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Insurance Law Alert

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An Ohio appellate court ruled that vertical exhaustion controls whether excess policies are implicated and that only the primary policy directly underneath an excess policy must be exhausted in order to trigger excess coverage. *The William Powell Co. v. OneBeacon Ins. Co.*, 2020 WL 3076571 (Ohio Ct. App. June 10, 2020). (Click here for full article)

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A California appellate court reversed a trial court decision that applied horizontal exhaustion to determine excess insurers' obligations, instead ruling that exhaustion of only primary policies directly underneath an excess insurance policy is required in order to trigger excess coverage. *SantaFe Braun, Inc. v. Ins. Co. of N. Am.*, 52 Cal. App. 5th 19 (2020). (Click here for full article)

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A California federal district court denied a policyholder's motion to compel arbitration, ruling that an arbitration agreement in a primary policy was not incorporated in a "follow form" excess policy in light of a conflicting "service of suit" clause in the excess policy. *Arch Specialty Ins. Co. v. University of Southern California*, No. 19-cv-6964 (C.D. Cal. July 20, 2020). (Click here for full article)

Illinois Appellate Court Rules That Insurer May Not Depreciate Labor Costs In Calculating Actual Cash Value

An Illinois appellate court ruled that labor costs may not be depreciated in the actual cash value calculation for property insurance. *Sproull v. State Farm Fire & Cas. Co.*, 2020 WL 4251702 (Ill. Ct. App. July 24, 2020). (Click here for full article)

New York Department Of Financial Services Files First Cybersecurity Enforcement Action Against Insurer

The New York Department of Financial Services filed its first action under the cybersecurity regulations applicable to entities subject to New York banking, insurance and financial services laws, N.Y. Comp. R. & Regs. Tit. 23 § 500 (2017). *In the Matter of: First American Title Ins. Co.*, No. 2020-0030-C (N.Y. State Dep't Fin. Servs. filed July 21, 2020). (Click here for full article)

COVID-19 Alerts:

Three Courts Reject Policyholders' Bids For Business Interruption Coverage, Citing Lack Of "Physical Loss Or Damage"

Trial courts in the District of Columbia and Michigan ruled that restaurant owners are not entitled to business interruption coverage stemming from government orders aimed at slowing the spread of COVID-19, finding that the insured properties did not sustain any direct physical loss or damage, as required by the policies. *Rose's 1, LLC v. Erie Ins. Exchange*, No. 2020 CA 002424 (D.C. Superior Ct. Aug. 6, 2020); *Gavrilides Mgmt. Co. LLC v. Michigan Ins. Co.*, No. 20-258-CB-C30 (Mich. Cir. Ct. Ingham Cty. July 2, 2020) (Oral Transcript).

In the Washington D.C. case, the court granted the insurer's summary judgment motion, ruling that the policyholder is not entitled to business interruption coverage for COVID-19-related loss. According to the policyholder's statement of material facts, the mayor of Washington D.C. declared a state of emergency, ordered the closure of non-essential businesses and issued a stay-at-home mandate that lasted several months. The policyholder argued that as a result of these orders, its restaurants were forced to close and incurred significant revenue losses. Erie Insurance denied coverage on the basis that there was no "direct physical loss" to insured property, as required by the policies.

Siding with Erie Insurance, the court rejected the policyholder's assertion that the loss was "direct" because the restaurant closures were the direct result of the mayor's orders, explaining that the orders "did not effect any direct changes to the properties." The court also dismissed the contention that the loss was physical because the COVID-19 virus is "material" and "tangible." The court emphasized that the policyholder "offer[ed] no evidence that COVID-19 was actually present on their insured properties at the time they were forced to close." Therefore, the policyholder could not establish the requisite material or tangible change to property under its own theory. Additionally, the court rejected the policyholder's attempt to equate "loss of use" with "direct physical loss," explaining that the latter requires a "direct physical intrusion on to the insured property."

