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UPDATED: Hinshaw Authors USA Chapter of Chambers Global Practice Guide on Insurance & Reinsurance – Trends and Developments

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In an updated version of the USA Chapter of the Chambers Global Practice Guide on Insurance & Reinsurance, Hinshaw attorneys Scott Seaman—the co-chair of the firm's global Insurance Services Practice Group—Jason Schulze and John DeLascio provide a wide-ranging review of key U.S. insurance and reinsurance trends and developments from January 1, 2020 through October 1, 2021.

The chapter is available on the Chambers and Partners website. It is also reproduced below.

Trends and Developments: January 1, 2020 Through October 1, 2021

Dominated by the COVID-19 pandemic, 2020 was a year that featured fast-paced activities and unprecedented challenges for insurers and reinsurers. The first three quarters of 2021 continued in a similar vein with increased attention to sustainability due to the Biden administration's agenda. Some of the more significant trends, decisions and developments are highlighted below.

ESG/Sustainability

Environmental, social and governance (ESG) criteria or standards – often referred to simply as sustainability – are having a significant impact on all sectors, including, and perhaps particularly, the insurance and financial sector. First and foremost, insurers are focused on their own practices and operations. They are setting and implementing goals regarding their own emissions, carbon blueprints, diversity and governance. Insurance companies are being viewed – with increasing frequency and severity – as agents for imposing affirmative ESG change on other entities such as their policyholders and vendors. The underwriting, pricing, investment, claims and business practices of insurance companies are under increased scrutiny, both internally and externally. State regulators and rating agencies are laser focused on ESG. The Biden administration is implementing an "all of government" focus on ESG, with the Federal Office of Insurance poised to increase the federal regulation of insurance, using climate change as a jumping-off point. (*See* S.M. Seaman, "Insurers Take the Lead on ESG/Sustainability Initiatives" (JD Supra Oct. 1,

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2021), available at https://www.jdsupra.com/legalnews/insurers-take-the-lead-on-esg-6954367/; S.M. Seaman, Comments Due to the Federal Insurance Office on its Wide-Ranging Work Relating to the Insurance Sector and Climate-Related Financial Risks(JD Supra Oct. 13, 2021), available at https://www.jdsupra.com/legalnews/comments-due-to-the-federal-insurance-9466044/).

ESG factors are driving losses and litigation with increasing frequency.

COVID-19 Business Interruption and Other Pandemic Coverage Litigation

The issuance of various governmental orders requiring businesses to temporarily modify or close their operations led to an almost immediate avalanche of claims and lawsuits involving first-party commercial property policies. By 1 October 2021, there had been approximately 2,039 COVID-19 coverage cases, with 1,825 involving business interruption, 1,646 extra expense, 1,566 civil authority, 184 ingress/egress, 103 contamination, 83 event cancellation, and 81 sue and labour. Approximately 462 cases were filed as putative class actions and 702 cases include allegations of bad faith. At the trial court level, insurers have prevailed in approximately 75% of the rulings on motions to dismiss in state courts and nearly 95% of the rulings by federal courts, mostly on the grounds that the virus claims do not involve "direct physical loss or damage" to property as required under most US policy wordings, governmental orders do not constitute loss of property, and/or virus exclusions preclude coverage. There are numerous motions to dismiss outstanding, many rulings on appeal, with new cases continuing to be filed. The first six appellate court rulings have all come from US Circuit Courts of Appeal, with insurers prevailing in each case in decisions rendered by the Sixth, Eighth, Ninth and Eleventh Circuits (involving the laws of ten states) (see S.M. Seaman, "Double Tic-Tac-Toe: Insurers Have Now Prevailed in the First Six U.S. Court of Appeals Decisions Regarding COVID-19 Coverage" (JD Supra Oct. 5, 2021), available at https://www.jdsupra.com/legalnews/double-tic-tac-toe-insurers-have-now-7587958/).

