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Courts Find That COVID-19-Related Losses Are Not Covered by Pollution Liability Policies and May Be Barred by Certain Pollution Exclusions

A federal judge in Arizona found that a resort's business interruption losses arising from the COVID-19 outbreak are not covered under the resort's Premises Pollution Liability Policy because that policy applied only to traditional environmental pollution and not a virus outbreak. Yet, two days earlier, another federal judge in the Western District of Missouri found that a pollution exclusion barred coverage for business interruption losses arising from the COVID-19 outbreak. Do the decisions conflict? No. The pollution exclusion, by its own terms, was clearly not limited to traditional environmental pollution because it expressly excluded coverage for viruses.

The Arizona Federal District Court's Decision

The insurer moved to dismiss a Lake Havasu City resort's claim that COVID-19 losses were covered under its pollution liability policy on the basis that COVID-19 does not constitute a "pollution condition." The policy defined pollution condition as follows:

> The discharge, dispersal, release, escape, migration, or seepage of any solid, liquid, gaseous or thermal irritant, contaminant, or pollutant, including soil, silt, sedimentation, smoke, soot, vapors, fumes, acids, alkalis, chemicals, electromagnetic fields (EMFs), hazardous substances, hazardous materials, waste materials, "low-level radioactive waste," "mixed waste" and medical, red bag, infectious or pathological wastes, on, in, into, or upon land and structures thereupon, the atmosphere, surface, water, or groundwater.

The policy did not specifically define “contaminant” or “pollutant.”

The district court viewed the issue through the lens of *Keggi*, an Arizona Supreme Court decision that addressed a pollution exclusion. *Keggi v. Northbrook Prop. & Cas. Ins. Co*., 199 Ariz. 43, 46, 13 P.3d 785, 788 (Ct. App. 2000). There, the court found that the pollution exclusion applied only to traditional forms of pollution and that bacterial contamination was not within its scope. The district court found that the same logic applies to pollution liability policies, which were created to fill the gap created by pollution clauses, as both policies used similar terms and addressed similar conditions.

Turning to the question of whether the coronavirus can constitute traditional environmental pollution, the court said it had “little trouble concluding that no plausible interpretation of ‘traditional environmental pollution’ includes a virus outbreak.” The court emphasized that a virus being considered a “contaminant” or “pollutant” in certain instances – the resort argued that different governmental agencies sometimes referred to a virus as such – does not render a COVID-19 outbreak traditional environmental pollution.

The Western District of Missouri Decision

A restaurant and caterer sought coverage under its commercial property insurance policy for business losses stemming from COVID-19 stay-at-home orders. It argued that customers and employees were likely infected with the coronavirus and thereby caused physical loss and damage to the restaurant owner’s property.

The main issue in the case was whether the policyholder could show that it suffered “direct physical loss of or damage to property.” Siding with the large majority of courts nationwide that have addressed the issue, the court found that the policyholder could not meet its burden and that the language in the policy plainly and unambiguously does not cover the claims. Notably, the

court departed from other rulings in the Western District of Missouri that allowed similar COVID-19-based claims to proceed. *See Studio 417, Inc. et al., v. The Cincinnati Ins. Co.*, No. 20-cv-03127, (W.D. Mo. Aug. 12, 2020); *K.C. Hopps, Ltd. v. The Cincinnati Ins. Co.*, No. 20-cv-00437 (W.D. Mo. Aug. 12, 2020); *Blue Springs Dental Care, LLC, v. Owners Ins. Co.*, No. 20-cv-00383 (W.D. Mo. Sept. 21, 2020). The court disagreed with the logic of these three other cases and based its decision on a reading of the policy as a whole. But it also relied on the policy's Pollution and Contamination exclusion, which was absent from the policies in the three other cases.

The policy did not cover "loss or damage caused by, resulting from, contributed to, or made worse by actual, alleged or threatened release, discharge, escape or dispersal of "Contaminants or Pollutants.'"

