The Voice of the Defense Bar

Covered Events

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From the Editor

By Albert Alikin

We know these are strange and trying times—we hope you, your families, and your colleagues are staying safe and healthy as the nation navigates through the eye of the coronavirus storm. Although conferences may have been postponed, DRI and the Insurance Law Committee remain committed to its members and its industry peers in providing the most up to date information and resources regarding our various practices and industries, including legal issues arising out of the COVID-19 pandemic. If you haven't already, please check out DRI's Coronavirus Information Center for more resources: https://www.dri.org/about/coronavirus-resources.

This edition of *Covered Events* is chock-full of legal analysis, insights and practice tips from fellow insurance coverage practitioners across the country. Thank you to all of our contributors and especially to the authors of this month's "Featured Articles." We know there is an insatiable desire for coronavirus information so we are pleased to include a little taste in this edition of what is sure to be much more to follow.

And, as always, if you have interesting insight to share on an issue affecting your particular practice area, please contact me or any of the other *Covered Events* editors. We are always happy to consider your article or case summary for future editions.

Best regards,

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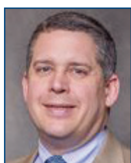
From the SLG Chair: Bad Faith

By Matthew M. Haar



DRI's Bad Faith subcommittee has several upcoming opportunities to meet other bad faith practitioners and to show off your skills. The editors of *Covered Events*, the ILC's e-newsletter, are always looking for case updates, and updates about bad faith issues are always well received. Also, periodically throughout the year we have the opportunity to submit feature articles in *Covered Events*. Please email me at matt.haar@saul.com if you're interested or have questions about these opportunities.

We were all disappointed that the Insurance Coverage and Claims Institute in Chicago in April was cancelled due to COVID-19, but that is all the more reason to plan now to attend Insurance Coverage and Practice Symposium in New York after Thanksgiving. ICPS will include a meeting of the Insurance Law Committee, and hopefully a meeting of the Bad Faith Subcommittee as well. Don't miss these great events and opportunities to connect with other bad faith practitioners.

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Does "Equal Consideration" in Response to Settlement Demands Allow for Reasonable Coverage Defenses?

By Zachariah E. Moura and Eric Retter

Policy limit demands are a favorite tool of plaintiffs' lawyers seeking to "open" an insured's liability policy. An insurer's failure to accept a reasonable policy limit demand when the liability of the insured is clear and the third-party claimant's damages are likely to exceed the policy limits can expose the insurer to the plaintiffs' holy grail: extracontractual or "bad faith" damages, with potential punitive damages as the proverbial cherry on top. Policy limit demands with a fuse, otherwise known as "time-limit demands," can be particularly sharp. The pressure they can put on claims personnel (and coverage counsel) to determine whether liability is, in fact, clear and whether the third-party's injuries are likely to exceed the policy limits can be severe, particularly when a time limit is involved. Yet what happens when both those questions are answered in the affirmative but there is an unresolved coverage question, perhaps because of an early time-limit demand—or simply because of a knotty factual problem?

If the carrier refuses the settlement demand and it turns out that there is no coverage, it will have no liability. But what if the carrier has reasonable grounds to dispute coverage and refuses on that basis but a court later determines that there is coverage for liability to the third-party? The answer is that most lawyerly one: it depends. Jurisdiction will determine the probable result. There is considerable variation on the question but in summary, the majority position is that reasonable coverage disputes do not excuse the carrier from liability for failure to settle, while the minority holds that they do.

Standards for Determining Satisfaction of Insurer's Duty to Its Insureds

The standards courts have imposed on liability insurers in determining whether the insurer has met its duty to its insured can be roughly divided into strict liability, negligence, and bad faith. *See generally*, Schwartz, *Statutory Strict Liability for an Insurer's Failure to Settle: A Balanced Plan for an Unresolved Problem,* 1975 Duke L.J. 901; Annotation, *Liability Insurer's Negligence or Bad Faith in Conducting Defense as Ground of Liability to Insured,* 34 A.L.R. 3d 533 (1970 & Supp. 1989). As explained below, many jurisdictions use the terms negligence and bad faith almost interchangeably in the context of a duty to settle analysis.

In the context of the analysis of third-party policy limit demands, these standards manifest as 1) strict liability and quasi-strict liability; 2) bad faith; and 3) the negligence or "equal consideration" standard.

Strict Liability and Quasi-Strict Liability

A few jurisdictions impose what amounts to strict liability for any refusal to settle within limits that results in an excess judgment. Rhode Island's highest court has held that an "insurer is liable for a judgment that exceeds the policy limits unless the insurer can demonstrate that it made a definite pretrial offer to settle the claim within the policy limits and that the claimant declined the offer." *Skaling v. Aetna Ins. Co.*, 799 A.2d 997, 1005–06 (R.I. 2002). West Virginia and South Carolina impose standards indistinguishable from strict liability. *See Shamblin v Nationwide Mutual Insurance Co.* 183 W. Va. 585 (1990); *Tyger River Pine Co. v. Maryland Cas. Co.*, 170 S.C. 286 (1933).

Under the quasi-strict liability standard, an insurer who fails to settle within policy limits does so at its own risk and although its position may not have been unreasonable, if the denial is later found to be wrongful, it is liable for the full amount which will compensate the insured for any detriment caused by the failure to accept a reasonable settlement offer. *See Crisci v. Security Ins. Co.,* 66 Cal.2d 425 (1967); *Rova Farms Resort, Inc. v. Investors Insurance Co.,* 65 N.J. 474 (1974).

In the context of a policy limit demand, that means that an insurer who does not pay a demand where liability is clear and damages are likely to exceed the policy limits, even where a reasonable dispute as to coverage exists, is going to be held liable for any excess judgment entered against its insured. As California's highest court articulated:

> The only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the

> amount of the settlement offer. Such factors as the limits imposed by the policy, a desire to reduce the amount of future settlements, *or a belief that the policy does not provide coverage*, should not affect a decision as to whether the settlement offer is a reasonable one.

Johansen v. California State Auto. Assn. Inter-Ins. Bureau, 15 Cal. 3d 9, 16 (1975) (emphasis added).

Thus, under the quasi-strict liability standard, "an insurer's 'good faith,' though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer." *Johansen*, 15 Cal.3d at 15–16.

Bad Faith

Under the bad faith standard, an insurer may be liable for a verdict in excess of policy limits when it is determined that the insurance company's conduct amounted to arbitrary, reckless, indifferent, or intentional disregard of its insured's interest. *See Comm. Union Ins. Co. v. Liberty Mut. Ins. Co.,* 426 Mich. 127, 393 N.W.2d 161 (1986); *State Farm Mut. Auto. Ins. Co. v. Floyd,* 235 Va. 136, 366 S.E.2d 93 (1988).

Some jurisdictions also apply a hybrid of the bad faith and negligence standards, which requires the insured to show the absence of a reasonable basis for denying benefits *and* the defendant's knowledge of — or a reckless disregard for — the lack of a reasonable basis for denying the claim. Thus, under this hybrid standard, "[a]n insurer will have committed the tort of bad faith only when it has denied a claim without a reasonable basis for doing so, that is, when the claim is not fairly debatable." *Shamblin*, 183 W.Va. at 592–93.

A few states limit insurers' liability for refusal to settle by requiring a showing of *subjective* culpability. For example, Missouri has held that bad faith requires proof of an insurer's "intentional disregard of the financial interest of [its] insured in the hope of escaping the responsibility imposed upon it by its policy." *Zumwalt v. Utilities Ins. Co.*, 360 Mo. 362, 370, 228 S.W.2d 750, 754 (1950). In Oklahoma, the level of culpability necessary for an insurer to be held liable for breach of the duty of good faith and fair dealing is the less-than-clear "more than simple negligence, but less than the reckless conduct necessary to sanction a punitive damage award," and courts will look to "whether the insurer had a good faith belief in some justifiable reason for the actions it took or omitted to take that are claimed violative of the duty of good faith and fair dealing." *Badillo v. Mid Century Ins. Co.*, 2005 OK 48, 121 P.3d 1080, 1093–94 (Okla. 2005). Thus, an insured in those jurisdictions may not recover upon a showing of mere negligence.

New York imposes an especially demanding standard, requiring that the insured show a "gross disregard of the interests [of the insureds] … in that there was a deliberate or reckless decision to disregard the interests of [the] insureds." *Pavia v. State Farm Mu. Auto. Ins. Co.,* 82 N.Y.2d 445, 455 (1993). The New York courts appear to have foreseen the proliferation of "set-up" time-limit demands:

> Permitting an injured plaintiff's chosen timetable for settlement to govern the bad faith inquiry would promote the customary manufacturing of bad faith claims.… Indeed, insurers would be bombarded with settlement offers imposing arbitrary deadlines and would be encouraged to prematurely settle their insureds' claims at the earliest possible opportunity in contravention of their contractual right and obligation of thorough investigation.

Pavia, 82 N.Y.2d at 455.

Under this standard, an insurer need only demonstrate that the coverage dispute was reasonable, and not in "gross disregard" of the insured's interests.

Negligence, or the "Equal Consideration" Standard

A minority of jurisdictions apply a negligence standard in determining whether an insurer will be exposed to extracontractual liability for failing to settle a demand within policy limits. The standard used in many jurisdictions is whether the insurer gave the insured's interests the same consideration it gives its own interests when faced with a demand for settlement within policy limits. *Rider v. State Farm Mut. Auto. Ins. Co.*, 514 F.2d 780, 785 (10th Cir. 1975) (Kansas law); *City of Glendale v. Farmers Ins. Exch.,* 126 Ariz. 118, 120 (1980); *Truck Ins. Exchange v. Bishara*, 128 Idaho 550, 554 (1996); *Long v. McAllister*, 319 N.W.2d 256, 262 (Iowa 1982); *Short v. Dairyland Ins. Co.*, 334 N.W.2d 384, 387 (Minn. 1983); *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255 (Miss. 1988). This standard can also be a factor in determining bad faith. *See, e.g. Comm. Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 917 (1980). For further discussion of the standard, *see also* 3 New Appleman on Insurance Law Library Edition §23.02 (2019).

The negligence standard generally involves an analysis of whether the insurer's breach of its duty of good faith and fair dealing with its insured is one which was reasonable under the circumstances. In other words, whether the facts show the absence of any reasonable basis for settling

the claim within policy limits. *See Farmers Group, Inc. v. Trimble,* 691 P.2d 1138, 1142 (1984) (en banc).

For example, Georgia requires that when "deciding whether to settle a claim within the policy limits, the insurance company must give equal consideration to the interests of its insured." *See Trimble*, 691 P.2d at 1142.

Similarly, in Arizona, "[m]ere mistake and inadvertence are not sufficient to establish a claim for bad faith." *Rawlings v. Apodaca*, 151 Ariz. 149, 157, 726 P.2d 565, 573 (Ariz. 1986).

It is generally a jury question as to whether the insurer, "in view of the existing circumstances, has accorded the insured 'the same faithful consideration it gives its own interest.'" *Piedmont Office Realty Tr., Inc. v. XL Specialty Ins. Co.*, 297 Ga. 38, 42, 771 S.E.2d 864, 867 (2015). The "equal consideration" standard has been criticized for its lack of guidance (a decision to settle prefers the insured's interest and a decision not to settle prefers the insurer's interest), but is still applied by several courts.

As the Georgia Supreme Court explained:

> Judged by the standard of the ordinarily prudent insurer, the insurer is negligent in failing to settle if the ordinarily prudent insurer would consider choosing to try the case created an unreasonable risk. The rationale is that the interests of the insurer and insured diverge when a plaintiff offers to settle a claim for the limits of the insurance policy. The insured is interested in protecting itself against an excess judgment; the insurer has less incentive to settle because litigation may result in a verdict below the policy limits or a defense verdict.

Cotton States Mut. Ins. Co. v. Brightman, 276 Ga. 683, 684–84, 580 S.E.2d 519, 521 (Ga. 2003).