Efforts by some policyholders to consolidate COVID-19 business interruption coverage cases have been largely rejected; the vast majority of COVID-19 coverage cases will not be subject to multidistrict litigation (MDL). On 14 August 2020, the Judicial Panel on Multidistrict Litigation denied a request to consolidate all COVID-19 federal litigation. The Panel later rejected a request to create mini-MDLs with regard to four insurers, although it did agree to centralise more than 30 lawsuits against Society Insurance Company (*in re Soc'y Ins. Co. COVID-19 Bus. Interruption Protection Ins. Litigation*, 20 U.S. Dist. LEXIS 183678 (J.P.M.L. 2 October 2020)).

Insurers are monitoring the numerous pending federal and state legislative proposals, but to date none have become law (*see* S.M. Seaman and J.A. Selby, "Tracking The Flurry Of COVID-19 Related Legislative & Regulatory Activity Impacting Insurers", *Mealey's Litigation Report: Catastrophic Loss*, Vol 15, No 7 (April 2020)). The activity level on other lines of policies – such as general liability, professional liability, D&O, and workers' compensation – is expected to increase.

Protests that give rise to rioting and looting have produced first-party claims. When coupled with COVID-19-related shutdowns, concurrent causation may be presented.

Cyber-Insurance Claims

To date, the vast majority of cyber coverage decisions have involved traditional first-party, third-party and crime/fraud policies. Claims under those policies commonly are referred to as silent cyber claims. Most insurers in the cyber-insurance market have now issued several iterations of cyber-specific policies. Rulings under these policies are expected to be rendered with increasing frequency over the next couple of years (*see* S.M. Seaman and J.R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 9th Ed. 2020-21) at Chapter 17 (Cybersecurity and Privacy Claims)).

Indeed, cyber-insurers experienced a steep increase in claims in 2020, driven primarily by ransomware, often coupled with data extraction, and business email compromise events. The costs associated with ransomware claims, in particular, have risen dramatically, due to increased ransom demands, threats to disclose extracted data, and related business interruption costs. The pandemic-driven massive shift to remote work spurred additional cyber claims activity. As a result, industry leaders are anticipating a hardening of the cyber-insurance market, as well as increased premiums and

underwriting scrutiny. A ransomware coverage decision was rendered by the Indiana Supreme Court in *G&G Oil Co. of Ind. v Cont'l W. Ins. Co*., 165 N.E.3d 82 (Ind. 2021) discussed below.

Property insurance

In January 2020, a federal district court in Maryland ruled that the first-party property coverage in a business owner's insurance policy (BOP) covered the replacement of the insured's computer system after a 2016 ransomware attack (*National Ink and Stitch, LLC v State Auto Property and Cas. Ins. Co*., 435 F. Supp.3d 679 (D. Maryland 2020) (applying Maryland law)). Following remediation, the system was still functional, but its performance was slowed by new protective software and it was likely that remnants of the virus remained on the system, increasing the risk of re-infection. The court determined that the "loss of reliability, or impaired functionality demonstrate the required damage to a computer system, consistent with the 'physical loss or damage to' language in the policy."

This decision does not materially advance efforts to secure cyber coverage under first-party property policies. The National Ink policy was issued in 2016, but written on the 1999 ISO form. More recent forms, such as the 2012 ISO BOP form, exclude computer-related losses.

Business email compromise

A Mississippi federal district court ruled that Computer Fraud Transfer and Funds Transfer Fraud coverages were not applicable to losses resulting from an email phishing scam (*Miss. Silicon Holdings, LLC v Axis Ins. Co*., 440 F. Supp.3d 575 (N.D. Miss. 2020)). The insured, Mississippi Silicon Holdings (MSH), had fallen prey to spoofed emails and wired more than USD1 million to fraudsters instead of a legitimate vendor. Three MSH employees approved the wire transfers before MSH learned that hackers had infiltrated its computer system and impersonated an authentic vendor.

MSH's insurer accepted coverage under the Social Engineering provision of its management liability policy, but not under the Computer Fraud Transfer and Funds Transfer Fraud coverage grants, which had much higher limits of liability. MSH instituted coverage litigation, alleging the loss fell within all three coverages.

