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April 2024 | Insurance Update | WWW.RIVKINRADLER.COM

North Carolina Supreme Court Hands Down Decisions on UIM Stacking, Workers' Comp Benefits, and a DPPA Claim

On March 22, 2024, the North Carolina Supreme Court decided three insurance cases worth noting.

UIM Stacking: *North Carolina Farm Bureau Mut. Ins. Co., Inc. v. Hebert*, No. 281A22

Departing from intermediate appellate court precedent since 1990, the North Carolina Supreme Court held that the owner of vehicle – who was a passenger and not the driver – could not combine the underinsured motorist (UIM) limits of his auto policy and his parents' auto policy to qualify for underinsurance benefits.

Under North Carolina's motor vehicle law, a vehicle is underinsured if the liability limits in the tortfeasor's auto policy is less than the UIM limits in the claimant's policy.

Hebert owned a Chevy Malibu that was involved in a serious accident injuring five people. Hebert was a passenger in the car, along with two others. His friend Corbett was driving.

Hebert had an auto policy in his name that insured the Chevy. The policy had matching liability and UIM limits: $50,000 per person, $100,000 per accident. For purposes of the UIM coverage, the Chevy was the at-fault vehicle and Corbett, not Hebert was the tortfeasor.

Hebert also qualified as an insured under his parents' auto policy with the same insurer. His parents' policy had UIM limits of $100,000 per person and $300,000 per accident. This policy, however, did not insure the Chevy.

The insurer paid the $100,000 per accident liability limits under Hebert's policy, which was paid mostly to the passengers. Hebert received $100 from the liability limits of his own policy, plus $99,900 in UIM benefits from his parents' policy, for a total recovery of $100,000.

Hebert requested the $50,000 in UIM benefits under his own policy. The insurer refused because the Chevy, as the at-fault vehicle, did not qualify as an underinsured vehicle. The dispute was litigated and both the trial and intermediate appellate courts ruled for Hebert. Applying the "stack and compare" rule, the courts allowed Hebert to stack his own policy's UIM limits with his parents' policy's UIM limits before comparison to the liability limits in Hebert's own policy ($150,000 UIM versus $50,000 liability).

The North Carolina Supreme Court ruled that this was an error, and that stacking was not permitted. The court explained that North Carolina's motor vehicle law only allows stacking of limits for policies on vehicles involved in the accident. "If an insured's UIM policy is not 'for' the vehicle involved in the accident and insured under the owner's policy, it is outside the scope of consideration when determining whether the at-fault vehicle is an underinsured highway vehicle." Thus, the UIM limits in Hebert's parents' policy could not be considered when determining whether Hebert's Chevy was underinsured.

The court noted that for thirty years, North Carolina intermediate appellate courts have allowed stacking of all available UIM limits, but that was based on an incorrect interpretation of "limits." The court said "limits" refers to the per-person and per-accident limits under a single policy, not limits from multiple policies. The North Carolina Supreme Court explained that the motor vehicle law only permits comparison of the liability limits of the at-fault vehicle with the UIM limits for the vehicle involved in the accident and insured under the owner's policy. Unlike most UIM situations, Hebert's Chevy was both the at-fault vehicle and the vehicle through which

Hebert (as an innocent injured passenger) sought UIM recovery. Because the liability limits in Hebert's auto policy insuring the Chevy was not less than the UIM limits (they were the same), the Chevy did not qualify as an underinsured vehicle.

Note: The North Carolina General Assembly recently amended the definition of "underinsured highway vehicle," which takes effect on January 1, 2025. The North Carolina Supreme Court said that it took no position on the interpretation of the amended statute.

Workers' Compensation: *Kluttz-Ellison v. Noah's Playloft Preschool*, No. 173PA22

The North Carolina Supreme Court for the first time formally endorsed the "directly related" test to determine whether workers' compensation benefits apply.

