



## THE TOP TEN (OR SO) COVERAGE DECISIONS OF 2018<sup>1</sup>

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Courts around the country issued many significant and diverse insurance coverage decisions in 2018. Among other issues, these opinions address the “unavailability exception” to the “pro rata” insurance allocation scheme, the scope of insurance bad faith, who is an “additional insured,” the potential for holding a claims handler liable for coverage decisions, coverage for “disgorgement” claims and the scope of coverage for complex computer fraud claims.

In reviewing and culling the 2018 coverage decisions down to a list of “top ten” cases, give or take a handful,<sup>2</sup> we considered several factors. First, we gave priority to decisions by state Supreme Courts or U.S. Courts of Appeal, as these cases will have

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<sup>1</sup>The views set forth herein are solely the views of the authors, and may not be deemed or construed to reflect the views, positions or beliefs of any client, organization, other attorney or any other person.

<sup>2</sup>Fifteen, actually. If we could do math, we probably would not be lawyers.

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lasting precedential effect and are most likely to be addressed in other jurisdictions considering similar or identical issues. Second, we considered cases that addressed newly developing insurance coverage issues. Lastly, we considered decisions that broke new ground by departing from prior precedent or “general rules.”

Our discussion of the top coverage decisions follows.

## ALLOCATION

### 1. *KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.*, 31 N.Y. 3d 51 (N.Y. Mar. 27, 2018)

In *KeySpan*, New York’s highest Court rejected the unavailability exception in



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considering for the first time whether, in a “pro rata” allocation scheme pursuant to which liability is spread equally across all triggered policy years, an insurer is liable to its policyholder for years outside of its policy periods where coverage was unavailable for purchase on the market. The Court of Appeals concluded that the policyholder, rather than the insurer, bears the risk for years during which coverage was unavailable.

The policyholder undertook costly remediation efforts and eventually filed an action seeking to recover the costs under a number of general and excess liability policies for claims arising from environmental contamination caused by manufactured gas plant operations over several decades. The insurer argued that it was not liable for any of the damage that occurred before the inception of its first policy in 1953 or after the expiration of its last policy in 1969. The policyholder argued that it should be responsible only for those years in which insurance was available in the marketplace, asking the Court to adopt the so-called unavailability rule and to hold that, in a pro rata time-on-the-risk allocation, liability should not be allocated to the policyholder for years in which insurance was unobtainable.

The Court of Appeals rejected application of the unavailability exception, holding instead that the policyholder, not the insurer, bears the risk for periods during which coverage was unavailable. In so ruling, the Court concluded, “because ‘the very es-

sence of pro rata allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period,” the unavailability rule “cannot be reconciled with the pro rata approach.”

**Insurer Perspective:** *KeySpan* rejects public policy arguments in favor of unambiguous policy terms, and reiterates the New York Court of Appeals’ focus on actual policy language in each specific case. *KeySpan* will result in a substantial increase in policyholders’ share of long-tail liabilities, which will grow as each year passes from the point where insurers stopped offering applicable coverage. *KeySpan* also serves as important precedent for upcoming consideration of *RT Vanderbilt Company, Inc. v. Hartford Accident & Indemnity Co., et al.*, 156 A.3d 539 (Conn. App. 2017), a case in which the Connecticut Supreme Court will consider the unavailability of insurance exception to pro rata allocation in 2019. *KeySpan* also raises questions on how to allocate a “mixed tower” of coverage containing policies with non-cumulation clauses as well as policies without such clauses.

**Policyholder Perspective:** It is highly unlikely that *KeySpan* is the last word on the unavailability exception (even in New York). The narrow ruling there was based on the particular limiting language of the policies at issue and certain faulty assumptions on the part of the Court concerning long-tail environmental coverage. As a preliminary matter, the

*KeySpan* Court was focused on the “happening during the policy period” language of the policies and how that limiting language warranted a pro-rata allocation—a point conceded by the policyholder. The Court simply could not harmonize the unavailability exception with the “happening during the policy period” language and pro-rata allocation. Suffice it to say that to the extent the limiting language of “happening during the policy period” does not appear in an insurance policy, then the Court’s holding would not apply, and the unavailability exception should protect the policyholder for periods of insurance unavailability. Even if the policy at issue does contain the limiting provision of “happening during the policy period,” that language, as we saw in *Viking Pump*, can be overridden by policies with noncumulation clauses that make only a single policy limit available for loss covered under multiple policies.

The Court’s ruling was also premised on the faulty assumption of consistent and continuous harm in long-tail environmental contamination cases. For unexplained reasons, the *KeySpan* Court assumed that yearly quantum of damage cannot be proven in long-tail environmental claims, thus concluding that the exact same amount of pollution (and presumably damage) takes place in each year. To the extent this ruling applies, policyholders should challenge this faulty assumption early and often through expert testimony showing that property damages is not exactly the same in each year.

**2. *Continental Insurance Co. v. Honeywell International, Inc.*, 188 A.3d 297 (N.J. June 27, 2018)**

In *Honeywell*, New Jersey’s highest Court considered whether the unavailability exception should apply in determining triggered years of insurance for purposes of allocation under New Jersey’s *Owens-Illinois* allocation scheme.

Honeywell, the successor to a manufacturer of brake and clutch pads containing asbestos, sought coverage for thousands of asbestos bodily-injury claims arising from exposure to its products. Despite insurance for asbestos claims becoming unavailable in 1987, Bendix Corporation, Honeywell’s predecessor company, continued to manufacture asbestos-containing products until 2001. When Honeywell sought coverage for its asbestos claims, the parties disputed the duration of the coverage block: Travelers argued that the coverage block should run until 2001, when Honeywell ceased manufacturing friction products. Honeywell maintained that the coverage block should end in the 1986–87 period, when first primary (1986) and then excess (1987) coverage for asbestos-related claims became unavailable.

The New Jersey Supreme Court upheld the unavailability exception in ruling that the policyholder bore no post-1987 allocation share for long-tail bodily-injury claims premised on exposure to products containing asbestos. In ruling that Honeywell need not contribute based on the time

after which the relevant coverage became unavailable in the marketplace (that is, since 1987), the Court affirmed the lower court’s determination to follow the unavailability exception to the method of allocation set forth in *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994), which utilizes a formula that considers time-on-the-risk and the total limits in each annual period vertically. In so ruling, the New Jersey Supreme Court stated, “[t]his case simply does not present facts on which to consider abandoning the unavailability exception, let alone whether to create a novel equitable exception to that exception that would retroactively deprive parties of paid-for insurance coverage due to their post-coverage-period conduct.”

