Client Alert

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Year in Review: Top Insurance Cases of 2019

There were a number of 2019 insurance coverage decisions that will undoubtedly shape the coverage landscape for years to come. Policyholders enjoyed a number of significant wins, including substantial victories in areas involving illusory coverage to directors and officers liability. The start of a new year gives us an opportunity to summarize some of 2019's most notable coverage decisions.

Social Engineering

Social engineering remained a hot topic in 2019 and there were several noteworthy decisions concerning loss resulting from social engineering or "phishing" schemes that helped shape the landscape in favor of policyholders.

- EDVA Finds Computer Fraud Occurred "Directly" From a Computer Despite Numerous Non-Computer Acts in the Causal Chain of Events. *Cincinnati Ins. Co. v. Norfolk Truck Ctr., Inc.*, No. 2:18-cv-531, 2019 WL 6977408 (E.D. Va. Dec. 20, 2019).

Following a bench trial, the United States District Court for the Eastern District of Virginia found in *Cincinnati Insurance Co. v. Norfolk Truck Center* that a commercial truck dealer's social engineering loss arose directly from a computer, thereby triggering the dealer's computer fraud coverage, notwithstanding that the scheme involved numerous non-computer acts in the causal chain of events. The case arose when the City of Norfolk placed an order for two trucks with the Norfolk Truck Center (NTC). In order to fill the order, NTC ordered parts from Kimble Mixer Company (KMC). On the same day the order was placed, a fraudster posing as a KMC employee and using a slightly modified email sent NTC's CEO two legitimate invoices for the order and provided wire instructions for payment. The CEO approved the invoices and directed his bank to issue payment pursuant to the instructions provided. After preparing the appropriate paperwork, which was executed by the CEO, NTC's bank issued the payment. It took over a month before KMC followed up for payment, at which point NTC realized it had been the victim of fraud.

The court rejected the argument that the loss did not result directly from a computer because NTC issued the payment pursuant to a legitimate invoice. The court was also unpersuaded by the insurer's argument that the number of actors involved both inside and outside of NTC over the course of six days demonstrated that the loss was not "directly" from a computer. Finally, the court rejected the insurer's argument that NTC's failure to uncover the fraud was an intervening cause.

- Insurer on the Hook for Loss Resulting From Phishing Scheme. *Principle Sols. Group, LLC v. Ironshore Indem., Inc.*, 944 F.3d 886 (11th Cir. Dec. 9, 2019).

In *Principle Solutions*, the Eleventh Circuit held that a loss of over $1.7 million to scammers was covered under a commercial crime insurance policy's fraudulent instruction provision. The loss resulted from a "sophisticated phishing scheme" where a scammer posed as an executive of Principle and persuaded an employee to wire the money to a foreign bank account. The fake executive instructed the employee that the details of the wire transfer would be provided from a purported outside attorney.

The Eleventh Circuit held that, when read together, the emails from the purported Principle executive and the second email from the purported outside attorney were a fraudulent instruction; the sole purpose of the email from the outside attorney was to provide the necessary details to make the wire transfer. The court held that the fraudulent instruction from the scammer unambiguously fell within the policy's fraudulent instruction provision. The court further held that only a proximate cause between the covered event and the loss was required, and proximate cause "encompasses 'all of the natural and probable consequences' of an action, 'unless there is a sufficient and independent intervening cause.' "

- Insurer Breached Duty to Defend in Social Engineering Scam. *Quality Sausage Co., LLC v. Twin City Fire Ins, Co.*, No. 4:17-CV-111 (S.D. Tex. Sept. 18, 2019), ECF No. 110.

A Texas federal court vacated its prior ruling and entered summary judgment for the insured in the *Quality Sausage* case, finding that the insurer had a duty to defend its insured against claims by its customer after a hacker impersonating the customer convinced the insured to wire $1 million out of the customer's account because the potential for coverage existed. The case arose from fraudulent wiring instructions received by HMI from a hacker pretending to be HMI's client. The instructions directed HMI to transfer $1 million from the client's account to a bank account controlled by the fraudster. After the fraud was discovered and the funds lost, the client sought compensation from HMI for the loss. HMI sought coverage and a defense under its D&O and crime coverage insurance with Twin City Fire Insurance Company, but the insurer denied coverage. HMI subsequently settled the underlying demand from its client and moved for summary judgment on the duty to defend. Twin City moved for summary judgment on the duty to defend, arguing that certain exclusions applied. The court denied both motions for summary judgment on the duty to defend, finding that fact issues existed regarding the application of the exclusions.

