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Covered Events

The newsletter of the Insurance Law Committee

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Committee Leadership

In This Issue

Leadership Notes

Note from the Editor

By Tiffany Brown

Spring has sprung! Here is the March 2017 edition of *Covered Events*.

Spring means longer days, sunnier skies, warmer weather, green grass, and a look ahead to summer. It's an exciting season, filled with change and a sense of something new. Soon warmer weather will be here and to aid your ability to enjoy it, your Insurance Law Committee will continue its work to keep you abreast of everting exciting and new in the wonderful world of insurance.

We are hoping for good weather next week in Chicago, where the ILC will host its annual Insurance Coverage and Claims Institute (fondly referred to as "ICCI") April 3–5 at the Loews Chicago Hotel. ICCI is an insurance coverage extravaganza! This year's ICCI will once again offer an unparalleled opportunity to engage with a distinguished faculty of insurance industry leaders, experts, and coverage lawyers on the latest trends in insurance law: ethical duties relating to the tripartite relationship, analysis of additional insured issues involving construction law, D&O coverage in a time of non-traditional claims, presentations by insurers about what they want and need from their counsel, and more!

Along with an excellent industry-only program in the afternoon on Wednesday, April 3, we will also have a mobster tour networking event off site to kick off the conference. In addition to up to 12.5 CLE credits to satisfy your individual State's reporting requirements, ICCI provides an excellent opportunity to sharpen the tools you need to compete successfully and network with industry leaders and experienced coverage lawyers from across the country, all while exploring the Second City! And, it's not too late to register because you can do so onsite! Here is a link to this year's program.

In the meantime, *Covered Events* will keep you up to date on emerging trends and issues. A special thanks goes out to all of our case summary contributors and the three authors of this month's featured articles: Dan Huckabay, Kevin Griffiths, and David Mackenzie, who have authored must-read articles about appeal bonds, trigger issues in excess exhaustion, and Canadian cyber class actions.

Enjoy the read.

Tiffany M. Brown is a partner of Meagher & Geer, P.L.L.P. in Minneapolis, where she focuses her practice on commercial litigation, with particular emphasis on insurance coverage disputes involving commercial, professional and personal lines of insurance, including breach of contract, declaratory judgments, and bad faith actions. Tiffany's practice also includes E&O liability defense. She has previous experience representing insurance companies in cases involving arson and other insurance fraud.

Commercial General Liability SLG

By Michael Strasavich

Let's face it. Sometimes, life is busy. Very busy. Work life, getting ready for trial. Home life, as a parent of three kids in high school. While all of these things can be sources of tremendous personal and professional enjoyment, they can also leave you out of breath, stressed, and at the end of another long day, wondering where all the time has gone. It's been that way lately.

But these are the times that I am truly blessed and honored to have tremendous people working alongside me not only on the Insurance Law Committee but also, more particularly, on the Commercial General Liability subcommittee. When I can't make a meeting, my vice chair Brandon McCullough reaches out to me afterward with the names of the new subcommittee prospects. And at the subcommittee member level, each time I have sought out people to publish articles in *Covered Events*, I usually wind

up with multiple volunteers (knock on wood). A chance to write for *Covered Events* is truly a great opportunity for anyone, with the newsletter going out not only to thousands of committee members each month, but with the ease of email forwards, the distribution net is even wider.

This month's article comes to us from The Gem State of Idaho courtesy of Kevin Griffiths of Duke, Scanlan, Hall in Boise. The issues discussed are familiar to all of us in CGL practice and liability insurance generally—issues of exhaustion, triggers of excess coverage, and the potential arguments for ambiguity in the controlling policy terms. The case law therein explores some interesting "end runs" around the operative policy language, necessity being the mother of all invention.

I must note that April is right around the corner, so let me strongly encourage your attendance at the Insurance Coverage and Claims Institute, which is annually held in Chicago. It is set April 3–5, and is always on my calendar. The panel as usual looks top-notch, and the program is set against the backdrop of the museums, restaurants, theater, and shopping that defines the Chicago downtown area. And I promise that the weather will be on the upswing after a rough winter.

If you'd like to be part of the Commercial General Liability Subcommittee, you can join through the DRI website or just drop me a line and I'd be glad to add you to the list. Or just let Brandon or me know in Chicago in April when we see you at ICCI.

Michael D. Strasavich practices on the Gulf Coast as a partner in the Mobile, Alabama, office of Burr & Forman LLP. He represents property insurers in coverage and litigation matters. He has spoken and written for DRI and others on insurance issues relating to hurricanes and other catastrophes. He is the chair of the DRI Insurance Law Committee's CGL Substantive Law Group.

Workers' Compensation SLG

By Kent M. Smith

It has been a long winter for us in the Midwest. In my home city of Des Moines, the National Weather Service announced it was the snowiest February on record with over two feet of snow in the capitol city. In my experience, leaders often emerge through adversity and I'm sure this winter has provided challenges across country.

As the chair of the DRI Insurance Law Committee's (ILC) Workers' Compensation Subcommittee, this winter has allowed me to reflect on benefits of being part of a "national" team. The Workers' Compensation Subcommittee provides resources, discussion, and collaboration on the trends of workers' compensation. These resources allow for our members to be leaders and idea generators in the field of workers' compensation. Its discussions drive new insights on how to move your litigation forward.

Our Subcommittee contributes content to *Covered Events*, the ILC's prestigious monthly e-newsletter, twice a year. I am hoping that you will become more involved in the ILC and our subcommittee, and that many of you will volunteer to either write an article, join the discussions online, or sign up new members to our subcommittee.

We encourage your attendance at the Insurance Coverage and Claims Institute, which is annually held in Chicago. It is set April 3–5. It is a great program. The city of Chicago provides a tremendous stage for this program.

If you'd like to be part of the Workers' Compensation Substantive Law Group, you can join through the DRI web site or just contact me and we can get bring you onboard.