The dissent notes what it termed the “absurdity” of applying the unavailability exception to a company that continues to place a knowingly dangerous product for which no insurer will provide coverage into the stream of commerce.

**Insurer Perspective:** Honeywell reiterates existing New Jersey law endorsing the unavailability exception. It presents counter-precedent to *KeySpan* in consideration of the application of the unavailability exception by the Connecticut Supreme Court in the upcoming *RT Vanderbilt* case. *Honeywell* also demonstrates that forum/choice of law is critical in determining allocation of damages for long-tail claims encompassing uninsured periods where coverage for claims at issue was not available in the marketplace, as the

*Honeywell* decision largely turned on the Court's choice of law determination between New Jersey as opposed to Michigan—Michigan utilizes pro rata time-on-the-risk, New Jersey utilizes the *Owens-Illinois* allocation formula.

**Policyholder Perspective:** *Honeywell* reaches the exact opposite result from the New York Court's decision in *Key-Span*. *Honeywell* confirms that the unavailability exception is alive and well in New Jersey. This case was essentially an “end-run” by the insurers on the *Owens-Illinois* case in which the New Jersey Supreme Court held that, “a policyholder is not responsible for the pro rata portion of liability that reflects a period of insurance unavailability.” Insurers sought to wiggle out of the broad holding of *Owens-Illinois* by asking for an equitable exception to the unavailability rule, on the premise that the policyholder continued to sell asbestos-containing products (brakes and clutches) after insurance became unavailable. In response, *Honeywell* recognized that it sold asbestos-containing products after insurance became unavailable but emphasized that it did not seek coverage for products manufactured after insurance became unavailable. Specifically, *Honeywell* maintained that it only sought coverage for lawsuits with a first date of exposure prior to insurance unavailability. The New Jersey Supreme Court agreed and applied the unavailability exception by relying on principles of public policy of “maximizing insurance resources, encouraging the spreading of risk throughout the insurance

industry, promoting the purchase of insurance when available, and simple justice” as detailed in its earlier ruling in *Owens-Illinois*.

Another critical point here is that the unavailability exception was not applied by the Court in a vacuum. First, there is no question that comprehensive general liability (CGL) policies cover these types of long-tail claims and risks, as long as there is injury during the policy period (*i.e.*, exposure in asbestos cases equals injury). Here, *Honeywell* only sought coverage for claims with a first date of exposure predating insurance unavailability. Second, the unavailability exception was not foisted on the insurer because the policyholder made a conscious decision not to buy insurance. If anything, the policyholder bought insurance to protect itself year after year and it only went bare after insurance was no longer available.

### **BAD FAITH/EXTRA-CONTRACTUAL LIABILITY**

#### **3. *Keodalah v. Allstate Insurance Co.*, 413 P.3d 1059 (Wash. Ct. App. Mar. 26, 2018)**

In *Keodalah*, a Washington State Court of Appeals issued an earth-shaking precedential decision in holding that an insurance adjuster can be held individually liable for bad faith and breach of consumer protection laws while handling claims in the regular course of his or her employment.

Keodalah, the policyholder, tendered a claim to Allstate seeking UIM coverage after he was involved in an accident where a motorcyclist struck his truck. The police department, witness interviews and an accident reconstruction firm hired by Allstate all indicated that motorcyclist's excessive speed caused the collision. Keodalah requested Allstate pay him the \$25,000 limit on his policy. When Allstate refused, Keodalah filed a coverage lawsuit against Allstate.

Allstate's adjuster, who was also Allstate's designated Rule 30(b)(6) corporate deponent, contradicted the Police Department conclusions and Allstate's own accident reconstruction analysis by testifying that Keodalah had run a stop sign and was talking on his cell phone at the time of the accident. At trial, Allstate asserted that Keodalah was seventy percent at fault for the accident. The jury, however, found the motorcyclist one hundred percent liable, and awarded Keodalah over \$100,000 for injuries, lost wages and expenses.

Keodalah then filed a second lawsuit against Allstate and Allstate's individual adjuster for bad faith and violations of the Washington Consumer Protection Act. The trial court dismissed the claims against the adjuster but certified the question for interlocutory appeal.

On appeal, Division One of the Washington State Court of Appeals reversed, holding instead that an insurance adjuster can be held individually liable for bad faith

and violation of Washington's consumer protection statute while handling claims in the regular course of his or her employment. In refusing to dismiss the bad faith claims against the adjuster personally, the Court of Appeals noted that "nothing" in Washington's bad faith statute "limits the duty of good faith to corporate insurance adjusters or relieves individual insurance adjusters from this duty," and further stating that the duty of good faith "applies equally to individuals and corporations acting as insurance adjusters."

The Court of Appeals also held that the individual adjuster could be held liable for a violation of Washington's Consumer Protection Act, even though there was no contractual relationship between the policyholder and the individual adjuster. In so ruling, the Court of Appeals noted that "nothing" in the Consumer Protection statute "requires that the plaintiff must be a consumer or in a business relationship with the actor."

**Insurer Perspective:** Hopefully the case will have no impact: the Washington Supreme Court has accepted review of *Keodalah*, which presents an undue expansion of bad faith law that unfairly exposes individuals to personal punitive liability simply for engaging in the regular conduct of their employment duties. *Keodalah* is a grossly erroneous decision. The intimidation factor that *Keodalah* raises unduly increases the complexity of both the claim-handling process and coverage litigation. Insurers should also note the

double-whammy effect of *Keodalah* and *Xia v. Probuilders*, 400 P.2d 1234 (Wash. 2017) (finding bad faith where insurer failed to anticipate change in law). If upheld, *Keodalah* likely will be cited by policyholders seeking to expand the available scope of bad faith liability in other jurisdictions.

**Policyholder Perspective:** Although the *Keodalah* case has been accepted for review, its finding that an insurance adjuster who fails to consider facts supporting coverage and instead testifies to support a bad faith decision, is likely to be cited as precedent. As recognized by at least one commentator, “[c]ases addressing whether an insurance adjuster (and not simply the insurer) can be liable for bad faith don’t come about every day.”<sup>3</sup> The case turned, in part, on a regulation (RCW 48.01.030), which imposes a duty of good faith and fair dealing on “*all persons* engaged in the business of insurance...” (emphasis added). The appellate court found that the definition of “person” included an individual adjuster who was acting within the course and scope of his or her employment. In addition, the court was likely struck by the fact that the adjuster contradicted, without apparent justification or foundation, the

findings of the Seattle police department who had interviewed witnesses, as well as other Allstate witnesses including an accident reconstruction firm whose conclusions all suggested that the motorist was at fault, triggering the duty to pay full limits—of \$25,000! Notably, even at trial on the underlying matter, Allstate continued to assert that the plaintiff—and not the insured motorcyclist—was at fault. While contrary to two other Washington district court decisions, the opinion currently stands as a cautionary tale: that an adjuster is part of the insurer team that is required to act reasonably. The issue, of course, will be whether the Washington Supreme Court will find personal liability for an agent of an insurer while acting as an agent.

