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Eleventh Circuit Rejects Insured's Bid for Advertising Injury Coverage of Two Lawsuits

The U.S. Court of Appeals for the Eleventh Circuit has ruled that an insurance company did not have to defend or indemnify its insured against two lawsuits alleging false claims in the insured's advertising.

The Case

A competitor sued the insured in a federal district court in Oregon, accusing the insured of making false claims in its marketing materials. In particular, the competitor contended that the insured claimed that its tuna products were superior to competitor products because the insured treated its tuna meat with a smoking process using filtered hickory wood chips, which exposed its tuna meat to low concentrations of carbon monoxide. The competitor's lawsuit asserted a claim for unfair trade practices and false advertising under the federal Lanham Act as well as a state law claim under Oregon's Unfair Trade Practices Act.

The insured notified its commercial general liability insurer about the Oregon suit, requesting defense and indemnification under the policy's advertising injury coverage provisions. The policy applied to "oral or written publication of material that … disparages a person's or organization's goods, products, or services." The insurer denied coverage, explaining that there was no claim for an "advertising injury." The suit alleged that the insured misrepresented the quality of its own tuna meat, not that the insured disparaged the competitor in its advertisements. At any rate, the policy further excluded "advertising injury" arising out of "the failure of the insured's goods, products or services to conform with advertised quality or performance."

The competitor later dismissed the Oregon lawsuit, but then sued the insured in California, alleging that the insured was falsely advertising its tuna products by claiming that it treated its tuna meat with filtered wood smoke while it actually was treating its tuna meat with synthetic carbon monoxide. Treating tuna meat with synthetic carbon monoxide purportedly allows vendors to make lower grade tuna meat appear as higher grade meat. The competitor asserted a claim for unfair trade practices and false advertising under the federal Lanham Act, as well as a claim for violation of California's Unfair Competition Law.

The insured did not notify its insurer of the California lawsuit and did not tender the suit to the insurer.

After more than three years of litigation, the district court entered judgment in favor of the insured, finding that its competitor failed to prove its claims by a preponderance of the evidence. In defending against the competitor's lawsuit, the insured contended that it incurred attorney's fees and costs of more than $3.6 million.

The insured sued its insurer in a federal district court in Florida, asserting that the insurer had wrongfully refused to defend it in the Oregon and California actions.

The district court ruled that the insurer did not have to defend or indemnify the insured. It concluded that: (1) the competitor's allegations did not fall within the policy's "advertising injury" coverage; (2) the claims were excluded because the competitor simply alleged that the insured's products did not conform to its representations about the quality of its tuna meat; and (3) that the insured's failure to comply with the policy's notice provisions negated the insurer's duty to defend the insured against the California action.

The insured appealed to the Eleventh Circuit.

The Eleventh Circuit's Decision

The circuit court, applying Florida law, affirmed.

The court did not decide whether the competitor's lawsuits fell within the "advertising injury" coverage, because it found that the exclusion applied. The circuit court explained that the complaints in the Oregon and California lawsuits accused the insured of "misrepresent[ing] the nature, characteristics and qualities of its tuna products" by claiming that its tuna meat was prepared in a manner different from its actual methods of preparation. Therefore, the circuit court ruled, the allegations fell under the policy exclusion for advertising injury arising from "the failure of [the insured's] goods, products or services to conform with advertised quality or performance." Accordingly, the Eleventh Circuit decided, the insurer had no duty to defend the insured against the two lawsuits and the district court had not erred in granting judgment in favor of the insurer based on the exclusion.

The Eleventh Circuit also agreed with the district court that the insurer did not have a duty to defend the insured against the California suit because the insured had not properly notified the insurer as required by the policy.