Similarly, Kansas employs a negligence standard for extracontractual damages, and something more than "mere error of judgment" is needed to establish bad faith. *Bollinger v. Nuss*, 202 Kan. 326, 341, 449 P.2d 502, 514 (Kan. 1969). An insurer "cannot be required to predict with exactitude the results of a trial; nor does the company act in bad faith where it honestly believes, and has cause to believe, that any probable liability will be less than policy limits." *Bollinger*, 202 Kan. at 341. It can be confusing that some jurisdictions, like Kansas, use "negligence" and "bad faith" almost interchangeably in the failure-to-settle context. As the Kansas Supreme Court has explained, "[w] hile the terms 'negligence' and 'bad faith' are not synonymous or interchangeable in a strict legal sense, they share common hues in the insurer's spectrum of duty, and the distinction between the tests is less marked than the terms would suggest." *Id.*

Whether the jurisdiction follows the "equal consideration" or the negligence test (or both), it will often employ a disregard-the-limits analysis, determining that with respect to the decision whether to settle or try the case, the insurer, acting through its representatives, must use such care as would have been used by an ordinarily prudent insurer with no policy limit applicable to the claim. *See, e.g., Clearwater v. State Farm Mut. Auto. Ins. Co.*, 164 Ariz. 256, 259 (1990); *Kooyman v. Farm Bureau Mut. Ins. Co.*, 315 N.W.2d 30, 34 (Iowa 1982), *but see Loudon v. State Farm Mut. Auto. Ins. Co.*, 360 N.W.2d 575 (Iowa Ct. App. 1984) (insurer that disregards the limits must nevertheless consider the insured's financial condition and the potential impact of an excess judgment when responding to a policy limits settlement offer); *Badillo*, 121 P.3d at 1080; *Goddard v. Farmers Ins. Co.*, 173 Or. App. 633, 642, *rev. denied*, 332 Or. 631 (2001); *Cowden v. Aetna Cas. & Sur. Co.*, 389 Pa. 459, 470 (1957).

Application to Coverage Questions

While "duty to settle" jurisprudence developed primarily in the context of whether liability is clear and damages are likely to exceed policy limits, jurisdictions are increasingly extending the defense of failure to settle policy demands to cases where there are reasonable questions of coverage. This does not include strict liability/quasi-strict liability jurisdictions, in which a reasonable dispute as to coverage will not alleviate an insurer's liability for an excess judgment awarded against its insured if it is later determined that the third-party claim was covered.

Unlike Georgia courts, where no explicit decision has extended the analysis regarding an insurer's rights and duties when faced with a time-limited demand to settle within its coverage limits to cases where there are *coverage* questions, as opposed to *liability* questions, courts in states including Kansas (*Assoc. Wholesale Grocers v. Americold Corp.*, 261 Kan. 806, 846, 934 P.2d 65, 90 (Kan. 1997)), Florida (*Robinson v. State Farm Fire & Cas. Co.*, 583 So.2d 1063, 1068 (Fla. 5th Dist. Ct. App. 1991)), Illinois (*Stevenson v. State Farm Fire & Cas. Co.*, 257 Ill. App. 3d 179, 184 (1993)), and Wisconsin (*Mowry v. Badger State Mut. Cas. Co.*, 129 Wisc.2d 496, 385 N.W.2d 171 (Wis. 1986)) have explicitly extended the rule to include coverage questions.

The Kansas case of *Snodgrass v. State Farm Mut. Auto. Ins. Co.* is instructive. In *Snodgrass*, the carrier declined to defend its insured because it believed that the vehicle the

insured was driving did not qualify for coverage under the "newly acquired automobile" or "non-owned automobile" provisions of the automobile policy. After the third-party plaintiff's offer to settle within policy limits during trial was rejected, the insured incurred a judgment in excess of the policy limits and he brought suit against his insurer for the excess judgment. *Snodgrass v. State Farm Mut. Auto. Ins. Co.,* 15 Kan. App.2d 153, 157, 164 (Kan. Ct. App. 1991). A jury returned a verdict for the insured, finding coverage and that the insurer acted negligently or in bad faith in refusing to settle within the policy limits.

The Court of Appeals reversed. It found that while there was "substantial competent evidence to support a finding" that the vehicle was a "newly acquired automobile" covered by the policy (*Snodgrass*, 15 Kan. App.2d at 163), the insurer "had a good faith argument that its policy did not provide coverage" for the vehicle and the insurer "should not be held liable for failing to 'prophesy the result.'" *Id.* at 168. The Kansas Supreme Court approved that rule in a subsequent case, holding that "an insurance company should not be required to settle a claim when there is a good faith question as to whether there is coverage under its insurance policy." *Americold*, 261 Kan. at 846.

In Wisconsin, the Supreme Court has held that:

> [I]t is not bad faith for an insurer to refuse to settle an insured's claim within the policy limits when the question of policy coverage is fairly debatable [even when the insured's liability for the incident is undisputed and when the victim's damages appear to exceed policy limits] and when the grounds for the refusal, if determined in the insurer's favor, would wholly defeat the indemnity responsibility of the insurer to its insured.... Bad faith should be found in [such a] case only if there was no fairly debatable coverage question.

Mowry, 129 Wis. 2d at 516–17.

A number of other courts agree with this position. *Martin v. Travelers Indem. Co.,* 450 F.2d 542, 552 (5th Cir. 1971) (Applying MS law) ("[I]t is one thing to impose upon the insurer the obligation to prosecute the insured's defense with reasonable diligence, and quite another thing to require the insurer to settle a claim at a cost of many thousands of dollars before the insurer has had a full opportunity to litigate a serious question of coverage."); *Cay Divers, Inc. v. Raven*, 812 F.2d 866, 871 (3d Cir. 1987); *Stevenson,* 257 Ill. App. 3d at 184; *Nat'l Serv. Fire Ins. Co. v. Williams*, 61 Tenn. App. 362, 369–70 (1969) (insurer acted under the "reasonable and bona fide belief" that insured was not an additional insured under the policy without being guilty of bad faith), *accord St. Paul Fire & Marine Ins. Co. v. Gothard*, 532 S.W.2d 271, 274 (Tenn. 1976).

In some other jurisdictions, such as Florida, the "insurer's diligence and thoroughness in investigating the facts specifically pertinent to coverage" is just one factor that courts should weigh in determining whether the insurer should be exposed to extracontractual damages. *Robinson,* 583 So.2d at 1068. Additional factors in determining whether an insurer should be exposed to extracontractual liability after denying a claim for wrongly disputing coverage include whether the insurer was able to obtain a reservation of the right to deny coverage if a defense were provided; efforts or measures taken by the insurer to resolve the coverage dispute promptly or in such a way as to limit any potential prejudice to the insureds; the substance of the coverage dispute or the weight of legal authority on the coverage issue; the insurer's diligence and thoroughness in investigating the facts specifically pertinent to coverage; and efforts made by the insurer to settle the liability claim in the face of the coverage dispute. *Id.*

Conclusion

As the above discussion demonstrates, determining whether a third-party policy limit demand involves clear liability of the insured and damages likely to exceed policy limits is not always the end of the analysis in evaluating a response. Depending on the jurisdiction, questions of coverage can still be an important factor in that analysis. Insurers and coverage counsel will need to stay abreast of the developing law in their respective states regarding the impact of reasonable coverage disputes on responses to policy limit demands.

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Perspective from a Corporate Policyholder's Counsel

Why New Insurance Claims—Such as COVID-19 Claims—Lead to Problems for Policyholders, Defense Counsel, and Insurance Companies

By William G. Passannante

The recent spread of the novel coronavirus (SARS-CoV-2), which causes coronavirus disease known as COVID-19, has and will cause disruption to businesses and communities and take a significant human toll.

The problems highlighted by the spread of SARS-CoV-2 provide a model to illustrate difficulties in the defense of liability claims and insurance issues in the context of new types of losses. Policyholders who have claims made against them and submit mundane insurance claims often end up meeting frustration in a process foreign to them. By contrast, trusted experienced defense counsel address complex claims every day, as do insurance companies, and their experience shows. Policyholders seldom make significant insurance claims, and thus have less experience related to new claims and liabilities.

As a lawyer for corporate policyholders, I can attest that the average purchaser of business insurance understands that the primary purpose of insurance is *to insure against losses*. Appleman, *Insurance Law and Practice* §7001 (1981); *Newmont Mines Ltd. v. Hanover Ins. Co.*, 784 F.2d 127, 135–36 (2d Cir. 1986) ("[T]he meaning of particular language found in insurance policies should be examined in light of the business purposes sought to be achieved…"). Indeed, most policyholders would say that purpose—to insure—meets their "*reasonable expectations.*" Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 Harv. L. Rev. 961, 967 (1970).

A new type of liability and new insurance claim accentuates the disparity in experience among defense counsel, claims professionals, and insurance policyholders. Misunderstandings and disputes in the context of an unusual insurance claim such as one related to COVID-19 will increase risk and costs associated with such losses. Experienced and trusted defense counsel, insurance claims personnel, and coverage professionals have more to offer their clients and customers on account of the heightened uncertainty involved in the unusual circumstances related to possible COVID-19 losses. The uniqueness of the liability, the losses, and the damages introduce exceptional uncertainty into the claims process. That uncertainty leads to problems for policyholders, defense counsel, and insurance companies.

Below, this article describes such problems in the context of possible COVID-19 losses related to: (1) D&O and securities claims; (2) business interruption and business income losses; and (3) the impact on claims handling. The article concludes with some suggestions related to unusual claims.

New Liability for Mistakes Made by Directors and Officers and Securities Claims

Suppose that management or the board of directors is alleged to have made a misstep in preparing for, disclosing the impact of, or responding to the COVID-19 event?

Classic D&O liability claims can be asserted by: securities holders, competitors, customers, vendors, and business partners. Securities claims have the highest average severity. Such claims ordinarily are covered by D&O liability insurance, usually with independent defense counsel paid for by the insurance company providing payment for a defense to the company and possibly to individual officer and director insureds.

The U.S. Securities and Exchange Commission ("SEC") has permitted an extension of time to meet reporting obligations relating to COVID-19, subject to conditions, which could give rise to future claims.

The SEC issued an Order permitting issuers subject to reporting requirements under the Securities Exchange Act of 1934 additional time in meeting certain of their obligations under federal securities laws. The Order provided extra time to meet reporting obligations by extending the time period from March 1, 2020 to April 30, 2020. SEC Release No. 34-88318 (March 4, 2020) (available at https://www.sec.gov/rules/other/2020/34-88318.pdf). The SEC Order contains several conditions including a direction to include "if appropriate, a risk factor explaining, if material, the impact of COVID-19 on its business." The SEC Order also notes that, the "Commission believes such statements, as furnished, to the extent they contain 'forward-looking

statements,' would be subject to the safe harbor under Exchange Act, Section 21E. *See* Private Securities Litigation Reform Act of 1995, 15 U.S.C. §77z-1 (1998)."

That Order was modified and superseded by an SEC Order dated March 25, 2020 (Available at https://www.sec.gov/rules/exorders/2020/34-88465.pdf), which extended the period of relief to July 1, 2020. In the SEC's March 25, 2020 press release (Available at https://www.sec.gov/corpfin/coronavirus-covid-19), the Commission states a number of questions regarding the effects of COVID-19 for companies to consider. The release questions the: (1) impact on financial condition and operations; (2) impact on capital and financial resources; (3) effect on assets on the balance sheet; (4) material impairment or changes in accounting judgment regarding certain assets; (5) impact on demand for the issuer's product or services, among others. The release states, that in sum, "each company will need to carefully assess COVID-19's impact and related material disclosure obligations."

The Commission's release also includes a fundamental reminder to avoid trading prior to the dissemination of material non-public information, referencing Fair Disclosure regulations. Regulation FD 17 CFR 243.100, *et seq.* The release states, "where a company has become aware of a risk related to COVID-19 that would be material to investors, the company, its directors and officers, and other corporate insiders who are aware of these matters should refrain from trading in the company's securities until such information is disclosed to the public."

