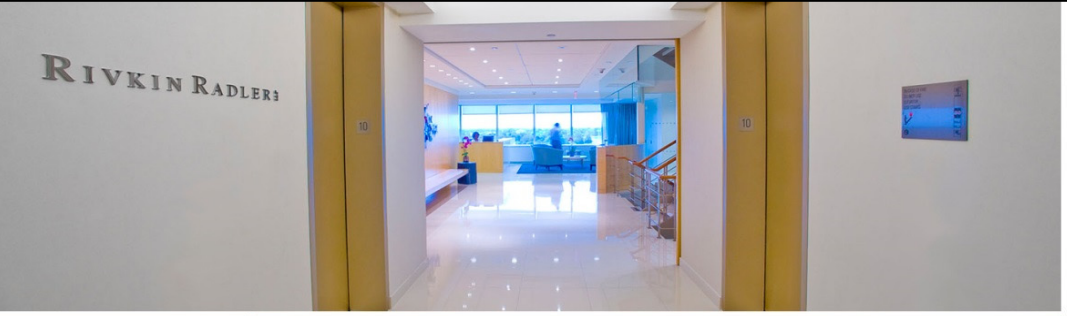

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State High Courts Weigh In on COVID-19 Business Interruption Losses, Side with Insurers

The Supreme Judicial Court of Massachusetts and the Iowa Supreme Court became the first two state high courts to rule on whether pandemic-based business interruption suits are covered. Both courts found that insurers were not responsible to pay because the policies covered only direct damage to property.

The Massachusetts high court recognized that the physical properties of the virus in some sense caused business to be suspended at the three restaurants seeking recovery, but the court found that the suspension was not attributable to a direct physical effect on the plaintiffs' property that can be described as a loss or damage. That the restaurants could continue to provide takeout and other services showed there were no physical effects on the property itself.

The golf club and restaurant challenging the insurers' denials in Iowa conceded that the virus was not present on their properties. They needed to take this position to avoid the policies' virus exclusion. The Iowa high court found that this concession removed any potential physical element to the loss of use of its property.

The Iowa Supreme Court also found that the civil authority coverage was not triggered by the government restrictions. Civil authority coverage, the court explained, requires damage to property causing conditions so dangerous that a civil authority prohibits access to the surrounding properties.

These two state high court decisions are in line with every federal appellate court to rule on the issue.

The cases are *Verveine Corp. v. Strathmore Ins. Co.,* No. SJC-13172 (Mass. Apr. 21, 2022), *Wakonda Club v. Selective Ins. Co.,* No. 21-0374 (Iowa Apr. 22, 2022) and *Jesse's Embers LLC v. Western Agric. Ins. Co.,* No. 21-0623 (Iowa Apr. 22, 2022).

Texas Supreme Court Rules That Insurer Had No Duty to Warn Insured During On-Scene Reporting of Accident

Reversing a full panel ruling by an intermediate appellate court, the Texas Supreme Court, in a case of first impression, held that an auto insurer owed no duty of care to its insured when the insured reported the accident while still at the scene.

The Case

The insured lost control of her vehicle on a wet road, skidded, and struck a guardrail. The vehicle was undrivable, but the insured was not injured. She first called her husband and then her insurance company to report the accident. The insured asked the insurer's call-center representative if she should take pictures of the damage. The representative replied "yes." As the insured continued to provide the representative with information about the incident, another vehicle lost control and struck the insured's husband, who was on the side of the road taking pictures. He was fatally injured.

The insured sued the insurer for negligence, negligent training and licensing, negligent undertakings, and gross negligence. All of the negligence claims asserted that the insurer's call-center employee was negligent in "instructing" the insured to take unnecessary photographs of a single-vehicle accident because it elevated the risk of harm to her husband. Contending that a

"special relationship" existed, the insured alleged that the insurer breached its duty to act as a reasonable and prudent insurance company when it instructed the insureds to take photographs from the scene. And if a duty did not already exist, she alleged that one arose when the call-center employee affirmatively acted to guide her through the post-accident claims process.