Kent M. Smith is a shareholder at Smith, Mills & Schrock Law in West Des Moines, Iowa. He is currently serving as President on the firm's Board of Directors and is a co-chair of the firm's workers' compensation practice group. Kent defends employers and insurance companies in workers' compensation, civil liability and employment law claims in Iowa and Nebraska. Kent also speaks regularly at the national and local level to trade groups and associations on workers' compensation, civil liability and employment law issues. Additionally, he provides in-house consultations to help companies mitigate exposure in workers' compensation and employment issues. Kent chairs the DRI Insurance Law Committee's Workers' Compensation Substantive Law Group.

Featured Articles

Appeal Bonds for Insurance Companies

By Dan Huckabay

You represent an insurance company and just received an adverse judgement. They want to appeal, but what about staying enforcement of the judgment? This is article will address this and many other related questions we commonly hear from attorneys.

The first step with any case is to review the policy language to determine the insurers' obligations. An excellent article addressing this topic was published in the October 2017 edition of DRI's *For The Defense* titled, "Examining Insurers' Obligations to Their Insureds Post-Verdict." As part of the article, the author, Susan Knell Bumbalo, looks at the costs the insurer is obligated to pay when a duty to appeal does exist.

The first area examined is whether the insurer is required to furnish the appeal bond to stay enforcement of the judgment. As the article points out, "The 1973 ISO primary policy form expressly required that the insurer pay for appeal bonds as part of the Supplementary Payments. When amended in 1985, standard ISO CGL policies removed that express requirement; but many excess policies include a provision in the Supplementary Payments section of the policy form obligating the insurer to pay the premium on appeal bond, but the provision will not require that the insurer actually furnish the bond."

When it is found that insurers are required by the policy to furnish the bond, the following questions need to be addressed.

Does the jurisdiction require the insurer to provide an appeal bond in order to stay enforcement of the judgment?

In most jurisdictions, insurers do need to post security with the court in order to stay enforcement. While there are exceptions like the state of Michigan that allow insurers to post the policy with the court as security (MCL 500.3036), most require insurers to put security with the court just like any other appellant.

Most commonly insurers will provide appeal bonds rather than use other forms of security like cash, because it can affect their capital requirements from a regulatory standpoint. Furthermore, most insurers can qualify for bonds at competitive premium rates.

Can the insurer bond the judgment themselves?

In order for an insurer to provide their own bond, they need to be licensed to transact surety business. According to the Insurance Information Institute, there were 2,538 property casualty insurers in the United States in 2016, and there are less than 200 of those insurers licensed and approved to transact surety according to the Federal Department of Treasury Listing of Certified Companies. As a result, most insurers do not have the ability to transact surety business, and therefore, need to obtain an appeal bond from a licensed third-party surety company.

What if the judgement is in excess of the insurance coverage?

As further addressed in Ms. Bumbalo's article, "Examining Insurers' Obligations to Their Insureds Post-Verdict," "the majority of courts have concluded, logically, that insurer's responsibility for a bond extends only to the limits of the policy..."

In those instances when a judgment is in excess of the insurance coverage provided by the insurer, the insurer will typically provide an appeal bond up to their policy limit. In order for the insured to stay enforcement of the judgment in excess of the policy limit, the insured will have to provide a separate appeal bond for the difference.

How do surety companies qualify insurers?

When surety companies underwrite insurers for an appeal bond, they essentially want to ensure that the insurer has the financial wherewithal and stability to pay the judgement if it is upheld on appeal.

The surety's review will include the AM Best rating of the insurer, if applicable, and possibly the most recent financial statement, which is usually publicly available as insurers are required to file statements with their state regulatory agency.

The surety companies specifically examine the size of the judgment relative to the insurer's capital base, their length of time in business, and their record of profitability.

What is the process and how long does it take?

Approving appeal bonds for most insurers is a relatively quick process that takes as little as a few hours to a couple days depending on the insurer's financial strength. All that is required to begin is to know the name of the insurer, the amount of the bond required, and to obtain copies of the court complaint and judgment if it has been entered.

Once approved, an authorized officer of the insurer will have to sign the surety's indemnity agreement, pay the surety's premium, and the appeal bond can be issued.

For insurers that need appeal bonds on a somewhat regular basis, a bond program can be established whereby bonds up to a certain dollar amount are pre-approved and can be issued instantaneously.

What are some of the common challenges that can arise?

Challenges can arise with insurers that are not rated by AM Best, are thinly capitalized relative to the bond amount and/or have an inconsistent track record with profitability. Insurers that are domiciled and hold their assets outside of US can add to the complexity of underwriting. These issues are by no means insurmountable, but it may increase the timeframe or terms required for securing the bond.

Conclusion

In the words of Abraham Lincoln, "Time is everything...," and this is particularly true when it comes to securing appeal bonds for insurers. We encourage all the attorneys and insurers we work with to start the process early even if the judgment has not been entered. Much of the preliminary leg work can be done with just a ballpark estimate of the bond amount potentially required.

Dan Huckabay is president of Commercial Surety Bond Agency (CSBA), one of the leading providers of appeal bonds in the nation. He has underwritten appeal bonds in almost every state and federal district court for clients ranging from individuals to Fortune 500 companies. Mr. Huckabay is a frequent presenter, author, and expert witness on the topic. He is also an active member of DRI's Appellate Advocacy Committee and most recently the Insurance Law Committee. CSBA is a corporate member of DRI.

Trigger Issues Arising from Excess Insurance Exhaustion Clauses

By Kevin A. Griffiths

Unlike primary commercial general liability ("CGL") policies, excess insurance policies tend not to use standardized language developed by the Insurance Services Office ("ISO"). Because of this, there is a great deal more variation in the language of excess policies and much less case law interpreting specific policy language. *See* Kenneth S. Abraham & Daniel Schwarcz, Insurance Law And Regulation: Cases And Materials 623 (6th ed. 2015) ("[T]here is no single widely used exhaustion clause."). This can create unique challenges in excess coverage work, particularly when determining if the excess policy's trigger language has been satisfied by exhaustion of benefits available under the underlying CGL policy. This article will focus on some of the key arguments raised by insureds in seeking to avoid strict compliance with the exhaustion of an underlying insurance policies to trigger excess coverage, which primarily focus on ambiguities in the excess policy language.

