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Businesses Across the Nation Sue Insurers Over Coronavirus Losses

As expected, insurers have seen a rash of business interruption claims caused by the COVID-19 pandemic. Many of these are turning into lawsuits.

Although each lawsuit is different, many of the cases share common elements. A common issue is whether the business losses caused by COVID-19 are "physical losses" under the relevant polices.

In some instances, an insured sued after it was denied business interruption coverage on the basis that the COVID-19 pandemic did not constitute a "physical loss" under an insurance policy. Examples include lawsuits by:

- A scuba diving shop in Florida, *Mace Marine Inc. v. Tokio Marine Specialty Insurance Co.*, 20-CA-000120-P, Circuit Court of the 16th Judicial Circuit.
- A group of movie theater and restaurants in Chicago, *Big Onion Tavern Group LLC, et al. v. Society Insurance Inc*., 20-cv-02005 (N.D. Ill.).
- A theater group in Indiana, *Indiana Repertory Theater Inc. v. The Cincinnati Casualty Co.*, 49D01-2004-PL-013137, Marion County Superior Court.

In other instances, policyholders, unwilling to wait for formal coverage determinations, filed suit for a declaration of coverage. Examples include lawsuits by:

- A restaurant in Philadelphia, *LH Dining L.L.C., d/b/a River Twice Restaurant v. Admiral Indemnity Company*, 20-cv-01869 (E.D. Pa.).

- A restaurant group in California, *French Laundry Partners, LP d/b/a The French Laundry, a limited partnership, et al. v. Hartford Fire Insurance Company, Superior Court for the State of California, County of NAPA.* In this case, the insured also seeks coverage under a "Property Choice Deluxe Form," which the restaurant group contends "specifically" covers losses from the virus.

- A casino owned by a Native American tribe in Oklahoma*, Chicksaw Nation Department of Commerce v. Lexington Insurance Company, et al.*, CV-20-35, District Court of Pontotoc County, State of Oklahoma.

Many states are also considering bills that would require insurers offering business interruption insurance to cover losses attributable to COVID-19. This includes New York, New Jersey, Ohio, Pennsylvania, Louisiana, and Massachusetts. The bills take various forms, but some would mandate that insurers cover COVID-19-related business interruption claims despite virus exclusions in many policies. There is a lot of uncertainty about the constitutionality of those bills. But, as the steady stream of lawsuits shows, coverage claims related to COVID-19 continue to mount.

Maryland High Court Adopts Pro Rata Allocation in Continuous Bodily Injury Case

The Maryland Court of Appeals held that damages from a continuous bodily injury judgment must be allocated on a *pro rata*, time-on-the-risk basis across all insured and insurable periods triggered by the plaintiff's injuries.

The Case

Lloyd E. Mitchell, Inc. ("Mitchell") was a mechanical contractor that sold, distributed, and installed products containing asbestos until 1976 when it ceased all operations. From January 1, 1974 through July 31, 1977, Mitchell was insured by the Maryland Casualty Company under a series of standard Comprehensive General Liability ("CGL") policy agreements. The policies

required the Maryland Casualty Company to pay on behalf of Mitchell "all sums which the insured shall become legally obligated to pay as damages because of . . . bodily injury . . . to which this insurance applies, caused by an occurrence." The policies defined "bodily injury" as "bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom."

In 1974, the Petitioner Patrick Rossello worked in the Union Trust Bank Building in which Mitchell was performing construction and renovations. Mr. Rossello unknowingly inhaled asbestos originating from the construction products used by Mitchell. Mr. Rossello's injuries developed over the next forty years, manifesting in a mesothelioma diagnosis in 2013. Mr. Rossello brought a strict liability and negligent failure to warn action against Mitchell. The case proceeded to trial and the jury returned a verdict in favor of Mr. Rossello for compensatory damages in the amount of $8,114,166.79. The trial court reduced the judgment for the settlement of joint tortfeasors and entered a final judgment in the amount of $2,682,847.26.

To collect his judgment, Mr. Rossello initiated garnishment proceedings against Zurich American Insurance Company ("Zurich"), successor by merger to Maryland Casualty Company.

Mr. Rossello contended that the entire judgment should be satisfied by the 1974 CGL policy, not subject to per occurrence or aggregate limits. Zurich responded that the relevant period of time to allocate the judgment is forty years, 1974 through 2013, *i.e.*, the year of exposure through the year of manifestation and diagnosis of mesothelioma. Alternatively, Zurich argued that the relevant time period should be twelve years, from 1974 through 1985 — 1985 being the last year that asbestos risk insurance was available to Mitchell.