The trial court dismissed the negligence and gross negligence claims. The intermediate appellate court at first affirmed, but on rehearing, the en banc panel reversed. The court found the duty of good faith and fair dealing was not conclusively negated because there was some evidence that the insurer instructed the insured to take accident scene pictures. The court felt that had to do with the processing of claims. The court also found that the insurer had assumed a duty by voluntarily undertaking action for the insured's benefit (insurance services and roadside assistance).

The Texas Supreme Court's Decision

The Texas high court reversed. It found that the duty of good faith and fair dealing did not apply to these facts. That duty applies only to "issues of timeliness and 'unscrupulous' conduct in the investigation, processing, and payment of claims." It does not apply to post-accident guidance ensuring an insured's safety.

The court found that the risk of being struck by another vehicle while standing on the side of the road existed no matter what activity was being carried out. The danger was no more or less foreseeable, the court explained, just because photographs were being taken. The court also found that the risk of harm to a third party who was not involved in the initial accident and later arrives on the scene was not reasonably foreseeable to the insurer. And if it were, that risk would have been equally foreseeable to someone in the insured's position. There is no duty to warn about open and obvious conditions.

The court also rejected the insured's negligent undertaking theory. It found that the call-center employee did not affirmatively act to protect the insured from harm nor did the insured rely on the employee's guidance to ensure her safety. And any failure to warn was an omission, not an undertaking.

The court disagreed with the intermediate appellate court's reasoning. It recognized that certain contract benefits such as collision coverage, personal injury protection benefits, and roadside assistance are helpful to insureds, but it failed to see how they are essential protective actions, or how providing them could increase the risk of harm.

The court held that the insurer owed no duty to the insured here and affirmed the trial court's summary judgment ruling for the insurer.

The case is *Elephant Ins. Co. v. Kenyon,* No. 20-0366 (Tex. Apr. 22, 2022).

South Carolina Supreme Court Adopts Post-Loss Exception for Assignment of Insurance Rights

In reversing both the trial and intermediate appellate courts, the South Carolina Supreme Court held that insurer's consent is not required for an assignment of insurance benefits made after a loss has occurred. Critical to the court's ruling is how "loss" is measured.

The Case

Ashley II owned contaminated property. It sued PCS Nitrogen (PCS) in federal court under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) for a declaration that PCS was liable for the remediation. Ashley II claimed that PCS's predecessor, Columbia Nitrogen Corporation (Old CNC) operated a fertilizer plant on the property from 1966

through 1972. PCS denied that it was the corporate successor to Old CNC and filed third-party claims for contribution against Old CNC's parents.

Here's some background. Old CNC sold the property in 1985 to a third party. The next year, it sold its fertilizer assets to CNC Corp. (New CNC). New CNC assumed some of Old CNC's liabilities, including those related to Old CNC's fertilizer business. Old CNC also transferred to New CNC its rights under insurance policies issued to Old CNC from 1966 to 1985. Old CNC dissolved after the transaction was completed. New CNC later merged with a fertilizer company that eventually merged with PCS in 1997.

PCS's effort to escape CERCLA liability fell flat. The federal court found PCS liable and ruled that there was no basis for imputing Old CNC's acts to its parents.

PCS then looked to Old CNC's insurer for defense and indemnity related to its CERCLA liability.

Those policies prohibited assignment of interests without the insurer's consent. Old CNC did not seek the insurer's consent when it transferred its insurance rights to New CNC. The insurer denied coverage on this basis, and PCS sued.

PCS argued that consent was unnecessary because the assignment happened after the loss occurred. The circuit court disagreed. It ruled that the assignment was not post-loss because no judgment had been entered against Old CNC. PCS did not become liable for Old CNC's operations until decades after the assignment. The intermediate appellate court affirmed, and PCS appealed.

The South Carolina Supreme Court's Decision

The South Carolina high court reversed.

