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Insurance Update

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California Supreme Court Holds Exhaustion of Underlying Insurance Not Required to Seek Declaratory Relief Against Excess Insurers

The California Supreme Court recently handed down a ruling that makes it easier for policyholders to bring their excess insurers into coverage litigation.

A dispute arose between former colleagues at an investment firm, and they became embroiled in litigation. Some colleagues (the policyholders) thought the investment firm's excess insurers should pay for their litigation expenses and brought a declaratory judgment action. The excess insurers claimed the dispute was not ripe. The trial court sustained the excess insurers' demurrer and the policyholders appealed.

The case went up to the California Supreme Court. The issue was exhaustion: To bring a declaratory judgment action against its excess insurers, must the policyholder first show that it exhausted its underlying insurance?

The California Supreme Court said "no." It held that policyholders must adequately plead their covered losses, but they don't have to allege exhaustion of all underlying insurance. Rather, they must only allege facts showing that coverage under an excess policy is reasonably likely to attach.

To be eligible for declaratory relief, a litigant must show that there is an actual controversy between the parties. California courts apply a two-part test to determine if an actual controversy exists: (1) Is the dispute sufficiently concrete that declaratory relief is appropriate? (2) Will the parties suffer hardship if judicial consideration is withheld?

Applying this test, the court concluded that an actual controversy existed even though coverage depended on the satisfaction of a future contingency. As for the first part of the test, the court found

that a trial court could tailor its declaration by explaining when any coverage responsibilities would become due. As for the second part of the test, the court felt that withholding declaratory relief would work a significant hardship on the policyholder. The court explained that otherwise, policyholders seeking recovery against multiple excess insurers would have to "engage in piecemeal litigation, scaling the tower of excess insurance policy by policy by securing a favorable judgment against each excess insurer" and "repeating this process until they reached the summit."

But wouldn't this also cause hardship for excess insurers who are dragged into a suit over a coverage claim that may never reach them? Possibly yes, but the court said any hardship was outweighed by the greater hardship on policyholders who would have to proceed sequentially against their excess insurers, layer by layer. Seriatim proceedings, the court noted, might prejudice both policyholders and insurers by risking inconsistent rulings in different forums.

And, in all events, the court emphasized, the policyholder must still adequately allege a practical or reasonable likelihood based on the facts of the case that its potential liability will reach into the excess coverage.

With this standard in mind, the court remanded the case to the Court of Appeal to reevaluate the adequacy of the policyholders' allegations as to the existence of an actual controversy.

The case is *Fox Paine & Co., LLC v. Twin City Fire Ins. Co.*, S287404 (Cal. July 27, 2026).

State Courts in Illinois and Ohio Reach Different Outcomes on Coverage for Opioid Claims

In *Walgreens*, an Illinois judge found that government lawsuits seeking costs related to the opioid crisis are not claims for damages "because of bodily injury." But in *Cardinal Health*, an Ohio judge found that an insurer owes a defense for these cases. The different results can be attributed to different policy language.

Opioid Litigation

Thousands of lawsuits across the nation have been filed against manufacturers, distributors, and retail pharmacies arising from the oversupply of prescription opioids and the resulting addiction, illness, and death. The suits were filed by state and local governments, Native American tribes, hospitals, and third-party payors, who allege that defendants failed to design and operate adequate systems to identify suspicious orders and report them when detected. The plaintiffs claim they paid for medical care, treatment, emergency response, law enforcement, judicial and correctional systems, and other services for individuals who used and abused opioids. Plaintiffs sought reimbursement for the costs of providing such care and other services related to the opioid crisis.

The *Walgreens* Decision

Walgreens is a retail pharmacy. It sought to recover from its liability insurers the costs to defend against the opioid suits, along with $7 billion in judgments and settlements. Walgreens sued its umbrella and excess insurers in Illinois state court for breach of contract and for declaratory judgment. The parties selected a few representative complaints and moved for summary judgment. The key issue was whether the complaints potentially sought damages because of bodily injury.

In assessing this issue, the court noted that the focus is not on whether the opioid crisis involved bodily injury in a general sense, but whether plaintiffs' own economic, institutional, or governmental losses incurred in responding to the opioid crisis constitute damages because of bodily injury within the meaning of the policies and Illinois law.

The court first considered Illinois law and found a consistent principle throughout the caselaw. The existence of bodily injury somewhere in the chain of events does not alone establish that a complaint seeks damages because of bodily injury. Courts must instead examine the nature of the damages actually sought. Where a plaintiff seeks to recover its own economic, budgetary, statutory, or institutional losses, bodily injury allegations in a complaint are insufficient to trigger coverage.

Applying this principle, the court found that the opioid complaints against Walgreens do not seek recovery for bodily injury sustained by injured persons, nor reimbursement of liability owed to such claimants. Instead, plaintiffs seek recovery of their own economic losses resulting from the opioid crisis.