After it ceased operations in 1976, Mitchell's last policy expired on July 31, 1977, after which it never again acquired insurance. The circuit rejected Mr. Rossello's contention that he was

entitled to the entire judgment under the 1974 policy. The court ruled that Mr. Rossello's damages must be allocated on a *pro rata* time-on-the-risk basis across all insured and insurable periods triggered by Mr. Rossello's injuries, *i.e.,* 1974-1985. Mr. Rossello appealed.

The Decision

The Maryland Court of Appeals affirmed the lower court's ruling.

The court observed that *pro rata* allocation had been adopted by the majority of states to address the issue. The court also noted that several lower courts in Maryland had applied *pro rata* allocation.

The court rejected Mr. Rossello's contention that, once the occurrence of a bodily injury triggered each policy, each policy became obligated by its terms to pay "all sums" the insured owed as a result of the injury. The court held that Mr. Rossello's position was "inconsistent with the remainder of the agreement because each policy provides coverage only for "bodily injury . . . which occurs *during the policy period*." The court noted that the definitions of occurrence and bodily injury made clear that "although the occurrence can take place at any time, the bodily injury must take place during the policy period."

The court also held that public policy reasons favored *pro rata* allocation. The court noted that *pro rata* allocation is more equitable than joint and several allocation. The court reasoned that joint and several allocation "creates a false equivalence" between an insured who has purchased insurance coverage continuously for many years and an insured who has purchased only one year of insurance coverage. The court also noted that *pro rata* allocation is easy to administer, efficient, and consistent with the reasonable expectations of the contracting parties.

The case is *Rosello v. Zurich Amer. Ins. Co.*, Case No. 24-X-14-000378 (Md. April 3, 2020).

Texas Supreme Court Holds That Eight Corners Rule Applies Even Absent a "Groundless, False or Fraudulent" Clause

On certified question from the U.S. Court of Appeals for the Fifth Circuit, the Texas Supreme Court instructed that the absence of a "groundless, false or fraudulent" clause by itself did not create an exception to the longstanding rule that the court may not look beyond the four corners of the complaint and the insurance policy in assessing the duty to defend.

The Case

A ten-year-old boy was killed in an ATV accident while under the supervision of his paternal grandparents. The boy's mother sued the grandparents alleging negligent supervision. The petition asserted that the accident happened on or near the grandparents' residence.

The grandparents notified their homeowner's insurer. The insurer agreed to defend under a reservation of rights but then immediately sought a declaration in federal court that it had no duty to defend or indemnify. The insurer contended that two exclusions applied.

The "motor vehicle" exclusion applied because the bodily injury arose from the use of the grandparents' ATV on a public recreational trail, not on the grandparents' property. To prove the accident's location, the insurer submitted the police report, which stated the location of the accident.

The insurer also claimed that the exclusion for bodily injury to an insured applied. The insurer argued that the boy was an "insured" because the grandparents were his joint managing conservators. As proof, the insurer submitted a court order from a suit affecting the parent-child relationship (SAPCR).

In response, the grandparents argued that the eight-corners rule prohibited the court from considering any evidence, including the crash report and the SAPCR order, when determining the insurer's duty to defend the lawsuit.

The federal district court disagreed with the grandparents. It held that the eight-corners rule did not prohibit consideration of the evidence because the rule applies only to insurance policies that explicitly require the insurer to defend "all actions against its insured no matter if the allegations of the suit are groundless, false or fraudulent." The court granted summary judgment to the insurer and the grandparents appealed.

On appeal, the Fifth Circuit certified a question to the Texas Supreme Court asking whether the absence of the "groundless, false or fraudulent" language was a permissible exception to the eight corners rule under Texas law.

The Texas Supreme Court's Decision

The Texas Supreme Court acknowledged that parties to an insurance policy can "contract around" the eight corners rule. But it found that an insurer does not contract away the eight-corners rule altogether merely by omitting from its policy an express agreement to defend claims that are "groundless, false or fraudulent."

The insurer contended that the eight-corners rule arose to enforce the "groundless, false or fraudulent" language that was commonly used in older policy forms. As that language is less common in today's policies, the insurer argued that the eight-corners rule itself must change, no matter how deeply embedded in the law it has become.

