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Judicial Panel on Multidistrict Litigation Centralizes Some COVID-19 Related Insurance Cases

As reported in our September update, the Judicial Panel on Multidistrict Litigation at its July 2020 hearing session requested further briefing to assess whether insurer-specific MDLs should be created.

On October 2, 2020, the Panel determined that it was appropriate to centralize 34 business interruption actions against Society Insurance Company, a regional insurer operating in six Midwestern states. The panel concluded that the actions against Society were comprised of common factual and legal issues and presented a manageable controversy that could be best streamlined by proceeding before a single judge.

The Panel, however, denied centralization with respect to claims against four other insurers – Hartford, Travelers, Cincinnati, and Lloyds of London. The fact that litigation was spread over numerous jurisdictions was a compelling factor against centralization because it would require the transferee court to interpret policy language under various state's law. Also, as for Lloyds, the Panel recognized that Lloyds was not a single insurer, but a group of several insurers whose policies may differ. Thus, the Panel did not believe that these actions could be managed efficiently by one judge.

Unlike the business interruption dockets involving these four insurer groups, the 34 actions against Society were concentrated in six nearby states, mostly Illinois. The Panel determined that

centralization presents the most efficient means of advancing these actions toward resolution and appointed the Northern District of Illinois as the transferee district.

The same day, the Panel also created two MDLs to centralize cases over coverage for canceled ski trips due to the pandemic. One MDL was created in Missouri for cases against Arch Insurance Company. The other was created in the Northern District of California for cases against United Specialty Insurance Company. The Panel refused to create an industrywide MDL, finding that few efficiencies would be gained by doing so.

The cases are: *In Re: Certain Underwriters at Lloyd's, London COVID-19 Business Interruption Protection Litigation* (MDL No. 2961); *In Re: Cincinnati Insurance Co. COVID-19 Business Interruption Protection Litigation* (MDL No. 2962); *In Re: Hartford COVID-19 Business Interruption Protection Litigation* (MDL No. 2963); *In Re: Society Insurance Co. COVID-19 Business Interruption Protection Litigation* (MDL No. 2964); *In Re: Travelers COVID-19 Business Interruption Protection Litigation* (MDL No. 2965); and *In Re: National Ski Pass Insurance Litigation* (MDL No. 2955).

Ninth Circuit Rejects Excess Insurer's "Improper Erosion" Theory

In a case of first impression, the U.S. Court of Appeals for the Ninth Circuit considered whether an excess insurer may challenge underlying insurers' payment decisions in a related claim on the basis that they improperly eroded liability limits and prematurely triggered excess coverage. The court held that absent a showing of fraud, bad faith, or a specific reservation of rights in its insurance policy, an excess insurer could not challenge such decisions.

The Case

Two separate lawsuits were filed against Northrop Grumman Corporation alleging ERISA violations relating to the administration of its employee savings and pension plans.

One was by the Department of Labor (DOL), which Northrop settled out of court. Northrop consented to pay certain amounts without admitting liability in exchange for a full release. The second suit was on behalf of the Savings Plan, which Northrop settled for $16,750,000.

Northrop sought coverage under its Employee Benefit Plan Fiduciary Liability Insurance. It maintained a primary layer and two excess layers.

The primary insurer determined that the DOL suit was covered and paid a portion of the settlement amount, exhausting the limits of its policy. The first layer excess insurer paid the remainder. The first layer excess insurer also paid a portion of Northrop's settlement with the Savings Plan, exhausting the limits of its policy. Northrop sought the remainder, roughly $9.7 million, from its second layer excess insurer, AXIS Reinsurance Company.

AXIS did not contest the validity of the settlement with the Savings Plan and covered its portion of the settlement. But AXIS contended that Northrop's settlement with the DOL was uninsurable as a matter of California law because it constituted disgorgement. It argued that the DOL settlement was not a covered loss and that the underlying insurers' improper payment of the DOL settlement prematurely triggered AXIS's excess liability policy for the Savings Plan settlement. It sued Northrop for reimbursement.

