RECENT DEVELOPMENTS IN INSURANCE COVERAGE LAW

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I. INTRODUCTION

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This article explores (1) the disparate ways that the United Kingdom and the United States have dealt with business income insurance coverage for the COVID-19 global pandemic; (2) the effect of consent-to-settle provisions in Massachusetts; and (3) California's adoption of vertical exhaustion in excess liability insurance cases.

II. COVID-19: THE INSURANCE COVERAGE POSITION IN THE UNITED KINGDOM AND THE UNITED STATES

Aaron Le Marquer and James Breese

The devastation that the outbreak of Covid-19 has brought to commercial policyholders is significant on both sides of the Atlantic. Insurers' responses to the claims for business interruption (BI) losses that have followed have been similarly impactful in both jurisdictions. Arguably, however, that is where the similarities end. The way in which policyholders are pursuing these claims—and the courts' approaches to them—are very different in the United Kingdom and the United States.

A. *The Financial Conduct Authority's Test Case*

In the United Kingdom, the Financial Conduct Authority (FCA), which regulates insurers, took the interventionist step of seeking a declaration from the court for a Test Case as to how non-damage BI extensions would respond, if at all, to claims for losses arising from Covid-19. This step was welcomed by policyholders in the United Kingdom given that the selected coverage issues are common to a significant proportion of the market, and over 370,000 policyholders were estimated to be affected by the outcome of the case. The clarity remains outstanding, however, as the case proceeds to the Supreme Court in late 2020.

While the Test Case could not, and was not intended to, resolve all aspects of possible BI disputes, it does look to resolve some key contractual uncertainties as well as issues relating to causation. Subject to the final outcome as determined by the Supreme Court, it may be that the FCA has helped narrow the scope of the disputes between insureds and insurers regarding BI.

B. *Legislative Changes in the United States*

The position described above has not been replicated in the United States. In fact, despite thousands of lawsuits relating to BI losses as a result of

Covid-19,[1] the Judicial Panel on Multidistrict Litigation (JPML) declined to consolidate them into a single global MDL proceeding.[2] The JPML reached this decision, given only "superficial" commonality and an absence of commonality in terms of the factual issues.[3] The JPML therefore felt that a consolidation of these claims could ultimately be inefficient, although there may yet be a consolidation of claims on a per insurer basis.[4] For the time being, however, each case will continue to be decided on its own merits, and it seems unlikely at this stage that there will be a test case to provide a binding authority on the common issues across all of those suits.

The efforts to assist policyholders on a collective basis have instead come from the legislature. Several bills under consideration in Congress look to create a scheme that ensures that, in certain cases, SMEs are indemnified for their BI losses arising from Covid-19. In return, insurers will be provided with state-backed reinsurance through a mechanism similar to the Pool Reinsurance Company Limited (Pool Re) in the United Kingdom.

The bills remain under consideration and have been met with some resistance from those looking to uphold the foundations of the U.S. Constitution. Article I of the U.S. Constitution prevents statutory changes that may "impair" contractual obligations.[5] As in the United Kingdom, the wait for policyholders therefore goes on.

C. *Legal Juxtapositions*

1. United States

In the United States, the BI claims have generally been pursued on the basis that Covid-19 has caused damage to property, which is required in order to satisfy the policy trigger. The courts have generally found in favor of insurers on that issue, but not in every case.

In *Studio 417, Inc. v. Cincinnati Insurance Co.*,[6] the court denied an insurer's motion to dismiss, finding that the loss of a possession, deprivation, and the inability to be able to use the premises for its intended purpose can amount to physical loss or damage, which were undefined terms in the policy. This holding, however, is something of an anomaly, given the long line