But the Texas Supreme Court disagreed, stating that it never held or suggested that the eight-corners rule is contingent on a groundless-claims clause. The court noted that "Texas courts of appeal have routinely applied the eight-corners rule for many decades, without regard to

whether the policy contained a groundless-claims clause" and that commentators considered the eight-corners rule a settled feature of Texas law.

The court observed that the insurer agreed to defend the policyholders if "a claim is made or a suit is brought against an insured for damages because of bodily injury . . . to which this coverage applies." To determine whether such a "claim" has been "made" or a "suit" has been "brought," courts first look to the petition. If the claim is "for damages because of bodily injury . . . to which coverage applies," the duty to defend is implicated.

Underlying the court's decision was the consistency and predictability that the eight-corners rule brings. "The eight-corners rule merely acknowledges that, under many common duty-to-defend clauses, only the petition and the policy are relevant to the initial inquiry into whether the petition's claim fits within the policy's coverage. This is how Texas courts have long interpreted contractual duties to defend."

In conclusion, the court acknowledged that the Fifth Circuit and some Texas courts have applied an exception to the eight-corners rule. Those decisions allowed extrinsic evidence on coverage issues that do not overlap with the merits of the underlying case in situations where the petition states a claim that could trigger the duty to defend, but the petition is silent on facts necessary to determine coverage. The court expressed no opinion on that practice, given the narrow question before it, but nonetheless stated that it was reserving comment on whether other policy language or other factual scenarios may justify the use of extrinsic evidence to determine whether an insurer must defend a lawsuit against its insured.

The court reiterated that it was answering only the question before it and determined that the mere absence of a "groundless, false or fraudulent" clause in an insurance policy does not present a permissible exception to the eight-corners rule.

The case is *Richards v. State Farm Lloyd's*, No. 19-0802 (Tex. March 20, 2020).

California Supreme Court: Vertical Exhaustion Applies in Continuous Injury Cases with Multiple Layers of Excess Insurance Over Multiple Policy Periods

The California Supreme Court has ruled that where a continuous injury triggers multiple layers of excess insurance over multiple policy periods, an insured can seek indemnification from upper layer excess policies after the exhaustion of directly underlying excess policies from the same policy period. The court reversed a 2017 decision of the California Court of Appeal, which held that excess policies were only triggered once all underlying excess policies from all relevant policy periods had exhausted.

Prior Case History

This case involved environmental claims arising out of Montrose Chemical Corporation's production of DDT at a Los Angeles area facility from 1947 to 1982. Montrose had purchased primary and excess comprehensive general liability insurance to cover its facility from 1961 to 1985. Following a series of partial consent decrees to resolve underlying claims, Montrose sought indemnification from its primary and excess insurers. The dispute dates back to the 1990s, and includes prior decisions by the California Supreme Court in 1993 and 1995.

The issue on appeal "concerns the sequence in which Montrose may access the excess insurance policies covering this period." The trial court below granted the insurers' motion requiring horizontal exhaustion of excess policies across all relevant policy periods. The Court of Appeal affirmed the trial court in part in 2017.

Horizontal vs. Vertical Exhaustion

The California Supreme Court decision centers on exhaustion between different layers of excess insurance. The court explicitly states that it "does not decide when or whether an insured

may access excess policies before all primary insurance covering all relevant policy periods has been exhausted."

In determining that vertical exhaustion was appropriate, the court looked to the language of the policies' "other insurance" clauses. The insurers argued that the "other insurance" clauses should be interpreted to require the exhaustion of all underlying other insurance, including from other policy periods. The court determined that while that argument was not unreasonable, it was not the only reasonable interpretation, noting that that none of the "other insurance" clauses explicitly required exhaustion of insurance with lower attachment points "purchased for different policy periods."

The court further explained that "other insurance" clauses were historically designed to prevent multiple recoveries for the same injury, not "dictating a particular exhaustion rule for policyholders seeking to access successive excess insurance policies in cases of longtail injury." It therefore rejected the insurers' arguments that the clauses were "a clear and explicit direction" to adopt horizontal exhaustion.

The Supreme Court also addressed the public-policy implications of horizontal exhaustion. The court pointed to one policy that provided for an "Underlying Insurance Limit of Liability" of $30 million. The court calculated that under horizontal exhaustion, "such a rule would increase the operative attachment point . . . to upwards of $750 million." The court also pointed to the practice of maintaining schedules of underlying insurance, "all for the same policy period," as more evidence the clauses could be read to apply to the specific policy period.

