Eighth Circuit Sides with Insurer in COVID-19 Business Interruption Claim

In the first federal appellate decision on whether business interruption claims due to the pandemic are covered, the Eighth Circuit ruled that a dental clinic's partial loss of use of its offices without any physical loss or damage did not fall within the policy's coverage grant.

The Case

An Iowa dental clinic stopped performing non-emergency procedures in March 2020 after the Iowa governor declared a state of emergency and imposed restrictions on dental practices due to the coronavirus outbreak. It resumed services in May 2020.

The dental clinic submitted a claim to its "all-risk" insurer for losses it suffered due to the suspension of non-emergency services. The policy insured against lost business income and certain extra expense sustained due to the suspension of operations "caused by direct 'loss' to property." The term "loss" was defined as "accidental physical loss or accidental physical damage."

The insurer contended that the policy did not afford coverage because there was no direct physical loss or physical damage to the clinic's property.

The clinic argued that the COVID-19 pandemic and the related government-imposed restrictions on performing non-emergency dental procedures constituted a "direct 'loss' to property" because the clinic was unable to fully use its offices. The clinic contended that the policy's disjunctive definition of "loss" as "physical loss" or "physical damage" created an

ambiguity that must be construed against the insurer. The clinic suggested that "physical loss" should mean "lost operations or inability to use the business" and that "physical damage" should mean a physical alteration to property.

The clinic sued and the federal district court granted the insurer's motion to dismiss. The clinic appealed.

The Eighth Circuit's Decision

The Eighth Circuit affirmed.

The court observed that the policy required direct "physical loss" or "physical damage" to trigger business interruption and extra expense coverage. It concluded that there must be some physicality to the loss or damage of property—*e.g.*, a physical alteration, physical contamination, or physical destruction.

That the loss or damage be physical in nature, the court explained, was consistent with the policy's coverage of lost business income and incurred extra expense during the "period of restoration." Property that has suffered physical loss or physical damage requires restoration. Because the policy provides coverage until property "should be repaired, rebuilt or replaced" or until business resumes elsewhere, it assumes physical alteration of the property, not mere loss of use, the court found.

The court determined that the dental clinic's complaint contained no facts showing that it had suspended activities due to direct "accidental physical loss or accidental physical damage," and thus, rejected the clinic's argument that the lost business and extra expense it sustained as a result of the suspension of non-emergency procedures were "caused by direct 'loss' to property."

In conclusion, the court stated that the "policy clearly does not provide coverage for [the clinic's] partial loss of use of its offices, absent a showing of direct physical loss or physical damage."

The case is *Oral Surgeons, P.C. v. Cincinnati Ins. Co.,* No. 20-3211 (8th Cir. July 2, 2021).

Rivkin Note: *Many pandemic-related business interruption suits will be reaching state and federal appellate courts. Insurers have mostly prevailed on motions to dismiss, as trial courts have generally found that the "direct physical loss" requirement has not been met. The complaint before the Eighth Circuit did not allege that the coronavirus was physically present on the policyholder's property and instead focused on government shutdown orders. In other cases, policyholders will be arguing that the virus was physically present. These forthcoming appeals will implicate additional arguments and policy provisions, including virus exclusions.*

Wisconsin Supreme Court Holds That "Concealment or Fraud" Condition Bars Coverage for Husband's Arson, Even Though Wife Was an Innocent Insured and Couple Was Legally Separated

Affirming the circuit court's grant of summary judgment in favor of an insurer, the Wisconsin Supreme Court held that a legally separated couple that continued to live together were spouses, and therefore, were both insureds under a homeowner's policy. Because the husband committed arson and lied about it to the insurer, the "concealment or fraud" condition barred coverage for the wife, who owned the house. The court also found that Wisconsin's domestic abuse statute did not prevent the insurer from denying coverage as to the wife because there was no evidence that she feared for her own safety.

The Case

A husband and wife entered into a separation agreement in 1998. Under the marital settlement agreement, the wife received sole ownership of their home. The couple continued to live in the home together, however. For religious reasons, neither party proceeded with a divorce.