First, it formally adopted the post-loss exception, finding that an assignment of insurance rights after a loss has already occurred does not require an insurer's consent. That's because "no

assignment" clauses are meant to protect the insurer from increased liability. After the events creating liability have occurred, the court reasoned, the insurer's risk cannot be increased by a change in the insured's identity. The court also found that such clauses cannot bar an insured from transferring a right to coverage once that right attaches.

Next, it addressed the central issue in the case: when did the loss occur?

PCS argued that the loss was post-assignment because the agreement was executed after the "occurrence" – the discharge of contaminants that resulted in property damage. The insurer argued that even if the discharge were an "occurrence," the *loss* would not have taken place until there was a judgment against the insured or a settlement with the insurer's consent. Only then, would the insurer's obligation to pay the insured become fixed.

The insurer's argument seems to make sense, but the court was not having it. It found that the insurer's coverage obligations arose sooner than that. It recognized that the insurer need not pay proceeds until judgment or settlement, but found that the insurer's coverage obligation arises from the event that leads to the insured's liability. The insured possesses a contingent right to coverage, the court noted, after an occurrence happens. Thus, the court determined that the loss arises at the time of the "occurrence," rather than when judgment is entered.

Because loss occurred before Old CNC executed the assignment in 1986, the South Carolina Supreme Court reversed the lower courts' rulings.

The policies in this case provided that the insurer "will pay on behalf of the insured" sums the insured became legally obligated to pay as damages because of property damage caused by an occurrence. Some liability policies state that they "indemnify" the insured, rather than "pay on behalf of" the insured, meaning that the insured itself must pay out judgements or settlements before obtaining reimbursement from the insurer. The South Carolina Supreme Court's ruling may

not necessarily apply when the insurer's obligation first arises after the insured has itself paid the judgment against it.

The court did not address the insurer's coverage defenses and held only that there was a valid post-loss assignment of insurance rights. But one final point is worth mentioning. The insurer contended that PCS's conduct in the CERCLA litigation increased the insurer's risk. In its third-party complaint against Old CNC's parents, PCS, then claiming it was not the successor to Old CNC, alleged that Old CNC's activities at the site contributed to contamination of the property. The insurer argued that its risk was increased because PCS sought to cast blame for contamination on old CNC, the insured. PCS contends it did not change the insurer's risk, which became fixed at the time of loss. As this issue was not part of the circuit court's ruling, the South Carolina Supreme Court permitted consideration of this issue on remand, noting that PCS's post-judgment conduct could serve to void coverage.

The case is *PCS Nitrogen, Inc. v. Continental Cas. Co.,* No. 28093 (S.C. Apr. 13, 2022).

Quick Note: The "no assignment" clause applies not only to the transfer of the insurance policy itself, but to property insured by the policy. The New Jersey Appellate Division in *Shen v. Hyundai Marine & Fire Ins. Co.*, No. A-1731-20 (N.J. App. Div. Apr. 19, 2022), enforced a "no assignment without consent" clause where the policyholder transferred her ownership interest in rental property to a limited liability company that she created without notifying her fire insurer. The policyholder argued that because she retained a 50% interest in the LLC, the deed transfer did not violate the policy's restriction on assignments. The court rejected this argument and found that the LLC was not a named insured and had no insurance rights.

California Appellate Court Finds That § 533 Willful Act Exclusion Bars Coverage for Public Nuisance Claim in Lead Paint Litigation

The California Court of Appeal held that the willful acts exclusion implied in every insurance policy by California Insurance Code § 533 barred coverage for a public nuisance claim where the insured's predecessor intentionally promoted lead paint despite being aware that it would likely harm children.

The Case

Several California counties and governmental entities sued paint manufacturers for promoting lead paint for interior use despite knowing the hazards it would create. They contended that the presence of lead paint in homes and buildings created a public health crisis. After a trial, the insured, ConAgra, and two other companies, were found jointly and severally liable and were ordered to pay into a fund to abate lead paint from homes built before 1978. ConAgra was liable only as a corporate successor to Fuller.