The district court awarded AXIS summary judgment and Northrop appealed.

The Ninth Circuit's Decision

The court first found insufficient legal precedent for AXIS's "improper erosion" theory and disagreed with the district court that excess insurers may generally contest the soundness of

underlying insurers' payment decisions. The Ninth Circuit instead held that an excess insurer may not challenge those decisions in order to argue that the underlying liability limits were not (or should not have been) exhausted absent a showing of fraud or bad faith, or the specific reservation of such a right in its contract with the insured.

Turning to AXIS's policy, the court determined that AXIS did not clearly reserve the right in its policy to challenge the underlying insurers' payment decisions, and therefore, could not second-guess those decisions.

Thus, the court did not reach the question of whether the DOL settlement violated California's public policy against paying insurance benefits to compensate an insured for disgorgement (but hinted that rule may not apply given that the DOL asserted several theories of recovery and there was no final adjudication of Northrop's alleged ERISA violations). The court noted that even if the DOL settlement required disgorgement, AXIS was the wrong insurer to raise it. The underlying insurers' failure to raise disgorgement, the court explained, did not permit AXIS to now raise the issue in connection with a *separate* insurance claim that AXIS concedes is covered.

In other words, AXIS never disputed the validity of the claim that Northrop asked it to cover – the Saving Plan settlement. Instead, AXIS sought to reduce its liability for that valid claim by disputing the validity of a different claim, the DOL Settlement, which it was never asked to cover. The court concluded that an excess insurer remains free to contest claims submitted to it during the claims adjustment process, even when an underlying insurer has already determined that the same claim falls within the scope of coverage. But, absent a specific contractual provision, it may not second-guess other insurers' payments of earlier claims without first showing that those payments were motivated by fraud or bad faith.

The Ninth Circuit reversed the district court's summary judgment order and remanded the case for further proceedings.

The case is *AXIS Reinsurance Co. v. Northrop Grumman Corp.,* No. 19-55135 (9th Cir. Sept. 14, 2020).

Insurer Had No Duty to Defend Landfill Operator in Criminal Proceeding Stemming from Pollution Incidents, Fifth Circuit Holds

The U.S. Court of Appeals for the Fifth Circuit upheld a district court's award of summary judgment in favor of an insurer, finding that the insured's obligation to clean up contamination did not create a duty on the part of the insurer to defend against criminal charges resulting from the same pollution incidents.

The Case

Waste Management, Inc., and Waste Management Hawaii, Inc. (collectively "WMI") operated the Waimanalo Gulch Sanitary Landfill under a contract with the city of Honolulu, Hawaii. On two occasions, heavy storms flooded a section of the landfill, resulting in contaminated water being discharged into the Pacific Ocean through an open manhole. The contamination included medical waste such as syringes, blood vials, and catheters, which washed up on nearby beaches.

The Environmental Protection Agency investigated and issued an Administrative Order on Consent (AOC) in January 2011. The AOC required WMI to clean up the discharge. The government also reserved the right to pursue WMI for other criminal and civil penalties. WMI completed the cleanup in August 2011.

In April 2011, the Department of Justice commenced a grand jury investigation into WMI's actions. WMI's Hawaii subsidiary and two of its employees were indicted for knowing discharge of

pollutants into U.S. waters. They ultimately pleaded guilty to negligent discharge of wastes in violation of the criminal penalties provision of the Clean Water Act. The plea agreement provided that it was separate from any potential civil claims against WMI.

In April 2019, WMI entered into a consent decree to resolve the civil proceedings arising from the pollution incidents.

WMI sought coverage under its Pollution Legal Liability insurance policy. The policy covered loss that WMI became legally obligated to pay as a result of a claim for cleanup costs resulting from a pollution condition beyond the boundaries of the insured property. The policy contained a duty to defend clause. The policy, however, did not apply to claims or loss "due to any criminal fines, criminal penalties or criminal assessments." The insurer denied coverage for all costs associated with the criminal proceedings.

WMI sued and the district court awarded the insurer summary judgment.