The Computer Transfer Fraud provision covered losses resulting "directly from Computer Transfer Fraud that causes the transfer, payment, or delivery of Covered Property from the Premises or Transfer Account to a person, place, or account beyond the Insured Entity's control, without the Insured Entity's knowledge or consent."

The Funds Transfer Fraud provision provided coverage for loss "resulting directly from the transfer of Money or Securities from a Transfer Account to a person, place, or account beyond the Insured Entity's control, by a Financial Institution that relied upon a written, electronic, telegraphic, cable, or teletype instruction that purported to be a Transfer Instruction but, in fact, was issued without the Insured Entity's knowledge or consent."

The court declined to adopt a proximate cause standard advocated by MSH, agreeing with the insurer that Computer Transfer Fraud coverage was not implicated because "nothing 'entered' into or 'altered' within [MSH's] Computer System... directly caused the transfer of any Money." Instead, the MSH employees caused the transfer. Because the fraudulent emails did not themselves manipulate MSH's computer system, a "Computer Transfer Fraud" did not directly cause the transfers.

The court further held that the requirement for the transfer to take place "without the Insured Entity's knowledge or consent" was not satisfied. The court rejected MSH's assertion that a more logical reading of the requirement would be that MSH had to have actual knowledge of material facts, such as the transferee's true identity, stating that MSH provided no legitimate reason to impose a heightened requirement into the policy. The court distinguished the Social Engineering Fraud provision, which "clearly authorizes coverage when an employee relies on information that is later determined to be false or fraudulent. In contrast, the Computer Transfer Fraud provision specifically states that coverage is only available when the loss occurs "without the insured entity's knowledge or consent."

The court also held that the Funds Transfer Fraud coverage was not triggered because the MSH employees had knowledge of, and consented to, the transfers. The court found no legitimate basis to accept MSH's argument that the policy required those MSH employees to know that the spoofed emails were fraudulent at the time of the transfers. The decision was affirmed by the Fifth Circuit in 2021.

In *Midlothian Enters. v Owners Ins. Co.*, 439 F.Supp. 3d 737 (E.D. Va. 2020), a Virginia federal district court ruled a crime insurer had no obligation to cover losses resulting from an email phishing scam. In that case, a Midlothian employee had complied with an email request, purportedly from the company president, to wire more than USD400,000 from Midlothian's bank account to a bank account in Alabama. Several days later, Midlothian discovered the email was fraudulent and tendered a claim to Owners Insurance Company, which denied coverage.

The crime policy provided coverage for theft of money and securities, but excluded coverage for "[l]oss resulting from your, or anyone acting on your express or implied authority, being induced by a dishonest act to voluntarily part with title to or possession of any property." The court had no trouble deciding that the exclusion unambiguously precluded coverage. The court rejected the insured's attempt to create ambiguities in the exclusion by highlighting terms with more than one meaning or interpretations that conclude in different results in the interpretation of the exclusion. The court stated: "The fact that a word or phrase has more than one dictionary definition... does not make a provision ambiguous."

The court also rejected the insured's argument that a victim of fraud can never act voluntarily, and that the exclusion does not apply where the instruction to make payment is fraudulent: "The fact that another individual pretended to authorize the transaction does not negate the voluntariness of the transfer..." Consequently, "[a]llowing coverage of a fraudulently authorized transaction despite an exclusion based on '*any* dishonest act' would unreasonably limit the exclusion and render the provision meaningless." (Emphasis in original.)

A New Jersey federal district court held that losses arising out of a phishing scam were not covered under a bank's Financial Institutions Bond. In *Crown Bank JJR Holding Co. v Great Am. Ins. Co*., 2020 U.S. Dist. LEXIS 23136 (D. N.J. 11 February 2020) (New Jersey law), a fraudster impersonated Jackie Rodrigues, the wife of a senior executive of Crown Bank. In a series of 13 emails from a spoofed email address, the impersonator requested wire transfers from the Rodrigueses' Crown Bank accounts to accounts in Singapore.

