Ohio Supreme Court: Ransomware Attack Not Covered Because Software Is Intangible and Cannot Suffer Direct Physical Loss or Damage

The Ohio Supreme Court held that a computer-software company was not entitled to coverage under its businessowners insurance policy for a ransomware attack because there was no "direct physical loss of or damage to" the software.

EMOI Services, LLC uses software it developed to assist medical offices with their record keeping, scheduling, and billing. A hacker invaded EMOI's computer systems and then encrypted files needed for its software and database systems. The hacker demanded a $35,000 ransom to restore the files.

EMOI paid the ransom and received a link to download a program that would decrypt the files. Most of the systems were returned to normal. No hardware or equipment was damaged as a result of the attack. EMOI later upgraded its software systems and instituted other measures to protect against future attacks.

EMOI submitted a claim to its insurer under the "Data Compromise" and "Electronic Equipment" endorsements in its policy, and sought recovery for the ransom payments, the costs of investigating and remediating the attack, and the costs of upgrading its security systems. The insurer denied the claim because the Data Compromise endorsement excluded coverage for any "threat, extortion, or blackmail," and the Electronic Equipment endorsement applied only to "media" that incurred "direct physical loss or damage."

Coverage litigation ensued and both parties moved for summary judgment. The trial court ruled for the insurer, but the intermediate appellate court reversed, giving EMOI an opportunity to show that the encryption damaged its software.

The Ohio Supreme Court reversed the intermediate appellate court, finding that the Electronic Equipment endorsement unambiguously required direct physical loss of, or direct physical damage to, electronic equipment or media. As software is an intangible item that cannot experience direct physical loss or damage, the endorsement did not apply.

The court rejected EMOI's argument that computer software is "media," and that the policy contemplates that software can be damaged, despite being nonphysical. The most natural reading of the phrase "direct physical loss of or damage to," the court explained, is that EMOI is insured for direct physical loss of its media and insured for direct physical damage to its media.

The court acknowledged that the policy's definition of "media" included "computer software," but noted that it is included only as long as the software is "contained on *covered* media." The court held that "covered media" means media that has a physical existence, as all examples of covered media in the definition – film, magnetic tape, paper tape, disks, drums, and cards – were of a physical nature. The court also held that there must be direct physical loss or physical damage of the covered media containing the computer software for the software to be covered under the policy. Indeed, the electronic-equipment endorsement stated that "direct physical loss of or damage to Covered Property [i.e., media] must be caused by a Covered Cause of Loss [i.e., risk of direct physical loss]."

Computer software, the court explained, is nothing but a set of instructions that a computer follows to perform specific tasks. While a computer or other electronic medium has physical components that are tangible in nature, the information stored there has no physical

presence. This information, the software, is intangible. The court was unwilling to find that the policy covered physical damage to computer software – an intangible – without there also being physical damage to the hardware on which the software was stored.

The Ohio Supreme Court thus reinstated the trial court's award of summary judgment for the insurer.

The case is *EMOI Servs. L.L.C. v. Owners Ins. Co.,* No. 2021-1529 (Ohio Dec. 27, 2022).

Ohio Supreme Court Holds Losses from Covid-Shutdown Orders Are Not a Direct Physical Loss

An audiology practice sought to recover lost income after it was forced to cease operations during Covid. The insurer, Cincinnati Insurance Company, denied coverage because the claim did not involve "direct, physical loss" to property. The insured sued in Ohio federal district court. The court certified the following question to the Ohio Supreme Court: Is the general presence of Covid in the community or on the surfaces at a premises a direct physical loss to property?

The Ohio Supreme Court said, "no," holding that the policy required a loss that was physical but the loss of use of a physical space is nonphysical.

The court noted that the policy provides coverage from when a loss occurs until it is repaired, rebuilt, or replaced. The court reasoned that something could not be repaired, rebuilt, or replaced if it was not damaged to begin with.

The court rejected the insured's argument that the addition of a virus exclusion in later policies signified that this policy covered losses without any physical alteration to property. The court said that the parol evidence rule prohibits the introduction of other agreements to create ambiguity.

The court also distinguished cases in which a property was rendered wholly uninhabitable due to falling rocks, seepage, or poisonous fumes. The court noted that the insured's premises were unsafe only to the extent that they served as an indoor space in which people could gather and Covid could be transmitted. The court said that its decision tracked the clear trend of law in other jurisdictions addressing this issue.

The case is *Neuro-Commc'n Servs. v. Cincinnati Ins. Co.*, 2022-Ohio-4379 (Ohio Dec. 12, 2022).

North Carolina Supreme Court Rules for *Pro Rata* Allocation

The North Carolina Supreme Court held that *pro rata* time-on-the-risk allocation applies to defense and indemnity costs in long-tail claim cases. The court explained that "the modern trend is to apply pro rata allocation when limiting language like 'during the policy period' exists, even when the policy contains a reference to paying 'all sums' arising out of certain liabilities."