In June 2013, while the wife was vacationing overseas, a fire destroyed the home. Both the husband and wife attested that the cause of the fire was unknown. An investigation revealed that the husband intentionally set the fire. He was convicted of arson.

The property was insured by Kemper. The wife was listed as the Named Insured under the policy. Spouses who resided in the same household were also Named Insureds. The policy listed the couple as "married."

Kemper denied coverage based on the "concealment or fraud" condition and then filed a declaratory judgment action seeking to apply the condition against both the husband and wife. On summary judgment, the parties stipulated that the wife was an "innocent insured" and did not conspire to damage the property. The court ruled in favor of Kemper and the case made its way up to the Wisconsin Supreme Court.

Wisconsin Supreme Court's Decision

The Wisconsin Supreme Court addressed three issues:

1. Was the husband an insured?
2. Did the "intentional loss" exclusion prevent the "concealment or fraud" condition from being applied to the wife?
3. Did Wisconsin's domestic abuse statute preclude denial of coverage as to the wife?

The first issue was whether the couple's legal separation affected the husband's status as a spouse for purposes of the Named Insured definition. Looking at several factors, the court found

that it was reasonable to treat the husband as a spouse – the couple lived under the same roof; although separated, they were in a relationship recognized in Wisconsin as marital; they listed their status in the insurance contract as “married”; they both claimed to be insureds in proof of loss statements; and the husband was repeatedly referred to as such in sworn testimony by the wife. Furthermore, the court found that Wisconsin law plainly distinguished between a divorce and a legal separation.

With respect to the second issue, the wife argued that the “concealment or fraud” condition was ambiguous because it conflicted with the “intentional loss” exclusion. The wife argued that whereas the “concealment or fraud” condition applies to all insureds if any insured conceals or misrepresents facts, the “intentional loss” exclusion applies only to an insured who commits or conspires to commit an act with the intent to cause a loss. The court disagreed and found there was no conflict because each provision applied in different circumstances. Where there is fraud, no insured can recover. Where there is intentional loss without fraud, an “innocent insured” can recover. Because the two provisions could be harmonized, the court applied the plain meaning of each.

Finally, the court found that a Wisconsin statute (§ 631.95(2)(f)) that allows "innocent insureds" to retain property insurance coverage that might otherwise be excluded due to intentional loss resulting from acts or patterns of domestic abuse, did not apply. The court found that the wife failed to point to any evidence that constituted “domestic abuse” within the meaning of the statute. The wife claimed that the act of arson was a physical act that may cause her to fear for her safety. But the court rejected this argument because there was no evidence that the husband started the fire to harm the wife. In fact, she was overseas when the arson occurred.

In short, the Wisconsin Supreme Court affirmed the circuit court's granting of summary judgment in favor of Kemper. The husband was an insured under the policy and because he misrepresented a material fact with the intent to deceive, the "concealment or fraud" condition applied to all insureds, including the wife. The Wisconsin domestic abuse statute did not override that condition because the record was devoid of any evidence that the husband's arson constituted domestic abuse against the wife.

The case is *Kemper Independence Ins. Co. v. Islami,* No. 2019AP488 (June 8, 2021).

Florida Supreme Court: Insurer Has Standing to Sue Insured's Defense Counsel for Legal Malpractice

Answering a certified question, the Florida Supreme Court held that a duty to defend insurer has standing through its contractual subrogation provision to maintain a legal malpractice action against counsel hired to represent the insured.

The Case

The insured accounting firm audited the financial statements of a corporation that later became the subject of an action by the Securities and Exchange Commission. After the SEC settled with the corporation, a court-appointed receiver sued the insured for accounting malpractice.

The accounting firm's insurer retained a law firm to defend the accounting firm in the litigation. The case ultimately settled before trial for $3.5 million. But the insurer contended that the law firm's failure to timely raise the statute of limitations defense significantly increased the cost of settlement. The insurer sued the law firm under several theories, including legal malpractice.

The law firm argued that the insurer lacked standing to sue because there was no privity of contract or attorney-client relationship between the law firm and the insurer. Instead, privity existed between the law firm and the insured as the client.