The court further justified vertical exhaustion in "[c]onsideration of the parties' reasonable expectations." The court rejected the insurers' argument that horizontal exhaustion was simple to apply, saying the Montrose policies came in "all shapes and sizes." Given the variability of policy

terms and exclusions, horizontal exhaustion, according to the court, would "create significant practical obstacles to securing indemnification."

The court also rejected the insurers' argument that vertical exhaustion conflicts with the court's recent adoption of the all-sums-with-stacking rule by "artificially break[ing] the long-tail injury into distinct periods." The court instead found that vertical exhaustion merely "relieves the insured of the obligation of establishing whether all of the applicable terms and conditions at any given "layer" of excess coverage are met before it accesses the next layer of coverage."

Equitable Contribution

Responding to arguments that vertical exhaustion is unfair to the selected insurers, the court said that the decision "does not alter the usual rules of equitable contribution between insurers" and that the "administrative task of spreading loss among insurers is one that must be borne by the insurers instead of the insured."

This case is *Montrose Chem. Corp. v. Superior Ct.*, S244737 (Cal. Apr. 6, 2020).

Tanning Salon Is Entitled to Defense in Privacy Suit Over Disclosure of Customer's Fingerprints, Illinois Appellate Court Holds

The Illinois Appellate Court found that an insurer had a duty to defend an insured tanning salon who was sued for violating a customer's statutory rights to privacy by disclosing her fingerprints to a third party without her consent.

The Case

In April 2016, Klaudia Sekura filed a proposed class action complaint against Krishna Schaumburg Tan, Inc., alleging in part that Krishna had violated her rights and the rights of those similarly situated under Illinois' Biometric Information Privacy Act. According the complaint,

Krishna, a tanning salon, requires members to have their fingerprints scanned for purposes of verifying their identification. Sekura alleged that she was never provided with, nor signed, a written release allowing Krishna to disclose her biometric data to any third party. Sekura alleged that Krishna violated the Biometric Information Privacy Act by, among other things, disclosing her fingerprint data to an out-of-state third-party vendor without her consent. Sekura brought claims for violation of the Act, unjust enrichment, and negligence.

Krishna sought coverage from West Bend Mutual Insurance Company. West Bend agreed to defend Krishna under a reservation of rights and then filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify Krishna.

The relevant policies defined "personal injury" as "injury, other than 'bodily injury,' arising out of one or more of the following offenses: . . . d. Oral or written publication of material that slanders or libels a person or organization . . .; or e. Oral or written publication of material that violates a person's right of privacy."

The policies also included an exclusion entitled "EXCLUSION - VIOLATION OF STATUTES THAT GOVERN E-MAILS, FAX, PHONE CALLS OR OTHER METHOD OF SENDING MATERIAL OR INFORMATION." This exclusion said that coverage under the policy did not apply to (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; and (3) any statute, ordinance or regulation, other than the TCPA or CAN-SPAM Act of 2003, that prohibits or limits the sending, transmitting, communicating or distribution of material or information.

The parties filed cross-motions for summary judgment. The circuit court found that Sekura's claims fell within the policies' coverage for "personal injury" as a "publication which

violates a person's right to privacy." The court furthered noted that the exclusion did not preclude coverage. West Bend appealed.

The Decision

The appellate court affirmed. The court rejected West Bend's argument that, under Illinois law, "publication" requires communication of information to the public at large. The court found that common understandings and dictionary definitions of "publication" clearly include both the broad sharing of information to multiple recipients and a more limited sharing of information with a single third-party. The court noted that if West Bend wished the term "publication" to be limited to communications of information to a large number of people, it could have explicitly defined it as such in its policy.

The court also rejected West Bend's argument that, even if Sekura's allegations came within the "personal injury" provision of the policies, coverage was barred by the violation of statutes exclusion. The court found that the exclusion was meant to bar coverage for the violation of a very limited type of statute – that is, statutes that govern certain *methods* of communication. The Biometric Information Privacy Act, the court noted, says nothing about methods of communication. Rather, the court found, the statute regulates "the collection, use, safeguarding, handling, storage, retention, and destruction of biometric identifiers and information." Accordingly, the court found that the exclusion did not apply to bar coverage.

