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Applying Connecticut law, a New York federal district court ruled that a policy exclusion did not bar coverage for cyber-fraud losses because a professional services exception to the exclusion restored such coverage. *SS&C Technology Holdings, Inc. v. AIG Specialty Ins. Co.*, 2020 WL 509028 (S.D.N.Y. Jan. 31, 2020). (Click here for full article)

Denying Cross-Motions For Summary Judgment, Virginia Court Addresses Novel Issues In Cyber Coverage Dispute

A Virginia federal district court addressed several novel cyber-related coverage issues, including the following: which act constitutes the operative "occurrence" in an email phishing scheme; the number-of-occurrences presented by cyber claims; the location of the occurrence for purposes of a territory provision; and the scope of admissible cybersecurity expert testimony. *Quality Plus Svs., Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2020 WL 239598 (E.D. Va. Jan. 15, 2020). (Click here for full article)

Notwithstanding "Relative Exposure" Policy Language, Delaware Court Rules That "Larger Settlement Rule" Controls Allocation

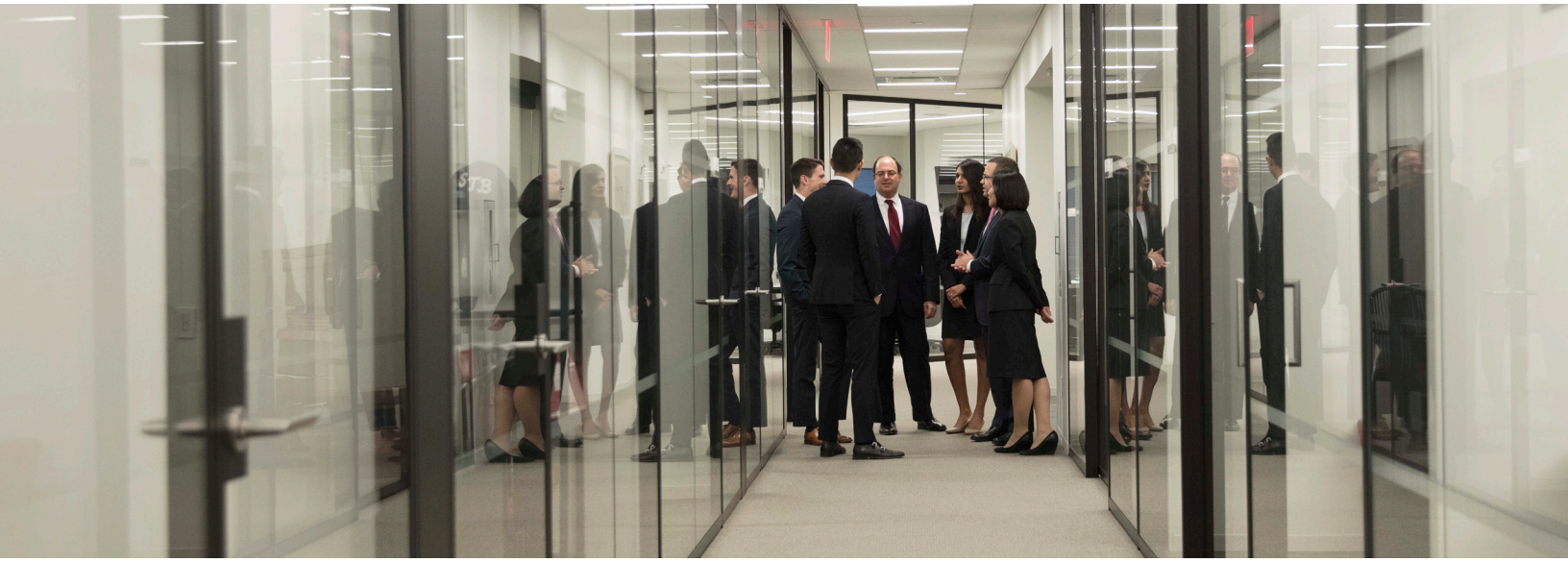
A Delaware court ruled that allocation of settlement payments between covered and non-covered payments must be based on the "Larger Settlement Rule," notwithstanding policy language referencing the insured's "relative legal and financial exposure" with respect to defense and settlement costs. *Arch Ins. Co. v. Murdock*, No. N16C-01-104 (Del. Super. Ct. Jan. 17, 2020). (Click here for full article)