The phrase "Contaminants or Pollutants" was defined to mean:

> any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste, which after its release can cause or threaten damage to human health or human welfare or causes or threatens damage, deterioration, loss of value, marketability or loss of use to property insured hereunder, including, but not limited to, bacteria, ***virus***, or hazardous substances as listed in the Federal Water, Pollution Control Act, Clean Air Act, Resource Conservation and Recovery Act of 1976, and Toxic Substances Control Act or as designated by the U. S. Environmental Protection Agency. Waste includes materials to be recycled, reconditioned or reclaimed. (Emphasis added).

The court found that the exclusion plainly applied to damage, loss of value, and loss of use of property caused by a virus. As the restaurant's losses were caused by the COVID-19 outbreak, it was clearly caused by a virus. The court rejected the policyholder's argument that the pollution exclusion applied only to traditional environmental and industrial pollution because the exclusion here expressly included "virus" in its definition of "Contaminants or Pollutants." The court further

rejected the policyholder’s argument that the “virus” language applied only if the claim involved “waste” or that the exclusion was ambiguous.

The cases are *London Bridge Resort LLC v. Illinois Union Ins. Co*., No. CV-20-08109-PCT-GMS (D. Ariz. Dec. 4, 2020) and *Zwillo V, Corp. v. Lexington Ins. Co.*, No. 4:20-00339-CV-RK (W.D. Mo. Dec. 2, 2020).

Washington Supreme Court Finds That a Bicyclist Qualifies as a Pedestrian

Reversing both lower courts, the Washington Supreme Court held that the undefined term “pedestrian” in an automobile policy included bicyclists. The decision was grounded in the definition of the term “pedestrian” as used in Washington’s insurance statute.

The Case

Todd McLaughlin was riding his bicycle on a Seattle street when a driver of a parked car opened the door into him. McLaughlin sought coverage under the Medical Payments provisions of his auto policy. The policy defined “insured” to include “You … as a pedestrian when struck by a motor vehicle designed for use mainly on public roads or a trailer of any type.” The term “pedestrian” was undefined.

McLaughlin’s auto insurer denied coverage because McLaughlin was not a pedestrian. The insurer pointed to state vehicle codes that excluded bicyclists from the definition of “pedestrian.” McLaughlin sued for breach of contract.

Both the trial and intermediate appellate courts sided with the insurer, finding that neither the ordinary and common meaning, nor the state motor vehicle code (RCW 46.04.400), included bicyclists within the meaning of pedestrian.

The Washington Supreme Court's Decision

The Washington high court reversed.

The court observed that the Washington Legislature in RCW 48.22.0059(11) defined "pedestrian" for purposes of casualty insurance as "a natural person not occupying a motor vehicle as defined in RCW 46.04.320." RCW 46.04.320(1) defines "motor vehicle" as "a vehicle that is self-propelled or a vehicle that is propelled by electric power obtained from overhead trolley wires but not operated upon rails."

Lacking a motor, the court determined that McLaughlin's bicycle was not a motor vehicle. Therefore, McLaughlin was an "insured" because he was injured while riding a bicycle and was struck by a motor vehicle – the door of a parked car.

Washington statutes are not entirely consistent. The Motor Vehicle Code defined "pedestrian" as "any person who is afoot or who is using a wheelchair, a power wheelchair, or a means of conveyance propelled by human power other than a bicycle." The Public Highways and Transportation chapter defined pedestrian the same way. Thus, under these two statutes, a bicyclist is clearly not a pedestrian. But the Washington Supreme Court found that the definitions in the Motor Vehicle Code and the Public Highways and Transportation chapter were limited to terms used in those specific titles.

Instead, it found that RCW 48.22.005(11), which applied to casualty insurance, was the appropriate statute to consider. That statute, the court found, could be read into insurance contracts and comports with Washington's strong public policy in favor of full compensation of medical benefits for victims of road accidents. Applying the definition of pedestrian in the insurance statute, the court reasoned, affords the insured the maximum protection and is consistent with the insured's reasonable expectations.

The court further explained that because "pedestrian" was undefined in the policy, and was subject to more than one reasonable interpretation, it was ambiguous, and must therefore be construed in favor of the insured.