On Twin City's motion for reconsideration, the court analyzed its prior ruling and held that its prior ruling was in error because coverage potentially existed based upon a demand letter, so the insurer had a duty to defend as a matter of law. The court vacated the portion of its prior order stating that fact issues existed, granting summary judgment to HMI on the duty to defend.

These cases continue to mark the breadth of coverage available to policyholders for social engineering and other computer-related fraud-induced losses under traditional insurance policies. With a myriad of other social engineering cases pending in courts throughout the country, we expect to see more noteworthy decisions in 2020.

Directors & Officers

2019 saw a flurry of decisions under directors and officers (D&O) insurance policies, including a bizarre and self-prompted change of heart by the Seventh Circuit.

- Seventh Circuit Withdraws Decision, Affirms Coverage for Emmis Shareholder Lawsuit Despite Notices to Multiple Insurers. *Emmis Commc'ns Corp. v. Ill. Nat'l Ins. Co.*, 937 F.3d 836 (7th Cir. 2019).

In the *Emmis Communications* case, the Seventh Circuit withdrew a controversial opinion that broadly interpreted an exclusion in Emmis' directors and officers liability policy, barring coverage for losses in connection with claims of circumstances "as reported" under Emmis' other insurance policy. The appeal to the Seventh Circuit stemmed from a district court ruling of summary judgment in favor of Emmis, rejecting the insurer's broad reading of the exclusion and concluding that the use of "as reported" in the past tense must "refer[] to events that had already occurred at the time of drafting." A three-judge panel in the Seventh Circuit initially reversed the district court and upheld the insurer's denial of coverage. However, on Emmis's petition for panel rehearing, the Seventh Circuit vacated the judgment in favor of the insurer, withdrew its initial opinion and affirmed the district court summary judgment decision. The reversal, while very rare, alleviated concerns about the chilling effect the court's broad reading of the exclusion may have on policyholders' decisions to provide notice under all potentially applicable insurance policies.

Hunton insurance recovery partner Michael Levine commented to Law360 that "[i]f you take Illinois National's interpretation of this language to its logical extreme, any common fact could conceivably trigger the exclusion. It could be something as minor as the mere fact that two claims were filed against the same corporate defendant. Emmis showed the Seventh Circuit why that interpretation led to an absurd result."

- Delaware Court Says Appraisal Action Constitutes a "Securities Claim"; Triggers D&O Coverage. *Solera Holdings, Inc. v. XL Specialty Ins. Co.*, 213 A.3d 1249 (Del. Super. Ct. 2019).

The Delaware Superior Court held that an appraisal action, which included $39 million in attorneys' fees, prejudgment interest and costs incurred in defending litigation that arose out of Solera Holdings, Inc.'s acquisition by Vista Equity Partners LP, constituted a covered "securities claim" under Solera's directors and officers liability insurance policy. The claim arose when Solera, a software company, announced a deal whereby it would be acquired by Vista and go private. A number of Solera's shareholders filed an appraisal action in March 2016 in Delaware Chancery Court, contending that the company's valuation was too low. Solera presented the appraisal claim to its D&O insurers to recover the attorneys' fees and costs incurred in defending the appraisal proceeding, but the insurers denied coverage. Solera filed suit, alleging breach of contract and seeking a declaratory judgment that the insurers were obligated to cover Solera's defense expenses and prejudgment interest awarded in the appraisal action. The court denied the insurers' motion for summary judgment and held that an appraisal action is a "securities claim" within the meaning of that term, defined in the D&O policies as "any claim for an alleged violation of law or rule regulating securities."

Solera marks the first opinion finding that an appraisal action is a covered securities claim under a D&O policy. In Law360, Hunton insurance recovery partner Syed Ahmad commented that "[t]his is a significant ruling because of the court's analysis about the reference to 'violation' which is in a variety of policy provisions. The court's rationale is another example of why the specific terms in a policy matter, and they matter a great deal. The court's reliance on dictionary definitions is also important because it provides another pathway to advance an interpretation of a term in a way that supports coverage."