1. Hannah Smith, *A Closer Look: Coronavirus Insurance Lawsuit Trends*, NU Prop. Cas. 360 (Sept. 4, 2020).
2. Alison Frankel, *JPML Rejects Nationwide Consolidation of Business Insurance Cases. Now What?* Reuters (Aug. 13, 2020).
3. Andrew G. Simpson, *Consolidation of COVID Business Loss Suits Denied; But Grouping by Insurer Eyed*, Ins. J. (Aug. 13, 2020).
4. *See* Frankel, *supra* note 2 (noting that "variations in policy language for businesses across different industries in different states 'will overwhelm any common factual questions.'").
5. U.S. Const. art. i, § 10.
6. 478 F. Supp. 3d 794 (W.D. Mo. Aug. 12, 2020).

of cases in which U.S. courts found that Covid-19 was incapable of causing physical damage to property, which is invariably the trigger for coverage.[7]

2. United Kingdom

The position of the majority in the United States is consistent with the prevailing view in the United Kingdom, as implicitly accepted by the FCA in its decision only to include "non-damage" BI extensions in the Test Case. More recently, this view has been confirmed by the Commercial Court in its recent judgment in *TKC London Limited v. Allianz Insurance Plc*.[8]

In that case, the claimant pursued its claim on the basis that temporary loss of use of property due to Covid-19 closure could amount to "loss of property."[9] The court, however, preferred the insurer's analysis and stated as follows:

> "[L]oss" here is similarly intended to have a physical aspect. . . . [T]hat "loss" cannot sensibly be interpreted as including mere temporary loss of use of property.[10]

It therefore remains the position in the United Kingdom that the only claims with realistic prospects of success will be those under non-damage BI extensions (e.g., Notifiable Disease or Non-Damage Denial of Access extensions). Notwithstanding the difficulties that the FCA Test Case has caused for some of those wordings, the prospects of a claim for BI losses succeeding is still greater if these extensions are operative, as opposed to being left to argue that Covid-19 has caused damage to property, for which at present there appears to be scant authority.

D. *Present Position in the United Kingdom*

The current outcome of the FCA Test Case has resulted in some clear winners and losers.[11] The winners are those insureds with disease-type wordings, provided that the wording is not limited to a specified list of diseases

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7. *See*, *e.g.*, Uncork & Create LLC v. Cinn. Ins. Co., 498 F. Supp. 3d 878 (S.D. W. Va. 2020); Turek Enters., Inc. v. State Farm Mut. Auto. Insur. Co., 484 F. Supp. 3d 492 (E.D. Mich. 2020); Pappy's Barber Shops, Inc. v. Farmers Grp., Inc. 487 F. Supp. 3d 937 (S.D. Cal. 2020).

8. TKC London Limited v Allianz Insurance Plc [2020] EWHC 2710 (Comm) (UK), *available at* https://insure.cooley.com/2020/10/26/property-lost-tkc-london-ltd-v-allianz-insurance-plc-2020-ewhc-2710.

9. *Id.*

10. *Id.*

11. *E.g.*, *Covid-19 Business Interruption Update—FCA Challenges* Orient Express v. Generali, Fenchurch Law Ltd. (July 14, 2020), https://www.lexology.com/library/detail.aspx?g=76fa5eea-5c07-4eb7-9ee6-9219595d2bb4; *see also* Leon Taylor, *UK Supreme Court Hands Down Judgment in the FCA's COVID-19 Non-Damage Business Interruption Insurance Test Case*, DLA Piper (Jan 18, 2021), https://www.dlapiper.com/en/uk/insights/publications/2021/01/uk-supreme-court-judgment-in-the-fca-covid-19-business-interruption-insurance; *UK Supreme Court Ruling on FCA Business Interruption Test Case Handed Down*, Debevoise & Plimpton: Debevoise in Depth (Jan. 18, 2021).

given that the list will not include Covid-19. In relation to such disease wordings, the court found that the national occurrence of Covid-19 was the single cause of the loss and that the individual outbreaks across the country were indivisible parts of it. This conclusion means that there will be coverage, provided that an insured can demonstrate that the disease occurred within the radius specified in the policy (typically twenty-five miles), but the coverage is not limited to losses caused only by the occurrence of disease within that radius. Provided that the trigger conditions are met, the policy will respond to all BI losses caused by the national pandemic, the government's response, and the general public's reaction.

