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Key insurance coverage decisions of 2017

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2017 was another robust year for consequential insurance coverage decisions. While many influential rulings were issued, the eight cases discussed in this expert analysis in particular addressed new liabilities, such as opioids and social engineering, as well as traditional ones, such as environmental contamination. Between the old and new, insurance coverage litigation can be expected to be active for the foreseeable future.

BEWARE OF THE STATUTE OF LIMITATIONS

As a general rule, a cause of action against an insurance company for breach of contract begins to run when the insurance company denies coverage. When the meter starts is important, as insurance policies generally stipulate that any litigation must be commenced within a fixed period.

The court in *R.T. Rogers Oil Co. Inc. v. Zurich American Insurance Co.*, 262 F. Supp. 3d 381 (S.D. W. Va. 2017), addressed the sometimes-tricky issue of what constitutes a denial.

In *Rogers* the policyholder owned and operated various gas stations throughout West Virginia and procured coverage with respect to its ownership and operation of underground storage tanks. After the policyholder removed a tank from its site, the West Virginia Department of Environmental Protection determined that the tank had released fuel into the ground.

On June 24, 2003 — six days after the tank had been removed — the policyholder gave notice to its insurance company, Zurich American Insurance Co. Zurich replied July 18, 2003.

On Oct. 10, 2003, the policyholder made a demand on Zurich for 100 percent of its costs. On May 28, 2004, Zurich offered 42 percent of the plaintiff's necessary and reasonable cleanup costs.

This is apparently where matters stood until the policyholder filed suit Dec. 14, 2015.

The U.S. District Court for the Southern District of West Virginia dismissed the complaint on the basis of the statute of limitations. It found that Zurich's offer to pay 42 percent of the cleanup costs constituted a denial of the policyholder's demand that payment be made in full.

Applying New York's six-year statute of limitations for breach of contract, the court held that the statute of limitations expired May 28, 2010, six years after Zurich made its offer. As such, the court ruled that what most would consider Zurich's counteroffer was instead a denial.

Policyholders should be aware of potential statute-of-limitations problems and calculate a cause of action's accrual date at the earliest possible time in order to avoid coverage issues.

WHO IS LITIGATING YOUR CASE?

Even when an insurance company agrees to defend its policyholder, conflicts can arise, particularly as to whether the attorney retained by the insurance company to defend its policyholder has a conflict. *OneBeacon America Insurance Co. v. Celanese Corp.*, 84 N.E.3d 867 (Mass. App. Ct. 2017), involved an extreme example of this situation.

Celanese Corp., the policyholder, contended that OneBeacon American Insurance Co. had a conflict even though OneBeacon agreed to defend without reserving its rights, thereby obligating itself for defense and indemnity costs.

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When OneBeacon appointed counsel, Celanese refused to cede its control of the defense or replace the counsel it had employed for the past 14 years with the representation selected by OneBeacon, arguing that OneBeacon had a conflict of interest.

The court disagreed, and Celanese lost $2.4 million in attorney fees in the interim between its rejection of OneBeacon's counsel and the court's ruling.

While Celanese pointed to several possible conflicts, the fundamental issue was created by the fact that the policy limited indemnity payments but did not limit attorney fees. This arrangement created an incentive for Celanese to fully litigate each case in an effort to minimize indemnity payments.

Celanese accused OneBeacon of using a litigation strategy that did the opposite — reducing defense costs and exhausting the policy limits as soon as possible.

The court disagreed. The judge reasoned that the record contained no evidence suggesting that OneBeacon had a policy of exhausting liability limits rapidly to avoid paying defense costs.

Policyholders often obtain defenses from their insurance companies and then stop paying attention. It would behoove policyholders to pay careful attention to how their insurance companies are litigating and settling claims on their behalf.

INSURANCE COVERAGE FOR OPIOID LITIGATION

Every new type of liability that corporations face gives rise to new insurance coverage litigation. The latest potential source of liability, opioids, is no exception.

At least five courts have addressed opioid insurance issues. Although those courts have reached varying results, the different outcomes were dictated at least in part by differences in the complaints they considered.

In particular, some complaints allege only intentional wrongdoing, while others contain mixed allegations of intentional, reckless and negligent conduct. Courts have not found coverage for the former, while some have found a duty to defend for the latter.