ConAgra's insurers filed a declaratory judgment action for a ruling that they did not have to cover ConAgra or its predecessor, Fuller. The insurers asserted, among other arguments, that § 533 prohibits coverage for ConAgra's intentional promotion of lead paint for interior residential use with actual knowledge of the health hazard that would result. Section 533 provides that "[a]n insurer is not liable for a loss caused by the willful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others." The statute reflects California's public policy of denying coverage for willful wrongs. A "willful act" under § 533 means "an act deliberately done for the express purpose of causing damage or intentionally performed with knowledge that damage is highly probable or substantially certain to result."

ConAgra argued that as a successor to Fuller, it could not be held responsible for Fuller's knowledge. And even if it could, the insurers failed to prove that Fuller's senior managers knew of the lead paint hazards, or that Fuller's conduct was anything more than reckless. The trial court ruled for the insurers, finding that § 533 precludes indemnification for liability arising from deliberate conduct that the insured expected or intended would cause damage. ConAgra appealed.

The Appellate Court's Decision

ConAgra made several arguments on appeal.

First, ConAgra argued that § 533 focuses on the insured's conduct, not the predecessor's. Thus, § 533 was not meant to apply to corporate successors for losses arising decades after its predecessor's wrongful acts. It pointed to cases finding § 533 inapplicable when the insured was merely vicariously liable. And it argued that there was no evidence that ConAgra knew of Fuller's lead paint promotions when the acquisition occurred.

But the appellate court rejected this argument because ConAgra knew when it acquired Fuller that it would be assuming its liabilities. And the court refused to treat successor liability as the functional equivalent of vicarious liability. As ConAgra became liable for the public nuisance created by Fuller's conduct, the court found that it stood in Fuller's shoes for purposes of § 533.

ConAgra next argued that even if the proper focus is on Fuller's conduct, § 533 still does not apply because the loss was too attenuated from Fuller's lead paint promotions. ConAgra argued that the statute required a direct causal relationship and a close temporal connection between the willful act and the loss.

The court rejected this argument too. It found that the question under § 533 is whether the loss was caused by a willful act of the insured. Fuller's willful conduct was found to be a

substantial factor in creating a public nuisance. ConAgra is liable for that conduct and seeks to recover sums it paid into an abatement fund because of those acts. The court ruled that ConAgra provided no support for applying a different causation analysis than that used to determine its underlying liability.

Third, ConAgra contended that the findings in the underlying suits did not prove that Fuller acted with the knowledge required by § 533. The underlying suits established that Fuller knew deteriorated paint presented hazards to children when Fuller promoted lead paint for interior use. But ConAgra argued actual knowledge was not enough. For § 533 to apply, senior management had to be substantially certain that its promotions would result in the loss.

The court disagreed. It found no support for ConAgra's contention that a corporation's knowledge under § 533 can be shown only by proving the knowledge of high-level corporate managers. At any rate, the underlying litigation established that Fuller knew of the hazards when it promoted lead paint for interior residential use. This meant that Fuller knew that lead paint was "substantially certain" to harm children. An insurer's duty to indemnify, the court emphasized, is determined by the actual basis of liability imposed on the insured.

Thus, the court affirmed the trial court's judgment for the insurers.

The case is *Certain Underwriters at Lloyd's London v. ConAgra Grocery Products Co., LLC*, No. A160548 (Cal. Ct. App. Apr. 19, 2022).

Quick Note: A few days earlier, another panel of the California Court of Appeal addressed intentional conduct in *Ghukasian v. Aegis Sec. Ins. Co.,* No. B311310 (Cal. Ct. App. Apr. 14, 2022). There, the insured directed a contractor to grade land and cut down trees on her neighbor's property, believing that the land and trees were within the boundaries of her property. The court found that the insured's homeowners insurer had no duty to defend. It focused on the immediate

cause of the injury – the leveling of land and cutting of trees. It did not matter that the insured did not intend the harm. The insured accomplished what she set out to do. There was no additional, independent act that produced the injury. The court also found that both causes of action – trespass and negligence – were based on the same intentional conduct.