The court concluded by stating that under the policy issued to McLaughlin:

> an insured would expect to be covered when injured in a collision with an automobile whether the insured was walking, skateboarding, using a wheelchair, standing on a sidewalk, sitting on a park bench, riding a bike, or doing something else. The average purchaser of insurance would expect to be covered by this policy when injured by an automobile. Accordingly, we hold that McLaughlin's injuries are covered by his insurance policy.

The oddity here is that the ambiguity was not in the ordinary meaning of the term "pedestrian" – the dictionary definition would not lead one to think of bicyclists as pedestrians – but rather in Washington statutes, which offered various technical meanings of the term. Typically, there is no reason for a court to look beyond the plain, ordinary, and popular meaning of a term where the party did not intend that term to have a technical meaning.

An extra wrinkle in this case is that the policy itself was issued in California and provided for MedPay benefits, as opposed to Personal Injury Protection benefits addressed by Washington statutes. But the parties apparently agreed that Washington law governed the dispute and the court found the differences between the coverages to be immaterial.

The lesson for insurers here, in the broadest sense, is to define as many terms in the policy as reasonably possible. But that could be a cumbersome endeavor, and this appears to be an aberrant decision. Adding a Washington-specific endorsement in automobile policies defining "pedestrian" may perhaps be the most efficient solution should an insurer desire that term to have a more limited meaning, keeping in mind, however, that the Washington Supreme Court noted that RCW 48.22.005(11) can be "read into" insurance contracts.

The case is *McLaughlin v. Travelers Commercial Ins. Co.*, No. 97652-0 (Wash. Dec. 10, 2020).

Montana Supreme Court Holds That Insurer Has No Duty to Defend or Indemnify Claim Based on Insureds' Retaliatory Conduct Following Easement Dispute

The Montana Supreme Court found that a claim based on the insureds' intimidation and harassment campaign following a dispute with a neighbor over property access did not assert an "occurrence." The insurer was therefore under no duty to defend or indemnify the insured.

The Case

The insureds owned property in a rural county that is accessed by Turk Road. Neighbors, the Floras and Michael Crites, used Turk Road to access their homes located further north. Turk Road was the only means to access these properties, and the neighbors claimed they had a right to use the road as it traversed the insureds' property.

In 2008, the insureds asked for permission to snowmobile and otherwise recreate on the Floras' property. The Floras were unable to grant permission because the property is in a conservation easement that prohibits motorized use. The insureds became upset and retaliated by preventing the Floras and Michael Crites from using Turk Road.

The neighbors allege that the insureds began a concerted campaign to intimidate and harass them and others who needed to use Turk Road to access their properties. The Floras then purchased an easement from an adjoining landowner and constructed a new driveway that did not traverse on the insureds' property. The driveway could also be used by Crites.

But that did not resolve the dispute. The insured threatened bodily harm to the Floras and Crites if they continued to use the new driveway. The insureds allegedly constructed snow berms and gates, felled trees, and created other obstacles to prevent them and others from using the new driveway to access their properties. Additionally, the Floras allege the insureds physically threatened them; interfered with the enjoyment of their property and home; and intimidated them, including discharging firearms at them. The Floras allege they were compelled to leave their home, upon advice of law enforcement, and because they feared for their lives. The Floras have been unable to find anyone to live in their home, even for free; and their home continues to sit vacant, to decay, and cannot be sold.

In the summer of 2011, Michael Crites disappeared. His dismembered remains were found several months later. The insured was charged with felony assault with a weapon for pointing a gun at Crites, and for felony evidence tampering for removing cameras that were being used by law enforcement to investigate Crites' murder.

The Floras and Crites' estate sued the insureds for assault, trespass, and civil conspiracy. They alleged that the insureds acted intentionally, purposefully, and with malice. The insureds tendered the claim to their insurer, who denied on the basis that there was nothing accidental about the insured's conduct that could be considered an "occurrence." The insurer also asserted the intentional acts exclusion. The insureds argued there were disputes of fact over whether they committed any wrongful or intentional acts.

