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August 2018 | Insurance Update | WWW.RIVKINRADLER.COM

Computer Fraud Policy Covered Insured's Loss Caused by Fraudulent Bank-Routing Instructions, Sixth Circuit Decides

The U.S. Court of Appeals for the Sixth Circuit, reversing a Michigan district court's decision, has ruled that a computer fraud policy covered a loss suffered by the insured when an impersonator caused an employee of the insured to enter fraudulent bank-routing instructions into its computer system. The Sixth Circuit also ruled that policy exclusions did not preclude coverage.

The Case

On March 18, 2015, the vice president and treasurer of American Tooling Center, Inc. ("ATC"), a tool and die manufacturer in Michigan, emailed an employee for one of its vendors, Shanghai YiFeng Automotive Die Manufacture Co., Ltd. ("YiFeng"), a Chinese company, requesting all outstanding invoices. An unidentified third party intercepted the email and, impersonating the YiFeng employee, began a correspondence with the ATC employee about the outstanding invoices.

On March 27, 2015, the impersonator emailed the ATC employee and claimed that, due to an audit, ATC should wire its payments to a different account from usual. YiFeng had previously (and legitimately) informed ATC that it had changed its banking details, and ATC had no process for verifying the changed information.

Consequently, the ATC employee wired the money to the new account.

On April 3, the impersonator emailed the ATC employee and informed him that "due to some new bank rules in the province," the previous wire transfer had not been credited to its account and, therefore, it would return the payment. The impersonator requested that the ATC employee instead wire the money to a different bank account, which he did.

The impersonator ran this scam two more times and the ATC employee wired additional payments of $1,575 and $482,640.41 on April 9, 2015 and May 8, 2015. In total, ATC transferred approximately $834,000 to the impersonator.

When the real YiFeng demanded payment, ATC realized that it had wired the money to an imposter. ATC paid YiFeng approximately 50 percent of the outstanding debt, and agreed that the remaining balance would be contingent on ATC's insurance claim.

ATC sought to recover the amount it had paid to the impersonator under its business insurance policy. ATC argued that it fell within the policy's computer fraud provision, which covered ATC's "direct" loss of money "directly caused" by computer fraud.

The insurer denied the claim, and ATC sued.

The U.S. District Court for the Eastern District of Michigan granted summary judgment in favor of the insurer, and ATC appealed to the Sixth Circuit.

The Sixth Circuit's Decision

The Sixth Circuit, applying Michigan law, reversed and held that ATC's loss was covered by the policy, that none of three policy exclusions cited by the insurer applied, and that ATC was entitled to summary judgment in its favor.

In its decision, the circuit court first ruled that the three wire transfers of money to the impersonator constituted a "direct loss" of ATC's money within the meaning of the policy, reasoning that ATC "immediately" lost its money when it transferred the approximately $834,000 to the impersonator. The circuit court found that there was "no intervening event."

Next, the Sixth Circuit decided that the impersonator's conduct constituted computer fraud as defined by the policy because the impersonator sent ATC fraudulent emails using a computer and these emails fraudulently caused ATC to transfer the money to the impersonator. The circuit court was not persuaded by the insurer's argument that computer fraud was limited to hacking and similar behaviors in which a "nefarious party" somehow gained access to and controlled the insured's computer, observing that if the insurer had wanted to limit the definition of computer fraud to that kind of criminal behavior, "it could have done so."

Finally, the Sixth Circuit ruled that ATC's loss had been "directly" caused by computer fraud, as required by the policy, "because the computer fraud was an immediate cause of its loss." The circuit court found that the "chain of events" that was precipitated by the fraudulent emails and that led to the wire transfers involved "multiple internal actions at ATC." In the circuit court's opinion, ATC suffered a loss immediately after each transfer, which marked the end of the computer fraud, as defined in the policy.

The Sixth Circuit also rejected the insurer's contention that Exclusions R, G, and H in its insurance policy precluded coverage.

