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2014 Insurance Coverage Litigation Year In Review

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Over the past year, courts handed down several significant insurance coverage decisions, including those regarding cyberliability that could shape the law governing this rapidly increasing exposure. While not intended to be an exhaustive review of all insurance coverage litigation decisions in 2014, the following highlights select decisions from across the country in connection with emerging and frequently litigated issues.

Coverage for Cyberliability

The number of cases concerning coverage for cyber-related liability resulting from data breaches increased in 2014, with courts considering a variety of coverage issues under traditional insurance policies, such as general liability, directors and officers, professional liability and crime policies. While the availability and diversity of cyberliability-specific insurance policies is growing, reported decisions concerning the interpretation of these new forms' terms and conditions are still scarce.

In Travelers Indemnity Co. of America v. Portal Healthcare Solutions LLC, the inadvertent online disclosure of confidential medical records was held to constitute a "publication" triggering the insurer's duty to defend.[1] The insured, Portal Healthcare Solutions, sought coverage for an underlying class action alleging that Portal failed to safeguard the confidential medical records of patients at a Northern Virginia hospital following the inadvertent online disclosure of certain records. These records were allegedly accessible, viewable, downloadable and printable by the general public, without any security restrictions, for approximately four months before being discovered. The insurance policies at issue contained two relevant conditions to coverage: first, an electronic "publication" of material, and second, that the publication give "unreasonable publicity to," or "disclos[e] information about," a person's private life. The policies did not, however, define any of these key terms. Looking to common dictionary definitions and resolving ambiguous terms in favor of the insured, the court held that the alleged online disclosure easily fell within the relevant policy language, thus triggering the insurer's duty to defend. In doing so, the court rejected each of the insurer's two defenses — that the disclosure had been inadvertent and that no third-party was alleged to have viewed the confidential records. The court held that the definition of "publication" does not depend upon the would-be publisher's intent, but rather on whether the information was, in fact, placed before the public. Likewise, the court found that

"publication" does not require actual access by a third party because it occurs at the moment the information is made available. Otherwise, a book that is bound and placed on the shelves of a book store would not be deemed "published" until a customer takes it off the shelf and reads it.

Another case, First Commonwealth Bank v. St. Paul Mercury Ins. Co., examined the effect of a data breach on an insured's compliance with the "voluntary payments" provision in its professional liability policy.[2] On or about Aug. 31, 2012, a customer of First Commonwealth Bank was the victim of malware that allowed an unknown third party to access the customer's computer system and obtain the online banking username and password for the customer's accounts at First Commonwealth. Following the breach, the unknown third party initiated three unauthorized wire transfers from the customer's accounts between Aug. 31, 2012, and Sept. 4, 2012, totaling more than $3.5 million. Once discovered, First Commonwealth was able to recover only $76,520 of the stolen funds and had to reimburse the remainder to the customer using its own funds. First Commonwealth subsequently tendered the claim to its insurer, St. Paul Mercury Insurance Company. St. Paul denied coverage, arguing that, by reimbursing the funds to the customer without St. Paul's consent, First Commonwealth violated the "voluntary payments" clause in the insurance policy, which provided that "[t]he Insureds agree not to settle or offer to settle any Claim ... [or] voluntarily make any payment ... without the Insurer's written consent." The district court rejected St. Paul's argument, noting that First Commonwealth was obligated to reimburse the funds promptly to its customer under Pennsylvania law — 13 Pa. C.S.A. § 4A204. As a result, the district court held that First Commonwealth's payments were not "voluntary" for purposes of applying the "voluntary payments" clause to exclude coverage. The rationale of First Commonwealth may apply prospectively to cybersecurity laws and regulations requiring a company to notify its customers when personally identifiable information has been breached. Once a data breach is discovered, and in the face of relevant notification laws and regulations, insurers should be unable to assert that the mandatory notifications, and associated costs, are "voluntary" and therefore barred from coverage absent prior insurer consent.

Coverage for Disgorgement and Restitution Claims

Insureds stand to benefit from several decisions courts have issued this year confirming the insurability of claims often characterized as "disgorgement" or restitution, relying upon careful examination of the definition of "loss" in the policies at issue in each case.

