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New York Court of Appeals: New York Law Does Not Require a Finding of Fraud for an Insurer to Withhold Payments to a Medical Services Corporation Improperly Controlled by Non-Physicians

The New York Court of Appeals, in first-party no-fault collections actions filed by a professional services corporation, upheld a jury verdict for the defendant insurers and held that an insurer need not show common law fraud to withhold payments to a medical services corporation improperly controlled by non-physicians in violation of New York professional corporate licensing rules.

The Case

In 2004, Andrew Carothers, M.D., a radiologist formed a professional services corporation. The company was named Andrew Carothers, M.D., P.C. (the "plaintiff"). The company provided magnetic resonance imaging ("MRI") services. The professional services corporation was incorporated after Carothers met Hillel Sher, a non-physician who owned and controlled two companies that held long-term leases for three, fully equipped, operational facilities in New York City.

Sher retained control of the corporation. For example, the corporation agreed to lease the premises and MRI equipment from Sher at above-market rates and Sher retained the unilateral right to terminate the leases without cause. Although Carothers opened a bank account on behalf of the plaintiff, he never wrote the checks from that account. Rather, plaintiff's executive secretary, Irina Vayman (who was introduced to Carothers by Sher) wrote the checks.

In addition, Carothers' oversight of the practice was limited. He did not have contact with referring physicians, he did not set up patient care protocols, and he did not evaluate or discipline employees. Carothers reviewed a small percentage of the MRI scans himself. Most of the scans were interpreted by a second radiologist who did not own the professional corporation.

Carothers' salary was lower than Vayman's salary. Moreover, throughout her employment, Vayman transferred large sums of money from the plaintiff's bank account to her own personal bank account and used plaintiff's account to cover her personal expenses. Also, Vayman, not Carothers, was listed as an authorized borrower's representative on a loan agreement with a third party.

In 2006, insurance companies stopped paying plaintiff's no-fault claims. The plaintiff then commenced multiple collections actions seeking to recover unpaid claims of assigned first-party,

no-fault insurance benefits. The insurers argued that the plaintiff was not entitled to seek reimbursement of the insurance benefits under 11 NYCRR 65-3.16(a)(12), which states that a health care provider is not eligible for reimbursement if the provider fails to meet any applicable New York State or local licensing requirements necessary to perform such work in New York. In particular, the carriers argued that the professional service corporation was controlled by unlicensed physicians in violation of New York law prohibiting unlicensed individuals from organizing a professional service corporation for profit or exercising control over such entities. Rather, the carriers argued that the professional corporation was actually owned and controlled by Sher and Vayman, who were not physicians.

The cases, involving 54 insurance carriers, proceeded to trial. Plaintiff's counsel requested that the court give a jury instruction on "the traditional elements of fraud," including fraudulent intent. The plaintiff cited *State Farm Mut. Auto. Ins. Co. v. Mallela*, 4 N.Y.3d 313 (2005), which held that insurance carriers may withhold payment for medical services provided by "fraudulently incorporated" enterprises to which patients have assigned their claims, regardless of the quality of care such entities have provided. Based on *Mallela*, the plaintiff argued that the insurers could only prevail if the professional corporation's ostensible or real managers engaged in conduct "tantamount to fraud." The trial court denied the request and the jury instruction contained no instruction on fraudulent intent or the elements of fraud. The jury awarded a verdict to the insurers.

The Appellate Term upheld the Civil Court's jury charge, reasoning that "[a] reading of the *Mallela* case demonstrates that the case involved fraud in the corporate form, rather than the more traditional forms of common-law fraud."

The Appellate Division affirmed the Appellate Term's ruling. That ruling was then appealed to the New York Court of Appeals.

The Decision

The New York Court of Appeals affirmed the lower court's order and held that the trial court did not err in declining to give a charge requiring the jury to find fraudulent intent or conduct "tantamount to fraud" in order to reach a verdict in favor of the insurers. The court found that the jury's finding that the corporation was in material breach of New York professional corporation licensure rules – namely, that it be controlled by licensed professionals under Business Corporation Law § 1507 – was enough to render it ineligible for insurance reimbursement under 11 NYCRR 65-3.16(a)(12).