In contrast, the losers are those with prevention of access-type wordings. For those insureds, the court generally found that the extensions provided only a narrow, localized form of coverage. The court did not apply the same wide interpretation of "vicinity" and "neighborhood" that it did for the disease-type wordings. Consequently, as the judgment stands, the pandemic, or nationwide responses to it, will in most cases not be sufficient to trigger the policy.

On issues of causation, and the application of trends clauses, the court found largely in favor of policyholders, rejecting insurers' arguments that they were entitled to deny or reduce claims on the basis that losses were not proximately caused by a narrowly drawn insured peril. The court found that the pandemic, the government's response, and resultant changes in consumer activity all formed part of a single indivisible cause of loss, rather than being independent (or interdependent) concurrent causes of loss. Specifically, the court not only distinguished the contentious *Orient Express v Generali* case,[12] which first formalized the "wide area damage" principle, but went as far as to say that it had been wrongly decided.

As the *Orient Express* case has been relied upon by insurers as a fundamental principle underpinning the adjustment of BI claims since the decision was first handed down in 2010, this aspect of the judgment has far-reaching consequences that go beyond the current Covid-19 landscape. Unsurprisingly then, the issue forms the focus of appeals filed by six of the insurers filed at the UK Supreme Court, which are expected to be heard before the end of 2020. The Supreme Court's decision is expected to bring some much-needed certainty to the issue and, as such, will be eagerly awaited by policyholders and insurers alike.

E. *Comment*

It appears that policyholders on both sides of the Atlantic continue, for the time being, to have to adopt a "wait and see" approach. Whether it be the introduction of new legislation in the United States or the need for a

12. Orient Express v Generali, [2010] EWHC 1186 (Comm) (U.K.), *available at* https://www.pinsentmasons.com/out-law/guides/orient-express-hotels-v-generali.

determination from the Supreme Court in the United Kingdom, the only certainty is that insureds are unlikely to see a great deal of proactivity from insurers for the time being.

Insurers in both countries continue to decline claims for BI losses, and that landscape appears unlikely to change to any great extent until some point in 2021 or beyond. Without overcoming the initial hurdles as to coverage, policyholders have not even been able to properly articulate their cases in respect to the quantification of claims and, for example, why the claims should not be aggregated and the relief provided by the government should not be deducted from the indemnity provided by insurers. While we hope that Covid-19 can be overcome soon enough, the consequences it leaves behind for insurance markets may rumble on.

III. IN A PAIR OF OPINIONS, CALIFORNIA ADOPTS VERTICAL EXHAUSTION METHODOLOGY

Timothy M. Thornton, Jr.

In *Montrose Chemical Corp. of California. v. Superior Court*,[13] the California Supreme Court addressed the issue of vertical exhaustion. Montrose manufactured the insecticide DDT at its facility from 1947 to 1982. In 1990, the United States and the state of California sued Montrose for environmental contamination allegedly caused by Montrose's operation of its facility. Montrose entered into partial consent decrees in which it agreed to pay for environmental cleanup. Montrose expended more than $100 million in the cleanup and asserted future liability of a similar magnitude. It sought coverage under its excess liability insurance in effect from 1961 to 1985. Primary insurance had been exhausted.

The court defined *attachment point* as the level of loss that must be reached before an excess insurer's coverage obligation begins.[14] The court categorized the policies' approach to describing the attachment point as fourfold:

1. Policies with a schedule of underlying insurance listing all of the underlying policies in the same policy period including and dollar amount.
2. Policies which reference a specific dollar amount of underlying insurance in the same policy period and which refer to a schedule of underlying insurance on file with the insurer.

13. 460 P.3d 1201, 1204 (2020) (*Montrose III*).

14. *Id.* at 1204 (citing Restatement of the Law, Liability Insurance § 39, cmt. d (Am. Law. Inst.)).

