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Ohio Supreme Court Holds That Insurer Has No Duty to Defend Opioid Suits

The Ohio Supreme Court held that a CGL insurer does not have a duty to defend a pharmaceutical distributor in suits brought by governmental entities seeking economic damages for losses caused by the opioid epidemic because the suits do not seek "damages because of bodily injury." In doing so, the Ohio Supreme Court reversed the intermediate appellate court and became the second state high court, along with Delaware, to find that insurers have no duty to defend opioid distributors in public nuisance suits by state and local governments.

The Case

The insured, Masters Pharmaceutical, Inc., a wholesale distributor of pharmaceutical products, filled and shipped orders of prescription opioids to pharmacies around the country. Twenty-two cities and counties in West Virginia, Michigan, and Nevada sued Masters and other pharmaceutical companies alleging that they failed to monitor and report suspicious orders of prescription opioids and failed to implement measures to prevent opioids from being diverted into the illicit market.

The governments alleged that Masters's conduct "greatly contributed to the vast increase in opioid overuse and addiction" and caused "a public-health and law-enforcement crisis" in their respective communities. The governments claimed economic losses, such as increased law-enforcement expenses, judicial expenditures, prison and public-works costs, emergency and

medical-care-services costs, substance-abuse-treatment expenses, and lost economic opportunity. They asserted claims for public nuisance and negligence.

Masters tendered the suit to its commercial general liability insurer, Acuity. Under those policies, Acuity has a duty to defend Masters against suits seeking "damages because of bodily injury" and a duty to indemnify Masters for damages it is legally obligated to pay.

Acuity sought a declaration that it had no duty to defend or indemnify Masters. The trial court awarded Acuity summary judgment, finding that the governments sought damages solely for their own economic loss, not damages for any citizen's opioid addiction. The trial court also found that there was a loss-in-progress, as Masters knew about the prescription opioid addiction problem before purchasing the policies from Acuity.

But that decision was reversed on appeal. The intermediate appellate court found that some of the governments' claimed losses, such as medical expenses and treatment costs, were arguably because of bodily injury. And it found that policy's loss-in-progress provisions did not apply because it was unclear whether Masters knew of some of the governments' damages before the first policy began.

The case made its way to the Ohio Supreme Court.

The Ohio Supreme Court's Decision

The state high court reversed, reinstating the trial court's entry of summary judgment in Acuity's favor.

The court first analyzed the allegations in the complaints and found that the governments tie their alleged losses to the aggregate economic injuries they have experienced as a result of the opioid epidemic, not to any particular bodily injury.

The court next analyzed the policies and determined that they require more than a tenuous connection between the damages sought and the bodily injury. It reasoned that the repeated use of the phrase “*the* bodily injury” throughout the insuring agreement suggests that the damages must be tied to a particular injury sustained by a person or persons. The court refused to interpret “damages because of bodily injury” expansively, as Masters had urged, to include any suit in which the damages sought merely relate to bodily injury. If the court did so, it would be difficult to determine whether *the* bodily injury occurred during the policy, was caused by an occurrence in the coverage territory, or had occurred in whole or in part before the policy period. In this sense, it found no support in Ohio law for the distinction used by some courts between the phrases “because of bodily injury” and “for bodily injury.” It also found that distinction irrelevant because the Acuity policies used those terms interchangeably in the insuring agreement.

The court explained that a sufficient connection will likely be found under standard CGL policies when the damages sought are for losses asserted by: (1) the person injured; (2) a person recovering on behalf of the injured person; or (3) a person or organization that directly suffered harm because of another person's injury—in which case, the existence and cause of the injury must be proved.

The governments did not seek damages for bodily injury sustained by themselves. Nor did they seek damages for bodily injury on behalf of their injured citizens (many pleadings expressly stated that the damages sought were not derivative of another’s injury). And they did not seek damages because of any particular opioid-related injury sustained by a citizen.

The court thus held that the governments’ suits did not allege “damages because of bodily injury” and that Acuity had no duty to defend. To hold otherwise, the court said, “would be to

conclude that a duty to defend exists simply because a consequence of the alleged public-health crisis is bodily injury, regardless of the fact that the underlying parties do not seek damages because of any particular bodily injury sustained by a person." This "extraordinarily expansive view," the court added, gave it "much pause given the potential floodgates it might open."

The Ohio Supreme Court did not reach Acuity's other issue on appeal, whether the loss-in-progress provisions applied.

