Insurance Litigation 2021

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LEXOLOGY®
Getting The Deal Through

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Lexology Getting The Deal Through is delighted to publish the eighth edition of *Insurance Litigation*, which is available in print and online at www.lexology.com/gtdt.

Lexology Getting The Deal Through provides international expert analysis in key areas of law, practice and regulation for corporate counsel, cross-border legal practitioners, and company directors and officers.

Throughout this edition, and following the unique Lexology Getting The Deal Through format, the same key questions are answered by leading practitioners in each of the jurisdictions featured. Our coverage this year includes a new chapter on Pakistan.

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Every effort has been made to cover all matters of concern to readers. However, specific legal advice should always be sought from experienced local advisers.

Lexology Getting The Deal Through gratefully acknowledges the efforts of all the contributors to this volume, who were chosen for their recognised expertise. We also extend special thanks to the contributing editors, Mary Beth Forshaw, Bryce Friedman and Karen Cestari of Simpson Thacher & Bartlett, for their assistance with this volume.

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United States

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PRELIMINARY AND JURISDICTIONAL CONSIDERATIONS IN INSURANCE LITIGATION

Fora

1 | In what fora are insurance disputes litigated?

Most insurance disputes are litigated in state or federal trial courts. An insurance action may be subject to original federal court jurisdiction by virtue of the federal diversity statute, 28 USC section 1332(a). In this context, an insurance company, like any other corporation, is deemed to be a citizen of both the state in which it is incorporated and the state in which it has its principal place of business.

If an insurance action is originally filed in state court, it may be removed to federal court on the basis of diversity. Absent diversity of parties or some other basis for federal court jurisdiction, insurance disputes are litigated in state trial courts. The venue is typically determined by the place of injury or residence of the parties, or may be dictated by a forum selection clause in the governing insurance contract.

Some insurance contracts contain arbitration clauses, which are usually strictly enforced. If an insurance contract requires arbitration, virtually every dispute related to or arising out of the contract typically will be resolved by an arbitration panel rather than a court of law. Even procedural issues, such as the availability of class arbitration and the possibility of consolidating multiple arbitrations, are typically resolved by the arbitration panel.

Practitioners handling insurance disputes governed by arbitration clauses should diligently comply with the procedural requirements of the arbitration process. Arbitration provisions in insurance contracts may set forth specific methods for invoking the right to arbitrate and selecting arbitrators. Careful attention to detail is advised, as challenges to the arbitration process are commonplace. An insurance dispute that originates in arbitration may ultimately end up in the judicial system as a result of challenges to the fact or process of arbitration.

Causes of action

2 | When do insurance-related causes of action accrue?

Insurance litigation frequently involves a request for declaratory judgment or breach of contract claims, based on allegations that an insurer breached its defence or indemnity obligations under the governing insurance policy. Insurance-based litigation may also include contribution, negligence or statutory claims. For any insurance-related claim to be viable, it must be brought within the applicable statute of limitations period, which is governed by state law. In determining whether a claim has been brought within the limitations period, courts address when the claim accrued. For breach of contract claims, the timing of claim accrual may depend on whether the claim is based on an insurer's refusal to defend or failure to indemnify. When a claim arises from an insurer's failure to defend, courts typically endorse one of the following positions:

- the limitations period begins to run when the insurer initially refuses to defend;
- the limitations period begins to run when the insurer refuses to defend, but is equitably tolled until the underlying action reaches final judgment; or
- the limitations period begins to run once the insurer issues a written denial of coverage.

When a claim arises from an insurer's refusal to indemnify a policyholder, courts have held that the claim accrues either when the underlying covered loss occurred or when the insurer issues a written denial of coverage.

A legal finding that a policyholder's claim is time-barred is equivalent to a dismissal on the merits.

Preliminary considerations

3 | What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

At the outset of insurance litigation, practitioners must conduct a careful evaluation of possible causes of action in light of the available factual record in order to assess procedural and substantive strategies. When an insurance dispute turns on a clear-cut question of law and could appropriately be resolved on a motion to dismiss or a motion for summary judgment, dispositive motion practice should be considered. For example, if an underlying claim for which coverage is sought alleges an occurrence that arose after the insurance policy at issue expired or alleges facts that fall squarely within the terms of a pollution exclusion, the insurer may file a dispositive motion to seek swift resolution of its coverage obligations. In contrast, where an insurance dispute presents contested issues of fact, practitioners should be vigilant about formulating case management orders and discovery schedules. Insurance-related discovery is often contentious, expensive and time-consuming, and may give rise to disputes regarding privilege or work product protection. In this respect, document retention policies must be implemented and in some cases, confidentiality stipulations may be appropriate. Finally, a preliminary assessment of any insurance matter should involve consideration of whether it is appropriate to request trial by jury or whether to implead third parties, including entities such as co-insurers, third-party tortfeasors or insurance brokers.

Damages

4 | What remedies or damages may apply?

Many insurance coverage lawsuits seek relief in the form of a judicial declaration that articulates the scope of coverage under the insurance policies in dispute. In essence, one or more parties request that the court enter a ruling that coverage is available or unavailable before addressing the appropriate remedy or damages. If the court issues a

ruling declaring coverage to be exhausted or otherwise unavailable, the appropriate remedy or damages may be dismissal of the action with or without costs imposed on the insured.

Where courts find coverage to be available, they often go on to address the issue of remedy or damages in a separate phase of the case. The most common measure of damages in insurance litigation is contractual damages, which may be awarded in connection with a breach of contract claim. The amount of contractual damages is typically based on the coverage due under the relevant policies (or, for a claim of rescission, the amount of premiums to be refunded). In complex insurance litigation, such as that involving multiple layers of coverage with injuries or damage spanning an extended period of time, the damages calculation may be more involved, often requiring expert testimony.

Aside from basic contractual damages, additional amounts may be recovered in certain insurance disputes. For example, some jurisdictions may allow consequential damages based on economic losses that flow directly from the breach of contract or that are reasonably contemplated by the parties. Additionally, some jurisdictions permit attorneys' fees awards under certain circumstances.

Whether attorneys' fees awards are available may be governed by state statute, relevant case law or, in some cases, the insurance agreements themselves. Arbitration clauses, in particular, may provide for the payment of the prevailing party's attorneys' fees and costs. While attorneys' fees may be difficult to recover, the threat of an attorneys' fees award may affect the dynamics of settlement negotiations.

Infrequently, the possibility of tort-based or punitive damages can arise in insurance litigation. These damages may come into play in the context of claims alleging that an insurer acted in bad faith or violated state unfair or deceptive practices statutes.