#### **4. *Harvey v. GEICO General Insurance Co.*, No. SC17-85, 2018 WL 4496566 (Fla. Sept. 20, 2018)**

In *Harvey*, the Florida Supreme Court issued a major bad faith decision in holding an insurer cannot evade bad faith liability by simply complying with what the Court termed a “checklist” of key obligations to its policyholder. Thus, an insurer can be liable for bad faith even though it advises its policyholder of settlement opportunities, the probable outcome of underlying litigation, and the possibility of an excess judgment.

The case arose out of a 2006 automobile accident in which Harvey, the policyholder, was found liable for the death of another motorist who left behind a wife

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<sup>3</sup>P. Rosner, *Coverage Opinions*, Vol. 8, Issue 1 (January 3, 2019). Paul Rosner of Soha & Lang, Seattle, opines that when cases of this nature come out, “it often involves the conduct of an outside adjusting company. But in *Keodalah*, the Washington Court of Appeals examined whether an adjuster, employed by an insurer, could be liable for bad faith” and here, a violation of the state’s Consumer Protection Act.

and three children. The policyholder had a policy with GEICO that provided \$100,000 in liability coverage. GEICO informed the policyholder that he likely faced liability in excess of his policy's available limits three days after accident. The policyholder thereafter hired his own attorney.

The attorney for the Estate of the deceased motorist asked GEICO's claims handler for a recorded statement regarding the policyholder's available assets, whether he had additional insurance, and whether he had been acting in the course and scope of his employment at the time of the accident. GEICO's claims handler (who at the time was handling 130 files) reportedly refused the request, but then conceded at trial that such a request was reasonable. GEICO did not immediately communicate the request for a statement to Harvey or his attorney. Harvey and his attorney did become aware of the Estate's request for a statement, but delayed in providing such information. GEICO tendered the full amount of the policy limits to the Estate's attorney within days of the accident, but the Estate ultimately returned GEICO's check and filed suit against Harvey.

At trial, a jury found the policyholder liable for over \$8 million in damages. The policyholder then sued GEICO for bad faith and won a jury verdict in excess of \$9 million. Florida's intermediate appeals court reversed, finding the evidence insufficient to establish bad faith and further

noting that the policyholder's own action contributed, at least in part, to the excess underlying verdict. Harvey appealed.

On appeal, the Florida Supreme Court reversed, and reinstated the jury verdict against GEICO. In its 4-3 decision, the majority noted that "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured." The insurer had been aware that there was significant financial exposure to its insured because of the multiple survivors and low limits of \$100,000. In the Court's view, the insurer's obligations "are not a mere checklist. An insurer is not absolved of liability simply because it advises the insured of settlement opportunities, the probable outcome of the litigation, and the possibility of an excess judgment." Thus, the critical inquiry is "whether the insurer diligently, and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment." In the Court's view, the totality of the circumstances revealed that GEICO failed to act as if the financial exposure to Harvey was "a ticking financial time bomb."

A scathing dissent filed by the Chief Justice characterized the majority's decision as essentially adopting a negligence standard for bad faith claims, which he predicted would 'incentivize a rush to the courthouse steps' by third-party claimants seeking to convert inadequate policy limits into a windfall.



**Insurer Perspective:** This 4-3 decision expands the circumstances that may be found to constitute bad faith under Florida law by adopting a negligence-type standard for bad faith actions. Moreover, and as the dissent notes, *Harvey* may incentivize third-party claimants faced with limited insurance recoveries to choose litigation over settlement in search of a windfall recovery. *Harvey* no doubt will be cited in other jurisdictions by policyholders attempting to broaden bad faith to encompass negligence as well as malice.

**Policyholder Perspective:** This decision is consistent with the law of many jurisdictions to the effect that an insurer must take steps independently to determine the availability of coverage, and cannot simply sit back and wait for its insured to respond. The Court reasoned that GEICO knew that its insured was at fault, knew that the deceased was a husband and father of three children giving rise to potentially catastrophic damages, and that it nevertheless “completely dropped the ball” and failed to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business.” In addition, the Court found that while negligence alone was not sufficient to prove bad faith, “[b]ecause the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, *negligence is relevant* to the question of good faith.” In a quotable quote, the Court flatly rejected the idea that “so long

as a checkmark appeared next to each item [on the checklist of obligations owed by an insurer to its insured], bad faith may not be found.”

*Moore v. GEICO General Insurance Co.*, 2018 U.S. App. LEXIS 35196 (11th Cir. Dec. 14, 2018)

*Moore* considered the interesting question of whether the acts of one insurer in settling a claim for its policyholder can be used by a different policyholder against a different, non-settling insurer as evidence of bad faith.

Once again—and this appears to be a theme in the cases cited above that have broader implications—the coverage issues arose out of a catastrophic automobile accident resulting from an intoxicated driver (Waters) and resulting road rage. Moore, the driver of the other car, lost control after Waters swerved into her vehicle, crossed the median, and crashed into a third car. Amy Krupp, the driver of the third car, was killed and her ten year old son sustained brain injuries. Krupp’s attorney made identical settlement offers to Waters’ and Moore’s insurers—payment of full policy limits, affidavits affirming that no other insurance was available and payment of limits within ten days.

Waters’ insurer, Peak Insurance, agreed and settled. GEICO tried to settle, but its offer was rejected as containing an overly broad release of “all officers, directors, agents or employees of the named insured”

and after the submission of what were alleged to be incomprehensibly vague affidavits about the existence of other insurance. The underlying case went to trial, with a jury returning a verdict of \$45 million in favor of the Krupps and finding Moore 10% liable, resulting in a judgment against Moore of over \$4 million. Moore then sued GEICO for bad faith.

