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2025 FMG Insurance Coverage Annual Report

A summary of the year's important insurance coverage and extra-contractual cases within FMG's footprint across the country.

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Contents

Arizona - 4

California - 8

Colorado - 12

Connecticut - 17

Delaware - 21

Florida - 24

Georgia - 29

Illinois - 33

Indiana - 39

Iowa - 43

Kentucky - 47

Massachusetts - 53

Michigan - 56

Minnesota - 60

Nevada - 64

New Jersey - 67

New Mexico - 69

New York - 74

Ohio - 76

Pennsylvania - 80

Rhode Island - 85

South Carolina - 87

Tennessee - 90

Texas - 96

Washington - 99

Wisconsin - 104

Arizona

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State Farm Automobile Ins. Co., v. Orlando

569 P.3d 394
(Ariz. 2025)

In vacating the Court of Appeals' opinion, the Arizona Supreme Court affirmed the Superior Court's entry of summary judgment, holding that an auto policy's definition of an "underinsured motor vehicle" did not encompass an ATV because an ATV is an off-road vehicle operated off public-roads. The Court further held that the UMA does not prohibit insurance carriers from excluding coverage for ATVs not operated on public roads under a UIM policy.

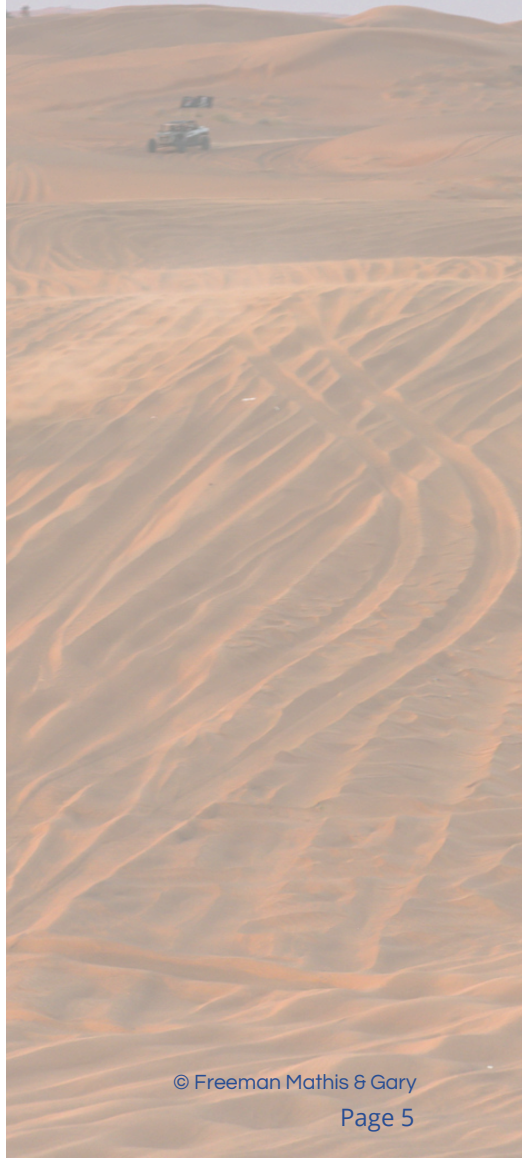
Plaintiff Jacey Lee Orlando sustained injuries in an off-road accident in the California Imperial Sand Dunes while riding as a passenger in an all-terrain vehicle ("ATV"). Orlando filed a claim with her insurer, State Farm, via her underinsured motorist ("UIM") policy for further coverage of her injuries. State Farm denied coverage on the basis that an "underinsured motor vehicle" did not include vehicles designed primarily for use off public roads, such as an ATV. Orlando argued that pursuant to the Uninsured/Underinsured Motorist Act ("UMA"), an insurer is required to provide UIM coverage for accidents involving off-road vehicles that do not occur on public roads.

The Court first examined the relationship between the Financial Responsibility Act ("FRA") and UMA. The FRA was designed to ensure that drivers on Arizona's public roads carry minimum liability insurance. However, many drivers still fail to purchase automobile insurance. To address this, the legislature enacted the UMA, which provides "coverage for injuries resulting from accidents with uninsured or unknown vehicles." Over time, uninsured and underinsured motorist coverage began to act as a "gap filler," allowing insureds to recover damages from inadequately insured drivers.

The Arizona Supreme Court held that the UMA's scope of coverage, whether uninsured or underinsured, must be read coextensively with what the FRA requires. Therefore, State Farm would only be required to provide UIM coverage to Orlando if the ATV qualified as a "motor vehicle" that the FRA requires to be insured.

The UMA operates with the FRA as a "congruent regulatory statutory scheme." Because of this, the Court interprets the UMA and FRA together to assess whether UIM coverage is required under the UMA. The FRA requires motor vehicles driven on Arizona highways to be sufficiently insured. However, this rule does not apply to ATVs or other off-road recreational vehicles when they are operated on dirt roads. In past cases, the Court has focused on two key questions when deciding what counts as a "motor vehicle" under the FRA: (1) is the vehicle at issue required to be insured under the FRA; and (2) did the accident at issue occur on a public highway. Additionally, Arizona law does not require an ATV to be registered unless it is driven on a public highway.

Based on the FRA definition of motor vehicle, the Court held that "UIM coverage of an off-road ATV accident is neither required nor prohibited under the UMA." Rather, UIM coverage is a matter of contract, and State Farm's definition of "underinsured motor vehicle" was permissible under Arizona law.



Centerpoint Mech. Lien Claims, LLC v. Commonwealth Land Title Ins. Co.

259 Ariz. 554 (2025)

Because a Morris agreement is only binding on an insurer as to the existence and extent of the insured's liability, coverage and liability are coextensive when a first-party Morris agreement does not resolve claims as to third parties. With a first-party agreement, the only liability is that of the insurer if it breached the policy terms by failing to defend the insureds. Thus, the concepts of liability and coverage in the context of a first-party Morris agreement necessarily overlap.

This case arose out of a dispute over the priority of liens on a multi-million-dollar residential condominium project. The holders of mechanics liens sued to enforce their liens, seeking priority over other creditors who later became involved with the project after involuntary bankruptcy proceedings. Meanwhile, some of these creditors who had secured title insurance policies insuring their deed of trust had priority over other liens or encumbrances. Crucially, in this case, the creditors agreed to subordinate their claims to the mechanics' lien claims.

The mechanics lien holders and creditors entered into a "*Morris* agreement" with an entity created to execute the agreement, Centerpoint Mechanic Lien Claims, LLC. *Morris* agreements typically come into play in liability actions when an insurer defends an insured under a reservation of rights. Such agreements recognize that an insurer's reservation of rights places the interests of the insurer and insured in a potential conflict, because if the insured is found liable then the insurer can contest coverage. Arizona courts have found that such a situation gives the insurer a "double-bite" at escaping liability. Therefore, if an insured provides notice to the insurer, and subject to court approval, the insured may settle the questions of liability and damages with a third-party plaintiff. So long as the agreement is reasonable and not collusive, which the insurer may contest during *Morris* proceedings, the agreement will bind the insurer as to liability and the damage amount. Once the *Morris* agreement is approved by the court, the insurer may not litigate the fact and amount of the insured's liability, but it may contest coverage under the policy.

On appeal, the Arizona Supreme Court assessed the issue of whether an insurer may contest coverage for lenders'/creditors' claims based on policy provisions stating, "(a) that the insurer's liability for loss or damage shall not exceed the indebtedness owed to the insured and (b) that there is no coverage for title defects or liens resulting in no loss to the insured." The parties agreed that the title insurance policy did not guarantee the loan, but only the priority of the deed of trust over encumbrances existing at the time the policy was issued, like a mechanic's lien.

The Court considered, in-depth, the effect of the *Morris* agreement on the insurer's ability to contest the insureds' liability. While the Court did not address whether *Morris* agreements are proper in the first-party context, the Court held a first-party *Morris* agreement necessitates that the concepts of liability and coverage overlap, since the "liability" is to the insured under the policy. The Court emphasized that a *Morris* agreement is binding on an insurer as to the existence and extent of the insured's liability only. Because the *Morris* agreement in this case did not resolve claims as to third parties (but only the insurer's liability to the insured), the Court held that coverage and liability were coextensive.

Applying this reasoning, the Court held that the only liability that was resolved by the *Morris* agreement in this case was the lien priorities. Ultimately, the Court, finding that the creditors were fully repaid, ruled that the insureds suffered no damages covered under the policy and the insurer did not breach the terms of the policy.

Cravens v. Montano

567 P.3d 745
(Ariz. 2025)

The Arizona Supreme Court held that, under a commercial automobile insurance policy, an employee operating a vehicle not owned by his employer is covered only if the vehicle's use is directly involved in or in furtherance of the employer's business purpose, which does not include a routine commute to and from an employer's office.

The case arose after an employee negligently caused a fatal collision while driving his mother's vehicle to his employer's office. The employee discovered that his company vehicle needed repair, so he drove to his mother's house to borrow her car. After completing his work for the day, he drove back to his employer's office to correct his timesheet when the accident occurred. At that time, Cincinnati Indemnity Company insured the employer under a commercial automobile policy that extended coverage to an employee using a "covered auto" "in connection with" the employer's business, which Cincinnati interpreted to mean the employee must have been acting within the course and scope of employment at the time of the accident.

The surviving spouse filed a wrongful death action against the employee and his employer. Cincinnati issued a reservation of rights letter to the employee, disputing its duty to defend or indemnify and asserting the employee was not acting within the scope of employment at the time of the collision. Thereafter, the employee and the surviving spouse entered into a Morris settlement agreement, stipulating to a $3.85 million judgment against the employee and an assignment of rights under the policy to the surviving spouse in exchange for a covenant not to execute the judgment against the employee's personal assets.

Cincinnati intervened, seeking to void the *Morris* agreement because it had no duty to indemnify under the policy. The trial court ruled against Cincinnati on the issue of coverage. The trial court further held that the settlement agreement was reasonable and granted summary judgment in favor of the surviving spouse. The court of appeals affirmed.

In vacating the court of appeals' coverage ruling and reversing the trial court's grant of summary judgment against Cincinnati, the Arizona Supreme Court held that the policy's phrase "in connection with your business" requires the vehicle's use to be directly involved with or in furtherance of the employer's business purpose, excluding routine commutes to and from an employer's office. The Court further reasoned that the phrases "in your business" and "in connection with your business" were ambiguous and had two competing interpretations; thus, an accurate interpretation of the policy required a reading of both. The Court concluded that the phrase means "less than the course and scope of employment but more than a mere association, link, or relationship" and that "the Policy's coverage for an employee's use of a covered auto 'in connection with your business' is contingent upon the employee's engagement in an employer's business at the time of the coverage event." The Court conclusively ruled that routine communicate to or from an employer's offices does not constitute "in connection with your business."

California

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11640 Woodbridge Condo. Homeowners' Assn. v. Farmers Ins. Exch.

110 Cal. App. 5th 211 (2025)

The California Court of Appeal reversed the trial court's grant of summary judgment to Farmers Insurance Exchange regarding the insured HOA's claim for water damage. The Court of Appeal found that there were triable issues of material fact as to the applicability of the water damage and faulty workmanship exclusions in the insured's "all-risk" condominium policy. The California Supreme Court granted review of the decision in July 2025, which remains pending.

Appellant 11640 Woodbridge Condominium Homeowners' Association hired Nelson Alcides Bardales, doing business as Local Roofer, to replace the roof of a condominium complex building. Over the first five days of his work, he removed approximately 80 percent of the roof membrane. Thereafter, a rainstorm damaged the exposed insulation and plywood. The roofer had to remove and replace the insulation and plywood before continuing the job. Before he completed the work, a second heavy rainstorm hit, causing water to enter all the condominium units and resulting in significant damage.

11640 Woodbridge made a claim under its Condo/Townhome Premier Policy written by respondent Farmers Insurance Exchange. Farmers denied the claim, determining that the losses resulted from nonaccidental faulty workmanship that was not covered under the water damage and faulty workmanship exclusions. 11640 Woodbridge subsequently filed suit in Los Angeles Superior Court, alleging breach of contract and breach of the implied covenant of good faith and fair dealing against Farmers. Farmers moved for summary judgment. The trial court granted the motion, concluding that there was no coverage under the Policy's exclusions as a matter of law.

The insured homeowners' association appealed. The Court of Appeal reversed the trial court's decision, finding that the Policy was an "all-risks" policy that covered all damage to 11640 Woodbridge unless specifically excluded.

Moreover, the Court found that there were triable issues as to whether the water damage and faulty workmanship exclusions precluded coverage. As for the water damage exclusion, it barred coverage unless a covered cause of loss allowed rainwater to enter through the roof. Farmers argued that the roofer's deliberate conduct in opening the roof (which allowed the water to enter) was not a covered cause of loss because it was non-fortuitous. The Court disagreed, noting that the policy contained no fortuity requirement. As such, the Court held there was a triable issue as to whether the roofer's conduct was a covered risk that triggered the exception to the water damage exclusion.

Regarding the faulty workmanship exclusion, the Court noted that it applied to damage caused by "negligent work." Farmers asserted that this exclusion precluded coverage because all of 11640 Woodbridge's losses were caused by the roofer's allegedly negligent decision to remove the entire roof before replacing any part of it. However, the Court of Appeal disagreed, finding that Farmers had failed to establish that the roofer's claimed negligent conduct was the sole cause of water entering the building. As such, the Court found that the trial court erred in finding that Farmers was entitled to summary judgment under the policy's water damage and faulty workmanship exclusions.

Murphy v. AAA Auto Insurance of Southern California

108 Cal.App.5th 476 (2025)

The California Court of Appeal affirmed summary judgment in favor of a personal automobile insurer, holding that a Compensated Carrying Exclusion unambiguously barred coverage when the insured was transporting property for compensation. The Court concluded that the exclusion applied to delivery work performed by employees and precluded coverage where an insured used his personal vehicle to transport property for compensation.

Plaintiff Andrew Murphy worked as a delivery driver for a cannabis retailer and delivery service known as Grassdoor. Using his personal vehicle, Murphy drove to Grassdoor's warehouse, where cannabis products were loaded onto his vehicle for his deliveries each workday. Murphy typically worked nine hours each day for five days per week and was compensated weekly.

At the time of the incident, Murphy was an insured under a personal automobile policy issued by Interinsurance Exchange of the Automobile Club. The policy contained a Compensated Carrying Exclusion, which stated that the policy "does not apply: (a) to any automobile . . . while used to carry persons or property . . . in each instance for: (1) a charge; (2) any form of compensation, voluntary payment or benefit; or (3) the promise or agreement for any form of compensation, voluntary payment or benefit."

While delivering products for Grassdoor, Murphy was involved in a vehicle collision resulting in damage to his vehicle. He submitted a claim to the Interinsurance Exchange, which denied coverage based on the Compensated Carrying Exclusion.

Murphy filed a lawsuit alleging breach of contract and argued that the exclusion was ambiguous and should not apply to delivery drivers who are employees rather than independent contractors. The Interinsurance Exchange moved for summary judgment, arguing that the exclusion barred coverage. The trial court granted summary judgment for Interinsurance Exchange, finding that the exclusion was unambiguous and enforceable.

The Court of Appeal affirmed, holding that the exclusion precluded coverage for damage sustained while Murphy was transporting property (i.e., cannabis products) for compensation. The Court found that the exclusion was unambiguous, conspicuous, and sufficiently understandable. The Court further noted that Murphy's employer, Grassdoor, was legally responsible for making him whole under Labor Code section 2802(a), which requires an employer to indemnify its employee for losses incurred in the discharge of his duties. Although Murphy argued the employer was insolvent, the Court stated the insurer's coverage obligations were not triggered by the employer's financial condition. Accordingly, the Court concluded that the Compensated Carrying Exclusion applied to bar coverage and that the Interinsurance Exchange's denial was proper.

Gharibian et al. v. Wawanesa General Ins. Co.

108 Cal.App.5th 730 (2025)

The California Court of Appeal upheld the trial court's ruling that wildfire debris which fell on the insureds' property did not cause "direct physical loss" of the type covered under a homeowner's policy. In so finding, the Court reasoned that the alleged damage did not significantly alter the insureds' property in a "lasting and persistent manner" but could be easily cleaned.

The plaintiff homeowners' claim arose out of the Saddle Ridge wildfire that burned half a mile away from their property. Although the insureds' property did not suffer any burn damage, they alleged that soot and ash entered their property and fell into their swimming pool. Their homeowners insurer, Wawanesa, retained industrial hygienists to evaluate the scope of repairs and the extent of damage to plaintiffs' property. Ultimately, Wawanesa paid the insureds $20,718.09 for professional cleaning services that they never used, electing to clean the property themselves. Ultimately, the insureds contended that their home suffered extensive damage, requiring interior painting, exterior wood and stucco painting, replacement of attic insulation, swimming pool work, and cleaning of the HVAC system, totaling $35,553.10.

Following initial discovery, Wawanesa moved for summary judgment arguing that the soot and ash debris did not cause physical damage to the property.

The trial court granted Wawanesa's motion, ruling that there was no evidence of a "direct physical loss" within the meaning of the policy. The plaintiffs appealed and the appellate court affirmed.

The Court of Appeal focused on whether the insureds had shown any "direct physical loss" to the property. The court reasoned that the damage "must result in some injury to or impairment of the property." The court applied the reasoning of the California Supreme Court in *Another Planet Entertainment, LLC v. Vigilant Ins. Co.*, which addressed whether the presence of the COVID-19 virus on the insured's premises could cause "direct physical loss." As *Another Planet* observed, there is a "long-standing California view that direct physical loss to property requires a distinct, demonstrable, physical alteration of property." In the case before it, the appellate court stated, there was no such evidence of physical alteration. In fact, the soot was incapable of causing physical damage. Moreover, while the ash could in theory cause damage if it became wet, there was no evidence that this occurred. Since there was no showing of a covered claim for "direct physical loss," the appellate court concluded that Wawanesa did not breach (and could not have breached) its insurance policy.

Colorado

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El Dueno, LLC v. Mid-Century Ins. Co.

2025 WL 1540329
(10th Cir. May 30, 2025)

The United States Court of Appeals for the Tenth Circuit held that a claimant must articulate an industry standard and demonstrate a violation of that standard by its insurer to prevail on a claim under Colorado Revised Statute sections 10-3-1115 that its insurer had no reasonable basis to deny coverage.

Plaintiff, El Dueno, LLC, was insured under a policy on a commercial building that included coverage for direct physical loss caused by hail. El Dueno submitted a claim to its insurer, Mid-Century Insurance Company, for roof damage sustained in a hailstorm. The adjuster handling the claim determined there was hail damage and authorized a $12,000 payment to the plaintiff. El Dueno then hired a contractor to repair the roof. The contractor estimated that to repair the roof and bring it up to code, it would cost $343,000. El Dueno submitted this estimate to Mid-Century, which then sent another payment to plaintiff for rooftop HVAC repairs.

When El Dueno submitted the new estimate, the Mid-Century hired an expert to determine whether it was hail that damaged the roof. The expert determined that hail did not damage the roof, and that any damage to the roof was preexisting or resulted from other causes. Mid-Century notified its insured that the policy did not cover the roof repairs but stated it would not seek to recoup the previously disbursed payments.

El Dueno filed suit against the Mid-Century for a single claim of unreasonable delay or denial of benefits under Colorado Revised Statute section 10-3-1115. Mid-Century retained another expert to inspect the roof. This expert agreed that hail did not damage the roof. El Dueno's expert disagreed.

To prevail on a claim for unreasonable payment denial or delay, a plaintiff must prove that "the insurer acted unreasonably and with knowledge of or reckless disregard for the fact that no reasonable basis existed for denying the claim." Here, the Court held that El Dueno failed to demonstrate that Mid-Century lacked a reasonable basis to deny coverage where the expert report stated that hail did not damage the roof.

Additionally, the Court discussed El Dueno's failure to establish evidence of an industry standard and found this to be fatal to its claim. The Court held that an industry standard must be articulated even where the case may be within the understanding of an ordinary person, as the Court must be able to compare the insurer's conduct with an articulated industry standard. Absent evidence of an industry standard, the Court held, El Dueno had shown no more than a disagreement, which is not enough to prevail on a claim under section 10-3-1115 under Colorado law.

New Hampshire Ins. Co. v. TSG Ski & Golf, LLC

128 F.4th 1337
(10th Cir. 2025)

The United States Court of Appeals for the Tenth Circuit found that where a complaint alleges that an insured knowingly published false statements, knowledge-of-falsity exclusions may apply to preclude a duty to defend even when a plaintiff is not required to prove knowledge as part of its claims.

In this case, the insured TSG Ski & Golf, LLC was sued in an underlying case in which the underlying plaintiffs plead, and later demonstrated, that TSG knowingly made false statements in debt collection letters. TSG requested a defense and indemnity from its insurers, New Hampshire Insurance Company and National Union Fire Insurance Company of Pittsburgh, PA, against the claims in the underlying lawsuit. The insurers declined based on knowledge-of-falsity provisions in their policies. In these provisions, both insurers excluded coverage for personal and advertising injury arising out of publication of material the insured knew to be false. The insurers then filed this action for declaratory judgment, and TSG filed counterclaims for breach of contract, common-law bad faith, and statutory bad faith.

The trial court granted summary judgment to the insurers on all claims, and the Tenth Circuit Court of Appeals affirmed. The Court of Appeals noted that the parties agreed that the allegations of the underlying complaint fell within the scope of coverage for personal and advertising injury. However, the Court stated, the allegations also triggered the knowledge-of-falsity exclusions.

The Court found that each element of the exclusions was alleged in the complaint. In particular, the Court noted that the underlying complaint "was replete with allegations that the false statements were published … with knowledge of their falsity."

Holding that the allegations in the complaint fell entirely within the knowledge-of-falsity exclusions, the Court affirmed that the insurers did not have a duty to defend TSG in the underlying lawsuit.

In reaching its holding, the Court of Appeals addressed TSG's counterarguments, holding that while the underlying plaintiff was not required to prove knowledge of falsity of the statements to prevail on its claims, the policy exclusions would still apply because the allegations set forth in the underlying complaint clearly alleged that TSG had knowledge the statements were false. The Court relied on and reiterated the Colorado Supreme Court's reasoning in *Thompson v. Maryland Cas. Co.*, 84 P.3d 496 (2004), explaining that the elements of claims set forth in the complaint did not need to be considered when assessing if the allegations plead in the complaint invoked coverage.

Additionally, the Court held the insurers had no duty to indemnify the TSG because testimony in the underlying lawsuit established that the TSG did, in fact, know the statements at issue were false when published. In making this ruling, the Court disagreed with the TSG's claim that the Court could not consider testimony from the underlying trial in making this determination.

The Court's ruling further establishes that the factual allegations in a complaint may apply to preclude coverage, including a duty to defend, even if such allegations may not necessarily make up an element of the underlying claims.

Scott v. Nationwide Agribusiness Ins. Co.

141 F.4th 1151
(10th Cir. 2025)

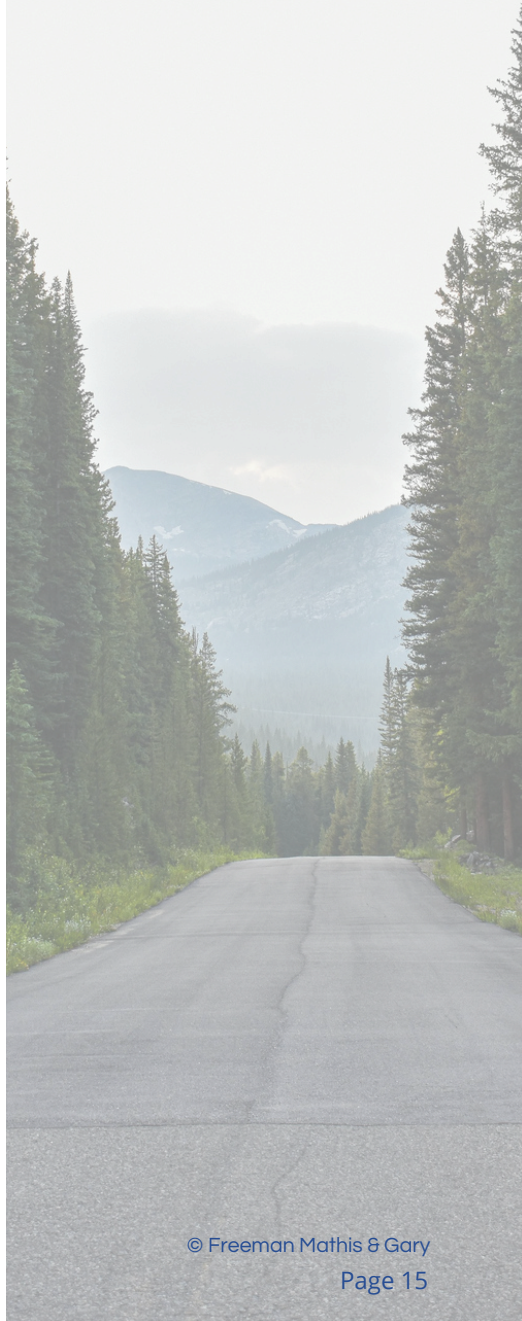
The United States Court of Appeals for the Tenth Circuit held that an auto liability policy may lawfully limit coverage to only the vehicles listed on the declarations page because Colorado's mandatory liability coverage is tied to specific vehicles rather than to every insured under the policy.

This matter stems from injuries Plaintiff Scott suffered in a motor vehicle accident caused by Ellen Cahill. Cahill and her vehicle were insured under a Hartford auto policy. She was also insured as a "resident relative" under a policy issued by Nationwide to Cahill's son. The Nationwide policy listed two vehicles as covered, neither of which was the vehicle involved in the motor vehicle accident. Scott and Cahill arbitrated their damages, and Scott was awarded nearly $425,000, which became a state court judgment. Hartford paid its policy limits of $25,000, leaving approximately $400,000 owed to Scott.

Scott filed a declaratory judgment in federal court in Colorado, demanding that Nationwide step in to cover the amount owed under her son's policy under which she was a covered resident relative. Nationwide moved for summary judgment, arguing that its policy only extended liability protection to accidents involving the two scheduled vehicles. Scott countered that, as an insured resident relative, Colorado law required Nationwide to cover her no matter what car she was driving. The federal district court sided with Nationwide, holding that Colorado's insurance statutes allow carriers to tie liability coverage to specific vehicles. Scott appealed.

The Tenth Circuit affirmed, finding that Colorado's mandatory insurance law requires owners to carry coverage "for the said motor vehicle," and that the financial responsibility statute demands policies "designate by explicit description" the vehicles covered. While Colorado's statutory definition of "insured" includes resident relatives, it does not compel an insurer to extend coverage to every household member in every car they may drive. Moreover, the Court reasoned, liability insurance attaches to the risk of a specific vehicle, and this is how premiums are set. As such, because Cahill's vehicle did not appear on the Nationwide policy declarations, the policy did not extend to cover the loss from the accident.

This ruling keeps Colorado in step with the plain language of its auto insurance statutes and preserves the industry standard of scheduling coverage by vehicle. While resident relatives remain insured, coverage only extends to operation of named vehicles under the policy.



Spectrum Retirement Communities, LLC v. Continental Casualty Co.

574 P.3d 733
(Colo. App. 2025)

The Colorado Court of Appeals affirmed the trial court's finding that COVID-19 and related government shutdown orders did not cause a "direct physical loss" under a commercial property policy, but reversed and remanded the dismissal of claims under a health care endorsement providing independent coverage for pandemic-related costs without a physical loss trigger.

