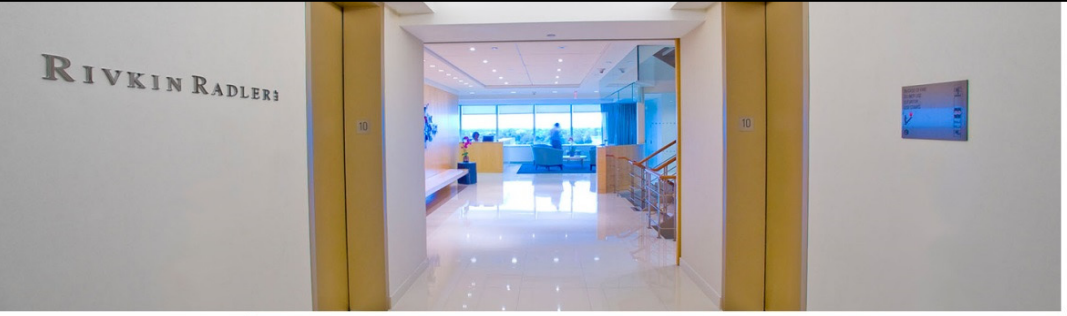

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Sixth Circuit Upholds Dismissal of Restaurant's Pandemic-Based Business Interruption Claim

The Sixth Circuit, joining two other circuits to have addressed the question, ruled that a restaurant's commercial property policy does not cover a business interruption claim due to the pandemic.

The Case

In March 2020, after the Ohio governor declared a state of emergency, the Ohio Health Department ordered restaurants across the state to close their doors to in-person diners. The insured operated an Italian restaurant. The closure orders resulted in significant losses for the restaurant, and it was forced to lay off employees.

The restaurant submitted a claim to its commercial property insurer, who denied coverage. The policy covered business interruption "caused by direct physical loss of or damage to property." The restaurant challenged the insurer's denial in court, but the district court ruled for the insurer. The restaurant appealed.

The Sixth Circuit's Decision

The Sixth Circuit affirmed. It ruled that government shutdown orders that barred in-person dining did not amount to a "direct physical loss of or damage to" property.

As the court explained, the coronavirus did not physically or directly alter the property. The restaurant was not tangibly destroyed, nor had the owner been tangibly or concretely

deprived of any of it. The insured still owns the restaurant and everything inside the space. It could have still put the premises to use for takeout dining, even if not for in-person dining.

The court suggested that the "direct physical loss" requirement is the "North Star" of this property insurance policy. The court observed that, if it were to find that business losses generated by statewide shutdown orders were covered, it would essentially erase these words from the policy. The court determined that the cause of the suspension of operations – the prohibition on in-person dining – did not arise from a physical loss of property or physical damage to it.

The court rejected the restaurant's argument that the policy was ambiguous. "Direct physical loss of" property, the court noted, does not mean what the restaurant says it means. It means direct physical loss of property, not merely the inability to use property.

The case is *Santo's Italian Café LLC v. Acuity Ins. Co.,* No. 21-3068 (6th Cir. Sept. 22, 2021).

Sixth Circuit Holds That Sealed Qui Tam Complaint Is a Claim First Made When Filed, Not When Unsealed

The Sixth Circuit, interpreting a directors & officers liability policy, held that a sealed qui tam complaint is a claim first made when the suit is filed, not when it is unsealed. Thus, the policy did not cover the insured's costs in responding to a governmental subpoena based on a sealed False Claims Act lawsuit.

The Case

The insured, Springstone Inc., provided behavioral health services for several facilities. In January 2017, it bought insurance from Hiscox Insurance Company. That insurance plan included Directors & Officers (D&O) liability coverage. Coverage B covered "the Loss of a Company arising

from a Claim first made against an Individual insured during the Policy Period or the Discovery Period (if applicable) for any actual or alleged Wrongful Act of such Individual Insured, but only when and to the extent that such Company has indemnified such Individual Insured for such Loss." Coverage C covered "the Loss of a Company arising from a Claim first made against a Company during the Policy Period or the Discovery Period (if applicable) for any actual or alleged Wrongful Act of a Company."

In July 2016, a qui tam lawsuit was filed under seal against Springstone. It alleged that Springstone had violated the False Claims Act by obtaining reimbursement from Medicare and Medicaid for medically unnecessary services. A year later, the Office of the Inspector General for the Department of Health and Human Services subpoenaed Springstone for documents related to its investigation.

