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Year in review: Notable insurance coverage developments of 2017!

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With 2017 behind us, we take this opportunity to reflect on the cases and other insurance developments that made this year memorable and will influence coverage decisions and disputes in 2018 and beyond.

LITIGATION DEVELOPMENTS

The past year was full of influential — and sometimes controversial — decisions that will surely impact the insurance coverage landscape. Here is our selection of some of the most significant cases from 2017.

Important bad-faith decisions of 2017

Texas Supreme Court rules that policyholders may recover for bad faith in the absence of coverage. *USAA Texas Lloyds Co. v. Menchaca*, No. 14-0721, 2017 WL 1311752 (Tex. Apr. 7, 2017).

In one of the most closely watched bad-faith cases of 2017, the Texas Supreme Court clarified substantial "confusion" among lower courts in Texas and resolved several important bad-faith concepts by announcing five rules addressing the relationship between contract claims under an insurance policy and tort claims under the Texas Insurance Code.

Among those principles was the rule that a policyholder may recover for loss caused by an insurer's bad-faith conduct, even if the insurance policy does not grant coverage for the claimed loss.

The ruling did not resolve all uncertainty about insurance bad-faith law in Texas, but we also likely have not seen the last of the *USAA* case, as the court granted rehearing earlier in December 2017.

Eleventh Circuit affirms jury award for insurer's negligent failure to settle. *Camacho v. Nationwide Mutual Insurance Co.*, No. 16-14225, 2017 WL 2889470 (11th Cir. July 7, 2017).

The balance of 2017 saw several other pro-policyholder bad-faith decisions, including notable decisions in California and Georgia. For instance, in July, the Eleventh Circuit affirmed a jury award arising from an insurer's failure to accept a time-limited settlement demand.

The decision in *Camacho* reiterates that under Georgia law, as elsewhere, an insurer's failure to settle a claim need only be negligent for the insurer to be found liable for the refusal to settle.

While the Eleventh Circuit's decision supports the use of reasonable, time-limited settlement offers as an efficient means to resolve coverage disputes, the insurer's arguments on appeal highlight the importance of carefully structuring settlement demands to avoid any ambiguity as to the scope or intent of such demands.

Important cyber/crime decisions of 2017

Chubb Owes $4.8M for Medidata social engineering loss. *Medidata Solutions Inc. v. Federal Insurance Co.*, No. 15-cv-907, 2017 WL 3268529 (S.D.N.Y. July 21, 2017).

The decision in *Camacho* reiterates that under Georgia law, as elsewhere, an insurer's failure to settle a claim need only be negligent for the insurer to be found liable for the refusal to settle.

In 2016, we highlighted the unfortunate trend of insurers contending that cybercrime losses are not covered under either crime or cyber insurance policies.

Policyholders had reason to be happy, however, when a New York federal court awarded summary judgment in favor of Medidata Solutions, Inc., finding that Medidata's $4.8 million loss suffered after Medidata was tricked into wiring funds to a fraudulent overseas account, a fraud that triggered coverage under the policyholder's commercial crime policy's computer-fraud and funds-transfer fraud provisions.

The award followed the court's ruling in March 2016 requiring additional expert discovery concerning the manner in which the fraudsters had manipulated Medidata's computer systems.

The *Medidata* decision, currently on appeal before the Second Circuit, underscores the breadth of coverage that should be available to policyholders under commercial crime policies for social engineering and other fraud-induced losses.

It also illustrates the complex factual and technical questions that can arise in cases seeking to enforce cyber and crime insurance for social engineering frauds and cyber breaches.

Court finds no crime coverage for computer-fraud losses. *Posco Daewoo America. Corp. v. Allnex USA Inc.*, No. 17-cv-483, 2017 WL 4922014 (D.N.J. Oct. 31, 2017).

Not all cybercrime decisions resulted in coverage in 2017, despite policyholders' continued efforts to assert coverage for a variety of cyber losses.