Spectrum Retirement Communities, LLC operated forty-three senior living and memory care facilities across ten states. When the COVID-19 pandemic hit, state and federal authorities mandated the facilities to stay open but required Spectrum to take certain precautions, which drove up costs and left vacancies in the facilities and decreased revenue. Spectrum filed a claim with its insurer, Continental Casualty Company for the lost revenue under an all-risk commercial property policy with a health care endorsement (HCE), which Continental denied.

Spectrum filed suit against Continental for breach of contract and bad faith stemming from the denial of coverage. At the onset of the suit, Continental moved to dismiss, arguing no physical loss had occurred. The trial court judge disagreed, finding that Spectrum had plausibly pleaded that the virus caused a "direct physical loss" under the policy. After eighteen months of discovery and based on new rulings from the Colorado Supreme Court and the Tenth Circuit requiring lasting structural changes to constitute a "direct physical loss," Continental moved for judgment on the pleadings.

The trial court granted judgment, finding that Spectrum's loss was not physical and that government orders alone could not trigger coverage under the policy. Spectrum appealed based on a 1968 case where the Colorado Supreme Court held gasoline vapors that soaked into a building's foundation constituted a covered physical loss.

In upholding the trial court's ruling, the Court of Appeals majority noted that in the case cited, the gasoline infiltrated the structure itself which required foundation repairs and rendered the building uninhabitable, while here, the virus sat on surfaces and ultimately the facilities never closed and remained inhabited. As a result, the Court ruled that Spectrum failed to plead facts that could establish it suffered a direct physical loss under the policy. However, the Court unanimously found that the trial court erred by failing to consider whether the loss was covered under the HCE, which did not require a physical loss as a prerequisite to coverage, and the case was remanded for further proceedings.

This ruling brings Colorado in line with the majority view rejecting business interruption coverage resulting from COVID-19 and shutdowns, but also highlights how specialized endorsements may provide coverage for certain businesses facing pandemic expenses.

Connecticut

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Bouazza v. Geico General Ins. Co.

230 Conn. App. 297 (2025)

The Connecticut Appellate Court held that the litigation privilege doctrine barred an insured's bad faith claim against an insurer to the extent the claim was based on conduct and communications made during the course of litigation, but did not bar allegations of bad faith premised on pre-litigation claim-handling conduct occurring outside a judicial proceeding.

In this matter, Plaintiff Saaida Bouazza filed a lawsuit against her insurer Geico General Insurance Company seeking underinsured motorist benefits arising out of a February 4, 2017, motor vehicle accident. The at-fault driver was insured under a liability policy of $20,000 per person and $40,000 per accident, and Bouazza settled her claim against the tortfeasor for the full limits of his policy. Bouazza was insured under an automobile policy issued by Geico that provided underinsured motorist coverage in the amount of $100,000 per person and $300,000 per occurrence. Bouazza alleged that the settlement with the at fault driver was insufficient to fully compensate her for her injuries. On June 30, 2020, Bouazza filed an offer of compromise in the amount of $50,000, which the Geico rejected. Geico filed its own offer of compromise in the amount of $20,000, which the Bouazza rejected. Bouazza later sought and was granted leave to amend her complaint to add a claim for breach of implied covenant of good faith and fair dealing, which the trial court bifurcated from the underinsured motorist claim.

Following a jury verdict in favor of Bouazza, Geico filed a motion to dismiss the bad faith count for lack of subject matter jurisdiction, arguing that the litigation privilege doctrine provided absolute immunity. Geico argued that the Bouazza's allegations of bad faith stemmed from conduct and communications during litigation, including its refusal to accept the her offer of compromise, as well as Geico's negotiation position after suit had been filed. The trial court granted the motion to dismiss, concluding that Bouazza's bad faith allegations challenged only the Geico's conduct in negotiating the settlement of the underinsured motorist claim.

On appeal, Bouazza argued that the trial court improperly applied the litigation privilege doctrine by failing to distinguish conduct occurring during litigation and conduct occurring during the pre-litigation claim-handling process. Bouazza argued that her allegations included refusal to make a reasonable offer on her underinsured motorist claim, refusal to accept her offer of compromise, intentional delay, failure to promptly adjust her claims, and evaluation practices to force her to accept less than fair value for her claim.

In affirming in part and reversing in part, the Connecticut Appellate Court held that litigation privilege applied to allegations based on communications and conduct occurring during the course of litigation, including settlement negotiations once suit had been filed. However, the Court concluded that the privilege did not extend to allegations of bad faith based on pre-litigation conduct, such as Geico's refusal to promptly adjust the claim, its uniform evaluation practices, and its alleged delays intended to pressure Bouazza into accepting an inadequate settlement. Because those allegations were not logically related to a judicial proceeding, the appellate court held they were not protected by the litigation privilege doctrine.

The Bouazza decision significantly narrows the scope of litigation privilege. While this decision clarifies that liability made for conduct during judicial proceedings is protected by litigation privilege, pre-litigation conduct, such as claim evaluation and settlement tactics, the Connecticut Appellate Court held it is not protected and may be subject to bad faith claims.

Gerald Metals, LLC, et al., v. Certain Underwriters at International Underwriting Association of London

231 Conn. App. 514 (2025)

The Connecticut Court of Appeals held that the trial court did not err in granting the Insurer's Motion for Summary Judgment which found that there was a lack of coverage under a marine cargo insurance policy for the alleged loss of property seized by the Chinese government. The Court held that collateral estoppel prevented the Insured from relitigating issues regarding whether the property was stolen or seized and, therefore, there was no coverage under the policy.

The Plaintiff in this case, two Gerald Metals entities, purchased 25,250 metric tons of alumina from a Chinese aluminum smelter. The material was shipped to a warehouse in China where it remained until the Plaintiffs sought to have the material transferred in connection with a pending sale. The Plaintiffs were not given access to the material.

On January 15, 2015, Gerald Metals submitted a claim to their insurer for the loss of the material. On January 18, 2016, the Insurer denied coverage based on an October 19, 2015 report prepared by surveyors hired by the Insurer that found that the property was still on site and remained under the detention of Chinese authorities. The Insurer stated that Gerald Metals being denied access to the material did not warrant a covered claim and that the policy's seizure exclusion applied.

Gerald Metals subsequently filed suit against the Insurer for breach of contract and breach of the implied covenant of good faith and fair dealing. During the course of the litigation, the Insurer learned that Gerald Metals submitted its claim to arbitration against the entity that warehoused the material. The decision of the Arbitrator found that Gerald Metals never had possession of the material as it received a receipt that was void and did not convey the material to Gerald Metals. Further, the facts that were established during the arbitration indicated that as a result of a fraud investigation into the seller of the material, a court order for preservation of the material was issued, resulting in a seizure of the material.

The Court of Appeals agreed with the trial court that Gerald Metals was collaterally estopped from relitigating issues as to whether the property was stolen or seized.

Therefore, it was determined that it was established that the property had in fact been seized. The Court further agreed with the trial court that Gerald Metals was unable to establish that it has an insurable interest in the property, that the claim did not involve "physical loss or damage" which would have triggered coverage, and even if there was "physical loss or damage", the seizure exclusion in the policy precluded coverage.

With respect to the coverage determination, the Court of Appeals noted that the policy did not define "physical loss or damage". As a result, it looked to recent decisions of the Connecticut Supreme Court which defined physical loss or damage as requiring some physical, tangible alteration to or deprivation of the property that renders it physically unusable or inaccessible. The court noted that stolen property could be considered because it is physically inaccessible to the insured as it was physically removed from the possession of the insured. Here, however, the court found that Gerald Metals merely lost the use of the property. Moreover, the alleged loss of use did not occur during the period of time alleged in the Complaint. The court noted that there was no evidence that they did not have access to the material during the time period set forth in the Complaint.

Finally, while acknowledging it was a matter of first impression in Connecticut, the Court held that the events in this case leading to a court ordered preservation of the material at the warehouse, thereby making it inaccessible to Gerald Metals, were considered a seizure under the applicable seizure exclusion in the policy. The court order was a form of seizure or detainment by legal process that was excluded from coverage. As a result, Gerald Metals was unable to show that there was a genuine issue of material fact that existed as to whether their loss was covered under the policy.

Theraplant, LLC v. National Fire & Marine Insurance Company

763 F.Supp.3d 209
(D. Conn. 2025)

The United States District Court for the District of Connecticut, applying Connecticut Law, granted the insurer's Motion for Summary Judgment finding that the subject insurance policy did not provide coverage for the Plaintiff's claimed business income loss. The court found that the Plaintiff failed to establish that the suspension of any business operations lead to a recoverable loss of income.

A fire at the Plaintiff Theraplant, LLC's facility damaged one of the seven flowering rooms in the facility, along with equipment and approximately 1,000 marijuana plants. Their insurer, National Fire & Marine Insurance Company, provided a commercial insurance policy which covered building and personal property damage. National Fire made payments to Theraplant which covered the damage to the building and equipment. Through an endorsement, though, the policy specifically excluded cannabis, marijuana, and products infused with marijuana from coverage. Theraplant did not obtain crop insurance from National Fire. In light Theraplant's failure to obtain crop insurance, the court noted that Theraplant was attempting to mold its claim for the loss of the marijuana plants into a business income loss under the additional business income coverage provided by National Fire.

In granting National Fire's Motion for Summary Judgment, the federal district court applied Connecticut law to find that Theraplant failed to provide any evidence to support its claim that a suspension of its operations resulted in a business income loss. The Court noted that there are six elements that must be established in a coverage dispute involving business income loss: 1) physical loss or damage; 2) to covered property; 3) caused by a covered peril during the policy period; 4) resulting in an actual loss of income; 5) due to necessary suspension of operations; and 6) during the period of restoration. The basis for National Fire's Motion for Summary Judgment was that Theraplant could not establish a causal link between the actual loss of income and the suspension of operations.

In reviewing the evidence presented, the Court found that Theraplant could not establish that the damaged flowering room would be used for any other stage of the operation during the restoration period or that the ongoing restoration delayed the transfer of plants to any other rooms that remained operational. There was simply no evidence presented that there was any lengthy delay in Theraplant's operations that lead to a loss of income.

The Court also noted that Theraplant was not directly addressing the causation issues but trying to argue that the fire was the efficient cause of the loss. The Court rejected Theraplant's attempted use of the "train of events test" because it could not establish that both the fire and the suspension of operations caused the business income loss.

The Court found that the purpose of business interruption insurance is to indemnify the insured against losses arising from the inability to continue normal business operations and functions due to damage sustained as a result of the hazard insured against. It is not meant to provide coverage for damaged or destroyed property. Here, Theraplant did not establish that any suspension of operations resulted in the loss. The Court noted that ongoing repairs did not force Theraplant to scale back its business and that allowing Theraplant to recover in this case would neither further nor serve the purpose of the business interruption insurance.

Delaware

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In Re Alexion Pharm., Inc. Ins. Appeals

339 A.3d 694
(Del. 2025)

The Supreme Court of Delaware held that the Delaware Superior Court erred in concluding that a Securities Exchange Commission ("SEC") investigation that was disclosed to the insurers was not related to a later securities class action. Since the Superior Court held the two were not related, the coverage of the class action fell into the second tower which had higher limits. The Supreme Court held that the class action arose out of the circumstances disclosed by Alexion to its first tower insurers meaning that coverage should have been placed in the first tower.

The issue on appeal in this insurance coverage dispute was whether an SEC investigation, disclosed by Alexion Pharmaceuticals, Inc. to its insurers was related to a later securities class action brought against the company and others by stockholders. As described by the Court, if it was related, the securities class action was covered by Alexion's first insurance tower. If not, it was covered by the second tower. The Court applied the "meaningful linkage" standard and determined that the securities class action arose out of the circumstances disclosed by Alexion to its first tower insurers and coverage should have been placed in the first tower.

Alexion was insured under two claims-made director and officer ("D&O") liability insurance programs covering different periods. The first, Tower 1, provided $85 million of coverage for claims between June 27, 2014, and June 27, 2015. The second, Tower 2, provided $105 million coverage for claims between June 27, 2015, and June 27, 2017.

In 2015, Alexion submitted a notice of circumstance to its Tower 1 insurers disclosing an SEC investigation of its worldwide grant-making policies and the company's disclosures regarding a particular drug. Alexion warned that the investigation may lead to further claims, including lawsuits brought by private litigants.

In December 2016, during the Tower 2 period, stockholders brought a federal securities class action alleging unethical and illegal sales and lobbying practices by its directors and officers. Alexion sought coverage for the securities class action under Tower 2.

Chubb originally accepted coverage under Tower 2 but later reassigned coverage to Tower 1, stating that the litigation arose from the circumstances and anticipated Wrongful Acts reported during the Tower 1 period and related to the original SEC investigation. Chubb concluded that the securities class action was covered under the prior period of coverage. In 2023, Alexion settled the securities class action. Although the settlement exceeded the coverage limits under both towers, Tower 2 provided $20 million more coverage than Tower 1.

Alexion filed a coverage action and sought a declaratory judgment that the securities class action was a claim first made under the Tower 2 period, arguing that the litigation was unrelated to the SEC Subpoena. The Superior Court of Delaware applied the "meaningful linkage" standard and determined that the SEC investigation was only loosely related to the class action, concluding that the factual connection between the SEC subpoena and the securities action was insufficient to make them related. However, on appeal the Delaware Supreme Court reversed this decision, stating that the trial court erred in identifying the objects of comparison for the "meaningful linkage" analysis. The Supreme Court noted that both involved the same alleged wrongdoing and the lawsuit explicitly referred to the SEC subpoena and the SEC's investigation and cited Bloomberg reporting on the investigation. It did not matter that different parties were involved, different theories of liability were asserted, or different relief sought. It was the common underlying act that controlled. As such, the Supreme Court concluded that the lawsuit was meaningfully linked to the wrongful acts disclosed to Chubb in the 2015 notice. Accordingly, coverage for the class action was under Tower 1.

In re CVS Opioid Ins. Litig.

346 A.3d 81, 2025 WL 2383644 (Del. 2025)

The Supreme Court of Delaware held that CVS's insurers, Chubb and AIG, did not owe coverage in lawsuits brought against CVS by governments, hospitals, and third-party payors that alleged CVS's role in the opioid epidemic caused them to incur significant public costs—for example, the costs of Narcan incurred by police and fire departments, and the costs of public clean-up efforts relating to discarded needles and other debris. The Court held that coverage was not available because the lawsuits against CVS do not seek damages for any specific person's bodily injury or damage to any specific property.

In an effort to recoup costs related to the opioid epidemic, entities across the United States have sued opioid manufacturers, distributors and retailers, including CVS. CVS sought coverage from its insurers for these lawsuits. In response, CVS's insurers filed a declaratory judgment action seeking a declaration that they owed no duty to defend.

Chubb and AIG issued multiple insurance policies to CVS generally providing coverage for liability "because of 'bodily injury'" or "'property damage'" "to which this insurance applies" if caused by an "occurrence" (i.e., an accident). Some of the Chubb policies contained a Pharmacist Liability Endorsement, which provided coverage for "damages because of 'bodily injury' arising out of a 'pharmacist liability incident,'" meaning "an actual or alleged negligent act, error, or omission" in the course of providing pharmacy services. Similarly, some of the AIG policies contained a Designated Professional Services Druggist Liability Endorsement, which provided that "'[b]odily injury' or 'property damage' arising out of the rendering of or failure to render professional health care services as a pharmacist shall be deemed to be caused by an 'occurrence.'"

Chubb and AIG argued that the underlying plaintiffs did not allege damages "because of" any specific person's bodily injury or damage to any specific property. Rather, the underlying plaintiffs sought to recover only their own economic losses, which were not sufficiently linked to any individual's bodily injury or damage to specific property. CVS argued that the underlying suits did allege damages because of bodily injury and that the Pharmacist Liability Endorsement under the Chubb policies and the Designated Professional Services Druggist Liability Endorsement expanded coverage under the policies, or were at least ambiguous enough to compel coverage, such that the "because of" language did not defeat coverage.

The Court sided with the insurers and found no coverage. The Court's analysis turned on its prior decision in *ACE Am. Ins. Co. v. Rite Aid Corp.*, which held that insurers have no duty to defend under policies providing coverage for lawsuits "for" or "because of" personal injury if the plaintiffs in those lawsuits allege only their own economic damages and not damages attributable to a specific person's bodily injury or damage to specific property. 270 A3d 239 (Del. 2022). Since the Chubb and AIG policies contained the same "because of" language at issue in *Rite Aid*, and the plaintiffs in the underlying suits against CVS did not seek damages for any specific person's bodily injury or damage to specific property but rather their own economic damages, no coverage was available under the policies.

CVS also argued that the Court should distinguish coverage for "bodily injury" from coverage for "property damage," because the "individualized, specific" requirement was only applied to bodily injury claims in *Rite Aid*. CVS argued that because bodily injury coverage is different from property damage coverage, the categories should be treated differently, and that because the underlying suits alleged property damage, the duty to defend was triggered. But the Court rejected this argument too, reasoning that the terms often appeared side-by-side in the policies and were both subject to the "because of" and "occurrence" requirements. The Court thus applied the "individualized, specific" requirement to property damage claims and held that the requirement was not satisfied in CVS's case.

This holding in this case is consistent with the majority of decisions in other jurisdictions dealing with these types of claims, which have largely rejected coverage for such non-individualized claims arising from the opioid epidemic.

Florida

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Direct Gen. Ins. Co. v. Creamer

2025 WL 2780245
(M.D. Fla. Sept. 30, 2025)

The United States District Court for the Middle District of Florida finds Florida's Tort Reform "safe harbor" provision applies retroactively to a policy issued before the enactment of tort reform.

Twenty-three days after a 2019 automobile accident, the at-fault driver's insurance carrier, Direct General Insurance Company ("DGIC"), tendered its bodily injury policy limits totaling $10,000.00 per person. DGIC's policy was effective from April 11, 2019 to January 31, 2020. The underlying plaintiff ultimately rejected DGIC's tender because a financial affidavit from Sean Creamer, DGIC's insured, could not be secured.

In the underlying case, a jury awarded a verdict of $1,250,000.00 that was subsequently increased to $1,809,567.48 – well in excess of the $10,000.00 bodily injury policy limits. DGIC then filed a declaratory judgment action in federal court, seeking a declaration that it had acted in good faith by tendering its limits in accordance with Florida's new "safe harbor" provision. The final excess judgment in the underlying case was entered on August 17, 2023, and on that same day the underlying plaintiff moved to add the insurer as a party to the final judgment. Importantly, DGIC's insured never assigned his rights under DGIC's policy to the underlying plaintiff.

During the declaratory judgment action in federal court, a dispute arose between the parties regarding the proper application of certain amendments to section 624.155 of the Florida Statutes as part of Florida's tort reform. Effective March 24, 2023, Florida's tort reform created a "safe harbor" provision providing an insurer with protection from bad faith claims if, within 90 days after receiving actual notice of a claim, it "tenders the lesser of the policy limits or the amount demanded by the claimant."

Here, DGIC tendered the full amount of its policy limits twenty-three days after it was notified of the claim, well within the 90-day window specified by section 624.155(4)(a).

The underlying plaintiff argued that Florida's tort reform was not retroactive and could not apply to a policy issued prior to March 24, 2023. The federal district court disagreed, explaining that the accrual of a bad faith claim is unrelated to the date on which the insurer issues a policy and instead is determined by the date the insured is legally obligated to pay a judgment in excess of his policy limits. Accordingly, since the triggering event for the "bad faith" claim – the entry of final judgment – did not occur until after the effective date of Florida's tort reform, DGIC was entitled to the safe harbor protections contained in section 624.155(4)(a), as amended.

Additionally, the federal district court also dismissed plaintiff's argument that applying Florida's tort reform retroactivity to a policy issued prior to its effective date would impair a vested contractual right. This was the case because underlying plaintiff, who was not a party to the policy, had no contractual right arising from that policy because he had not been assigned Creamer's rights under DGIC's policy. Even so, the Court stressed that this "right" did not arise until after the effective date of Florida's tort reform because the right arose when the final judgment was entered, which was in August 2023.

Estate of Joseph Hancock v. Florida Farm Bureau Gen. Ins. Co.

2025 WL 2679946
(Fla. Dist. Ct. App. Sept. 19, 2025)

Florida's Second District Court of Appeals found that it is appropriate for a trial court to instruct a jury that, in a bad faith case, an insurer's actions must be the "cause" of the underlying excess verdict.

On September 19, 2025, Florida's Second District Court of Appeals affirmed a final judgment in favor of Florida Farm Bureau General Insurance Company ("FFB") in a bad faith action. The case arose out of a fatal accident on May 28, 2016, in which FFB insured the driver that struck Mr. Hancock. Within days after the accident, FFB contacted Mrs. Hancock, Mr. Hancock's widow and personal representative of Mr. Hancock's estate, to tender FFB's $50,000 policy limit in bodily injury liability coverage.

It was undisputed that Mrs. Hancock intentionally refused to respond to multiple settlement overtures. In fact, on two occasions, an FFB adjuster went to the Hanock home and taped an envelope containing the $50,000 check to the door. At trial, Ms. Hancock testified that FFB's actions were "aggressive" and "otherwise upsetting" which impeded a settlement because she was "too frustrated with FFB's conduct to settle her claim within policy limits." FFB responded that the case could have never settled within limits because Ms. Hancock wanted to "punish" FFB's insured because she pressed for criminal charges against the insured.

Following a wrongful death suit against the FFB's insured, Mr. Hancock's estate was awarded $13,550,592 in damages. Thereafter, FFB's insured assigned her rights under her FFB policy to the Estate. In the subsequent bad faith action, the Estate alleged that FFB used improper and harassing tactics to pressure Mrs. Hancock to settle on behalf of the Estate, dissuading Mrs. Hancock from accepting the bodily injury liability limit and resulting in the excess judgment against its insured driver.

FFB argued that it did not cause the excess judgment where Ms. Hancock never intended to settle the claim, despite FFB's undisputed efforts to do so.

The jury determined that FFB acted in bad faith in handling the wrongful death claim, but that its actions were not the legal cause of the excess judgment against its insured driver. The estate then appealed, arguing: (1) the trial court improperly instructed the jury that FFB's "bad faith" had to be the cause of the excess judgment; and (2) the verdict form improperly required the jury to determine a causal connection between FFB's bad faith and the excess judgment.

The Second DCA held that the trial court's instruction was consistent with Florida's standard instruction 404.6(a) on legal cause. The verdict form similarly asked the jury to determine: (1) FFB's conduct as "bad faith" and (2) the existence of a causal connection between the "bad faith" and excess judgment against the insured driver.

The Court rejected the Estate's argument that the instruction and verdict form were unnecessarily confusing on the issues of causation (the severity of the accident) versus the failure to settle (FFB's claim handling). The Court emphasized that a trial court has discretion to formulate appropriate jury instructions which should not be reversed absent a miscarriage of justice or requisite jury confusion. The Second DCA found no such grounds for reversal, particularly where at trial the parties espoused the above two theories on the cause of the excess judgment, and the Estate conceded that causation was at issue for the jury's determination.

Martinez v. GEICO Cas. Ins. Co.

152 F.4th 1323
(11th Cir. 2025)

Applying Florida law, the Eleventh Circuit found that GEICO did not act in bad faith when it did not immediately tender its $10,000 per-occurrence limit because it had legitimate questions as to its insured's liability for the accident and it had questions as to whether its insured's vehicle was a "covered auto" under its policy. The Eleventh Circuit further sanctioned GEICO's actions in scheduling a global mediation conference to distribute its low aggregate to multiple claimants – including the plaintiff – who were seriously injured in the accident.

GEICO insured Diana Guevara, an allegedly at-fault party in a car accident that resulted in serious injury to the Plaintiff, Katherine Martinez. GEICO could not resolve Martinez's claims as she rejected GEICO's $10,000 per-occurrence limit offer. Martinez secured a verdict against Guevara in excess of GEICO's limits, and Guevara then assigned her rights under GEICO's policy to Martinez. Martinez then pursued a claim against GEICO for bad faith in failing to resolve the claims against its insured within its limits. The district court granted summary judgment in GEICO's favor. On appeal, the Eleventh Circuit upheld the district court's entry of summary judgment in GEICO's favor.

Martinez argued that GEICO acted in bad faith because it untimely delayed its tender offer. She insisted that the combination of her severe injuries and the low limits of the policy necessitated that GEICO immediately tender its per-occurrence limit to her despite legitimate questions of liability and coverage. GEICO argued that carriers must be allowed a reasonable time to diligently investigate questions of both liability and coverage before tendering policy limits. When utilizing the totality of the circumstances test, the Eleventh Circuit found that none of GEICO's actions, considered alone or in their totality, amounted to bad faith and granted GEICO's motion. In so doing, the Court rejected each of Martinez's counterarguments.

First, Martinez argued that GEICO should have tendered its limits even though it had questions as to whether it insured the vehicle that Guevara was operating at the time of the accident.

The Court rejected this argument, affirming the principle that insurers are not obligated to pay uncovered claims. The Court highlighted the fact that GEICO conducted its coverage investigation with diligence and set aside the aggregate coverage limit for a global settlement conference before it ultimately determined that Guevara's vehicle was covered under its policy. Martinez also attacked the timeliness of GEICO's investigation. She argued that GEICO's failure to meet internal timeliness guidelines in the interviewing of key witnesses and gathering of requisite documents proved bad faith. The Court rejected this argument, noting that the mere failure to comply with internal guidelines, while perhaps evidence of negligence, did not amount to bad faith.

Martinez argued that GEICO acted in bad faith by failing to offer her the policy's $10,000 per-occurrence limit before a global mediation with all injured parties. The Court determined that doing so would have been improper because liability on the part of GEICO's insured was not immediately apparent. Additionally, the Court found that where there are multiple claimants, a carrier should not immediately pay policy limits to the "most injured party," as this could put the insured at risk of an excess judgment that may be minimized by "wiser settlement practices."

Last, Martinez argued that GEICO improperly refused to engage in settlement negotiations above policy limits. The Court affirmed that carriers are not obligated to engage in settlement negotiations with claimants who are clearly unwilling to negotiate within policy limits.

Sheriff of Broward County v. Evanston Insurance Company

159 F.4th 792
(11th Cir. 2025)

The Eleventh Circuit finds the word "occurrence" ambiguous in the context of the tragic 2018 shooting at Marjory Stoneman Douglas High School.

In the aftermath of the Parkland school shooting in 2018, victims filed over sixty lawsuits against the Broward County Sheriff's Office ("BCSO") for allegedly failing to secure Marjory Stoneman Douglas High School once the shooting started.

The BCSO maintained excess insurance with Evanston Insurance Company ("Evanston"). The excess policy provided coverage to BCSO after the exhaustion of a $500,000 self-insured retention ("SIR") for each occurrence and a $500,000 aggregate deductible. BCSO initiated a declaratory judgment action against Evanston in the U.S. District Court for the Southern District of Florida to determine whether the Parkland shooting represented one occurrence or a separate occurrence for each shooting victim under Florida law. If BCSO prevailed, it would be responsible for one SIR and exhaustion of the $500,000 aggregate deductible. If Evanston prevailed, BCSO would need to exhaust multiple SIRs and the deductible before Evanston would provide liability coverage.

The decision turned on the appropriate interpretation of *Koikos v. Traveler's Insurance Company,* 849 So.2d 263 (Fla. 2003). In *Koikos*, a gunman shot two separate but nearly concurrent rounds, striking two people who then filed two separate suits. In that case, the insured argued that there were two "occurrences" because the policy carried a $500,000 "per occurrence" limit.