The court distinguished several cases frequently cited by policyholders in this context, noting that none of them support the proposition that a government edict, standing alone, constitutes direct physical loss under a property policy. *See, e.g., Gregory Packaging, Inc. v. Travelers Prop. Cas. Co. of Am*, 2014 WL 6675934 (D.N.J. Nov. 25, 2014) (ammonia leak that rendered property unusable was a direct physical loss because it constituted "an actual change in insured property . . . causing it to become unsatisfactory for future use or requiring that repairs be made to make it so"); *Western Fire Ins. Co. v. First Presbyterian Church.*, 437 P.2d 52 (Colo. 1968) (direct physical loss requirement satisfied by release of gasoline fumes into church because building became "infiltrated and saturated so as to be uninhabitable").

In the Michigan case, the policyholder sought coverage for losses it allegedly sustained after the Michigan governor issued an executive order that limited the restaurants' business to take out and delivery. The policy provided business interruption coverage for loss of income due to a suspension of operations caused by direct physical loss or damage to an insured property. In a ruling from the bench, the judge held that physical loss must be tangible and alter the "physical integrity of the property." Noting that the underlying complaint did not allege any confirmed cases of COVID-19 at the insured locations, the court concluded there was no physical damage to the insured's property. The ruling supports insurers' contention that there is no coverage for losses arising from limitations on access to premises due to COVID-19-related government orders because the requisite physical loss or damage is lacking.

In addition, the court rejected the policyholder's assertion that a virus exclusion was ambiguous and inapplicable because the losses were caused by an executive order rather than the virus itself. The court held that even assuming that the loss stemmed from government action rather than the actual virus, coverage would nonetheless be barred by an exclusion relating to acts or decisions of government entities.

Employing similar reasoning, a Texas federal district court dismissed several barbershops' COVID-19-related coverage claims in *Diesel Barbershop, LLC v. State Farm Lloyds*, No. 5:20-CV-461 (W.D. Tex. Aug. 13, 2020). The court ruled that the policyholders failed to allege direct physical loss to insured property. The court acknowledged that some courts have found physical loss absent tangible destruction in other contexts, but deemed

those cases distinguishable, concluding that "the line of cases requiring tangible injury to property are more persuasive here." In addition, the court held that even if the policyholders had alleged direct physical loss, coverage would be barred by a virus exclusion. In so ruling, the court rejected the policyholders' assertion that the exclusion did not apply because the losses were caused by government orders, rather than presence of the virus itself. The policyholders also argued that an anti-concurrent causation clause, which operated as a "lead-in" to the virus exclusion and barred coverage for excluded events "regardless of . . other causes of the loss; or . . . whether other causes acted concurrently or in any sequence with the excluded event to produce the loss," was ambiguous. The court rejected this contention, stating that "Plaintiffs have pleaded that COVID-19 is in fact the reason for the Orders being issued and the underlying cause of Plaintiffs' alleged losses. While the Orders technically forced the Properties to close to protect public health, the Orders only came about sequentially as a result of the COVID-19 virus." Finally, the court ruled that a civil authority provision was inapplicable based on the lack of requisite physical damage to neighboring property.

Two Courts Decline To Dismiss COVID-19 Coverage Claims

In contrast to the rulings discussed above, a Missouri federal district court declined to dismiss a COVID-19-related coverage suit against a property insurer, finding that the allegations sufficiently stated claims for coverage under several policy provisions. *Studio 417, Inc. v. The Cincinnati Ins. Co.*, 2020 WL 4692385 (W.D. Mo. Aug. 12, 2020).

Hair salons and restaurants sought coverage under policies that covered "accidental [direct] physical loss or accidental [direct] physical damage," unless otherwise excluded. The policies did not define physical loss or physical damage and did not include a viral or communicable disease exclusion. The court concluded that the policyholders adequately alleged a direct physical loss because the complaint alleged that COVID-19 "is a physical substance" that "live[d] on" and was "active on inert physical surfaces" and "attached to and deprived Plaintiffs of their property, making it 'unsafe and unusable.'" The court emphasized that the policy covered physical loss or physical damage and reasoned that it "must give meaning to both terms." The court noted that in other cases, courts have required a "tangible alteration" in order to establish physical loss, but explained that those cases were decided on summary judgment or were factually distinguishable. Here, on the insurer's motion to dismiss, the court accepted as true the policyholders' assertion that the virus is a physical substance that was likely on their premises and caused them to suspend operations.

Based on the same reasoning, the court declined to dismiss coverage claims pursuant to provisions for civil authority coverage, ingress and egress coverage, dependent property coverage, and sue and labor coverage.