"Related Acts" Provision And "Prior Acts" Exclusion Do Not Relieve Insurer Of Duty To Defend Shareholder Derivative Suit, Says Pennsylvania Court

A Pennsylvania federal district court ruled that a D&O insurer was obligated to defend a shareholder derivative suit, finding that a "related acts" provision and a "prior acts" exclusion did not bar coverage. *Vito v. RSUI Indem. Co.*, 2020 WL 424592 (E.D. Pa. Jan. 27, 2020). (Click here for full article)

California Appellate Court Rules That Non-Signatory Is Bound By Arbitration Clause In Insurance Policy

Reversing a trial court decision, a California appellate court ruled that a non-signatory to an insurance policy was bound by an arbitration clause contained therein. *Philadelphia Indem. Ins. Co. v. SMG Holdings, Inc.*, 2019 WL 7790891 (Cal. Ct. App. Dec. 31, 2019). (Click here for full article)



Occurrence Alert:

Delaware Supreme Court Rules That Physical Attack Cannot Be "Accidental," Even Where Resulting Injury Was Unintended

Abrogating contrary Delaware case law, the Delaware Supreme Court ruled that the determination of whether an incident was an "accident" for purposes of coverage under a homeowner's policy must focus on the intent of the insured party, not the victim. Applying this standard, the court concluded that an intentional assault was not a covered "occurrence" even where the assailant did not expect the resulting death. *USAA Casualty Ins. Co. v. Carr*, 2020 WL 467935 (Del. Jan. 29, 2020).

Amy Joyner-Francis suffered sudden cardiac death after being assaulted by Trinity Carr. Evidence in a criminal trial demonstrated that the assault was a contributing cause of the victim's death and that death was a "result outside the risk of which Carr should have been aware." Following the criminal trial, Carr was named as a defendant in a civil suit. USAA, which provided homeowner's insurance to Carr's mother, sought a declaration that it had no duty to defend or indemnify.

The Delaware Supreme Court ruled that USAA had no duty to defend or indemnify the suit against Carr. The court held that Joyner-Francis's death was not an "occurrence," defined as "an accident . . . which results . . . in . . . bodily injury." The court explained that the determination of whether an incident constitutes an accident must be made from the insured's perspective, rather than the victim's. Therefore, because Carr intended the physical attack, it could not be deemed accidental. The court rejected Carr's assertion that the resulting death was accidental because it was not foreseeable, stating that "the question is whether the events that caused [the victim's] death were accidental, not whether the death itself was an accident."

Additionally, the Delaware Supreme Court ruled that even if the attack could be construed as an "occurrence," coverage would be excluded by a clause that applies to injury "which is reasonably expected or intended by any insured even if the resulting bodily injury . . . is of a different kind, quality or degree than initially expected or intended." The court deemed this provision unambiguous, finding the meaning of the exclusion to be clear: coverage is excluded where the insured intended to cause some injury, even if the actual resulting injury was more or less serious than intended.

Duty To Defend Alert:

Tenth Circuit Declines To Expand Limited Exceptions To "Four Corners" Complaint Rule

The Tenth Circuit ruled that extrinsic facts could not be used to trigger an insurer's duty to defend where the complaint failed to allege facts giving rise to the possibility of coverage. *Chavez v. Arizona Auto. Ins. Co.*, 947 F.3d 642 (10th Cir. 2020).