The circuit court rejected the insured's contention that it had no obligation to notify the insurer of the California suit because that case involved the same set of allegations that the competitor had voluntarily dismissed in the Oregon lawsuit only days before. The circuit court pointed out that the policy required notice of the filing of any "suit" against the insured. Moreover, the Eleventh Circuit added, although the Oregon and California suits alleged the same wrongful conduct and advanced claims under the federal Lanham Act, their respective state law claims differed; the Oregon suit alleged a violation of Oregon's Unfair Trade Practices Act and the California suit alleged a violation of California's Unfair Competition Law.

The Eleventh Circuit concluded that the insured's failure to adhere to the policy's notice requirement constituted a material breach of the policy that substantially prejudiced the insurer. That released the insurer from any duty to defend the insured.

The case is *Scott, Blane, and Darren Recovery, LLC v. Auto-Owners Ins. Co.*, No. 17-12945 (11th Cir. Apr. 3, 2018).

Exclusion Barred Coverage of Losses Resulting from Fraudulent Email Scheme, Ninth Circuit Concludes

The U.S. Court of Appeals for the Ninth Circuit has ruled that an exclusion in an insurance policy precluded coverage for an insured's losses stemming from a fraudulent email scheme.

The Case

The insured sued its insurer, seeking coverage for "computer fraud" under its insurance policy. The insured allegedly had suffered a loss as a result of a fraudulent email scheme that caused its employees to change account information to a fraudster's account and then to wire four payments to that account.

The U.S. District Court for the Western District of Washington granted summary judgment to the insurer, and the dispute reached the Ninth Circuit.

The Ninth Circuit's Decision

The circuit court affirmed.

In its decision, the Ninth Circuit ruled that, even assuming without deciding that the policy generally covered the kind of computer fraud that had caused the insured's losses, coverage was foreclosed.

The circuit court observed that Exclusion G provided that the policy "will not apply to loss or damages resulting directly or indirectly from the input of Electronic Data by a natural person having the authority to enter the Insured's Computer System. . . ."

Here, the circuit court explained, the insured's losses resulted from employees authorized to enter its computer system changing wiring information and sending four payments to the fraudster's account. These employees "ha[d] the authority to enter" the insured's system when they "input" electronic data, on the insured's computers, to change the wiring information and to authorize the four wire transfers, the Ninth Circuit said.

Their conduct, the circuit court held, fit "squarely" within the exclusion.

The Ninth Circuit rejected the insured's argument that it was entitled to coverage as a result of the rule of efficient proximate cause. That rule, the circuit court said, could be applied only when two or more *perils* combined in sequence to cause a loss and a *covered peril* was the predominant or efficient cause of the loss. Here, it concluded, there was only one "peril" – computer fraud – so the rule of efficient proximate cause did not apply.

The case is *Aqua Star (USA) Corp. v. Travelers Casualty and Surety Company of America*, No. 16-35614 (9th Cir. Apr. 17, 2018).

Insurer That Issued Umbrella Excess Policies Did Not Have to Defend Insured, Wisconsin Appellate Court Decides

An appellate court in Wisconsin has ruled that an insurer that issued umbrella excess insurance policies to an insured did not have to defend the insured against environmental contamination claims.

The Case

After being identified as a potentially responsible party ("PRP") in connection with environmental contamination at numerous sites across the country, the insured notified its insurers and sought defense and indemnity under a layered program of primary, umbrella, and umbrella excess insurance policies issued at various times between 1954 and 1985.

The insurers refused to defend or indemnify the insured, and the insured sued and moved for summary judgment.

The trial court granted the insured's motion against an insurer that had issued five umbrella excess policies to the insured, deciding that this insurer had breached its duty to defend "by failing to defend when it was fairly debatable whether the claim was covered."

After the trial court awarded damages to the insured, the insurer appealed.

The Appellate Court's Decision

The appellate court reversed, finding that the insurer had no duty to defend the insured under its umbrella excess policies.

In its decision, the appellate court explained that the insurer had agreed to provide a defense only for occurrences covered under its policies but not covered under the underlying policies. Therefore, the appellate court reasoned, if an occurrence was covered by the underlying primary or excess insurance policies, then the insurer that issued umbrella excess insurance policies had no duty to defend.