And this rule, that there is no accident when the insured performs a deliberate act unless some additional, independent, and unexpected happening produces the damage, is at the heart of the *McKesson* decision discussed next.

California Federal Court Finds That Opioid Complaints Do Not Allege an Occurrence, Insurers Have No Duty to Defend

Insurance disputes stemming from opioid litigation have typically considered whether there is a claim seeking damages "because of bodily injury." The Delaware Supreme Court's *Rite Aid* decision from earlier this year is one example. For more, see our February 2022 Insurance Update (page 1). A federal judge in California recently disagreed with *Rite Aid* but found no coverage for a different reason: the alleged injury was not the product of an accident.

The Case

McKesson sold and distributed prescription drugs. It is a defendant in thousands of suits part of the opioid multidistrict litigation in the Northern District of Ohio. The suits allege that McKesson failed to control the supply chain, report suspicious orders, prevent diversion, or halt opioid shipments in quantities it knew or should have known reflected overuse. McKesson settled certain suits – the "Track One" suits – shortly before trial.

The State of Oklahoma later filed a similar suit against McKesson. It alleged that McKesson flooded the state with more opioids than could be used for legitimate medical purposes and failed

to report orders that it knew or should have known were likely being diverted for illicit uses. The complaint alleged that McKesson caused foreseeable and preventable harm to the state.

McKesson sought to recover its defense costs from its insurers. The insurers sought declaratory judgments that they did not have to defend or indemnify McKesson in the opioid suits. All parties moved for summary judgment.

The Decision

The policies covered bodily injury that is caused by an "occurrence" (defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions"). Summarizing California law, the court found that an accident is never present when the insured performs a deliberate act unless some independent and unforeseen event produces the damage. The complaints alleged both negligent and non-negligent acts, and the court separately analyzed each.

The court quickly dispensed with the non-negligent claims. Allegations that McKesson engaged in a scheme to evade the law and increase profits, the court found, "can only describe intentional, deliberate acts."

The negligence-based claims alleged that McKesson distributed opioids without effective controls, including fulfilling orders prescribed by "pill mills. In essence, the plaintiffs alleged that McKesson sold and distributed opioids in a way that created and fostered an illegal secondary market, and that its conduct resulted in foreseeable injury. The court found that the deliberate act of distributing opioids was central to each of the negligence claims.

McKesson argued that the complaints often used the phrase "should have known," keeping open the possibility of an accident because McKesson might not have intended the injuries. But

the court rejected this argument because it conflated two distinct issues: whether the injury was foreseeable versus whether the injury-producing acts of the insured were deliberate.

The court focused on the facts of each claim, not the labels of each cause of action. Negligence, the court explained, is not synonymous with an accident because a claim for negligence may be based on deliberate conduct that presents an unreasonable risk of foreseeable harm. The "knew or should have known" language showed that the complaints alleged foreseeable harm. It did not go to the issue of whether the injury producing conduct was deliberate.

Having determined that the negligence claims, like the other claims, rested on allegations of deliberate conduct, the court next considered if there was an additional, unexpected event that produced the injuries. The court found no intervening event. The injuries allegedly flow directly from the sheer quantities of McKesson's opioid shipments. McKesson argued that its shipments were diverted. But the court found that because the plaintiffs alleged that the quantities of McKesson's distribution so vastly exceeded legitimate use, that opioid diversion was the expected and foreseen outcome. McKesson's distribution itself, the court concluded, is alleged to have produced the injuries.

The court held that because the suits did not meet the "occurrence" requirement, there was no potential for coverage. The insurers thus had no duty to defend.

The case is *AIU Ins. Co. v. McKesson Corp.,* No. 20-cv-07469-JSC (N.D. Cal. Apr. 5, 2022).

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