In November, for example, a New Jersey district court granted an insurer's motion to dismiss a suit to enforce coverage brought by Posco Daewoo America Corporation under the computer fraud provision of its crime insurance policy.

In contrast to the fact situations in *Medidata* and other cyber insurance cases, Daewoo did not seek to enforce coverage for money fraudulently transferred or stolen from its own accounts. Rather, Daewoo sought coverage for amounts that had been designated for payment to Daewoo by a third-party supplier and stolen from the supplier after a criminal impersonated a Daewoo employee.

The court held that the crime policy did not cover the lost sums because Daewoo did not "own" the money stolen from the supplier.

The court did not reach the parties' conflicting positions on whether Daewoo experienced a "direct loss" under the policy — an issue that has been the primary point of dispute in other legal battles over the meaning of "computer fraud" coverage.

However, the court left the door open for rulings upholding coverage in other fact situations, noting that New Jersey precedent in cyber insurance cases interprets the word "direct" as requiring "proximate cause."

We are likely to see further decisions in this case in 2018 as the court gave Daewoo 30 days to amend its complaint, which it did in November.

Important D&O and E&O decisions of 2017

New York trial court's TKO of Bear Stearns' insurer ill-gotten gains arguments after lengthy coverage war. *J.P. Morgan Securities Inc. v. Vigilant Insurance Co.*, 51 N.Y.S.3d 369 (Sup. Ct. 2017).

In what may be the fatal blow in a longstanding dispute regarding coverage for settlement amounts paid to settle SEC investigations, a trial level court in New York entered summary judgment for the policyholder in the Bear Stearns D&O coverage litigation.

Among other important holdings, the court found that the documentary and testamentary evidence presented by Bear Stearns overwhelmingly demonstrated that its misconduct profited customers only, and did not result in "ill-gotten gains" for Bear Stearns itself.

Bear Stearns' insurers argued that the SEC settlement payments were uninsurable disgorgement and, therefore, did not represent covered "loss" under the policies, but the trial court disagreed.

The court's latest knockout of the insurers' coverage arguments undercuts the frequent contention by D&O and professional liability insurers that public policy or policy exclusions (or both) preclude coverage for a loss they deem to constitute "disgorgement" of "ill-gotten gains."

The opinion also reinforces that settlements made by policyholders, even with regulatory agencies, do not activate policy exclusions for personal conduct such as dishonest acts or personal profit exclusions, where the settlement does not assert such prohibited conduct.

Finally, the opinion reiterates the prior finding by New York's highest court, the New York Court of Appeals, that settlement payments must be predicated on the profits improperly acquired by the policyholder in order to implicate the public policy exception to coverage or other related exclusions, even where such payments are labeled expressly as "disgorgement."

Medidata illustrates the complex factual and technical questions that can arise in cases seeking to enforce cyber and crime insurance for social engineering frauds and cyber breaches.

Insurer must pay post-merger defense costs under merged entity's D&O policy. *BCB Bancorp Inc. v. Progressive Casualty Insurance Co.*, No. 13-cv-1261, 2017 WL 4155235 (D.N.J. Sept. 18, 2017).

A New Jersey federal court reminded corporate policyholders this fall that they should carefully consider insurance coverage implications when structuring mergers, acquisitions, or other transactions that may affect available insurance assets.

The court granted summary judgment to a surviving bank asserting coverage rights under a D&O policy issued to an entity that had earlier dissolved in a statutory merger, based in part on the wording of the parties' merger agreement that structured the transaction in accordance with the New Jersey Business Corporation Act ("NJBCA").

In so holding, the court refused to permit the insurer to deny coverage for post-merger defense costs incurred in connection with a pre-merger shareholder class action lawsuit, rejecting the insurer's argument that its duty to defend the original policyholder's officers and directors ended when the policyholder dissolved and merged into the surviving entity.

The court stated that, "[u]nder the NJBCA, the surviving corporation of a merger in essence steps into the shoes of the merged entity for the purposes of the merged entity's rights and liabilities," including with respect to the merged entity's insurance policies.