The coverage dispute arose out of a car accident in which Marlena Whicker rear-ended a taxi, injuring its passenger. At the time of the accident, Whicker was living with the owner of the vehicle, but was not listed as an insured on the automobile policy. However, the policy covered drivers who were using the vehicle with a named insured's permission. The injured passenger, as assignee of Whicker, sued the automobile insurer, seeking payment for a $700,000 default judgment that had been issued in the tort litigation.

The Tenth Circuit dismissed the complaint against the insurer, ruling that the underlying complaint did not trigger the insurer's duty to defend. More specifically, the court held that the complaint's failure to plausibly allege (or raise an inference) that Whicker was a permissive insured under the policy was fatal to the request for a defense. In so ruling, the court reiterated Colorado's "four corners" complaint rule, under which the duty to defend arises only when the allegations in the complaint create the possibility of coverage under the relevant policy. The court declined to consider extrinsic evidence bearing on Whicker's potential status as a permissive driver, noting that the Tenth Circuit has recognized only two narrow exceptions to the

"four corners" rule (permitting consideration of "indisputable [extrinsic] facts" and facts known from "parallel judicial proceedings"), neither of which applied here.

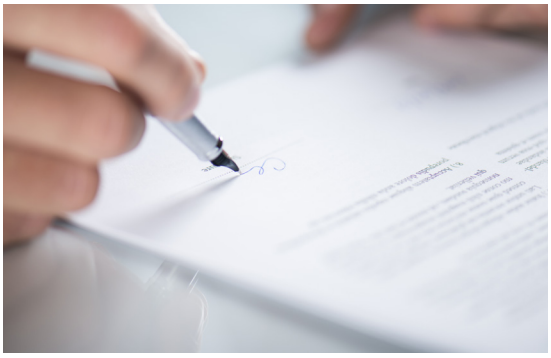
Excess Alert:

Missouri Court Addresses Horizontal Exhaustion And "Drop Down" Obligation Following Primary Insurer's Insolvency

Applying California law, a Missouri federal district court ruled that language in excess policies was ambiguous as to whether it required excess insurers to "drop down" and provide coverage following a primary insurer's insolvency. In addition, the court ruled that coverage under the excess policies was contingent upon horizontal exhaustion of all applicable primary policies, but that issues of fact existed as to the period of continuous loss. *O'Reilly Auto Enters. v. U.S. Fire Ins. Co.*, 2020 WL 520129 (W.D. Mo. Jan. 31, 2020).

The coverage dispute arose out of underlying asbestos-related claims. O'Reilly, successor-in-interest to the original policyholder, sought a declaration regarding the defense and indemnity obligations of excess insurers Columbia Casualty Company and Continental Casualty Company. The excess insurers sought summary judgment on two issues: (1) that they were not obligated to "drop down" due to the insolvency of Home Insurance Company, the primary insurer underlying both excess policies; and (2) that they owed no duty to defend or indemnity under the principle of horizontal exhaustion because other primary policies (issued by United States Fire) were not exhausted. The court denied the motion.

The court ruled that excess policy language was ambiguous as to the excess insurers' duty to "drop down" following Home's insolvency. The court explained that policies can preclude "drop down" obligations if they expressly state that excess liability is triggered when primary insurance is "exhausted by payment of the underlying policy limit." However, the excess policies at issue contained the following language: "if the applicable limit of liability of the underlying insurance is less than as stated in the schedule of underlying insurance because the aggregate limit of liability of the underlying insurance has been reduced this policy becomes excess of such reduced limit of liability." The court deemed the term "reduced" ambiguous, explaining that it may or may not include reduction by Home's insolvency. Construing this ambiguity in favor of coverage, the court ruled that the excess insurers were obligated to bear the risk of Home's insolvency. In so ruling, the court rejected the excess insurers' contention that a separate "loss" provision, which defined loss as "sums paid as damages in settlement of a claim or in satisfaction of a judgment," operated to preclude "drop down" coverage absent actual payment by underlying insurance.