Where monetary damages are awarded in an insurance action, a corollary issue is the imposition of pre-judgment (or post-judgment) interest. The imposition and rate of interest may be determined by the parties via explicit contractual language. Absent governing language, the question of whether a prevailing party is entitled to pre-judgment or post-judgment interest and, if so, the applicable interest rate, is typically governed by state law. When pre-judgment interest is allowed, determination of the accrual date is paramount because opposing positions can differ by many years, and resolution can have a significant impact on the total damages award. Courts have utilised different events for determining the interest accrual date, including when payment was demanded, when payments are deemed due under the applicable policy and when the complaint was filed.

5 | Under what circumstances can extracontractual or punitive damages be awarded?

Certain states permit policyholders to seek extracontractual or punitive damages when an insurer allegedly has acted in bath faith or violated unfair or deceptive practices statutes. Bad faith allegations frequently relate to an insurer's refusal to defend or settle an underlying matter, but can also stem from other conduct, such as claims-handling practices. Some jurisdictions do not recognise tort claims arising out of an insurer's breach of contract. In those jurisdictions, a policyholder's recovery typically is limited to contractual damages, with no opportunity for punitive damages. Some courts in those jurisdictions, however, may allow recovery of extracontractual damages (eg, lost income or related economic losses) against an insurer if the losses were foreseeable and arose directly out of the breach of contract.

In jurisdictions that recognise bad faith tort claims against an insurer, policyholders face several obstacles when seeking punitive damages. In most but not all cases, a punitive damages claim is not actionable without an adjudication that the insurer has breached the insurance contract. Even where an insurer is held to have breached a contract, and a policyholder has established bad faith or statutory violations, punitive damages are extremely difficult to recover. Most jurisdictions strictly require the party seeking punitive damages to meet a high burden and to prove 'wilful or malicious' conduct, 'malice, oppression or fraud' or 'gross or wanton behaviour' by the insurer. Furthermore, some jurisdictions impose an elevated burden of proof, requiring that bad faith be shown by 'clear and convincing evidence'.

INTERPRETATION OF INSURANCE CONTRACTS

Rules

6 | What rules govern interpretation of insurance policies?

All jurisdictions in the United States interpret insurance contracts in accordance with the plain meaning of policy language in order to effectuate the intent of the parties at the time the contract was made. The preliminary inquiry in insurance contract interpretation is whether the insuring agreement or insuring clause provides coverage for the loss at issue.

If coverage does not exist under the insurance policy, the inquiry ends, and there is no need to look to policy exclusions or other provisions.

If coverage potentially exists (ie, if a loss falls within the scope of coverage set forth in the insuring clause), the second inquiry is whether the policy contains any exclusions from or limitations on that coverage. While exclusions may be narrowly construed, courts will enforce exclusions and other coverage limitations when their clear and unambiguous terms bar or restrict coverage.

Insurance policies frequently contain endorsements, which are contractual amendments that must be read as part of the policy. Valid endorsements supersede and control conflicting policy terms.

Ambiguities

7 | When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision may be deemed ambiguous if a word or phrase is reasonably susceptible to more than one construction.

A split in jurisdictional authority may be a basis for finding ambiguity. However, an ambiguity does not exist by virtue of the parties' differing interpretations or simply because a clause is complex and requires judicial analysis. Similarly, the absence of a definition for a policy term, or the existence of multiple meanings for a term or phrase does not, without more, render it ambiguous.

Once it is determined that an insurance policy contains an ambiguity, courts employ several methods for resolving the ambiguity.

First, extrinsic evidence regarding the mutual intent of the parties at the time of contract formation may be considered to interpret the policy. This extrinsic evidence may include testimony as to the circumstances surrounding contract formation, premium amounts, course of dealing and industry custom and practice. Second, many jurisdictions in the United States will, under certain circumstances, employ the 'reasonable expectations' doctrine, under which the policyholder's objectively reasonable expectations as to coverage are relevant to the interpretation of an ambiguous policy term. A minority of jurisdictions have rejected formulations of the reasonable expectations doctrine in favour of traditional contract interpretation principles.

When all other principles of contract interpretation have failed to resolve an insurance policy ambiguity, some courts in the United States apply a contra-insurer rule of construction. Under the contra-insurer rule, ambiguous policy provisions are interpreted strictly against the insurer (as drafter of the policy) in favour of policy coverage.

The contra-insurer rule has been applied to interpret ambiguous policy exclusions in situations where the insurer exercised significant

control over the drafting of the language at issue. Notably, however, the facts of a particular case may render the rule inapplicable. In particular, courts have declined to apply the contra-insurer rule when the parties to the insurance contract possess equivalent bargaining power.

Therefore, the contra-insurer rule may not be applied under the following circumstances:

- when the policyholder is a large, sophisticated business or corporate entity;
- when counsel or specialised insurance brokers have acted on behalf of the policyholder in the negotiation of the insurance policy;
- when the ambiguous provision or policy has been drafted by the policyholder or an agent of the policyholder;
- when the policy is a customised, individually negotiated 'manuscript' policy; or
- when it is established that the parties share equal bargaining power.

NOTICE TO INSURANCE COMPANIES

Provision of notice

8 | What are the mechanics of providing notice?

Although the language of notice provisions varies among policies, all notice provisions serve a similar purpose: to enable an insurer to adequately investigate and respond to claims. Most general liability policies require a policyholder to provide notice as soon as practicable to the insurer of all claims brought against the policyholder or of occurrences that may give rise to a covered claim. Many general liability policies also require a policyholder to provide the insurer with copies of court papers and demands.

Most policy provisions require notice to be in writing, and to contain information necessary to enable the insurer to determine whether coverage may be implicated. In addition, notice should be provided by the policyholder (rather than a third party) to the insurer or an authorised agent of the insurer.

Obligations

9 | What are a policyholder's notice obligations for a claims-made policy?

Claims-made policies typically provide coverage only if a claim is made during the policy period and reported to the insurer during the policy period or any applicable extended reporting period. Timely reporting is an essential element of a claims-made policy. Accordingly, a policyholder's failure to report in good time under a claims-made policy may result in a denial of coverage.

Therefore, a critical issue in insurance litigation relates to what events constitute a 'claim' for the purposes of the reporting requirement of a claims-made policy. Most courts have held that a 'claim' contemplates the assertion of a legal right by a third party against the policyholder.