Under the same definition of "occurrence" as found in Evanston's policy, the *Koikos* court found that the shooting constituted two occurrences, not one.

At first blush, *Koikos* appears to support Evanston's argument – that in the Parkland shooting case, there were upwards of sixty "occurrences" based upon each separate pull of the gunman's trigger. The Eleventh Circuit, however, rejected this argument.

The Eleventh Circuit reasoned that *Koikos* turned on that court's decision that the term "occurrence" was ambiguous. And, when a term is ambiguous, it is construed against the insurer and in favor of the insured. In *Koikos*, the policy had a $500,000 limit per occurrence. By construing each victim as a separate occurrence, the insured received two $500,000 limits, maximizing coverage.

For the Parkland shooting case, the Eleventh Circuit held that the ambiguous term "occurrence" should be interpreted in the insured's favor. Thus, the Parkland shooting was considered a single occurrence, maximizing BCSO's coverage under Evanston's policy. BCSO would only need to satisfy one SIR, instead of sixty, and then exhaust the deductible.

The Court's decision results in opposite outcomes, but outcomes reached for the same reason: to maximize coverage for an insured when faced with interpreting an ambiguous term in an insurance policy.

Georgia

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Allred v. Progressive Cnty. Mut. Ins. Co.

914 S.E.2d 399
(Ga. Ct. App. 2025)

The Georgia Court of Appeals held that residence and domicile – and, in turn, whether a person qualifies as a "resident relative" under an insurance policy – typically present mixed questions of law and fact for the jury to answer.

Stephanie Allred sought uninsured/underinsured motorist coverage benefits from her parents' Progressive automobile policy after she was involved in a motor vehicle accident. At the time, she attended graduate school in Atlanta, where she rented an apartment and sometimes worked. She was single, had no children, and drove a vehicle insured by a State Farm policy for which her father paid the premiums. Allred also maintained a room at her parents' home in Ohio, which she visited two or three times over an 18-month period. After the accident, she moved in with her parents.

Allred brought suit against the driver of the other vehicle and against Progressive to recover uninsured/underinsured motorist coverage benefits. The trial court awarded Progressive summary judgment on the grounds that Allred was not an insured under the policy because she did not qualify as her father's "relative" as the policy defined that term.

The policy defined "relative" as: "A person residing in the same household as you, and related to you by blood, marriage or adoption and includes a ward, stepchild or foster child. Your unmarried dependent children temporarily away from home will qualify as a relative if they intend to continue to reside in your household."

In reversing the trial court's decision, the Georgia Court of Appeals considered several factors to determine whether Allred was a resident for insurance coverage purposes, the most important of which is whether the person has set up a separate household under separate management. Other overarching factors include financial independence and living accommodations. Ultimately, the Court of Appeals found the following created a question of fact as to Allred's residency at the time of the accident: the room Allred maintained at her parents' house, the financial assistance she received from her parents, and her status as an unmarried college-aged student with no kids who rented an apartment. Based on these facts, the Court of Appeals held that a jury could determine that Allred intended to continue living with her parents in Ohio and only intended to live in Georgia temporarily. Without providing more detail, the court recognized there may be "outlier" cases that could be resolved on summary judgment, but this case was not one of them.

Patterson v. United Servs. Auto. Assoc.

917 S.E.2d 799
(Ga. Ct. App. 2025)

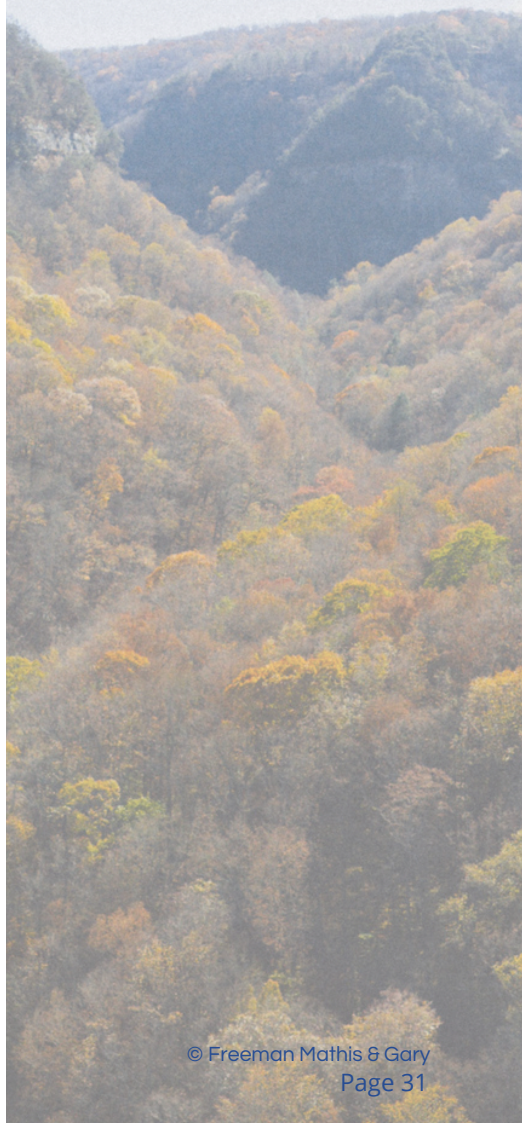
The Court of Appeals of Georgia held that an insured's 21-month delay in reporting an accident to his UM carrier was unreasonable as a matter of law, thus justifying the carrier's denial of coverage.

A pedestrian sustained bodily injuries after being struck by a vehicle in May 2019. The liability carrier for the motorist tendered its policy limits in March 2021 and, that same day, the pedestrian's attorney sent a letter of representation to his uninsured/underinsured (UM) carrier. When the UM carrier denied coverage, the pedestrian filed suit.

The UM carrier moved to dismiss the suit on the grounds that the pedestrian had failed to comply with his policy's notice provision, which provided that the carrier "must be promptly notified of how, when, and where an accident or loss happened." The trial court granted the UM carrier's motion finding that, as a matter of law, the 21-month delay between the accident and the pedestrian's notice to his UM carrier constituted a breach of the policy's notice provision.

The Court of Appeals of Georgia affirmed the trial court's decision, rejecting the pedestrian's argument that whether the 21-month delay was justified should have been a question for the jury. In so doing, the Court noted that while the justification for delayed notice may typically be a jury question, the facts of a particular case "may render an insured's delay in giving notice of an occurrence to his insurer unjustified and unreasonable as a matter of law." And it found that this was just such a case.

Specifically, the Court of Appeals rejected the pedestrian's proffered justification for his delayed notice, which was that he was unaware that his UM coverage applied to pedestrian accidents until he consulted with an attorney. The Court addressed that argument by reaffirming the principle that the "mere ignorance of coverage, without other justification for delay, presents no jury question." The Court of Appeals likewise rejected the pedestrian's argument that the notice provision was ambiguous since he had not actually read his policy, finding that "any ambiguity *in the unread policy* cannot have been a reason for his delay in providing prompt notification."



Transworld Food Serv., LLC v. Nationwide Mut. Ins. Co.

2025 WL 2449061
(11th Cir. Aug. 26, 2025)

In a case litigated by FMG partners Phil Savrin and Bill Buechner, The Court of Appeals for the Eleventh Circuit affirmed summary judgment for FMG's client, the insurer, on three separate coverage claims. First, the Court found that the insurer's negotiations did not permanently waive the policy's one-year time bar on suit but merely tolled the period. Second, the insured's reliance on other coverage that was ultimately denied did not justify a four-month delay in notice to the insurer under a "prompt notice" provision. And third, coverage for the "suspension" of operations applies only to a complete, rather than partial, shutdown of operations.

The insured, Transworld Food Service, LLC, leased space in a warehouse to store food in a freezer. Practically every year, Transworld presented a property loss claim to Nationwide Mutual Insurance Company for coverage. In January 2016, a water main outside the warehouse failed, causing flooding that allegedly cracked the insulated walls of the freezer and damaged the food inside. Then, in July 2017, roofers accidentally cut the freon supply line to the freezer, which allegedly damaged the compressor and caused food to spoil. Transworld promptly presented a claim to the roofer's insurance company but waited until the claim was partially paid in November 2017 to notify Nationwide of the loss. Lastly, in July 2018, Transworld claimed that a leak from a nearby unit ruined food in the freezer.

For the 2016 loss, Nationwide made partial payments, with a final payment in March 2018 when it denied owing the remainder. Transworld then waited until July 2019 to file the lawsuit, despite a contractual suit limitation of one year. The Court of Appeals for the Eleventh Circuit found that Nationwide's payments tolled but did not waive the limitation period. The suit was, therefore, time barred.

For the 2017 loss, the Eleventh Circuit found that Transworld's four-month delay was not "prompt notice" under the policy. In doing so, it distinguished cases that found a fact issue as to whether the delay was justified, finding that Transworld's reliance on other coverage did not justify the delay as a matter of law.

Lastly, the 2018 policy granted coverage for "loss of 'business income' [Transworld] sustain[ed] due to the necessary suspension of [Transworld's] 'operations' during the 'period of restoration.'" Joining courts in other jurisdictions, the Eleventh Circuit found that, because Transworld's operations had only partially but not completely ceased, its operations had not been "suspended" to come within the grant of coverage.

Illinois

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Niemiec v. Markel Ins. Co.

2025 IL App. (1st) 242222

The Illinois Appellate Court upheld a policy provision requiring "final adjudication" at trial before coverage for defense costs applies, denying reimbursement to a teacher who defended an underlying sexual misconduct lawsuit that was later dismissed for want of prosecution. The court held that the provision was not ambiguous and that merely limiting coverage to specific scenarios did not make it "illusory."

Matt Niemiec, a high school teacher, sought payment for his legal defense costs after a sexual misconduct lawsuit against him was dismissed for want of prosecution. The school district's insurer, Markel Insurance Company, denied coverage under a comprehensive general liability policy, which provided defense cost reimbursement only if the underlying lawsuit resulted in a "final adjudication" in which the insured was found to have not committed, attempted to commit, participated in, directed or consented to sexual misconduct. The policy further defined "final adjudication" as an actual trial involving a finding of facts, the presentation of witnesses, and a final resolution on the merits in which all appeals are exhausted.

The circuit court granted the insurer's motion to dismiss the teacher's complaint seeking reimbursement of defense costs.

On appeal, Niemiec argued the policy was ambiguous, provided illusory coverage, and violated public policy. He claimed the policy's definition of "final adjudication" was ambiguous because it conflicted with the policy "promising coverage for a successful defense." He also argued that a literal interpretation of "final adjudication" would render the coverage illusory—that is, it would result in the policy providing no coverage at all — because he could not force the plaintiff in the underlying lawsuit to go to trial.

The appellate court rejected these arguments. It held that the requirement for a final adjudication in the teacher's favor following a trial on the merits was not ambiguous and did not conflict with any promise of coverage for a "successful defense." The court noted that the term "successful defense" did not appear anywhere in the policy and appeared to have been created by the teacher himself. It also held that coverage was not illusory because it applied only in cases where the insured prevailed at trial. The court emphasized that requiring a trial verdict does not eliminate coverage entirely but instead merely limits coverage to specific circumstances. Finally, it held that the public policy arguments were forfeited because they were not raised in the trial court.

Starstone Insurance SE v. City of Chicago

133 F.4th 764
(7th Cir. 2025)

The United States Court of Appeals for the Seventh Circuit held that attorneys' fees and costs paid to an underlying Plaintiff as part of the settlement of a civil rights case were part of the "ultimate net loss" and were therefore covered damages that an excess insurer was required to pay on behalf of its insured.

Jacques Rivera sued Chicago and several of its police officers for alleged civil rights violations under 42 U.S.C. §1983. The case settled for $18.75 million. The City of Chicago ("the City") paid the first $15 million itself, while Starstone Insurance Company insured the City for liability from $15 million to $20 million. The City requested reimbursement of $3.75 million in attorneys' fees and costs that were included in the settlement. However, Starstone refused, arguing the fees and costs are not damages under Starstone's policy language. Starstone subsequently filed the suit seeking a declaratory judgment that it had no duty to pay. The federal district court ruled that Starstone must pay, and Starstone appealed.

The crux of the case was whether attorneys' fees and costs are included as damages under the policy. Starstone contended that legal fees and costs did not constitute damages and that the policy precluded indemnity for these fees and costs. The district court concluded the entire $18.75 million was the "ultimate net loss," regardless of how the funds were divvied up, and that the City, and therefore Starstone, was "legally obligated to pay" these amounts. On appeal, the Seventh Circuit affirmed this decision.

The Court of Appeals further found the exclusion cited by Starstone precluding coverage for "equitable relief or other than monetary damages" did not apply to attorneys' fees and costs. Starstone also argued that the $3.75 million did not compensate Rivera, the original plaintiff, but instead compensated his legal team. The Court also rejected that argument, noting that payment of legal fees by a defendant compensates a plaintiff, who does not thereafter need to pay his legal team.

The Seventh Circuit noted this was a novel issue where neither state nor federal appellate courts had rendered decisions on similar language in the last 16 years. The court conceded that "it cannot be sure" its decision "reflects Illinois law, but in the absence of material Illinois cases it is the best we can do." Until an Illinois court addresses this issue, the *Starstone* case will provide persuasive authority that attorneys' fees and costs are included in the "ultimate net loss" that an excess insurer will have to pay as indemnity for its insured.

ISMIE Mut. Ins. Co. v. Pergament

2025 IL App. (1st) 230787

The Illinois Appellate Court clarified that where an insured settles a case by assigning his rights against the insurer to the plaintiff, but the insured takes on no legal obligation to pay the settlement amount, that the insurer has no duty to indemnify the insured.

The underlying lawsuit stemmed from Dr. Pergament collecting genetic samples from Taryn and Doug Kessel, testing for a genetic disorder (MSUD) for the Kessel's unborn baby. Dr. Pergament is the medical director of Northwestern Reproductive Genetics (NRG). Dr. Pergament then sent those samples to a genetic testing lab to run the diagnostic tests. The record reflects that the lab erroneously reported that Doug was not a carrier for MSUD. Dr. Pergament subsequently advised the Kessels (incorrectly) that Doug was not a carrier for MSUD. The couple's child was born in October 2009 with MSUD. The Kessels alleged that Dr. Pergament, NRG, and the testing lab were negligent. They further alleged that, had they learned that Doug was a carrier for MSUD, they would have learned the fetus had MSUD and terminated the pregnancy. The Kessels sought damages for the expenses necessary to care for their child due to the disease.

Dr. Pergament held a professional liability insurance policy issued by ISMIE. Upon notifying ISMIE about the Kessels' lawsuit, ISMIE sent Dr. Pergament a letter stating its position that "some of the claims brought against you may not be covered under your insurance policy, and we reserve our rights accordingly." The policy did not provide indemnity for injuries due to liability for any management activities involving any business that is not insured under the policy. Here, NRG was not insured under the ISMIE policy.

When the Kessels sued Dr. Pergament and related entities alleging professional negligence and emotional distress, ISMIE defended Dr. Pergament under a reservation of rights, explicitly excluding liabilities tied to his management roles.

Settlement discussions occurred, culminating in an agreement where Dr. Pergament assigned his rights under the ISMIE policy to the Kessels in exchange for a release of liability and dismissal of claims against him and related entities. Notably, under the settlement, Dr. Pergament did not have any personal obligation to pay the settlement amount; instead, any payment was to be made by ISMIE per the assigned rights.

In September of 2018, ISMIE commenced the instant action by filing a complaint seeking a declaration that it had no duty to indemnify Dr. Pergament. ISMIE argued Dr. Pergament was never legally obligated to pay where the settlement specifically relieved him of that obligation. The trial court granted summary judgment to ISMIE, holding there was no duty to indemnify since ISMIE did not breach its duty to defend and a bona fide coverage dispute existed. On appeal, the Kessels argued that the court erred in granting summary judgment to ISMIE because ISMIE breached the policy by refusing to indemnify Dr. Pergament. The court rejected this argument as it was undisputed that ISMIE continued to defend Dr. Pergament under a reservation of rights and Dr. Pergament had not yet incurred any liability in the underlying lawsuit. The court found the trial court correctly entered summary judgment in favor of ISMIE as ISMIE owed no indemnity obligation for the settlement of the underlying lawsuit where Dr. Pergament was not legally obligated to pay anything under the terms of the settlement.

This holding illustrates that for indemnity to apply under a professional liability policy, an insured must be legally obligated to pay damages. One will not be indemnified when a settlement assigns policy rights but expressly relieves the insured of financial liability.

Citizen's Insurance Company of America v. Mullins Food Products Inc.

135 F.4th 1082
(7th Cir. 2025)

The United States Court of Appeals for the Seventh Circuit held that an Access or Disclosure Exclusion that bars coverage for any claim "arising out of any access to or disclosure of any person's or organization's confidential or personal information" unambiguously excludes coverage for claims under the Biometric Information Privacy Act ("BIPA"). However, a Statutory Violations Exclusion that does not name BIPA and concludes with a broad catchall is ambiguous and does not bar coverage on BIPA claims.

The insured scanned its employees' fingerprints to help monitor and manage its workers' time on the job. In turn, it disseminated electronic information derived from scanning its employees' biometric identifiers to third-party vendors. A former employee filed a putative class action in the Circuit Court of Cook County seeking damages for the company's BIPA violations. Citizens filed an action seeking a declaration that it had no duty to defend or indemnify the insured over multiple policy periods based on two exclusions: the Access or Disclosure Exclusion and the Statutory Violations Exclusion.

The policy provided for coverage for "personal and advertising injury" which was expressly defined to include "oral or written publication, in any manner, of material that violates a person's right of privacy." The 2016 and 2017 policy periods included an "Access or Disclosure Exclusion" which barred coverage for a personal and advertising injury arising out of any access to or disclosure of any person's or organization's confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any other type of nonpublic information. The 2015 policy period did not include the "Access or Disclosure Exclusion." All three relevant policy periods included a "Statutory Violations Exclusion" which excluded coverage for personal and advertising injury arising directly or indirectly out of any action or omission that violates or is alleged to violate the Telephone Consumer Protection Act (TCPA), the CAN-SPAM Act, the Fair Credit Reporting Act (FCRA), or *any federal, state or local statute, ordinance or regulation that addresses, prohibits, or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating, or distribution of material or information.*

After the federal district court granted summary judgment to Citizens, finding that both the "Access or Disclosure Exclusion" and the "Statutory Violations Exclusion" barred coverage, the case was appealed to the United States Court of Appeals for the Seventh Circuit. As to coverage under the 2016 and 2017 policy periods, the Seventh Circuit agreed that the "Access or Disclosure Exclusion" unambiguously excludes coverage for BIPA claims. The court reasoned that the ordinary understanding of confidential or personal information includes handprints and other biometric identifiers usable for identity theft. The court described the exclusion as straightforward and explicit, and the language plainly includes biometric identifiers.

The Court cited to *Thermoflex Waukegan v. Mitsui Sumitomo Insurance USA, Inc.*, a Seventh Circuit decision, which held that "the ordinary understanding of 'confidential or personal information' includes handprints and other biometric identifiers usable for identity theft." That decision reinforces this decision as to the "Access or Disclosure Exclusion" because the Court left no doubt as to the interpretation of confidential or personal information.

However, the Seventh Circuit held that the broad catchall in the Statutory Violations Exclusion, the sole exclusion at issue with respect to coverage under the 2015 policy period, was ambiguous and thus did not exclude coverage for BIPA claims. The court explained that the plain-text reading of the exclusion in isolation would purport to exclude or "swallow" coverage for a large swath of statutory claims that the policy otherwise leads an insured to believe are covered as claims for personal and advertising injuries.

Citizen's Insurance Company of America v. Mullins Food Products Inc., (Continued)

The court looked at the three statutes expressly identified preceding the catchall for guidance as to what the catchall would apply to. The court distinguished the three statutes, finding the TCPA and the CAN-SPAM Act were unlike BIPA in that they regulated communications and the FCRA deals with credit history distribution, as patently different from BIPA. As a result, the court found the catch-all ambiguous and, therefore, the Statutory Violations Exclusion did not exclude coverage for BIPA claims. The Seventh Circuit then remanded the case to the District Court for a determination of whether the insured provided timely notice to Citizens.

As for the "Statutory Violations Exclusion," the Court relied on the Illinois Supreme Court decision in *West Bend Mutual Insurance Company v. Krishna Schaumburg Tan, Inc*. The *Krishna* Court held that the catchall provision of the Statutory Violations Exclusion did not unambiguously exclude coverage for BIPA violations. Krishna focused on the statutes expressly mentioned in the exclusion just prior to the final catchall provision and observed that "regulating telephone calls, faxes, and emails is fundamentally different from regulating the collection, use, storage, and retention of biometric identifiers and information.

Based on Krishna and Thermoflex, the Court looked for a proper understanding of the scope of the catchall by looking to the three statutes expressly identified immediately preceding the catchall for guidance as to what other types of statutory violations are subsumed within the catchall.

The Seventh Circuit's holding here appears to conflict with the holding of the 1st District Illinois Appellate Court's decision in *National Fire Insurance Co. v. Visual Pak Co. Inc.*, 2023 IL App. (1st) 221160. In that case, the Appellate Court interpreted a policy exclusion substantially similar to the Statutory Violations Exclusion, which it determined was not ambiguous. As a result, the Appellate Court in *Visual Pak* found that coverage for BIPA claims was barred. In light of these two rulings, it appears that the interpretation of the Statutory Violations Exclusion, or similarly worded exclusions, under Illinois law will remain unsettled until the Illinois Supreme Court addresses this issue.

Indiana

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Allianz Glob. Risks US Ins. Co. v. Technicolor USA, Inc.

266 N.E.3d 755
(Ind. Ct. App. 2025)

The Indiana Court of Appeals upheld insurance coverage for both defense costs and indemnification in a foreign mass toxic tort case. The court rejected arguments based on the known loss doctrine and policy deemer clauses, reasoning that the two class actions involved had different claimants and therefore did not establish certain knowledge of loss or damages.

Technicolor USA faced two class actions in Taiwan involving former employees of its Taiwanese subsidiary, TCETVT, who alleged injuries from exposure to toxic chemicals between 1970 and 1992. The first class action was filed in 2004, and the second in 2016 after additional claimants were barred from joining the first. Taiwanese courts held TCETVT and certain parent entities liable under veil-piercing theories.

Technicolor purchased six policies from Allianz effective January 2014, including three commercial general liability policies and three umbrella policies. After the second lawsuit was filed, Technicolor sought defense costs and indemnity under these policies. The Commercial Court granted partial summary judgment for Technicolor, finding Allianz owed a duty to defend under its umbrella policies. Allianz appealed, arguing coverage was barred by the known loss doctrine and deemer clauses because Technicolor had prior knowledge of similar claims.

The Court of Appeals rejected these arguments. On the known loss doctrine, the court explained that coverage is barred only when a loss is substantially certain—"virtually inevitable"—at the time the policy is issued. Although Technicolor was defending the first class action when it purchased Allianz policies, the second lawsuit involved a different set of claimants who were unknown until the first class closed in 2016. Allianz did not show that liability for the second action was inevitable in 2014.

The court also addressed the deemer clauses in Allianz's umbrella policies, which limit coverage for bodily injury to injuries not known before the policy period. Technicolor is deemed to have knowledge when it reports an injury, receives a demand, or otherwise becomes aware of damage. The record showed Technicolor received claims for the second class action only after the policies took effect. Allianz failed to prove that Technicolor had prior knowledge of injuries to these claimants before 2014.

Accordingly, the court affirmed coverage for defense costs and indemnity under the umbrella policies. Neither the known loss doctrine nor the deemer clauses barred coverage because the second class action involved separate claimants and Technicolor lacked pre-policy knowledge of their injuries.

This holding illustrates that the known loss doctrine can be a valid defense when a loss is "virtually inevitable" at the time of the policy's creation. Although coverage was ultimately found here, the court's decision reinforces that insurers may be justified in denying coverage if they can prove substantial certainty of liability before the issuing of a policy. Further, the court here confirmed that deemer clauses apply to bodily injury claims when the insured had prior knowledge. The deemer clause did not apply to Technicolor due to the timing of the class membership closing, but this case sets a standard that can guide insurers in the enforcement of these clauses in similar contexts.

Baldwin v. Standard Fire Ins. Co.

269 N.E.3d 1197
(Ind. 2025)

The Indiana Supreme Court adopted Section 26 of the Restatement (Second) of Liability Insurance, holding that an insurer satisfies its duty of good faith by filing an interpleader when multiple claims threaten to exceed policy limits.

The Indiana Supreme Court addressed how insurers should respond when multiple claims threaten to exceed policy limits. The case arose from a 2018 automobile accident in which Bradley Baldwin was severely injured after being struck by Tommi Hummel's vehicle. Hummel carried an auto policy with bodily injury limits of $50,000 per person and $100,000 per accident. Baldwin sued the Hummels and later made a time-limited settlement demand for $50,000, the per-person limit.

Standard Fire declined the demand, citing concerns that paying Baldwin alone would exhaust half the policy and leave insufficient funds for other potential claimants, including Hummel's two passengers. Instead, the insurer filed an interpleader action, deposited the $100,000 policy limit with the court, and continued to defend the Hummels. Baldwin counterclaimed, alleging breach of the duty of good faith and bad faith. The trial court granted summary judgment for Standard Fire, and the court of appeals partially reversed, finding fact issues on both claims.

The Supreme Court affirmed summary judgment for Standard Fire and adopted Section 26 of the Restatement (Second) of Liability Insurance as Indiana law. Section 26 imposes two key principles: first, an insurer facing multiple claims under a single policy limit must make a good-faith effort to settle in a way that minimizes the insured's overall exposure; second, the insurer may satisfy this duty by invoking a "safe harbor" through interpleader. To qualify, the insurer must deposit the policy limits with the court, name all known claimants, and, if obligated, continue to provide a defense until the claims are resolved or the duty to defend ends.

Applying this standard, the Court held that Standard Fire acted within its obligations by rejecting Baldwin's initial demand and filing an interpleader. Accepting Baldwin's demand could have excluded other claimants and exposed the Hummels to personal liability. By interpleading the full policy limits, naming all known claimants, and continuing the defense, Standard Fire met the safe harbor requirements and did not breach its duty of good faith or act in bad faith.

This decision clarifies Indiana law on multi-claimant scenarios and provides a defined framework for insurers managing competing claims against limited policy proceeds.

State Farm Mut. Auto. Ins. Co. v. DiPego, et al.

259 N.E. 3d 336
(Ind. 2025)

The Indiana Supreme Court held that an electric scooter qualified as a "land motor vehicle," and thus was considered an "uninsured motor vehicle" for purposes of uninsured motorist coverage.

Michelle DiPego was injured in Baltimore, Maryland, when an electric scooter rider struck her while she was walking on a city path. The rider fled, and Michelle sought uninsured motorist (UM) coverage under her Indiana State Farm auto policy. The policy provided UM coverage for accidents involving an "uninsured motor vehicle," defined as a "land motor vehicle" that is either uninsured or whose owner and driver are unknown.

State Farm denied coverage, asserting that the scooter was not a "land motor vehicle." Michelle filed a declaratory judgment action, and both parties moved for partial summary judgment. The trial court ruled in favor of Michelle, finding the scooter met the policy definition. State Farm appealed, arguing (1) the scooter was not a "land motor vehicle," and (2) there was a factual dispute about whether the scooter was uninsured.

The Indiana Supreme Court affirmed. On the first issue, the Court applied the plain and ordinary meaning of "land motor vehicle," noting that the term refers to a self-propelled vehicle designed to operate on land.