The most recent opioid insurance case is *Traveler's Property Casualty Co. v. Actavis Inc.,* 16 Cal. App. 5th 1026 (Cal. Ct. App., 4th Dist. 2017). The city of Chicago, along with the California counties of Santa Clara and Orange, sued Actavis. The trial court denied coverage, finding that the underlying complaints alleged intentional wrongdoing but not accidents.

The California Court of Appeal said, "The California action and the Chicago action do not create a potential for liability for an accident because they are based, and can only be read as being based, on the deliberate and intentional conduct of [the insured] that produced injuries — including a resurgence in heroin use — that were neither unexpected nor unforeseen."

In contrast, in *Cincinnati Insurance Co. v. H.D. Smith Wholesale Drug Co.,* 829 F.3d 771 (2016), the 7th U.S. Circuit Court of Appeals addressed the duty to defend against a complaint brought by the West Virginia attorney general that contained a mix of statutory and common law claims alleging negligent and intentional conduct.

The appeals court found that the insurance company had to defend the entire suit because of the negligence counts. The court held that if a single count is potentially covered, the insurance company must defend the entire case.

Uncomfortable as this result is for policyholders, the manner in which the plaintiff drafts its complaint may very well be dispositive on the coverage issue — and the policyholder can do little, if anything, about it.

THE LAST PULL OF THE CONTINUOUS TRIGGER

Air Master & Cooling v. Selective Insurance Co. of America, 452 N.J. Super. 35 (N.J. Super. Ct. App. Div. 2017), is an important case for two reasons.

First, although most courts have accepted the continuous trigger theory, under which multiple consecutive insurance policies and insurers must respond to a claim, the theory has been limited to environmental and toxic tort cases.

In *Air Master*, however, the New Jersey Superior Court Appellate Division applied it in a construction case involving progressive damage caused by construction defects over a period of several years.

Second, the court addressed the question of when that continuous trigger ended. Policyholders have looked to policy language stating that the policy provides coverage for bodily injury and property damage as long as it is unexpected and unintended from the standpoint of the insured. As a result, policyholders have argued that the trigger period continues until they gain knowledge of the claim.

The court in *Air Masters* disagreed. It held that the trigger period ends with the "essential" manifestation of the injury, which it defined as "the revelation of the inherent nature and scope of that injury."

Exactly what that means in a given context is anyone's guess and is sure to create additional litigation.

GEESE, GANDERS, RESERVATIONS OF RIGHTS AND NOTICE

Policyholders and insurance companies alike often prefer vague or boilerplate language when communicating with each other. For both, such a practice contains the most severe risk, as demonstrated by two decisions that came down in 2017.

At least one commentator has selected *Harleysville Group Insurance v. Heritage Communities*, 803 S.E. 2d 288 (S.C. 2017), as the most important insurance coverage decision of the year.

That decision addressed the all-too-frequent reservation-of-rights letter from an insurance company that contains a brief recitation of the underlying facts, about 10 pages of excerpts from the policy and no explanation of why the insurance company might deny coverage.

The court struck the reservation-of-rights letter and stated: "It is axiomatic that an insured must be provided sufficient information to understand the reasons the insurer believes the policy may not provide coverage. ... Generic denials of coverage coupled with a copy of all or most of the policy provisions (through a cut-and-paste method) is not sufficient."

Harleysville should serve as a wakeup call for insurance companies, while providing an important weapon to policyholders faced with inadequate reservation-of-rights letters.

However, as demonstrated by *First Horizon National Corp. v. Houston Casualty Co.*, No. 15-cv-2235, 2017 WL 2954716 (W.D. Tenn. June 23, 2017), what is good for the goose is good for the gander.

In *First Horizon* the policyholder filed a notice of circumstance with its directors-and-officers insurance company. The notice-of-circumstance provision required "full particulars as to dates, persons, and entities involved, potential claimants, and the consequences which have resulted or may result therefrom."

The court found First Horizon's notice was so vague and boilerplate that it failed to advise Houston Casualty Co. of the nature of the potential liability.

Indeed, as the court noted, the notice did not mention the Justice Department's $610 million settlement demand. The court, therefore, threw out the notice and denied coverage on the basis of late notice, and First Horizon lost $75 million in insurance coverage.

Policyholders frequently want to convey as little information as possible to their insurance companies. *First Horizon* indicates the perils of such an approach.

Medidata Solutions v. Federal Insurance Co.

In *Medidata Solutions Inc. v. Federal Insurance Co.*, 268 F. Supp. 3d 471 (S.D.N.Y. 2017), the policyholder, a company that provided scientists with cloud-based services, was defrauded of more than $4 million.