Pursuant to their Customer Agreement with Crown Bank, the Rodrigueses were permitted to request wire transfers by email, and Crown Bank was required to verify each request by calling the account holder at a designated phone number. Upon receipt of each of the fraudulent email requests, Crown Bank employees requested information needed to complete the transfer and emailed a wire transfer authorisation form back to the impersonator. The impersonator would forge Mrs Rodrigues's signature, and then email a PDF of the completed form back to the bank. Bank employees printed the PDF and then matched the forged signature on the form to the signature the bank had on file for Mrs Rodrigues. Bank employees never called the designated phone number to verify the requests, even though the wire transfer form indicated that the call had been made. By the time the fraud was uncovered, over USD2 million had been transferred from the Rodrigueses' accounts. Crown Bank sought coverage for the loss under its Financial Institutions Bond and its Computer Crime Policy for Financial Institutions. Its insurer denied coverage under both policies, and coverage litigation ensued.

Crown Bank asserted that its claim was covered by Insuring Agreement D of the Financial Institutions Bond. That provision applied to: "Loss resulting directly from the Insured having, in good faith, paid or transferred any Property in reliance on any Written, Original... (4) Withdrawal Order... (6) Instruction or advice purportedly signed by a customer of the Insured or by a banking institution... which (a) bears a handwritten signature of any maker, drawer or endorser which is Forgery; or (b) is altered, but only to the extent the Forgery or [alteration] causes the loss. Actual physical possession of the items listed in (1) through (6) above by the Insured is a condition precedent to the Insured's having relied on the items. "

The term "Original" was defined as "the first rendering or archetype and does not include photocopies or electronic transmissions, even if received and printed." "Written" was defined as "expressed through letters or marks placed upon paper and visible to the eye."

The parties' central dispute was whether Crown Bank had actual physical possession of the "Written, Original" wire transfer forms, a condition precedent to coverage under Insuring Agreement D. The insurer argued that the bank failed to satisfy that condition because printouts of the electronically transferred PDFs from the impersonator did not fall within the Bond's definition of "Original". Crown Bank contended that a PDF itself is not an electronic transmission, and each printout of a wire transfer authorisation form from a PDF was a "first rendering" within the definition of "Original".

The court rejected the Bank's arguments because “documents transmitted electronically are not originals, even if received and printed”, according to the Bond. The Bank’s additional contention that the “first rendering or archetype” language in the definition of Original was ambiguous as applied to PDFs also missed the mark: “Regardless of any ambiguity concerning whether a PDF may qualify as an ‘Original’ without electronic transmission, where a PDF (or any electronic file format) is transmitted electronically, it cannot qualify as an ‘Original’ as defined in the [Bond].”

In *G&G Oil Co. of Indiana v Continental Western Ins. Co*., 145 N.E.3d 642 (Ind. App. Ct. 2020), an Indiana appellate court held that a ransom payment did not fall within a multi-peril policy’s commercial crime and fidelity coverage part because the attacker did not use a computer to fraudulently cause the insured to purchase bitcoin for the ransom payment.

The court deferred ruling on whether there was coverage under the Computer Systems Fraud Insuring Agreement in the crime policy pending further briefing on the insured’s objectively reasonable expectation of coverage under that policy.

The Indiana Supreme Court, on appeal, concluded the term “fraudulently cause a transfer” equates “to obtain by trick”. The court noted that every ransomware attack is not necessarily fraudulent. For example, if no safeguards were put in place, it is possible a hacker could enter a company’s servers unhindered and hold them hostage. There would be no trick there. Thus, a question of fact exists precluding the entry of summary judgment in favor of the policyholder. The court reversed the grant of summary judgment in favour of the insurer on the second issue, finding there is sufficient causal connection between the alleged fraud and the policyholder’s use of the computer. Its transfer of Bitcoin was nearly the immediate result from the use of a computer. Though the policyholder’s transfer was voluntary, it was made only after consulting with the FBI and other computer tech services and was made under duress. Under those circumstances, the “voluntary” payment was not so remote that it broke the causal chain.