The trial court agreed and found that the insurer lacked standing to directly pursue a legal malpractice action against the law firm. The intermediate appellate court affirmed. But mindful of the insurer's public policy argument that law firms would be shielded from liability resulting from their malpractice, the appeals court certified the question to the Florida Supreme Court

The Florida Supreme Court's Ruling

The Florida Supreme Court noted that the insurer also based its standing argument on the insurance policy's subrogation provision and reframed the certified question as:

> Whether the insurer has standing through its contractual subrogation provision to maintain a malpractice action against counsel hired to represent the insured where the insurer has a duty to defend.

Subrogation is the substitution of one person in the place of another with reference to a lawful claim or right. The Florida high court determined that the insurer's right to contractual subrogation was clearly expressed in the insurance policy. It explained that "[w]here an insurer has a duty to defend and counsel breaches the duty owed to the client insured, contractual subrogation permits the insurer, who—on behalf of the insured—pays the damage, to step into the shoes of its insured and pursue the same claim the insured could have pursued." Because the *insured* is in privity with the law firm, contractual subrogation allows the insurer to step into the shoes of the insured.

Here, in accordance with the terms of the insurance policy, the insurer retained the law firm to defend the accounting firm in the receiver's litigation and paid $3.5 million. Thus, the court concluded, the insurer has standing through contractual subrogation to maintain a malpractice

action against counsel hired to represent its insured. And, the public policy concerns that have caused the court to generally prohibit the assignment of legal malpractice claims did not exist in these circumstances because the subrogated claim originates by contract from the insured to the insurer – the same entity that hired the law firm in the first place. The court stated that the lawyer is on notice of subrogation claims included in the policy and Florida public policy does not shield the law firm from accountability for its professional malpractice.

In answering the certified question in the affirmative, the Florida Supreme Court concluded that the insurer has standing to maintain a legal malpractice action against counsel hired to represent its insured where the insurer is contractually subrogated to the insured's rights under the insurance policy.

The case is *Arch Ins. Co. v. Kubicki Draper, LLP*, No. Sc19-673 (Fla. June 3, 2021).

Kentucky Supreme Court: There Can be No Bad Faith for Insurer's Failure to Settle If Insured's Underlying Liability Is Uncertain

The Kentucky Supreme Court dismissed a third-party bad faith claim for failure to settle on the basis that there was reasonable uncertainty over the insured's liability.

The Case

While working the night shift at a surface mine, a man was killed when the lube truck he was operating crashed and overturned, crushing him underneath the truck. After the accident, a Mine Safety and Health Administration (MSHA) investigation revealed the lube truck's brakes were improperly maintained and malfunctioned at the time of the accident. MSHA also noted that the man was not wearing a seatbelt. MSHA ultimately concluded that these two circumstances –

along with mine management's failure to conduct preoperational equipment checks – caused the fatal accident.

The man's widow brought a negligence and wrongful-death action against four companies involved in the mining operation, including the man's employer. The companies were insured by either Arch Specialty Insurance Company or National Union Fire Insurance Company. The companies asserted several defenses (including workers' compensation immunity, no duty, bailment law, etc.) and also sought an apportionment instruction based on the man's own negligence in failing to wear an available seat belt. The employer was dismissed from the case and the remaining parties were ordered to mediate.

At the first mediation, Arch tendered its full $1 million limit to settle all claims against its insureds. National Union was unwilling to contribute its $6 million policy limits given its assessment of its insureds' defenses. The widow refused to accept anything less than National Union's full policy limits. The mediation was unsuccessful.

At the second mediation, Arch again tendered its full liability limit toward a global settlement, but the widow demanded $1 million to settle claims only against one of Arch's insureds. Arch refused to settle, insisting that it had an obligation to both of its insureds and could not exhaust its policy limits to protect only one of its insureds, leaving the other exposed. The widow continued to demand full policy limits from National Union. The second attempt at mediation also failed.

A short time later, the widow settled with Arch, accepting the full $1 million policy limits to resolve all claims with Arch's insureds. Later, National Union settled its claims for $2 million.