Facial Ambiguity

Given the variation in excess policy language, it is unsurprising that one of the leading cases on construction of exhaustion clauses relied upon ambiguity in the language used in exhaustion clauses to preclude their strict enforcement. In *Zeig v. Massachusetts Bonding & Insurance Co.*, 23 F.3d 665 (1st Cir. 1928), the leading case on this issue for nearly a century, the court was asked to construe an exhaustion clause which provided, in relevant part, "[this policy] shall apply and cover only after all other insurance herein referred to shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance." *Id.* at 665.

The insurer in *Zeig* argued that this language only triggered coverage under the excess policy when the full limits of the underlying policy were paid by the insurer. *Id.* This

argument was rejected by the First Circuit, which found that the insured need only have recovered an amount equivalent to the limits of the underlying policy because the exhaustion clause was ambiguous as to the source of those payments. *Id.* at 666. Based upon that conclusion, the court determined that the ambiguity must be construed against the insurer, triggering coverage upon recovery of an amount equivalent to the limits of the underlying policy. *Id.* "The cases that follow *Zeig* generally rely on an ambiguity in the [exhaustion clause] or a lack of specificity in the excess contract as to how the primary [underlying] insurance is to be discharged." *Comerica, Inc. v. Zurich Amer. Ins. Co.*, 498 F. Supp. 2d 1019, 1030 (E.D. Mich. 2007).

To combat this issue, many insurers began making specific reference to a specific listing of controlling underlying insurance policies necessary to fulfill the exhaustion condition, *see*, *e.g. Terra Indus., Inc. v. Nat'l Union Fire Ins. Co.*, 383 F.3d 754, 757–58 (8th Cir. 2004) (construing an excess policy with a detailed definition of "retained limit" used to define exhaustion conditions). As insurer's make policies more detailed and add more schedules to deal with specific coverage situations; however, inconsistencies between different parts of the policy can give rise to another common enforcement issue, referred to as structural ambiguity.

Structural Ambiguity

Structural ambiguity arises when a clause of a policy is clear on its face, but when construed with other language in the policy, is determined to be ambiguous. This issue arose in the *Terra Industries Case*, *supra*, where the insurer employed a detailed definition of the term "retained limit" to determine exhaustion, which included reference to a "Schedule of Underlying Insurance" that specifically listed the insured's underlying CGL policies. *Id.* at 757. The definition of "retained limit" also contained a catch-all provision, which provided that "the applicable limits of 'any other underlying insurance'" must be exhausted before the excess coverage would be triggered. *Id.* In *Terra Industries*, a coverage issue arose because the insurer discovered that the insured had other potentially applicable CGL policies, which had not been included in the "Schedule of Underlying Insurance." *Id.*

The insurer argued that, based upon the "other underlying insurance" language, trigger of the excess policy had not yet occurred because the limits of the non-scheduled CGL policy had to be exhausted. *Id.* The Eight Circuit rejected this argument because the "other underlying insurance" and "retained limit" language was not included in the section of the policy that would specifically apply to the claims at issue, an additional gap-filling coverage known as a "sunrise endorsement." *Id.* at 757–58. The "sunrise endorsement" also specifically referred to listed policies and their limits as "the . . . underlying coverages and limits" that must be exhausted before coverage was triggered. *Id.* at 758. Based upon this structural ambiguity between the body of the excess policy and the "sunrise endorsement," the court found that trigger had occurred so long as the limits of the specific policy referenced in that endorsement were exhausted. *Id.*

As *Terra Industries* demonstrates, even if the insurer employs more detailed language and specific schedules to more clearly outline exhaustion and trigger conditions for excess policies, it must be careful to ensure that they are applied consistently across all sections and endorsement of the policy to avoid an unfavorable policy construction due to structural ambiguity.

Functional Equivalence/Policy Limits

Another common argument made by insureds to avoid strict compliance with exhaustion requirements is that some combination of payments from the underlying insurer and the insured/ someone acting on the insured's behalf constitute the functional equivalent of exhaustion of the underlying policy. This was the argument that was accepted in *Zeig*, *supra*, where the First Circuit found that failure to provide specific language concerning exhaustion by payment of policy limits allowed the insured to demonstrate exhaustion by payment of the equivalent of limits of the underlying policy from a variety of sources. *Zeig*, 23 F.3d at 666. A variation on this argument arises in situations where the insured has settled with the underlying insurer for less than policy limits but is still subject to liability in excess of the total limits of the underlying insurance policy.

In these cases, the contention is that the insured should be liable for the difference between the settlement with the underlying insured and the total limits of liability of the underlying insurance, but trigger has occurred. *See*, *e.g.*, *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 659 (7th Cir. 2010) ("[T]his construction of the policy neither has a punitive effect on [the insurer] nor does it alter its underwriting considerations. [The insured] is not asking [the insurer] to drop down and pay the remainder of the CGL limits after its settlement with the CGL insurers. As required by the CGL settlements, [the insured] paid the remainder of the CGL limits itself. [the insured] only asks [the insurer] to cover the liability [the insured] is 'legally obligated to pay as damages in excess of the 'underlying insurance,' as stated in the umbrella policy."). The court in

Trinity Homes notes that its acceptance of this argument is bolstered, at least in part, by public policy favoring out-of-court settlement. *Id.* The court in *Trinity Homes* was careful to note however, that this outcome would be avoided by express policy language conditioning exhaustion on actual payment of the full limits of the underlying policy. *Id.* ("[I] n each [case cited by the insurer], the policy clearly stated that the coverage was not triggered absent a payment of the full CGL policy limit by the insurer.").