The director of a preschool needed knee surgery after falling from a ladder while changing a light bulb at the preschool. The director previously had a total knee replacement, and the fall loosened some hardware. But her physicians would not operate unless she lost weight. They referred her for bariatric surgery. The issue was whether the preschool's workers' compensation insurer had to pay for the weight loss surgery.

The state Industrial Commission and the North Carolina Court of Appeals said the insurer had to pay.

But the North Carolina Supreme Court ruled that the commission and appeals court failed to properly apply the "directly related" test. The commission looked only to whether the bariatric surgery was medically necessary. And the appeals court considered just the treatment rather than the condition.

Under the "directly related" test, an employee can be compensated only for treatment that has a strong causal connection to the employee's workplace injury. This test requires a showing that the condition for which treatment is sought: (1) was caused by the workplace injury; (2) was

aggravated by the workplace injury; or (3) did not require medical treatment or intervention of any kind before the workplace injury but now requires treatment solely to remedy the workplace injury.

If any of these criteria are met, the treatment is directly related to the workplace injury and is compensable. If not, the treatment is, at most, indirectly related to the workplace injury and not compensable.

An employee can satisfy the test by showing, for example, the workplace injury "materially accelerated" the condition requiring treatment. But the employee must show that "the condition did not require medical treatment or intervention of any kind before the workplace injury but now requires treatment to aid in treatment of the workplace injury."

The court said without a strong causal connection between the workplace injury and the preexisting condition, "workers' compensation would too easily transform into general health insurance, forcing employers to cover treatments for medical conditions with no connection to the workplace injury." Workers' compensation insurance is not health insurance.

The court remanded the case to the Industrial Commission with instructions to apply the "directly related" test.

DPPA: *North Carolina Farm Bureau Mut. Ins. Co., Inc v. Lanier Law Grp.*, No. 235PA21

We previously wrote about North Carolina's Driver Privacy Protection Act (DPPA), which restricts disclosure of personal information in connection with motor vehicle records. Here's an update.

Personal injury attorneys were sued in a putative class action suit for allegedly obtaining and using drivers' personal information from accident reports to advertise legal services in

violation of the DPPA. They ultimately defeated the suits because they used information from law enforcement reports, not motor vehicle records, and thus could not be sued under the DPPA.

The coverage dispute centered on whether a law firm's insurer had to defend the firm in these suits under the personal and advertising injury coverage. The insurer argued that an exclusion for willful violation of a penal statute applied, and the North Carolina Court of Appeals agreed. The court held that an alleged "knowing" violation was the same as a "willful" violation.

The case went up to the North Carolina Supreme Court. One justice did not participate and the six remaining were deadlocked at 3-3. So, the insurer preserved the victory, but the intermediate appellate court decision will have no precedential value.

Colorado Supreme Court Finds That Notice-Prejudice Rule Applies to First-Party Policies

The Colorado Supreme Court for the first time extended the notice-prejudice rule to first-party homeowners property insurance policies. The rule had been applied in the context of uninsured/underinsured motorist coverage and third-party occurrence policies. The court found that the same policy concerns apply to first-party policies too.

Under the notice-prejudice rule, an insurer must show it was prejudiced by the insured's untimely notice of a claim before it can deny coverage for late notice. The rule does not apply to claims-made policies where notice is an essential term of the policy. Courts apply the notice-prejudice rule where timely notice is a condition to maintaining coverage.

There were two first-party cases on appeal to the Colorado Supreme Court, both involving hail damage.

One policyholder, Gregory, submitted her claim five months after the one-year notice period expired. She claimed to have just learned that a hailstorm damaged her roof 18-months earlier when a contractor, who inspected her home as she was preparing to sell it, informed her of the damage. The other policyholders, the Runkels, also didn't discover the roof damage until a year later when informed by their contractor. They filed a claim ten days after the one-year notice period.

The insurers denied coverage in each case for late notice, and those denials were upheld by the trial and intermediate appellate courts. The Colorado Supreme Court reversed, finding that three policy concerns for departing from the "traditional" approach applied to these homeowner claims as well. Those concerns are: (1) the adhesive nature of insurance contracts, (2) the public's interest in compensating tort victims, and (3) the inequity of allowing an insurer to receive a windfall from a technicality. The court acknowledged that the policyholders here were not tort victims, but said that similar concerns applied because they sustained losses through no fault of their own.