With respect to horizontal exhaustion, the court noted that under California law, the presumption is that excess coverage does not attach until all applicable primary policies have been exhausted. To overcome this presumption, a policy must include language stating that it is "excess to a specifically described policy and that coverage attaches only when the limits of the specific policy are exhausted." The excess policies did not contain this language. Rather, they defined "loss" as sums paid after deductions for "all recoveries, salvages and other insurances." In addition, other provisions referenced "other insurance," further supporting the position that the excess policies were not intended to attach until all primary insurance had been exhausted.

Notwithstanding this finding, the court held that it was not in a position to grant the excess insurers' summary judgment motion as to whether their obligations were subject to the exhaustion of U.S. Fire's primary policies. The court explained that "the principles of horizontal exhaustion apply only where the period of continuous loss is the same for the

primary and excess policies at issue." Here, the excess insurers failed to show the absence of a genuine dispute regarding the period of continuous loss and whether it spanned coverage periods in which U.S. Fire issued primary policies.

Professional Services Alert:

Nebraska Supreme Court Rules That Professional Services Exclusion Does Not Bar Coverage For Civil Rights Claims Against Law Enforcement Agents

The Nebraska Supreme Court ruled that a professional services exclusion did not apply to civil rights claims against a county and law enforcement officers. *Gage County v. Employers Mutual Casualty Co.*, 304 Neb. 926 (2020).

Six individuals who spent nearly two decades in prison for crimes they did not commit alleged civil rights violations against Gage County, several county offices and certain individual law enforcement officers (collectively "Gage County"). Gage County thereafter sought defense and indemnity under a general liability policy and an umbrella policy issued by Employers Mutual Casualty Company, both of which contained professional services exclusions. A Nebraska district court granted the insurer's summary judgment motion, ruling that the exclusions barred coverage. The district court reasoned that "professional services" encompasses conduct that involves specialized knowledge, training and experience, including law enforcement services. The Nebraska Supreme Court reversed.

The parties disputed the correct legal standard for determining whether underlying conduct constitutes "professional services." Gage County argued that "professional" must be interpreted in accordance with case law involving Nebraska's statute of limitations for professional negligence claims, Neb. Rev. Stat. § 25-222 (2016). In contrast, the insurer argued that insurance case law involving professional liability policies was controlling. The court declined to resolve this dispute, stating that "[t]his case does not require us to import definitions from our case law to answer the question of whether law enforcement is considered a profession, because the plain language of the [Employers insurance] policies answers that question."

The court explained that when the Employers policies are read together "as a whole," it is clear that the professional services exclusions are not intended to apply to acts of law enforcement. Although the general liability policy did not define "professional services," the umbrella policy and a linebacker policy (not at issue) contained a list of professions encompassed by the exclusion which did not include law enforcement. In addition, the umbrella policy listed law enforcement as an "occupation" under a separate occupations liability exclusion. According to the court, these provisions indicate that the parties understood law enforcement to be outside the scope of the professional services exclusion.

Cyber Alerts:

Professional Services Exception To Policy Exclusion Restores Coverage For Email Phishing Claims, Says New York Court

Applying Connecticut law, a New York federal district court ruled that a policy exclusion did not bar coverage for cyber-fraud losses because a professional services exception to the exclusion restored such coverage. *SS&C Technology Holdings, Inc. v. AIG Specialty Ins. Co.*, 2020 WL 509028 (S.D.N.Y. Jan. 31, 2020).

SS&C, a financial technology company, provided business processing management services to Tillage Commodities Fund. SS&C fell prey to an email phishing scheme in which "spoof" emails purportedly from Tillage requested wire transfers. Before the fraud was discovered, SS&C sent nearly $6 million of Tillage's funds to bank accounts in Hong Kong. Tillage sued SS&C, alleging negligence and breach of contract, among other causes of action. SS&C sought defense and indemnity under a Specialty Risk Protector Policy. The insurer agreed to defend SS&C, but refused to indemnify the settlement between Tillage and SS&C.