Conclusion

Ultimately, as the above discussion demonstrates, strict enforcement of trigger conditions will come down to clarity of policy language. In absence of adoption and interpretation of trigger and exhaustion language through development and use of ISO forms or otherwise, lurking ambiguity in trigger and exhaustion will continue to be an issue in determining the insurer's obligations under excess polices.

Kevin A. Griffiths joined the firm of Duke Scanlan & Hall, PLLC, as an associate attorney in November 2012. Mr. Griffiths has experience in insurance coverage, insurance bad faith and extracontractual liability, medical malpractice, legal malpractice, construction defect, premises liability and insurance defense litigation. Prior to entering the private sector, Mr. Griffiths spent one year as a law clerk for the Honorable Jim Jones, Justice of the Idaho Supreme Court.

Canadian Cyber Class Actions Face Uphill Battle

By David Mackenzie

The Canadian cyber-insurance market, like others around the world, has been maturing. While there is clearly room for that market to grow, Canadian insurers are routinely issuing coverage to protect against digital privacy breach. While insurers have seen loss-experience with first party data breach expense, ransomware and business interruption claims develop in recent years, knowledge and understanding of third party risk caused by covered data breaches remains limited. Here, we review the third party claim experience that is only just now emerging and taking shape.

Class actions seeking damages arising out of data loss and privacy breaches are becoming increasingly common. This is, in part, because the bar to certification of such actions in Canada is considerably lower than it is in the United States. Notwithstanding their increasing frequency, all Canadian actions to date either remain at the certification stage or have been resolved through settlements. As a result, we have yet to see judicial analysis of the causes of action being advance and determination of damages. Notwithstanding this fact, an examination of cyber breach class action certification and settlement approval decisions is instructive.

While a number of causes of action have been advanced in these lawsuits, only three have been met with a measure of success at the certification stage: negligence, breach of contract and Intrusion on Seclusion. Further, as a result of the inherent difficulty in establishing compensatory damages on a class-wide basis, class counsel will frequently advance claims for nominal damages. In order to better understand the exposure facing defendants and their insurers, we examine the available judicial commentary on the above-noted causes of action and the meaning of "nominal damages" in the Canadian context.

Negligence

There are three primary pitfalls with respect to cyber-negligence claims in Canada. In many cases, each may prove insurmountable.

First, actual class-wide damage is rarely present in a data/privacy breach scenario and it is unclear in Canada that a plaintiff has a cause of action in negligence in what usually amounts to pure economic loss. Courts presented with such claims must determine whether such claim can proceed by balancing considerations of foreseeability, proximity and public policy. In the recent decision, *Broutzas v Rouge Valley Health System*, 2018 ONSC 6315, investment dealers were not in proximity with mothers of recently born children in circumstances where it was a third party actor that sold the mothers names and addresses to the investment dealers. On the other hand, in *Tucci v Peoples Trust Company*, 2017 BCSC 1525,a bank was in sufficient proximity to its customers that it could face class

claims in negligence for financial losses, if it was shown that it failed to meet an appropriate standard of care in protecting client information from criminal hackers.

Second, if a cause of action exists, to succeed there must be actual loss (economic or otherwise). Proving actual damages on a class wide basis, as is required in negligence, may be an insurmountable challenge, particularly where the risks involved are primarily future identity theft. In many circumstances most class members will not, in fact, have suffered an actual identity theft or other provable loss as the result of a data breach. While they may face a greater risk of loss, mere increased risk is not clearly compensable in Canadian negligence law.

Finally, even if a negligence cause of action is certified, class counsel must still prove the claim. In circumstances where the defendant ran good security, but was simply beaten by a better criminal or state actor, has the defendant fallen below an expected standard of care? Recovery in cyber negligence claims in Canada is far from certain.

Breach of Contracts

Breach of contract allegations, where the relationship is primarily commercial in nature, have generally met with initial success at certification. Causes of action in breach of contract were certified in both *Condon v Canada*, 2014 FC 250, and *Tucci*. As noted above, *Tucci* was an action against a bank by its customers. Similarly, *Condon* was an action by student loan recipients for loss of their information. Successful certification has been elusive, however, in circumstances where there is no express contract, and allegations are premised on the existence of implied terms arising out of the relationship between putative class members and the defendant(s).

Certification is not a sure measure of success. While proof of the existence of a contract whose terms could be breached may be sufficient for certification in Canada, to succeed at trial class counsel must establish an actual breach of a contractual term. With respect to breaches of privacy or loss of data this task may be inherently difficult as most commercial contracts favor the drafter, and are often either silent on privacy and data protection issues or are most favorable to the defendant.

On the other hand, one benefit of advancing an action in contract for class members is that it is unnecessary to prove actual damage, as nominal damages are recoverable on proof of a breach under Canadian contract law. Some doubt has been raised, however, as to whether nominal damages are available in the class context in Canada. As noted by the certification court in *Condon*, the defendant had strong arguments to suggest that nominal damages should not be awarded in circumstances where the primary beneficiary of such damages would be class counsel rather than class members themselves. As such, like negligence claims, it is not clear that breach of contract claims offer a direct path to recovery for class members in the data and privacy breach context.

Intrusion upon Seclusion

Unlike negligence, intrusion upon seclusion is an intentional tort and requires intentional or reckless conduct on the part of the defendant. The standard further requires that the defendant invade the plaintiff's private affairs or concerns without lawful justification. In breach scenarios involving a third party, such as a hacker, this element will be difficult to prove. Similarly, where a laptop or hard drive is lost, the risk created is that unknown third parties, not the defendant, will intrude the plaintiff's privacy. As the settlement Court in *Condon* noted in approving the proposed resolution of that action, "[b]efore there can be an award of damages, however, the onus remains on the plaintiffs to establish first that an intrusion actually occurred." (Condon Settlement, 28.) The risk of future harm in the form of a prospective privacy breach that has not yet occurred can almost certainly not be the basis for an intrusion upon seclusion claim. Furthermore, to succeed, a plaintiff must demonstrate that a reasonable person would regard the invasion as highly offensive and causing distress, humiliation and anguish. These elements present a high barrier to success for breach related class actions and as a result it is unlikely that intrusion upon seclusion would be able to be established at trial.