During the bad faith trial, Moore put on evidence that Peak, Waters' insurer, had been able to settle the claim for its insured arising from the same facts and circumstances as evidence of GEICO's bad faith. GEICO moved *in limine* to avoid introduction of that testimony. The federal district trial court denied GEICO's motion, but later ruled that it had erred in permitting the evidence of the other settlement. The district court then granted GEICO's motion for a new trial, at which GEICO prevailed.

On appeal, the Eleventh Circuit affirmed, finding that the district court did not abuse its discretion in concluding that the Peak settlement was inadmissible under Rule 403—that a court may exclude evidence that is unfairly prejudicial, confusing, or might mislead the jury, cause undue delay, or present cumulative evidence. In reaching its decision, the Court of Appeals noted that while the evidence “certainly had some probative value,” that value was outweighed by Rule 403 considerations of potential prejudice to GEICO and possible jury confusion.

**Insurer's Perspective:** In *Moore*, the District Court and the Eleventh Circuit got it right in excluding evidence of how a *different* insurer handled and settled a claim for a *different* policyholder. Nonetheless, the Eleventh Circuit left open the question of whether evidence of how another insurer handled a claim might be admissible to demonstrate that another insurer acted in bad faith in handling an identical or substantially similar claim.

**Policyholder's Perspective:** This decision might well have come out the other way—in favor of admissibility—if the issue had been the duty to defend under similar policy language as opposed to the issue of bad faith failure to settle or if the evidence had been introduced for the limited purpose of showing custom and practice in the industry. And like so many cases with which we all deal, admissibility might well depend on the timing of raising an issue, the similarities of the policy language as applied to the circumstances, and a host of other issues that might show how a reasonable insurer would act under a certain set of regulatory guidelines or factual circumstances. Query whether the court might have considered the admission of the settlement if the coverage provided, both in terms of a defense and indemnity obligations, were more closely aligned. In any event, this case stands as another cautionary tale to insurers and for the adage (as do so many of our cases) that bad facts and policy language can lead to unexpected consequences and a host of issues at trial.

**5. *Century Surety Co. v. Andrew on Behalf of Pretner*, 134 Adv. Op. 100, 2018 WL 6609591 (Nev. 2018)**

Nevada’s highest court considered whether, under Nevada law, the liability of an insurer that breached its duty to defend, but has not acted in bad faith, is capped at the policy limit plus any defense costs, or whether the insurer is liable for all losses consequential to the insurer’s breach.

In *Pretner*, a company owner negligently struck Mr. Pretner with a truck, leading to severe brain injury. The insurer refused to defend under a commercial general liability policy with \$1 million in limits because it concluded after an investigation that the company owner was not driving the truck within the scope of his employment at time of accident. The driver defaulted and assigned his insurance rights to Pretner pursuant to a settlement. The district court entered a \$18 million default judgment against the driver and his company, finding that the driver was driving within the scope of his employment. The driver did not offer a defense.

On appeal, the Nevada Supreme Court rejected the majority rule that a breaching insurer’s liability is capped at its policy limits, plus any defense costs that the policyholder paid. Instead, the Court held that an insurer who breaches its duty to defend may be held liable for consequential damages, including a judgment in excess of policy limits, “even if insurer did not act in bad faith.” The Court concluded that the majority view placed an “artificial limit” on

the insurer’s liability within the policy limits for a breach of the duty to defend. Significantly, the Court cited ALI’s Restatement of the Law of Liability Insurance, which provides that the damages that an insured may recover for breach of a liability policy includes consequential damages.

**Insurer Perspective:** *Pretner* is the first major decision to cite to ALI’s Restatement of the Law of Liability Insurance. *Pretner* also will be cited by policyholders in other jurisdictions as a basis for seeking recovery of judgments in excess of policy limits for the breach of duty to defend, even in the absence of bad faith.

**Policyholder Perspective:** *Pretner* is consistent with the law of other jurisdictions, such as California, which hold an insurer liable for losses flowing from a failure to defend even if there might be a dispute as to coverage. In other words, the *Pretner* case joins those jurisdictions holding that if an insurer is going to deny coverage, even where there is a dispute over coverage, it will be liable for the damages flowing as a consequence of its breach of the duty to defend—even under the new ALI Restatement.<sup>4</sup> Notably, Century Surety con-

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<sup>4</sup>Specifically, section 48 of the ALI Restatement of the Law of Liability Insurance—Damages for Breach of a Liability Policy, which provides in relevant part: The damages that an insured may recover for breach of a liability insurance policy include ... (4) Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of contracting as a probable result of the breach, which sums are not subject to any limit of the policy.”

tinued to assert that the driver was acting outside of the scope of his employment even after being apprised of the default, after which it could have changed its coverage position and preserved its coverage defenses. The imposition of liability is not automatic, and is subject to proof: “However, we are not saying that an entire judgment is automatically a consequence of an insurer’s breach of its duty to defend; rather, the insured is tasked with showing that the breach caused the excess judgment and [he also] is obligated to take all reasonable means to protect himself and mitigate his damages.”

## DISGORGEMENT CASES

### 6. *J.P. Morgan Sec., Inc. v. Vigilant Ins. Co.*, 84 N.Y.S.3d 436 (N.Y. App. Div. 1<sup>st</sup> Dept. Sept. 20, 2018)

This case arose out of a policyholder’s monetary settlement of a Securities and Exchange Commission (“SEC”) proceeding and related private litigation predicated on the policyholder’s violations of federal securities laws. The trial court had found that the insurers were obligated to cover the \$140 million “disgorgement” payment that the policyholder made to the SEC as part of a settlement over market-timing and late-trading claims, plus more than \$146 million in interest. The question addressed by the New York Appellate Division, among other things, was whether the disgorgement payment was a “loss” under the terms of the policy or a penalty. In this case, the “ill-gotten gains” that were being

disgorged were improper profits acquired by third-party hedge fund customers, as opposed to the policyholder.

The insurers argued that there is no coverage because, in *Kokesh v. Securities and Exchange Commission*, 137 S. Ct. 1635, 198 L.Ed.2d 86 (2017), the United States Supreme Court conclusively defined the nature of the SEC disgorgement remedy as a penalty, not a loss. In a unanimous opinion, the New York Appellate Division agreed: “[A]s [the insurers] argue, *Kokesh* and the long-standing legal principles on which it relied fatally undermine the motion court’s holding that the \$140 million of the SEC disgorgement remedy that plaintiff seeks to recover is a covered loss under the policies.”