Accurately disclosing the "impact of COVID-19 on its business" is a significant undertaking for an issuer, and one that might be second-guessed after-the-fact by the plaintiffs' securities bar. As the outbreak has developed rapidly, assessing the likely impact on current and future operations is difficult. The current increased pricing volatility in the financial markets means that disclosures may well have a more significant impact on share price. Such volatility in relation to disclosures is the recipe for allegations in a classic securities "stock drop" case. Given the backdrop of increased D&O liability exposure from the opinion in *Cyan, Inc. v. Beaver County Employees Retirement Fund* (138 S. Ct. 1061 (2018)), which upheld plaintiffs' right to bring certain securities class actions in state courts, it is not outrageous to forecast increased liability exposure on account of the impact of COVID-19. Some commentators have described how and when COVID-19 may require disclosures by an issuer. Adele Hogan, *When Coronavirus May Trigger SEC Disclosure Requirements,* Law360 (Feb. 25, 2020, 4:48 PM EST) (available at https://www.law360.com/articles/1245738/when-coronavirus-may-trigger-sec-disclosure-requirements).

"Custom and Usage" Is Less Customary in New Claims

If they happen, such unusual securities claims will lead to similarly new types of insurance claims seeking defense and payment for settlements and judgments. As part of that defense process, experienced defense counsel will assess the matter, determine reasonable defense strategies, and evaluate timing of litigation or a settlement. In the context of an unusual claim those actions are more difficult. The first D&O liability insurance claim related to COVID-19 will be un precedented, and thus more fraught. For example, new claims do not have the same body of "custom and usage" in the industry, and such custom and usage may be admissible to give meaning to terms. *National Union Fire Ins. Co. v. Continental Illinois Corp.,* 658 F. Supp. 781 (N.D. Ill. 1987); *Carey-Canada, Inc. v. California Union Ins. Co.,* 118 F.R.D. 242, 244 (D.D.C. 1986) (drafting history documents and interpretive materials relevant). Without such a broad body of prior usage with regard to the specifics of a novel claim, additional areas of disagreement are more likely to emerge.

Indeed, central issues regarding insurance coverage potentially impacting COVID-19 already are the subject of debate, such as, Randy Maniloff, *Coronavirus and CGL Coverage: Is it an "Occurrence"?*. Available at https://www.coverageopinions.info/Vol9Issue2/CGLCoverage.html. The Maniloff article contrasts the treatment of "occurrence" and "accident" in *Liberty Mut. Ins. Co. v. Estate of Bobzien* (377 F. Supp. 3d 723 (W.D. Ky. 2019) (intentional exposure to second-hand smoke not an "accident")) *with Campanella v. Northern Properties Group, LLC* (No. 19-cv-171, 2020 U.S. Dist. LEXIS 34454 (D. Minn. Feb. 28, 2020) (disease caused by exposure to chicken feces was an accident)).

Commentators will spill more ink on these coverage topics.

Unusual Insurance Losses Caused by Business Income Disruption

Most property insurance policies, often based upon the ISO Standard Property Insurance policy, contain business interruption or business income insurance. The purpose of such insurance is to pay the policyholder loss arising from the inability to continue its normal operations, and to place the policyholder – from an earnings standpoint – into the position it would have occupied but for the loss-causing event. *Pennbarr Corp. v. Insurance Co. of North America,*

976 F.2d 145 (3d Cir. 1992); *Keetch v. Mutual of Enumclaw Ins. Co.*, 831 P.2d 784 (Wash. Ct. App.1992).

One common type of coverage contained in property insurance policy forms is Civil Authority coverage. In *Sloan v Phoenix of Hartford Insurance Co.* (207 N.W.2d 434, 435–36 (Mich. Ct. App. 1973)), the policy contained the following clauses:

> This policy covers against loss resulting directly from necessary interruption of business caused by damage to or destruction of real or personal property by peril(s) insured against during the term of this policy, on premises occupied by the insured and situated as herein described....
>
> *Interruption by Civil Authority.* This policy is extended to include the actual loss as covered hereunder, during the period of time, not exceeding 2 consecutive weeks, when as a direct result of the peril(s) insured against, access to the premises described is prohibited by order of civil authority.

The court affirmed a determination of civil authority coverage relating to a government curfew. If access to your premises is prevented by an order of civil authority on account of COVID-19, business income coverage may be implicated.

Similarly, many current property programs include Civil Authority coverage and do not exclude loss caused by bacteria, viruses ,or communicable diseases. Indeed, some policies explicitly define such events as a peril insured under the policy. Thus, in the context of the COVID-19 event a closure under an "order of civil authority" should trigger the business income coverage under many property programs.

Insurance companies might argue the "physical loss or damage" under a property policy does not include the COVID-19 event. *Phoenix Ins. Co. v. Infogroup, Inc.*, 147 F. Supp. 3d 815, 826 (S.D. Iowa 2015) (holding that material questions of fact existed regarding cross-motions related to damage to premises). The court looked to dictionary definitions of "physical loss" since the insurance policy left the term undefined:

> The dictionary defines "physical" as "having material existence: perceptible especially through the senses and subject to the laws of nature." MERRIAM–WEBSTER, available at http://www.merriam-webster.com/dictionary/physical. The common usage of physical in the context of a loss therefore means the loss of something material or perceptible on some level.

Phoenix Ins., 147 F. Supp. 3d at 823.

Another case, *Murray v. State Farm Fire and Cas. Co.* (509 S.E.2d 1 (W. Va.1998)), supports the proposition that loss of use of premises constitutes physical loss or damage. In *Murray*, government employees required owners to leave their homes due to the possibility of falling rock, and found that loss of use sufficient to trigger coverage. *Id. See also, Customized Distribution Servs. v. Zurich Ins. Co.*, 862 A.2d 560 (N.J. Super. Ct. App. Div. 2004) (customers' change in perception of a product constituted physical loss or damage); *Manpower Inc. v. Ins. Co. of Penn.,* No. 08C0085, 2009 U.S. Dist. LEXIS 108626 (E.D. Wis. Nov. 3, 2009) (inaccessibility of personal property constituted a physical loss). *Western Fire Ins. Co. v. First Presbyterian Church*, 437 P.2d 52 (Colo. 1968); *Advance Cable Co. v. Cincinnati Ins. Co.*, No. 13-cv-229-wmc, 2014 U.S. Dist. LEXIS 32949 (W.D. Wis. Mar. 12, 2014), *aff'd*, 788 F.3d 743 (7th Cir. 2015) (cosmetic hail damage to roof covered); *Pepsico, Inc. v. Winterthur Int'l Am. Ins. Co.,* 24 A.D.3d 743 (2d Dep't 2005) (unmerchantable "off-tasting" beverage covered).

The argument that the coverage is triggered is even more straightforward under policies that explicitly include bacteria, viruses, and communicable disease as a covered peril. Or, under policies which exclude bacteria and fungus, but not viruses—as SARS-CoV-2 is a virus.

Further, note that other coverage under a property insurance program may be available, possibly not subject to the insurance company argument regarding "direct physical loss or damage." Check for coverage clauses for: (1) communicable disease coverage; (2) contingent business income coverage; (3) contingent extra expense coverage; and (4) ingress and egress coverage. These and similar provisions may provide coverage for events that interfere with suppliers or customers, or prevent or hinder access to premises.

Impact on Claims Handling and Settlement of Novel Claims

Uncertainty in unusual claims possibly leads to uncertainty in defense, claims handling and settlement posture by all involved. The "unknowns" surrounding COVID-19 will cause greater uncertainty in defense and claim evaluation. Maintaining a stance consistent with the insurance companies' duty of good faith and fair dealing becomes more difficult with increased uncertainty. Most states' laws support that a duty of good faith and fair dealing is implied in an insurance policy. *E.g., Rowe v. Nationwide Ins. Co.*, 6 F. Supp. 3d 621 (W.D. Pa. 2014). Similarly defense counsel, who ordinarily assess an overall defense to provide protection to the policyholder – and by extension to the insurance company

– are left in a more difficult position with the unusual claim. Without the reliable body of historical data, history and experience associated with the more mundane types of claim, the task of developing a strategy to resolve liability and losses related to COVID-19 will be more complex.

Experienced defense counsel will develop those strategies, but the uncertainty associated with them will be significant. Should we fight the COVID-19 liability claim or not? Should we adopt an administrative claims processing approach? Should we fight liability at perhaps significant cost and risk? Unusual claims render all these questions fraught with additional uncertainty.

At the policyholder and insurance company level the impact of that uncertainty increases. Should the policyholder aggressively contest all claims against it? Is it in their interest to do so? Should claims be resolved? Defense counsel guides the policyholder on difficult defense questions, and then the claims professionals must fit that defense appraisal and tactical decision-making into its claims program. The uncertainty at various levels in unusual claims sometimes leads to sub-optimal decision-making. Policyholders may argue that the claims decision-making was so incorrect that it amounts to bad faith because of malicious or dishonest conduct to avoid an obligation to the policyholder. *Employers Equitable Life Ins. Co. v. Williams*, 665 S.W.2d 873 (Ark. 1984).

One regularly recurring problem is the need to resolve claims quickly – perhaps driven by plaintiffs' or trial court deadlines—leaving little time for dispassionate consideration. Yet, courts have held that the good faith duty reasonably and fairly to settle includes a duty to act promptly. *See Hayes Bros., Inc. v. Economy Fire & Cas. Co.,* 634 F.2d 1119, 1122–24 (8th Cir. 1980). Further, disagreements about agreeing to a settlement or not can lead to disputes regarding the duty to settle claims. "By refusing to settle within the policy limits, an insurer risks being charged with bad faith on the premise that it has 'advanced its own interests by compromising those of its insured.'" *Pavia v. State Farm Mut. Auto. Ins. Co.*, 82 N.Y.2d 445, 452 (1993); *see also, New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co.*, 295 F.3d 232 (2d Cir. 2002), *vacated by, remanded by and in part*, 352 F.3d 599 (2d Cir. 2003).

The assertion of these arguments in a context of mundane claims is difficult. In the context of possible and unusual COVID-19 claims, the arguments take on additional substantial variation and bite.

Suggestions Regarding New Claims

Suggestions regarding unusual losses or claims may serve as the beginning of an insurance checklist in the event of a COVID-19 loss. Things to consider include: giving notice, consulting trusted defense counsel, keeping track of limitations periods, keeping written records, possibly enlisting help, and considering the availability of other insurance.

Give Notice

If you have a claim or loss, give notice and comply with time limits. Usually, your insurance broker should give notice under the potentially implicated policies. The broker should send you a copy of the notice letter.

Consult Trusted Defense Counsel

In the event of significant loss or potential claims related to COVID-19, consult experienced trusted defense counsel. Preparation in the face of possible significant losses is always worthwhile. Let your insurance company know the identity of selected trusted defense counsel.

Beware of Time Limitations

Property and business interruption losses often take time to resolve. Extend by written agreement limits on time to provide "proof of loss" or to make repairs.

Keep a Diary

The lawyers' adage that, "If it's not in writing, it did not happen," is a guide. Document loss-related items and emergency expenses related to the COVID-19 event. Keeping complete and accurate records is helpful to ensure proper payment. Consider video and photographs to document losses.

If You Have a Claim, Consider Help

Accounting firms, adjusters, and brokers often have groups that specialize in property and business income insurance accounting. The insurance company might hire its own adjuster, and one or more accounting firms or law firms. Getting your proper insurance recovery requires preparation. Be prepared – more than the other side.

Consider Other Insurance

COVID-19 may cause far-reaching effects and implicate various relationships and lines of insurance. Consider providing notice of an "occurrence" or of "circumstances"

under certain liability insurance policies. Vendor agreements may contain applicable indemnity provisions. Also, determine the availability of "additional insured" status under the insurance policies of others.

Consult with your insurance broker or risk manager regarding the implications on insurance renewals of the COVID-19 events.

Conclusion

The impact of COVID-19 and the disruption it causes will continue its human toll.

The spread of COVID-19 also illustrates potential difficulties in defense of liability claims and insurance issues in the context of new types of losses. Above we described such problems in the context of possible COVID-19 losses related to: D&O and securities claims; business interruption and business income losses; impact on claims handling; and suggestions related to unusual claims.

Defense counsel together with their policyholder clients and insurance professionals on all sides of the COVID-19 issue can be a force to help solve serious liability issues.

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Gables: Do the AIA's Standard Construction Contract Forms Really Waive

By Alex J. Brown

In March of 2014, a catastrophic fire destroyed a four-story apartment complex that was under construction and just weeks away from completion. The fire insurer covering the construction project paid the property owner more than $17 million in fire insurance proceeds. That should have been the end of the story, but it is just the beginning.