- Governmental Civil Investigations Trigger Insurer's Duties to Defend and Indemnify. *Conduent State Healthcare, LLC v. AIG Specialty Ins. Co.*, No. N18C-12-074 MMJ CCLD, 2019 WL 2612829 (Del. Super. Ct. June 24, 2019).

The Delaware Superior Court held that a government-conducted civil investigation constitutes a "Claim" sufficient to trigger coverage under a professional liability insurance policy. Conduent alleged that the insurer breached its obligations by refusing to defend and indemnify Conduent for costs incurred in connection with a Medicaid fraud investigation. After considering cases reaching differing conclusions, the court concluded that the civil investigation demand from Medicaid was a "Claim" because it stated a "demand for … non-monetary relief" targeted at the insured. The court then considered whether the civil investigation demand alleged a "Wrongful Act," as required by the policy, and found no material distinction between an investigation of an alleged unlawful act and an allegation of an unlawful act, concluding that this was merely a "distinction without a difference."

- Court Rejects Insurers' Argument that Insureds Breached D&O Insurance Policies by Failing to Cooperate and Settling Lawsuits for $222 Million Without Consent. *Arch Ins. Co. v. Murdock*, No. N16C-01-104 EMD CCLD, 2019 WL 2005750 (Del. Super. Ct. May 7, 2019).

The Delaware Superior Court ruled that insurers could not rely on written consent and cooperation clauses in directors and officers liability insurance policies to avoid coverage for settlements by Dole Food Company, Inc., in shareholder disputes involving fraud in a go-private transaction. The court also held that settlement payments by the company to its shareholders were not an excluded "increase in the consideration paid," but a covered loss. The insurance dispute stemmed from a lawsuit shareholders brought in 2015 against Dole's former CEO, DFC Holdings, LLC, and David Murdock, who owned 40 percent of Dole's stock and was a director and officer of Dole. The shareholders alleged that Murdock used DFC to acquire the remaining shares of Dole at an artificially low price in order to take the company private. The court found that Murdock, the former CEO and DFC breached their duty of loyalty. San Antonio Fire & Police Pension Fund brought

similar claims against Dole and Murdock. Both cases settled. The combined settlements reportedly totaled $222 million.

According to Dole, DFC and Murdock, they notified the D&O insurers of their intent to settle the shareholder disputes, shared information relevant to the ongoing settlement negotiations and formally asked the insurers to contribute funds toward the resolution. The insurance company refused to fund the settlement amount and instead sued the policyholder seeking a declaration of no coverage under the policies.

The court determined that, based on the record, there was a question of fact as to whether the insurers unreasonably withheld their consent to the settlements. The court similarly concluded that there was a genuine issue of material fact as to whether the insurers had a reasonable opportunity to participate before the settlements were finalized, and could not rule that the policyholders breached the written consent provision. The court also ruled that the settlements were a "Loss," which the policies defined, in relevant part, as "all monetary amounts which the insureds become legally obligated to pay on account of a Claim, including damages, settlement amounts and judgments[.]"

Long Tail Claims

- *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indem. Co.*, 216 A.3d 629 (Conn. 2019).

The Connecticut Supreme Court affirmed that state law permits an "unavailability of insurance" rule, under which a policyholder is not liable to pay a share of its own defense and indemnity costs for periods when insurance for a certain risk was unavailable in the marketplace. Instead, those costs must be divvied up on a proportional, or "pro rata," basis among insurers that issued policies covering the risk in other periods. The court applied the rule in *Vanderbilt* because the insured was unable to obtain coverage after 1985 for individuals' claims for asbestos injuries allegedly caused by exposure to the company's industrial talc. The court also affirmed that an "occupational disease" exclusion in some of Vanderbilt's policies bars coverage not only for asbestos claims brought by the company's own workers, but also those brought by people who were allegedly sickened by Vanderbilt's products in the "course of their work for other employers."

Hunton insurance recovery partner, Syed Ahmad, explained in Law360 that, "as with other decisions breaking new ground, this case will naturally be the focus for future battles in other states about the scope of this and similar exclusions. Time will tell if what the court did here will be the start of a trend, with other courts following suit, or if the case will turn out to be an outlier with other states going their separate ways."

- Third Circuit Limits Pennsylvania's *Kvaerner* Decision; Unexpected and Unintended Injury May Constitute an "Occurrence" Under Pennsylvania Law. *Sapa Extrusions, Inc. v. Liberty Mut. Ins. Co.*, 939 F.3d 243 (3d Cir. 2019).

