HAYNES BOONE

Insurance Recovery

2024 YEAR IN REVIEW

Micah E. Skidmore
Partner

CONTENTS

INTRODUCTION

This resource serves as both a comprehensive update on recent insurance law developments and a valuable reference for understanding evolving coverage issues across multiple lines of coverage. The 2024 year in review article provides in-depth analysis of landmark cases addressing commercial property, directors and officers (D&O), general liability and cyber insurance policies.

Notable highlights include:

- The mechanics of appraisal and clarification of "ensuing loss" provisions in commercial property policies
- Evolution of D&O coverage for non-recourse judgments and a new approach to analyzing the “bump up” exclusion
- Important developments in coverage for contractual liability, “bodily injury” and vertical exhaustion of general liability insurance and
- A rare policyholder victory in COVID-19 business interruption coverage

The article examines these developments through detailed case analysis, offering practical insights for insurance professionals, risk managers and legal practitioners. Each section provides thorough discussion of the reasoning behind key decisions and their implications for future coverage disputes. The review concludes with analysis of developments on a range of subjects, including priority of coverage disputes and the impact of external documents on policy interpretation.

COMMERCIAL PROPERTY INSURANCE

I. ENSUING LOSS PROVISIONS

Among the most litigated terms in commercial property insurance policies is the so-called "ensuing loss" exception to any number of exclusions typically found in such policies. Its formulation may vary from one policy to another, but typically, where a policy may exclude faulty workmanship, settlement, deterioration or any number of other perils, the "ensuing loss" provision preserves coverage for loss or damage resulting from an otherwise-excluded peril. In *Gardens Condominium v. Farmers Insurance Exchange*, 2 Wn.3d 832 (Wash. 2024), the Washington Supreme Court had occasion to interpret a "resulting loss" provision in a dispute between a condominium owner and its commercial property carrier over water damage to the underside of a roof system, including sheathing and supporting framing, when a defective design resulted in both inadequate ventilation and condensation below the roof system. The subject policy excluded coverage for faulty design, with the qualification that "[i]f loss or damage [caused] by a Covered Cause of Loss results, we will pay for that resulting loss or damage." The insurer, Farmers, denied the condominium's claim, arguing that "the resulting loss exception applies only if a covered event breaks the causal chain between the excluded risk and subsequent losses or if there is damage to other property." After the trial court granted summary judgment in favor of Farmers, and the Court of Appeals reversed, the Washington Supreme Court relied upon prior precedent in *Vision One, LLC v. Philadelphia Indemnity Insurance Co.*, 174 Wn.2d 501, 276 P.3d 300 (2012) and *Sprague v. Safeco Insurance Co. of America*, 174 Wn.2d 524, 276 P.3d 1270 (2012), to affirm that "[a] resulting loss exception applies whether or not the covered peril is independent." The policy in question "d[id] not state that the covered cause of loss must be independent from the faulty workmanship or that it cannot be a natural consequence of faulty workmanship." Accordingly, "a resulting loss exception must have effect to preserve coverage for loss resulting from covered perils regardless of whether the peril is the natural consequence of an excluded peril."

3534 E. Cap. Venture, LLC v. Westchester Fire Ins. Co., 104 F.4th 913 (D.C. Cir. 2024) is another "ensuing loss" case decided this year. Here, insureds under two builders risk policies sought coverage for water damage to a residential and retail complex in Washington, D.C. after humidity and condensation under the structure's roof damaged interior wood, insulation and drywall. The insurers refused coverage under a provision excluding coverage for losses "caused by" either "dampness of atmosphere" or "changes in temperature," "unless direct physical LOSS by an insured peril ensues." The district court granted summary judgment for the insurers upon finding that the exclusion applied, and "the ensuing-loss exception to the exclusions did not apply because losses from "water damage" to the building were "inextricably intertwined" with—and indeed were "one and the same" as—losses covered by the dampness and temperature exclusions." On review, the D.C. Circuit Court of Appeals sidestepped the debate over causation and whether the exclusion applied in the first

instance to conclude that the "ensuing loss" provision preserved coverage. Specifically, the court rejected the insurers' argument that "water damage did not ensue from dampness and temperature changes if the dampness and temperature changes directly caused the water damage" and instead reasoned that (1) apart from excluding losses caused by "dampness of atmosphere" and "changes in temperature," the policies do insure losses caused by or resulting from "water damage"; (2) the common, ordinary meaning of "ensue" is to "result from"; (3) "two interpretive presumptions favor the insureds—the rule that ambiguities must be resolved against the insurer, as well as the rule that policy exclusions must be construed narrowly" (citations omitted); and (4) other decisions, including those issued under Maryland law, favor a broad reading of "ensuing loss" provisions.

II. APPRAISAL

"Appraisal" provisions in commercial property insurance policies remain a frequent source of coverage litigation for insurers and policyholders. This remained true in 2024. In *American Coastal Ins. Co. v. San Marco Villas Condo. Ass'n, Inc.*, 379 So. 3d 1099 (Fla. 2024), a condominium association sought payment for property damage resulting from Hurricane Irma, in opposition to arguments from its commercial property carrier that (1) the value of the insured's losses were substantially less than what was being claimed; and (2) the insured's claim was barred by a policy condition that voids coverage when the insured commits fraud or makes material misrepresentations about the insurance. When the insured moved to compel appraisal to resolve the first of the insurer's arguments, the insurer, American Coastal, opposed the motion on the basis that appraisal was inappropriate where coverage had been denied outright. After the trial court and intermediate court of appeals granted the insured's request for appraisal, the Florida Supreme Court considered whether the policy allowed the trial court to determine the order in which American Coastal's coverage defenses would be determined. Based on the provision granting American Coastal the right to deny a claim even if there is an appraisal, the court reasoned that appraisals could occur before resolution of coverage issues, and "a trial court has discretion in determining the order in which coverage and amount-of-loss issues are resolved."