The fire insurer stepped into the owner's shoes and filed a subrogation action against one of the service providers at the construction site, a security company that was providing "fire watch." The security company settled the owner/fire insurer's subrogation claim for $14 million, and then successfully sued the general contractor for contribution of half that amount ($7 million) under Maryland's version of the Uniform Contribution Among Tortfeasors Act ("UCATA"). On appeal, Maryland's intermediate appellate court affirmed (but reduced the award on grounds not pertinent here). *Gables Construction, Inc., v. Red Coats, Inc.*, 241 Md. App. 1 (2019), *cert. granted*, 464 Md. 25 (2019). The general contractor appealed again, presenting an issue of first impression that will soon be decided by Maryland's highest court, and which is likely to have an impact around the country. *Id.*

In *Gables*, the Maryland high court will decide whether the waiver of subrogation claim provisions ("WOS Provisions") contained in the general contractor's construction contract with the property owner ("Prime Contract"), and which are based on the widely used American Institute of Architects ("AIA") construction contract forms, operate to waive the security company's statutory contribution claim against the general contractor under Maryland's Uniform Contribution Among Tortfeasors Act ("UCATA"), a uniform statute that has been adopted in many States. Although the security company was not a party to the Prime Contract, the general contractor argues that the security company is asserting its UCATA claim while "standing in the shoes" of the property owner who agreed to the WOS Provisions, such that the security company is bound by the property owner's waivers of claims in the Prime Contract.

The issue does not simply turn on a comparison of the contractual language of the AIA forms to the statutory language of UCATA. Subrogation claims are, at least in Maryland, purely equitable claims. The waiver at issue in the *Gables* case, and in similar cases, is thus a purported *contractual* waiver of a *statutory* contribution claim that

is also alleged to simultaneously be a purely *equitable* subrogation claim.

Courts around the country have struggled to weigh and integrate the language and policy considerations implicated by the convergence of these statutory, contractual and equitable issues. This article is intended to identify and highlight the conflicting resolutions of this issue by courts around the country, and to alert insurers—as well as property developers, general contractors, subcontractors, and other construction industry service providers—of the complex issues and risks arising from the assertion of contribution/subrogation claims under UCATA in connection with construction projects that utilize AIA forms.

Underlying Facts in *Gables*

The *Gables* Prime Contract was based on the AIA's A102™-2007 Standard Form of Agreement Between Owner and Contractor, which incorporated a second AIA form, the A201™-2007, General Conditions of the Contract for Construction.

The general contractor agreed in the Prime Contract (per the standard AIA forms) to be "fully and solely responsible for the jobsite safety." The contractor further agreed to "comply with all applicable laws, statutes, ordinances, codes, rules and regulations . . . applicable to performance of the Work. . ." Notwithstanding these contractual and statutory commitments, the general contractor failed to even create a fire safety program for the work site.

The general contractor argued that it was relying on the security company to create and implement a fire safety program because the security company had a contractual obligation to perform "fire watch." In response, the security company argued that the general contractor's contractual and statutory responsibilities for safety at the site were non-delegable.

The March 2014 fire was caused by multiple open-flame propane heaters that had been left burning in the fourth floor hallway of the apartment complex overnight. To make matters worse, a stack of wood trim was left in the hallway, just inches from one of the open-flame heaters.

The general contractor's site supervisor left early that day, while subcontractor painters were still painting and the open-flame heaters were in use. The parties disputed whether the security company was required to conduct internal walkthroughs of the complex as part of its "fire watch" duties during overnight rounds.

It was undisputed, however, that the general contractor never told the security company that the heaters were in use or had been left running on the fourth floor. Neither the painters nor the security company was trained in the use of the heaters supplied by the general contractor, and the heating manufacturer's instruction manual was not kept at the site. It is fortunate that the security guard on duty that night did not, in fact, conduct internal walkthroughs of the building and stumble upon the open-flame heaters. That is because the non-conforming use constituted multiple violations of the heater manufacturer's instructions, which warned of "Death; Serious bodily injury or burns … [or] Asphyxiation due to lack of adequate air supply or carbon monoxide poisoning."

On pre-trial motion, the trial court found that the general contractor committed numerous violations of construction industry fire protection standards, published by the National Fire Protection Association, that have been incorporated into Maryland State and local county fire safety law. The trial court similarly found that the security company breached its duties of care in performing "fire watch" as a matter of law.

Rulings of the Trial Court and Intermediate Appellate Court

The *Gables* jury considered, and rejected, the general contractor's affirmative defense that the WOS Provisions in its Prime Contract operated to waive the security company's contribution/subrogation claim. The trial court entered a $7 million judgment in the security company's favor. On appeal, Maryland's intermediate appellate court also rejected the general contractor's attempt to rely on the Prime Contract's WOS Provisions. *Gables Constr.*, 241 Md. App., at 34 ("[the general contractor], in error, argues that the waiver of subrogation in the Prime Contract limits the amount it must contribute to [the security company]").

Gables Presents Complex Questions of First Impression for Maryland's High Court

In briefing and argument at Maryland's high court, the general contractor and the security company did not simply make contrary arguments, but as described below, the parties attacked these issues from fundamentally different perspectives. Predictably, both sides characterized the split of authority among state courts that have considered these issues to favor their respective positions. Due to the complexity of the issues presented and the nationwide

significance of the case, the AIA was permitted to file an *amicus* brief.

The General Contractor Argues that It Cannot Be a "Joint Tortfeasor" Under UCATA, Because the General Contractor Was Never "Liable in Tort" to the Property Owner, Given the Property Owner's Waivers of All Claims Against the General Contractor Under the Prime Contract's WOS Provisions

The general contractor argues that it cannot be required to provide contribution to the security company because only "joint tortfeasors" are obligated to provide contribution under Maryland's UCATA, and the contractor is not a "joint tortfeasor" as that term is defined in the statute. Maryland's UCATA defines a "joint tortfeasor" as a person who is "jointly or severally liable in tort" with another for the same injury to property. Md. Code Ann., Cts. & Jud. Proc. §3-1401(c). According to the general contractor, the security company was standing in the property owner's shoes in asserting its contribution/subrogation claim, and the contractor cannot be jointly "liable in tort" to the property owner because the AIA's WOS Provisions in the Prime Contract fully waived all of the property owner's claims against the general contractor. The general contractor interprets the term "liable in tort," as used in UCATA, to require that a party have present legal responsibility in order to qualify as a "joint tortfeasor." *Montgomery County v. Valk Mfg. Co.*, 317 Md. 185, at 191–92, 199–200.

In support of its proposed interpretation, the general contractor cites to cases from around the country for the proposition that a person cannot be a joint tortfeasor based on "mere culpability" for the commonly caused injury, but rather, "joint tortfeasors" must have present legal liability to the injured party. *See e.g., Morgan v. Moug*, 2008 WL 1733623, *7 (W.D.N.C. Apr. 10, 2008); *Cherry Hill Manor Associates v. Paul Faugno, Esq.*, *et al.*, 182 N.J. 64, 72–73 (2004); *Fujistu Microelectronics, Inc. v. Lam Research Corp.*, 174 Or. App. 513, 516 (2001); *Universal Gym Equip., Inc. v. Vic Tanny Intern., Inc.*, 207 Mich. App. 364, 370 (1994); *Velazquez v. Day & Zimmerman, Inc.*, 884 F.2d 492, 497 (9th Cir. (HI) 1989); *Ianire v. Univ. of Delaware*, 255 A.2d 687, 689 (Del. Super. Ct. 1969); *Koenigs v. Travis*, 246 Minn. 466 (1956). Even though the jury found the general contractor to have jointly caused the property owner's injuries, the contractor argues that its "mere culpability" for causing the harm was insufficient to create joint tortfeasor status in the absence of any present legal possibility of liability to the property owner—and this theoretical liability had been eliminated prior to the fire by the WOS Provisions.

The general contractor also maintains that, as a matter of public policy, a holding in its favor will not cause a disfavored return to "pre-UCATA" days, when there was no statutory or common law right to contribution among joint tortfeasors, and injured parties could pick and choose which among multiple joint tortfeasors to hold accountable (the security company)—and which to release from liability (the general contractor). The general contractor argues that because the property owner waived all claims against the contractor in the Prime Contract prior to the fire, the contractor was never "liable in tort" to the property owner, and was thus never a "joint tortfeasor," so the policy considerations underlying UCATA are irrelevant.

Finally, the general contractor argues that if the security company is permitted to bring a contribution claim against the contractor while standing in the property owner's shoes, then the fundamental and significant value of the WOS Provisions, which are in use in AIA form-based construction contracts around the country, will be destroyed. In its *amicus* brief, the AIA supports this argument, asserting that the WOS Provisions are intended to transfer the costs of fire risks to insurers, who are better positioned to accept the risks because they can charge an insurance premium for their acceptance of the risks and spread those risks over numerous insured projects. Ironically, the AIA also argues that the risk re-allocation reduces the likelihood of litigation.

The security company's response to these policy arguments is that all of those purposes are undercut by the general contractor's breach of the Prime Contract in failing to ensure that the fire insurer had waived subrogation claims. Had the fire insurer been asked to waive subrogation, as the Prime Contract required, the insurer would have charged an appropriate premium as compensation for the waiver. Since the fire insurer did not waive subrogation, the insurer did not fully and finally accept the fire risk that the general contractor sought to transfer to the insurer. Thus, while it is true that waivers of subrogation clauses are included in construction contracts "to cut down the amount of litigation that might otherwise arise due to the existence of an insured loss," (4 Philip J. Bruner & Patrick J. O'Connor, Jr., *Bruner & O'Connor on Construction Law* §11:100, at 306–07), in *Gables*, the fire insurer *caused all of the litigation*. It did so by firing the first shot by funding the property owner's suit against the security company, which led to the security company's subrogation/contribution claim against the general contractor.

The Security Company Argues that the Weight of Authority (and Better-Reasoned Authority) Favors a Holding that the Security Company Is Not Bound by the Property Owner's Waiver of Subrogation in the Prime Contract

The security company's argument begins at a more fundamental level. As a baseline, the security company notes that it proved a statutory UCATA contribution claim. In its appeal, the general contractor is attempting to recast the security company's statutory contribution claim as a purely equitable subrogation claim, and to then apply a contractual waiver of equitable subrogation claims to bar the statutory cause of action. As a result, to prove its affirmative defense, the general contractor is first required to establish that the security company's claim is a "subrogation" claim. If the security company's contribution claim is not also a "subrogation" claim, then the WOS Provisions are entirely inapplicable.

Maryland recognizes three separate categories of subrogation claims: (1) "legal"/"equitable" subrogation; (2) statutory subrogation; and (3) conventional subrogation, which arises from a contract. *See Bachmann v. Glazer & Glazer, Inc.*, 316 Md. 405, 413 (1989). The security company argues that it is entitled to subrogation under all three of these theories—as applicable subrogation principles cut through the competing contractual, statutory and equitable principles presented in the appeal.

The Security Company Argues that It Is Entitled to "Equitable Subrogation"

The security company first argues that it is entitled to "equitable subrogation," which is triggered when a party, "to protect its own interests, pays the debt of another." *Fishman v. Murphy ex rel. Estate of Urban*, 433 Md. 534, 552, 72 A.3d 185, 195 (2013). Maryland courts "always" grant subrogation under these circumstances where equity requires it. *See Motor Vehicle Sec. Fund v. All Coverage Underwriters, Inc*., 22 Md. App. 586, 602 (1974). The security company argues that equity requires the general contractor to provide contribution because the general contractor would be unjustly enriched if it avoided making any contribution despite having caused the fire by violating multiple state, county, and industry fire safety codes. Further, it would be inequitable to find that the WOS Provisions of the Prime Contract prohibit the security company's contribution/subrogation claim when the security company was sued because the contractor breached its Prime Contract obligation to ensure that the fire insurer waived its right to sue the security company in the first instance.