The case is *Acuity v. Masters Pharm., Inc.*, No. 2020-1134 (Ohio Sept. 7, 2022).

Ohio Appellate Court Rules for Sherwin-Williams on Lead Paint Abatement

Reversing the trial court, the Ohio Court of Appeals ruled that a paint manufacturer's payment into a fund to abate lead paint qualified as damages under liability insurance policies and that those damages were "because of bodily injury and property damage." The court also held that even though the company knew lead paint was hazardous when promoting its indoor use, that was insufficient for coverage purposes to establish that the company intended to harm children, or that harm flowed naturally from its conduct.

The Case

Multiple California municipalities led by Santa Clara County sued Sherwin-Williams and other lead paint manufacturers for public nuisance. After a trial, Sherwin-Williams and other companies were found jointly and severally liable and ordered to pay into a fund to abate the nuisance. Liability was based on defendants' promotion of lead paint for interior use with knowledge of the hazard that such use would create.

The California Court of Appeal upheld the trial court's abatement order because it was a permissible equitable remedy. The court noted that the abatement fund provided no compensation for past harm. Rather, it would be used to pay for the prospective removal of the hazards that defendants created.

The California Court of Appeal also upheld the trial court's findings that the paint manufacturers had actual knowledge that lead exposure harmed children, that lead paint used in residences would deteriorate, and that the dust resulting from the deterioration would poison children, causing serious injury.

Sherwin-Williams filed a coverage action in Ohio against its insurers and moved for partial summary judgment against National Union seeking a declaration that its policy respond first. National Union and other insurers filed their own summary judgment motions for a declaration of no coverage. The trial court granted the insurers' summary judgment motion on the grounds that there were no damages. The trial judge personally disagreed that payment of millions of dollars into an abatement fund were not "damages" but held that the parties were bound by the California Court of Appeal's ruling. Sherwin-Williams appealed and the insurers cross-appealed.

The Ohio Court of Appeals' Decision

The intermediate appellate court reversed.

Sherwin-Williams' appeal centered on whether the monies it was ordered to pay to abate the public nuisance are damages covered by its insurance policies. It argued that the trial court was mistaken when it found the parties were bound by the California Court of Appeal's ruling, arguing that Ohio law determined whether payment into the abatement fund were damages under the insurance policies and that the California decision did not address this insurance coverage issue.

Sherwin-Williams argued that the plain and ordinary meaning of "damages" includes sums it must pay to remediate and abate the presence of lead paint. The insurers argued that the abatement fund was not "damages" because it did not compensate the government entities or anyone else for loss, but was a prophylactic remedy that sought only to avoid future injuries.

The Ohio appellate court had the benefit of two recent coverage decisions involving other defendants ordered to pay into the same abatement fund – NL Industries and ConAgra. A New York intermediate appellate court sided with NL Industries in its coverage action, but a California intermediate appellate court ruled against ConAgra. The Ohio Court of Appeals found the New York decision more persuasive.

The Ohio Court of Appeals reasoned that ordinary dictionary definitions of "damages" have been construed to include equitable relief for the government's environmental cleanup costs. It found that the abatement fund was not directed only at preventing future harm, but also reimbursed the government plaintiffs for money depleted by their efforts to remediate lead paint from California homes. Thus, the court found that Sherwin-Williams' payment into the abatement fund qualified as damages.

The insurers raised several challenges of their own.

They argued that because Sherwin-Williams was found liable for promoting lead paint for interior use knowing that children would be poisoned, the trial court erred when it held that Sherwin-Williams did not expect or intend the harm. But the Ohio appeals court disagreed, reasoning that there was no evidence that Sherwin-Williams intended to cause harm when it promoted the lead paint. The court acknowledged that Sherwin-Williams was found in the underlying *Santa Clara* action to have known that lead paint was hazardous, and that it would deteriorate and cause serious injury. But according to the court, "actual knowledge of a hazard is

not the same as finding that Sherwin-Williams' intentional conduct and the resulting injuries were so intrinsically tied that Sherwin-Williams' conduct necessarily resulted in the harm."

The insurers also argued that the government entities in the *Santa Clara* action did not suffer any bodily injury or property damage themselves, and therefore, there was no claim for "damages because of bodily injury or property damage" as required by the policies. The insurers noted that the government entities were not required to show that anyone suffered bodily injury or property damage to establish their nuisance claim. Again, the court disagreed with the insurers. Even though bodily injury and property damage were not required elements of the governments' public nuisance claim, the court held there was a connection between lead poisoning to children and property damage to buildings as a result of Sherwin-Williams' promotion of lead paint. Sherwin-Williams' liability was thus imposed because of bodily injury or property damage.