The insurer moved for summary judgment after obtaining discovery from claimants admitting that the allegations against the insured were for strictly intentional conduct. The lower court granted the insurer summary judgment on the duty to defend but ruled that the issue of

indemnity was not yet justiciable because liability had not yet been determined in the underlying action.

The Montana Supreme Court's Ruling

The Montana Supreme Court held that the insurer had neither a duty to defend nor a duty to indemnify the insureds because any bodily injury or property damage did not result from an "occurrence." The court applied a two-part objective test to analyze whether conduct was accidental rather than intentional. First, it looked at whether the act itself was intentional. Second, it considered whether the consequences from that act were expected or intended from the actor's standpoint. The second prong requires an objective inquiry to determine what could reasonably be expected to result from an intentional act.

The court observed that the Floras and the estate of Crites alleged the insureds' conduct was both intentional and purposeful – they intended to cause the very type of harm that the Floras and the estate suffered.

It rejected the insureds' suggestion that their denials to the allegations created factual disputes. The court stated that the insureds "cannot create coverage where it does not exist simply by denying the claims when the claims themselves do not trigger coverage."

The Montana Supreme Court affirmed the lower court's ruling on the duty to defend but reversed on the duty to indemnify, where the lower court committed clear error. The duty to defend is broader than the duty to indemnify. Where there is no duty to defend, there can be no duty to indemnify.

The case is *Farmers Ins. Exch. v. Wessel*, No. DA 19-0727 (Mont. Dec. 22, 2020).

Oklahoma Supreme Court Upholds Assignment of Homeowner's Property Insurance Claim to Contractor

The Oklahoma Supreme Court ruled that a homeowner's post-loss assignment of a property insurance claim to the contractor that repaired her property after a storm was an assignment of a chose in action, and not an assignment of the policy. The insurer's written consent was therefore not required.

The Case

The insured filed a claim with her insurer after her home was damaged by a storm. She also assigned her insurance claim to the contractor who repaired her home. The contractor's appraiser determined storm damage in excess of $36,000. The insurer appraised the damage at around $21,000.

The insured and the contactor sought the difference and sued the insurer for breach of contract and bad faith. The insurer moved to dismiss on the basis that the policy prohibited an assignment without the insurer's written consent. It relied on Oklahoma statute 36 O.S. § 3624, which allows an insurance policy to state that it is not assignable.

The district court granted the insurer's motion. The insured then dismissed her claims without prejudice to re-filing and the construction company appealed.

The Oklahoma Supreme Court's Decision

The court reversed.

It noted that while provisions requiring an insurer's consent for an assignment are generally enforced, there is an exception to the general rule. An exception applies when the

subject of the assignment is not the policy itself, but only the right to receive funds for a covered loss and the assignment takes place after the loss has occurred.

Summarizing Oklahoma law, the court described the difference between an assignment of a chose in action and one to create insurance rights. In short, the prohibition on assignments without the insurer's consent applies only to pre-loss assignments. The court observed that most courts adhere to this rule, which is based on a longstanding public policy against restraints on assigning a chose in action. This public policy, the court explained, outweighs any policy favoring contractual freedom to create such a restraint in an insurance policy because it does not increase an insurer's risk.

The court declined to rule upon whether a bad faith chose in action is assignable.

The case is *Johnson v. CSAA Gen. Ins. Co*., No. 118689 (Okla. Dec. 15, 2020).

Tennessee Supreme Court Reinstates Summary Judgment in Favor of Insurance Agent in Dispute Over Failure to Procure Excess UIM Coverage

The Tennessee Supreme Court, siding with an insurance agent, held that a statutory rebuttable presumption that the insured accepted the coverage provided by virtue of its payment of premium, applied to actions against an insurance agent for negligent failure to procure excess uninsured motorist coverage.

The Case

While residing in Georgia, a married couple, Dr. Talat Parveen and Mr. Khurshid Shaukat, had a personal umbrella liability policy with State Farm Fire and Casualty Company that provided $2,000,000 in excess uninsured motorist coverage.