The court acknowledged that the term "fraudulently incorporated" in *Mallela* – which came from the Second Circuit's certified question – "may be misleading." But, the court clarified that *Mallela* does not require a finding of fraud for the insurer to withhold payments to a medical service corporation improperly controlled by non-physicians. Rather, the court held that a corporate practice that shows "willful and material failure to abide by" licensing and incorporation statutes may support a finding that the provider is not an eligible recipient for reimbursement under 11 NYCRR 65-3.16(a)(12) without meeting the traditional elements of common-law fraud.

The court also rejected the plaintiff's attempt to characterize the improper control of plaintiff by unlicensed persons as simply an instance of improper fee splitting of a professional service corporation's profits with a non-physician, which, under prior Appellate Division case law, was not a defense to a no-fault action. The court noted that "the jury in this case determined that plaintiff was controlled by unlicensed persons, rather than merely splitting fees with them."

Accordingly, the court affirmed the Appellate Term's decision.

The case is *Andrew Carothers, M.D., P.C., v. Progressive Insurance Company*, 2019 N.Y. Slip Op. 04643 (N.Y. June 11, 2019).

Rivkin Comment: Rivkin Radler partner Barry I. Levy successfully argued the appeal before the Court of Appeals for the prevailing insurer and was assisted by Evan H. Krinick, Michael A. Sirignano, Cheryl F. Korman, and Stuart M. Bodoff.

STOLI Policies Are Void, New Jersey Supreme Court Decides

The Supreme Court of New Jersey, in a case of first impression, has ruled that stranger-originated life insurance ("STOLI") policies violate New Jersey's insurable interest requirement and are void as against public policy.

The Case

In April 2007, an insurer received an application for a $5 million insurance policy on the life of Nancy Bergman. The application listed the Nancy Bergman Irrevocable Trust dated 4/6/2007 as the sole owner and beneficiary of the policy. Nancy Bergman signed the application as the grantor of the trust, and her grandson, Nachman Bergman, signed as trustee. The trust had four additional members. All of them were investors, and all were strangers to Ms. Bergman.

The investors deposited money into the trust account to pay most if not all of the policy's premiums. The original trust agreement provided that any proceeds of the policy would be paid to Nachman Bergman.

Ms. Bergman was a retired middle school teacher, yet the insurer received an inspection report that listed her annual income as more than $600,000 and her overall net worth at $9.235 million. In reality, her income was about $3,000 a month from Social Security and a pension, and her estate was later valued at between $100,000 and $250,000.

On July 13, 2007, the insurer issued the $5 million policy. At the time, the trust was the sole owner and beneficiary. The policy contained an incontestability clause that barred the insurer from challenging the policy – other than for non-payment of premiums – after it had been "in force during the lifetime of the Insured" for two years.

On August 21, 2007, about five weeks after the policy was issued, Nachman Bergman resigned as trustee and appointed the four investors as successor co-trustees. The trust agreement was amended so that most of the policy's benefits would go to the investors; they also were empowered to sell the policy on their own.

More than two years later, in December 2009, the trust sold the policy to SLG Life Settlements, LLC, for $700,000. The investors received nearly all of the proceeds from the sale. Afterward, a company named LTAP acquired the policy for a brief period, and Wells Fargo Bank, N.A., obtained it in a bankruptcy settlement in or about 2011. Wells Fargo continued to pay the premiums.

After Nancy Bergman died in 2014 at age 89, Wells Fargo sought to collect the policy's death benefit. The insurer declined to pay and went to court, seeking a declaratory judgment that the policy was void ab initio as part of a STOLI scheme.

The U.S. District Court for the District of New Jersey, applying New Jersey law, concluded "that this was a STOLI transaction lacking insurable interest in violation of [the state's] public policy. . . . As such, it should be declared void ab initio." The district court also ruled that Wells Fargo was entitled to recover its premium payments.

Both parties appealed. The Third Circuit certified two questions of law to the Supreme Court of New Jersey:

> (1) Does a life insurance policy that is procured with the intent to benefit persons without an insurable interest in the life of the insured violate the public policy of New Jersey, and if so, is that policy void ab initio?
>
> (2) If such a policy is void ab initio, is a later purchaser of the policy, who was not involved in the illegal conduct, entitled to a refund of any premium payments that [it] made on the policy?

The New Jersey Supreme Court's Decision

The New Jersey Supreme Court answered both questions in the affirmative.