Dictionaries define "motor vehicle" as a wheeled, self-propelled conveyance not operated on rails. Based on these definitions, the Court concluded that an electric scooter qualifies as a "land motor vehicle" under the policy. The Court rejected State Farm's reliance on Indiana's Motor Vehicle Code, explaining that statutory definitions do not control insurance policy interpretation, which is viewed from the perspective of an ordinary policyholder.

On the second issue, the Court held that State Farm waived its argument regarding whether the scooter was uninsured. State Farm did not raise this point in its summary judgment briefing and confirmed at the hearing that the issue was not in dispute. Under Indiana law, arguments not presented to the trial court cannot be raised for the first time on appeal.

Accordingly, the Court affirmed summary judgment for Michelle, holding that the electric scooter was a "land motor vehicle" and that State Farm's challenge to its uninsured status was waived.

Iowa

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Heartland Co-Op v. Nationwide Agribusiness Ins. Co., LLC

18 N.W.3d 729
(Iowa 2025)

The Iowa Supreme Court affirmed a commercial insurance policy's coverage for earnings and extra expense loss "for any one loss" applied to the entire insured entity, not "any one loss" at each of the insured entity's locations.

In this lawsuit, Heartland Co-Op ("Heartland") alleged that Nationwide Agribusiness Insurance Company ("Nationwide") wrongfully denied its claim for earnings and extra expense loss exceeding $3 million. Heartland is an agricultural cooperative with numerous locations across multiple states. In August of 2020, a derecho significantly impacted Heartland's operations. Heartland reported damage at 48 locations to Nationwide, and Nationwide paid Heartland approximately $131 million for the derecho-related losses. However, Nationwide denied Heartland's claim for earnings and extra expense loss exceeding $3 million.

Nationwide's commercial insurance policy provided coverage to Heartland for loss of earnings and extra expense "for any one loss" subject to a limit of $3 million. Heartland contended the earnings and extra expense coverage applied to each damaged location, meaning each of its 48 locations should have received earnings and extra expense coverage up to $3 million (resulting in a potential total of $144 million in earnings and extra expense coverage on top of the $131 million already paid). Nationwide, on the other hand, contended that Heartland's interpretation was contrary to the policy's plain language, as its claim arose from a single derecho, or, in other words, "one loss."

Nationwide thus moved to dismiss, arguing that the $3 million limit "applie[d] per occurrence as a blanket limit rather than on a per location basis." The district court granted Nationwide's motion and dismissed the case, finding Heartland's interpretation of the policy unreasonable. On appeal, the Court of Appeals affirmed.

The Iowa Supreme Court subsequently affirmed the Court of Appeals, finding that the earnings and extra expense loss covered Heartland as a single entity rather than each of Heartland's locations. Indeed, the policy provided the following: "'We cover only the extra expenses that are necessary during the 'restoration period' that 'you' would not have incurred if there had been no direct physical loss or damage to property caused by or resulting from a covered peril." The Supreme Court found the policy language unambiguous and reasoned "you" in the policy squarely referred to Heartland as an entity, not Heartland's individual locations. Moreover, the Supreme Court noted that the policy's schedule of coverages contained two checkboxes providing the limits on earnings and extra expense coverage. One box provided a limit for each covered location – the coverage Heartland sought - and the other box providing one limit for Heartland as a whole – the coverage Nationwide provided. The latter box was checked.

Waterloo Cmty. Sch. Dist. v. Employers Mut. Cas. Co.

18 N.W.3d 257 (Iowa 2025), as amended (May 16, 2025)

The Iowa Supreme Court clarified that an insurer is not required under the ordinance and law provision of the policy to pay for the cost of rebuilding portions of a structure that were already in violation of building codes before the covered loss occurred, even though some violations were unknown to the insured.

After a snowstorm caused the collapse of a school's roof, subsequent investigations revealed significant deterioration in the school's load-bearing walls. The school district demanded that its insurer pay to restore all the compromised structural elements throughout the building under the commercial property insurance policy. The insurer, however, agreed to pay only for the repairs associated with the collapsed roof section. The school district filed suit, alleging a breach of the policy for the insurer's refusal to pay costs to restore the building.

The district court granted summary judgment in favor of the insurer, holding that the insurer was only obligated to pay for the collapsed roof section. The ordinance and law ("OL") provision in the insurance policy clearly excluded coverage for costs associated with pre-existing code violations, regardless of whether the insured had knowledge of those violations prior to the loss. The school requested and was granted an interlocutory appeal, and the Iowa Supreme Court affirmed the district court's holding.

Generally, owners of older buildings are "grandfathered" under prior buildings codes, protecting them from retroactive application of new codes and ordinances. However, an OL provision of a policy provides a caveat to this rule where there are pre-existing code violations rather than violations of codes that took effect after the building was constructed. The OL provision of the policy excludes coverage where the insured violates an ordinance or law that "(1) you were required to comply with before the loss even when the building was undamaged; and (2) you failed to comply with".

The Town of Waterloo's building code prohibited occupancy of unsafe structures. The snowstorm did not cause the deterioration of the mortar in the load-bearing walls, which the court found had made the structure unsafe even before the storm. The insured's failure to correct the deterioration in the load-bearing walls before the storm violated the local building code, although there was no evidence that the insured was aware of the defect.

This case illustrates that an unambiguous OL provision may be applied to bar coverage for pre-existing code violations even when the insured has not been cited or is unaware of the defect. To hold otherwise would convert the insurance policy into a general maintenance contract. The court therefore required the insurer to pay only to repair the damage from the partial roof collapse but not the cost to remedy the longstanding deterioration in other areas of the building unaffected by the collapse.

John Dostart v. Columbia Insurance Group

20 N.W. 3d 225
(Iowa 2025)

The Iowa Supreme Court held that a consumer fraud claim arising out of defective workmanship in constructing the claimants' home did not constitute an "occurrence" and did not result in "property damage." As a result, the Iowa Supreme Court found that the lower courts erred in not granting the insurer's motion for summary judgment.

The Dostarts filed a complaint for breach of contract and warranty and consumer fraud against their general contractor, Tyler Custom Homes, and its owner, James Harmeyer, who were constructing a residence for the Dostarts. They alleged the contractor failed to complete construction on the home. Although the jury rejected the Dostarts' breach of contract and warranty claims, it found in favor of them on the consumer fraud claims, awarding them $182,408.30 in actual damages and $17,591.70 in exemplary damages. Following the verdict, Tyler Custom Homes and Harmeyer's insurer, Columbia Insurance Group, determined that the consumer fraud claim was not covered by the commercial general liability insurance policy. Thus, Columbia declined to indemnify the judgment, and the Dostarts were unable to collect it directly from Tyler Custom Homes and Harmeyer.

As a result, the Dostarts sued Columbia. Columbia filed a motion for summary judgment arguing that there was no coverage because: (1) consumer fraud is not considered an "occurrence" under the policy, (2) the consumer fraud did not result in "property damage" as it is defined in the policy, (3) the policy's intentional acts exclusion applies to consumer fraud, and (4) the policy excludes exemplary damages. The district court granted summary judgment in favor of Columbia on the fourth argument, finding that the policy excludes exemplary damages. But the district court found that there were genuine issues of material fact surrounding the remaining arguments. The Iowa appellate court affirmed this finding.

However, the Iowa Supreme Court disagreed with the appellate court and district court, finding that the courts erred in denying Columbia's motion for summary judgment. Regarding Columbia's first argument, the Iowa Supreme Court determined that consumer fraud here did not qualify as an "occurrence" within the policy. In reaching this decision, the Court relied on case law holding that faulty or defective workmanship is not an accident, but a foreseeable occurrence, and thus is not considered an "occurrence" pursuant to the policy's language. Second, the Court found that the consumer fraud did not result in "property damage" as that term is defined in the policy because the damages claimed were to the very property on which Tyler Custom Homes performed work. Damages incurred to complete construction of the house were not considered "physical injury to tangible property," and therefore did not meet the definition of "property damage" under the policy. Based on these two holdings, the Court deemed it unnecessary to address the intentional acts exclusion. Thus, the Court remanded the case with instructions to grant Columbia's motion for summary judgment.

Overall, this case highlights that CGL policies are not to be interpreted in ways that turn them into performance bonds guaranteeing the completion of the work the insured contractually agreed to complete. Instead, they exist in this context to cover damages arising from accidental "occurrences" that result in "property damage".

Kentucky

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Austin v. State Farm Fire & Cas. Co.

786 F.Supp.3d 1080
(W.D. Ky. 2025)

In upholding policy language defining an insured, the Western District of Kentucky rejected the application of a Kentucky Statute barring insurers from making coverage decisions based on domestic violence.

Tammy Austin married James Moore in 2015, and the couple purchased a house together three years later. Only Mr. Moore's name was listed on the deed, and the State Farm homeowner's policy obtained for the home listed Mr. Moore as the sole Named Insured. In November of 2020, Ms. Austin moved out of the home after Mr. Moore began using methamphetamine and physically abusing her.

Roughly a year after Ms. Austin moved out, Mr. Moore burned the house down and committed suicide. Ms. Austin filed a claim with State Farm for her portion of the home's value and for the value of personal property left behind in the home. State Farm denied the claim, relying on the definition of an insured, which it claimed did not apply to Ms. Austin. The policy applied only to named insureds and those that met the specific definition set forth in the policy. "Insureds" included, in relevant part, a "spouse" of a named insured, where the relationship is "recognized and valid" in the state where it was established, "so long as the person… resides primarily with the named insured[.]"

Ms. Austin's challenge to State Farm's denial of her claim relied on Kentucky Revised Statute 340.12-211.

This statute bars insurers (1) from limiting coverage to an insured based on the fact that an insured incurred bodily injury resulting from domestic violence and (2) from denying coverage to an innocent co-insured where the reason for such denial is based on an intentional act exclusion and that intentional act is part of a pattern of domestic violence.

Ms. Austin claimed that but-for bodily injury resulting from the domestic violence perpetrated by Mr. Moore, she would have continued to reside with Mr. Moore and would have remained an insured under the policy. Therefore, State Farm's denial constituted a denial of coverage based on physical abuse. The court rejected this argument because State Farm denied the claim on the basis of the definition of an insured, not on the occurrence of domestic violence.

Additionally, Ms. Austin claimed that Mr. Moore's burning of the home was an act of domestic violence, and thus the denial of her claim violated the statute. The Court rejected this argument on the same basis, because State Farm denied the claim on the basis of the definition of an insured, not on the basis of an intentional act. The second section of the statute applies only where coverage was denied under an intentional act exclusion, the intentional act was a part of a pattern of domestic violence, and the perpetrator is criminally prosecuted. None of these criteria were met here, so the Court upheld the denial of coverage.

Banks v. Farmers Prop. & Cas. Ins. Co.

2025 WL 1348916
(E.D. Ky. 2025)

The Eastern District of Kentucky rejected Plaintiffs' contention that their insurer had breached the insurance contract, instead finding that Plaintiffs had not produced evidence sufficient to show that the alleged damage was covered under the policy.

In March of 2023, communities across Kentucky experienced a wind and hailstorm which caused damage to homes, vehicles, and other property. Plaintiffs Kyle and Janice Banks were among those that experienced property damage. The Banks filed a claim with the issuer of their homeowner's insurance policy, Farmers Property and Casualty Insurance Company, seeking compensation for the damage to their home.

An inspector contracted by Farmers inspected the Banks' property and reported that "two downspouts, a hose bib, and some vinyl siding" had been damaged in the storm. The inspector estimated that the cost to repair the damage would be $1,871.54. In response to this report, Farmers issued a check for $655.25 to the Banks. The amount of this payment reflected the total assessed damage, minus the calculated depreciation, minus the Plaintiffs' deductible.

Without further communication with Farmers, the Banks filed suit in state court alleging that Farmers had breached the insurance contract. To support this contention, Plaintiffs produced an estimate for the cost of completing a full roof and siding replacement.

After removing to Federal Court and winning dismissal of Plaintiffs' other claims, Farmers argued that Plaintiffs had failed to produce evidence that a full siding and roof replacement was needed or that such a replacement was covered by the policy. By producing only the replacement estimate, Plaintiffs had made no causal connection between the covered cause of loss and the damage warranting such replacement and thus had not shown that the repairs were needed or that the damage was covered.

The Court agreed with Farmers, citing the Kentucky requirement that the burden of proving coverage is on the beneficiary of the policy who must "establish… by some evidence, his right to recover." By producing only the replacement estimate, Plaintiffs failed to create a genuine issue of material fact sufficient to defeat Farmers' motion for summary judgement.

Equally unpersuasive to the court were Plaintiffs' claims that the reasonable expectations doctrine required coverage. Without identifying some portion of the policy that was ambiguous, the Court held that reasonable expectations doctrine did not apply.

Phoenix Ins. Co. v. Wehr Constructors, Inc.

134 F.4th 933
(6th Cir. 2025)

In determining coverage under multiple policies related to construction claims, the United States Court of Appeals for the Sixth Circuit found that a commercial general liability policy may give rise to defense obligations even where no direct claims are asserted and no recovery is sought against its insured. Relying on parol or extrinsic evidence, the Court of Appeals also found that though not specifically defined in the policy, the term "construction manager" has an industry specific definition which may be applied to determine coverage.

Wehr Constructors, Inc., entered into a contract with St. Claire Medical Center for the construction of an addition to the medical center. When Wehr allegedly breached the conditions of the contract, St. Claire terminated the contract and sued Travelers Surety to enforce Wehr's performance bond. Though St. Claire did not name Wehr a as defendant and did not seek damages from Wehr directly, Travelers Surety was allowed by the court to permissively join Wehr in the action.

Wehr sought coverage under three insurance policies: a commercial general liability policy issued to it by Phoenix Insurance Company, a professional liability policy issued to it by St. Paul Surplus Lines Insurance Company, and an "umbrella" excess policy issued to it by Travelers Property and Casualty Insurance Company ("Travelers Property").

In regard to Phoenix, the district court had found that St. Claire never actually asserted a cause of action directly against Wehr, so the commercial general liability policy's "suit" requirement was not met. As to St. Paul, the district court concluded that Wehr had not specifically agreed to act as a construction manager for the project, so the alleged loss did not result from the insured's contractor professional services, as required by the policy. The district court concluded that Travelers Property also did not have a duty to defend Wehr in the St. Claire litigation based on the absence of a "suit" against the insured.

On appeal, the Sixth Circuit found that the claimed damages to the preexisting St. Claire building, beyond the mere faulty workmanship of project at issue, potentially may be of the type covered under the Phoenix policy.

The court then examined the Phoenix policy's duty to defend language and definition of "suit" to find that the policy did not limit Phoenix's defense obligations to only those suits asserting claims directly against Wehr. Therefore, the Sixth Circuit determined that Phoenix had an obligation to provide a defense to Wehr in the underlying suit after it was joined by Travelers Surety.

Next, the Sixth Circuit examined St. Paul's defense obligations to Wehr. The parties agreed that St. Paul did not have a duty to defend Wehr unless Wehr specifically agreed in the construction agreement to perform as a construction manager. The policy did not define the term construction manager, and thus the Court found that term was ambiguous. However, noting that it may consider parol and extrinsic evidence, the Court found that the evidence presented by the parties demonstrated that, though not specifically defined in the policy, the term "construction manager" has an industry specific definition. And, that Wehr did not specifically agree to serve as a construction manager, as that term is commonly applied in the construction industry. Therefore, the Sixth Circuit found that St. Paul's defense obligation under the policy was not triggered.

Lastly, the Court vacated the district court's decision regarding Travelers Property, an excess insurer. The Court noted that the record was unclear as to whether the district court had made a holding that was sufficiently appealable with regard to Travelers, and, regardless, the Court's ruling on the Phoenix policy necessitated further proceedings to determine Travelers Property's coverage obligations.

State Auto Prop. & Cas. Co. v. Greenville Cumberland Presbyterian Church

706 S.W.3d 35
(Ky. 2024)

The Kentucky Supreme Court interpreted the word "collapse" to include instances where only part of the insured building is damaged.

Greenville Cumberland Presbyterian Church is housed in a historic church building, which is well over 100 years old. The Church was insured by State Auto against physical loss or damage, including damage resulting from a "collapse" of the building. Damages not covered by the policy included "settling, cracking, shrinkage, bulging, or expanding."

In September of 2019, a contracted roofing repair man noticed that the roof had dropped several inches between two days of work. An engineer was hired to examine the roof structure and discovered that the roof trusses were severely rotted at the ends designed to rest on top of the exterior walls. Temporary shoring was installed, and the Church roof was repaired.

When the Church filed a claim with State Auto, the claim was denied on the basis that the Church had not "collapsed" under the terms of the policy. The damage to the roof instead fell under one of the non-covered structural damages, such as settling.

When moving the court for summary judgment, State Auto directed the court to the definition of "collapse" applied by Kentucky courts: the common meaning of the word collapse controlled in the absence of a definition in the policy.

Under the definition used by Kentucky courts, only the sudden and complete breakdown of the structure or part of the structure constituted a collapse. Prior cases refer to images of a "cave in," a "fall together into a flattened form" or a "loss of firm connection or rigidity and support..." in defining the term.

The Kentucky Supreme Court distinguished these cases based on the policy language at issue. Under the terms of the State Auto policy, even a collapse of "part of the structure" constituted a collapse. The court reasoned that the roof of the Church was a part of the structure, so the failure of the roof could constitute a collapse even without the Church being left as a pile of rubble. The court concluded that the roof structure's dropping by several inches over a short period of time constituted a collapse rather than mere "settling, cracking, shrinkage, bulging, or expansion."

The Court explained that without reaching this conclusion, coverage for a collapse would be illusory. The duty of the insured to mitigate against damages, complied with here when the Church installed the emergency shoring beams, prevented what would certainly have been a collapse in the traditional sense. Since by complying with the duty to mitigate the Church prevented a full-blown collapse, denial based on the definition of collapse would render coverage illusory.

Colemon v. Westport Insurance Company

--- S.W.3d ---, 2025 WL 3768513 (Ky. Dec. 18, 2025)

Kentucky's Supreme Court gave an end-of-2025 reminder that policy language means more than trigger theory when applying Kentucky law to insurance policies.

After spending 28 years in prison, William Virgil was exonerated and released from prison. He sued various insurance companies who insured the City of Newport and police officers whose investigation of a murder led to Mr. Virgil's conviction and incarceration. A critical question became whether coverage existed under the City's law enforcement policies only for the year Mr. Virgil was convicted or for all the years of Mr. Vigil's incarceration.

The Sixth Circuit Court of Appeals considered this question in *St. Paul Guardian Ins. Co. v. City of Newport, Ky.*, 804 F. App'x 379 (6th Cir. 2020). St. Paul Guardian Insurance Company insured the City for a period of four years during Mr. Virgil's incarceration. Examining the language of the *St. Paul* policies, the Sixth Circuit reasoned that the *St. Paul* policies covered injuries caused by a wrongful act—in this case malicious prosecution—and thus the malicious prosecution could not itself be the injury. The Court held that that wrongful act resulted in physical and dignitary harms that constituted continuous and ongoing injury, and thus each policy during which that harm continued was triggered.

In 2025, the Kentucky Supreme Court considered Mr. Virgil's case with regard to Westport Insurance Company, which insured the City for a period of two years in the middle of Mr. Virgil's 28-year incarceration. Examining the language of the Westport policies, the Court reasoned that the policies defined an "occurrence" as "an offense that results in personal injury," and expressly listed malicious prosecution as a covered offense. Under that framework, malicious prosecution itself constituted the injury alleged for coverage purposes. As a result, later incarceration-related harms were treated as damages flowing from that injury, not as separate triggering events. Thus, the Court concluded that Westport had no duty to defend or indemnify the City for Mr. Virgil's wrongful conviction claims because the "personal injury" occurred when criminal charges were filed, which was decades before Westport's policy periods.

Notably, the Kentucky Supreme Court did not reject the Sixth Circuit's analysis; it confined it to policies drafted like *St. Paul's*. The Court emphasized that insurance contracts must be enforced as written and that courts may not recast policy definitions to accommodate long-tail liability or equitable considerations.

Massachusetts

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Federated Mutual Insurance Co. v. Peterson's Oil Service, Inc.

155 F.4th 1
(1st Cir. 2025)

The United States Court of Appeals for the First Circuit affirmed the lower court's determination that the insurer had a duty to defend against an entire class action because, under the "in for one, in for all" principle, the presence of some claims within the policy period required defense of the whole class action, even though other claims arose before coverage began.

In March 2019, Peterson's Oil Service was sued in Massachusetts state court in a class action alleging that it sold home heating oil containing biodiesel in excess of industry standards, causing damage to customers' heating equipment. The court certified two subclasses: one for customers who received the oil from 2012 to February 2019, and another for those who received the oil from March 2019 onward. The Plaintiff in the coverage action, Federated Mutual Insurance Company, did not insure Peterson's until July 5, 2019, under a policy requiring it to defend suits seeking damages for property damage that occurred during the policy period. In late 2021, Peterson's requested defense in the class action, and Federation subsequently filed the federal court litigation seeking a declaratory judgment that it had no duty to defend or indemnify under the policy's "known loss" provision.

The federal district court held Federated had a duty to defend, reasoning that while Peterson's was aware of property damage that began prior to July 5, 2019 (in light of the litigation and media coverage), it did not know about any damage to customers who first received oil after July 5, 2019. The court applied the "in for one, in for all" principle under Massachusetts law, requiring defense of the entire suit. This principle states that "where an insurer is obligated to defend an insured on one of the counts alleged against it, the insurer must defend the insured against all counts, including those that are not covered."

On appeal, the Court of Appeals affirmed and held Federation had a duty to defend Peterson's in the class action unless all of the allegations in the action fell outside of the policy coverage. Federation asked the First Circuit to view the entire class action as a unit, such that Peterson's knowledge of the action as a whole before the policy went into effect would preclude coverage for all claims. The appellate court disagreed, finding that "coverage centers around individual 'occurrences' causing injury to property." This matters, the court opined, because if "the provision of enriched oil to each customer was a separate "occurrence," then providing oil to each new customer would constitute new "property damage" under the policy. Under that view, Peterson's knowledge of earlier customers' "property damage" could not, by the policy's language, be knowledge of "property damage" to a different customer's heating equipment that had not yet occurred."

Applying the usual and ordinary meaning of "occurrence," the First Circuit found that the provision of heating oil to each new customer constituted a separate "occurrence." Specifically, the Court of Appeals reasoned that "occurrence" connotes a "relatively concrete, time-bound quality." Therefore, it held that "occurrence" in this case could be "naturally understood as referring to the provision of oil to multiple customers across multiple years." Further, to the extent that this reasoning at least deemed the term "occurrence" ambiguous, such ambiguity must be construed in favor of Peterson's. Thus, the Court found that the policy did not foreclose coverage for the post-July 5, 2019 claimants, and per the "in for one, in for all" principle, Federation had a duty to defend state action.

Privilege Underwriters Reciprocal Exchange v. Hilinski

105 Mass. App. Ct. 329 (2025)

The Massachusetts Appeals Court held that, as a matter of first impression, an excess policy's exclusion for injured family members did not violate Massachusetts public policy. In addition, the Court held the Defendants were entitled to underinsured motorist (UIM) coverage because the applicable follow-form provision in the excess policy did not clearly and unambiguously incorporate UIM coverage limitations or exclusions from the auto policy.

This case involved a 2018 motor vehicle accident in which the Hilinskis' teenage daughter suffered an injury while riding in a golf cart. The Hilinskis had an automobile policy and an excess policy with the Plaintiff, Privilege Underwriters Reciprocal Exchange. The auto policy provided $250,000 in bodily injury liability coverage and $250,000 in underinsured motorist (UIM) coverage, while the excess policy provided $10 million in excess liability coverage and $1 million in excess UIM coverage. Privilege offered to pay the $250,000 bodily injury liability policy limit to settle Callie's claim but denied that any excess liability coverage applied or that UIM coverage was available under either policy.

On appeal, the Court considered two main issues: first, as a matter of first impression, whether an exclusion in the excess policy for liability claims by injured family members violates Massachusetts public policy. Second, the court considered whether a nonstandard follow-form clause in the excess insurance policy should be read to import the same restrictions on UIM coverage that exist in the underlying auto policy.

As to the first issue, the Hilinskis argued that, under their excess policy, their daughter should receive either liability coverage or UIM coverage. In regard to liability coverage, the excess policy excluded coverage for injuries to the policyholders or their family members. The Hilinskis argued that, as a matter of public policy, such a liability exclusion should be invalid because it prevents victims of auto accidents from receiving full compensation.

The Appeals Court rejected this argument, finding the exclusion was neither unfair nor against public policy; the Appeals Court reasoned that in the absence of any state law prohibiting the exclusion in umbrella or excess insurance policies, there was no public policy against such a provision. Any change to this exclusion should be made by the state Legislature or the Commissioner of Insurance, rather than the courts.

As to the second issue, there was no dispute that the Hilinskis were not entitled to UIM coverage under the auto policy, because the bodily injury liability coverage was not less than the UIM limit. However, the Hilinskis argued that they should still be afforded coverage under the UIM benefits in the excess policy. The excess liability policy stated the insurer would pay "damages for bodily injury an insured is legally entitled to receive from the owner or operator of an uninsured or underinsured auto" in excess of the underlying insurance limits. The excess policy stated the family member exclusion applicable to excess liability coverage "does not apply to coverage provided under Excess Uninsured/Underinsured Motorists Coverage if a limit for this coverage is shown on your Declarations." Further, the excess policy's follow-form provision stated Privilege "will cover damages to the extent that they are both covered by the required underlying insurance and not excluded by this policy." The Appeals Court determined the language of the follow-form provision was ambiguous, as it defined "underlying insurance" as "liability insurance." Because UIM coverage is not liability insurance, the Appeals Court held the follow-form provision did not unequivocally apply the same exclusions to UIM coverage in the auto policy to UIM coverage under the excess policy. Given the follow-form's ambiguity, the Appeals Court applied the longstanding precedent that unclear policy language must be interpreted against the insurer in favor of coverage of the insured.

Michigan

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Hairston v. LKU

---N.W.3d---, 2025 WL 1014229 (Mich. 2025)

The Michigan Supreme Court ruled that unresolved bad-faith claims are not suitable for garnishment proceedings.

In 2016, Darnell Hairston was severely injured at work, requiring medical attention that included the amputation of his right hand and right forearm. He sued his employer Zeeland Farm Services (ZFS), a supervisor, and later Specialty Industries, which designed the machinery. ZFS and the supervisor settled, but Hairston's claims against Specialty Industries went to trial. The jury found that Specialty Industries was grossly negligent and awarded Hairston over $13.7 million in damages.

Specialty Industries had two insurance policies in effect with two separate insurers that are applicable to this accident, a primary policy with a $1 million limit and an excess liability policy with a $8 million limit. The insurers providing those policies paid their policy limits, but a portion of the judgment remained unpaid. Hairston and Specialty Industries agreed that Specialty Industries would pay $1 million and assign any claims against the insurers, including bad-faith refusal to settle, to Hairston. Hairston then served writs of garnishment on the two insurers for the remaining judgment amount.

The trial court "quashed" the writs, ruling that the bad-faith claims could not be litigated through garnishment because they were unresolved. The Court of Appeals reversed, relying on *Rutter v. King*, 57 Mich. App. 152 (1974), which allowed garnishment for bad-faith claims. The insurers appealed.

