INSURANCE LAW IN THE DISTRICT OF COLUMBIA

I. TYPES OF LIABILITY INSURANCE POLICIES

Generally speaking, third-party insurance policies cover losses of or damages to third parties that are caused by or allegedly caused by the policyholders' actions or inactions. The most common third-party policy is a general liability policy, which protects against liability for claims by other companies or individuals. General liability policies cover risks associated with liability for property damage, bodily injury, and personal and advertising injury.

Professional liability policies are a type of third-party policy that covers liabilities arising from professional services. These policies are also known as errors and omissions policies and are generally purchased by licensed professionals such as contractors, architects, doctors, lawyers, and others.

Directors and officers liability policies are another example of third-party coverages. D&O policies, as they are known, protect companies, company management, individual directors and officers, and sometimes employees from claims arising out of the performance of their duties. The coverage generally applies to claims by, among others, investors, shareholders, lenders, and regulatory entities and to risks associated with offering of securities and company management. D&O policies typically do not cover claims for property damage or bodily injury and related losses.

Cyber liability coverages vary but are another third-party coverage typically designed to protect liability for data breaches, privacy claims, and other cybersecurity exposures. Potential claimants within this coverage include individuals and companies whose private, personal, proprietary, or confidential information has been compromised by a cyber breach event. Coverage issues concerning this type of policy are less developed. A separate chapter devoted to this critical and developing type of coverage is included at IX. Another type of coverage is first-party insurance policies. Those policies generally cover losses of or damages to the policyholder. An example is property insurance, which protects against physical loss to the insured's property. It also covers repairs and other costs that the insured incurs. Crime policies are another example of a first-party coverage. These policies protect against employee theft and similar types of internal company losses. Cyber insurance policies may contain first-party coverages. Such coverage would apply to losses associated with notifying those affected by a breach and restoring systems and computer networks back to pre-breach status. First-party cyber insurance policies can also cover other costs incurred in response to a data breach such as forensic costs to determine the cause of a breach of public relations costs to mitigate the fall-out from a breach

II. THE DUTY TO DEFEND

A. *General*

In the most general terms, individuals and companies purchase third-party policies to protect against the risk that they will face claims by third parties alleging injuries or other losses and damages. Commonly, policyholders, also known as "insureds," seek coverage from their liability insurers when they are named as defendants in lawsuits or receive demands seeking damages. Depending on the terms of the policy, subpoenas and other documents can also trigger the protection afforded by a policy.

Under many policies, liability insurers have a "duty" to defend their insureds against covered claims. The duty to defend obligates insurers to fund an insured's defense of claims and lawsuits. This means paying for attorneys and other costs necessary for the defense. The insurer's obligation to defend affords it various rights under the policy. Depending on the policy language, for instance, insurers may be permitted to appoint the lawyers to represent their insureds, often from a "panel" of counsel the insurer frequently hires. Additionally, insurers with a duty to defend may be permitted to control the defense of a lawsuit and exercise a final say on whether to settle the case when damages are within the limits of the policy. *See Eureka Inv. Corp., N. V. v. Chicago Title Ins. Co.*, 530 F. Supp. 1110, 1116 (D.D.C. 1982) (stating that an insurer that agrees to defend "is accorded the absolute control of the litigation" (citation omitted)), *aff'd in part, rev'd in part*, 743 F.2d 932 (D.C. Cir. 1984). This means that the policyholder may not be permitted to do more than cooperate in the defense of the claim. In *Eureka Investment*, the court's basis for affording the insurer control over settlement when damages do not exceed policy limits was that only the insurer's economic interests will be affected by the outcome of the litigation, so long as the insurer acknowledges that the claim is covered. *Id.*

B. *When an Insurer's Duty to Defend Arises*

Whether an insurer has a duty to defend is determined based upon the allegations in a complaint against the insured. If the allegations in the complaint are within the policy's coverage, then the duty is triggered. *See Am. Cont'l Ins. Co. v. Pooya*, 666 A.2d 1193, 1197 (D.C. 1995); *Washington v. State Farm Fire & Cas. Co.*, 629 A.2d 24, 26 (D.C. 1993).

To determine whether an insurer has a duty to defend, the District of Columbia considers only the complaint and the policy. This limited analysis is known as the "eight corners rule." *See Carlyle Inv. Mgmt., L.L.C. v. Ace Am. Ins. Co.*, 131 A.3d 886, 896 (D.C. 2016) (noting that the court will compare the "four corners" of the complaint with the "four corners" of the insurance policy (citing *Fogg v. Fidelity Nat'l Title Ins. Co.*, 89 A.3d 510, 512 (D.C. 2014)). The insurer's duty to defend is broader than its duty to pay judgments or settlements that may ultimately result from claims against its insureds. *See id.* This is because the duty to defend is based on the mere *potential* that the insured will be liable for a covered claim. *See Travelers Indem. Co. of Ill. v. United Food & Commercial Workers Int'l Union*, 770 A.2d 978, 991 (D.C. 2001) ("[A]n insurer's obligation to defend is triggered only when the insured tenders to the insurer the defense of an action which is potentially within the policy." (citation omitted)). As a result, the duty to defend is determined based upon the allegations alone and "is not affected by facts ascertained before suit or developed in the process of litigation or by the ultimate outcome of the suit." *Am. Cont'l Ins. Co. v. Pooya*, 666 A.2d 1193, 1198 (D.C. 1995) (*citing Washington v. State Farm Fire & Cas. Co.*, 629 A.2d 24, 26 (D.C. 1993)). Further, the court is not bound by the literal wording of the complaint in determining whether there is a duty to defend. *Id.* at 1197. Rather, the court considers "all plausible claims encompassed within the complaint . . . ." *Id.* If "the allegations state a cause of action within the policy coverage [that] give[s] fair notice to the insurer" that a covered occurrence is alleged, this "gives rise to a duty to defend under the terms of the policy." *Id.* In other words, the insurer must defend if, based upon the allegations, there is any possibility that the insured could be liable for a covered claim. *See Stevens v. United Gen. Title Ins. Co.*, 801 A.2d 61, 67 (D.C. 2002) ("This court must look to whether the allegations included in the complaint state a cause of action within the policy's coverage, and whether the allegations raise the possibility of coverage." (citation omitted)); *Pooya*, 666 A.2d at 1198 ("[I]f it is possible that the allegations of a complaint would bring it within coverage of the policy, the insurer is obligated to defend, even if it ultimately is not required to pay a judgment."). This means that an insurer may have to defend a lawsuit before it is clear whether it will be obligated to indemnify the insured for a settlement or judgment. *Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 896.

In determining whether there is a duty to defend, the court must resolve any doubt in favor of the insured. *See id.* ("We must construe the underlying complaints in favor of the insured."); *Stevens*, 801 A.2d at 67 ("Any doubt as to whether there is a duty to defend must be resolved in favor of the insured."). Further, the insurer must defend the entire action if a single count in the complaint would potentially be covered if the insured were found liable. *See Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 896 ("If the allegations of the complaint state a cause of action within the coverage of the policy the insurance company must defend." (citation omitted)); *see also Wash. Sports & Entm't, Inc. v. United Coastal Ins. Co.*, 7 F. Supp. 2d 1, 7 (D.D.C. 1998) ("The insurer must defend an entire claim if it appears that at least one count of a complaint falls within the scope of policy coverage, even though the insurer might later be absolved of a duty to indemnify on certain counts."). Finally, the D.C. Court of Appeals has stated that if the court finds that an insurer does not have a duty to defend, then the insurer cannot have an obligation to pay judgments or settlements on the insured's behalf. *Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 896.

C. *Unjustified Breach of the Duty to Defend*

The D.C. Circuit has held that an insurer's unjustified refusal to defend a covered claim constitutes a breach of contract and that remains binding law in D.C. *Siegel v. William E. Bookhultz & Sons, Inc.*, 419 F.2d 720, 723 (D.C. Cir. 1969). See also Douglas v. Lyles, 841 A.2d 1.5 (D.C. 2004) (recognizing that D.C. Circuit decisions rendered prior to February 1, 1971, are precedented case law in the District of Columbia. As a remedy for the breach, the insured is entitled to recover its defense expenses, any settlement or judgment of the claim, and "any additional loss legally traceable to the breach." *Id.* The *Siegel* court also held that the insured was entitled to an award of its attorneys' fees incurred in establishing the insurer's obligation to defend. According to the court, an insurer that denies coverage acts at its own peril in disregarding the insured's claim to a defense. *Id.* at 725. The court stopped short, however, of creating a blanket rule that insureds may always recover fees incurred in establishing coverage. *Id.* ("We do not, of course, imply that insurers cannot properly undertake to exonerate themselves from unassumed risks without accountability for the insured's costs of representation in the process."). In this case, however, the court held that fees were appropriate due to the

insurer's oppressive abandonment of an "obviously helpless insured," on dubious grounds, after initially providing a defense. *Id.*

The District of Columbia has not adopted a blanket exception to the American Rule that would permit insureds to recover attorneys' fees when they prevail in securing coverage in a legal action with their insurers. The Court of Appeals recognized such an exception in a single opinion, but that decision was vacated and settled prior to a rehearing en banc. *See Potomac Residence Club v. W. World Ins. Co.*, 711 A.2d 1228, 1231–38 (D.C. 1997), *reh'g en banc granted, judgment vacated*, 711 A.2d 1250 (D.C. 1998). The rule in the District of Columbia remains, for now, that absent a contract or statutory provision or a showing, as in *Siegel*, that the defendant's conduct was willfully and oppressively fraudulent, attorneys' fees are not allowed as damages or costs in an insurance coverage action. *See, e.g., Cont'l Ins. Co. v. Lynham*, 293 A.2d 481, 483 (D.C. 1972).