However, under certain circumstances, an agency subpoena or administrative proceeding might satisfy the claim requirement for the purposes of a triggering notice under a claims-made policy. In contrast, a mere request for information or communication alleging wrongdoing will not typically rise to the level of a claim in this context.

Certain provisions in claims-made policies may operate to extend or otherwise affect a policyholder's notice obligations. First, an extended reporting period (often mandated by state statutory law, which varies by jurisdiction) may provide a reasonable period of time following the policy's expiry date in which the policyholder may provide notice. Second, a 'savings' clause may provide that claims made during a limited period after the expiry of the policy will be deemed to have been made during the policy period, so long as the policyholder gives notice to the insurer of facts or circumstances giving rise to the claim. Similarly, an 'awareness' provision might extend coverage beyond the policy period where facts giving rise to a claim were known and reported to the insurer during the policy period, but no formal claim was asserted until after the policy's expiry.

Timeliness

10 | When is notice untimely?

Notice of a claim under a claims-made policy will be deemed untimely if it is provided after termination of the policy period or any extended reporting period and has not been the subject of a timely notice of circumstances within the applicable reporting period. Notice provisions in occurrence-based policies typically do not set forth a specific time period for notice, but rather contain language requiring notice to be given 'promptly' or 'as soon as practicable'. The timeliness of notice under these and similar provisions is generally judged by a reasonableness standard.

Typically, whether notice is timely presents a question of fact to be resolved in light of the specific circumstances in any given case. In some cases, however, a court may rule on reasonableness as a matter of law. For example, when the delay in providing notice is lengthy (ie, months or years), or when the policyholder has offered no legitimate excuse for the delay, a court may deem notice unreasonable as a matter of law.

Several factors may affect the reasonableness determination. First, a policyholder's lack of knowledge of an occurrence may excuse a delay in notice where the policyholder has otherwise acted with due diligence. Second, a policyholder's reasonable belief that liability would not be imposed or that a claim would not arise has, in some circumstances, militated against a finding of late notice. Courts across United States jurisdictions are split as to whether a policyholder's lack of knowledge of coverage or of a policy's existence may excuse or otherwise affect the late notice analysis.

11 | What are the consequences of late notice?

Late notice under a claims-made policy may result in forfeiture of coverage. The consequences of untimely notice under occurrence-based policies differ across jurisdictions in the United States. A minority of jurisdictions hold that notice is a condition precedent to coverage, such that untimely notice results in an automatic forfeiture of rights under the policy. Under this approach, prejudice is presumed to flow from the insurer's delay in receiving notice. A majority of jurisdictions require the insurer to demonstrate prejudice as a result of untimely notice in order to deny coverage on this basis. However, jurisdictions in this category have held that late notice bars coverage where the applicable policy language explicitly makes prompt notice a condition precedent to coverage. Several jurisdictions have endorsed a middle-of-the-road approach to late notice, under which the presence or absence of prejudice to the insurer is just one factor to be considered in deciding whether untimely notice should result in a forfeiture of coverage.

Insurers can establish prejudice by several means. Prejudice has been found where late notice has prevented the insurer from being able to investigate claims, to interview witnesses, to participate in settlement negotiations or to collect reinsurance. Similarly, prejudice exists where an insurer has lost its ability to enforce contractual rights, such as the right to defend claims against the policyholder. Decisions relating to prejudice are highly fact-specific, and courts frequently employ flexible analyses based on the particular factual record presented.

INSURER'S DUTY TO DEFEND

Scope

12 | What is the scope of an insurer's duty to defend?

Some liability insurance policies require an insurer to provide a defence for a policyholder when it is named as a defendant in underlying litigation. An insurer's duty to defend claims against a policyholder is determined by reference to the allegations in the underlying complaint.

If the allegations articulate a claim that potentially falls within the policy's coverage, courts generally require the insurer to provide a defence. However, courts have found no duty to defend under the following circumstances:

- when the insured is not sued in its insured capacity;
- when the complaint alleges intentional or inherently wrongful acts;
- when the allegations in the complaint fall exclusively within policy exclusions; and
- when factual issues conclusively negate the possibility of coverage.

Courts have issued conflicting rulings as to whether extrinsic evidence, outside the 'four corners' of the underlying complaint, may be considered in evaluating an insurer's defence obligations.

Although an insurer's duty to defend frequently extends through the duration of the underlying litigation against the policyholder, there are certain circumstances under which courts have deemed it appropriate for an insurer to withdraw its defence. If, for example, the underlying claims have been limited to claims that fall outside the scope of policy coverage, an insurer may be allowed to terminate its defence. Additionally, some courts have ruled that an insurer's defence obligations terminate upon exhaustion of policy limits, although many courts reject the notion that an insurer can terminate its defence simply by tendering policy limits.

Failure to defend

13 | What are the consequences of an insurer's failure to defend?

When a court determines that an insurer has breached its duty to defend, it may be responsible for all reasonable defence costs incurred in the underlying litigation. In addition, an insurer that has refused to defend might, in some jurisdictions, be held responsible for the legal costs incurred in a declaratory judgment action brought to enforce that duty. Courts are split as to whether other, more severe consequences result from a breach of an insurer's defence obligations. For example, under certain circumstances, courts have held that an insurer that breaches its duty to defend should be held responsible for indemnity costs as well. To the extent that indemnity costs may be awarded as a result of the breach of the duty to defend, courts have imposed a requirement that such indemnity costs be reasonable in light of the claims and factual record. Similarly, an insurer that unreasonably denies a defence might, under certain circumstances, be held to have waived certain defences to coverage.

STANDARD COMMERCIAL GENERAL LIABILITY POLICIES

Bodily injury

14 | What constitutes bodily injury under a standard CGL policy?

CGL policies generally provide coverage for bodily injury or property damage sustained by third parties (rather than the policyholder) as a result of an occurrence.

Insurance coverage litigation frequently centres on whether the underlying claims against the policyholder allege bodily injury or property damage within the meaning of the applicable insurance policy, and whether the events giving rise to the injury or damage were caused by an occurrence.

The phrase 'bodily injury' in insurance contracts generally connotes a physical problem. However, a number of courts have ruled that the term also encompasses non-physical or emotional distress, either standing alone or accompanied by physical manifestations.

The question of whether bodily injury exists may also arise where an underlying complaint alleges non-traditional or quasi-physical harm, such as biological or cellular level injury or medical monitoring claims. Courts addressing these and other analogous bodily injury questions have arrived at mixed decisions. Bodily injury determinations are often case-specific, turning on the particular factual record presented.

Property damage

15 | What constitutes property damage under a standard CGL policy?