A New Jersey trial court also denied an insurer's motion to dismiss COVID-19-related coverage claims, citing the lack

of legal authority in this context and the absence of a developed factual record. *Optical Services USA/JC1 v. Franklin Mutual Ins. Co.*, No. BER-L-3681-20 (N.J. Super. Ct. Bergen Cty. Aug. 13, 2020) (Oral Transcript). There, the operative policy covered business interruption losses resulting from direct covered loss, defined as "the fortuitous direct physical loss as described in Part 1(c)." The policy further stated that covered loss means "fortuitous direct physical damage to or destruction of covered property by a covered cause of loss." The insurer argued that the complaint failed to allege direct physical damage because it expressly admitted that "there is no known instance of COVID-19 transmission or contamination within the premises of plaintiffs' businesses." In contrast, the policyholders contended that the loss of "physical functionality and the use of their business" by virtue of the government mandates constitutes a covered loss. Declining to rule as a matter of law, the court noted the lack of controlling New Jersey authority in this context and the absence of discovery in this matter. The insurer did not contend that a virus exclusion in the policy applied.

Subrogation Alert:

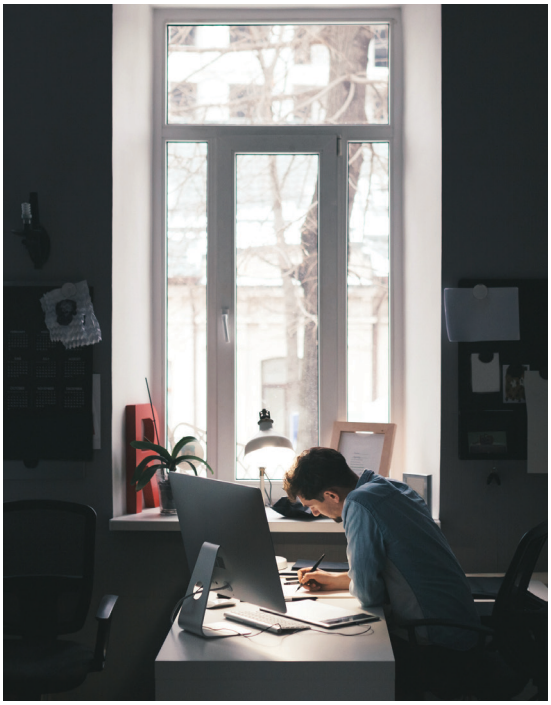
New Jersey Supreme Court Rules That "Made Whole" Doctrine Does Not Apply To Self-Insured Retention Or Deductible Payments

Addressing a matter of first impression under New Jersey law, the New Jersey Supreme Court ruled that the made whole doctrine, under which an insurer is not permitted to seek subrogation until the insured has been fully compensated for its loss, does not apply to self-insured retentions or deductible payments. *City of Asbury Park v. Star Ins. Co.*, 2020 WL 3493526 (N.J. June 29, 2020).

Star Insurance provided workers compensation coverage to the City of Asbury. The policy included a self-insured retention of $400,000 per occurrence, as well as a subrogation provision that allowed Star Insurance to be subrogated to the City's rights after payment is made under the insurance contract. When a City employee was injured, the City paid the employee $400,000 (the full amount of its self-insured retention) and Star Insurance paid an additional $2.6 million. After a third-party tortfeasor paid the injured employee additional amounts, the City and Star Insurance sought reimbursement of amounts paid to the employee. The question before the court was whether, under the made whole doctrine, the City had priority to recover its self-insured retention before Star Insurance could recover any of its payments.

The New Jersey Supreme Court, answering a question certified by the Third Circuit, ruled that the made whole doctrine does not apply "to first-dollar risk that is allocated to an insured under an insurance policy, *i.e.*, a self-insured retention or deductible." The court explained that such payments reflect risk that the insured agreed to assume in exchange for a reduced premium. Therefore, prioritizing reimbursement of a self-insured retention over an insurer's loss "would, in effect, convert the policy into one without a self-insured retention."

As the court noted, the Supreme Courts of Connecticut and Pennsylvania have reached similar conclusions, whereas the Supreme Court of Washington ruled that a first-party insurer, upon receiving partial recovery through subrogation, was obligated to reimburse its "fault-free insureds for the full amount of their deductible before any portion of the subrogation proceeds can be allocated to the insurer."