As to the first certified question, the court ruled that STOLI policies are against public policy. The court ruled that the policies were not merely voidable, but were void ab initio.

According to the court, if a third party without an insurable interest procured or caused an insurance policy to be procured in a way that feigned compliance with New Jersey's insurable interest requirement, the policy was "a cover for a wager on the life of another" and violated New Jersey public policy. In the court's opinion, the swift transfer of control over a life insurance policy and its benefit, from a named beneficiary who had an insurable interest to investors who did not have an insurance interest in the named beneficiary, did not satisfy New Jersey's insurable interest requirement.

The court stated that "[i]t would elevate form over substance to conclude that feigned compliance with the insurable interest statute – as technically exists at the outset of a STOLI transaction – satisfies the law."

As to the second certified question, the court decided that a party to a STOLI policy may be entitled to a refund of premium payments depending on the circumstances and that, among other relevant factors, courts should consider a later purchaser's participation in and knowledge of the original illicit scheme.

To decide the appropriate remedy in the context of a void STOLI policy, the court said, a trial court should "develop a record and balance the relevant equitable factors." The court said that those factors included a party's level of culpability, its participation in or knowledge of the illicit scheme, and its failure to notice red flags. Depending on the circumstances, the court concluded, a party may be entitled to a refund of premium payments it made on a void STOLI policy, particularly a later purchaser who was not involved in any illicit conduct. The court declined to comment on the compromise award fashioned by the district court in this case.

The case is *Sun Life Assurance Co. of Canada v. Wells Fargo Bank, N.A.*, No. A-49 (N.J. June 4, 2019).

Insurer's Denials in Bad Faith Action Did Not Waive Attorney-Client Privilege, South Carolina Supreme Court Rules

The Supreme Court of South Carolina has ruled that an insurer that denied liability or that asserted good faith in an answer to a bad faith complaint did not place privileged communications "at issue" in the case and, therefore, did not waive the attorney-client privilege with respect to those communications.

The Case

After a construction company settled a construction defect lawsuit brought by a property owners association, the construction company and the owners association sued the construction company's excess commercial liability insurance carrier, alleging bad faith failure to defend or indemnify.

The insurer asserted that it acted in good faith in denying coverage, and the plaintiffs sought to discover why the insurer denied coverage. The plaintiffs sought production of the insurer's file on the construction company's claim for excess coverage relating to the association's suit and the insurer's files relating to all of the construction company's claims under its excess liability policies.

The insurer objected that these files contained material protected by the attorney-client privilege. The U.S. District Court for the District of South Carolina disagreed, holding that the files were not protected by the attorney-client privilege because the insurer put them "at issue" in the case by denying liability for bad faith failure to defend or indemnify.

The insurer asked the Fourth Circuit to vacate the district court's order granting the motions to compel. The circuit court certified the following question to the Supreme Court of South Carolina:

> Does South Carolina law support application of the "at issue" exception to attorney-client privilege such that a party may waive the privilege by denying liability in its answer?

The South Carolina Supreme Court's Decision

The South Carolina Supreme Court analyzed the issue narrowly in the limited context of a bad faith action against an insurer and answered the certified question as follows: "No, denying liability and/or asserting good faith in the answer does not, standing alone, place the privileged communications 'at issue' in the case."

In its decision, the court first rejected the view of those jurisdictions that have broadened the crime-fraud exception to the attorney-client privilege and have ruled that the privilege does not extend to any communications in furtherance of any crime or tort, including bad faith insurance claims. These jurisdictions, the court added, typically have found the entire pre-denial claim file discoverable. The court said that this approach placed "only nominal value" on the importance of the attorney-client privilege.

The court also rejected what it characterized as the "other extreme," upholding the attorney-client privilege absent direct, express reliance on a privileged communication by a client in making out its claim or defense. In the court's view, this approach failed to balance the attorney-client privilege with any competing policy considerations.

Instead, the court adopted what it characterized as a middle-ground approach, explaining that determining if the attorney-client privilege was waived in a tort action against an insurer for bad faith refusal to deny coverage required a "case-by-case analysis of the facts."