Property damage typically requires injury to or loss of use of tangible property. Therefore, the mere risk of future damage is generally insufficient to constitute property damage. Similarly, it is generally held that the inclusion of a defective component in a product, standing alone, does not constitute property damage. Numerous other allegations of harm or potential harm to property have generally been deemed to fall outside the scope of covered property damage, including the following:

- injury to intangible property (such as computer data);
- injury to goodwill or reputation;
- pure economic loss; and
- diminished property value.

However, although economic loss is not equated with property damage, courts may use a policyholder's economic loss as a measure of damages for property damage where physical damage is found to exist.

Occurrences

16 | What constitutes an occurrence under a standard CGL policy?

Virtually all modern-day general liability insurance policies provide coverage for an occurrence that takes place during the policy period. The insurance term 'occurrence' is typically equated with or defined as an accident or an event that results in damage or injury that was unexpected and unintended by the policyholder.

Insurance litigation frequently involves several issues relating to the occurrence requirement:

- whether intentional conduct that results in unexpected or unintended harm constitutes an occurrence;
- whether negligent conduct that results in expected or intended harm constitutes an occurrence;
- whether an event or series of events constitutes a single occurrence or multiple occurrences;
- whether the occurrence falls within a given policy period (ie, what is the operative event that triggers a policy?); and
- how insurance obligations should be divided among multiple insurers (or the policyholder) when an occurrence spans multiple policy periods (ie, allocation).

Although it is a widely accepted principle that insurance policies provide coverage only for fortuitous events, and cannot insure against intentional or wilful conduct, it is less clear whether (and under what circumstances) intentional conduct that results in unexpected and unforeseen damage can constitute a covered occurrence. This question has arisen in a multitude of factual contexts, including claims arising out of faulty workmanship, pollution and fax blasting in violation of federal statutes. In evaluating the occurrence issue, some courts focus on the

initial conduct of the policyholder, while other courts look to whether the resulting harm was unexpected or unintended.

17 | How is the number of covered occurrences determined?

The determination of whether damage or injury is caused by a single occurrence or by multiple occurrences has significant implications for available coverage. The number of occurrences may impact both the policyholder's responsibility for deductible payments and the per occurrence policy limits that are available. Thus, it is a hotly contested issue in insurance litigation. Most courts utilise a cause-based analysis to determine the number of occurrences. Under the cause-oriented approach, if there is one proximate cause of the injury, there is one occurrence, regardless of the number of claims or incidents of harm.

In contrast, under an effects-oriented analysis, the focus is on the number of discrete injury-causing events.

A number of occurrences disputes arise in virtually all substantive areas of insurance litigation, including claims arising out of asbestos, environmental harm, natural disasters, and the manufacture or distribution of harmful products.

Coverage

18 | What event or events trigger insurance coverage?

Litigation that centres on whether a given policy period has been implicated by an occurrence is generally referred to as a 'trigger of coverage' dispute. 'Trigger' describes what must happen within the policy period for an insurer's coverage obligations to be implicated. In cases involving ongoing or continuous property damage or personal injury, the question of what triggers policy coverage may be complex. From a legal perspective, courts employ several different methods to resolve trigger disputes. For bodily injury claims, the operative trigger event has been held to be:

- at the time of exposure to a harmful substance;
- at the time the injury manifests itself;
- at the time of actual 'injury in fact'; or
- a combination or inclusion of all of the above.

Property damage claims have also given rise to multiple trigger approaches, some of which focus on the initial event that set the property damage into motion, while others look to the time that physical damage became evident. From a factual perspective, parties are often required to submit voluminous evidence in support of their position as to when property damage or bodily injury actually occurred. Expert witnesses are often retained to address trigger issues.

19 | How is insurance coverage allocated across multiple insurance policies?

When an occurrence triggers multiple policy periods, disputes frequently arise as to how indemnity costs should be allocated among various insurers. The emerging trend in courts in the United States is a pro rata approach, which apportions loss among triggered policies based on insurers' proportionate responsibilities. In applying pro rata allocation, courts have considered:

- the time that each insurer is on the risk;
- the policy limits of each triggered policy;
- the proportion of injuries during each policy; or
- a combination of these and other factors.

Pro rata allocation also typically contemplates policyholder responsibility for periods of no coverage or insufficient coverage. The pro rata allocation approach stems from policy language that limits insurers' obligations to damage 'during the policy period'. Some jurisdictions that utilise a pro rata approach recognise an 'unavailabilty' exception. The unavailability exception provides that apportionment to the insured for uninsured periods is not warranted if insurance was unavailable in the marketplace during the relevant time frame. If this unavailability is established, losses during the uninsured periods are allocated among the insurers.

A minority of courts endorse a joint and several liability approach, under which a policyholder is entitled to select a single policy from multiple triggered policies from which to seek indemnification. This approach stems from common policy language requiring an insurer to pay 'all sums' that the policyholder becomes legally obligated to pay. Notably, even courts that endorse all sums allocation typically allow a targeted insurer to pursue contributions from other triggered insurers.

FIRST-PARTY PROPERTY INSURANCE

Scope

20 | What is the general scope of first-party property coverage?

First-party property insurance policies, unlike third-party liability policies, compensate a policyholder for damage to the policyholder's own property. Therefore, although first-party insurance litigation can give rise to some of the same issues presented in third-party liability coverage cases, first-party insurance disputes may turn on issues specific to first-party insurance policies, and courts in the United States have become increasingly cognisant of the distinction between the two types of policies.

As a preliminary matter, first-party policies often impose certain obligations on the part of the policyholder as condition precedents to coverage. The policyholder is typically required to set aside damaged property to allow the insurer to conduct an inspection.

Policyholders are also obligated to provide a sworn statement or proof of loss within a certain time period. Failure to fulfil either of these obligations may result in a forfeiture of coverage. Furthermore, first-party policies frequently contain suit limitation clauses, which provide that coverage litigation against the insurer must be brought within a certain time frame after the date of the loss (often one or two years). In some cases, the suit limitations clause in the policy may be shorter than the applicable statute of limitations.

If a property insurance claim has been properly preserved and asserted against an insurer, insurance disputes frequently turn on causation-related issues (ie, whether the loss at issue was caused by a covered peril). Causation issues may become complicated where a covered peril and an excluded peril combine to cause a loss. Under these circumstances, many courts employ the efficient proximate causation rule, which holds that when a loss is caused by both covered and excluded perils, there is coverage only if the covered peril is the dominant cause of the damage. Therefore, where an insured risk was only a remote cause of the loss, there is typically no coverage.