In 2013, the couple moved to Tennessee and met with Jeffrey Norris, an insurance agent for ACG South Insurance Agency, LLC. Shaukat maintained that during this roughly thirty-minute meeting, he provided Norris with his State Farm umbrella policy and explained that they wanted the exact same coverage in Tennessee. Norris denied this account of the meeting.

Norris provided Shaukat with a quote for a personal umbrella policy through Safeco Insurance Company of America. A copy of the quote provided to Mr. Shaukat revealed no separate line item for excess uninsured motorist coverage, nor did the policy's premium reflect the inclusion of such coverage. Even so, Shaukat accepted coverage and purchased the Safeco umbrella policy. The insureds received a copy of the policy and a declarations page and paid the premiums, which did not include a charge for excess uninsured motorist coverage.

The insureds renewed the Safeco umbrella policy and paid the premiums in 2014 and 2015. Each subsequent notice of renewal included a copy of the policy and a declarations page, which did not list excess uninsured motorist coverage as a separate line item. Moreover, the policy itself specifically contained an exclusion for "Uninsured Motorists or Underinsured Motorists coverage or any similar coverage, unless this policy is endorsed to provide such coverage as shown in the Declarations."

On November 10, 2015, while the Safeco policy was in effect, Dr. Parveen was involved in an automobile accident. Dr. Parveen sustained personal injuries, and her vehicle was totaled as a result of the crash. The insureds then discovered that the driver of the vehicle who caused the accident was underinsured. In a later meeting with Mr. Norris, they further discovered that the Safeco umbrella policy did not include excess uninsured motorist coverage.

The couple sued their insurance agent and agency after they were denied coverage by the insurance carrier. The agent claimed that the suit was barred by Tennessee Code Annotated

section 56-7-135(b), which provides: “The payment of premium for an insurance contract, or amendment thereto, by an insured shall create a rebuttable presumption that the coverage provided has been accepted by all insureds under the contract.”

The trial court found that it was undisputed that the insureds had paid the premium for the policy and that the insureds had failed to rebut the statutory presumption under section 56-7-135(b) that they had accepted the provided coverage, which did not include excess uninsured motorist coverage. Therefore, the trial court granted the insurance agent’s motion for summary judgment.

The Court of Appeals, however, reversed, concluding that the rebuttable presumption did not apply to actions against an insurance agent. The Supreme Court of Tennessee granted the agent leave to appeal.

The Decision

The Tennessee Supreme Court reversed the Court of Appeals’ decision. The court concluded that the rebuttable presumption in Tennessee Code Annotated section 56-7-135(b) applied to actions against an insurance agent by insureds for negligent failure to procure an insurance policy as directed.

The court disagreed with the Court of Appeals that the use of the phrase “under the contract” in the statute meant that the Tennessee General Assembly intended to restrict its application to actions between the parties to the insurance contract. The court found that the phrase “under the contract” serves to clarify that the presumption only applies against those insured under the contract, not third parties. The court reasoned that if the legislature had intended to limit the statute’s rebuttable presumption to actions against certain persons or entities, it would have done so.

The court concluded that because the insureds failed to rebut the statutory presumption, the trial court properly granted the agent's motion for summary judgment. The court reversed the judgment of the Court of Appeals and reinstated the judgment of the trial court.

The case is *Parveen v. ACG South Ins. Agency, LLC*, No. E2018-01759-SC-R11-CV (Tenn. Dec. 4, 2020).

Kentucky Supreme Court Rules That Captive Insurers Are Exempt from Unfair Claims Settlement Practices Act

The Kentucky Supreme Court affirmed the dismissal of a bad faith action against a foreign captive healthcare insurer, finding that it was not subject to the requirements of the Kentucky Unfair Claims Settlement Practices Act.