The case is *West Bend Mut. Ins. Co. v. Krishna Schaumburg Tan, Inc*., No. 1-19-1834 (March 20, 2020).

Ninth Circuit: No Coverage for Negligent Misrepresentation Claim Involving Aircraft Purchase in Absence of Allegations Involving Property Damage or an Occurrence

The Ninth Circuit, applying Arizona law, found no coverage for a negligent misrepresentation claim involving the purchase of an aircraft.

The Case

In January 2005, 757BD purchased an aircraft with the assistance of National Union's insured, Aero Jet. Aero Jet was allegedly involved in pre-purchase negotiations and inspection of the aircraft, and later entered into a Management Services Agreement with 757BD relating to the aircraft on January 21. Aero Jet was insured by National Union under a Gold Medallion Comprehensive Business Aircraft Policy for two successive periods from January 30, 2005 to April 30, 2006 and from April 30, 2006 through April 30, 2007.

In November 2005, Aero Jet discovered "bubbling paint" on the wings of the aircraft and other evidence of corrosion. A metallurgist expert investigated the cause and concluded that the likely cause was exposure to chloride-based paint stripper when the aircraft was repainted in 2002 by Duncan Aviation. The aircraft was out of service for some time and 757BD spent a substantial sum of money repairing the plane.

757BD then sued the seller of the aircraft, Duncan Aviation, Aero Jet, and others. The complaint alleged claims against Aero Jet for breach of fiduciary duty and negligent misrepresentation in connection with the purchase of the aircraft, claiming Aero Jet knew or should have known of the true condition, but represented the aircraft was in normal working condition.

Aero Jet sought coverage from National Union. National Union denied liability coverage and refused to defend.

Aero Jet and 757BD entered into a stipulated judgment on the claims for breach of fiduciary duty and negligent misrepresentation. Aero Jet and 757BD then entered into a agreement, in which Aero Jet assigned all of its rights against National Union to 757BD. 757BD sued National Union. The district court found that coverage was not available under the National Union policies because there was no property damage caused by an occurrence during the policy period.

The Ninth Circuit's Decision

The Ninth Circuit affirmed.

Applying Arizona law, the court reasoned that, as to the counts for breach of fiduciary duty and Claim IX for negligent misrepresentation, the complaint alleged that 757BD had suffered monetary damage from its reliance on Aero Jet's inspection of the aircraft prior to purchase and from Aero Jet's alleged failure to discover/turn over all relevant maintenance records pertaining to the aircraft. The court reasoned that this type of economic loss did not allege "property damage" under the policies.

The court further held that, even if there were "property damage" within the meaning of the policy, there was no "occurrence" within the policy period. The court cited Arizona cases which concluded that misrepresentations – negligent or intentional – do not qualify as "accidents" or "occurrences." The court noted that all of the allegations against Aero Jet related to the purchase of the aircraft, which occurred before the first policy period incepted. Therefore, the court agreed with the district court that even if damage caused by the alleged misrepresentation

and breach of fiduciary duty constituted "property damage," that damage occurred before the policy's effective date, and thus, there could be no coverage.

The case is *757BD, LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 18-16760 (9th Cir. Mar. 9, 2020).

The Sixth Circuit, Applying Kentucky Law, Adopts Continuous Trigger of Coverage for Malicious Prosecution Claims

In an unpublished decision, the Sixth Circuit, applying Kentucky law, adopted a continuous trigger of coverage for malicious prosecution claims under a law-enforcement liability policy provision.

The Case

After serving twenty-eight years of his seventy-year sentence for murder, William Virgil was released from prison and granted a new trial on the strength of new DNA evidence. The charges against him were subsequently dismissed. Virgil sued the City of Newport, Kentucky, and various police officers under 42 U.S.C. § 1983, alleging, among other claims, malicious prosecution. The City's insurers brought a declaratory judgment action in a Kentucky federal court seeking a ruling that that they had no duty to defend or indemnify the City and its officers from Virgil's lawsuit.

From July 2007 to July 2010, the City was insured via three, one-year insurance policies, each of which included an identical law-enforcement liability (LEL) provision. The LEL provision provided coverage for "amounts any protected person is legally required to pay as damages for covered injury or damage that:

- results from law enforcement activities or operations by or for you;
- happens while this agreement is in effect; and

• is caused by a wrongful act that is committed while conducting law enforcement operations."