In William Beaumont Hosp. v. Federal Ins. Co., the insured hospital sought coverage for an $11.3 million settlement with a class of registered nurses who had sued for wages and treble damages based on an alleged unlawful agreement among area hospitals to share compensation information in a manner that harmed competition and depressed the nurses' wages.[3] Denying coverage, the hospital's insurer argued that the settlement constituted "disgorgement" of an advantage unlawfully gained by providing below-market compensation and was excluded from the policy's definition of "loss." Turning to the dictionary definitions of the terms "disgorge," which means "to give up illicit or ill-gotten gains," and "gain," which is "an increase in or addition to what is of profit, advantage, or benefit ... resources or advantage acquired or increased," the court held that the settlement did not constitute a "disgorgement" because the allegations were that the insured hospital had wrongfully retained, rather than acquired, the wages at issue. Moreover, and in response to the insurer's arguments, the court did not find any Michigan public policy prohibiting insurance coverage for disgorgement or restitution claims.

The insured in U.S. Bank Nat'l Assoc. v. Indian Harbor Ins. Co. likewise sought coverage for a $55 million settlement and associated defense costs in connection with three underlying class actions brought by its

customers alleging overcharging of overdraft fees and sought the return of such fees.[4] The bank's insurers denied coverage, arguing that the settlement was restitutionary in nature and therefore excluded from the policies' definition of "loss," which precluded coverage for "[m]atters which are uninsurable under the law pursuant to which this Policy is construed." This was an undefined and vague restriction on what constitutes "loss" and that often appears in D&O polices. Finding no Delaware statute or case law precluding insurance coverage for settlements constituting restitution, the court ruled that the settlement was not uninsurable under the governing law and therefore did not fall within the "loss" carveout. As further support for its decision, the court pointed to an exclusion in the policies precluding coverage for ill-gotten gains (such as restitution), but only as determined by a final adjudication in an underlying action. According to the court, this demonstrated that the policies excluded restitution only in the event of a final adjudication, and by implication, did not exclude restitution arising out of a settlement.

In another case, Peerless Insurance Co. v. Pennsylvania Cyber Charter School, the insurer challenged its duty to defend or indemnify its insured, Pennsylvania Cyber Charter School ("PA Cyber"), against an underlying lawsuit brought by several county school districts alleging that they were entitled to the return of certain funds pursuant to a recent ruling by the Pennsylvania Supreme Court in another case.[5] On cross-motions for summary judgment, the court granted PA Cyber's motion seeking to enforce the insurer's duty to defend and denied the insurer's cross-motion. The insurer later filed a motion for reconsideration as to its duty to defend. In denying that motion as well, the court first held that the return of funds sought in the underlying claims constituted a "loss" to PA Cyber in satisfaction of the policy's insuring agreement because PA Cyber had used the funds, as intended, to educate children in the school districts. The court noted that other jurisdictions have not uniformly excluded restitutionary claims from the definition of "loss" where the restitutionary funds are offset by a benefit provided, or services rendered, by the policyholder. Moreover, during the time period alleged in the underlying complaint, PA Cyber was legally entitled to collect and use the funds as it did because the Pennsylvania Supreme Court had not yet issued its ruling in Slippery Rock Area School District v. Pennsylvania Cyber Charter School, 31 A.3d 657 (Pa. 2011), which changed the law regarding the collection and use of such funds. As a result, the court held that PA Cyber did not receive a profit or advantage to which it was not entitled at the relevant time and rejected the insurer's remaining defenses based on the illegal profit or advantage exclusion and Pennsylvania public policy.

Related Claims Decisions

Courts continued to struggle with the application of so-called related claims provisions in 2014, including whether these provisions operate as a coverage condition or exclusion. In Borough of Moosic v. Darwin National Assurance Co., the Third Circuit held that a "related claims" provision can operate to preclude coverage despite that it does not appear in the exclusions section of the policy.[6] The insurer denied coverage for an underlying action brought against the insureds as public officials during the policy period; the insured argued that the underlying action was related to any earlier mandamus action brought prior to the policy period — pointing to a policy provision deeming related claims to have been first made at the time of the earliest claim. That provision appeared in the "Conditions" section of the policy. The Third Circuit reasoned that, despite its location, the related claims provision was not a condition precedent to coverage because there was no act the insured must perform or event that must occur for there to be no related claims first made prior to the policy period. Instead, it held that the related claims provision acted to limit coverage and thus was an exclusion.

Numerous cases also examined the basis for determining "relatedness," with several rejecting insurer arguments that claims fell outside the current policy period based on their alleged relationship to a prior

event, which the insurer argued constituted a related claim.