The Fifth Circuit's Decision

The Fifth Circuit affirmed.

Texas law controlled. Under Texas law, the duty to defend is measured by the "eight corners" rule.

WMI argued that all of the proceedings arising out of the pollution incidents were part of a single, coordinated enforcement process. Thus, according to WMI, the existence of a demand for cleanup costs in the AOC triggered the insurer's duty to defend all proceedings derived from the same factual allegations. WMI's argument was based on consideration of federal enforcement guidance documents. But these were extrinsic to the complaint and insurance policy, and under the eight corners rule, were not to be considered by the court in assessing the insurer's duty to defend.

But even if it were appropriate to consider the guidance documents, the court noted that the AOC was not a claim that triggered the insurer’s duty to defend the criminal allegations. Under the policy, when there is a claim for cleanup costs, the insurer has a duty to defend against "such claim." This policy language, the court explained, provides a common-sense limit on the insurer's duty to defend. It stated: “Were we to agree with [WMI] that the AOC, read in combination with the guidance documents, triggered a duty for [the insurer] to defend in all criminal or civil proceedings arising from the same pollution incidents, we would effectively be reading this bargained-for restriction out of the contract.”

WMI alternatively argued that the indictment constituted a claim for cleanup costs. According to WMI, the insurer had a duty to defend against the criminal allegations because cleanup costs were a potential outcome of the criminal proceedings. And even though the indictment did not seek a remedy from WMI, the lack of an explicit demand for a remedy merely introduced an ambiguity as to whether the indictment was a claim, which ambiguity should be construed in its favor.

The court disagreed, explaining that under the plain language of the policy, the insurer only has a duty to defend against written demands seeking a remedy from WMI for a covered loss. As the indictment did not seek a remedy, it did not trigger the duty to defend.

The court affirmed the district court’s ruling that the insurer was under no duty to defend against the criminal allegations.

The case is *Waste Mgmt. v. AIG Specialty Ins. Co.,* No. 19-20674 (5th Cir. Sept. 4, 2020).

Repeated Fuel Thefts by Truck Drivers Who Exploited Programming Glitch Constituted Multiple Occurrences, 11th Circuit Holds

Applying Florida's "cause theory," the Eleventh Circuit ruled that a fuel distributor's loss stemming from a programming error that enabled truck drivers over the course of a year to steal fuel when filling their vehicles constituted separate "occurrences," requiring the insured to satisfy separate deductibles.

The Case

Port Consolidated, Inc. ("Port") operates a cardlock fuel facility in Riviera Beach, Florida. Cardlock facilities are unattended fueling stations that grant access only to those customers with a "CFN card."

When a customer uses a CFN card at a cardlock facility, a computer system records information about the transaction, which is used to generate a weekly invoice that is issued to the customer. Customers can request restrictions on their CFN cards, including limits on the gallons of fuel to be pumped per transaction. These restrictions are "pegged" to the CFN card so that the facility's computer system can enforce the restrictions.

Allied Trucking was one of Port's customers. Allied allowed its affiliated truck drivers, who were independent contractors, to use the facility. The CFN cards limited any single purchase to 75 gallons. Due to a programming error, the drivers were able to exceed the limit by up to an extra hundred gallons. Allied, however, was invoiced only for 75 gallons per transaction.

Port discovered a fuel inventory shortage in February 2015 and its investigation led it to discover the programming error that originated from a 2013 upgrade. During the time period in question, the price of fuel never exceeded $4 per gallon. Port invoiced Allied for the extra fuel taken by the drivers but Allied refused to pay.

Port then sought coverage under its commercial property insurance policy. The policy was subject to a per occurrence deductible of $1,000. The insurer denied coverage on the basis that the alleged thefts were excluded and that each theft was a separate occurrence that did not exceed the $1,000 deductible.

Port sued and the district court ruled in the insurer's favor.

The Eleventh Circuit's Decision

On appeal, the Eleventh Circuit agreed that the fuel thefts constituted separate occurrences that individually did not exceed a deductible.