Privacy violations

In the absence of comprehensive federal laws, individual states continue to adopt their own privacy laws and regulations. For example, the ground-breaking California Consumer Privacy Act (CCPA) went into effect in January 2020. Similar to the EU’s General Data Protection Regulation, the CCPA created a number of privacy rights for California consumers and obligations for businesses that collect and process personal information. Although the California Attorney General has yet to commence a CCPA enforcement action, several class-action lawsuits have already been filed pursuant to the Act’s limited private right of action. Despite the recent enactment of the CCPA, California residents voted in November to approve the California Consumer Privacy Rights Act (CPRA), which further expands consumer privacy rights. The CPRA also creates a state-wide privacy agency that will be charged with enforcement of privacy laws. This likely will lead to increased enforcement actions for privacy violations in California.

In New York, a proposed amendment to the state’s Civil Rights Law would create criminal liability for certain privacy violations, and the proposed It’s Your Data Act would create CCPA-like consumer privacy rights but with a broader private right of action. In July 2020, the New York Department of Financial Services, the state’s powerful financial regulator, initiated its first enforcement action for alleged violations of its first-in-nation 2017 cybersecurity regulation.

Increased regulatory enforcement and the further proliferation of privacy and cyber laws and regulations will likely drive increased cyber-insurance claims activity for both breach and information misuse events going forward.

Several decisions on the privacy front were issued in 2020. In *Brighton Collectibles, LLC v Certain Underwriters at Lloyd’s London*, 798 F. App’x 144 (9th Cir. 2020), an insurer was required to defend a putative class action alleging that the insured retailer collected and sold customers' personal information in violation of California's Song-Beverly Credit Card Act. The insured argued that the claim triggered its personal injury coverage, which applied to personal injury caused by an offence arising out of the insured's business, which includes “oral or written publication of material that violates a person's right of privacy.”

Based on California Supreme Court precedent holding that the overriding purpose of the Credit Card Act is to protect the personal privacy of consumers, the Ninth Circuit found that the class action alleged an invasion of privacy sufficient to trigger the insurer’s duty to defend. The court rejected the insurer's assertion that coverage was barred by the policies' exclusions for “advertising, publishing, broadcasting or telecasting done by or for” the insured. The court stated: “The word ‘publishing’ in this coverage exclusion cannot be read to have the same meaning as the word 'publication' in the personal

injury provision. Such a reading would exclude coverage for virtually any publication over which [the insured] might realistically be sued, rendering the policies' express coverage for publications that violate privacy rights practically meaningless."

The court also noted that the "grouping of 'publishing' with 'advertising..., broadcasting or telecasting' in the coverage exclusion suggests that the exclusion applies only to broad, public-facing marketing activities."

The Illinois Supreme Court found that a claimed violation of Illinois' Biometric Information Privacy Act fell within (or potentially within) businessowners liability policies affording personal and advertising injury coverage (*W. Bend Mut. Ins. Co. v. Krishna Schaumburg Tan, Inc*., 2021 IL 125978 (20 May 2021)). The plaintiff in the underlying suit alleged she purchased a membership from the policyholder, a salon that granted her access to other salons. Enrolling in the programme purportedly required that the plaintiff have her fingerprint scanned in order to verify her identity. The plaintiff alleged that the policyholder never provided her with, nor did she sign, a release allowing the policyholder to disclose her biometric data to any third party. Nevertheless, the policyholder purportedly disclosed her fingerprint data to an out-of-state third-party vendor. The plaintiff asserted claims for violation of BIPA, unjust enrichment and negligence.

Because the policies did not define "publication," the court turned to the dictionary definition and case law, and held that "publication" has at least two definitions and means both the communication of information to a single party and the communication of information to the public at large." As such, the salon's disclosure of fingerprint data to another party constituted a "publication." The court the held the violation of statutes exclusion did not bar coverage for the claim since BIPA was dissimilar from the statutes enumerated in the exclusion.

