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EXPERT ANALYSIS

Year in Review: Insurance Coverage Developments in 2016

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Insurance coverage law continued to evolve through 2016. As the year draws to a close, we take this opportunity to reflect on the cases and law that made this year memorable and will influence coverage decisions and disputes in 2017.

LITIGATION DEVELOPMENTS

The critical court decisions of 2016 departed from established precedent or forged new ground, interpreted traditional policies and new, and, overall, gave policyholders much to be thankful for as they embark on 2017. Here is our selection of the top cases for 2016.

Most important bad faith decisions of 2016

Denial of coverage unreasonable, even where coverage was only "fairly debatable." *Home Loan Inv. Co. v. St. Paul Mercury Ins. Co.*, 827 F.3d 1256 (10th Cir. 2016).

There should be no debate that *Home Loan Investment Company v. St. Paul Mercury Insurance Company* was one of the most significant "bad faith" decision of the year.

After a jury verdict in favor of a policyholder on its breach of contract and statutory bad faith claims, a Colorado federal court rejected an insurer's motion for judgment as a matter of law (JMOL) on the policyholder's statutory bad faith claim.

The insurer argued that, because coverage was "fairly debatable," the insurer's coverage decision could not be, as a matter of law, unreasonable (as required by the statute).

On appeal, the Tenth Circuit disagreed and, relying on Colorado appellate authority, held that "fair debatability is not a threshold inquiry that is outcome determinative as a matter of law; it is not necessarily sufficient, standing alone, to defeat a bad faith claim."

The decision, therefore, represents a significant departure from the frequently seen argument by insurers that issues of fact necessarily preclude a finding of bad faith.

Bad faith claim survives, despite no coverage. *Travelers Property Casualty Company of America et al. v. Federal Recovery Services et al.*, 156 F. Supp. 3d 1330 (D. Utah 2016).

Not to be outdone by the Tenth Circuit (in *Home Loan Investment*, discussed above), a federal judge in Utah saw fit to allow a claim for bad faith even in the absence of coverage, thereby dispelling the notion that proof of coverage is a prerequisite to bad faith.

The decision is an important reminder that bad faith claims apply to all insurer activities — not just coverage determinations.

The coverage dispute occurred when Federal Recovery Services (FRS) sought defense and indemnity for suit brought by a fitness center.

The fitness center alleged that FRS intentionally misused customers' private financial information, which interfered with FRS's business dealings.

The court found no coverage under the Travelers' "CyberFirst Policy" because the alleged misconduct was willful and malicious — not negligent, as required for coverage.

However, the court refused to dismiss FRS's claim that Travelers acted in bad faith by imposing inappropriate conditions precedent to claim initiation and failing to diligently investigate, fairly evaluate, and promptly communicate with FRS.

The decision is a reminder that bad faith conduct may exist in more than just the carrier's ultimate claim decision.

Most important claims-made decision of 2016

Insurers in New Jersey not required to show prejudice from late notice. *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 129 A.3d 1069 (N.J. 2016).

The New Jersey Supreme Court dealt a blow to policyholders in February when it refused to apply the state's *Cooper* doctrine to claims-made insurance policies, making late notice potentially fatal when coverage depends on a claim being made during the policy period.

The underlying suit arose when a financial group failed to fund a loan for intended purchasers of property, causing the intended sellers to terminate the purchase agreement.

The intended purchasers served their complaint against the financial group in February, but the group did not provide notice to its D&O carrier until August (during the policy period, but well after the policy's requirement that notice be given within 30 days after first receipt of the claim).

The insurer denied coverage for late notice, among other reasons — a decision affirmed by the trial court, intermediate appeals court and New Jersey Supreme Court.

In doing so, the New Jersey Supreme Court limited application of its decision in *Cooper v. Government Employees Insurance Company*, 51 N.J. 86 (1968), which requires that insurers prove how late notice under occurrence-based policies caused prejudice to the insurer.

Nevertheless, the decision is not an absolute bar in the absence of prejudice: the Court noted that its decision was not "a sweeping statement about the strictness of the as soon as practicable notice requirement in claims made policies generally," but rather applied only where the policy's unambiguous requirements of the policy were negotiated between sophisticated business entities.