The Michigan Supreme Court reversed the Court of Appeals' decision, abrogating *Rutter*. It held that under MCR 3.101(G)(1), garnishment applies only to property or debts that are settled and are not contingent. A bad-faith refusal to settle claim is not "sufficiently liquidated" because liability must still be proven. The Court emphasized that statutes concerning garnishment are strictly construed and that unresolved claims cannot be pursued through garnishment. It also rejected reliance on *Rutter*, noting that it was decided before current court rules and is therefore no longer binding. The Court explained that, overall, bad faith claims are complex and therefore are unsuitable for garnishment proceedings.

Spine Specialists of Michigan P.C. v. MemberSelect Insurance Company

---N.W.3d ---, 2025 WL 978735 (Mich. 2025)

The Michigan Supreme Court held that the tolling provision added to MCL 500.3145 in 2019 does not apply retroactively to claims that accrued before the amendment's effective date. The Court reasoned that the statute change was substantive and lacked clear legislative intent for retroactivity.

A medical provider, Spine Specialists of Michigan, sued MemberSelect Insurance Company to recover payment for treatment provided to Jeremy Woods after a car accident. Woods had assigned his right to personal protection insurance (PIP) benefits under his no-fault policy to Spine Specialists. They then filed a complaint in September of 2020, seeking payment for services performed in April and May of 2019. MemberSelect refused to pay, arguing that most claims were barred by Michigan's "one-year back rule" in MCL 500.3145, which limits recovery to expenses incurred within one year before filing suit.

The trial court agreed in part, ruling that claims for services before June 11, 2019, the date Michigan amended the statute, were barred. The Court of Appeals affirmed, reasoning that PIP benefits accrue when treatment occurs, not when payment is denied. Woods' treatment happened before June 11, 2019, and therefore the pre-amendment statute applied and those claims were time-barred.

Spine Specialists appealed to the Michigan Supreme Court, arguing that the amended statute should apply because the lawsuit was filed after the amendment took effect. The amendment added a tolling provision to MCL 500.3145(3), which pauses the one-year limit from the time a claim is submitted until the insurer formally denies it. If it applied, this could make older claims recoverable. As a result, the Supreme Court had to decide whether this tolling provision applies retroactively to claims that accrued before June 11, 2019.

Before the amendment, the one-year-back rule strictly limited recovery to expenses incurred within one year before filing suit. After the amendment, the rule allows extra time if the insurer delays a denial. The Michigan Supreme Court held that the tolling provision is a substantive change because it affects the amount recoverable and imposes a new duty on insurers to issue formal denials.

The Supreme Court held that Michigan law presumes changes to statutes apply only prospectively. Retroactive application requires explicit legislative intent, which was not the case with the amended MCL 500.3145. The amendment to the statute was given "immediate effect," but the Michigan Supreme Court found that only means it became effective right away, not that it applies retroactively. The Legislature could have written language to make the tolling provision apply to all cases filed after June 11, 2019, regardless of when the claims occurred, but it did not.

The Supreme Court also noted that retroactive application would impose new obligations to insurers for past actions. In particular, insurers reasonably relied on the one-year-back rule to establish the boundaries of their liability exposure and retroactive application would disrupt this reliance and potentially expose insurers to expanded liability without notice or recourse. This would disrupt settled expectations and create unfair liability. Therefore, the Court held that the tolling provision applies only to claims that accrued after June 11, 2019.

Ware v. Meemic Insurance Company

--- N.W.3d ---, 2025 WL 714806 (Mich. App. 2025), appeal granted, 26 N.W.3d 432 (Mich. 2025)

The Michigan Court of Appeals ruled that a vehicle qualified as an "uninsured motor vehicle" when it was covered by a policy, but the insurer had denied coverage for the accident.

Plaintiff Ibo Ware sought uninsured motorist (UM) damages from his insurance company after being injured in a vehicle collision. The other vehicle was insured by State Farm at the time of the accident, but State Farm later denied coverage because its insureds, the Schillings, failed to provide timely notice of the accident and litigation. Meemic Insurance Company, Ware's insurer, argued that the Schillings' vehicle was insured at the time of the accident and therefore did not qualify as "uninsured."

The trial court denied Meemic's summary disposition and granted Ware's motion to refer the remainder of the case to arbitration. Meemic appealed, and the appellate court affirmed.

The court first addressed whether the vehicle that hit Ware was an "uninsured motor vehicle" under the policy. Michigan law does not require UM or underinsured motorist coverage, so the terms of coverage are governed by the language of the contract itself. The policy stated that Meemic would pay damages for bodily injury sustained by an insured person caused by an accident arising out of the ownership, operation, maintenance, or use of an uninsured motor vehicle. The policy stated in relevant part "uninsured motor vehicle means a motor vehicle which is not insured by a bodily injury liability policy or bond that is applicable at the time of the accident."

The court interpreted "applicable" to mean capable of being applied in the appropriate context and that a policy is applicable when the insured is entitled to the protection afforded under the policy. In other words, the policy had to provide coverage for the accident at issue. The court reasoned that protection under a liability policy is afforded depending on the terms of the policy at issue and whether the insured complied with those terms.

Therefore, while there was a liability policy in place at the time of the accident, that fact did not mean that the policy necessarily applied at the time of the accident and instead the liability policy only becomes applicable when the insured performs their obligations under the agreement. State Farm had denied coverage for noncompliance by the insured with the policy's notice provisions and therefore its policy was not applicable at the time of the accident. As a result, the vehicle was considered uninsured under Meemic's policy and Ware was entitled to UM benefits. The Michigan Supreme Court will next consider this issue, as it has granted Meemic's leave to appeal.

The Court of Appeals also addressed arbitration. Meemic's policy excluded coverage disputes from arbitration. After deciding coverage, the trial court referred remaining issues to arbitration, but the appellate court reversed. The appellate court agreed with Meemic that the case should not be divided by nonarbitrable and arbitrable issues. The court held that dividing the issues undermines arbitration's efficiency and violates Michigan precedent. In other words, if the court must determine arbitrability, it must decide all issues.

Minnesota

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African Econ. Dev. Solutions v. West Bend Mut. Ins. Co.

2025 WL 1651214
(D. Minn. June 11, 2025)

The United States District Court for the District of Minnesota held that the property insurance policy at issue, which had language covering fire damage and excluding damage caused by "vandalism," and expressly differentiated between those two perils, was ambiguous as to whether "vandalism" included arson and, therefore, covered a fire loss caused by arson.

Sometimes arson is vandalism; sometimes it's not. It depends on the language of the entire insurance policy at issue.

African Economic Development Solutions ("AEDS") purchased a vacant property containing a one-story building in St. Paul, Minnesota. AEDS bought a property insurance policy from West Bend Mutual Insurance Company ("West Bend"). The policy covered all direct physical loss to the property unless the loss was excluded or limited under the policy. A Minnesota-specific addition to the policy provided coverage for "all loss or damage caused by fire and any damage caused by lighting." The policy excluded coverage for any act of vandalism if the property was vacant for more than 60 consecutive days before such loss.

In February 2022, the property, having been vacant for more than 60 consecutive days, was severely damaged by a fire caused by intentional human conduct. Based on the policy's exclusion for vandalism following the vacancy period, West Bend denied AEDS's claim for coverage. AEDS filed suit in federal court in Minnesota. It sought, in part, the court's declaration that the fire damage to the property was covered under the policy.

Both parties moved for summary judgment. West Bend argued that an intentionally-set fire constituted vandalism and was, therefore, excluded from coverage. AEDS, on the other hand, argued that the policy was ambiguous as to whether fire damage caused by vandals was covered and that the ambiguity should be construed in favor of finding coverage. For its part, the court agreed that under the plain meanings of arson and vandalism, arson would ordinarily be included as a form of vandalism.

However, based on the policy at issue in the case, the court agreed with AEDS that the policy was ambiguous as to whether fire damage caused by an intentional human act was excluded as "vandalism." It therefore granted AEDS' partial motion for summary judgment.

The court noted that courts interpreting insurance policies must determine the meaning of the plain language of the policy while also viewing the language in the context of the entire policy. The court emphasized the importance of determining what agreement the contracting parties intended to make.

In reaching its decision, the court analyzed two lines of cases addressing whether arson fell within a policy exclusion for vandalism. One line of cases involved policies that did not explicitly distinguish between fire losses and vandalism losses. Those decisions interpreted vandalism to include arson, and determined coverage was excluded. The court noted that the absence of differentiation between fire and vandalism resulted in no ambiguity in those policies. Therefore, the plain meanings of arson and vandalism were applied: arson is a form of vandalism.

However, the other line of cases analyzed whether intentionally setting property on fire was "vandalism" and therefore excluded under a policy that also contained provisions explicitly covering fire damage while also expressly differentiating between vandalism and fire throughout the policy. The court found that such cases deemed the policies ambiguous as to whether the excluded peril of vandalism did or did not include arson.

The court found that the policies in this second line of cases were most like the insurance contract at issue between AEDS and West Bend. Accordingly, the court found, under that particular language, ambiguity in the question of whether arson was included in the peril of "vandalism" (and therefore excluded). Based on this perceived ambiguity, the Court ruled in favor of AEDS and granted its motion for partial summary judgment.

Great Northwest Ins. Co. v. Campbell

24 N.W.3d 256
(Minn. 2025)

The Supreme Court of Minnesota applied a Minnesota statute governing replacement cost to require an insurance company to pay for all work (but not overhead and profit) necessary to repair a damaged roof such that it is compliant with applicable code requirements, notwithstanding a policy endorsement excluding coverage for roof repairs beneath the roof's outermost layer even if the repair is required by law.

In May 2022, a hailstorm damaged the roof of a home in Saint Paul, Minnesota. The home was insured under a homeowner's replacement cost policy issued by Great Northwest Insurance Company. A contractor was approved by Great Northwest to remove and replace the damaged shingles. Upon removal, the contractor discovered gaps in the roof decking that were larger than permitted by the state building code underneath new roof shingles. The contractor therefore put in new decking so that the replacement shingles could be installed in compliance with code.

Great Northwest denied coverage for the cost of installing the new decking and for the contractor's overhead and profit. Great Northwest relied on a policy endorsement barring coverage for any layer of roofing material beneath the outermost layer, even if such material is required by law, ordinance, or building code. The policy also contained an endorsement excluding coverage for overhead and profit on the materials and labor associated with roofing or the roofing system. The homeowner, however, argued that Minnesota Statute § 65A.10, which requires replacement cost insurance to cover the cost of replacing, rebuilding, or repairing the damaged portion of the property in accordance with minimum code requirements in the case of a partial loss, required coverage for both the decking cost and the overhead and profit costs.

The Supreme Court of Minnesota held that Great Northwest was required to pay for installing the new decking but was not required to cover the contractor's overhead and profit. The court reasoned that the new decking was necessary for the damaged shingles to be replaced in compliance with building codes.

The court distinguished a prior decision in which it held that an insurer that agreed to cover the cost of repairing drywall damaged in a storm was not required pay to repair cracked masonry not related to the storm event. In that case, the City of Saint Paul would not allow repair of the drywall until the masonry was brought into compliance with code requirements. However, the city's requirements were not based on the building code applicable to repairing the drywall damaged in the storm. Therefore, the Minnesota statute did not apply.

In the case at hand, under the governing code, the shingles could not be installed on decking with the gaps as large as existed on the house at issue. Therefore, the covered replacement cost included the cost to replace the decking.

However, the Court also found that the contractor's overhead and profit were not a necessary cost of repairing the damaged property. The statute requires coverage only for costs necessary for code compliance, and this work does not require the use of a general contractor, which renders overhead and profit costs unnecessary and not covered.

Timeless Bar, Inc. v. Illinois Cas. Co.

144 F.4th 1072
(8th Cir. 2025)

The United States Eighth Circuit Court of Appeals held that, in applying a fire insurance policy's misrepresentation and dishonest acts exclusions, the intentional and fraudulent acts of an executive officer are attributed to his corporation.

In 2016, a husband and wife purchased The Press Bar and Parlor and operated it through Timeless Bar, Inc. The couple, Andrew and Jessie Welsh, were the corporation's only shareholders and officers. They had another entity, Horseshoe Club, LLC, of which they were the only members, to hold the real estate. Timeless Bar, Inc., was the named insured on a business owner policy issued by Illinois Casualty Company ("ICC") covering the bar's business property and operation. Horseshoe Club, LLC, was an additional insured.

Andrew was chief executive officer of Timeless Bar and chief executive manager of Horseshoe Club. Jessie managed the bar's day-to-day operations.

In early 2020, about four months after Andrew and Jessie divorced, the bar was destroyed by fire. Timeless Bar and Horseshoe Club submitted a $1.96 million insurance claim. Andrew and Jessie each signed the sworn proof of loss claiming they did not know the origin of the fire and denying any act by the insured.

Shortly thereafter, however, an investigation by law enforcement determined that Andrew had actually set the fire. He was arrested and charged with arson, and he pled guilty. Based on Andrew's arson and deceit, ICC denied coverage for the fire claim, based on three policy provisions: the "Concealment, Misrepresentation, or Fraud" condition; the "Dishonesty" exclusion; and, the "Intentional Acts" exclusion barring coverage for losses caused with intent but not barring coverage to an innocent co-insured.

Timeless Bar, Horseshoe Club, and Jessie Welsh sued ICC for breach of the insurance contract, asserting they were innocent of Andrew's acts. Jessie's claim was dismissed for lack of standing because she was not insured under the policy. The district court held that Andrew's actions were attributable to the corporate entities and granted summary judgment for ICC.

On appeal, the Eighth Circuit affirmed the decision. The court found that Andrew materially misrepresented the claim by lying about the cause of the fire, which breached the "concealment, misrepresentation, or fraud" condition and barred coverage. It held that there was no Minnesota precedent for corporations or LLC's to be protected as innocent co-insureds (Jessie was not an independent co-insured under the policy).

Timeless Bar and Horseshoe Club asserted that under Minnesota's standard fire insurance policy statute, § 65A.01, the policy is void only if "the insured has willfully and with intent to defraud, concealed or misrepresented" the claim. The parties argued that because they did not participate in starting the fire, there was no willful intent to defraud as required to void the policy. However, under Minnesota agency principles, the court found that corporations and LLC's act through their agents. Fraudulent conduct within the scope of the officer's authority is imputed to the entity. Because Andrew was an officer for both entities, his conduct was legally attributable to them. His filing of the fraudulent claim constituted a violation of the "concealment, misrepresentation, or fraud" by Timeless Bar and Horseshoe Club, and there was therefore no coverage under the policy.

Nevada

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Iovino v. AmTrust Financial Services, Inc. et al.

776 F. Supp. 3d 889
(D. Nev. 2025)

The U.S. District Court of Nevada held NRS § 616C.215(3)(c) voided a workers compensation exclusion in an underinsured/uninsured motorist policy and applied the recent holding from AmTrust North America, Inc. v. Vasquez, 555 P. 3d 1164 (Nev. 2024) which overruled precedent prohibiting "double recovery" of amounts compensated by a workers' compensation insurer. The Court also held that a parent holding company could not be liable for the claims decisions of its subsidiaries when there was no joint venture.

Iovino worked as a truck driver for TopNotch Services, Inc., when he was injured in an accident with an unknown driver. He made a claim for uninsured motorist benefits with TopNotch's insurance carrier, Security National Insurance Company. Iovino claimed Security National paid less than half of the benefits owed despite his injuries in excess of the policy's $1 million limits. Iovino also received payment for his medical bills from TopNotch's workers' compensation insurance carrier, Insurance Company of the West. Iovino sued Security National, its parent company, AmTrust Financial Services, and its claim processor, AmTrust North America, for breach of contract, bad faith, unfair claims practices, and fraud.

The Court held Iovino could not assert a claim against AmTrust Financial because it operated as a parent holding company and did not control the daily operations of Security National and AmTrust North America. The factors the Court considered included: AmTrust Financial's logo on the Security National policy and its email signatures constituted a trade name; Security National and Amtrust North America had their own boards of directors and corporate officers; and AmTrust Financial did not have any involvement in administering policies or claims handling decisions. The Court also noted that Iovino did not have any evidence showing AmTrust Financial entered into a joint venture or agency relationship with Security National or AmTrust North America to support his claims. With respect to Iovino's breach of contract claim, the defendants asserted Security National did not have to provide coverage for medical expenses already paid by Insurance Company of the West because of a workers' compensation exclusion in the uninsured motorist policy.

They further argued NRS § 616C.215(5) prohibited Iovino from obtaining "double recovery" of his medical bills. In response, Iovino contended that NRS § 616C.215(3)(c) voided the workers' compensation exclusion of the uninsured motorist policy. By its terms, NRS § 616C.215(3)(c)(1) voids any uninsured motorist insurance policy provision "[l]imiting the rights of the injured employee. . . because of the receipt of any [workers'] compensation. . . ." Agreeing with Iovino, the Court held the workers' compensation exclusion under the underinsured motorist policy was void and violated public policy under NRS § 616C.215(3)(c). The Court pointed to the recent holding in *AmTrust North America, Inc. v. Vasquez*, 555 P. 3d 1164 (Nev. 2024), which overruled case law relied on by defendants. Applying *Vasquez*, the Court also found Iovino was obligated to reimburse Insurance Company of the West for his medical expenses, and as a result, would not receive "double recovery" as prohibited under NRS § 616C.215(5).

For his bad faith claim, the Court found Iovino had not shown the defendants acted in bad faith when excluding payment for his medical bills under the uninsured motorist policy's workers compensation exclusion. There was no evidence that the defendants knew their interpretations of NRS § 616C.215(3) and (5) were wrong under the recent holding from *Vasquez*. In fact, the Court noted, the defendants had a reasonable basis for their argument because of extensive case law supporting their position at the time. As such, although the Court found in favor of Iovino on the breach of contract claim, it held that the defendants' conduct was not in bad faith as a matter of law.

Liberty Mutual Fire Ins. Co. v. Acuity, A Mutual Ins. Co., et al.

788 F. Supp. 3d 1133
(D. Nev. 2025)

The U.S. District Court of Nevada addressed whether a building owner qualified as an additional insured under a contractor's general liability policy. The Court observed that for an entity to qualify as an additional insured, the insured must have agreed to this in writing, and the damages must have arisen from the insured's acts. The court found that although the contract between the owner and contractor may have expired prior to the loss, it imposed a continuing duty to name the building owner as an additional insured and there were sufficient facts alleged to implicate the contractor in the alleged injuries, giving rise to a duty to defend.

Richard Kline was working as an employee for Royal Refrigeration, Inc., when he fell through the roof of a building owned by YESCO, LLC. Kline sent a pre-suit demand to YESCO's general liability carrier, Liberty Mutual Fire Insurance Company. In turn, Liberty Mutual tendered the claim to Royal's carrier, Acuity. Liberty Mutual alleged that under the Independent Contractor Agreement (ICA) between Royal and YESCO, Royal agreed to indemnify and defend YESCO from Kline's negligence claims. As such, Liberty Mutual argued, YESCO qualified as an additional insured under the Acuity policy.

The Acuity policy applied to "Any. . . organization for whom you are performing operations who you and such. . . organization have agreed in writing in a contract or agreement that such. . . organization be added as an additional insured on your policy. . ." However, the additional insured coverage only applied to liability "caused, in whole or in part" by Royal's conduct.

Acuity declined to defend and indemnify YESCO because the ICA's two-year term had expired more than a year before Kline's accident. Consequently, Liberty Mutual filed suit seeking a declaration from the court that Acuity owed a duty to defend and indemnify YESCO.

The court found that YESCO at least potentially qualified as an additional insured under Royal's policy. In so doing, the court first observed that Royal had agreed in the ICA to name YESCO as an additional insured. Further, although the ICA may have no longer been in effect at the time of Kline's accident, the ICA nonetheless obligated Royal to name YESCO as an additional insured for any services even if performed after the ICA expired.

The court further noted that the definition of additional insured in Acuity's policy only applied to damages caused by Royal's "acts or omissions" or "the acts or omissions of those acting on [Royal's] behalf." Although Kline's negligence complaint only named YESCO as a defendant, the court stated that the complaint named Does and Roes, which could potentially include Royal. In addition, Acuity was on notice from pre-suit demands that the event happened while Kline was providing services to YESCO on behalf of Royal. These allegations were sufficient under the broad duty to defend standard to trigger a duty to defend YESCO against Kline's suit under Nevada law.

As for the duty to indemnify, the court found that the claim was unripe because the parties in the underlying action were still engaged in the discovery process. As such, it remained to be seen whether Royal or Kline "caused, in whole or in part" Kline's injuries as required for YESCO to qualify as an insured for purposes of the duty to indemnify.

New Jersey

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Chiaccheri v. Zurich American Insurance Company

2025 WL 2467683
(3rd Cir. 2025)

The United States Court of Appeals for the Third Circuit certified to the New Jersey Supreme Court the unresolved question of whether N.J.S.A. § 17:28-1.1(f) requires corporate auto insurance policies to provide underinsured motorist (UIM) coverage to employees at the same level as the policy's bodily injury liability limits. The outcome of this case could significantly reshape UIM coverage obligations in New Jersey, with broad implications for insurance policy design, employer liability, and consumer premiums statewide.

Craig Chiaccheri was injured in a car accident while driving a company vehicle during the course of his employment with The TJX Companies, Inc. The vehicle was insured under a commercial auto policy issued by Zurich American Insurance Company, which provided $2 million in bodily injury liability coverage. However, the policy included endorsements that limited underinsured motorist (UIM) coverage to just $15,000 per person. After accepting the at-fault driver's $100,000 liability policy limit in settlement, Chiaccheri pursued additional compensation through his employer's underinsured motorist (UIM) coverage. Zurich denied the claim, stating that the at-fault driver's coverage exceeded the policy's UIM limit, and therefore, the driver was not legally considered underinsured.

Chiaccheri filed suit, arguing that the Zurich policy's UIM limitation violated New Jersey law, specifically N.J.S.A. § 17:28-1.1(f), and was void as against public policy. He further contended that the statute required Zurich to provide him with UIM coverage equal to the policy's $2 million bodily injury limit. The fedaral district court disagreed, granting summary judgment in favor of Zurich. The Court interpreted the statute narrowly, concluding that it only prohibited "step-down" provisions, clauses that reduce UIM coverage for employees based on their personal auto policies, but did not require UIM coverage to match bodily injury limits.

On appeal, the United States Court of Appeals for the Third Circuit acknowledged that the statutory language was ambiguous and that the issue had not yet been addressed by the New Jersey Supreme Court. The Court reiterated that statutory interpretation begins with the plain language of the statute, but when that language is unclear, courts may look to legislative history to better understand the Legislature's intent.

Chiaccheri argued that the statute's reference to "maximum uninsured or underinsured motorist coverage available under the policy" meant the highest amount legally permissible under the policy, here, $2 million. Zurich, on the other hand, maintained that the phrase referred to the actual UIM limits stated in the policy, which were $15,000 per person.

Recognizing the broader implications for New Jersey's insurance market and the potential impact on employer liability and policy pricing, the Third Circuit certified two questions to the New Jersey Supreme Court. The first asks whether N.J.S.A. § 17:28-1.1(f) requires underinsured motorist (UIM) coverage for employees to match the policy's bodily injury liability limits when the named insured is a corporate or business entity. The second asks whether policy endorsements that limit UIM coverage to an amount lower than those liability limits violate the statute or are otherwise contrary to public policy. The Court noted that the answers to these questions could have far-reaching consequences, not only for the parties involved but also for how insurers draft commercial auto policies and how employers assess their coverage needs. The outcome may also influence how courts interpret similar statutory language in future disputes, particularly where employee protections and insurance coverage intersect. By certifying the questions, the Third Circuit deferred to the New Jersey Supreme Court to provide authoritative guidance on a matter of first impression with statewide significance.

This case is significant because it could clarify the scope of UIM coverage obligations under New Jersey law for corporate auto policies. A ruling in favor of Chiaccheri's interpretation could expand coverage requirements for insurers and employers, while a ruling for Zurich would affirm the current practice of allowing lower UIM limits through policy endorsements. Regardless of the outcome, the decision is positioned to influence how commercial auto policies are written and priced in New Jersey going forward.

New Mexico

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Chisholm's-Vill. Plaza LLC v. Cincinnati Ins. Co.

No. 23-2133, 2025 WL 1178099 (10th Cir. Apr. 23, 2025)

Interpreting New Mexico law, the Tenth Circuit held that the district court erred in granting Plaintiff's motion for summary judgment on the basis that the New Mexico Supreme Court would adopt an outlier approach to pollution exclusions in favor of the insured. Rather, the Court held that New Mexico law would find that the insurers' pollution exclusions unambiguously excluded coverage and that neither owed a duty to defend.

The City of Las Cruces and the County of Doña Ana filed an action against Plaintiff Chisholm's Village Plaza under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), asserting claims of cost recovery and contribution. According to Las Cruces and Doña Ana, a dry-cleaning business that previously occupied Chisholm's property "released" hazardous substances into the soil of the surrounding area and contaminated water at the site. Subsequently, Chisholm's sought coverage for cleanup costs under its policies with Fidelity and Guaranty Insurance Underwriters and Cincinnati Insurance Company. Both Fidelity and Cincinnati denied coverage, along with a duty to defend or indemnify, based on an absolute pollution exclusion detailed in each policy. Thereafter, Chisholm's filed this lawsuit against both insurers, alleging breach of contract for failing to pay defense costs in the CERCLA suit and bad faith for failing investigate coverage.

When applying state law, the federal Court of Appeals is bound by the decisions of the state's highest court. If no controlling decision exists, the court must try to predict how the state's highest court would rule. In New Mexico, the rule is clear: If the allegations in a complaint against an insured plainly fall outside the scope of the policy's provisions, the insurer has no duty to defend or indemnify. When a policy term can be interpreted in more than one way, courts read the contract as a whole and consider whether other sections of the policy clarify the term. If ambiguity persists after examining the policy language, courts may then turn to extrinsic evidence.

The Court of Appeals applied these principles to determine whether the CERCLA complaint alleged facts that potentially fell within—or were excluded by—the insurers' policy provisions. The Tenth Circuit concluded that the allegations fell squarely within Fidelity's pollution exclusion. The complaint asserted that hazardous materials released on Chisholm's property contaminated the water. Fidelity's exclusions expressly excluded coverage for claims "arising from the alleged release of contaminants like chemicals and waste." Since the alleged damage fell within this exclusion, Fidelity owed no duty to defend or to investigate.

The Tenth Circuit disagreed with the district court that the New Mexico Supreme Court would adopt an outlier approach in interpreting pollution exclusions—requiring a policy to specify the exact type of pollutant by name for the exclusion to be considered clear. The Tenth Circuit found that such an interpretation would be inconsistent with established precedent. New Mexico case law indicates that it is unreasonable to require insurers to provide an exhaustive list of "noncovered activities" for an exclusion to be considered unambiguous.

The Court similarly found that Cincinnati's pollution exclusion clearly excluded coverage. It held that the district court erroneously interpreted an alternative liability provision, suggesting that certain exceptions could override the exclusion. According to the lower court, if a complaint alleged "common law liability for nuisance or trespass, the pollution exclusion does not preclude coverage," potentially triggering a duty to defend. However, the CERCLA complaint asserted no such tort claims against Chisholm's. Thus, the Tenth Circuit held that the exception to the pollution exclusion did not apply, and Cincinnati had no duty to defend Chisholm's.

Kane v. Syndicate 2623-623 Lloyd's of London

No. A-1-CA-41254, 2025 WL 1733046 (N.M. Ct. App. June 16, 2025)

The Court of Appeals of New Mexico upheld the district court's decision that the phrase "for a security breach" is an ambiguous policy term. The Court held that the phrase is ambiguous because there are multiple reasonable meanings of the phrase. It extends to claims of loss "because of," "resulting from," or "on account of" a security breach.

