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Insurance Law Alert

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Three State Supreme Courts Dismiss Suits Seeking Coverage For Pandemic-Related Losses

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Reversing Trial Court, California Appellate Court Rules That Civil Authority Endorsement Provides Coverage For Business Losses

A California appellate court ruled that a business was entitled to coverage for pandemic-related losses under a civil authority endorsement and that a mold exclusion that referenced viruses did not apply. *Butter Nails and Waxing, Inc. v. Underwriters at Lloyd's, London*, No. B311455 (Cal. Ct. App. Aug. 25, 2022). (Click here for full article)

Texas Jury Awards Policyholder $48 Million For Covid-19-Related Loss

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Opioid Alert:

Ohio Supreme Court Rules That Insurer Has No Duty To Defend Underlying Opioid Litigation

The Ohio Supreme Court ruled that a liability insurer had no duty to a distributor of pharmaceuticals against lawsuits brought by West Virginia cities and counties alleging economic losses caused by the opioid epidemic. *Acuity v. Masters Pharm., Inc.*, 2022 WL 4086449 (Ohio Sept. 7, 2022).

The underlying suits alleged that Masters failed to monitor and report suspicious opioid pharmaceutical orders which contributed to an epidemic that caused financial harm to the government entities. As discussed in our February 2019 Alert, an Ohio trial court granted the insurer's summary judgment motion, ruling that the damages sought in the underlying litigation were not "because of" bodily injury, as required by the policy, and instead were economic loss claims. Additionally, the trial court held that there was no coverage because the policy excluded claims for bodily injury that were previously known to Masters. According to the underlying suits, Masters filled suspicious orders and knew of the opioid addiction crisis prior to obtaining insurance from Acuity.

As reported in our June 2020 Alert, an intermediate appellate court reversed, ruling that "the policies expressly provide for a defense where organizations claim economic damages, so long as the damages occurred because of bodily injury." The appellate court deemed it irrelevant that the government entities themselves did not sustain bodily injury, noting that their economic losses were "because of" bodily injury. The appellate court also ruled that a loss-in-progress provision did not bar coverage.

This month, the Ohio Supreme Court reversed the appellate court decision. The court rejected Masters' assertion that "damages because of bodily injury" should be construed to "include any suit in which the damages sought merely relate to bodily injury, regardless of whether the claims are in fact tied to any particular bodily injury sustained by a person." Instead, the court held that damages need to "be tied to a particular bodily injury sustained by a person or persons." That standard was not met here because the governments' theories of relief were not based on specific opioid-related injuries stemming from Masters' failure to take proper care, but rather that Masters' failure caused a public health crisis resulting in economic damages to the government entities. The court noted:

> To be sure, the opioid epidemic, as a public health crisis, necessarily relates to bodily injuries, such as opioid addictions, hospitalizations, and deaths. But allegations of bodily injury alone do not automatically bring an action within the coverage for "damages because of bodily injury."

Settlement Alert:

Seventh Circuit Rejects Umbrella Insurer's Contract And Tort Claims Against Policyholder, Finding No Breach Of Settlement Duty

The Seventh Circuit affirmed the dismissal of an umbrella insurer's suit against its policyholder, ruling that the policyholder did not breach any contractual or extra-contractual duty to settle the underlying suit. *N. Am. Elite Ins. Co. v. Menard, Inc.*, 43 F.4th 691 (7th Cir. Aug. 4, 2022).

An injured customer brought suit against Menard, a home improvement store. Menard was insured under a $1 million policy issued by Greenwich, which sat above a $2 million self-insured retention. The Greenwich policy covered up to $1 million of liability. Liability exceeding $3 million implicated an umbrella policy issued by North American. In the underlying suit, the claimant offered to settle for $1.98 million. Menard did not respond to the offer, despite North American's encouragement to accept. Prior to the verdict, Menard entered into a high-low settlement that capped its obligations at $6 million. The jury ultimately returned a verdict of $13 million, which was reduced to $6 million under the agreement. North American indemnified Menard for its liability in excess of $3 million and then sued Menard, seeking reimbursement. An Illinois district court dismissed the suit and the Seventh Circuit affirmed.