Coverage Alerts:

Professional Services Exclusion Bars Coverage For Claims Alleging Fake Lab Results, Says Kentucky Court

A Kentucky federal district court ruled that a professional services exclusion barred coverage for a suit alleging that a laboratory reported false test results and that the insurer had no duty to defend or indemnify the underlying claims. *State Farm Fire and Casualty Co. v. Compliance Advantage, LLC*, 2020 WL 3800517 (E.D. Ky. July 7, 2020).

The underlying suit alleged that the laboratory reported false results to government agencies that led to the plaintiff's loss of child custody. State Farm sought a declaration that it had no duty to defend or indemnify the suit based on a professional services exclusion, which applied to injury or damage "arising out of the rendering or failure to render any professional service or treatment," including but not limited to "treatment, advice or instruction of any medical, surgical, dental, x-ray or nursing services." The court concluded that the underlying claims, based on the laboratory's taking of samples and transmission of results to third-parties, fell squarely within the exclusion. The court rejected the laboratory's counter-assertion that the loss resulted from equipment malfunction or other "ministerial conduct" rather than the provision of professional services. The court explained that Kentucky law interprets "arising out of" expansively to mean "originating from," "growing out of" or "flowing from," such that "all that is required is some causal connection."

Reversing Trial Court, Illinois Appellate Court Enforces Assault And Battery And Firearms Exclusions

An Illinois appellate court ruled that an insurer had no duty to defend an underlying suit based on exclusions for assault and battery and firearms, and that the insurer was not estopped from denying coverage based on its refusal to defend. *Markel Internat'l Ins. Co. Ltd. v. Montgomery*, 2020 WL 4333619 (July 24, 2020).

The underlying complaint against a bar, its owner and security guard, and two assailants (collectively, the "Defendants") sought damages for the death of a patron and serious injuries to another. Markel disclaimed coverage based on exclusions relating to assault and battery, firearms and liquor liability. Thereafter, Markel sought a declaration that it had no duty to defend or indemnify the claims. The Defendants counterclaimed, alleging breach of contract, bad faith and coverage by estoppel. An Illinois trial court ruled in the Defendants' favor, finding that the complaint asserted a claim that potentially fell within the scope of coverage and that Markel's denial was vexatious and unreasonable under Illinois statutory law. The trial court also ruled that Markel was estopped from asserting defenses under the policy and was obligated to pay the underlying default judgment.

The appellate court reversed, ruling that Markel had no duty to defend and was not estopped from denying coverage. The court reasoned that all of the underlying claims "arose out of" assault and battery and/or use

of a firearm. The court deemed it irrelevant that the underlying complaint alleged negligence, explaining that "the alleged negligence is inseparable from the assault and battery and the use of a firearm . . . regardless of how the causes of action were pleaded."

Additionally, the appellate court rejected the trial court's estoppel ruling. Under Illinois law, estoppel applies only when an insurer has breached its duty to defend. However, estoppel does not apply where, as here, the insurer's defense obligation was not triggered in the first instance.

Seventh Circuit Rules That Damages Phase Of Underlying Litigation Is Not A "Claim" Under Claims-Made Policy

The Seventh Circuit ruled that the "damages argument" in a trial of a thirteen-year old suit against the policyholder is not a "claim" that triggered coverage under a claims-made policy. *Market Street Bancshares, Inc. v. Federal Ins. Co.*, 962 F.3d 947 (7th Cir. 2020).

In 2003, Peoples National Bank was sued in connection with a failed business deal. Nine years later, a court entered judgment against the bank on one claim. In 2014, the bank obtained a professional liability policy from Federal Insurance. The claims-made policy, in effect from 2014 to 2017, defined "claim" as "a written demand for monetary or non-monetary relief . . . [or] a civil proceeding commenced by the service of a complaint or similar pleading." It further provided that a claim "will be deemed to have first been made when such Claim is commenced as set forth in this definition." In 2015, the court granted summary judgment to the underlying plaintiff on the remaining claims against the bank, and in 2016, the underlying suit went to trial on damages. The bank notified Federal Insurance of the damages trial, taking the position that it gave rise to a "claim" under the policy. Federal denied coverage. In ensuing coverage litigation, an Illinois federal district court granted Federal's summary judgment motion and the Seventh Circuit affirmed.