The widow then sued both Arch and National Union for bad faith under the Kentucky Unfair Claims Settlement Practice Act (KUCSPA). She contended that the insurance companies

leveraged claims by forcing global settlements instead of negotiating each claim individually; the companies acted in bad faith by sending only one attorney to the second mediation to negotiate for both insurers and their respective insureds; and Arch and National Union would not settle unless she reduced the settlement request from National Union.

Arch and National Union each moved to dismiss. The trial court granted the insurers' motions. The widow appealed. The intermediate appellate court affirmed, and the case was heard by the Kentucky Supreme Court.

The Decision

The Kentucky high court affirmed the trial court's order. In doing so, it clarified some legal principles on third-party bad faith.

The court reiterated that, under Kentucky law, to maintain a third-party bad faith claim, the insurer must: (1) be obligated to pay the insured's claim under the policy; (2) lack a reasonable basis in law or fact for denying the claim; and (3) either have known there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed. The third prong, the court added, required actual damage and outrageous conduct by the insurer.

The court determined that the widow could not satisfy any of these elements.

As to the first prong, the court found that Arch could not have acted in bad faith under KUCSPA because no contractual duty to pay the claims against the insureds existed. Arch's policy expressly excluded "bodily injury to an employee of the insured arising out of and in the course of employment." Under the policy, this included leased employees, like the widow's husband. The court did not need to consider any of the other elements as to Arch, but chose to do so anyway because of the "paucity of guidance" in Kentucky's third-party-bad faith precedent. National Union, in contrast, had a potential obligation to pay.

As to the second prong, the court held that Arch's liability was not reasonably clear because its insureds may have been immune from the claim and because Arch's policy excluded bodily-injury coverage for employees. The court similarly found that the liability of National Union's insureds was not beyond dispute. They had potential immunity defenses, limited liability under bailment law, and questions remained as to who was at fault and how fault would be apportioned.

As to the third prong, the court held that the widow failed to show actual damage or outrageous conduct. The court found that Arch's conditioning a settlement on receiving a release for both of its insureds was not improper "leveraging," which occurs when an insurer attempts to force a settlement under one portion of a policy to influence settlement of another portion of the policy. Both Arch and National Union ultimately settled. The widow's complaint did not allege any damage caused by any delay in settlement. Mere delay, the court noted, does not give rise to bad faith. The court also questioned how the widow could complain about a delay in settlement when she refused to budge from her settlement demand.

For these reasons, the court found that the widow failed to satisfy a third-party bad faith action against either Arch or National Union.

The case is *Mosley v. Arch Specialty Ins. Co.*, 2018-SC-0586 (Ky. June 17, 2021).

Tenth Circuit: Insurer Has No Duty to Settle Non-Covered Claim While Defending Under a Reservation of Rights

The Tenth Circuit, applying Utah law, found that an insurer has no duty to settle a non-covered claim even if the insurer is defending the insured under a reservation of rights.

The Case

Third-party plaintiff, Thomas Brooks, suffered a traumatic brain injury during a fight in a Utah gym when Jacob Dockstader hit him in the head with a dumbbell. The blow left Brooks permanently disabled and Dockstader pleaded guilty to aggravated assault. Following the criminal case, Brooks sued Dockstader for assault and battery, and negligence.

Dockstader demanded that Owners Insurance Company defend and indemnify him under a homeowner's policy issued to his parents. Dockstader contended that he did not intend to hit Brooks but just "swung a dumbbell in Brooks' general direction to ward him off." Because he did not intend to make contact, he claimed the policy covered this "accidental" injury.

Owners accepted Dockstader's defense under a reservation of rights but did not believe its policy covered his conduct. The policy excluded coverage for intentional acts causing "bodily injury or property damage reasonably expected or intended by the insured." The exclusion stated that it "applie[d] even if the bodily injury or property damage [was] of a different kind or degree, or [was] sustained by a different person or property than that reasonably expected or intended."

Owners simultaneously bought a declaratory judgment action in Utah federal court for a ruling on whether it had a duty to defend.

Brooks, meanwhile, offered to settle for the policy's $500,000 limit. But Brooks asserted that his actual damages far exceeded the policy limit. Owners accepted Brooks' first offer, but only if coverage was found to exist in the declaratory judgment action. Brooks made two additional offers to settle for policy limits.