**Insurer Perspective:** The decision in this case is consistent with the principle that insurers should not have to cover policyholders for their ill-gotten gains, regardless of whether those gains were in favor of the policyholder or third parties. It relies on the Supreme Court’s decision in *Kokesh* holding that disgorgement is a penalty, and therefore not insurable as a covered “loss.” Thus, any policy that excludes coverage for penalties will not provide coverage. Reliance on policy language rather than public policy makes the determination of coverage clearer for everyone.

**Policyholder Perspective:** Although the court’s opinion stated that *Kokesh* had provided the missing precedent establish-

ing that disgorgement is a penalty regardless of whether linked to the wrongdoer's gains or gains that were enjoyed by others, the case fails to consider precedent around the country to the effect that courts must look at the nature of the calculations and the fact that the insured did not directly share in those profits. The court also was not swayed by the fact that the payment was later placed in a fund for distribution to others, which would arguably change the nature of the payment into compensation going to victims of securities fraud to offset their losses, relying on Second Circuit precedent in *Fishbach Corp.*, 133 F.3d 170, 175 (2d Cir. 1997) to the effect that such compensation was "distinctly a secondary goal." We expect these issues to be vigorously argued outside of New York and the Second Circuit.

**7. *In re: TIAA-CREF Insurance Appeals, Nos. 478, 2017, 479, 2017, 480, 2017, 481, 2017, 2018 WL 3620873 (Del. July 30, 2018)***

*In re: TIAA-CREF Insurance Appeals*, the Supreme Court of Delaware held unanimously, under New York law, that settlement payments made in connection with civil ERISA class actions are insurable losses. Under the policies at issue, "loss" excluded "matters which may be deemed uninsurable under the law pursuant to which" the policy is to be construed. The policyholder contended that it was entitled to coverage for its defense costs and settlement payments under several layers of primary and excess liability coverage. The in-

surers, on the other hand, argued that the settlement payments were "disgorgements," and that, under New York law, a disgorgement cannot be the subject of an insurance claim as a matter of public policy.

The Supreme Court of Delaware sided with the policyholder, finding that the lower court "was correct in distinguishing the New York cases barring insurability, which proscribe it in situations in which the insured's wrongdoing resulted in ill-gotten gains." Instead, the Court held that New York's public policy against insurability in cases of disgorgement does not apply to the class action settlements at issue, as it did not involve "ill-gotten gains" or other improperly acquired funds in the hands of the policyholder.

**Insurer Perspective:** Although the Supreme Court of Delaware recognized New York's public policy against insurance coverage for disgorgement of ill-gotten gains, it found this case was distinguishable on several grounds. First, it noted that there was never any finding that TIAA had done anything improper, and therefore the damages were not "ill-gotten gains." Second, the Court noted that this case involved a class action lawsuit as opposed to a regulatory proceeding. Thus, this case, decided three months prior to *J.P. Morgan v. Vigilant*, does not change the basic premise under New York law that disgorgement claims are generally uninsurable as a matter of public policy.

**Policyholder Perspective:** *TIAA-CREF* shows that not all disgorgement claims are the same and not all disgorgement claims are uninsurable. This case and several others in other jurisdictions are significant blows to the insurance industry's public policy argument against coverage for disgorgement claims. A bright-line test is emerging from these line of cases that even under New York law, which purports to treat all disgorgement as uninsurable, so long as the policyholder does not reap improper profits and the underlying settlement does not represent the return of ill-gotten gains by the policyholder, then the claim is an insurable loss under the policy.

## COMPUTER FRAUD/ HACKING CASES

### 8. *Interactive Communications International Inc. v. Great American Insurance Co.*, No. 17-11712, 731 Fed. Appx. 929 (11th Cir. May 10, 2018)

This case arises out of a “Computer Fraud” policy issued to policyholders involved in the sale of “chits” to consumers, who can then redeem them by loading their value onto a debit card. The policyholders lost millions of dollars when fraudsters manipulated a glitch in the computerized interactive-telephone system that enabled the fraudsters to redeem chits multiple times. The Court of Appeals held that the policy did not cover this loss because it did not “result[] directly” from the com-

puter fraud, as required by the policy's plain language.

The policy at issue protected against “Computer Fraud.” Specifically, the policy provided coverage for “loss of, and loss from damage to, money, securities and other property resulting directly from the use of any computer to fraudulently cause a transfer of that property from inside the premises or banking premises: (a) to a person (other than a messenger) outside those premises; or (b) to a place outside those premises.” The policyholders sought coverage for \$10.7 million lost to debit card holders who fraudulently manipulated the system to effectuate duplicate redemptions of chits. The court held that the loss is not covered because, although the scam was perpetrated through “the use of a[] computer,” the loss did not “result[] directly” from a computer fraud, as the plain language of the policy requires. More specifically, the court held that although the fraudsters' manipulation of the policyholders' computers set into motion the chain of events that ultimately led to the loss, their use of the computers did not “directly”—*i.e.*, immediately and without intervention or interruption—cause that loss, as “the chain of causation involved intervening acts and actors between the Step-1 fraud and the Step-4 loss.”

**Insurer Perspective:** Although the Court of Appeals disagreed with the district court regarding whether the loss arose out of the “use of a computer,” it found that there was no coverage because the loss

did not *result directly* from the use of the computer. This decision provides important clarity on whether a policy’s “resulting directly” language requires only a showing of proximate cause, or whether it requires more immediacy between the conduct and result. The Eleventh Circuit explained that if the phrase “resulting directly” has a plain and ordinary meaning, courts are obligated to enforce such language as written. For purposes of the policy at issue here, “one thing results ‘directly’ from another if it follows straightaway, immediately, and without any intervention or interruption.”

**Policyholder Perspective:** The Court’s narrow ruling in *InComm* ignores the very purpose of a crime policy insuring computer fraud claims and gives the back of the hand to the reasonable expectation doctrine. The purpose of the policy was to insure computer fraud risks. The court recognized that the claim involved the use of a computer, albeit with intervening steps such as the use of a telephone to communicate with that computer. The intervening steps were enough for the court to reach its absurd ruling that the loss did not result “directly” from the use of the computer. Query whether the policyholder would have bought the policy if informed of such tortured interpretation during the underwriting and procurement process. There are several decisions from higher courts in other jurisdictions reaching the complete opposite result than the holding in *InComm*. This decision is also a good reminder why policyholders should carefully review the policy language before

binding coverage. Here, insurer’s insertion of the word “directly” in the grant of coverage resulted in the denial of the claim. As a minimum, the grant of coverage should have used the phrase “directly or indirectly,” which is routinely used by insurers in policy exclusions.