Harleysville should serve as a wakeup call for insurance companies, while providing an important weapon to policyholders faced with inadequate reservation-of-rights letters.

In summer 2014 Medidata Solutions Inc. notified its finance department of the company's short-term business plans, which included a possible acquisition. Medidata's finance personnel were instructed to "to be prepared to assist with significant transactions on an urgent basis."

In September 2014 an accounts payable employee responsible for processing all Medidata's travel and entertainment expenses received an email purportedly sent from Medidata's president. The email message contained the president's name, email address and picture in the "From" field, as was consistent with internal email messages Medidata's employees received.

The message said Medidata was close to finalizing an acquisition and that an attorney named Michael Meyer would contact that employee. The email advised the employee that the acquisition was strictly confidential and instructed her to devote her full attention to Meyer's demands. The employee replied, "I will certainly assist in any way I can and will make this a priority."

On that same day, the employee received a phone call from a man who claimed to be Meyer and demanded that the employee process a wire transfer for him. The employee explained to Meyer that she needed an email from Medidata's president requesting the wire transfer and further explained she needed approval from Medidata's vice president and director of revenue.

Shortly thereafter, the accounts payable employee, vice president and director of revenue received a group email purportedly sent from Medidata's president stating: "I'm currently undergoing a financial operation in which I need you to process and approve a payment on my behalf. I already spoke with [the accounts payable employee], she will file the wire and I would need you two to sign off."

The email contained the president of Medidata's email address in the "From" field and a picture next to his name. In response, the accounts payable employee logged on to Medidata's online banking system and submitted the wire transfer for approval.

The vice president and director of revenue logged on to the online banking system and approved a wire transfer of nearly $4.8 million to a bank account provided by Meyer.

Unfortunately, all the emails in the chain were fraudulent, and the account to which the money was wired was set up by fraudsters.

The policyholder sought coverage under its $5 million insurance policy, which contained a "crime coverage section" that included coverage for computer fraud, funds transfer fraud and forgery.

The insurance company denied coverage under the computer fraud clause because there had been no "fraudulent entry of data into Medidata's computer system."

It further maintained there was no coverage under the policy's funds transfer fraud clause because the wire transfer was made with the company's knowledge and consent.

Finally, the insurer rejected Medidata's claim for forgery coverage because the emails did not contain an actual signature and did not meet the policy's definition of a financial instrument.

The U.S. District Court for the Southern District of New York considered cross-motions for summary judgment and found that coverage was appropriate under the policy's computer fraud coverage clause as well as its funds transfer fraud coverage clause.

Ultimately, the court held that the policyholder demonstrated its losses were a direct result of a computer violation and occurred without its knowledge or consent.

In an age of ever-evolving technology, where new threats arise with great frequency, policyholders should be aware of technological vulnerabilities and ensure that coverage for any such potential risk is procured.

E.M. Sergeant v. Travelers Indemnity

While the insurance buzz for 2017 concentrated on new liabilities such as opioids and social engineering, many policyholders still find themselves entangled with the traditional long-tail liabilities — chiefly environmental, asbestos and other toxic torts.

These continuous trigger liabilities can date back to the 1950s and beyond. Locating applicable insurance policies for such claims is a major hurdle. In New Jersey, a policyholder can prove insurance policies by a preponderance of the evidence. *E.M. Sergeant Pulp & Chemical Co. v. Travelers Indemnity Co.,* No. 12-cv-1741, 2017 WL 239339 (D.N.J. Jan. 19, 2017), demonstrates how little evidence the policyholder may need.

E.M. Sergeant Pulp & Chemical Co.'s records consisted chiefly of several ledger entries that were more than 50 years old and identified Travelers Indemnity Co. and policy numbers. Sergeant supplemented these documents with expert testimony on such issues as the interpretation of the policy numbers and standardized policies.

The court relied heavily on the expert testimony in denying Travelers' motion for summary judgment based on the fact the physical policies were missing. The case subsequently settled.

Policyholders often believe that they need copies of policies to prove coverage, while insurance companies deny claims because of the lack of the actual policies. *E.M. Sergeant* shows the benefit of insurance archaeology and the potential value of even a limited amount of secondary evidence.

2017 was an eventful year for insurance coverage litigation. As new and old issues alike continue to be litigated, some issues will likely be clarified, whereas others will be litigated in perpetuity.

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