The court rejected Walgreens' attempt to distinguish the leading opioid decisions in other jurisdictions—*Rite Aid* (Delaware)*, Acuity* (Ohio)*,* and *Westfield* (6th Cir.). The court found that these decisions, just like the Illinois decisions, focus on the nature of the damages sought and distinguish between claims seeking recovery for bodily injury and claims seeking recovery of plaintiffs' own economic or institutional losses resulting from bodily injury suffered by others.

The court also declined to follow the Seventh Circuit's *H.D. Smith* decision, which found that the policy did not require that claims must be brought by or on behalf of injured persons. The court was unpersuaded by the analogy the *H.D. Smith* court drew between government opioid claims and traditional derivative claims, finding that plaintiffs' claims in the opioid suits were not tied to any particular bodily injury in the manner contemplated by traditional derivative claims. Also, the court noted that *H.D. Smith* did not discuss or analyze the leading Illinois appellate decisions and found *H.D. Smith's* analysis difficult to reconcile with those decisions.

The court was also unpersuaded by Walgreens' argument that the phrase "because of bodily injury" is broader than the phrase "for bodily injury." While some Illinois decisions have noted that "because of" might be broader than "for," other Illinois decisions treat the phrases as functionally equivalent. The umbrella policies at issue used both formulations in the policy. And even if "because of" is broader than "for," the court stated that the phrase does not extend to every economic loss that would not have been incurred absent bodily injury. Illinois law makes clear that the existence of a causal connection to bodily injury is not, by itself dispositive. Rather, the inquiry focuses on the nature of the damages for which recovery is sought.

The opioid complaints seek recovery of plaintiffs' own governmental, institutional, hospital, and payor expenditures allegedly incurred in responding to the opioid crisis. Those expenditures, the court reasoned, "may have been occasioned by bodily injuries suffered by others, but the damages sought remain the plaintiffs' own losses."

In granting the insurers summary judgment, the court held that the complaints do not potentially seek damages because of bodily injury. The bodily injury allegations simply explain why those plaintiffs may have incurred those costs, but they do not convert the claim into suits for bodily injury damages under Illinois law.

The *Cardinal Health* Decision

Cardinal Health is a pharmaceutical products wholesaler that distributes prescription medications, including opioids, to licensed and registered pharmacies. It sued its excess insurers in Ohio state court seeking a declaration that these insurers must defend and indemnify Cardinal Health in the opioid suits. Cardinal Health moved for partial summary judgment against National Union seeking a declaration that the exemplar complaints potentially fell within NU's umbrella policy.

NU cross-moved for partial summary judgment, arguing that the suits do seek damages because of bodily injury, the Ohio Supreme Court's *Acuity* decision precludes coverage, and the suits do not allege harm caused by an accident.

But the court found that *Acuity* did not control the outcome. In that case, the Ohio Supreme Court held that an opioid supplier was not entitled to a defense because the phrase "damages because of bodily injury" requires more than a tenuous connection between the alleged bodily injury sustained by a person and the damages sought. The court instructed that for the duty to defend to be triggered, the damages sought must be for losses asserted by: (1) the person injured; (2) a person recovering on behalf of the injured person; or (3) a person or organization that directly suffered harm because of another person's injury, if the existence and cause of that injury can be proven.

In *Acuity*, "bodily injury" was defined as "bodily injury, sickness or disease sustained *by a person*, including death resulting from any of these at any time." Also, according to the *Cardinal Health* court, references to "the" bodily injury coupled with a requirement of lack of knowledge of specific losses led the *Acuity* court to narrowly interpret the phrase "because of bodily injury."

The *Cardinal Health* court compared the language in NU's policy to that in *Acuity*.

In NU's policy, "bodily injury" means "bodily injury" but also includes "mental injury, mental anguish, humiliation, shock or death if directly resulting from bodily injury, sickness, disability or disease." Whereas the policy in *Acuity* applied to "bodily injury … sustained by a person," no similar requirement was present in NU's policy.

Also, whereas the policy in *Acuity* was limited to sums the insured "becomes legally obligated to pay as damages," the NU policy applied to "sums … that the Insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the Insured."

The *Cardinal Health* court found these differences significant. Because the NU policy is not limited to injuries sustained by a person, the court interpreted NU's policy to provide coverage for plaintiffs' economic losses if they are tenuously connected to bodily harm suffered by individuals. The court thus interpreted "because of bodily injury" more broadly than the Ohio Supreme Court in *Acuity.* Under this broader interpretation, the court found that each of the exemplar complaints alleged a tenuous connection to the individual harms suffered by opioid victims.

NU next argued that the bodily injury alleged in the exemplar complaints was not caused by an "occurrence," defined as "an accident, including continuous or repeated exposure to conditions, which results in Bodily Injury or Property Damage neither expected nor intended from the standpoint of the Insured." Some counts in the complaints alleged intentional conduct. But the complaints also asserted claims for negligence.

The court considered whether the negligence claims alleged intentional conduct with foreseeable harm and found that the allegations in the complaint had all the hallmarks of negligent, not intentional conduct. The court also found that the inferred intent doctrine did not apply.