The policy's Modified Investment Advisor Exclusion applied to:

> Loss in connection with a Claim made against an Insured alleging . . . the exercise of any authority or discretionary control by an Insured with respect to any client's funds or accounts. Provided, however, that this exclusion shall not apply to any Claim arising out of your performance of Professional Services. Notwithstanding the foregoing sentence, it is expressly understood and agreed that there shall be no coverage for the monetary value of any funds lost due to the Insured's exercise of such authority or discretionary control . . . .

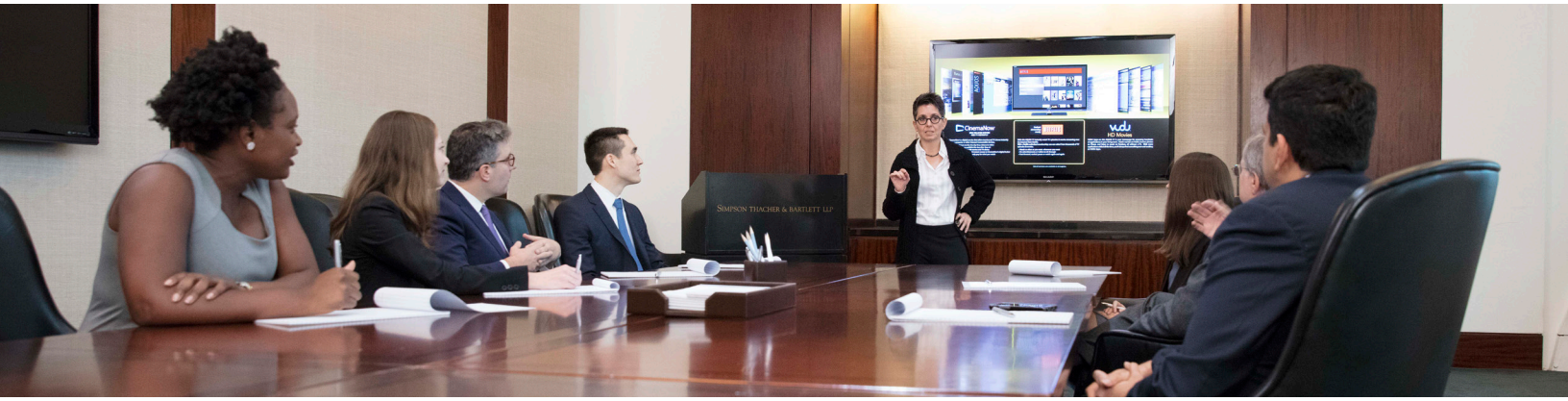
The parties agreed that the "Provided, however" exception to the exclusion applied because the Tillage action arose out of SS&C's professional services. The central issue in dispute was whether the "Notwithstanding" sentence, which operated as a "carve out" to the exception, was applicable. The court held that it was not. The court explained that the agreement between Tillage and SS&C did not give SS&C "authority or discretionary control" over Tillage's funds. Although SS&C had administrative privileges (*i.e.*, the ability to transfer funds at the direction of Tillage), SS&C had no independent authority to act without Tillage's approval. Additionally, the court held that the "Notwithstanding" clause was ambiguous as to whether "funds lost" encompassed funds that were stolen. As such, the court resolved this ambiguity in SS&C's favor and granted its summary judgment motion on its breach of contract claim.

However, the court dismissed SS&C's claim alleging breach of the implied covenant of good faith and fair dealing. The court stated that while the insurer's coverage position was found to be "lacking in merit," it was "not so totally frivolous as to warrant the inference that it was made in bad faith."