Most important cyber/crime decisions of 2016

Pro-policyholder

Cyber loss covered where essential employee negligence was not overriding cause of bank loss. *State Bank of Bellingham v. BancInsure, Inc.*, 823 F.3d 456 (8th Cir. 2016).

In May, the Eighth Circuit gave an important boost to policyholders in *State Bank of Bellingham v. BancInsure, Inc.*, when it rebuffed a common insurer argument — that employee negligence breaks the causal chain between third-party criminal acts and otherwise covered losses.

The bank's insurance claim arose from fraudulent wire transfers achieved by a Trojan horse virus after an employee inadvertently left physical tokens in a bank computer, which were part of the multi-pronged wire transfer approval process.

The bank's insurer denied coverage under a financial institution bond based on employee-caused loss exclusions, a theft of confidential information exclusion, and exclusions for mechanical failure.

The Court found the loss covered by the policy, holding that "[e]ven if the employees' negligent actions 'played an essential role' in the loss and those actions created a risk of intrusion into Bellingham's computer system by a malicious and larcenous virus, the intrusion and the ensuing loss of bank funds was not 'certain' or 'inevitable.'

The 'overriding cause' of the loss Bellingham suffered remains the criminal activity of a third party."

The holding — that employee negligence did not convert direct loss into indirect loss — came at a critical time for financial institutions, who faced a spike in cyber-attacks in 2016.

Availability to public was sufficient to trigger duty to defend under CGL's "electronic publication" coverage. *The Travelers Indem. Co. of America v. Portal Healthcare Solutions*, 644 Fed. Appx. 245 (4th Cir. 2016).

The Fourth Circuit's decision in *Portal Healthcare* was one of the more controversial rulings for 2016.

The underlying class action alleged that Portal Healthcare failed to protect confidential patient medical records by inadvertently posting those records on the Internet in a manner that could be publicly accessed.

Portal Healthcare sought coverage under a provision of its commercial general liability policy that covered "electronic publication of material" in certain circumstances.

The dispute between Portal Healthcare and its insurer centered on whether there had been "publication."

In finding that the insurer had a duty to defend Portal Healthcare against the class action, the district court (whose decision was affirmed) emphasized that (1) "'publication' does not hinge on the would-be-publisher's intent", (2) that "unintentional publication is still publication" and (3) that "publication does not hinge on third-party access."

As Hunton & Williams LLP partner Syed Ahmad explained, *Portal Healthcare* was a "critical ruling because this issue of what constitutes a publication comes up in a lot of different kinds of policies that most businesses have, such as [general liability] and specialized policies."

The decision was also an important victory for policyholders who seek coverage for cyber claims under traditional insurance policies.

Pro-insurer

No coverage where expectations did not meet policy language. *P.F. Chang's China Bistro, Inc. v. Federal Ins. Co.*, No. 2:15-cv-1322 (SMM), 2016 WL 3055111 (D. Ariz. May 31, 2016) (on appeal; pending dismissal following successful mediation on Nov. 22, 2016).

Perhaps the worst decision of the year for cyber insurance consumers came from a federal court in Arizona in May 2016.

In *P.F. Chang's China Bistro, Inc. v. Federal Insurance Company*, the court rejected the restaurant giant's attempt to recover $2 million it paid following a 2013 breach where hackers obtained and posted on the Internet approximately 60,000 credit card numbers belonging to Chang's customers.

At the time of the loss, Chang's was insured by Federal under a "CyberSecurity by Chubb Policy."

Federal agreed to reimburse Chang's nearly $1.7 million for claims brought by injured customers and issuers, but refused to reimburse an additional $2 million in fees and PCI-DSS assessments that were passed down to Chang's by credit card service providers.

The court agreed that Federal had no liability for the fees, holding, in part, that a common contract exclusion applied and that Chang's had no reasonable expectation of coverage.

The court reached its holding despite Federal's aggressive marketing of the policy as "a flexible insurance solution designed by cyber risk experts to address the full breadth of risks associated with doing business in today's technology-dependent world," and despite the insurer's full knowledge of Chang's critical PCI-DSS exposure.

As Hunton & Williams LLP attorneys Michael Levine and Sergio Oehninger explained, policyholders should expect continued litigation about issues like these, since cyber forms remain mostly untested in court. However, because the meaning of these new policies is still debatable, businesses should not be discouraged from taking the fight to the insurer in the face of a coverage denial.