The court held that the "the language 'during the policy period' cabins the phrase 'all sums' to a finite period of time." From this, the court decided that "the insurers did not agree to cover all sums arising out of benzene exposure without regard to the policy periods during which incidents of exposure took place. Instead, '[c]onsistent with the policy language limiting coverage to that which occurs 'during the policy period,' the timing of the [occurrence/injury] dictates … the portion of damages for which each policy is responsible.'"

The court rejected the "all sums" approach, because "[t]hese cases … tend to represent an outdated view of the proper interpretation of 'pro rata' language," and "[t]he truncated

contractual interpretation they apply fails to fully consider the limiting effect of the phrase 'during the policy period.'"

The court held that, in the context of a benzene-related injury, which occurs at the time of exposure, its decision was unaffected by the presence of certain non-cumulation provisions. The court reasoned that such clauses apply when more than one policy must indemnify for the same loss, not where the policy must indemnify for a loss that occurred outside its policy period.

The court also adopted an exposure trigger, finding that bodily injury occurs during a claimant's exposure and not when the claimant later becomes sick.

The case is *Radiator Specialty Co. v. Arrowood Indem. Co.*, 2022-NCSC-134 (N.C. Dec. 16, 2022). Michael Kotula and Robert Maloney of Rivkin Radler LLP represented one of the prevailing insurers, Fireman's Fund Insurance Company.

New Jersey Supreme Court Holds That Broker Had Duty to Inform About Available Workers' Comp Coverage, But Applies Gross Negligence Standard

The widow of a partial owner of a family run nursery sued the nursery's insurance broker for failing to advise about the availability of workers' compensation insurance for the company owners. The New Jersey Supreme Court was asked to decide whether the insurance broker had a duty to notify the owners of the option to purchase workers' compensation insurance for them, and if so, what standard applied, ordinary negligence or something more?

First, some background. The New Jersey Workers' Compensation Act provides that the members of a limited liability company (LLC) who actively perform services on behalf of the LLC are eligible for workers' compensation coverage if the LLC elects to obtain that coverage for its members. N.J.S.A. 34:15-36.

The nursery was originally owned by the decedent's father and uncle. They eventually formed an LLC, each owning a 50% interest in the LLC. The brothers chose not to purchase workers' compensation coverage for themselves, as LLC members, because it was too expensive. The decedent had originally worked as an employee at the nursery and was covered by workers' compensation insurance. But the decedent and his brother later took over their uncle's share of the business and became LLC members. They were no longer covered by workers' compensation insurance, but the LLC had the option to purchase benefits for all LLC members. The members never affirmatively requested such coverage.

The defendant was the nursery's insurance broker for many years. He had annual meetings with the nursery's management to discuss the LLC's insurance needs. During the meeting when the decedent and his brother first became LLC members, the broker did not tell them that they were no longer covered or that they could opt to purchase coverage. The broker's position was that all three LLC members knew that they were excluded from workers' compensation coverage and were satisfied because they were saving premium dollars. The broker continued to get the same coverage that the nursery bought for the past ten years.

At trial, the decedent's father and brother testified that had they been aware of the availability of insurance coverage for LLC members, they would have bought it.

The case made its way up to the New Jersey Supreme Court, where the court held that the broker owed a duty to inform the individual members that they could purchase workers' compensation insurance but found that no liability will be imposed unless the insurance broker causes damage by a willful, wanton, or grossly negligent act or omission.

In reaching this conclusion, the court found that it was foreseeable that if the broker did not inform the LLC members of the availability of workers' compensation benefits, that the

members' dependents would be harmed if the member were to suffer a fatal work-related accident. The court also found that the nature of the risk was significant, and that the insurance broker had both the opportunity and ability to communicate to the LLC members their options. It also determined that imposing such duty was in the public interest.

The New Jersey Supreme Court remanded the case to the trial court to determine whether the evidence supported a finding that the broker caused damage by a willful, wanton, or grossly negligent act of commission or omission.

The case is *Holm v. Purdy,* No. 086229 (N.J. Dec. 13, 2022).

Fourth Circuit Affirms Trial Court's Ruling That Insurers' Reservation of Rights Letters Did Not Provide a Basis for Denial under South Carolina Law

A homeowners association sued a general contractor for construction defects in townhomes. The contractor notified its two commercial general liability insurers, who issued successive policies during that period. Both insurers defended under a reservation of rights.

The construction defect suit was bifurcated. After the first phase, the homeowners association obtained a judgment against the contractor. The homeowners association, as a judgment creditor, then filed a declaratory judgment action against the two insurers seeking coverage for the Phase I judgment, and later, a settlement reached before the second trial. The homeowners association prevailed before the district court and the insurers appealed. The issue was whether the insurers properly reserved their rights to contest coverage.

The Fourth Circuit looked to the South Carolina Supreme Court's decision in *Harleysville Group Insurance v. Heritage Communities, Inc.*, 420 S.C. 321, 803 S.E.2d 288 (S.C. 2017), which instructed that "an insured must be provided sufficient information to understand the reasons the

insurer believes the policy may not provide coverage," and held that "generic denials of coverage coupled with furnishing the insured with a copy of all or most of the policy provisions (through a cut-and-paste method) is not sufficient."