Denying Cross-Motions For Summary Judgment, Virginia Court Addresses Novel Issues In Cyber Coverage Dispute

Most recent cyber-coverage decisions have focused on interpretation of Computer Fraud provisions. *See* January 2020 Alert; May 2019 Alert; July/August 2018 Alert; May 2018 Alert. In a decision issued last month, a Virginia federal district court addressed other issues that may arise in the cyber claim context: which act constitutes the operative "occurrence" in an email phishing scheme; the number-of-occurrences presented by cyber claims; and the location of the occurrence for purposes of a territory provision. In addition, the court ruled on the scope of admissible expert testimony in this context. *Quality Plus Svs., Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2020 WL 239598 (E.D. Va. Jan. 15, 2020).

Over the course of about two weeks, a Quality Plus employee received five emails, purportedly from the President of the company, instructing her to make wire transfers to banks in Mexico and Hong Kong. After the payments were made, Quality Plus discovered that the emails were fraudulent and sought coverage under a Funds Transfer Fraud provision. The provision, which covered loss "resulting directly from a Fraudulent Instruction directing a financial institution to transfer, pay or deliver Funds," contained a $1,000,000 per occurrence limit with a $10,000 deductible.



National Union argued that Funds Transfer Fraud coverage was inapplicable and that several exclusions barred coverage. In addition, National Union claimed that a Territory Condition, which limited coverage to loss "resulting directly from an Occurrence taking place within the United States of America," precluded coverage.

The court ruled that the operative "occurrence" was the transmission of the emails by the criminals (rather than Quality Plus's instructions to the banks to transfer the funds). However, the court ruled that coverage could not be decided as a matter of law based on the following disputed issues of fact:

The Location From Which The Sender Transmitted The Emails: National Union argued that the terms of the Territory Condition were not met because evidence indicated that the fraudulent emails were sent from Nigeria. In response, Quality Plus contended that the IP addresses could have been fabricated and proffered testimony that one of the purported hackers "sounded American, with no identifiable accent" during a phone call with Quality Plus's President. Emphasizing that the location of the origin of the emails would be outcome determinative as to coverage, the court denied summary judgment on this issue.

The Number Of Occurrences: The policy defined "Occurrence" as an act or event, or combination or series of acts of events "committed by the same person acting alone or in collusion with other persons." Quality Plus argued that the losses resulted from five separate occurrences because different individuals were responsible for sending each fraudulent email. It emphasized that the emails contained at least four different signature blocks and that the five transactions occurred over a seventeen-day period and involved four different banks in two countries. In contrast, National Union claimed that there was only one occurrence because the emails were sent by the same person acting alone or in concert with others, as evidenced by the common IP addresses and other similarities. The court concluded that the number-of-occurrences issue should be decided by the finder of fact, based on evidence relating to common identifying characteristics (or lack thereof) in the emails.

Finally, the court denied Quality Plus's motion to exclude National Union's expert witness. The expert's opinion supported National Union's contention that the emails were similar to each other and were sent from Nigeria. The court ruled that the expert met the standards set forth in Federal Rule of Evidence 702, finding that his specialized cybersecurity knowledge would help the trier of fact to understand the evidence and that his opinions were based on reliable principles and methods.

D&O Alerts:

Notwithstanding "Relative Exposure" Policy Language, Delaware Court Rules That "Larger Settlement Rule" Controls Allocation

A Delaware court ruled that allocation of settlement payments between covered and non-covered payments must be based on the "Larger Settlement Rule," notwithstanding policy language referencing the insured's "relative legal and financial exposure" with respect to defense and settlement costs. *Arch Ins. Co. v. Murdock*, No. N16C-01-104 (Del. Super. Ct. Jan. 17, 2020).

The dispute arose out of underlying shareholder litigation against Dole Food Company and its executives. The lawsuits were settled for a total of $222 million. Previous rulings in this matter addressed various coverage issues under policies in Dole's insurance program. In the present motion, the court addressed allocation of the settlement payments.