Courts have also utilised a concurrent causation doctrine to allow for coverage when a loss is caused by both excluded and covered events. Under this approach, a court may award a percentage of coverage under the policy based on the portion of damage caused by covered risks. Importantly, the proximate or concurrent cause doctrines may not be used to create coverage where the policy has clearly excluded certain perils by virtue of explicit policy language.

Similarly, first-party policies may contain anti-concurrent causation clauses that operate to exclude coverage where loss is caused by a combination of covered and uncovered perils.

Valuation

21 | How is property valued under first-party insurance policies?

First-party property insurance disputes often involve questions relating to the proper valuation of covered property. The basic types of coverage for property damage are 'replacement cost' coverage and actual cash value (ACV). Policy language controls the application of each type of coverage. Replacement cost coverage is usually defined to allow replacement of 'like kind and quality' property (ie, the functional equivalent of the lost or damaged property). Therefore, courts often limit replacement cost damages to the amount of money it would take to reconstruct the property as it stood prior to the loss, and may be unwilling to allow a policyholder to recoup the costs necessary to comply with newly enacted code or safety regulations. In contrast, ACV coverage typically allows a policyholder to recover the depreciated value of the lost or damaged property. Some policies may provide that a policyholder can recover the ACV of destroyed property and subsequently make a claim for replacement costs. These policies generally require the policyholder to provide notice (within a certain period of time) of its intent to seek replacement costs. In addition, such policies invariably include as a condition precedent to supplemental replacement costs a requirement that the policyholder first complete restoration of its property. Many states have passed legislation that sets forth certain statutory minimum coverage requirements for first-party property policies.

Natural disasters

22 | Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

The potentially catastrophic losses associated with natural disasters present significant challenges for both insurers and policyholders. In the United States, insurance is available for certain risks associated with natural disasters through a combination of private insurance and governmental programmes. Some risks associated with natural disasters are uninsurable.

Hurricane

Hurricane damage may be covered under first-party property insurance policies, depending on the cause of the damage. Hurricanes typically involve one or more different perils, including wind, rain, storm surge, flooding, mould and power outages. Some perils, such as wind and windstorm, are routinely covered under property insurance policies. Others, such as flooding, generally are excluded. Thus, the underlying cause of the damage for which coverage is sought is critical. Identification of the cause is a fact-intensive inquiry and may require the use of experts. Moreover, specific policy provisions may come into play in assessing hurricane damage coverage under a property insurance policy. An 'anti-concurrent causation clause', for example, may limit coverage for hurricane damage arising from multiple perils, if one of the perils is excluded. Specific exclusions, for example, for wind, flooding or mould, may bar coverage.

In addition to seeking coverage for property damage, policyholders impacted by hurricane damage frequently invoke business interruption coverage, which provides reimbursement for lost income when business is interrupted because of direct physical damage to or loss of insured property owing to a covered peril. Business interruption coverage typically extends to the period of restoration, or the reasonable amount of time it takes for business operations to return to normal following physical damage to property or equipment. Litigation often revolves around the date on which the insured could have repaired, rebuilt or replaced its property to resume operations, which may precede the date on which the policyholder actually did return to business. Litigation also frequently involves the correct measure of recovery for business interruption losses. Courts have typically found that recovery should reflect what the insured business would have earned had no interruption occurred, using the earnings minus expenses of the business before the interruption to determine lost income recovery.

Flood

Property insurance policies typically exclude coverage for floods. Courts in the United States enforce flood exclusions to bar coverage for damage caused by naturally occurring floods, burst dams and other natural flood events. By contrast, courts consistently refuse to apply the flood exclusion to bar coverage for damage caused by human negligence, for example, a burst water main or pipe. Conflicting conclusions may arise with respect to flood damage that arises, in part, from human conduct. After Hurricane Katrina, for example, a flood exclusion was held to bar coverage for damage caused by breaches in the levees surrounding New Orleans, despite the involvement of human negligence in that flood.

Flood insurance is available from insurers in the United States through the National Flood Insurance Program (NFIP) together with a recently expanded private insurance market. Federal courts have exclusive jurisdiction to hear actions under the NFIP. Under the NFIP, the Federal Emergency Management Administration subsidises and administers flood insurance at affordable rates to homeowners and business owners in participating communities. Various coverage limits exist for homes, businesses and personal property. Additionally, coverage is subject to a number of exclusions, including losses: 'substantially confined to the insured premises' (as opposed to widespread), caused by 'earth movement' (except where such losses arise from mudslides proximately caused by flooding), resulting from the policyholder's neglect to use reasonable protective measures, caused by normal erosion, and caused by a flood in progress at the time of purchase of the insurance policy.

The future of the NFIP is uncertain. Following Hurricanes Katrina, Sandy and Harvey, the programme has been heavily in debt. The government is continuing to debate reforms that include requiring greater participation by the private market and restricting coverage for severe repetitive-loss properties. In 2018, the government removed a non-compete clause from the NFIP to encourage private insurers to enter the flood insurance market. As a result, private insurers are able to service NFIP flood policies and offer primary flood insurance.

Wildfire

Most first-party property insurance policies cover fire damage, including losses resulting from catastrophic wildfires. Coverage traditionally also extends to losses resulting from smoke, soot and ash. In some high-risk areas, however, insurers will exclude coverage for wildfires, requiring policyholders to purchase a rider or separate policy for this coverage. As with any policy, coverage is determined based on the applicable policy language and the facts of the case. Among other issues, courts have grappled with whether wildfire losses caused by smoke, soot or ash are excluded under common exclusions for damages caused by smog or pollution, with inconsistent results.

Earthquake

First-party property insurance policies typically exclude coverage for earthquakes. Instead, policyholders may purchase a separate policy or an endorsement from their private insurer or, in California, the California Earthquake Authority. Notably, first-party property insurance and earthquake insurance policies are not intended to overlap. Accordingly, earthquake policies typically do not cover fire or water damage initially caused by an earthquake. Furthermore, most earthquake policies contain an exclusion for earthquakes that are 'not naturally occurring' or 'human-made'. Recently, insurers and regulators have disputed coverage for earthquake losses in areas adjacent to natural gas extraction, or fracking, which has been shown to cause or contribute to an increase in seismic activity.

DIRECTORS' AND OFFICERS' INSURANCE

Scope

23 | What is the scope of D&O coverage?