The Seventh Circuit ruled that the underlying "damages assertion—advanced about thirteen years into the lawsuit—" did not constitute a "claim" that triggered Federal's defense and indemnity obligations. The court rejected the bank's assertion that the underlying damages assertion was "a written demand for monetary relief," finding instead that it was merely a part of the civil action that began in 2003. The court deemed it irrelevant that the damages argument went beyond the scope of the original legal theories and facts alleged in the underlying complaint, explaining that the operative question is how the policy defines "claim," "not where the causes of action in a lawsuit begin and end." The court stated: "reading a 'civil proceeding' as spanning less than the complete civil action opens the door to a single action between two parties encompassing multiple 'claims,' which would defeat the purpose of making the insurer's risk exposure easy to identify."

Excess Alerts:

Eleventh Circuit Rules That Sublimit Provision Precludes Coverage Under Excess Policy

The Eleventh Circuit ruled that an excess insurer had no duty to provide coverage, finding that a sublimit provision in an excess policy unambiguously limited the applicable coverage. *Starstone National Ins. Co. v. Polynesian Inn, LLC*, 2020 WL 3121299 (11th Cir. June 12, 2020).

The coverage dispute arose out of a physical assault at a hotel. The hotel's primary insurance policy provided $1 million in liability coverage per-occurrence. It also included a "Limited Assault or Battery Liability Coverage" endorsement that made available separate coverage for bodily injury caused by assault or battery, subject to a $25,000 per-occurrence limit. The excess

policy followed form to the primary policy and provided coverage in excess of the primary policy's "Total Limits" – a list that included the $1 million per-occurrence limit. However, the excess policy explicitly excluded coverage for any "[s]ublimit of liability, unless coverage for such sublimit is specifically endorsed to the Policy." The parties disputed whether the $25,000 per-occurrence limit for assault and battery injuries was a "sublimit" under the excess policy.

The court ruled that the assault and battery endorsement established a "sublimit" such that excess coverage was not implicated. Although "sublimit" was not defined in the policy, the court reasoned that the $25,000 per-occurrence limit for assault and battery injuries constituted a sublimit because it "caps the insurer's exposure at an amount below the ordinary policy limit for a subcategory of loss." The court rejected the hotel's assertion that the endorsement created a "standalone limit" (rather than a sublimit) because it existed "apart from" and "not under or subordinate to the $1 million per-occurrence limit."

Reversing Trial Court, Ohio Appellate Court Endorses Vertical Exhaustion For Triggering Excess Policies

An Ohio appellate court ruled that vertical exhaustion controls whether excess policies are implicated and that only the primary policy directly underneath an excess policy must be exhausted in order to trigger excess coverage. *The William Powell Co. v. OneBeacon Ins. Co.*, 2020 WL 3076571 (Ohio Ct. App. June 10, 2020).

The coverage dispute arose out of thousands of asbestos-related bodily injury claims against Powell. In a previous ruling, the appellate court applied a "triggering-event" theory and held that each exposure to asbestos constitutes a separate occurrence. *See* January 2017 Alert. Thereafter, an Ohio trial court held a bench trial on remaining issues and concluded that horizontal exhaustion applies, such that all triggered primary policies must be exhausted before excess coverage is available. The appellate court reversed.

Although the terms of OneBeacon's and Federal's excess policies varied somewhat, each provided indemnification for sums that Powell became legally obligated to pay "in excess of the insured's retained limits." Retained limits was defined as "the total of the applicable limits of liability of the underlying insurance as set forth in Schedule A hereof, plus the applicable limits of any other underlying insurance collectible by the insured." The court deemed this language, when read together with other policy provisions, as unambiguously requiring vertical exhaustion. The court explained that vertical exhaustion is:

> reflected in OneBeacon's policies' definition of the term "underlying insurance" ("collectible insurance with any other insurer [ ] available to the insured covering a loss *also covered hereunder*") and Federal's policy provision regarding "Other Insurance" ("any other insurance [ ] available to the insured *covering a loss also covered by this policy*"). . . . Thus, underlying insurance–insurance available to cover a loss also covered by the excess policy–must also be insurance covering an occurrence during the policy period.
>
> In other words, the policy language reveals that "underlying insurance" "refers only to policies covering the same risk, such as concurrent policies." Prior and subsequent policies, on the other hand, insure against different risks in different time periods.