The court reversed the trial court's decision granting summary judgment to the insurers.

The case is *Sherwin-Williams Co. v. Certain Underwriters at Lloyd's London,* No. 110187 (Ohio Ct. App., 8th App. Dist. Sept. 1, 2022). This appeal was decided about a week before the Ohio Supreme Court's *Acuity* decision discussed above. The Ohio Court of Appeals' ruling that there were "damages because of bodily injury or property damage" may not hold up given the *Acuity* ruling.

South Carolina and Washington Supreme Courts Find No Direct Physical Loss or Damage Caused by States' Covid-19 Shutdown Orders

Two Supreme Courts – in South Carolina and Washington – siding with insurers, found no coverage for economic losses sustained by policyholders due to Covid-19 shutdowns. The South Carolina case involved an indoor dining ban. The Washington case concerned a ban on

nonemergency dental care. In each case, the insureds sought coverage for lost business income caused by shutdown orders. And, in each case, the state supreme courts found no coverage because the insured's losses were not "direct physical loss or damage."

These decisions follow the overwhelming majority of jurisdictions to address the issue during the Covid-19 pandemic.

The Cases

The cases involved different types of businesses, but the facts were similar.

In the South Carolina case, the policyholder operated a restaurant. The restaurant sued to recover for business interruption losses under a commercial property insurance policy. The restaurant sued in state court, but the case was removed to federal court. The district court certified to the South Carolina Supreme Court the question of whether the presence of Covid-19 in or near the restaurant's properties, and related governmental orders, which allegedly hindered or destroyed the fitness, habitability, or functionality of the property, was "direct physical loss or damage" to property.

In the Washington case, the policyholder was a dental practice that had a property insurance policy. The dental practice sought coverage because it could not use its offices for nonemergency dental practice under a state proclamation.

The Decisions

The South Carolina and Washington Supreme Courts each concluded that business losses because of Covid-19 shutdown orders were not covered because they did not involve "direct physical loss or damage."

The policies did not define "direct physical loss or damage," so the courts interpreted those terms by their common meaning; that is, that something material or tangible be damaged. The

courts acknowledged that the government shutdown orders affected the business's bottom lines, but this did not mean they suffered a physical loss or damage. As the Washington high court put it, the dental practice only suffered a "constructive loss of property." The court further observed that although the dental practice was unable to use its office the way it wanted, it was not dispossessed of its property. Both courts distinguished Covid-19 from other traditional contamination such as gasoline, toxic torts, odors, and smoke, which can alter covered property.

Each court also emphasized that its conclusion was all the more true because the policy provided business interruption coverage "during the period of restoration." The policyholders had nothing to restore, reinforcing that no direct physical loss occurred. Both courts also observed that their rulings aligned with the vast majority of decisions during the pandemic.

The South Carolina high court considered only whether a direct physical loss occurred. It's unclear whether the policy in that case contained a virus exclusion. But the Washington Supreme Court went further and also found that coverage would be barred under a virus exclusion. The court didn't have to consider the virus exclusion because it already found there was no direct physical loss, but the court addressed the issue anyway because it was likely to be raised in other cases.

The dental practice argued that the virus exclusion did not apply because its loss was caused by the governor's proclamation, not Covid-19. The Washington Supreme Court considered the efficient proximate cause rule. Under that rule, where a covered peril sets other causes into motion that produce the result for which recovery is sought, the loss is covered even if other events in the chain of causation are excluded from coverage. The opposite, however, is not true. When an excluded peril sets in motion a causal chain that includes covered perils, the efficient proximate cause rule neither mandates coverage nor mandates exclusion. The parties may be

unable to contract around the efficient proximate cause rule, but they can agree to say that coverage is excluded (or covered) for a causal chain initiated by an excluded peril.

With these principles in mind, the Washington State Supreme Court assumed for purposes of its analysis that a loss from the government shutdown order would be covered. The court held that, although the determination of efficient proximate cause is usually a question of fact, summary disposition was appropriate because the causal chain was clear; Covid-19 caused the proclamation. In other words, an excluded peril (the virus) initiated a sequence of events that included the shutdown order. The efficient proximate cause rule thus did not mandate coverage or exclusion because the policy terms controlled. The policy stated that "[l]oss or damage will be considered to have been caused by an excluded event if the occurrence of that event: . . . Initiates a sequence of events that results in loss or damage, regardless of the nature of any intermediate or final event in that sequence." Thus, the policy said that coverage is excluded for a causal chain initiated by an excluded peril; therefore, the virus exclusion would apply.