**9. *St. Paul Fire & Marine Ins. Co. v. Rosen Millennium Inc.*, 337 F. Supp. 3d 1176 (M.D. FL 2018)**

In this case, the U.S. District Court for the Middle District of Florida held that there is no coverage for a data breach under a commercial general liability policy unless the policyholder, rather than a third party, is responsible for the act of “publication.”

IT provider Rosen Millennium sought coverage for claims asserted by its subsidiary, Rosen Hotels and Resorts, Inc., that Rosen Millennium was responsible for a network hacking incident that exposed hotel customers’ credit card data. The policies at issue provided coverage for “personal injury offense,” including “[m]aking known to any person or organization covered material that violates a person’s right of privacy.” The parties disputed whether the data breach satisfied the “making known,” *i.e.*, “publication,” requirement. The court held that this requirement was not satisfied because there was no publication by the policyholder, as the data breach publication was perpetrated by third-party hackers. In reaching this conclusion, the Court relied on the language of the policy that requires

the personal injuries to “result from [the insured’s] business activities. The court thus held that the insurer did not have a duty to defend against the data breach claims.

**Insurer Perspective:** This case is consistent with decisions in other jurisdictions finding that, in order to trigger coverage under a commercial general liability policy, the “publication” of personal information must be by the policyholder rather than by a third party. In addition, it is an important reminder for insurers to argue that courts must read the policy as a whole and not interpret individual clauses in isolation.

**Policyholder Perspective:** *Rosen Millennium* continues the trend of denying coverage for data breach claims under CGL policies. The court narrowly interpreted the “making known” or “publication” requirement of the personal injury coverage by requiring that the policyholder (not the hacker) be the one who publishes or “make known” the confidential and sensitive information. This requirement fails to take into account the policyholder’s involvement in the publication of the sensitive information by its obvious failure properly to secure its IT infrastructure, so third-party hackers could not gain access to sensitive information. The take-away from *Rosen Millennium* could well be that some courts will hold that CGL policies were not designed to cover cyber breaches. Policyholders should consider procuring dedicated cyber or crime policies to protect themselves against data breach claims.

## SPOOFING/CYBER THEFT CASES

### 10. *Medidata Solutions Inc. v. Federal Insurance Co.*, 729 Fed. Appx. 117 (2d Cir. 2018)

In *Medidata Solutions*, the U.S. Court of Appeals for the Second Circuit held that Federal Insurance Company must cover a \$4.8 million loss that its policyholder, Medidata Solutions Inc., suffered when Medidata was tricked by fraudsters who posed as Medidata’s president in an email spoofing attack into wiring money overseas. A computer fraud provision in the policy at issue covered losses stemming from any “entry of Data into” or “change to Data elements or program logic” of a computer system. Federal contended that this policy language limited coverage to only hacking-type intrusions. Federal further argued that Medidata did not sustain a “direct loss” as required by the policy. The Second Circuit disagreed with both arguments. The Court of Appeals first found that the fraudsters “crafted as a computer-based attack that manipulated Medidata’s email system, which the parties do not dispute constitutes a ‘computer system’ within the meaning of the policy.” The spoofing attack “made a change to a data element, as the email system’s appearance was altered by the spoofing code to misleadingly indicate the sender.” The Second Circuit also held that Medidata sustained a “direct loss,” finding that the false emails were the proximate cause of the loss at issue.



**Insurer Perspective:** In this case, the Second Circuit acknowledged that no computer hacking occurred, but broadly construed the policy language to find that the “computer-based attack” of introducing false emails into Medidata’s email system was sufficient to bring the claims into the policy’s coverage. On the “direct loss” question, the Second Circuit essentially declined to follow New York law on proximate cause, finding that the spoofing was the proximate cause of the loss, regardless of the fact that in order for the spoof to be completed and successful, the Medidata employees were required to take further action to effectuate the transfer of funds. The Second Circuit justified its holding by reasoning, in somewhat contradictory fashion, that “[t]he chain of events was initiated by the spoofed emails, and unfolded rapidly following their receipt.” The employees’ actions therefore were not, in the Court of Appeals’ view, “sufficient to sever the causal relationship between the spoofing attack and the losses incurred.” In other words, the law of proximate cause proves to be flexible depending on the result desired.

**Policyholder Perspective:** In *Medidata*, the Second Circuit rejected two key arguments that insurers constantly raise to defeat coverage for social engineering and cyber theft types of claims. First, the decision rejected the insurer’s argument that the computer fraud coverage is intended to cover only direct “hacking-type intrusions” of the policyholder’s computer. The court found that the policy language pro-

viding for “entry of Data into” or “change to Data elements or program logic of” a computer system was sufficient to place the claim within the computer fraud coverage of the policy. Second, the court did away with insurers’ lack of a “direct loss” argument due to certain intervening steps involving policyholder’s employee in the transfer of funds. The court recognized that New York law equates “direct loss” with proximate cause but nonetheless found that the cyber-attack in *Medidata* was the proximate or “direct cause” of the policyholder’s loss in that case: “The chain of events was initiated by the spoof emails and unfolded rapidly following their receipt. While it is true that the Medidata employees themselves had to take action to effectuate the transfer, we do not see this action as sufficient to sever the causal relationship between the spoofing attack and the losses incurred.”

**11. *American Tooling Center Inc. v. Travelers Casualty and Surety Co. of America*, 895 F.3d 455 (6th Cir. 2018)**

In *American Tooling*, the U.S. Court of Appeals for the Sixth Circuit held that an insurer had to cover its policyholder’s losses stemming from thieves posing as a vendor using fraudulent emails to deceive the company into wiring money to a sham bank account. In finding that the losses were covered, the Sixth Circuit rejected the insurer’s argument that the Computer Fraud provision of the policy limited coverage to situations where a third party gains

actual access to and/or controls the insured's computer to cause the loss.

**Insurer Perspective:** As in the Eleventh Circuit decision in *Interactive Communications*, the Sixth Circuit here considered the meaning of “direct loss caused by Computer Fraud.” The Sixth Circuit distinguished *Interactive Communications* by finding that, although there were multiple steps required before American Tooling suffered its loss, the loss occurred immediately following the last step taken by American Tooling (the transfer of the funds), whereas in *Interactive Communications*, there were a few more steps required between the transfer and when the policyholder lost control of the funds. The Sixth Circuit also construed “Computer Fraud,” which the policy defined as “[t]he use of any computer to fraudulently cause a transfer” of money from “inside the premises” to a person or place “outside the premises,” in overly broad fashion in finding that the fraudster’s use of a computer to send fraudulent emails fell within the “Computer Fraud” policy definition. Despite this broad construction, the Court rejected application of two relevant exclusions in the policy by narrowly construing them to find that the relevant information inputted in the course of the scam did not constitute “electronic data.”