It is possible that the District of Columbia Court of Appeals, if confronted with this issue again, would adopt the position of Maryland courts, as it had in the initial ruling in *Potomac Residence Club*. Maryland recognizes an exception to the American Rule where the insured establishes coverage in an action against an insurer that wrongfully denied its obligations. *See Collier v. MD-Individual Practice Ass'n, Inc.*, 607 A.2d 537, 542 (Md. 1992) (attorneys' fees may be obtained by "an insured who succeeds in obtaining a declaratory judgment that a liability policy provides coverage"); *but see Bausch & Lomb Inc. v. Utica Mut. Ins. Co.*, 625 A.2d 1021, 1037 (Md. 1993) (reversing award of attorneys' fees where insurer was not obligated to defend or indemnify insured); *N. Assurance Co. v. EDP Floors, Inc.*, 533 A.2d 682, 690 (Md. 1987) (insurer not liable for insured's attorney fees in declaratory judgment action seeking to establish duty to defend, where insurer's refusal to defend was not wrongful).

Finally, while not addressed by the D.C. Court of Appeals, the Maryland Court of Appeals and a District of Columbia federal court have held that an insurer that wrongfully refuses to defend waives the right to rely on an insured's purported untimely notice of the claim as a defense to providing coverage. *See St. Paul Fire & Marine Ins. Co. v. Molloy*, 420 A.2d 994, 996 (Md. Ct. Spec. App. 1980) ("The Court of Appeals has held that the insurer will waive the defense of failure to give timely notice of injury if he fails to specify the defense at the time liability is denied."), *rev'd on other grounds*, 433 A.2d 1135 (Md. 1981); *Washington Sports & Entertainment, Inc. v. United Coastal Ins. Co.*, 7 F. Supp. 2d 1, 7-8 (D.D.C. 1998). The defense of untimely notice of claims is addressed in § IV.A, below.

D. Conflicts of Interest

When the insurer is defending its insured, their financial interests are often aligned because a finding that the insured is not liable benefits the interests of both the insured and the insurer. The attorney appointed to defend the insured, therefore, can effectively represent the interests of both parties. However, under some circumstances, the interests of the insurer and the insured may diverge. This issue arises frequently, with varying rules across jurisdictions about how to protect the insured. A common solution to address conflicts of interest is to require the insurer to pay for separate, independent counsel to represent the insured, often of the insured's choosing. Two situations in which a conflict may arise are: (1) when the claimant seeks damages in an amount greater than the available insurance limits; and (2) when the insured faces some claims covered by the policy and others not covered by the policy.

1. Damages in Excess of Available Insurance

   Often, a lawsuit against an insured will seek damages that are greater than the amount of insurance coverage available to pay for judgments and settlements. In that situation, the insurer's and the insured's interests may not completely align. While the insurer's liability is capped at the policy limit, the insured's liability is not. District of Columbia courts have not specifically addressed the potential conflicts that arise in this situation. Maryland courts, however, have addressed this issue and, as mentioned above, Maryland law is persuasive authority in the District of Columbia. *See Douglas v. Lyles, 841 A.2d 1, 5 (D.C. 2004).*

   The Maryland Court of Appeals has held that only a *potential* conflict of interest exists where the claim against the insured seeks damages in excess of the policy limit:

   > The insured, wishing to avoid the risk of a judgment in excess of policy limits, will desire to settle the claim as early as possible. The insurer, who risks nothing beyond the limits of the policy, may wish to delay settlement based upon a judgment that a more favorable settlement may be made at a later time.

   Allstate Ins. Co. v. Campbell, 639 A.2d 652, 659 (Md. 1994). The court stated that the mere potential for a conflict, by itself, does not obligate the insurer to appoint a separate lawyer to represent the insured's interests. *Id.* The insurer should, however, make the insured aware that a potential conflict of interest exists and that the insured should consult independent

counsel concerning the possibility that it will have to pay damages beyond the available insurance. *Id.*

2. Covered and Uncovered Claims

Occasionally, an actual, rather than potential, conflict develops between the insurer and the insured. In this circumstance, Maryland courts, like many jurisdictions, have held that the insurer must pay for independent counsel to represent the insured. *Allstate Ins. Co. v. Campbell*, 639 A.2d 652, 658 (Md. 1994) ("[I]f an actual conflict develops during the course of the representation, the attorney may not continue to represent both [the insurer and the insured]."). Such a conflict has been found to exist in Maryland where a dispute remains over the insurer's obligation to cover a judgment against the insured. *See Brohawn v. Transamerica Ins. Co.*, 347 A.2d 842 (Md. 1975). In *Brohawn*, the insured was sued for personal injuries arising from a dispute with a nursing home where her grandmother was a resident. The plaintiffs sought to establish the insured's liability on alternative theories of negligence, a claim covered by her policy, and assault, a claim not covered by her policy. The Maryland Court of Appeals recognized that this created a conflict of interest. The insurer's and the insured's interests were aligned insofar as a verdict that found the insured not liable would benefit both of them. *Id.* at 851. However, if the insured was to be found liable, the insured would benefit from a negligence verdict since that would be covered by the policy. The insurer, on the other hand, would stand to benefit from a verdict since that would not be covered by the policy. The court held that in this situation, the insured was entitled to independent counsel to protect its interests:

> When such a conflict of interest arises, the insured must be informed of the nature of the conflict and given the right either to accept an independent attorney selected by the insurer or to select an attorney himself to conduct his defense. If the insured elects to choose his own attorney, the insurer must assume the reasonable costs of the defense provided.

Id. at 854. While District of Columbia law is not developed on the subject, it may adopt a similar rule as Maryland given that District of Columbia courts find Maryland law to be persuasive authority.

III. DUTY TO INDEMNIFY

The duty to indemnify is a separate duty in most liability policies and generally obligates the insurer to pay for settlements or judgments in underlying claims against the insured. The standards for determining whether a duty to indemnify differs from the duty to defend because it depends upon the "true facts" rather than the alleged facts in the complaint. *Salus Corp. v. Cont'l Cas. Co.*, 478 A.2d 1067, 1069–70 (D.C. 1984). Thus, courts evaluating whether an insurer has a duty to indemnify are not confined to comparing the complaint to the policy.

IV. DEFENSES TO COVERAGE

A. Late Notice

When an insured receives notice of an occurrence, demand letter, lawsuit, or other claim, an insurance policy often requires the insured to provide timely notice to the insurer. Courts have stated that the requirement of timely notice is designed to protect the interests of the insurer who may be on the hook for the entire amount of its policy limits, as well as the public, which benefits from the timely administration of insurance claims. *See Diamond Serv. Co. v. Utica Mut. Ins. Co.*, 476 A.2d 648, 652 (D.C. 1984) ("It is in order to promote the efficient and economic liability insurance administration that [notice] provisions are given effect in the interest of the public as well as the insurer."); *Greycoat Hanover F St. Ltd. P'ship v. Liberty Mut. Ins. Co.*, 657 A.2d 764, 769 (D.C. 1995) (finding that delayed notice "deprived the insurance companies of the opportunity to plan and implement an appropriate litigation strategy").

Most, if not all, insurance policies contain provisions identifying the requirements for notifying insurers of occurrences, claims, demand letters, lawsuits, and other losses. Notice provisions vary with respect to their wording and requirements. Common policy language addressing notice reads, in part:

> 2. Duties In The Event Of, Occurrence, Offense, Claim Or Suit
>
> a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:
>
> (1) How, when and where the "occurrence" or offense took place;
>
> (2) The names and addresses of any Injured persons and witnesses; and
>
> (3) The nature and location of any Injury or damage arising out of the "occurrence" or offense.

> b. If a claim is made or "Suit" is brought against any insured, you must:
>
> (1) Immediately record the specifics of the claim or "suit" and the date received; and
>
> (2) Notify us as soon as practicable.
>
> You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

Courts have uniformly held the words "as soon as practicable" to mean "within a reasonable time in view of all the facts and circumstances of each particular case." *Diamond Serv. Co.*, 476 A.2d at 652 (quoting *Greenway v. Selected Risks Ins. Co.*, 307 A.2d 753, 755 (D.C. 1973)). Whether an insured provided timely notice is usually a fact question for a jury. *See Travelers Indem. Co. of Ill. v. United Food & Commercial Workers Int'l Union*, 770 A.2d 978, 991 (D.C. 2001) (citing *Starks v. N. E. Ins. Co.*, 408 A.2d 980, 982 (D.C. 1979)). However, the reasonableness of the timing of providing notice can be a question of law when the parties do not dispute the evidence as to timing:

> The 'question whether an insured has acted reasonably becomes a question of law . . . when reasonable persons can draw but one inference and that inference points "unerringly" to the conclusion that the insured has not acted reasonably under the circumstances.

Greycoat 657 A.2d at 768 (alteration in original) (*citing Starks*, 408 A.2d at 982). The District of Columbia Court of Appeals applies a three-part test to determine whether an insured's delay in providing notice was reasonable:

(1) what the insured could reasonably have believed was his obligation under the policy;
(2) what the insured could reasonably have believed about the seriousness of the injury and his liability for it; [and]
(3) what the insured could reasonably have believed about the likelihood of a claim being made against him.

See Diamond Serv. Co., 476 A.2d at 653 (citing *Starks*, 408 A.2d at 983). In the District of Columbia, "where compliance with notice provisions is a contractual precondition to coverage, a failure timely to notify releases the insurer from liability" and the insurer need not show prejudice resulting from any such failure. *Greycoat*, 657 A.2d at 768. In so concluding, the *Greycoat* court stated that notice provisions "are of the essence of the contract." *Id.*

B. Breach of Cooperation Clause

Most insurance policies include a provision that obligates an insured to cooperate with the insurer in investigating, defending, and settling a claim. One example of this provision reads, in part:

> SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS
>
> 2. Duties In The Event Of, Occurrence, Offense, Claim Or Suit
>
> c. You and any other involved insured must:
>
> …
>
> (3) Cooperate with us in the investigation or settlement of the claim or defense against the "suit"

An insured that violates this provision by failing to adequately cooperate may forfeit all coverage under the policy. However, a breach of this clause will not forfeit coverage unless the insurer demonstrates prejudice resulting from that breach. *See Nationwide Mut. Ins. Co. v. Burka*, 134 A.2d 89, 90 (D.C. 1957) (requiring that insurer show that insured's actions in breaching cooperation clause were in bad faith and prejudicial); *see also Allstate Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 767 A.2d 831, 840 (Md. 2001) ("[T]he insurer must establish a substantial likelihood that if the cooperation or notice clause had not been breached, the insured would not have been held liable." (citation omitted)).