No coverage where email was not direct cause of loss. *Apache Corp. v. Great Am. Ins. Co.*, No. 15-20499, 2016 WL 6090901 (5th Cir. Oct. 18, 2016).

In October 2016, the Fifth Circuit Court of Appeals rendered a surprising reversal that stands to limit coverage for cyber-crime losses under commercial crime policies.

The insured, Apache Corporation, sought coverage after an employee inadvertently made authorized payments of legitimate vendor invoices to criminal bank accounts.

The criminal scheme started with a fraudulent phone call and was confirmed by a fraudulent e-mail that appeared to be on the vendor's letterhead, which contained a fake vendor number that Apache Corporation used to confirm the payment.

Shortly after the transfer, Apache Corporation learned about the fraud and was able to recover some, but not all, of its losses. It sought to recover the balance from its insurer, which denied coverage.

The district court ruled in Apache Corporation's favor, but the Fifth Circuit reversed, holding that the loss was not a "direct result" of "computer use" as required by the policy.

The "computer use" — i.e., the fraudulent email — was merely one part of a larger fraudulent scheme and, thus, incidental to the unauthorized transfer of money.

The case — *Apache Corporation v. Great American Insurance Company* — is illustrative of the significant gaps that still exits for cyber and other technology-related losses and the need for targeted negotiation for specific coverage at the application stage.

Most important excess decisions of 2016

Excess policy's ambiguity required payment of "limits" twice. *Westchester Surplus Lines Inc. Co. v. Keller Transport Inc.*, 365 P.3d 465 (Mont. 2016).

Careful attention to detail won the day in *Westchester Surplus Lines Inc. Co. v. Keller Transport Inc.* when the Montana Supreme Court awarded what the insurer considered to be *double* excess coverage for losses arising from the same incident.

The dispute, here, centered on the meaning of "General Aggregate" in an excess insurance policy.

After a tanker truck spill, the primary insurer paid limits on the auto part of its commercial policy, as did the excess carrier (or so it thought).

When a later suit triggered and exhausted the general liability (GL) portion of the policy, the policyholder sought excess coverage again, making the argument that the policy was ambiguous and, thus, should be interpreted in favor of coverage because it was not clear whether "General Aggregate" (undefined in the excess policy) was intended to be the maximum liability for the entire policy, or with respect to each coverage part (auto and GL).

The Court agreed and ordered payment of excess coverage for the GL claims.

The decision decimated insurer expectation about excess limits and underscored why it is important to never assume policy meaning based on past experience.

All sums interpretation causes duty to pay defense costs above limits. *In re Viking Pump, Inc.*, 52 N.E.3d 1144 (N.Y. 2016) (unanimous), *opinion after certified question answered,* 148 A.3d 633 (Del. Sept. 12, 2016) (excess insurers had duty to defend pump manufacturers and to pay defense costs in addition to policy limits, but were not responsible for expenses above policy limits).

Responding to certified questions from the Delaware Supreme Court, the New York Court Appeals unanimously held that the "all sums" allocation method, under which each of an insured's policies can be liable for an entire loss, applied to this asbestos injury coverage dispute where the relevant policies contained "noncumulation" and "prior insurance" provisions; the court expressly rejected the pro rata approach advocated by the carriers.

The court also held that vertical, not horizontal, exhaustion was appropriate, even where all triggered primary policies have not be drained.

As Hunton & Williams partner Syed Ahmad explained, the decision is a boon to policyholders: "Under all-sums, policyholders can seek to recover all amounts owed from one insurer, which will make things much easier for them to recover for a particular loss, … [and] [v]ertical exhaustion provides additional pathways to recovery. Instead of requiring the policyholder to exhaust all primary coverage first, they can select particular policies and go up vertically."

Most important first party property decision of 2016

Covered cause + not covered cause = coverage. *Sebo v. American Home Assurance Co., Inc.*, Case No. SC14-897, 2016 WL 7013859 (Fla. Dec. 1, 2016).