**Policyholder Perspective:** In *American Tooling*, which was decided less than a week after the *Medidata* opinion, the Sixth Circuit hopefully landed the knockout punch to the “direct loss” and “hacking”

defenses of the insurer’s in cyber theft and spoofing types of cases. In rejecting the insurer’s lack of “direct loss” defense, the Sixth Circuit offered a simple analogy: “Imagine Alex owes Blair five dollars. Alex reaches into her purse and pulls out a five-dollar bill. As she is about to hand Blair the money, Casey runs by and snatches the bill from Alex’s fingers. [Insurer’s] theory would have us say that Casey caused no direct loss to Alex because Alex owed that money to Blair and was preparing to hand him the five-dollar bill. This interpretation defies common sense.” This simple analogy crystallizes the absurdity of insurer’s “direct loss” defense in cyber theft or spoofing claims. Similarly, the court rejected the insurer’s “hacking” argument that its policy required a computer to “fraudulently cause the transfer” as opposed “to simply use a computer and have a transfer that is fraudulent” by noting that the policy language had no requirement that the fraud “cause any computer to do anything.” The Sixth Circuit simply refused to limit the definition of computer fraud as written in the policy to hacking or gaining of unauthorized access to policyholders’ computers.

## ADDITIONAL INSURED

### 12. *Gilbane Building Co./TDX Construction Corp. v. St. Paul Fire & Marine Insurance Co.*, 31 N.Y.3d 131 (2018)

In *Gilbane*, the New York Court of Appeals held that a construction manager

did not qualify for coverage as an additional insured under a prime contractor's commercial general liability insurance policy because the two companies did not have a direct written contract confirming such coverage as required by the insurance contract.

The construction manager, a joint venture between Gilbane Building Company and TDX Construction Corporation, sought coverage under prime contractor Samson Construction Company's GL policy for claims arising on a hospital project. Samson had agreed in writing with the project's owner to acquire additional insured coverage for several entities, including the construction manager. The construction manager argued that the agreement between Samson and the owner was sufficient for it to be an additional insured under Samson's policy.

The blanket additional insured endorsement in Samson's Liberty Mutual policy provided:

**WHO IS AN INSURED (Section II) is amended to include as an insured any person or organization *with whom you have agreed to add as an additional insured by written contract but only with respect to liability arising out of your operations or premises owned by or rented to you* (emphasis added).**

Gilbane argued that the agreement between Samson and the owner caused it to

be an additional insured under Samson's policy. Liberty Mutual claimed it had no duty to defend Gilbane because Gilbane did not have a direct written contract with Samson.

The New York trial court denied Liberty's motion for summary judgment, finding that the endorsement required only a written contract to which Samson was a party (*i.e.*, the contract between project's owner and Samson). Because that contract obligated Samson to name Gilbane as an additional insured, Gilbane was entitled to additional insured coverage under the Liberty policy.

The New York Appellate Division reversed and the New York Court of Appeals affirmed, finding that Gilbane was not covered under the Liberty Mutual policy. In so ruling, the Court of Appeals held that the language of the additional insured endorsement at issue—*i.e.*, "*with whom you have agreed to add as an additional insured by written contract*"—required both the named insured and the additional insured to be parties to the same contract. The Court of Appeals also rejected consideration of any extrinsic evidence regarding the parties' intentions, as such evidence can only be considered if the contract is first found to be ambiguous.

The dissent objected to the narrow reading of the exclusion and focus on the single word "with," noting that this resulted in the majority "finding clarity where none exists."

**Insurer Perspective:** The New York Court of Appeals again reaffirmed that plain contract language will be enforced as written. The inclusion of the word “with” was different than other additional insured endorsements that required only that the named insured “agree” in a written contract to provide additional insured coverage. The importance of this decision is that the specific words of the policy matter. It is necessary to carefully review the policy language and not assume that the policy contains “standard” language.

**Policyholder Perspective:** For policyholders, this opinion is consistent with additional insured decisions that turn on a strict reading of the coverage grant or in other words, the explicit language of the policy. It is notable, however, that the provision at issue was a so-called “blanket” additional insured endorsement that extends coverage to any person or organization that the named insured is obligated to name by virtue of a written contract. In addition, the court refused to give weight to a written contract under which the general contractor had clearly agreed that a construction manager would be part of the construction “team.” As such, it seems to ignore the common usage in the construction industry and an insured’s reasonable expectations in light of recognized industry practice. As the dissent recognized (albeit unsuccessfully), the construction manager should have been considered as an additional insured based on principles of the “risk transfer regime” that is the norm in that particular industry.

## INTENTIONAL CONDUCT/ OCCURRENCE

### 13. *Liberty Surplus Insurance Corp. v. Ledesma & Meyer Construction Co., Inc.*, 5 Cal. 5th 216, 418 P.3d 400 (Cal. June 4, 2018)

In *Ledesma*, a student filed a lawsuit against a school district contractor, alleging that the contractor was negligent in hiring, retaining, and supervising an employee who sexually abused her. The contractor tendered the defense to its insurers, who defended under a reservation of rights while seeking declaratory relief in federal court that it had no obligation to defend or indemnify the contractor. The general liability policy at issue provided coverage for “bodily injury” “caused by an ‘occurrence,’” which the policy defined as “an accident.”

The district court granted summary judgment to the insurer on its claim for declaratory relief, reasoning that the student’s injury was not caused by an “occurrence” because the “alleged negligent hiring, retention and supervision were acts antecedent to the sexual molestation,” and, “[w]hile they set in motion and created the potential for injury, there were too attenuated from the injury-causing conduct” committed by the policyholder’s employee. In addition, the district court found that negligent hiring, supervising and retaining cannot be an “accident” simply because the insured did not intend the injury.

The policyholder appealed and the Ninth Circuit certified the following question to the California Supreme Court: When a third party sues an employer for the negligent hiring, retention, and supervision of an employee who intentionally injured that third party, does the suit allege a covered “occurrence” under the employer’s commercial general liability policy? The Supreme Court of California concluded that it can. In so ruling, the Court found that the definition of “accident” (and therefore the definition of occurrence) is broader than the term negligence and therefore include negligent acts. The Court focused on the coverage available to the employer, not the employee. The Court noted that the insurer’s arguments, if accepted, would leave employers without coverage for claims of negligent hiring, retention, or supervision whenever an employee’s conduct is deliberate, which would be inconsistent with California law. As a result, the Court concluded, “[a]bsent an applicable exclusion, employers may legitimately expect coverage for such claims under comprehensive general liability insurance policies, just as they do for other claims of negligence.”