No District of Columbia courts have found that an insured forfeited its right to coverage because it failed to cooperate. In one District of Columbia Court of Appeals opinion, the court applied Maryland law and held that an insured's failure to cooperate was prejudicial and the insurer was, therefore, excused of its obligations. *See Coleman v. Aetna Ins. Co.*, 309 A.2d 306 (D.C. 1973). In *Coleman*, a pedestrian sued a bus company and its president after she was struck by a bus that she maintained was owned by the company. The insurer provided a defense to the bus company and its president. *Id.* at 308. The chief defense to the claims was that the bus involved in the accident was not actually owned by the defendant company. *Id.* The president of the company was the only individual that could provide the testimony necessary to support this defense, but he failed to appear at depositions or trial. *Id.* The court found that failure breached the cooperation clause. *Id.* According to the court, the absent president's testimony was "vital to the defense" and the breach, therefore, "substantially prejudice[d]" the insurer. *Id.*

The insurer therefore was excused from providing coverage. *Id.* Similarly, the Maryland Court of Appeals held that an insured had forfeited the right to coverage because it had breached the policy's cooperation clause by refusing to attend depositions and cooperate with discovery. *Allstate Ins. Co.*, 767 A.2d at 842–44.

Finally, at least one decision applying District of Columbia law has held that an insurer waives an otherwise viable defense of an insured's failure to cooperate if the insurer appeals a verdict entered against its insured. *See Nationwide Mut. Ins. Co. v. Thomas*, 306 F.2d 767, 769 (D.C. Cir. 1962) (insurer waived right to claim noncooperation by appealing a judgment on the merits). In *Thomas*, the insurer, by appealing the case on the merits, was liable for a judgment against its insured that may have resulted directly from the insured's failure to cooperate.

C. *Misrepresentation on Policy Application*

When insureds apply for coverage or for a renewal of a policy that is already in place, they typically must complete an application containing questions, including about the risks that the insureds may face. Insurers may rely upon an applicants' answers to underwrite the proposed coverage. Applications often contain questions concerning any losses, claims or litigation known to the insured, or that the insured reasonably expects may arise. The wording of these questions varies by coverage and insurer, but some examples are:

> 1. Do the principals of the firm have knowledge of any error, omission, or any other circumstance that is, or could be, a basis for a claim under the proposed policy?
>
> 2. Are you aware of any facts or circumstance that you reasonably believe may result in a claim being made against the applicant?
>
> 3. Is the applicant aware of any circumstances, occurrence, or condition resulting in accident or injury to person or persons; damage to property including loss of use thereof; unresolved job controversy or complaint regardless of amount, or allegation of discrimination, which may result in the making or assertion of a claim against him, his predecessors in business, or any of the present or past partners or officers?

If an insured does not respond accurately to this type of question, that could amount to a misrepresentation of information material to the risk that the insurer agreed to cover. Insurers may seek to rescind, or render void, a policy issued to an insured that made a material misrepresentation on an application. If a policy is rescinded, coverage is not only precluded for a particular claim that may be at issue, but is revoked entirely for the remainder of the policy term and no coverage is available for any future claims. Generally, an insurer seeking to rescind a policy must show that it relied on an insured's inaccurate answer in issuing the policy.

There is limited District of Columbia authority addressing whether an insurer may rescind a policy due to an insured's misrepresentation on an application. In *Government Employees Insurance Co. v. Govan*, 451 A.2d 884 (D.C. 1982), the insurer declined to defend a suit against the insured, claiming that the car insurance policy was void *ab initio*, or voided from the outset, due to an incorrect answer on the application indicating that the insured had not committed any traffic violations in the preceding three years. *Id.* at 885. The court rejected the insurer's misrepresentation defense, finding that the insurer had failed to establish that it had actually relied on the incorrect questionnaire answers in agreeing to issue the policy. *Id.* at 885–86. This was because the insurer was indisputably aware of other inaccuracies on the application, even if it did not know about the undisclosed traffic violations. *Id.* The insurer's failure to reasonably inquire into the insured's driving record meant that it was not entitled to rescind the policy based on the inaccuracies it could have discovered. *Id.*

District of Columbia federal courts have recognized that "[i]t is well-established that *deliberate* misrepresentation or concealment of a material fact in an application for insurance renders that policy void *ab initio*." *See Colonial Penn Ins. Co. v. Owens*, 728 F. Supp. 798, 802 (D.D.C. 1990) (emphasis added). If such a misrepresentation "materially affect[ed] the insurer's decision to take on a certain risk," the insurer may be permitted to rescind the policy. *Wash. Sports & Entm't, Inc. v. United Coastal Ins. Co.*, 7 F. Supp. 2d 1, 10 (D.D.C. 1998). In *Colonial Penn*, the court found that the policy was void where the insured indicated she had not been in an automobile accident in the prior 36 months despite having been involved in a fatal crash a mere nine hours earlier. 728 F. Supp. at 803. In *Washington Sports*, the insurer argued that the insured architects who had constructed the MCI Center had failed to disclose that the Department of Justice (DOJ) had sent letters stating a belief that the arena's design was not compliant with the Americans with Disabilities Act (ADA). 7 F. Supp. 2d at 11. The court held that rescission was not warranted, even though the lawsuit for which the insureds sought coverage alleged that the arena was not ADA compliant. According to the court, the

insured's failure to identify the DOJ's concerns "may appear troubling under the floodlamp of hindsight," but did not amount to "a material misrepresentation at the time." *Id.* There was no evidence that the insureds knew that they would be sued or that the arena ran afoul of the ADA. *Id.* Rather, the evidence showed that the preliminary discussions with the DOJ did not change the fact that the insureds had a good faith belief that the issue would be resolved short of litigation. *Id.* at 10. District of Columbia Code § 31-4314 governs false statements in applications for life insurance policies. *See Skinner v. Aetna Life & Cas.*, 804 F.2d 148, 149 (D.C. Cir. 1986); *Johnson v. Prudential Ins. Co.*, 589 F. Supp. 30, 35 (D.D.C. 1983), *aff'd*. 744 F.2d 878 (D.C. Cir. 1984); *Blair v. Inter-Ocean Ins. Co.*, 589 F.2d 730, 732 (D.C. Cir. 1978).

The Maryland Court of Appeals has held that a misrepresentation in a liability insurance policy application warrants rescission of the policy if the misrepresentation is material. *Semelsberger v. Hatem*, 296 A.2d 398, 402 (Md. 1972). In that case, an insured misrepresented facts on an application concerning her husband's use of a vehicle to be insured under a liability policy. She also identified him as not being an impaired driver when, in fact, he only had one eye. *Id.* at 402–03. It did not matter, according to the court, whether the insured mistakenly or intentionally misrepresented the facts. *Id.* at 403 (citing *State Farm Mut. Auto. Ins. Co. v. West*, 149 F. Supp. 289, 305 (D. Md. 1957)). Either way, the effect of the inaccurate answer was the same: the insurer was in "no better position," whether the misstatement was intentional or not. *Id.* (citation omitted).

D. *Expected or Intended Injury*

Liability insurance generally does not protect against harm or injury that an insured intended to cause. This limitation on insurance coverage can arise in different ways. First, many insurance policies, by their terms, cover loss resulting from "occurrences," often defined as accidents "neither expected or intended from the standpoint of the insured." Second, and similarly, insurance policies may include a separate exclusion known as the expected and intended injury exclusion, which bars coverage for "bodily injury or property damage expected or intended from the standpoint of the insured." Third, courts may find that public policy dictates that insurance should not protect the perpetrator of an intentionally harmful act.

There is limited District of Columbia authority addressing whether, and to what extent, insurance coverage is permissible for claims involving allegations that the insured acted with the intent to cause an injury. The District of Columbia Court of Appeals has recognized that public policy may preclude coverage for wrongdoers that act with intent, but did not decide the issue because the underlying case was still pending. *See Salus Corp. v. Cont'l Cas. Co.*, 478 A.2d 1067, 1070 (D.C. 1984) (recognizing policy considerations which may preclude protecting a wrongdoer from paying for an intentional injury he caused) (citing *Sherman v. Ambassador Ins. Co.*, 670 F.2d 251, 260 (D.C. Cir. 1981)). In addition to issues of public policy, the court noted that the policy's definition of "occurrence," which excluded expected or intended injuries, may bar coverage for a judgment that the insured intended to cause the injury at issue.

The Maryland Court of Appeals has held that an "expected or intended" exclusion does not apply where the insured did not intend the resulting injury, even if the injury was foreseeable. *See Sheets v. Brethren Mut. Ins. Co.*, 679 A.2d 540, 548-50 (Md. 1996). The court rejected a rule that an injury is expected or intended merely because the insured *should have* foreseen the injury. *Id.* at 549 (holding that liability policies would be rendered meaningless if they excluded coverage for damages that should have been foreseen or expected by insured).

At least one Maryland decision has, however, recognized that certain injuries, such as those resulting from sexual assault, are expected or intended as a matter of law, regardless of what the insured claimed to have believed. *See Pettit v. Erie Ins. Exch.*, 709 A.2d 1287, 1289, 1294 (Md. 1998) (finding that intentional injury provisions excluded coverage for claims of adult sexual molestation of children as a matter of law).