The Seventh Circuit rejected North American's contention that the self-insured retention made Menard an insurer, subject to certain responsibilities to settle. The court noted the absence of legal support for such a position and reasoned that a self-insured retention is more akin to a deductible than a form of "insurance." In addition, the court ruled that Menard did not violate any contractual duty to North American by failing to accept the initial settlement offer. The court emphasized the differing language in the Greenwich primary policy as compared to the North American umbrella policy, noting that the former contained broad contractual obligations to exercise "utmost good faith" in settling, whereas the latter included less expansive language relating to cooperation. The court concluded that North American's claims failed as a matter of law because they did not allege failure to cooperate, but rather a violation of Menard's good faith duties under the Greenwich policy—duties that were owed only to Greenwich. The court rejected North American's assertion that the duty of good faith implied in all Illinois contracts required Menard to give it the same consideration that it had promised to Greenwich.

Related Claim Alerts:

Washington District Court Rules That Two Actions Were Not "Related Claims" Under D&O Policy

A Washington district court rejected an insurer's contention that two actions against directors of a software company were "related claims" and therefore subject to coverage under only the earliest policy. *Smartsheet, Inc. v. Fed. Ins. Co.*, 2022 WL 3160379 (W.D. Wash. Aug. 8, 2022).

All of the claims at issue involved allegations that directors of Smartsheet duped investors into selling their shares before the company went public. A class action complaint brought in December 2019 alleged that a Smartsheet director, Ryan Hinkle, failed to disclose knowledge relating to the company's plans to go public after a tender offer. Separately, in June 2018, Megan Colacucio served an arbitration demand on her ex-husband, Brett Frei, a different Smartsheet director, alleging that she was tricked into selling her shares to Frei as part of a divorce settlement for significantly less than the tender offer price.

Federal issued a series of D&O policies to Smartsheet during this time frame. The 2018-2019 policy provided that:

> All Related Claims [Claims for Wrongful Acts based upon, arising from, or in consequence of the same or related facts, situations, transactions or events or the same related series of facts, situations, transactions or events] shall be deemed a single Claim made in the Policy Period in which the earliest of such Related Claims was first made.

Federal argued that the arbitration demand and the class action were related claims and

must be treated as a single claim under the 2018-2019 policy. In contrast, Smartsheet contended that the arbitration demand was not a "claim" within the meaning of the policy because it arose out of personal conduct in the underlying divorce settlement. The court rejected Smartsheet's assertion, concluding that the arbitration demand constituted a "claim" because it accused Frei of breaching his fiduciary duties as director of Smartsheet.

However, the court concluded that the arbitration demand and class action were unrelated and distinct claims under Federal's policies. The court emphasized that the two actions shared "only limited overlap" relating to the alleged misrepresentations pertaining to the tender offer. More specifically, the court explained that the arbitration demand focused on Frei's omissions to Megan Colacurcio individually, relating to her ability to sell her shares in the tender offer rather than in the divorce settlement, whereas the class action concerned Hinkle's alleged concealment from investors of the plans to take Smartsheet public after the tender offer. Given the different injuries and directors involved and the absence of any allegations of a common scheme between Hinkle and Frei, the court ruled that the two actions "share[d] little logical connection." While the court acknowledged some overlap and similarity between the two actions, it deemed that overlap insufficient to meet the "related claims" standard.

Eleventh Circuit Rules That Indemnification Claim "Correlated" To Previous Claim And Was Thus Outside The Scope Of Coverage

The Eleventh Circuit ruled that a 2018 claim against a policyholder "correlated" with an act that gave rise to a previous claim made before the policy incepted and was thus outside the scope of coverage. *Datamaxx Applied Tech., Inc. v. Brown & Brown, Inc.*, 2022 WL 3597311 (11th Cir. Aug. 23, 2022).