The South Carolina Supreme Court decision is *Sullivan Mgmt. v. Fireman's Fund Ins. Co.,* No. 28105 (S.C. Aug. 10, 2022). The Washington Supreme Court decision is *Hill & Stout, PLLC v. Mut. of Enumclaw Ins. Co.*, 100211-4 (Wash. Aug. 25, 2022).

Washington Supreme Court Finds Claims-Made Policies That Provide No Prospective or Retroactive Coverage Violates Washington Public Policy

The Washington Supreme Court held that where a contractor's liability insurance policy provided coverage only for "occurrences" and resulting "claims-made and reported" that take place within the same one-year policy period, and provided no prospective or retroactive

coverage, those requirements together violated Washington public policy and rendered the "occurrence" or "claims-made and reported" provisions unenforceable.

The Case

The insured, Baker and Son Construction Inc., was a subcontractor on a project to remodel a motel. On October 31, 2019, a Baker employee allegedly caused a two-by-four to fall from a railing, striking the contractor's principal in the head. The principal died in his sleep that night. On September 23, 2020, Baker received notice from an attorney representing the deceased's widow that she was pursuing a wrongful death claim against the subcontractor.

Baker had two CGL policies with Preferred Contractors Insurance Company (PCIC), one for January 5, 2019 to January 5, 2020 and one for January 5, 2020 to January 5, 2021. The policies specified that they applied only if the "'bodily injury' or 'property damage' is caused by an 'occurrence' that first takes place or begins during the 'policy period.'" The policies also contained an endorsement, which says the policy did not provide continuous coverage between renewed policies and applied only to claims first made and reported within the policy period. Read together, these provisions unambiguously stated that PCIC policies only covered losses that occurred and were reported to PCIC within the applicable one-year policy period.

Baker tendered the wrongful death claim to PCIC, which denied coverage. Because the death occurred in October 2019 and the widow did not notify Baker of her intent to sue until September 2020, the occurrence and reporting dates did not occur in the same policy period. The 2019 policy did not cover the claim because it was not reported within the policy period, and the 2020 policy did not provide coverage because the claim arose from events that happened before the policy period began on January 5, 2020.

The widow filed a wrongful death suit in Washington state court. PCIC filed a declaratory judgment action in federal court for a declaration that it had no duty to defend or indemnify Baker for the accident. The district court denied PCIC's motion for summary judgment and granted partial summary judgment to Baker and the widow.

The Washington Supreme Court considered the following certified question:

> When a contractor's liability insurance policy provides only coverage for "occurrences" and resulting "claims-made and reported" that take place within the same one-year policy period, and provide[s] no prospective or retroactive coverage, do these requirements together violate Washington public policy and render either the "occurrence" or "claims-made and reported" provisions unenforceable?

The Decision

The court answered "yes" to the certified question, noting that Washington state has a public policy, dictated through statute, that requires contractors to be financially responsible to members of the public injured by their negligence.

The court acknowledged that parties ordinarily are free to exercise their freedom to contract, and courts rarely refuse to enforce an insurance provision as contrary to public policy. But this case presented an exception. That's because the PCIC policies failed to provide prospective or retroactive coverage, which meant a claim would be covered only if it both occurred and was reported within the policy's twelve-month period. The court found that these restrictions rendered coverage so narrow as to be illusory.

The court recognized that insurers are not required to issue occurrence policies or to provide retroactive coverage to contractors switching from an occurrence to a claims-made policy. But once an insurer enters the market, the court explained, it cannot issue policies that essentially cause contractors to default on their statutorily mandated financial responsibility.

For these reasons, the court answered the certified question in the affirmative and instructed that "a contractor's CGL policy that requires the loss to occur and be reported to the insurer in the same policy year and fails to provide prospective or retroactive coverage is unenforceable."

The case is *Preferred Contractors Ins. Co., Risk Retention Grp., LLC v. Baker & Son Constr., Inc.*, No. 100466-4 (Wash. Aug 11, 2022).

Theft of Cryptocurrency Is Not a Direct Physical Loss,California Federal Court Holds

A federal judge ruled that stolen cryptocurrency was not a covered loss under a homeowners policy requiring a "direct physical loss" to personal property because the digital currency was not tangible property.