Nominal Damages

As discussed above, proof of actual damages on a class-wide basis may be difficult in the data/privacy breach context. To overcome this problem, Class counsel have been asserting a right to nominal damages in respect of proved breach of contract and intrusion on seclusion claims. A settlement in which the damages paid were characterized as "nominal" was approved, in fact, in *Condon*. That settlement was premised on evidence that individuals had spent up to four hours dealing with the data breach that had occurred, and on an assigned rate of $15 per hour of time spent, entitling each class member to a $60 recovery. (Condon Settlement at 9, 23.)

Nominal damages are available when the plaintiff has established a cause of action but not a right to compensa-

tory damages. Because of their non-compensatory nature, nominal damages are meant to be "a sum of money that may be spoken of, but that has no existence in point of quantity," and are damages in the name only. Canadian cases assumed that the proper amount was $1, an amount which is still being awarded. However, in recent years some courts have granted significantly larger awards ; this is controversial. In cases where larger sums have been referred to as "nominal damages," there is often evidence—as in Condon—that what the court is really doing is providing compensation for a loss that it has found difficult to quantify. Nominal damages are not simply small damages awards; they are qualitatively different from other types of damages because they are not meant to compensate a loss but to symbolically recognize that a plaintiff has been wronged. As a result there is uncertainty as to whether and to what extent they would be awarded in breach-related class actions, if those cases were determined at trial.

Conclusion

At present class action claims in Canada for data/privacy breach should be evaluated primarily on the basis of whether they pose viable negligence, breach of contract or intrusion on seclusion claims. As noted above, each of these causes of action will not be easily established. Furthermore, even should they prove their case, the matter of damages remains thorny In the event that genuine losses cannot be proved on a class-wide basis, it remains uncertain as to whether nominal damages can be awarded in the class action context.

In short, while the form of third party data/privacy breach is beginning to come into focus, there is little in the way of certainty and predictability in respect of actual dollars and cents exposure that can yet be discerned. The arguments available to class counsel appear poorly designed for the purpose they are presently being advanced to serve. Policyholders, insurers and their defence counsel have a myriad of defences that may yet succeed notwithstanding recent certification decisions. At present, and absent legislation that creates a cause of action designed and intended to address data/privacy breach liability and damages issues, it appears that the defence has the upper hand.

David R. Mackenzie is a partner of Blaney McMurtry LLP in Toronto. A coverage litigator, he focuses on commercial liability, cyber, professional indemnity and first-party property claims. David frequently advises insurers on policy-drafting matters, and is often asked to write on insurance coverage matters, particularly involving cyber, technology and information risks. He is the Chair of the Canadian Defence Lawyers Insurance Coverage Section, and is called to the Bar in Ontario, British Columbia and Washington State, giving him a national and international perspective.

First Circuit

Professional Services-ERISA Exclusions (MA)

The U.S. Court of Appeals for the First Circuit has ruled in *Scottsdale Ins. Co. v. Byrne*, No. 18-1526 (1st Cir. January 16, 2019) that a Massachusetts District Court did not err in declaring that a business and management indemnity policy was required to provide coverage for allegations that the insured mismanaged funds under its control. Despite separate exclusions in the policy for losses arising out of the rendering of professional services or for ERISA claims, the First Circuit declared that the underlying claims were not limited to allegations that the insured had mismanaged real estate developments so as to be subject to the "professional services" exclusion. Further, while agreeing that the underlying allegations of ERISA misconduct were excluded, the First Circuit declined to find that parallel allegations of negligence were likewise excluded merely because they arose from the same set of facts.

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Second Circuit

Late Notice (NY)

In a dispute between an auto and a GL insurer for claims arising out of damage to a customer's facility arising out of the insured's delivery of milk that was contaminated with metal filings, the Second Circuit has issued a summary order, affirming a New York District Court's declaration that the CGL insurer was entitled to recover its settlement payment from the auto insurer. In *Harleysville Worcester Ins. Co. v. Agri-Mark, Inc.*, No. 18-1300 (2d Cir. Feb. 1, 2019), the court rejected Wesco's argument that it did not receive notice of the claim and further ruled that Wesco had not proved that it was prejudiced by any late notice.

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Eighth Circuit

Excess/Follow Form/"Intentional Acts" Exclusion (MT)

The U.S. Court of Appeals for the Eight Circuit has given broad effect to the "follow form" language in an excess liability policy. In *Houston Cas. Co. v. Strata Corp.*, No. 17-3405 (8th Cir. Feb. 6, 2019), the court rejected the claimant's argument that the policy's follow form language should not extend to endorsements and merely refer to the main body of the underlying Liberty Mutual policy. The Eighth Circuit agreed with a North Dakota District Court that the follow form language clearly applied to exclusions, whether they were in the main body of the policy or added by endorsement and that the exclusion in question unambiguously precluded coverage for allegations in the underlying wrongful death action that the mine operator's deliberate and intentional acts had caused the employee's death.

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Ninth Circuit

Related Acts (CA)

Attorneys Ins. Mut. Risk Retention Grp., Inc. v. Liberty Surplus Ins. Corp., **--- Fed. Appx. ---, 2019 WL 643442 (9th Cir. Feb. 15, 2019)**

The U.S. Court of Appeals for the Ninth Circuit held that an insurer must contribute to the defense of an attorney who was accused of malpractice twice in two successive policy years. The underlying accusations arose out of attorney J. Wayne Allen's involvement in an estate matter.

Third parties filed malpractice suits against Allen, first on Feb. 1, 2010 (during the 2009–2010 policy period) in probate court and again on Sept. 24, 2010 (during the 2010–2011 policy period) in a related civil action. Liberty Surplus Insurance Corp. (Liberty) issued the 2009–2010 policy and Attorney's Insurance Mutual Risk Retention Group Inc. (AIMRRG) issued the 2010–2011 policy. After Liberty declined coverage for Allen in the civil action, AIMRRG, which had been defending Allen, sued Liberty for defense cost contribution. The trial court entered summary judgment in favor of AIMRRG and Liberty appealed.