Thus, the court held that NU had a duty to defend.

The cases are *Walgreen Co. v. Ace Amer. Ins. Co.*, No. 2022 CH 04283 (Ill. Cir. Ct., Cook Cty. June 18, 2026) and *Cardinal Health Inc. v. American Alternative Ins. Corp*., No. 22 CV 5990 (Ohio Ct. Comm. Pleas, Franklin Cty. July 17, 2026).

Illinois Court Imposes Discovery Spoliation Sanctions Against Insurer for Failing to Preserve ESI

In October 2022, H.D. Smith Wholesale Drug Company sued Cincinnati Insurance Company (the Insurer) for indemnification of its defense and settlement liabilities incurred in defending several prescription opioid lawsuits. H.D. Smith later sought discovery spoliation sanctions against the Insurer for failing to preserve certain electronically stored information (ESI). The ESI involved custodial emails and underwriting files.

The Insurer had a two-year automatic deletion policy for custodial emails and a ten-year deletion policy for underwriting materials, but it did not suspend those policies for an earlier coverage action involving the same parties, overlapping policies, and similar opioid-related coverage issues. Its only litigation hold, issued in 2017, was limited to one policy and told recipients that no special action was needed to preserve emails or broad categories of documents.

The court granted H.D. Smith's motion for spoliation sanctions in part. The court found that the Insurer had a duty to preserve the ESI going back to 2012, when the earlier suit was filed. The information was relevant because it went to rebutting the Insurer's "knowledge-based" defenses that H.D. Smith was aware of an ongoing loss before the policies incepted. The court concluded that the Insurer did not take reasonable steps to preserve the ESI – by, for example, suspending automatic

deletion processes. The court concluded that the Insurer destroyed the ESI with the intent to deprive H.D. Smith of that information.

As a spoliation sanction, the court instructed the jury that it could presume that the destroyed information was unfavorable to the Insurer. The court also awarded H.D. Smith its attorneys' fees in bringing the spoliation motion. However, the court said that dismissing the Insurer's knowledge-based defenses was too strong a sanction because H.D. Smith still had other evidence to prove its case.

The case is *H.D. Smith Wholesale Drug Co. v. Cincinnati Ins. Co.*, 22-cv-3210 (C.D. Ill. July 22, 2026).

New Jersey Federal Court Finds Insurer's Duty to Preserve Evidence Arose After It Denied Coverage for $1M Claim

The duty to preserve relevant evidence is triggered when the party in possession of the evidence reasonably knows or should know that litigation is pending or probable. But insurers handle many claims. When should an insurer suspect that litigation is reasonably likely? A New Jersey federal court provides some instruction.

Ace American Insurance Company issued a Premises Pollution Liability policy to the Municipality of Princeton, New Jersey in March 2019. In June 2019, the New Jersey Department of Environmental Protection discovered illegal dumping at a municipal property in Princeton. Princeton and Ace began discussing coverage in July and August 2019.

About a year later, Princeton sought Ace's approval so that the remedial work could begin. Having not received Ace's approval, Princeton sent a demand for coverage letter on September 9, 2020, and a second letter on September 30 threatening to take legal action if Ace did not respond by October 2, 2020. Receiving no response, Princeton sent a third letter to Ace on December 1, 2020, stating that it would proceed with the remedial work and that it was reserving its rights and remedies against Ace.

Ace denied coverage on December 17, 2020. Princeton responded by saying that it would proceed with the remediation and that it disagreed with the coverage denial.

Princeton sued Ace in New Jersey federal court on October 31, 2023, after the remedial work was completed. In September 2025, during discovery, Princeton learned that Ace had deleted ESI of its senior claims manager in September 2021 (and its lead underwriter in March 2025). A dispute developed over when Ace's duty to preserve evidence arose.

Princeton argued that the duty arose in September 2020, when it sent its demand for coverage, and no later than December 2020, when Ace denied coverage. Princeton said that is the point when the relationship unambiguously went from cooperation to disagreement.

Ace argued that its duty to preserve evidence was not triggered until Princeton filed its complaint, as litigation was not reasonably foreseeable before then.

The court held that the duty to preserve evidence arose when Ace denied coverage. By that time, Ace was aware that Princeton had retained counsel, that Princeton disagreed with the coverage denial, that Princeton said it would proceed with the work and reserved all legal remedies, and that the claim was valued at $1 million.

Given these factors, the court held that coverage litigation became reasonably foreseeable upon Ace's denial. The court emphasized that while not all claim denials result in litigation, it is relatively common for claim disputes of $1 million to lead to litigation, "especially when the injured party is a municipality with tax-payer money at stake." It was thus incumbent on Ace to promptly execute a litigation hold on issuance of the coverage denial letter in December 2020.

The case is *Mun. of Princeton v. Ace Am. Ins. Co*., No. 23-cv-22756 (D. N.J. Aug. 31, 2026).