The Third Circuit ruled that differing "occurrence" definitions can have materially different meanings in the context of whether product defect claims constitute an "occurrence" triggering coverage under general liability insurance policies. The coverage dispute arose from an underlying action in which a window manufacturer alleged that, between 2000 and 2010, Sapa sold roughly 28 million defective aluminum window extrusions. The window manufacturer alleged that the extrusions, which are metal frames that hold glass window panes in place, began to oxidize and break down shortly after they were installed, causing Marvin to incur substantial costs to fix and replace them. Marvin sued Sapa in 2010 in Minnesota federal court, and the parties settled in 2013. Sapa sought coverage for the settlement from its eight general liability insurers for the period implicated by Marvin's allegations. The insurers denied coverage and Sapa brought suit in the Middle District of Pennsylvania. The district court held that there was no coverage available under any of Sapa's 28 liability policies because Marvin's claims did not arise from an "occurrence" that triggered coverage.

The Third Circuit held that product claims against Sapa may be covered under policies that define an "occurrence" as an accident resulting in bodily injury or property damage "neither expected nor intended from

the standpoint of the insured." However, the court affirmed that coverage was not triggered under policies lacking the "expected" or "intended" limitation, reasoning that, under those policies, there was no question that the intentional manufacturing of Sapa's product was too foreseeable to amount to an "accident."

The Third Circuit's ruling in *Sapa* reaffirms a fundamental rule of contract construction—that contracts, including insurance policies, must be interpreted based on their specific language.

Late Notice

- California Supreme Court Holds that Requirement of Prejudice for Late Notice Defense is a Fundamental Public Policy of the State for Choice of Law Analysis. *Pitzer Coll. v. Indian Harbor Ins. Co.*, 447 P.3d 669 (Cal. 2019).

California's highest court held in *Pitzer College* that the state's insurance notice-prejudice rule is a "fundamental public policy" for the purpose of choice of law analyses. This unanimous ruling, issued in response to certified questions from the Ninth Circuit, confirmed and emphasized California's common law rule that policyholders who provide "late notice" may proceed with their insurance claim, absent a showing by the insurer of substantial prejudice. The California Supreme Court also extended the prejudice requirement, holding that a first-party insurer must show that it was prejudiced before denying coverage under a policy's "consent provision," which typically provides that the policyholder must obtain the insurer's "consent" before incurring costs and expenses.

Malicious Prosecution

The increase in wrongful conviction litigation has given rise to new insurance coverage issues. In 2019, several courts considered the insurance triggers for claims of wrongful convictions and malicious prosecution under commercial general liability policies.

- New Illinois Supreme Court Trigger Rule for CGL Personal Injury "Offenses" Could Have Costly Consequences for Policyholders. *Sanders v. Ill. Union Ins. Co.,* 2019 IL 124565.

The Illinois Supreme Court's decision in *Sanders v. Illinois Union Insurance Co.* announced the standard for triggering general liability coverage for malicious prosecution claims under Illinois law. The Sanders case arose out of the wrongful conviction of Rodell Sanders in 1994 by the City of Chicago Heights. Mr. Sanders sought recompense for, among other things, malicious prosecution through a federal civil rights action against the city. In its decision, the court construed what appears to be a policy ambiguity against the policyholder in spite of the longstanding rule of *contra proferentem*, limiting coverage to policies in place at the time of the wrongful prosecution, and not the policies in effect when the final element of the tort of malicious prosecution occurred (i.e., the exoneration of the plaintiff).

- Missouri Appeals Court Says Malicious Prosecution Injury Occurs in Each Year of Incarceration; Counter to the Illinois Supreme Court's Recent Sanders Decision. *Ferguson v. St. Paul Fire & Marine Ins. Co.*, No. WD82090, 2019 WL 6703892 (Mo. Ct. App. Dec. 10, 2019).

In contrast to *Sanders*, the Missouri Court of Appeals, Western District, found only weeks later in *Ferguson* that a public entity liability policy covered the injuries sustained by a man who had been wrongfully convicted, notwithstanding that the policy was issued years after the relevant prosecution. The case arose out of the 2005 wrongful conviction of Ryan Ferguson by the City of Columbia in Boone County, Missouri. Ferguson was incarcerated from 2005 until his release in 2013. After his release, Ferguson sued Columbia for violations of his constitutional rights and malicious prosecution. Columbia and one of its insurers entered into a partial settlement with Ferguson for $2.75 million and Ferguson ultimately was awarded over $11 million following a bench trial. As a judgment creditor, Ferguson sought equitable garnishment against two of

Columbia's insurers that had denied coverage. The insurers did not dispute liability but challenged the availability of coverage on the ground that none of the policies were in place at the time of Ferguson's wrongful conviction.