On appeal, Liberty argued that a provision limiting its liability for multiple related claims applied to preclude coverage. Specifically, Liberty argued that its policy "limits coverage so that if multiple claims regarding the same set of facts are made against an insured in multiple policy periods, the claims are all considered initially made during the policy period in which the first claim is made." Liberty further argued that because claims must be reported during the policy period in which they are made, it had no obligation to defend Allen against the civil action because he failed to report the related claim during the 2009–2010 policy period. The appellate court stated that although Liberty's interpretation "may create an ambiguity in the meaning of the multiple related claims provision as a whole, the district court did not err because ambiguities in an insurance policy are resolved against the insurer." Therefore, the appellate court ultimately affirmed the trial court's grant of summary judgment in favor of AIMRRG.

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Eleventh Circuit

Pollution Exclusion (GA)

Evanston Ins. Co. v. Sandersville Railroad Co., **--- Fed. Appx. ---, 2019 WL 495131 (11th Cir. Feb. 8, 2019)**

The U.S. Court of Appeals for the Eleventh Circuit held that an insurer has no duty to defend or indemnify a suit brought by a railroad worker against his employer based on the absolute pollution exclusion in its commercial general liability policy. In the underlying lawsuit, the railroad employee (Flowers) contracted lung disease as a result of inhaling welding fumes. Flowers sued his employer, Sandersville Railroad Company (Sandersville), claiming, among other things, that Sandersville failed to provide him with proper welding and safety equipment and a properly ventilated workspace. Sandersville's liability insurer, Evanston Insurance Company (Evanston), agreed to defend Sandersville in the underlying lawsuit while reserving its right to deny coverage under the policy's absolute pollution exclusion.

Sandersville ultimately settled the underlying lawsuit without any contribution from Evanston. Evanston then filed suit against Sandersville in the United States District Court for the Middle District of Georgia, seeking a ruling that the policy's absolute pollution exclusion applied to preclude coverage for the expenses incurred by Sandersville in the underlying lawsuit. The trial court ruled that the welding fumes constituted a "pollutant" as defined in the policy such that the absolute pollution exclusion applied to preclude coverage. The appellate court ultimately agreed with the trial court, holding that "[u]nder the policy's absolute pollution exclusion, welding fumes unambiguously qualify as an 'irritant or contaminant, including … fumes'" such that there was no coverage for the underlying lawsuit under the policy.

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California

Arbitration/TPAs

The California Court of Appeal has ruled in *QBE Insurance Corporation v. American Claims Management, Inc.*, D073345 (Cal. App Feb 4, 2019) that a trial court did not err in confirming an arbitration of panel's award allowing QBE to recover $18.5 million against a third party claims administrator based upon ACM's mishandling of an underlying automobile accident claim. Emphasizing the narrow scope of judicial review of arbitration awards, the Fourth District declared that the objections raised by ACM did not fit within the statutory purview for overturning arbitration awards, nor was the panel's award so irrational that it could not stand.

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Connecticut

Discovery/30(b)(6) Depositions

A federal judge in Connecticut has ruled that the deposition of Scottsdale's corporate representative should go forward in Connecticut, ruling that the general presumption that a deposition should take place where the corporation was headquartered, were overcome in this case by consideration of fairness and efficiency. Further, Judge Dooley ruled in *Ice Cube Building, Inc. v. Scottsdale Ins. Co.*, No. 17-1973 (D. Conn. Feb. 11, 2019) that the scope of the

deposition should be limited to the insurer's handling and adjustment of the insured's claim.

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Late Notice /Suit Limitations

Discuillo v. Allstate Ins. Co., United States District Court, **District of Connecticut, 02/08/19**

Property insurance policies require that an insured give prompt notice of loss to the insurer. Many jurisdictions, like Connecticut, require the insurer to demonstrate material prejudice as a result of the late notice in order to avoid coverage. In *Discuillo*, the district court found that a 14-month delay by the homeowner-insured in reporting a water intrusion loss was untimely notice that prejudiced the carrier.

Connecticut requires, absent waiver, an unexcused, unreasonable notification delay and resulting material prejudice to the insurer. Discuillo claimed that a February 2015 storm breached her roof and the resulting water intrusion damaged a bathroom and two bedrooms. However, in the mistaken belief that she needed to "save up" the money for her deductible, the homeowner waited over a year to contact Allstate. She finally reported the claim in April 2016. Notwithstanding the delay, Allstate investigated the loss, estimated the repair costs at just over $9,000 and paid Discuillo $4,591.64 after depreciation and deductible. Unsatisfied with the payment, Discuillo sued Allstate, but not until in January 2017, to compel arbitration and for breach of contract.

Allstate moved for summary judgment, arguing that the insured did not comply with the policy conditions, that it was prejudiced by the late notice, and that the suit was, in any event, outside the policy's 18-moth suit limitations provision. The district court agreed with Allstate on each point.

The court held that a 14-month delay in notice was not prompt. "Under no circumstances could such notice be said to have been given 'promptly." Next, the court concluded that "prejudice to the defendant is manifest." With timely notice, the court reasoned, Allstate could have investigated sooner to assess the then-existing damage and prevent further loss to the property. Moreover, the district court determined that Connecticut courts find suit limitation provisions binding and that an insured's failure to comply with such provisions is a defense to an action. Here, the suit limitations provision required that the insured be in full compliance with the policy conditions and that she bring suit within 18 months of the loss. Discuillo did neither; she did not report the claim promptly, she did not protect the property from further loss, and she waited more than 18 months to sue. Discuillo argued that her demand to compel arbitration was not a suit or action and, therefore, not subject to the provision. The court disagreed, holding that a suit demanding arbitration clearly falls within the suit limitations provision.