The security company also argues that more fundamental public policy considerations strongly support its right to recovery because Maryland courts have found "an obvious lack of sense and justice in a rule which permits the entire burden of a loss for which two defendants were equally, unintentionally responsible to be shouldered onto one alone according to the accident of … the existence of liability insurance . . . or the plaintiff's collusion with the other wrongdoer." *Valk*, 317 Md. 185, 189–90 (1989) (citing *Prosser and Keeton on Torts* §50, 337–38 (W. Page Keeton 5th ed. 1984). When the general contractor chose to attempt a contractual waiver of an equitable claim by incorporating the AIA's WOS Provisions in the Prime Contract, the general contractor accepted that equitable principles may preclude enforcement of its contractual waivers.

Alternatively, the Security Company Argues that It Is Entitled to *"Statutory Subrogation"*

In Maryland, statutory subrogation "occurs where a statute provides expressly the right to subrogation." *Fishman*, 433 Md. at 552. UCATA arguably creates a statutory right of "subrogation" amongst joint tortfeasors by authorizing one joint tortfeasor (the security company) to recover contribution from another joint tortfeasor (the general contractor) once the joint tortfeasor (the security company) has paid more than the payor's fair share to an "injured person" (the property owner). Md. Code Ann., Cts. & Jud. Proc. §3-1402(a),(b).

The security company argues that the Prime Contract's WOS Provision is an ineffective "release" of the security company's contribution claim under UCATA. Maryland's UCATA states that releases are ineffective to extinguish contribution claims unless the release "[p]rovides for a reduction, to the extent of the *pro rata* share of the released tortfeasor [the general contractor], of the injured person's [property owner's] damages recoverable against all other tortfeasors [the security company]." Md. Code Ann., Cts. & Jud. Proc. §3-1405(2). According to the security company, the AIA WOS Provision's noncompliance with UCATA deprived the security company of the statutory protection of a *pro rata* reduction of the owner's claimed damages to account for the general contractor's joint tortfeasor status.

The security company also relies on prior Maryland authority explaining that the "central premise . . . [of] UCATA is that a party should be held accountable for damages caused by his or her negligence." *Parler & Wobber v. Miles & Stockbridge*, 359 Md. 671, 704–05 (2000). UCATA

was enacted specifically to remedy the "unfairness" arising from the fact that absent a statutory right of contribution, an "injured person," such as the property owner, can unilaterally pick and choose which among a pool of potential defendants to sue for damages (*i.e.*, choosing to sue the security company and to waive claims against the general contractor). *Id.* at 685–86.

At present, the only two limited exceptions that Maryland courts have ever found to absolve a party from UCATA claims are immunities and contributory negligence. *See Miles & Stockbridge*, 359 Md. at 702. Maryland's high court created those two limited exceptions because "[b]oth immunity and contributory negligence arise directly out of the wrongdoing itself," and not out of a private agreement between the parties. *Valk*, 317 Md. at 197, n.16. The security company argues that if Maryland's high court creates a third, contractual exception to UCATA, as the general contractor requests, we will return to pre-UCATA days in which injured parties can contractually pick and choose whom to hold accountable for causing their losses.

Courts sitting in Massachusetts and Delaware have, like Maryland, specifically held that a contractual agreement between the original plaintiff (the property owner) and a third party sued in contribution (the general contractor) does *not* defeat the original defendant's (the security company's) contribution claims arising from property damage. *See, e.g.*, *QBE Ins. Corp. v. Anufrom*, No. CV 17-10540-RGS, 2018 WL 3720056, at *3 (D. Mass. Aug. 3, 2018); *ASN Park Essex, LLC v. E.M. Duggan, Inc.*, No. CIV.A. 2011-3535, 2012 WL 6765591, at *3–4 (Mass. Super. Dec. 26, 2012) (Apx. 010-013); *Fireman's Ins. Co. of Washington D.C. v. Fire-Free Chimney Sweeps, Inc.*, N. CIV.A. 07C-06-287-JOH, 2010 WL 1268158, at *3 (Del. Super. Ct. Jan. 5, 2010) (Apx. 014-017); *Great American Assur. Co. v. Fisher Controls, Intern., Inc.*, No. CIV.A. 02C-05-168 JR, 2003 WL 21901094, at *4 (Del. Super. Ct. Aug. 4, 2003) (Apx. 018-025). These cases support the security company's argument that "mere culpability" in causing a loss is all that is required for a party to be a "joint tortfeasor" who is "liable in tort" under UCATA—not present legal liability, as asserted by the general contractor.

Three additional jurisdictions have more broadly held that a contribution defendant's defenses to claims that could have been asserted by the original plaintiff (the property owner), but were not, are no bar to contribution claims. *Security Fire Prot. Co. v. City of Ripley*, 608 S.W.2d 874, 877–78 (Tenn. Ct. App. 1980); *Ross v. Otwell*, 315 So.2d 333, 336 (La. Ct. App. 1975); *New Amsterdam Cas. Co. v. Holmes,* 435 F.2d 1232, 1234 (1st Cir. 1970); *see also Lifespan Corp. v. Gilbane Bldg. Co.*, No. C.A. 02-3630, 2005 WL 477733, at *4 (R.I. Super. Feb. 24, 2005).

Finally, the Security Company Argues that It Is Entitled to "Contractual Subrogation" *as Well*

Finally, the security company argues that it is also entitled to "contractual" subrogation, which is "based on contract but is nevertheless subject to principles of equity." *Bachmann*, 316 Md. at 416–17 (citing 10 S. Williston, *A Treatise on the Law of Contracts*, §1265 at 845 ("to permit the guarantors to escape their obligation would result in unjust enrichment. This is precisely the result that the doctrine of subrogation was designed to avoid")). Here, the security company reiterates that it would be unjust to absolve the general contractor from liability under the Prime Contract's WOS Provisions when it was the general contractor's breach of the Prime Contract (failing to ensure that the fire insurer waived subrogation) that directly caused the security company—and by extension the general contractor—to be sued.

The security company also argues that, more generally, the detriment of the subrogation waiver should not be imposed on the security company because the security company did not have the benefit of the insurance policy that was obtained by the parties to the Prime Contract. *Hartford Underwriters Ins. Co. v. Phoebus*, 187 Md. App. 668, 677, 979 A.2d 299, 304 (2009), *aff'd sub nom. John L. Mattingly Const. Co. v. Hartford Underwriters Ins. Co.*, 415 Md. 313, 999 A.2d 1066 (2010) (a waiver of subrogation '"is a risk-shifting provision premised upon the recognition that it is economically inefficient for parties to a contract to insure against the same risk'"); quoting TX. C.C., Inc. v. Wilson/Barnes Gen. Contractors, Inc., 233 S.W.3d 562, 567 (Tex. App. 2007)); *see also Tokio Marine & Fire Ins. Co. Ltd. v. Emp'rs Ins. of Wausau, 786 F.2d 101, 105 (2nd Cir. 1986)* (finding the purpose is to "require[] one of the parties to the contract to provide [property] insurance for all of the parties"); *Behr v. Hook, 173 Vt. 122, 127 (2001)* ("[b]y shifting the risk of loss to the insurance company regardless of which party is at fault, these clauses seek to avoid 'the prospect of extended litigation which would interfere with construction'"). It would have been very simple for the general contractor to have added the security company as an insured under the fire policy, which would have also prevented the fire insurer's suit against the security company.

We look forward to the Maryland high court's take on all of these issues, which is expected any day. Regardless of how these issues are decided in Maryland, insurers, property developers, general contractors, subcontractors, and

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other construction industry service providers should be mindful of these issues in drafting construction contracts, obtaining insurance for construction projects, and litigating contribution and subrogation claims arising from the mishaps that may occur on and around construction sites.

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Walter Guy Frush from Ohio

What the Death of a Solider in 1918 May Teach Us About Insurance Policy Analysis in the Time of COVID-19

By Marc Shrake and Barry Miller

Drafted in July 1918, Walter Guy Frush said goodbye to his mother, father, and five older brothers and left Licking County, Ohio, to fight for the United States in the Great War. He was sent 65 miles south to train at Camp Sherman, near Chillicothe, Ohio. Camp Sherman resembled a small town. It had its own utility system and a railroad, with of course barracks and offices, as well as theaters, a hospital, a library, and a farm. It also held a German POW camp. *See* https://ohiohistorycentral.org/w/Camp_Sherman. Named after famous Ohioan and Civil War general William Tecumseh Sherman, Camp Sherman was new, and quickly built to catch up the United States with its entry into the war in April 1917. From September 1917 through the end of the war, more than 40,000 soldiers trained there. *Id.*

The Spanish Flu Pandemic

Tragically, influenza arrived at Camp Sherman shortly after Walter Frush did. This was part of the 1918 H1N1 flu pandemic, which terrorized the world for about two years. *Id.*

Worldwide, the "Spanish flu" infected 500 million people and killed an estimated 20–50 million, including an estimated 675,000 people in the United States. And unlike the current coronavirus (SARS-CoV-2) that causes coronavirus disease 2019 (COVID-19), the virus that caused the Spanish flu targeted healthy adults 15 to 34 years old and ultimately lowered the average life expectancy in the United States by more than 12 years. *See* https://www.cdc.gov/flu/pandemic-resources/reconstruction-1918-virus.html; Barbara Jester et al. Readiness for Responding to a Severe Pandemic 100 Years After 1918. Am J Epidemiol. July 2018. 187(12): 2596–2602.

The Spanish flu first appeared in early March 1918 and seemed like nothing more than a highly contagious and virulent strain of a seasonal flu. One of the first registered cases was that of an Army cook, hospitalized with a 104-degree fever, at Camp Funston in Kansas, home to 54,000 troops. By the end of March 1918, 1,100 troops had been hospitalized and 38 had died after developing pneumonia. *See* https://www.history.com/news/spanish-flu-second-wave-resurgence.

Troops deployed to Europe took the virus with them. Throughout April–May 1918, the virus raced through England, France, Spain, and Italy, infecting an estimated 75 percent of the French troops and half the British troops that spring. But this first stage of the virus generally caused only high fever and malaise for a few days, with mortality rates similar to seasonal flu. ("Spanish flu" was so-named because Spain's newspapers, uncensored, were the first to report a serious illness running through the troops.) *Id.*

Reported Spanish flu cases dropped over the summer of 1918. But in Europe a mutated strain of the virus developed that could kill healthy younger people within 24 hours of showing an infection. *Id.*

Deadlier Strain: The Second Wave

In late August 1918, ships left Plymouth, England, carrying troops unknowingly infected with the deadlier strain of Spanish flu. As these ships docked at their various desti-

nations, the second wave of the global pandemic began. During September–November 1918, the death rate from the Spanish flu took off. *Id*.

In October 1918 alone, 195,000 Americans died. And unlike a seasonal flu, which tends to attack the very young and very old, this second wave of the Spanish flu went after otherwise healthy 25- to 35-year-olds. British military pathologists who performed autopsies on soldiers killed in this second wave likened the lung damage to the effects of chemical warfare. *Id*.

The Death of Walter Guy Frush

At Camp Sherman in Chillicothe, Ohio, thousands of soldiers contracted Spanish flu in the late summer and early fall of 1918, and nearly 1,200 died.

One of those soldiers was Walter Guy Frush. He died on October 9, 1918, before he ever made it out of camp. *Frush v. Ohio State Life Ins. Co.*, 31 Ohio Dec. 49 (Court of Common Pleas of Licking County 1920), *cited in Bending v. Metropolitan Life Ins. Co.*, 74 Ohio App. 182 189–91, 58 N.E.2d 71, 74–75 (1944).

Denial of Emma Laura Frush's Life Insurance Claim

Mrs. Frush made her claim for $1,000 under Walter's life insurance policy. The policy was sold by Ohio State Life Insurance Company in June 1916, about a year before the United States entered the war and two years before Walter went off to Camp Sherman.

Ohio State Life denied the claim, offering only a return of premium, based on the following policy exclusion:

> This policy shall be null and void, except for the amount of premium paid, if the insured shall die within one year by self-destruction, whether sane or insane; or if the insured shall at any time engage in military or naval service in time of war (the militia not in actual service excepted) unless a special written permit therefor has been obtained from the Company.