The Case

Plaintiff brought a medical malpractice action against KentuckyOne Health and other healthcare providers following the deaths of his wife (an expectant mother) and newborn son. Plaintiff also sued Catholic Health, an entity that sponsors KentuckyOne Health and its affiliates, and First Initiatives, which provides self-insurance coverage to Catholic Health, its affiliates and employees, including KentuckyOne Health and its physicians. First Initiatives is a wholly owned subsidiary of Catholic Health. Pursuant to one self-insurance agreement, First Initiatives covered all of Catholic Health's subsidiaries and their employees for employment-related conduct.

Plaintiff contended that First Initiatives violated the Kentucky Unfair Claims Settlement Practices Act (UCSPA) (KRS 304.12-230), by engaging in bad faith settlement negotiations. As a captive insurer, First Initiatives claimed that it was not subject to the UCSPA.

A captive insurance company is typically a company that insures the liabilities of its owner. The insured is usually the sole shareholder and the only customer of the captive insurer. A subsidiary provides captive insurance to its parent company so that the parent company can deduct the premiums set aside as loss reserves. The creation of a captive insurance company can bring tax, economic, and commercial benefits . . . [and] can serve as a way to insure risks that are otherwise difficult to insure on the traditional insurance market.

Plaintiff sought a declaration that First Initiatives was subject to the UCSPA because it did not self-insure Catholic Health and was actually in the business of insurance because it issued a policy to KentuckyOne Health and Catholic Health. Plaintiff also argued that First Initiatives had an independent corporate identity distinct from Catholic Health that rendered self-insurance between the two entities impossible.

The trial court denied Plaintiff's motion for declaratory judgment on the UCSPA claims, reasoning that First Initiative was a captive insurer, and therefore, the statute did not apply. The Court of Appeals affirmed the trial court's decision.

The Kentucky Supreme Court's Decision

The Kentucky Supreme Court affirmed. The court noted that Kentucky law defined a pure captive insurer as "an insurer that only insures the risk of its parent and affiliated companies or controlled unaffiliated businesses and can include a branch captive insurer." The court found "[t]hat is precisely the relationship between First Initiatives and Catholic Health."

The court added that First Initiatives was organized to create the most efficient risk-financing program available in order to maximize Catholic Health's nonprofit resources in the furtherance of its mission to provide healthcare services to the public. The court observed that First Initiatives was a foreign captive insurer – it was not registered in Kentucky, nor did it conduct

business anywhere in the United States. First Initiatives did not pay premium taxes in Kentucky. Its principal place of business is in the Cayman Islands, where it is subject to that country's captive insurance laws. The court concluded that the language in KRS 304.49-150(1) specifically exempts captive insurers such as First Initiatives from the UCSPA.

The court also rejected Plaintiff's argument that First Initiative fell under a statutory exception to the UCSPA exemption for captive insurers. That exception only applied to a foreign captive insurer "lawfully transacting the business of insurance" in Kentucky prior to July 14, 2000, unless the foreign captive insurer petitions the commissioner requesting that this subtitle be applicable to the foreign captive insurer. The court concluded that First Initiatives never transacted insurance in Kentucky because an agreement between a parent and a captive insurer does not shift the risk of loss. The court noted that Catholic Health retained the entire financial stake in the self-insured, professional liability claims paid to claimants – in other words, liability for the deaths of Kimberly and Harold Merritt, III remained with Catholic Health. The court added that neither KentuckyOne nor the defendant physician paid premiums to Catholic Health or First Initiatives, nor did they purchase insurance policies from them. Rather, one self-insurance agreement covered all of Catholic Health's subsidiaries and their employees for employment-related conduct.

Because the Kentucky Legislature "clearly and unequivocally excluded captive insurers from the requirements of the UCSPA," the court affirmed the Court of Appeals' decision.

The case is *Merritt v. Catholic Health Initiatives, Inc*., 2018-SC-0155-DG (Ky. Dec. 28, 2020).

Based on Common Sense Reading of Policy, Ninth Circuit Finds No Coverage for Golf Cart Accident

Affirming the district court's ruling, the Ninth Circuit found that a homeowner's policy excluded a claim for negligent supervision arising from a golf cart accident, as the accident did not happen at an insured location. The court rejected the insureds' argument that the relevant "occurrence" was the insureds' negligent supervision while at their home.