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Performance Bonds

A federal district court has granted summary judgment to the bond company for the developer of a minor league baseball stadium, declaring that it was entitled to be reimbursed for over $39 million that it had paid on the insured's behalf. In *Arch Insurance Company v. Centerplan Construction Co.*, No. 16 1891 (D. Conn. Feb. 13 2019), Judge Bryant declared in a 63 page opinion that the property developer was obliged to reimburse Arch for over $39,000,000.00 for sums that it paid on behalf of Center Plan in response to demands from the City of Hartford under indemnity undertakings arising out of the stadium project. The court ruled that Arch had the right to demand collateral security when, in its sole discretion, it determined that the principal would potentially be liable to indemnify it on certain agreements. Further, the court ruled that the defendants had failed to provide persuasive evidence that Arch had acted in bad faith in issuing payment to the City of Hartford with respect to the underlying losses.

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Florida

Conflicts of Interest

A federal district court has rejected an insurer's bid to disqualify the Andrews Hunton law firm from representing an insured in coverage litigation against it, ruling in *Ranger Construction Co. v. Allied World Nat. Assur. Co.*, No. 17-81226 (M.D. Fla. Jan. 29, 2019) that the law firm did

not obtain an unfair information advantage as the result of documents that it obtained in the prior representation.

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D&O/Securities Sale Exclusion

A federal district court has ruled in *Colorado Boxed Beef Co., Inc. v. Evanston Ins. Co.*, 2019 WL 77376 (M.D. Fla. Jan. 2, 2019), that allegations that various corporate officers made misrepresentations in connection with their purchase of stock shares was excluded from coverage under a management liability policy in light of language in the policy stating that it did not apply to loss ""[b]ased upon, arising out of or in any way involving…the actual, alleged or attempted purchase or sale, or offer or solicitation of an offer to purchase or sell, any debt or equity securities."

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Idaho

Prior Publication Exclusion

Scout, LLC v. Truck Ins. Exch., **--- P.3d ---, 2019 WL 347471 (Idaho Jan. 29, 2019)**

The Idaho Supreme Court ruled that an insurer does not have to cover a pub's costs to defend a lawsuit alleging that the pub infringed a brewery's trademarks. In the underlying complaint, Oregon Brewing Company (OBC) accused the Boise-based pub owner, Scout, LLC (Scout), of infringing on OBC's federally registered trademarks. Scout posted an image of the allegedly infringing logo on Facebook in October 2012, approximately one month prior to acquiring its liability policy from Truck Insurance Exchange (Truck Insurance). Truck Insurance invoked its policy's prior publication exclusion, and refused to defend Scout in the OBC lawsuit.

Scout ultimately resolved the OBC lawsuit by agreeing to stop using the allegedly infringing material and re-branding its restaurant. Scout subsequently sued Truck Insurance, claiming that the coverage denial amounted to breach of contract and bad faith. However, the Idaho Supreme Court agreed with Truck Insurance and found that Scout's October 2012 Facebook post constituted a prior publication within the meaning of the exclusion. The Supreme Court found that the prior publication exclusion is unambiguous and "clearly indicates that if an injury arises after coverage is purchased, it will not be covered if the material was published prior to coverage." Therefore, the Supreme Court held that Truck Insurance's denial of coverage was not improper.

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Illinois

Bad Faith/Section 155

The Illinois Appellate Court has ruled in *Charter Properties, Inc. v. Rockford Mutual Ins. Co.*, 2018 Il. App. (2d) 170637 (Ill. App. Ct. 2019), that a trial court did not err in awarding bad faith damages against a property insurer based upon its vexatious delay in adjusting the insured's first party claim. In affirming the lower court's Award of Section 155 damages, the Second District declared that the trial court had not abused its discretion in awarding attorney's fees to the insured and rejected the insurer's contention that it had a good faith basis for its coverage position. In particular, the court took note of the fact that even after the insured had submitted its proof of loss statements, the insurer held in in abeyance pending completion of its investigation then rejected it as premature because the rebuild was not complete and then pulled its adjuster off the project without completing a final estimate of the insured's loss.

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Massachusetts

Bad Faith

Judge Woodlock has ruled in *River Farm Realty Trust v. Farm Family Casualty Insurance Company*, No. 16-12386 (D. Mass. Feb 4, 2019), that a property insurer did not act in bad faith in its adjustment of a homeowner's ice damn claims. In this case, the District Court found that Farm Family had paid everything that the insured was contractually entitled to. While conceding that the adjustment of the insured's claim was defective in various respects, the District Court declined to find that any inadvertent delays rose to the level of an "extreme or egregious business" so as to give rise to liability under Chapter 93A. Further, the

court ruled that the insured had failed to present evidence that the insurer's investigation was unreasonable nor did it fail to effectuate settlement in a timely fashion. MM's Bill Schneider represents the insurer in this case.

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New York

Bad Faith

Bryant v. General Casualty Company of Wisconsin, **United States District Court, Northern District of New York, 01/30/19**

Plaintiff owned the building located at 634 Ulster Avenue, Kingston, New York. Plaintiff purchased a commercial property and casualty insurance policy from Defendant. On March 24, 2017, while the building was leased to a tenant who operated a restaurant, the building allegedly sustained a covered collapse loss. Plaintiff alleges that Defendant refuses to pay the claim even though he gave Defendant notice of the loss and cooperated with its investigation. Plaintiff alleged that his damages included the cost of repairing and replacing the property damage as well as the value of the rental revue from the tenant, who was forced to close the restaurant and relocate.

Plaintiff brought a lawsuit alleging breach of contract. Plaintiff also asserted that he was entitled to recover consequential, extra-contractual damages. Defendant moved to dismiss arguing that Plaintiff was seeking damages specifically provided for in the policy terms.

The court's analysis focused on the question of how to adequately please bad faith in New York. The court observed that most courts hold that a breach of the implied covenant is not a separate cause of action in a breach of contract case, but is instead one way of establishing a breach. Then, somewhat confusingly, the court stated that some courts are willing to recognize bad faith as a standalone cause of action, and stated that a distinct bad faith tort cause of action is "lurking" in New York case law. The court stated this without citing to the Court of Appeals' decisions in *New York University* or *Rocanova*.