The court concluded that the injuries sustained as a result of a malicious prosecution are continuous and ongoing and, consequently, Ferguson sustained "personal injury" during each year he was incarcerated as long as the injury was sustained during the policy period. The court further held that the insurers' policies "plainly and unambiguously [provide] coverage for injuries sustained during the policy period even though the wrongful act occurs before the policy period," and since Ferguson was found to suffer emotional distress and mental anguish during each year of his incarceration, he suffered "bodily injury" each year.

With respect to claims like *Sanders* and *Ferguson*, the National Registry of Exonerations, which compiles statistics concerning exonerations from wrongful convictions, states that exonerations have grown tremendously since 1989, the first year of the database. Similarly, jury awards for wrongful convictions have also generally risen year over year. These conditions, combined with the tendency of policyholders of yesteryear to procure less coverage than policyholders of today and the uncertainties of even locating or obtaining coverage under legacy policies, creates a perfect storm that could leave the policyholder on the hook for a significant portion of an award for malicious prosecution.

Policy Exclusions

No matter the type of insurance, policy exclusions are always of critical importance. From the war exclusion to contractual liability, decisions based on exclusions to coverage featured prominently in 2019.

- *James River Ins. Co. v. Doswell Truck Stop, LLC*, 827 S.E.2d 374 (Va. 2019).

The Virginia Supreme Court overturned a circuit court decision and unanimously held that an insurer was not obligated to indemnify a truck stop under a commercial liability policy for litigation involving injuries caused by an exploding tire. The dispute arose when a truck stop employee invited a customer into the garage area while the employee repaired the tire on the customer's tractor trailer. According to the court's ruling, the employee over-inflated the tire, causing it to explode and injure the customer. The truck stop's insurer denied coverage, contending that the claim was precluded by the policy's auto exclusion for coverage arising out of an auto's maintenance. The insurer filed a declaratory action against the truck stop seeking a coverage determination.

The trial court ruled in favor of the policyholder and found that the meaning of "maintenance" of an auto was ambiguous because it could mean regular repair operation or a possessory interest other than ownership or use. The trial court also ruled that even if the auto exclusion barred coverage, there was coverage under a separate provision of the policy that provided premises liability. On appeal, the high court disagreed and said " 'regular repair operations' is the only interpretation of maintenance that can be reasonably applied to every instance of the term in the Policy," and it is not ambiguous. The court also said the auto exclusion precluded coverage of the premises liability provision of the policy.

- Seventh Circuit Says Contract Exclusion Renders E&O Coverage Illusory. *Crum & Forster Specialty Ins. Co. v. DVO, Inc.*, 939 F.3d 852 (7th Cir. 2019).

The Seventh Circuit held that a manufacturer's insurer must cover its insured, a designer and builder of anaerobic digesters, under its errors and omissions policy for claims alleging breach of contract, despite an exclusion in the policy for claims arising out of the breach of an express or oral contract. The coverage action arose from a 2013 lawsuit filed against DVO in Wisconsin state court by WTE-S&S AG Enterprises LLC, alleging that DVO breached a contract based on its failure to properly design and build an anaerobic digester, a tank that converts cow manure into electricity. In addition, WTE alleged that DVO engaged in an unethical kickback scheme.

The federal court held that the breach of contract exclusion precluded coverage for the underlying state court action. On appeal, however, the Seventh Circuit found that Wisconsin law, as in many states, interprets the "arising out of" language at issue broadly, and that applying it to a breach of contract exclusion would effectively preclude coverage for almost any action related to work performed under a contract render the professional liability coverage in the E&O policy illusory.

- It's Not Rocket Science: Ninth Circuit Rejects Insurer's Attempt to Invoke War Exclusion for Hamas Rocket Attack. *Universal Cable Prods., LLC v. Atl. Specialty Ins. Co.*, 929 F.3d 1143 (9th Cir. 2019).