GTBM developed a software product that provides access to motor vehicle and warrant information from various law enforcement databases. GTBM entered into an agreement with Datamaxx to incorporate the product into Datamaxx's existing product in order to create a jointly-developed enhanced product. However, GTBM subsequently initiated arbitration against Datamaxx, alleging that it violated the terms of the agreement by marketing its own competing product using GTBM's technology. The parties ultimately settled. Following settlement, Datamaxx marketed another new product that also allegedly used the GTBM technology. GTBM again initiated arbitration against Datamaxx, alleging that it breached the 2014 settlement agreement, the original agreement and the implied covenants of good faith and fair dealing. Datamaxx tendered the claim to Chubb, which denied coverage. In ensuing litigation, a Florida district court granted Chubb's summary judgment motion and the Eleventh Circuit affirmed.

The Chubb policy provided that "[a]ll claims that correlate with an act will be deemed to have been made at the time the first of such claims is deemed to have been made" and that coverage does not apply to any loss "in connection with any claim that correlates with an act, if such act also correlates with any claim deemed to have been made before the beginning of this policy period."

As a preliminary matter, the Eleventh Circuit held that the district court erred in treating "correlate" and "relate" as synonymous and in applying "related claim" decisions as binding precedent. The Eleventh Circuit explained that while "correlates" is narrower than "relates," it "requires nothing more than a showing that acts and claims 'tend to vary, be associated, or occur together in a way not expected on the basis of chance alone.'" Applying this standard, the court concluded that the acts giving rise to the 2018 claim against Datamaxx correlated with the 2014 claim. The court explained that Datamaxx's alleged second attempt to circumvent and violate its agreement with GTBM necessarily correlated with its first attempt to do the same thing.

Datamaxx argued that there was no correlation because each incident involved a different Datamaxx product that operated through distinct functionality. The court deemed this a "distinction without a difference."

Cyber Coverage Alerts:

Email Impersonation-Wire Transfer Loss Is Not Covered By Computer Fraud Provision, Says Minnesota Court

A Minnesota district court granted an insurer's motion to dismiss, finding that losses stemming from a fraudulent email and subsequent wire transfer were subject to coverage under a social engineering fraud provision, and not a computer fraud provision. *SJ Computers, LLC v. Travelers Cas. & Sur. Co. of Am.*, 2022 WL 3348330 (D. Minn. Aug. 12, 2022).

A fraudster tricked SJ Computers into wiring nearly $600,000 into his bank account. The bad actor emailed fraudulent invoices to the company's purchasing manager, purporting to be one of the company's vendors and providing new wire transfer instructions. He then hacked into the purchasing manager's email account and, impersonating him, forwarded the invoices to the CEO for payment. The CEO made several unsuccessful attempts to verify the changes with the actual vendor, but ultimately proceeded with the wire transfer without obtaining verification.

When the fraud was discovered, SJ Computers sought coverage under a social engineering provision, which defined social engineering fraud as "the intentional misleading of an Employee or Authorized Person by a natural person impersonating: (1) a Vendor . . . through the use of a Communication." Subsequently, SJ Computers revised its claim to seek coverage under a computer fraud provision, which included a significantly higher liability limit and covered a "direct loss . . . directly caused by Computer Fraud," with Computer Fraud defined as "an intentional, unauthorized, and fraudulent entry or change of data or computer instructions directly into a Computer System." The policy provided that the two provisions were mutually exclusive and that any loss caused by social engineering fraud was excluded under the computer fraud provision and vice versa. Travelers accepted coverage for the loss under the social engineering fraud provision, but denied coverage under the computer fraud provision. SJ Computers sued, and the court dismissed its complaint.