First, the circuit court ruled that Exclusion R, which excluded coverage for a transfer of money in an "exchange or purchase" with the impersonator, did not apply because ATC had not given or surrendered money to the impersonator in an "exchange or purchase."

Next, the circuit court decided that exclusion G, which excluded coverage for a loss resulting from the input of "Electronic Data" into ATC's computer system, also did not apply. The Sixth Circuit explained that the ATC employee's manual entry of fraudulent bank-routing instructions into ATC's computer system was not "Electronic Data" given that the policy's definition of that term excluded "instructions or directions" to a computer system.

Finally, the Sixth Circuit ruled that exclusion H, which excluded loss resulting from "forged, altered or fraudulent documents or written instruments used as source documentation in the preparation of Electronic Data," did not apply because the ATC employee's entries did not constitute "Electronic Data" as defined in the policy.

The case is *American Tooling Center, Inc. v. Travelers Casualty and Surety Co. of America*, No. 17-2014 (6th Cir. July 13, 2018).

Insured's Failure to Notify Insurers of Government's Settlement Offer Doomed Its Bid for Coverage of Settlement Payment, Sixth Circuit Affirms

The U.S. Court of Appeals for the Sixth Circuit, affirming a decision by a federal district court in Tennessee, has ruled that a mortgage lender that failed to notify its insurers of a settlement offer made by the U.S. Department of Justice while it was investigating the mortgage lender under the federal False Claims Act was not entitled to coverage of the payment the mortgage lender ultimately made to settle the government's investigation.

The Case

In 2012, the Office of Inspector General ("OIG") for the U.S. Department of Housing and Urban Development ("HUD") began an investigation into whether First Horizon National Corp. had violated the federal False Claims Act in its certifications to HUD about its compliance with the underwriting and quality-control requirements of its Fair Housing Act ("FHA") mortgages. This investigation included subpoenas and civil investigative demands ("CIDs") for interrogatory responses, depositions, and document production over the course of a year.

On April 29, 2014, a lawyer from the U.S. Department of Justice ("DOJ") made an oral settlement offer by phone to First Horizon in the amount of $610 million, which he then confirmed in writing via email. The email expressly referred to the $610 million as a "settlement offer" and explained that the DOJ "would welcome further discussion and information sharing but believe[d] that for it to be productive, First [Horizon] should provide a counterproposal." The email contained a list of the First Horizon mortgages that the DOJ said were materially deficient.

First Horizon did not disclose the government's $610 million settlement offer to its insurers, or forward the email to them.

On June 1, 2015, First Horizon settled with the government for $212.5 million, which First Horizon paid in full. Thereafter, it sent a demand letter to its insurers demanding coverage.

The insurers denied the claim and First Horizon sued. The U.S. District Court for the Western District of Tennessee concluded that the April 2014 settlement offer was a claim that First Horizon failed to give appropriate notice of under its insurance policy. Therefore, the district court ruled, the insurers had properly denied coverage.

First Horizon appealed to the Sixth Circuit, arguing that the April 2014 email was not a "demand" that triggered a "claim" because a "demand" was "a forceful statement coupled with a threat of consequences" and the April 2014 email contained "no forceful statement seeking money accompanied by any threat of consequences" or "anything 'under claim of right.'"

The Sixth Circuit's Decision

The Sixth Circuit affirmed.

In its decision, the circuit court stated that, as the district court had explained, a communication still could be a demand even if phrased as a "request" where it was "a request to do a particular thing specified under a claim of right," that "may be couched in the customarily-used polite language of the day," and that "need not expressly demand payment" if by implication its meaning was "clear."

Under this standard, the circuit court decided, the April 2014 email was a demand.

The Sixth Circuit concluded that a "notice of circumstance" provided by First Horizon in May 2014 was insufficient to alert its insurers to a claim by First Horizon because it did not include any mention of the April 2014 settlement offer, which they learned about only through a litigation discovery request in June 2015, "well after" First Horizon had made an official claim (in February 2015) and had filed its lawsuit (in April 2015). Therefore, the circuit court concluded, First Horizon was not entitled to coverage for the settlement payment it made to the government.