The Colorado Supreme Court instructed that late notice claims under first-party occurrence-based homeowners' policies must follow a two-step approach.

First, a court must consider whether notice was timely or whether the policyholder had a reasonable excuse for any delayed notice. Second, if notice was untimely and delay was unreasonable, then the court must decide whether the insurer was prejudiced by the late notice. The insurer has the burden to prove that it was prejudiced.

As a result, the court remanded Gregory's suit to give the insurer a chance to establish prejudice. It remanded the Runkels' suit to determine whether the delayed notice was unreasonable.

Three justices dissented, suggesting that the majority's extension of the notice-prejudice rule misunderstands the insurance market and favors abstract public policy over the freedom of contract.

The cases are *Gregory v. Safeco Ins. Co. of America*, No. 2022SC399, and *Runkel v. Owners Ins. Co*., No. 2022SC563, decided March 11, 2024.

Fifth Circuit Holds That Coverage Dispute Over Hurricane Damage Must Be Arbitrated Despite Louisiana's General Prohibition

Bufkin, whose apartment complex was damaged by Hurricane Laura, held a surplus lines insurance policy issued by eight US-based insurers and two foreign insurers. An endorsement said that the policy was to be treated as separate contracts between Bufkin and each insurer. The policy also had an arbitration clause that called for the application of New York law.

Bufkin felt its insurers were too slow in paying its claim and sued the US-based insurers in Louisiana state court. Bufkin later amended its complaint to add the two foreign insurers, but only so that it could dismiss them with prejudice from the suit.

The domestic insurers removed the case to federal court and then moved to compel arbitration under the Federal Arbitration Act (FAA) and the Convention on the Recognition and Enforcement of Arbitral Awards (the Convention). In short, the Convention is a treaty that compels enforcement of written arbitration agreements between citizens of signatory countries. For it to apply here, one party to the insurance contract could not be an American citizen.

Bufkin sought to keep the case in court, arguing that Louisiana's anti-arbitration statute reverse preempted the FAA under the McCarran-Ferguson Act. McCarran-Ferguson leaves insurance regulation to the states unless the federal statute specifically relates to the business of

insurance. The FAA is not specific to insurance. McCarran-Ferguson does not apply to treaties, but Bufkin argued that the Convention did not apply because its suit named only the domestic insurers that participated in the surplus lines policy.

The district court sided with Bufkin, but the Fifth Circuit reversed.

The issue centered on whether there was one insurance contract to which all the insurers were parties, or ten separate contracts. If separate, then the contracts with the domestic insurers would not fall under the Convention. But the domestic insurers argued that even so, arbitration must be compelled under the doctrine of equitable estoppel.

This doctrine allows a non-signatory to a contract with an arbitration clause to compel arbitration with a signatory if the signatory has alleged interdependent and concerted misconduct. The insurers argued that Bufkin's amended petition alleged that the foreign and domestic insurers engaged in the same conduct and that Bufkin's proof of loss ascribed a common course of conduct to the insurers as a group.

The Fifth Circuit agreed with the insurers, finding that Bufkin had alleged substantially interdependent and concerted conduct. Bufkin's amended petition did not differentiate between the domestic and foreign insurers, nor did it suggest that the insurers' conduct was separate from each other. Instead, Bufkin alleged that the insurers collectively engaged in the same conduct.

The Fifth Circuit said the district court was not free to disregard the foreign insurers in considering the domestic insurers' motion to compel arbitration. It held that equitable estoppel was appropriate to compel arbitration under the Convention, even though Bufkin was no longer pursuing claims against the foreign insurers.

The case is *Bufkin Enters., L.L.C. v. Indian Harbor Ins. Co.*, No. 23-30171 (5th Cir. Mar. 4, 2024).