The policies then defined "injury or damage" as "bodily injury, personal injury, or property damage." The policies defined "personal injury" means any "injury, other than bodily injury, caused by any of the following wrongful acts [, including] . . . [m]alicious prosecution."

The parties cross-moved for summary judgment. The district court granted the insurer's motion.

The Decision

The Sixth Circuit reversed. Applying Kentucky law, the court held that the insurer must defend any claim in which covered injuries occurred while the policies were in effect regardless of when the wrongful causal act occurred.

The court first noted that the policies applied an injury-based trigger of coverage, not an act-based trigger. In reaching this conclusion, the court pointed to the fact that the temporal requirement in the policy – that the injury or damage happen while the agreement is in effect, only applied to injury. By contrast, the court noted, the LEL provisions' other requirements – that the injury result from the insured's law enforcement activities and be caused by a wrongful act committed while conducting law enforcement operations – did not have a temporal limitation.

The court then analyzed Virgil's alleged injuries. The court noted that Virgil was not alleging a malicious prosecution injury, but rather a malicious prosecution claim. The court observed that the alleged injuries were the various harms that were caused by or flowed from the wrongful act. The court noted that LEL provisions expressly covered injuries "caused by" the wrongful act; here, that is malicious prosecution. Therefore, the court reasoned, the malicious prosecution could not be the injury. Rather, the court held that the common understanding of

injury was consistent with the City's argument that the injury was Virgil's loss of personal liberty and attendant emotional pain and suffering.

The court expressly disagreed with an Illinois decision*, St. Paul Fire and Marine Insurance Co. v. City of Zion*, 2014 IL App (2d) 131312, 385 Ill. Dec. 193, 18 N.E.3d 193 (Ill. App. Ct. 2014), which held that a malicious prosecution claims trigger coverage under policies in effect only at the initiation of the prosecution. *Zion* had held that the favorable termination of the prosecution could not be the occurrence that triggers coverage because the termination marks the beginning of the judicial system's remediation of a wrong, not an injury.

The Sixth Circuit agreed with *Zion* that a covered injury does not happen upon exoneration, but it disagreed with *Zion*'s presentation of the injury as "dichotomy: either the injury occurs at the time of the commencement of the prosecution or upon exoneration." The court held that nothing in the policies required that binary choice.

First, the court reasoned the policies feature an injury-based trigger of coverage, not an act-based trigger. To find that the injuries caused by the malicious prosecution only arise when the malicious prosecution begins came close to rewriting the policies as containing an act-based trigger.

Second, the court noted that other sections of the LEL provisions showed that the insurer knew how to achieve the result it was arguing for in the case. The court cited language in the policies that stated that some forms of property damage are considered "to happen at the time of the wrongful act that caused it." The court held that the inclusion of such language with respect to property damage, but not personal injury damage, weighed in favor of a ruling that a malicious prosecution claim could cause harm or loss after the prosecution began but before exoneration.

The court held that Virgil's injuries were caused by malicious prosecution and were continuous, that is, they happened repeatedly during the relevant coverage period. The court therefore reversed the district court's grant of summary judgment to the insurers.

The case is *St. Paul Guardian Ins. Co. v. City of Newport*, No. 19-5948 (6th Cir. Mar. 30, 2020) (unpublished). *See* Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. *See also* U.S. Ct. App. 6th Cir. Rule 32.1.

Ninth Circuit Rules that Liability Risk Retention Act of 1986 Pre-Empted Washington State's Anti-Arbitration Statute as to Risk Retention Groups Chartered Out-of-State

On a certified question of law, the Ninth Circuit held that Washington's anti-arbitration statute was preempted by the Liability Risk Retention Act of 1986 ("LRRA") as it applies to risk retention groups chartered in another state.

The Case

Allied Professionals Insurance Company ("APIC") was a risk retention group chartered in Arizona and doing business in Washington. APIC insured Dr. Michael Scott Anglesey, a chiropractor in Washington. In December 2012, Dr. Anglesey provided chiropractic treatment to Mr. Eliseo Gutierrez, which allegedly resulted in Mr. Gutierrez suffering a stroke. A few months later, Dr. Anglesey renewed his coverage with APIC but did not inform the company of the potential malpractice claim against him by Mr. and Mrs. Gutierrez. When Dr. Anglesey later notified APIC of this potential claim, the company advised him that it was denying coverage and rescinding his 2012 and 2013 insurance policies.