The Florida Supreme Court's decision in *Sebo v. American Home Assurance Company, Inc.* dealt a victory to the state's policyholders by resolving — in part — a common Hurricane Alley struggle over what causation theory applies where multiple covered/not covered causes are at play (like wind, water, or workmanship).

The debate is between the efficient proximate cause theory (which affords coverage if a covered cause sets other causes in motion) or concurrent cause theory (which affords coverage if the perils combine to cause the loss, neither peril alone could have done so, and at least one peril is covered).

In this case, the Court held that, where there was no reasonable way to distinguish the proximate cause of loss between rain (a covered cause) and construction defect (not covered), the concurrent causation doctrine afforded coverage under an all-risk insurance policy.

Although the decision may be limited to the all-risk context, the *Sebo* decision has far-reaching implications for Florida policyholders as it solidifies the application of the concurrent cause doctrine and supports the general rule that policies are interpreted in favor of finding coverage.

The straightforward application of the concurrent cause doctrine also promotes the predictability and judicial efficiency that has been lacking in other jurisdictions. For example, in the areas affected by Hurricane Katrina, cases vary considerably on whether wind or rain was the efficient proximate cause of hurricane damage.

Most important product contamination decision of 2016

***Potential* product contamination is covered under accidental contamination policy.** *Foster Poultry Farms, Inc. v. Certain Underwriters at Lloyd's*, London, 137 F. Supp. 3d 1252 (E.D. Cal. 2015), *amended*, 2016 WL 235211 (E.D. Cal. Jan. 20, 2016), *bench trial award*, 2016 WL 541441 (E.D. Cal. Feb. 11, 2016) (settled April 2016).

Foster won coverage for its contamination losses back in October 2015, but since the case continued into 2016 (with an award of $2.7 million in damages), it is worth mention again.

The case arose from a USDA order to suspend operations due to prevalence of salmonella and cockroaches in Foster's largest chicken-processing plant.

Foster's insurer denied coverage under its "accidental contamination" and "government recall" forms.

In subsequent litigation, the court granted Foster's motion for summary judgment, finding that Foster's noncompliance with federal sanitation regulations were "error[s] in production" covered by the policy.

The court also held that there need not be absolute certainty of bodily injury; rather, the government standard — where possible contamination was sufficient to warn against public consumption — triggered coverage.

Chief among the lessons offered by this decision is the importance of policy phrasing, whether with respect to the nature of the insured event, the danger affecting a consumable product or causation.

Policyholders should ensure, therefore, that they understand the implications of the provisions in their policies based on the varying factual scenarios that may present an insurance claim arising out of food contamination.

Most Important Case-Lessons from 2016

Even inadvertent omissions at application stage can lead to rescission. *H.J. Heinz Company v. Starr Surplus Lines Ins. Co.*, No. 15-cv-0631, 2016 WL 374307 (W.D. Pa. Feb. 1, 2016), *aff'd*, No. 16-1447, 2017 WL 108006 (3d Cir. Jan. 11, 2017).

A Pennsylvania federal court imposed a policyholders' nightmare in February 2016 by ordering rescission of an accidental contamination and government recall insurance policy issued to the H.J. Heinz Company.

The case arose after Heinz sought $25 million from its insurer for its business interruption losses after Chinese authorities discovered lead in its baby cereal.

Despite a jury verdict in the policyholder's favor, the court rescinded the policy on the grounds that Heinz made material misrepresentations and omissions regarding its claim history, which Heinz claimed were inadvertent errors by its new Global Insurance Director.

Although a jury agreed that Heinz's errors were unintentional, the court found that even unintentional material misrepresentations were sufficient to void the contract.

The decision is an important reminder that an insurance application is not just procedural hurdle to obtaining a policy; the representations made therein may be a later bar to coverage if the policyholder is not careful and thorough when answering questions.

The best defense may plead you out of coverage. *Petroterminal de Panama, S.A. v. Houston Cas. Co.*, No. 15-2941-cv, 2016 WL 4703898 (2d Cir. Sept. 8, 2016).

Litigators like few things more than winning a case, but sometimes a cracker-jack defense team can plead the client right out of coverage. Such was the case in *Petroterminal*.

In the underlying dispute, Castor Oil sued Panama-based Petroterminal de Panama for losses resulting from an oil spill. Petroterminal tendered the Castor suit under its primary marine liability and excess bumbershoot policies.