Fourth Circuit Upholds Rescission of Professional Liability Policy Due to Material Misstatement in Policy Application

Former patients of Pediatric Partners for Attention and Learning sued the clinic and its founder after learning that the state's inhouse psychologist, Avery, was not actually a psychologist at all.

Avery was hired as an educational advocate, a position that did not require a license. Avery later told the founder that she completed her Ph.D. in general psychology and would soon be earning a Psy.D. in clinical psychology. It was a fabrication. Avery never enrolled in a Ph.D. or Psy.D program and did not even have a college degree. But the founder believed Avery and promoted her to Director of Cognitive and Instruction.

Avery was asked to produce her license. She managed to dodge that a few times and produced fake diplomas instead, which satisfied the founder. She was allowed to administer cognitive testing to the clinic's patients while holding herself out as a psychologist. Avery would later be allowed to provide therapy services to patients.

In 2014, the Virginia Department of Health Professions (VDHP) investigated a complaint that Avery was practicing psychology without a license and spoke with the founder about it. The VDHP closed the matter as "undetermined." Avery continued to find excuses when the founder asked for her license.

In 2017, while Avery was working part-time at the clinic (she was secretly transferring her therapy patients to her side job), the founder applied for professional liability insurance. The founder represented in the insurance application that none of her employees had been the subject of disciplinary investigations or proceedings, despite knowing about the 2014 VDHP investigation. Certain employees of the clinic also needed to complete applications. Through the

clinic's insurance agent, the founder was told that part-time unlicensed employees need not submit separate applications. Avery was not listed as an employee on the application.

Based on the information submitted, the insurer issued the professional liability policy to the clinic. The clinic later terminated Avery's employment, not for fraud but unavailability. Avery was arrested in 2019 and later convicted.

Patients then sued the clinic and its founder. The clinic sought a defense under its professional liability policy.

The insurer filed a declaratory judgment action seeking to rescind the policy because of the founder's material misstatement in her insurance application (that none of her employees had been the subject of disciplinary investigations or proceedings). The district court found this was a material misstatement and awarded the insurer summary judgment.

The Fourth Circuit affirmed. The patients were party to the action and argued that there was a question over whether the founder subjectively knew her misstatement was false. The Fourth Circuit said it did not matter. "Under Virginia law, unless an insured qualified her statements as being to the best of her knowledge, or with some similar limitation, 'clear proof of mere falsity of the statements [is] sufficient.'" The founder did not qualify her statement but certified that it was true. The insurer therefore did not have to show that the founder knew her representation was false.

The patients also argued that the founder's representation was not a misstatement because the term "disciplinary investigative proceedings" was ambiguous as to whether it included the VDHP's investigation of Avery. The patients argued that "proceeding" should be narrowly construed to mean legal administrative actions or hearings. But the Fourth Circuit said that the

words surrounding the term “proceeding” must also be considered and found that “disciplinary investigative proceedings” was not meant to be limited to formal hearings.

The court next found that the misrepresentation was material. The insurer’s underwriters attested that had the founder disclosed the VDHP’s investigation, they would not have issued the policy. The patients’ argued that the founder’s statement was immaterial because the insurer renewed the policy after learning of claims against the founder. The court rejected this argument, noting that while the insurer renewed the policy after paying expenses related to complaints against the founder, it did so at a higher premium.

For these reasons, the court upheld the district court’s order allowing the insurer to rescind the policy.

The case is *Medical Mut. Ins. Co. v. Gnik*, No. 22-1994 (4th Cir. Feb. 16, 2024).

California Federal District Court Finds Breach of Contract Claim Arising from Spoofing Loss Was a Potentially Covered Wrongful Act Under D&O Endorsement

A property owners association fell victim to a spoofing scam when its treasurer wired money to an imposter, believing it was paying a paving contractor. The paving contractor demanded payment and filed a mechanics lien on the property. A subcontractor filed a similar lien and later sued for breach of contract.