In the court's view, a waiver could not be based solely on "the mere filing of a bad faith action, the denial of bad faith [in the answer to the complaint], or the affirmative claim of good faith." An insurer did not waive the privilege, the court added, unless it "*asserted some claim or defense*, such as the reasonableness of its evaluation of the law, *which necessarily includes the information received from counsel*." In that situation, the court said, the insurer interjected the issue of advice of counsel into the litigation to the extent that recognition of the privilege would deny the opposing party access to proof without which it would be impossible for the factfinder to fairly determine the very issue raised by that party.

The court concluded by emphasizing the "sanctity of the attorney-client privilege," adding that as part of the standard it was adopting, the party seeking waiver of the attorney-client privilege must make a "prima facie showing of bad faith."

The case is *In re Mt. Hawley Ins. Co.*, No. 27892 (S.C. June 12, 2019).

Oregon Appellate Court Narrows Meaning of 'Prior Insurance' and 'Direct Loss'

An appellate court in Oregon, affirming a trial court's decision in an insurance coverage case involving a loss allegedly due to a bookkeeper's embezzlement, has issued a decision interpreting

the “prior insurance” provision and “direct loss” term in a series of annual insurance policies issued to the bookkeeper’s employer.

The Case

In July 2013, Summit Real Estate Management, LLC, said that it discovered that its bookkeeper had been embezzling from the company for eight years. It notified its insurer and engaged an accounting firm to conduct an audit to determine the scope of the embezzlement. The firm determined that, between February 2005 and July 2013, the bookkeeper had stolen at least $856,700.

Summit sought reimbursement from its insurer for the $856,700 that had been embezzled, for $25,245 that it paid the accounting firm to conduct the audit, and for $8,000 in employee time spent investigating the embezzlement and assisting the accounting firm with the audit.

The insurer agreed to cover $327,600 of Summit’s claim, representing payment only for those funds that were embezzled after August 1, 2010. It determined that, because the embezzlement was not discovered until July 2013, two policies had been implicated by “loss or damage discovered no later than one year from the end of the Policy Period”: the policy in effect from August 1, 2011 to August 1, 2012 and the policy in effect from August 1, 2012 to August 1, 2013. The insurer agreed to pay for losses that occurred during those periods and agreed that, under the prior insurance provision in the policy in effect from August 1, 2011 to August 1, 2012, Summit also was entitled to recover for losses that would have been covered under insurance in effect for the policy period from August 1, 2010 to August 1, 2011.

The insurer denied coverage for any embezzlement that occurred in previous policy periods – that is, for everything before August 1, 2010. The insurer also denied coverage for the amounts Summit sought for the audit and for its own employee time; as for those amounts, the insurer told Summit that there was “no coverage provided in the policy for your expenses in order to determine the amount of your loss. The [employee dishonesty coverage] only covers the direct loss” whereas “[y]our expenses are the indirect costs related in determining the amount of your claim.”

Summit sued the insurer. Among other things, it argued that it was entitled to coverage for losses in all of the earlier policy periods based on the prior insurance provision in its annual insurance policies. It also contended that the expenses it incurred in verifying its losses were very much a “direct loss” that the insurer was obligated to cover.

The trial court granted summary judgment in favor of the insurer, and Summit appealed.

The Oregon Appellate Court’s Decision

The appellate court affirmed.

In its decision, the appellate court agreed with the insurer that the phrase “prior insurance” referred only to the insurance in effect for a policy period that terminated when the period for the

new coverage began. Accordingly, it ruled, only three policy periods were implicated: 2010-11, 2011-12, and 2012-13.

The appellate court also decided that the insurer was not obligated to pay for the costs Summit incurred in substantiating its claim for embezzlement losses. According to the appellate court, the "direct loss" covered by Summit's insurance policies did not include Summit's expenditures in substantiating its insurance claim.

The appellate court reasoned that the "plain meaning" of the phrase direct loss referred to a "proximate, rather than remote," relationship between the covered acts of employee dishonesty and the resulting loss or damage. It added that the "only reasonable and sensible interpretation" of the term direct loss was that the insurer was insuring against loss of or damage resulting "from the dishonest acts," not losses that resulted from the damage from those dishonest acts.

The appellate court said that Summit's costs to substantiate its claim did not represent losses proximately caused by the alleged embezzlement, but instead were expended as a result of the damage – that is, as a part of Summit's efforts to document the loss. Accordingly, it concluded, the trial court properly determined that Summit's direct losses did not include the accounting or employee labor expenses it incurred.