E. *Coverage for Punitive Damages*

Some jurisdictions do not permit insurance coverage for punitive damages assessed against insureds as part of judgments in litigation. Courts reason that allowing a wrongdoer to recover punitive damages from an insurer would frustrate punitive damages' purpose to punish misconduct and deter future wrongdoing. *See, e.g., Hartford Accident & Indem. Co. v. Vill. of Hempstead*, 397 N.E.2d 737, 743 (N.Y. 1979). Despite courts across jurisdictions frequently addressing the issue, there is limited law in the District of Columbia addressing the insurability of punitive damages.

The District of Columbia Court of Appeals has held that an insurer is not excused from its duty to defend a claim that seeks punitive damages. *See Salus Corp. v. Cont'l Cas. Co.*, 478 A.2d 1067, 1071 (D.C. 1984). According to the *Salus* court, without any judgment against the insured, it is "premature and inappropriate" to find that an insurer owes no coverage under the policy merely because the insured may ultimately be liable for punitive damages. The court further explained that:

> [i]t may well be that once the 'ultimate liability' of [the insured] is determined, the contractual duty of the appellee-insurers to pay punitive damages would be negated by proof of [the insured's] intentional misconduct. However, that remains for future resolution.

Id. at 1072. The court, therefore, did not resolve the question of whether, and under what circumstances, punitive damages are insurable.

The District of Columbia Court of Appeals has acknowledged that the issue of whether punitive damages are insurable has been left "open" by the court. *See In re Estate of Corriea*, 719 A.2d 1234, 1241 n.5 (D.C. 1998) ("[W]e noted that the court had left this issue open in *Salus Corp. v. Continental Cas. Co.*, 478 A.2d 1067, 1071–72 (D.C. 1984)"). Some jurisdictions prohibit insurance coverage for punitive damages based on *intentional* misconduct, but permit coverage for damages based on some lesser degree of culpability, such as recklessness. In the District of Columbia, punitive damages can be based on merely reckless conduct, in addition to willful misconduct. *See Johnathan Woodner Co. v. Breeden*, 665 A.2d 929, 938 (D.C. 1995), *opinion amended on denial of reh'g*, 681 A.2d 1097 (D.C. 1996) (punitive damages permissible for "a tortious act accompanied with fraud, ill will, recklessness, wantonness, oppressiveness, willful disregard of the plaintiff's right, or other circumstances tending to aggravate the injury" (citation omitted)).

As explained above, the *Salus* court opined that an insurer's obligation to pay a judgment awarding punitive damages may be "negated by proof of [the insured's] intentional misconduct." *Salus*, 478 A.2d at 1072. Based upon the *Salus* court's focus on the intentional nature of the misconduct, it is possible that the District of Columbia Court of Appeals would permit insurance coverage for punitive damages based on unintentional, but not intentional misconduct. However, the court has yet to address the issue.

To the extent the District of Columbia Court of Appeals looks to Maryland law, the Maryland Court of Appeals supports the insurability of punitive damages as not against public policy. *See First Nat'l Bank of St. Mary's v. Fid. & Deposit Co.*, 389 A.2d 359, 367 (Md. 1978) ("[W]e find that 'the common sense of the entire community would (not) pronounce it' against public policy for the Bank's insurance company to pay the judgment for exemplary damages assessed against the Bank here."). The court in *First National Bank* expressly rejected authority finding that the deterrent effect of punitive damages would be negated if covered by insurance. *Id.*

V. EFFECT OF OTHER INSURANCE POLICIES

A. 'Other Insurance' Clause

A claim or lawsuit can implicate more than one insurance policy. An individual, business, or other organization may purchase more than one policy at a time to provide additional limits of coverage. Or, an individual, business, or other organization may qualify as an insured under policies that they did not purchase but that may nevertheless provide coverage based upon a business or other relationship with the holders of those policies. For example, a delivery driver for a pizza restaurant may be covered under both his personal automobile liability policy and a policy that the restaurant purchased to cover risks presented by its drivers. If the delivery driver gets into an accident and is sued, he may be entitled to coverage under both policies. A dispute that often arises in this type of situation concerns the respective coverage obligations between the insurers that issued each of the policies.

Most insurance policies contain provisions addressing the effect of other available insurance on the insurer's obligations to defend and indemnify. These provisions are known as "other insurance" provisions. The most common types of other insurance provisions are: (a) "pro-rata" other insurance clauses; (b) "excess" other insurance clauses; and (c) "escape" other insurance clauses. An example of how each type of provision may be worded is as follows:

> ***Pro-Rata Other Insurance Clause:*** If the insured has other insurance against a loss covered by this policy . . . the company shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability . . . bears to the total applicable limit of liability of all valid and collectible insurance against such loss.
>
> ***Excess Other Insurance Clause:*** The insurance afforded (by this policy) shall be excess insurance over any other valid and collectible insurance.
>
> ***Escape Other Insurance Clause:*** This insurance does not apply to any injury or damage to the extent that the insured has available any other valid and collectible insurance.

Each of these provisions has a different effect on an insurer's obligations when there are other insurance policies that afford coverage to the same insured. A pro-rata other insurance clause is designed to limit an insurer's obligation to only a proportional share

of the loss when another policy provides concurrent coverage. *Jones v. Medox, Inc.*, 430 A.2d 488, 489 & n.1 (D.C. 1981). In other words, if two insurers issue policies that both provide primary coverage for a loss, than each will contribute, proportionally, to the defense and indemnity of the mutual insured at the same time. *Id.* An excess other insurance clause, in contrast, is designed to limit an insurer's obligation to provide coverage to only after the other policy or policies have paid out their limits in the defense or indemnity of a claim. *Id.* A policy with an escape clause is designed to excuse the insurer of all liability for the loss when there is other valid and collectible insurance. *Id.*

The District of Columbia gives effect to other insurance provisions where possible. Some courts have declined to recognize the validity of other insurance clauses altogether and instead prorate liability among all implicated policies. *See id.* at 492 (describing that some courts consider all other insurance clauses to be "mutually repugnant" regardless of their nature and requiring proration of liability). The District of Columbia has rejected this approach, holding that other insurance clauses are enforced as written where they can be reconciled and do not conflict. *Id.* at 492–93; *see also Cont'l Cas. Co. v. Hartford Fire Ins. Co.*, 116 F.3d 932, 939 (D.C. Cir. 1997) ("Under District of Columbia law, where 'other insurance' provisions in an excess insurance policy and a pro-rata policy can be reconciled to give effect to the intent of the contracting parties, the court will do so."). In *Jones*, the District of Columbia Court of Appeals held that an insurance policy with a pro-rata clause and another policy with an excess clause are not "mutually repugnant." 430 A.2d at 493 (citations omitted). The court reconciled the provisions so that the policy with the excess other insurance clause would not be triggered until after the other policy was exhausted. *Id.*; *see also Nolt v. U.S. Fid. & Guar. Co.*, 617 A.2d 578, 582 (Md. 1993) ("Where an excess clause from one policy conflicts with a pro rata clause from a concurrently effective policy, we disregard the pro rata clause in favor of the excess clause."). Because the pro-rata clause only applies to other insurance that is "valid and collectible," it did not apply since the other policy's excess other insurance provision made the other insurance collectible only after exhaustion of the insurance with the pro-rata other insurance clause. *Id.*

However, where the other insurance provisions are not reconcilable, the court will "sweep away" the contractual language and order that each insurer contribute a proportional share to the loss. *Jones*, 430 A.2d at 489. For example, the Maryland Court of Appeals holds that where two policies each contained excess other insurance clauses, the liability was to be shared equally between them. *See also Nolt*, 617 A.2d at 582 ("Where both policies provide for excess coverage only, liability is shared equally by the insurers."); *Ryder Truck Rental, Inc. v. Schapiro & Whitehouse, Inc.*, 269 A.2d 826, 831 (Md. 1970).

Finally, District of Columbia courts have not directly addressed the validity of escape other insurance clauses. Some courts have refused to enforce these provisions on public policy grounds. *See, e.g., Certain Underwriters at Lloyds, London v. Arch Specialty Ins. Co.*, 200 Cal. Rptr. 3d 786, 799 (Cal Ct. App. 2016), *as modified on denial of reh'g* (May 10, 2016), *review denied* (June 29, 2016). It is not clear whether the District of Columbia Court of Appeals would adopt a position that escape clauses are not enforceable.

B. What Policies Are Triggered

Sometimes property damage, bodily injury, or other loss events that give rise to claims or lawsuits against an insured do not occur as an isolated event in time. Instead, injuries may continue over a period of many months, even years or decades. A dispute over which insurance policies cover these type of long-term injuries can arise where there are numerous insurance policies that were in effect over the period of ongoing loss. These types of long-term injuries can occur in a variety of contexts. This section addresses the question of which policies are triggered in the context of two common types of continuous injuries, bodily injury and property damage.

1. Bodily Injury Claims

Some types of bodily injury may occur over a long period of time. The insurance industry has confronted these types of long-term injuries on a large scale in the context of asbestos exposure cases, as well as long-term exposures to pollutants or contaminants. For example, workers at factories, power plants, or in other industrial work environments have, in numerous cases, been exposed to asbestos for decades before developing mesothelioma and other pulmonary diseases caused by the asbestos. Where there is a continuous bodily injury to an individual or group of individuals, such as exposure to asbestos or other pollutants, the issue of which insurance policies are implicated often arises. The District of Columbia Court of Appeals has not definitively addressed this issue. The issue does, however, arise nationally in many cases.