In *Rodriguez v. Safeco Insurance Company*, 684 S.W.3d 789 (Tex. 2024), a homeowner disputed the amount owed by a homeowners' insurer for tornado damage occurring in 2019. After the insured, Rodriguez, filed suit, the insurer, Safeco, requested appraisal. Ultimately, after Safeco paid the ensuing appraisal award and related statutory interest, the remaining dispute between the parties involved Safeco's obligation to pay Rodriguez's attorneys' fees. Following the district court's grant of summary judgment in favor of Safeco, the Fifth Circuit Court of Appeals certified the following question to the Texas Supreme Court: "In an action under Chapter 542A of the Texas Prompt Payment of Claims Act, does an insurer's payment of the full appraisal award plus any possible statutory interest preclude recovery of attorney's fees?" In response, the Court

looked to the language of Section 542A.007 of the Texas Insurance Code, which provides that "[t]he allowable amount of attorney's fees is 'calculated by . . . [first] dividing the amount to be awarded in the judgment to the claimant for the claimant's claim under the insurance policy for damage to or loss of covered property' by another amount." Then, reasoning that "[b]ecause the insurer has already paid all amounts owed under the insurance policy plus any possible statutory interest, there is not and never will be an 'amount to be awarded in the judgment to the claimant for the claimant's claim under the insurance policy,'" the Court concluded that "there will never be a non-zero amount of permissible attorney's fees under the formula described in section 542A.007(a)(3)." After dismissing concerns that this result will encourage abusive and unfair practices by insurers, the Court answered the Fifth Circuit's certified question in the affirmative.

III. NOTICE-PREJUDICE

In *Gregory v. Safeco Ins. Co. of Am.*, 2024 CO 13 (Colo. 2024), homeowners insurers, Safeco Insurance Company of American and Owners Insurance Company, denied two different policyholders' claims for roof damage from two different hailstorms on the basis that the notices provided by the homeowners, the Gregorys and Runkels, were given after the deadlines set forth in the policies. After underlying district courts granted summary judgment in favor of the insurers and their late notice defense to coverage, and intermediate appellate courts affirmed, the Colorado Supreme Court granted review to consider whether to adopt a notice-prejudice rule in this context. After examining the historical development of the notice-prejudice rule in the liability context, the Court determined to apply a notice-prejudice rule to "first-party, occurrence-based homeowners' insurance policies." This ruling was based primarily on the Court's determination that:

(1) "[a]bsent further legislative guidance, we cannot countenance a forfeiture of coverage that occurs despite an insurer's failure to provide the statutory protections afforded by our legislature," referring to the specific requirements regarding notice to insureds, who may forfeit coverage without timely notice under a "claims-made" liability policy;

(2) homeowners policies are not ordinary bilateral contracts, but are adhesive contracts drafted by the insurer for an insured with little bargaining power;

(3) like tort victims, whose compensation justified recognition of the notice-prejudice rule in the liability context, "[t]hose who obtain homeowners' insurance to cover the cost to repair unforeseen damage to their homes, typically for which the insureds bear no fault, should be compensated according to that insurance coverage"; and

(4) "allowing the insurers in the instant cases to declare a forfeiture of coverage would afford them the same windfall [that justified recognition of the notice-prejudice rule in the liability context], namely, the ability to rely on a technicality to avoid their obligation to pay legitimate claims for which the insureds purchased coverage and paid all of their premiums."

IV. "SURFACE WATER"

Two cases this year addressed the "surface water" policy term in a property context. In *Laur v. Safeco Ins. Co. of Ind.*, 2024 U.S. App. LEXIS 14576 (5th Cir. Jun. 14, 2024), a homeowner sought coverage when an irrigation line froze and burst resulting in flood damage to the insured's basement. The subject policy insured freezing to a landscape sprinkler system unless the resulting loss is excluded as either "surface water" or "water below the surface of the ground." After the district court adopted the magistrate judge's decision to grant summary judgment on the exclusion in favor of the insurer, Safeco, the Fifth Circuit Court of Appeals affirmed. Specifically, the Court reasoned that (1) the water damaging the homeowner's basement both originated below the surface of the ground and flowed at ground level; and (2) while one Texas court had previously held that "water below the surface of the ground" is "water of natural origin," the language of the subject policy encompassed subterranean water of any source. Though not expressly addressed in the court's reasoning, the opinion implicitly equates water running at ground level with the undefined term, "surface water."

Factually, *Zurich American Insurance Co. v. Medical Properties Trust Inc.*, 237 N.E.3d 733 (Mass. 2024) is the inverse of the *Laur* case. Here, a hospital sought coverage for water damage resulting from, among other things, accumulation of rainwater on rooftops, which seeped into the interior of the hospital. The subject commercial property policy included a "flood" sublimit, which applied to "[a] general and temporary condition of partial or complete inundation of normally dry land areas or structure(s) caused by[ ] [t]he unusual and rapid accumulation or runoff of surface waters." After the United States District Court in Massachusetts ruled that "surface waters" included rainwater accumulating on rooftops, in an ensuing interlocutory appeal, the First Circuit Court of Appeals certified the following question to the Massachusetts Supreme Judicial Court: "Whether rainwater that lands and accumulates on either (i) a building's second-floor outdoor rooftop courtyard or (ii) a building's parapet roof and that subsequently inundates the interior of the building unambiguously constitutes 'surface waters' under Massachusetts law for the purposes of the insurance policies at issue in this case?" In response, after reviewing relevant caselaw and finding no "consistent interpretation," the Court concluded that the undefined term, "surface waters" is ambiguous in this context, and "[a]s we must resolve such ambiguity in favor of the policyholders and against the insurance companies that drafted the policies, we conclude that the definition of 'surface waters' does not include the rainwater that landed and accumulated on the rooftop courtyard and parapet roofs in this case, or at least it does

not unambiguously include such accumulation of water on a roof."