The case is *Summit Real Estate Management, LLC v. Mid-Century Ins. Co.*, No. A163203 (Ore. Ct. App. June 19, 2019).

Batch Clause Endorsement Combines Occurrences Across Different Policy Periods, Eighth Circuit Holds

The U.S. Court of Appeals for the Eighth Circuit, affirming a decision by a federal district court in Minnesota, has ruled that claims arising from a defective lot of goods constituted a single occurrence deemed to occur when the insured was first notified of the alleged damage.

The Case

In the 1990s, Donaldson Company, Inc., designed and manufactured plastic ducts for the air-intake system of trucks manufactured by Western Star Trucks. It was later sued for an alleged design defect in its plastic ducts. Donaldson settled a truck dealer's claim for $6 million, with its commercial general liability ("CGL") insurer contributing $3,548,387.10 and its excess carrier contributing $2,451,612.90.

Thereafter, the CGL insurer sued Donaldson and the excess insurer to recover amounts it had contributed to the settlement.

A "Batch Clause Endorsement" in the CGL policies provided:

> As respects "Products Completed Operations Hazard," all "bodily injury" or "property damage" arising out of and attributable directly or indirectly to the continuous, repeated or related exposure to

> substantially the same general conditions affecting one lot of goods or products manufactured, sold, handled or distributed by you or others trading under your name, shall be deemed to result from a single "occurrence." Such "occurrence" will be deemed to occur with the first injury notified to you during the policy period.

The U.S. District Court for the District of Minnesota found that the endorsement combined property damage, including damage that took place across multiple policy periods, into one occurrence that took place when Donaldson first was notified of the alleged damage.

The district court determined that coverage existed under a policy period if Donaldson received notice during that policy period – and that it was immaterial whether actual injury occurred during that policy period.

According to the district court, the number of policy years and deductibles implicated depended on the number of product "lots" involved. The district court rejected the argument that the endorsement only combined injuries that took place during an individual policy year into a single "occurrence."

The district court found that two lots of ducts were responsible for the damage in the lawsuit Donaldson settled for $6 million, that Donaldson was notified of damage related to both lots in January 2000, and, therefore, that all of the property damage related to each of the two lots constituted an occurrence within the 1999-2000 policy period, for a total of two occurrences.

Accordingly, the district court found that, because there were two "occurrences," two $500,000 per-occurrence deductibles applied to the $6 million settlement, which was allocable to the 1999-2000 CGL policy. Of the $6 million settlement, the district court allocated $785,591.44 to the 1999-2000 CGL policy and $5,214,408.56 to the 1999-2000 excess policy. Because Donaldson previously paid one $500,000 deductible, the district court ordered that it pay the CGL insurer an additional $500,000. But as the excess carrier previously paid only $2,451,612.90 toward the settlement, the district court ordered it to reimburse the CGL insurer $2,762,795.66.

The excess insurer appealed to the Eighth Circuit. It challenged the district court's interpretation of the endorsement and corresponding finding that only the 1999-2000 policy period was triggered, asserting that the property damage had to occur during the policy period regardless of the language in the endorsement. It also argued that a minimum of four lots of ducts were involved.

The Eighth Circuit's Decision

The Eighth Circuit affirmed.

In its decision, the circuit court rejected the excess insurer's interpretation of the endorsement. Instead, the Eighth Circuit found, there was only a "single unambiguous interpretation" of the endorsement: All "property damage" affecting a defective "lot of goods or products" was

consolidated into a single "occurrence" deemed to occur when the insured was first notified during the policy period.

Moreover, the circuit court reasoned, the excess insurer's interpretation conflicted with the "main purpose" of batch clauses: to reduce the number of occurrences whenever the same product caused multiple bodily injuries or property damage.

The Eighth Circuit concluded by agreeing with the district court that two lots were implicated, explaining that Donaldson designed two different types of ducts for Western Star trucks and that Donaldson thereafter made only minimal changes to the ducts with "no effect" on their "functioning, specifications, product numbers, appearance, or quality."

The case is *National Union Fire Ins. Co. of Pittsburgh, PA v. Donaldson Co., Inc.*, No. 18-1063 (8th Cir. June 14, 2019).