31 Ohio Dec. at 49–50

Walter's mother argued that her son had not been engaged in combat service and did not die as a result of his military service, and that nothing he did in military service contributed to or caused his death.

In analyzing the coverage question, the Licking County Court of Common Pleas took two steps sometimes used by courts today, 100 years later: (1) it used a public policy analysis to redraft the terms of the contract, and (2) it conducted a causation analysis.

Court's Public Policy Review

The court was concerned that the exclusion contradicted Ohio public policy by discouraging volunteer service in the military. The court acknowledged that Walter Frush had been conscripted into service but recognized its decision could affect future voluntary enlistments. On this point the court reached the following conclusion:

> I have no doubt that voluntary enlistment in the army would be, more or less, affected in the minds of some if they were insured and knew that entering military service would forfeit their insurance. That the insured in this case was drafted would not affect the fact that such provision in the policy would deter voluntary enlistments, and if that were the effect it would be against public policy, and, as stated in the above cited case, if it tended to create that result as necessarily flowing from it, it would be against public policy.

31 Ohio Dec. at 49–50 (citing *Hard v. Harris*, 14 Ohio Cir. Dec. 714 (1 Ohio C.C. (N.S.) 113) (1903)).

On this basis, the court created its own military service exclusion that it believed to be consistent with public policy. The court deemed void the portion of the exclusion reading "if the insured shall at any time engage in military or naval service in time of war," but allowed that "[i]n order to come within the meaning of that clause it seems to me that such *engagement in military service should be the cause or occasion of the death of the insured in order for the company to escape liability.* If the death of the insured was caused by something outside of his military service, and which might have occurred in the same way if he had not been in military service, then the service he was engaged in was not the occasion of his death." 31 Ohio Dec. at 52–53 (emphasis added) (citing *Welts v. Connecticut Mut. Life Ins. Co.*, 48 N.Y. 34, 38–40 (1871)).

Court's Causation Analysis

Based on the court-revised contract, the court then analyzed the causation question by defining a term in its newly created exclusion: "Engagement in military service means to expose into dangers which were not incident to civil life." 31 Ohio Dec. at 53.

So, the causation question was whether Walter Guy Frush's death was caused by a "danger which was not incident to civilian life." The court concluded not.

While the Spanish flu pounded Camp Sherman soldiers largely, if not entirely, because of the training and movement of troops for armed engagement in war, this was not a cause that would permit Ohio State Life Insurance Company to rely on the exclusion to deny Emma Laura Frush the insurance benefits for the death of her youngest child. This was because, the court said, "as is well known, the danger in civil life was just as great as in military service in respect to the disease called the 'Flu.' The insured in this case did not come to his death by reason of his induction into military service. . . . In this case the drafting into the military service and the entering of such service . . . was not the occasion or cause of the death of the insured." 31 Ohio Dec. at 53.

Indeed, the court accurately recognized that despite the quarantine of the surrounding community of Chillicothe to prevent the spread of the epidemic, some people outside of the camp still became ill and died of the disease. *See* https://ohiohistorycentral.org/w/Camp_Sherman.

However, based on the full record of the Spanish flu epidemic, which likely was not available in late 1919-early 1920, the court could have reached the opposite conclusion. As understood now, the facts indicate that Walter moved from his home in Licking County to Camp Sherman to train to join a war that, by the necessity of continuing to fight, was actively spreading the disease around the world. Had Walter stayed home, he would not have died from the Spanish flu. This conclusion, however, would have ignored the public policy concern expressed by this and other courts that simply joining the military, alone, should vitiate coverage and thereby serve as a deterrent to volunteering to fight for one's country.

COVID-19 and Insurance Coverage

After the armistice, Camp Sherman was dismantled over the following decade, and none of the original buildings remain. On that land now are a Veterans Administration hospital, a couple of prisons, a national park, and a wildlife refuge. *Id*. No doubt these facilities are taking precautions against the spread of SARS-CoV-2 and the dangers of COVID-19, and working to determine whether they have any risk transfer mechanisms in place.

As with the case of Walter Guy Frush and the Spanish flu, all claims for insurance coverage arising out of today's coronavirus pandemic—whether based on property damage, business interruption or other time element loss, extra expense, event cancellation, an employment issue, or liability for defense or indemnity—will require an understanding of the terms of the policy, a detailed factual analysis (quite possibly at the nanoscopic level), an understanding of history, and knowledge of and experience with the applicable jurisdiction's law on causation.

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Recent Cases of Interest

First Circuit

Bad Faith/"Judgment"/"Claim" (MA)

Capitol Specialty Ins. Corp. v. Higgins, **No. 19-1496 (1st Cir. March 11, 2020)**

The U.S. Court of Appeals for the First Circuit has affirmed a multi-billion dollar bad faith judgment against a strip bar's liability insurer for failing to fully investigate an accident claim involving an exotic dancer but rejected efforts by the dancer to increase the award. In *Capitol Specialty Ins. Corp. v. Higgins*, No. 19-1496 (1st Cir. March 11, 2020), the court rejected the injured party's claim that her trebled award should have be based upon the $7.5 million consent judgment that she had separately negotiated with the insured bar declaring instead that statutory damages

awarded under the Massachusetts Consumer Protection Act (G.L. c.93A) must be based upon the injured party's actual damages. The court also rejected the claimant's argument that the District Court's entry of her $7.5 million consent judgment was a "judgment" to which Chapter 93A applied, especially as there was sufficient evidence of collusion with respect to the settlement. The court also rejected Higgins' claim that she was entitled to a separate award based upon an assignment of rights that she had received from the insured bar. The court ruled that there was no evidence that the bar had suffered any injury due to the insured's investigation (which had been shut down after the bar's owner swore to the insurer that they never served drinks to dancers), nor was the insured's contribution of $50,000 to the consent judgment settlement was not an injury that had been caused by Capitol nor was there evidence of any other independent injuries upon which an assigned claim could be asserted. While therefore rejecting the claimant's cross-appeal, the First Circuit for the most part affirmed the district court's entry of liability as regards the insurer. In particular, the court rejected Capitols' claims that Section 3(9)(d)'s requirement that insurers properly investigate "claims" was triggered by a letter of representation from claimant's counsel, even though the later did not demand any specific dollar amount. The court criticized Capitol for not following the advice of its independent adjuster to interview other individuals, which would have confirmed that the bar did indeed serve alcohol to dancers, as Capitol should likely have already known since it often writes coverage for bars. The court further found that it was not "clear error" for the District Court to find that the insurer's breach was "willful." Similarly, even though Judge Hillman's opinion provided very little explanation as to how he found $1.8 million in actual damage, the court found that this was not "clear error" as there was some evidence at trial concerning the catastrophic effect of these event on the claimant's life. On the other hand, the court ruled that pre-judgment interest only applied to the base award and not to the full trebled amount of 93A damages.

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Broad Definition of Claim Precludes Coverage for an SEC Investigation Formal Order Received in a Prior Policy Period (MA)

On March 20, 2020, the U.S. Court of Appeals for the First Circuit affirmed a summary judgment ruling by the U.S. District Court for the District of Massachusetts in favor of two excess D&O insurers, Zurich Services Corporation (Zurich) and X.L. Global Services, Inc. (XL), both of which had denied coverage for the Claim at issue. In *Jalbert v. Zurich Services Corporation et al.*, Case No. 18-2244 (1st Cir. March 20, 2020), the First Circuit ruled that a Formal Order of Investigation issued by the Securities and Exchange Commission (SEC) during a prior policy period constituted a Claim made during the prior D&O policy period, thereby permitting the excess insurers under the subsequent policy period to deny coverage for those subsequent actions as follow-form excess insurers.

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Fourth Circuit

Privacy Exclusion (NC)

Hartford Cas. Ins. Co. v. Davis & Gelshenen, LLP

Applying North Carolina Law, Violation of Privacy Exclusion Precludes Coverage for Insured's Alleged Violation of the Drivers Privacy Protection Act, 18 U.S.C. §§2721–2725

The putative class action plaintiffs alleged that Gelshenen Law violated the Driver's Privacy Protection Act by obtaining their names and addresses from official accident reports submitted to the Department of Motor Vehicles and using them to mail advertisements for legal services.

The court agreed with the Hartford that the exclusion for "personal and advertising injury arising out of the violation of an individual's right to privacy created by any state or federal act, unless the insured would have been liable even in the absence of such state or federal act" applied.

The second applicable exclusion at issue was that for personal and advertising injury arising directly or indirectly from a statute, ordinance, or regulation that prohibits or limits sending, transmitting, communicating, or distributing material or information. The court did not address the application of this exclusion.

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Fifth Circuit

Professional Liability Coverage (LA)

IberiaBank Corp. v. Ill. Union Ins. Co., --- F.3d ---, 2020 WL 1284958 (5th Cir. Mar. 18, 2020)

The U.S. Court of Appeals for the Fifth Circuit ruled that Illinois Union Insurance Company (Illinois Union), a unit of Chubb Ltd., and Travelers Casualty and Surety Co. of America (Travelers) do not have to provide coverage for a professional liability claim by IberiaBank Corporation (IberiaBank).

IberiaBank asked Illinois Union and Travelers to cover an $11.7 million settlement agreed to by IberiaBank and federal regulators. The settlement arose after IberiaBank was accused of selling poorly underwritten mortgages and procuring Federal Housing Administration (FHA) insurance for borrowers after falsely certifying that it had met Department of Housing and Urban Development (HUD) guidelines.

In deciding whether the insurers were obligated to pay for the settlement, the trial court looked to the policy language, which stated that the policy only covered liability for wrongful acts brought by third-party clients. The trial court determined that HUD did not qualify as a client of IberiaBank. The appellate court agreed with the trial court's analysis and went further to note that in order to be a "client" of the bank, a party would have to pay for bank services. Given that HUD did not pay for any services, it could not be considered a "client." Thus, the settlement with HUD was not covered under the professional liability policy.

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Duty to Defend – Extrinsic Evidence (TX)

Richards v. State Farm Lloyds, 2020 Tex. LEXIS 236 (Tex. March 20, 2020)

Texas Supreme Court, on certified question from the Fifth Circuit, opines that the state's "eight-corners rule" to determine the duty to defend applied to preclude consideration of an insurer's extrinsic evidence barring coverage for underlying injury claims, even though the homeowner's policy at issue did not contain language requiring defense of "groundless, false or fraudulent" suits.* The court expressly recognized, however, that parties are free to contract around the "eight-corners rule" and that insurance policy terms that are inconsistent with the rule would control (the omission of "groundless, false or fraudulent" language here was deemed insufficient to overcome the rule). It also noted but did not pass judgment on an exception to the rule that has been applied by the Fifth Circuit, derived from *Northfield Ins, Co. v. Loving Home Care, Inc.*, 363 F.3d 523 (5th Cir. 2004), *reh'g and reh'g en banc denied*, 2004 U.S. App. LEXIS 8706 (Apr. 29, 2004). As described, that exception "allows extrinsic evidence bearing on the duty to defend when (1) 'it is initially impossible to discern whether coverage is potentially implicated' and (2) 'the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case.'"

* The policy provides for a defense "[i]f a claim is made or a suit is brought against an insured for damages because of bodily injury. . .to which this coverage applies, caused by an occurrence."

White & Williams LLP
Complex Insurance Coverage Reporter: Top Developments
March 2020

Sixth Circuit

Actual Cash Value (OH)

Perry v. Allstate Indem. Co., --- F.3d ---, 2020 WL 1284960 (6th Cir. Mar. 18, 2020)

The issue before the U.S. Court of Appeals for the Sixth Circuit was whether labor costs could be depreciated in calculating the actual cash value amount (ACV) owed for water damage to the policyholder's home. Allstate Indemnity Company (Allstate) and the policyholder agreed that the estimated cost to repair the property damage was approximately $33,000. Allstate asserted that after deducting the cost of depreciation, which included labor costs in addition to wear-and-tear, the ACV amount was approximately $28,400. The policyholder disagreed, arguing that depreciation only encompasses physical wear-and-tear and not labor costs.