The appellate court concluded that because the underlying excess policies' coverage for environmental claims was identical to the underlying primary policies' coverage, the claims against the insured presented only two options: either the occurrences were covered by all policies, in which case the umbrella excess insurer had no duty to defend, or there was no coverage under any of the policies, also resulting in the umbrella excess insurer having no duty to defend.

The case is *Johnson Controls, Inc. v. Central National Ins. Co. of Omaha*, No. 2014AP2050 (Wisc. Ct. App. Apr. 25, 2018).

Insurer Did Not Have to Defend Contractor That Failed to Comply with Additional Conditions Endorsement

A federal district court in Washington has ruled that a contractor was not entitled to coverage of a lawsuit where it failed to comply with conditions contained in an "Additional Conditions Endorsement" to a commercial general liability insurance policy.

The Case

A general contractor was sued for allegedly: (1) failing to perform its work in a workmanlike manner or to perform its work at all; purchase required materials; and use licensed, registered, and bonded subcontractors; and (2) abandoning its work. The contractor tendered the lawsuit to its commercial general liability insurance carrier.

The insurer contended that the general contractor had not complied with the "Additional Conditions Endorsement" to the policy because it had not obtained any certificates of insurance or hold harmless agreements from its subcontractors and because it had not been named as an additional insured on its subcontractors' own commercial general liability insurance policies. The insurer asked the U.S. District Court for the Western District of Washington to declare that it had no duty to defend or indemnify the contractor, and it moved for summary judgment.

The Court's Decision

The court granted the insurer's motion, finding that the "plain language" of the policy made clear that the contractor was "not entitled to coverage."

In its decision, the court explained that the policy required that the contractor obtain certificates of insurance and hold harmless agreements with its subcontractors and be named as an additional insured on its subcontractors' policies. The contractor met none of these conditions, the court found.

The court was not persuaded by the contractor's argument that it did not have to meet these conditions because it was "simply . . . unaware" of them as they "were buried in such a long insurance policy."

The court observed that the contractor had not explicitly contended that the insurer had to demonstrate actual prejudice resulting from the contractor's failure to comply with the conditions, and that Washington courts had not decided whether an insurer had to demonstrate prejudice in the context of an Additional Conditions Endorsement. The court ruled, however, that the contractor's failure to comply with the conditions expanded the insurer's risk and, therefore, was "substantial and material."

Finally, the court rejected the contractor's contention that because some of the claims against it were "wholly unrelated to work performed by subcontractors," denying coverage based on the endorsement "would be unduly harsh and overly technical." The court pointed out that the

endorsement, when read in isolation and in the context of the entire policy, "clearly" required the contractor to take specific actions that it had not taken. Moreover, the court observed, the policy did "not state or otherwise indicate that the conditions applied only to claims directly related to [the contractor's] subcontractors." In any event, the court said that the complaint against the contractor alleged "multiple breaches" related to its use of subcontractors.

Accordingly, the court concluded, the contractor was not entitled to coverage and the insurer had no duty to defend or indemnify the contractor for any liability incurred in the lawsuit that had been filed against it.

The case is *Developers Surety and Indemnity Co. v. Alis Homes, LLC*, No. C17-0707JLR (W.D. Wash. Apr. 16, 2018).

Court Approves Insured's Settlement with Two Insurers after Finding Non-Settling Insurers Were Protected

A federal district court in Washington has issued a decision explaining, and then applying, the standard for approving an insurer's settlement with an insured when other insurers have not settled.

The Case

King County, Washington, sued a number of insurers, seeking a determination of the insurers' liability for defense and indemnity related to a federal enforcement action for contamination at sites in and around the Lower Duwamish Waterway in Seattle.