DIRECTORS & OFFICERS LIABILITY INSURANCE

I. "LOSS" & NON-RECOURSE JUDGMENTS

When the only asset available to satisfy a third-party's claim for damages is a liability policy, insureds and plaintiffs may try to find ways to move the locus of the dispute from the plaintiff-policyholder to the plaintiff-insurer through a non-recourse judgment, particularly when the liability carrier has denied coverage. This was the case in *In re Illinois National*, 685 S.W.3d 826 (Tex. 2024), where an insolvent oil company agreed to a non-recourse judgment to resolve underlying securities litigation against the company. The securities litigation triggered two different towers of D&O coverage, but all D&O insurers refused to defend or indemnify the insured, Cobalt. Cobalt and the underlying securities plaintiffs, GAMCO, filed suit against the insurers with Cobalt seeking to recover its defense costs and GAMCO seeking to recover the limits of the D&O towers. After the trial court granted a series of dispositive motions in favor of Cobalt and GAMCO, the insurers filed a mandamus petition, which was ultimately granted review by the Texas Supreme Court on the following questions:

(1) given the non-recourse nature of the settlement between GAMCO and Cobalt, did the insureds sustain a "loss" under the policies, which define "loss" to include damages, judgments, settlements, defense costs, or other amounts for which Cobalt is "financially liable" or "legally obligated to pay";

(2) does GAMCO have standing to pursue claims against the D&O carriers; and

(3) is the settlement agreement between Cobalt and GAMCO binding on the insurers or evidence of coverage or the amount of loss?

On the first issue, the Court ruled that (a) "[a] settling insured need not admit to wrongdoing or concede legal liability to accept a legal obligation to pay under a settlement agreement"; (b) "[b]ecause the settlement agreement establishes that Cobalt is legally obligated to pay and is 'in fact liable' to GAMCO for any recoverable insurance benefits, Cobalt has suffered a 'loss' under the policies." Second, the Court ruled that "the no-direct-action rule does not prevent GAMCO from suing the Insurers directly." Third, the Court ruled that the settlement was not binding on the insurers or admissible to establish coverage or the amount of Cobalt's loss because it did not result from a "fully adversarial proceeding," *i.e.*, Cobalt did not have a "meaningful incentive" to ensure that the settlement accurately reflected the underlying plaintiff's damages.

II. "CLAIMS FIRST-MADE"

Another critical component of coverage under most directors and officers liability policies is the existence of a "claim" "first made" during the policy period. This requirement is the source of frequent disputes over what constitutes a "claim" and whether the first assertion of a "claim" occurred outside the policy period. Judicial decisions issued this

year confirm how difficult and fact-intensive this determination may be. For example in *Certain Underwriters at Lloyds v. Anchor Ins. Holdings, Inc.*, 2024 U.S. App. LEXIS 29494 (11th Cir. Nov. 20, 2024), the Eleventh Circuit Court of Appeals ruled in favor of certain underwriters at Lloyd's, London, who refused coverage under a November 2018-2019 policy for a complaint filed against the insured, Anchor, in December 2018, based on the fact that (1) investors sent recission demands to entities formed to invest in Anchor (the "THD Entities") in April and May 2018; (2) investors filed suit against the THD Entities in June 2018; and (3) investors sought to depose Anchor and one of its directors in October and November 2018. According to the Eleventh Circuit, on these facts and without discussing the distinction between Anchor and the THD Entities, "the record demonstrates no genuine dispute of material fact that a claim was made prior to the policy's inception."

As a contrasting example, in *Zurich Am. Ins. Co. v. Syngenta Crop Prot. LLC*, 314 A.3d 665 (Del. 2024), the Delaware Supreme Court affirmed the superior court's grant of summary judgment in favor of an insured herbicide manufacturer, Syngenta, under a claims-made general liability policy. The Court concluded that letters issued by a plaintiffs lawyer purporting to represent unnamed victims of exposure to Syngenta's pesticide by (1) proposing to pursue a few "bellwether" cases while tolling the remainder and (2) demanding preservation of documents, did not constitute a "claim for damages" prior to the inception of the policy at issue. Borrowing from precedent in the D&O context, unlike a "claim," which would require the assertion of an existing right or a demand for relief, the letters from underlying plaintiffs' counsel, "[i]f the letter [from underlying plaintiffs' counsel] demands—or even requests—anything, … is an opportunity to discuss a process by which claims not yet made might be adjudicated or otherwise resolved in the future" without requesting monetary relief. The Court's analysis also implicitly suggests that a "claim" is not a "claim" without an identifiable claimant.

III. "BUMP UP" EXCLUSION

Although technically released in 2025, the Delaware Superior Court in *Harman International Industries, Inc. v. Illinois National Insurance Company*, 2025 Del. Super. LEXIS 5 (Jan. 3, 2025) is an important ruling on the application of the so-called "bump up" exclusion found in many D&O policies. This exclusion provides that "[i]n the event of a Claim alleging that the price or consideration paid or proposed to be paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest in or assets of an entity is inadequate, Loss with respect to such Claim shall not include any amount of any judgment