The court rejected Port's primary argument that all of its losses should be construed as a single "occurrence" and its alternate argument that there is a disputed issue of material fact as to the definition of "occurrence" within the policy that precluded summary judgment.

The policy's general definitions did not define the term "occurrence," but the court applied its plain and ordinary meaning. It further observed that Florida law applies the cause theory in determining the number of "occurrences," and in the absence of clear language to the contrary, "occurrence" is defined by the immediate injury-producing act.

The court found that the immediate injury-producing acts consisted of numerous alleged fuel thefts by several of Allied's affiliated drivers from different fuel dispensers at the facility on different days over the course of a year. Because each alleged fuel theft was an act separated and distinguishable in "time and space," the court concluded that each one constituted a separate "occurrence" under the policy.

As any one fuel theft was at most $400, no single incident exceeded the policy's $1,000 deductible. Therefore, the court found that the district court properly awarded summary judgment to the insurer.

The case is *Port Consol., Inc. v. Int'l Ins. Co. of Hannover,* No. 19-13544 (11th Cir. Sept. 8, 2020).

Engineering Company Accused of Helping Village Conceal Use of Contaminated Well Water Was Not Entitled to Coverage, Illinois Appellate Court Finds

Residents accused a water engineering firm of misrepresenting water quality and advising a village to conceal the fact that its drinking water was contaminated. An intermediate Illinois appellate court upheld a trial court's ruling that the residents' claim was not covered because injury did not result from an "occurrence."

The Case

The Village of Crestwood supplied its residents with Lake Michigan water purchased from a neighboring town and water from privately owned wells. The Illinois Environmental Protection Agency informed the Village that one of its wells was contaminated and unsafe for human consumption. The Village told residents that its water came exclusively from Lake Michigan and was safe to drink. In truth, however, the Village used the contaminated well as a drinking water source and avoided testing it for pollutants.

The insured, Burke Engineering Corporation, was retained by the Village to perform audits of its water supply and to help prepare water usage reports for government agencies. Burke knew the Village had been using contaminated well water but prepared reports concealing that fact from state regulators and the public. Evidence showed that Burke prepared private documents for Village officials detailing the pumping of millions of gallons from the contaminated well while simultaneously preparing false audit reports for state regulators concealing the well's use.

Residents sued Village officials along with Burke. The initial pleadings against Burke included claims for negligence, common law fraud, and conspiracy to commit fraud. In the negligence count, the plaintiff-residents alleged that Burke "by and through its agents breached their fiduciary duty by failing to disclose the harmful chemicals in the water to the public." In the same count, the plaintiff-residents alleged Burke "intentionally concealed the fact that it was using well water contaminated with hazardous chemicals to supply tap water … to avoid the cost of making water safe."

The trial court dismissed with prejudice all claims against Burke except the civil conspiracy to commit fraud count, which it dismissed without prejudice. In dismissing the negligence count, the court stated that the residents failed to allege that Burke had a duty under the administrative code and that the court could not "imagine a scenario" in which the residents could properly plead such a duty.

The residents amended their complaint to support their claim for civil conspiracy to commit fraud. Specifically, the residents alleged that Burke advised the Village how to conceal the use of the contaminated well for the illegal purposes of avoiding detection by authorities and avoiding mandated testing and reporting. They also alleged that Burke conspired with the Village and Village officials by agreeing to deceive the residents on the use and presence of contaminated well water.

Burke tendered the residents' suit to its insurers. One insurer defended under a policy with eroding defense limits, and another denied coverage. Burke ultimately settled for $18.3 million and assigned its insurance rights to the residents.

The non-defending insurer sought a declaration of non-coverage on the basis that Burke's conduct was alleged to be intentional, and therefore, any injury did not result from an

“occurrence,” defined as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” The trial court agreed and granted the insurer summary judgment.

The Appellate Court’s Decision

The appellate court affirmed.

The residents argued that the insurer’s duty to defend was triggered by their allegation that Burke was negligent in breaching its fiduciary duty to inform the public about contaminated water. Even though those allegations were later dismissed with prejudice, the residents argued that recovery was still possible because they filed amended complaints preserving the negligence counts for appeal and intended to amend their complaints to allege negligence based on statutory violations.