The appellate court began its analysis by noting that the Ohio Supreme Court has not addressed this issue. It further noted that the undefined term "depreciation" was ambiguous. Under Ohio law, an ambiguous term is interpreted against the insurer, so long as the policyholder's interpretation of the term is reasonable. The appellate court found that the policyholder's interpretation of depreciation "has

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been recognized as reasonable by numerous state and federal courts, including our own, because depreciation traditionally refers to value lost from physical wear and tear." Thus, the appellate court held that it was improper, as a matter of law, for Allstate to depreciate labor costs to arrive at the ACV amount.

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Seventh Circuit

"Occurrence" (IL)

Lexington Ins. Co. v. Chicago Flameproof & Wood Specialties Corp., No. 19-1062 (7th Cir. Feb. 27, 2020)

The Seventh Circuit has ruled that an Illinois District Court did not err in ruling that a CGL insurer did not owe coverage for three law suits in which property owners alleged damage due to the installation of the insured's fire retardant treated lumber products. *In Lexington Ins. Co. v. Chicago Flameproof & Wood Specialties Corp.*, No. 19-1062 (7th Cir. Feb. 27, 2020), the Seventh Circuit ruled that the insured's decision to ship products without obtaining certification for them pursuant to the International Building Code (IBC) failed to allege an "occurrence." Not only was the insured's decision to ship uncertified lumber was not an unexpected event but the subsequent "ripping and tearing out of the FlameTech lumber was the natural and ordinary consequence of supplying lumber that was not IBC-certified." The court declined to find a duty to defend based upon allegations of negligent misrepresentation and the like, declaring that "although some of the allegations used the language of 'negligence' or 'reasonable care,' the injury alleged stems from Chicago Flameproof's 'unilateral decision' to supply the uncertified lumber and concealment of having done so."

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Ninth Circuit

Song-Beverly Coverage (CA)

Brighton Collectibles v. Certain Underwriters at Lloyd's

Applying California Law, Violation of California's Song-Beverly Credit Card Act, Cal. Civ. Code §1747.08, Covered

Brighton was sued in a putative class action in which the plaintiffs alleged that it sold its customers personal information in violation of California's Song-Beverly Credit Card Act. The trial court held that the claim did not state an enumerated "personal and advertising injury." The Ninth Circuit reversed, holding that the claim was covered under the offense of oral or written publication of material that violates a person's right to privacy. The court reasoned that the Act's overriding purpose was to protect the personal privacy of consumers. Consequently violating the Act violated the plaintiffs' right of privacy.

Lloyd's contended that the policy exclusion for advertising, publishing, broadcasting or telecasting done by or for the insured defeated the duty to defend. The court disagreed. It held that the word publication in the covered offense could not be interpreted in the same matter as "publication" contained in the exclusion because otherwise, all of the coverage available to the insured for the oral or written publication of material that violates a person's right to privacy would be defeated by the publication language in the exclusion.

Instead, the publication language in the exclusion indicated that the exclusion only applied to broad public-facing marketing activities because it was grouped with "advertising, broadcasting or televising." Brighton's sale of consumer information to select marketers was a publication within the meaning of the covered offense, but it did not rise to the level of widespread, public-facing publishing within the meaning of the exclusion.

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Tenth Circuit

Additional Insureds/Fee Awards (WY)

Lexington Ins. Co. v. Precision Drilling Co., No. 18-8072 (10th Cir. Feb. 26, 2020)

Having previously ruled that Wyoming's anti-indemnity statute did not preclude a well drilling company from

seeking additional insured coverage from an oil and gas operator's liability insurer, the Tenth Circuit has now ruled in Lexington Ins. Co. v. Precision Drilling Co., No. 18-8072 (10th Cir. Feb. 26, 2020) that that the drilling company was entitled to coverage because that the claims against it arose out of worker operations being performed by the company on the insured's behalf. The court rejected Lexington's argument that the additional insured language required that the named insured have a right of control over the work of the subcontractor employing the injured party. The court also ruled that Lexington was bound to indemnify the additional insured for the full amount of a three million settlement, declaring that language in Lexington's umbrella policy setting policy limits at the amount required by a written "insured contract" in this case reference the five million dollar umbrella limit and not merely two million dollars as Lexington had argued. However, the court refused to find that Precision was entitled to an award of prejudgment interest or attorney's fees, noting that the policies in question were issued in Texas and not in Wyoming as required by Wyo. Stat. Ann. §26-15-124(c) (2018).

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U.S. District Court, District Of Oregon

Occurrence

Nevada Capital Ins. Company v. Sego Contractors Inc.

False Imprisonment and Violation of Privacy Claims Not an Occurrence under Coverage A and Excluded Under Coverage B by the Knowing Violation of Another's Rights exclusion

The underlying plaintiff alleged that she was sexually assaulted by the individual defendant from age 13 to 18 with the knowledge, permission, and encouragement of the insured corporate defendants, which were all owned by the individual defendant. Among others, she pled causes of action for false imprisonment and the invasion of privacy. The court held that all of the claims arose out of the sexual assault so there was no occurrence under Coverage A. Under Oregon law, there is no accident if "an injurious intent is necessarily inferred from [the] type of intentional conduct."

The insureds argued that Coverage B provided coverage for plaintiff's claims of false imprisonment and violation of privacy, which are enumerated offenses. The court concluded that the Coverage B exception for Knowing Violation Of Rights Of Another exclusion, which precludes coverage for personal and advertising injury caused by or at the direction of the insured with the knowledge that the act would violate the right of another and inflict personal and advertising injury, applied. The court also held that the policy's employment-related practices exclusion applied because the plaintiff was apparently in the defendant's employ.

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Illinois

A First: GL Coverage for Illinois Biometrics Action, Distribution of Material Exclusion Doesn't Apply

In *West Bend Mutual Insurance Company v. Krishna Schaumburg Tan, Inc.*, 2020 Ill. App. LEXIS 179 (Ill. Ct. App. March 20, 2020), the Illinois Appellate Court issued a first-of-its-kind decision: that underlying allegations of violation of the Illinois Biometric Information Privacy Act (BIPA) constituted "personal and advertising injury," and coverage for which was not prohibited by the catch-all provision of the Distribution of Material (or "TCPA") exclusion. The decision potentially opens the door to a flood of insurance claims for one of the fastest-growing areas of privacy litigation in the United States.

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Kentucky

Motor Vehicle

Davis v. Progressive Direct Ins. Co., --- S.W.3d ---, 2020 WL 962360 (Ky. Ct. App. Feb. 28, 2020)

The Kentucky Court of Appeals ruled that a horse-drawn buggy is not a "motor vehicle" for purposes of uninsured motorist coverage. The policyholder was operating a motorcycle on a rural road in Barren County, Kentucky, where she encountered a horse-drawn buggy traveling in the opposite direction. As she got closer, the horse jumped into the oncoming lane, causing her injuries and damage to the motorcycle. The policyholder sought uninsured

motorist benefits through an automobile policy issued by Progressive Direct Insurance Company (Progressive). Progressive denied benefits on the basis that the horse-drawn buggy is not a "motor vehicle."

On appeal, the policyholder advocated that the horse-drawn buggy is a "motor vehicle" pursuant to Kentucky's Motor Vehicle Reparations Act (Act). She argued that under the Act, the "primary litmus test for qualification as a motor vehicle … is that the vehicle in question regularly transports persons or property on public highways." While true, the appellate court found the policyholder missed an essential part of the Act's definition — the "motor vehicle" must be "propelled by other than muscular power." According to the appellate court, this phrase plainly required a "motor vehicle" to be self-propelled by an internal engine, which the horse-drawn buggy clearly lacked.

For her second argument, the policyholder asserted that the horse-drawn buggy qualifies as a trailer and, thus, constitutes an "uninsured motor vehicle," which was defined under the policy as a "land motor vehicle or trailer of any type." Again, the appellate court disagreed, relying on a prior decision, *Rosenbaum v. Safeco Ins. Co. of America*, 432 S.W.2d 45 (Ky. 1968), which held that a policyholder reasonably expects that uninsured motorist coverage will provide protection for collisions with another automobile, not with a horse-drawn wagon. Relying on *Rosenbaum*, the appellate court reasoned that a horse-drawn buggy cannot qualify as a "motor vehicle" because a "person of 'ordinary and usual understanding' would dismiss the notion due to the absence of a motor." Thus, the appellate court ruled that Progressive did not owe uninsured motorist benefits.

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Massachusetts

Uninsured Premises Exclusion

Green Mountain Insurance Company v. Wakelin, SJC-12760 (Mass. Mar. 3, 2020)

The Supreme Judicial Court of Massachusetts ruled this week in Green Mountain Insurance Company v. Wakelin, SJC-12760 (Mass. Mar. 3, 2020) that language in a homeowner's policy excluding coverage for bodily injury arising out of a premises that were owned by the policyholder, but not insured under the policy, did not apply to an incident in which four individuals died from carbon monoxide poisoning in an uninsured location in Maine. The court declared that the purpose of homeowner's insurance is to provide protection against two distinct perils: (1) liability resulting from the insured premises and (2) liability stemming from the insured's conduct which may occur at any place on or off the insured premises. In this case, the court found that the exclusion was meant to apply to injuries resulting from physical conditions in uninsured locations, and that it, therefore, did not apply to this incident, which arose out of the malfunction of a portable generator. The court concluded "that the generator did not constitute a "condition" of the uninsured premises, and the accident caused by the generator therefore cannot trigger the uninsured premises exclusion. It was Wakelin's failure to instruct his children on how to properly use the generator rather than any condition or defect on the property that is the basis for his potential liability here." The court declared that "arising out of" a premises location was different from exclusionary language for injuries "that occurs on" said premises.

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New Jersey

Named Peril

Robert Cusamano v. New Jersey Ins. Underwriting Ass'n, No. A-1704-18T2, 2020 WL 1026748 (N.J. Super. Ct. App. Div. Mar. 3, 2020)

A New Jersey Superior Court, Appellate Division held that the New Jersey Insurance Underwriting Association (Underwriting Association) did not owe coverage for water damage caused by a leaking pipe under a named perils insurance policy. The insureds made a claim under their policy after discovering that a "rotted connection" in a drain line was causing water to leak in the kitchen of their duplex. The Underwriting Association declined coverage on the basis that water damage from a leaking pipe was not one of the named perils under the insureds' policy. In response, the insureds brought an action against the Underwriting Association, alleging breach of contract and bad faith.

The insureds argued that the policy was ambiguous because the water damage exclusion did not specifically identify "water damage from leaking pipes." According to

the insureds, when a policy "carve[s] out narrowly defined definitions of excluded losses, it blurs the boundaries of where coverage begin or ends."

The appellate court disagreed, reasoning that "the covered perils defined the outer bounds of coverage" exclusions apply to covered perils, only. The specific perils covered under the insureds' policy included "fire or lightning; internal explosion; windstorm or hail; explosion; riot or civil commotion; aircraft; vehicles; smoke; volcanic eruption; vandalism or malicious mischief." It did not include water damage caused by a leaking pipe. Because the insureds' loss was not a covered peril, the appellate court ruled that there was no need to consider the water damage exclusion. As a result, the Underwriting Association did not have a coverage obligation for this loss.

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New York

Ambiguity

Baron v. New York Mut. Underwriters, Appellate Division, Second Department

Where Question of Coverage Is Involved, Question of Ambiguity Is Resolved on the Ordinary Policyholder Standard

Plaintiffs solicited a quote for fire insurance from defendant Karis & Karis, Inc. Karis was able to obtain an acceptable quote, and undertook the effort to prepare the formal application of insurance for plaintiffs. As part of that process, plaintiff, Michael, was asked by Karis if plaintiffs had any "losses" in the previous five years. Michael responded by asking if "losses" meant prior insurance claims, to which Karis' employee responded that the term "losses" was synonymous with claims. Plaintiffs, accordingly, responded in the negative.

Plaintiffs eventually submitted a claim for a fire loss that occurred during the policy. As part of its investigation, NYMU discovered that plaintiffs had damage (unspecified) over the previous five years. As such, and even though there was no "claim" submitted in connection with the previous "losses," NYMU voided the policy due a material misrepresentation in underwriting.