One of the most frequently cited decisions nationally addressing insurance coverage for long-term bodily injury exposures is an opinion by the United States Court of Appeals for the District of Columbia Circuit. In that case, the court applied a "continuous" trigger of coverage that implicated all

policies in effect from the date of an individual's exposure to asbestos through the date he manifested a resulting disease. *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981). In *Keene*, the insured was a manufacturer of thermal insulation materials that contained asbestos. Numerous individuals claiming injuries from exposure to the asbestos-containing products brought suits against the insured manufacturer. *Id.* at 1038. Even after the claimants were no longer exposed to asbestos, the fibers in their lungs continued to aggravate their internal injuries. *Id.* These injuries did not result in the manifestation of mesothelioma until years after exposure in many cases. *Id.* at 1045 ("[W]e can still expect thousands of cases of those diseases to manifest themselves throughout the rest of the century."). The court applied a broad rule, holding that all policies from the date of initial exposure to asbestos fibers through the date the resulting disease outwardly manifested itself in an individual were triggered. *Id.* at 1047 ("We conclude, therefore, that inhalation exposure, exposure in residence, and manifestation all trigger coverage under the policies."). The court rejected arguments by various insurers that only the policies in place when the actual disease manifested should be triggered. *Id.* The court also rejected another insurer's arguments that only the policies in place during the exposure period were triggered. *See id.* ("We interpret 'bodily injury' to mean any part of the single injurious process that asbestos-related diseases entail.").

The court in *Keene* further held that a policyholder is permitted to seek full defense and indemnity coverage from any insurance policy that is triggered, an allocation approach commonly referred to as "all sums". *Id.* at 1049–50 ("[The insured] may select the policy under which it is to be indemnified."). The insurers could then assert claims against one another for contribution. *Id.* at 1050 n.35 ("[N]othing we hold today bars insurers from collecting from one another under the doctrine of contribution.").

Neither the District of Columbia nor the Maryland Court of Appeals has addressed whether they would apply the same trigger of coverage as in *Keene* that extends from initial exposure through manifestation and includes the "exposure in residence" period in between. However, the Maryland Court of Appeals has held that all of the policies in place during the period an individual is exposed to harmful conditions are triggered. *See Lloyd E. Mitchell, Inc. v. Maryland Cas. Co.*, 595 A.2d 469, 478 (Md. 1991) ("[A] minimum coverage under the policy is triggered upon exposure to and inhalation of asbestos fibers during the policy period by a person who suffers bodily injury as a result of that exposure."). The court rejected a rule that only the triggered policies are those in place when a disease manifests itself. *See id.* at 476 ("The trial court's determination that the policy now before us provides coverage only after an asbestos-related disease becomes manifest during the policy period is an interpretation at odds with the policy language and the clear weight of authority in the country."). The court did not address whether, as in *Keene*, the policies in effect during the period following exposure to asbestos, but prior to manifestation of any disease, are also triggered. The question of whether the District of Columbia Court of Appeals would follow *Keene* is, therefore, not resolved.

2. Property Damage

The District of Columbia has not definitively adopted a rule addressing what policies are triggered where there is a continuous property damage, such as ongoing environmental contamination that may occur for years prior to discovery. The Maryland Court of Appeals has held that, in a case of ongoing damage, the proper inquiry to determine what policies are triggered is whether during any given policy period there is detectable property damage. *See Harford Cty. v. Harford Mut. Ins. Co.*, 610 A.2d 286, 295 (Md. 1992) (explaining that the court must determine "[w]hether at any time during the policy period the discharge of contaminants into the soil and underlying groundwater is of sufficient gravity to prove detectable 'property damage'"). *Harford County* involved claims against an insured arising from groundwater contamination, purportedly due to the insured's operation of landfills over a lengthy period of time. *Id.* at 287. The court declined to hold that only the policies in effect when property damage is actually discovered are triggered. *See id.* at 294 ("Notwithstanding the difficulty that may be encountered in determining exactly when contaminants from a landfill may cause property damage, we hold that 'manifestation' is not the sole trigger of coverage in environmental pollution cases."). The court noted that expert testimony would likely be necessary to determine whether there was "detectable" property damage during any given policy period. *See id.* at 295.

The District of Columbia Court of Appeals has not directly addressed a coverage question involving continuous property damage as in *Harford County*. However, the court appears to have acknowledged the rule adopted in that case, which may shed light on how the District of Columbia would treat this issue. In *Wrecking Corporation of America, Virginia, Inc. v. Insurance Company of North America*, 574 A.2d

1348 (D.C. 1990), an insured demolition contractor was sued when a wall collapsed at a worksite after the insured completed its operations. The insurer maintained that there was no coverage because the wall collapse, which caused the property damage, had occurred after the policy was cancelled by the insured. *Id.* at 1349. The insurer maintained that this meant its policy was not triggered even though the allegedly negligent acts that led to the wall collapse took place while the policy was in force. *Id.* The court recognized "the prevailing rule" as being that '"property damage occurs' at the time the damage is discovered or when it has manifested itself." *Id.* at 1349–50 (citations omitted). However, the court noted a "limited exception" to this rule "where the damage can be characterized as being 'continuous or progressive.'" *Id.* at 1350 (citing authority from other jurisdiction). In the case at hand, the court found that there was no evidence of damage of a continuous or progressive nature or any initial damage occurring during the policy period. *Id.* As a result, the court held that there was no coverage. However, the court's recognition of an exception to the manifestation rule for "continuous" injuries at least suggests that the District of Columbia Court of Appeals would apply a similar rule as in *Harford* to continuous property damage cases involving successive insurance policies. While not binding authority, at least one District of Columbia federal opinion has characterized the *Wrecking Corporation* case as adopting a continuous trigger in property damage cases. *See Young Women's Christian Ass'n of Nat'l Capital Area, Inc. v. Allstate Ins. Co. of Canada*, 275 F.3d 1145, 1154 (D.C. Cir. 2002) (characterizing *Wrecking Corporation* as recognizing, under District of Columbia law, the "continuous" trigger rule applied in *Keene*).

VI. INSURER BAD FAITH

A. *Source of Duty*

In addition to breach of contract actions, a number of jurisdictions recognize a cause of action in tort when the insurer handles a claim, submitted by its insured, in bad faith. In a ruling involving a first-party homeowner's policy, the District of Columbia Court of Appeals diverged from those jurisdictions by not recognizing in that case a bad faith cause of action in tort, either by statute or common law. The court reasoned that, because an insurance policy establishes a contractual relationship between the parties, contract law should govern any disputes relating to the respective obligations of the parties:

> Disputes relating to the respective obligations of the parties to an insurance contract should generally be addressed within the principles of law relating to contracts, and bad faith conduct can be compensated within those principles. We see no compelling basis for complicating matters by intertwining such disputes with considerations peculiar to tort.

See Choharis v. State Farm Fire & Cas. Co., 961 A.2d 1080, 1087 (D.C. 2008); *see also Washington v. GEICO*, 769 F. Supp. 383, 387 (D.D.C. 1991) ("Although recognizing that disagreement exists, the Court finds that District of Columbia law does not recognize the tort of bad faith denial of an insurance claim."); *Athridge v. Aetna Cas. & Sur. Co.*, No. Civ. A. 96-2708 (RMU/JMF), 2001 WL 214212, at *3, 5 (D.D.C. Mar. 2, 2001) (recognizing that "District of Columbia law is immature" and that "the District of Columbia has not yet seen fit to create a bad faith tort . . . ."). *But see Washington v. Grp. Hospitalization, Inc.*, 585 F. Supp. 517, 520 (D.D.C. 1984) ("Many jurisdictions have recognized a cause of action in tort for the bad faith refusal of an insurer to pay. The District of Columbia is no exception."), *disapproved of by Choharis*, 961 A.2d at 1088. The Court of Appeals, in *Choharis*, stated that it was up to the legislature, and not the courts, to create "special burdens" for insurers in the District of Columbia. 961 A.2d at 1090–91.

The District of Columbia Code, similar to many other jurisdictions, prohibits certain unfair claim practices by insurers. *See* D.C. Code § 31-2231.17. The statute prohibits insurers from engaging in various acts of claims-handling misconduct with a frequency that indicates a general business practice. *Id.* This includes misrepresenting pertinent facts or provisions relating to a claim; refusing to pay a claim for arbitrary or capricious reasons; and failing to settle claims promptly, among several other enumerated acts. *Id.* § 31-2231.17(a)–(b). However, the statute specifically provides that it does not "create or imply a private cause of action for a violation of th[e] chapter." D.C. Code § 31-2231.02(a). This means that insureds cannot assert a violation of this statute as a cause of action against insurers in a dispute over coverage.

a. Duty to Settle

As mentioned above, some jurisdictions permit actions in tort against insurers for bad faith in the handling of claims, refusal to pay claims, or failure to settle claims, among other types of misconduct. While the District of Columbia Court of Appeals has declined to recognize a tort of bad faith against an insurer, it has not directly addressed an argument that such a claim should be permitted where an excess judgment

results from an insurer's failure to settle a lawsuit against its insured. In *Choharis v. State Farm Fire & Casualty Co.*, the court agreed with the reasoning of a federal case acknowledging that neither the District of Columbia nor Maryland recognize a tort of bad faith breach of contract for refusing to defend. 961 A.2d 1080, 1088 (D.C. 2008) (agreeing with analysis in *Fireman's Fund Ins. Co. v. CTIA – The Wireless Ass'n*, 480 F. Supp. 2d 7 (D.D.C. 2007)). In *Fireman's Fund*, the court rejected an insured's bad faith breach of contract claim by looking to Maryland law and indicating that Maryland does not recognize a tort cause of action for a "quintessential failure-to-defend claim." 480 F. Supp. 2d at 11. Further, the *Choharis* court agreed with the rule in Maryland that there is no tort of bad faith in the context of first-party insurance disputes. 961 A.2d at 1088. The Court of Appeals has not expressly held, however, that an insured cannot seek amounts in excess of the policy limits under any circumstances, such as an insurer's failure to settle. The District of Columbia would likely look to Maryland law if confronted with these issues. *See, e.g., id.* at 1088 & n.10 (referring to Maryland as a "sister jurisdiction" from which the District of Columbia derives its common law).