3. Policies which reference a specific dollar amount of underlying insurance in the same policy period and identify some of the underlying insurers.
4. Policies which reference a specific dollar amount of underlying insurance that corresponds with the combined limits of the underlying policies in that policy period.[15]

All of the excess policies required that "other insurance" must be exhausted before the excess policies would be triggered. The court looked not just at policy conditions labeled "other insurance," but instead applied a functional analysis and found such "other insurance" provisions variously in the following:

- the insuring agreement (promising to pay "loss" defined in part as sums paid in damages "after making deductions for all . . . other insurances . . . other than the underlying insurance and excess insurance purchased specifically to be in excess of this policy"[16]);
- the definition of *retained limit* (defined as the total limits or underlying insurance and the limits of "any other underlying insurance"[17]);
- the loss payable provision (stating that the policy will pay ultimate net loss as sums paid "after making deductions for all . . . other insurance (other than recoveries under the underlying policies, policies of co-insurance, or policies specifically in excess hereof)"[18]);
- the limits provision (the insurance applies "only after all underlying insurance has been exhausted"[19]); and
- any other insurance condition (if other insurance applies, "this policy shall be in excess of and shall not contribute with such other insurance"[20]).

Montrose sought a declaration that (1) it could seek indemnification from an excess policy if it showed that the directly underlying insurance in the same period was exhausted; (2) it was not required to show that all policies in all other policy periods with lower attachment points were exhausted; and (3) Montrose could select the manner in which to allocate its liabilities across the policies.

The court described this as a rule of "vertical exhaustion" or "elective stacking."[21] This rule is contrasted with the rule of "horizontal exhaustion."

15. *See id.* at 1205.
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.* at 1205–06.

Under horizontal exhaustion, Montrose could access an excess policy only after it exhausted other policies with lower attachment points from every triggered policy period.

The trial court found for the insurers and held that excess policies required horizontal exhaustion in the context of multi-year injury or damage. The court of appeal affirmed, concluding that the plain language of many of the excess policies attach only upon exhaustion of all available insurance. Shortly after that, another court of appeal disagreed with the court of appeal in *Montrose* and determined that vertical exhaustion was appropriate given the policy language and California case law.[22]

The Supreme Court granted review in *Montrose* and held that a rule of vertical exhaustion is appropriate. It began with a review of California insurance law principles. First, California follows a continuous injury trigger of coverage. Second, the state follows an "all sums" rule so that coverage extends to all harm caused by a covered occurrence, even if some of the harm results beyond the policy period. Third, the state follows an "all sums with stacking indemnity" principle which effective stacks coverage from different policy periods for form "one giant 'uber-policy.'"[23] Montrose argued for a rule of vertical exhaustion under which "an insured would be permitted to access any higher layer excess policy once it has exhausted the directly underlying excess policy covering the same period."[24]

The court observed that the insurer's proposed rule of horizontal exhaustion was not unreasonable, but that it was not the only possible interpretation. While the policies clearly required exhaustion of underlying insurance, the policies did not clearly and explicitly state that Montrose must exhaust insurance purchased for different policy periods. Thus, the policies could be interpreted as requiring only exhaustion of directly underlying insurance policies, or as also requiring exhaustion of underlying insurance in other policy periods.

The court then considered other language in the policy to interpret the language in the context of the whole agreement. It noted that language making the policy excess to other insurance except excess insurance purchased specifically to be excess of that policy could be read to require exhaustion of every other policy at every attachment point, including even higher attachment points. This was not the reading argued for by the insurers who contended that "other insurance" meant "other underlying insurance," but the insurers could not explain why the reference to "other insurance" could not also mean "other directly underlying insurance."[25]

22. State v. Cont'l Ins. Co., 223 Cal. Rptr. 3d 716 (Ct. App. 2017).
23. *Montrose III*, 460 P.3d at 1207.
24. *Id.* at 1209.
25. *Id.* at 1210.