Springstone informed Hiscox that it had received the subpoena and sought coverage for its response under the D&O policy. Hiscox denied Springstone's request on the basis that there was no "Claim" during the policy period and the subpoena did not allege a "Wrongful Act." In 2019, the qui tam lawsuit was dismissed, and the complaint was unsealed. Springstone informed Hiscox of the lawsuit and again sought coverage for its response. Hiscox denied that second request for coverage.

Springstone then sued Hiscox in Kentucky state court. Springstone alleged: (1) a breach of contract; (2) common law bad faith; (3) violations of the Kentucky Unfair Claims Settlement Practice Act and Kentucky Consumer Protection Act; and (4) unjust enrichment. Hiscox removed the case to federal court and moved to dismiss. The district court agreed with Hiscox and found no coverage. Springstone appealed.

The Decision

The Sixth Circuit, applying Kentucky law, affirmed the district court's ruling. The court noted that the qui tam complaint was filed six months before the policy period and therefore was not first made during the policy period. The court rejected Springstone's argument that the claim was first made when the qui tam action was unsealed. The court observed that a lawsuit is first created when it is filed, not unsealed, and a qui tam's unique posture does not inherently avoid coverage. The court observed that an insured can ensure such coverage by extending policy claim discovery periods beyond the coverage term.

The court also found that no coverage existed under Coverage B because there was no indemnification of an individual insured. The court noted that although some individual insureds have documents relevant to the subpoena, they did not have any financial obligations related to those requests.

The court also found that no coverage existed under Coverage C because of an exclusion that barred coverage for non-monetary relief. The exclusion foreclosed payment for defense costs, including the costs to respond to the subpoena.

The case is *Springstone, Inc. v. Hiscox Ins. Co.,* Case No. 20-6014 (6th Cir. Sept. 17, 2021). Note: This case is unpublished.

Sixth Circuit Voids Policy Based on Misrepresentations About Insured's Business

The Sixth Circuit, applying Tennessee law, held that a policy was void ab initio based on the insured's misrepresentations in its insurance application about business conducted at the insured premises.

The Case

In January 2018, Howard Jesmer applied for property insurance with Erie Insurance Company to cover "comprehensive perils" to his home in Arlington, Tennessee. As part of the application process, Jesmer met with an Erie agent at the property. Jesmer orally answered the insurance application's questions about the property as the agent completed the written questionnaire. Jesmer answered "no" to the question "Is Applicant conducting any business or occupational pursuits at the premises?" However, at the time of the application, Jesmer occasionally towed vehicles for his father's business from the property and regularly stored trucks on the property. Erie issued a policy on the property covering certain residential and property losses.

In October 2018, Jesmer filed a proof of loss under the policy related to a fire at the property. Erie denied the claim, in part, because a business was being operated from the insured location at the time of the loss. Jesmer sued. A Tennessee federal district court granted summary judgment to Erie on the basis that Jesmer's misrepresentations rendered the policy void under Tennessee law. Jesmer appealed.

The Decision

The Sixth Circuit affirmed. The court held that reasonable minds could not disagree that Jesmer's insurance application misrepresented his business and occupational pursuits at the property, and that as a matter of law, this misrepresentation increased Erie's risk of loss.

The court rejected Jesmer's argument that he could not have misled Erie about any business operations at the premises because Erie's agent completed the application at the premises and would have seen the tow trucks. The court determined that, under Tennessee law, Jesmer, and not the agent, was ultimately responsible for ensuring that his insurance application

contained truthful information. The court added that Jesmer did not allege that the agent misled him in any way and that Jesmer had the chance to review and sign the application before submitting it to Erie.

The court also found that Jesmer's tow-trucking activities on the premises were business pursuits because they were motivated by profit and were regular and continuous. Jesmer did not have an ownership interest in the business, but this factor was not dispositive. The applicable inquiry, the court observed, was whether the individual expected to receive, and did receive, compensation for that activity. The court noted that Jesmer earned $1,000 per week as an employee of the company.

Lastly, the court held that Jesmer's misrepresentations were material. The court pointed to the undisputed testimony of Erie's underwriter, who averred that had Jesmer disclosed that he operated his father's business out of the premises, the policy would not have been written because Erie's risk of loss would have increased. The court added that Erie's broad insurance application seeking information about "any business or occupational pursuits" at the premises signified that Erie considered disclosure of all business activity to be "necessary to an honest appraisal of insurability." Having answered "no" to the relevant question, the court found that Erie was deprived of the opportunity to make an informed determination about whether, and at what cost, to insure the property.