Accordingly, the court held that "an insurance contract must contain specific exclusionary language to prevent a transfer of rights to the surviving entity under the NJBCA." No such exclusion existed in the insurance policy, so the transfer of assets in the merger preserved the dissolved entity's insurance rights.

Important excess insurance decisions of 2017

"Think hard before saying no": Ninth Circuit disparagement coverage ruling gives policyholders lifeline in settlement negotiations involving excess insurers. *Teleflex Medical Inc. v. National Union Fire Insurance Co. of Pittsburgh PA*, 851 F.3d 976 (9th Cir. 2017).

In *Teleflex*, the Ninth Circuit affirmed a jury verdict finding that AIG must pay $3.75 million in damages plus attorneys' fees to cover a settlement between LMA North America, Inc. ("LMA") and a competitor over LMA's allegedly disparaging advertisements characterizing the competitor's products as unsafe.

AIG had refused to fund LMA's settlement, arguing that it had an absolute right to veto the settlement under the AIG policy's "no action" and "voluntary payments" clauses.

The Ninth Circuit disagreed and affirmed the bad-faith judgment, holding that, under California's standard set forth in *Diamond Heights Homeowners Association v. National American Insurance Co.*, 227 Cal. App. 3d 563 (1991), an excess insurer has three options when presented with a proposed settlement of a covered claim that has met the approval of the policyholder and the primary insurer: (1) approve the proposed settlement; (2) reject it and take over the defense; or (3) reject it, decline to take over the defense, and face a potential lawsuit by the policyholder seeking contribution toward the settlement.

AIG's "foot-dragging" and refusal to contribute to LMA's settlement did not satisfy the *Diamond Heights* standard.

The Ninth Circuit's decision in *Teleflex* provides important support to policyholders who are negotiating with excess insurers for coverage of large settlements and may encourage excess insurers to participate in settlements to avoid bad-faith liability.

First Circuit rules settlement agreement can trigger excess insurance coverage under policy language, but this settlement did not. *Salvati v. American Insurance Co.*, No. 16-1403, 2017 WL 1488238 (1st Cir. Apr. 26, 2017).

In contrast to *Teleflex*, the settlement arrangement in *Salvati* was not sufficient to establish coverage under the applicable excess liability policy.

There, the policyholder reached a settlement with the underlying claimant, which allowed the claimant to recover from the excess insurer, but stipulated that the settlement was not contingent on the ultimate availability of excess coverage or that the policyholders had engaged in any wrongdoing.

When the claimant asserted his rights against the excess insurer, the excess insurer argued that the settlement did not trigger coverage because only a judgment can "legally obligate" a party to pay "damages," as required by the policy.

The First Circuit disagreed, holding that the term "damages" did not require a judgment and that the settlement *could* trigger coverage, but that the actual settlement at issue did not do so because it did not require the policyholder to pay anything more than the primary limits.

The *Salvati* case is a good reminder, therefore, of the importance that the wording in settlement agreements can have on the applicability of insurance.

Important first-party insurance cases of 2017

Third Circuit pours salt in the wound, holds Heinz policy void due to misrepresentations in the policy application. *H.J. Heinz Co. v. Starr Surplus Lines Insurance Co.*, 675 Fed. App'x 122 (3d Cir. 2017).

H.J. Heinz Company's coverage dispute continued in 2017, but unfortunately did not provide more favorable results.

As discussed in last year's annual coverage roundup, in February 2016, a Pennsylvania federal court ordered rescission of an accidental contamination and government recall insurance policy issued to Heinz after Heinz sought $25 million from its insurer for business-interruption losses sustained after lead was found in some of its baby cereal products.

The district court based the rescission on findings that Heinz had materially misrepresented its claim history when it purchased the policy. Heinz claimed the incorrect information was an inadvertent error by its new Global Insurance Director.

Although a jury agreed that Heinz's errors were unintentional, the district court found that even unintentional material misrepresentations suffice under Pennsylvania law to void an insurance contract.