Directors' and officers' liability insurance policies, commonly referred to as D&O policies, provide coverage for claims against a company or its directors and officers. D&O coverage is typically limited to losses incurred owing to claims against the company or its directors and officers. Thus, the initial determinations must be whether the underlying action against the company or individuals qualifies as a claim under the policy and whether the alleged losses are insured.

In most contemporary D&O policies, the term 'claim' includes civil, criminal and administrative proceedings, and demands for damages or relief. Therefore, D&O policies often do not provide coverage for expenses arising out of investigations (such as subpoenas and other preliminary investigative measures) unless a proceeding has been initiated. Nonetheless, some courts have ruled, based on applicable policy language and the particular factual record, that D&O coverage is implicated as a result of a regulatory investigation, even absent formal proceedings. In recent years, the trend has been for D&O insurers to offer policies that provide coverage for regulatory investigations directed against individual insureds when they are clearly identified as the targets of such investigations. In addition, many D&O policies cover costs associated with an interview of an insured person in connection with an investigation of the insured entity. By contrast, if an investigation appears to target only the insured entity, without identifying any individuals, coverage typically remains limited. The term 'loss' is generally defined to include settlements, damages, judgments and defence costs. Litigation as to the scope of covered loss may arise where the policyholder's payments are deemed restitutionary (ie, disgorgement payments) rather than compensatory, or where the policyholder's payments are essentially a redistribution of assets within a corporation, rather than a compensable loss. A court's loss evaluation will turn on the applicable policy language as well as the nature of the payments for which the policyholder seeks indemnification.

Litigation

24 | What issues are commonly litigated in the context of D&O policies?

Commonly litigated issues include the scope of coverage for investigations commenced by government agencies and the insurability of fee awards granted to class action plaintiffs' counsel in the context of securities class actions. Other issues involve the timeliness of notice and the question of whether certain claims arising at different times are related to one another so as to trigger D&O coverage in the earliest policy during which the claim arose or whether these claims are unrelated so as to trigger two separate policy years.

In addition, D&O policies may be subject to rescission by insurers where it is established that the application for insurance contained material misrepresentations or omissions. Litigation relating to rescission claims turns on several issues. First, courts will evaluate whether the misrepresentation or omission was material. In many jurisdictions, materiality relates to whether the insurer would have issued the policy or offered the same terms had it known the truth. Second, the success of a rescission claim may, in some jurisdictions, depend on whether the policyholder had an intent to deceive in connection with the misrepresentation. Third, the identity of the party that made the misrepresentations may be relevant, particularly where coverage is sought by an 'innocent' director or officer who had no involvement in the application process. Some courts have held that once a material misrepresentation is established, the policy is void as to all directors and officers. In response, many D&O policies now contain non-imputation language precluding rescission as against any innocent directors or officers.

If there is a potential for D&O coverage, many policies contain provisions that require the insurer to advance defence costs for covered claims. Such provisions vary, and issues may arise as to whether an insurer is obligated to advance defence costs contemporaneously as they are incurred or whether the insurer is allowed to wait until the claim is resolved before providing reimbursement of defence costs. There is no judicial consensus on this issue, and rulings turn primarily on the specific language presented. In certain cases, an insurer may be entitled to an allocation of defence costs for covered versus non-covered claims.

Defence costs aside, substantive disputes in D&O insurance litigation often relate to the interpretation of several common policy exclusions, such as the 'insured versus insured' exclusion, which excludes coverage for claims against insured directors and officers brought by, or with the assistance or solicitation of, an insured organisation or insured person. Courts have issued conflicting rulings as to whether claims asserted by an entity that acts on behalf of the corporation (such as bank regulators, receivers, bankruptcy trustees or other litigation entities) should be considered an insured for purposes of the exclusion. Rulings in this context are driven primarily by applicable policy language, including carve-backs from the exclusion that preserve coverage for derivative and shareholder claims. In recent litigation, courts have addressed whether the 'insured versus insured' exclusion applies to actions in which claims are asserted by both insureds and non-insureds. In these 'mixed' claim situations, courts have found that claims brought by non-insured persons with the assistance or solicitation of insured persons are barred from coverage by the insured versus insured exclusion. In contrast, where a non-insured person is found to have brought a claim without such assistance or solicitation, courts have applied allocation clauses in the D&O policies to extend coverage to claims brought by non-insureds, while excluding coverage for claims brought by insureds.

Other litigated exclusions include what are known as 'conduct' exclusions, which bar coverage for claims arising from a director's or officer's deliberately wrongful or fraudulent acts, or the improper gaining of personal profit. Here, issues may arise regarding whether the alleged conduct has been finally adjudicated so as to trigger the exclusions. Issues can also arise regarding whether or not the director is alleged to have acted beyond his or her capacity as a director. If so, courts will find coverage is excluded. Also frequently litigated is the 'professional services' exclusion. Most D&O policies exclude coverage for claims alleging a failure to provide professional services or a breach of an obligation to provide professional services. Typically, these claims would be covered under an errors and omissions (E&O) policy. At times, however, policyholders may discover a gap, such as a situation in which a claim for professional services is not covered under the policyholder's E&O policy and is excluded under its D&O policy. This has led to disputes over the scope of the professional services exclusion in D&O policies, with outcomes typically being highly fact-driven.

CYBER INSURANCE

Coverage

25 | What type of risks may be covered in cyber insurance policies?

Cyber insurance policies may provide coverage for various types of cyber risks, such as liabilities arising from security breaches or first-party losses arising from network failures. Thus, a cyber policy may offer third-party liability coverage for claims against the insured alleging failure to protect confidential information, which is usually

defined to include information in the insured's custody or control from which an individual may be uniquely and reliably identified or contacted (eg, name, address, telephone number, social security number or health-related information). A cyber policy also may provide first-party coverage for network interruption loss arising from a breach or failure of an insured's computer system, including where the breach or failure results in the receipt of malicious code or other unauthorised access to secure information. The insured's loss is typically measured by the amounts paid to remedy a 'material interruption' plus any net income that the insured would have earned but for the interruption. Further, a cyber policy may provide event management coverage for loss sustained in managing a security failure or privacy breach, as well as cyber extortion coverage for losses incurred in addressing threats to the insured's computer network. Since cyber insurance is a relatively new insurance product, the law regarding the interpretation of cyber insurance policies is not developed. Issues may arise relating to the nature and amount of technological detail that the insured must provide to support a claim under a cyber insurance policy and the calculation of loss arising from a cyber event. Issues may also arise regarding how exclusions such as those based on lightning, wind, water, flood or other natural causes, and the identity of the person or persons causing a network breach (eg, former employees), will impact the coverage that is available.