The court agreed with Travelers that the loss at issue was not caused by computer fraud, defined to expressly exclude any "entry or change [of data or computer instructions] made by an Employee . . . in reliance upon any fraudulent . . . instruction." The court stated: "That is precisely what happened here." SJ Computers argued that the fraudulent conduct was actually two separate acts (the hacking into the email system and subsequent wire transfers) and that only the latter act was excluded from the computer fraud provision, whereas the former was not because the bad actor was not an employee. The court rejected this argument, finding it illogical to fragment the fraud into separate acts. Further, the court held that even if the hacking component could be considered in isolation, computer fraud coverage would still be unavailable because the hacking did not "directly cause" a "direct loss," as required by that provision. Rather, the loss was directly caused by a series of subsequent actions, including the ultimate wire transfer of funds.

Finally, the court ruled that even if the loss could be construed to fall within the computer fraud provision, coverage would be barred by an exclusion that applied to losses resulting from fraudulent instructions used by an employee to enter data or send instructions. That exclusion applied to all coverages except the social engineering fraud provision, thus

further supporting the conclusion that the type of fraud experienced by SJ Computers was social engineering fraud rather than computer fraud.

Eleventh Circuit Says Deceptive Transfer Fraud Provision Does Not Provide Coverage For Loss Stemming From Email Impersonation Scheme

Affirming a Florida district court decision, the Eleventh Circuit ruled that an insurer had no duty to indemnify wire transfer losses stemming from an email impersonation scheme. *Star Title Partners of Palm Harbor, LLC v. Illinois Union Ins. Co.*, 2022 WL 4075048 (11th Cir. Sept. 6, 2022).

Star Title, a settlement agent, clears title for property to be sold and distributes funds at closing. For the sale in question, the seller identified Capital Mortgage Services ("CMS") as its lender and lienholder. The fraud arose when a fraudster purporting to be a CMS representative contacted Star Title and provided payment instructions. When Star Title realized it was the victim of an email impersonation scheme, it sought coverage for losses incurred as the result of a wire transfer.

The operative policy clause provided coverage for the loss of funds resulting from the intentional misleading of an employee . . . "sent by a person purporting to be an employee, customer, client or vendor." The Eleventh Circuit ruled that coverage was unavailable because CMS was not a customer, client or vendor of Star Title. The court reasoned that "Star Title does not employ CMS for any purpose or control CMS' work performance in any manner. Nor does Star Title sell CMS any particular product or provide it any particular service."

Star Title argued that CMS should be considered a client or customer because Star Title provided a service to CMS by holding payoff funds in escrow and delivering those funds to CMS on behalf of sellers. Rejecting this assertion, the court explained that Star Title's customer/client was the seller, not CMS.

Public Policy Alert:

Washington Supreme Court Rules That Hybrid Occurrence/Claims-Made Policy With No Retroactive Date Violates Public Policy

The Washington Supreme Court ruled that a general liability policy that requires a loss to occur and be reported within the same policy year and provides neither prospective nor retroactive coverage violates state public policy. *Preferred Contractors Ins. Co. v. Baker & Son Constr. Inc.*, 514 P.3d 1230 (Wash. Aug. 11, 2022).

The coverage dispute arose out of a wrongful death claim against a construction company. The injury occurred during a 2019 policy period, but the claim against the company (and its tender of the claim to its insurer) occurred during a 2020 policy period. Each policy was a claims-made policy that required claims to be made and reported

within the policy period. The claims-made provisions, set forth in endorsements, also limited each policy period to one year and did not provide continuous coverage between renewal policies. However, the policies also included occurrence-based language, stating that bodily injury must take place during the policy period.

The Washington Supreme Court addressed the following certified question:

> When a contractor's liability insurance policy provides only coverage for "occurrences" and resulting "claims-made and reported" that take place within the same one-year policy period, and provide no prospective or retroactive coverage, do these requirements together violate Washington public policy and render either the "occurrence" or "claim-made and reported" provisions unenforceable?