or settlement representing the amount by which such price or consideration is effectively increased ….” After Harman International Industries, Inc. (“Harman”) entered into a reverse triangular merger with Silk Delaware, Inc., resulting in Harman becoming a wholly owned subsidiary of Samsung Electronics America, Inc. (“Samsung”), former Harman shareholders filed suit alleging violations of federal securities laws in the proxy statement issued in connection with the transaction. Harman’s primary D&O insurer, Illinois National, initially agreed to pay for the defense of the shareholder suit, but years later refused coverage based on the “bump up” exclusion. The excess D&O carriers followed Illinois National’s lead. The securities lawsuit was later settled, according to the parties, in order to avoid the cost of continuing the litigation. Harman then filed suit to recover the amount of the settlement from its D&O insurers. On cross-motions for summary judgment, the Delaware Superior Court ruled that the transaction was, despite its form as a reverse triangular merger, “an acquisition of all or substantially all of an entity’s assets or ownership” because it resulted in Harman becoming an independent, wholly owned subsidiary of Samsung, only Harman shareholders voted on the transaction, and the parties to the transaction referred to it as an “acquisition.” However, the Court also ruled that the subject “bump up” exclusion did not apply to the settlement because (1) inadequate deal price was not a viable remedy in any of the claims asserted in the shareholder suit; and (2) no part of the settlement represents an amount by which the transaction price or consideration was increased because, based on the record evidence, (a) the parties agreed that the purpose of the settlement was to avoid the cost of litigation, which was projected to exceed the amount received in settlement; and (b) the settlement amount did not result in a material increase in consideration based on the Harman shares outstanding. Moreover, the settlement class was defined to capture only those “indirectly” impacted by the transaction, *i.e.*, “shareholders that held at the time of the merger vote but sold prior to receiving any deal consideration,” and “[t]o be true to the exclusion’s language, any portion of a settlement amount excised from ‘Loss’ must be limited to injury incurred at the actual time of the acquisition.”

GENERAL LIABILITY INSURANCE

I. “PROPERTY DAMAGE” & “OCCURRENCE”

One legal current that policyholders often swim against in pursuing general liability coverage is the notion—not rooted in policy terms or the law—that general liability insurance does not cover claims for breach of contract. The legal articulation of this implicit bias, held by many adjusters, goes something like this. A breach of a contractual obligation can never be an “accident” or an “occurrence.” Or, damage to the subject matter of a contract is only an economic loss, not “property damage.” While other courts have dispelled these and similar arguments in the past, the law on this point has been reemphasized again in *Cornice & Rose Int’l, LLC v. Acuity*, 2024 U.S. App. LEXIS 29925 (7th Cir. Nov. 24, 2024). Here, an architectural firm sought a defense under a general liability

policy against allegations that the firm was negligent in providing architectural services, which resulted in a series of defects in a building in Iowa, including a non-code-compliant elevator, cabinets that blocked windows, and defective ventilation resulting in rotting of structural members supporting the roof. The general liability insurer resisted the firm's claim on the basis that there was no "property damage" and no "occurrence" justifying coverage. Relying on a recent decision from the Illinois Supreme Court in *Acuity v. M/I Homes of Chicago, LLC*, 2023 IL 129087, 473 Ill. Dec. 486, 234 N.E.3d 97, reh'g denied (Jan. 22, 2024), the Seventh Circuit Court of Appeals affirmed that (1) "property damage" means only physical injury to tangible property, regardless of whether the damage occurred to property within the scope of the insured's project; and (2) an "occurrence" means only "an unforeseen occurrence, usually of an untoward or disastrous character, or an undesigned, sudden, or unexpected event of an inflictive or unfortunate character," which includes defects in a building that are not intended or expected by the insured firm. Upon also concluding that the *Acuity* case did not represent a prospective change in the law, but rather a reiteration of existing principles of contractual interpretation, the Court concluded that the insurer, Acuity, must defend the firm, Cornice & Rose.

II. NOTICE PREJUDICE

In *Gea Mech. Equip. United States, Inc. v. First State Ins. Co.*, 2024 U.S. App. LEXIS 20024 (3d Cir. Aug. 9, 2024), the Third Circuit Court of Appeals clarified the burden of proof imposed on insurers seeking to establish prejudice from late notice of a third-party claim under New Jersey law. Here, the insured corporate defendant under primary and excess liability policies gave notice of an underlying personal injury lawsuit only after failed settlement negotiations and a runaway verdict had been entered against it. In subsequent coverage litigation with the insurers, the district court granted summary judgment on the insurers' late-notice defense, finding that (1) the insured, "GEA[,] breached the notice provisions of its primary and excess policies, and (2) the insurers were 'appreciably prejudiced . . . as a matter of law' because they were 'deprived completely of any opportunity to participate in the defense of the Thornton Action until after a verdict and judgment was entered.'" However, under prevailing New Jersey law, "appreciable prejudice" requires "two showings: one that 'substantial rights have been irretrievably lost,' and one that the insurer would have had a 'likelihood of success . . . in defending against the accident victim's claim.'" While on review, the Third Circuit Court of Appeals agreed that substantial rights were irretrievably lost in the case based on the timing of the insured's notice, the district court did not assess the likelihood of success in defending the claim, including the likelihood of settling "the underlying case for a small sum or a smaller sum than that for which the insured ultimately settled the claim." As a result, the Court remanded the case to the district court for further proceedings.