One month after Brooks' third settlement offer, Owners moved for summary judgment in the declaratory judgment action. Without including Owners, Brooks and Dockstader then entered into a settlement agreement, which Dockstader admitted liability on Brooks' negligence claim and

agreed to a judgment of $5 million. Brooks agreed not to execute the judgment against Dockstader personally in exchange for assignment of all Dockstader's rights against Owners.

Brooks then intervened and filed a third-party complaint alleging that Owners breached its fiduciary duties and the implied covenant of good faith and fair dealing by failing to settle within policy limits even though Dockstader faced a significant likelihood of judgment in excess of those limits.

The district court granted Owner's summary judgment in its declaratory judgment action and dismissed Brooks' third-party complaint. Brooks appealed.

The Appellate Decision

The Tenth Circuit affirmed.

The court held that the duty to defend does not include an absolute duty to settle where the insurer has filed a declaratory judgment action disputing coverage and the district court ultimately finds none.

The court emphasized that the test of an insured's conduct is "reasonableness." It would be unreasonable, the court explained, to require an insurer to accept any offer within policy limits regardless of circumstances and however questionable the issues of liability and damages may be. The court found that Owners reasonably believed the policy did not cover Dockstader's conduct because it knew Dockstader pled guilty to aggravated assault and it knew Brooks' complaint, in part, alleged intentional conduct.

The court added that Owners did not gamble in deciding whether to accept an offer or take the case to trial. "If the policy covered Dockstader's conduct, Owners agreed to pay Brooks the Policy limit—trial was never a consideration." In pursuing a declaratory judgment action, the court noted, Owners bore the risk that the district court would determine coverage existed and it might

be on the hook for any judgment in excess of Brooks' settlement offers—even if the excess exceeded the policy limits. The risks associated with Owners' conditional acceptance of Brooks' settlement offers were borne by Owners, not Dockstader.

The majority disagreed with the dissent's focus on the timing of the settlement offers and that at the time the settlement offers were made, Owners was obligated to zealously guard Dockstader's interests in deciding whether to accept or reject Brooks' offers. Taking the dissent's view to its logical conclusion, the majority explained, meant that an insurer would have to pay an uncovered claim any time a claimant offered to settle before coverage was decided. In the majority's view, that would make an insurer's right to seek a declaratory judgment illusory and would run contrary to Utah law, which ties the duty to defend to the existence of covered claims.

Owners was ultimately found to have no duty to defend or indemnify. Therefore, it had no duty to settle. The circuit court affirmed the district court's judgment in favor of the insurer.

The case is *Owners Ins. Co. v. Dockstader*, No. 19-4156 (10th Cir. June 29, 2021).

Eleventh Circuit: Invasion of Privacy Exclusion Unambiguously Bars TCPA Claim

Finding that a consumer class action suit alleging violations of the Telephone Consumer Protection Act of 1991 (TCPA) arose out of an invasion of privacy, the Eleventh Circuit upheld a district court's grant of summary judgment in favor of an insurer.

The Case

Consumers, in a class action suit, sued iCan for sending unsolicited text messages to cellular telephones without the recipients' consent. The complaint alleged that iCan "not only invaded the personal privacy of Plaintiff and members of the putative Classes, but also intentionally and

repeatedly violated the TCPA." It also alleged that "iCan has caused consumers actual harm in the form of annoyance, nuisance, and invasion of privacy," and that the text messages caused wear and tear on the phones' hardware (including the phones' battery), consumed the phones' memory, and disturbed plaintiffs' use and enjoyment of their phones.

iCan tendered the claim to its insurer. The insurer denied coverage and refused to defend. The policy contained an exclusion for claims "based upon, arising out of, or attributable to any actual or alleged defamation, invasion of privacy, wrongful entry or eviction, false arrest or imprisonment, malicious prosecution, abuse of process, assault, battery or loss of consortium." The insurer asserted that this exclusion applied because the complaint was based upon allegations that the class members' privacy rights were violated by iCan sending unsolicited text messages.

iCan later settled with the plaintiffs for roughly $60 million. The settlement agreement included a promise not to enforce the judgment against iCan, in exchange for iCan assigning all of its rights under its insurance policy to the plaintiffs. Plaintiffs then filed a declaratory judgment action against the insurer to recover the settlement proceeds.