In *Massachusetts Bay Insurance Co. v Impact Fulfillment Services*, 2021 U.S. Dist. LEXIS 182970 (M.D. N.C. 24 September 2021), the district court found that the general liability insurers had no duty to defend their policyholder, Impact Fulfillment Services, in a proposed class action from Impact's Illinois employees. The underlying suit alleged that Impact scanned workers' fingerprints to track work hours without their consent, in violation of BIPA. Contrary to the Illinois Supreme Court's decision in West Bend, the North Carolina federal court found the distribution of materials exclusion bars coverage for the exact type of illegal information collection regulated by BIPA. Applying North Carolina law, the court noted the exclusion in the policies before it – which was revised in 2013 by ISO – was broader than the exclusion in West Bend. Specifically, the exclusion included the terms "printing, dissemination, disposal, collecting and recording" of information and materials. The exclusion also bars coverage for violations of the Fair Credit Reporting Act, in addition to violations of the Telephone Consumer Protection Act and Can-Spam Act, which were also barred under the earlier version of the exclusion. By contrast to the Illinois Supreme Court, the North Carolina federal court concluded that "BIPA is of the same kind, character and nature" as the Telephone Consumer Protection Act, the Fair Credit Reporting Act and other federal and state statutes for which coverage is barred by the exclusion.

Lead Paint

Coverage issues relating to the USD400 million-plus lead paint abatement fund involving three lead paint manufacturers are being addressed in three separate coverage actions. The courts have reached different conclusions in each on motions for summary judgment.

First, a California trial court ruled, in *Certain Underwriters at Lloyd's of London v Conagra Grocery Products Company*, CGC-14-536731, Cal. Super. Ct., San Francisco Cty. (25 February 2020), that California's wilful acts insurance law precluded coverage for public nuisance claims against the insured based on its predecessor's promotion of lead paint. Evidence in the underlying liability litigation established that the predecessor had actual knowledge that lead paint on residential interior surfaces posed a public health hazard.

In the subsequent coverage litigation, the court rejected the insured's attempt to be "insulated from" that knowledge, as well as its argument that the scienter findings in the underlying litigation were insufficient to meet the wilfulness standard of California Insurance Code §533, which provides that an "insurer is not liable for a loss caused by the willful act of an insured." The fact that senior managers of the predecessor company were not proven to have knowledge of the relevant hazards made no difference, according to the court. Under §533, an entity's employees' collective knowledge "is what matters." The case is on appeal.

Next, in *Sherwin-Williams v Certain Underwriters at Lloyd's of London*, CV-06-585780, Ohio Ct. Common Pleas, Cuyahoga Cty (4 December 2020), the court rejected the insurers' arguments that Sherwin-Williams either expected or intended the damages. It nonetheless granted summary judgment to the insurers on the grounds that the abate fund does not constitute "damages" under the policies. Finally, in *Certain Underwriters at Lloyd's, London v NL Industries*, 650103/2014, N.Y. Sup. Ct., New York Cty (29 December 2020), the court denied the insurers' motion for summary judgment based on similar grounds.

Long-Tail Claims – Allocation

Allocation of losses among insurers and policyholders continues to be a driving issue in long-tail claims. Pro rata allocation continues to be the majority approach and is superior to the "all sums" allocation alternative (see S.M. Seaman and J.R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 9th Ed. 2020-21)). Maryland's high court unanimously held that a commercial general liability (CGL) insurer was responsible for only a pro rata share of a USD2.7 million judgment against its insured based on a worker's bodily injury due to exposure to asbestos at the now defunct insured's property (Rossello v Zurich American Insurance Company, 468 Md. 92, 226 A.3d 444 (2020)). The worker, who developed mesothelioma decades after his asbestos exposure, argued that the policy's all sums language supported joint and several allocation, allowing him to collect the entire judgment against a single insurer. Joining the majority of states that have considered the issue, the court held that damages for continuous injury must be allocated on a pro rata basis across all insured and insurable periods triggered by the worker's injuries. The court stated that all sums allocation is inconsistent with the policy requirement for bodily injury to occur "during the policy period."