The appellate court disagreed. It found that the complaints alleged Burke knew of the contamination, concealed that fact from the residents, and intentionally misrepresented the water’s safety. Such allegations do not allege an unforeseen occurrence.

The court further stated that the “negligence” label attached to the complaints was irrelevant. In assessing the duty to defend, courts look at the actual facts, not the labels. “And the factual allegations that Burke failed to disclose the contamination and conspired with the Village to hide that fact set forth only intentional conduct.” The court emphasized that the underlying complaints contained no factual allegations supporting the existence of an "occurrence" as defined by the policies.

The residents further argued that because they informed the insurer that they intended to amend the complaint to raise a statutory negligence claim against Burke, and because they planned to pursue their common law negligence claim on appeal, that the insurer knew Burke

might be found liable under a negligence theory, thereby triggering the insurer's duty to defend. The court rejected this argument as well because nothing in the record supported the residents' assertion that Burke's conduct was accidental.

The case is *General Cas. Co. of Wisconsin v. Burke Engineering Co.,* No. 1-19-1648 (Ill. Ct. App. Sept. 14, 2020).

Texas Federal Court Rules That Insurer Had No Duty to Defend Leaky Roof Case, Finding "Your Work/Your Product" Exclusions Applied

A roofing manufacturer's attempt to secure a defense in a case involving its roofing system guaranty was defeated when the Northern District of Texas agreed with the insurer that two exclusions aimed at avoiding coverage for the insured's defective products and faulty workmanship applied.

The Case

Siplast manufacturers roofing and waterproofing systems. The Archdiocese of New York purchased a Siplast roofing system for its Cardinal Spellman High School in the Bronx, New York. A third-party contractor installed the roof system. The roof system came with a 20-year guaranty.

A few years after the roof system was installed, school officials noticed water damage in the ceiling tiles throughout the building. Siplast initially took the position that the school's claim was not covered by the guaranty but later attempted to repair the leaks. The school hired a consultant who concluded that there were significant issues with both the workmanship and the materials comprising the roof membrane system. The school alleged that the only way to remediate the issue was to replace the failed membrane system with a new one, at a cost of $5 million. The school ultimately sued Siplast for breach of guaranty.

Siplast notified its commercial general liability insurer, who denied coverage. Siplast then filed a declaratory judgment action seeking a defense.

The Decision

On the parties' summary judgment motions, the court first considered whether the alleged property damage was caused by an "occurrence." The court found that there was an "occurrence" because nothing in the underlying complaint alleged that Siplast intended or expected its roof system to fail.

The court next considered the policy's exclusions for property damage to the insured's work and products. The policy provided that the insurance does not apply to "'Property damage' to 'your product' arising out of it or any part of it." Nor did the insurance apply to "'Property damage' to 'your work' arising out of it or any part of it and included in the 'products-completed operations hazard.'" "Your product" was defined as "Any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by: (a) You." "Your work" was defined as "work or operations performed by you or on your behalf," and included "warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of 'your work.'"

The insurer argued that Siplast was not being sued for damage to property other than its own work and products that the school sought to replace. In other words, the school was seeking only the cost to replace the roofing system, not any damage that resulted to the school from the defective roof.

Siplast argued that the complaint alleged damage to the interior of the building given that school officials observed water stains on the ceiling.

The court held that these exclusions unambiguously precluded coverage for the school's claim. The court acknowledged that the complaint mentioned damage to school property other than the roof, but found that the school was not asserting a claim for damages separate from the roofing system. The school sued based on Siplast's failure to replace the roof as required by the guaranty. The school did not claim that Siplast's breach caused it any other damages.

Thus, the court determined that the insurer had no duty to defend or indemnify Siplast based on the "your work/your product" exclusions.

The case is *Siplast, Inc. v. Employers Mut. Cas. Co.,* No. 3:19-cv-1320-E (N.D. Tex. Sept. 25, 2020).

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