Plaintiffs argued that the invasion of privacy exclusion did not apply because the class action alleged harms other than invasion of privacy, TCPA claims do not include an element of invasion of privacy, and the exclusion is ambiguous and should be resolved in favor of coverage.

The Eleventh Circuit's Decision

The Eleventh Circuit rejected plaintiffs' arguments and affirmed the district court's ruling in favor of the insurer.

Applying Florida law, it noted that it must read the insurance policy as a whole, giving each provision its full meaning and operative effect. It then focused on three operative terms in the invasion of privacy exclusion: (1) "Claim"; (2) "arising out of"; and (3) "invasion of privacy."

The policy defined “Claim” as “a civil proceeding against any Insured commenced by the service of a complaint or similar pleading.” Based on this definition, the court found that if any of the allegations of the complaint are excluded from coverage, the entire lawsuit is excluded, even if the complaint contains allegations that would otherwise be covered. So, if the civil proceeding "arose out of . . . an invasion of privacy," the insurer would not be liable for any part of the consent judgment.

The court next turned to the “arising out of” language. Noting the breadth of the phrase as interpreted by the Florida Supreme Court, the Eleventh Circuit found that if the class action suit has a connection with invasion of privacy, the lawsuit falls under the invasion of privacy exclusion.

Finally, the court determined that the class action arose out of an invasion of privacy because the complaint alleged that iCan intentionally invaded the class members’ privacy and sought recovery for those invasions.

As the civil proceeding arose out of an invasion of privacy, the court concluded that the invasion of privacy exclusion applied.

The court considered, but rejected, plaintiffs’ argument that by listing multiple tort causes of action but not statutory causes of action like the TCPA, the exclusion does not reach a TCPA claim. In other words, plaintiffs argued that the exclusion was limited to common law torts. The court explained that the policy does not “cabin” the invasion of privacy exclusion to claims alleging common law torts, but rather, broadly excludes civil proceedings arising out of an invasion of privacy.

Applying principles of policy interpretation, the court found that the exclusion barred coverage for the class action suit and affirmed summary judgment to the insurer.

The case is *Horn v. Liberty Ins. Underwriters, Inc.,* No. 19-12525 (11th Cir. June 1, 2021).

Cost of Complying with Methamphetamine Cleanup Order Barred by Pollution Exclusion, Missouri Appellate Court Holds

Finding that methamphetamine was a "contaminant," and therefore, a "pollutant" within the meaning of a homeowner's policy, the Missouri Court of Appeals affirmed a trial court's ruling that the insurer was not obligated to pay the insured's costs in complying with an order directing her to remediate methamphetamine from her home.

The Case

The insured's grandson was arrested for methamphetamine possession and distribution. The grandson lived with the insured. Liquid and solid methamphetamine was found in the basement and later testing showed that it was present throughout the house. The St. Louis County Public Works Department posted an Order to Vacate on the insured's house. The order required that the house be remediated before it could be reoccupied.

The insured submitted a claim to her homeowner's insurer for the cost to remove methamphetamine residue from her house. The insurer denied the claim because the policy did not provide coverage for the "costs to comply with any ordinance or law which requires any 'insured' or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, pollutants in or on any covered building or other structure."

The term "pollutants" was defined as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste."

The policy also excluded "any loss arising out of any act an 'insured' commits or conspires to commit with the intent to cause a loss" and further stated that "[i]n the event of such loss, no

‘insured’ is entitled to coverage, even ‘insureds’ who did not commit or conspire to commit the act causing the loss.”

The insured filed a suit in the St. Louis County Circuit Court alleging that the insurer breached the insurance contract and vexatiously refused to pay. The insurer moved for summary judgment and the trial court granted the insurer’s motion.

The insured appealed, contending that summary judgment was improper because: (1) the ordinance did not require a cleanup and that the substance at issue was not a pollutant; (2) the intentional act exclusion did not apply; and (3) the vexatious refusal claim is an issue for a jury, not summary judgment.