Dr. Anglesey subsequently informed APIC that he was planning to execute a consent judgment in favor of Mr. and Mrs. Gutierrez and to assign his rights against APIC to them. They

had agreed to seek satisfaction on the judgment from APIC and not from Dr. Anglesey. APIC demanded that all claims against APIC be sent to arbitration, pursuant to an arbitration clause in the underlying policies. Dr. Anglesey refused, and APIC sued Dr. Anglesey and Mr. and Mrs. Gutierrez to seek rescission of the policy and declaratory relief and to compel arbitration of those claims.

The district court granted APIC's motion to compel arbitration, stayed the proceedings, and certified a question of law to the Ninth Circuit: whether the LRRA preempts Wash. Rev. Code § 48.18.200(1)(b) as applied to risk retention groups?

The Decision

The Ninth Circuit held that the Washington's anti-arbitration statute was preempted by the LRRA as it applies to risk retention groups chartered in another state.

The court described the "tripartite" regulatory scheme for risk retention groups under the LRRA and Product Liability Risk Retention Act of 1981 ("PLRRA"). The court noted that the LRRA and PLRRA (1) preempt state laws regulating the operation of risk retention group; (2) authorize the chartering state to regulate the groups' formation and operation; and (3) limit the secondary regulatory authority of nondomiciliary states over risk retention groups.

The court noted that the LRRA was passed by Congress to support a struggling insurance market by eliminating the need for compliance with numerous non-chartering state statutes that would otherwise thwart the interstate operation of risk retention groups. The court observed that the LRRA is an exception to the McCarran-Ferguson Act's preference for state regulation of insurance.

The court rejected the Defendants' contention that the LRRA was only designed to keep states from treating risk retention groups differently than other insurance companies. The court

noted that the LRRA's preemption provision is broadly worded and has been held to apply to any state statute which "places a restriction on risk retention groups that is not required by the LRRA or by all other states." The court concluded that Washington's anti-arbitration statute regulates the operation of a risk retention group. The court held that allowing a state such as Washington for force foreign risk retention groups to alter their contract would undermine the goal of the LRRA.

The case is *Allied Prof'ls Ins. Co. v. Anglesey*, No. 18-56513 (9th Cir. Mar. 12, 2020).

QUICK NOTES:

In our September 2019 update, we reported on the Texas Court of Appeals' decision in *StarNet Ins. Co. v. RiceTec, Inc.,* No. 01-18-00536-CV (Aug. 27, 2019). Reversing the trial court, the intermediate appellate court ruled that an aerial herbicide-spraying exclusion contained in an endorsement negated an insurer's duty to defend a lawsuit against the insured for damages caused by spraying performed on the insured's behalf. Earlier this month, the Texas Supreme Court denied the policyholder's petition for review. *RiceTec Inc. v. StarNet Ins. Co*., No. 19-0927 (Tex. April 3, 2020).

In our November 2019 update, we discussed *Princeton Excess and Surplus Lines Ins. Co. v. Hub City Enterprises, Inc.*, No: 6:18-cv-1608-Orl-41GJK (M.D. Fla. Oct. 3, 2019), which involved an extra-large inflatable beach ball that was passed around the crowd at Rum Fest 2017. One attendee was injured when he attempted to push the ball away from himself. A Florida federal district court ruled that the promoter's insurer did not need to defend the suit based on the amusement device exclusion. The Eleventh Circuit recently affirmed, finding that the inflatable beach ball was being used as an amusement device because it was being "struck," or "pushed" by

the Rum Fest attendees. *Princeton Excess & Surplus Lines Ins. Co. v. Hub City Enterprises, Inc.*, No. 19-14193 (11th Cir. March 30, 2020).

In *Liberty Mut. Ins. Co. v. Estate of Bobzien*, a man sued his father's estate alleging that childhood exposure to his father's cigarette smoke caused the development of lung disease and other illnesses. In support of its claim for coverage, the estate argued that the disease and illness was an unintended result of the father's smoking habit, and therefore, was an "accident." Despite the exposure having occurred decades before any policy period, the estate contended that its claim was covered because the illness developed within the policy period. Affirming the district court, the Sixth Circuit ruled that there was no "occurrence" because the exposure to secondhand smoke happened outside the policy period and nothing alleged in the complaint constituted an "accident" resulting in "bodily injury." The court also found that the policies' household exclusion applied. *Liberty Mut. Ins. Co. v. Estate of Bobzien,* No. 19-5457 (6th Cir. March 27, 2020).

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