In January 2017, the Third Circuit affirmed the district court's ruling, writing: "The materiality of Heinz's misrepresentation is self-evident. For the 10-year period identified in the application, Heinz disclosed only one loss in excess of a $5 million [self-insured retention]. In reality, however, Heinz experienced three losses exceeding a $5 million SIR, totaling more than $20 million. ... Heinz's misrepresentations were of such magnitude that they deprived Starr of 'its freedom of choice in determining whether to accept or reject the risk.'"

As previously explained, the decision offers an important reminder that an insurance application is not just a procedural hurdle to obtaining a policy.

Insurers frequently look for grounds to try to rescind their insurance policies, and, for that reason, the facts and information provided therein may be a later bar to coverage if the information proves to be inaccurate.

Policyholders should work with critical personnel, through risk managers, insurance brokers, and coverage counsel to ensure that application disclosures and submissions are accurate.

Bad faith occurred when insurer refused to pay; subsequent payment not relevant. *Saddleback Inn LLC v. Certain Underwriters at Lloyd's London*, No. G051121, 2017 WL 1180419 (Cal. Ct. App. Mar. 30, 2017).

In March 2017, a California appellate court affirmed a finding that a first-party property insurer acted in bad faith when it searched for a reason to deny coverage for a fire loss and conducted an incomplete and non-objective investigation, even though the insurer subsequently paid the claim.

The decision illustrates the principle that an insurer's conduct should be determined based on what it knows when it refuses to pay the claim, and that it cannot use subsequent developments to salvage prior bad-faith conduct.

In *Saddleback*, the insurer, Lloyd's, hired a lawyer to investigate a fire loss at the Saddleback Inn. Internal communications at Lloyd's during the course of the investigation revealed that the insurer was looking for a reason to deny coverage.

The attorney investigating the claim acted consistent with those communications and, despite receiving the original insurance application materials and an e-mail indicating the correct parties to be named as insureds under the policy, made only a limited inquiry to underwriters and failed to interview the broker before leading the insurer to deny coverage because the wrong entity had mistakenly been identified as the named insured.

Even though the court ultimately reformed the policy based on the parties' mutual mistake, and even though the insurer ultimately paid the loss plus interest, the subsequent developments did nothing to erase the insurer's earlier bad-faith conduct.

Important environmental/pollution insurance cases of 2017

Missouri Appellate Court adopts "all-sums" approach and vertical exhaustion for long-tail disputes. *Nooter Corp. v. Allianz Underwriters Insurance Co. et al.*, *Nooter Corp. v. Allianz Underwriters Insurance Co.*, No. ED 103835, 2017 WL 4365168 (Mo. Ct. App. Oct. 3, 2017), *reh'g and/or transfer denied* (Nov. 13, 2017).

The "all-sums" approach adopted by the New York Court of Appeals in last year's significant *Viking Pump* case, discussed in our 2016 insurance year in review, received company in 2017.

In addition to a July 2017 remand of an environmental litigation dispute by the Second Circuit based on the intervening *Viking Pump* decision, in October, a Missouri appellate court upheld a lower court's ruling that an "all-sums" allocation should apply in determining exhaustion of the policyholder's liability insurance coverage and, in so holding, rejected the pro-rata, proportional allocation sought by the insurers.

The appellate panel further held that coverage could be exhausted vertically.

While these decisions are in line with a growing number of court opinions, insurers have long-argued that horizontal exhaustion — exhaustion of all triggered policies at the primary or same layer of excess coverage — should apply to long-tail liabilities.

It remains critical, therefore, that policyholders anticipate these insurer arguments and understand whether their policies support application of all-sums and vertical exhaustion approaches.

Washington Supreme Court refuses to disturb pro-policyholder pollution exclusion ruling based on "efficient proximate cause." *Xia v. ProBuilders Specialty Insurance Co. RRG*, 400 P.3d 1234 (Wash. 2017).