The Fourth Circuit found that the insurers' letters, like in *Harleysville*, failed to expressly reserve their rights as to whether any damages resulted from acts meeting the definition of occurrence, whether any damages occurred during the applicable policy periods, and what damages were attributable to non-covered faulty workmanship (e.g., the your-work exclusion). The Fourth Circuit found that the insurers' reservation of rights letters failed to inform the insured that the insurers intended to litigate coverage issues and did not apprise the insured of potential conflicts of interest.

The Fourth Circuit said that one insurer's reservation of rights letter merely referred the insured to certain policy exclusions and simply summarized the gist of those exclusions. But simply stating the exclusion, without more, the court explained, does not constitute an adequate reservation of rights.

The court criticized the other insurer's letter too, which it acknowledged "presents a closer question." That insurer said: "[i]t is doubtful that the claim alleges the happening of an 'occurrence' or that the claim alleges 'property damage' within the policy definition, and if there is no 'occurrence' or 'property damage' as defined by the policy, there is no coverage." The court found this to be insufficient because the insurer failed to explain why it found it doubtful. The court said this language was at best ambiguous and must be construed strictly against the insurer and liberally in favor of the insured.

The court rejected the insurers' arguments for why *Harleysville* did not apply. First, it found that *Harleysville* was not limited to a narrow context – applying a deferential standard of

review to the findings of a special referee after an evidentiary hearing – but applied broadly to cases assessing the sufficiency of an insurer's reservation of rights. Second, even though the insurers' letters here were written before *Harleysville* was decided, it found that *Harleysville* applied retroactively. Third, it found that the settlement agreement as to the Phase II damages did not rectify any deficiencies in the original reservation of rights letters, and simply agreeing to litigate coverage in a later declaratory judgment action does not itself create an adequate reservation of rights.

The case is *Stoneledge at Lake Keowee Owners' Ass'n v. Cin. Ins. Co.*, No. 19-2009 (4th Dec. 13, 2022). It's an unpublished decision but offers a valuable lesson: insurers should be descriptive in their reservation of rights letters and must explain why there may be no coverage.

Eleventh Circuit Holds that "Suicide-by-Cop" Is "Suicide" for Purposes of Exclusion

North American Company for Life and Health Insurance issued two life insurance policies to Justin Caldwell. The policies excluded "suicide" from coverage.

Justin successfully carried out a plan to provoke police officers to shoot and kill him. North American sought a declaratory judgment that it did not owe coverage to the policies' beneficiaries. The beneficiaries argued that the term "suicide" requires a death by one's own hand and that "suicide-by-cop" is a term of art that refers to justifiable homicide. The district court ruled for the beneficiaries.

The Eleventh Circuit, applying Florida law, reversed. The court held that suicide only requires an intent to end one's life. The specific method, the court determined, is irrelevant. The court noted that dictionary definitions of "suicide" do not restrict its meaning to acts that involve

no third parties. The court added that to rule otherwise would thwart the purpose of insurance, which is to protect against unforeseen risks.

The court found that suicide by cop was not materially different than throwing oneself in front of a train. If a man throws himself in front of a train, the court suggested, nobody will argue that the conductor committed homicide. Likewise, the court concluded, police officers are trained to, and have little choice but to, use deadly force to stop a civilian who threatens them or others.

The court cautioned that it was not deciding whether "suicide" covers every imaginable instance of suicide-by-cop. But where there was no dispute that the individual here intended to carry out a plan to end his own life, the exclusion applied.

The case is *N. Am. Co. for Life v. Caldwell*, No. 22-10534 (11th Cir. Dec. 14, 2022).

Washington Federal Court Finds Claims Arising from Treasure Hunt Are Not Covered

A few months back, we reported on a coverage dispute arising from a treasure hunt to salvage gold from a ship that sunk at the turn of the 20th century. After an unsuccessful excursion, Rodger May sought to continue the hunt without his partners but claimed they kept intellectual property from him needed for the search. The court found that the insureds were not entitled to a defense because the partners' refusal to remit the intangible property was not an "occurrence," as they were aware of the consequences of not turning over the intellectual property.

Now, the court considered the insurer's summary judgment motion against May (as assignee) on the duty to indemnify. May argued that based on a $7.5 million covenant judgment awarded to him, it was reasonable to infer that his partner withheld the intellectual property

accidentally, because he could not have foreseen the consequential harm flowing from his refusal to turn over the property to May.

But the court wasn't buying it. Under Washington law, an "occurrence" must be an accident, and both the results and the means must be unforeseen, involuntary, unexpected, and unusual. Even if the potential results of withholding the property were unforeseen – which May argued was an issue for the fact finder – the court found no evidence suggesting that the means are. May's partner willfully withheld the intellectual property because he thought it belonged to someone other than May. The court found that this evidence suggested the means of withholding, which deprived May of the intellectual property, were not an accident.

The court awarded the insurer summary judgment and also dismissed May's counterclaims for bad faith and breach of fiduciary duties.

The case is *Great Am. Ins. Co. v. May*, No. C21-1002-JCC (W.D. Wash. Dec. 19, 2022).

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