III. HORIZONTAL V. VERTICAL EXHAUSTION

Another issue that recurs in coverage disputes with some regularity is the debate over horizontal versus vertical exhaustion, *i.e.*, "can an insured access a first-level excess insurance policy upon exhaustion of underlying primary insurance obtained for the same policy period (vertical exhaustion), or is the insured required to exhaust all primary policies issued during the continuous period of damage (horizontal exhaustion)?" The California Supreme Court addressed this question in *Truck Ins. Exchange v. Kaiser Cement & Gypsum Corp.*, 16 Cal. 5th 67 (Cal. 2024). Here, a primary general liability insurer, Truck, sought contribution from the insured's first-level excess insurers for underlying product liability suits filed against an asbestos manufacturer, Kaiser. Prior to the Court's 2024 decision, issues related to Truck's contribution claim had been decided both in coverage litigation involving Kaiser and unrelated parties, including, most notably, *Montrose Chemical Corp. of California v. Superior Court*, 460 P.3d 1201 (Cal. 2020) ("Montrose III"). With this background, the Court began by distinguishing between contract-based coverage disputes between an insurer and insured, and contribution claims, such as the one filed by Truck, which are rooted in principles of equity. Notwithstanding this observation, the Court's subsequent analysis focused primarily on the language in the subject excess policies. Specifically, where the underlying court of appeals focused its analysis—ultimately denying Truck's contribution claim—on the "other insurance" provisions in the subject excess policies, the California Supreme Court reasoned that (1) there is no basis to distinguish between first-level and upper-level excess policies when it comes to the interpretation of the standard "other insurance" clause appearing in such policies; (2) such "other insurance" provisions have historically been interpreted to apply to policies issued for the same policy period, not other policy years. The Court also recited the various practical complications involved in identifying the precise attachment point for any excess policy, if horizontal exhaustion of any underlying policy was required. With these considerations, the Court ruled that "the language of the first-level excess policies, when considered in conjunction with the insured's reasonable expectations and the historical role of 'other insurance' provisions, is most naturally read to mean that the insured may access the policies upon exhaustion of the directly underlying policies that were purchased for the same period." In other words, vertical exhaustion is the rule governing the attachment of first-level excess insurance under California law. That said, the Court also acknowledged that resolution of this question did not fully resolve whether Truck is entitled to equitable contribution from the excess carriers, and the Court remanded the case for further proceedings to address these claims.

IV. "BODILY INJURY"

Several decisions in recent years have focused on what qualifies as "bodily injury" or "property damage" within a liability policy. The Pennsylvania Supreme Court added to this dialogue in *Kramer v. Nationwide Prop. & Cas. Ins. Co.*, 313 A.3d 1031 (Penn. 2024),

where parents of a drug dealer sought a defense under a homeowner's policy against a wrongful death suit brought by the mother of a decedent who overdosed while staying at the parents' home in September 2018. The homeowners' insurer, Nationwide, refused coverage based on a controlled substances exclusion, but the trial court granted summary judgment in favor of the parents, concluding that the underlying plaintiffs' negligence claims were distinct from the injuries resulting from the use of controlled substances. The intermediate appellate court affirmed, adding that while Nationwide would have no obligation to pay damages or defend the parents for injuries resulting from the use of controlled substances, the wrongful death lawsuit arguably included other damages "rooted in 'emotional distress, mental distress or injury, or any similar injury," to which the controlled substances exclusion would not apply.

Before the Pennsylvania Supreme Court, Nationwide challenged the notion that the underlying plaintiff's "emotional distress" triggered a duty to defend under the subject policy, whose definition of "bodily injury" expressly "does not include emotional distress, mental anguish, humiliation, mental distress or injury, or any similar injury unless the direct result of bodily harm." The Supreme Court agreed. Without expressly addressing whether the underlying plaintiff's emotional distress resulted from bodily harm, the Court ruled that "[t]he Superior Court's determination that Mother did not suffer a bodily injury as defined in the Policy for purposes of the wrongful death claim requires a conclusion that there is no coverage for the wrongful death claim. Therefore, the Superior Court's interpretation that Nationwide was potentially required to pay out for Mother's emotional and mental distress damages for that wrongful death claim is contrary to the unambiguous provisions of the Policy and erroneous as a matter of law." The Court also refused the parents' request for a remand to the Superior Court for the entry of an order in favor of Nationwide so they could file their own appeal from that order.

V. EXCESS COVERAGE FOR DEFENSE COSTS

At the end of the year, the Texas Supreme Court addressed an excess liability carrier's obligation to pay defense costs incurred by its insured in *Ohio Casualty Insurance Company v. Patterson-UTI Energy, Inc.*, 2024 Tex. LEXIS 1123 (Tex. Dec. 20, 2024). Here, an oil-field equipment and service provider, Patterson, sought payment for defense expenses incurred in connection with underlying personal injury litigation from an excess liability insurer, Ohio Casualty, after underlying policy limits were exhausted. Ohio Casualty's policy insured Patterson for "loss," which it defined as "those sums actually paid in the settlement or satisfaction of a claim which [Patterson is] legally obligated to pay as

damages after making proper deductions for all recoveries and salvage." The trial court granted summary judgment in favor of Patterson and the court of appeals affirmed. On review before the Texas Supreme Court, Patterson argued that the "damages" covered by Ohio Casualty's policy included defense expenses based on (1) language in the underlying policy covering defense expenses and (2) the absence of language in the excess policy repudiating that coverage. The Court rejected the bottom-up analysis advocated by Patterson and adopted by the lower courts—starting with the primary policy and ending with the excess. Instead, the Court ruled that the analysis of coverage from Ohio Casualty must begin with the excess policy, whose terms only extend coverage for sums paid to an adverse party, not for fees paid to Patterson's counsel. The Court also rejected Patterson's argument that references to "attorneys' fees" in policy exclusions for asbestos and pollution confirm that coverage exists for such fees in the absence of an applicable exclusion.

