happen to have clients who operate or participate in reinsurance associations, this is the case for you. In essence, the Iowa Individual Health Benefit Reinsurance Association (IIHBEA) sued for an assessment against Iowa State University, University of Northern Iowa and the University of Iowa as "members" of the association. Through a complex series of arguments including constitutional prohibitions against the state acting as a surety, the Iowa Supreme Court upheld the assessments based upon the statutory language establishing the reinsurance association and the terms of the contract. Note that these assessments were not insignificant. The assessment against UNI was over half a million dollars; ISU was required to pay nearly a million and a half; and the University of Iowa ordered to pay over $4.2 million.

C. *Griffin v. NYLife Securities, LLC*, slip opinion, No. 23-1685, 2024 WL 4366609 (Iowa Ct. App. Oct. 2, 2024) (an unpublished decision)

While not directly concerning insurance law, Griffin involves the obligations of agents holding licenses to sell insurance and securities. In 1988, Griffin purchased whole life insurance policies for himself and his wife. Part of the goal of the life insurance policies was to avoid payment of taxes as the death benefits passed income tax free. In fact, Mr. Griffin collected the million and a half dollars on the death of his wife. Having received the funds tax free, Mr. Griffin concluded that whole life policies were an excellent investment and purchased an additional whole life policy for himself, an additional whole life policy for his new wife and policies for their two children.

Unfortunately, Mr. Griffin's financial situation was not stable. He borrowed money from the policies for everything from household expenses to a trucking business. Eventually the premiums were unpaid, and the policies lapsed or were surrendered due to nonpayment.

Mr. Griffin then sued NYLife, asserting several basis for recovery: 1) breach of fiduciary duty; 2) fraudulent non-disclosure; 3) negligent misrepresentation/omission; 4) constructive fraud; 5) breach of contract; 6) negligent supervision and respondeat superior; 7) violation of insurance trade practices; and 8) punitive damages. As described by the court, Mr. Griffin alleged that he had "virtually no understanding" about investing, including the products which were sold to him but relied upon the agent to recommend how to invest his money. The court disposed of the claims as follows:

1) Breach of fiduciary duty. This claim was barred by the applicable five-year statute of limitations even after application of the discovery rule. The insured received timely reports on the status of these policies and knew or should have known of any potential claim more than five years earlier.
2) Fraudulent non-disclosure. Although this claim is not subject to the protection of the discovery rule, again the statute of limitations had expired.
3) Constructive Fraud. Although the discovery rule applies to the five-year statute of imitations in this case, the claim "starts to accrue at the point the plaintiff discovers 'the fact of the injury and its cause.'" Since the policies (10 in total) were purchased between 1988 and 2000, the plaintiff was forced to rely on the discovery rule. The court found that the discovery rule was unhelpful. "We have detailed the relevant evidence dispelling this claim above in relation to Griffin's other claims. In short, a reasonable person who had taken our life insurance policies to "build( ) cash value" and had subsequently taken out loans on the policies and was unable to make premium and loan interest payments would be placed on inquiry notice to discovery" whether the "investments" were accumulating value. *7
4) Failure to supervise the agent. This claim too was defeated by the statute of limitations based upon all of the facts previously articulated.
5) Negligent misrepresentation/omission. In essence, the plaintiff asserted that the agent misrepresented life insurance as an investment, failed to disclose all fees associated with the policies, failed to disclose or concealed the taxes incurred, failed to recommend a suitable financial portfolio and failed to disclose that borrowing funds from one policy to pay premiums on another could fail. Noting that only persons who are in the business of supplying information to others can be liable for negligent misrepresentation, the court held that unless an insurance producer holds "himself out as an insurance specialist, consultant, or counselor and received compensation for

consultation and advice apart from commissions paid by an insurer, the duties and responsibilities of the insurance producer are limited." Plaintiff was unable to generate any genuine issue of material fact supporting his contention that the insurance producers held themselves out as consultants, specialists or counselors.

6) Breach of contract. Mr. Griffin asserts that he had a contract with the producers pursuant to which they would manage his "investment" account in a reasonable and prudent manner. Most of these claims too were barred by the statute of limitations. There were no facts that supported the remainder of the claims.
7) Breach of Fair Trade Practices Act. Iowa does not recognize a private cause of action for breach of the insurance fair trade practices and the plaintiff withdrew this claim.
8) Punitive damages. As there was no viable claim, punitive damages could not be sustained.

And here's to a wonderful 2025!!