A third-party posing as a senior account manager at one of the insured's vendors emailed a fraudulent invoice to the insured, New Mexico Health Connections, Inc. ("NMHC"). As a result, NMHC wired $4,415,833.11 to a fraudulent bank account over five different transfers. The actual vendor then reached out to NMHC demanding payment due under their contract. In response, NMHC reported the claim to its insurer, a Lloyd's syndicate d/b/a Beazley USA Services, Inc. ("Beazley") requesting a defense and indemnity with respect to the vendor's claims.

The parties agreed that this fraud was perpetrated by a third party and constituted a security breach as defined by the Policy. However, they disagreed on whether the claim was one for damages "for a security breach" as opposed to an ordinary breach of contract claim for failure to pay a vendor.

Beazley argued that the language at issue applied only to claims directly for a security breach itself, and not for claims caused by a security breach. However, the district court sided with NMHC, concluding that "for a security breach" provides coverage for claims that arise from or flow from a security breach as well.

The Court of Appeals, focused on analyzing the insurance Policy with the goal of ascertaining the intentions of the contracting parties, applied various principles of interpretation to determine whether "for a security breach" is an ambiguous phrase.

The Court focused on the meaning of the word "for." The Policy did not define the word "for", nor did it distinguish "for" from similar interchangeable terms like "arising out of" and "resulting from." Additionally, other provisions in the Policy used far more specific phrases like "as a direct result." Accordingly, the Court found that other terms in the Policy did not resolve the issue.

As such, the Court continued to look at dictionary definitions of "for." Ultimately, it found that the word "for" has multiple commonplace definitions, and the preferred meanings put forth by the parties were included within the common usage. The Court found that this further supported a finding that the phrase was ambiguous. Lastly, the Court considered how other courts have defined the term as well as the lack of industry practice within the cybersecurity realm that might shed light on the term's meaning. Both factors supported a finding that the phrase was ambiguous.

Ultimately, because every one of the above interpretive aids the Court looked to supported multiple reasonable meanings of the phrase "for a security breach" and the term "for," the Court found the phrase to be ambiguous. Such ambiguity in an insurance policy was construed in the insured NMHC's favor and Court determined that Policy afforded coverage.

Kileen v. Didio

The New Mexico Supreme Court held that insurers must offer uninsured/underinsured motorist coverage on a per-vehicle basis for multi-vehicle policies and disclose premiums accordingly.

Plaintiff, Kileen, was involved in an accident and suffered injuries and related damages exceeding the other vehicle's coverage limits. As a result, Kileen sought to recover UIM coverage from his own insurer, Progressive. Progressive denied Kileen's claim because he rejected UM/UIM coverage when he purchased the policy by signing and returning a form. Progressive did not offer UM/UIM coverage on a per-vehicle basis or disclose premiums accordingly.

Kileen then sued Progressive, alleging the insurer failed to offer UM/UIM coverage on a per-vehicle basis for a multi-vehicle policy as required by New Mexico law. New Mexico's UM/UIM statutes require an insurer to offer UM/UIM coverage in minimum limits and such higher limits as may be desired by the insured, up to the limits of liability.

The lower court granted summary judgment in favor of Progressive, and the Court of Appeals affirmed this decision. However, the New Mexico Supreme Court reversed the lower courts' decision. The primary question considered by the New Mexico Supreme Court was whether the Legislature's statutorily mandated offer of UM/UIM coverage must be offered on a per-vehicle, per-policy basis.

The Court held that New Mexico's UM/UIM statutes require insurers to offer UM/UIM coverage on a per-vehicle basis. The Court reasoned that the statutory requirement should be construed liberally to encourage insureds to purchase such coverage, and public policy supports the ruling. The Court held the policy was void because Kileen was never afforded a meaningful opportunity to accept or reject the coverage, and consequently, that decision was not knowingly and intelligently made.

Progressive argued that the imposition of a per-vehicle requirement would result in confusion or the burden of an infinite number of choices; however, the Court stated that an insurer does not need to disclose every permutation imaginable, but there needs to be an opportunity for the insured to reject or select coverage on each vehicle. Lastly, the Court further clarified that UM/UIM personal injury coverage in New Mexico does not follow the vehicle but instead follows the insured, insuring against bodily injury.

Overall, this case signifies how New Mexico courts liberally construe New Mexico UM/UIM statutes to encourage insurers to offer coverage on a per-vehicle basis for multi-vehicle policies to consumers.

No. S-1-SC-39256, 2025 WL 1791659 (N.M. June 30, 2025), reh'g denied (July 15, 2025)

Komis v. Farmers Ins. Co.

No. A-1-CA-41014, 2025
WL 1924033
(N.M. Ct. App. July 8, 2025)

The Court of Appeals of New Mexico held that the district court erred in finding that the assailants' intentional acts were not covered under an uninsured/underinsured motorist policy. The Court held that intentional acts for which an uninsured vehicle is used as an active accessory in causing the insured's injuries are covered under an uninsured/underinsured policy.

Peter Komis was brutally attacked in the driveway of his home one night after returning from work. Three masked assailants, who arrived at the scene in an uninsured vehicle, beat and shot him multiple times. Immediately after the attack, the assailants fled the scene to where they had parked their vehicle. The assailants were never apprehended or identified.

The central issue in this case surrounds the application of a test laid out in *Britt v. Phoenix Indem. Ins. Co*. for determining whether intentional conduct and its resulting harm arises out of the use of an uninsured vehicle. Under *Britt*, the trier of fact first considers whether there is a sufficient causal nexus between the use of the uninsured vehicle and the resulting harm. Importantly, the vehicle must be an active accessory in causing the injury. Second, if there is a sufficient causal nexus, the trier of fact will consider whether an act of independent significance broke the causal link between the use of the vehicle and the harm suffered. Lastly, the trier of fact must consider whether the use of the vehicle was a normal use of the vehicle.

The district court found that the uninsured vehicle in this case was used for a normal purpose. However, the district court found that the vehicle was not an active accessory in the attack on Komis.

In reviewing the district court's decision, the Court of Appeals considered several factors to determine if the first prong of the Britt test was satisfied. One primary factor in deciding whether the vehicle was an active accessory in the attack is considering the state of mind of the uninsured vehicle's operator. If the driver intentionally operated the vehicle in such a way as to facilitate the attack, the first prong is likely met. Additionally, if the use of the vehicle offers certain advantages in the commission of the crime which are unavailable without the vehicle, like storing weapons, concealing the perpetrators' identities, and escaping--it was likely an accessory.

The assailants in Komis used the vehicle to transport weapons used in the attack, conceal their identities, position them prior to their attack, and facilitate a swift flight from the crime scene. Therefore, the Court determined that all these facts support the decision that the first prong in the *Britt* test was met here.

As to the second prong, the Court determined that the district court's findings demonstrated that the intent to attack Komis did not develop independently of their use of the uninsured vehicle. As such, the causal chain was not broken. Because there was no dispute that the third prong was satisfied, the Court of Appeals held that all three prongs of the *Britt* test had been met and reversed the district court's grant of summary judgment in favor of Farmers.

New York

Prepared by:

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Liberty Insurance Corporation v. Hudson Excess Insurance Company

147 F.4th 249
(2nd Cir. 2025)

The United States Court of Appeals for the Second Circuit affirmed the trial court's decision on indemnity in a declaratory judgment action arising from an underlying New York state construction injury action. The Court held that the federal district court's determination on the duty to indemnify and proximate cause was not premature, despite the fact that the issue was still pending in the underlying state action.

Liberty Insurance Corporation insured a construction premises owner in connection with an underlying state construction accident action. Liberty brought this declaratory judgment action in federal court seeking a determination that Hudson Excess Insurance Company had a duty to defend and indemnify Liberty's insured in that underlying state action. Hudson insured a subcontractor that employed the plaintiff in the underlying action. The underlying plaintiff brought suit against the general contractor and Liberty's insured, the premises owner, for injuries allegedly sustained as a result of a scaffolding collapse. Liberty argued that its insured was an additional insured on the Hudson commercial general liability policy obtained by the subcontractor.

Following a bench trial where Liberty and Hudson stipulated that the District Court would determine any issues of fact and conclusions of law based on the parties' Stipulations or Agreed Statements of Fact, and the parties' Proposed Findings of Facts and Conclusions of Law, the District Court entered a judgment in favor of Liberty, declaring that Hudson had a duty to defend and indemnify the owner, and that pursuant to New York Insurance Law § 1213(d), Hudson was required to reimburse Liberty for its attorneys' fees in connection with the declaratory judgment action. After the briefing was completed for the appeal before the Second Circuit, the court in the underlying state action granted summary judgment in favor of Hudson's insured, dismissing all of the third-party claims brought by Liberty's insured and the general contractor, which included claims for contractual indemnification and contribution, and common law indemnification and contribution. Thus, there were no claims remaining against Hudson's insured prior to the Second Circuit's decision.

On Appeal, Hudson argued that it was premature of the district court to make a determination as to indemnification, as the disputed factual issues surrounding proximate cause had not been decided and, in supplemental briefing, that the entry of summary judgment in favor of Hudson's insured on the third-party claims, which was entered after the district court's decision, established that there was no duty to indemnify.

The Second Circuit affirmed the decision of the district court on the issue of indemnity, concluding that the district court did not err in its finding that Hudson's insured proximately caused the underlying plaintiff's injuries, and that a duty to indemnify Liberty arose from that finding, as well as the language of the subcontract agreement between the underlying construction parties. The Second Circuit held that other New York courts had made determinations as to proximate cause in other declaratory judgment actions, and that the district court was not premature in its decision in light of the stipulations made by Liberty and Hudson prior to the bench trial. The Second Circuit also raised Hudson's failure to seek a dismissal or stay of the declaratory judgment action during the pendency of the state court action. Moreover, the Second Circuit held that the later summary judgment decision in the underlying state action had no retroactive effect on the district court's judgment.

Despite the fact that it affirmed the district court's decision on liability, the Second Circuit did reverse the district court's award of attorneys' fees in favor of Liberty. The Second Circuit agreed with Hudson's argument that it was exempt from paying attorney's fees by operation of the safe-harbor provision of N.Y. Ins. Law § 1213(e). The Court agreed with Hudson that its general liability policy was authorized by the statutory language of Section 1113(a)(13).

Ohio

Prepared by:

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OTARMA v. Miami Township

2025-Ohio-2897, --- N.E.3d ---, 2025 WL 2374827 (2d Dist.)

The Ohio Second District Court of Appeals found that OTARMA, an Ohio statutory public entity/local government joint self-insurance risk pool, was entitled to recover its attorneys' fees and costs incurred in defending its insured in an earlier court action.

OTARMA is an Ohio political subdivision self-insurance risk pool. Miami Township, OH is a Member of the OTARMA risk pool.

In 2013, Roger Gillispie sued Miami Township in federal district court stating claims under 42 U.S.C. 1983 and state law. The Township tendered defense of the suit to OTARMA, which accepted the defense under a reservation of rights. In its reservation of rights, OTARMA reserved its right to seek reimbursement for any defense costs incurred in defending against claims for which it is determined no coverage is owed, although the contract between the Township and OTARMA did not provide OTARMA with that right.

While the federal lawsuit was pending, OTARMA filed a declaratory-judgment action seeking determination that it had no duty to defend or indemnify the Township. Following briefing on cross-motions for summary judgment, in July 2022 the trial court sustained OTARMA's motion and overruled the Township's competing motion. The trial court found that there was no duty to defend any of the pending counts. OTARMA thereafter notified the Township that it would discontinue funding the defense. The trial court granted the Township's motion to stay enforcement of the judgment pending appeal since the Gillispie case was set to be tried soon on the remaining non-covered counts. The appellate court allowed the stay to continue, and OTARMA provided the defense through trial. As to the merits, the appellate court found that only one count against the Township was covered and that OTARMA's duty to defend ended on September 21, 2020, when the federal court in the Gillispie lawsuit entered judgment on that count.

OTARMA thereafter filed the present action against the Township seeking recovery of its fees and costs incurred in defending the Township after September 21, 2020, through trial. The trial court entered judgment in favor of OTARMA in the amount of $528,782.95.

Among its various arguments on appeal, the Township posited that the case was not a "special proceeding" and that "OTARMA improperly attempted to monetize a declaratory judgment to deprive the Township of the legal rights to which it would have been entitled in a civil action, including a jury trial, use of discovery, and an adversarial factual proceeding on questions of implied contract or unjust enrichment." The Second District disagreed, holding complaints for relief under R.C. 2721.09 are special proceedings and provide the statutory outline for pursuing declaratory relief.

In addition, the Township argued that OTARMA had no right to recover its defense costs incurred defending the Township after the dismissal of the only covered count. After examining previous decisions by other Ohio appellate districts and the Sixth Circuit, the Second District found that Ohio would follow the majority rule and allow insurers to seek reimbursement from their insureds for defense costs when the insurer did not have a duty to defend where the insured timely and explicitly reserves the right to seek reimbursement, and provides adequate notice of the possibility of reimbursement. The court found that allowing OTARMA to obtain reimbursement was particularly appropriate since it had been ordered to continue to defend despite the finding of no coverage.

The Second District did, however, determine that the trial court had erred in not holding a hearing on OTARMA's fee application and had failed to properly consider the parties' evidence relative to the value of the claim.

Fire-Dex, LLC v. Admiral Insurance Company

139 F.4th 519
(6th Cir. 2025)

The Sixth Circuit Court of Appeals adopted a standard for district courts to use to determine whether to abstain from exercising jurisdiction over "mixed actions"—actions that seek both coercive relief (damages) and noncoercive relief (declaratory). It found that district courts should apply the traditional rules of mandatory jurisdiction and abstention to coercive claims and the discretionary standard found in the Declaratory Judgment Act to declaratory judgment claims.

Fire-Dex, Inc., was sued in a class action by firefighters alleging, inter alia, product liability and resulting exposure to carcinogens. Fire-Dex tendered the claim to its insurer, Admiral Insurance Company ("Admiral"), for indemnity and defense. When Admiral declined, Fire-Dex sued Admiral in the federal district court seeking declaratory relief.

The district court initially determined that while it did have diversity jurisdiction, under the applicable federal declaratory judgment statute (28 U.S.C. § 2201(a)) and the statute's use of the permissive "may", declined to exercise subject matter jurisdiction. Fire-Dex then sued in state court, pursuing declaratory relief, breach of contract, and bad faith. Admiral answered and counterclaimed and sought removal to federal court. Fire-Dex moved to remand the matter to state court. While diversity jurisdiction again was satisfied, the district court remanded both Fire-Dex's claim for declaratory relief and Admiral's counterclaim for declaratory relief back to state court. It stayed Fire-Dex's claim for breach of contract and bad faith. Admiral appealed.

The Sixth Circuit accepted the appeal and, following an entertaining and didactic lesson in history, procedure, and application of the abstention doctrine, determined, in material part, that because the Fire-Dex claim requested coercive relief (i.e., money damages) as well as declaratory relief, the district court should have exercised jurisdiction over all claims. The court pointed out that a "mixed action"—one that pairs a request for coercive relief with a request for declaratory relief—raises a question of what standard should guide the district court in deciding whether to exercise jurisdiction.

After all, district courts have limited discretion in refusing to abstain from exercising jurisdiction over claims for coercive relief: if the court has subject matter jurisdiction the court must exercise jurisdiction over that claim unless one of the limited, traditional abstention doctrines applies. In contrast, under the Declaratory Judgment Act, the court has discretion to decline to exercise jurisdiction over declaratory claims.

The Sixth Circuit found that pairing of the two claims did not affect the district court's "unflagging obligation" to exercise jurisdiction over the coercive claim, but also did not deprive the district court of the discretion provided by the Declaratory Judgment Act to decline jurisdiction over the declaratory claim. In other words, the presence of one claim should not impact the other.

It found that a district court should apply the normal rules regarding abstention to each claim. The court should exercise jurisdiction over the coercive claim unless one of the traditional abstention doctrines apply. The district court should separately exercise its discretion over whether to determine the declaratory action, but the Sixth Circuit observed that if the claims involved the same legal issues the equitable principles of "efficiency, fairness, and federalism" would counsel against abstaining and thus a court likely would abuse its discretion if it did not determine the claims together.

In this case, the Sixth Court found that the district court erred in remanding the declaratory judgment claims and staying the claims for breach of contract and bad faith. The district court should have exercised jurisdiction over the coercive claims since no traditional abstention doctrine supported not doing so, and also exercised jurisdiction over the declaratory claims because the claims turned on the same legal issues.

Turner v. Pontones

2025-Ohio-253, 262 N.E.3d 537 (7th Dist.)

The Ohio Seventh District Court of Appeals held that a side-by-side recreational vehicle was an "auto" under a Farm/Business policy issued by State Farm Fire and Casualty Insurance Company ("State Farm"), and thus a "non-owned auto" under an exception to a motor vehicle exclusion in the policy.

The resident daughter (Kelly Pontone) of State Farm's named insureds (Donald and Kathryn Pontone) owned a recreational side-by-side vehicle. State Farm had issued a Farm/Business policy to Donald and Kathryn. There was some evidence the side-by-side was occasionally used for farm purposes. Kelly drove the side-by-side through a fence and into a ditch, resulting in the death of her passenger. Decedent's Estate brought suit, and the Pontones submitted a claim for defense and indemnity to State Farm. State Farm elected to defend under a reservation of rights and also elected to intervene in the tort/wrongful death action.

The Policy contained an exclusion to liability coverage, which prevented liability coverage for bodily injury "arising out of the ownership, maintenance, use. . . of: 2) a motor vehicle owned or operated by or rented or loaned to any insured." The Policy defined "motor vehicle" as including: "[a.] a land motor vehicle designed for travel on public roads or subject to motor vehicle registration . . . [c.] a "recreational vehicle" while off an insured location. And the Policy defined "Recreational vehicle", as "a motorized vehicle designed for recreation principally off public roads that is owned or leased by an insured. This includes, but is not limited to, a motorized all-terrain vehicle, amphibious vehicle, dune buggy, go-cart, golf cart, snowmobile, trailbike, mini-bike and personal assistive mobility device . . . ."

Importantly, the Policy did not specifically define the term "auto." The Policy also identified the following exemption to the exclusion: "Exclusion [e.] (2) does not apply to bodily injury or property damage arising out of the use of any non-owned auto by any person other than you."

On cross motions for summary judgment, the trial court determined there was no coverage under the Policy since the recreational side-by-side vehicle was not an "auto" because it was a recreational vehicle designed for use off of public roads and thus the exception to the exclusion did not apply. The Executor appealed.

The Ohio Seventh District reversed, finding that the side-by-side qualified as an "auto". The appellate court noted that State Farm could have specifically defined the term "auto" in the "non-owned auto" exception to the exclusion of coverage, but did not. The court therefore reviewed the various definitions of "auto" provided by the parties, and found that the term as used in the exception was capable of numerous plain and ordinary meanings. The term therefore was ambiguous and should be construed against State Farm.

The appellate court found that the trial court erred by not construing the term "auto" against State Farm, as the drafter, but instead adopting a restrictive meaning for the word. The court believed that the definition of "auto" offered by the Estate and insureds—which included any land vehicles designed for carrying passengers and not restricted to public roads—was not unnatural, strained, or caused absurd results. The court held that the trial court should have accepted the less restrictive definition and therefore reversed the trial court's judgment.

Pennsylvania

Prepared by:

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Devincenzo-Gambone v. Erie Ins. Exch.

2025 PA Super 235
(Oct. 17, 2025)

The Superior Court of Pennsylvania upheld a finding of bad faith where an insurer failed to adequately communicate with its insured that it intended to challenge a stacking determination made at a binding arbitration. The Superior Court also affirmed the trial court's calculation of pre-judgment interest in the award for the bad faith claim as beginning the moment an insured first makes a claim under a policy as opposed to the date the bad faith claim is filed.

Dina Gambone was injured in a car accident. After settling with the tortfeasor, she filed an under-insured motorist (UIM) claim under an Erie Insurance Exchange policy. The parties agreed to binding arbitration on the UIM claim. The arbitrator found that stacking provisions of the UIM policy applied and awarded Gambone $300,000. Erie tendered $250,000 but withheld $50,000 and then filed a petition to modify the award based upon the arbitrator's stacking determination. That petition was denied, and Gambone then filed suit alleging bad faith.

After a non-jury trial, the trial court concluded that Erie acted in bad faith and awarded attorney's fees and pre-judgment interest. Erie raised three issues on appeal: 1) There was insufficient evidence to support the bad faith claim; 2) The trial court improperly calculated the fee award by failing to follow the lodestar approach; 3) The trial court improperly calculated the interest amount by using the date Gambone first sought coverage as opposed to the date the bad faith lawsuit was filed, as well as by calculating the award with a compound interest rate.

The Superior Court affirmed in part and reversed in part.
First, the court concluded the record showed that the parties agreed to binding arbitration on all accounts, including the stacking question. Although Gambone never specifically asked Erie to waive its right to challenge the stacking issue, the court found this was not determinative because the duties of reservation flow from Erie to Gambone, not the other way around. The Superior Court also noted it was only after Gambone dismissed her UIM claim that Erie moved to challenge the arbitration award.

In all, the Superior Court found that Erie failed to properly communicate with its insured regarding the scope of the arbitration, and thus declined to upset the finding that it acted in bad faith.

Next, the Superior Court held that the trial court erred in awarding $100,000 in attorney's fees for the UIM claim. The trial court based this award solely on the contingency fee between Gambone and her counsel. While a contingency fee can be considered in the calculation, the Superior Court stressed it cannot, as it did here, serve as the ceiling for such an award. Rather, a trial court must use the lodestar approach, which requires determining the amount of time litigating the UIM claim and multiplying it by a reasonable hourly rate. The Superior Court also noted that the trial court's separate award of $117,000 in attorney's fees for litigating the bad faith claim was not capable of review because the trial court molded the amount with a broad-brush without explanation or detail. The Superior Court found this contravened the lodestar approach and was an abuse of discretion.

The final issue was the trial court's use of the date Gambone first filed her claim in its calculation of the pre-judgment interest award, which turned on the meaning of the word "claim" in the bad faith statute. Finding little guidance from the plain text of the statute, the Superior Court concluded the best reading of the word "claim" is, as the trial court found, the moment an insured makes a request to the insurer for payment based on the policy's terms. This reading, the court explained, comports with legislative intent by enhancing the deterrence factor inherent in the statutory scheme. The Superior Court therefore affirmed the trial court's use of the date Gambone initially filed her claim in the pre-judgment interest calculation. That said, the Superior Court found it was error to apply compound interest to the award as that is not permitted by the statute.

Chris Eldredge Containers, LLC v. Crum & Foster Specialty Ins. Co., Nat. Union Fire Ins. Co. of Pittsburgh, PA, Selective Ins. Co. of America, Craig Logan

335 A.3d 1216
(Pa. Super. 2025)

The Superior Court of Pennsylvania found that an exclusion in an auto policy was ambiguous because it did not specify a causation standard and did not specify whose ownership or use of a covered auto triggered the exclusion. The Superior Court resolved the ambiguities in favor of the insured and held that the exclusion applied only where the injuries alleged in the underlying suit "arose out of" the insured's "use or ownership" of a covered auto.

An employee of Eldrege Containers was driving a vehicle owned by Ottawa Terminal. The Eldrege driver backed into a tractor owned by Safety-Kleen Systems, Inc., causing damages and injuring the Safety-Kleen driver. The driver of the Safety-Kleen tractor brought suit against Eldrege for personal injuries. Eldrege, in turn, sought defense and indemnification under a general liability policy issued by Crum & Foster (C&F). The C&F policy covered the Safety-Kleen tractor—the one that sustained the damage. C&F disclaimed coverage on the grounds that the injuries alleged in the underlying suit "arose out of" the "use or ownership" of the Safety-Kleen tractor.

Eldredge filed a declaratory judgment action challenging that reasoning. Eldredge argued the exclusion language was ambiguous and should be interpreted as applying only where the insured's use of the covered auto is the proximate cause of the injuries. The trial court rejected that argument and concluded that the exclusion was not ambiguous, and therefore granted judgment on the pleadings in C&F's favor.

On appeal, the Superior Court reversed. The Court first determined the phrase "arising out of" in the exclusion was indeed ambiguous because it did not clearly indicate whether the injuries must "arise out of" the use of the covered auto or whether, as in this case and as Eldredge argued, the injuries could "arise out of" the use of a non-covered auto.

Resolving the ambiguity in favor of the insured, the court reasoned the causation standard implicit in the "arising out of" language is triggered only where the injuries are proximately caused by a covered auto. Because the injuries here arose out of the use of a non-covered auto (the Ottawa tractor), and not the covered auto (the Safety-Kleen tractor), the court found the "arising out of" language in the exclusion did not bar coverage.

Similarly, the court found the "use or ownership" language in the exclusion was also ambiguous because it did not specify whose ownership triggered the exclusion. That is, whether the covered auto that caused the injuries could be owned by someone other than the insured. Again resolving the ambiguity in favor of *the insured,* the court concluded the exclusion was operable only where the insured owned or used the auto that caused the injuries.

As Eldrege did not own, maintain, use, or entrust the tractor that caused the injuries here, the court found this portion of the exclusion also did not bar coverage.

On those grounds, the Superior Court held that the exclusion was not applicable and that C&F was required to defend and indemnify Eldredge in the underlying suit.

Erie Ins. Exch. v. Russo

343 A.3d 291
(Pa. Super. Ct. 2025)

The Pennsylvania Superior Court ruled that inter-policy UIM benefit stacking is unavailable in cases where an employee is not specifically listed as an insured under their employer's policy.

The Superior Court of Pennsylvania affirmed a trial court's decision that an individual injured in a motor vehicle accident while driving his employer's car could not stack UIM benefits from his personal motor vehicle insurance policy on top of his employer's UIM benefits. Notably, the Court reached its decision on different grounds from the trial court, ruling that policy stacking was unavailable to the individual because he did not qualify as an "insured" under his employer's policy.

In November 2018, Richard Russo was seriously injured in a motor vehicle accident. The accident occurred while Mr. Russo was driving a vehicle supplied by his employer, Lancaster Plumbing, Heating, Cooling and Electrical during the course of his employment. At the time, Mr. Russo was covered under Lancaster's insurance and he also maintained an individual policy with Erie Insurance Exchange. Mr. Russo received $35,000 in UIM benefits from Lancaster's policy. But because this did not fully cover the costs of Mr. Russo's injuries, he sought to stack the UIM benefits from his personal policy with Erie. Erie, however, denied him any UIM benefits, noting that his policy's "regular use" exclusion did not apply to injuries he sustained while operating a vehicle that (1) he did not own, (2) he regularly used and (3) was not insured under his policy.

Erie then filed suit, seeking a declaratory judgment that the regular use exclusion precluded Mr. Russo from recovering UIM benefits. The trial court stayed its decision pending litigation concerning whether regular use exclusions were valid under Pennsylvania's Motor Vehicle Financial Responsibility Law ("MVFRL"). Once the Supreme Court of Pennsylvania upheld the validity of regular use exclusions in *Rush v. Erie Ins. Exch.*, 308 A.3d 780 (Pa. 2024), the court entered judgment on the pleadings in favor of Erie.

On appeal, the Pennsylvania Superior Court turned its focus specifically to whether Mr. Russo qualified as an "insured" under his employer's policy. The Court noted that §1738 of the MVFRL only permits inter-policy stacking of UIM insurance in cases where an individual "is an insured under both policies implicated in a stacking situation." Therefore, unless Mr. Russo qualified as an insured under his employer's policy, he could not stack his own policy's UIM benefits atop Lancaster's.