For example, in RSUI Indemnity Co. v. Sempris LLC,[7] the insured, Sempris, sought a defense and indemnity for an underlying putative class action — the Toney Action[8] — in which it was alleged that Sempris and its telemarketing company violated the Telephone Consumer Protection Act in making unsolicited telemarketing phone calls. On cross-motions for summary judgment, the insurer argued that the Toney Action was related to certain prior actions that had been filed against Sempris[9] and therefore was not a claim first made during its policy period. Rejecting the insurer's arguments, the court held that the Toney Action was not related to the prior actions. In each of the prior actions, the plaintiffs alleged that they contacted a third-party product vendor to purchase various consumer products and were enrolled in Sempris' membership program as part of the same transaction, for which they were later billed. The claims were fraud-based, alleging that the plaintiffs had not consented to enrollment in the membership program as part of their purchase. By contrast, the plaintiff in the Toney Action alleged that she placed an online order with a third-party product vendor and was subsequently contacted by a third-party telemarketer about enrollment, but was never enrolled in, or billed for, the Sempris membership program. The claims in the Toney Action instead arose under the TCPA based on the plaintiff's allegation that her telephone number was listed on the National Do Not Call Registry. None of the fraud-based allegations in the prior actions formed the basis of a claim under the TCPA. According to the court, these factual differences were critical when viewed against a backdrop of strong Delaware precedent supporting a broad interpretation of common "relatedness" policy language.

Similarly, in Lexington Ins. Co. v. Lexington Healthcare Group Inc., the Supreme Court of Connecticut held that 13 negligence actions seeking damages for wrongful death or serious bodily injury did not constitute related claims following a deadly fire at a nursing home on property leased by the insured, Lexington Healthcare.[10] Ruling that the claims did not allege "related medical incidents," the court applied a separate per medical incident coverage limit to each fire victim. Although each claim arose from "a common precipitating factor" (i.e., the fire), the court held that the claims were not unambiguously "related" because they alleged "distinct losses to different individuals." Moreover, each loss was allegedly caused by different negligent acts, errors or omissions by the insured, as each victim was "differently situated in terms of his or her proximity to the fire and resultant smoke, access to an exit, and personal health and mobility issues."

Conclusion

Insurance coverage litigation was very active in 2014, and 2015 is shaping up to be another active year. Look for continued developments in connection with the frequently litigated topics discussed in this article, as well as an increase in the number and scope of coverage cases addressing cyberliability.

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DISCLOSURE: Jenner & Block LLP served as coverage counsel to Sempris in RSUI Indemnity Co. v. Sempris LLC.

[1] Travelers Indemnity Co. of America v. Portal Healthcare Solutions LLC, Case No., 1:13–cv–917 (GBL) (E.D. Va. Aug. 7, 2014).

[2] First Commonwealth Bank v. St. Paul Mercury Ins. Co., Civil Action No. 14–19 (W.D. Pa. Oct. 6, 2014).

[3] William Beaumont Hosp. v. Federal Ins. Co., 552 Fed. App'x 494 (6th Cir. 2014).

[4] U.S. Bank Nat'l Assoc. v. Indian Harbor Ins. Co., No. 12–cv–3175 (PAM/JSM) (D. Minn. July 3, 2014), reconsideration denied (D. Minn. July 24, 2014).

[5] Peerless Insurance Co. v. Pennsylvania Cyber Charter School, Civil Action No. 2:12–cv–1700 (W.D. Pa. May 13, 2014), reconsideration denied (W.D. Pa. Aug. 29, 2014).

[6] Borough of Moosic v. Darwin National Assurance Co., 556 Fed. App'x 92 (3d Cir. 2014).

[7] RSUI Indemnity Co. v. Sempris LLC, C.A. No. N13C–10–096 MMJ CCLD (Del. Super. Ct. Sept. 3, 2014).

[8] Sarah Toney, et al. v. Quality Resources Inc. et al., No. 13-cv-42 (N.D. Ill.).

[9] Dioquino v. Sempris LLC, Case No. 2:11-CV-05556-SJO-MRW (C.D. Cal.); Daniell v. Sempris LLC, Case No. 2012-CH-44123 (Cook Cty. Ill.); Valencia v. Sempris LLC, Case No. 12-CV-2985 (S.D. Cal.); Herman v. Sempris LLC, Case No. 13-CV-0020 (W.D. Mich.) (collectively, the "prior actions").

[10] Lexington Ins. Co. v. Lexington Healthcare Group Inc., 84 A.3d 1167 (Conn. 2014) (en banc).