Two insurers subsequently reached settlements with the county, agreeing to pay $800,000 and $1.6 million, respectively, in exchange for a full release. In connection with these settlements, the parties filed claim-bar motions intended to prohibit contribution, subrogation, and related claims against the settling insurers.

The District Court's Decision

The district court granted the motions.

In its decision, the district court explained that a bar order was appropriate where the proposed settlement was reasonable and the interests of non-settling defendants were protected.

It then found that the two settlements were reasonable, noting that the reasonableness requirement was "not a high hurdle." It pointed out that the parties asserted that they had resolved their claims in arm's-length negotiations and that there was no evidence that the settlements were collusive or inadequate.

The district court next found that the claim-bar orders left the non-settling insurers "with adequate protection against an unfair allocation of liability."

The district court noted that the non-settling insurers retained the right to their existing claims and defenses – and that they eventually might avoid liability entirely. It added that the county had represented that, at the end of the case when calculating damages owed by any remaining non-settling insurer, it would agree to an appropriate setoff to ensure that it did not receive a double recovery. This provided non-settling insurers with the protection to which they were entitled, the district court concluded.

The case is *King County v. Travelers Indemnity Co.*, No. 14-CV-1957 BJR (W.D. Wash. Apr. 16, 2018).

Virginia Court, Citing *Viking Pump*, Applies "All Sums" Allocation to Excess Policies

A federal district court in Virginia, in a coverage case involving long-tail asbestos-related claims, has ruled that "all sums" allocation applied to certain excess insurance policies, even though the insured previously had adopted a "pro rata" allocation method in settlements with other insurers.

The Case

From the 1930s until 2003, Hopeman Brothers, Inc., specialized in the engineering, manufacture, and installation of marine interiors on ocean-going vessels. During this period, Hopeman used several kinds of asbestos-containing panels.

Beginning in 1979, Hopeman was named in over 123,000 claims alleging personal or bodily injury from exposure to asbestos fibers contained in marine interior materials provided by Hopeman.

Hopeman ultimately settled coverage disputes with a number of its insurers, agreeing to a modified pro rata allocation.

In February 2013, Hopeman notified its excess insurers that certain underlying policies had been exhausted. Hopeman later sued two excess insurers, alleging that they had breached their obligation to pay various asbestos-related claims. The company also asked the court to declare, among other things, that the excess insurers had to pay an "all sums" share of amounts incurred for asbestos-related claims arising during the relevant policy periods, as well as all sums incurred in defense of those claims.

The excess insurers contended that Hopeman had previously indicated that their policies required a pro rata allocation method for the long-tail asbestos claims and had settled with other insurers for pro rata allocation. They argued that Hopeman should not be permitted to seek "all sums" allocation under their policies.

The parties moved for summary judgment.

The District Court's Decision

The district court, applying New York law, first ruled that "all sums" allocation applied because the excess insurers' policies contained or followed form to non-cumulation clauses that were "identical" to those construed in *In re Viking Pump, Inc.*, 27 N.Y.3d 244 (2016).

The district court next decided that, although Hopeman had previously agreed to modified pro rata allocation in settlements with other insurers, it did not have to use that method for the excess insurers. According to the district court, Hopeman had a "reasonable explanation" for previously using the modified pro rata allocation method and had not "opted out" of an all sums allocation by settling with other insurers on a pro rata basis. Therefore, the district court ruled, Hopeman was not precluded from seeking an "all sums" allocation method in its action against the excess insurers.

The district court also concluded that, under *Viking Pump*, the excess policies required "vertical" exhaustion of directly underlying insurance, and that the non-cumulation clauses only reduced the excess insurers' policy limits to the extent that Hopeman already had recovered for the same "occurrence" or same "loss" under prior insurance at the same "layer" or horizontal "tier" of coverage.

The case is *Hopeman Brothers, Inc. v. Continental Casualty Co.*, No.: 4:16cv187 (E.D. Va. Apr. 2, 2018).

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