VI. BIPA COVERAGE

2024 also saw more guidance for policyholders and insurers facing claims under Illinois' Biometric Information Privacy Act, 740 ILCS 14/1 to 14/20 ("BIPA"). In *Thermoflex Waukegan, LLC v. Mitsui Sumitomo Ins. USA, Inc.*, 102 F.4th 438 (7th Cir. 2024), a defendant in an underlying BIPA lawsuit, Thermoflex, sought a defense under three policies—the Basic, Excess and Umbrella policies. Affirming the district court, Judge Easterbrook concluded that an exclusion for "[claims] arising out of any access to or disclosure of any person's or organization's confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any other type of nonpublic information" barred coverage for Thermoflex's BIPA liability. Because the Excess policy contains the same exclusion, the Court ruled consistently that there is no coverage under the Excess policy. The Court also found that three exclusions in the Umbrella policy did not unambiguously relieve the insurer, Mitsui, of its obligation to defend the BIPA claims. First, the Court ruled, following the Illinois Supreme Court's decision in *West Bend Mutual Insurance Co. v. Krishna Schaumburg Tan, Inc.*, 183 N.E.3d 47 (Ill. 2021), that a "Statutory Violation" exclusion, addressing laws distinct in kind from BIPA, did not apply. Second, a "Data Breach Liability" exclusion, focused on public "disclosure" of confidential information, also did not apply to BIPA claims. Third, the Court ruled that an exclusion addressing "employment-related practices" also did not unambiguously apply. As a result, the Court affirmed that Mitsui owed a defense under the Umbrella policy.

VII. OPIOID LIABILITY COVERAGE

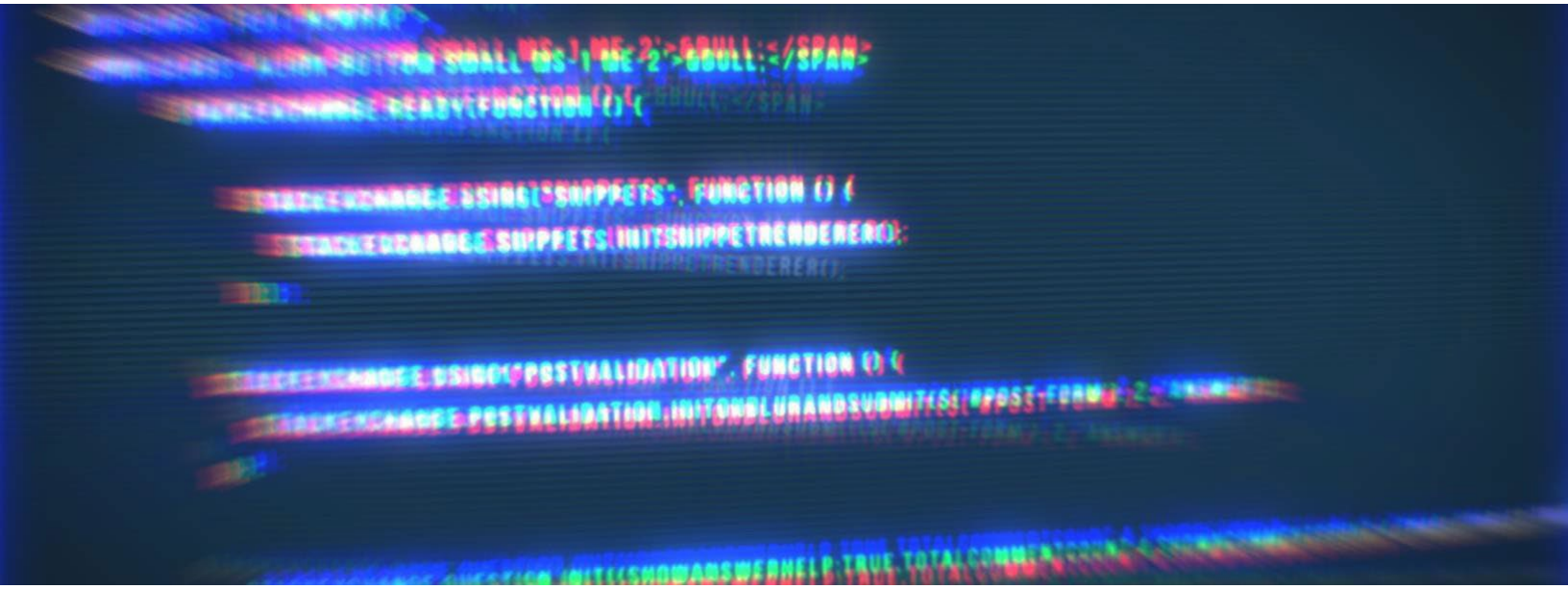
Over the past several years, appellate courts have issued several significant opinions addressing coverage for liability claims arising out of the opioid crisis, which have broader implications for general liability coverage at large. The Ninth Circuit Court of Appeals added to this precedent in *AIU Ins. Co. v. McKesson Corp.*, 2024 U.S. App. LEXIS 1806 (9th Cir. Jan. 10, 2024). However, in this case, the focus was not on whether the underlying

lawsuit alleged "damages because of 'bodily injury,'" but rather whether the underlying injury was caused by an "occurrence" or "accident" as required by the subject policy. After the district court granted summary judgment in favor of the insurer, AIU, the Ninth Circuit framed the issue as "a two-step inquiry: do the complaints in the Exemplar Suits allege anything other than strictly deliberate conduct? And if not, do they countenance 'some additional, unexpected, independent, and unforeseen happening' which may have produced the damage?" While the underlying suits alleged that the insured, McKesson, "intentionally flooded the market with opioids and intentionally flouted safeguards," the underlying plaintiffs also asserted claims for negligence, alleging what the insured "should have known." Despite these allegations, the Ninth Circuit ruled that the obligation to defend was established by the factual allegations of intentional conduct, as opposed to the legal causes of action asserted, and references to what the insured "should have known" were limited to establishing the foreseeability of the underlying plaintiffs' injuries. The court also concluded that the conduct of downstream actors, including doctors, pharmacists and opioid addicts, did not qualify as an "additional, unexpected, independent, and unforeseen happening" rendering the underlying plaintiffs' injuries "accidental" for purposes of AIU's duty to defend.