Mr. Russo argued that he qualified as an insured under Lancaster's policy because the policy specifically contemplated injuries of employees made in the course of their employment. In opposition, Erie argued that "insured," as used in the MVFRL, is a term of art that must be strictly construed to only include "class one" insureds consisting of "a policy's named insureds, resident relatives of a named insured, and where the insured is a corporation, officers of the corporation."

Ultimately, the Court agreed with Erie's position. The Court noted that the Supreme Court of Pennsylvania had previously held that courts must use the definition of "insured" found in MVFRL § 1702 when interpreting its use of the term in § 1738. Examining the language of § 1702, the Court found that Mr. Russo did not fall under that definition, nor the definition of a "class one" insured as established in prior case law. Consequently, the Court ruled that Mr. Russo was not entitled to stack benefits and affirmed the trial court's decision to validate Erie's denial.

Erie Ins. Exch. v. Baluch

330 A.3d. 825
(Pa. Super. Ct. 2025)

The Pennsylvania Superior Court ruled that household vehicle exclusions to underinsured motor vehicle (UIM) policies are invalid in cases where an insured seeks to stack coverage from two separate policies, absent a waiver as prescribed by the Motor Vehicle Financial Responsibility Law.

The Pennsylvania Superior Court reversed a lower court ruling, which had upheld the validity of household exclusions that prevented an insured from stacking UIM benefits from two policies in the context of a single-vehicle accident with a family member. In doing so, the Court ruled that such exclusions constituted disguised waivers of stacking that violated the Motor Vehicle Financial Responsibility Law ("MVFRL").

In April 2022, Hannah Baluch and her stepfather were seriously injured in a single-vehicle motorcycle accident. Ms. Baluch was included as an insured on her stepfather's motor vehicle policy ("Policy 1"), which covered the motorcycle. Policy 1 included $100,000 per person in liability coverage and an additional $100,000 in UIM coverage from Erie Insurance Exchange ("Erie"). Additionally, Ms. Baluch maintained a personal motor vehicle policy with Erie ("Policy 2"), which also provided $100,000 in UIM coverage. And both policies selected to stack UIM coverage. Following the accident, Ms. Baluch received $100,000 in liability coverage from Policy 1 and $100,000 in UIM coverage from Policy 2. However, Erie denied Ms. Baluch any UIM benefits from Policy 1.

Erie justified the denial by relying on Policy 1's definition of "underinsured motor vehicle," which excluded any vehicles that were insured under Policy 1. Erie filed suit for a declaratory judgment "seeking a judicial determination that no further benefits were due under Policy 1." Erie argued that the courts were bound by the cases *Wolgemuth v. Harleysville Mut. Ins. Co.*, 370 535 A.2d 1145 (Pa. Super. Ct. 1988) and *Newkirk v. United Servs. Auto. Ass'n*, 564 A.2d 1263 (Pa. Super. Ct. 1989), which supported the conclusion that in a single-car accident an insured under a policy cannot receive both liability coverage and UIM benefits from the same policy. The trial court agreed and granted Erie's motion for judgment on the pleadings, ruling that the exclusion was valid.

On appeal, the Pennsylvania Superior Court ruled that the trial court erred both in relying on *Wolgemuth* and *Newkirk* and in validating the exclusion. The Court noted that in *Wolgemuth* and *Newkirk*, the individuals seeking to claim UIM benefits had only collected liability insurance from the same policies for which they were seeking UIM benefits. Critically, the cases did not consider whether insureds could stack UIM benefits from multiple policies in the case of a single vehicle collision. Conversely, the Court noted that Ms. Baluch's claim did involve a request to stack benefits from two separate policies. As such, the Court ruled that *Wolgemuth* and *Newkirk* did not apply because they did not explicitly address the issue of stacking.

The Court noted that the MVFRL specifically provides for the default stacking of UIM benefits and only allows insureds to waive the ability to stack coverage by signing a written waiver form. Then, the court reasoned that because Ms. Baluch would have been able to stack Policy 1's UIM benefits with her own UIM benefits in Policy 2 absent Policy 1's household vehicle exclusion, the exclusion functioned as a "disguised waiver of stacking." Thus, the Court ruled that the exclusions were invalid for violating the MVFRL.

On November 4, 2025, the Supreme Court of Pennsylvania granted Erie's Petition for Allowance of Appeal. The appeal directly questions whether the Superior Court erred in invalidating the household vehicle exclusion under MVFRL, so it remains to be seen whether insurers will be able to use household vehicle exclusions to deny coverage stacking from multiple policies in future.

Rhode Island

Prepared by:

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Vermont Mutual Insurance Company v. New England Property Services Group, LLC

331 A.3d 993 (R.I. 2025)

The Rhode Island Supreme Court held that the Superior Court properly exercised jurisdiction over a dispute arising from an insurance appraisal. The Court concluded that the appraisal process used to determine the value of the insurance claim was similar to arbitration and therefore subject to the procedural requirements of the Arbitration Act. Ultimately, however, the Court vacated the appraisal award due to evident partiality on the part of the Defendant's party-appointed appraiser, in violation of the requirements of the Arbitration Act.

This case arises from a homeowners insurance claim under a policy issued by Plaintiff Vermont Mutual. After a windstorm, the insured homeowner hired contractor Steven Ceceri to remediate the damage. Of note, Mr. Ceceri is the sole owner of Defendant New England Property Services Group, LLC (NEPSG). The homeowner later assigned her claim to Mr. Ceceri, authorizing him to pursue the damage award. Mr. Ceceri disputed Vermont Mutual's initial coverage decision and sought appraisal for the value of the underlying claim.

Under the homeowners policy, if an insured demands appraisal, each party must select "a competent appraiser." The two appraisers then jointly choose an umpire. Together, the appraisers determine the amount of loss. If they cannot agree, they submit their valuations to the umpire. A decision made by the umpire and either appraiser determines the value of the loss. NEPSG appointed Mr. Ceceri as its appraiser. Vermont Mutual opposed Mr. Ceceri's designation due to his apparent financial interest. The appraisal proceeded, however, with Mr. Ceceri valuing the loss at $207,053.11 and Vermont Mutual's appraiser valuing the loss at $67,645.99. The final award was $144,855.37, exclusive of interest. Pursuant to the State's Arbitration Act, Vermont Mutual petitioned to vacate the award in the Superior Court and NEPSG cross-petitioned to confirm. The Superior Court confirmed the award, and Vermont Mutual timely appealed.

On appeal, the Rhode Island Supreme Court considered three central issues: first, whether the Superior Court had subject matter jurisdiction over petitions filed pursuant to the Arbitration Act; second, whether the appraisal process constituted arbitration and was thus subject to the procedural requirements of the Arbitration Act; and third, whether the appraisal award should have been vacated due to "evident partiality."

On the issue of subject matter jurisdiction, the Rhode Island Supreme Court found that under Section 10-3-11 of the Arbitration Act, any party to an arbitration "may apply to the court for an order confirming the award" within one year. Considering this authorization, the court determined that the Superior Court properly exercised its jurisdictional power to confirm the appraisal award.

Next, the court addressed whether the appraisal process qualified as an arbitration and was therefore subject to the Arbitration Act. Relying on precedent, the court reaffirmed that appraisal provisions in insurance policies function as arbitration when they require each party to appoint appraisers, jointly select an umpire, and issue a binding award. This process constitutes a form of dispute resolution analogous to arbitration. The court emphasized that the title of the proceeding is immaterial. Rather, it is the substance of the process that defines its nature. On that basis, the court held that the appraisal procedure at issue was equivalent to arbitration and therefore governed by the Arbitration Act.

Lastly, the Rhode Island Supreme Court addressed Vermont Mutual's claim that Mr. Ceceri's role in the appraisal showed "evident partiality" under § 10312(2) of the Arbitration Act. The court applied a two-part test, holding that: (1) the party seeking to vacate the award must establish the appraiser has an improper interest, and (2) there must be a causal nexus between that interest and the award. As NEPSG's sole owner and assignee of the claim, Mr. Ceceri had a direct financial stake in the award, satisfying the first prong. The court also found a causal nexus, noting that Mr. Ceceri's appraisal of $207,053.11 contrasted sharply with Vermont Mutual's appraisal of $67,645.99. The final award of $144,855.37 was likely indicative of Mr. Ceceri's inflated valuation. Concluding that his financial interest influenced the outcome, the Court held that the award should have been vacated for evident partiality, despite proper jurisdiction and applicability of the Arbitration Act.

South Carolina

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Amoruso v. United Servs. Auto. Ass'n

2025 WL 1649918 (S.C. Ct. App. June 11, 2025)

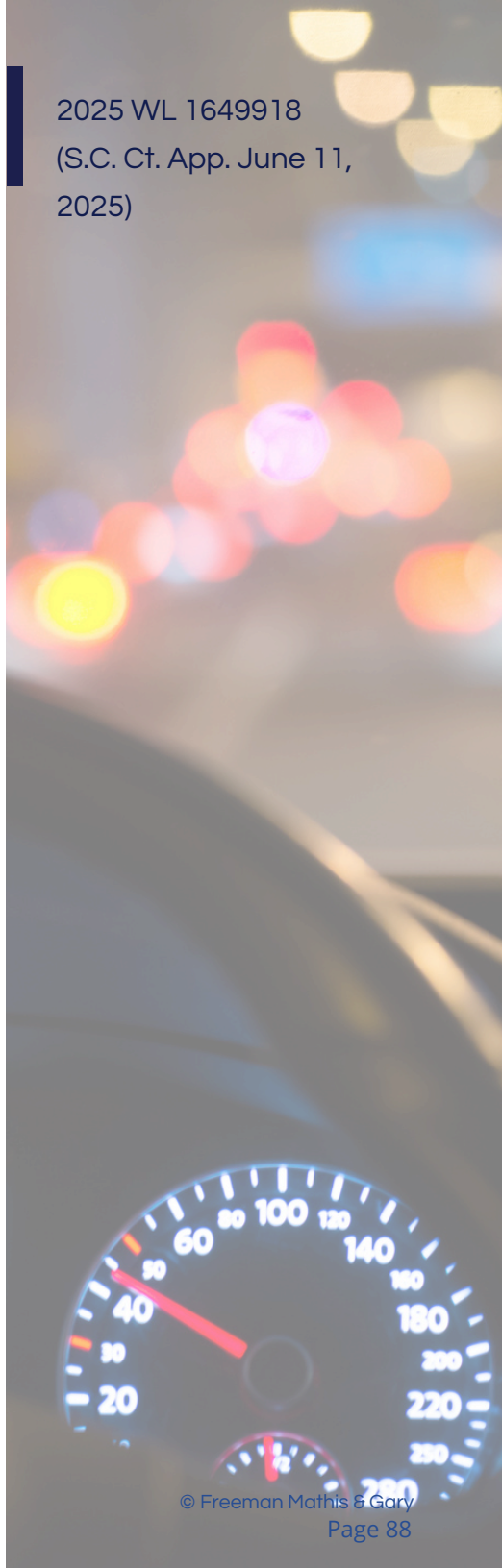
The South Carolina Court of Appeals affirmed the circuit court's grant of summary judgment in favor of USAA against its insured Amoruso and held that USAA was not required to provide underinsured motorist coverage for Amoruso's camper and horse trailer which were not involved in the disputed accident because they did not qualify as motor vehicles under the South Carolina Code. Though unpublished, and therefore non-binding, the case shows that not all "vehicles" require an offer of underinsured motorist coverage in South Carolina.

Amoruso was the named insured on a USAA insurance policy that listed six of her vehicles on the declarations page, including a camper and horse trailer. The policy defined "your covered auto" as "any vehicle shown on the Declarations." However, despite the trailer and camper being shown on the declarations page as vehicles, they were insured only for "physical damage," which included collision and comprehensive coverage. Amoruso was injured in an accident while operating one of her insured vehicles and sought stacked underinsured motorist ("UIM") coverage from USAA for the vehicle she was operating in addition to her other insured vehicles.

Following the Circuit Court's grant of summary judgment in favor of USAA, Amoruso appealed, arguing that the Circuit Court erred in finding that: (1) USAA was not required to offer UIM coverage for her camper and horse trailer; (2) her auto policy should be reformed to include UIM coverage; and (3) Amoruso should recover stacked UIM coverage for the camper and trailer in addition to the UIM funds she obtained from other insured vehicles.

The Court noted that South Carolina Code section 38-77-30(9) defines a motor vehicle as "every self-propelled vehicle which is designed for use upon a highway including trailers and semitrailers designed for use with these vehicles." Importantly, the parties agreed prior to appeal that the horse trailer and camper at issue "were not self-propelled vehicles and were designed to be used with self-propelled vehicles." As a result, when considered in connection with South Carolina Code section 38-77-30(9), the camper and horse trailer only become motor vehicles for the purpose of UIM coverage when they are attached to a self-propelled vehicle which is designed for use upon a highway.

The Court highlighted that finding otherwise would lead to the "absurd result of categorizing vehicles that are otherwise stationary and designed to be used with self-propelled vehicles as motor vehicles." Based on this reasoning, the Court of Appeals found that USAA was not required to make an offer of UIM coverage on these vehicles because the horse trailer and camper did not constitute motor vehicles as defined by South Carolina law.



Hood v. United Servs. Auto Ass'n

910 S.E.2d 767
(S.C. 2025)

The Supreme Court of South Carolina held that no cause of action in tort exists for insureds against their insurance carrier because a tort action is duplicative of a first-party bad faith claim. The Court reasoned that the duty owed by insurance carriers to their insureds is created by contract which, when combined with the statutory scheme for bad faith, allows insureds to pursue only breach of contract and bad faith claims.

Therese Hood filed suit her insurer USAA alleging claims of: (1) bad faith handling of her claim for underinsured motorist benefits and (2) general negligence. At trial, the jury found in favor of USAA on the bad faith claim and for Hood as to the negligence claim. But the trial court entered a judgment notwithstanding the verdict against Hood, finding that South Carolina does not recognize a separate cause of action for negligence against insurers because of their decisions in the claims handling process.

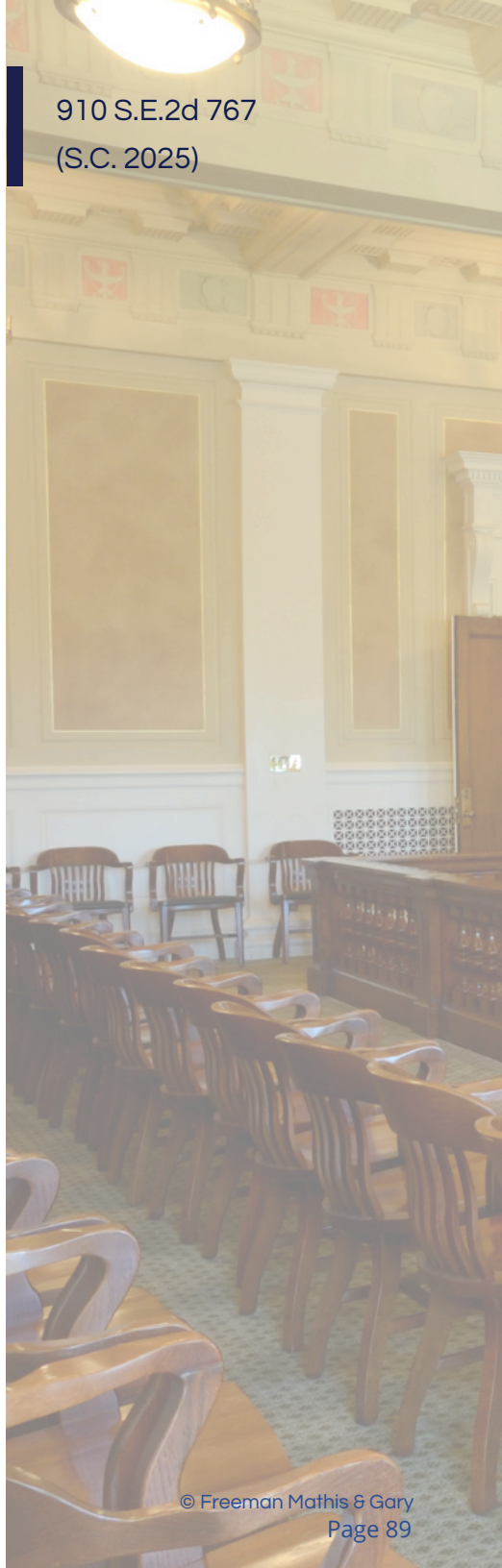
On appeal, the South Carolina Court of Appeals agreed, pointing out that an insurer's negligence is already considered when determining whether it acted in bad faith. The appellate court stated specifically that "there is no tort against an insurance company for negligence that does not also cross the threshold of breaching the duty of good faith and fair deadline arising out of the insurance contract."

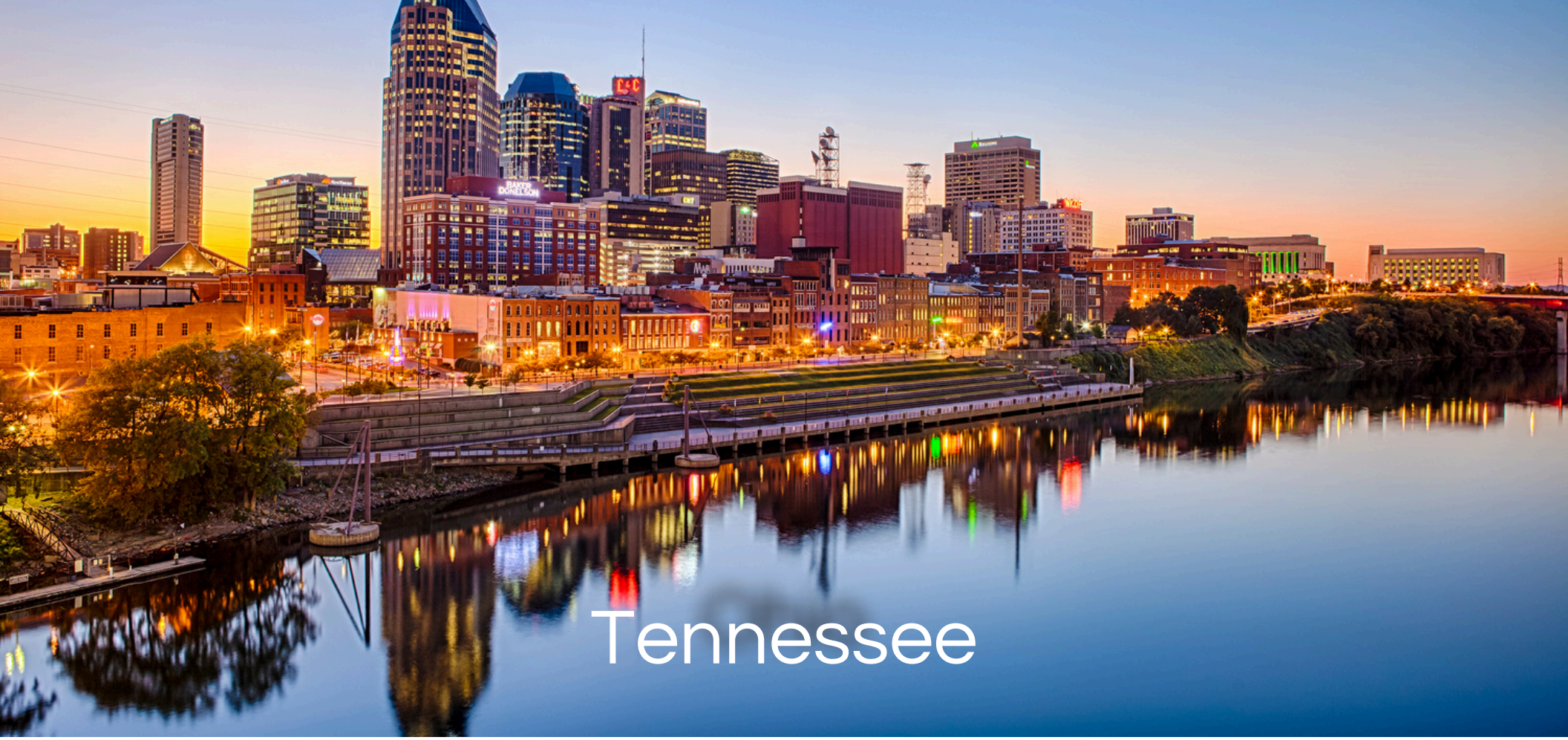
The Supreme Court of South Carolina granted certiorari to reiterate that South Carolina does not recognize a separate cause of action for insureds in negligence against their insurance carriers.

In support, the Court noted that Hood's arguments were all rooted in how USAA acted in defending her in the liability lawsuit with respect to the automobile collision in which she was involved, USAA's subsequent litigation of the related underinsured motorist action, and whether USAA breached its internal policies for litigation – all of which stemmed from the insurance contract. In this way, Hood's bad faith claim *was* her tort claim.

As additional support, the Court noted its disagreement with Hood's argument that a negligence claim must arise from an insurance contract since those seeking insurance who are not yet under contract enjoy that legal protection. The Court easily distinguished negligent procurement claims from bad faith claims which are rooted in the separate duty of good faith and fair dealing and stated that, although the insurance business is affected with a public interest, insureds obtain a level of protection with bad faith claims that is at least the same as that offered from negligence claims.

To conclude its opinion, the Court stated unequivocally that "we take this opportunity to clarify what was already clear: the only claims available to the insured under an insurance contract are contract and bad faith claims."





Tennessee

Prepared by:

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Walters & Mason Retail, Inc. v. Hartford Fire Ins. Co.

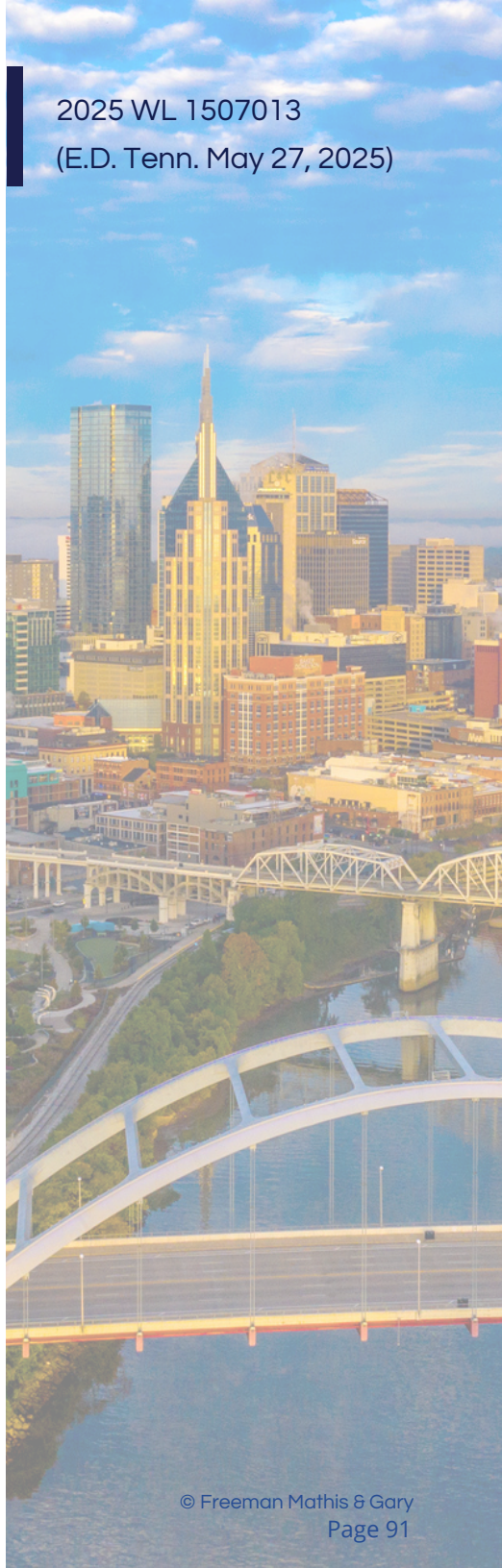
2025 WL 1507013
(E.D. Tenn. May 27, 2025)

The United States District Court for the Eastern District of Tennessee held that a property insurance policy's exclusion for "Fungus, Wet Rot, Dry Rot, Bacteria, or Virus" unambiguously included viruses and, therefore, barred coverage for COVID-19-related business losses.

Walters & Mason Retail, Inc., sued its insurer, Hartford Fire Insurance Company, after Hartford denied coverage for business interruption losses following government shutdowns based on COVID-19. Walters & Mason, a retailer, faced profit losses and sought recovery under a property insurance policy issued by Hartford.

Hartford filed a motion to dismiss. Applying Tennessee law, the court found that the policy clearly and unambiguously does not cover losses caused directly or indirectly by a virus, including the coronavirus that caused COVID-19. Tennessee courts interpreting a contract must consider whether the language is clear and unambiguous. If so, then the plain and ordinary meaning of the language controls, and the court does not consider other factors to determine the parties' intent.

In this case, the policy's exclusion stated, "We will not pay for loss or damage caused directly or indirectly by . . . spread or any activity of fungus, wet rot, dry rot, bacteria, or virus." The court found this language to be unambiguous. The court rejected the argument that a New York-specific endorsement separating the exclusions and with a standalone exclusion only for viruses rendered the policy ambiguous. The court also rejected the argument for coverage based on the absence of the word "pandemic" in the exclusion. The court determined the scope of the exclusion by its plain terms and rejected the argument that the limited scope of the exceptions to the exclusion created any ambiguity. The court concluded that the exclusion unambiguously barred coverage for COVID-19-related business losses and granted Hartford's motion to dismiss.



Builders Mut. Ins. Co. v. GCC Constr., LLC

714 F. Supp. 3d 1022 (E.D. Tenn. 2024), aff'd, No. 24-5152, 2024 WL 5074878 (6th Cir. Dec. 11, 2024)

The federal district court found that a builders risk insurance policy did not cover repair and replacement of a wall that was structurally unsound before policy inception. The court held that the impaired structural integrity revealed by the collapse of bricks was not "direct physical loss" as defined by the court. There was also no evidence of "bad faith" that would have warranted the imposition of Tennessee's statutory penalty of up to 25% of total covered liability. The Sixth Circuit affirmed.

In 2021, Tahini Main Street, LLC ("Tahini") and general contractor GCC Construction, LLC ("GCC") began renovating a century-old brick building in Chattanooga, Tennessee. The building was insured under a builders risk policy issued by Builders Mutual Insurance Company ("Builders") covering "direct physical loss or damage" from a "collapse" caused by hidden decay.

During the renovation, GCC was cutting a new window into the building's brick walls when bricks from higher up suddenly fell out, revealing that the wall's interior had deteriorated. Tahini and GCC sought coverage under the Builders policy, contending that the wall and entire building were structurally unsound as a result of the collapse of bricks.

Before trial, the United States District Court for the Eastern District of Tennessee granted summary judgment that the fallen bricks constituted a "collapse" under the policy. Following a bench trial, the court found that the minor collapse of the bricks did not cause the structural instability of the wall. Rather, the building significantly deteriorated and became structurally unsound before renovations began.

The policy only provided coverage for "direct physical loss or damage" that resulted from a collapse due to hidden decay, not pre-existing damage revealed by a collapse. The fact that the insureds only *discovered* the pre-existing structural issues with the wall after the collapse of bricks did not convince the court that the collapse *caused* the structural problems.