**Insurer Perspective:** While *Ledesma* was highly publicized, its overall implications are questionable; the Court’s decision essentially focused on whether the hiring of an employee was negligent—a recognized cause of action—and whether the alleged negligence was a causal connection “close enough” to the injury to

justify imposition of liability on the policyholder. Thus, and as the Court noted, “a finder of fact *could* conclude that the causal connection between [the policyholder’s] *alleged* negligence and the injury inflicted by [the employee] was close enough to justify the imposition of liability on [the policyholder].” Accordingly, while acknowledging that “insurance does not generally cover intentionally inflicted injuries,” the Court cited prior case precedent in noting that “the public policy against insurance for one’s own intentional sexual misconduct does not bar liability coverage for others whose mere negligence contributed in some way to the acts of abuse.”

**Policyholder Perspective:** There is nothing “questionable” about *Ledesma*’s findings at all, especially in the context of California’s broad requirement of a defense if there is *any* potential for liability under a covered claim. The claims against the employer were for negligent hiring, retention and supervision. The Court recognized that an employer may not have knowledge or even the ability to determine whether an employee will commit a bad act, giving rise at the very least to a duty to defend. In addition, *Ledesma* recognized that in determining the availability of coverage, a trial court must focus on the specific acts of the particular insured, and not facts that would be imputed to the employer without some knowledge or ratification that might later bar coverage on an indemnity basis.

**14. Hartford Roman Catholic Diocesan Corp. v. Interstate Fire & Casualty Co., 905 F.3d 84 (2d Cir. 2018)**

In this case, the Second Circuit addressed two questions under Connecticut law: can sexual abuse resulting in injury be considered an “occurrence” under liability policies? If so, are claims arising from such sexual abuse barred by an Assault and Battery Exclusion?

The Hartford Roman Catholic Diocese (“Archdiocese”) tendered several claims to its excess insurers seeking coverage for claims arising from alleged sexual abuse inflicted by priests of the Archdiocese on Parish school students. The excess insurers denied coverage on the grounds that (1) the alleged sexual abuse and resultant injuries did not constitute an “occurrence” under the policies, and (2) the Assault and Battery Exclusion in the relevant policies barred coverage for the claims.

The policy defined “occurrence” as “[A]n accident or a happening or event or a continuous or repeated exposure to conditions which unexpectedly and unintentionally results in personal injury, or damage to property during the policy period.” The insurer contended that there is no coverage if the “happening or event” causing the injury is intended or expected; that intention and expectation is an objective test rather than a subjective question viewed from the standpoint of

the insured; and that the “extraordinary circumstances” present in this case would justify or require an objective test. The Archdiocese argued that a subjective standard applied, so that the question was whether the injury itself, as opposed to the “happening or event” causing the injury, was expected or intended from the policyholder’s standpoint.

The Assault and Battery Exclusion at issue stated:

This coverage does not apply: (a) To liability of any Assured for assault and battery committed by or at the direction of *such* Assured except liability for Personal Injury or Death resulting from any act alleged to be assault and battery for the purpose of preventing injury to persons or damage to property (emphasis added).

The insurer contended that the exclusion evidences the intent to bar recovery as to *all* Assureds if any one of them commits the assault and battery, arguing that the phrase “such Assured” refers back to the phrase “any Assured” and thus encompasses them all. Thus, because the priests are among the “Assureds,” recovery should be excluded as to the Archdiocese as well. The Archdiocese argued that the exclusion applies only to a person “acting within the scope of his duties,” and that the assailant priests were not acting within the scope of their duties when they committed assault. It also argued that the exclusionary language applied only to insureds who com-

mitted or directed the assault rather than “all” insureds. It also raised the “familiar principle” that ambiguities are construed against the insurer, although the court did not need to consider the ambiguity argument.

After summary judgment motion practice and a ten day bench trial, the U.S. District Court for the District of Connecticut held that the insurer breached its duty to indemnify the Archdiocese for the sexual abuse claims. In so ruling, the Court held that the assault and battery exclusion did not bar coverage, and that the loss at issue arose from a covered “occurrence.”

The Second Circuit affirmed the trial court’s ruling that the policy at issue did not preclude coverage “based on well-settled principles’ of Connecticut law.” While finding it “unlikely” that the assailant priests were “Assureds” under the contract because they were not acting within the scope of their duties when committing assault, the Court of Appeals held that even if they were Assureds, the Assault and Battery Exclusion barred coverage only for the actual assailants, not for all Assureds. In the Second Circuit’s view, under a contrary reading, “blameless insureds would lose coverage by the act of someone else, and their coverage would be rendered illusory.”

On the occurrence question, the Second Circuit rejected the insurer’s argument that the “accident or happening” it-

self must be unexpected and unintended, even if the resulting injury comes as a surprise. In the Second Circuit’s view, the proper inquiry is whether injuries were expected, not whether the events or happenings causing such injury were deliberate or expected. The Second Circuit also rejected the insurer’s argument for an objective test of what a reasonable person knew or should have known for determining intention and expectation. Instead, the Second Circuit applied a subjective test—even if Archdiocese’s conduct was reckless, it still constituted an “occurrence” because the resulting injury was not intended. The Court of Appeals also rejected the insurer’s request for application of an objective test due to “exceptional circumstances.”

**Insurer Perspective:** The Second Circuit’s decision sets an unsettling precedent for these types of claims. The decision turned on a narrow reading of the Assault and Battery exclusion, holding that it did not bar coverage in circumstances where it clearly was intended to do so. Also, the Second Circuit’s “occurrence” analysis unduly expands coverage to deliberate, intentionally harmful conduct in situations that are particularly egregious.

**Policyholder Perspective:** The Second Circuit’s decision is consistent with the finding in *Ledesma*, cited above, as well as typical rules of construction followed in most states: that language of an insuring agreement is to be construed broadly in favor of coverage, and that lan-

guage in an exclusion or provision limiting coverage should be construed narrowly. It is also consistent with the argument that language will be deemed to be ambiguous and should be construed in favor of coverage if the language selected by the insurer is susceptible to two different interpretations.