The association tendered the claim to its insurer under its policy’s Directors and Officers Liability Endorsement, which provided liability coverage for the wrongful acts of the association’s directors and officers. The insurer denied any duty to defend or indemnify because the claim was not based on a wrongful act of an officer, but a failure to pay a debt owed under a contract.

The association sued its insurer in federal court in California, and the insured moved to dismiss. The district court denied the insurer's motion.

The court found that the paving contractor's breach of contract claim was not "necessarily disqualified" from coverage. The policy didn't have an exclusion for contractual violations. And the association provided the insurer with extrinsic facts that suggested a potential for coverage based on the treasurer's negligence in wiring the money to the imposter's bank account. The court pointed to emails showing the deception that led to the treasurer's payment error and the treasurer's failure to contact the paving contractor to confirm the wiring instructions before transferring funds.

The court found this extrinsic evidence created a potential for coverage because it suggests that the treasurer committed a "wrongful act" when he sent the money to the wrong bank account. That mistake, the court reasoned, gave rise to the paver's breach of contract claim. If not for the treasurer's error, the paver's payment would not have been misdirected into the imposter's account.

The insurer cited California caselaw that holds an insured's failure to pay amounts due under a contract does not qualify as a "wrongful act." But the court distinguished those cases, finding that the association was not trying to pass on its contractual obligations to its insurer. Instead, it failed to pay – and suffered a loss – because of the imposter's deception.

The court ruled that the claimed loss potentially fell within the basic scope of coverage.

Most cases involving similar spoofing scams consider coverage under the computer fraud provisions of commercial crime policies. This case is unique because it concerns a D&O policy.

The case is *Bridlewood Ests. Prop. Owners Ass'n v. State Farm Gen. Ins. Co*., No.: 23-cv-00195-AJB-AHG (S.D. Cal. Mar. 18, 2024).

New Hampshire Federal Court Finds No Duty to Defend Class Action Suit Describing Negative Health Effects from CPAP Machines but Seeking Only Economic Loss

SoClean manufactures air purifiers and accessories for sleep equipment. It was sued in a class action for not disclosing the risk of ozone exposure from its continuous positive airway pressure (CPAP) sanitizing machine. Plaintiffs alleged violations of various consumer protection statutes, breach of warranty, negligent misrepresentation, and so on.

The class action plaintiffs at first sought damages for bodily injury but later dropped those claims to increase the chances of class certification. The complaint still alleged facts about negative health effects, pain and suffering, and property damage resulting from using the SoClean machines. But the complaint did not seek damages for that. Instead, it sought damages based on the price of the SoClean machines (that plaintiffs suffered economic injury when they bought the machines).

SoClean sought coverage under its primary and umbrella commercial general liability policies. The policies applied to claims "seeking damages because of 'bodily injury' or 'property damage.'" The insurer sought to get clear of any duty to defend the class action suit and filed a declaratory judgment action in federal court in New Hampshire.

The court surveyed the law to determine the meaning of "because of." It noted cases in the context of opioid litigation, cell phone radiation, consumer statutes, and others, where courts considered whether allegations related to bodily injury in the underlying claims – without any claims for bodily injury damages – constituted damages because of bodily injury. Most of those cases found that damages based on a theory of economic loss, rather than injury to any plaintiff, do not constitute "damages because of bodily injury."

SoClean argued that a demand letter showed counsel's intent to continue pursuing claims for bodily injury and property damage. SoClean argued that the demand letter constituted a "suit," and alternatively, that plaintiffs in the class action suit could still amend the complaint. The letter made a policy limit demand held open for ten days, but that date could be extended if the insurer were to mediate.

The court found that neither the demand letter nor offer to mediate qualified as a "suit" for purposes of coverage. And the duty to defend depends on the current operative pleading, not a hypothetical claim. The court said that potential amendments to the class action complaint might impact coverage in the future, but such potentialities do not impact coverage under the present facts. The court did not need to consider potential future amendments. It only had to consider the operative complaint.

The case is *Liberty Mut. Fire Ins. Co. v. SoClean, Inc.*, No. 22-cv-00079 (D. N.H. Mar. 6, 2024).

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