The case is *First Horizon National Corp. v. Houston Casualty Co.*, Nos. 17-5767/5844 (6th Cir. July 10, 2018).

Pollution Exclusion Barred Coverage of Costs to Remove "Rock Fines" from Stream

The U.S. District Court for the Northern District of Texas has ruled that an umbrella insurer did not have to defend or indemnify its insured in connection with a New Jersey pollution claim arising out of its discharge of "rock fines" into a stream near its rock quarry.

The Case

The insured operated a rock quarry in New Jersey where it quarried rock and crushed the rock into small stones and rock fines – small particles of rock generated as part of the stone crushing process. After it pumped rock fines into a stream, New Jersey officials issued notices of

violation reflecting that the insured had violated various environmental laws and regulations. New Jersey required that the insured remove the rock fines to ensure protection of fish habitats that had been covered by the rock fines and prevent their further migration.

The insured notified its primary and umbrella insurers of the government's claim and demanded reimbursement for all costs to remove the rock fines and to defend the claim.

The umbrella insurer asked the district court to declare that it had no duty to defend or indemnify the insured against the New Jersey pollution claim. The umbrella insurer moved for summary judgment.

The District Court's Decision

The district court, applying Texas law, granted the insurer's motion.

In its decision, the district court ruled that the umbrella insurance policy's pollution exclusion was "clear, unambiguous, and absolute."

Rock fines, the district court said, were "clearly waste material generated in the rock crushing process." That rock fines were wanted or useful did "not change their nature," the district court added.

Moreover, the district court continued, rock fines were materials intended to be reclaimed within the meaning of "waste material" as defined in the policy. In addition, they were solids, and they became irritants or contaminants when they were discharged and dispersed where they did not belong.

"Without question," the district court concluded, the absolute pollution exclusion in the umbrella policy applied and was "fatal" to the insured's claims for defense and indemnity from the umbrella insurer.

The case is *Great American Ins. Co. v. ACE American Ins. Co.*, No. 4:18-CV-114-A (N.D. Tex. July 10, 2018).

Pollution Exclusion Precluded Coverage of Suit Alleging Carbon Monoxide Entered Condo Unit

The U.S. District Court for the Southern District of Florida has ruled that a pollution exclusion precluded coverage for a lawsuit seeking damages after a woman died from carbon monoxide poisoning in a condominium unit.

The Case

After a woman died from carbon monoxide poisoning in a rented condominium unit in Broward County, Florida, her mother filed a wrongful death complaint against the homeowners

association that was in control of all common elements for the unit. According to the complaint, it was believed that the carbon monoxide had come from a motor vehicle in the unit's garage, had seeped into the air conditioner ducts or vents and then into the plaintiff's daughter's bedroom, and then had been inhaled by her.

The association's insurer asked a Florida court to declare that it had no duty to defend the association in the underlying lawsuit. The insurer moved for summary judgment.

The District Court's Decision

The district court granted the insurer's motion, finding that the policy's pollution exclusion precluded coverage.

In its decision, the district court explained that carbon monoxide was a pollutant under the policy, so that the allegations in the underlying lawsuit fell within the pollution exclusion.

The association argued that the allegations in the underlying lawsuit brought the claim within an exception to the exclusion for fumes produced by equipment used to heat, cool, or dehumidify the building. The association reasoned that because the underlying complaint only stated that the carbon monoxide was *believed* to have come from the motor vehicle, it might have been produced by or originated from the building's heating, cooling, or dehumidifying equipment, and the exception could potentially apply.

The district court was not persuaded by this argument, reasoning that the underlying complaint identified only the motor vehicle left running in the garage as a potential source of the carbon monoxide and that it could "not infer any other sources to create a duty to defend."

Moreover, the district court concluded, the fact that the carbon monoxide entered the unit through the air conditioning ducts or vents did not mean that the carbon monoxide had been produced by, or had originated from, the ducts or vents. It "originated from and was produced by the motor vehicle," the district court concluded.