Ruling on a separate issue, the court endorsed an "all sums" allocation, under which Powell is entitled to choose one insurer to indemnify all costs incurred during the period of continuous injury.

Citing Recent *Montrose* Decision, California Appellate Court Vacates Trial Court's Horizontal Exhaustion Ruling

Our April 2020 Alert reported on the California Supreme Court's decision in *Montrose Chem. Corp. of Ca. v. Superior Court of Los Angeles Cty.*, 2020 WL 1671560 (Cal. Apr. 6, 2020), which held that applicable policy language entitled the policyholder to access coverage under a higher level policy once it had exhausted directly underlying excess policies for the same policy period, and did not require exhaustion of every lower level excess policy during the relevant time frame.

Last month, a California appellate court, citing *Montrose*, reversed a trial court decision that applied horizontal exhaustion to determine excess insurers' obligations. *SantaFe Braun, Inc. v. Ins. Co. of N. Am.*, 52 Cal. App. 5th 19 (2020). The appellate court concluded that exhaustion of only primary policies directly underneath an excess insurance policy is required in order to trigger excess coverage. Noting that the policy language at issue was comparable to that in *Montrose*, the court stated that "[t]he 'other insurance' clauses are similarly ambiguous and the 'other aspects of the insurance policies' including the scheduling of the applicable primary policies and definitions of ultimate net loss suggest 'the exhaustion requirements were meant to apply to directly underlying insurance and not to insurance purchased for other policy periods.'" The court declined to rule on the rights of excess carriers to seek contribution from primary insurers whose policies do not directly underlie the excess policies.

Faulty Workmanship Alert:

Michigan Supreme Court Rules That Faulty Work Resulting In Damage To Insured's Work Product May Be Covered Under General Liability Policy

Reversing an appellate court, the Michigan Supreme Court ruled that faulty workmanship by a subcontractor may constitute a covered "occurrence" under a general liability policy, even where it damages only the insured's work product. *Skanska USA Building Inc. v. M.A.P. Mechanical Contractors, Inc.*, 2020 WL 3527909 (Mich. June 29, 2020).

Skanska, the construction manager on a renovation project, used MAP as a subcontractor for heating and cooling work. MAP obtained a general liability policy from Amerisure, which listed Skanska as an additional insured. A few years after construction was complete, it was discovered that MAP had installed expansion joints backward, resulting in significant damage to the heating system. After repairing the damage, Skanska sought coverage from Amerisure. The insurer denied coverage, stating that there had been no covered "occurrence" under the policy.

A Michigan trial court denied the insurer's summary judgment motion, finding that an occurrence "may have happened" because MAP did not purposefully install the expansion joints backward. The trial court further held that although faulty workmanship "standing alone" does not constitute a covered occurrence, there may be a potential occurrence where damage goes beyond the scope of the insured's own work. An appellate court reversed, granting summary judgment to Amerisure and finding that there is no occurrence where, as here, the only damage was to the insured's own work product. The Michigan Supreme Court reversed.

The Michigan Supreme Court noted that while the policy contained an exclusion barring coverage for an insured's own work product, there was an exception to

the exclusion for work performed by a subcontractor. The court explained: "If faulty workmanship by a subcontractor could never constitute an 'accident' and therefore never be an 'occurrence' triggering coverage in the first place, the subcontractor exception would be nugatory." Moreover, the court emphasized the lack of support for the appellate court's ruling that "accident" cannot include damage limited to the insured's own work product. Finally, the court distinguished *Hawkeye-Security Ins. Co. v. Vector Constru. Co.*, 185 Mich. App. 369 (1990), in which the court held that damage to an insured's own work due to faulty construction is not an "occurrence." The court noted that *Hawkeye* involved a 1973 policy with different language and presented the question of whether an insurer owed coverage to a general contractor for damages resulting from its own defective work, not the work of a subcontractor.

Advertising Injury Alert:

New Jersey Appellate Court Rules That Advertising Injury Coverage Encompasses Copyright Infringement Claims

A New Jersey appellate court ruled that copyright infringement claims alleged covered "advertising injury," triggering the insurer's duty to defend. *Superior Integrated Solutions, Inc. v. Mercer Ins. Co. of N.J.*, No. A-1027-18T4 (N.J. App. Div. July 10, 2020).