The Ohio Supreme Court rejected the application of an all sums allocation for a product defect property damage claim where there was no evidence that the injury was over time (*Lubrizol Advanced Materials, Inc. v National Union Fire Ins. Co. of Pittsburgh, PA*, 2020-Ohio-1579, 2020 Ohio LEXIS 1009 (2020)). Under the facts of that case, the court stated that "the operative contract language is not the reference to policy coverage for 'those sums' but rather to injury or damage 'that takes place during the Policy Period.'" There was "no reason to allocate liability across multiple insurers and policy periods if the injury or damage for which liability coverage is sought occurred at a discernible time. In that circumstance, the insurer who provided coverage for that time period should be liable, to the extent of its coverage, for the claim." The court distinguished cases where it applied all sums allocation, noting that those cases involved progressive environmental pollution and asbestos bodily injury claims.

In the long-running Montrose environmental coverage litigation, the California Supreme Court adopted a vertical exhaustion requirement, allowing the policyholder to access coverage under any excess policy upon exhaustion of directly underlying excess policies for the same policy period (*Montrose Chem. Corp. of Cal. v Superior Court*, 9 Cal. 5th 215, 260 Cal. Rptr. 3d 822, 460 P.3d 1201 (2020)). Relying on the policies' "other insurance" clauses, the court rejected the horizontal exhaustion method advocated by the insurers, noting that none of those clauses clearly or explicitly states that Montrose must exhaust insurance with lower attachment points purchased for different policy periods.

Traditionally, Florida courts did not allow contribution claims among liability insurers for defence costs. Fl. Stat. § 624.1055 was enacted to expressly provide that courts shall allocate defence costs among liability insurers that owe a duty to defend the policyholder against the same claim, suit or other action "in accordance with the terms of the liability insurance policies". The statute does not apply to motor vehicle liability insurance or medical professional liability insurance.

Construction Defect

Cases across the country have reached differing results as to whether defective construction is an "occurrence" or "accident" under general liability policies (see S.M. Seaman and J.R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 9th Ed. 2020-21) at Chapter 16 (Construction Defect Losses)).

In a unanimous decision, the Michigan Supreme Court held that an "accident" could include faulty subcontractor work that was unintended by the insured, thereby constituting an occurrence under a CGL policy (*Skanska United States Bldg. v M.A.P. Mech. Contractors*, No 159510-159511, 2020 Mich. LEXIS 1194 (29 June 2020)). The court rejected the insurer's argument that covering faulty subcontractor work would convert the policy into a performance bond, noting that "the CGL

policy covers what it covers" and there is no basis to eliminate coverage because similar protections may be available under another insurance product.

Opioids Coverage

In the wake of the nationwide opioids epidemic, various state and local governments sued numerous entities involved in the manufacture, sale, distribution and prescription of opioid pharmaceutical products. Facing staggering potential liabilities, these entities have turned to their insurance companies for coverage under CGL and other policies.

There have been several significant settlements reached in the past several months. These include pharmaceutical distributors' USD215 million settlement with two Ohio counties, the distributors' USD1.179 billion settlement with the State of New York and its participating subdivisions, Johnson and Johnson's USD230 million settlement with the State of New York, and a USD26 billion global settlement between drug distributors and a group of state attorneys general in the National Prescription Opioid MDL.

In terms of coverage decisions, in *Acuity v Masters Pharm. Inc.*, 2020 WL 3446652 (Ohio App. Ct. June 24, 2020), the court reversed the trial court's ruling that the insurer had no duty to defend a pharmaceutical distributor against opioid lawsuits. In finding a duty to defend, the court determined that, although the government entities were seeking their own economic losses, some of those losses, such as medical expenses and treatment costs, were arguably "because of" bodily injury. The decision is currently on appeal before the Ohio Supreme Court. *See also Cincinnati Ins. Co. v. H.D. Smith, L.L.C.*, 829 F.3d 771 (7th Cir. 2016). Other decisions have ruled in favor of insurers on this issue (*Cincinnati Ins. Co. v Richie Enters.*, LLC, 2014 WL 3513211, at *5 (W.D. Ky. July 16, 2014); *Travelers Property Cas. Co. of Am. v Anda, Inc.*, 90 F.Supp.3d 1308 (S.D.Fla.2015), *aff'd*, 658 Fed. Appx. 955 (11th Cir.2016)). It also rejected the insurer's argument based on the loss in progress or Montrose clause, ruling coverage for opioid claims would be barred only if the insured had knowledge of the specific injuries at issue.