The case is *Colony Ins. Co. v. Great American Alliance Ins. Co.*, No. 17-62467-CIV-DIMITROULEAS (S.D. Fla. July 17, 2018).

Insurer Had No Duty to Defend Suit Filed After Waffle House Shooting

The U.S. District Court for the Northern District of Georgia has ruled that an insurer had no duty to defend its insureds against a lawsuit filed after a fatal shooting at a Waffle House restaurant, even though the lawsuit alleged negligence, and notwithstanding that the insurance policy contained a professional services endorsement.

The Case

After a fatal shooting at a Waffle House restaurant, a premises liability lawsuit was filed against The EJIII Development Company and Waffle House, Inc. The suit alleged that EJIII had negligently failed to "provide and/or properly train security guards"; had failed to "implement adequate security policies" for Waffle House by failing to "identify hazardous conditions" and "warn patrons"; had negligently hired, trained, or supervised its employees; and had created, failed to warn of, or failed to discover "dangerous conditions." It also asserted that Waffle House was liable due to negligent training, employment, supervision, and retention; under a respondeat superior theory; and for failure to maintain safe premises.

Relying on its policy's assault-and-battery exclusion, the defendants' insurer asked the district court to declare that it had no duty to defend or indemnify the defendants in connection with the claims asserted in the lawsuit. The insurer moved for summary judgment.

EJIII and Waffle House did not argue that the assault-and-battery exclusion did not apply. Rather, they contended that the policy's endorsement providing professional liability coverage for EJIII's security services overrode and negated the assault-and-battery exclusion. In particular, they argued that because the claims in the underlying lawsuit arose out of EJIII's rendering of, or failure to render, professional security services, the claims were covered by the endorsement.

The District Court's Decision

The district court granted the insurer's motion, holding that the insurer had no duty to defend the insureds in the underlying action.

In its decision, the district court explained that the allegations in the underlying lawsuit – even those alleging negligence – arose from an alleged assault and battery or physical altercation within the meaning of the assault-and-battery exclusion.

The district court then rejected EJIII and Waffle House's argument that the endorsement prevailed to provide coverage. The district court reasoned that although the professional liability endorsement added coverage to Coverage A, the assault-and-battery exclusion, which was added to the subsequent "Exclusions" paragraph, could have only one meaning: claims stemming from an assault or battery were not included in Coverage A. In the district court's opinion, this was the case regardless of whether those claims would otherwise have been covered under the portion of Coverage A in the body of the policy or the portion added through an endorsement.

The district court concluded from the "plain language of the policy" that the assault-and-battery exclusion applied to claims stemming from an alleged assault and battery, even if those claims otherwise would have been covered by the professional liability endorsement.

The case is *Nautilus Ins. Co. v. EJIII Development Co.*, No. 1:17-cv-2048-TCB (N.D. Ga. July 19, 2018).

Applying Texas Law, Delaware Supreme Court Decides That Insured's Assignment of Policies Was Invalid

The Delaware Supreme Court, in an insurance coverage dispute involving asbestos-related liabilities, has decided that Texas law governed various insurance policies that were silent as to choice of law and that, as a result, the insured's assignment of those policies without the insurer's consent meant that the assignment was invalid.

The Case

CNH Industrial America, LLC, sought coverage for historic asbestos-related liabilities at J.I. Case, Inc., some of whose assets had been transferred to CNH during a 1994 corporate reorganization. CNH contended that three insurance policies that had been issued in 1972, 1978, and 1985 had been validly assigned to CNH by J.I. Case's former parent, Tenneco, Inc., as part of the 1994 reorganization.

CNH argued that the assignment was valid under Wisconsin law, which applied because J.I. Case was headquartered in Wisconsin.

For its part, the insurer argued that the assignment was invalid under Texas law because it had not consented to the assignment, as required by the policies. It contended that Texas law applied because the policies had been negotiated, contracted, and performed in Texas.