CYBER/NETWORK SECURITY/PRIVACY LIABILITY

I. SYSTEM FAILURE COVERAGE

In *Southwest Airlines Co. v. Liberty Ins. Underwriters, Inc.*, 90 F.4th 847 (5th Cir. 2024), an airline sought coverage under a cyber insurance policy for more than $77 million in losses, including discounts, travel vouchers, refunds, reward points and advertising costs incurred after a computer failure resulted in massive disruptions to flight schedules in July 2016. The subject policy, issued by Liberty, included "System Failure Coverage" for "Loss … that an Insured incurs … solely as a result of a System Failure," but Liberty argued that the customer incentives made the subject of Southwest's claim resulted from "business decisions," rather than a "system failure." Liberty also argued that Southwest's losses were excluded. The district court initially agreed with Liberty, granting summary judgment against Southwest. On appeal to the Fifth Circuit, however, the court concluded that a "sole cause" must also be an independent, "precipitating" cause of the loss, as opposed to one link in the causal chain originating with the failure of Southwest's computer system. Therefore, "the district court erred in concluding that Southwest's five categories of costs were all precluded as a matter of law because they were discretionary." With regard to the exclusions, the Court of Appeals again disagreed with the district court, concluding that an exclusion for "consequential damages" could not embrace the costs composing Southwest's claim without "render[ing] much of the coverage under the policy complete illusory." Following a similar line of reasoning, the Fifth Circuit also ruled that an exclusion barring coverage for "liability to third-parties" "d[id] not apply to



Southwest's customers and, in turn, does not preclude costs related to Southwest's payments to its customers."

OTHER NOTABLE INSURANCE DECISIONS & ISSUES

I. PRIORITY OF COVERAGE

Disputes over the priority of coverage often involve considerations of both policy terms and the parties' intent and expectations relative to the type of coverage at stake. Over the past year, several courts expressed views on how such priority disputes could be resolved and which considerations—policy terms or parties' expectations—take precedence. In *Great Am. Ins. Co. v. State Farm Fire & Cas. Co.*, 104 F.4th 1011 (7th Cir. 2024), two insurers disagreed over which insurer had responsibility to defend a member of a community college district's Board of Trustees against a wrongful termination lawsuit filed by the district's former president. Great American Insurance Company was the assignee of rights under an indemnity policy issued by the Illinois Community College Risk Management Consortium (the "Consortium Policy") covering the Board of Trustees and its members against losses arising from employment practices wrongful acts, including wrongful termination and defamation.

One member of the district's Board of Trustees was also insured by a personal umbrella liability policy issued by State Farm Fire & Casualty Company, whose policy included a duty to defend third-party claims "when the basis for the suit is a Loss that is not covered by any other insurance policy but is covered by this policy." After the district court granted State Farm's motion to dismiss Great American's claims to recoup defense costs paid to protect the Board member, Hamilton, from the underlying liability claims, the Seventh Circuit Court of Appeals affirmed, finding that (1) "[w]e are not concerned with the labels—primary, excess, or umbrella—however, but rather with the expectations of the parties—that is, what each insurer has agreed to cover in the respective policies"; and (2) according to the State Farm policy, "State Farm will only cover loss not covered by another insurer."

II. COVERAGE IMPACTED BY EXTERNAL DOCUMENTS

In recent years, several cases have focused on the extent to which external documents, including third-party contracts, can influence the interpretation and scope of coverage under an insurance policy. In *Snell v. United Specialty Ins. Co.*, 102 F.4th 1208 (11th Cir. 2024), the Eleventh Circuit Court of Appeals considered how an application for a commercial general liability policy affected a landscaper's right to be defended in an underlying personal injury lawsuit. The district court granted summary judgment in favor of the insurer, United, on the basis that the policy's liability coverage for "Specified Operations," which the policy defined to include "landscaping," did not include the assembly and installation of a trampoline, which was the subject of the underlying personal injury suit. The district court also found that under an Alabama statute, the policy must be construed in accordance with the "application which is a part of the policy," and the insured's policy application did not include "recreational or playground equipment construction or erection." On appeal, the insured, Snell, argued that "the district court overread [Ala. Code] § 27-14-17(a) to mean that an application is *necessarily* part of the insurance contract, rather than part of the contract if it is expressly incorporated" (emphasis in original). However, the Court of Appeals rejected this argument to find, among other things, that "the insurance application is to be construed as a part of the policy itself" (citing *Atlanta Cas. Co. v. Russell*, 798 So.2d 664, 667 (Ala. 2001)). Therefore, "the district court correctly held that Snell's insurance application—which Alabama law requires us to consider part of the policy—expressly disclaims the work he did here."

III. *COBLENTZ* AGREEMENTS UNDER FLORIDA LAW

In *Davis v. Great N. Ins. Co.*, 2024 U.S. App. LEXIS 13286 (11th Cir. Jun. 3, 2024), the Eleventh Circuit Court of Appeals considered what conduct qualified as a refusal to defend an insured as required for an enforceable *Coblentz* agreement under Florida law. Here, a condominium owner filed suit against a property management company, alleging that the manager's negligent work on a drainage pipe resulted in mold and ensuing health problems for the owner. The manager was insured under primary and excess liability policies issued respectively by AmTrust and Chubb. AmTrust defended the manager against the owner's lawsuit, subject to a reservation of rights. Chubb, as the excess insurer, initially responded to the owner's lawsuit by "monitoring th[e] matter under a complete reservation of rights," but two years later retained additional counsel to participate in the manager's defense leading up to an anticipated trial, again subject to a complete reservation of rights. The manager rejected Chubb's "offer of a qualified defense," and shortly thereafter, the owner plaintiff entered into a *Coblentz* agreement with the manager whereby the manager and primary insurer agreed to pay a small sum to the plaintiff, as well as a $14.5 million consent judgment recoverable only from Chubb.