In another pro-policyholder environmental coverage decision, the Washington Supreme Court reaffirmed coverage for the policyholder's liability for injuries for carbon monoxide, holding that an insurer acted in bad faith when it improperly relied on the absolute pollution exclusion (APE) in the policy to deny coverage for a lawsuit involving alleged release of carbon monoxide gas inside a home.

In *Xia*, the insurer asked the high court to clarify the applicability of the APE to a homeowner's claim arising from negligent installation of a hot water heater that led to a release of carbon monoxide gas.

In a split decision that "reaffirm[ed] the importance of examining and understanding the causal chain of events leading to the claimed injury and damage," the majority ruled for the policyholder based on the "efficient proximate cause" rule.

Under that rule, if the initial event in a causal chain is a covered risk, then coverage applies regardless of whether subsequent uncovered events within the chain are excluded by the policy, even when such uncovered events are the cause-in-fact of the claimed loss.

This decision confirms that the APE is intended — consistent with insurance representations at the time it was drafted and presented for approval by state insurance commissions — for limited application to preclude coverage only for true industrial pollution.

Insurers overuse it, leading at least in some instances to decisions that limit its reach to its intended application. This is true even for claims that have an environmental nexus when they involve allegations of other negligent conduct outside the industrial pollution context.

Other important case-lessons of 2017

Defense of hazing claims against college student covered under parents' homeowners' policy. *Allstate Insurance Co. v. Ingraham*, No. 15-cv-3212, 2017 WL 976301 (D.S.C. Mar. 14, 2017).

Policyholders are often surprised to hear that their insurance policies cover more than the run-of-the-mill claim. For example, a general liability policy may cover a cyber-related loss.

A 2017 South Carolina district court found that a homeowners' policy obligated an insurer to defend a college student against hazing allegations.

That case involved a dispute over coverage for a lawsuit alleging that the policyholders' child was involved in hazing freshman swimmers on the University of Virginia's men's swim team.

Allstate contended that it had no duty to defend under the parents' homeowners' policy because the allegations against the student arose out of "intentional hazing" so that there was no "accident" under the policy.

The court rejected that argument, finding Allstate's characterization of the underlying allegations and the applicable law too narrow. Rather, the underlying allegations were not solely based on intentional conduct and, in any case, intentional conduct that produced an unintended injury constituted an "accident" under the policy.

For similar reasons, the court did not accept the argument that the intentional acts exclusion released Allstate from its duty to defend.

A trial court judgment may not constitute an "adjudication." *Stein v. Axis Insurance Co.*, No. B265069, 2017 WL 914623 (Cal. Ct. App. Mar. 8, 3017).

Conduct exclusions in D&O insurance policies often contain "final adjudication" language, but not all exclusions are created equal, as shown by a March California appellate court decision.

The court there interpreted the plain language of a conduct exclusion to hold that a trial court's entry of judgment against the policyholder did not constitute a "final adjudication."

In the *Stein* case, an excess-layer insurer, Houston Casualty Company (HCC), denied coverage for defense of a criminal appeal, contending, in part, that coverage was barred by the policy's Willful Misconduct Exclusion because the policyholder had been convicted and sentenced by the trial court.

The California Court of Appeal rejected HCC's argument regarding the Willful Misconduct Exclusion, which provided that "[e]xcept for Defense Expenses, the Insurer shall not pay Loss in connection with any Claim occasioned by willful misconduct," but only "if there has been ... a *final adjudication* adverse to [the] Insured Person in the underlying action."

The court rejected HCC's argument that "final adjudication" in the policy means "final under federal law until it is reversed," stating that "a thing that is 'final until reversed' is not final"; and that "[a]n appellate court can render an adjudication as well as a trial court can, with the added benefit of greater finality."

Stein is a reminder that, in selecting D&O coverage, policyholders should pay careful attention to the proposed wording of the policy's conduct exclusions and examine the policy language identifying the events that activate the exclusion.

Policyholders should also consider the existence and scope of any carve-outs (such as defense expenses or repayment obligations).

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