This was a clue to the court that the "plain language . . . is not adequate to resolve the dispute in the insurers' favor."[26]

The court noted the historical reason for "other insurance" clauses was to prevent multiple recoveries when more than one policy provided coverage. The court stated that such clauses "have not generally been understood as dictating a particular exhaustion rule for policyholders seeking to access successive excess insurance policies in cases of long-tail injury."[27] The use of other insurance clauses or the equitable doctrine of contribution affects apportionment among insurers, however, and not between the insured and the insurer.[28] These observations from *Dart Industries, Inc. v. Commercial Union Insurance Co.*[29] undermine the insurers' claim that "other insurance" clauses clearly and explicitly call for a rule of horizontal exhaustion.[30]

The court found that other policy language suggested that the exhaustion requirements were meant to only apply to directly underlying insurance. First, the policies explicitly stated an attachment point, generally by reference to a dollar amount. Horizontal exhaustion would in effect raise the attachment point significantly above that stated dollar amount. For example, one policy attached excess of $30 million each occurrence and in the aggregate, but horizontal exhaustion would increase the attachment point for this policy to upwards of $750 million. Second, the schedules of underlying insurance only refer to underlying insurance in the same policy period.[31] In sum, the court found that the other insurance clauses, when considered in light of other policy language and in light of the historical role of such clauses, were most naturally read to allow a vertical exhaustion approach.

Finally, to the extent that the policy remained ambiguous, the court would resolve ambiguities to protect the objectively reasonable expectations of the insured. This outcome would favor a rule of vertical exhaustion. The court noted some practical difficulties of a horizontal exhaustion rule. The layers are not uniform in amount across time. Instead, the policies have their own distinct exclusions, terms, and conditions. Given these facts, the court asked how horizontal exhaustion would apply. The first layer policy in 1984 reached as high as the thirteenth layer in 1974. The court asked, "In which layer is the 1984 policy?" Some policies have lower attachments points but higher coverage limits, and the policies do not say how this policy should apply to a policy from another period. This seems to be criticizing the effect of a "layer by layer" approach, which neither party

26. *Id.*
27. *Id.* at 1211.
28. *Id.*
29. 52 P.3d 79 (Cal. 2002).
30. *Montrose III*, 460 P.3d at 1211.
31. *Id.* at 1212.

argued in this case, where the parties argued for a lower attachment point approach.[32]

Further outlining practical difficulties of the horizontal exhaustion approach, the court noted that if a lower layer insurer claimed an exclusion applied, then a court could not say if the excess policy would apply until it had decided whether the exclusion applied. Such a rule would put the insured to considerable expense and delay of proving coverage under all other lower layers of coverage before it could access coverage under the excess policy.[33]

As to the argument of unfairness to the insurer picked by the insured to respond, the court pointed out that the selected insurer could seek equitable contribution from other insurers. This option moves the administrative task of spreading the loss from the insured to the insurers, which is not obviously unfair in the court's estimation.[34]

Finally, the court distinguished the leading case on horizontal exhaustion in California— *Community Redevelopment Agency v. Aetna Casualty & Surety Co.*[35]—as a dispute regarding contribution among primary and excess insurers, and not a dispute between excess insurers and their insured.

A few months after *Montrose III* was decided, the court of appeal decided another excess insurance case. In *SantaFe Braun, Inc. v. Insurance Co. of North America*,[36] the insured, Braun, sought coverage for numerous asbestos-related claims under various excess policies. The trial court applied the horizontal exhaustion doctrine and entered judgment for the excess insurers, finding that Braun had failed to establish that the primary insurance and that, in some cases, lower layer excess insurance had been exhausted. The court of appeal reversed.[37]

Braun had tendered these asbestos-related claims to its primary and excess insurers. The primary insurers agreed in writing with Braun to defend and settle the claims while the primary insurers resolved allocation among themselves. The primary insurers later entered into an agreement paying the limits of their policies into a trust that would continue to pay defense costs and claims on behalf of Braun. Subsequently certain excess insurers settled with Braun.