Under Maryland law, a bad faith tort cause of action is only permitted where an insurer fails to settle a claim made against its insured and that failure exposes the insured to a judgment in excess of policy limits. *See Kremen v. Md. Auto. Ins. Fund*, 770 A.2d 170, 176 (Md. 2001) (recognizing that "an insurer can be sued by its insured in tort for wrongful failure to settle a claim") (*citing Mesmer v. Md. Auto. Ins. Fund*, 725 A.2d 1053, 1061 (Md. 1999)). In such a situation, the insured is left responsible for amounts in excess of the policy limits. The Maryland Court of Appeals has permitted insureds to recover the full amount of the judgment, the policy limits notwithstanding, where an insurer is liable for bad faith failure to settle. *Id.* at 177 ("Ordinarily the measure of damages in a bad faith failure to settle case is the amount by which the bonafide judgment rendered in the underlying action exceeds the amount of insurance coverage."). Further, under Maryland law, an insurer may still be liable for bad faith failure to settle even where there was never an unconditional offer to settle the case and the insured itself did not want to settle. *Id.* at 178.

To determine whether an insurer has acted in bad faith by failing to settle, its conduct is judged by a standard of reasonableness. *See Allstate Ins. Co. v. Campbell*, 639 A.2d 652, 655 (Md. 1994) ("[A] n insurer must use 'reasonable care' in defending the insured and that a refusal to settle must be based upon 'an informed judgment based on honesty and diligence.'" (citation omitted). The insurer, nevertheless, does not have an absolute duty to settle a case whenever there exists the potential for a judgment in excess of policy limits:

> [W]hile an insurer has a duty to enter into good faith negotiations 'where reasonable and feasible' to settle a claim within policy limits, . . . there is no requirement that it 'rush to the settlement of a claim' against the insured to avoid an excess judgment.

Id. at 659 (*citing* 7C John A. Appleman, Insurance Law & Practice § 4711, at 377 (Walter F. Berdal ed., 1979)). Additionally, a claim for bad faith failure to settle in Maryland can be assigned to the injured party. *Med. Mut. Liab. Ins. Soc'y of Md. v. Evans*, 622 A.2d 103 (Md. 1993). This is potentially important because the insured is often left with little to bargain with when facing an excess judgment that may be in the millions of dollars.

Finally, as mentioned above, Maryland does not permit a bad faith tort cause of action against an insurer that wrongfully denies that it has a duty to defend. *Mesmer*, 725 A.2d at 1061 ("We have repeatedly indicated that the obligation to defend . . . [is] entirely contractual."); *Vigilant Ins. Co. v. Luppino*, 723 A.2d 14, 17 (Md. 1999) ("An insurer's obligation to defend is contractual, and, therefore, a cause of action for breach of the duty to defend sounds in contract.").

VII. PROCEDURAL ISSUES

A. Statute of Limitations

Contract law governs the respective obligations of the insurer and the insured under an insurance policy. In the District of Columbia, a party claiming breach of contract must commence an action within three years of the breach. *See* D.C. Code § 12-301(7). A cause of action for breach of contract accrues at the time of the alleged breach. *See Murray v. Wells Fargo Home Mortg.*, 953 A.2d 308, 321 (D.C. 2008). A contract is breached when a party fails to perform at the time performance is due. *Id.* at 320 (citing 9 Arthur L. Corbin, Corbin on Contracts § 943 (interim ed. 2002)). The absence of a specific monetary injury does not prevent the accrual of an action for breach of contract. *Wright v. Howard Univ.*, 60 A.3d 749, 753 (D.C. 2013). When a contract

fails to supply a specified time for the performance of an act, the law implies that it must be done within a reasonable time. *Murray, 953 A.2d at 320* (*citing Indep. Mgmt. Co., Inc. v. Anderson & Summers, LLC*, 874 A.2d 862, 869 (D.C. 2005)).

The District of Columbia Court of Appeals has recognized that a trial court found that the limitations period for a suit against an insurer begins to run on the date that the insurer denies that it owes a duty to defend. *See P'ship Placements, Inc. v. Landmark Ins. Co.*, 722 A.2d 837, 841 (D.C. 1998) (insured's claim that insurer breached duty to defend was barred by statute of limitations when not brought within three years following denial of coverage). This holding differs from a Maryland court's decision that a cause of action for breach of the duty to defend does not accrue until after a judgment is entered, even though the insured could file a suit at an earlier time. *See Luppino v. Vigilant Ins. Co.*, 677 A.2d 617, 621 (Md. Ct. Spec. App. 1996) (holding that statute of limitations begins to run when judgment was rendered against insured that he was legally obligated to pay). The District of Columbia Court of Appeals has not addressed the *Luppino* case. A District of Columbia federal court has held that the statute of limitations on a claim for breach of the duty to indemnify accrued when performance is due and not when the insurer denies its obligations. *Nat'l R.R. Passenger Corp. v. Lexington Ins. Co.*, 357 F. Supp. 2d 287, 293 (D.D.C. 2005). The court in that case held that the *Landmark* decision was not inconsistent with its ruling because in the *Landmark* case, there was no indication that performance was not yet due.

Sometimes insurance policies specify a time period within which an insured must bring suit that differs from the three-year statutory period. The District of Columbia Court of Appeals has enforced these provisions, finding that they do not run afoul of public policy. *See Centennial Ins. Co. v. Dowd's Inc.*, 306 A.2d 648, 651 (D.C. 1973) (noting that the legislature has the power to legislate on the topic of contractual limitation periods but has not done so).

B. *Declaratory Judgment Actions*

Either an insurer or an insured can file a declaratory judgment action to determine the parties' rights under the policy. *See, e.g., McIntosh v. Washington*, 395 A.2d 744, 748 (D.C. 1978) ("A declaratory judgment is one which determines and declares the rights of the parties without being immediately coupled with a coercive decree."). Courts can declare whether or not an insured has a right to a defense at the outset of a lawsuit, since that determination relies only on the allegations in the complaint. *Salus Corp. v. Cont'l Cas. Co.*, 478 A.2d 1067, 1069–70 (D.C. 1984) ("[W]hereas the duty to defend depends only upon the facts as alleged to be, the duty to indemnify, *i.e.*, ultimate liability, depends rather upon the true facts." (alteration in original) (citation omitted)). If a court finds that the insurer has a duty to defend, it may require that the question of whether the insurer must indemnify the insured for a judgment must wait for future resolution. *Id.* at 1071–72. This is because the duty to pay depends on the "ultimate liability of the insured determined upon proven facts . . . ." *Id.* at 1071.

In the District of Columbia, there "is no general right to trial by jury in a declaratory judgment action, which is a creature of equity, unless that action presents a 'legal' issue." *See Diamond Serv. Co. v. Utica Mut. Ins. Co.*, 476 A.2d 648, 650 (D.C. 1984) (quoting *Beacon Theatres, Inc. v. Westover*, 359 U.S. 500 (1959)); *Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 477-78 (1962); *see also McIntosh*, 395 A.2d at 748 (describing declaratory judgment action as "essentially an equitable action, . . . [that] differs from other equitable actions on the question of immediate relief sought rather than on jurisdictional concerns"). While there is no trial as a matter of right, the parties can, however, agree to a jury trial to resolve fact issues. *See Diamond*, 476 A.2d at 650 n.1 (noting that Superior Court Civil Rule 57 permits a party to demand a trial by jury and ordering such a trial where the other party made no objection to a jury demand).

The District of Columbia Court of Appeals has not addressed whether the injured third-party claimant is a necessary party to a declaratory judgment action. Joinder of necessary parties is governed by District of Columbia Superior Court Rule of Civil Procedure 19(a). A necessary party is one that "claims an interest relating to the subject of the action and is so situated that the disposition of the action in the person's absence may . . . impair or impede the person's ability to protect that interest . . . ." *District of Columbia v. Am. Univ.*, 2 A.3d 175, 184 (D.C. 2010) (citing D.C. Super. Ct. R. Civ. P. 19(a)). A District of Columbia federal court has held that an injured party is a necessary party to a declaratory judgment action, but is not indispensable. *See U.S. Fire Ins. Co. v. Milton Co.*, 938 F. Supp. 56, 57 (D.D.C. 1996) ("It is clear that an injured party is a *necessary* party in a declaratory judgment action brought to test the coverage of an insurance policy." (emphasis in original)). The Maryland Court of Appeals has also not addressed this question.

C. *Assignment of Rights*

It is not uncommon for an insured to assign its rights under an insurance policy to an injured party in exchange for a release from liability. If an insurer

denies coverage, for instance, and the insured cannot afford to pay a judgment or settlement, it might assign its rights against its insurer to the injured party. The injured party may then pursue the insurer standing "in the shoes" of the insured. The District of Columbia permits the "free assignability of claims." *See Antal's Rest., Inc. v. Lumbermen's Mut. Cas. Co.*, 680 A.2d 1386, 1388 (D.C. 1996) (citing *Nat'l Union Fire Ins. Co. v. Riggs Nat'l Bank*, 646 A.2d 966, 971 (D.C. 1994). As the District of Columbia Court of Appeals has explained:

> In general, all contractual rights may be assigned, including the right to sue for enforcement of a claim. The right to assign is presumed, based upon principles of unhampered transferability of property rights and of business convenience. The effectiveness of an assignment does not normally depend upon the consent of the obligor unless the rights to be assigned involve the performance of unique personal services.

Flack v. Laster, 417 A.2d 393, 399 (D.C. 1980) (citing, *inter alia*, D.C. Code §§ 28–2302–2304).

Courts will, however, enforce anti-assignment clauses contained in agreements so long as the clauses contain "clear unambiguous language." *Antal's Rest., Inc.*, 680 A.2d at 1388. Many insurance policies contain language prohibiting the assignment of an insured's rights under the policy that is not consented to by the insurer. These clauses typically contain language similar to the following:

> Your rights and duties under this policy may not be transferred without our written consent except in the case of death of an individual named insured.

The District of Columbia Court of Appeals has held that an anti-assignment clause does not restrict the assignment of claims after a loss has occurred:

> A provision in a policy providing that the policy shall be void if assigned without the company's consent applies to assignment before loss. Such a clause restricting assignment does not in any way limit the right of assignment after the loss has occurred, and the rights of the parties become fixed thereby.