The Appellate Court’s Decision

The Missouri Court of Appeals found that there was no coverage and affirmed the trial court’s decision.

The court first addressed whether methamphetamine is a “pollutant,” and more specifically, a “contaminant.” Applying the ordinary meaning of that term, the court found that methamphetamine is a “contaminant” because it is a substance that makes a house “unfit for use by the introduction of unwholesome or undesirable elements.” The Public Works Department found that the insured’s house was unfit for human occupation due to the presence of methamphetamine in the house. Since it is a contaminant, the court concluded that methamphetamine met the policy's definition of a “pollutant.”

The court next addressed the insured’s argument that the Order to Vacate required her to remove methamphetamine only if she sought to reoccupy her house. As she was not required to reoccupy her house, the insured argued that she was not actually required to clean up the methamphetamine.

The court was unpersuaded. It found the insured's assertion unreasonable because an ordinary person purchasing homeowner's insurance would understand that an ordinance prohibiting entry into a house until a hazardous condition is removed is in fact a requirement to remove it. As the Order to Vacate required the insured to clean up the methamphetamine from her house, the court found that the exclusion applied and that such costs were not covered by the policy.

The court did not need to reach the insured's remaining arguments because the lack of coverage was dispositive of all issues.

The case is *Vogelsang v. Travelers Home Marine Ins. Co.,* No. ED109377 (Mo. Ct. App. June 29, 2021).

Insurer Not Liable for the Negligence and Elder Abuse of an Independent Broker, California Appellate Court Rules

A California appellate court, reversing a jury verdict, held that an insurer was not liable for negligence and elder abuse of an independent broker.

The Case

In 2016, Victor Pantaleoni sold a $100,000 National Western Life Insurance Company (NWL) annuity to Barney Thomas Williams, who had contacted Pantaleoni to revise a living trust after the death of Williams's wife. When Williams returned the annuity to NWL during a 30-day "free look" period, Pantaleoni wrote a letter over Williams's signature for NWL to reissue a new annuity. In 2017, NWL charged Williams a $14,949.91 surrender penalty. Pantaleoni also apparently forged documents and inflated Williams's financial status in applications to NWL.

In December 2017, Williams sued Pantaleoni in California state court alleging claims for elder financial abuse, negligence per se, and breach of fiduciary duty. Williams later amended the complaint to add NWL in place of a Doe defendant. The jury awarded Williams damages against NWL, including punitive damages, totaling almost $3 million. NWL moved for a judgment notwithstanding the verdict, which the trial court denied. NWL appealed.

The Decision

The appellate court reversed. The court held that Pantaleoni was effectively an insurance broker acting on behalf of the insured rather than an insurance agent acting on behalf of NWL. The court noted that Pantaleoni sold annuities for multiple insurance companies and his contract specified that he was an "independent contractor" and not an NWL employee. Because Pantaleoni was an independent contractor and agent for Williams in the purchase of the annuity, the court concluded that NWL had no duty to supervise Pantaleoni. The court observed that much of the claimed negligent conduct that Williams attributed to NWL amounted to insufficient supervision of Pantaleoni. Because NWL had no duty to supervise Pantaleoni, the court found that these claims should be dismissed.

The court also held that the California Insurance Code did not obligate NWL to investigate William's answers to a suitability questionnaire and did not furnish a duty of care for a negligence claim.

The court also found that the evidence did not support a claim under California's elder abuse statute. In this regard, the court noted that the statute was limited to the taking of property of an elder by one who knew or should have known that this conduct was likely to be harmful to the elder, and there was no evidence that NWL knew or should have known of Pantaleoni's fraudulent conduct. The court found that the statute did not impose a duty to

investigate even by a financial institution mandated to report suspected elder abuse. To conclude otherwise, the court held, would transform every dispute between a person over 65 regarding the conduct of an independent agent into an elder abuse action against an insurer.

For these reasons, the court reversed the judgment and remanded the case to the trial court with directions to enter judgment in favor of NWL.

The case is *Williams v. National Western Life Ins. Co.*, C090436 (Cal. Ct. App., 3d App. Dist. June 11, 2021).

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