For these reasons, the court affirmed the order of the district court awarding summary judgment to Erie.

The case is *Jesmer v. Erie Ins. Co.,* No. 21-5186 (6th Cir. Sep. 30, 2021). Note: This case is unpublished.

Third Circuit Enforces Policy's Consent Clause, Holds That Prejudice Showing Is Not Required Under Claims-Made Policy

Upholding the district court's finding in a favor of an insurer, the U.S. Court of Appeals for the Third Circuit ruled that the insurer owed no indemnity under an errors and omissions (E&O) policy because the policyholder settled claims against it without first obtaining the insurer's consent. The court held that the insurer did not need to show appreciable prejudice to enforce the consent provision.

The Case

The policyholder, Benecard Services, Inc., manages prescription drug benefit plans. It was sued by a former business partner for breach of contract and fraudulent misrepresentation. Benecard ultimately settled the suit.

Benecard's E&O insurer paid defense costs but refused to indemnify the settlement because Benecard violated the policy's consent clause. That clause stated that "[n]o coverage is available under this Policy for . . . any settlements or offers made without the Underwriter's prior written consent."

Benecard contested the insurer's denial, arguing that the consent clause is unenforceable unless the insurer proves appreciable prejudice. The district court disagreed and awarded summary judgment for the insurer. Benecard appealed.

The Third Circuit's Decision

The Third Circuit affirmed, noting the policy's requirement that the policyholder first obtain the insurer's written consent before settling any action was an express condition to coverage.

The court rejected Benecard's argument that the insurer must show appreciable prejudice to enforce the consent clause. Applying New Jersey law, the Third Circuit found that the

appreciable prejudice doctrine applies only to occurrence policies and only where the policyholders are unsophisticated consumers. The doctrine has no application to claims-made policies because they are held by knowledgeable policyholders who purchased their insurance through sophisticated brokers. The Third Circuit stated that Benecard is not an individual consumer, unaware of the terms of its policy, but a corporate insured that obtained that policy through a broker.

The court further rejected Benecard's argument that the claims-made exception applies only to the policy's notice requirement, not its consent requirement. Quoting the New Jersey Supreme Court, the Third Circuit stated that the court "has *never* afforded a sophisticated insured the right to deviate from the *clear terms* of a 'claims made' policy." The Third Circuit found that the consent clause is a clear term of the E&O claims-made policy, and therefore, no showing of prejudice is required to enforce it.

The court also rejected Benecard's estoppel argument. Benecard contended that the insurer knew that Benecard was considering settlement, yet the insurer failed to remind it of the E&O policy's consent clause. Benecard contended that this violated the insurer's duty of good faith and fair dealing and that the insurer should therefore be estopped from denying coverage.

The Third Circuit was not persuaded. It found no evidence that the insurer led Benecard to believe the consent clause had been satisfied or that the insurer's silence induced Benecard to change its position to its detriment. The court further emphasized that an insurer is under no obligation to remind its insureds that they must comply with conditions precedent stated plainly in the policy.

The case is *Benecard Servs. v. Allied World Specialty Ins. Co.,* No. 20-2359 and 20-2360 (3d Cir. Sept. 8, 2021). Note: this case is unpublished.

Wisconsin Appellate Court Holds That Professional Services Exclusion Bars Negligence Claim Against Gunsmith

A Wisconsin appellate court determined that a professional services exclusion barred coverage for a negligence claim against a gunsmith, even where the gunsmith performed the service without charge.

The Case

Adam Kodra sued Harold Fredd and his employer, Northern Precision Rifles, in Wisconsin state court. Northern Precision's insurer, United States Automobile Association (USAA), was added to the action. The complaint alleged that Fredd's negligence in customizing Kodra's rifle caused the injuries that Kodra suffered when he fired the rifle and it exploded.

USAA moved for summary judgment on that basis that the applicable homeowners policy barred coverage under the policy's "professional services" exclusion. The policy defined "professional services" as "any type of service to the public that requires members rendering a service to obtain an advanced degree and/or obtain a license or other legal authorization to provide the services" and set forth a non-exhaustive list of examples. The trial court granted summary judgment to USAA.

Kodra appealed, arguing, among other things: (1) that the exclusion did not apply to licenses for non-white collar occupations such as gunsmithing; and (2) if the exclusion applied to licenses for gunsmithing, it did not apply here because Fredd did not need a license for his work on Kodra's rifle that he performed at no charge.

The Decision

In a per curiam opinion, the Wisconsin Court of Appeals affirmed the trial court's decision.