A policy provision addressing the allocation of insurance coverage stated that:

> If in any Claim, the Insureds who are afforded coverage for such Claim incur Loss jointly with others (including other Insureds) who are not afforded coverage for such Claim, or incur an amount consisting of both Loss covered by this Policy and loss not covered by this Policy because such Claim includes both covered and uncovered matters, then the Insureds and the Insurer agree to use their best efforts to determine a fair and proper allocation of covered Loss . . . . In making such determination, the parties shall take into account the relative legal and financial exposures of the Insureds in connection with the defense and/or settlement of the Claim.

The insurers argued that the provision requires allocation between covered and uncovered loss (the "relative exposure" rule), and that the Dole parties bear the burden of proving whether and to what extent a settlement payment pertains to a covered loss. In contrast, the Dole parties asserted that the Larger Settlement Rule applies, under which the entire amount of the settlement is recoverable unless the insurers are able to establish that some uncovered liability increased the overall settlement amount.

The court deemed the allocation provision unambiguous, but "mostly unhelpful." The court explained that the provision relates only to a situation in which the parties work together to arrive at a "fair and proper allocation," and does not address the situation presented here, where the parties have failed to agree on allocation and leave that determination to the court. Absent language providing guidance, the court concluded that the Larger Settlement Rule must apply. In so ruling, the court noted that policy language covers "all Loss that the Insured(s) become legally obligated to pay" and does not limit coverage based on "[a]ny type of pro rata or relative exposure analysis." The court emphasized that the insurers retained their subrogation rights under the policies to seek payment from uncovered underlying defendants.

"Related Acts" Provision And "Prior Acts" Exclusion Do Not Relieve Insurer Of Duty To Defend Shareholder Derivative Suit, Says Pennsylvania Court

A Pennsylvania federal district court ruled that a D&O insurer was obligated to defend a shareholder derivative suit, finding that a "related acts" provision and a "prior acts" exclusion did not bar coverage. *Vito v. RSUI Indem. Co.*, 2020 WL 424592 (E.D. Pa. Jan. 27, 2020).

In April 2017, a minority shareholder of Unequal Technologies Company sent the company an inspection of records demand. In June 2018, the shareholder filed suit against the company, two directors and other affiliated entities. The complaint alleged that the shareholder was deprived of an elected seat on the board and that one of the directors engaged in various acts of fraud. RSUI, the company's D&O insurer, refused to defend. The insurer argued that another shareholder's 2015 demand letter and 2016 derivative suit were "prior related acts" that, together with the 2018 action, constitute one interrelated claim that was first made prior to RSUI's 2017-2018 policy period. In support of this assertion, RSUI pointed to eight overlapping allegations between the two law suits. Alternatively, the insurer argued that the 2018 shareholder suit was based on wrongful acts that occurred before the first policy was issued in 2013.

The court rejected these assertions. The court acknowledged the similarities between the 2016 action and the current suit, but concluded that "significant differences" rendered them separate claims. In particular, the court noted that the prior action sought different relief, involved different parties and was based on a more limited set of factual allegations. Moreover, the court noted that

"at its core," the later suit was based on the company's alleged refusal to give the minority shareholder a seat on the board in 2017—an issue not raised in the 2016 shareholder suit.

In addition, the court dismissed RSUI's argument that the "prior acts" exclusion barred coverage because numerous events pre-dating the first policy (issued in 2013) formed the basis of the 2018 suit. The court deemed it irrelevant that some counts in the 2018 action were based on conduct that occurred prior to 2013, emphasizing that much of the alleged wrongdoing occurred during or after 2017 and that the pre-2013 conduct was "not a necessary 'but for' cause of the [2017] election claims."