CNH agreed that, if Texas law applied, the policies had not been properly assigned to it by Tenneco during the reorganization, negating coverage.

The trial court, applying the factors described in the *Restatement (Second) of Conflict of Laws*, gave the greatest weight to J.I. Case's principal place of business, which was in Wisconsin, and applied Wisconsin law to the coverage dispute. It then entered judgment against the insurer for more than $13 million.

The insurer appealed to the Delaware Supreme Court.

The Delaware Supreme Court's Decision

The court reversed.

In its decision, the court explained that, when applying the *Second Restatement* factors to a corporate-wide insurance program, the inquiry should center on the insurance contracts and not the underlying claims. Otherwise, the court said, the insurance policies could be subject to different interpretations depending on the state law where each claim arose.

The court then reasoned that:

- Texas-based Tenneco – not J.I. Case – had sought insurance coverage through a corporate-wide insurance program covering operations across multiple jurisdictions; and

- Tenneco had negotiated and secured insurance coverage and managed its insurance program out of its Texas offices.

Therefore, the court ruled, under the *Second Restatement* factors, Texas had the most significant relationship to the contracting parties and the dispute, and Texas law applied. Because the parties agreed that Tenneco's assignment of the policies to CNH without the insurer's consent was invalid under Texas law, the court reversed the trial court's decision and directed that judgment be entered in favor of the insurer.

The case is *Travelers Indemnity Co. v. CNH Industrial America, LLC*, No. 420, 2017 (Del. July 16, 2018).

Excess Policies Did Not Cover Asbestos-Related Claims Asserted Against General Motors, Delaware Supreme Court Rules

The Delaware Supreme Court, affirming a lower court's decision, has ruled in favor of 14 insurance companies that sold excess general liability insurance policies to General Motors from the late 1960s to the mid-1980s, concluding that the excess policies did not cover asbestos-related claims asserted against General Motors.

The Case

After General Motors entered bankruptcy in 2009, it assigned its rights to proceeds under pre-1986 excess general liability insurance policies to a trust, as required by the bankruptcy plan of reorganization. The trust asserted a variety of claims against the excess insurers in a Delaware state court.

The court ruled that the asbestos-related claims at issue were not covered under any of the post-1971 primary "claims-made" policies because none of the claims had been reported to either General Motors or the primary insurer during any post-1971 policy period. It then reasoned that claims not covered under the post-1971 primary insurance policies were not covered under the post-1971 excess policies, and it granted summary judgment to all of the post-1971 excess insurers.

Next, the court, applying Michigan law, ruled that pro rata allocation – not all sums – applied to the pre-1972 excess policies, and it granted summary judgment to all of the pre-1972 excess insurers.

The combined effect of these decisions was to grant summary judgment for all of the excess insurers.

The trust appealed to the Delaware Supreme Court.

The Delaware Supreme Court's Decision

The Delaware Supreme Court affirmed.

In its decision, the court first agreed with the lower court that, under Michigan law, pro rata allocation, not all sums, applied to the pre-1972 excess policies.

Next, the court agreed with the lower court that the trust was estopped from arguing that any of the claims at issue in the case triggered coverage under the post-1971 primary policies. Accordingly, the court ruled, the excess policies did not have to respond to claims that did not trigger coverage under the primary policies. The court noted that judicial estoppel was not the only reason that the trial court had decided that the post-1971 primary policies were claims-made and that each claim was a separate occurrence. The court explained that the trial court also had determined that an endorsement to the primary policies had been intended by the parties to convert them from occurrence-based to claims-made.

Additionally, the court rejected the trust's argument that the excess policies required the excess carriers to respond to claims even if they had not been triggered under the primary insurance, stating that any policy language providing for that should be "clear and unambiguous," and concluding that there was no language to that effect in the excess policies.

The case is *Motors Liquidation Co. DIP Lenders Trust v. Allstate Ins. Co.*, No. 381, 2017 (Del. July 10, 2018).

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