The court answered the question in the affirmative, finding that Washington statutory law sets forth public policy that promotes contractors' financial responsibility for bodily injuries. In particular, the court held that Chapter 18.27 RCW, which regulates the registration of contractors and requires contractors to carry at least $100,000 in financial responsibility for bodily injuries, primarily through insurance, establishes a public policy to protect the public from the negligence of contractors.

As the court noted, the New Jersey Supreme Court deemed a similar policy unenforceable as against public policy.

COVID-19 Alerts:

Three State Supreme Courts Dismiss Suits Seeking Coverage For Pandemic-Related Losses

In *Hill & Stout, PLLC v. Mutual Enumclaw Ins. Co.*, 515 P.3d 525 (Wash. Aug. 25, 2022), the Washington Supreme Court ruled that "direct physical loss" of property does not include loss of intended use of property due to government orders and thus that coverage was unavailable. The court stated:

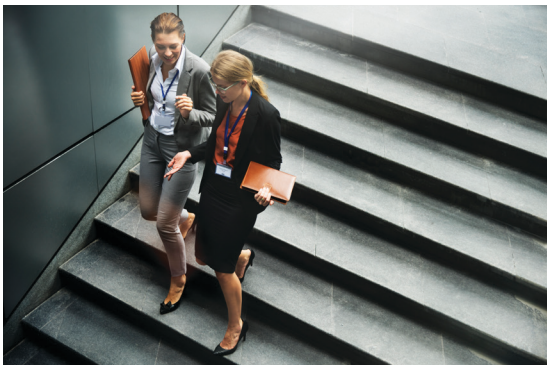
> HS was still able to physically use the property at issue. The property was in HS's possession, the property was still functional and able to be used, and HS was not prevented from entering the property. Under the Proclamation, HS was not able to use the property in the way that it wanted, but this alleged "loss" is not "physical."

The court ruled that in any event, coverage was barred by a virus exclusion. The policyholder argued that under the efficient proximate cause test, there may be coverage if the predominating cause of the loss is determined to be the government orders rather than the virus. Rejecting this assertion, the court held that the causal chain here was clear: the virus (an excluded peril) led to the proclamations, which led to the business losses.

In *Sullivan Mgmt., LLC v. Fireman's Fund Ins. Co.*, 2022 WL 3221920 (S.C. Aug. 10, 2022), the South Carolina Supreme Court, answering a certified question, ruled that the presence of COVID-19 in or near insured property, and/or related government orders, did not constitute "direct physical loss or damage" to property. The court explained that while government orders affected business operations, the mere loss of access to a business is not the same as physical loss or damage. The court further held that allegations of actual viral presence did not alter its conclusion, noting that the policy's restoration provision indicated that "damage" requires repair or replacing, which was not required here.

The Oklahoma Supreme Court also ruled that "direct physical loss or damage" requires "immediate, actual or tangible deprivation or destruction of property," and does not encompass a loss of use of property during the pandemic. *Cherokee Nation v. Lexington Ins.*

Co., 2022 WL 4138429 (Okla. Sept. 13, 2022). A district court had ruled that several insurers were obligated to cover business losses sustained by the Cherokee Nation in the wake of government-mandated shutdowns (*see* February 2021 Alert). Reversing the decision, the Oklahoma Supreme Court reasoned that "direct physical loss or damage" does not include an inability to use property for its intended purpose.



Vermont Supreme Court Rules That Trial Court Erred In Dismissing Complaint Against Reinsurers For COVID-19-Related Losses

Reversing a lower court decision, the Vermont Supreme Court ruled that a complaint sufficiently alleged "direct physical loss or damage to property" so as to withstand a motion to dismiss on the pleadings. *Huntington Ingalls Indus., Inc. v. Ace Am. Ins. Co.*, 2022 WL 4396475 (Vt. Sept. 23, 2022).