Missouri Appellate Court: No Coverage Owed to Utility Accused of Exceeding Easement Rights by Installing Fiber Optic Cable for Telecommunications Purposes without Landowners' Permission

A Missouri Appellate Court ruled that an insurer did not have a duty to defend a utility against a claim alleging that the utility exceeded its easement rights by installing fiber optic cable across landowners' properties because the claim did not seek damages because of property damage or personal injury.

The Case

The insured, KAMO Electric Cooperative, Inc. and its wholly-owned subsidiary K-PowerNet, LLC (collectively "KAMO") were named as defendants in a federal class action suit. Plaintiffs alleged that KAMO illegally installed or used over 2,000 miles of fiber-optic cable throughout the state on the class members' land. Although KAMO had an electric utility easement across most of the properties, plaintiffs alleged that the easements did not allow KAMO to use fiber optic cable for commercial telecommunications purposes. The class members asserted various claims, including trespass and unjust enrichment.

In defending against these claims, KAMO argued that their use of the fiber optics was intangible, imposed no additional burden to the easement, and resulted in no physical interference with the class members' property.

On March 31, 2014, the federal court issued an order establishing KAMO's liability to only those easements which did not permit the use and lease of the land for telecommunications purposes. Thereafter, KAMO notified its insurers of the class action complaint. Navigators Insurance Company defended KAMO under a reservation of rights. Navigators then demanded that two other insurers, American Home Assurance Company ("American Home") and Arch Insurance Company ("Arch") contribute toward KAMO's defense. American Home and Arch declined to participate.

In 2016, Navigators filed an action in Missouri state court alleging that American Home and Arch wrongfully refused to defend KAMO and that Navigators was entitled to equitable subrogation and equitable contribution for having solely defended KAMO.

The trial court awarded summary judgment to American Home and Arch. Navigators appealed.

The Decision

The Appellate court affirmed the lower court's ruling.

The court first considered whether there was coverage under Coverage A of the American Home and Arch policies, which provided coverage for "Bodily Injury and Property Damage Liability" Coverage. The policies defined "property damage" as "[p]hysical injury to tangible property, including all resulting loss of use of that property."

The court agreed that the lower court correctly characterized the class members' claim as being trespass in the form of expansion of its easement. The court acknowledged that, under Missouri law, the claims could not be for the loss of use of tangible property because an easement is intangible.

The court also concluded that, even if it had a duty to consider information in the record external to the petition, it would have only "solidified the ultimate conclusion" reached by the court. As the court noted, in the federal lawsuit, KAMO conceded that its use of the fiber optics was intangible and resulted in no physical interference with the plaintiffs' properties.

The court next considered whether there was coverage under Coverage B of the policies, which provided "Personal and Advertising" coverage for "[t]he wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor."

The court held that the lower court did not err in concluding that KAMO, which owned nothing other than the easement itself, was not the "owner" of the "premises" claimed by the class members to have been trespassed upon.

Therefore, the court concluded that the lower court did not err in granting summary judgment in favor of American Home and Arch on the issue of their duty to defend KAMO.

The case is *Navigators Ins. Co. v. American Home Assur. Co.*, Docket No. WD82118 (Mo. Ct. App. West. Dist., June 25, 2019).

First Circuit: Intellectual Property Exclusion Bars Coverage for Trademark Infringement Claim

The First Circuit, applying Massachusetts law, held that an intellectual property exclusion to personal and advertising injury coverage barred coverage for a claim arising out of trademark infringement.

The Case

The insured, Sterngold Dental, LLC ("Sterngold"), manufactured and sold dental products. The insured was sued by a competitor in the market for dental products, Intra-Lock International, Inc. ("Intra-Lock"), which alleged that Sterngold infringed Intra-Lock's registered OSSEAN trademark – a trademark denoting a component of its osseointegrative dental implant coating product – by using nearly identical marks, OSSEO and OSSEOs, for a nearly identical product.

Sterngold settled the Intra-Lock suit. Sterngold's insurer, HDI Global Insurance Company ("HDI") refused to reimburse Sterngold for the settlement amount.

The relevant policy obligated the insurer to defend and indemnify the insured against claims arising out of "personal and advertising injury." However, coverage for such injuries was subject to certain exclusions, including the intellectual property exclusion. The intellectual property exclusion excepted from coverage personal and advertising injury "arising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights."