After noting that a federal firearms license is required for gunsmithing, the court rejected Kodra's argument that the professional services exclusion includes only white-collar professions that require advanced degrees and continuing education. Rather, the exclusion stated that it applies to "*any type* of service to the public that requires members rendering a service to obtain an advanced degree and/*or* obtain a license or other legal authorization to provide the services and *includes, but is not limited to* . . . ." (emphasis added by court). The use of the phrase "any type," the court emphasized, imposed no limitation or qualitative distinction beyond what was stated – "an advanced degree and/or a license or other legal authorization." And the use of the word "or" signified that an advanced degree is not required if only a license is required. The court noted that Kodra failed to point to any language in the exclusion suggesting that, where a license is necessary to provide a service, something more is required for the service to be a "professional service." The court also reasoned that the list of examples of professional services was non-exhaustive.

The court similarly rejected Kodra's argument that Fredd did not need a license for his work on Kodra's rifle because he performed the service at no charge. The court noted that Fredd was required to obtain a federal firearms license for his gunsmithing business and Fredd was engaged in that business when he performed the work for Kodra, whether or not he charged Kodra for the work. The court reasoned that, just as a physician who treats a patient without charge would still be rendering a professional service because the physician requires a license to practice, a person who customizes a gun at no charge is still rendering a professional service because the gunsmith requires a license to operate his business.

For these reasons, the court affirmed the trial court's award of summary judgment to USAA under the policy's professional services exclusion.

The case is *Kodra v. Fredd*, 2020AP1989 (Wis. Ct. App. Sept. 30, 2021). Note: This case is unpublished.

North Carolina Federal Court Finds Insurers Had No Duty to Defend or Indemnify BIPA Claim

Applying the interpretive principle of *ejusdem generis*, a North Carolina federal court held that the Illinois Biometric Information Privacy Act (BIPA) is of the same nature as statutes listed in the insurance policies' exclusion for Recording and Distribution of Material or Information. As such, the insurers had no duty to defend or indemnify a class action suit alleging BIPA violations.

The Case

The insureds are North Carolina companies that operated a facility in Illinois. They used their employees' fingerprints for payroll timekeeping. The insureds did not inform their employees of the purpose, length of collection, or use of employees' biometrics, and the employees neither consented to nor waived the storage and use of their biometrics. The employees were unaware what the insureds did with their fingerprints.

An employee filed a class action suit against the insureds alleging BIPA violations. The insureds sought coverage under their commercial general liability policies. The primary and excess insurers denied coverage and filed a declaratory judgment action in North Carolina federal court seeking a declaration that they had no duty to defend or indemnify the insureds in the BIPA suit.

The District Court's Decision

The dispute primarily centered on the Recording and Distribution of Material or Information Exclusion, which provided:

> This insurance does not apply to:

. . . .

"Personal and advertising injury" arising directly or indirectly out of any action or omission that violates or is alleged to violate:

(1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law;

(2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law;

(3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transactions Act (FACTA); or

(4) Any federal, state or local statute, ordinance or regulation, other than the TCPA, CAN-SPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits, or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.

The insurers argued that this exclusion applied because BIPA is analogous to the statutes enumerated in the exclusion. The court agreed.

The court observed that the exclusion contains catch-all language – "[a]ny federal, state or locate statute" – following the list of specifically enumerated statutes: the TCPA, the CAN-SPAM, and the FCRA/FACTA. Applying North Carolina rules of construction, and particularly, the principle of *ejusdem generis*, the court determined that the exclusion applies to statutes "of the same kind, character and nature" as the TCPA, the CAN-SPAM, and the FCRA/FACTA.

Turning to BIPA, the court found that it regulates the retention, collection, disclosure, and destruction of biometric identifiers or biometric information. The language of the exclusion, which

bars the collection and dissemination of information, the court held, is "consonant with BIPA's prohibition against collection and disclosure of biometric identifiers and biometric information." The court concluded that BIPA is of the same kind, character, and nature as the statutes identified in the exclusion. The court added that the main purpose of this exclusion is to exclude from coverage statutes that protect and govern privacy interests in personal information. Like those statutes, the court noted, BIPA protects and governs a person's privacy interest in their biometric information.

As the court determined that the insurers were under no duty to defend or indemnify the class action suit, it granted the insurers' motion for judgment on the pleadings.

The case is *Massachusetts Bay Ins. Co. v. Impact Fulfillment Servs., LLC,* No. 1:20CV926 (M.D.N.C. Sept. 24, 2021).