Id. (citations omitted). This means that the provision applies to assignments of the insurance policy before a loss or claim arises, whether the clause refers assignment of "your rights" or assignment of the policy itself. *See id.* at 1388–89 (rejecting argument that expressly prohibiting assignment of "your rights" instead of "of the policy" meant that the general rule in the District of Columbia did not apply).

D. *Burden of Parties to Insurance Contract*

In seeking coverage, the insured bears the burden of establishing that a loss or claim is within the terms of the policy. *Robinson v. Aetna Life Ins. Co.*, 288 A.2d 236, 238 (D.C. 1972) (holding that insured "must bring himself within the terms of the policy in order to receive payment"); *Council for Responsible Nutrition v. Hartford Cas. Ins. Co.*, No. 06-1590 (RMC), 2007 WL 2020093, at *4 (D.D.C. July 12, 2007) ("The insured bears the burden of showing that the underlying complaint comes within the policy's grant of coverage . . . .") (*citing Cameron v. USAA Prop. & Cas. Ins. Co.*, 733 A.2d 965, 969 (D.C. 1999)). Where, however, an insurer argues that an exclusionary provision bars coverage for an otherwise covered loss or claim, the insurer has the burden of proof. *See Carlyle Inv. Mgmt., L.L.C. v. Ace American Ins. Co.*, 131 A.3d 886, 896–97 (D.C. 2016). The insurer must, therefore, prove the facts which bring the claim at issue within the exclusion on which the insurer relies. *See Cameron*, 733 A.2d at 969 ("The burden is on [the insurer] to prove that the loss falls within an exclusion."); *Nationwide Mut. Fire Ins. Co. v. Wilbon*, 960 F. Supp. 2d 263, 267 (D.D.C. 2013) ("The insured bears the burden of showing that the underlying complaint comes within the policy's coverage, . . . and the insurer bears the burden of showing that an exclusion under the policy applies.").

E. *Lost Insurance Policies*

At times, insurance policies may be misplaced, lost, or destroyed. It is common for claims or losses to involve insurance policies issued decades earlier that still provide coverage. For instance, a lawsuit filed this year may allege pollution damage or bodily injuries resulting from exposure to contaminants dating back 50 or 60 years. A dispute over the terms or even existence of the policy can result if neither the insurer nor the insured are in possession of the original policy that was issued.

In the District of Columbia, the best evidence rule requires that, when the contents of a writing are to be proved, the original must be produced, unless its absence is satisfactorily explained. *Walker v. United States*, 402 A.2d 813, 813–14 (D.C. 1979). Courts permit secondary evidence of the contents of a writing if it is established that the original is lost. *Id.* at 814; *Abulqasim v. Mahmoud*, 49 A.3d 828, 837 (D.C. 2012) (same). A party seeking to introduce secondary evidence has the burden of demonstrating that the missing document cannot

be found and that it was lost or destroyed without fraudulent intent. *See Edmunds v. Frank R. Jelleff, Inc.*, 127 A.2d 152, 155 (D.C. 1956).

Neither the District of Columbia Court of Appeals, nor the Maryland Court of Appeals has provided specific guidance on what evidence can be introduced to establish the existence of a lost policy or what standard of proof must be met.

VIII. POLICY INTERPRETATION

A. *Choice of Law*

The District of Columbia employs the "governmental interest analysis" to determine which jurisdiction's laws apply to a dispute over insurance coverage. *See Vaughan v. Nationwide Mut. Ins. Co.*, 702 A.2d 198, 202 (D.C. 1997). Under that analysis, courts:

> first look at each jurisdiction's policy to see what interests the policy is meant to protect, and then consider which jurisdiction's policy would be most advanced by applying the law of that jurisdiction. Part of the test of determining the jurisdiction whose policy would be most advanced is determining which jurisdiction has the most significant relationship to the dispute.

Id. at 202 (citing *District of Columbia v. Coleman*, 667 A.2d 811, 816 (D.C. 1995)). Courts also consider several factors:

> (1) the place of contracting; (2) the place of negotiation of the contract; (3) the place of performance; (4) the location of the subject matter of the contract; (5) the residence and place of business of the parties; and (6) the principal location of the insured risk.

See Adolph Coors Co. v. Truck Ins. Exch., 960 A.2d 617, 620 (D.C. 2008) (citing Restatement (Second) of Conflicts of Laws §§ 188, 193 (1971)). In *Adolph Coors*, the court held that Colorado law applied because that was where the insured was incorporated, the insurer was also headquartered outside of the District of Columbia, the parties had negotiated the insurance policy in Colorado, and the District of Columbia's only connection was that one underlying suit was filed there. *Id.* Similarly, in *Holmes v. Brethren Mutual Insurance Co.*, 868 A.2d 155 (D.C. 2005), the District of Columbia Court of Appeals considered the governmental interest analysis to determine that Maryland law governed a dispute for the following reasons:

> (1) the insured, Bingo World, is a Maryland corporation, as is the insurer, Brethren; (2) the policy was prepared in Maryland and delivered to Bingo World there; and (3) this is not a personal injury action based on the accident occurring in the District, but rather a suit concerning the scope of insurance coverage.

See id. at 157 n.2; *see also Vaughan*, 702 A.2d at 202 (applying Maryland law where insureds were citizens of Maryland, the vehicle involved in an accident was in Maryland, and that was also the location where the insurance rates are adjusted).

Finally, as discussed above, even where District of Columbia law would apply, the Court of Appeals generally looks to Maryland cases where there is no authority in the District on a particular issue:

> We have held that when 'there are no District cases squarely on point, . . . [and] [i]n the absence of appellate or other authority in this jurisdiction,' this court may give Maryland law special attention because the District 'was carved out of Maryland and derives its common law from that State.'

Hill v. Md. Cas. Co., 620 A.2d 1336, 1337 (D.C. 1993) (alteration in original) (citation omitted).

B. *Policy Ambiguities*

When disputes arise over the interpretation and application of insurance policy language, courts will often determine whether the language at issue is clear or ambiguous. Because an insurance policy is a contract, District of Columbia courts construe its terms according to contract law principles. *Carlyle Inv. Mgmt., L.L.C. v. Ace Am. Ins. Co.*, 131 A.3d 886, 894 (D.C. 2016) ("Contract principles are applicable to the interpretation of an insurance policy."); *Stevens v. United Gen. Title Ins. Co.*, 801 A.2d 61, 66 (D.C. 2002). The "first step" in the construction of an insurance contract is "to determine what a reasonable person in the position of the parties would have thought the disputed language meant." *Travelers Indem. Co. v. United Food & Commercial Workers Int'l Union*, 770 A.2d 978, 986 (D.C. 2001) (citation omitted). In determining whether a contract is ambiguous, District of Columbia courts examine the policy on its face, giving the language used its plain meaning, unless, in context, it is evident that the terms used have a technical or specialized meaning. *Beck v. Cont'l Cas. Co. (In re May)*, 936 A.2d 747, 751 (D.C. 2007) (*citing Tillery v. Dist. of Columbia Contract Appeals Bd.*, 912 A.2d 1169, 1176–77 (D.C. 2006)). The court adheres to an "objective

law of contracts," which means that courts will enforce language as written unless it is not "susceptible of a clear and definite meaning . . . in light of all the circumstances surrounding the parties at the time the contract was made." *Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 894–95 (citations omitted). In conducting that inquiry, District of Columbia courts will consult dictionary definitions of disputed terms. *See Hartford Fin. Servs. Grp. v. Hand*, 30 A.3d 180, 187 n.13 (D.C. 2011) (consulting Black's Law Dictionary for meaning of "damages").

If language has two reasonable constructions, courts will find the language ambiguous and can then consider extrinsic evidence, including relating to the parties' subjective intent. *See Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 895 (finding that where there is an ambiguity "external evidence may be admitted to explain the surrounding circumstances and the positions and actions of the parties at the time of contracting" (citation omitted)); *Sears v. Catholic Archdiocese of Wash.*, 5 A.3d 653, 661 n.15 (D.C. 2010) ("Extrinsic evidence of the parties' subjective intent may be resorted to only if the document is ambiguous" (citation omitted)). However, an insurance policy is not ambiguous merely because the insurer and the insured disagree as to the meaning of certain language or provisions. *Carlyle Inv. Mgmt., L.L.C.*, 131 A.3d at 894-95 (citing *Tillery*, 912 A.2d at 1176). The inquiry focuses on what a reasonable person would believe the language meant. *Id.* at 895 (*citing Travelers Indem. Co.*, 770 A.2d at 986).

Ambiguities in an insurance contract are construed in favor of coverage and against the insurer, who drafted the policy. *See id.* ("We follow "[t]he general rule applicable in the interpretation of an insurance policy . . . that, if its language is reasonably open to two constructions, the one most favorable to the insured will be adopted." (alteration in original) (citation omitted)); *Vaulx v. Cumis Ins. Soc'y, Inc.*, 407 A.2d 262, 265 (D.C. 1979) ("This resolution of ambiguities against the party who drafted the terms of the offer is especially suitable in the case of insurance contracts.").

In *Carlyle Investment Management, L.L.C.*, the court found ambiguous an exclusion in a directors and officers liability policy for claims arising out of "professional services." *Id.* at 895–97. The definition of "professional services" in the policy was complex, included eight subparts, and used several undefined terms. *Id.* at 895. Therefore, the court held that it was not clear what conduct of the insureds' constituted a "professional service" for purposes of the exclusion. The court held that this ambiguity meant that the exclusion did not apply and the insureds were entitled to coverage.