Litigation

26 | What cyber insurance issues have been litigated?

While not yet widespread, litigation has begun regarding the scope of cyber insurance coverage for data breaches, hacking incidents, accidental loss or disclosure of personal data, network failures and other cyber-related events. To date, decisions that have addressed such claims suggest that courts will apply fundamental insurance principles to the interpretation of cyber insurance policies and will uphold insurers' denials of coverage where policy language supports such a result. For example, a restaurant chain sought coverage under its cyber insurance policy for all costs arising from a data breach in which its customers' credit card information was stolen. The cyber insurer covered the costs of conducting a forensic investigation into the data breach and of defending litigation filed by customers. The insurer denied coverage, however, for nearly US$2 million in fees assessed by the restaurant chain's banks pursuant to contract. An Arizona federal court upheld the insurer's coverage denial. First, the court found the fees fell outside the policy's coverage for 'privacy injury' claims because the banks did not sustain any unauthorised disclosure of private information. The court then found that while the fees potentially constituted 'privacy notification expenses' under the policy, coverage was barred by the policy's definition of loss and a contract exclusion. By way of further example, an electronic data processing and storage company sought a determination from a federal court that its cyber insurer owed a duty to defend a suit by an insured's customer seeking damages for the insured's refusal to turn over electronic billing data. The court denied the policyholder's motion for summary judgment, finding that the underlying action did not trigger the cyber insurer's duty to defend. The court found the complaint did not allege damages arising from an error or omission but, rather, from the policyholder's alleged knowledge, wilfulness and malice. Notably, demonstrating that courts apply fundamental insurance principles when interpreting cyber policies, the court looked to traditional insurance law to preclude consideration of extrinsic evidence in determining the scope of the cyber policy's duty to defend.

A potentially recurring issue in the context of cyber insurance litigation is the extent to which the policyholder has undertaken appropriate measures and procedures to prevent hacking and data breaches. For example, an insurer sought a declaratory judgment that it had no duty to defend and indemnify claims against its insured arising from a data breach in which electronic healthcare patient information was released. The insurer alleged that coverage was precluded by the Failure to Follow Minimum Required Practices exclusion, requiring that the insured continuously implement procedures and risk controls identified in the policy application, or risk losing coverage. The court dismissed the lawsuit based on an alternative dispute resolution agreement. Nonetheless, the complaint suggests a defence upon which cyber insurers may seek to rely as disputes arise.

With respect to general liability policies, policyholders have attempted to obtain coverage for cyber losses pursuant to 'personal and advertising injury' provisions, which typically provide coverage for losses arising out of the publication of material that violates an individual's right to privacy. In some instances, courts have concluded that personal and advertising injury provisions do not encompass cyber-related claims. For example, when a policyholder accidentally lost computer data containing employees' personal information, an insurer's coverage denial was upheld because there had been no 'publication' of the material to third parties. Personal and advertising injury coverage has also been rejected for losses caused by computer hacking. In one instance, a court found that there was no coverage because a hacker, and not the policyholder, had committed the privacy violation. By contrast, a court found that a general liability insurer was required to defend a class action alleging the policyholder's online release of confidential medical records. Because the information was posted on the internet, the court found it constituted publication and, thus, the class members' claims potentially triggered coverage. Numerous courts have addressed whether a 'computer fraud' provision encompasses losses arising out of 'spoofing' or other similar fraudulent activities. In these cases, a key question is whether the underlying computer fraud is sufficiently prominent in causing the losses at issue, particularly where policy language requires the loss to arise 'directly' out of use of a computer. The availability of general liability coverage for hacking incidents and cyber-related losses under other policy provisions will depend on the particular policy language and the nature of the underlying claims. Thus, for example, where a policy limits 'forgery' to include only fraudulent written instruments, courts have denied coverage for claims arising out of hackers' online bank transfers. Similarly, where a policy explicitly states that the 'fraudulent entry' of data is limited to losses caused by unauthorised access into the policyholder's computer system, losses caused by an authorised user's entry of fraudulent information into the computer system may fall outside coverage.

In the first-party property context, parties have litigated whether computer data constitutes physical property, such that lost computer data could be covered property. In addition, litigation has arisen concerning the extent to which computer fraud insurance covers loss incurred as a result of wire transfers initiated by fraudulent emails. Where courts have found a sufficient causal connection between an unauthorised entry into a computer system and the loss-causing wire transfer – for example, an employee's transfer of funds outside the company in response to a fraudulent email – coverage may apply. As with general liability coverage, outcomes in the first-party context vary, and depend largely on applicable policy language and the factual record presented. For example, where a policy includes coverage for 'loss of use', courts may be more inclined to find that expenses associated with lost data are within the scope of coverage. However, a federal court has reiterated the fundamental principle that first-party insurance coverage does not impose a duty to defend or indemnify against legal claims for harm suffered by third parties because of a data breach.

TERRORISM INSURANCE

Availability

27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

The threat of terrorism remains a permanent feature of modern life. While terrorism insurance is available in the United States, it is subject to a number of limitations and the extent to which it may provide coverage in the wake of a terrorist attack remains unclear.

In 2002, following the 9/11 attack in the United States, Congress passed the Terrorism Risk Insurance Act (TRIA), which sought to ensure the continued availability of commercial property and casualty insurance for terrorism risk. Conceived as a temporary programme to allow private markets to stabilise and build insurance capacity to absorb future losses for terrorism events, the TRIA has been extended until 31 December 2020. It requires that insurers make available terrorism risk insurance for commercial property and casualty losses resulting from certified acts of terrorism, and provides for shared public and private compensation for insured losses. The Act also requires insurers to offer coverage for terrorism on the same terms and conditions as non-terrorism-related losses. The TRIA does not regulate premium rates, which remain within the authority of each state insurance regulator.

Under the TRIA programme, the federal government will reimburse insurers for 85 per cent of terrorism-related losses that exceed a certain threshold, subject to a premium-based deductible. The threshold for reimbursement was originally set at US$100 million in aggregate losses. As of 2015, the threshold increases by US$20 million each year, reaching US$200 million by 2020. Notably, the TRIA's backstop is not available unless the Treasury Secretary certifies that the act was 'part of an effort to coerce the civilian population of the US or to influence the policy or affect the conduct of the US Government by coercion'. To date, no act has been so certified, despite several recent incidents having been described as terrorist acts in the press and by law enforcement.