The Case

A minor who sustained injuries while riding in an electric golf cart sued Billy and Amber Reece for negligent supervision and entrustment. The Reeces sought coverage under their homeowner's policy.

The policy excluded coverage for motor vehicle accidents, including accidents resulting from negligent supervision or entrustment. The exclusion had an exception, however, for vehicles designed for recreational use off public roads, so long as the "occurrence" took place at the "insured location." The "insured location" was the Reeces' home. The accident happened on a public roadway.

Because the public roadway was not an "insured location," the insurer denied coverage. The Reeces argued that relevant location for purposes of a negligent entrustment claim was not where the accident happened, but where the alleged negligent supervision took place. As the alleged negligent supervision took place at their home, they argued, the "occurrence" took place at an insured location.

The Decision

The Ninth Circuit rejected the insureds' argument. The court found under a common-sense reading, the homeowner's policy clearly intended to exclude motor vehicle accidents and any resulting injuries suffered away from the insured location. Because the "occurrence" did not take place at an insured location, there was no coverage.

The case is *Integon Nat'l Ins. Co. v. Reece*, No. 19-17567 and 17568 (9th Cir. Dec. 11, 2020).

Ninth Circuit Finds That Separation of Insureds Clause Did Not Render "Any Insured" Language Ambiguous

The Ninth Circuit affirmed a district court's ruling that an Employer's Liability Exclusion applied where the injured claimant was an employee of one of two insureds covered under the same policy. The court applied the plain language of the policy and rejected the insured's attempt at creating an ambiguity based on the existence of a Separation of Insureds provision in the policy.

The Case

J&J Realty Holdings (J&J) leased its parking lot to Lance Campers Manufacturing Company (Lance). Great American E&S Insurance Company issued a joint insurance policy to J&J and Lance. The policy contained an Employer's Liability Exclusion, which barred coverage for liability for injuries by an employee of any insured. An endorsement modified the original exclusion by changing the language from "the insured" to "any insured."

A Lance employee sustained an injury in the parking lot and sued both J&J and Lance. Great American denied coverage to both J&J and Lance on the basis that the claimant was an employee of "any insured."

J&J argued that the "any insured" language was ambiguous given the policy's Separation of Insureds clause. Under that clause, the insurance was to apply "as if each named insured were the only named insured" and "separately to each insured against whom a claim is made or suit is brought."

The district court disagreed and enforced the Employer's Liability Exclusion. J&J appealed.

The Decision

The Ninth Circuit affirmed. The court found that the phrase "an employee of any insured" unambiguously referred to an employee of either J&J or Lance. As the claimant was a Lance employee, the Employer's Liability Exclusion applied.

The court rejected J&J's argument that the Separation of Insureds clause rendered the "any insured" language ambiguous. The court reasoned that applying the Separation of Insureds Clause to limit the universe of "any insured" to only the party seeking coverage (in this case, J & J) would require reading the phrase "any insured" as if it said, "the insured." As those words are meaningfully different, such a reading would nullify the "any insured" endorsement. That interpretation would violate the rule of policy construction that requires courts to give force and effect to every provision and not in a way that renders some clauses meaningless.

The court further noted that J&J's proposed interpretation would render meaningless other parts of the Employer's Liability Exclusion as well. The exclusion says that it applies "whether the insured may be liable as an employer or in any other capacity." Reading the exclusion to apply only to the employer of employees that sustain injuries during the course of employment, the court explained, would mean that the employer's liability would always be in its capacity as an employer and never in "any other capacity." That would render the "in any other capacity" language meaningless.

Additionally, the court emphasized, “the fact that the text of the provision specifically contemplates the exclusion applying to both employers and non-employers further supports applying the plain language of the Employer's Liability Exclusion to exclude coverage for the underlying action.”

The court also found that the district court properly held that J&J’s bad faith claim could not survive in the absence of any potential for coverage.

The case is *J&J Realty Holdings v. Great Am. E&S Ins. Co*., No. 19-56172 (9th Cir. Dec. 11, 2020).

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