Superior, a software application developer, was sued by a competitor for copyright infringement of a computer program used by car dealerships. The complaint alleged that Superior made an unauthorized copy of a file and actively solicited customers to use Superior's services, resulting in substantial harm to the competitor. Superior sought coverage under a provision that covered "Advertising Injury arising out of an offense committed in the course of advertising goods, products, or services of your business/operations." Mercer Insurance refused to defend, citing several policy exclusions. A New Jersey trial court granted Superior's summary judgment motion, ruling that the underlying complaint alleged covered advertising injury and that none of the exclusions barred coverage. The appellate court affirmed.

The court rejected Mercer Insurance's assertion that there was no coverage because Superior never engaged in "advertising" and instead only engaged in "selling" of its services through use of a competitor's copyrighted program. The court explained that the underlying allegation that Superior "profited from its theft of [a competitor's] [copyrighted] intellectual property by selling integration services made possible only by its copy infringement" alleged a claim of advertising activity. The court also rejected the contention that the infringement must occur within an advertisement itself.

Arbitration Alert:

California Court Rules That Arbitration Agreement In Primary Policy Does Not Require Excess Insurer To Arbitrate, Notwithstanding "Follow Form" Clause

A California federal district court denied a policyholder's motion to compel arbitration, ruling that an arbitration agreement in a primary policy was not incorporated in a "follow form" excess policy in light of a conflicting "service of suit" clause in the excess policy. *Arch Specialty Ins. Co. v. University of Southern California*, No. 19-cv-6964 (C.D. Cal. July 20, 2020).

Arch Specialty issued excess policies to USC that followed form to lower level excess policies issued by Ironshore. Ironshore's policies, in turn, followed form to primary policies issued by BETA. When a dispute regarding Arch's duty to cover underlying claims against USC arose, USC moved to compel arbitration. USC argued that the Arch policies incorporated the arbitration agreement included in the BETA policies by virtue of the "follow form" clauses in the Arch Specialty and Ironshore excess policies. The court disagreed.

Arch Specialty's follow form clause incorporated the provisions of underlying insurance "except for . . . [a]ny other provision inconsistent with this coverage."

The court concluded that a service of suit endorsement in Arch Specialty's policy was inconsistent with the arbitration provision in BETA's policy. The service of suit endorsement requires the insurer to "submit to the jurisdiction of any court of competent jurisdiction within the United States" and provides that "[a]ll matters arising under this Policy shall be determined in accordance with the law and practice of such Court." Noting the breadth of both the BETA arbitration clause (which applies to "[a]ll disputes in any way concerning, arising out of or relating to this Contract") and the service of suit endorsement, the court deemed them inconsistent and in conflict.

The court distinguished case law holding that a service of suit clause and arbitration provision can be read together in a manner that allows a party to enforce arbitration in a court of law. As the court noted, those decisions involved differently-worded service of suit and arbitration clauses, or a single policy that included both clauses, whereas here, the excess policy prioritized its terms over inconsistent terms in an underlying policy.

Property Insurance Alert:

Illinois Appellate Court Rules That Insurer May Not Depreciate Labor Costs In Calculating Actual Cash Value

As discussed in previous Alerts, the highest courts of several states, and appellate courts in many others, have ruled on whether an insurer may depreciate labor costs in calculating actual cash value ("ACV"). *See* March and April 2020 Alerts; April 2019 Alert; March 2017 Alert; January and February 2016 Alerts. Outcomes have turned largely on policy language, as well as governing jurisdictional law and public policy considerations. Last month, an Illinois appellate court weighed in, ruling that labor costs may not be depreciated in the ACV calculation. *Sproull v. State Farm Fire & Cas. Co.*, 2020 WL 4251702 (Ill. Ct. App. July 24, 2020).