In the original complaint, Plaintiff had a cause of action for breach of contract and breach of the implied covenant of good faith and fair dealing. Plaintiff then filed an amended complaint. The amended complaint only contained a breach of contract cause of action.

The court concluded that the decision to eliminate the second cause of action suggested that Plaintiff was not pursuing a separate bad faith claim. Further, the single count complaint did not plausibly allege a bad faith claim. The pleading contained a few paragraphs that could be read as being suggestive of bad faith, but they were conclusory and circular. While the allegations in the complaint sufficiently alleged that Defendant did not perform its obligations under the policy, they did not amount to bad faith that would warrant compensation beyond the policy's limits.

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Animal Exclusion

Truck Insurance Exchange v. Michael J. Paonessa, Sr., et al., **United States District, Western District of New York, 02/05/19**

This action stems from an alleged dog bite to defendants Lindsey R. Cortes ("Cortes") and Jennifer L. Drake ("Drake") while on Michael J. Paonessa Sr. ("Paonessa Sr.") property on or about May 5, 2016. The alleged dog was owned by defendant Michael J. Paonessa Jr. ("Paonessa Jr."). Following the alleged dog bite, Cortes and Drake commenced an action in New York State Supreme Court, Niagara County for their alleged personal injuries and damages.

Prior to the alleged dog bite, Truck Insurance Exchange issued a homeowners policy to defendants Paonessa Jr. and Paonessa Sr. (the "Policy"). The Policy included an "Animal Exclusion," which excluded coverage for bodily injury caused by any animals or creatures owned by or entrusted to any insured.

Truck Insurance Exchange commenced this action on May 18, 2018, seeking a declaratory judgment that it is not obliged to defend or indemnify any of the defendants in relation to the dog bite incident.

The court concluded that Truck Insurance Exchange was entitled to declaratory judgment. The court found given the Complaint alleges that Cortes and Drake's injuries were sustained when they were bitten by a dog on the insured's

property, the Animal Exclusion applied as a clear bar to coverage.

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Estoppel/Employer's Liability Endorsement (NJ law)

The State Insurance Fund v. Selective Insurance Company, **New York Appellate Division, First Department, 2/21/17**

Due to the employer's liability endorsement, which is clear and unambiguous, the umbrella policy issued by Selective did not cover All Waste Interiors LLC.

Both sides agreed that New Jersey law governs the issue of whether defendant should be estopped from denying coverage to All Waste. The State Insurance Fund contended that Selective' s reservation of rights was untimely and, as such, Selective should be estopped from denying coverage to All Waste.

Under New Jersey law, an unreasonable delay in disclaiming coverage can estop an insurer from later repudiating responsibility under the insurance policy. Griggs v Bertram (88 NJ 347, 443 A2d 163 [1982]. This is true even where an insurer neither assumes actual control of a case nor undertakes the preparation of any defense. When an insurer fails to inform its insured of the possibility of a disclaimer of coverage within an unreasonable period of time, it can be estopped from denying coverage.

The New York Appellate Division, First Department, reviewed the Record and found that none of the situations mentioned in *Griggs v. Bertram* applied to this case. According, the Court reversed, declared that there was no coverage under Selective's policy and vacated the nearly $1.5 million dollar judgment against Selective.

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Rhode Island

Bad Faith/Duty to Settle/Third Party Claimants

Clarifying an issue that had arisen in the wake of earlier bad faith rulings such as *Asermely*, *Skaling* I and II and *DeMarco*, the Rhode Island Supreme Court has ruled that liability insurers do not have any common law liability to third party claimants in the absence of a reasonable settlement demand within policy limits or an assignment of the insured's rights. In *Summit Ins. Co. v. Stricklett*, No. 2017 185 (R.I. Feb. 5, 2019), the Supreme Court declared that the fiduciary obligations of insurers to settle in good faith runs only to the insured or to a party to whom the insured have assigned their rights.

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Texas

Bad Faith

The Texas Supreme Court has announced that it will hear two cases against State Farm Lloyds on the Menchacha issue of whether and when policyholders are entitled to statutory damages beyond what they are entitled to contractually.

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Attorney–Client Privilege

In re: City of Dickinson, **--- S.W.3d ---, 2019 WL 638555 (Tex. Feb. 15, 2019)**

The Texas Supreme Court ruled that emails exchanged between an insurer's corporate representative and its counsel in advance of the filing of an affidavit by the corporate representative were subject to the attorney-client privilege. The Supreme Court rejected the City of Dickinson's (City) argument that the privilege did not apply when the corporate representative also served as the insurer's expert witness.

The City purchased a commercial windstorm policy from Texas Windstorm Insurance Association (TWIA). Following Hurricane Ike in 2008, the City sought coverage from TWIA, and later brought a proceeding to recover amounts the City alleged had not been paid out from TWIA. The City filed a motion for summary judgment and, in responding to the motion, TWIA filed an affidavit of its corporate representative, which contained both fact and expert testimony. The City moved to compel discovery of emails exchanged between the corporate representative and TWIA's counsel.

On appeal to the Texas Supreme Court, the City argued that it was entitled to discovery of the emails because the state's discovery rules allowed for production of documents relied on by a party's expert, even if the expert is an employee of a party in the case. The Supreme Court

disagreed, saying that "[w]e will not create a new exception to the [attorney-client] privilege here," because "the City concede[d] that the email communications between [the witness and TWIA]'s attorney would be privileged had [TWIA] not designated [the witness] as a testifying expert." The Supreme Court held that "our discovery rules do not operate to waive the attorney-client privilege whenever a client or its representative offers expert testimony." The Supreme Court reasoned that allowing discovery of emails relating to the corporate representative's testimony or affidavit may have a chilling effect on attorney-client communications relating to such testimony.

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