In a win for policyholders, the Ninth Circuit rejected an insurer's argument that the common meaning of "war" applied when interpreting a war exclusion, instead of the customary usage of the term, pursuant to Cal. Civ. Code 1644, and revived NBC Universal's attempt to recover at least $6.9 million in costs incurred to relocate the production of a television show from Jerusalem during the 2014 Israeli-Palestinian conflict. In *Universal*, the appellate court considered whether losses incurred by plaintiffs Universal Cable Productions, LLC, and Northern Entertainment Productions, LLC (collectively, Universal), arising from moving production of its television series *Dig* out of Jerusalem in 2014 following a rocket attack by Hamas, were covered under Universal's television-production insurance policy, which contained three so-called "war" exclusions.

The court found that the insurer failed to prove that the "warlike action" exclusion applied because Hamas was not a de facto sovereign and Hamas was not engaging in "warlike action" by a military force. The court also found that " 'war' has a special meaning in the insurance industry requiring hostilities between de jure and de facto governments."

Other Noteworthy Decisions

- Washington High Court Holds Insurers Bound by Representations in Agent's Certificates of Insurance. *T-Mobile USA Inc. v. Selective Ins. Co. of Am.*, 787 F. App'x 395 (9th Cir. 2019).

In responding to a certified question from the Ninth Circuit, the Washington Supreme Court held that an insurer is bound by representations regarding a party's additional insured status contained in a certificate of insurance issued by the insurer's authorized agent, even where the certificate contains language disclaiming any effect on coverage. To hold otherwise, the court noted, would render meaningless representations made on the insurer's behalf and enable the insurer to mislead parties without consequence.

The certified question and ruling stem from T-Mobile USA's appeal of the district court's summary judgment ruling in favor of Selective Insurance Company on T-Mobile USA's breach of contract and declaratory judgment claims. Selective issued the insurance policy to a contractor of T-Mobile Northeast, LLC, a wholly owned subsidiary of T-Mobile USA. Through endorsement, the policy extended "additional insured" status to T-Mobile NE because the contract between T-Mobile NE and the insured required that T-Mobile NE be added as an additional insured. Additional insured status was not, however, extended to T-Mobile USA, as T-Mobile USA had not entered a written contract with the insured. Despite the fact that T-Mobile USA was not an additional insured under the policy, Selective's authorized agent, acting with Selective's apparent authority, issued a certificate of insurance to T-Mobile USA, stating that T-Mobile USA was "included as an additional insured" under the policy.

Based on the agent's representations in the certificate of insurance, T-Mobile USA argued that it had additional insured status because Selective is bound by its agent's representations that T-Mobile USA was included as an additional insured. The Washington Supreme Court agreed with T-Mobile USA, holding that, under Washington law, an insurance company is bound by the representation of its agent under such circumstances.

- Hunton Insurance Team Wins Summary Judgment on Firm's Own Hurricane Harvey Business Income Loss. *Hunton Andrews Kurth LLP v. Great N. Ins. Co.*, No. 2019-17480 (157th Dist. Ct., Harris County, Tex. Dec. 6, 2019).

A Texas judge has ruled that Hunton Andrews Kurth is entitled to coverage from Great Northern Insurance Co., a unit of Chubb, Ltd., for losses its predecessor firm suffered when Hurricane Harvey closed its Houston office and disrupted business in 2017. The court held that the insurance policy, written specifically for a law firm, covered business income loss until the firm's operations were restored to their pre-loss levels. The court rejected Chubb's argument that coverage lasted only until the physical damage that closed the building had been repaired. Rather, siding with Hunton, the court found that the policy language affords, in addition to ordinary business income coverage during the damage period, "extended period" coverage that commences after the damaged property is repaired and after the firm's operations resume.

Michael Levine, a partner on Hunton's insurance recovery team that led the coverage litigation and who argued the firm's summary judgment motion, commented to Law360 that "[i]t is disingenuous for an insurance company to come in after the fact and contend that any extended interruption is the result of damage in other parts of the city. If you cover hurricanes, then you should cover the loss caused by the hurricane, and not later contest causation when the insurer has already conceded that physical loss has occurred to covered property."

- Georgia Supreme Court Holds "Valid Offer" Necessary For Establishing Bad Faith Failure to Settle. *First Acceptance Ins. Co. of Ga., Inc. v. Hughes*, 826 S.E.2d 71 (Ga. 2019).