The Case

Siblings inherited digital property valued at $339,000 from their father. The digital property, which included Bitcoin and Etherium, was maintained in a Coinbase account. That account was hacked, and the digital property was stolen.

The siblings made a claim under their father's homeowners policy. The policy covered direct physical loss of personal property due to "theft," including "attempted theft and loss of property from a known place when it is likely that the property has been stolen."

The siblings ultimately sued the insurer for a declaratory judgment, breach of contract, and breach of the implied covenant of good faith and fair dealing.

The Decision

The court found that the loss was not covered. The issue was whether the siblings' loss of cryptocurrency was a direct physical loss. The court found that under California law, the term "physical" means having a material existence formed out of tangible matter. Because cryptocurrency is intangible, its theft could not constitute a physical loss under the policy. As the siblings failed to allege "direct physical loss," the court found there was no coverage and dismissed all of the siblings' claims. But the court granted the siblings leave to amend the complaint.

The case is *Burt v. Travelers Com. Ins. Co.,* No. 22-cv-03157-JSC (N.D. Cal. Aug. 16, 2022).

Computer Fraud Coverage Does Not Apply to Social Engineering Loss, Minnesota Federal Court Holds

A Minnesota federal judge ruled that money stolen after a company's CEO was tricked into wiring funds to an impersonator was covered only under the crime policy's social engineering fraud coverage, not the computer fraud coverage. Those two coverage grants were mutually exclusive, and the loss clearly involved social engineering fraud.

The Case

A bad actor emailed fraudulent invoices to the insured's purchasing manager that purported to be from one of its vendors. The email directed payment to be made by wire transfer to an account number different from the number used in the past. The bad actor then hacked the purchasing manager's email account, and impersonating the purchasing manager, forwarded them to the insured's CEO for payment with the new wire-transfer instructions. The CEO attempted to confirm the new payment instructions with the vendor but received no response. He then wired

nearly $600,000 to what he thought was the vendor before the payment deadline expired. When the insured discovered the fraud, the thief had already made off with the money.

The insured initially submitted a claim to its crime insurer under the social engineering fraud coverage part. But that coverage carried a limit of only $100,000. The insured then sought to recover under the policy's computer fraud coverage, which carried a $1 million limit. The insured contended that the loss was not due to social engineering fraud. The dispute ended up in court.

The Decision

The court held that only the lower social engineering fraud limit applied, not the higher computer fraud limit.

First, there wasn't "computer fraud" as defined by the policy. The definition excluded any "entry or change [of data or computer instructions] made by an Employee [or] Authorized Person . . . made in reliance upon any fraudulent . . . instruction." That's exactly what happened – the CEO used the computer system to change the wire payment instructions and initiate a transfer to what he thought was a vendor relying on a fraudulent instruction. The court rejected the insured's argument that it was the victim of two separate fraudulent acts: (1) the bad actor hacking into the insured's email system and forwarding the fraudulent invoices from the purchasing manager's email account to the CEO; and (2) the CEO acting on those fraudulent invoices and emails by initiating the wire transfers to the bad actor's account.

Second, the court viewed the incident as a single course of fraud and reasoned that the hacking of the email account alone did not directly cause a "direct loss" to the insured. Indeed, the insured would not have suffered any financial loss had the CEO not acted.

Third, even if the claim met the requirements of computer fraud, that coverage was limited by an exclusion for “loss resulting from forged, altered, or fraudulent . . . instructions used as source documentation to enter Electronic Data or send instructions[.]” The court found that this was precisely the type of loss at issue and further noted that the exclusion did not apply to the social engineering fraud coverage.

Fourth, the incident met the policy’s definition of social engineering fraud: “the intentional misleading of an Employee . . . by a natural person impersonating . . . a Vendor . . . [or] an Employee . . . through the use of a Communication.” And the policy stated that computer fraud does not include social engineering fraud.

The court refused to accept the insured’s tortured reading of the policy. The court found that the policy “clearly anticipates—and clearly addresses—precisely the situation that gave rise to [the insured’s] loss, and the Policy bends over backwards to make clear that this situation involves social-engineering fraud, not computer fraud.”

The case is *SJ Computers, LLC v. Travelers Cas. & Sur. Co. of Am.*, No. 21-CV-2482 (PSJ/JFD) (D. Minn. Aug. 12, 2022).

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