While the TRIA has increased the availability of coverage, there are significant uncertainties and limitations as to its scope. For example, the TRIA does not address coverage for nuclear, chemical, biological or radiological attacks. Because policies have long included nuclear exclusions, insurers are not required to offer coverage for these types of attacks. On the other hand, the Department of Treasury recently clarified that stand-alone cyber liability policies covering acts of cyber terrorism are also backstopped by and must comply with the TRIA. Additionally, the TRIA only applies to losses that occur on US soil, or to US flagged vessels, carriers or US missions, and does not address the lack of available coverage for terrorism-related risks that result in losses outside the United States. Furthermore, as mentioned above, the TRIA only covers loss resulting from terrorism certified by the Treasury Secretary. Other acts or 'non-certified' acts of terrorism are generally excluded. However, owing to the infrequency of certification, some insurers have begun to offer endorsements covering losses resulting from non-certified terrorism.

Exclusions for terrorism-related risks are a recent and evolving innovation, and remain largely untested in the courts.

UPDATE AND TRENDS

Key developments of the past year

28 Are there any emerging trends or hot topics in insurance law in your jurisdiction?

A significant emerging area of insurance litigation in recent months has been first-party property disputes arising out of virus-related business losses. Litigation has largely centered around potential coverage under 'business interruption' and 'civil authority' policy provisions. The first wave of court decisions across various US jurisdictions indicates that policyholders are unlikely to obtain coverage for losses of income that stem from government orders aimed at slowing the spread of covid-19. The majority of courts have concluded that policyholders' business losses were not caused by the requisite 'physical loss of or damage to' covered property. Likewise, courts have typically rejected policyholders' contentions that access was 'prohibited' to insured property, as required by common civil authority coverage policy provisions. Finally, numerous courts have enforced virus exclusions to bar coverage for coronavirus-related losses, dismissing policyholder arguments that such exclusions are ambiguous or inapplicable.

Additionally, data breach incidents, cyberattacks, ransomware incidents and other computer-related activities, which continue to proliferate, have given rise to numerous legal claims by customers, shareholders and first-party insured entities. As such, courts will likely be called upon to address the parameters of first-party property and third-party liability insurance coverage for these claims. As this body of case law develops, courts will continue to apply governing jurisdictional law to decide whether specific coverage and exclusionary provisions encompass particular factual scenarios. Novel coverage questions in future litigation will likely pertain to whether damage to software or other computer components constitutes covered property damage, whether the taking of personal data constitutes a publication sufficient to trigger personal and advertising injury coverage and whether causation has been established between the losses at issue and the computer fraud that initiated the relevant chain of events. Courts may also face matters of first impression relating to the timing and number of losses or occurrences under applicable policy language.

In addition, coverage disputes arising out of climate change events may emerge in the coming months. Natural disasters such as wildfires, storms, earthquakes and floods occur with increasing frequency. As such, future litigation is likely to implicate the scope of first- and third-party coverage for the widespread losses associated with these events. Coverage disputes in this context may involve interpretation of policy provisions relating to causation, particularly when losses are caused by a complex interaction of covered and excluded perils, such as wind, flooding and storm surges. Natural disaster-related coverage disputes may also implicate the scope of coverage for financial losses stemming from a business interruption or the appropriate measure of damages for replacing or rebuilding damaged property, or both.

Finally, coverage disputes have begun to arise out of the opioid epidemic that has plagued cities across the United States. As lawsuits against opiate manufacturers and distributors resolve litigation arising out of the 'opioid crisis,' courts will likely be faced with novel coverage questions relating to whether operative policy provisions encompass specific underlying claims. A small but growing body of case law in this context is developing. One court has already ruled that an insurer had no obligation to defend or indemnify a distributor in a suit filed by government agencies, finding that the underlying claims sought damages for economic loss rather than for covered bodily injury. In another state, a court ruled that an insurer had no coverage obligation because the underlying claims, based on deceptive marketing practices and statutory violations, alleged only excluded intentional activity, rather than

a covered accidental 'occurrence'. However, a few other courts have required insurers to defend opioid litigation, finding that underlying claims seek to impose liability 'because of' bodily injury even where claims are brought by government entities to recover costs of government services rather than affected individuals. Future litigation will likely address similar issues in the duty to indemnify context, as well as the application of specific policy exclusions..

Coronavirus

29 What emergency legislation, relief programmes and other initiatives specific to your practice area has your state implemented to address the pandemic? Have any existing government programmes, laws or regulations been amended to address these concerns? What best practices are advisable for clients?

The coronavirus pandemic and government restrictions on activities of people and businesses aimed at slowing the spread of the virus have resulted in widespread economic losses. Many businesses across the United States have sought first-party coverage for those losses, primarily under 'business interruption' and 'civil authority' policy provisions. While specific language varies somewhat across policies, business interruption coverage typically covers loss of business income sustained during a necessary suspension of operations or period of restoration caused by 'direct physical loss of or damage to' covered property. Although the application of insurance law to covid-19 pandemic-related losses is still developing, the majority of courts that have addressed this issue in recent months have concluded that business losses stemming from government-mandated closures or restrictions of a business do not satisfy the 'direct physical loss of or damage to' requirement typical in first-party insurance policies. While certain courts have deemed allegations of actual virus particles on insured premises to be sufficient to allow a case to proceed to hearing, other courts have rejected this reasoning, noting that virus particles can be eliminated with disinfectant and thus do not establish the requisite physical loss or damage under first party policies. Additionally, policyholders have generally not found success in seeking coverage under civil authority coverage provisions, which typically cover losses sustained by action or order of civil authority that prohibits access to insured property due to direct physical loss of or damage to other, nearby property. Aside from the 'direct physical loss or damage' hurdle, policyholders' civil authority coverage claims have been dismissed by courts in several jurisdictions on the basis that access to insured property was not 'prohibited' or that there is no causal link between any alleged physical damage and the civil authority order, or both. Finally, courts in numerous states have enforced virus exclusions to bar coverage for coronavirus-related claims. In this context, courts have largely rejected policyholder arguments that virus exclusions are ambiguous or inapplicable.

Several legislatures in the United States have actively considered legislation that would retroactively change existing business-interruption and loss-of-use insurance policies to remove contracted-for virus exclusions and potentially require coverage of covid-19-related business income losses. The benefit of such legislation would be conferred on 'small businesses', often defined as those with 100 or fewer employees. The proposals would often provide a mechanism to reimburse insurance companies that are compelled to pay claims that were not covered by the insurance contracts. The reimbursement mechanism would be funded through special assessments on licensed insurers in the state. Insurers believe such legislation would be unconstitutional and thrown out by the courts. No such legislation has been enacted into law to date.

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