Under Florida law, the enforceability of a *Coblentz* agreement is determined by

analyzing (1) whether there was coverage under the relevant insurance policy; (2) whether the insurer wrongfully refused to defend; and (3) whether the settlement amount was unreasonable and negotiated in bad faith. In a subsequent lawsuit against Chubb to recover the consent judgment, the district court granted summary judgment in favor of Chubb, finding that the amount of the consent judgment was not reasonable. On appeal, the Eleventh Circuit Court of Appeals ruled that (1) Chubb did not wrongfully refuse to defend by offering to defend the manager under a reservation of rights; (2) Chubb's reservation of rights on exhaustion was not an advanced repudiation of coverage; and (3) as an excess carrier, Chubb would not generally be required to provide a defense when the primary insurer has already done so.

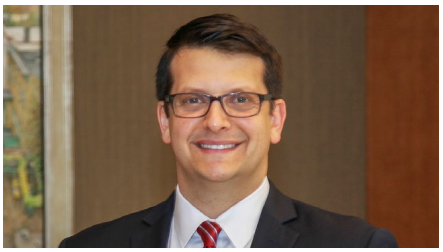
IV. *STOWERS* LIABILITY UNDER TEXAS LAW

Westport Ins. Corp. v. Pa. Nat'l Mut. Cas. Ins. Co., 117 F.4th 653 (5th Cir. 2024) addressed liability under Texas' *Stowers* doctrine, which governs an insurer's duty of care in responding to settlement demands against an insured, as between a primary and excess liability carrier. As context for this dispute, the carriers' common insured, IA, was an insurance agency facing third-party claims from a client that the agent failed to obtain necessary coverage for a marina damaged by a flood in 2007. Leading up to a trial against IA in 2012, the primary insurer, Westport, with limits of $5 million, repeatedly denied settlement demands ranging from $2 million to $5.9 million. Westport refused these plaintiff demands, on more than one occasion, against the concurrent demands from the excess carrier, Penn National, to settle the case within the limits of the primary policy. After the trial court entered judgment against IA for approximately $13.7 million, inclusive of interest, costs and fees, Westport sued Penn National for $7.7 million in excess liability it paid to satisfy the judgment against IA, and Penn National counterclaimed for breach of Westport's *Stowers* duty. Following inconclusive rulings on cross-motions for summary judgment, a jury found in favor of Penn National, finding that Westport breached its *Stowers* duty as to four separate plaintiff demands, of which three survived post-trial motions. On appeal, the Fifth Circuit Court of Appeals made the following notable rulings: (1) Westport's right to recover for Penn National's breach of contract was independent of a finding on Westport's breach of the *Stowers* duty, *i.e.*, *Stowers* is not a breach of contract defense; and (2) Penn National has standing to pursue the *Stowers* claim against Westport, even without having paid the full amount of the excess judgment rendered against the insured. In addressing the substance of the underlying plaintiff demands, the Court also held that an offer promising a full release under *Stowers* "does not require 'the release of potential, unasserted, and distinct claims made by third parties.'"

V. COVID-19 BUSINESS INTERRUPTION

Finally, in *North State Deli, LLC v. Cincinnati Insurance Company*, 2024 N.C. LEXIS 970 (N.C. Dec. 13, 2024), the North Carolina Supreme Court granted a group of plaintiff bars and restaurants a rare victory in their claim for business interruption coverage arising from the COVID-19 pandemic. Trial and appellate courts across the country have found that such claims do not satisfy the requirement for "direct physical loss or damage" under commercial property insurance. But in *North State Deli*, the trial court granted summary judgment in favor of the insureds. Notwithstanding a reversal from the court of appeals, the North Carolina Supreme Court also sided with the insureds after reasoning that it is the burden of the drafting insurers, who have longstanding notice of the court's rules of construction, to "clearly 'mark out and designate' the contours of their polic[ies]." Applying the ordinary, dictionary meaning of the terms "direct physical loss," "a covered cause of loss must, absent an intervening factor, result in the material deprivation, dispossession, or destruction of property." This, the court also found, could reasonably be expected to include closures due to government orders and the loss of "use" of property: "At bottom, a reasonable person in the position of the insured would understand the restaurants' policies to include coverage for business income lost when virus-related government orders deprived the policyholder restaurants of their ability to physically use and physically operate property at their insured business premises."

MEET THE PARTNERS



Adrian C. Azer
Partner | Washington, D.C.

David P. Bender
Partner | Dallas - North

Emily Buchanan
Partner | Dallas

Barry I. Buchman
Partner | Washington, D.C.

Natalie DuBose
Partner | Dallas

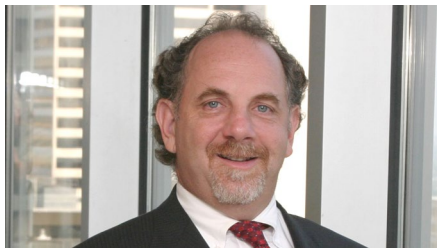
Peter A. Halprin
Partner | New York

Ernest Martin Jr.
Partner | Dallas

Cristen Rose
Partner | Washington, D.C.

Robert Shulman
Partner | Washington, D.C.

Micah E. Skidmore
Partner | Dallas



David Taubenfeld
Partner | Dallas

Leslie C. Thorne
Partner | New York

Greg Van Houten
Partner | Washington, D.C.

HAYNES BOONE

Austin
Charlotte
Chicago
Dallas
Dallas - North
Denver
Fort Worth
Houston
London
Mexico City
New York
Northern Virginia
Orange County
Palo Alto
San Antonio
San Francisco
Shanghai
The Woodlands
Washington, D.C.

haynesboone.com