The lower Delaware court ruled, in *Rite Aid Corp. v ACE American Insurance Co.*, that general liability insurers must defend their policyholders in litigation filed by government entities seeking to recover for amounts that they allegedly spent to provide health, emergency and other services to citizens addicted to prescription opioids. That decision is now before the Delaware Supreme Court on appeal.

In October 2020, AIG-related insurers filed suit against McKesson Corporation, seeking a declaration that they are not obligated to cover lawsuits against the drug distributor for its role in the opioids epidemic. The insurers had denied coverage on multiple grounds, including that:

- their policies were not triggered because McKesson has not established that it exhausted or satisfied the self-insured retentions or limits underlying the policies;
- McKesson failed to provide the insurers with sufficient information about the underlying lawsuits for the insurers to evaluate coverage;
- the lawsuits do not stem from an accident, and therefore there was no occurrence;
- the underlying plaintiffs do not seek recovery for damages because of bodily injury;
- McKesson cannot show that the plaintiffs' damages were caused by bodily injuries that occurred during the respective policy periods;
- McKesson had knowledge of bodily injury prior to the policy periods; and
- McKesson expected or intended bodily injury to occur.

In October 2020, the Ninth Circuit held that a doctor's professional liability policy did not coverage an opioid-related wrongful death claim (*National Fire & Marine Ins. Co. v Estate of Diana Hampton*, 19-17235 (9th Cir. 21 October 2020)). The insured doctor had admitted that he wilfully violated federal controlled substances laws, which resulted in the death of a Nevada woman. The court held that the policy's exclusion for any wilful violations of law "clearly applied" to the claim.

Other

Insurers are monitoring the Aqueous Film Foam (firefighting foam) claims, particularly with respect to environmental property damage claims, which are subject to MDL proceedings in the Federal District Court for the District of South Carolina. Sports-related concussion claims have resulted in numerous settlements and a class-action settlement for medical monitoring. The National Collegiate Athletic Association has a coverage action pending in Indiana state court. Wildfires have joined hurricanes and tornadoes as frequent producers of casualty claims.

Insurers are assessing the impact of expected policy changes and priorities of the Biden administration on claims. The emphasis on climate change may produce additional claims and claim types, but success in that area could reduce the frequency and severity of events such as hurricane and wild fires. The administration's emphasis in other areas, such as civil rights and consumer protection, will be watched as well.

Reinsurance

For nearly 30 years, the majority rule has been that the "reinsurance stated" limits in a facultative reinsurance contract capped a reinsurer's total liability for indemnity and defence costs (*Bellefonte Reinsurance Co. v Aetna Cas. and Sur. Co*., 903 F.2d 910 (2d Cir. 1990)). The New York Court of Appeals, in its 2017 Global Re decision, ruled that there is no blanket rule, and directed courts to look at the language of the particular reinsurance contract to determine the scope of the limits. In 2020, in *Global Reinsurance Corporation of America v Century Indemnity Company*, 2020 WL 995860 (S.D.N.Y. 3 March 2020), the district court concluded on remand after conducting an evidentiary hearing that the stated limit capped losses and also capped expenses where there are no losses, but did not cap expenses where there are losses.

In *Utica Mut. Ins. Co. v Fireman's Fund Ins. Co*., 957 F.3d 337 (2d Cir. 2020), the court ruled that a reinsurer was not obligated to pay the ceding company as a matter of law because the underlying asbestos-related bodily injury claims did not excess the attachment points of the reinsured umbrella policies. In reversing, the Second Circuit held that the follow the settlements doctrine does not override the terms of the reinsurance contract.

Finally, reinsurers are evaluating their exposures for COVID-19-related cessions (Seaman, S.M. and Lenci, E., "Reinsurers Must Prepare for Coronavirus-Related Claims", Law360 (9 April 2020)).