The insurer agreed to advance defense costs, subject to recoupment in any later coverage action.

After Petroterminal successfully defended the lawsuit, the insurer denied coverage and sought to recoup its earlier payments based on Petroterminal's successful underlying defense (which established that the alleged losses were not due to its negligence, but rather the Panamanian government's "attachment" of Castor's oil).

On appeal, the Second Circuit Court of Appeals affirmed, holding that the "duty to reimburse" required recoupment where the loss was not covered, as was the case here.

However, the apparent dilemma facing Petroterminal — win the case but lose coverage — could have been avoided. For instance, had Petroterminal settled the Castor litigation without obtaining a factual finding as to the cause of Castor's losses, that settlement would have been covered, as would all of Petroterminal's defense costs — a far-greater victory of sorts.

The lesson? Where insurance coverage is at stake, be cognizant of the requirements for coverage and consider those requirements as you determine the optimal strategy for your underlying defense.

LEGISLATIVE, REGULATORY & RULE OF LAW DEVELOPMENTS

2016 also welcomed a handful of regulatory and rule-making developments affecting the insurance policyholders.

Flood Insurance Market Parity and Modernization Act (FIMPMA) passed U.S. House

FIMPMA amends the Flood Disaster Protection Act of 1973. The bill was unopposed in the U.S. House, with 419 yeas and 14 not voting.

Supporters claim the bill would open the flood insurance market to more private insurers by clarifying acceptable policies which, to date, mortgage lenders have by-and-large limited to National Flood Insurance Program policies.

The act was referred to the U.S. Senate's Committee on Banking, Housing and Urban Affairs in May, where there has been no subsequent reported action.

New York moves forward on proposed cyber security regulations affecting financial services companies

On December 19, 2016, the New York State Assembly Standing Committee on Banks heard testimony about a proposed regulation that would require financial services companies to develop and implement cybersecurity programs to defend against cyber-attacks.

This would be the first regulation of its kind in the United States.

Financial services companies remain concerned that the proposed legislation does not account for cost and burden to small- and mid-sized firms, trickle-down effects on consumers, or the diversity of risk facing the market.

New Jersey sends ride-hailing bill to Governor Christie's desk

On December 19, 2016, the New Jersey state legislature passed, by overwhelming majority, a measure that set minimum insurance requirements, among other constraints, for ride-hailing businesses like Uber and Lyft.

Minimum limits include at least $1.5 million in insurance coverage for death, bodily injury and property damage occurring during a hired ride.

Pending Restatement of the Law of Liability Insurance

In May, the American Law Institute (ALI) approved the first three Chapters of the forthcoming Restatement of the Law of Liability Insurance. (Final chapters will be voted on in May 2017).

ALI Restatements are typically highly regarded by judges, meaning that this new restatement may prove to be a critical resource for courts in coverage disputes.

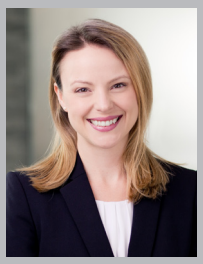
Key provisions of the draft include:

- Improved standard for the duty to cooperate, by clarifying that a breach of the duty to cooperate will bar coverage "only if the insurer demonstrates that the failure caused or will cause prejudice to the insurer." Thus, the draft rejects the minority rule that a breach of the duty to cooperate allows the insurer to avoid its obligations, regardless of whether the breach prejudiced the insurer.
- Adoption of the "complaint-allegation" rule, which determines the insurer's duty to defend based on the allegations of the complaint alone, subject to limited exceptions.
- Favored reservation of rights letters over outright denial of the duty to defend.
- Prevention of insurer control over the defense or settlement of an action if the insurer breaches the duty to defend.
- Elimination of the right to contest coverage if the insurer lacks a reasonable basis for its failure to defend.

- "Clearer" standard for "reasonable insurer," including duty to make "reasonable settlement decision[s]" through investigation, negotiation, and pursuit of informed advice about exposure and risk.

- Adoption of the majority rule that an insurance policy term is interpreted according to its plain meaning, but with a policyholder-favored exception where "extrinsic evidence shows that a reasonable person in the policyholder's position would give the term a different meaning."

Until next year, cheers!



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