Sterngold then sued HDI, alleging breach of its duty to defend and indemnify Sterngold against Intra-Lock's claim. HDI moved to dismiss the complaint for failure to state a claim upon which relief can be granted. The district court granted the motion. Sterngold appealed.

The Decision

Applying Massachusetts law, the First Circuit affirmed the dismissal of Sterngold's action.

The court held that, even assuming Intra-Lock's complaint alleged a claim for advertising injury, the claim fell within the intellectual property exclusion. The court reasoned that the underlying claim arose out of the infringement of Intra-Lock's trademark. The court noted that the complaint labeled its claim as one for the "Infringement of [its] OSSEAN Trademark" and that Sterngold willfully infringed and diluted that trademark.

The court also rejected Sterngold's argument that the OSSEO and OSSEOs marks were slogans, and thus fell within an exception to the intellectual property exclusion for "infringement, in your 'advertisement', of copyright, trade dress or slogan." The court noted that Intra-Lock never pursued a slogan infringement claim, nor did its complaint even mention the word "slogan." The court also noted that word "slogan," given its ordinary meaning, meant "a phrase expressing the aims or nature of an enterprise . . . [and/or] a catch phrase used in advertising or promotion." But, the court observed, nothing in the record suggested that Intra-Lock ever used OSSEAN as a slogan. Rather, Intra-Lock essentially claimed that OSSEAN was a source identifier of its proprietary product.

For these reasons, the court concluded that HDI had no duty to defend or indemnify Sterngold for Intra-Lock's claim.

The case is *Sterngold Dental, LLC v. HDI Global Ins. Co.*, Appeal No. 18-2084 (1st Cir. July 2, 2019).

New York Appellate Court: Insurer's Failure to Provide Timely Notice to Other Insurers Defeats Contribution Claim

The Case

In 2013, New York State commenced an action under the Navigation Law seeking to hold defendants strictly liable for the total cost of cleaning up petroleum discharged from an underground storage and dispensing system at defendant Richmond Automotive Center. Specifically, the State sought recovery from Richmond Automotive and its partners, as well as the defendant insured Kirkwood Heating Oil, Inc. – a corporation that periodically supplied petroleum products to the underground petroleum storage and dispensing system. One of Kirkwood's insurers, Utica Mutual Insurance Company, was also named as a defendant.

Utica then commenced a third-party action for contribution and/or indemnification against Kirkwood's other insurers, American Automobile Insurance Company ("AAIC"), National Surety Corporation ("NSC"), and Arch Insurance Company. Arch moved for summary judgment seeking to dismiss the third-party complaint filed against it. Arch argued that its policies excluded coverage for property damage arising out of the presence of methyl tertiary butyl ether ("MTBE"), a gasoline additive. AAIC and NSC also moved for summary judgment dismissing the third-party complaint against them on the basis of late notice.

The trial court granted both motions. Utica appealed.

The Decision

The Appellate Division, Third Department affirmed.

The court applied the MTBE exclusion to bar coverage. The court reasoned that the petroleum cleanup and removal costs sought to be recovered by the state arose out of, or were the result of, MTBE contamination at both the spill site and the Honeoye Municipal District Well.

The Appellate Division also affirmed the trial court's determination that AAIC and NSC were entitled to summary judgment dismissing the third-party complaint based on late notice. The court observed that, despite the fact that Utica Mutual received notice of the contamination in 2007, Utica Mutual delayed more than three years in notifying AAIC and NSC of the underlying incident.

The court rejected Utica Mutual's proffered excuse for the delayed notice. The court ruled that although Utica Mutual may not have known until August 2010 that AAIC and NSC had previously provided insurance coverage to Kirkwood, Utica Mutual had failed to make reasonably diligent efforts to discover whether Kirkwood had other insurance coverage. The court noted Utica Mutual waited until July 2010 to inquire about prior insurers. Therefore, the court concluded, Utica Mutual had failed to raise an issue of fact as to whether it was "justifiably ignorant" of ACIC's and NSPC's prior insurance coverage.

The case is *State of New York v. Flora, et al*., 2019 N.Y. Slip Op. 04801 (3d Dep't June 13, 2019).

Rivkin Comment: Rivkin Radler Partners Michael A. Kotula, Larry A. Levy, and Robert A. Maloney represented some of the successful insurers.