While the policy did not define "direct physical loss," the court adopted a definition of the phrase that does not include economic losses but involves an actual change in the property, caused by an accident or other fortuitous event directly upon the property, from a satisfactory state to an unsatisfactory state. The building's structural issues did not fall within this definition because the collapse itself did not change the state of the building from satisfactory to unsatisfactory but rather made the insureds aware of the pre-existing unsatisfactory state of the building. Accordingly, the insureds' claimed lost rental profit and lost profit from the halt in renovations were not caused by "direct physical loss" because they were economic damages.

The court also summarily rejected the insureds' so-called "bad faith" claim. By statute, Tennessee law imposes a statutory penalty of up to 25% of the amount of liability on insurers who, in bad faith, do not pay a covered claim within 60 days. In this case, the insureds produced no evidence of the amount paid to repair the bricks, and thus the court did not award any damages. In addition, the insureds' initial claim requested that the entire wall be replaced and did not mention the specific collapse of the fallen bricks. The insurer and its adjusters saw the wall still standing and, reasonably, concluded it did not collapse. Six months later the insureds sent a demand letter and notice of "bad faith," asserting for the first time that the collapse from the window cut had caused the "direct physical loss." After reviewing the claim, the insurer filed a declaratory judgment action. The court held that insurer investigated the claim with ordinary care and diligence regarding any coverage based on the fallen bricks. These findings were then affirmed by the Sixth Circuit Court of Appeals.

Hanover Am. Ins. Co. v. Tattooed Millionaire Entm't, LLC

152 F.4th 768
(6th Cir. 2025)

The Sixth Circuit held that a joint loss payable clause allowed for the division of insurance proceeds between lessor and lessee based on the value of those interests as determined under the lease, that the lessor was barred by his own claim-related misdeeds and fraud from recovering any policy proceeds, and that the insurance company could not rely on the lessor's fraud to withhold proceeds from the lessee.

Following a long and winding procedural road, the Sixth Circuit provided direction on insurance obligations among a lessor, a lessee and a single property insurance carrier, after the lessor submitted fraudulent claim documents.

Brown purchased a music studio in Memphis, Tennessee. Hanover American Insurance Company issued a property insurance policy insuring the premises as well as the instruments and equipment throughout the studio. Brown leased Studio B to Falls, who also purchased an insurance policy from Hanover for the instruments and equipment within Studio B as well as lost business income.

The music studio suffered a break-in and a fire caused by arson. The building and certain equipment were damaged, and additional equipment was stolen. Brown and Falls combined their claims into one document and separately signed proofs of loss. Hanover made an advance payment of $250,000 to Falls, the lessee and $2.2 million to Brown, the lessor.

Hanover eventually discovered that Brown forged receipts for the purchase of equipment. Hanover filed a declaratory judgment action seeking a ruling that it owed nothing further to Brown or Falls. Brown and Falls counterclaimed for breach of contract based on Hanover's failure to pay. A jury determined that Brown made material misrepresentations in his claim, and that Falls had made none. The jury found that Hanover owed Falls another $2.5 million in coverage for the instruments and equipment, and about $250,000 in lost business income. Hanover then moved for judgment as a matter of law under Rule 50(b), arguing for reversal of the verdict as to Falls, which the district court granted. Falls and Brown appealed.

The Sixth Circuit determined that Hanover had forfeited its right to make its Rule 50(b) post-judgment motion because it did not file a Rule 50(a) pre-judgment motion as to Falls. Accordingly, the court affirmed the district court judgment as to Brown but reversed and remanded as to Falls, instructing the lower court to reinstate the jury verdict.

Falls then sued Brown in Tennessee state court for an allocation of the insurance payout. Hanover interpled the $2.5 million insurance payout and attempted to raise new claims and additional arguments against Falls. In the interpleader action, the district court found that Hanover was precluded from arguing against recovery by Falls. After hearing expert testimony surrounding the value of the studio, the equipment, and Falls' leasehold, the district court awarded $2,066,217.30 to Falls and found that Brown was barred by Tennessee public policy from receiving the remaining payout he otherwise would have.

On appeal, the Sixth Circuit affirmed that Hanover was precluded from conflating Brown's fraud with Falls's recovery rights to contest the amount owed to Falls, because Hanover had allowed the original case to be submitted under a theory of separate liability. The Court also found that, when dealing with a lease agreement, the parties' intent regarding repair and replacement of property controls the distribution of insurance funds. Here, the lease indicated that the lessee was required to insure the equipment in the studio. Reading the lease with policy language stating that proceeds were to be paid to the parties jointly, the Sixth Circuit affirmed the district court's allocation between Brown and Falls and affirmed the district court's valuation of Falls's leasehold and payout amount. The court also affirmed the ruling precluding Brown from recovering the remainder of his payout for engaging in fraud related to his insurance claim.

Luke, Inc. v. Berkley Nat'l Ins. Co.

2025 WL 2210783
(W.D. Tenn. 2025)

The United States District Court for the Western District of Tennessee held that there was no delay-in-completion coverage under a builders risk policy because construction of the building itself was complete at the time of the flood. The court applied the plain policy language, which determined coverage based on completion of the physical building rather than operational status.

Luke owned a skilled nursing facility that was under construction and had not yet opened when a pipe burst and caused water damage. Luke submitted a claim to its insurance company, Berkley National Insurance Company, under a builders risk insurance policy. Berkley paid the cost to repair the water damage. However, Berkley contended the construction of the facility was "complete" before the water damage and took the position that the claim did not fall within the policy's delay-in-completion coverage for expenses during a delay period if a covered loss delayed the "completion of construction, erection, or fabrication of a covered building or structure."

Luke argued that completeness should be determined by whether the facility is operational and whether turnover has taken place from the contractor to the owner for possession after completing all required tasks. At the time of the water damage, Luke's facility had not passed final inspections and the nurse-call system had not been tested as required. Luke argued that Tennessee law requires 100 percent completion, citing other cases that involved different policy language and selected statutes.

Berkley argued that "completion" as used in the policy should be applied to the physical building itself. The project was already physically complete because, at the time of the damage, there were no "construction, erection, or fabrication" steps left to take, and the remaining tasks were not part of physically constructing the facility. The architect on the project had already issued a certificate of substantial completion. And, Luke itself had already represented in an application under oath that the construction was "100% Complete."

The district court agreed with Berkley, based on Tennessee law regarding the application of insurance policies. Reading the plain text of the policy as a whole, the court found that "completion" referred to the physical condition of the structure rather than any remaining licensing or inspection tasks to make the facility operational. To hold otherwise would render meaningless the terms following "completion of construction" in the policy -- "erection, or fabrication of a covered building or structure" -- none of which require or refer to operational status of the building.

US Framing Int'l LLC v. Continental Bldg. Co.

134 F.4th 423
(6th Cir. 2025)

The Sixth Circuit affirmed dismissal under Tennessee's insurance fraud statute of a subcontractor's claim against a general contractor who filed an insurance claim after their contract ended. Dismissal of the subcontractor's suit was affirmed because the alleged economic harm was not "directly related," as required under the statute, to the alleged fraud.

A general contractor hired a subcontractor to perform work in Tennessee and Michigan. The general contractor had an insurance policy covering damage caused by the subcontractor, subject to certain policy terms and conditions. Disagreements arose over delays in the subcontractor's work in Tennessee. The general contractor and the subcontractor ultimately agreed to end their relationship, and the general contractor stated it would terminate further payments. The general contractor then filed an insurance claim for damage allegedly caused by the subcontractor.

The subcontractor sued the general contractor, arguing that its insurance claim was false in that the subcontractor was not at fault. The subcontractor argued that the general contractor's insurance claim violated Tennessee Statute § 56-53-101, *et seq.*, which bans fraudulent or unlawful insurance acts. The statute provided recovery of damages, including all economic damages directly resulting from violation of the statute.

The district court granted the general contractor's motion to dismiss, and the subcontractor appealed. On appeal, the Sixth Circuit affirmed the district court's dismissal because the subcontractor did not "plausibly allege" an economic injury "directly resulting" from the contractor's alleged fraud.

The court considered two possible interpretations of the "directly resulting" wording. The subcontractor argued that it required only proximate causation. The general contractor argued that it required immediate causation. Reading the Tennessee statute narrowly, the Sixth Circuit concluded that the subcontractor's alleged damages were too remote: non-payment for the Michigan project had occurred before the contractor filed its insurance claim, and the subcontractor's claimed legal expenses were caused by its own decision to file suit.

Texas

Prepared by:

Gabriel Canto

Abraham & Co. Inc. v. Markel Ins. Co.

721 S.W.3d 37
(Tex. App. 2025)

The Houston Court of Appeals clarified the enforceability of water damage endorsements, holding that a $750,000 limit applied across all locations despite broader policy limits, and that adjusters may face general negligence liability for post-loss conduct.

Abraham & Co., a seller of Oriental rugs in the Houston area, held a property insurance policy with Markel Insurance Company covering multiple locations. During Winter Storm Uri in 2021, a pipe burst at one Abraham location, saturating rugs and causing extensive damage. Abraham filed a claim expecting the $2 million policy limit to apply, but Markel paid only $750,000, citing a water damage endorsement. Abraham sued Markel and its adjuster, H&H Claims Consultants, for breach of contract, extra-contractual violations and negligence.

Markel and H&H moved for summary judgment, arguing the water damage endorsement unambiguously limited coverage to $750,000 for water damage across all locations. The trial court agreed, finding the endorsement enforceable despite unchecked boxes in its form. The court also dismissed Abraham's extra-contractual claims, noting no independent injury beyond the alleged breach. However, it preserved Abraham's general negligence claim against H&H, which allegedly instructed Abraham to leave wet rugs in place, leading to mold and further damage.

The appellate court affirmed the trial court's interpretation of the endorsement, emphasizing that endorsements modify policies even if form boxes are left blank. The court rejected Abraham's ambiguity argument and upheld the dismissal of contractual and statutory claims. Importantly, the court distinguished between impermissible negligent claims handling and actionable general negligence, allowing Abraham's claim against the adjuster to proceed.

In re American Risk Insurance Company, Inc.

2025 WL 3275144
(Tex. Ct. App. Nov. 25, 2025)

The Houston First Court of Appeals held that an insurer's payment of an appraisal award forecloses an insured's further recovery unless the insured can establish an independent injury.

American Risk Insurance Company, Inc. issued an insurance policy to Moses and Christie Francis covering their residential property. When the insureds filed a claim for a water leak from a washing machine, American Risk assigned an independent adjuster to investigate the claim and issued payment of $9,500.51 to the Francises.

The Francises then sent another demand to American Risk and, after further inspections, American Risk issued another payment of $14,839.01 to the insureds. The Francises then invoked the appraisal process under the policy, and an appraisal award was issued which found the replacement cost for the damage to their property to be $56,934.65. American Risk then paid the appraisal award, less prior payments, depreciation, statutory interest, and the Francises' deductible.

The Francises then filed an action against American Risk, alleging violations of chapters 541 and 542 of the Texas Insurance Code and breach of the common law duty of good faith and fair dealing. American Risk moved to dismiss the Francises' claims, arguing that the claims had no basis in law or fact because American Risk had paid the appraisal award in full. The trial court denied the motion, and American Risk sought a writ of mandamus.

The Court of Appeals conditionally granted American Risk's writ of mandamus and held that the trial court had abused its discretion denying the motion to dismiss. The appellate court reasoned that, under Texas law, an insurer's payment of an appraisal award usually forecloses an insured's further recovery of actual damages for benefits under the policy unless the insured can establish an independent injury. In this case, despite allegations of delayed handling of the claim and a general grievance that the appraisal had to occur at all, the Francises did not allege an independent injury or that they were entitled to any benefit that they did not receive. As such, the Court found that any further claims under the Texas Insurance Code or common law were foreclosed because the benefit to which the Francises were entitled had been satisfied. Thus, the Court vacated the denial of American Risk's motion to dismiss ordered the trial court to dismiss the Francises' complaint.

Washington

Prepared by:

Galina Jakobson
Tiffany Lee

Anderson v. Farmers Insurance Company of Washington

578 P.3d 341
(Wash. App. 2025)

The Washington Court of Appeals held that legal malpractice claims acquired involuntarily through a bankruptcy sale were not assignable under state law, reaffirming and expanding the public policy limitations described in Kommavongsa v. Haskell, 149 Wash.2d 288, 67 P.3d 1068 (2003). The Court clarified that insurance bad faith and other independent claims are not subject to the same prohibition.

Cristina Anderson was severely injured in a pedestrian-vehicle accident and obtained a $21 million jury verdict against the driver, Wendy Gibson, who was insured by Farmers. After the verdict, Gibson filed for Chapter 7 bankruptcy, and Anderson purchased Gibson's potential claims against Farmers from the bankruptcy trustee. Anderson then filed suit against Farmers, alleging legal malpractice, insurance bad faith, and violations of the Consumer Protection Act (CPA) and Insurance Fair Conduct Act (IFCA).

Farmers moved to dismiss the complaint under CR 12(b)(6), arguing that Washington law prohibits the assignment of legal malpractice claims, even when acquired involuntarily through bankruptcy. The trial court agreed and dismissed all of Anderson's claims. On appeal, the Court of Appeals affirmed in part and reversed in part.

The Court affirmed the trial court's holding that the legal malpractice claims were not assignable under Washington law, even when acquired through an involuntary bankruptcy sale. Relying on *Kommavongsa v. Haskell*, the Court emphasized that public policy concerns include: 1) The potential for a trial-within-a-trial that could lead to an abrupt and shameless shift of positions by the assignee's attorney and 2) Possibly compromising the ability of judgment-proof defendants who are underinsured or uninsured to obtain representation.

However, the Court reversed the trial court's finding that all of Anderson's claims were barred. In so doing, the Court distinguished between legal malpractice claims and insurance bad faith claims. It held that the latter are not subject to the same assignment prohibition. The Court noted that Anderson's complaint alleged that Farmers acted in bad faith by prioritizing its own financial interests over those of its insured, failing to conduct a proper defense, and interfering with the litigation strategy. These allegations, if proven, could support a bad faith claim independent of malpractice by defense counsel.

Additionally, the court held that Anderson's independent claims—such as those for declaratory judgment, garnishment, injunctive relief, and CPA violations—were improperly dismissed. These claims were not acquired through assignment but were brought in her own right as a judgment creditor. The Court thus held that it was error to dismiss such claims along with the legal malpractice claims. The Court remanded the case back to the trial court for further proceedings, including a determination as to which of Anderson's claims against Farmers were independent from the legal malpractice claims.

Hughes v. American Strategic Insurance Corp.

766 F.Supp.3d 1129 (W.D. Wash. 2025)

The Western District of Washington granted the insurer's motion for summary judgment, holding that its emailed renewal notice satisfied Washington law and that the homeowners policy properly lapsed for nonpayment before a later fire loss. The court's decision serves as a reminder that policyholders are expected to read and understand their policy terms and renewal obligations even when those notices are sent electronically.

This insurance coverage dispute arose from a fire at the residential property of plaintiffs James and Dena Hughes in August 2023. In September 2020, Mr. Hughes completed Defendant American Strategic Insurance Corp.'s ("ASI") electronic signature process, agreeing to conduct transactions electronically pursuant to the company's terms and conditions. In July 2022, ASI generated and emailed a 12-page "renewal offer packet" to Mr. Hughes. The packet contained a "Renewal Premium Notice" which explicitly instructed Plaintiffs to pay the minimum amount due to maintain their coverage. This notice was sent 61 days prior to the renewal deadline. The Hughes failed to make the payment, and the policy lapsed before the fire loss occurred.

The Hughes brought five causes of action against ASI: breach of insurance contract, breach of the implied covenant of good faith and fair dealing, violation of the Washington Consumer Protection Act, violation of Washington Revised Code § 48.30.015, and bad faith tortious conduct. They subsequently filed a motion for partial summary judgment, arguing that ASI's renewal and lapse notices did not comply with Washington law. As a result of this defective notice, the Hughes argued, the policy was automatically renewed by operation of law. They further asserted that their consent to receive electronic notifications was ineffective because the terms and conditions were not presented in a conspicuous manner and did not clearly specify which notices and documents the consent covered. In response, ASI filed a cross-motion for summary judgment seeking a determination that they rightfully denied plaintiffs' claim for insurance coverage.

The Court first analyzed whether the Hughes' consent to receive electronic notifications about their insurance policy was effective. It concluded that the Hughes had agreed to receive insurance documents electronically when they set up their ASI online account. Further, the Court stated, the Hughes accepted terms and conditions that were sufficiently clear and conspicuous under Washington law.

The Court further analyzed ASI's compliance with Washington's statutory requirements for policy renewal. Washington law requires that a renewal notice be sent within a specific timeframe and state the amount required to maintain coverage. The Court found that ASI's notice was sent within the required timeframe and clearly stated the premium amount due. The Court highlighted that insureds have an "affirmative duty under Washington law to read their policy and be on notice of the terms and conditions of the policy." The Hughes had received the email, had consented to electronic delivery, and had failed to act on the clear instructions in the premium notice. Therefore, the fault for the policy lapse rested with the insureds.

Because ASI met its statutory duty to provide notice and the Hughes failed to meet their duty to pay or monitor their policy, the Court found no genuine issue of material fact that the policy validly lapsed. The Court granted summary judgment in favor of ASI.

Mesa Underwriters Specialty Ins. Co. v. Razorhone, LLC

762 F.Supp.3d 1033
(W.D. Wash. 2025)

The Western District of Washington denied an insurer's motion for summary judgment after finding the underlying complaint too ambiguous to support application of a policy exclusion. The court reaffirmed Washington's strict "eight corners" rule, emphasizing that insurers must defend their policy holders unless an exclusion plainly applies.

This case originated as a declaratory judgment action brought by plaintiff Mesa Underwriters Specialty Insurance Company against the insured, defendant Razorhone, LLC. Mesa sought a judicial declaration that it had neither a duty to defend nor a duty to indemnify Razorhone in an underlying state lawsuit, which involved a dispute over discharge of stormwater at the Semiahmoo real estate development. Underlying plaintiffs in that lawsuit alleged that Razorhone's clearcutting of trees in connection with its Sea Smoke development caused severe flooding issues, resulting in erosion and property damage.

In this declaratory judgment action, Mesa filed a motion for summary judgment, arguing that coverage for the property damage due to clearcutting was barred by the insurance policy's New Residential Construction Exclusion. Razorhone opposed the motion, arguing that clearcutting occurred only in particular parcels of Sea Smoke that were completely unrelated to any new residential construction.

Mesa's argument focused on the assertion that any clearcutting on the Sea Smoke site had to be considered in connection with new residential construction, making the exclusion applicable as a matter of law. To support this position, Mesa pointed to city council documents and industry definitions characterizing Sea Smoke as a planned unit development that includes new residential construction. The Court rejected this approach because Washington law prohibits an insurer from relying on extrinsic evidence to deny coverage. The Court reaffirmed Washington's strict "eight corners" rule where the duty to defend is determined only from the underlying complaint and the insurance contract. While insurers may look outside the complaint to trigger a defense, they cannot use external facts to deny that duty.

The Court further found the underlying complaint ambiguous regarding whether Razorhone's clearcutting was performed for residential or nonresidential development. Accordingly, the Court declined to conclude that the underlying complaint clearly alleged damage arising from new residential construction. Washington law requires that any ambiguity in the underlying allegations be construed liberally in favor of the insured. Moreover, the exclusion applies only when the work is related to new residential construction. Therefore, the Court held that coverage remained possible and denied Mesa's motion for summary judgment as to the duty to defend.

Kinsale Insurance Co. v. VBC Madison LP

2025 WL 2592195 (W.D. Wash. Sept. 8, 2025)

The U.S. District Court for the Western District of Washington denied Kinsale Insurance Company's motion for summary judgment, holding that Washington's efficient proximate cause rule applied to liability policies and prevented enforcement of a fire exclusion when a covered peril initiated the causal chain. The Court also found factual disputes regarding whether the insured's building was "secured," precluding application of the Unsecured Property Exclusion.

This case arose from two fires at a building owned by VBC Madison LP in Seattle. After a June 2022 fire, VBC spent approximately $4 million on cleanup, selective demolition, and security measures, including plywood barricades, tamper-resistant screws, and concrete bolts. On January 1, 2024, the building caught fire again. The Seattle Fire Department classified the cause as "undetermined," speculating it was likely due to homeless activity involving cooking or drug use. The fire spread to an adjacent property, causing $1.05 million in damage and triggering subrogation claims against VBC.

Kinsale insured VBC under a commercial general liability policy and defended it under a reservation of rights. While conceding the claims fell within the insuring agreement, Kinsale sought declaratory judgment that coverage was barred by two exclusions: (1) the Fire or Fire-Related Injury or Damage Exclusion, which broadly excluded any claim "arising out of" fire regardless of other contributing causes, and (2) the Unsecured Property Exclusion, which applied to losses involving vacant buildings unless "secured" at all access points.

The Court rejected Kinsale's arguments, emphasizing Washington's efficient proximate cause rule, which mandates coverage when a covered peril sets in motion a causal chain ending in an excluded peril. Kinsale argued that the efficient proximate cause rule applies only to first-party property claims. However, the Court disagreed, citing *Xia v. ProBuilders Specialty Ins. Co*., 188 Wash. 2d 171, 400 P.3d 1234 (2017), as modified (Aug. 16, 2017), where the Washington Supreme Court applied the rule in a third-party liability context. The Court held that insurers cannot contract around the efficient proximate cause rule by using broad "arising out of" language or anti-concurrent causation clauses. Because the cause of the fire was disputed and the efficient proximate cause could have been a covered risk such as trespassing or vandalism, summary judgment was inappropriate.

The Court also denied summary judgment as to the Unsecured Property Exclusion. Although the building was vacant, evidence showed that VBC implemented extensive security measures. Photographs revealed that firefighters had to cut through bars and plywood to access the building, suggesting it was secured. Conflicting evidence—including a fire department report noting an "unsecured" stairwell—created a genuine issue of material fact. Therefore, the Court found that summary judgment based on the Unsecured Property Exclusion was precluded.

Wisconsin

Prepared by:

Madeline Krolczyk
Ryne Sack
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Cincinnati Ins. Co. v. Ropicky

415 Wis.2d 1, 16 N.W.3d 634 (Ct. App. 2025)

The Wisconsin Court of Appeals held that the ensuing loss exception reinstated coverage for rainwater damage despite a construction defect exclusion and found the fungi exclusion ambiguous in light of an additional coverage endorsement. The case was remanded for allocation of losses and reinstatement of bad faith claims.

James Ropicky and Rebecca Leichtfuss held an "Executive Classic" homeowners policy issued by Cincinnati Insurance Company for their Wisconsin home. On May 11, 2018, a severe storm drove wind-driven rain into the home through gaps in flashing, causing extensive water infiltration and damage to interior walls and structural components. The insureds submitted a claim later that month. Cincinnati's adjuster inspected and retained an engineer, whose July report concluded that gaps in flashing and other vulnerabilities were created during construction. Based on this report, Cincinnati issued a letter denying most of the claim under the policy's Construction Defect Exclusion, paying only $10,000 under a fungi endorsement and a small amount for other damage.

The policy excluded coverage for "physical loss caused by or consisting of defective materials, construction or repair," but contained an ensuing loss exception for damage caused by a separate covered peril. The trial court agreed with Cincinnati that the exclusion barred coverage beyond the limited payment. On appeal, the Wisconsin Court of Appeals assumed the exclusion applied but held that the ensuing loss exception reinstated coverage for damage caused by the rainstorm. The court explained that while the cost to correct the defect remains excluded, the immediate cause of the damage was wind-driven rain—a covered peril—making the resulting water damage an ensuing loss under the policy's plain language.

The court also addressed Cincinnati's reliance on the Fungi Exclusion and related endorsement. Cincinnati argued that the exclusion barred all coverage beyond the $10,000 fungi limit. The court disagreed, finding ambiguity in how the endorsement interacts with the exclusion. It concluded that the endorsement does not simply cap coverage but may provide additional coverage for losses caused by a covered peril even if fungi contributed to the damage. The court emphasized that the endorsement's language could reasonably be read to preserve coverage for storm-related damage while limiting only the portion of loss caused by fungi or rot.

Because material factual disputes remained regarding the extent of damage attributable to fungi and the cost to repair construction defects, the court remanded for further proceedings, including allocation of losses. It also reinstated the insureds' bad faith claim, which the trial court had dismissed after granting summary judgment to Cincinnati.

This decision underscores that under Wisconsin law, the presence of a construction defect may not automatically bar coverage for damage caused by a separate covered peril. Even if the cost to correct the defect remains excluded, the damage caused by the covered peril may be covered under the ensuing loss exception.

Prunty v. Maple Valley Mut. Ins. Co.

417 Wis.2d 69, 24 N.W.3d 207 (Ct. App. 2025)

The 3rd District Court of Appeals held that the insured violated and subsequently breached the terms of his insurance policy by failing to submit to an examination under oath before filing his breach of contract lawsuit against the insurer. It was immaterial that the insured later sat for a deposition as that did not cure his breach of the policy.

Robert Prunty purchased a homeowner's policy from Maple Valley Mutual in 2021 and answered "No" when asked if any building contained a woodburning unit. An inspection revealed a stove in the garage, but after Prunty represented that it was cracked and unusable, Maple Valley allowed it to remain under conditions prohibiting reconnection or installation of any other stove. Prunty signed a Loss Prevention Service Form confirming the stove was "not useable."

In January 2023, a fire damaged Prunty's home. Maple Valley's initial investigation suggested the fire originated near the stove's exhaust piping. The insurer raised concerns about misrepresentation and requested an EUO under the policy's "What Must Be Done in Case of Loss" section. Rather than comply, Prunty filed suit for breach of contract and bad faith.

Both parties moved for summary judgment. Maple Valley argued that Prunty's misrepresentation triggered the policy's fraud provision and that his refusal to sit for an EUO violated a condition precedent to coverage. Prunty contended the insurer could not deny coverage based on misrepresentation without rescinding the policy and that his later deposition cured any breach. The circuit court granted summary judgment for Maple Valley, finding that Prunty breached the policy by refusing the EUO and that a deposition did not satisfy the contractual requirement.

On appeal, the Wisconsin Court of Appeals affirmed. The court emphasized that the policy plainly required the insured to submit to an EUO "as often as reasonably requested" and did not permit substitution of a deposition.

EUOs serve a distinct purpose: they allow insurers to gather information before litigation to evaluate coverage and protect against false claims. Depositions, by contrast, occur after suit and under civil procedure rules. Allowing a deposition to replace an EUO would render the contractual provision meaningless.

The court also addressed materiality and prejudice. Assuming those elements applied, the court found both satisfied. Prunty's refusal prevented Maple Valley from completing its investigation and making a coverage determination, exposing it to litigation costs and potential bad faith liability. His later deposition came "too late to be meaningful," echoing prior Wisconsin precedent in *State Farm Fire & Cas. Ins. Co. v. Walker*, 157 Wis.2d 459, 459 N.W.2d 605 (Ct. App. 1990), which held that post-suit compliance does not cure an EUO breach. The court noted that EUO provisions are fundamental to the insurer's ability to decide its obligations without litigation, citing long-standing authority that such clauses protect insurers from fraudulent claims.

Prunty argued that answering questions at a deposition substantially complied with the policy and that Maple Valley suffered no prejudice. The court rejected these arguments, explaining that prejudice arose because Maple Valley was forced to litigate without completing its investigation and faced additional costs and risks. The insurer's inability to make a pre-suit coverage determination was itself prejudicial.

This decision confirms that failure to comply with an EUO request before filing suit constitutes a material and prejudicial breach of the policy. In doing so, it also resolves a novel question in Wisconsin law: a deposition after litigation does not satisfy the EUO requirement.

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