C. *Reasonable Expectations Doctrine*

Courts in various jurisdictions consider the "reasonable expectations" of insureds in interpreting policy terms. In other words, the courts look at what a reasonable insured would expect to be covered under the policy at issue. In the District of Columbia, the court will not consider an insured's reasonable expectations where a policy term or provision is clear and unambiguous. *See Redmond v. State Farm Ins. Co.*, 728 A.2d 1202, 1205–06 (D.C. 1999) (holding that where exclusion was clear the doctrine of reasonable expectations is inapplicable). However, where the court determines that the policy contains an ambiguity, the court will consider what the insured reasonably expected the policy to cover. *Id.* at 1206; *W. Exterminating Co. v. Hartford Accident & Indem. Co.*, 479 A.2d 872, 877 (D.C. 1984) ("We would agree that if the policy were ambiguous, then the objective reasonable expectations of Western should guide an interpretation of the insurance contract . . . .").

While the District of Columbia Court of Appeals has acknowledged this rule of interpretation, no decisions in the jurisdiction have expressly applied it. The United States Court of Appeals for the District of Columbia Circuit applied it in *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1044 (D.C. Cir. 1981). In *Keene Corp.*, discussed in § V.B., the court held that latent injuries that were "unknown and unknowable" to the insured at the time it purchased insurance must at least be covered by the policies in force when the injuries manifested themselves. *Id.* According to the court, to hold otherwise would be contrary to the insured's reasonable expectations. *Id.*

IX. COVERAGE FOR CYBER EVENTS

Generally speaking, cyber risks are risks involving or arising specifically from the use of computers or computer networks. Losses resulting from cyber risks may be covered under insurance policies specifically addressing cyber risks and under traditional insurance policies that can address a variety of risks, including cyber.

A. *Cyber Insurance Policies*

D.C. courts have not published any decisions involving coverage under policies designed to cover losses arising out of cyber-related events. Even outside of D.C., rulings concerning those policies are rare.

In one of the few examples, a federal court case in Arizona involved a breach leading to the disclosure of about 60,000 credit card numbers of customers of P.F. Chang's. *P.F. Chang's China Bistro, Inc. v. Fed. Ins.*

Co., No. CV-15-01322-PHX-SMM, 2016 WL 3055111 (D. Ariz. May 31, 2016). Under its "CyberSecurity by Chubb Policy," Federal Insurance paid P.F. Chang's more than $1,700,000 for costs related to the breach. In the lawsuit, the parties disputed coverage for another $1,929,921.57 that P.F. Chang's had paid to a third-party credit card processor pursuant to P.F. Chang's contractual obligation to reimburse the processor for damages related to the breach. For the coverage to apply, the policy required a claim against P.F. Chang's for a privacy injury, which the policy defined as an "injury sustained or allegedly sustained by a Person because of actual or potential unauthorized access to such Person's Record." The court concluded that it was the restaurant's customers that had suffered the privacy injury, not the credit card processor. Because the restaurant was seeking coverage for payments to the credit card processor and not to the customers, the payments were not covered under the "privacy injury" coverage.

A Utah federal court considered coverage under a "CyberFirst Policy" that Travelers had issued to Federal Recovery, a company that handled electronic data for its customers. *Travelers Prop. Cas. Co. of Am. v. Fed. Recovery Servs., Inc.*, 103 F. Supp. 3d 1297 (D. Utah 2015). Global Fitness, an owner and operator of fitness centers, had sued Federal Recovery for withholding portions of data related to Global Fitness's members. Federal Recovery sought coverage for that lawsuit under a portion of Travelers's cyber policy covering "any error, omission or negligent act." The court found no coverage because Global Fitness's complaint against Federal Recovery did not allege that Federal Recovery withheld the data because of an error, omission, or negligent act. To the contrary, Global Fitness's complaint alleged that Federal Recovery knowingly withheld the data. Thus, there was no coverage under the part of the policy covering "any error, omissions or negligent act."

B. Traditional Insurance Policies

Courts also have evaluated coverage for cyber-related losses under traditional insurance policies that cover a variety of risks, including cyber risks.

1. Publication

   General liability policies typically provide coverage for advertising injuries resulting from a "publication". When confidential, electronic information is lost or disclosed, an issue may arise regarding whether there was a publication of that material.

   Some of the cases involving non-cyber policies relate to whether confidential information has been "published" as that term is used in general liability policies. The decisions have come out both ways and, in part, turn on the applicable facts on policy language. *Compare Travelers Indem. Co. of Am. v. Portal Healthcare Sols., LLC*, 644 F. App'x 245 (4th Cir. 2016) (finding a publication of private medical records where those records were accessible on the Internet through a simple Google search even though there was no evidence that any third party in fact accessed the records), *with Zurich Am. Ins. Co. v. Sony Corp. of Am.*, No. 651982/2011, 2014 WL 3253541 (N.Y. Sup. Ct. Feb. 24, 2014) (finding no publication where third-party hacker and not policyholder had published confidential information because, according to court, the policy did not cover publications by third parties (as opposed to by the policyholder)), *and Recall Total Info. Mgmt., Inc. v. Fed. Ins. Co.*, 83 A.3d 664, 673 (Conn. App. Ct. 2014), *aff'd*, 115 A.3d 458 (Conn. 2015) (finding no publication where computer tapes had fallen out of a van transporting the tapes and the tapes were lost because there was no evidence that the confidential information on the tapes "was ever accessed by anyone").

2. Loss of or Damage to Code

   Certain general liability policies and property policies provide coverage for loss caused by direct physical loss or damage to property. There can be coverage under those policies for claims arising out of hacking or other cyber events because computer code or data may have been damaged or lost. One issue that arises is whether loss of or damage to computer code or data constitutes "direct physical loss or damage," as is generally required to trigger coverage. Some courts have found loss or damage in these situations. *NMS Servs., Inc. v. Hartford*, 62 F. App'x 511 (4th Cir. 2003) (finding erased data was "direct physical loss" covered under property policy); *Eyeblaster, Inc. v. Fed. Ins. Co.*, 613 F.3d 797 (8th Cir. 2010) (finding that frozen computers, pop-up ads, and commandeered browser constituted "property damage" because it was a loss of use of property); *Lambrecht & Assocs., Inc. v. State Farm Lloyds, 119 S.W.3d 16* (Tex. Ct. App. 2003) (finding that loss of computer code was "physical loss"). Other courts have found no loss or damage. *Am. Online, Inc. v. St. Paul Mercury Ins. Co.*, 347 F.3d 89 (4th Cir. 2003) (finding computer crashes resulting from software upgrade was not a physical loss to tangible property); *Camp's Grocery, Inc. v. State Farm Fire & Cas. Co.*, No. 4:16-cv-0204-JEO, 2016 WL 6217161 (N.D. Ala. Oct. 25, 2016) (finding no coverage for third-party claims following a point-of-sale attack where the claimants alleged harm to "intangible" data).

3. Crime Coverage

   Cyber losses can also involve criminal acts and, therefore, may trigger coverage under crime insurance policies or financial institution bonds. *See Retail*

Ventures, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 691 F.3d 821 (6th Cir. 2012) (finding coverage for data breach under crime policy); *State Bank of Bellingham v. BancInsure, Inc.*, 823 F.3d 456 (8th Cir. 2016) (finding coverage under financial institution bond for losses resulting from hacking even though one of three security measures was negligently left disabled and computers were mistakenly left running overnight). For example, courts have found coverage under a crime policy for losses resulting from social engineering schemes. *Medidata Sols. Inc. v. Fed. Ins. Co.*, No. 15-cv-907 (ALC), 2017 WL 3268529 (S.D.N.Y. July 21, 2017) (finding coverage under a crime policy for a cloud-based service provider's loss of $4.8 million resulting from an employee being deceived into transferring that amount as a result of a fraudulent email); *Principle Sols. Grp. LLC v. Ironshore Indem. Inc.*, No. 1:15-CV-4130-RWS, 2016 WL 4618761 (N.D. Ga. Aug. 30, 2016) (finding coverage under crime policy for company's loss resulting from employee's receipt of email from individual posing as executive of company and rejecting insurer's argument that fraud did not "directly" result in loss). Other courts have found no coverage for such schemes. *Am. Tooling Ctr., Inc. v. Travelers Cas. & Sur. Co. of Am.*, No. 5:16-cv-12108, 2017 WL 3263356 (E.D. Mich. Aug. 1, 2017) (finding no coverage under a crime policy for a manufacturer's $800,000 loss, reasoning that the fraudulent email that prompted wire transfers to fraudsters did not "directly" cause the transfer given intervening events). *See Apache Corp. v. Great Am. Ins. Co.*, 662 F. App'x 252 (5th Cir. 2016) (where fraudulent email was an "incidental" part of multi-faceted scheme, court found no coverage under crime policy because computer fraud did not "directly" cause the loss); *Aqua Star (USA) Corp. v. Travelers Cas. & Surety Co. of Am.*, No. C14-1368RSL, 2016 WL 3655265 (W.D. Wash. July 8, 2016), *appeal docketed*, No. 16-35614 (9th Cir. Aug. 1, 2016) (finding no coverage under crime policy for losses resulting from hackers posing as employees that led other employees to change account information due to exclusion that policy "will not apply to loss resulting directly or indirectly from the input of Electronic data by a natural person having the authority to enter the Insured's Computer System"); *Pestmaster Servs., Inc. v. Travelers Cas. & Sur. Co. of Am.*, 656 F. App'x 332 (9th Cir. 2016) (where transfer was fraudulently induced but made by authorized user, the court found no unauthorized transfer of funds and thus no computer fraud coverage); *Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 37 N.E.3d 78 (N.Y. 2015) (finding crime policy coverage applicable to "the use of any computer to fraudulently cause a transfer" did not apply to payments for fraudulent claims where losses resulted from submissions from authorized users and did not result from unauthorized access); *Taylor & Lieberman v. Fed. Ins. Co.*, No. CV 14-3608 RSWL (SHx), 2015 WL 3824130 (C.D. Cal. June 18, 2015), *appeal docketed,* No. 15-56102 (9th Cir. July 17, 2015) (finding crime coverage did not apply to transfers resulting from hacker posing as client because, according to court, fraudulent emails "did not immediately and without intervening cause result in loss").