Arbitration Alert:

California Appellate Court Rules That Non-Signatory Is Bound By Arbitration Clause In Insurance Policy

Reversing a trial court decision, a California appellate court ruled that a non-signatory to an insurance policy was bound by an arbitration clause contained therein. *Philadelphia Indem. Ins. Co. v. SMG Holdings, Inc.*, 2019 WL 7790891 (Cal. Ct. App. Dec. 31, 2019).

Future Farmers of America licensed use of the Fresno Convention Center for an event. In connection with the license, Future Farmers obtained insurance from Philadelphia Indemnity that covered itself as well as "managers, landlords, or lessors of premises" and any organization "as required by contract." During the event, an attendee was injured in the parking lot. When the attendee sued SMG Holdings, the property manager of the Convention Center and parking lot, Philadelphia Indemnity refused to defend, arguing that SMG was not covered for an injury that occurred in the parking lot. Thereafter, Philadelphia Indemnity moved to compel arbitration pursuant to an arbitration clause in the policy. A trial court denied the petition, ruling that SMG was not a third-party beneficiary of the policy and that Philadelphia Indemnity was equitably estopped from forcing SMG to arbitrate because it had denied SMG's tender. The appellate court reversed.

The appellate court concluded that SMG could be compelled to arbitrate because it was an intended third-party beneficiary of the policy. The court explained that beneficiary status was demonstrated by policy language covering "managers," and because the license agreement for use of the Convention Center required Farmers to name SMG as an additional insured. In addition, the court ruled that SMG was estopped from arguing that it was not bound by the arbitration clause because it had sought to benefit from the policy by tendering defense to Philadelphia Indemnity.

Conversely, the court ruled that Philadelphia Indemnity was not equitably estopped from enforcing the arbitration clause against SMG. The court explained that the insurer did not argue that SMG was not an insured under the policy, but instead denied coverage based on the location of the accident giving rise to injury. Finally, the court rejected SMG's assertion that the arbitration clause was limited to disputes between Philadelphia Indemnity and Future Farmers because the arbitration clause referred to "the insured" (rather than "any insured" or "an insured"). The court stated: "by the policy's terms, SMG is an 'insured' by virtue of it being a manager and a party required by contract to be covered. That SMG is not the named insured is of no consequence."

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Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

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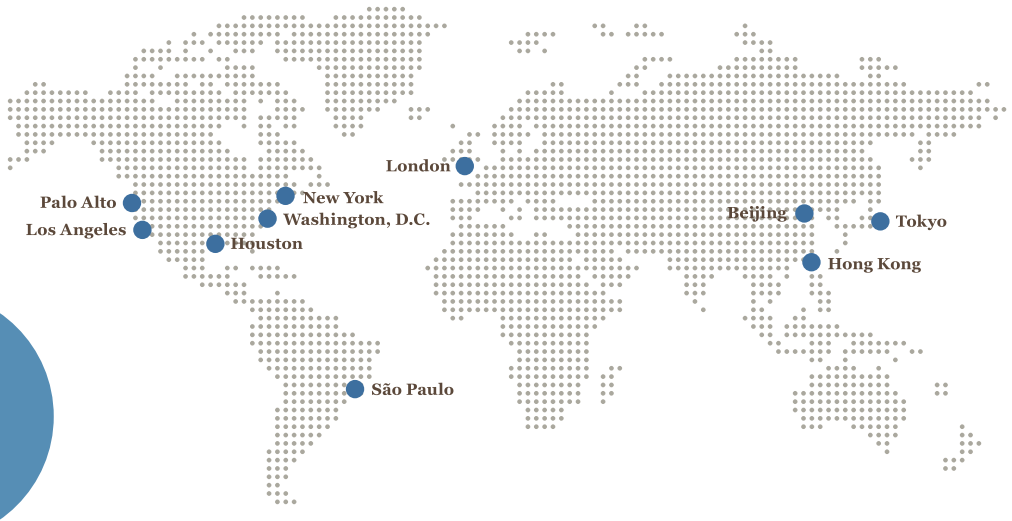

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