The court of appeal noted that *Montrose III* had not answered the question here—whether, in a continuous loss case with multiple primary policies, all of those primary policies covering all triggered time periods must be exhausted (i.e., horizontal exhaustion) before the first level excess

32. *Id.*
33. *Id.*
34. *Id.* at 1214.
35. 57 Cal. Rptr. 2d 755 (Ct. App. 1996).
36. 265 Cal. Rptr. 3d 692 (Ct. App. 2020), *review denied*, (Sept. 30, 2020).
37. *Id.* at 694.

policies are triggered, or whether coverage under the excess policies is triggered once the directly underlying primary policies specified in each excess policy are exhausted (i.e., vertical exhaustion).[38]

The court in *SantaFe Braun* found the language of the policies to be comparable to the language interpreted in *Montrose III*. The excess insurers argued that the fundamental "qualitative differences" between primary and excess policies required horizontal exhaustion at the primary level. The specific differences noted were that primary coverage is "first dollar" coverage, has an immediate obligation to respond, receives significantly higher premiums and offers lower limits, and has the right to control the defense and settlement. The court of appeal disagreed with these arguments. It felt these differences applied whether a rule of horizontal or vertical exhaustion applied. Addressing the premium issue, the court stated that premiums were calculated as a percentage of the underlying premium, and that the risk assessment was based upon the scheduled underlying limits and not based on cumulative limits of underlying coverage in other years of coverage which would be "speculative and unpredictable."[39]

The court first considered five first layer excess policies. These policies attached "only after the primary . . . insurers have paid or have been held liable to pay the full amount of their respective ultimate net loss liability" as scheduled on the policy.[40] Further, the policies provided that the limit of the insurers' liability under these policies would be the "amount of ultimate net loss as will provide the assured with total limits" scheduled on the policy as the "total limits."[41] The schedule identified certain primary insurance policies and their limits, and also referred to "and any and all policies arranged by or on behalf of the assured as renewals, replacements or otherwise."[42] The policies defined the excess insurer's "ultimate net loss" as the amount payable "after making deductions . . . for other valid and collectable insurances, excepting however the . . . primary and underlying excess [policies]. . . ."[43] Finally the policies incorporated "other insurance" conditions from the primary policies, which provided that the policies would be "excess of such other valid and collectable insurance."[44]

Two of these policies provided that they were triggered upon the exhaustion of specified scheduled policies plus "any and all policies arranged by or on behalf of the assured as renewals, replacements or otherwise."[45]

38. *Id.* at 699.
39. *Id.* at 701.
40. *Id.* at 699.
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.* at 701.

These two policies, however, did not contain definitions of *ultimate net loss* contained in the other designated first level excess policies. The court found that this language was comparable to that interpreted in *Montrose III*. The court held that, absent explicit policy language to the contrary, the insured "becomes entitled to the coverage it purchased from the excess carriers once the primary policies specified in the excess policy have been exhausted."[46]

Another group of higher-level excess insurance policies promised to pay "all sums which the assured shall be obligated to pay or incurs as costs and/or expenses. . . ."[47] These policies also provided that the insurers would only be liable "for the excess of . . . the amount covered under assured's [primary] liability policies," it being agreed that those underlying primary policies "may have anniversary dates other than 1st July."[48] (Presumably, this date was the anniversary of these higher-level excess policies.) The policies did not have schedules of underlying insurance and included a generally worded "other insurance" clause (presumably an excess other insurance clause). The court rejected the excess insurers' arguments premised upon the "other insurance" clauses. It held that "the reference . . . to underlying primary insurance by date supports the conclusion that exhaustion is required only of primary policies that overlap with the policy period of the excess policies."[49] The matter was remanded to allow the insured to offer proof of exhaustion of underlying policies in light of the vertical exhaustion ruling.

Together, these two cases place California in the vertical exhaustion camp. Because California often serves as a bellwether for other states on coverage issues, it will be interesting to see if other states adopt the reasoning of *Montrose* and *SantaFe Braun*.

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46. *Id.*
47. *Id.* at 702.
48. *Id.*
49. *Id.* at 702–03.