A military ship building company and its captive insurance subsidiary sued reinsurers seeking a declaratory judgment that they are entitled to coverage for property damage, business interruption and other losses suffered as a result of the pandemic and related government orders. The complaint alleged that there was direct physical loss or damage to property because the virus adhered to surfaces and lingered in the air at the insured property site. The complaint further alleged that the viral presence altered and impaired the functioning of the property, requiring physical, remedial alterations such as sanitization efforts, installation of barriers, and the redesign of space. A Vermont trial court dismissed the complaint, holding that there was no loss of or damage to property because the shipbuilding yards remained operational despite the alleged viral presence. The Vermont Supreme Court reversed, ruling that under Vermont's "extremely liberal" notice-pleading standards, the allegations were sufficient to withstand a motion to dismiss on the pleadings. In particular, the court held that allegations of a physical alteration to property based on the viral presence sufficiently pled "direct physical damage." However, the court emphasized that mere allegations of loss of use due to a government order would not satisfy the "direct physical loss or damage" requirement. The court remanded the matter for factual development of the record, noting the possibility that "the science when fully presented may not support the conclusion that presence of a virus on a surface physically alters that surface in a distinct and demonstrable way."

Reversing Trial Court, California Appellate Court Rules That Civil Authority Endorsement Provides Coverage For Business Losses

A California appellate court ruled that a business was entitled to coverage for COVID-19 pandemic-related losses under a civil authority endorsement and that a mold exclusion that referenced viruses did not apply. *Butter Nails and Waxing, Inc. v. Underwriters at Lloyd's, London*, No. B311455 (Cal. Ct. App. Aug. 25, 2022).

The endorsement provided coverage for loss "caused by interruption of business due to 'Civil Authority Action' that requires evacuation of the 'described premises.'" The appellate court concluded that the undefined term "evacuation" encompassed the public health orders requiring non-essential businesses to close during the pandemic. Importantly, the court distinguished this endorsement from the more common civil authority coverage provisions, which require damage to nearby property, a prohibition on access to insured property and a causal connection between the civil authority order and the damaged property.

In addition, the court ruled that an exclusion, which applied to "organic pathogens" and defined that term to include "mold, fungus, bacteria or virus," did not bar coverage. The court reasoned that the exclusion did not "conspicuously, plainly or clearly" exclude losses stemming from government orders addressing a viral pandemic and instead, was

"more reasonably understood" to exclude losses stemming from mold or mildew. The court stated:

> the inclusion of the term "virus" in the list of "organic pathogens" does not make the Mold Exclusion applicable to every claim stemming directly or indirectly from a virus. Rather, an insured would reasonably understand the exclusion to apply only where the claimed losses were related in some way to the presence of the "organic pathogen" on the business premises.

Texas Jury Awards Policyholder $48 Million For COVID-19-Related Loss

In the first jury verdict of its kind, a Texas jury awarded Baylor College of Medicine $48 million in a suit for COVID-19-related business interruption losses. *Baylor College of Medicine v. XL Ins. Am. Inc.*, No. 2020-53316 (Tex. Dist. Ct. Sept. 2, 2022). The judge had previously denied the insurer's summary judgment motion, finding issues of fact as to whether the presence of the virus caused direct physical loss of or damage to property. We will keep you posted on any appeals in this matter.

Insurance News Alert:

House Subcommittee Report Highlights Lack Of Diversity In U.S. Insurance Companies

The United States House of Representatives released a report this month that outlines the lack of diversity in the largest property, casualty, and life insurance companies in the United States. The report, prepared by the financial services committee and entitled "Diversity and Inclusion: Holding America's Largest Insurance Companies Accountable," is based on data from more than two dozen of the nation's largest insurance companies. The report concludes that women and people of color are significantly underrepresented in these entities in terms of both employee population and executive positions. The report recommends certain "immediate actions" to promote diversity and inclusion, including the collection of workforce data, pay and equity audits, and the formation of partnerships with minority-centered institutions and universities.

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