The Georgia Supreme Court ruled that First Acceptance Insurance Co. need not pay a $5.3 million excess judgment against its insured, even though the insurer could have settled the claim for the $50,000 policy limit. The case stemmed from a July 2012 jury verdict finding the policyholder at fault in a five-vehicle crash that killed the policyholder and injured five others. The $5.3 million verdict was obtained by two plaintiffs who suffered a neck injury and a traumatic brain injury, respectfully.

After receiving a $5.3 million verdict, the administrator of the policyholder's estate, sued First Acceptance, alleging bad faith in the insurer's failure to accept plaintiffs' demands and settle the claims within the policy limits. The administrator sought to recover the excess judgment as well as punitive damages and attorney's fees. The trial court granted summary judgment to the insurer in 2016, but the Georgia Court of Appeals reversed that judgment the following year. The Georgia Supreme Court again reversed, entering judgment in favor of the insurer. The high court reasoned that an insurer's duty to settle arises only after the injured party presents a valid, time-limited offer to settle within the insured's policy limits. According to the Georgia Supreme Court, the plaintiffs' demands did not include a deadline for acceptance by the insurer, thus the insurer did not act unreasonably by not accepting the offer before it was withdrawn.

The head of Hunton's insurance coverage group, Walter Andrews, explained in Law360 that the decision stands to hinder settlements and potentially subject innocent insureds to staggering liability beyond that covered by their insurance because the court took "an overly narrow approach" that is "disturbing and is likely to act as a deterrent to settlements in the future. By creating this false and narrow test, it means that insurance companies in Georgia will not be trying to settle personal injury cases unless the settlement negotiations are initiated by the injured party, which means that fewer cases will settle and cases will linger longer in courts, which is not in the interests of either the injured parties or the insured defendants."

- Opioid Settlement Triggers Insurer's Duty to Indemnify Where Covered Claims Are "Primary Focus" of the Action. *Cincinnati Ins. Co. v. H.D. Smith Wholesale Drug Co.*, No. 12-3289, 2019 WL 4727039 (C.D. Ill Sept. 26, 2019).

A federal court in Illinois ruled that Cincinnati Insurance Company was required to indemnify H.D. Smith for a $3.5 million settlement it reached with the State of West Virginia. The settlement resolved an action in which West Virginia alleged that H.D. Smith contributed to the state's opioid addiction epidemic through its negligent distribution of opioid prescription drugs. The underlying lawsuit was brought by the West Virginia

attorney general against H.D. Smith and 13 other drug manufacturers and distributors in June 2012. The suit included counts for negligence, unjust enrichment, public nuisance, violations of the West Virginia Uniform Controlled Substances Act and violations of the West Virginia Consumer Credit and Protection Act.

Generally, the duty to defend the entire lawsuit is triggered by the presence of just one covered claim among others that may not be covered. The court's decision in H.D. Smith illustrates a similar concept in the context of settlement and indemnity. Under the Illinois federal court's ruling, an insurer's duty to indemnify can be triggered by the settlement of a lawsuit that contains mixed covered and noncovered claims as long as the covered claims are, as the court explained, the "primary focus" of the action.

- Texas Supreme Court Holds Anadarko's $100M Deepwater Horizon Defense Costs Are Not Subject To Joint Venture Liability Limits. *Anadarko Petroleum Corp. v. Houston Cas. Co.*, 573 S.W.3d 187 (Tex. 2019).

Reversing a Texas Court of Appeals decision that allowed Anadarko's Lloyd's of London excess insurers to escape coverage for more than $100 million in defense costs incurred in connection with claims from the Deepwater Horizon well blowout, the Supreme Court of Texas held that the insurers' obligations to pay defense costs under an "energy package" liability policy are not capped by a joint venture coverage limit for "liability" insured. The Texas Supreme Court rejected the insurers' reading of the policy, and found that the term "liability insured" refers to Anadarko's liability to third parties for damages and the joint venture provision, which contained a limit only with respect to Anadarko's liability and did not limit the insurers' responsibility for Anadarko's defense expenses.

Sergio Oehninger, counsel on Hunton's insurance recovery team, commented to Law360 that "[t]he insurer's position could have cost the insured over $100 million in defense costs. The opinion makes clear that a policyholder's defense costs in similar disputes will not be subject to the joint venture provision's limit of liability, or to any other similar limit for 'liability insured.' "

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