Plaintiffs commenced the instant action against NYMU challenging the rescission of the policy, and also sought damages against Karis. On motions for summary judgment, plaintiffs' argued that the term "losses" was ambiguous and thus could not provide a basis for NYMU's rescission. In addition, and regardless of the definition of the term, the application was only signed by one of the plaintiffs, Michael. As such, it was reasoned that plaintiff's partner, John, should still be entitled to coverage as an "innocent insured." Plaintiffs also sought to preclude EUO testimony Michael because the deposition was taken without advising Michael's counsel.

The trial court held that plaintiffs failed to establish, as a matter of law, that "losses" was ambiguous. The lower court also ruled that the "innocent insured" doctrine was inapplicable to this case. Finally, the court ruled that NYMU's counsel who conducted the EUO had violated his ethical obligations by soliciting testimony from an individual he knew was represented. As such, the testimony was inadmissible in the current proceedings.

On appeal, the Second Department agreed that plaintiffs had not met their burden of establishing ambiguity in the term "losses." The Court noted that ambiguity is not created "merely because the parties interpret them [the term(s)] differently." The test for ambiguity is not what the parties think, but rather what would be the reasonable expectation of an average insured reading the policy.

The Second Department also agreed that the innocent insured doctrine was inapplicable to the current issue.

The Court also affirmed the trial court's decision that NYMU's decision to solicit the EUO testimony of a represented individual without this lawyer present resulted in the transcript being precluded from introduction in this action.

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Classic Wind vs. Rain Battle – Ties Go to the Jury

Martin J. Ain, et al., appellants, v. Allstate Ins. Co., respondent. Additional Party Names: Deluxe Plus Homeowners Policy, Fed. Emergency Mgmt. Agency, Nat'l Flood Ins. Program, Pac. Specialty Ins. Co., **2017-04188, 2020 WL 1437749 (N.Y. App. Div. Mar. 25, 2020)**

Plaintiff's home was significantly damaged when Superstorm Sandy pushed ashore on October 29–30, 2012. At

that time, plaintiff's home was insured by the National Flood Insurance Program, an excess flood policy, and a Deluxe Homeowners' policy issued by Allstate. The court provides that plaintiff was compensated for damage caused by flood from both the primary and excess flood policies.

Allstate disclaimed coverage for any damage caused by flood/tidal waters, but acknowledged that some damage may have been attributable to wind damage and offered to resolve the claim for $10,742.02.

Plaintiff rejected the offer, and commenced the instant lawsuit in December of 2013. Allstate eventually moved for summary judgment on the basis that the damage was flood or flood related. Allstate also cited the "weather" exclusion, and an exclusion which limited coverage to the predominant cause.

In support of its argument, Allstate submitted the affidavits of two retained expert engineers. Allstate also submitted the report of plaintiff's retained expert engineer.

With regard to the experts, the court noted that one of the engineers noted he could not determine the extent of damage that might have been wind driven. He did opine, however, that a large portion of the observed damage was directly attributable to wave damage and tidal forces.

Allstate's other retained engineer opined that the predominant cause of the loss was water damage caused by the flood waters pushed by the storm. This particular engineer then opined that he did not believe windspeeds at the home would have reached a speed which would have caused the damage asserted by plaintiff. Any damage that would have been attributable to wind would have been minimal.

However, plaintiff's retained expert conclusively opined that wind speeds were capable of causing structural damage to the insured dwelling. Accordingly, plaintiff's expert posited that it was impossible to know what losses were caused by flood and what losses were attributable to wind.

On that basis, the court found that Allstate failed to meet its burden on its motion for summary judgment. The first expert, who equivocated in his response, was precluded as speculative. Where the expert could not provide testimony on the extent, if any, of wind damage, it was impossible for him to therefore conclude the loss was predominantly caused by flood.

Allstate's second expert's opinion was directly countered by plaintiff's own expert engineer. In such a circumstance, were two experts present compelling and supported views, a question of fact necessarily must result. On that basis alone, the reliance upon the flood exclusion was insufficient to support summary judgment.

The court also found a question of fact on the applicability of the "weather conditions" and the predominant cause of loss exclusions, respectively. The first provision precludes coverage for losses where a "weather condition" contributed with an otherwise excluded cause of loss. The court noted that only the "dominant, efficient and proximate cause of loss" controlled whether the damage was covered. As such, where a question of fact existed as to the dominant, efficient and proximate cause of the loss it followed that a question of fact as to the application of this exclusion had to be found. Along this same logic, Allstate's reliance upon the predominant cause exclusion was also foiled on a question of fact.

In so holding, the court rejected the theory that the entire storm was a "weather condition" that contributed to an excluded cause of loss (flooding). Such a conclusion would apply the weather exclusion to losses which may have otherwise been covered (wind), and thus make hurricane coverage illusory.

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Claim File Material Concerning the Defense of the Named Insured Is Not Discoverable in Declaratory Judgment Action Involving Coverage

1415, LLC v. New York Marine & Gen. Ins. Co., **2018-11913, 2020 WL 1161270 (N.Y. App. Div. Mar. 11, 2020)**

1415 LLC contracted with Park Developers to perform renovations on a residential building in Brooklyn. Park had 1415 named as an additional insured on a liability policy with NY Marine.

In January 2014, one of Park Developers' employees commenced a personal injury action against 1415 LLC, alleging violations of the Labor Law. 1415 LLC answered the complaint in the personal injury action and sought defense and indemnification from New York Marine. New York Marine did not respond to 1415 LLC's multiple requests.

The following year, 1415 LLC commenced a third-party action to the personal injury action, seeking indemnification from Park Developers. New York Marine provided counsel to Park Developers in the third-party action

beginning on July 14, 2015. New York Marine disclaimed coverage to 1415 LLC in the personal injury action on April 6, 2016, on the ground that 1415 LLC had violated conditions to coverage. 1415 LLC then commenced this action seeking a judgment declaring that New York Marine is obligated to defend and indemnify it in the personal injury action.

The battle was over claim notes created after July 14, 2015, asserting that the notes were protected from disclosure based on the attorney–client privilege and as material prepared for litigation against 1415 LLC in the third-party action.

While CPLR 3101(a) provides for full disclosure of "all matter material and necessary in the prosecution or defense of an action," this principle is limited by CPLR 3101(b) and (c), which make "privileged matter" and "attorney's work product" absolutely immune from discovery. In addition, pursuant to CPLR 3101(d)(2), material that is prepared in anticipation of litigation "is subject to a conditional privilege, and, thus, is subject to disclosure only by a party's showing that he or she is in substantial need of the material and is unable to obtain the substantial equivalent of the material by other means without undue hardship."\.

The withheld material was protected by the attorney-client privilege and was privileged material prepared for litigation. Generally, the payment or rejection of claims is part of the regular business of an insurance company, and, thus, reports prepared by insurance investigators, adjusters, or attorneys before the decision is made to pay or reject a claim are not privileged and are discoverable

While the material 1415 LLC seeks from New York Marine was prepared before the determination to reject 1415 LLC's claim for defense and indemnification in the personal injury action, the withheld material concerns the defense of Park Developers in the third-party action brought by 1415 LLC.

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North Carolina

First Party/Actual Cash Value

Accardi v. Hartford Underwriters Ins. Co., **No. 42A19 (N.C. Feb. 28, 2020)**

The North Carolina Supreme Court has ruled that a homeowners insurance policy was not ambiguous due to its failure to explicitly state that labor depreciation will be deducted when calculating the actual cash value (ACV) of storm damage to the insured's home. While acknowledging that courts around the country are split on this issue, the court declared in Accardi v. Hartford Underwriters Ins. Co., No. 42A19 (N.C. Feb. 28, 2020), that "the policy language provides no justification for differentiating between labor and materials when calculating depreciation, and to do so makes little sense."

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Texas

Duty to Defend

Richards v. State Farm Lloyds, **--- S.W.3d ---, 2020 WL 1313782 (Tex. Mar. 20, 2020)**

The Supreme Court of Texas held that an insurer was not required to defend its insureds in a lawsuit arising out of a fatal All-Terrain Vehicle (ATV) accident. In the underlying lawsuit, the mother of 10-year-old Jayden Meals sued Jayden's grandparents, Janet and Melvin Richards, after Jayden died from injuries sustained in an ATV accident while under the Richards' supervision. The Richards asked their homeowners' insurer, State Farm Lloyds (State Farm) to provide a defense to the lawsuit. State Farm originally agreed to provide a defense under a reservation of rights, but then filed an action against the Richards in the U.S. District Court for the Northern District of Texas, seeking a declaration that it had no duty to provide coverage (defense or indemnity) for the underlying lawsuit.

State Farm moved for summary judgment on the grounds that various policy exclusions applied to preclude coverage. In support of their position, State Farm submitted various pieces of extrinsic evidence, including the police vehicle crash report. The Richards argued that the submission of extrinsic evidence was improper pursuant to Texas' eight-corners rule. This rule provides that an insurer's duty to defend is determined only by the allegations of the complaint and the language of the insurance policy. The federal district court rejected the Richards' argument and applied the policy-language exception to the eight-corners rule. Under this exception, the eight-corners rule only applies to insurance policies that explicitly require the insurer to defend all actions against its insured regardless of whether the allegations are groundless,

false or fraudulent. The Richards' policy did not contain a groundless-claims clause. Therefore, the district court granted summary judgment in favor of State Farm and the Richards appealed.

On appeal, the U.S. Court of Appeals for the Fifth Circuit certified the following question to the Supreme Court of Texas: Is the policy-language exception to the eight-corners rule articulated in B. Hall Contracting Inc. v. Evanston Ins. Co., 447 F. Supp. 2d 634 (N.D. Tex. 2006), a permissible exception under Texas law? Ultimately, the Supreme Court stated that "State Farm did not contract away the eight-corners rule altogether merely by omitting from its policy an express agreement to defend claims that are 'groundless, false or fraudulent.'" Therefore, the Supreme Court opined that the policy-language exception to the eight-corners rule did not apply but, instead, the eight-corners analysis must be used to determine whether there is a duty to defend.

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Wisconsin

Duty to Defend

Choinsky v. Employers Ins. Co. of Wausau, **--- N.W.2d ---, 2020 WL 727822 (Wis. Feb. 13, 2020)**

The Wisconsin Supreme Court held that two insurers did not breach a duty to defend their insured for a lawsuit alleging wrongful termination of benefits because the insurers properly sought the court's approval of their coverage position.

In 2012, the Germantown School District (District) discontinued long-term care insurance for active employees, which also resulted in the discontinuation of the insurance for retirees. A group of retired teachers filed a class action complaint against the District, alleging this decision was wrongful and constituted "intentional and willful disregard" of the retirees' rights. Employers Insurance Company of Wausau and Wausau Business Insurance Company (collectively, Wausau) initially denied coverage to the District on the basis that the lawsuit alleged intentional conduct. Later, Wausau sought to intervene in the class action lawsuit and asked the court to bifurcate the insurance dispute from the class action and to stay the class action, pending a ruling on the insurance dispute. When the trial court refused to stay the class action, Wausau agreed to reimburse the District for defense costs incurred and fund the District's defense going forward, under a full reservation of rights to continue, challenging their coverage obligations.

A jury found that Wausau had a duty to defend because the class action complaint could be read as alleging that the District's decision was negligent. On a subsequent motion for attorney fees relating to establishing coverage, the trial court issued a decision that Wausau had not breached the duty to defend because it followed a "judicially preferred approach to the coverage dispute" by seeking the court's approval of its coverage position. The appellate court affirmed the trial court's decision.

The Wisconsin Supreme Court affirmed the ruling of the appellate court, holding that Wausau did not breach its duty to defend the District because it followed one of the four "judicially preferred approaches" in intervening in the liability case and asking for a court determination of coverage. The Supreme Court held that Wausau's actions in attempting to "hav[e] coverage decided before liability," and "provid[ing] a full defense, retroactive to the date of tender" when the trial court denied Wausau's motion to stay the class action proceedings were proper, notwithstanding the fact that Wausau initially denied the District's tender of coverage. In light of this conduct, the Supreme Court held that Wausau "complied with its contractual responsibilities to [the District] and therefore" did not breach its duty to the District. The Supreme Court concluded by stating "this court has repeatedly said that when an insurer follows a judicially preferred procedure to resolve a coverage dispute, it will not risk breaching its duty to defend."

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