The State Farm policy stated that "we will pay only the actual cash value at the time of the loss of the damaged part of the property, up to the applicable limit of liability." The policy did not define ACV or explain how it is calculated, nor did it indicate that costs are subject to depreciation. When State Farm depreciated both labor and materials in calculating ACV payment, the policyholder filed a putative class action, alleging breach of contract and deceptive business practices. An Illinois trial court denied State Farm's motion to dismiss. The trial court noted the lack of Illinois case law and the jurisdictional split on this issue, and ultimately concluded that ACV was ambiguous and should be construed in the policyholder's favor. In so ruling, the trial court rejected State Farm's argument that Illinois statutory law, which states that the method for calculating ACV is "replacement cost of property at time of loss less depreciation, if any," permits depreciation of both labor and materials. 50 Ill. Adm. Code 919.80 (d)(8)(A) (2002). Thereafter, the trial court certified the following question to the appellate court:

> Where Illinois' insurance regulations provide that the "actual cash value" or "ACV" of an insured, damaged structure is determined as "replacement cost of property at time of loss less depreciation, if any," and the policy does not itself define actual cash value, may the insurer depreciate all components of replacement cost (including labor) in calculating ACV?"

The appellate court answered the question in the negative. The court reasoned the phrase "replacement cost of property" refers to "real property–an asset that can lose value over time due to wear and deterioration, resulting from use or the elements, and does not refer

to services, such as labor." In so ruling, the court noted that an average, reasonable person would expect that depreciation would apply only to physical property and materials, and not to labor services.

Regulatory Alert:

New York Department Of Financial Services Files First Cybersecurity Enforcement Action Against Insurer

As discussed in our April 2019 and May 2018 Alerts, the New York Department of Financial Services enacted cybersecurity regulations applicable to entities subject to New York banking, insurance and financial services laws. The regulations impose certain minimum requirements for cybersecurity practices, including the maintenance of a cybersecurity program and response plan, the designation of a senior officer to oversee cybersecurity, routine risk assessment, notification of a security incident to the Department and annual compliance certification. See N.Y. Comp. R. & Regs. Tit. 23 § 500 (2017).

This month, the Department filed its first action under the regulations against First American Title Insurance Company, alleging failures relating to the company's information systems which led to a data breach involving customers' personal information. *In the Matter of: First American Title Ins. Co.*, No. 2020-0030-C (N.Y. State Dep't Fin. Servs. filed July 21, 2020). The filing alleges that from October 2014 through May 2019, customers' bank account information, mortgage and tax records and social security numbers were available on the insurer's public website due to a known vulnerability in its computer system. The Department claims that First American failed to conduct appropriate security reviews and risk assessments and misclassified the vulnerability as "low," among other things. Although First American confirmed the breach, it has denied the charges. A hearing in this matter is scheduled for October 26, 2020.

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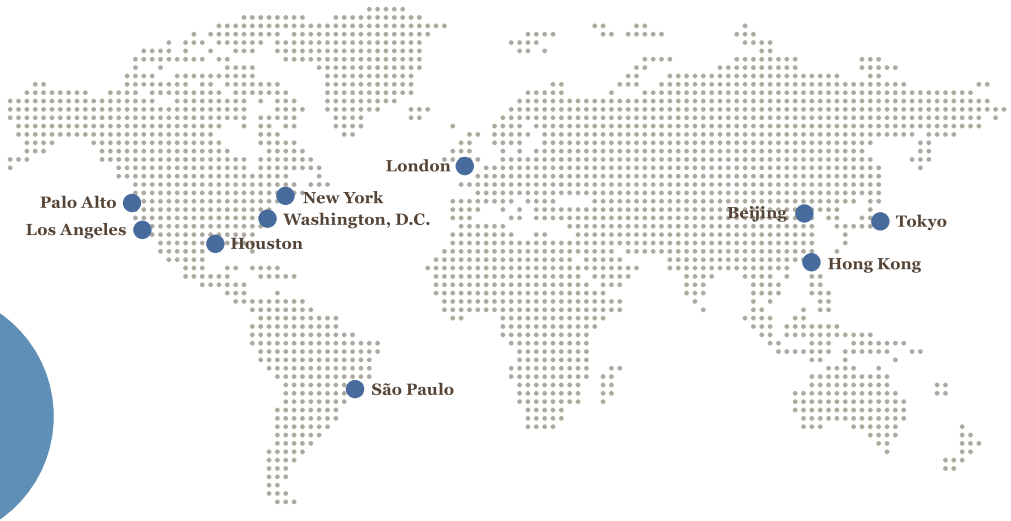

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